Approved Medical Practitioners

Mental Health (Care and Treatment) (Scotland) Act, 2003 Training Manual

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Mental Health (Care and Treatment) (Scotland) Act, 2003 Training Manual

Scottish Executive, Edinburgh 2005

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List of Common Abbreviations

AMP – approved medical practitioners

CO – compulsion order

CORO – compulsion order with restriction order

CTO – Compulsory treatment order

ECT – electroconvulsive therapy

EDC – emergency detention certificate

NMD – neurosurgery for mental disorder

MHO – mental health officer

STDC – short-term detention certificate

TO – treatment order

The 1984 Act – The Mental Health (Scotland) Act 1984

The 2003 Act – The Mental Health (Care & Treatment) (Scotland) Act 2003

Disclaimer
Whilst every effort has been made to ensure that the information in this booklet is accurate at the time of publication, this cannot be guaranteed. If you have questions regarding the 2003 Act or its implementation, please contact the Mental Health Law team at the Scottish Executive, or the Mental Welfare Commission.

1. Introduction

1. Introduction

The 2003 Act will come into force in October 2005. It will affect all professionals in Scotland working in mental health.

This booklet is designed to complement the training programme through which psychiatrists can receive Section 22 accreditation as approved medical practitioners (AMPs) (Box 1).

Box 1. Approved medical practitioners (AMPs)

Section 22-AMPs are those doctors who have undertaken requisite training in the 2003 Act. They must be fully registered medical practitioners who are either:

- Members or fellows of the Royal College of Psychiatrists, or
- Have four years' continuous experience in the specialty of psychiatry and are sponsored by their local medical director.

Training for AMPs consists of a day of knowledge-based learning and a self-assessment exercise (available on the NHS Education for Scotland website at www.nes.scot.nhs.uk/mha/amp). Completion of training involves a day of workshop-based training on the 2003 Act.

The booklet should be a valuable and practical reference tool for AMPs and it is hoped that it will also be a useful resource for other people interested in the application of the 2003 Act.

The booklet reviews specific areas of the 2003 Act and explores priority areas for AMPs. These are:

- Mental disorder
- Medical treatment.

The 2003 Act's three principal civil certificates:

- Short-term detention certificate (STDC) – Section 44
- Compulsory treatment order (CTO) – Section 64
- Emergency detention certificate (EDC) – Section 36.
- Other issues relating to the 2003 Act:
- Transfers (within and outwith Scotland)
- Unlawful detention
- Absconding
- Suspension of compulsory measures
- The responsibilities of statutory bodies in administering the 2003 Act
- New rules on patients' rights and representation
- Offences
- The 2003 Act and the criminal justice system.

A comparison of the major changes in the 2003 Act is shown in Table 1.

Table 1. Mental Health (Care and Treatment) Act Scotland 2003: comparison with the 1984 Act

2003 Act	1984 Act
Principles (Section 1)	No principles
Tribunal (Section 21)	Sheriff Court
Short-Term Detention (Sections 44). MHO consent required.	Sections 26. Relative/nearest relative or MHO consent required
Emergency (Section 36)	Sections 24 and 25
Compulsory Treatment Orders (Section 64(4)(a))	Section 18 Orders
Assessment Orders (Section 52D) Criminal Procedure (Scotland) Act 1995 (the '95 Act) inserted by Section 130	Section 52, the '95 Act
Treatment Orders (Section 52M), the '95 Act, inserted by Section 130	Section 70 (for patients transferred from prison)
Interim Compulsion Orders (Section 53), the '95 Act, inserted by Section 131	Interim Hospital Orders (Section 53), the '95 Act
Compulsion Orders (Section 57A(2)), the '95 Act, inserted by Section 133	Hospital Orders (Section 58), the 95' Act
Patient Representation/Named Person (Section 250-254 and Section 257)	Nearest Relative (Section 53)
Advocacy (Section 259)	No formal right to advocate
Advance Statements (Section 275)	No duty re Advance Statements
Local Authority Responsibilities (Section 25-35) (Section 7-11 and Section 92)	Local Authority Responsibilities
Medical Responsibilities (Section 22-24)	No specific Medical Responsibilities
Directions, Regulations, Code of Practice, Local Procedures	Directions, Regulations, Code of Practice, Local Procedures

Section 2

2. Overview & Principles

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2. Overview & Principles

Unlike the 1984 Act, the 2003 Act is based on a set of guiding principles formulated by the Millan Committee, which are not contained verbatim in the Act but help to set the tone and guide its interpretation. As a general rule, anyone who takes any action under the 2003 Act has to take account of these ten guiding principles:

1. **Non-discrimination** – People with mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.
2. **Equality** – All powers under the 2003 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.
3. **Respect for diversity** – Service users should receive care, treatment and support in a manner that affords respect for their individual qualities, abilities and diverse backgrounds, and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.
4. **Reciprocity** – Where society imposes an obligation on an individual to comply with a programme of treatment or 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.
5. **Informal care** – Wherever possible, care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.
6. **Participation** – Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully. Information should be presented in an understandable format.
7. **Respect for carers** – Those who provide care to service users on an informal basis should be respected for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
8. **Least restrictive alternative** – Service users should be provided with any necessary care, treatment and support in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account, where appropriate, of the safety of others.
9. **Benefit** – Any intervention under the 2003 Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.
10. **Child welfare** – The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the 2003 Act.

These lead to another set of underpinning principles to be taken into consideration when implementing the provisions of the 2003 Act. Practitioners must:

- Take into account the past and present wishes of the patient
- Take into account the views of the named person, carer or guardian
- Consider the range of treatment options available
- Provide maximum benefit with minimum restriction to the patient
- Ensure the patient does not face any kind of discrimination on the grounds of age, gender, religion, sexual orientation or ethnicity
- Inform the carer about intended actions and take into account his or her needs.

Mental disorder

This is defined as mental illness, personality disorder and learning disability, however caused or manifest.

Mental disorder is **NOT** defined by any of the following, on their own or in combination:

- Sexual orientation
- Deviancy
- Acting as no prudent person would act
- Behaviour that causes or is likely to cause harassment, alarm or distress to any other person
- Dependence on alcohol/drugs.

Changes to the definition of mental disorder from the 1984 Act are shown in Table 2.

Table 2. Changes to the definition of mental disorder from the 1984 Act

2003 Act	1984 Act
Mental illness or personality disorder	Mental illness including personality disorder
Learning disability	Mental handicap
However caused or manifested	However caused or manifested
	Mental impairment
	Severe mental impairment
NOT	**NOT**
Sexual orientation	Promiscuity
Sexual deviancy	Sexual deviancy
Trans-sexualism	Other immoral conduct
Transvestitism	Dependence on alcohol or drugs
Dependence on, or use of, alcohol or drugs	
Alarming or distressing behaviour	
Acting as no prudent person would act	

Medical treatment

Medical treatment, as defined by the 2003 Act, includes:

- Pharmacological/physical treatments
- Psychological interventions
- Nursing and care
- Habitation and rehabilitation.

Medical treatment for a physical disorder is **NOT** authorised by the 2003 Act.

The underlying principles apply, in particular that the patient has the necessary information to understand the treatment and his or her views are taken into account.

Medical treatment is authorised under Part 16 of the 2003 Act for patients subject to a:

- Short-term detention certificate
- Compulsory treatment order
- Interim compulsory treatment order
- Assessment order
- Treatment order
- Compulsion order
- Hospital direction
- Transfer for treatment direction.

Changes to the definition of medical treatment are shown in Table 3.

Table 3. Changes to the definition of medical treatment

2003 Act (Section 329)	1984 Act (Section 125)
Medical treatment is treatment for mental disorder including nursing, care, psychological intervention, habilitation and rehabilitation including education, training in work, social and independent living skills	Medical treatment includes nursing, and also includes care and training under medical supervision

Treatment is not authorised under Part 16 for an EDC, nurses' holding power, and removal orders. Nurses can detain patients for urgent medical examination for up to two hours under Section 299 of the 2003 Act. Once the doctor arrives, a further hour of detention is allowed. It is not good practice to immediately institute a second period of nurses' holding power once the initial two hours has elapsed.

If treatment is not subject to special safeguards (see below), it can be given either with the written consent of the patient or, failing that, if the RMO determines that it is in the patient's best interest and records the reasons for giving this treatment in writing. This would include medication within the first two months. It would also include forms of treatment (not covered by safeguards) given throughout the period of compulsion.

If the patient does not or cannot further consent after two months of compulsory treatment, the responsible medical officer must arrange for a designated medical practitioner (via the Mental Welfare Commission) to examine the patient and certify that he or she does not/cannot consent, and that the treatment is authorised and is in the best interests of the patient.

Designated Medical Practitioners (DMP) replace the Section 98 doctors, appointed by the Mental Welfare Commission.

Electroconvulsive therapy (ECT) may only be given if the patient can consent, and does so in writing. If the patient is incapable of giving consent, a designated medical practitioner must authorise the treatment on the basis of ECT being required in the patient's best interest. If the patient resists or objects to ECT, then it can only be used after the DMP states that it is required to save life; or prevent serious suffering or deterioration in the patient's condition.

The patient must consent to any proposed neurosurgery. If the patient is incapable of consenting, a designated medical practitioner and two lay people appointed by the Mental Welfare Commission must record both the incapacity to consent and lack of opposition to proposed neurosurgery. The Court of Session authorises the neurosurgery.

Section 243 of the 2003 Act allows urgent treatment for mental disorder for any detained patient (including those on an emergency order) in order to save the patient's life, or to prevent serious suffering or deterioration in the patient even if the patient does not/cannot consent. Also, urgent treatment is allowable under section 243 to prevent a detained patient behaving violently or being a danger to him/herself or others. If Section 243 is used, the Mental Welfare Commission must be notified of the details within seven days.

3. Short-term detention certificate (STDC)

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3. Short-term Detention Certificate (STDC) – Section 44

The short-term detention certificate (STDC) lasts for 28 days. Transfer to hospital must occur within three days of the certificate being granted. Detention is only authorised once the receiving hospital managers have been given the certificate.

Criteria for issuing an STDC

The AMP *must consider it likely* that the following criteria are met:

- The patient has a mental disorder.
- The patient has significantly impaired decision-making ability (see Appendix 2) with respect to medical treatment for mental disorder, as a result of his or her mental disorder.
- Detention in hospital is necessary to determine what medical treatment is required and to provide that treatment.
- Significant risk exists to the health, safety and welfare of the patient or to the safety of others if the patient is not detained.
- There are sufficient grounds for believing that granting of an STDC is necessary for a patient who is refusing to accept treatment on a voluntary basis.

The word 'likely' that the criteria are met means that the AMP needs to be satisfied only on the balance of probabilities. The meaning of the new criterion of 'significantly impaired decision making ability' is explored in Appendix 2. The AMP also now has to formally state that detention is necessary (i.e. that informal alternatives have been considered or attempted).

Granting an STDC

An STDC may only be granted by an AMP. Where the patient refuses to be examined by an AMP, an EDC (see later) may have to be issued.

The AMP must consult a MHO when considering issuing an STDC to gain his or her consent. Where practicable, the AMP should also consult the patient's named person, and must complete the STDC within three days of examining the patient.

Revoking and extending an STDC

The certificate must be revoked by an AMP prior to 28 days if detention criteria are no longer met.

It can be extended by:

Section 47

An AMP may extend an STDC by three working days using Section 47. This allows an application for a CTO to be made, which may be particularly important if the patient's mental state has changed in recent days. A MHO should be consulted, where possible, regarding an extension certificate.

Once an extension certificate is completed, the AMP must inform the patient, the named person, Tribunal, Mental Welfare Commission, MHO and any guardian or welfare attorney.

Section 68
Once a CTO application has been submitted, the patient can be detained for a further five working days from expiry of the STDC under Section 68 of the 2003 Act to allow the Tribunal to have a hearing.

Right of appeal about an STDC

The patient and named person have the right to apply to the Tribunal for revocation of the short-term detention order.

The Tribunal will consider at appeal whether the criteria for STDC are met. The Mental Welfare Commission has the power to revoke a certificate if the criteria are not met, but will principally be assisting the person make an application to the Tribunal although the Commission may refer direct to the Tribunal, if appropriate. This represents a change from the 1984 Act.

The responsible medical officer must review the need for continued detention, and revoke the certificate if criteria are no longer met.

If revocation of the certificate occurs, the responsible medical officer must write to notify the patient, named person, the consenting MHO, and any guardian or welfare attorney. Written notice of the revocation must go to the Tribunal and Mental Welfare Commission within seven days.

Comparison of the conditions and effects of short-term detention between the 1984 and 2003 Acts is shown in Tables 4 and 5.

Table 4. Short-term detention in hospital – conditions

2003 Act Part 6 (Section 44-56)	1984 Act (Section 26)
From hospital or community	From emergency detention in hospital
Approved medical practitioner (Section 22)	Approved medical practitioner (Section 20)
Mental disorder likely	Mental disorder
Likely that decision-making ability is significantly impaired	
To determine medical treatment needed, or give medical treatment under Part 16	Appropriate to be detained
Significant risk to health, safety or welfare of patient, or safety of others	Interests of patient's health or safety or with a view to protection of others
Consent from MHO	Consent from MHO or nearest relative
Certificate issued within three days of examination	Examination within three days of Section 24 detention
Extension for up to three working days	Extension for up to three working days

Table 5. Short-term detention in hospital – effects

2003 Act	1984 Act (Section 26)
Removal to hospital within three days	
Starts immediately and revokes any emergency detention certificate	Starts when emergency detention expires
Detention for up to 28 days (plus 3)	Detention for up to 28 days (plus 3)
Determine treatment	
Compulsory treatment allowed	Compulsory treatment allowed
Duty to inform named person, guardian, welfare attorney, Tribunal, Mental Welfare Commission	Duty to inform Mental Welfare Commission, nearest relative, local authority
MHO interview prior to consent	MHO interview and social circumstance report to Mental Welfare Commission
Responsible medical officer continuing duty to review	
Application by patient or named person to Tribunal for revocation	Appeal to Sheriff (the exception)
Appeal to Sheriff Principal (if appeal to the Tribunal fails)	No further appeal

4. Compulsory Treatment Order (CTO)

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4. Compulsory Treatment Order (CTO) – Section 63

Only a MHO can apply for a CTO, once he or she has received two mental health reports. The application would include a proposed care plan and must occur within 14 days of the date of the second of the two medical examinations which gave rise to the mental health report. Doctors should consult the MHO prior to any decision to initiate the CTO application.

Criteria for issuing a compulsory treatment order

- The patient must have a mental disorder.
- Medical treatment is available and would be likely to prevent the mental disorder worsening, or alleviate its effects.
- Significant risk to health, safety and the welfare of the patient, or to the safety of others, exists if medical treatment is not provided.
- The patient's ability to make decisions about his or her treatment is significantly impaired by mental disorder.
- The treatment cannot be provided informally.

The responsible medical officer will provide in the mental health report:

- Confirmation that these criteria have been met, giving reasons to justify each decision.
- A description of the patient's symptoms and consequent effects of the mental disorder.
- The 'measures' that should be authorised under the order.
- The date of the medical examination.

'Measures' authorised through CTOs

'Measures' that could be authorised by the Tribunal following the suggestion of the MHO or mental health report through CTOs include:

- Detention in a specific hospital
- Giving medical treatment
- Requirement to attend at a specified time and place to receive treatment
- Requirement to reside at a specific address
- Requirement to allow home visits by the responsible medical officer, MHO, community psychiatric nurse and appropriate others
- Requirement to inform/obtain approval from of the responsible medical officer to a proposed change of address.

Imposition of community-based 'measures' would only be recommended if they provide a safe alternative to hospitalisation, and voluntary community care had previously failed. The principle of 'least restrictive alternative' of care should remain paramount.

Mental health reports to support a CTO application

Mental health reports for CTOs require that two medical examinations are carried out. Criteria apply to these examinations, which are:

- They must be completed by either two AMPs, or by one AMP and the patient's GP.
- The two medical examinations may occur simultaneously or separately, but no more than five days apart.
- The medical examination should include the assessments noted for an EDC (page 19).
- Consideration of the patient's past psychiatric history and probable success of long-term treatment should be included; advice on these issues should be sought from the MHO and other relevant parties.
- Patients should be able to have their named person and/or an independent advocate with them at the medical examination.
- The two mental health reports should agree on the category of mental disorder.
- The same 'measures' should be specified in the two reports.
- Any doctor who provides a mental health report should be able to attend a Tribunal hearing.

An AMP must also state whether the patient should receive written notice of any CTO application, and whether the patient is capable of arranging representation at a Tribunal. These points should be discussed with the MHO.

CTOs in operation – Section 64

The Tribunal will either:

- Grant the application
- Refuse the application, or
- Authorise an interim CTO.

Granting the application

If the CTO is granted, the stated compulsory 'measures' last initially for six months. The Tribunal may (unusually) specify different or additional compulsory 'measures'.

The Tribunal can also specify 'recorded matters' (Box 2). These are particular types of treatment or services viewed as being essential.

Box 2. Recorded matters

The Tribunal records aspects of care from the patient's care plan that are considered to be essential, and notes them as recorded matters. For instance, a sixteen year-old person's need to be cared for in a child and adolescent service may be noted as a recorded matter; if an NHS Board is unable to provide this service to the patient, the Tribunal can refer the issue to the Mental Welfare Commission.

The responsible medical officer has a duty to notify ('make a reference to') the Tribunal when a recorded matter is not provided. This must contain the name and address of the patient and named person, as well as the reason for the reference. The patient, named person, MHO, Mental Welfare Commission, and any guardian/attorney must also be notified of the reference to the Tribunal.

Once the Tribunal has made the CTO, any removal to hospital under the order must occur within seven days.

The responsible medical officer must prepare a care plan. The care plan will reflect the 'proposed care plan' (proposed by the MHO for the Tribunal) and will contain details of:

- The medical treatment
- Community services
- Any other services or treatment to be given.

Interim CTO

An interim CTO is authorised by the Tribunal when it is felt additional information is required before it can determine the application. The interim order lasts for up to 28 days.

Best practice dictates that a care plan be developed and implemented during an interim CTO. The responsible medical officer can revoke the interim order if detention criteria are no longer met under its duration, but must give written reasons to the patient, named person, MHO, Tribunal, Mental Welfare Commission, and any guardian/attorney.

No more than two interim CTOs with a total of 56 consecutive days can be authorised.

Reviewing the CTO

The criteria applied during review are the same as those applied during application. The presumption applied is that the criteria are no longer being met – the responsible medical officer must therefore be able to demonstrate that the criteria are still being met to justify continuation.

Mandatory review must occur during the last two months of the order, bearing in mind that an initial order lasts for six months. Extensions last another six months, and thereafter for 12 months.

Mandatory review for a CTO occurs two months prior to expiry of the order and must consist of:

- Medical examination of the patient, including a determination of whether criteria for compulsion are met.
- Consultation with the MHO, relevant service providers, and other appropriate individuals.

Best practice suggests that a mandatory review should involve a case conference. Further (less formal) reviews are mandatory 'from time to time'.

Following review, the responsible medical officer may:

1. Revoke the CTO (Section 82). If the responsible medical officer revokes the order using Section 82, written notification giving reasons for revocation must be sent to several parties (Box 3).

Box 3. Notification list for revocation or variation of a compulsory treatment order

- The patient
- Named person
- MHO
- Tribunal
- Mental Welfare Commission
- Any guardian or welfare attorney

2 Apply to the Tribunal to vary the compulsory measures or recorded matters (Section 95) in the order. This is done after review and consultation with the MHO and other relevant service providers lead the responsible medical officer to believe that a variation in the CTO terms is required. The intention to vary the order must be communicated to several parties (Box 3). The Section 95 application will contain: the name and address of the patient and named person; the details of the modification to the compulsory measures and/or recorded matters being sought; and whether or not the MHO is in agreement with the application. The most recent draft of the patient's care plan and mental health report should accompany the application.

The care plan should state:

– Which compulsory measures have been granted
– Which recorded matters have been specified
– When the next mandatory review of the order is due.

3 Extend the order, with (Section 92) variation in the compulsory measures and/or recorded matters. When the responsible medical officer wishes to extend the CTO but vary its terms he or she must notify the MHO beforehand, usually at least two weeks prior to expiry. The other parties who need to be notified about a Section 92 application are shown in Box 3.

The Section 92 application to the Tribunal must take account of the MHO's and any other relevant service providers' views. It must state: the name and address of the patient and named person; what modifications of compulsory measures or recorded matters are being sought, with accompanying reasoning; and whether or not the MHO consents to the application. The responsible medical officer should also provide the most recent draft of the patient's care plan alongside the Section 92 application, and the MHO will also provide a report.

4 Extend the order without (Section 86) variation in the compulsory measures and/or recorded matters. The responsible medical officer must notify the MHO if he or she wishes to extend the order under Section 86 without a variation in terms, usually two weeks before expiry. The responsible medical officer's record of determination to extend the CTO must contain: the reasons for the extension; a note of what type of mental disorder exists; and whether or not the MHO agrees to the extension. This record goes to the parties shown in Box 3. The responsible medical officer is allowed to withhold the record from the patient only if significant harm to the patient or others would ensue. If the record is withheld, the reasons must be noted.

The Tribunal does not need to review the responsible medical officer's Section 86 determination unless:

- There is disagreement between the RMO and the MHO on the need for extension.
- The MHO has failed to inform the responsible medical officer of whether or not he or she agrees to the extension or with the original order.
- No Tribunal hearing has been held on the CTO for two years.

Rights of Appeal

The patient or named person can appeal to the Tribunal for revocation of a Section 86 (extending order) or, at least three months after the imposition of a CTO, Section 92 or 95.

Non-compliance with a CTO

Non-compliance is a serious issue. The responsible medical officer has the authority to have a non-compliant patient taken into custody and conveyed to hospital on the grounds that:

- Efforts to contact the patient have failed.
- It is urgent and likely to prevent a significant deterioration in the patient's mental health.

The relevant sections of the 2003 Act involved are:

- Section 112 (non-compliance with 'attendance requirement')
- Section 113 (detention for 72 hours in hospital)
- Section 114 (non-compliance with a CTO)
- Section 115 (non-compliance with an interim CTO).

Sections 112 and 113

Where the only lack of compliance is with the 'attendance requirement' of the CTO, the responsible medical officer can invoke Section 112, after MHO consent has been obtained.

Section 112 allows the patient to be conveyed to the place of treatment, or hospital, and be detained there for up to six hours to allow administration of medical treatment under Part 16 of the 2003 Act.

Section 112 should be used in preference to Section 113, where appropriate, consistent with the principle of least restrictive alternative. Once the patient is in hospital, detention of 72 hours under Section 113 is allowed. Once the initial 72 hours has expired, further detention can be authorised through invoking Section 114 or 115.

Sections 114 and 115

After the initial 72 hours has expired following actioning of Section 113, further detention of 28 days can be authorised through the responsible medical officer completing a Section 114 for a CTO, and a Section 115 for an interim CTO.

Section 114 is granted and signed by the responsible medical officer. It must state his or her reasons for believing that a significant deterioration in the patient's mental health is likely if he or she is not further detained in hospital.

Detention under Section 114 would start at the point when the certificate was granted, and would last a further 28 days if the following criteria apply:

- The patient is currently under Section 113 (that is, within the 72 hours specified).
- The patient has been examined by the responsible medical officer or another AMP.
- The responsible medical officer is considering whether the specified compulsory measures need to be varied, such as making a Section 95 application to the Tribunal.
- The patient's MHO consents.
- The responsible medical officer has consulted the patient's named person, where practicable.

The criteria for Section 115 (non-compliance with an interim order) are as above.

Once Sections 113, 114 and 115 are in place, the specified compulsory measures of the CTO are suspended, except for those relating to the administration of medical treatment.

Comparisons of the conditions and effects of CTOs between the 1984 and 2003 Acts are shown in Tables 6 and 7.

Table 6. Compulsory treatment order/Section 18 – order conditions

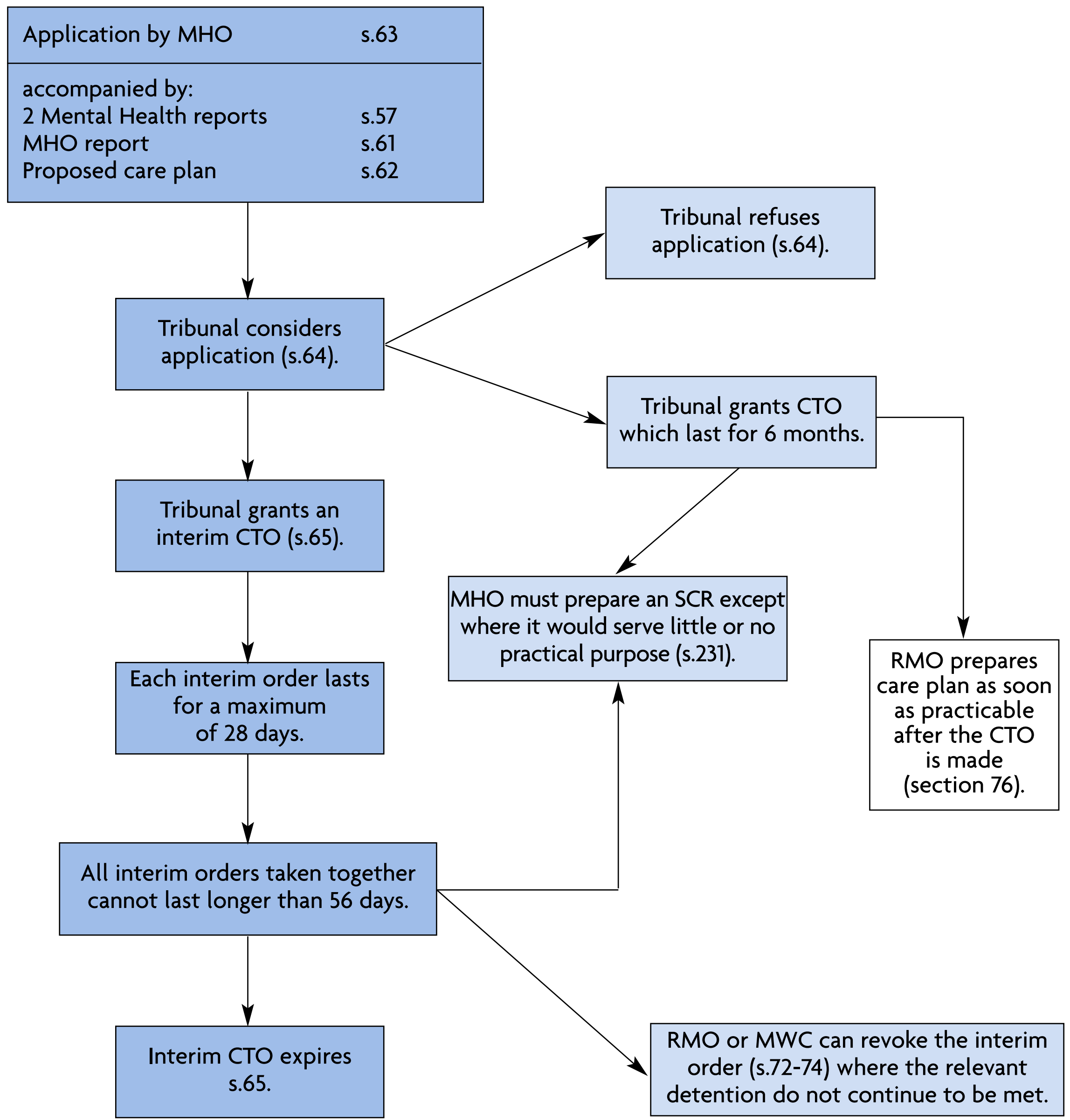
2003 Act Part 7 (Section 57-129)	1984 Act (Section 18-23 and Section 27-34)
MHO application, which specifies compulsory measures sought, medical treatment proposed, other	MHO application which states need for detention in hospital for treatment
Two mental health (medical) reports, one MHO report and a proposed care plan (PCP)	Two medical reports, MHO application
Two AMPs or one AMP and one GP or one AMP and one GP	One AMP (Section 20) and one GP or, if exceptional, two AMPs
Both medical reports must specify at least one of the same types of mental disorder	Specify same mental disorder
Treatment likely to prevent mental disorder worsening or alleviate symptoms or effects	Treatment likely to alleviate or prevent deterioration in condition
Significant risk to health, safety or welfare of patient or safety of any other person, decision-making ability re medical treatment is significantly impaired and order is necessary	Necessary for health or safety of patient or for protection of other persons that he should receive medical treatment in hospital
Mental health reports must specify compulsory treatment measures	No measures specified
Dispense with notice to patient if notice is likely to cause significant harm to patient or other person	Dispense with service on patient if likely to prejudice health or treatment

No more than five days between mental health reports	No more than five days between medical reports
No conflict of interest in relation to medical examination	No pecuniary interest or relationship with patient
Separate medical examinations unless consent from patient (if capable) or named person/guardian/welfare attorney (if incapable)	Separate medical examinations unless consent
Notification by MHO to patient, named person and Mental Welfare Commission	MHO informs nearest relative unless impracticable
MHO informs patient of right to advocate and helps patient access these services	
MHO prepares report and PCP	
Application to Tribunal within 14 days of second mental health report for detention in hospital or treatment in community	Application to Sheriff within 14 days of MHO interview and seven days of of later medical report. For detention in hospital
Tribunal hearing. Right to attend for patient, named person, Guardian or Attorney, MHO, doctors, primary carer, curator *ad litem*, anyone else with an interest in the application	Sheriff Court hearing. Right to attend for patient, nearest relative, patient's representative, mental health officer
Tribunal can make order sought in whole or in part and can specify measures other than those set out in the application	Sheriff can grant or refuse application
Emergency and short-term detention extension certificate extends detention for three working days (from date of issue for emergency detention and from end of 28 days for short-term detention)	Section 26 extended for up to five working days
Detention under short-term and/or extension certificate extended by five working days once application for CTO made	Sheriff court hearing within five working days (Section 21.) Section 26 extended until application determined
Tribunal decision before end of five working-day extension period.	
Removal to hospital or specified place of residence within seven days of CTO	Removal to hospital within seven days

Table 7. Compulsory treatment order/Section 18 – order effects

2003 Act	1984 Act
The CTO lasts initially for six months	Lasts initially for six months
Tribunal can make interim order for up to 28 days. The total length of the interim order may not exceed 56 continuous days	No interim orders, but Section 26 extended until final determination
No interim order without opportunity for patient to be heard	
Measures authorised by interim order or full order could include: • detention in hospital • giving of medical treatment • requirement to attend at specified places to receive medical treatment and/or community care services or other treatment, care or services • requirement to reside at a specified address • requirement to allow access to mental health officer, responsible medical officer, etc • approval of or inform mental health officer for change of address	Order authorises detention in hospital but leave of absence with or without conditions possible later for specified maximum periods of time
Responsible medical officer duty to review interim and final compulsory treatment order, within two months of end of order. Duty to consult MHO and others	Responsible medical officer duty to review within two months of end of Section 18. Duty to consult those involved with treatment
Mental Welfare Commission power to evoke CTO	Mental Welfare Commission power to discharge detailed patients
Responsible medical officer duty to make care plan (Section 76)	
Responsible medical officer power to extend by six months and then by 12 months. Consent of mental health officer must be sought	Responsible medical officer power to extend by six months and then 12 months
Appeal to Tribunal against extension	Appeal to Sheriff against renewal
Failure of a community-based patient to attend for treatment gives responsible medical officer or authorised representative power to take patient to hospital or specified place and keep him or her there for up to six hours to give treatment or to determine whether capable of consenting to treatment	Absence without leave or failure to comply with conditions of leave of absence gives mental health officer hospital staff, constable and persons authorised by managers of hospital power to take patient back to hospital
Failure to comply generally with CTO in community gives responsible medical officer or authorised person power to take patient to hospital for up to 72 hours for examination and for further 28 days if considering variation or application to Tribunal. MHO consent needed. Patient can apply to Tribunal to revoke	

Consideration of a Compulsory Treatment Order Application – Flowchart



5. Emergency detention certificate

Criteria for granting an EDC 21
Terms of the EDC 21
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5. Emergency Detention Certificate (EDC) – Section 36

It is worth noting that the 2003 Act intends that the STDC be used in preference to an emergency detention certificate (EDC) whenever possible. Any fully registered medical practitioner may complete an EDC (i.e. not just AMPs).

Criteria for granting an EDC

- It is likely that the patient has a mental disorder.
- It is likely that the patient has significantly impaired decision-making ability with respect to medical treatment for mental disorder.
- The doctor must be satisfied that significant risk to the patient or others exists, which would be ameliorated by detention under an emergency certificate.
- The doctor must be satisfied that the need for the certificate is urgent and that detention under an STDC would be either inappropriate or unfeasible.

It is worth noting that the first two criteria listed above contain the word 'likely'. This means that the medical practitioner needs to be satisfied only on the balance of probabilities. The meaning of the new criterion of 'significantly impaired decision making ability' is explored in Appendix 2.

Terms of the EDC

An EDC:

- Lasts 72 hours
- Allows transfer to hospital within 72 hours, then detention for up to a further 72 hours; transfer between hospitals can occur within the 72 hours
- Must be given to hospital managers to authorise detention
- Should have the consent of the MHO, whenever possible
- Allows medical treatment to be given in an emergency
- Can be served on a child of less than 16 years; if no child and adolescent in-patient services are available, the Mental Welfare Commission must be informed
- Carries no right of appeal.

The same doctor who completes the medical examination must complete the EDC.

What is a medical examination?

The medical examination for an EDC involves:

- A face-to-face assessment
- Mental state examination
- Basic physical examination
- An assessment of risk and of decision-making ability.

Occasionally, it is not possible to perform a complete examination, such as when the patient is in a police cell.

The doctor must sign the certificate on the day of examination, or within four hours (whichever is the greater time).

The doctor who grants the EDC should arrange the patient transfer, or delegate the transfer arrangements. He or she also has a responsibility to ensure the certificate is passed on to the receiving hospital's managers.

Ideally, the medical assessment should be joint, involving a doctor and the MHO. It is permissible for a doctor to grant an EDC without MHO consent, but only in exceptional circumstances, such as:

- The patient being in immediate danger or trying to abscond
- No MHO being available.

A MHO can seek a warrant (Section 35) from a sheriff allowing a person to be detained for three hours to enable a medical examination into mental disorder to be carried out. Should removal to a place of safety be required, a Section 293 warrant can be sought.

If it is likely that a period of detention longer than 72 hours is required, then an STDC should be sought as soon as possible. The EDC is revoked upon granting a short-term certificate.

An AMP can revoke an EDC under Section 39 if the detention criteria are not satisfied. The hospital managers have a duty (under Section 38 (2)) to arrange an AMP review of an EDC 'as soon as practicable'.

Comparisons of the conditions and effects of EDCs between the 1984 and 2003 Acts are shown in Tables 8 and 9.

Table 8. Emergency detention – conditions

2003 Act Part 5 (Section 36-43)	1984 Act (Section 24-25)
Likely that the patient has a mental disorder	Likely that the patient has a mental disorder
Decision-making ability likely to be significantly impaired	No mention of decision-making ability
Matter of urgency to determine medical treatment	Admission to hospital urgent necessity
Risk to health, safety or welfare of patient, or safety of others if not detained	Risk to health or safety of patient or for protection of other people
Short-term detention would involve undesirable delay	
Consent from MHO where practicable	Consent of relative or MHO where practicable
Certificate issued on same day as medical examination or four hours between examination and certificate	Recommendation on same day as examination

Table 9. Emergency detention – effects

2003 Act (Section 36-43)	1984 Act (Section 24-25)
Removal to hospital within 72 hours	Removal to hospital within three days
Detention for up to 72 hours	Detention for up to 72 hours
Detention ends when short-term detention imposed	Detention lasts for 72 hours unless discharged prior to this
Duty to inform nearest relative or person residing with patient, named person, Mental Welfare Commission and local authority if no MHO consent obtained	Duty to inform Mental Welfare Commission and nearest relative
No new emergency detention immediately after expiry	No new Section 24/25 immediately after expiry
Power to suspend	
No appeal	No appeal
No compulsory treatment except where the treatment is urgently required (Section 243)	No compulsory treatment

6. Suspension of compulsory measures

Suspension of an EDC 25
Suspension of an STDC (Section 53) 25
Revoking suspension of a detention certificate (Section 54) 25
Suspension of CTOs and interim CTOs (Sections 127 and 128) 25
Revoking suspension of a CTO and interim CTO (Section 129) 26

6. Suspension of Compulsory Measures

Suspension of an EDC (Section 41)

An EDC can be suspended using Section 41, although the detention does not need to be suspended to allow patients to be transferred for emergency medical investigations and treatment. Suspending an EDC would be unusual, given its brief timescale.

Suspension of an STDC (Section 53)

An STDC can be suspended by the responsible medical officer completing Section 53. The suspension certificate can last for any period stipulated by the responsible medical officer, and conditions may be attached to allow, for example, a suspension to occur while the patient is at home on pass. Again, suspension of an STDC is not required to access emergency treatment for physical disorder.

Revoking suspension of a detention certificate (Section 54)

Suspension of a detention certificate may be revoked through Section 54. The responsible medical officer must then notify:

- The patient
- Named person
- MHO
- Mental Welfare Commission
- Any person authorised to keep the patient in their charge.

Suspension of CTOs and interim CTOs (Sections 127 and 128)

The responsible medical officer can suspend any of the compulsory measures in the CTO and the hospital detention requirement specified in an interim CTO.

Section 127 allows suspension of hospital detention for up to six months (a significant change from the terms of the 1984 Act). The expiry of the suspension certificate cannot be later than the expiry of the treatment order or interim order, and conditions (such as specifying the place of residence) can be attached to a suspension certificate. The responsible medical officer remains responsible for the patient's care during a suspension certificate.

If the suspension certificate is for longer than 28 days, the responsible medical officer must notify (write to) the following before the certificate is granted:

- The patient
- Named person
- GP
- MHO.

A suspension certificate allowing transfer to a second hospital for emergency treatment for a physical disorder should be granted for a patient under a compulsory or interim CTO (unlike the EDC and STDC). The patient can only be detained in the second hospital if the hospital is a residence condition specified in the suspension certificate.

Compulsory measures specified in a CTO (other than hospital detention) may be suspended by using Section 128, provided the suspension is no longer than three months.

Prior to granting a suspension certificate under Section 128, the responsible medical officer must notify (write to) the following of their intention:

- The patient
- Named person
- The MHO.

Additionally, the responsible medical officer must notify the Mental Welfare Commission within 14 days of the reasons behind and duration of the suspension certification under Section 128.

Revoking suspension of a CTO and interim CTO (Section 129)

A suspension certificate granted under Section 127 or 128 can be revoked by using Section 129. If this occurs, the patient, named person, MHO and GP should be notified as soon as possible, and the Mental Welfare Commission should be notified within 14 days.

7. Other issues relating to the 2003 Act

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Transfers outwith Scotland 27
Unlawful detention 28
Absconding 28

7. Other Issues Relating to the 2003 Act

Transfers within Scotland

For a 'domestic transfer' (that is, within Scotland) under a CTO, Section 124 requires the managers of the hospital in which the patient is detained to:

- Gain the consent of the managers of the receiving hospital
- Notify the patient, the named person and the primary carer at least seven days prior to transfer; this can be waived if the transfer is urgent, or if the patient consents to the transfer.

Once the transfer has occurred, managers of the receiving hospital must notify (write to) the Mental Welfare Commission within seven days of the date of the transfer, providing the name and address of the receiving hospital and whether the seven-day notice was given.

Appeals against transfer under a CTO occur under Section 125, and Section 126 for the State Hospital.

There are no formal procedures for transferring a patient under an EDC, an STDC or an interim CTO; consent and prior notification are, however, advised.

Transfers outwith Scotland

Section 289 allows transfer outwith Scotland under a community CTO, but this is likely to be uncommon, as the patient would be subject to a hospital-based order on arrival in, for instance, England. The warrant for such a transfer would be issued by the patient's responsible medical officer, and not Scottish Ministers.

Section 290 allows cross-border transfer of hospital-based patients detained under the 2003 Act. Hospital managers must notify the patient, primary carer, named person, MHO, and the Mental Welfare Commission.

On receipt of a detained patient in a Scottish hospital from across the border, the responsible medical officer must notify (write to):

- The managers of their hospital
- The Mental Welfare Commission
- The Tribunal
- The local authority in which the hospital is located (enabling designation of a MHO)
- The Scottish Ministers (for a restricted patient).

The receiving responsible medical officer should prepare a care plan for the newly-arrived patient.

Unlawful detention

Section 291 focuses on appeals to the Tribunal for review of the need for voluntary patients to remain in hospital. Examples include:

- An informal patient lacking capacity to consent to admission and not objecting to treatment
- An informal patient being denied free egress (for example, being sited in a locked ward).

Section 315 states it is an offence to wilfully ill-treat or neglect a patient.

Absconding

Section 301 deals with patients who abscond while subject to a CTO. This includes failing to be recalled from suspension, and failing to comply with the residence or change of address requirement.

Section 302 deals with the other sections, including STDCs, EDCs, and interim CTOs.

Both sections make the patient 'liable to be taken into custody', bearing in mind the principle of least restrictive alternative. Section 303 allows the MHO, a police officer, a member of the hospital staff, or any other person authorised by the responsible medical officer to take the patient into custody or return him or her to hospital.

Any period of unauthorised leave does not affect the expiry date of the CTO, unless it is within 14 days of the due date. In this case, another 14 days of detention is enacted, during which the responsible medical officer must carry out the mandatory review.

Patients under an STDC who return from unauthorised leave within 13 days of the certificate expiry date can face the specified measures being authorised for another 14 days.

8. Responsibilities of statutory bodies in administering the 2003 Act

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Independent advocacy services 30

8. Responsibilities of Statutory Bodies in Administering the 2003 Act

A number of statutory bodies have defined responsibilities under the 2003 Act. These include:

- The **Mental Welfare Commission** which is set up by parliament to exercise protective functions in Scotland for people with a mental disorder. This is principally done via the 2003 Act, and the Adults with Incapacity (Scotland) Act 2000. For example, the Commission can revoke a short-term detention certificate, extension certificate, interim CTO, CTO or compulsion order. The Mental Welfare Commission also has responsibility to promote best practice and monitor and report on use of the 2003 Act.
- **NHS Boards** which are required to maintain and update lists of AMPs. Section 230 states that hospital managers must appoint an AMP to act as a patient's responsible medical officer 'as soon as is reasonable and practicable'. Managers of medical/surgical hospitals will therefore need to have arrangements to provide AMPs in place, and medical/surgical consultants should not discharge a detained patient without prior revocation of detention by the appointed AMP.

NHS Boards have a responsibility to provide adequate services for mentally disordered children (those under 18 years), and a duty to provide services to allow mothers in hospital with post-natal depression or other peri-natal mental disorder to be placed with their children under one year old, where clinically appropriate.

- **Local authorities** have a duty to promote the well-being and social development of people with mental disorder outwith hospital, and facilitate socio-cultural and recreational activities for those in hospital. This would include help with travel to facilities.

Local authorities have a duty to appoint a sufficient number of MHOs, and ensure that one is allocated to each detained patient.

The Code of Practice to the 2003 Act recommends that localities develop appropriate 'Psychiatric Emergency Plans' (PEPs) in consultation with the multidisciplinary team, local agencies (such as police and ambulance services and MHOs) and user and carer groups. These PEPs would detail the process for detention and transfer of patients in a safe, calm and dignified manner.

Local authorities' duty to inquire deals with orders to gain access to remove individuals who are thought to have a mental disorder, including:

- Local authorities' duty under Section 33 to inquire into the situation of a mentally disordered person over 16 years of age who may be vulnerable to neglect or ill-treatment.
- The MHO can apply to a sheriff for Section 35 warrants, which confer powers of access and detention for assessment and allows access to medical records, but not the removal of the person.
- The MHO can apply to a sheriff for power to grant a removal order under Section 293 to remove a mentally disordered person to a place of safety and detain him or her there for up to 72 hours.
- Power invested in an authorised (Section 292) individual to remove a mentally disordered person to a place of safety, including allowing police to open locks.
- Power given to police (under Section 297) to remove a mentally disordered person from a public place to a place of safety.

Approved medical practitioners are not directly involved in these sections.

- **Independent advocacy services**. Local authorities, NHS Boards and the State Hospital have a duty to secure independent advocacy services for people with mental disorder. Advocacy is support and representation enabling influence over care and welfare.

Advocates do not determine what a person's 'best interests' may be. They should be permitted to:

- Attend meetings or consultations regarding treatment.
- Receive appropriate correspondence and other information.
- Have reasonable access to their client.

Independent advocates should be independent to the patient, meaning they should not be care providers.

9. New rules on patients' rights and representation Act

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Advance statements 31
Offences 32

9. New Rules on Patients' Rights and Representation

New rules on the patient's rights and representation are set out under the 2003 Act. These include rules in relation to:

- **The named person.**

The named person:

- Replaces the 'nearest relative' (except under EDCs).
- Has official standing.
- May often be a partner or carer.
- Represents and looks after the interests of the patient.
- Must have their views taken into account.
- Is chosen by the patient.
- Must be nominated in writing, witnessed by a prescribed person; the nominee can refuse or later revoke the nomination.
- Must be aged over 16 years.
- Can apply to the Tribunal, and can appear or be represented at the Tribunal.
- Should receive information on the whereabouts of the patient if he or she is subject to an EDC.
- Must be interviewed by the MHO if an application for an STDC or CTO is being made.

Where there is no named person, the primary carer adopts the role. In addition, the Tribunal can appoint a named person.

- **Advance statements**. This is a written statement on how the patient would or would not want to be treated for mental disorder in the future, should his or her decision making become impaired.

Any person providing medical treatment (such as a responsible medical officer) is 'to have regard to' preferences detailed in an advance statement. Designated medical practitioners should ascertain the presence of and views within the advance statement. Statements drawn up from October 2004 are considered valid, but a statement can be withdrawn once the patient's capacity has been established and witnessed.

When making an advance statement, the person needs to have 'the capacity of properly intending' the wishes specified in it, and a witness needs to sign agreeing to such. The following professionals may act as witnesses:

- A doctor (GP, responsible medical officer, or another doctor)
- A registered nurse (community psychiatric nurse or another nurse)
- A solicitor
- A social worker (MHO or another social worker)
- A clinical psychologist
- An occupational therapist, or
- A social service worker such as a supervisor or manager of a care service.

Where the wishes expressed in an advance statement are not followed, the reasons must be recorded and copied to:

- The patient
- Named person
- Guardian or welfare attorney
- The Mental Welfare Commission.

Advance statements must comply with the terms of the 2003 Act and can neither bind a doctor into illegal or unethical treatment, nor require a doctor to provide specific services or treatments.

There is no standard form on which to make an advance statement (although proformas do exist), but it should contain the name and address of:

- The patient
- GP
- Named person
- Guardian or welfare attorney.

Copies of advance statements should be stored in medical notes.

Offences

There are no statutory duties specified here, but details are provided regarding non-consensual sexual acts (Section 311) and sexual offences (Section 313). Ill-treatment and wilful neglect (Section 315) are addressed in Part 21 of the 2003 Act.

10. The 2003 Act and the Criminal Justice System

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10. The 2003 Act and the Criminal Justice System

Entrance into the criminal sections of the 2003 Act occurs after an individual is charged with an offence punishable by imprisonment and is thought to be suffering from a mental disorder.

A brief overview of the criminal justice system in Scotland and provisions for people with mental order within it is set out below.

Criminal justice system in Scotland

Summary Procedure applies to the Sheriff and District courts, where less serious offences are prosecuted. These cases must be heard within 40 days (or be dropped), and the prosecution has a duty to alert the Court to a suspicion that the alleged offender may be mentally unwell. At the conclusion of the evidence, the sheriff is required to reach a verdict of guilty, not guilty, or not proven.

Solemn Procedure applies to more serious cases. Here, cases must be heard within 110 days. After the evidence, the jury must determine whether guilty, not guilty, or not proven.

Provision for people with mental disorder within the criminal justice system

While the Tribunal is the forum for determining applications under the civil procedures of the 2003 Act, the Courts (Sheriff Court and High Court) remain the locus for such matters in relation to criminal procedures.

The responsible medical officer is the main witness with regard to mental disorder in the Courts, and has a new statutory role when the final disposals of a compulsion order and a hospital direction are being considered by the Court.

The system may be divided into the following stages:

- *Pre-conviction*, in which the person accused of an offence makes a plea of guilty or not guilty, assuming he or she is fit to plead.
- *Post-conviction, pre-sentencing*, in which, unless acquitted, reports may be requested to facilitate the Court's final decision in sentencing the person.
- *Sentencing*, in which the Court determines the disposal, having had regard for all the circumstances of the offence.

Under the Criminal Procedure (Scotland) Act 1995, there are various pre-existing mental health options available to the Court, such as probation with a treatment requirement. These remain largely unaltered by the 2003 Act. Setting these aside, the new orders that the 2003 Act inserts into the 1995 Act are arranged in this sequence of pre-conviction, post-conviction and sentencing.

Aims of the new legislation

The 2003 Act inserts amendments (Box 4) in the Criminal Procedure (Scotland) Act 1995 with the intention of:

- Creating greater flexibility in the process of assessing and treating mentally disordered people before they face trial and before they are sentenced, in parallel with civil proceedings for emergency and short-term detention.
- Introducing greater flexibility of disposals available to the Court in line with the CTO potential for community-based compulsion and hospital detention.
- Accommodating the changes imposed by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, whereby issues of public safety have to be taken into account in the assessment and disposal of those who have committed serious offences.

Box 4. Insertions into the Criminal Procedure (Scotland) Act 1995 from the 2003 Act

Insertions in the 1995 Act are denoted by the placement of capital letters after the original Section number. For instance, Section 130 of the 2003 Act inserts sections 52A to Q into the 1995 Act. This also explains irregularities in paragraph numbering in the 2003 Act.

While the 2003 Act repeals the 1984 Act in its entirety, it preserves the relationship between criminal procedures legislation, which contains the authority to make disposals, and mental health legislation, which deals with the way in which these matters are managed by mental health professionals and systems. Since the narrow, pre-existing disposals in the Criminal Procedure (Scotland) Act 1995 did not meet the requirements of the broad redesign of mental health law, Part 8 of the 2003 Act inserts new mental health disposals into the 1995 Act and Parts 9 to 13 set out the consequences of these changes in terms of reviews, extensions and variations of orders.

Pre-conviction provision

The period before conviction may be divided into the period before trial and the trial period up to the point of conviction.

The *pre-trial* period begins when a person has been arrested and charged. In this period, during which the accused may be in custody or awaiting trial on bail in the community, anyone may alert the prosecutor to the potential presence of mental disorder.

Assessment orders

The assessment order allows a person awaiting trial or sentence to be examined by an AMP (Box 5). It is therefore not exclusive to the pre-trial/pre-conviction period, but can be actioned within any of the three defined legal stages of:

- Pre-conviction
- Post-conviction, pre-sentencing
- Transfer of sentenced prisoners.

The prosecutor and Scottish Ministers (through the prison governor) have authority to apply to the Court for an assessment order or a treatment order. Alternatively, where it appears to the Court that the accused has a mental disorder, the Court has authority to make such orders on its own initiative.

While the key focus is on assessment, the order also authorises the administration of treatment in accordance with Part 16 of the 2003 Act. Treatment may be given under an assessment order even if the patient does not consent, provided a favourable second opinion from an independent AMP is obtained.

Box 5. Conditions for granting an assessment order

The assessment order can only be granted under specified conditions, which are:

- That there are *reasonable grounds* for believing:
  - *that the person in respect of whom the application is made has a mental disorder*
  - *that medical treatment would be likely to prevent the mental disorder worsening, or alleviate the symptoms or effects of the mental disorder*
  - *that if the assessment order were not made there would be a significant risk to the health, safety or welfare of the person or a significant risk to the safety of any other person.*
- That, if an assessment order were made by a registered medical practitioner, the person could be admitted to a suitable hospital before the expiry of the period of seven days beginning with the day on which the order is made.
- That it would not be reasonably practicable to carry out the assessment mentioned above unless an order were made.

There is a duty on the responsible medical officer to provide a psychiatric report to the Court before the expiry of the assessment order to address the question of whether a treatment order should be made. The responsible medical officer should consult with the designated MHO on this issue.

Duration of the order is for the period of remand or committal. The order is terminated when the Court has made its disposal.

Treatment orders

A treatment order can be made at any stage of the process prior to sentencing where the accused has an evident mental disorder that requires medical treatment.

As with an assessment order, it is initiated by prosecutors' or the Scottish Ministers' application to Court, or at the Court's own initiative. It requires the evidence of two medical practitioners, one of whom must be an AMP (Box 6).

Box 6. Evidence for granting a treatment order

The evidence must persuade the Court that the conditions for the treatment order are met. These are:

- *That a mental disorder exists.*
- *Available medical treatment would be likely to alleviate or prevent deterioration of the patient's condition.*
- *There would be significant risk to the health, safety or welfare of the person, or the safety of others, without such treatment.*

Note that, unlike an assessment order, there is no stipulation of the need only for 'reasonable grounds for believing' that the conditions of the treatment order are met. In their evidence to the Court, the two medical practitioners must be sure that the conditions are met.

Potential outcomes of the trial process

Acquittal of the offence

The Code of Practice to the Criminal Procedure (Scotland) Act 1995 states that a mentally disordered person acquitted of any offence may still require treatment, if necessary by compulsion using any of the civil routes – emergency or short-term detention, or by application for a CTO.

A new emergency measure has been introduced in the 2003 Act for insertion in the 1995 Act under Section 60C. This is a new power that gives Courts the authority to cover the loophole of a high-risk mentally disordered person walking free if a trial collapses. It meets the contingency of such an individual being acquitted from Court and being free to leave while still requiring treatment and manifesting risk to self or others.

Under Section 60C, and upon evidence from two medical practitioners, the Court may authorise the removal of the acquitted person to a place of safety and detention for up to six hours for the purpose of securing a medical examination. The order ceases before expiry of this six-hour period if the patient is subsequently detained under either emergency or short-term detention.

Insanity in bar of trial

This implies that the accused has a mental disorder that renders him or her:

- Unfit to plead
- Unable to instruct a legal defence
- Unable to participate in the trial process.

Criteria for a judgement of insanity in bar of trial and considerations regarding 'sane and fit to plead' status have to be met (Boxes 7 and 8).

Box 7. Criteria for a judgement of insanity in bar of trial

Criteria for insanity in bar of trial are not based on statute but were set out recently in *Stewart v HMA:*

The question [for the trial judge] was whether the appellant, by reason of his material handicap, would be unable to instruct his legal representatives as to his defence or to follow what went on at his trial. Without such ability he could not receive a fair trial.

A requirement of a previous judgement (*HMA v Brown*) that the accused be able to tell the truth and remember events accurately has been overturned. The test excludes amnesia for the circumstances of the alleged offence in itself (*Russel v HMA*), and inability to give instruction due to physical defects, such as deaf mutism, are probably excluded (*HMA v Wilson*).

It should be noted that unlike England and Wales, fitness to plead does not encompass the ability to challenge a juror.

Box 8. Considerations regarding 'sane and fit to plead' status

From a practical perspective, the following questions may be useful in determining the 'sane and fit to plead' status of an individual:

- 'Do you know what the police have said you have done?'
- 'When they ask you in Court if you did it, do you know what your plea will be?'
- 'What is the difference between saying "guilty" and "not guilty"?'
- 'Can you tell your lawyer what you think happened?'
- 'If a witness says something in Court you don't agree with, who would you tell?'

Features of an individual's mental state due to his or her disorder to be taken into consideration include the individual's:

- Ability to communicate – schizophrenic thought disorder, manic flight of ideas, depressive poverty of speech, dysphasia or dementia.
- Beliefs – for example, the individual may have delusions that he or she has a divine mission, and that the court process is irrelevant. Psychosis per se does not necessarily equate with insanity.
- Comprehension – may be impaired in dementia, acute confusion or learning disability.
- Attention and concentration – may be impaired in any of the conditions listed above.
- Memory – amnesia for the alleged offence is irrelevant in law, but short-term memory impairment due to organic impairment may be sufficiently severe to make it impossible for the individual to follow proceedings in Court.

Pre-verdict psychiatric reports to the Court need to address the issue of fitness to plead and insanity in bar of trial (see Appendix 3 for a suggested model report).

If, after a period of (in-patient) assessment, a finding of insanity in bar of trial is made, two medical practitioners (one of whom must be an AMP) must provide evidence under Section 54 (a temporary compulsion order).

The prosecutor may drop proceedings for minor offences and pass the case over for informal treatment or compulsory treatment under civil procedure. For more serious offences, an Examination of the Facts (Section 55) occurs.

Determination of insanity at the time of the offence (Box 9) and diminished responsibility (Box 10) are also important issues that need consideration.

Box 9. Determination of insanity at the time of the offence

Matters to be considered here are whether 'reason was alienated', and whether the mental disorder 'played an overwhelming role' in the commission of the offence.

As a guide, the psychiatrist should consider:

- Whether there was a manifest mental disorder at the time of the alleged offending, **and**
- Whether the alleged offender was unaware of either the nature or the moral wrongfulness of his or her behaviour as a direct result of the mental disorder.

If the psychiatric evidence is challenged in Court, the issue of insanity is determined by the judge or sheriff in summary cases and the jury in solemn cases.

If the defence is successful, the individual is acquitted on the grounds of insanity. The finding appears on his or her criminal record, albeit without a conviction.

Box 10. Diminished responsibility

This defence was narrowly defined in Scotland, but this changed after the recent case of Galbraith v HMA. Adapted from that case:

In essence, the judge must decide whether there is evidence that, at the relevant time, the accused was suffering from an abnormality of mind which substantially impaired the ability of the accused, as compared with a normal person, to determine or control his acts…that is, that his state of mind should have bordered on insanity. The abnormality of mind may take various forms. It may mean that the individual perceives physical acts and matters differently from a normal person. Or else it may affect his ability to form a rational judgment as to whether a particular act is right or wrong or to decide whether to perform it. In a given case, any or all of these effects may be operating.

The plea can only be used in charges of murder, and if successful the individual is convicted of culpable homicide. The statutory test does allow 'substantial impairment' secondary to the mental abnormality of personality disorder. It is for the Court to determine whether any particular abnormality can lead to a plea of diminished responsibility. No mental abnormality (short of insanity) brought on by the accused taking alcohol or controlled drugs or sniffing glue will lead to a plea of diminished responsibility.

Conviction stage

If a person who has had no previous symptoms has been convicted of an offence, but he or she appears to have a mental disorder, the Court may arrange for assessment and treatment before sentencing occurs by making either:

- An assessment order (Section 52D), or
- A treatment order (if the need is to secure a period of treatment before sentencing, as per Section 53D).

In either case, the responsible medical officer must make a psychiatric report to the Court with recommendations, especially if any mental health disposal is being considered. The responsible medical officer should consult with the designated MHO during the preparation of the report.

Alternatively, an interim compulsion order may be considered. This option allows for a prolonged period of in-patient assessment before the final disposal is made.

An interim compulsion order is distinguishable from an assessment order in that it is renewable, consequently allowing the lengthy assessment that may be required of people who have committed serious offences and/or appear to pose considerable risk. It would therefore be considered where more serious disposals of greater restriction were being considered and is now required (except in exceptional circumstances) where a hospital order with restriction is being considered as the final disposal.

On completion of the assessment process, whether or not it involves renewals of the interim compulsion order, the responsible medical officer must provide the Court with a written report to assist the Court in making the appropriate disposal.

Details and conditions of an interim compulsion are shown in Boxes 11 and 12.

Box 11. Details of an interim compulsion order

An interim compulsion order lasts for a period of 12 weeks and is renewable for consecutive periods of 12 weeks, adding up to one year in total.

The order gives authority to:

- Detain the patient in a place of safety.
- Convey him or her to a specified hospital within seven days of the order being made.
- Detain him or her in that hospital.
- Give medical treatment in accordance with Part 16 of the 2003 Act.

For the Court to consider an order of this length, the offender must have been convicted of an offence other than murder (punishable by imprisonment). The Court must also be satisfied that it is appropriate to make an interim compulsion order having regard to all the circumstances, including the nature of the offence and alternative disposals available.

The responsible medical officer should obtain a MHO's view of the suitability and availability of such alternative services. The responsible medical officer can advise the Court of the appropriateness of the interim compulsion order only once these options have been discounted.

Box 12. Conditions of an interim compulsion order

- Requires two medical recommendations, one of which must be from an AMP.
- Reasonable grounds for:
  - Believing that the offender has a mental disorder.
  - Considering that available medical treatment would alleviate or prevent deterioration of the condition.
  - Considering that the offender's health, safety or welfare, or that of any other person, would be at risk if such treatment was not provided.
  - Considering that a compulsion order or hospital direction would be an appropriate post-conviction disposal, and that a suitable hospital placement is available.

Post-conviction disposals

Following conviction for an offence and any proper assessment for mental disorder, the Court must determine what to do with the offender. There is a wide range of disposals available under the Criminal Procedure (Scotland) Act 1995:

- Imposition of any sentence, custodial or community-based.
- Interim compulsion order; this is an option available to the Court to enable it to make the most appropriate final disposal.
- Compulsion order (inserted into the 1995 Act by the 2003 Act) (see Box 13). Although the 2003 Act states that the criteria for a compulsion order and a hospital direction are the same, the Code of Practice to the 2003 Act recommends a hospital direction (as opposed to a compulsion order) be imposed where no link can be made between the offence and the presence of mental disorder.
- Compulsion order with a restriction order (inserted into the 1995 Act by the 2003 Act) (see Box 14).
- Hospital direction (inserted into the 1995 Act by the Crime and Punishment (Scotland) Act 1998).
- Section 200 (pre-dating the 2003 Act) for remand on bail, or in hospital for enquiry into the possibility of mental disorder; this order lasts three weeks, with the possibility of one three-week extension. This hospital remand is unlikely to be used in future because of the assessment and treatment orders.
- Guardianship or intervention order (not discussed in any detail in this booklet).
- Probation order with a requirement for treatment (Section 230 of the 1995 Act, pre-dating the 2003 Act). The doctor or psychologist providing the treatment must agree to this, as must the local authority providing the supervising (probation) officer. This order can last up to three years.

Box 13. Compulsion orders

Compulsion orders mirror the civil provision of a CTO.

Conditions of a compulsion order are:

- Recommendations are required by two medical practitioners (one of whom has to be an AMP) verifying the conditions for the order.
- There must be evidence of mental disorder.
- There must be availability of medical treatment likely to alleviate or prevent the disorder from worsening.
- There must be the presence of risk to the health, safety or welfare of the person, or risk to the safety of any other person.
- There must be a demonstrable necessity for making the order.
- A report from the MHO is required.

Box 13. Compulsion orders

It is also worth noting that:

- The significant impairment of decision-making test of civil orders does not have to be met.
- The compulsion order endures for up to six months, and is renewable for six months in the first instance and annually thereafter.
- The compulsion order may enforce detention in hospital or compulsion in the community; measures set out in Section 66 (1) of the 2003 Act apply to the order.
- To warrant imposition of a compulsion order, the offender must have been convicted of an imprisonable offence other than murder.
- Where detention in the State Hospital is required by the compulsion order, the Court must be satisfied that the offender requires to be detained in conditions of special security such as can only be provided in a state hospital.
- Where a compulsion order requires compulsion in the community, the local authority must first of all agree to those services being available (by way of contrast, there is no such safeguard in setting out the requirements of a CTO in relation to recorded matters).

Box 14. Compulsion order with a restriction order

A restriction order allows additional scrutiny of a mentally disordered offender who may pose a serious risk to others. The emphasis is therefore on protection of the public as the offender progresses through rehabilitation.

The criterion for a restriction order is that without it, there is a risk that the patient would commit offences as a result of his or her mental disorder if at large in the community.

It is granted without time limit and, while it is always made in conjunction with a compulsion order, it cannot be made in respect of compulsory measures in the community. In short, a restriction order made with a compulsion order has the effect of indefinite detention in a hospital setting and supervised follow up on discharge.

Conditions for restriction

The restriction order is made after oral evidence given to the Court by one of the medical practitioners (who must be an AMP) recommending the compulsion order.

The conditions that must be satisfied place emphasis on the level of risk posed, with particular emphasis on the protection of the public from serious harm, and the strength of relationship between the risk and the specified mental disorder.

This should be discussed in the context of the principle of least restriction in relation to the freedom of the offender, balanced against:

- Protection of the public
- Conditions of serious risk to the public
- The relationship between the risk and the mental disorder.

A restriction order is ordinarily made following an extensive period of assessment under an interim compulsion order. In the exceptional minority of cases where this has not happened, there must be clear reason for not having made an interim order and initial assessment. Risk assessment (see Appendix 4) is a crucial constituent of the early overall assessment.

At this time, there approximately 300 restriction orders in place in Scotland (one half of the patients affected reside in the State Hospital), with approximately ten new restriction orders imposed each year.

Patient safeguards and right of appeal

The major safeguards for individuals with mental disorder who are subject to criminal proceedings are:

- The Tribunal
- The named person
- The right to advocacy
- The ability to write advance statements
- The Mental Welfare Commission.

The right of appeal exists against the level of security imposed in a particular case, either under a compulsion order (with or without restriction), compulsory treatment order, a hospital direction or a transfer for treatment direction is to the Tribunal. This right of appeal will come into force no later than 1 May, 2006.

11. Appendix 1

Notifying and informing the Mental Welfare Commission – timelines for responsible medical officers 43

11. Appendix 1 – Notifying and informing the Mental Welfare Commission – timelines for responsible medical officers

Some of the finalised forms may automatically lead to nofication, and the details are not yet determined. The MWC is based at K floor, Argyll House, 3 Lady Lawson Street, Edinburgh EH3 9SH, telephone: 0131 222 6111, but will move to Falkirk in March 2006.

In this table, **inform** means 'telephone or write', whereas **notify** means 'in writing'.

Section	Type	Within/When	How
48(2)	Grant extension To STDC	24 hours	Inform
49(4)	Revoke STDC or extension	7 days	Notify
54(3)	Revoke suspension of STDC	ASAP	Inform
74(1)	Revoke interim CTO	ASAP	Inform
82(1)	Revoke CTO	7 days	Notify
87(2)	Extension of CTO	ASAP	Inform
91	Extension and variation of CTO	ASAP	Inform
94/91	Variation of CTO	ASAP	Inform
97/91	Recorded matter not met (copy to Tribunal)	ASAP	Notify
127	Suspension of CTO or interim CTO detention	14 days	Notify
128	Suspension of other (community) CTO measures	14 days	Notify
129	Revoke Section 127 or 128	14 days	Notify
144	Revoke CO	7 days	Notify
153	Extend CO	ASAP	Inform
157	Extend/vary CO (copy to Tribunal)	ASAP	Inform
160/157	Vary CO	ASAP	Inform
177/116	Detention on community CO	7 days	Notify
177/116	Revoke detention under community CO	7 days	Notify
179/127/128	Suspension of detention or other measure of CO	14 days	Notify
224	Suspension of more than 28 days for CO, TO, restriction, hospital direction	14 days	Notify
225	Revoke Section 224 suspension	14 days	Notify
243	Urgent medical treatment	7 days	Notify
248	Report on NMD or ECT	After treatment	Notify
310	Absconding	To be decided	Notify

12. Appendix 2

Significantly impaired decision-making ability 45

12. Appendix 2 – Significantly impaired decision-making ability

Introduction

Significantly impaired decision-making ability (SIDMA) is not the same as 'incapacity' under the Adults with Incapacity (Scotland) Act 2000.

SIDMA occurs when a mental disorder affects the person's ability to believe, understand and retain information, and to make and communicate decisions. It is consequently a manifestation of a disorder of mind.

SIDMA arises out of mental disorder alone; 'incapacity' can also arise from disease of the brain or impaired cognition, and can include physical disability.

SIDMA is not the same as limited or poor communication, or disagreements with professional opinion.

The vast majority of people with mental illnesses retain their ability to make decisions throughout the course of their illness. All adults are assumed to have a decision-making ability or capacity as a starting point.

The 'Bournewood Gap'

This relates to an important case in English law in which a House of Lords decision to overrule a judgement that all patients incapable of offering consent had to be detained was itself overturned by the European Court of Human Rights. The ramifications of this reversal are still to reveal themselves, but the 2003 Act provides for application to the Tribunal in relation to unlawful detention of an informal patient.

Issues arising

The Millan Committee clearly stated that: 'It should not be the function of mental health law to impose treatment on those who are clearly able to make decisions for themselves.' Further information on the Millan Committee is available at www.scotland.gov.uk/Topics/Health/care/15216/1444.

The new law in Scotland recognises that patients with mental disorder may have impaired capacity which, while damaging their ability to make decisions, does not render them entirely incapable. For example, a mentally ill person may have significantly impaired decision-making ability with regard to his or her treatment plan, but might well be able to continue to manage his or her financial affairs competently.

English case law has been influential in this regard, particularly the case of Re C (1994). This determined that capacity could fluctuate, and that the essential components of capacity were an ability to:

- Comprehend information
- Retain information
- Believe the information presented
- Arrive at a choice based on the above, whilst understanding the implications of not agreeing to a particular suggested treatment.

That is the ability to reason and weigh evidence before arriving at a decision, and the ability to communicate a decision by talk, sign, or other means is also important.

It is well known that non-consensual emergency treatment can be administered under common law. In Scotland, however, this is under-developed and generally a defence of 'necessity' – in other words, that it was necessary to act in an emergency situation in the patient's best interests – is invoked.

It is worth noting that significant impairment in decision-making ability is required only to be 'likely' for emergency and short-term detention orders. This means that the medical practitioner or AMP need only be satisfied that this criterion is met on the balance of probabilities (51% or more). The sophistication of the assessment of decision-making ability is, of course, dependent on the circumstances of assessment.

With a CTO, the Tribunal is required to be 'satisfied' that the individual in question has significantly impaired decision-making ability.

It is also worth noting that there is no precise threshold for significantly impaired decision-making ability. It is understood, however, to be more than just a deficiency in communication, or a disagreement with the treating professionals. As noted above, it is separate from incapacity, but is based on similar factors: an ability to believe, understand and retain information pertaining to treatment.

13. Appendix 3

Psychiatric report to the Court 47

13. Appendix 3 – Psychiatric report to the Court

Suggested structure/contents of a psychiatric report to the Court

A good psychiatric report to the Court uses plain English, and explains medical jargon. It will also be sufficiently comprehensive to preclude where possible a requirement for oral evidence.

Key heading areas in the report

Preliminary information

- At whose request the assessment was undertaken, circumstances of assessment (place, time, any constraints on assessment such as inadequate time to complete assessment due to prison routine)
- Sources of information used (interview with the person, interviews with others, documents examined)
- The person's capacity to take part or refuse to take part, and understanding of the limits of confidentiality
- If any important sources of information could not be used, there should be a statement explaining why this was the case.

Background history

- Family history
- Personal history
- Medical history
- Psychiatric history
- Recent social circumstances
- Personality
- Forensic history

Circumstances of offence or alleged offence

Progress since offence or alleged offence

Current mental state

Opinion

Would cover all or some of the following matters:

- Fitness to plead
- Presence of mental disorder currently and whether the criteria for the relevant order are met
- Presence of mental disorder at the time of the offence:
  - the relationship between any mental disorder and the offence (this is still relevant even if – the person has been convicted, as it may affect the choice of disposal)
  - whether the person was insane at the time of the offence
  - in murder cases, whether there are grounds for diminished responsibility

- Assessment of risk:
  - the risk of harm to self or others
  - the risk of re-offending
  - the relationship between this risk and any mental disorder present
  - does the person require to be managed in a secure setting, and if so, should this be at a state hospital?
- What assessment or treatment does the person require?
  - does the person need further assessment?
  - where? Does the person need a period of in-patient assessment and at what level of security?
  - why? What issues remain to be clarified?
- Does the person require treatment for a mental disorder or condition?
  - what treatment do they need, and where?
- State any matters that are currently uncertain and the reasons they remain uncertain.

Recommendation

- Should the Court consider using any particular order?
- If so, what arrangements have been made for the person to be received in hospital or elsewhere under this order?
- Whose care will the person be under?
- Consider whether an alternative order may be appropriate if circumstances change so that the order recommended above cannot be acted on. For example:
  - if the person is or is not found to be insane
  - if the person is or is not convicted.

Medical practitioner's details

- Name
- Current post
- Current employer
- Qualifications
- Registration status with the General Medical Council
- Approved under Section 22 of the 2003 Act and with which NHS Board
- A statement that the report is given on 'soul and conscience'
- A statement as to whether the medical practitioner is related to the person
- A statement as to whether the medical practitioner has any pecuniary interest in the person's admission to hospital or placement on any community-based order
- The medical practitioner should sign the report.

14. Appendix 4

Risk assessment 49

14. APPENDIX 4 – Risk assessment

Two key criteria have to be considered in risk assessment:

- The standard criterion for civil detention – 'significant risk to the health, safety, or welfare of the person, or to the safety of any other person'
- The criterion for a restriction order – 'the risk that as a result of the mental disorder he would commit offences if set at large.'

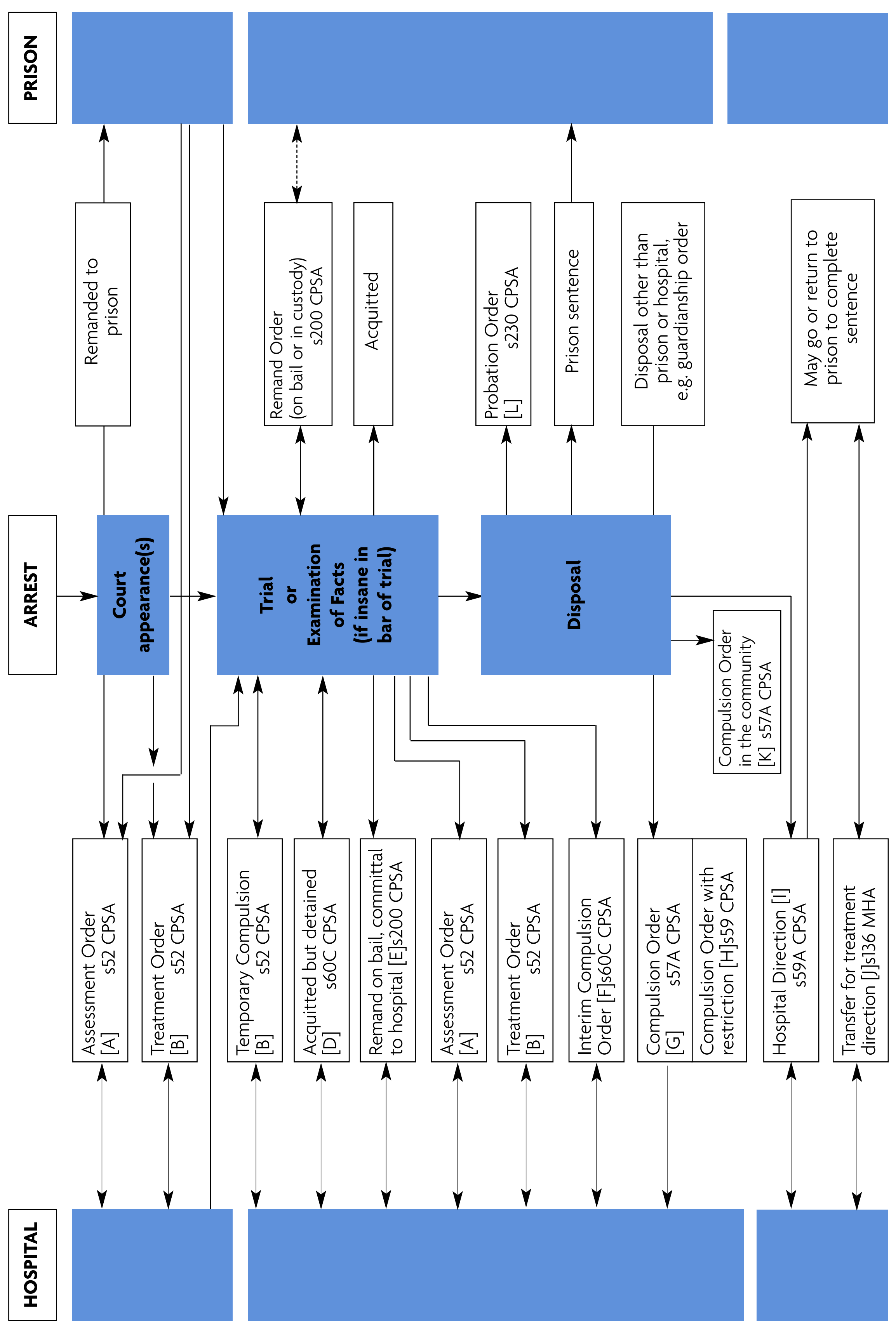
During risk assessment, it is expected that detailed consideration of the background history (including history of violence and offending, history of mental disorder, suicidal behaviour and psychiatric treatment, and history of drugs and alcohol misuse), as well as any index offence and its circumstances, will be made. Factors that might exacerbate or protect against the risk should also be considered.

Psychiatrists might be expected to use a standardised risk assessment tool when forming a judgement on risk. Many examples of usable risk assessment tools exist, including the modified Sainsbury tool and the Glasgow Risk Screen. Other more detailed risk assessment tools (such as the HCR-20) can be found in forensic psychiatry settings.

15. Appendix 5

Procedures available for the assessment and treatment of mentally disordered offenders at the various stages of the criminal justice process 51

15. Appendix 5 – Procedures available for the assessment and treatment of mentally disordered offenders at the various stages of the criminal justice process



16. Glossary of commonly-used terms in the 2003 Act

16. Glossary of Commonly-used Terms in the Act

Advance Statement: a written, witnessed document made when the patient is well, setting out how he or she would prefer to be treated (or not treated) if they were to become ill in the future. The Tribunal and any doctor treating the patient must have regard to the advance statement, they must send the Commission a written record of the ways they have worked outwith these instructions, and the reasons why, if the advance statement is not followed.

Approved Medical Practitioner (AMP): a medical practitioner who has been approved under section 22 of the Act by a NHS Board or by the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder. An approved medical practitioner will often be a consultant psychiatrist. Only an approved medical practitioner can grant a short-term detention certificate (STDC); and at least one of the two mental health reports forming part of a CTO application must be provided by an approved medical practitioner.

Authorised person's warrant/a 'section 292 warrant': authorises a person to enter the premises of another person where the person entering the premises has already been given the authority under another provision of this Act to take the person to another place or into custody. This could happen, for example, in a situation where a patient has absconded and a person who has been authorised under section 303 of the Act to take that patient into custody or to return them to hospital requires entry to the premises where the patient has been found.

Assessment Order: a pre-disposal order made by the court under Section 52D of the Criminal Procedure (Scotland) Act 1995 authorising hospital detention for up to 28 days so that the patient's mental condition may be assessed.

Care Plan: a document prepared by the patient's responsible medical officer under Section 76 of the Act after a CTO has been made. It lays out the forms of medical treatment and the other services the patient will be receiving while subject to the CTO. This document should not be confused with the 'proposed care plan', which is prepared under Section 62 of the Act as part of the application for a CTO.

Compulsion Order: a mental health disposal made by the court under Section 57A of the Criminal Procedure (Scotland) Act 1995 authorising compulsory measures (either hospital or community-based) for a period of six months, if not otherwise renewed.

Compulsory Treatment Order (CTO): an order granted by the Tribunal under Section 64(4) of the Act. It authorises any of the compulsory measures listed at Section 66(1) for a period of six months, if not otherwise renewed. The CTO can be renewed for six months, then for twelve months thereafter.

Designated Medical Practitioner: this is a medical practitioner appointed by the Mental Welfare Commission under Section 233 of the Act. The function of a designated medical practitioner is to provide a second medical opinion with respect to certain medical treatments being given under Part 16 of the Act.

Emergency Detention Certificate (EDC): a certificate issued under Section 36(1). Subject to strict criteria, it authorises the removal of a person to hospital within 72 hours and the detention of that person in hospital for up to a further 72 hours.

Extension Certificate: a certificate issued under Section 47(1). It extends a period of short-term detention by three days to allow for the preparation of an application for a CTO.

Forensic Criteria: for a Court to make a mentally disordered offender subject to a mental health disposal, it must be satisfied that all of the following criteria are met:

- The person has a mental disorder
- Medical treatment is available which would be likely to prevent that disorder worsening or be likely to alleviate the symptoms or effects of the disorder
- There would be a significant risk to the person or to others if treatment were not provided
- The making of the disposal is necessary.

Hospital Direction: a mental health disposal made by the court under Section 59A of the Criminal Procedure (Scotland) Act 1995 which is made in addition to a sentence of imprisonment. It allows the person to be detained in hospital for treatment of their mental disorder and then transferred to prison to complete their sentence once detention in hospital is no longer required.

Independent Advocate: a person who enables the patient to express their views about the decisions being made about their care and treatment by being a voice for the patient and encouraging them to speak out for themselves. An independent advocate is employed by an advocacy organisation which is not directly managed by the NHS Board or local authority. All people with mental disorder have a right to independent advocacy, not only those subject to compulsory measures.

Interim Compulsion Order: a pre-disposal order made by the court under Section 53 of the Criminal Procedure (Scotland) Act 1995 authorising hospital detention for 12 weeks (but can be renewed regularly for up to one year) so that the court can gather further evidence on whether the forensic criteria apply.

Interim Compulsory Treatment Order (CTO): an order granted by the Tribunal under Section 65(2). It authorises compulsory measures for a period of up to 28 days at a time.

Mental Health Officer (MHO): is a social worker who has received special training in the use of the Mental Health Act. The MHO has a number of specific responsibilities under the Act. The comparable role in England and Wales is an Approved Social Worker.

MHO's Report: a report under Section 61 which is prepared by the MHO as part of the application for a CTO. It must detail background information on the person who is the subject of the application.

Mental Health Report: a report required under Section 57(4) and prepared by a medical practitioner. The practitioner must lay out in this report the reasons why a CTO is appropriate.

Named Person: a 'named person' is someone nominated by a person in accordance with the provisions of the Act to support them and protect their interests. The named person is entitled to receive certain information about the person and to act on behalf of the person in certain circumstances and at certain times set out in the Act. Section 250 sets out the meaning of 'named person'.

Nearest Relative: there are occasions in the act where the nearest relative is given information about a person coming under the provisions of the Act such as when a person is removed to a place of safety. Section 254 sets out a list of the people who will be considered in identifying a person's nearest relative.

Nurse's Holding Power: a power that can be exercised by nurses 'of a prescribed class' by way of Section 299 to detain a patient for up to two hours, while awaiting a medical examination. Where necessary the detention may be extended by up to one hour while the examination is carried out.

Place of Safety: Section 300 defines a place of safety as a hospital, premises which are used to provide a care home service or any other suitable place (other than a police station) where the occupier is willing to temporarily receive a person with mental disorder. However, if no place of safety is available, a police officer may remove a person to a police station which should then be treated as a place of safety for the purposes of the person's detention.

Proposed Care Plan: a document drawn up under Section 62 of the Act by the MHO who is making the application for a CTO. It contains details of the medical treatment for mental disorder, the community care services; and any other forms of care and treatment which it is proposed to provide to the patient if the CTO is made. The 'proposed care plan' should not be confused with the "care plan" which is prepared under Section 76 of the Act by the patient's responsible medical officer subsequent to the making of a CTO.

Removal Order: an order granted by a sheriff or a justice of the peace under Section 293(1). It authorises certain persons to enter the premises of an individual at risk in order to remove them to a place of safety.

Responsible Medical Officer (RMO): the RMO is appointed by the hospital managers when a patient is detained under the Mental Health Act in that hospital. The RMO can be any medical practitioner but will usually be an AMP.

Restricted Patient: a patient who has been made subject to a compulsion order and a restriction order by the court.

Restriction Order: an order made by the court under Section 59 of the Criminal Procedure (Scotland) Act 1995 at the time of disposal and is added to a Compulsion Order. It means that the measures specified in the Compulsion Order will then be without limit of time.

Short-term Detention Certificate (STDC): this is a certificate issued under Section 44(1). Subject to strict criteria, it authorises the detention of a person in hospital for a period of up to 28 days.

Social Circumstances Report: a report produced under Section 231 of the Act. It must be produced by the patient's MHO within 21 days of any of the following events taking place: the granting of an STDC; the making of an interim CTO; of a CTO; an assessment order; a treatment order; an interim compulsion order; a compulsion order; a hospital direction; or a transfer for treatment direction. However, an MHO does not need to complete an SCR where he is satisfied that an SCR would serve little or no practical purpose.

State Hospital: The State Hospital Carstairs provides care and treatment in conditions of special security for around 240 patients from Scotland and Northern Ireland with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting.

Transfer for Treatment Direction: an order that is made by the Scottish Ministers under Section 136 of the new Act which allows the transfer of a prisoner to hospital for treatment of a mental disorder.

Treatment Order: a pre-disposal order made by the court under Section 52M of the Criminal Procedure (Scotland) Act 1995 authorising hospital detention for treatment of a person's mental disorder. The order ceases at the end of the period for which the person is on remand or is committed.

17. Sources of further information

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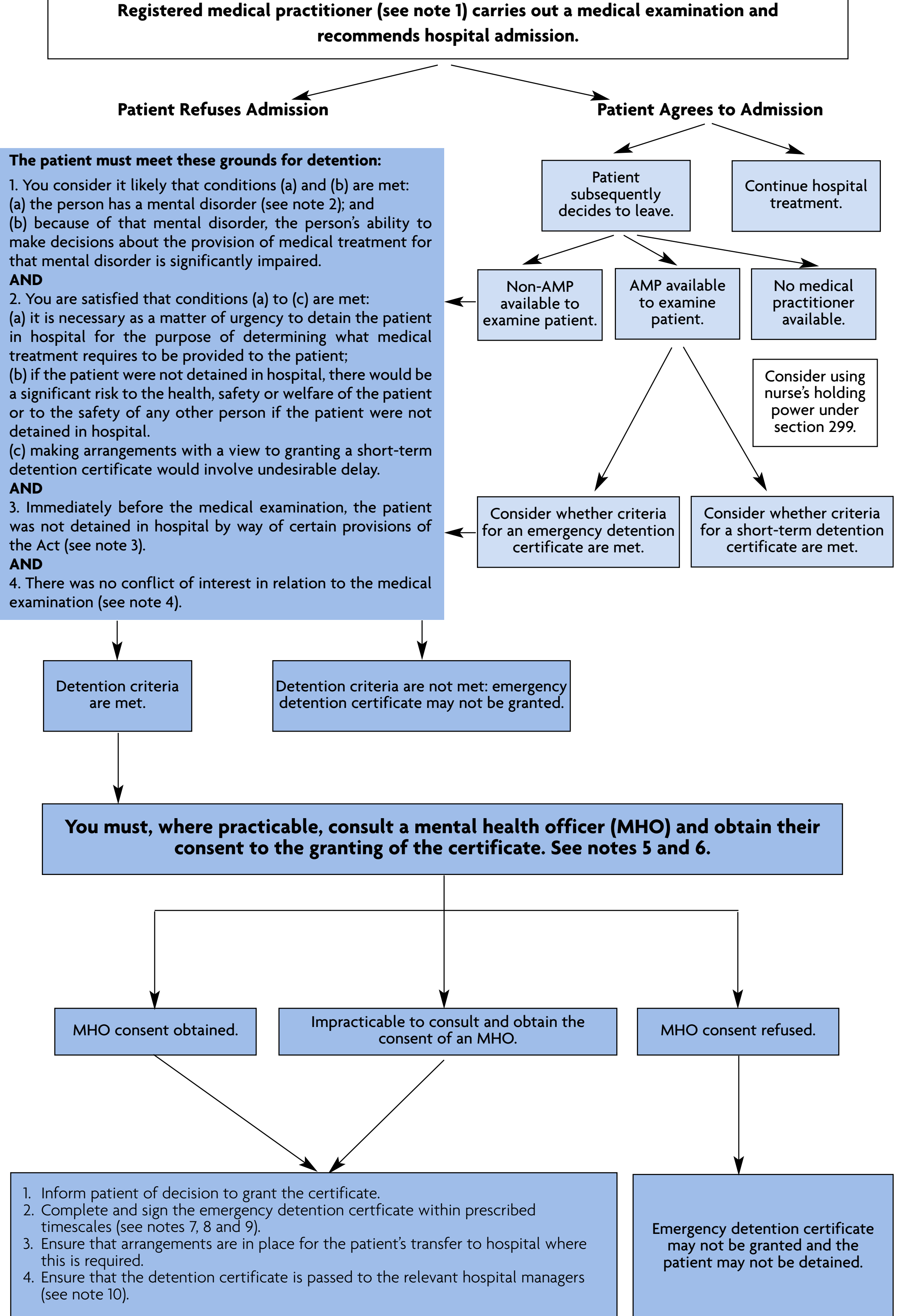
17. Sources of further information

- The Mental Health (Care & Treatment) (Scotland) Act 2003. (www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030013.htm)

A print version is published by The Stationery Office Limited as the *Mental Health (Care & Treatment) (Scotland) Act 2003*, ISBN 0 10 590055 9.

- The Code of Practice
- The NHS Education for Scotland website. (www.nes.scot.nhs.uk/mha/amp/amp.htm)
- McManus J, Thomson LDG (2005), *Mental Health and Scots Law in Practice*. Edinburgh, W Green. ISBN 0414014758.
- The Mental Welfare Commission for Scotland website (www.mwcscot.org.uk/).

Guide for medical practitioners on the granting of an emergency detention certificate under section 36 of the Mental Health (Care and Treatment) (Scotland) Act 2003



Throughout the process of granting an emergency detention certificate, you are bound to have regard to the principles of the legislation as laid out in sections 1 to 3 of the Act.

Note 1: Any registered medical practitioner may grant an emergency detention certificate. You do not have to be an approved medical practitioner.

Note 2: Section 328(1) of the Act defines "mental disorder" as "mental illness, personality disorder or learning disability, however caused or manifested". Section 328(2) further states that a person is not mentally disordered by reason only of sexual orientation; sexual deviancy; trans-sexualism; transvestism; dependence on, or use of alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to an other person; or acting as no prudent person would act.

Note 3: The relevant provisions are set out at section 36(2) of the Act and they are: an emergency detention certificate; a short-term detention certificate; an extension certificate issued under section 47 of the Act pending an application for a CTO; section 68 of the Act (i.e. the extension to the detention period authorised once a CTO application has been submitted to the Tribunal); a certificate granted under sections 114(2) or 115(2) of the Act (i.e. a certificate issued subsequent to a patient's non-compliance with the terms of a community-based interim CTO or a CTO). [DN – Add something in about definition of "immediately before"? (depending on content of Code on this point)]

Note 4: [DN – conflict of interest material to be added once regs/Code of Practice material have been finalised]

Note 5: The medical practitioner must consult and seek the consent of an MHO to the granting of the certificate. All reasonable efforts should be make to contact an MHO. However, where the urgency of the situation is so great that it would not be practicable for this consultation to take place then it is permissible for the practitioner to grant the EDC without consent. [DN - Add in best practice material about consulting and discussing the situation with other members of the multi-disciplinary team depending on what the final version of the Code says.]

Note 6: Best practice would be that if one MHO refuses to grant consent, then .... [DN – revise according to the final version of the Code]

Note 7: A valid emergency detention certificate can be issued on any document if form [x] is not available. However, it is strongly recommended that form [x] be used in all circumstances. If form [x] is not used, the emergency detention certificate must state the practitioner's reasons for believing the conditions mentioned at points 1 and 2 on the blue box overleaf to be met and must be signed by the medical practitioner.

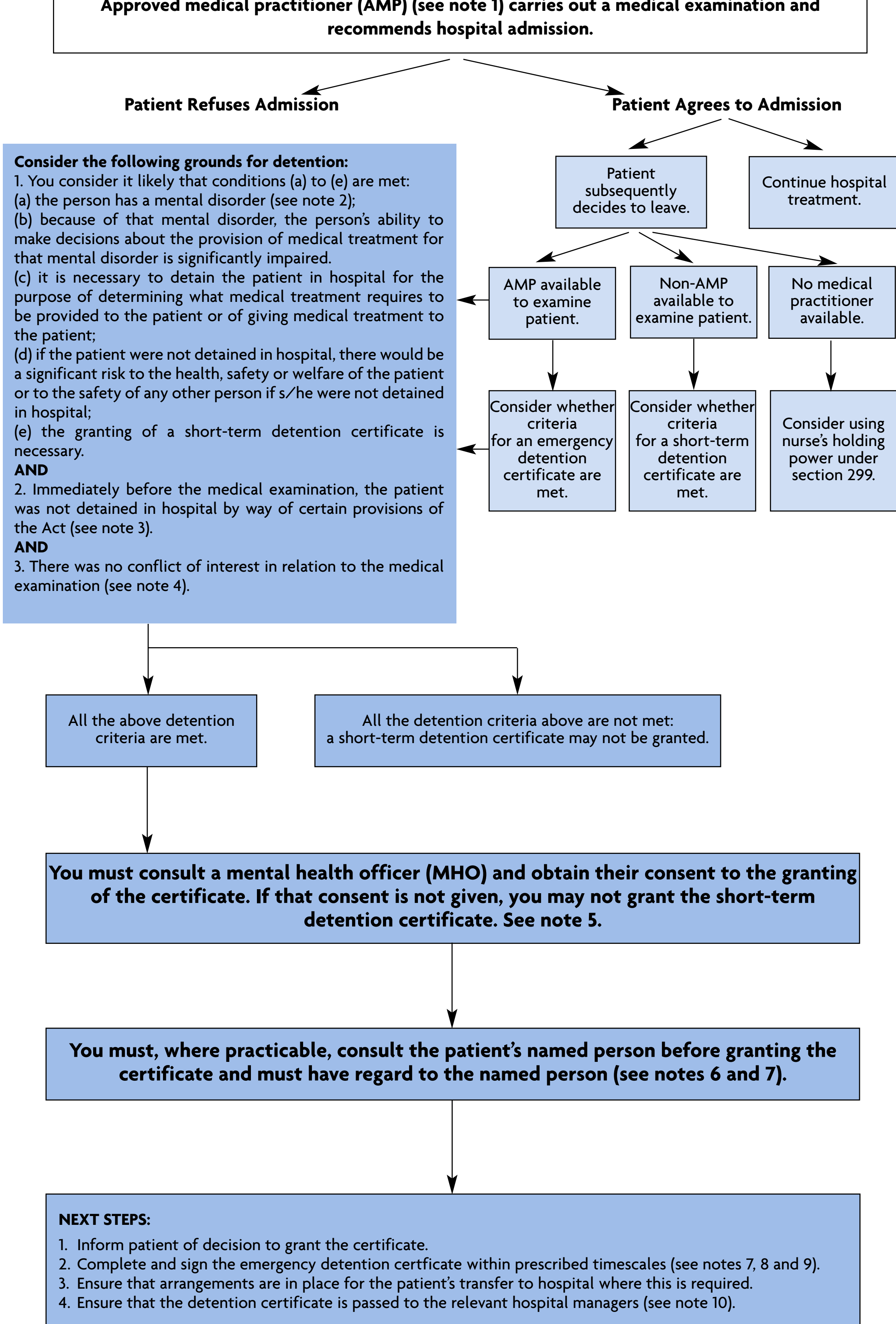
Note 8: The emergency detention certificate must be completed either by the end of the day on which the medical examination takes place (if the examination takes place before 8pm) or within 4 hours of the medical examination being completed (if it takes place after 8pm).

Note 9: The emergency detention certificate authorises, first, the patient's transfer to hospital within 72 hours of the certificate being granted; and, secondly, the patient's detention in hospital for 72 hours.

Note 10: Section 36(7) of the Act states that the patient's detention in hospital is only authorised is the emergency detention certificate is given to the managers of the hospital before the patient is admitted to hospital under the authority of the certificate. If the patient is already in hospital when the certificate is granted, then the certificate must be given to the hospital managers as soon as practicable after it was granted [DN – clarification of "hospital managers" required? depends on final content of Code on this point].

The purpose of this leaflet is to act as a guide only. It does not provide full and comprehensive coverage of everything you ought to know about emergency detention. For fuller information, please consult the Act and its Code of Practice.

Guide for medical practitioners on the granting of a short-term detention certificate under section 44 of the Mental Health (Care and Treatment) (Scotland) Act 2003



Throughout the process of granting an emergency detention certificate, you are bound to have regard to the principles of the legislation as laid out in sections 1 to 3 of the Act.

Note 1: Only an approved medical practitioner may grant a short-term detention certificate (i.e. a medical practitioner approved under section 22 of the Act).

Note 2: Section 328(1) of the Act defines "mental disorder" as "mental illness, personality disorder or learning disability, however alone of sexual orientation; sexual deviancy; trans-sexualism; transvestism; dependence on, or use of alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to an other person; or acting as no prudent person would act.

Note 3: The relevant provisions are set out at section 44(2) of the Act. They are: a short-term detention certificate; an extension certificate issued under section 47 of the Act pending an application for a CTO; section 68 of the Act (i.e. the extension to the detention period authorised once a CTO application has been submitted to the Tribunal); a certificate granted under sections 114(2) or 115(2) of the Act (i.e. a certificate issued subsequent to a patient's non-compliance with the terms of a community-based interim CTO or a CTO);

Note 4: [DN - conflict of interest material to be added once the regs/Code on this point are finalised.]

Note 5: [DN - Add best practice material about consulting the MHO and other members of the multi-disciplinary team etc depending on the final text of the Code.]

Note 6: A short-term detention certificate can only be granted if you have consulted the patient's named person about the proposed granting of the certificate, where it was practicable to do so, and if you have had regard to their views.

Note 7: You should ask the MHO whose consent you have sought to the granting of the certificate about the identity of the patient's named person. Section 45(1) of the Act places that MHO under a duty to interview the patient and to ascertain the named and address of the patient's named person before s/he consents to the granting of the certificate, where it is practicable to do so. If the MHO cannot carry out these duties, s/he must provide you within 7 days of you consulting him/her with a copy of a record which states the steps which s/he took in trying to carry out these duties.

Note 8: A valid short-term detention certificate can be issued on any document if form [x] is not available. However, it is strongly recommended that form [x] be used in all circumstances. Where form [x] is not used, a valid short-term detention certificate must state the practitioner's reasons for believing the conditions mentioned at point 1 of the blue box overleaf to be met and must be signed by the practitioner.

Note 9: The short-term detention certificate must be completed within 3 days of the completion of the medical examination.

Note 10: The short-term detention certificate authorises, first, the patient's transfer to hospital within 3 days of the certificate being granted [DN – re-draft once wording of Code on the timescales has been finalised]; and, secondly, the patient's detention in hospital for 28 days.

Note 11: Section 44(6) of the Act states that the patient's detention in hospital if only authorised if the certificate is given to the managers of the hospital before the patient is admitted to hospital under the authority of the certificate. If the patient is already in hospital when the certificate is granted, then the certificate must be given to the hospital managers as soon as practicable after it was granted.

The purpose of this leaflet is to act as a guide only. It does not provide full and comprehensive coverage of everything you ought to know about short-term detention. For further and fuller information, please consult the Act and its Code of Practice.

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