MILLAN COMMITTEE REVIEW OF THE MENTAL HEALTH (SCOTLAND) ACT 1984

2nd consultation
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1: INTRODUCTION

The Millan Committee

1.1 The Millan Committee, chaired by the Rt Hon Bruce Millan, was set up by the UK Government early last year to undertake a comprehensive review of the Mental Health (Scotland) Act 1984. Its report will be submitted to the Scottish Executive.

1.2. The remit given to the Millan 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.”

1.3 Its membership is a reflection of the wide range of people who work with or are affected by mental health law: it includes people representative of users and carers; general and forensic psychiatry; social work; health board management; general medical practice; local authority management; nursing; the legal profession; the judiciary and the voluntary sector.

The work of the Millan Committee so far

1.4 Since its inception, the Millan Committee has been anxious to consult with as many of those with an interest in mental health as is feasible, in order to get a clearer picture of what people around Scotland would wish from a new Mental Health Act.

1.5 The consultation process has so far consisted of:

- 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.
A shorter Consultation Document aimed at users and 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. 202 responses were received.

“Have Your Say”, a consultation document aimed at people with learning disabilities. Around 600 copies were distributed via statutory and learning disability organisations, and 102 responses were received.

28 fact-finding visits around Scotland and northern England, during which the Committee spoke to health, legal and social work professionals; people with mental illnesses; people with learning disabilities; carers; and people working in the voluntary sector about their experiences with the Mental Health (Scotland) Act and their ideas for a new Mental Health Act.

3 day-long consultative events for users and carers, held in 3 different Scottish cities.

3 days of oral evidence-taking with a selection of organisations representative of a range of different interests.

3 day-long symposia on specific issues of interest: one on Learning Disability, one on Dementia, and one on Children’s issues.

1.6 The Committee has also gathered a wide range of evidence from other sources, and has commissioned some research specifically for this Review.

The 2nd consultation

1.7 The Committee is now coming to early conclusions about the shape that it thinks a new Mental Health Act might take. The Committee therefore wishes to consult again with those who have a stake in the legislation, to find out whether the directions in which the Committee is moving are acceptable (and if not, why not), and whether there are any other factors that the Committee should take into account in its deliberations.

1.8 Much of this document is set out in terms of the options that appear to the Committee to present themselves. There may be others: the Committee would be interested in hearing what they are and why respondents are in favour of them. When the Committee has reached a view, this is stated, and comments upon it are requested. On some issues the Committee has not yet reached a view: this is also made clear, and further advice sought from respondents.

1.9 Further copies of this document may be obtained from the Secretariat, and it is also available on the Millan Committee website:

www.scotland.gov.uk/millian

Responses should be sent to: The Millan Committee Secretariat
Room 335
St Andrew’s House
Regent Road
Edinburgh
EH1 3DG

Or in electronic form to: Millan.Committee@scotland.gov.uk

The deadline for responses is 25 May 2000.
2: Principles

2.1 The Committee has heard evidence that declaratory principles in legislation have proven useful in guiding those who use the law on a day to day basis. Principles are included in the Children (Scotland) Act 1995 and the Adults with Incapacity (Scotland) Act 2000. Mental health law is undeniably complex, and the Committee is of the view that it would be helpful to those who work with it to make the guiding principles, by which the rest of the legislation should be interpreted, clear.

2.2 The Committee is therefore minded to recommend that the following key principles are included in the legislation:

1. Non-discrimination
   People with mental disorder should wherever possible retain the same rights and entitlements as those with other health needs.

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

3. 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.

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.

The Committee has heard some concerns, however, that the principle of reciprocity might disadvantage voluntary patients by diverting resources towards those subject to compulsory interventions.

2.1 Do you think that the advantages of reciprocity outweigh any potential disadvantages?
5. Benefit
Any intervention should be likely to produce for the adult a benefit which cannot reasonably be achieved other than by the intervention.

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. 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 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.

8. Equality
All powers under the Act, particularly those relating to access to services, assessments and the provision of services shall be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national, ethnic or social origin.

9. 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.

10. Effective inter-agency communication
Service users are entitled to the benefit of effective sharing of information, consistent with the obligations of confidentiality and the law, amongst those involved in their care and treatment.

11. Child welfare
The welfare of a child with mental disorder must be paramount in any consideration of interventions which might be imposed on the child under a Mental Health Act.

2.2 Are there any of the above principles which you think should not be included?

2.3 Are there any of the above principles which you think should be formulated differently?

2.4 Are there any other principles which you think should be added?
The Name of the Act

2.3 The Committee has heard representations that calling the legislation a “Mental Health Act” is somewhat misleading, in that it refers, in fact, to mental disorders or disabilities of various sorts.

2.4 The Committee has heard that the positive protection and promotion of good mental health is a different activity to the protection and treatment of people with mental disorders.

2.5 Some have also informed the Committee that the name of the Act leads people to believe that mental illness is the only thing covered by it, instead of properly indicating that it includes other important areas (at present) such as learning disability and dementia.

2.5 Do you think that the name of the Act should be changed? If so, what do you think it should be changed to?
How should we define “mental disorder”?  

3.1 A broad definition of mental disorder is given in the Act at present. Mental disorder is defined as meaning “mental illness or mental handicap however caused or manifested.” In 1999, the words “including personality disorder” were added after the words “mental illness.” Promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs are expressly excluded from the definition of mental disorder.

3.2 The Committee is in favour of retaining a broad definition of mental disorder, and evidence has been presented to the Committee that this will permit access to mental health services for a range of people who may want or need them. (However, as at present, other criteria would need to be in place, in addition to mental disorder, before anyone could be subject to compulsory interventions. This is dealt with in Section 4.)

3.3 The term “mental disorder” has the advantage of making no assumptions as to the cause or permanency of the disability, and is flexible enough to encompass changes in diagnostic practice and custom. The Committee understands the concerns of some respondents who have given evidence to them that “mental disorder” is a stigmatising term. However, the Committee takes the view that any term used in legislation could be potentially viewed as stigmatising, particularly when it is linked in the public mind to detention and other compulsory measures, and that the key to changing attitudes does not lie in the terms used in the law, but in tackling public understanding of mental disorders.

3.4 An alternative might be to link the definition of mental disorder to a diagnostic system, such as ICD-10 or DSM-IV. However, given the regularity with which diagnostic systems are updated, the Committee does not favour this but suggests instead that guidance could refer in more detail to diagnostic systems and would be updated when necessary.

3.5 Within the definition of mental disorder, the Committee is considering the proposal that there should be three discrete categories. The proposal is that each of these should be broadly defined, again to give flexibility to the legislation. The Committee also proposes that there continue to be specific exclusions from the legislation. These issues, on some of which there has been considerable diversity of view, are outlined further below.
Categories of Mental Disorder

3.6 There are three sub-categories of mental disorder which the Committee is considering the inclusion of in the new Mental Health Act.

1) Mental Illness

3.7 This category would cover psychosis, and non-psychotic disorders such as anorexia nervosa, severe obsessive compulsive disorder and disorders of mood. It would also include dementia and acquired brain injury with associated mental symptoms.

3.8 The Committee takes the view that this term should be retained in the legislation in its current broad form and should not be more closely defined. This would continue to leave the primary legislation flexible enough to remain relevant to changing psychiatric practice over time.

2) Learning Disability

3.9 The Committee has not yet concluded its deliberations on whether learning disability should be included in a Mental Health Act. If it is, the Committee takes the view that it should form a separate category, “Learning Disability”, which would replace “Mental Handicap”, “Mental Impairment” and “Severe Mental Impairment” as defined in Section 1 of the current Act.

3.1 Do you agree that “mental disorder” should be broadly defined in the legislation (the detail of the three sub-categories of mental disorder, outlined below, notwithstanding)?

3.2 Are you happy that the detail of the diagnostic basis of this term be outlined in guidance and regularly updated?

3.3 Are you in favour of the continuation of “mental illness” as a sub-category of “mental disorder” and which, as at present, is not closely defined in primary legislation?

3.4 Do you agree that this category, “mental illness”, should include elements such as dementia and brain injury, as well as non-psychotic illnesses such as anorexia nervosa?

3.5 If so, do you think that “mental illness” is the appropriate term for this category, or how would you prefer it to be described?

3.6 Alternatively, do you think that mental illness should be narrowly defined to exclude disorders such as anorexia nervosa, dementia etc? If so, what provision should be made for people suffering from these illnesses?
3.10 The Committee anticipates that the Adults with Incapacity (Scotland) Act 2000, when implemented, will provide the legal framework for much of the necessary care and support for this vulnerable group. However, there are people with learning disabilities who will not be covered by its provisions, for a number of different reasons. The question is then what is the most appropriate legal framework for those amongst that group who require compulsory interventions.

3.11 The Committee’s provisional view at this time is that learning disability should continue to remain in the Act, as a separate category of mental disorder. However, the Committee is minded to recommend that further work be undertaken, by a body with appropriate expertise, to consider the implications of the Executive’s upcoming Review of Services for People with Learning Disabilities, and the nature of compulsory measures which may be appropriate for people with learning disabilities. The body would be specifically mandated to consider the questions of whether, over the medium to long term, learning disability should be removed from a Mental Health Act and whether a separate piece of legislation for learning disability should be framed.

Should learning disability be in the Act?

Problems with the inclusion of learning disability

3.12 The Committee has heard powerful evidence from the learning disability movement that people with learning disabilities should be removed from the Mental Health Act and instead covered by specifically drafted legislation.

- There is concern that the framing of the legislation has in the past and would in the future be driven by considerations of mental illness, and the specific needs of people with learning disability not thoroughly addressed.
- The view has been expressed to the Committee that challenging behaviours are, at times, the consequence of poor services or unskilled care, and that if services improved the need for containment or restraint would lessen.
- Since learning disability itself is not susceptible to medical treatment, the Act is largely used to deal with behavioural difficulties (sometimes, but not always, involving criminal offences). It can be argued that an Act with a primary focus on medical treatment is not the appropriate place to deal with such problems.

3.13 The Committee accepts that there is some validity in these concerns. Research into the use of the Act amongst people with learning disabilities suggests that the pattern of detention for this group is substantially different from the operation of the Act in relation to mental illness.

3.14 The Committee also notes that the Scottish Executive’s Review of Services for People with Learning Disabilities is to be published shortly, and that this may lead to major changes in services. Should the traditional “mental handicap” hospitals continue to diminish in size, the operation of the Act for people with learning disabilities may become increasingly problematic.

3.15 If the scope of the Mental Health Act changes (for example, by making provision for compulsory treatment in the community, and including psychological interventions
within specially regulated treatments), some of these issues may be addressed. Nevertheless, the Committee is anxious that learning disability should not remain as an afterthought, in a review led by mental illness considerations.

**The case for retention in the Mental Health Act**

3.16 There are some circumstances in which the use of Mental Health Act legislation may be appropriate for this group (certainly in preference to no legislation existing):

- Protection may be needed for those who are not prepared to accept treatment and who display challenging behaviours: protection both from risk of self-harm and for the safety of others.
- It can be difficult to distinguish between mental illness and learning disability. A period of assessment may be needed to understand the patient’s problems.
- Clear safeguards in law may be required for matters such as restraint and behaviour modification.
- Being included in the Mental Health Act may provide rights and access to services to people in this group which might have to be replicated elsewhere if the group were removed from the Act.
- When people with learning disabilities are involved in offending behaviour, inclusion in mental health law allows them the possibility of being dealt with through the healthcare, rather than the penal system.

**Definitions**

3.17 The Committee believes that the term “mental handicap” should be replaced by the term “learning disability”: both because it is regarded as more acceptable by service users and representative organisations, and because it is increasingly the term used by official bodies (it is the term used, for example, in the Scottish Executive’s forthcoming Review of Services).

3.18 As with the term ‘mental illness’, the Committee’s current view is that it would not be necessary or appropriate to define the term further. It is felt that the term would apply to people with a significant lifelong condition that started before adulthood, and affects...
their intellectual development. As well as people with conventional intellectual impairments, such as people with Down Syndrome, it could include people with conditions such as Aspergers Syndrome, if they require assistance to learn skills or to cope independently in the community.

3.19 The definitions of “mental impairment” and “severe mental impairment” given in the Act at present\(^5\) may not be appropriate or necessary.

3.20 The original purpose of the two definitions was to draw a distinction between those who were less severely impaired, who could only be detained if ‘treatable’; and people with more severe impairments, for whom treatability was not required. The Committee is considering the recommendation that, should people with learning disabilities remain subject to compulsory interventions under the Act, a ‘treatability’ criterion should apply in all cases. See Section 4, paragraphs 38-43.

3.21 Another difficulty with the current definitions is that they appear to make an inappropriate link between learning disability and abnormal aggressiveness.

3.10 Do you agree that the term ‘learning disability’ should replace ‘mental handicap’, ‘mental impairment’, and ‘severe mental impairment’?

3.11 Do you agree that the term should not be further defined?

Personality Disorder

3.22 Personality disorder is a term which covers a wide spectrum of conditions and into which a relatively large number of people fall (American studies have suggested a prevalence of between 5.9% and 13% amongst the general population\(^6\)).

3.23 Personality disorders are described in ICD-10 as:

“Deeply ingrained and enduring patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual or a given culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance.”

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\(^{5}\) Mental Health (Scotland) Act 1984, s1(2):

““mental impairment” means 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 cognate expressions shall be construed accordingly;

“severe mental impairment” means 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; and cognate expressions shall be construed accordingly; and other expressions have the meanings assigned to them in section 125 of this Act.”

3.24 In saying that, however, it should be acknowledged that there has for many years been debate amongst psychiatrists and psychologists about the causes and manifestations of personality disorders.

3.25 What is clear is that:

- The general term “personality disorder” covers a wide range of behaviours and characteristics.
- People with personality disorders form a needy group with high usage of psychiatric and psychological services.
- Most people with personality disorders pose no risk to anyone but themselves. The potentially dangerous group of people with severe anti-social personality disorder (which encompasses the concept of “psychopathy”) is only a tiny subset of the different types of personality disorder which exist.

3.26 Currently, personality disorder is mentioned in s1 of the Act, as a type of mental illness, and, by implication, in s17(1)(a) (“the mental disorder… is a persistent one manifested only by abnormally aggressive or seriously irresponsible conduct”). The Committee's proposal would be that the s17 definition be deleted, and, if it is to be retained in the Act, personality disorder should form a distinct category of mental disorder. The Committee also suggests that the Act should not contain a close definition of personality disorder, but instead should leave the definition broad, in the same way as it currently does for mental disorder and mental illness. This would allow for future changes in practice and definition amongst health-care professionals.

Should personality disorder be in the Act?

Arguments against personality disorder remaining in the Act

3.27 At present few people are admitted to Scottish hospital services with a primary diagnosis of personality disorder, and the Committee would expect that this would continue to be the case.

3.28 However, the Committee has heard serious concerns from some respondents about the inclusion of personality disorder in the Act at all:

Treatability

3.29 The evidence for the “treatability” of personality disorder is currently modest, and most treatments currently being undertaken and evaluated are psychosocial and thus difficult, if not impossible, to impose compulsorily. The Committee is given to understand that there is most evidence of success amongst people with borderline personality disorders, who tend to be greatly troubled by their disorders and are often very frequent users of psychiatric and psychological services. However, there is no body of evidence at present (that the Committee is aware of) that compulsory medical or psychological interventions can make a great difference to those who do not wish them, particularly those people with severe antisocial personality disorder.

3.30 Many clinicians take the view that personality disorder is untreatable, and should not, therefore, fall within the remit of an Act concerned with treatment. To go some way towards meeting this concern the Committee would recommend that, if personality

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7 As a result of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, s3(1)
disorder were in the Act, “treatability” should be a condition before any compulsory interventions for personality disorder can be put in place.

Capacity

3.31 If a capacity test were introduced (see further below), it is likely that almost all people with personality disorders would be assessed as being capable and would not, therefore, be subject to compulsory interventions under the Act.

3.32 The Committee will suggest below that although, in the main, under a capacity test, capable people would not be subject to compulsory interventions, it would be possible, in certain circumstances, to subject capable people with mental disorders who pose a serious risk to others to such interventions. However, concerns have been raised with the Committee that, this being the case and personality disorder remaining in the Act, medical practitioners will be asked to become “social policemen” responsible for the supervision and containment of people who are antisocial rather than ill. The issues surrounding serious offenders with personality disorders are being addressed by the MacLean Committee, but, in general, the Millan Committee is agreed that social control should not be a matter for health agencies.

Stigma

3.33 There are also serious concerns from some respondents, particularly in the voluntary sector, that “personality disorder” is a particularly stigmatising term:

- There is confusion in the public mind regarding personality disorder and its relationship to offending behaviour: it is not understood that the vast majority of people with personality disorder do not pose a risk to the public. The Committee would argue that there is a need for the public to be better informed about personality disorders in general.

- Personality disorder is a clinical concept. However, arguably, from a user’s perspective, to be labelled as being “personality disordered” is to have one’s own self fundamentally criticised and undermined in a way in which to be labelled as being “mentally ill” is not.

3.34 The Committee feels, therefore, that serious consideration should be given as to whether “personality disorder” is an appropriate phrase to use in legislation. It might be that it could be replaced with descriptions of life-long behavioural problems, for example.

Services

3.35 Despite personality disorder having appeared (albeit not explicitly) in the Mental Health Act for many years, evidence has been given to the Committee that being labelled as having a “personality disorder” has nonetheless served to deny some patients access to services. It is not clear to the Committee that this situation would change if personality disorder remained in the Act.

Arguments for personality disorder remaining in the Act

3.36 It might not be in the best interests of people with personality disorder to remove them from the protection and access to information, support and services that the Mental Health Act can provide under certain circumstances.
3.37 Although the evidence for treatability is currently modest, the Committee would not wish to hinder future developments in treatment.

3.38 There are also questions of uncertain or dual diagnoses: it has been argued that some whose condition and needs may not have changed but whose diagnosis changes to personality disorder can find themselves abruptly denied access to services.

3.39 Although long term compulsory interventions are unlikely to be appropriate in many cases, short term interventions to deal with a crisis or for assessment may well be appropriate.

3.40 At present it is possible for a person to be detained under one category of mental disorder and to have his detention later renewed, or, if a restricted patient, continued, under a different category. Also a diagnosis may change during a period of detention, yet the authority to detain continues on the basis of the original diagnosis.

3.41 The Committee intends to recommend that when the original category changes, there should be automatic recourse to the forum for appeals (see Section 10) to test the validity of ongoing detention.

3.12 Do you think that personality disorder should continue to be included in the Mental Health Act?

3.13 If so, do you agree that the definition should be broad, to allow for changes in definition and practice in the future?

3.14 If you do not think that personality disorder should be in the Act, what would the effect be for people, especially non-offenders, seeking medical or psychological help with their personality disorder?

Change in category

3.40 At present it is possible for a person to be detained under one category of mental disorder and to have his detention later renewed, or, if a restricted patient, continued, under a different category. Also a diagnosis may change during a period of detention, yet the authority to detain continues on the basis of the original diagnosis.

3.41 The Committee intends to recommend that when the original category changes, there should be automatic recourse to the forum for appeals (see Section 10) to test the validity of ongoing detention.

3.15 Do you agree that there should be an automatic review if the diagnosis of a mentally disordered person’s category of mental disorder changes?

Exclusions from the definition of mental disorder

3.42 The Mental Health (Scotland) Act 1984 states 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”\(^8\).

\(^8\) Mental Health (Scotland) Act 1984, s1(3)
3.43 The Committee has been considering whether these exclusions are still appropriate.

**Sexual orientation or behaviour**

3.44 The Committee accepts that sexual orientation or interests should not be a criterion for defining mental disorder.

3.45 However, terms used in the Act such as “promiscuity” and “immoral conduct” are dated and the Committee feels that these should no longer appear in mental health legislation.

3.16 Do you think that these terms relating to sexual orientation or behaviour should be removed from the legislation? Do you think that they should be replaced with any other terms?

**Alcohol or substance misuse**

3.46 The Committee again takes the view that these should not be sole grounds for treatment under the Act. However the Committee also feels that the use of drugs, alcohol or other substances should not debar a person from treatment if they are a feature of the person’s underlying mental disorder or have led to the development of a mental disorder.

**Anti-social behaviour**

3.47 The Committee takes the view generally that it does not wish mental legislation to be used for the social control of undesirable or criminal behaviour in the absence of mental disorder.

**Further Exclusion**

3.48 The Committee is further minded to incorporate an exclusion from the definition of mental disorders on the sole ground of “acting as no prudent person would act”, as suggested by the Scottish Law Commission in relation to Incapable Adults\(^9\), and as included in the Adults with Incapacity Act\(^10\).

3.17 Do you agree that:

- substance abuse;
- undesirable or criminal behaviour in the absence of mental disorder; and
- “acting as no prudent person would act”

should be specifically excluded from the legislation?

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\(^10\) Adults with Incapacity (Scotland) Act 2000, s1
4: Grounds for Compulsory Interventions

4.1 The Committee has not as yet reached a final view about what the grounds should be for compulsory interventions under the Mental Health Act. This is an area where the Committee would find further views particularly helpful. Mental disorder will clearly have to be present, but is not in itself a sufficient condition for undertaking interventions against the mentally disordered person’s wishes.

4.2 Apart from mental disorder, criteria for interventions under the 1984 Act are based on appropriateness, treatability and risk. They are also fundamentally based around detention in hospital.

Detention in hospital

4.3 The 1984 Act binds together compulsory treatment and detention in hospital and indeed this is fundamental to the drafting of the 1984 Act.

4.4 However, this link no longer reflects psychiatric practice. Most patients now live and are treated outwith psychiatric hospitals.

4.5 The Committee will deal later in this paper with compulsory treatment in the community. Whatever its final recommendations on the question of a Community Treatment Order may be, it is worth pointing out that leave of absence already involves compulsory treatment in the community which is incompatible with the link between compulsion and detention in hospital.

4.6 With the increased emphasis on community care generally, the Committee intends to recommend that the exclusive link in the Act between compulsory treatment and detention in hospital be removed.

Care Planning

4.7 The Committee is minded to recommend that compulsory interventions of whatever sort should always be linked to a Care Plan.

4.8 This Care Plan would give a detailed account of the level of service that the service user should expect and any compulsory element to the care. There would be a clear expectation in guidelines that any element of the Care Plan that involved compulsion would be kept to a minimum. Care Plans would apply both to detained patients in hospital and to any person subject to compulsory interventions in the community.

4.9 The Care Plan would be regularly reviewable by the forum for appeals (see Section 10).

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11 Mental Health (Scotland) Act 1984, s17
Appropriateness and Capacity

4.10 One of the tests for compulsory interventions is “appropriateness”. The Committee takes the view that this test is too vague to be ethically sustainable, and provisionally favours a change to some type of capacity test (or possibly another type of test with capacity as an element). However, the Committee would welcome comments on the form such a test should take. Appropriateness and the form a capacity test might take are outlined below.

Appropriateness

4.11 The Act states that a person can be detained in hospital if he is suffering from “a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital”\(^\text{12}\). The person must also fulfil the risk criterion\(^\text{13}\) (on which see paragraphs 26-37).

4.12 It has been argued that the “appropriateness test” should no longer have a place in the Act for a number of reasons:

- “Appropriate” is a rather general and vague term, and “necessary” suffers from the same disadvantage. The result is that the appropriateness test becomes rather circular in nature, effectively stating that part of the legal test for whether someone should be detained in hospital is whether that person should be detained in hospital.
- It is not a strong theoretical or human rights standpoint from which to argue that a compulsory intervention has been justifiable.
- It contributes to the binding together of hospitalisation and treatment.

4.13 However, militating in favour of some form of the appropriateness test is the fact that it is well known and understood by mental health practitioners. Some practitioners would also argue that, far from having contributed to any inappropriate detentions, the appropriateness test serves to give the necessary firm legal support to cases when it is clear to professionals that a mentally disordered person requires hospitalisation and treatment.

4.14 There is also a question of whether there is, in fact, any replacement criterion that could be introduced which would not be subject to even more difficulty. This is dealt with further below.

An Alternative to the Appropriateness Test

Capacity

4.15 The Committee is inclined to the view that capacity be used as one of the criteria to be taken into consideration before compulsory measures can be undertaken. However, it

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\(^{12}\) Mental Health (Scotland) Act 1984, s17(1)(a)

\(^{13}\) The risk criterion is that “it is necessary for the health and 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”: Mental Health (Scotland) Act 1984, s17(1)(b)
has not yet concluded its thinking on the questions of

- How capacity and risk should interrelate (see paragraphs 29-36); and
- Whether the capacity test should be modified by another factor.

4.16 A majority of respondents to the Committee’s first consultation document were in favour of the use of capacity as one of the criteria for compulsory measures.

4.17 The following are the justifications given for its use:

- Capacity has the advantage of possessing more intrinsic meaning than "appropriateness".
- A capacity test provides a specific and ethically justifiable reason for over-ruling a person’s autonomy, in that the person’s ability fully to exercise their autonomy has already been temporarily or permanently usurped by the mental disorder.
- It is consistent with how the law regards other types of general medical treatment (and the Principle of Non-Discrimination supports it in this regard).

Definition

4.18 Capacity to take a decision depends on being adequately informed about the nature and purpose of the decision and the likely effects of deciding one way or another. It also requires a perception of the relevance of the decision to the person and an ability to weigh the information in the balance to arrive at a true choice, rather than a choice which is determined by the effects of the disorder itself. Lack of insight in psychotic illness, for example, can therefore be a factor influencing a judgement of incapacity in relation to treatment and other decisions.

4.19 The Committee assumes that there would be a presumption of capacity, unless incapacity can be shown to be present.

4.20 As pointed out by a number of respondents, unwillingness to comply as a result of incapacity should not be confused with other reasons for reluctance to accept medication, such as unpleasant side effects.

4.21 The implication of a capacity test (which would interact with the risk criterion for detention, on which see paragraphs 26-37) is that if someone has capacity and nevertheless wishes to take a risk with their own mental health by not complying with treatment, they are freely allowed to do so, as in the case of physical illness.

Problems with the capacity test

4.22 Serious concerns about the capacity test have also been raised with the Committee.

- Many clinicians have taken the view, in relation to detention and treatment, that "capacity" is an amorphous concept with little real relevance to everyday practice (although, having said that, it is fundamental to the Adults with Incapacity Act). Capacity is a complex, multi-faceted concept which varies over time. It is hard for many people to understand and evidence has been given to the Committee that it is not straightforward for clinicians to assess.
The threshold at which someone would be declared incapable is not clear.

What would happen if someone had a level of capacity which fluctuated around the level at which someone may be declared incapable is also not clear.

The Committee would not wish that any capable person who needed access to services should be denied them because of the capacity test, and this would have to be made clear in guidance.

The complexity of capacity may leave a decision that someone is incapable to decide on issues of medical treatment open to regular legal challenges. However, this might have the positive effect of clarifying on precisely what grounds such a declaration may be made.

The concept of “a true choice” made by the patient also raises many questions: particularly how exactly that would be defined.

There are also questions over whether the introduction of a capacity test would have any effect on the practical implementation of detention procedures. Some people have taken the view that capacity would become no less circular a concept than appropriateness, and would be overridden by “lack of insight” to indicate a clinical viewpoint that the patient required compulsory treatment.

Some users have reported to the Committee that they would find being declared “incapable” stigmatising or even offensive. However, given that compulsory interventions are, unfortunately, necessary for some service users at times, the Committee is not convinced that any other term with the same effect would necessarily be any more welcome.

### Practical implications

4.23 If a capacity test were introduced:

- The Committee takes the view that for practical reasons Emergency/Assessment orders (such as the current s24/s25) should require the presence of mental disorder and risk of serious harm but only the “likelihood” that there is incapacity.
- A problem might be that it could restrict the extent to which the Mental Health (Scotland) Act could be used as a vehicle to divert mentally disordered offenders from the criminal justice system, for example by Hospital Orders.

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14 Adults with Incapacity (Scotland) Act, s1(6):

“For the purposes of this Act, and unless the context otherwise requires –

“incapable” means incapable of –

(a) acting; or
(b) making decisions; or
(c) communicating decisions; or
(d) understanding decisions; or
(e) retaining the memory of decisions,

as mentioned in any provision of this Act, by reason of mental disorder or of inability to communicate because of physical disability; but a person shall not fall within this definition by reason only of a lack or deficiency in a faculty of communication if that lack of deficiency can be made good by human or mechanical aid (whether of an interpretative nature or otherwise)”
There might be implications for Part X of the Mental Health Act (consent to treatment), which already differentiates between those who are detained and capable of consenting to treatment and those who are not capable of consenting to treatment.

There might be implications for mentally disordered young people. There is already legislation which allows for decisions on the capacity of young people\textsuperscript{15}, and it might not be straightforward in the case of young people with mental disorders to integrate the applicable pieces of legislation and decide upon their legal capacity.

Other options

4.24 It could be that a new criterion for detention, perhaps a modified appropriateness or capacity test, or perhaps something altogether different, is required for the new Mental Health Act.

4.25 Evidence has been presented to the Committee that capacity could have a part to play in any test but need not be more than one factor amongst others. A possible way to formulate this might be to require that the ability of the person to make judgements about his or her care or treatment must be significantly impaired, as a result of mental disorder. This would then be considered, alongside other factors, such as the nature and degree of risk, and the extent to which compulsory treatment is likely to reduce risk and/or restore the patient’s ability to make informed choices.

Risk

4.26 The Committee is persuaded that risk should continue to be a criterion for interventions under a Mental Health Act. However, the questions of what type of risk and to whom are rather more difficult.

Definition of risk

4.27 It may be that a wider definition of risk is appropriate than that contained within the present Act. The 1984 Act allows detention only where “it is necessary for the health or safety of that person or for the protection of other persons that he should receive such treatment [medical treatment in a hospital]”\textsuperscript{16}.

\textsuperscript{15} Age of Legal Capacity (Scotland) Act 1991
\textsuperscript{16} Mental Health (Scotland) Act 1984, s17(1)(b)
4.28 These criteria do not deal adequately with the situation of a patient, such as one with a hypomanic illness, where “health or safety” are less of an immediate issue than risk to financial affairs from unbridled spending, or reputation, from disinhibited sexual activity. A new, alternative phrase such as “risk of serious harm” could encompass these situations.

4.29 If a capacity test were introduced it might be appropriate for there to be a different level of risk to self and/or others required for compulsory interventions, dependent on whether the person is capable or incapable.

4.30 Where an individual is assessed as being incapable, it should be possible to intervene when it is deemed that there is risk of serious harm (either to the person’s health, personal safety or life, or to the safety of others).

4.31 However, serious problems arise with people deemed capable who pose a risk. This has been recognised by those who favour a capacity test for compulsory intervention. There are two alternatives:

- It could be that the presence of a risk of serious harm to others should be the only time when a capable person (unless an offender) should be subject to compulsory interventions. The risk of harm could be based on actual evidence from past behaviour of causing, or having been likely to cause, serious harm when ill. This is on the basis that a capable person who wishes to make decisions which might result in harm to him or herself should be given the right to do so as would be the case with a physical disorder.

- Alternatively, it could be that the presence of a substantial risk of serious harm to self or others could mean that a capable person could be subject to compulsory interventions. This would mean that a capable suicidal person, for example, could be subject to compulsory measures under the Mental Health Act (although only if they were mentally disordered). However, this could mean that people’s capacity to make decisions about their own treatment might be overruled on a regular basis, which could make the capacity test redundant. This problem could perhaps be overcome by making it clear that the overruling of a capable person who wished to harm him or herself should only be undertaken in exceptional circumstances.

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**4.7 Do you think that the current definition of risk should be broadened?**

**4.8 If so, what should it be broadened to? “Risk of serious harm”, or something else?**

**Level of risk**

4.29 *If a capacity test were introduced* it might be appropriate for there to be a different level of risk to self and/or others required for compulsory interventions, dependent on whether the person is capable or incapable.

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4.32 The Committee is interested in other ways in which the question of what criteria there should be for compulsion could be formulated.

4.33 The Committee notes that the UK Government recently published a Green Paper on the reform of the English and Welsh Mental Health Act\textsuperscript{17}. In contrast to the findings of the Richardson Committee\textsuperscript{18}, which based its criteria for compulsion on capacity, it contains a model of compulsory interventions based in a large part on risk, stating:

“The principal concern about this [the Richardson] approach is that it introduces a notion of capacity, which, in practice, may not be relevant to the final decision on whether a patient should be made subject to a compulsory order. It is the degree of risk that patients with mental disorder pose, to themselves or others, that is crucial to this decision. In the presence of such risk, questions of capacity – while still relevant to the plan of care and treatment – may be largely irrelevant to the question of whether or not a compulsory order should be made.”\textsuperscript{19}

4.34 It sets out one possible set of criteria for compulsory interventions as being:

- “The presence of a mental disorder which is of such seriousness that the patient requires care and treatment under the supervision of specialist mental health services;

AND

- That the care and treatment proposed for the mental disorder, and for conditions resulting from it, is the least restrictive alternative available consistent with safe and effective care;

AND

- That the proposed care and treatment cannot be implemented without use of compulsory powers;

AND

- Is necessary for the health or safety of the patient;

AND/OR

- For the protection of others from serious harm;

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\textsuperscript{17} Reform of the Mental Health Act 1983: Proposals for Consultation. (Department of Health, 1999)

\textsuperscript{18} Review of the Mental Health Act 1983: Report of the Expert Committee (Department of Health, 1999)

\textsuperscript{19} Reform of the Mental Health Act 1983: Proposals for Consultation. (Department of Health, 1999), p32
AND/OR

For the protection of the patient from serious exploitation” 20

4.35 As can be seen from this list, risk to self or others (the last three criteria) play a fundamental role, whereas incapacity does not feature.

4.36 As already indicated, the Committee is inclined to the view that capacity be used as one of the criteria to be taken into consideration before compulsion can take place. However, it would be interested to hear whether a scheme similar to that proposed by the Department of Health would be more favoured by respondents.

4.12 Do you think that the Scottish Act should replace the tests of appropriateness (or capacity) plus risk with a test based in a large part on risk, along lines similar to the DoH proposals?

Measuring risk

4.37 The Committee has received evidence that the current procedures for assessing risk are subjective, and rely strongly on clinical intuition. It has been heard that risk is not something which depends solely on the degree of mental disorder, but a variety of personal and social factors can influence it. It has been suggested to the Committee that the Act should support a more formalised and multi-disciplinary risk assessment, perhaps supplemented by guidance as to the use of appropriate risk assessment procedures.

4.13 Do you have any comments on how risk should be assessed?

Treatability

4.38 This criterion (“treatment likely to alleviate or prevent a deterioration of his condition”21) currently applies to people with:

- “abnormally aggressive or seriously irresponsible conduct” (essentially severe anti-social personality disorder); and
- mental impairment.

4.39 Much of the evidence presented to the Committee has suggested that the retention of this criterion would be appropriate for personality disorder (not just severe anti-social personality disorder) and learning disability, because detention without treatment serves no protective or therapeutic function for them and simply constitutes containment.

4.40 In relation to mental illness, it is assumed, and is implicit in the Act, that people being detained compulsorily should always be receiving treatment (in the widest sense).

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20 Ibid, pp32-33
21 Mental Health (Scotland) Act 1984, s17(1)(a)
4.41 The difference between mental illness and personality disorder/learning disability may be 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 learning disability, it has been argued that such detention is as at best containment, and at worst imprisonment.

4.42 However, there is an alternative view that all compulsory admissions should be with the intention of treatment, and that this is reflected in the proposed key principles. On that basis, an additional treatability test may be unnecessary.

4.43 The Committee has not yet reached a view on this matter.

4.14 Do you think that the treatability criterion should continue to apply to:

- people with personality disorder?
- people with learning disabilities?
5: DETentions Under the Act

Current legislative position

5.1 At the time the 1984 Act was passed, there was an assumption that the primary route into detention would be by a six-month detention, supported by two medical recommendations and approved by a Sheriff.22

5.2 The outcome has been different: in fact, emergency 72-hour detentions23 are used in the vast majority of cases as the route into detention.

5.3 There may be a number of reasons for this:

- The provisions for a six-month detention are perceived as complex by some practitioners;
- Applying for and having such a detention approved is too slow a process to be used in a true emergency;
- A six-month order may be unnecessary if the real need is for short-term assessment or care.

5.4 However, the Committee has serious concerns about the excessive use of emergency detentions:

- Not all such detentions appear to be being made in a true emergency situation.
- Such orders are for 72 hours of detention without the right to an appeal.
- There are questions over the status of someone who requires treatment during the time of their emergency detention. Emergency detentions are effectively admissions for assessment only, and any treatment undertaken during that time is not provided for in the Act, but is carried out under common law.

5.5 The Committee feels that for these reasons the numbers of emergency detentions must be substantially reduced.

Change in use of current emergency detention order

5.6 Although there would be advantages to having the length of emergency detentions reduced to, for example, 24 hours, the Committee’s view is that this may be impractical, as it does not take account, for example, of the availability of consultant psychiatrists. However, the Committee is strongly of the view that the law should be clear that the duration of emergency detentions should be kept to an absolute minimum. The Committee accepts, therefore, that for practical reasons the maximum

22 Mental Health (Scotland) Act 1984, s18
23 Mental Health (Scotland) Act 1984, s24 and s25
length of an emergency detention might necessarily have to continue to be 72 hours.

5.7 However, the Committee favours a change in the law’s provisions to allow a patient, once assessed by their RMO, to move straight onto a short term detention for treatment if that is considered necessary. This move would give the patient the right to an appeal as soon as he or she had been transferred onto a short-term detention, and would give the RMO a clearer legal right to treat if necessary. It could happen in one of two ways:

- If emergency detention is required, this need not last the full 72 hours, but would be superseded by short-term detention as soon as the necessary procedures have been followed.
- If the necessary assessments have already been made beforehand in the community, but there is still the need for a swift compulsory admission to hospital, the need for an emergency detention could be avoided altogether by a new provision allowing the patient to go straight from the community to short term detention.

**Length of short-term detention**

5.8 At present, in all parts of mainland Britain, a short-term detention, with the right of appeal, lasts for 28 days.\(^{24}\)

5.9 In England and Wales, the proposal by the Richardson Committee\(^{25}\) was that this should be replaced by a new provision for a 7-day assessment or assessment and treatment order, which would then be reviewed and could be extended, if required, for a further 21 days.

5.10 The Committee has not reached a conclusion on whether a short term detention should last for 7 days in the first instance, and whether an interim review at 7 days is necessary given that patients already have the right of appeal against their detention. Alternatively, short-term detentions could be granted for 28 days, on the understanding that if there was no further need for detention during that time the patient would be discharged.

5.3 Given that an appeal against short-term detention already exists, do you think that a short-term detention should last for 7 days (extendable up to 28) or should continue to be granted for 28 days?

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24 Mental Health (Scotland) Act 1984, s26 and Mental Health Act 1983, s2
Change in six-month detention order

5.11 Under the Act at present, detentions under the provisions of Section 18 (which are for six months, in the first instance, and are renewable on application) require two medical recommendations and the approval of the Sheriff.

5.12 In practice, many Section 18 detentions do not last as long as six months, the patient being discharged from hospital or becoming an informal patient.

5.13 It is an important point of principle that no patient should be kept under detention any longer than is absolutely necessary, and that the case of the patient (under whatever provision he or she is being detained) should be kept under continuous review to determine whether there is a continuing need for compulsory measures. The Committee intends to recommend that this should be explicitly stated in the Act.

5.14 Arguably, Section 18 could be reworked in some way in order to make it easier to obtain without prior emergency or short-term detention. However, this may not be practical, particularly as the Committee may recommend that Care Plans, as well as the legality of the detention, are to be considered by the Sheriff or Tribunal when approval and reviews of detentions take place. Section 18 detentions are most likely, therefore, to continue to be something that happens only after an initial period of detention and assessment.

Appeals

5.15 As has already been stated, there is no appeal against an emergency detention, but there are appeal procedures in place against both short-term detentions (s26) and long-term detentions (s18). A person subject to detention may make an appeal to the Sheriff or the Mental Welfare Commission for Scotland (MWC) for release at any time during their detention.\(^{26}\)

Short-term detention

5.16 Although patients have the right to appeal against their detention under Section 26, the Committee has heard evidence that the appeal procedure is not fast enough to make any material difference to the length of time patients are detained on such a Section. As a result, it may be that people are discouraged from using their right to appeal. The Committee would be interested in hearing whether there is any way in which the appeal procedure could be improved to encourage appeals against short-term detention.

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\(^{26}\) Mental Health (Scotland) Act 1984, ss 3(3), 26(6), 26A(6), 30(6) and 35
Form of appeal

5.17 An appeal can only be made against the person’s detention in hospital. There are no powers at present for a patient to appeal against specific elements of their care, nor for the Sheriff or MWC to require that changes be made to someone’s specific care package. It may be that, if compulsory measures are introduced in the community, the forum for appeals (see Section 10) should be asked to consider elements of the person’s care. In particular, the Committee intends to recommend that the forum for appeals be charged with approving or rejecting a Care Plan (see Section 4, paragraphs 7-9) and this may address this point.

Frequency of appeal

5.18 At present it does not appear that there is any limit on the frequency with which a patient may appeal their detention to the Sheriff or MWC. The Committee would be interested to discover whether this causes any difficulties in practice.

5.6 Are there any comments that you would like to make on the procedures for appeal?
6: **Compulsory Treatment in the Community**

6.1 The Committee has heard a great deal of evidence, from all sectors, that there are some patients who can manage reasonably well in the community whilst on medication but who may lack insight into their illness, and so will not comply voluntarily with their medication. If they do not require hospitalisation, the Principle of Least Restrictive Alternative supports the argument that they should be maintained in their own home if at all possible.

6.2 The Committee is considering whether to recommend the introduction of a new power to treat people, in certain specific circumstances, against their will in the community, but would welcome further views on this.

**Current Legislative Position**

6.3 There are currently two Orders which have relevance to care in the community.

**Leave of Absence**

6.4 Leave of Absence (LOA) already provides for an element of compulsion in the community. Leave of Absence involves the patient living outside hospital but being subject to recall if they refuse to take their medication. The provisions have a maximum length of 12 months, and the person is released from their obligation to take their medication at the end of that time (however, intensive follow-up by secondary psychiatric services is routinely undertaken).

6.5 Most consultees have argued that the arrangements for LOA work well, though some psychiatric opinion is against the limitation of Leave of Absence to 12 months.

6.6 The view of the Committee is that there should be no change in the Leave of Absence arrangements, but that Leave of Absence in any particular case should be terminated as soon as appropriate: the 12 month period should not be looked upon as a standard duration but as a maximum.

**Community Care Order**

6.7 Community Care Orders (CCOs), which were introduced in 1995\(^{27}\), have not proven popular with psychiatrists because there is no power to compel medication and they are also considered to be excessively bureaucratic.

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\(^{27}\) Mental Health (Patients in the Community) Act 1995
6.8 If the Committee recommends Community Treatment Orders, it would also suggest that its provisions include and replace those aspects of the CCO that work to improve co-ordination and co-operation between services and users.

Proposed Community Treatment Order

Who would a Community Treatment Order (CTO) apply to?

6.9 It is important to stress that the Committee would only envisage the use of such an Order for a small, specific group of mentally ill people:

- for whom it would be an alternative to compulsory hospitalisation;
- who have demonstrably relapsed whilst off medication in the community in the past; and
- 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 demonstrably been tried and failed.

What would a Community Treatment Order look like?

6.10 The Committee has agreed that, if a CTO were introduced, it should have certain key elements. These are:

- There would be 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.
- The CTO would be linked to a Care Plan, which would detail the services that the person would receive (see Section 4, paragraphs 7-9). This Care Plan would be approved by the forum for appeals (see Section 10). Any element of the Care Plan which involved compulsion should have to be kept to a minimum.
- There would be regular review of the need for the Order, and provision for regular appeal. There would also be the right for the patient to challenge individual parts of the Care Plan.
- There would be provision for specialist psychiatric assessment to take place outside a hospital setting: in this way people who may be suffering the onset of an episode of mental illness can be assessed, and potentially put on a formal Care Plan (which may include compulsory medication) without having to be taken from their homes into hospital for assessment.
- If a person who might be subject to these provisions would prefer to be treated in hospital to receive their treatment, they would have their wishes respected.
- There is a question of whether the Order need necessarily follow on directly from a period of hospitalisation (as Leave of Absence does at present) or whether it could be used without a person (who fulfils all the criteria given above) necessarily going into hospital first. The Committee anticipates that a majority of people subject to a CTO will go onto it on their discharge from hospital. However, it may be a needless disruption for some people, who are living in the community but are suffering the onset of a period of mental illness, to be transferred to hospital before being placed on a CTO.
What would the grounds for discharge from the Order be?

6.11 The Committee has agreed that the grounds for discharge from the Order should be:

- The patient has improved and the grounds for intervention no longer apply; or
- The patient now agrees the need for treatment; or
- The patient is now capable but still refuses treatment and there is no substantial risk to others.

Name of the Order

6.12 The Committee has used the phrase “Community Treatment Order” in its discussions on this matter. However, it could be that, given that the Order it proposes links intimately to Care Planning; is far more wide-reaching than dealing with medication alone; and includes such elements as rights to services, another name for the order would be more appropriate. The Committee has an open mind on this matter, although to indicate that it is a direct alternative to hospitalisation, “Hospital Alternative Order” is a possibility. “Community Alternative” has also been suggested.

6.6 Do you have any opinions on the name of the Order?
7: Patients’ Rights

Civil and social rights

7.1 The Committee has been considering questions of whether people with mental disorders face specific disadvantages in respect of their civil and social rights.

7.2 Since the Committee last consulted, a Home Office Working Party\(^{28}\) has recommended that people detained in hospital as a result of mental disorder should be allowed the right to vote. This recommendation has been accepted by the UK Government, which will be legislating on the matter in the near future. As a result, the Committee is no longer concerning itself with this issue.

7.3 The Committee has heard a great deal of evidence to suggest that stigma attached to mental health problems is a major problem for many service users. The Committee intends to recommend that a major programme of public education on the subject be undertaken, to challenge many of the common misconceptions and prejudices that exist about mental disorders.

7.4 The Committee is also concerned that people who are detained may face particular disadvantages in relation to access to benefits. In particular, the Committee has been informed that people on Leave of Absence may lose their entitlement to Housing Benefit, because they are deemed not to be discharged (although the Committee has not yet been able to investigate this).

7.1 Do you agree that the Committee’s report should recommend that action be taken:
- to address the stigma attached to mental health problems; and
- to clarify difficulties in respect of benefits for detained patients?

7.2 Do you wish to draw any other specific problems faced by mental health service users to the Committee’s attention?

Service provision

Rights to services for detained patients

7.5 As already indicated (Section 4, paragraphs 7-9), the Committee has agreed that any patient facing interventions against their will should have a formal, regularly reviewable
Regular multi-disciplinary needs assessments would be required by the reviewable nature of the Plan.

7.6 The Committee further considers that if a person had been detained, they should be entitled to a consideration of their aftercare needs.

Rights to services for non-detained patients

7.7 The Committee is minded to recommend that non-detained people with a mental disorder should have the right to request an assessment of their needs and a Care Plan, and this would be provided if required. However, the right to a Plan and an assessment would not be enshrined in primary legislation. To do so would differentiate voluntary patients in mental health services from patients with other health needs, which would run contrary to the Principle of Non-Discrimination.

Guidance

7.8 The Committee suggests that guidelines could outline what form an assessment or Care Plan should take for both detained and non-detained patients. This could include a statement that an assessment of needs could sometimes be carried out (or the lead be taken on it) by a CPN, an MHO or other professional rather than a psychiatrist. Guidelines could reflect minimum standards periodically set down by Clinical Standards Boards, the Scottish Health Advisory Service and the Mental Welfare Commission. Standards in guidance should be subject to regular reviews and updates.

Payment for services

7.9 The Committee takes the view that patients subject to compulsion should have the right to be treated in a safe environment and not to be forced to pay for certain aspects of their care (particularly accommodation and prescriptions) if they are being required to accept them. The Committee welcomes the recent guidance, issued by the Scottish Executive, which states that aftercare services which are provided by local authorities under Section 7 of the current Mental Health (Scotland) Act must be given free of charge29.

29 Scottish Executive Circular No: CCD2/2000, inserting Section 100.5A into the Executive’s Charging for Residential Accommodation Guide (CRAG)
7.10 There may be resource implications to not charging for any compulsory measures, particularly in the case of long-term places of residence in non-hospital settings. In addition, there are undoubtedly questions of whether this would serve as a perverse financial incentive for someone to refuse treatment unless given under compulsion.

7.11 However, the Committee takes the view that it is an important point of principle that someone should not be made to pay for a service that they are actively opposed to receiving.

Multi-agency working

7.12 The Committee has agreed that there should be a requirement for Health, Social Work, Housing and other bodies to co-operate in the delivery of Mental Health services. Such co-operation should go beyond just simply care planning and should also deal with care implementation. The Committee suggests that the detail of such a requirement might be best placed in a Code of Practice or other guidance, but it could be put, in general terms, in primary legislation.

7.13 Where this co-operation failed and the service provided to the patient was affected, there should be the right to an appeal by the patient to the Sheriff or Tribunal involved in the individual’s care plan.

Rights of Non-Detained Patients

7.14 There have been questions raised of whether specific safeguards need be put in place for non-detained patients.

7.15 The Committee has heard evidence that some non-detained patients may in fact be *de facto* detained because of fear of detention should they try to leave, or simply because they do not feel capable of protesting (although incapable patients who do not resist treatment are likely in the near future to be covered by the Adults with Incapacity Act).

7.16 The Committee has heard representations that the concept of “consent” as it is currently used to define someone as a voluntary patient should therefore be replaced...
by “evident willingness” to accept treatment and/or hospitalisation. It is minded to support such a move, which should clarify the position of such patients.

7.17 Rather than recommend that specific safeguards, different to those for detained patients, be put in the legislation for voluntary and informal patients, the Committee would favour the inclusion of such patients in many of the safeguards that it feels should be put in place for all patients, such as:

- Safeguards for certain irreversible or otherwise controversial treatments;
- Right to appropriate, comprehensible information;
- Right to advocacy;
- Protections applying to those being treated in settings other than hospitals; and
- Revision and strengthening of the Code of Practice.

An alternative view

7.18 Alternatively, it has been argued that there should be specific safeguards put in place in primary legislation for voluntary/informal patients. These would necessarily relate to voluntary patients not deemed incapable, since compliant incapable patients should fall within the provisions of the Adults with Incapacity (Scotland) Act 2000.

7.19 The argument against specific safeguards, in which the Committee sees some merit, is that such safeguards should be unnecessary if best practice is implemented and users are fully involved in their treatment.

Advance directives

7.20 Advance directives constitute an attempt, while well, for a person to make plans for his or her future treatment (usually medical treatment) when ill. Usually the scenario envisaged is a time in the future when, because of mental distress or illness, the person may not be able to take medical decisions for themselves.
7.21 In psychiatry, advance directives can take a variety of forms:

- A patient may have discussions with his or her consultant, who will record the patient’s wishes and preferences about treatment on the patient’s notes.
- A patient may fill out a “crisis card” naming people to contact in an emergency. They may ask the doctors to discuss the patient’s care with that person and the card may also specify types of treatment that the patient does or does not want.
- A patient may sign a “contract” with their consultant setting out the terms of their discharge from hospital and the sort of conditions which might result in the patient being recalled. The contract might spell out the patient’s preferences about future treatment.
- An advance directive could be a formal document, perhaps in a standard format, in writing and witnessed by, for example, a doctor or a solicitor.

Advantages of advance directives

7.22 There are several advantages to advance directives. From the patient’s point of view, advance directives represent a way of reducing uncertainty about the future and of giving the patient more control over their lives. If drawn up in partnership with their doctor, they can represent a way of negotiating treatment options, and can reduce the powerlessness many patients feel when faced with the psychiatric system. They are, in essence, a way of promoting patient autonomy.

7.23 From the doctor’s point of view, advance directives often reduce the need for compulsion by persuading patients to agree the type of symptoms which might necessitate their readmission. It has been shown that compliance with treatment is improved if patients understand the need for treatment and feel their views are listened to and respected. In addition, doctors are required to consider a patient’s preferences when deciding on treatment: an advance directive can assist in this.

Legal effect of advance directives

7.24 Whilst many people, and the vast majority of respondents to the first consultation, would want to see the encouragement of patients to plan and discuss for the future, there is less agreement about the kind of legal effect advance directives should have. The problems usually arise if the patient wishes to refuse treatment recommended by the doctor. Advance consents are not usually a problem.

7.25 Many people have argued that a valid advance directive, made when the person was well and understood what they were doing, should not be overruled by the compulsory powers of the Mental Health Act. This is in line with the general principle that capable persons are entitled to refuse medical treatment. Some have thus argued that someone, when well, should be able to refuse treatments for mental disorders they may suffer in the future, even in circumstances where this could result in death. However there are certain problems around this:

- It may be difficult to be certain that capacity was present at the time of making the statement.
- It is not clear what degree of information and understanding a person would need before making the statement. It could be argued that unless someone has
experienced mental illness and the procedure in question, it will be difficult to give informed refusal for the future.

- Treatments or a patient’s circumstances may change between the making of the advance directive and the events in question.
- It is not clear for how long an advance directive should be valid.

7.26 A solution, which the Committee presently favours, would be that advance directives should be binding unless the result of a refusal to accept treatment would be to put the patient’s life in danger, or if others were at risk. It would also be possible to refuse to comply with an advance directive if not satisfied that it is valid (for example, if there is evidence that the person was not competent at the time it was entered into). A doctor would have to be prepared to justify a refusal to comply with an advance directive.

**An alternative**

7.27 Alternatively, there could be an assumption that doctors will take account of the provisions of a patient’s advance directive, and the Code of Practice would detail the expectation that doctors would comply with the provisions wherever practicable. However, there would be no statutory requirement for doctors to do so.

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7.12 Do you think that advance directives should be binding unless the results of a refusal would put the patient’s life in danger or put others at risk? Or are there any other circumstances which would lead to them not being binding?

7.13 Alternatively, do you think that advance directives should have no legislative status except for an expectation that they will be considered?

7.14 Or do you think that advance directives should operate in some other fashion?
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**Advocacy**

**Individual advocacy**

**Right to advocacy**

7.28 The Committee has heard a great deal of evidence that advocacy is a key ingredient of modern mental health care. The Committee has therefore agreed that there should be a right to advocacy for all service users. This would include patients regardless of their legal status and whether they were in hospital or in the community.

7.29 The Committee is aware that the Deputy Minister for Community Care announced on 18 February that the Scottish Executive was to fund an Advocacy Development Worker to work
with local health and social work services to develop an integrated advocacy service for every Health Board area in Scotland. The Committee welcomes this development.

The operation of the right to advocacy

7.30 The Committee is aware that advocacy is a broad concept, the practice of which continues to develop. Therefore, it would not suggest that a particular type of advocacy be specified in the legislation. However, standards for advocacy might be detailed in guidance.

7.31 The Committee takes the view that services would be obliged to ensure that information regarding advocacy is freely available to users, and that they are encouraged to use the service. It would then be up to the patient to decide whether he or she wants an advocate.

Access by advocates

7.32 The Committee has heard the case made that an advocate should have as much access to medical notes; information; therapeutic sessions; ward rounds (etc) as the patient wishes. However, there are serious concerns from clinicians that the presence of a third person during, for example, a clinical session, could compromise the treatment that is being given.

 Provision of advocacy

7.33 The Committee is minded to recommend that there should be an obligation on service providers to facilitate the development of and ensure the availability of advocacy.

7.34 The primary responsibility for the quality of an advocacy service would lie with the body contracted to undertake the advocacy. However, the ultimate duty to ensure quality and availability of service could lie with the Health Board and/or Local Authority, as purchasers of services. This duty would be framed in such a way as to avoid any suggestion that purchasers were entitled to control or direct the operation of independent advocacy services.

An alternative view

7.35 A statutory nationwide advocacy body could be set up to run and/or monitor advocacy services. Alternatively, this task could be given to the Mental Welfare
Commission. However, the Committee currently takes the view that advocacy is best supported at local level, with assistance from central agencies when necessary. This would serve to support local practice best suited to individual circumstances. There is a possibility that there could also be external inspection of services to complement this.

### 7.17 Do you agree that a statutory responsibility for ensuring that advocacy is available and ensuring its quality should be introduced?

### 7.18 If so, should this responsibility lie jointly with Health Boards and Local Authorities?

### 7.19 Alternatively, do you think that there should be a central body for the promotion of advocacy?

### 7.20 If so, would it provide services, or monitor their quality, or would it have some other function?

#### Collective advocacy

7.36 Collective advocacy can be defined as users, perhaps facilitated, acting on behalf of a group to pursue their views. Collective advocacy does not simply mean Patients’ Councils in hospitals, but, increasingly, means self-advocacy by groups of users in the community.

7.37 The users’ movement is a powerful force for change. Some groups complain that they are not recognised as a legitimate voice for users by those working in the statutory sector. However, the Committee has heard representations from such self-advocacy groups which suggest that it is counterproductive to have users’ groups set up by statutory organisations. Instead, they should evolve in response to local needs, being given support as necessary.

7.38 Therefore, the Committee takes the view that collective advocacy groups should be recognised as having a legitimate input into decision-making by statutory organisations, but should not be set up by them.

### 7.21 Do you agree that collective advocacy groups should be given recognition by statutory organisations?

### 7.22 If so, should they be independent or should statutory organisations call them into being?
8: PROTECTION OF VULNERABLE PEOPLE

Special Treatments to be included in the Act

The Options

8.1 The Committee is persuaded that certain treatments require particular safeguards to be put in place. Examples of these treatments might be psychosurgery; medication at levels outwith the recommended range; behavioural modification; restraint and ECT.

8.2 There are several ways in which this protection could be legislated for:

- Treatments and their safeguards could be specified in primary legislation (i.e. in the Mental Health Act itself). This is a clear, open way in which to put protections in place, and the provisions would be fully scrutinised by Parliament. However, the Act is unlikely to be amended frequently enough to keep pace with changes in psychiatric and other practice, and new treatments, which might excite as much controversy as some present treatments, would not then attract special protections.

- The Act could specify the characteristics which all “special” treatments share. Treatments which had those characteristics (an example of such a characteristic might be “irreversibility”) would then fall under the protections specified in the Act. This would make the Act flexible enough to account for changes in practice in the future, but raises the question of what those shared characteristics might be and whether there might be confusion over which treatments are included and which are not.

- The Act could be non-specific, in the way detailed above, but Regulations, which also have the force of law, could go into specifics on treatments and safeguards. The advantage of using Regulations is that they can be updated as required, to take account, for example, of new treatments becoming available. However, they are less subject to Parliamentary control, since they cannot be amended by Parliament but only approved or rejected. There might then be some doubt over whether this is appropriate when very controversial treatments are in question.

- The Code of Practice could contain advice on protections that should surround certain treatments (as CRAG good practice guidance does relating to ECT and voluntary patients). However, the Code of Practice does not have the force of law, and so anything contained within it is advisory only.

8.3 The main options appear to the Committee therefore to be either:

- to name certain treatments in the Act itself, supplemented by Regulations; or
not to name any treatment in the Act (although possibly to outline the characteristics of “special” treatments) but to use Regulations to give protections for all “special” treatments.

8.4 In the light of these various considerations, the Committee is interested in views as to whether it is possible to clarify, in primary legislation, the broad criteria which would determine whether a type of treatment required specific safeguards.

- **8.1 Do you think that the Act should detail the broad criteria for special treatments?**
- **8.2 If so, what would those criteria be?**

8.5 The Committee is inclined towards the recommendation that certain treatments which have irreversible consequences (e.g. psychosurgery) should be specifically identified, by name, in the Act itself. The Committee also recognises that certain other treatments excite such controversy (e.g. forcible feeding, ECT, behaviour modification and some forms of restraint) that they should perhaps also be specifically mentioned in the Act.

- **8.3 Do you think that certain treatments should be named in the Act itself, instead of in regulations?**
- **8.4 If so, which treatments would this be?**
- **8.5 Alternatively, do you think that all special treatments should be detailed in Regulations, and the Act’s provisions should be more general?**

**Code of Practice**

8.6 The Committee feels that the Code of Practice should underline the requirement for all treatments, and their potential consequences, to be discussed fully with the patient.

8.7 The Code of Practice could also give general advice on how to approach these treatments, and might possibly mention other special treatments over which practitioners should take particular care.

- **8.6 What do you think the Code of Practice should say about special treatments?**
Safeguards

8.8 At present, the Act details treatments which require consent and a second opinion (it names psychosurgery and Regulations add surgical implantation of hormones to reduce sex drive\(30\)) and others which require consent or a second opinion (drug treatment (after the latter has been being given for three months) and, by Regulation, ECT\(^{31}\)).

8.9 The Committee has not yet reached a firm view on what additional safeguards there should be for special treatments. It may be appropriate, as in the present Act, to have a range of safeguards, which could apply for different treatments. The range might include:

- A second opinion;
- A second opinion plus consent; or
- Approval by the court or other forum.

8.10 It has been suggested that patients capable of consenting who do not wish to have certain treatments should never be overruled, and that for patients subject to compulsion who are incapable of consenting, the normal safeguard would be that their wishes should be taken account of and a second opinion sought.

8.7 What do you think the safeguards for special treatments should be?

Treatment of adults with incapacity

8.11 The Adults with Incapacity (Scotland) Act 2000 includes a provision giving medical practitioners the authority to do “what is reasonable in the circumstances” to give medical treatment to safeguard or promote the physical or mental health of an adult with incapacity.

8.12 The authority to treat will include treatment in a hospital setting. It will therefore cover treatment for mental or physical conditions for mentally disordered patients who are not detained, and will also apply to treatment for physical conditions for detained patients. Under the provisions of the 2000 Act:

- Any medical practitioner (not necessarily Mental Welfare Commission-approved) can assess the patient as incapable and provide necessary treatment. The Act includes provision for appeal to the sheriff against an assessment of incapacity for an adult;
- Excepted treatments and their safeguards will be specified in regulations. Consultation on such treatments and safeguards is to be carried out later this year. The Committee understands that the Scottish Executive presently proposes that psychosurgery, ECT and surgical implantation of hormones and sterilisation should be regulated;

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\(30\) Mental Health (Scotland) Act 1984, s97
\(31\) Mental Health (Scotland) Act 1984, s98
The authority to treat specifically excludes:
  – the use of force or detention unless it is immediately necessary and only for as long as necessary; and
  – placing an adult in hospital for treatment of mental disorder against their will.

Welfare guardians and attorneys with powers in relation to medical treatment may consent to treatment on behalf of an adult but may not consent to excepted treatments on their behalf, or consent to treatment on a detained patient which would be covered by Part X of the Mental Health (Scotland) Act 1984.

8.13 The Committee’s general view is that there should be a consistency of approach between treatments which have special safeguards under the Adults with Incapacity (Scotland) Act, and special treatments under the Mental Health Act.

8.14 It has been suggested that this might not be practicable in every case. In particular, the Mental Health Act requires a second opinion for drug treatment for mental disorder, given to a detained patient for over 3 months, if the patient has not consented. The committee has received evidence that the number of people in the community who are not capable of consenting to long term medication for mental disorder is such that this would impose an unduly heavy burden on the limited number of approved second opinion doctors. On the other hand, it has also received representations that there is evidence of over use of such medication, particularly in relation to patients with dementia.

8.15 One possible option would be that a second opinion would not be mandatory in every case, but could be insisted upon, whenever requested by a relative, carer or advocate.

Voluntary capable patients

8.16 Another issue, which may require further consideration, is whether there are any treatments which are so significant in their implications that they require special safeguards even where the patient is neither incapable, nor subject to compulsory measures under mental health law. For example, it has been suggested that psychosurgery should never be carried out on anyone without having been first authorised by the Mental Welfare Commission (this is the current practice, but on a non-statutory basis).

8.8 Do you have any comments on:
  • the relationship between safeguards for special treatments in mental health law, and those in the Adults with Incapacity (Scotland) Act 2000?
  • the suggestion that some treatments may require special approval, even where the patient is neither incapable, nor subject to compulsion?
Restraint

8.17 The Committee takes the view that in the case of restraint falling short of ‘detention’ additional safeguards are primarily a question of good practice. A Code of Practice could incorporate controls on the use of restraint, such as setting of standards and policies, inclusion in care plans, inspection and registration. The Committee suggests that there could be a formal obligation on hospital and residential authorities to have a written policy on restraint, which could be monitored by the Mental Welfare Commission.

8.18 The Committee further suggests that there should be no restraint which effectively constitutes detention without the use of formal detention procedures.

8.9 Do you agree with these recommendations on restraint?

Sex and the Mental Health Act

Current legislative position

8.19 Two sections of the current Act contain protections against sexual abuse: one forbidding sexual relationships with women with significant learning disabilities\(^{32}\), and another which forbids sexual relationships between male staff members and patients\(^{33}\). There is protection for men against homosexual abuse in the Criminal Law (Consolidation) (Scotland) Act 1995\(^ {34} \).

8.20 The general effect of these sections is as follows:

- Sex (outwith marriage) with a woman with significant learning disability is potentially a criminal offence, unless the person did not know of the disability.
- It is an offence to ‘procure’ or ‘encourage’ such a woman to have unlawful sex.
- It is an offence for male staff of nursing homes and hospitals to have sex with women (or men) who are receiving treatment for any mental disorder (mental illness or learning disability).
- A male homosexual act is presumed to be illegal if one of the participants is ‘suffering from a mental deficiency of such a nature and degree that he is incapable of living an independent life or of guarding himself against severe exploitation’.

Criticisms of current law

8.21 However, serious concerns have been expressed to the Committee about the current legal framework. Most importantly, s106, in its focus on protections against sexual abuse, seriously compromises the fundamental human rights of people with learning disabilities to a sexual life. Furthermore:

- Mental Health Act protection does not apply equally to men who may be sexually abused.

\(^{32}\) Mental Health (Scotland) Act 1984, s106
\(^{33}\) Mental Health (Scotland) Act 1984, s107
\(^{34}\) Criminal Law (Consolidation) (Scotland) Act 1995, s13
What would a new framework look like?

8.22 The Committee believes that special protections against abusive or coercive sexual relationships should be in place for those made vulnerable by mental disorder. However, the Committee takes the view that a more balanced approach is required in the Act.

8.23 One way forward would be to create a new offence similar to the offence of abuse of trust in the Sexual Offences (Amendment) Bill currently before the UK Parliament. This Bill makes it an offence for a person aged 18 or over to have sexual intercourse or engage in other sexual activity with a person under that age where they are in a “position of trust” in relation to the younger person. A position of trust could exist if the younger person was detained in an institution and the older person worked there in a caring, training, or supervisory role, or if the younger person was in residential care, a nursing home or hospital and the older person worked there. Similar protections will be available in educational settings.

8.24 In mental health law, the position of trust test could cover people in hospitals, nursing homes, residential care and other settings as well as day hospitals and people with learning disabilities attending training projects. As with the current law, people who were guardians or who supervised community treatment services would also be regarded as in positions of trust.

8.25 However it may be that this test does not go far enough to protect people who are vulnerable because of mental disorders. They may be vulnerable to exploitation by other residents, visitors to the hospital or home or people they meet in the community. The Committee would like to recommend a test which looks more at the quality of the relationship between the two parties.

8.26 The Committee is therefore minded to recommend that the Act’s provisions relating to sexual relationships should be revised as follows:
• They should be based on capacity to agree to sexual relationships.
• It would be an offence to have a relationship with a woman or man who, because of mental disorder, was unable to understand the nature of their act and its consequences.
• It would be an offence to have sexual relations with a person unable to make a free choice because of vulnerability or suggestibility.
• The provisions should apply equally to men and women who are vulnerable, and to assaults of heterosexual or homosexual nature, including lesbian assaults.
• Relationships with staff and paid carers should continue to be prohibited on the basis that they are potentially exploitative, though the current provisions prohibiting relationships between patients and staff need to be revised to reflect the wide variety of places in which a person with a mental disorder may find themselves receiving care.
• The defence that the accused person did not know about the person’s disability should continue.

8.27 It may be that an effective way to achieve a balance between the right to sexual self-expression and the right to avoid abusive relationships would be to supplement the legislation by the drafting of guidelines, approved by the police and Crown Office. Such guidance would stress the importance of multi-disciplinary assessments of people’s ability to consent to sexual relationships and their ability to make free choices.

8.10 Do you agree that the law relating to sexual abuse of people with mental disorder should change to the form suggested?

8.11 If not, how do you suggest that the law handles cases of sexual abuse of people with mental disorder?

Children and young people

8.28 Children and young people are subject to the provisions of the Mental Health Act, but are nowhere mentioned in it. The Committee believes that there will continue to be a need for this small number of young people to be subject to compulsory measures of care because of their mental state. This should be provided by mental health legislation, which contains detailed safeguards of key importance for this vulnerable group.

8.29 The Committee intends to recommend that future mental health legislation specifically recognises the special needs of children and young people, probably by containing a special section or sections which address these issues.

8.30 The Committee is considering recommending that there should be a requirement that children and young people should be cared for in age-appropriate settings. This would
not include adult in-patient wards. Special consideration should be given to the needs of 16-18 year olds, who, while no longer legally “children”, may not be appropriately cared for in adult facilities.

8.31 The Committee has received powerful evidence about the shortage of specialist mental health services for children and young people, when set against the template of services contained in the Framework for Mental Health Services. In particular it noted the lack of adolescent forensic psychiatry services (which means that young people with these needs may have to receive care outside Scotland). The Committee is, therefore, considering recommending imposing a statutory duty on health boards to ensure that there are adequate services for children and young people in their areas.

8.12 Do you agree that the Mental Health Act should require special provision to be made for the mental health needs of children and young people?

8.32 The Committee notes the complexities caused by the interaction of legislation on child protection issues and mental health legislation and the difficulties involved in having two different systems of legislation for children at risk. The Children (Scotland) Act 1995 and the Children’s Panel system are not involved if a child or young person is detained under the Mental Health Act, but some of the safeguards in that system could be of use to children who are mentally disordered.

8.33 Similarly, the Committee is concerned to ensure that children and young people subject to compulsory measures of supervision under the Children (Scotland) Act, perhaps because of challenging behaviour, have their mental health needs met. The Committee has not yet reached a final view as to whether better co-ordination of the two systems, including multi-disciplinary assessment, requires legislation, or whether this is a question for a Code of Practice or other guidance, but would welcome comments.

8.13 Do you agree there is a need for better co-ordination of the legislation for children at risk and mental health legislation?

8.14 If so, can guidance be contained in a Code of Practice or in some other way, or is new legislation required? What might any such guidance or legislation say on these issues?

8.34 The Age of Legal Capacity (Scotland) Act 1991 has a complex interaction with mental health legislation. It authorises doctors to treat competent children and young people without their parents’ consent. However there remains some concern whether a refusal of treatment by a competent young person will be similarly respected. This is particularly difficult in the mental health field, as the illness itself may reduce the young person’s ability to consent. There are concerns about using parental consent in such situations, as the young person may, rightly or wrongly, claim that their parents are the cause of their distress.
8.35 The Committee is therefore considering the recommendation that a new Mental Health Act should make it clear that if a young person appears to resist necessary treatment for a mental disorder, the provisions of the Act should be used as necessary rather than reliance being placed on parental consent. This should be the case whatever the age of the child or young person, provided the grounds for compulsory intervention otherwise applied. The young person in that situation would then have the benefit of the safeguards provided by the Act, such as second opinions, right to appeal to the sheriff or forum and the protective role of the Mental Welfare Commission.

8.36 Concern was expressed on consultation that certain irreversible treatments or treatments regarded as controversial, such as ECT, should not be given to young people without their consent. The Committee is not currently minded to exclude any treatments completely for any group of people, on the grounds that there might be circumstances where there is a pressing medical need to give such treatments. However the Committee does wish to consider whether further safeguards are needed for specific treatments for children beyond these required by the Adults with Incapacity Act. For example, the current good practice guidance on ECT recommends that if ECT is given to a young person under the Mental Health Act, a third medical opinion be given by a consultant specialising in child and adolescent psychiatry. The Committee would be inclined to support the use of such safeguards but would welcome further comments.

8.37 The Committee was urged to ensure that the principles of the UN Convention on the Rights of the Child are incorporated into the new Mental Health Act. Most of these principles would be included if the recommendations the Committee have made in Section 2, setting out general principles for the Mental Health Act, were accepted. These recommendations also include the specific principle that in any consideration of an intervention where a child or young person is involved, the welfare of the child should be paramount.

8.38 The Committee was concerned to hear of the difficulties faced by young carers who look after parents or other adults with mental disorders. It is anxious to establish that they receive the help they need. The Committee is currently inclined to the view that such help should be provided under the provisions of the Children (Scotland) Act, but would welcome further comments.
8.19 Do you agree that protection of young carers should be by means of the Children (Scotland) Act rather than a matter for mental health law?

Women, members of ethnic minorities and people with physical and sensory disabilities

8.39 The Committee acknowledges that women, members of ethnic minorities and people with physical and sensory disabilities have specific needs when they have mental disorders, and that these may not be adequately addressed by the legislation and by all services at present.

8.40 The two principles of Respect for Diversity and Equality may place on services an obligation to provide services appropriate to people’s specific needs, taking into account:

Women

• the need for single-sex accommodation, which has been highlighted as key by many respondents; and
• appropriate services for the family where there are children; and

Members of Ethnic Minorities

• the need for translation and interpretation services if required (which is also suggested by the principles of Participation and Provision of Information); and
• the need for the provision of information in community languages; and
• the effect and importance of religious or cultural imperatives; and

People with Physical and Sensory Disabilities

• where a person has a disability and has concomitant needs, how these are to be provided for;
• in particular, the need for interpretation and other services for some people with sensory disabilities.

8.41 The above may be a matter for legislation or a Code of Practice, or it may be that any obligations should be placed on authorities in another fashion, given that it may be difficult to ensure that all types of service are available in all parts of Scotland.

8.20 Do you think the provision of these particular services to women, members of ethnic minorities and people with physical and sensory disabilities should be required as a matter of law?

8.21 If not, how could the requirement to provide them be enforced?

8.22 Do you think that there are any other services which service providers should be obliged to deliver to women, to members of ethnic minorities or to other particular groups?
The interface with Adults with Incapacity and Vulnerable Adults

Adults with Incapacity (Scotland) Act 2000

8.42 The Adults with Incapacity (Scotland) Act 2000 was passed by the Scottish Parliament on 29 March 2000 and will shortly receive Royal Assent. The Act will be implemented progressively in stages from April 2001 to April 2002.

8.43 The 2000 Act makes provision as to the property, financial affairs and personal welfare of adults who are incapable by reason of mental disorder or inability to communicate. Provisions regarding medical treatment are dealt with earlier in this Section, paragraphs 11-15. In addition:

- Mental Health Act guardianship will be replaced by the new form of welfare guardianship introduced by the 2000 Act which will allow the welfare powers to be matched to the specific needs of the adult;
- Appropriate powers and duties are given to the Mental Welfare Commission to exercise protective functions in relation to any adult with incapacity with an intervention order or a welfare guardian and who is incapable by reason of, or by reasons which include, mental disorder (replacing those powers currently held under the 1984 Act); and
- Hospital management of patients’ funds will be replaced by new financial management powers for establishments (including hospitals).

8.44 The Committee has already made its views known to the Executive on the provisions of the Bill (as it then was) in relation to financial and welfare issues.

The draft Vulnerable Adults Bill

8.45 The Committee supports the recommendations of the Scottish Law Commission Report on Vulnerable Adults (1997), which seeks to replace the existing Section 117 of the Mental Health (Scotland) Act 1984 which deals with the compulsory removal of vulnerable people from premises to hospitals and other places of safety.

8.46 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 it believes to be, vulnerable. 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.

8.47 Mental disorder is likely to be the predominant condition associated with vulnerability, although the provisions would also apply to those vulnerable through age or infirmity. The Mental Welfare Commission would have a role in enacting the provisions, which would apply only to those whose vulnerability is associated with mental disorder. Questions thus arise of how this Act should interact with the Mental Health Act.

8.48 The Committee suggests that the provisions of the draft Vulnerable Adults Bill proposed by the SLC which relate to people with mental disorders should be included in a new Mental Health Act.

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35 As well as Section 47 of the National Assistance Act 1948 (as amended by the National Assistance (Amendment) Act 1951).
Consolidation

8.49 The Committee is therefore considering the recommendation that, if a new Mental Health Act is approved by Parliament, Parliament should then consider a consolidation of that Act and the Adults with Incapacity Act, including any amendments to the latter which may be included in the new Mental Health Act. The new Act (under whatever name) would then be a comprehensive code dealing with the protection, treatment and detention of mentally disabled people. This would have the following advantages:

- There would be a comprehensive code dealing with mental health law, which would be easily accessible.
- Bringing the two into one act might make it easier to sort out any anomalies or loose ends.
- If a capacity test were introduced in mental health law, distinctions between the Mental Health Act and AWI would lessen.
- People may move in and out of needing help under the Mental Health Act and/or the Adults with Incapacity Act.

8.50 However, there could be problems with such a consolidation:

- If a capacity test were introduced in the Mental Health Act and it differed from the test in the Adults with Incapacity Act, confusion could be caused between the two.
- The general principles of the two Acts may be different in some regards.

8.23 Do you think that the provisions of the draft Vulnerable Adults Bill should be included in a new Mental Health Act?

8.24 Do you think that Parliament should consider a consolidation of the legislation relating to mental health?

8.51 A consolidation measure, which codifies but does not amend the law, requires very little Parliamentary time. It would be desirable, therefore, that the drafting of any new Mental Health Act should be done in a way which would facilitate consolidation with the Adults with Incapacity Act, and the Committee also intends to recommend this.
9: CARERS AND NEAREST RELATIVES

Rights of carers

9.1 At present, carers have the right to have their needs assessed by Social Work agencies with a view to putting appropriate services in place. Many carers have made the point to the Committee that this provision in the legislation is not consistently applied and that not all carers are, in fact, receiving this service. This is an important issue, although arguably this inconsistency should best be addressed by services and resourcing rather than mental health legislation.

9.2 The Committee has considered whether this right should be extended to include a formal assessment of their needs by health as well as social work. It has provisionally decided that it should not be, on the basis that the social work assessment would indicate whether there are any issues that health agencies should consider. It is suggested that instead steps should be taken to ensure that all carers who want one are given the assessment that they are already entitled to.

9.3 The Committee is agreed that carers should receive appropriate support services to enable them to remain in a caring role, where this is in the best interests of the user. This is required by the Principle of Respect for Carers. However, it may be that this should be encapsulated in guidance or the Code of Practice rather than primary legislation.

9.4 The Committee feels that the carer for a detained incapable patient should have the right in law to challenge compulsory measures. This should include the right to request a second opinion.

9.5 The Committee does not feel that this right should apply to the carers of capable detained patients unless permission has been given by the patient.

9.1 Do you agree that carers should continue to have their needs assessed and that social work should be the primary agency in this?

9.2 Do you agree that guidance or the Code of Practice, rather than the Act itself, should make it clear that carers should receive support services as appropriate to help them in their caring role?
9.3 Do you agree that carers should have the right to challenge interventions when the person they are caring for is incapable?

9.4 Do you think that carers should have the right to challenge interventions when they are caring for a capable person?

**Consent by “nearest relative”**

9.6 The Committee has provisionally concluded that the nearest relative (or replacement, see below) should no longer be required by legislation to consent to a mentally disordered person's detention or have the power to initiate a detention. The Committee has received a considerable amount of evidence that the involvement of relatives has a negative effect on family relationships which are key to the support and care of a person who has a mental disorder.

**Definition of “nearest relative”**

9.7 The “nearest relative” as defined in the Act is not always the person that the user, or indeed the relative concerned, would wish. An appeal to the Sheriff to change the nearest relative currently exists but only on very limited grounds, which do not include the wishes of the user or the unsuitability of the nearest relative. The Committee feels that this inflexibility should be addressed.

9.8 Therefore, the Committee has provisionally concluded there should be the right for a patient to name a “nominated person” to replace their “nearest relative” as defined in the Act, although it recognises that there could be some practical problems with this, particularly if the user tried to change their nominated person very frequently. This person would then have the status of primary carer, and rights to information and assistance that go with that. At times of conflicts of interests, their interests would take precedence over those of “nearest relatives”. This would be undertaken on the following conditions:

- Having a nominated person would not be mandatory. If no nomination were made, the nearest relative would retain formal status as defined in the Act.
- The named person would have to agree, having been made aware of the responsibilities attached to the role.
- The patient would have to make the nomination when competent to do so.
- There would be an appeal to the Sheriff against the nomination, which could be made either by the service provider or another person (such as a relative or carer). This would address concerns that the user might nominate an abusive or otherwise inappropriate person.

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36 Mental Health (Scotland) Act 1984, s56(3):

"An application for an order under this section may be made upon any of the following grounds, that is to say—

(a) that the patient has no nearest relative within the meaning of this Act, or that it is not reasonably practicable to ascertain whether he has such a relative or who that relative is;

(b) that the nearest relative of the patient is incapable of acting as such by reason of mental disorder or other illness;

(c) where the application is made by the nearest relative of the patient, that he is unwilling or considers it undesirable to continue to act as such."
Insofar as the nearest relative remained within the statute, the definition would be amended to encompass unmarried partners, whether of the same or opposite sex.

It has been suggested that a person other than the nominated person who has undertaken a significant responsibility for caring for the person should be entitled to appropriate information to carry out the caring role.

It may also be that family members or others, even though not acting as carers, could be adversely affected by the behaviour of a mentally disordered person and they should also be entitled to information, for example of a person’s discharge from hospital. This entitlement may override the right of the patient to confidentiality.

9.6 Do you agree that a “nominated person”, as described above, should replace the “nearest relative”, in the circumstances described above?

9.7 If so, do you agree that there should be appropriate information given to the person’s carer, if the carer is not the nominated person? What should that be?

9.8 Do you agree that there should be a certain amount of information given to family members who might neither be the nominated person nor the carer? What information should that be and in what circumstances?
10: FORUM FOR APPEALS

10.1 The Committee has not yet reached a view on whether the Sheriff Court or some form of tribunal will be the most appropriate forum for considering mental health measures under the new Mental Health Act. The Committee would therefore welcome further comments.

Function of the forum

10.2 At present the Sheriff is asked to decide on legal grounds whether a detention is legal or not.

10.3 It is clear that the shape of an appropriate forum in the future will strongly depend on the function that it is asked to perform. It seems likely that the forum will no longer simply be considering whether the legal test for detention has been met but, for example, whether a Care Plan is appropriate. It may also be that the forum will take into consideration not only whether the correct legal steps have been followed, but also the quality of decision making.

10.4 The Committee feels that these points strengthen the case for either a specialist body or the need for expert advice to the sheriff if the sheriff’s role is retained.

10.1 Do you agree that the function of the forum should be broadened beyond simply determining that the grounds for compulsion are met?

The choice of fora

10.5 Four options are outlined below and the Committee would ask that respondents indicate their preferred option. If you have strong feelings against one of the options, the Committee would also be interested in your views.

Option 1: Sheriff as at present

10.6 Sheriffs are not mental health specialists, and have varying levels of understanding of mental health issues. However, they have specialist expertise in understanding and applying the law in a wide variety of situations. They are independent and impartial. There is also the advantage of their universal availability reasonably local to most people: a major advantage of the Sheriff courts is the speed at which they can undertake reviews. In addition, they will be involved in making decisions under the Adults with Incapacity (Scotland) Act.
10.7 At present the decision that the Sheriff is asked to make is a simple yes or no, on legal grounds, to detention. However, if the Sheriff were being asked to approve a Care Plan then their role will have moved away from this strictly legal decision into questions of treatment and care. This could cause difficulties for a non-specialist.

10.8 Many users have reported that they feel daunted by the court system, and sometimes feel as though they are being “criminalised” by being in court. Many Sheriffs, however, now undertake proceedings informally in chambers or even in hospitals. This could become mandatory for proceedings.

10.9 If this option were to be preferred, the Committee is likely to wish to make detailed recommendations about how the operation of the system can be improved. Some of our respondents have suggested, for example, that there should be “specialist” sheriffs for mental health matters, but doubts have been raised as to whether that is practicable.

**Option 2: Sheriff plus advisor(s)**

10.10 This model would mean that an advisor, or more than one, from a mental health background attend proceedings and is available to advise the Sheriff. The presence of a specialist advisor could address concerns about the Sheriff's lack of specialist expertise in mental health matters, whilst retaining the judicial impartiality and independence of the Sheriff.

10.11 The presence of an advisor might also address questions of whether a Sheriff has the expertise to approve, reject or require further information about a Care Plan.

**Option 3: Mental Health Review Tribunal**

10.12 In England and Wales, Mental Health Review Tribunals (MHRTs) consist of a chair with a legal background (a judge, if the patient is on Restrictions), a psychiatrist, and another member (usually a nurse or social worker). They are informal in nature, which
may address user concerns about the “criminalisation” of mental health hearings in the
Sheriff Court system. At the moment, the MHRTs are only responsible for hearing
appeals: they do not authorise initial detentions.

10.13 Many respondents have argued in favour of a Scottish Tribunal system, which
could operate in different areas of the country in order to provide local
accessibility. It is suggested that membership could be drawn from lawyers,
medical practitioners, lay persons and those with knowledge of social work and
community care provision.

10.14 It has been suggested that a specialist review tribunal could:

- Serve to combine the tasks of Sheriffs and various others in deciding on
  admission of patients to hospital, community care orders and mental health
  guardianship.
- Replace the authority given to hospital managers to discharge patients.
- Replace the authority given to the Mental Welfare Commission to review detention
  and discharge patients.
- Authorise the variation and renewal of a compulsory intervention.
- Be responsible for providing the second medical opinion in treatments requiring this
  safeguard (currently provided by a doctor appointed by the Mental Welfare
  Commission).

10.15 Evidence suggests, however, that the behaviour of MHRTs in terms of releasing
patients from hospital varies greatly in different areas of England and Wales. It might
be, therefore, that the specialist input of the Tribunal members does not mean that
decisions are more consistent or necessarily always appropriate.

10.16 In addition, concerns have been expressed to the Committee that there are sometimes
serious delays before hearings take place.

| 10.6 Do you think that a type of Mental Health Review Tribunal should
  be the forum for reviews of compulsory interventions? |
| 10.7 If so, which of the suggested possible functions would it be
  appropriate for the Tribunal to have? |
| 10.8 How can consistency in judgements be assured? |

Option 4: Tribunal (other model)

10.17 There are a variety of different models for tribunals that could be used for decisions on
compulsory measures under the Act.

10.18 The Children’s Panel system, for example, could provide a model. Hearings are
informal and undertaken by trained lay members, but decisions can be appealed to the
Sheriff if required, or the issues can be remitted to the Sheriff if there is dispute about the grounds for referral to the hearing.

10.19 A potential disadvantage of this model could be a lack of legal expertise, which could have human rights implications.

- **10.9** Do you think another type of tribunal should be instigated for reviews of compulsory measures under the Act?
- **10.10** If so, what would this tribunal look like?
11: The Role of the Mental Welfare Commission for Scotland

11.1 The Mental Welfare Commission for Scotland (MWC) is constituted under Part II of the 1984 Act.

11.2 The Commission’s functions are to protect the interests of individuals with mental disorder and to propagate good practice, which it does in a number of ways, including:

- Visiting patients in hospitals and elsewhere;
- Monitoring and reviewing detentions, guardianship and Community Care Orders;
- Considering whether complaints have been dealt with appropriately;
- Producing an Annual Report which includes specific guidance on certain matters; and
- Conducting enquiries into deficiency in care.

Visits

11.3 The MWC visits every psychiatric and learning disability hospital annually. Some representation has been made to the Committee that these visits be undertaken more frequently, but the Commission would require additional resources to do this.

11.4 Visits encompass:

- Meetings with every patient who has been detained over two years, and thereafter every two years;
- Interviews with all other patients who request them; and
- Meetings with staff, managers, relatives and advocacy groups.

11.5 However, the Committee is concerned that some vulnerable service users may not be receiving all the protections of the MWC:

Informal/voluntary patients

11.6 Meetings with non-detained patients currently rely on the patient (or sometimes their advocates or relatives) seeking an interview with the Commission.
11.7 However, some of the most vulnerable may neither feel able to do so nor have a supporter to do so on their behalf. Therefore, the Committee is persuaded that there is a strong case for the MWC being involved in reviews of the cases of non-detained patients.

**Patients in the community**

11.8 The MWC currently makes visits to some community facilities, but it has no statutory powers to do so and can therefore only visit by agreement with the relevant authority.

11.9 The MWC cannot currently insist on meeting with mentally disordered persons living in the community (including in community psychiatric facilities) without concern first being raised about that individual’s welfare (by the individual him or herself, or by another). This raises concerns that the most vulnerable people – those who will not or cannot raise concerns for themselves and do not have support from others – are being overlooked.

11.10 The Committee takes the view that the powers of the MWC in the community should be as extensive as its powers in hospitals.

**Unannounced visits**

11.11 The MWC currently undertakes a small number of unannounced visits to hospitals. The Committee is minded to take the view that unannounced visits should be a statutory requirement to help encourage maintenance of good practice, both in hospitals and in community facilities.

11.12 The MWC has power to discharge detained patients, and reviews, on request, the case of any detained patient (except for emergency detentions).
11.13 However, many of those who have given evidence to the Committee, particularly users, have told us that they perceive the MWC as a “rubber stamping” or psychiatry-dominated organisation, because in fact it actually releases very few patients. The MWC would argue, though, that this both illustrates that most detentions are legitimately undertaken and overlooks the cases where, as part of the Commission’s review, issues are resolved informally with the user and their care staff.

11.14 Serious concern has also been expressed that emphasis on reviews on request marginalises those who do not complain about their detention, who may be amongst the most vulnerable patients.

11.15 The MWC’s powers to discharge run alongside those of the Sheriff, although about 20 times more applications for release are currently made to the MWC than to the Sheriff Courts. The Committee has heard evidence that these two routes for appealing against detention are confusing.

11.16 One possibility (particularly if the forum for appeal were considering elements of care beyond the remit of the Sheriff at present), would be that the MWC could have this role removed and instead could focus its resources on monitoring the quality of care given to individuals.

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**Complaints**

11.17 The Commission does not operate as a primary complaints body, in that it does not, in normal circumstances, investigate initial complaints about mental health care. Such complaints must first be addressed to the relevant NHS body or local authority.

11.18 The Commission’s role on complaints intersects with the Health Service Commissioner's role on NHS complaints.

- If a person is not happy with the outcome of a complaint which they have made locally about *mental health care*, they can refer their complaint to the Mental Welfare Commission.
- However, complaints about other forms of health treatment (i.e. non-mental health treatment) should be referred to the Health Service Commissioner, as should complaints about the Mental Welfare Commission.
- The Health Service Commissioner can consider complaints about the way the MWC has handled a case, although not complaints about the Commission’s decisions.
11.19 It could be that the Principle of Non-Discrimination (which requires that mental healthcare be treated in the same manner as other types of healthcare) suggests that the role of the Health Service Commissioner should be extended to cover all types of complaints about treatment. This would also be less confusing for service users. On the other hand, the MWC has expertise on the particular issues surrounding mental health services that a general Ombudsman might not have. If the Commission were to retain this role, it has been suggested that the appointment of a Commissioner with specific responsibilities for complaints might be appropriate.

11.20 The Commission can undertake full and formal complaints investigations but, in practice, rarely does, partly because of resource difficulties. However, it carries out a great deal of detailed informal investigation about complaints. This allows the MWC to recommend good practice, and can help facilitate communication between relevant authorities and parties making complaints. Some would argue, however, that the perception of some users that the MWC is “in league” with mental health services is not aided by this type of approach.

### Deficiency in care

11.21 The Commission has a formal power to hold public enquiries, but has never done so, since 1984. It does hold about 3 or 4 major enquiries every year into deficiencies in care. These are reported to the Executive and/or local bodies. In some cases the enquiries are summarised in the Annual Report.

11.22 Such enquiries can have a positive impact, but there have been concerns about whether the lessons are widely enough disseminated, and the extent to which the patient (or their family) is entitled to know the outcome.

11.23 The Committee is minded to recommend that the Commission should have an independent power to publish reports on its enquiries.

### Powers to enforce recommendations

11.24 In its current form, the MWC is basically a reporting body, not an enforcing body. The Commission makes recommendations both specifically relating to certain individuals (including as part of Deficiency in Care Inquiries) and generally through its promotion.
of good practice. However, apart from discharging patients from detention or guardianship, it has few powers of enforcement. It could be that it should be given more power to enforce its recommendations.

11.9 Do you think the MWC should have more power to enforce its recommendations?

11.10 If so, what sanctions should be available to it against service providers or others who fail to comply?

Joint working with other monitoring bodies

11.25 It has been suggested to the Committee that there can be confusion and overlap between the roles of the MWC, and bodies such as the Scottish Health Advisory Service (SHAS) (which monitors the quality of health services generally, rather than investigating individual cases); the Clinical Resources Advisory Group (CRAG); the Social Work Services Inspectorate (SWSI) and the new Clinical Standards Board (CSB).

11.11 Should co-ordinated activity and efforts to avoid duplication of labour between the MWC and SHAS (and perhaps others) be enshrined in the new legislation?

Accountability

11.26 At present, the MWC is financially accountable to the Scottish Executive and to Ministers, and on the other hand, has a formal reporting role (by means of its Annual Report) to the Scottish Parliament.

11.27 However, it has been suggested that the MWC could be made more directly accountable to the Parliament, perhaps by making a regular report to the Health and Community Care Committee.

11.12 Do you think that the MWC should be more directly accountable to the Scottish Parliament in this fashion?

Membership of the MWC

11.28 The Committee has heard a variety of comments about the make-up of the MWC.

11.29 The following have been suggested as additions to the MWC:
• A full-time nursing commissioner.
• Increased user and carer representation, perhaps drawn from local/national collective advocacy groups.
• A Complaints Commissioner (see paragraph 19).
• A Police Commissioner.
• More people drawn from further down the promotion scale in various professions so that the views and experience of “front line” professionals are better represented.

11.30 It might also be desirable for the structure of the MWC to change. As with other health bodies, there could be a distinction between Executive and Non Executive members.

**11.13 Do you think that the make-up and structure of the MWC should be changed?**

**11.14 If so, in what way?**

**Second Opinion Doctors**

11.31 If there were to be increased use of second opinion doctors, for example to authorise Community Treatment Orders, there could be resource and workload implications for the Commission, who currently provide them. It could be that they could be provided at local level, perhaps by Tribunals or by local offices of the MWC if either of these were introduced.

**11.15 Do you have any comments on the provision of Second Opinion Doctors?**

**Possible New Roles for the Commission**

**New “Auditing” Role**

11.32 The Committee is considering whether the MWC should be given a stronger role, in relation to auditing standards of mental health care.

11.33 Within the Health Service, the Clinical Standards Board has been established to set out best practice in a range of health care issues, including mental health. Locally, such standards are monitored by a process of clinical governance. For social work, guidance is given by the Scottish Executive, with professional input from the Social Work Services Inspectorate. There is currently no body which has specific responsibility for auditing care standards across the country (although the Accounts Commission has recently undertaken a review of local authority mental health services...
and, of course, the Scottish Health Advisory Service investigates NHS mental health services).

11.34 A broad approach would be for the MWC to investigate standards of care across the country, for example, in relation to schizophrenia, or children’s mental health services. It could report to local agencies, Ministers, and the Scottish Parliament on the extent to which standards, set by the Clinical Standards Board or other agencies, are being achieved. Their approach in doing so could be similar to that adopted by the Audit Commission in England and Wales.

11.35 Such a role would be a major extension of the responsibilities of the MWC, with considerable resource implications.

11.36 A more targeted approach would be for the MWC to audit the extent to which mental health services meet the requirements of, and reflect the principles of, the Mental Health Act. Arguably, this might more appropriately reflect the special expertise of the MWC.

11.37 It would also be a development of some of the activities currently undertaken by the MWC, particularly within its visiting programme. For example, the MWC has recently considered and reported on the management of patients’ funds, and policies in relation to locked wards.

11.38 The proposal would be that this be formalised into a statutory role for the MWC, with appropriate investigative and reporting powers. The operation of the role would be integrated with other methods of quality assurance, so far as possible. It is envisaged that the role would encompass both health and local authority services.

Geographical dispersal

11.39 Some people, especially in more rural areas, complain that it is difficult to access the Commission, the office and all the staff of which are currently located in Edinburgh.

11.40 It has been suggested to the Committee that there could instead be some form of smaller “central” Mental Welfare Commission Office, dealing with wider policy issues, complemented and supported by a series of local offices around Scotland, dealing with individual cases and local concerns.

11.41 However, the Committee is conscious that such a move would have very significant resource implications, and might mean that the MWC’s consistency of approach could be compromised.
11.42 As an alternative, it has been suggested to the Committee that the MWC should make efforts to form closer links with other advice services, such as the Citizen’s Advice Bureau. These are widespread around the country and could perhaps form a useful local contact point for the MWC.

11.43 The Committee has also heard that the use of new technologies, such as video conferencing and the internet, might serve to allow easier access to the Commission for people in more rural areas of Scotland.

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11.18 Do you think that the MWC should disperse to the regions in the fashion described above?

11.19 If not, do you think that the MWC should investigate methods for improving its accessibility to people outside the central belt? If so, do you have any suggestions for how it should do this?

11.44 It could be that if Tribunals of some type were introduced to review detentions in the place of Sheriff Courts (see Section 10), they could also be given the function of serving as the local arms of the MWC as described above. However, such a move is clearly, at present, entirely conditional upon the decision taken on the appropriate forum for appeals.
12: Roles of professions in the Act

General Practitioners

12.1 The great majority of detentions at present are emergency admissions, which may be initiated by GPs, potentially with limited knowledge of mental health or the Mental Health Act.

12.2 The Committee has also heard evidence from GPs that they often lack either the specialist expertise or personal knowledge of the patient to undertake responsibilities such as being the second doctor supporting a detention under s18.

12.3 The Committee has agreed that there is a strong case for more specific compulsory GP training in mental health and the use of the Act. However, if such training was universal, it may cover people who would never make use of it. If not universal, then there may be problems of achieving adequate coverage, particularly in rural areas. Also, it would be undesirable to give GPs disincentives to work with mentally ill people by imposing training requirements.

12.4 It has been suggested to the Committee that the new GP co-operatives should be required to have an adequate number of properly trained GPs in their area, as local authorities have to with Mental Health Officers.

12.1 Do you agree that GPs require compulsory training in the Mental Health Act before being able to initiate detentions?

12.2 Do you agree that GP co-operatives should be required to have an adequate number of GPs properly trained in mental health and in the use of the Act?

Second Opinion Doctors

12.5 The Committee feels that there may also be a need to clarify the role of the Second Opinion Doctor relating to special treatment safeguards. At present, it has been suggested that the Doctor essentially confirms that the treatment being given is not outwith an appropriate professional range of responses. Alternative roles could include:

- advising whether the treatment is the best option medically; and

37 Mental Health (Scotland) Act 1984, s98(3)
advising whether the treatment is the most appropriate in terms of other factors (e.g., least restrictive alternative, having regard to wishes of patient etc).

12.6 It has also been observed that the specific training required of Second Opinion Doctors is much less extensive than that required for Mental Health Officers (although the doctors should be experienced practitioners).

### ROLES OF PROFESSIONS IN THE ACT

#### Mental Health Officers

12.7 Currently, the Act requires local authorities to appoint Mental Health Officers (MHOs). The Act does not specify that they belong to any profession, but regulations set out that they should have a professional qualification in social work, and have completed an approved training course. Applications for long term detention (under s18) are normally made by MHOs, and they (alongside the nearest relative) can consent to emergency detention.

12.8 The Committee feels that it is important to retain, and perhaps enhance, the role of an independent third party in decisions concerning compulsory interventions.

12.9 The question of whether MHO status should be extended to professions other than social work (particularly, community psychiatric nurses and/or occupational therapists and/or psychologists) has been considered by the Committee. Arguments have been presented to the Committee on both sides.

12.10 On balance, the Committee is not persuaded that MHO status should be extended to other professions. Social workers have specific expertise in dealing with the interface between compulsion and advocacy for a client. Most importantly, social work is independent from the health system. The Committee is not currently convinced that the benefit in terms of potentially increasing the number of MHOs around the country is outweighed by the potential disadvantages of extending the professional boundaries of MHO status.

#### Community Psychiatric Nurses

12.11 Some evidence has been presented to the Committee that Community Psychiatric Nurses (CPNs) often play the leading role in emergency detentions. This may amount...
to power without responsibility, as the formal responsibility is placed on GPs who may, in fact, simply be acting on the advice of the CPN.

12.12 It is possible that CPNs could be allowed to initiate emergency detentions on their own behalf (in the place of GPs rather than as MHOs). This would represent a significant broadening of the traditional nursing role. Some may consider that it would also represent a danger for the therapeutic relationship between CPN and patient.

12.13 If this suggestion is accepted, a further possibility is that CPNs could be given the power to act as the second medical recommendation for a long-term (s18) detention. Again, such a move would be to give the nursing profession a power that has long been the preserve of medical practitioners. The Committee is interested in the views of respondents on this matter.

**Questions:**

- **12.6** Do you think that CPNs should be given the power to initiate emergency detentions on their own behalf?
- **12.7** Do you think that CPNs should be given the power to act as a second medical recommendation for a long-term detention?
- **12.8** If so, would they replace the GP's role in the Mental Health Act, or should the Act allow for either professional to give the second medical recommendation?

**Responsible Medical Officer**

12.14 Evidence has also been presented to the Committee that psychologists have a more active role than psychiatrists in treating some people, such as people with personality disorder or learning disability. These are people for whom psychosocial interventions are likely to be more important or effective than medical interventions, although the latter may also be required.

12.15 This raises the question of whether the Responsible Medical Officer (RMO) need always be a psychiatrist, or whether the responsible person, in appropriate cases, could be a psychologist.

**Questions:**

- **12.9** Do you think that a psychologist could be the responsible clinical officer in certain cases?
- **12.10** If so, how do you think this could be framed in the legislation without disrupting the chain of accountability? In particular, which profession would take responsibility if the person has co-morbid mental illness and personality disorder or learning disability, or if the diagnosis is doubtful?
13: FORENSIC ISSUES

13.1 The Committee has considered a range of issues concerning people who have mental disorders, and who come into contact with the criminal justice system. In addition, the MacLean Committee is considering the issue of the sentencing and treatment of serious violent and sexual offenders, including those with personality disorders. The Committee is due to report shortly, and the Millan Committee will take account of the recommendations of the MacLean Committee before finalising its own report.

Mental Health Disposals

13.2 The Committee’s view is that the range of disposals for mentally disordered offenders is adequate. It is possible for a mentally disordered person to be diverted from the criminal justice system by the police or fiscal, or to be made subject to a Hospital Order or direction by the court, or transferred from prison after sentencing. There is, however, some evidence that, despite this, the outcomes for mentally disordered offenders are not always appropriate.

13.3 Some of the problems appear to relate to the availability of services (such as formal diversion schemes) and the need for better training. These are matters which should be addressed in the context of the Strategy for Mentally Disordered Offenders, the operation of which is currently being reviewed.

13.4 Other problems may relate to the process by which needs are assessed in the courts. The Committee wishes to see a more thorough and multidisciplinary assessment process become the norm when a mentally disordered offender is sentenced. In particular, it wishes to propose that any recommendations by a psychiatrist in relation to a mental health disposal should be accompanied by a Social Enquiry Report by a Mental Health Officer, but it would be interested in other practical suggestions by which this aim might be achieved.

13.1 Do you agree that Mental Health Officers should also report to the court where mental health disposals are under consideration?

13.2 Do you have any other proposals to improve the assessment process before a criminal court considers a mental health disposal?

Hospital Directions and Interim Hospital Orders

13.5 Problems have arisen in the past where a diagnosis which has led to a Hospital Order has turned out to be incorrect, or has changed. This may call into question the
continued detainability of the patient, even where the patient continues to present a risk to public safety.

13.6 Hospital Directions (which allow a hospital disposal to run alongside a prison sentence) and Interim Hospital Orders are intended to address this problem, although their use by the courts to date is limited. Research is ongoing into these orders, and the Committee will consider this research in due course.

13.7 Provisionally, however, the Committee is inclined to make the following recommendations.

- In the event that personality disorder remains within the Mental Health Act, Hospital Orders should not be available for offenders with a primary diagnosis of personality disorder. Where hospital treatment is felt to be appropriate, a Hospital Direction should be used.
- 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. Whenever a recommendation is made by a psychiatrist for a Hospital Order, the psychiatrist should be required to explain why an Interim Hospital Order is not appropriate.
- The criteria for Hospital Directions should be clarified, and distinguished from those for Hospital Orders. Current guidance (which does not allow a psychiatrist to recommend whether a Hospital Direction may be more appropriate than a Hospital Order) should be revised.

13.3 Do you agree with these proposals relating to Hospital Directions and interim Hospital Orders?

13.4 Do you have any other proposals in relation to Hospital Directions and interim Hospital Orders?

Restricted patients

13.8 Currently, patients in receipt of an Hospital Order or a Hospital Direction may be subject to additional restrictions, imposed for public safety reasons38. Restricted patients can only be discharged by Scottish Ministers, or by a Sheriff on appeal, and not by the Responsible Medical Officer, nor the Mental Welfare Commission.

New body for decisions on discharge and recall

13.9 The Committee is concerned that the process by which decisions are taken by Scottish Ministers in relation to the discharge of restricted patients is not sufficiently transparent, and can lead to a concern that political considerations might influence Discharge decisions.

13.10 The Committee is inclined to recommend that an independent body should consider questions of the absolute and conditional discharge, and recall, of restricted patients.

38 Criminal Procedure (Scotland) Act 1995, s59, and cf. Mental Health (Scotland) Act 1984 s62
The body could either have the authority to take such decisions (as a designated life tribunal does in respect of discretionary life sentences) or make recommendations to Ministers (as the Parole Board does for mandatory life prisoners). The body could take various forms:

- The suggestion has been made that the Parole Board, either sitting as a Board, or in the form of a special tribunal (as with Designated Life Tribunals) could take on the role, subject of course to suitable training.
- The Mental Welfare Commission has also been suggested to take on the role, as it already has the power to discharge non-restricted patients. However, this might conflict with the Commission’s important monitoring role in relation to this group of patients.
- Alternatively, a new, and entirely separate body could be instituted to undertake these reviews.

13.11 If the body were to act as a quasi-judicial body, with the power to discharge patients and not simply the power to make recommendations to Ministers, it is for consideration whether the power of the sheriff to review such cases would be removed. The body's decisions would be challengeable by judicial review.

13.5 Do you agree that an independent body should have a role in decisions regarding the discharge and recall of restricted patients?

13.6 If so, should such a body have the power of discharge or the responsibility only of making recommendations to the minister? If the body, acting quasi-judicially, had the power of discharge, would there still be a need for a separate appeal to the Sheriff?

13.7 Do you have any comments on the Committee’s suggestions as to the nature and powers of such a body?

13.8 If a new body were taking discharge decisions, how would the day-to-day management of restricted patients be undertaken?
Conditional Discharge

13.14 There is concern that there may not be an adequate mechanism to deal with patients on conditional discharge, who do not comply with the conditions. Recall to hospital is only possible when it can be shown that the patient requires detention in hospital for further treatment. The Committee feels that there should be a mechanism to allow action to be taken where conditions are not met. The obvious sanction is return to hospital, but there are problems about re-admitting patients in the absence of evidence that they need treatment as a hospital in-patient. The Committee is interested in views as to whether conditional discharge should operate in a way which is more like parole. In particular, it feels that there should be a process for a formal review of conditional discharge where conditions are breached.

Levels of security

13.15 Currently, patients have only a limited opportunity to appeal against an order requiring them to be detained in the State hospital. Beyond the initial appeal period of 28 days, there is no legal right to challenge continued detention in the State hospital, as opposed to a local hospital at a lower level of security. The Committee understands that a considerable number of patients are ‘entrapped’ in the State hospital: they no longer require the level of security of the State hospital, but alternative arrangements have not been made.

13.16 It seems to the Committee unjust that patients should be subject to greater degrees of restriction than they require, and inconsistent with the established right of restricted patients to seek absolute or conditional discharge.

13.17 The Committee is therefore minded to recommend the introduction of a new right of appeal to the Sheriff against the level of security at which a patient is held. The patient would have the right to make this appeal periodically, perhaps annually or bi-annually.

13.18 The Committee notes the proposed development of Medium Secure Units in Scotland, and suggests that this might facilitate the introduction of such a right of appeal. However, there are questions of whether there should be any sanction against Health Boards who do not provide facilities as directed by the Sheriff. It has been suggested that, after a period, the Sheriff could require an explanation to be given to him or her in court of why this has not been done.

13.9 Do you believe there should be a formal review of conditional discharge if the conditions are not observed?

13.10 Do you have any other proposals which would improve the supervision of restricted patients on conditional discharge?
Insanity and diminished responsibility

13.19 Currently, a person who is not able to understand and participate in the trial process can be found “insane in bar of trial”, or “unfit to plead”\(^{39}\). More rarely, a person who can show that they were “insane” at the time of commission of the offence is entitled to be acquitted from the charge, although is still subject to a range of mental health disposals.

13.20 The procedures for dealing with offenders who are unfit to plead, or submit an insanity defence, were amended in 1995, to add a new “examination of facts” to consider the evidence that the person committed the alleged criminal act, and to give the courts a wider range of options for disposal\(^{40}\). However, the definitions of “insanity” were not changed, nor was the mechanism for determining that an accused person is insane.

13.21 Research conducted into the new provisions has found general support for the new procedures, and the evidence received by the Committee confirmed this (although there are concerns that having an examination of facts when the accused person is unfit to plead, followed by the possibility of a criminal trial on recovery introduces an element of “double jeopardy”).

Definitions

13.22 The Committee has received a considerable amount of evidence to the effect that the definitions of insanity no longer bear any resemblance to modern psychiatric practice. However, it has been submitted that change could be difficult because a body of caselaw has been established around the current definitions, and the effect of a new definition might, initially at least, be unpredictable.

13.23 Similar criticisms have been made of the definition of diminished responsibility, which serves to reduce a charge of murder to one of culpable homicide. The definition of this includes “a state of mind bordering on, but not amounting to, insanity”, but the precise meaning of this, and its relation to clinical diagnoses, is unclear. It is also not clear that the definition usefully distinguishes between offenders, either on the grounds of culpability or risk.

13.24 The evidence required before a court can establish insanity (in either sense) or diminished responsibility is that of two qualified psychiatrists. It has been suggested

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\(^{39}\) Criminal Procedure (Scotland) Act 1995, s54ff
\(^{40}\) Criminal Procedure (Scotland) Act 1995, s55
that it should be possible to have expert evidence from other sources, particularly psychologists. This has been argued as particularly appropriate in the case of fitness to plead, since this often relates to the individual's cognitive ability to understand the trial process, rather than a degree of mental illness.

13.25 The Committee is sympathetic to the arguments for reform in this area. However, its preliminary view is that the issues raised, which relate primarily to the common law and the Criminal Procedure (Scotland) Act 1995, rather than the Mental Health (Scotland) Act 1984, may be too complex to be addressed fully in this review. It is minded to recommend that an independent review of the law and procedures relating to insanity and diminished responsibility be established.

Murder

13.26 One area, which may require more urgent attention, relates to people who are charged with murder, and successfully argue that they were insane at the time of commission of the offence. Unlike other offenders who are acquitted by reason of insanity, the court has no discretion in the disposal, and must impose a Hospital Order with restrictions 41.

13.27 The difficulty arises where the accused person is not significantly mentally disordered at the time of the disposal (in other words, they have recovered from the mental disorder from which they were suffering at the time of the offence). A Hospital Order may be inappropriate for such an offender, since they may not require hospital treatment. Indeed, they may be able quickly to appeal against the continuance of the order and be discharged.

13.28 Simply releasing the individual may be acceptable in cases where a mental disorder is unlikely to recur. However, 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 already committed murder, should simply be discharged into the community without supervision.

13.29 The Committee is inclined to recommend that the same options should be available for offenders charged with murder who are acquitted by reason of insanity as other offenders (i.e. Hospital Orders (with or without restrictions), guardianship, supervision and treatment orders, or, in exceptional circumstances, no order (effectively discharging the patient)).

Supervision and Treatment Order

13.30 A criticism which has been made of supervision and treatment orders is that they lack sanctions for non-compliance. The Committee feels that they could be strengthened in two ways. Where medication is indicated to reduce risk of a deterioration in mental state, such orders could contain a requirement to accept medication and a sanction in the case of non-compliance would work in a similar way as the proposed community treatment order. As with conditional discharge (discussed below), there may be a case for linking supervision and treatment orders more closely to risk assessment and management procedures, which would allow recall to secure services in the event of non compliance with supervision conditions.

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41 Criminal Procedure (Scotland) Act 1995, s57(3)
Appropriate Adults, and support for vulnerable persons

13.31 In 1998, the Scottish Executive issued guidance to the police, local authorities and health boards, encouraging the development of “appropriate adult” schemes. These are arrangements under which a mentally disordered person being interviewed by the police (whether as a witness or a suspect), is given access to an independent appropriate adult, to assist them to understand and participate in the interview. It is also possible for assistance to be given up to and during the trial.

13.32 In England and Wales, the scheme is a statutory one, established under the Police and Criminal Evidence Act 1984. The Committee is considering whether to recommend that a statutory scheme should be established in Scotland, and is interested in views on whether this is necessary or desirable.

13.33 A statutory scheme might help to ensure that appropriate adults are universally available, since there is evidence that this is not yet the case in Scotland. However, it raises complex issues about the status and role of appropriate adults, and the effect of a failure to provide an appropriate adult on admissibility of evidence. On balance, the Committee is currently inclined to the view that the appropriate adult should be encouraged, but that further development on an informal basis, coupled with research into existing schemes and updating of good practice guidance, is the best approach.

13.34 So far as witnesses with mental disorders are concerned, the Scottish Office issued a consultation paper, “Towards a Just Conclusion”, in 1998, and the Committee understands that further proposals will be made by the Scottish Executive shortly. It may also be necessary for the Executive to consider the implications of the ruling of the European Court of Human Rights in the case of Thompson and Venables for adult accused persons who may have a mental disorder. The Committee has therefore not addressed these issues in detail at this stage.

13.13 Do you agree that there should be a review of the law relating to insanity and diminished responsibility?

13.14 Are there any changes to the law in relation to insanity and diminished responsibility, which should be introduced without such a review?

13.15 Do you support an amendment to the Criminal Procedure (Scotland) Act, which would make people who commit homicide, and who are acquitted by reason of insanity, subject to the same range of disposals as others acquitted by reason of insanity?

13.16 Do you support any strengthening of the sanctions for offenders subject to supervision and treatment orders?
The interface with the Criminal Procedure (Scotland) Act 1995

13.35 The Committee has discussed the possibility of moving all legislation relating to mentally disordered offenders into a Mental Health Act, although it has not made a decision on this matter. At present, there are provisions relating to mentally disordered offenders in two major separate pieces of legislation. Although people working in the criminal justice system may find this relatively convenient, as criminal provisions, including those relating to people with mental disorder, are held together in the Criminal Procedure (Scotland) Act 1995 (CPSA), it may be confusing for medical practitioners and other non-legal specialists dealing with mentally disordered offenders.

13.36 If there were to be a consolidation, the Committee therefore suggests that the provisions relating to mentally disordered offenders could move from the CPSA to the Mental Health Act. An alternative might be to duplicate the sections of the legislation relating to mentally disordered offenders and place these sections in both Acts. However, this could cause some confusion.

Practical problems with the current legislation

13.37 Under s52 of the CPSA, it appears that untried prisoners can be remanded in psychiatric hospitals, for assessment only, for up to 110 days. It has been argued that Part X of the Mental Health (Scotland) Act does not apply to such patients, meaning that they cannot be treated against their will for mental disorder (although the legal position is unclear). The Committee believes that it is wrong that an untried prisoner should be held in hospital without treatment for such a lengthy period. Although an additional detention under s18 of the Act is possible, this has practical difficulties. The Committee favours a power allowing treatment, provided there is consent from a second doctor with the appropriate expertise.

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42 Mental Health (Scotland) Act 1984, Part VI; Criminal Procedure (Scotland) Act 1995, Part VI (and also cf. s204, s207, s210 and s307).
13.38 It has been pointed out that, when a Hospital Order is recommended for a patient, it is on the basis that they are detainable under mental health law. If the patient is then acquitted, the order cannot be imposed. Unless a psychiatrist is in court to impose an emergency detention, the accused person may be lost to services.

13.39 One suggestion that has been made is that, in the event of a Hospital Order being recommended, but the accused person being acquitted, the court should be able to reconvene immediately as a civil court to consider an application for detention in terms of s18. In this case, the two recommendations for a Hospital Order would be treated as an application for a s18.

13.40 An alternative would be to give the Court a transitional power, based on the two recommendations for a Hospital Order, to keep the person in detention, under the Court can reconvene for a s18 hearing.

13.41 Once a patient is remanded to prison, it appears to be difficult to have them transferred to hospital for assessment of their mental state under the terms of s52 (rather than treatment under s70). On some occasions, the nobile officium power of the Court of Session has been required to resolve this. The Committee believes that this should be dealt with in the statutory provisions.

13.42 This Act was passed by the Scottish Parliament following the discharge of Noel Ruddle from the State hospital.
13.43 The Act:

- introduced a new right of appeal from decisions of the Sheriff in relation to restricted patients;
- amended the definition of mental illness in section 1 of the 1984 Act to include “personality disorder”; and
- introduced a new “public safety” test which required to be satisfied before a Sheriff or Scottish Ministers could discharge a restricted patient.

13.44 At the time of the legislation, the Committee expressed its concern that the Bill could have undesirable consequences. It seemed wrong to the Committee that the necessary regard for public safety should be given absolute priority over other important considerations, including the rights of the patient, and the appropriate role of mental health services. The Committee continues to have these concerns.

13.45 During the debates on the Bill, the Executive stressed that it was intended as an interim measure, pending consideration of the reports of this Committee and the MacLean Committee.

13.46 The Committee’s detailed recommendations in relation to this legislation will depend on the overall shape of its proposals, not least the question of whether personality disorder should be included within mental health law. However, it may be helpful to set out its general approach:

- The Committee notes that the almost universal psychiatric opinion is that personality disorder is distinct from mental illness, and the Committee believes therefore that it should be dealt with separately in mental health law.
- The Committee also accepts that public safety is an important consideration in decisions regarding the discharge of mentally disordered persons who have offended. However, the Committee believes that the primary aim of the State hospital, and other secure mental health services, should be to offer treatment, and not preventative detention. Where people are neither mentally impaired so as to have reduced culpability for their behaviour, nor in need of treatment, the Committee believes that any detention on the grounds of risk should be dealt with by criminal law rather than mental health law.
- In relation to future cases, it would be hoped that improved assessment procedures, and better use of options such as Interim Hospital Orders and Hospital Directions would reduce the risk of people being inappropriately placed in the State hospital under Hospital Orders.

13.47 It is less clear what new legislative measures could be applied to deal with patients who may currently be in the State hospital without a penal disposal, and who may be deemed both untreatable and high risk. Although the scale of this problem may have been greatly exaggerated (since people who may be equally dangerous are regularly released from prison), there may be a few people who fall within this category.

13.48 One possibility that has been suggested to the Committee is that there should be a reversion to the presumed position prior to the Reid case. Treatability was considered to be necessary for entry to detention, but lack of treatability did not necessarily mandate discharge.
Mental Welfare Commission inquiry into the care of Noel Ruddle

13.49 The Mental Welfare Commission inquiry into the care of Noel Ruddle has made a number of recommendations for legislative change in relation to restricted patients. These include:

“9 The Memorandum on Procedure on Restricted Patients should be reviewed and replaced by an explicit statement of the actual roles of the Responsible Medical Officer, Psychiatric Adviser, Scottish Ministers, State Hospital Managers and Medical Sub-Committee, and the interface between the RMO and Scottish Ministers should be examined and clarified.”

13.50 The Committee’s provisional view that there should be a change to the arrangements for dealing with restricted patients (see paragraphs 8-14) would address the issue of the interface between the RMO and Scottish Ministers. The Committee notes that there has been confusion as to the role and status of the Medical Sub-Committee at the State Hospital, and will consider whether this requires to be clarified in legislation.

“11 The review of legislative provisions should consider the introduction of:

(a) review by the court in the event of a change of diagnosis of a restricted patient from that which supported the initial Hospital Order.

(b) an interim procedure or delayed discharge after successful appeal which would allow the implementation of community care plans, when an appeal against detention is considered.

(c) arrangements, which would supplement conditional discharge, for the supervision and care of discharged patients who have high needs and pose a risk to public safety.

(d) an independent body to assume the powers and responsibilities of Scottish Ministers in relation to restricted patients.

(e) definitions of mental disorder which are unambiguous and which correspond closely with clinical practice.”

13.51 Apart from 11(b), all of these recommendations are addressed elsewhere within this consultation paper.

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44 Ibid, p68
45 Ibid, p68
13.26 Do you have any comments on the recommendation that there should be an interim procedure or delayed discharge after successful appeals against detention by restricted patients, to allow care plans to be put in place?

13.27 Do you have any other comments on legislative issues, arising out of the Mental Welfare Commission inquiry into the care and treatment of Noel Ruddle?
14: Code of Practice

14.1 Section 119 of the 1984 Act requires the First Minister to prepare, and from time to time revise, a Code which gives guidance *inter alia* on issues relating to the detention and discharge of patients and medical treatment of persons suffering from mental disorder.

14.2 However, there have been concerns from some respondents that revisions of the Code do not take place with sufficient regularity as to keep it relevant to current practice in mental health. The Committee is therefore minded to recommend that the Code of Practice should be updated at regular, and perhaps statutory, intervals.

14.3 One possibility is that a revised Code of Practice might enhance the MWC’s role in being guided by, in promoting and advancing the principles set out in a new Mental Health Act. More generally, the Code could serve to give more detailed guidance on matters of mental health legislation and practice than at present.

14.4 It would also be helpful if the Code could be expressed as far as possible in terms that are accessible to non-professionals, including users and carers. There is, in any case, need for some information about the Act to be available in comprehensible form to all those interests. Some voluntary organisations are already active in providing this, but it is not a matter that should be left only to them.

14.5 The Committee is also considering the possibility that there should be a body, drawn from user, carer and professional interests, which should oversee the implementation of new mental health law. Such a “consumer’s group” could perhaps monitor and update the Code, to ensure that it is accessible to and relevant to all the key interests.
15: THE EUROPEAN CONVENTION ON HUMAN RIGHTS

15.1 The European Convention on Human Rights (ECHR) has been a fundamental element of the Scottish legislative framework since the institution of the Scottish Parliament last year.

15.2 The Committee is anxious to ensure that mental health patients are given rights fully compatible with ECHR, and, in particular, would not wish that it should inadvertently make any recommendations which might be vulnerable to ECHR challenge.

15.1 Are there any human rights issues that you wish to raise?
16: OTHER

16.1 Are there any other points you wish to raise?
2: Principles

2.1 Do you think that the advantage of reciprocity outweighs any potential disadvantage that may result?

2.2 Are there any of the above principles which you think should not be included?

2.3 Are there any of the above principles which you think should be formulated differently?

2.4 Are there any other principles which you think should be added?

2.5 Do you think that the name of the Act should be changed? If so, what do you think it should be changed to?

3: Definitions

3.1 Do you agree that “mental disorder” should be broadly defined in the legislation (the detail of the three sub-categories of mental disorder, outlined below, notwithstanding)?

3.2 Are you happy that the detail of the diagnostic basis of this term be outlined in guidance and regularly updated?

3.3 Are you in favour of the continuation of “mental illness” as a sub-category of “mental disorder” and which, as at present, is not closely defined in primary legislation?

3.4 Do you agree that this category, “mental illness”, should include elements such as dementia and brain injury, as well as non-psychotic illnesses such as anorexia nervosa?

3.5 If so, do you think that “mental illness” is the appropriate term for this category, or how would you prefer it to be described?

3.6 Alternatively, do you think that mental illness should be narrowly defined to exclude disorders such as anorexia nervosa, dementia etc? If so, what provision should be made for people suffering from these illnesses?
3.7 Do you agree that there should be detailed consideration given to a separate legal framework for compulsory measures in relation to learning disability?

3.8 If so, do you agree that learning disability should be included in a Mental Health Act as a separate category until such consideration has been given to a separate legal framework?

3.9 If not, do you think learning disability should form a distinct sub-category of mental disorder in a new Mental Health Act? Would “learning disability” thus replace “mental impairment”?

3.10 Do you agree that the term ‘learning disability’ should replace ‘mental handicap’, ‘mental impairment’, and ‘severe mental impairment’?

3.11 Do you agree that the term should not be further defined?

3.12 Do you think that personality disorder should continue to be included in the Mental Health Act?

3.13 If so, do you agree that the definition should be broad, to allow for changes in definition and practice in the future?

3.14 If you do not think that personality disorder should be in the Act, what would the effect be for people, especially non-offenders, seeking medical or psychological help with their personality disorder?

3.15 Do you agree that there should be an automatic review if the diagnosis of a mentally disordered person’s category of mental disorder changes?

3.16 Do you think that these terms relating to sexual orientation and behaviour should be removed from the legislation? Do you think that they should be replaced with any other terms?

3.17 Do you agree that:

- substance abuse;
- undesirable or criminal behaviour in the absence of mental disorder; and
- “acting as no prudent person would act” should be specifically excluded from the legislation?

4: Grounds For Compulsory Interventions

4.1 Is there a way in which the appropriateness test could be modified or formulated as to make it an ethically justifiable ground on which to undertake compulsory interventions?
4.2 Do you think that a capacity test (questions of risk aside, as they are dealt with below) should replace the appropriateness test?

4.3 Is there a workable, flexible and well-understood definition of capacity? Is the definition of incapacity given the Adults with Incapacity Act appropriate for a new Mental Health Act? If not, how should incapacity be defined?

4.4 Do you have any comments on the practical implications of a capacity test?

4.5 Do you support a criterion for intervention which is neither appropriateness nor capacity as they are outlined above?

4.6 If so, what do you think that might be?

4.7 Do you think that the current definition of risk should be broadened?

4.8 If so, what should it be broadened to? “Risk of serious harm”, or something else?

4.9 Do you think that, if a capacity test were introduced, there should be different levels of risk for capable and incapable people?

4.10 If so, if a capable person is to be compelled to take treatment or detained against their will, should risk to others be the only justification?

4.11 Or should serious or life threatening risk to self also justify such an intervention when the person is capable of making their own decisions?

4.12 Do you think that the Scottish Act should replace the tests of appropriateness (or capacity) plus risk with a test based in a large part on risk, along lines similar to the DoH proposals?

4.13 Do you have any comments on how risk should be assessed?

4.14 Do you think that the treatability criterion should continue to apply to:
   - people with personality disorder?
   - people with learning disabilities?

5: Detentions under the Act

5.1 Do you agree that it should be possible to move onto a short-term detention straight from an emergency detention (without waiting 72 hours)?

5.2 Do you agree that it should also be possible to have a short-term detention straight from the community?
5.3 Given that an appeal against short-term detention already exists, do you think that a short-term detention should last for 7 days (extendable up to 28) or should continue to be granted for 28 days?

5.4 Do you agree that there should be an explicit statement in the Act that the need for detention should be kept under continuous review?

5.5 Do you think that the provisions of the six-month detention order should be modified, and, if so, in what way?

5.6 Are there any comments that you would like to make on the procedures for appeal?

6: Compulsory Treatment in the Community

6.1 Do you agree that there may be a need for compulsion in the community, for some patients?

6.2 If you agree, are the descriptions of:
   • to whom the CTO would apply
   • the scope of the CTO
   • the grounds for discharge from the CTO
   given above acceptable to you?

6.3 Do you think that someone need necessarily be admitted to hospital immediately before they may be put onto a CTO? Or do you think there might be cases when a person, who fulfils the criteria for a CTO might not need to be admitted at all before going onto the Order?

6.4 Are there particular safeguards that you would wish to see, to prevent such an Order being over-used?

6.5 If you do not agree that there is a need for some form of CTO, what do you think should be done for this small group for whom non-compulsory interventions do not appear to be working?

6.6 Do you have any opinions on the name of the Order?

7: Patients’ Rights

7.1 Do you agree that the Committee’s report should recommend that action be taken:
   • to address the stigma attached to mental health problems; and
• to clarify difficulties in respect of benefits for detained patients?

7.2 Do you wish to draw any other specific problems faced by mental health service users to the Committee's attention?

7.3 Do you agree that there should be a right for detained patients to have:
• an assessment;
• a Care Plan;
• implementation of that Care Plan; and
• a consideration of their aftercare needs?

7.4 Should there be a distinction made between the rights to these services for detained or non-detained patients?

7.5 Do you agree that a patient subject to compulsion should not have to pay for the compulsory element of their care?

7.6 Do you agree that there should be a statutory requirement on agencies to co-operate?

7.7 If so, should this requirement be legally enforceable?

7.8 Do you think a form of words similar to “evident willingness to accept treatment” should replace “consent to treatment” as currently used?

7.9 Do you agree that voluntary patients should be included in many of the Act's broad safeguards?

7.10 Do you agree that this may reduce the need for specific safeguards relating to voluntary patients only?

7.11 Alternatively, do you think that there will still be a need for safeguards in the Mental Health Act which relate to voluntary patients only?

7.12 Do you think that advance directives should be binding unless the results of a refusal would put the patient's life in danger or put others at risk? Or are there any other circumstances which would lead to them not being binding?

7.13 Alternatively, do you think that advance directives should have no legislative status except for an expectation that they will be considered?

7.14 Or do you think that advance directives should operate in some other fashion?

7.15 Do you agree that there should be a statutory right to access to advocacy for all mental health service users, whatever their legal status?
7.16 Do you think an advocate should have access to all elements of a patient’s care if the patient so wishes?

7.17 Do you agree that a statutory responsibility for ensuring that advocacy is available and ensuring its quality should be introduced?

7.18 If so, should this responsibility lie jointly with Health Boards and Local Authorities?

7.19 Alternatively, do you think that there should be a central body for the promotion of advocacy?

7.20 If so, would it provide services, or monitor their quality, or would it have some other function?

7.21 Do you agree that collective advocacy groups should be given recognition by statutory organisations?

7.22 If so, should they be independent or should statutory organisations call them into being?

8: Protection of vulnerable people

8.1 Do you think that the Act should detail the broad criteria for special treatments?

8.2 If so, what would those criteria be?

8.3 Do you think that certain treatments should be named in the Act itself, instead of in regulations?

8.4 If so, which treatments would this be?

8.5 Alternatively, do you think that all special treatments should be detailed in Regulations, and the Act’s provisions should be more general?

8.6 What do you think the Code of Practice should say about special treatments?

8.7 What do you think the safeguards for special treatments should be?

8.8 Do you have any comments on:

- the relationship between safeguards for special treatments in mental health law, and those in the Adults with Incapacity (Scotland) Act 2000?
- the suggestion that some treatments may require special approval, even where the patient is neither incapable, nor subject to compulsion?

8.9 Do you agree with these recommendations on restraint?
8.10 Do you agree that the law relating to sexual abuse of people with mental disorder should change to the form suggested?

8.11 If not, how do you suggest that the law handles cases of sexual abuse of people with mental disorder?

8.12 Do you agree that the Mental Health Act should require special provision to be made for the mental health needs of children and young people?

8.13 Do you agree there is a need for better co-ordination of the legislation for children at risk and mental health legislation?

8.14 If so, can guidance be contained in a Code of Practice or in some other way, or is new legislation required? What might any such guidance or legislation say on these issues?

8.15 Do you think it would be helpful to clarify the law on treatment for psychiatric disorder where a child or young person resists treatment and it is considered necessary to overrule their objections?

8.16 If so, do you agree that there are circumstances in which it would be more appropriate to use Mental Health Act provisions than rely on parental consent?

8.17 Do you agree that additional safeguards may be needed for some treatments for young people?

8.18 If so, which treatments might need these additional safeguards, and should they be provided by means of legislation?

8.19 Do you agree that protection of young carers should be by means of the Children (Scotland) Act rather than a matter for mental health law?

8.20 Do you think the provision of these particular services to women, members of ethnic minorities and people with physical and sensory disabilities should be required as a matter of law?

8.21 If not, how could the requirement to provide them be enforced?

8.22 Do you think that there are any other services which service providers should be obliged to deliver to women, to members of ethnic minorities or to other particular groups?

8.23 Do you think that the provisions of the draft Vulnerable Adults Bill should be included in a new Mental Health Act?

8.24 Do you think that Parliament should consider a consolidation of the legislation relating to mental health?
9: Carers and nearest relatives

9.1 Do you agree that carers should continue to have their needs assessed and that social work should be the primary agency in this?

9.2 Do you agree that guidance or the Code of Practice, rather than the Act itself, should make it clear that carers should receive support services as appropriate to help them in their caring role?

9.3 Do you agree that carers should have the right to challenge interventions when the person they are caring for is incapable?

9.4 Do you think that carers should have the right to challenge interventions when they are caring for a capable person?

9.5 Do you agree that nearest relatives should no longer consent to nor have the power to initiate detentions?

9.6 Do you agree that a “nominated person”, as described above, should replace the “nearest relative”, in the circumstances described above?

9.7 If so, do you agree that there should be appropriate information given to the person’s carer, if the carer is not the nominated person? What should that be?

9.8 Do you agree that there should be a certain amount of information given to family members who might neither be the nominated person nor the carer? What information should that be and in what circumstances?

10: Forum for Appeals

10.1 Do you agree that the function of the forum should be broadened beyond simply determining that the grounds for compulsion are met?

10.2 Do you think that the Sheriff Court should be retained for decisions on compulsory interventions in essentially the same form as at present?

10.3 If the Sheriff Court is retained, what improvements would you like to see to the procedures for Mental Health Act cases?

10.4 Do you think that the Sheriff should be retained but with an advisor or advisors?

10.5 If so, what professional background do you think such an advisor or advisors would have to have, and how could their independence be ensured?

10.6 Do you think that a type of Mental Health Review Tribunal should be the forum for reviews of compulsory interventions?
10.7 If so, which of the suggested possible functions would it be appropriate for the Tribunal to have?

10.8 How can consistency in judgements be assured?

10.9 Do you think another type of tribunal should be instigated for reviews of compulsory measures under the Act?

10.10 If so, what would this tribunal look like?

11: The role of the Mental Welfare Commission for Scotland

11.1 Do you agree that the powers of the MWC should extend to non-detained patients, without requests for an interview having to be made or concerns about an individual being raised?

11.2 Do you agree that the powers of the MWC should extend to patients outside hospitals, without requests for an interview having to be made or concerns about an individual being raised?

11.3 Do you think that there should be a statutory requirement for the MWC to undertake unannounced visits? If so, should this be to facilities in the community as well as hospitals?

11.4 Do you think that the MWC should continue to undertake reviews of detentions?

11.5 If so, do you think that it should begin to review the detentions of those who have not made an appeal to the Commission for discharge? How could it do this without being overwhelmed with cases?

11.6 Should the monitoring of complaints about all types of healthcare be dealt with by the same authority?

11.7 If not, should the MWC undertake formal investigations of complaints about mental healthcare more frequently?

11.8 Do you agree that the Commission should have an independent power to publish its Deficiency in Care reports?

11.9 Do you think the MWC should have more power to enforce its recommendations?

11.10 If so, what sanctions should be available to it against service providers or others who fail to comply?

11.11 Should co-ordinated activity and efforts to avoid duplication of labour between the MWC and SHAS (and perhaps others) be enshrined in the new legislation?
11.12 Do you think that the MWC should be more directly accountable to the Scottish Parliament in this fashion?

11.13 Do you think that the make-up and structure of the MWC should be changed?

11.14 If so, in what way?

11.15 Do you have any comments on the provision of Second Opinion Doctors?

11.16 Do you agree that the MWC should have a formal responsibility to audit the quality of mental health services?

11.17 If such a role were introduced, should it be a general role in relation to mental health care, or a specific role in relation to the procedures and principles set out in a new Mental Health Act?

11.18 Do you think that the MWC should disperse to the regions in the fashion described above?

11.19 If not, do you think that the MWC should investigate methods for improving its accessibility to people outside the central belt? If so, do you have any suggestions for how it should do this?

12: Roles of professions in the Act

12.1 Do you agree that GPs require compulsory training in the Mental Health Act before being able to initiate detentions?

12.2 Do you agree that GP co-operatives should be required to have an adequate number of GPs properly trained in mental health and in the use of the Act?

12.3 Do you agree that the role of the Second Opinion Doctor should be broadened to include advice on whether the treatment is the best one available?

12.4 Should the legislation strengthen the requirements for training of Second Opinion Doctors?

12.5 Do you agree that MHO status should remain one that is given to specially trained social workers only?

12.6 Do you think that CPNs should be given the power to initiate emergency detentions on their own behalf?

12.7 Do you think that CPNs should be given the power to act as a second medical recommendation for a long-term detention?

12.8 If so, would they replace the GP’s role in the Mental Health Act, or should the
Act allow for either professional to give the second medical recommendation?

12.9 Do you think that a psychologist could be the responsible clinical officer in certain cases?

12.10 If so, how do you think this could be framed in the legislation without disrupting the chain of accountability? In particular, which profession would take responsibility if the person has co-morbid mental illness and personality disorder or learning disability, or if the diagnosis is doubtful?

13: Forensic issues

13.1 Do you agree that Mental Health Officers should also report to the court where mental health disposals are under consideration?

13.2 Do you have any other proposals to improve the assessment process before a criminal court considers a mental health disposal?

13.3 Do you agree with these proposals relating to Hospital Directions and interim Hospital Orders?

13.4 Do you have any other proposals in relation to Hospital Directions and interim Hospital Orders?

13.5 Do you agree that an independent body should have a role in decisions regarding the discharge and recall of restricted patients?

13.6 If so, should such a body have the power of discharge or the responsibility only of making recommendations to the minister? If the body, acting quasi-judicially, had the power of discharge, would there still be a need for a separate appeal to the Sheriff?

13.7 Do you have any comments on the Committee’s suggestions as to the nature and powers of such a body?

13.8 If a new body were taking discharge decisions, how would the day-to-day management of restricted patients be undertaken?

13.9 Do you believe there should be a formal review of conditional discharge if the conditions are not observed?

13.10 Do you have any other proposals which would improve the supervision of restricted patients on conditional discharge?

13.11 Do you agree that detained patients should have the right to appeal periodically against the level of security under which they are held? How often should detained patients have the right to make this appeal?

13.12 Ought there to be a mechanism, in individual cases, for the Court to review
the non-provision of mental health services at an appropriate level of security?

13.13 Do you agree that there should be a review of the law relating to insanity and diminished responsibility?

13.14 Are there any changes to the law in relation to insanity and diminished responsibility, which should be introduced without such a review?

13.15 Do you support an amendment to the Criminal Procedure (Scotland) Act, which would make people who commit homicide, and who are acquitted by reason of insanity, subject to the same range of disposals as others acquitted by reason of insanity?

13.16 Do you support any strengthening of the sanctions for offenders subject to supervision and treatment orders?

13.17 Do you wish to see a greater development of appropriate adult schemes?

13.18 Should such schemes be placed on a statutory basis?

13.19 Do you have any comments as to how persons with mental disorders can best be supported in the criminal justice process?

13.20 Do you think that the advantages to medical practitioners of moving the provisions of the CPSA relating to mentally disordered persons into the Mental Health Act would outweigh the disadvantages to those in criminal justice?

13.21 Do you agree that compulsory treatment should be possible for untried prisoners, remanded in hospital under s52 of the CPSA, provided this has been approved by two appropriately qualified medical practitioners?

13.22 Do you agree that, in the event of a Hospital Order being recommended, and the accused person being acquitted, the court should reconvene immediately (or should have the power to hold the patient until it can reconvene), on the basis that the Hospital Order recommendation operates as an application for detention?

13.23 Do you agree that it should be possible to transfer remanded prisoners to hospital for assessment?

13.24 Do you agree with the Committee’s general approach to the issues raised by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999?

13.25 Do you have any views as to what steps, if any, should be taken to deal with current patients who are subject to Hospital Orders with restrictions, who would not be detainable but for the provisions of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999?

13.26 Do you have any comments on the recommendation that there should be an
interim procedure or delayed discharge after successful appeals against detention by restricted patients, to allow care plans to be put in place?

13.27 Do you have any other comments on legislative issues, arising out of the Mental Welfare Commission enquiry into the care and treatment of Noel Ruddle?

14: Code of Practice

14.1 In general, should the Code cover more areas or be made stronger than at present? If so, what else should it do?

14.2 Do you agree the Act should require that the Code be updated regularly and, if so, how often?

14.3 Do you think that the Code of Practice should contain clearer delineation of the MWC’s role?

14.4 Do you think that there should be a “consumer’s group”, independent of the MWC, to oversee the implementation of mental health law? If so, how would this work in practice?

15: The European Convention on Human Rights

15.1 Are there any human rights issues that you wish to raise?

16: Other

16.1 Are there any other points you wish to raise?