

Renewing Mental Health Law
policy statement



executive summary



SCOTTISH EXECUTIVE

Working together for a healthy, caring Scotland



Introduction

1. We will bring forward a Bill to the Scottish Parliament early next year, which will replace the Mental Health (Scotland) Act 1984. This will implement our commitment, in *Programme for Government, Making it Work Together*, to modernise the statutory framework for meeting the needs of people with mental illness.
2. The introduction of new legislation goes hand in hand with the measures set out in *Our National Health; a plan for action, a plan for change* for improving the quality and consistency of care in Scotland's mental health services.

The Millan Report

3. We are taking forward the vast majority of the recommendations made by the Millan Committee in their report *New Directions, Report on the Review of the Mental Health (Scotland) Act 1984*.

Statement of Principles

4. The Mental Health Bill will have a clear underlying set of principles. These will provide a clear context for the interpretation of the legislation and any intervention under the Act should take account of the stated principles.
5. The principles are:
 - **Non-discrimination** - People with a mental disorder should wherever possible retain the same rights and entitlements as those with other health needs.
 - **Equality** - All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin.
 - **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.
 - **Reciprocity** - Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.
 - **Informal care** - Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.



Executive Summary

- **Participation** - Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of both past and present wishes, so far as they can be ascertained. Service users should be provided with all the information and support necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.
- **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.
- **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 effective care, taking account where appropriate of the safety of others.
- **Benefit** - Any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.
- **Child welfare** - The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Whom the Act Covers

6. The presence of mental disorder will remain as the essential criterion for determining whether a person is covered by the provisions of the Mental Health Bill. There will be three categories of mental disorder: mental illness, learning disability and personality disorder.
7. We will undertake a review of the appropriateness of including people with learning disabilities within mental health law.

Grounds for Compulsion

8. The new Mental Health Bill will set out more clearly than before the grounds which must be met before compulsory care is justified.
9. The tests which must be satisfied, before long-term compulsion may be imposed will be based on:
 - the presence of mental disorder;
 - the necessary care and treatment cannot be provided by agreement with the patient;



- the person's decision-making ability is impaired to a nature or degree which would justify compulsory measures;
- the treatment proposed is likely to benefit the patient by alleviating or preventing deterioration in the patient's mental disorder, or associated symptoms of that disorder;
- the treatment proposed is the least restrictive and invasive alternative available, which is compatible with the delivery of safe and effective care; and
- there is a significant risk of harm to the health or safety or welfare of the patient or a significant risk of harm to other persons if such treatment is not administered.

Compulsory Interventions

10. The existing broad framework of emergency detention (up to 72 hours), short-term detention (up to 28 days) and long-term compulsion (up to 6 months, renewable for a further 6 months and then annually) will be retained. We will take measures designed to reduce the use of emergency detention, and to strengthen the role of mental health officers in the process.

Long-Term Compulsory Interventions

11. We will introduce a more flexible form of long-term compulsion, which will build on the current procedures for 'section 18' detention, with strengthened safeguards for service users. We will move from the current position – where all detention orders contain the same powers – to one where the compulsory powers are only those appropriate to the particular case, and reflect the principles of the legislation. Depending on the needs of the patient, it will be possible for the order to require admission to hospital, or to allow the patient to remain in a community setting.
12. A plan of care will be central to the statutory process. The plan will set out the interventions and support that the patient can expect in the short, medium and longer term. The aim is to achieve person-centred care delivered by a range of agencies that is flexible and responsive to the patient's needs.
13. Following consultation, we have built on the Millan Committee's proposals concerning community based care and treatment to strengthen the safeguards for service users.
14. We will make it clear in the Code of Practice (see paragraph 39) that community-based orders should only be imposed where alternative approaches to secure adequate compliance with necessary treatments have been shown to be impracticable.
15. We will set out in regulations the conditions which can be imposed by a community order. There will be no presumption that any of these conditions will automatically be



Executive Summary

imposed. Under the *least restrictive alternative* principle, a condition will only be specified as compulsory where it can be shown that this is essential to the appropriate delivery of necessary care.

16. We will make it clear in the Bill that it should not be possible for treatment to be given forcibly except in a hospital or other clinical setting. We will also set out guidance in the Code of Practice on treatments which should only be given in a clinical setting, even where the patient is not resisting the treatment.
17. In all cases, the responsible medical officer will be required to keep the needs of the patient under continuing review during the period of compulsion. If the patient no longer meets the criteria for compulsion, the responsible medical officer will be under an obligation to discharge the order.
18. The care team looking after the person will undertake a full multi-disciplinary review before any renewal of the order. The patient and the Named Person (see paragraph 30) will be able to appeal to the Mental Health Tribunal (see paragraphs 19-24) to remove the order. Furthermore, the Millan Committee recommended that all orders should be reviewed by the Tribunal at least once every three years. We intend to strengthen this further, for all long term orders, by reducing the maximum period between reviews by the Mental Health Tribunal to two years.

Mental Health Tribunal

19. A new tribunal to hear cases brought under the Mental Health Act will be created.
20. The tribunal will consider each of the new criteria for compulsion, and whether to grant compulsory powers, which will be tailored to the needs of the individual patient. In doing so, it will take account of the patient's plan of care, and apply the principles of the Act.
21. The tribunal will consist of three members, and be chaired by an experienced lawyer. There will also be a medical practitioner with experience in mental health. This will often be a psychiatrist, although it will also be possible for other medical practitioners with appropriate experience and expertise to serve. The third member will be a person with experience of the assessment, planning and delivery of mental health services, for example from a social work, nursing or voluntary sector background.
22. The procedures for mental health hearings will be designed to encourage the participation of service users and carers. The tribunal will operate as informally as possible, while meeting the requirements of due process. Hearings will not be held in a courtroom, but in a hospital or other appropriate venue.
23. The Millan Committee recommended that the medical member of the forum should conduct an examination of the patient prior to the hearing. We have concluded that this



is not desirable but that, in addition to the patient's right to seek an independent opinion, the tribunal will be able to seek an independent medical opinion if they decide one is needed.

24. Patients and Named Persons will have access to free legal representation for mental health hearings.

Special Safeguards for Particular Treatments

25. The existing safeguards for particular treatments will be retained and extended. Independent second opinions will be required for any of the following treatments, when given without consent to a patient subject to compulsion:

- Medication intended to reduce sexual drive;
- Electro-convulsive therapy;
- Medication for mental disorder given for over 2 months;
- Medication given above the recommended dosage;
- Forcible feeding.

26. Neurosurgery for mental disorder will require the same stringent safeguards for all patients, whether subject to compulsion or not. These are that:

- the patient must consent to the procedure;
- two lay persons appointed by the Mental Welfare Commission must certify the patient is capable of giving such consent; and
- an independent doctor with suitable expertise must approve the procedure.

Rights of Users and Carers

27. Although much of the Mental Health Act concerns the situation of patients who are subject to compulsory care, our aim is that the new Mental Health Act should form part of our strategy for improving the rights of all users of mental health services. This means protecting patients' rights, even when they are treated informally; improving the procedures for assessing and meeting needs; and strengthening the voice of patients. We are also committed to ensuring that carers and families receive better support, and have a greater opportunity to be appropriately involved in decisions about care and treatment.



Executive Summary

28. The Code of Practice will give guidance on protecting the rights of informal patients. We will introduce a new right for service users and their families to request an assessment of the service user's needs.
29. Local authorities and NHS Boards will be asked to make advocacy available for all mental health service users. Patients will have a right to make advance statements setting out their wishes for care and treatment and to have this taken into account by professionals.
30. Patients will have the right to appoint a Named Person to help represent their interests in Mental Health Act proceedings. Where the patient is unable to make such a nomination, the primary carer or nearest relative will take this role.

Vulnerable People

31. People with mental health problems or learning disabilities are, too often, at risk of neglect and abuse, and our proposals for the Mental Health Bill will add additional protection.
32. We will introduce the measures recommended in the Scottish Law Commission's report on Vulnerable Adults, to improve the procedures for intervention in cases of suspected abuse, where the person is mentally disordered. We will also update and strengthen the offences in the Act which address sexual abuse, neglect and ill-treatment.

Mental Welfare Commission

33. The Mental Welfare Commission for Scotland will continue to play a key role in safeguarding the welfare of people with mental disorders, and will have a broader range of powers. We will ensure that its membership reflects the perspectives of users, carers and professionals. The Commission will be expected to promote the principles of the Act, and protect the rights of patients.

Offenders with Mental Disorder

34. Although the great majority of people with mental disorder do not pose any risk to the public, there is a small number who do offend, usually in relatively minor ways. It is important that proper assessment is available, and that the courts have a wide range of disposals, to ensure that the offender receives the right care and treatment, and that the public interest is safeguarded.
35. The current system contains a sophisticated range of disposals to deal with offenders with mental disorder, and we will build on, rather than replace, the existing system. The proposals will ensure more thorough assessment prior to the court making a disposal, and deal with some anomalies of the current legislation.



High Risk Patients

36. Scottish Ministers will continue to oversee the management of patients made subject to restriction orders by the criminal courts. However, the Mental Health Tribunal, chaired by a sheriff, will authorise all discharges and transfers to lower levels of security of restricted patients. We will explore ways of making it easier for patients to transfer to appropriate levels of security when justified by improvements in their conditions.

The Mental Health (Public Safety and Appeals) (Scotland) Act 1999

37. The 1999 Act introduced a number of provisions including a new test in determining whether a restricted patient should be discharged. It provided that a restricted patient should continue to be detained in hospital if suffering from a mental disorder and it was necessary to protect the public from serious harm.
38. An appeal against the legislation has been taken to the Judicial Committee of the Privy Council. In the light of the judgement we will consider how best to make provisions in the new Act which will balance the rights of the patient with the legitimate interests of the community to protection.

Making the Act Work

39. The new Act will bring about major changes in mental health law and practice. A comprehensive Code of Practice will be developed, in consultation with interested parties. We intend to publish the Code before implementation of the new legislation, and will seek to make it accessible to all.



© Crown copyright 2001
ISBN: 0 7559 0237 8

Executive Summary

You can get further copies of the summary from:

Public Health Division
Room 3ES
St Andrew's House
Regent Road
Edinburgh
EH1 3DG
Phone: 0131 244 2451
Fax: 0131 244 5076

If you ask, we can provide the summary in some community languages or on a computer disk.

The summary and full Policy Statement are also available on the website at
www.scotland.gov.uk/health/mentalhealthlaw

Produced on behalf of the Scottish Executive by **Astron**. B21741 10/01