special articles

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The Mental Health (Care and Treatment) (Scotland) Act 2003: civil legislation

In March 2003 the Scottish Parliament passed the Mental Health (Care and Treatment) (Scotland) Act. The major civil provisions of this new mental health legislation are due to commence in October 2005 and are described here. It is essential that all psychiatrists working in Scotland become familiar with these provisions.

The impetus for the Mental Health (Care and Treatment) (Scotland) Act 2003 came largely from a change in psychiatric practice with the move towards care in the community. The 1960 and 1984 Scottish Mental Health Acts combined detention and treatment in psychiatric hospital. In addition, secondary legislation and anomalies in the 1984 Act had led to increasing confusion with and complexity of the existing legislation. There was an extensive consultation process (Scottish Executive, 2001), and recognition that guidance (Health Department, 2004*a*,*b*) and a training strategy were required to avoid some of the deficiencies in knowledge found in practitioners using the 1984 legislation (Humphreys, 1994). Comparisons with the proposals for England and Wales have been made elsewhere (Darjee & Crichton, 2004).

Major developments within the new Act

Principles

The Act sets out a number of principles that must be considered by any person utilising the provisions of the Act or, indeed, deciding to take no action under the Act. These principles include:

- participation of the patient in the process;
- respect for carers, including consideration of their views and needs;
- the use of informal care wherever possible;
- the use of the least restrictive alternative;
- the need to provide the maximum benefit to the patient;
- non-discrimination against a person with mental disorder;
- respect for diversity, regardless of a patient's abilities, background and characteristics;
- reciprocity in terms of service provision for those subject to the Act;
- the welfare of any child with a mental disorder being considered paramount;
- equality.

New definitions

The Act defines mental disorder as 'any mental illness, personality disorder or learning disability however caused or manifested'. A person is not considered to have mental disorder by reason only of sexual orientation, sexual deviancy, transsexualism or transvestism; dependence on, or use of, alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; or acting as no prudent person would act (section 328).

The Act defines the term 'approved medical practitioner' (section 22): this is a doctor with the required qualifications, experience and training who has special experience in the diagnosis and treatment of mental disorder. Such practitioners will be approved by Health Boards and will include members of the Royal College of Psychiatrists and other doctors with significant experience in psychiatry.

The Mental Health Tribunal for Scotland

The Act establishes the Mental Health Tribunal for Scotland (Part 3). It replaces the Sheriff Court in considering applications for longer-term detention and conditions for community residence. It has a major role in the review of compulsory treatment orders (CTOs) and will consider cases of possible unlawful detention of voluntary patients (section 291). Scottish Ministers will appoint tribunal members and these will include lawyers, psychiatrists and others with training and active involvement in caring for people with mental disorders. Lawyers will convene each locally held tribunal.

Compulsory treatment orders

The purpose of a CTO is to create individual measures for the care and treatment of a patient who requires a degree of compulsion to accept these (section 64(4)).

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This is done through a care plan which may specify detention.

Services for children and postnatal depression

The Act requires that health boards provide adequate services and accommodate the needs of children and young people (section 23). Similarly, health boards must provide services and accommodation for mothers with babies (section 24). Any mother who normally looks after her child aged less than 12 months can continue to do so in hospital if admitted for the treatment of postnatal depression and if this is not likely to endanger the health or welfare of the child.

Patient representation

One of the underlying principles of the Act is increased patient participation. Access to advocacy services has therefore been enshrined in the Act (section 259). As before, hospital managers must ensure that patients subject to the Act understand and can exercise their rights (section 260). In addition, all necessary assistance must be provided to patients with communication difficulties to allow them to participate in medical examinations and proceedings under the Act (section 261).

The Act creates the new role of the patient's 'named person' (sections 250–257). This role is set out under the various procedures of the Act. The named person acts independently of the patient, but should provide support and represent the patient's interests. The named person is nominated by the patient and this nomination can be revoked. The patient's primary carer or nearest relative assumes this role if no nomination of a named person is made or the nominee refuses to accept the role.

The Act legislates for advance statements (sections 275, 276). An advance statement describes an individual's preferences for treatment of a mental disorder in the event that his or her ability to make decisions about treatment becomes significantly impaired. These statements need to be made in writing, witnessed and placed in the case notes. Responsible medical officers (RMOs) should refer to these in making future treatment decisions, but can overrule the patient's wishes provided reasons for doing so are given to the patient, the named person, any welfare attorney, any guardian and the Mental Welfare Commission.

Powers of detention and compulsory measures

The civil legislation to detain and treat patients under the new Act is set out in Table 1. This includes comparable sections from the 1984 Act.

Authority to suspend

For each of these measures the authority to detain can be suspended by the patient's RMO: section 41, emergency detention; section 53, short-term detention; section 127, CTO or interim CTO. This is the equivalent of leave of absence under the 1984 Act. During any suspension of detention, conditions can be specified by the RMO in the interest of the patient or for the protection of any other person. This can include the patient being kept in the charge of a person authorised in writing for this by the RMO. Detention in hospital may be suspended under a CTO for up to 6 months or for a maximum of 9 months in any 12-month period. The Mental Welfare Commission must be notified within 14 days of any suspension of detention longer than 28 days. An RMO can suspend other CTO measures (section 128) for up to 3 months.

Non-compliance with a CTO or interim CTO

If a patient fails to attend for treatment as required by a CTO or interim CTO, the RMO can take, or authorise another person to take, the patient into custody and to transport the patient to the agreed place of attendance or to any hospital (section 112). A patient can be detained for up to 6 h to give any medical treatment authorised in the CTO or to determine whether the patient can consent to medical treatment and agrees to do so.

If a patient, not subject to detention, fails to comply with any measure in a CTO or interim CTO, the RMO can arrange for the patient to be taken into custody and transported to hospital (section 113). Such action must be discussed with the mental health officer (a social worker with special training in mental disorders) and consent obtained. Prior to this, endeavours must be made to contact the patient and to give the patient the opportunity to comply with the measure. The RMO must be of the view that it is reasonably likely that there would be a significant deterioration of the patient's mental health if the patient was to continue to fail to comply with the CTO and that it was urgent to detain the patient in hospital. The patient can be detained in hospital for up to 72 h or until a medical examination has been completed by an approved medical practitioner. Subsequently, an RMO can grant a certificate authorising the continued detention in hospital of a patient for 28 days pending review or application for variation following non-compliance with a CTO (section 114). A 28-day order is also available for non-compliance with an interim CTO (section 115(2)). The interim CTO must not end during the initial 72-h detention period and no variation of CTO measures is required.

A CTO ends on formal revocation as set out in Table 1, following a successful appeal or if a patient is absent for 3 months. A CTO continues for 14 days to allow an RMO review if a patient is absent for more than 28 days but less than 3 months, is absent for less than 3 months but the order ends during this period, or if the unauthorised absence ends within 14 days of the termination of the order.

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Table 1. Mental Health (Care and Treatment) (Scotland) Act 2003: powers of detention and compulsory measures

Measure	Section	Conditions	Duration	Signatories/ consent	Revocation	Appeal[1]	Treatment	1984 Act equivalent[2] (section)
Emergency detention	36(1)	1. Mental disorder 2. Significantly impaired ability to make decisions about treatment 3. Significant risk to health, safety or welfare; or safety of others • Necessary and urgent • Undesirable delay to obtain short-term detention certificate	Up to 72 h	One fully registered doctor/ MHO if practicable	By an AMP	Nil	Nil Urgent – section 243	24 (out-patient) 25(1) (in-patient)
Short-term detention in hospital	44(1)	• Conditions 1–3 as before • Necessary to detain to assess or give medical treatment • Short-term detention certificate is necessary	28 days	AMP/MHO	By RMO or Mental Welfare Commission	To Mental Health Tribunal	Authorised	26
Short-term detention: extension certificate	47(1)	• Conditions 1–3 as before • Necessary to detain to assess or give medical treatment • Application for CTO to be made because of a change in patient's mental health • Not practical to apply for CTO before expiry of short-term detention certificate	3 working days (excludes Saturday, Sunday or Bank holiday)	AMP/MHO	By RMO or Mental Welfare Commission	To Mental Health Tribunal	Authorised	26A
Extension of short-term detention pending determination of application by the tribunal	68	• Application for CTO made before expiry of short-term detention • Pending determination by tribunal	5 working days	AMP	By RMO	Nil	Authorised	–
Interim CTO	65	• Conditions 1–3 as before • Available treatments likely to prevent mental disorder from worsening or alleviate symptoms or effects • Interim CTO is necessary pending full determination of CTO by tribunal	28 days (maximum total 56 days)	Application for CTO made/ tribunal	By RMO or Mental Welfare Commission	Nil	Measures specified by tribunal	–
Compulsory treatment order: non-urgent admission or ongoing detention and/ or treatment	64(4)	• Conditions 1–3 as before • Available treatment likely to prevent medical disorder from worsening or alleviate symptoms or effects • CTO is necessary	6 months, renewable for 6 months and yearly thereafter	Two fully registered doctors (1 AMP) Application by MHO must include proposed care plan Mental Health Tribunal approval	By RMO or Mental Welfare Commission	To Mental Health Tribunal	Measures specified by tribunal	18
Nurses' power to detain pending medical examination	299	• Mental disorder • Necessary for the protection of patient's health, safety or welfare; or safety of others to immediately restrain from leaving hospital • Not practical to secure immediate medical examination • Necessary to carry out a medical examination to determine if an emergency or short-term detention certificate is required	2 h or 1 h from the time of the doctor's arrival if it is in the 2nd hour of detention	Registered mental nurse	Nil	Nil	Nil	25(2)
Removal to place of safety from a public place (police)	297	• Police officer suspects mental disorder in a person in a public place • In immediate need of care and treatment • In patient's interest, or for the protection of others, to remove person to a place of safety	24 h	Police officer	Nil	Nil	Nil	118

AMP, approved medical practitioner; CTO, compulsory treatment order; MHO, mental health officer; RMO, responsible medical officer.

1. Tribunal decisions can be appealed to the Sheriff Principal. Appeals against the decisions of the Sheriff Principal are made to the Court of Session.

2. Mental Health (Scotland) Act 1984 equivalent.

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Medical treatment

As with the 1984 Act, an independent review process of medical treatment is set in place with the new Act. Medical treatment is defined as treatment for mental disorder and includes nursing; care; psychological intervention; habilitation and rehabilitation, including education, training in work, social and independent living skills. The designated medical practitioner (section 233) provides this independent review; this is a doctor with the necessary qualifications and experience to give a second opinion on medical treatment. The Mental Welfare Commission continues to organise second opinions and to train designated medical practitioners. The Act considers treatment under four separate headings:

(a) Psychosurgery: as with the old Act, a patient capable of consenting must do so before any psychosurgery can be carried out and must be assessed by a designated medical practitioner and two lay people appointed by the Mental Welfare Commission. Under the new Act, for the first time, if the patient is incapable of consenting but does not resist or object, neurosurgery can be performed; again, the patient must be reviewed by a designated medical practitioner and two lay people but, in addition, the Court of Session must order that the treatment is lawful if satisfied that the neurosurgery is in the patient's best interest.

(b) Electroconvulsive therapy can be given if the patient consents or, if the patient is incapable of consenting, a designated medical practitioner certifies that it is in the patient's best interest (sections 237–239). If the patient resists or objects, the designated medical practitioner must certify that it is necessary to give the therapy to save the patient's life, to prevent serious deterioration or to alleviate serious suffering on the part of the patient. Electroconvulsive therapy cannot be given to a patient with the capacity to consent who declines it.

(c) Any medicine (or medicine given for the purpose of reducing sex drive, except surgical implantation of hormones) given as treatment for a mental disorder for more than 2 months since the patient became subject to the Act must go through a consent or second opinion procedure (section 240). This includes artificial nutrition. Previously there was a 3-month time scale for this. If the patient refuses to give consent or is incapable of doing so, a second opinion must be obtained from a designated medical practitioner.

(d) Urgent medical treatment for a patient detained in hospital, who does not consent or is incapable of consenting to it, may be given to save the patient's life, to prevent serious deterioration, to alleviate serious suffering or to prevent the patient from behaving violently or being a danger to himself or others (section 243). This is a new provision. This does not authorise electroconvulsive therapy in a patient capable of consenting.

Comment

A great deal of time and effort has gone into establishing a new Mental Health Act in Scotland and it is essential that all psychiatrists working in Scotland become familiar with these provisions (McManus & Thomson, 2005). The Act's underlying principles are to be welcomed, in particular increased patient representation. However, new legislation in itself does not develop services nor create new treatments for mental disorder, although the principles of reciprocity and maximum benefit may encourage the former.

One of the underlying principles of the Act is to improve communication. The Act would win no prizes from the plain English campaign. Its cross-references are multiple and it is more difficult to follow than its predecessor. Other jurisdictions have shown that it is possible to provide legislation in a more user-friendly manner (State of Victoria, 1986).

The development of tribunals is new to Scotland. The practicalities of this system are still being resolved, particularly the issue of staffing. There will be an increased workload on consultant psychiatrists arising from this. The role of the president of the tribunal and the individual chairmen of each local tribunal will be important in setting the tone and working practices. Although it is essential that the evidence is heard, it would be greatly regrettable if these proceedings were to become adversarial and prolonged. It will be important that RMOs do not use tribunals as a means of taking difficult decisions that otherwise belong to them.

Lastly, it will be important to evaluate the implementation of the new Act to ensure that maximum benefit is indeed obtained for patients requiring its provisions.

Declaration of interest

None.

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