

New Directions

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

Executive Summary

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TERMS OF REFERENCE

1. The Committee, which was chaired by the Rt Hon Bruce Millan, was set up by the UK Government in February 1999 to undertake a comprehensive review of the Mental Health (Scotland) Act 1984.

2. The remit given to the Committee was:

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

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

And to *make recommendations.*”

INTRODUCTION

3. There has not been a fundamental review of mental health law in Scotland for more than 40 years. The law needs to be reformed to reflect the development of community based mental health services, the greater involvement of service users and carers in decisions concerning treatment, and the greater awareness of the need to respect human rights.
4. A new Act should be based on principles set out in the Act itself. The circumstances in which people with mental disorders should be made subject to compulsory care and treatment should be set out as precisely as possible.
5. A reformed system requires a new legal forum, which is able to address in a more considered way the particular issues which arise in mental health cases. A new mental health tribunal, which would replace the present role of the sheriff in mental health hearings, is proposed.
6. Although substantial reform is needed, it is important to retain the positive aspects of the 1984 Act. In particular, nearly 90% of patients receiving treatment for mental disorder in hospital are admitted on an informal basis, and the aim should be to preserve the emphasis on voluntary, rather than compulsory treatment.
7. However, there is a general need to strengthen and clarify the rights of service users, whether subject to compulsion or otherwise, to advocacy, information and services. The rights of carers also need to be strengthened.
8. It is also important to ensure that the rights afforded by the Act apply with equal force to people with particular needs, such as members of ethnic minority communities, children and people with disabilities.
9. The reforms proposed may, to some degree, increase the workload of professionals, who are already under considerable pressure. It will be important both that new procedures are as straightforward as possible, and that the need for greater support is borne in mind.
10. The extent to which the resources presently available to mental health services are adequate was not included in our terms of reference. We note, however, that the Accounts Commission has identified that no area in Scotland has a comprehensive range of services for adults with mental health problems, and the Mental Welfare Commission has highlighted continuing under-investment in maintaining in-patient services, alongside a dearth of therapeutic and recreational activities for many service users.
11. These findings are consistent with much of the evidence received by the Committee. Without adequate services, the aspirations which underlie the recommendations we make for new mental health law will not be fully met.

FRAMEWORK OF A NEW MENTAL HEALTH ACT

The need for reform

12. There have been major changes in mental health care over the last two decades, which mean that some of the fundamental assumptions of the 1984 Act no longer hold. In addition, changes to the 1984 Act and to other related legislation have meant that the legislation is often confusing in its effect and sometimes anomalous, and there are significant practical problems with its operation. These have led us to conclude that the 1984 Act should be repealed and replaced with a new Act of the Scottish Parliament.
13. The new Mental Health Act, based on clear principles, should clarify and improve the rights of service users and carers, and make it easier for these rights to be used effectively. In particular, it should ensure that care and treatment are provided, wherever possible, without resort to compulsion.

The scope of a new Mental Health Act

14. Mental health legislation needs to provide principally for those circumstances where compulsory measures of care and treatment for mental disorder are necessary, including provisions for offenders with mental disorders. Provision should however continue to be made for other matters dealt with in the 1984 Act, particularly rights to aftercare and other local authority services, and protection from abuse.
15. The Adults with Incapacity (Scotland) Act 2000 replaces parts of the 1984 Act with new provisions, particularly in relation to guardianship and the management of patients' funds. The new Mental Health Act and the Adults with Incapacity (Scotland) Act 2000 should, in due course, be consolidated into a single Act.

Principles of the new Act

16. The Mental Health Act should contain a Statement of Principles. Interventions under the Act and the guidance in the Code of Practice should have regard to these Principles. The Principles should be:
 - (i) **Non discrimination** - People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs.
 - (ii) **Equality** - All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national or ethnic or social origin.

- (iii) **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.
- (iv) **Reciprocity** - Where society imposes an obligation on an individual to comply with a programme of treatment of 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.
- (v) **Informal Care** - Wherever possible, care, treatment and support should be provided to people with mental disorder without recourse to compulsion.
- (vi) **Participation** - Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Service users should be provided with all the information 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.
- (vii) **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.
- (viii) **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.
- (ix) **Benefit** - Any intervention under the Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.
- (x) **Child welfare** - The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Who would be covered by the new Act

- 17. It is desirable to have a broad term which would specify when the Act might apply. The basis for the application of the Act should be the presence of 'mental disorder'. The responsibilities of the Mental Welfare Commission, and the duties of local authorities and the NHS under the Act, should apply to people with mental disorders and, where appropriate, their carers and families.
- 18. It should only be possible for a person to be subject to compulsory measures of care under the Act where that person has a mental disorder.

19. The general term, 'mental disorder', should be divided into three categories: mental illness, learning disability and personality disorder. The legislation should not seek to define 'mental disorder' or these categories, but guidance should be given as to their application in the Code of Practice. For the avoidance of doubt, some conditions whose inclusion within these categories may be questioned are discussed further.

Mental illness

20. The term 'mental illness' is intended to cover psychotic disorders such as schizophrenia, but also non-psychotic conditions such as disorders of mood, severe obsessive compulsive disorder and anorexia nervosa. It would also cover dementia and acquired brain injury with associated mental symptoms.

Learning disability

21. The term 'learning disability' is intended to include people with autistic spectrum disorders and would replace the terms 'mental handicap', 'mental impairment', and 'severe mental impairment', currently in the 1984 Act.
22. There are strong arguments for making separate legislative provision for people with learning disabilities. People with learning disabilities have different needs from people with mental illnesses, and many people feel that the 1984 Act does not reflect these differences adequately.
23. However, it would be premature to remove the category of learning disability from mental health legislation at this stage. To do so might result in some people with learning disabilities being denied necessary and appropriate care and support. A comprehensive and expert review should take place at an early date to review the position of learning disability within mental health legislation.

Personality disorder

24. There are different views about the inclusion of personality disorder within the Mental Health Act. However, it is accepted that many people with personality disorders require mental health services, and so the duties and responsibilities provided for in the Act should extend to this group.
25. The question of whether it should be possible to be subject to compulsory measures of care on the basis of a diagnosis of personality disorder is more difficult. In recent years, very few people have been detained under the category in the 1984 Act most relevant to personality disorder. The view of psychiatrists is generally that, insofar as personality disorders can be treated successfully, this can only be done with the co-operation of the patient.
26. However, the distinction between personality disorder and mental illness is not always clear-cut in an individual case. Where mental disorder is present, the question of possible compulsion should be determined on the basis of the

grounds for compulsion set out below, rather than the particular form of the disorder. It should therefore be possible for a person with a primary diagnosis of personality disorder to be subject to compulsory measures, but it is anticipated that such situations will arise infrequently.

Exclusions

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

Change of category of disorder

28. Where, on renewal of long term compulsion, the diagnosis of a person changes from one of the categories of mental disorder to another, there should be a review of the case by a mental health tribunal.

COMPULSORY TREATMENT

Grounds for compulsion

29. The criteria for detention in the 1984 Act are inconsistent with the recommended principles of the new Act, and would be inappropriate for the proposed community orders. New grounds for compulsory measures of care should be based on the ethical and practical justifications for requiring, in some circumstances, people with mental disorders to accept treatment without consent.
30. The basis of such interventions should be impaired judgement, risk, and benefit to the patient.
31. Consideration was given to whether incapacity to make a treatment decision should be an essential condition of compulsory treatment. It was felt that a criterion of impaired judgement was a more appropriate formulation.
32. The conditions which would require to be met before long term compulsory measures could be imposed are as follows:
 - ◆ The presence of mental disorder;
 - ◆ The necessary care and treatment cannot be provided by agreement with the patient;
 - ◆ It can be shown that, as a consequence of the person's mental disorder, the person's judgement is impaired to a nature or degree which would justify compulsory measures;
 - ◆ The treatment proposed to be administered under the plan of care for the patient is likely to provide a benefit for the patient by alleviating or preventing deterioration in the patient's mental disorder, or associated symptoms of that disorder;
 - ◆ The care and treatment proposed is the least restrictive and invasive alternative available compatible with the delivery of safe and effective care; 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 a treatment is not administered.

For emergency and short term detention, it would only be necessary to show a reasonable likelihood that the person's judgement was impaired.

33. The same criteria should apply to all three categories of mental disorder. The 'treatability' criterion, which currently applies to people with mental impairment and those whose mental disorder 'is a persistent one manifested only by abnormally aggressive or seriously irresponsible conduct', should be abolished. The recommended criterion of benefit makes such a provision unnecessary.

Compulsory interventions

34. The compulsory measures in the 1984 Act are based on detention in hospital. Compulsory treatment is not possible without prior admission to hospital. In approving detention or considering appeals, the sheriff court is primarily concerned with whether the criteria for detention are met, not in what interventions will take place following detention.
35. The principles recommended for the new Act suggest a move towards more flexible forms of compulsion, based on the needs and circumstances of the individual patient. In particular, compulsory treatment should no longer be exclusively linked to hospital detention, and the authorisation of compulsory measures should require consideration of the proposed treatment.

Plan of care

36. A plan of care should be prepared for any patient who is the subject of an application for long term compulsion. This should specify the proposed plan of treatment, care and support from health, social work and other agencies, and should be submitted to a mental health tribunal for approval.
37. The tribunal should require to be satisfied that the compulsory elements of the plan of care are justified, and that the plan contains provision for an adequate and appropriate level of service. Where the tribunal is not so satisfied, it could refuse to approve the order for compulsion, or could approve a temporary order for up to 28 days, to allow a revised plan to be submitted.

A new form of long term compulsion

38. There should be two forms of long term compulsion, a hospital based order (similar to detention under the 1984 Act) and a community order. Both would be based on an application to a mental health tribunal, and the procedure and time limits would be identical.
39. The possibility of compulsory treatment in the community is supported by many health professionals, but user groups are divided. There is opposition to the possibility of forcible treatment in people's own homes, and concern that such orders would increase the use of coercion, without ensuring the delivery of adequate support. The proposals for a community order have taken account of these concerns.
40. Although a community order could include a requirement to accept medical treatment, it would only be possible to administer such treatment forcibly in a clinical setting.
41. Other compulsory aspects of a community order might include that the person reside in a particular place, attend specified services, or allow access to professionals. Regulations should set out the range of compulsory measures which could be imposed by a community order.

42. The Code of Practice should identify standards of care which should be observed for patients subject to community orders.

Moving between community and hospital based orders

43. It should be possible to move between a community order and a hospital based order. Where a patient fails to comply with a community order, the responsible medical officer should be able to require the patient to be admitted to a hospital or clinic for treatment. Unless the order is discharged, a tribunal must consider the case within 2 months of such an admission to hospital.

Leave of absence

44. For patients subject to hospital based orders, the possibility of leave of absence should remain, but should be restricted to a maximum continuous period of 6 months. Thereafter the patient, if not discharged from compulsion, would require to be transferred to a community order or readmitted to hospital.

Community care orders

45. The current provision for community care orders would be superseded, and should be abolished.

Initiating and approving compulsion

46. The 1984 Act provides that emergency (72 hour) detention is initiated by a medical practitioner. Short term (28 day) detention is initiated by a psychiatrist, and long term (6 month detention) is initiated by an application to the sheriff court from a mental health officer, with two medical recommendations, normally from a psychiatrist and the patient's GP. The nearest relative also has the power (seldom used) to initiate an application for long term detention.
47. The Act also provides that, where practicable, consent from a mental health officer or a relative should be obtained to emergency or short term detention.

The role of relatives

48. Relatives of service users should not be expected to consent to or initiate compulsion under the Act, and these provisions should be removed. This may relieve some of the burden from relatives and alleviate the often damaging effect that this procedure can have on the relationship with the service user.

The role of GPs

49. General practitioners should continue to have a role in initiating emergency detention and supporting applications for long term compulsion. There should be a requirement for general practitioners to receive greater training in mental health issues, including the use of the Mental Health Act.

The role of psychiatrists

50. The initiation of short term detention, and the first medical recommendation for long term compulsion, should continue to be by a doctor certified by a health board as having special experience in the diagnosis and treatment of mental disorder. Regulations should specify the criteria to be applied by health boards in so certifying doctors, which should include having attended appropriate training.

The role of mental health officers

51. Mental health officers should continue to be qualified social workers, appointed by local authorities. A mental health officer should be required to consent to emergency detention, where practicable, and to short term detention, in all cases. A mental health officer should report to the tribunal in all applications for long term compulsion, and prepare a report on any renewal of compulsion. In any case where the mental health officer does not support renewal, the matter must be considered by a tribunal.

The role of nurses

52. There was little support for the introduction of any new statutory role for nurses in the Mental Health Act and this is not recommended. The Code of Practice should contain guidance on the responsibilities of nurses under the Act, and encourage GPs to discuss proposed detentions with community psychiatric nurses. NHS Trusts should be required to ensure that nurses dealing with patients subject to compulsion have an adequate understanding of the Act.

Duration, reviews and appeals

53. The existing 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) should be retained. However, a series of changes are recommended that would make the procedures more flexible.

Nurse's holding power

54. There is currently a power for nurses to hold, for up to 2 hours, a patient who is seeking to leave hospital and who may require emergency detention. The power should be amended to allow, where necessary, the doctor a further hour to assess whether detention under the Mental Health Act is appropriate.

Short term detention

55. Currently, short term detention can only be used following the expiry of a period of emergency detention. Transfer from emergency to short term detention should be possible as soon as the necessary procedures are completed.

56. It should be possible for a patient to be made subject to short term detention without a prior emergency detention, and this should be done in preference to an emergency detention wherever practicable. It is intended that this will reduce the current heavy reliance on emergency detention as a route to compulsory admission to hospital.

Long term compulsion

57. Long term compulsion (either a hospital based order or a community order) should require prior approval of a mental health tribunal, based on recommendations by two doctors, one of whom is certified as having special experience in the treatment of mental disorder, and a mental health officer.

Appeals and reviews

58. The patient or the patient's 'named person' (see paragraph 106) should have the right to oppose an application to a mental health tribunal for long term compulsion, and to appeal against the imposition of short term detention, or the renewal of long term compulsion.
59. After the first three months of a long-term compulsory order an application to the tribunal for variation of the order should be available to the patient or the patient's named person.
60. The Act should provide that the condition of a patient and the continuing need for compulsion should be kept under constant review by the care team, and if the patient no longer meets the criteria for compulsion, he or she should be discharged.
61. The responsible medical officer and the Mental Welfare Commission should retain the power to discharge the patient from compulsion. The rights of hospital managers and nearest relatives to discharge patients should be removed.
62. If a patient subject to long-term compulsion has not appealed within a period of three years, a review by the tribunal should take place. The necessity of compulsion would be re-appraised, and the plan of care would be approved or amended as required.
63. The participation of patients' carers and families in any procedures for compulsion should be encouraged. Mental health service managers should be under a duty to ensure that, so far as practicable, patients subject to compulsion are aware of the nature and effect of the compulsion, and their rights in relation to this. The Code of Practice should give guidance on the most effective implementation of these duties.

Medical treatment

64. It should be possible to give medical treatment to a patient subject to short-term detention or long-term compulsion for his or her mental disorder without consent, subject to the safeguards in relation to special treatments set out below.

65. It should be possible to treat a patient subject to emergency detention for his or her mental disorder, on a similar basis to emergency treatment for patients subject to other forms of detention. This would replace the existing use of common law treatment powers with a statutory framework based on the degree of urgency and necessity of the treatment.

Forum for compulsory measures

66. Consideration was given as to whether the sheriff court should continue as the forum for mental health hearings. Account was taken of a range of evidence including consultation responses, research into the operation of mental health hearings in sheriff courts (published alongside the Report) and evidence from the tribunal system in England and Wales.
67. The current procedural requirements in relation to Scottish mental health hearings are limited. The extent to which these hearings effectively protect the rights of patients varies considerably between individual cases. Although there is some good practice locally, many orders are made on the basis of limited evidence, often very brief written reports. There is generally little participation by patients or their families in the process. Most patients are unrepresented, and few exercise appeal rights.
68. The fundamental change involved in creating a new independent forum for mental health hearings in Scotland is recognised, but such a change is necessary. A number of key requirements of a reformed system are set out.
69. There should be statutory rules of procedure, drawn up after consultation with service user and professional interests, which should encourage the attendance of patients, and ensure that other persons concerned with the care and treatment of the patient may be required to attend as necessary.
70. There should be a procedure for straightforward access to free legal representation by solicitors accredited in mental health law. A *curator ad litem* should be appointed in every case where the forum is satisfied that a patient is unable to instruct legal representation.
71. Hearings should be in private, and in hospital, unless the patient or patient's representative requests otherwise. Health boards should have a statutory duty to provide suitable facilities for the holding of hearings.
72. All members of the forum should receive ongoing training in mental health issues.

A mental health tribunal

73. There are two possible options which could meet the requirements just outlined. These are a new tribunal, chaired by a legal member, and the retention of the sheriff, but sitting alongside two expert assessors.

74. The creation of a new system of mental health tribunals is recommended, rather than the retention of the sheriff. The new arrangements would provide for the appropriate degree of expertise and authority and also allow an open discussion of the best options for the service user.
75. Each tribunal should have 3 members: a legal chair, a medical member, and a member with experience of mental health services. The medical member should examine the patient prior to the hearing. Any findings should be available to the hearing, and the medical member should be able to be questioned by the parties or their representatives.
76. Organisationally, there should be a national structure, with a senior member of the judiciary at its head. Funding should be by the Scottish Executive Justice Department, and the Minister for Justice should appoint tribunal members.
77. It would be essential that the system be properly resourced, including with the necessary administrative support.

Treatments and interventions requiring particular safeguards

78. Part X of the 1984 Act specifies additional safeguards for a number of treatments for mental disorder, including ECT and psychosurgery. The provisions in the Act are generally acceptable, but further protection is appropriate for a variety of treatments.
79. The new Act should specify factors to be taken into account, when considering whether a treatment for mental disorder should attract special safeguards. These should include the extent to which the treatment may be hazardous, irreversible, novel, involve significant physical distress, carry a risk of serious side effects, or be perceived as controversial by society, or significant sections of society.
80. Neurosurgery for mental disorder should continue to require the patient's consent, certified by two independent persons, and approval by a doctor approved by the Mental Welfare Commission. These protections should be extended to informal patients.
81. Neurosurgery for mental disorder on a patient incapable of consenting should require the approval of the Court of Session. It should never be given to a patient who resists treatment.
82. Either the patient's consent or approval by a doctor approved by the Mental Welfare Commission (a 'second opinion' doctor) should be obtained before the following treatments may be administered to patients subject to compulsion:
 - ◆ ECT.
 - ◆ Continued medication for mental disorder after the expiry of a 2 month period.

- ◆ Oral medication to reduce sex drive.
 - ◆ Medication for mental disorder in excess of the recommended dose or for purposes other than the recommended purposes.
83. However, ECT should not be given where a patient capable of making a treatment decision has not consented.
 84. Forcible feeding on a patient subject to compulsion should require the approval of a second opinion doctor.
 85. The role of second opinion doctors should be clarified. The second opinion doctor should consider whether the proposed treatment is appropriate, bearing in mind the Principles of the Act, and any possible alternative treatment approaches. A second opinion should be renewed at least every 2 years.
 86. The Mental Welfare Commission should have responsibility for oversight of the special treatments included in the Act and regulations, and should advise Scottish Ministers of any new treatments that may require to be added.
 87. Where a child is incapable of consenting on his or her own behalf to a treatment, which is a special treatment under the Mental Health Act, the same protections should apply as if the child were subject to compulsion under the Mental Health Act.
 88. Any second opinion required for a person aged 18 or under should be by a specialist in child and adolescent psychiatry. In addition, should the responsible medical officer not be such a specialist, a further opinion by such a specialist should be obtained.

Other provisions relating to patients subject to compulsion

89. There should continue to be provision to allow patients subject to compulsion to be transferred between hospitals, by agreement between the managers of the respective hospitals. For patients subject to long term compulsion, proper notice should be given to the patient and, where appropriate, the primary carer. There should be a right of appeal to a mental health tribunal against a transfer within 28 days of the transfer taking place.
90. The legislation dealing with interference with the correspondence of patients should be updated to include new forms of communication, including electronic mail and faxes. Legislation should also clearly regulate the extent to which patients can have access to mobile phones, the Internet etc, and only restrict access in clearly defined circumstances.
91. The Code of Practice should contain general guidance on the use of these measures and on other special measures of security including searches and sharing information regarding service users with other agencies.

RIGHTS OF USERS AND CARERS

Rights of informal patients

92. Some service users feel under pressure to accept admission to hospital, or treatment, for fear of detention if they do not comply. This can lead to patients effectively being compelled to accept treatment, without the protections afforded by the Act. The Mental Welfare Commission should issue guidance on best practice in relation to the use of compulsory measures of care and treatment when patients are reluctant to accept treatment on a voluntary basis.
93. The Adults with Incapacity (Scotland) Act 2000 will improve the safeguards for service users who are not able to make a fully autonomous decision about their treatment, and overlaps in some respects with mental health law. The Codes of Practice for the new Mental Health Act and the Adults with Incapacity (Scotland) Act 2000 should provide guidance on the circumstances when it is appropriate to admit, detain or treat a patient compulsorily under mental health legislation, rather than under the Adults with Incapacity Act.
94. Protection for incapable patients in relation to 'exceptional treatments' under the Adults with Incapacity Act should be consistent with that in relation to special treatments for patients subject to compulsion under the Mental Health Act.
95. The only exception to this should be in relation to incapable patients in the community, in receipt of medication for mental disorder for over 2 months. To provide a second opinion by a specialist approved by the Mental Welfare Commission in all such cases is likely to be impracticable. However, any person with an interest in the welfare of such a patient should be entitled to require that such an opinion be obtained.

Service users' rights to assessment and services

96. The rights of service users, their carers and families to have the service user's needs for mental health services assessed should be strengthened. In particular, any application for long term compulsion should be after a multi-agency assessment, which would form the basis of a plan of care.
97. Where a person has previously had contact with mental health services, the service user or any carer should have a right to request that an assessment of the person's needs be undertaken by mental health services. Mental health services would not be bound to comply with such a request, but would be required to give reasons for any refusal to do so.
98. In line with the principle of reciprocity, there should be a duty on health boards and local authorities to provide appropriate services to patients subject to compulsion, as detailed in their plan of care.

- 99. The current duties of local authorities to provide 'after-care' and, in respect of persons with learning disabilities, 'training and occupation', should be updated and broadened.
- 100. There should be a duty on local authorities to provide or arrange care and support services and day activities to persons who are, or have been, suffering from a mental disorder. These day activities should include employment, training and education and social activities.

Individual and collective advocacy

- 101. Enabling service users to have access to independent advocacy is an integral aspect of ensuring that the Principles of the Act are upheld. All mental health service users should have a right to obtain access to an advocate.
- 102. It should be the joint duty of health services and local authorities to ensure those advocacy services are available and that service users are informed of the services, and to ensure that advocacy is of a satisfactory standard.
- 103. Local authorities and health services should support and recognise collective advocacy.

Advance statements

- 104. An advance statement is a statement by a person of the types of treatment and care he or she wishes to receive, should they lose decision making capacity in the future. Greater use should be made of advance statements, as a means by which service users may make their views and wishes known, and have greater involvement in decisions concerning their care and treatment.
- 105. No change is proposed to the legal status of advance statements for voluntary patients. Where a patient is subject to compulsion under the Mental Health Act, an advance statement should not be legally binding, but should be given due weight by the professionals involved in his or her care, and by the tribunal.

Rights of informal carers

- 106. The provisions for the 'nearest relative' in the 1984 Act contain a number of deficiencies and anomalies, and should be replaced by a more flexible system, based around the concept of a 'named person'.
- 107. The service user would be entitled to nominate a named person. Should this not be done, the named person would be the primary carer. In the absence of a nominated person or primary carer, the nearest relative would take the role. The tribunal should be entitled to replace a named person.

108. The named person should, where practicable, be consulted when compulsion is considered, and should have rights to be represented at tribunal hearings and to appeal against decisions of the tribunal. In addition, the named person should be entitled to be notified of;
- ◆ the service user's legal status under the Mental Health Act,
 - ◆ any application for compulsory measures,
 - ◆ any hearing by the tribunal,
 - ◆ any decision to discharge the service user from compulsory measures.
109. The rights of carers should be strengthened. The Code of Practice should set out the rights of the primary carer to information. Tribunals should be required to consider the implications for carers of any orders they might make.
110. The Scottish Executive should formulate an information strategy for carers of mentally disordered persons, and local authorities should take steps to ensure carers are aware of their rights to have their own needs assessed.

Civil and social rights

111. People with mental disorders can face specific disadvantages in areas such as housing, social work, health and welfare benefit legislation.
112. The UK government should review the extent to which social security rules may adversely affect people with mental disorders.
113. The Scottish Executive should develop guidance on positive action in relation to the housing needs of people with mental disorders.
114. There should be a campaign of public education designed to improve public understanding of mental disorder, and attitudes towards people with mental disorders, and to reduce the stigma of mental disorder.

Groups with specific needs

115. There are a number of groups whose needs are not adequately addressed at present by existing legislation and services, including people with disabilities, children and young people, women and members of ethnic minorities.
116. There should be a statutory obligation on health boards to provide or secure age appropriate mental health services, including secure services, for children and young people. Any child or young person subject to compulsion should have a named social worker and an advocate.
117. The Code of Practice should contain guidance on the interaction between the Children (Scotland) Act 1995 and the Mental Health Act.

118. Single sex accommodation should be available to those who wish it.
119. People with disabilities who require assistance with communication, and people whose first language is not English who require interpretation and translation facilities, in relation to compulsory measures should receive these, as of right.
120. Local authorities and health boards should be required to obtain information regarding the mental health service needs of people from minority ethnic communities in their area, and to develop policies for meeting these needs.

SAFEGUARDS FOR VULNERABLE PEOPLE

Protection of vulnerable adults

121. The Scottish Law Commission proposals regarding vulnerable adults should be implemented in respect of adults with mental disorder. This would strengthen the duties of local authorities to protect people at risk, and would introduce a staged series of interventions, including access to the person, assessment and, where necessary, removal to a place of safety. The Code of Practice should include guidance as to the exercise of functions under these proposals.
122. Where a person is removed to a place of safety under the provisions concerning vulnerable adults, and requires compulsory measures of care under mental health law, the normal provisions of the Mental Health Act should then apply.
123. It should be an offence for a person wilfully to ill-treat or neglect a person with mental disorder who is in their care. No offence would be committed where the person acted in good faith and with reasonable care.

Police powers and responsibilities

124. The police power to take a person in a public place who is, or appears to be, mentally disordered to a place of safety should be retained, but restricted to 24 hours. Health boards should be placed under a legal duty to provide such places of safety, which should not be in police stations other than in exceptional circumstances.

Protection from sexual exploitation and abuse

125. The current provisions in the 1984 Act concerning the sexual exploitation of those who are vulnerable by reason of mental disorder are not satisfactory, and in many respects anomalous. They should be replaced by two new offences: sexual abuse of a mentally disordered adult, and sexual abuse by staff and formal carers. Both offences should apply to all kinds of sexual relationship, and all kinds of mental disorder.
126. The offence of sexual abuse of a mentally disordered adult would be committed where the mentally disordered adult is incapable of consenting, or giving free agreement, to the relationship. The offence of sexual abuse by staff and formal carers would apply to the whole range of formal caring relationships.

The regulation of private hospitals

127. The regulation of private mental hospitals should be removed from the Mental Health Act. The proposed Scottish Commission for the Regulation of Care should assume responsibility for the registration of and setting out the required standards of care for, private hospitals which care for people with mental disorders.

THE MENTAL WELFARE COMMISSION

Mental Welfare Commission

128. The Mental Welfare Commission for Scotland should continue to exercise a broad protective function in relation to people with mental disorders, whether or not subject to compulsion, and its powers should be extended in some respects.
129. The membership of the Commission should include increased representation of service users and carers. At least two members should have personal experience of mental disorder, and two members should have personal experience as carers.
130. The Commission should be accountable to the Scottish Parliament, as well as the Scottish Executive.
131. There should be a review of the structure and internal management arrangements of the Commission. The Memorandum of Agreement between the Mental Welfare Commission and the Scottish Executive should be published.
132. The Commission should have a responsibility to promote the Principles of the new Mental Health Act and monitor its operation.
133. The Commission should retain the power to discharge patients subject to compulsion (other than restricted patients), the responsibility to visit mental health services, including unannounced visits, and the power to conduct enquiries into deficiencies in care. It should have a duty to visit people with mental disorder in prisons. Its rights to interview service users and inspect records should be extended to community mental health services.
134. The agency with responsibility for the investigation of the handling of complaints under the NHS complaints procedure which concern a patient with mental disorder should be the Health Service Commissioner (the 'NHS Ombudsman'). The Memorandum of Understanding between the Health Service Commissioner and the Mental Welfare Commission should be published.
135. The Commission should publish reports on visits and inquiries and guidance and advice, as well as an Annual Report. It should also collect and publish statistical information.

OFFENDERS WITH MENTAL DISORDER

The legislative framework

136. The Mental Health (Scotland) Act 1984 and the Criminal Procedure (Scotland) Act 1995 contain a complex framework for dealing with mentally disordered persons who come before the criminal courts. Consideration should be given to consolidating the relevant provisions of the Criminal Procedure (Scotland) Act 1995 within the new Mental Health Act.

Unconvicted persons with mental disorder

137. It is possible for mentally disordered persons awaiting trial on a criminal charge to be committed to hospital. However, the law is not entirely clear as to when they can be treated without consent, or about when remanded prisoners can be transferred for assessment. It should be possible for an accused person to be committed to hospital for assessment on the basis of a single medical recommendation. Thereafter, the provisions should broadly reflect those for detention under civil proceedings.
138. Where a person is acquitted of a criminal charge, and the court has received recommendations that would have entitled it to make a hospital order on conviction, and it appears to the court that an emergency detention of the person may be required, the court should be able to order the detention of the person in a place of safety for a period of up to six hours to allow examination by a medical practitioner.

Convicted offenders with mental disorder

139. The current range of disposals available to the court for convicted offenders is generally adequate, though there is evidence that the necessary services to support the range of disposals are not always in place.
140. Improvements are needed in the system of assessment prior to disposal. The court should receive a report from a mental health officer in a criminal case before making any mental health disposal that currently requires the evidence of two medical practitioners. The court should also be entitled to require further evidence from a chartered clinical psychologist in appropriate cases.
141. It is important that a full assessment of the patient's mental condition and associated risk is made in serious cases. Where a hospital direction or restriction order is in prospect, the responsible medical officer should either recommend an interim hospital order, to allow time for a full assessment to be made, or indicate why such a recommendation is not appropriate.

142. Hospital directions allow a convicted offender to receive a prison sentence, but to be sent to hospital for treatment for mental disorder, and returned to prison once treatment in hospital is no longer required. They may be particularly appropriate when the connection is not clear between an offender's mental disorder and the crime they committed, or where alleviating the mental disorder will not reduce the risk that the offender will commit further crimes. The current statutory criteria for hospital directions and associated guidance should be clarified, to encourage their use in appropriate situations.
143. Prisoners should have the right to appeal against a transfer to hospital for treatment for a mental disorder, or the refusal to authorise such a transfer.
144. It should be possible for convicted offenders to receive community orders. Before making such an order the court should receive advice from a mental health tribunal.

High risk patients

145. The MacLean Committee made proposals for the sentencing disposals for, and future management and treatment of 'serious violent and sexual offenders who may present a continuing danger to the public'. This included proposals concerning mentally disordered offenders. The relevant recommendations of the MacLean Report could readily be incorporated into the proposed framework for a new Mental Health Act.
146. Scottish Ministers should no longer have a role in relation to the management and discharge of restricted patients. Instead, the Parole Board, sitting as a Restricted Patients Review Board, should take over the responsibility of Ministers for decisions concerning discharge.
147. The Risk Management Authority, if established as proposed by the MacLean Report, should be given responsibility for those aspects of Ministers' responsibility for restricted patients which are currently delegated to officials. The Authority should ensure that adequate arrangements are in place for restricted patients subject to conditional discharge, and issue guidance on best practice in managing such patients.
148. The mental health tribunal should take the place of the sheriff court in hearing any appeal against compulsion brought by a restricted patient. For such cases the tribunal should be chaired by a sheriff.
149. The criteria for admission to the State Hospital should be updated. Patients should have a right of appeal to a tribunal, seeking to be transferred from the State Hospital, or a medium secure facility, to conditions of lower security.

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

150. The Mental Health (Public Safety and Appeals) (Scotland) Act 1999 was passed following a successful appeal for absolute discharge by a restricted patient. It introduced, as an interim measure, a new 'public safety' test to decisions concerning the release of restricted patients.
151. This provision should be repealed as unnecessary in the light of the recommendations for reform in this report and those of the MacLean Committee, including improved assessment of risk, more appropriate use of hospital directions and interim hospital orders, and new sentences for high risk offenders. Transitional arrangements may be necessary for a small group of high risk patients already detained under current legislation.

Insanity and diminished responsibility

152. The Scottish Law Commission should be invited to review the special defences of insanity, insanity in bar of trial and diminished responsibility.
153. The range of disposals available to a court in relation to a person charged with murder and acquitted by reason of insanity should be extended to be the same as for persons charged with other offences who are acquitted on that basis.

Appropriate adults

154. 'Appropriate adult' schemes assist in ensuring that the needs of mentally disordered persons who come into contact with the police are recognised.
155. The Scottish Executive should commission research investigating the effectiveness of the current schemes. In future, the Executive should consider the possibility of formalising the appropriate adult scheme on a statutory basis.
156. A comprehensive training strategy should be put in place for police officers on dealing with members of the public who have a mental disorder, and the use of the police powers under mental health law.

INTERNATIONAL AND CROSS BORDER ISSUES

Cross border issues

- 157. There should be liaison between government departments in the different administrations of the UK to ensure that the provisions for cross border transfers in the various Mental Health Acts remain complementary.
- 158. There should normally be advance notice given to the patient, named person and the Mental Welfare Commission of a proposed transfer from Scotland to another part of the UK.
- 159. There should be a right of appeal to a tribunal against a decision to transfer a patient outwith Scotland.
- 160. The Mental Welfare Commission should visit patients transferred to Scotland within 3 months.
- 161. Ministers should be able to transfer mentally disordered patients from another country, who do not have a right of abode in the UK, to countries outside the UK, only if satisfied that the patient will receive adequate care in the receiving country. Patients should have the right to appeal against removal from the UK.
- 162. Specialist advocacy should be provided to asylum seekers and refugees with mental disorders to assist them in understanding their legal position and to provide liaison with their legal representatives and/or immigration officials.

Hague Convention on the International Protection of Adults

- 163. A new Mental Health Act should, as far as possible, be consistent on the relevant issues with the provisions of the Hague Convention on the International Protection of Adults.

European Convention on Human Rights and the Council of Europe White Paper on Psychiatry

- 164. The European Convention on Human Rights is now a fundamental part of Scottish Law and Scottish legislation must now be consistent with the provisions of the Convention. The Committee has borne the Convention in mind in making its recommendations, but it will be for the Scottish Parliament and Scottish Executive to ensure that any subsequent legislation meets the requirements of the Convention.

OTHER MATTERS

Regulations, research and other issues

165. There should be a co-ordinated programme of statistical and other information gathering and of research relating to the new Mental Health Act.
166. The Scottish Executive should develop a strategy to ensure that all those who have to operate the new Mental Health Act are appropriately trained.

The State Hospital

167. The provisions in the Mental Health (Scotland) Act 1984 in relation to the constitution of the State Hospital are no longer necessary and should be repealed.

Code of Practice

168. There should continue to be a Code of Practice for the Mental Health Act, which should be more extensive than the current Code.
169. The Code should operate as a guide to the Principles of the Act and their implications for care and treatment, and give advice on best practice to professionals and service providers. It should also provide a straightforward guide to the provisions of the Act.
170. The Scottish Executive should develop and implement a strategy to promote awareness of the Code amongst all those with an interest; and the Code should be updated on a regular basis with a full revision taking place at least every five years.

Implementation and monitoring of the new Act

171. An Implementation and Monitoring Group should be established to ensure that the Mental Health Act and any associated regulations and guidance is implemented in accordance with its underlying principles. The Group should represent user, carer, voluntary sector, service provider and professional interests.

ANNEXES

The following annexes are contained in the Report:

- Annex 1 Summary of the Mental Health (Scotland) Act 1984, its History and Comparison with England and Wales
- Annex 2 Organisations and Individuals from whom Consultation Responses were received
- Annex 3 Note of Places Visited
- Annex 4 Organisations and Individuals from whom Oral Evidence was taken
- Annex 5 Consultation with Users and Informal Carers
- Annex 6 Special Events
- Annex 7 An Evaluation of section 18 of the Mental Health (Scotland) Act 1984 – Executive Summary
- Annex 8 Review of Literature relating to Mental Health Legislation – Summary
- Annex 9 Scottish Law Commission Report on Vulnerable Adults – List of Recommendations
- Annex 10 Mentally Disordered Offenders and Criminal Proceedings – summary of research into operation of the provisions contained within Part VI of the Criminal Procedure (Scotland) Act 1995 relating to unfitness to plead, examination of facts and the insanity defence.

Details of main report and related publications

The report of the Committee, entitled 'New Directions: review of the Mental Health (Scotland) Act 1984', is available from the Stationery Office, price £25, SE 2001/56, (ISBN no 1-84268-892-8).

A Review of Literature relating to Mental Health Legislation, by Dr Jacqueline M Atkinson and Lesley E Patterson, Department of Public Health, University of Glasgow, has been published by the Scottish Executive Central Research Unit and is available from the Stationery Office, price £5.

An Evaluation of section 18 of the Mental Health (Scotland) Act 1984, by Alison Bean, Anne McGuckin and Suzi Macpherson has been published by the Scottish Executive Central Research Unit and is available from the Stationery Office, price £5. A summary is available from the Central Research Unit: Legal Studies Research Findings No. 30.

Copies of these materials are available on the Internet at www.scotland.gov.uk/millan