

mental health

(care and treatment) (scotland) act 2003

code of practice

volume 1

mental health | code of practice
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volume 1

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introduction to volume 1

introduction

Coverage of this volume

- 01 Volume 1 of the Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 deals with a range of issues relating to the general framework within which the Act operates. These subjects include, for example, the duties placed on health boards and local authorities (Part 4); cross-border transfers of patients (section 289 and 290); and medical treatment (Part 16). It therefore provides Code of Practice material on Parts 1, 2, 3, 4, 14, 16, 17 (chapters 1 and 2), 19, 21, 22 as well as sections 229-231, 281-286, 289-291, 328 and 329.
- 02 This volume does not look at the range of issues about what can be termed “civil compulsory powers” which relate to an emergency detention certificate; a short-term detention certificate; an extension certificate; a compulsory treatment order; an interim compulsory treatment order; and absconding from any of these certificates/orders. These procedures are set out in Parts 5, 6, 7 and 20 of the Act and are discussed in Volume 2 of the Code of Practice.
- 03 Neither does this volume look at the procedures surrounding the compulsory care and treatment of a person with a mental disorder who has committed any form of criminal offence. These procedures which are set out in Parts 8 to 13 of the Act are examined in Volume 3 of the draft Code of Practice.

Structure of this volume

- 04 This volume is divided into 18 chapters. Chapter 1 provides a description of the principles of the legislation as set out in sections 1 and 2 of the Act and the definition of “mental disorder” and “medical treatment” (under sections 328 and 329). It then concludes with a brief overview of matters in relation to children and young people.
- 05 Chapter 2 describes the power and duties of the Mental Welfare Commission for Scotland as set out in Part 2 of the Act. It includes the role and functions of the Commission, and emphasises the importance of ensuring that notifications required by the Act are correctly made. Attached to Chapter 2 is an Annex setting out the notifications required, who must comply with each particular duty, and the timescales within which the notifications must be made.

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- 06 Chapter 3 discusses the Mental Health Tribunal for Scotland ('the Tribunal'), which is an independent judicial body, established by Part 3 and Schedule 2 of the Act. The Tribunal is the body that makes the decisions in a wide range of situations on the care and treatment of patients who are subject to the Act. This chapter provides guidance on the types of proceedings the Tribunal determines.
- 07 Chapter 4 sets out the powers and duties on Health Boards, under Part 4 Chapter 1. Health Boards have further responsibilities and functions under other parts of the Act, and those relevant sections of the Code of Practice should also be referred to where appropriate.
- 08 Chapter 5 sets out the powers and duties on local authorities, under Part 4 Chapter 2. Local authorities have further responsibilities and functions under other parts of the Act, and those relevant sections of the Code of Practice should also be referred to where appropriate.
- 09 Chapter 6 examines issues which can be grouped together under the heading of patient representation. It therefore looks at a person's right to nominate a named person (Part 17 Chapter 1), to make an advance statement (sections 275 to 276) and a patient's right to advocacy (section 259).
- 10 Chapter 7 discusses the duty placed on local authorities and health boards with regard to the assessment of a person's needs for community care services (sections 227 and 228). This duty applies to both civilly detained patients and to mentally disordered offenders.
- 11 Chapter 8 describes what is meant at section 291 by "unlawful detention". It offers good practice guidance with regard to informal patients, who can be described as voluntary patients receiving care and treatment for mental disorder in hospital, and who are not subject to compulsion or detention under either the 2003 Act or the Criminal Procedure (Scotland) Act 1995.
- 12 Chapter 9 turns to the appointment of the patient's responsible medical officer and the designation of the patient's mental health officer (sections 230 and 229).

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- 13 Chapter 10 covers the subject of medical treatment for mental disorder which may be given in accordance with Part 16 of the Act. It looks at, for example, safeguards which the Act puts in place with respect to certain treatments, such as electro-convulsive therapy (ECT). It also examines issues relating to the giving of urgent medical treatment (under section 243).
- 14 Chapter 11 provides guidance on the preparation of a social circumstances report by the patient's MHO (Part 15 section 231) which relates to both civilly detained patients and to mentally disordered offenders.
- 15 Chapter 12 focuses on communications and safety and security in hospitals. This chapter provides guidance on the withholding of correspondence of people detained in hospital (sections 281 to 283) and the use and interception of telephone calls (sections 284 and 285). It then turns to the issues surrounding safety and security in hospitals, including the restriction of certain articles to be kept by patients; the taking of samples of body fluid and other materials; prohibitions and restrictions on visitors; and the search and surveillance of both patients and visitors.
- 16 Chapter 13 provides an overview of appeals against certain decisions of the Tribunal and the sheriff principal (Part 22). The majority of appeals against decisions of the Tribunal are made to the sheriff principal under section 320(2). However complex cases, where an appeal is made under section 320(2), may be remitted by the sheriff principal, or on the motion of any party to the appeal, to the Court of Session.
- 17 Chapter 14 discusses the procedures to be followed in relation to the cross-border transfer of detained patients (sections 289 and 290).
- 18 Chapter 15 deals with a range of other duties and powers under the Act, such as a local authority's duty to inquire into the situation of a vulnerable mentally disordered person and the associated warrants and orders which may be applied for in pursuance of this duty (sections 33, 35 and 293), an authorised person's warrant to take or retake a patient (section 292); a nurse's holding power (section 299) and the police's power to remove a mentally disordered person from a public place to a place of safety (section 297). It also describes what is meant at section 300 of the Act by a "place of safety" and provides guidance on the issues which local agencies would be expected to agree upon when designating places of safety within their locality.

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- 19 Chapter 16 examines offences and provides best practice guidance in relation to Part 21 of the Act. The offences include sexual offences where someone is providing care services for a person with mental disorder; non-consensual sexual acts; ill-treatment and wilful neglect of a mentally disordered person, and of inducing and assisting a person to abscond.
- 20 Chapter 17 provides a glossary of important terms which are commonly used throughout this volume.
- 21 Chapter 18 gives a list of both statutory and non-statutory forms. Although there is no requirement to use the non-statutory forms, you are strongly recommended to do so as these draw attention to some procedural requirements under the Act. Failure to observe procedural requirements may invalidate either the application or certificate or report etc. From September 2005, all forms will be available on the Scottish Executive website at: www.scotland.gov.uk/health/mentalhealthlaw

Good practice versus best practice

- 22 The phrase “best practice” has been used throughout this Code of Practice in preference to the phrase “good practice”. This is to provide consistency with the duty placed on the Commission by way of section 5 of the Act to “promote best practice” in relation to the operation of the Act. The use of the term “best practice” does not imply that any of the activities or duties described in that way is purely aspirational or less likely to be achieved than an activity or duty which might elsewhere be described as being indicative of “good practice”.

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Patient confidentiality

23 The section 1 principles require that any decision or course of action being considered (other than a decision about medical treatment) should as far as practical and reasonable, take into account the needs and circumstances of the patient's carer and the importance of providing such information to any carer as might assist the carer to care for the patient. However, when a person is considering the information to be shared with the carer, it would be best practice to consider in every case the patient's right to confidentiality about their private medical details and treatment options, before information is supplied. It should also be noted that the Community Care and Health (Scotland) Act 2002 amends the Social Work (Scotland) Act 1968 to give carers a right to have their carer needs assessed by the local authority. It would be best practice to bring this assessment right to the notice of any carer providing a substantial amount of care where the carer appears to have unmet caring needs.

Interpretation of timescales under the Act

24 The Act uses a number of ways of counting the time period in relation to Orders, etc. In all cases, the relevant section of the Act is specific about how these time periods should be counted.

25 Where the Act specifies a number of hours these should be counted in hours from the time of signing the certificate, etc. Examples of this are the period of 72 hours provided for at section 36(8) and in section 44(5)(a) where the Act says "the period beginning with the granting of the certificate".

26 Where the Act specifies a number of days or weeks beginning at a certain point, these are counted from the beginning of the 1st day of the period. Examples of this are the period of 3 days provided for at section 44(5)(a) and the 7 day period in section 45(3)(b) where the Act states "before the expiry of the 7 day period beginning with the day on which the MHO is consulted...", and the period of 28 days provided for at section 44(5)(b) where the Act says "a period of 28 days beginning with ... the beginning of the day on which ...".

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- 27 The Act also provides at some points for time periods (generally months or years) ending at a specific time. For example, section 165 states “the period of two years ending with the day on which the order would have ceased to authorise these measures...”. This period will be counted back from the beginning of the day on which the order ceases to have effect.
- 28 At some sections the Act specifically says “working” days. Section 47(8) of the Act defines a “working day” as a day which is not:
- (a) a Saturday;
 - (b) a Sunday; or
 - (c) a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in Scotland.
- 29 At all other places where the Act mentions days, weeks or months these are calendar days, weeks, months as appropriate.

Note

The Act should be read in conjunction with all subordinate legislation made under the Act. The Code of Practice refers to the regulations, orders and directions made under the Act at appropriate points.

Readers should be aware in particular of two orders made under the Act – The Mental Health (Care and Treatment) Scotland Act 2003 Modification Order 2004 (SSI No. 533) and The Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Enactments) Order 2005 – which have amended the Act.

The Code points out where important changes have been made but practitioners may be advised to check the relevant orders themselves and to seek their own legal advice as required, when referring to the relevant provisions of the Act.

At the time of drafting this version of the Code, some of the regulations and orders referred to have not yet been approved by the Scottish Parliament. It was felt that nonetheless it was helpful to the reader to include references prospectively. Practitioners are advised to check the mental health pages on the Scottish Executive website for current information and links to the latest versions of subordinate legislation on OPSI.

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Note on abbreviations

Although the use of abbreviations has been avoided wherever possible, the following are used commonly throughout this volume:

Commission:	Mental Welfare Commission
CPN:	Community Psychiatric Nurse
CTO:	Compulsory Treatment Order
ICTO:	Interim Compulsory Treatment Order
DMP:	Designated Medical Practitioner
MHO:	Mental Health Officer
RMO:	Responsible Medical Officer
Tribunal:	The Mental Health Tribunal for Scotland

The following pieces of legislation are also on occasion referred to in an abbreviated form:

“the 1995 Act”:	Criminal Procedure (Scotland) Act 1995
“the 2000 Act”:	Adults with Incapacity (Scotland) Act 2000
“the Act”:	The Mental Health (Care and Treatment) (Scotland) Act 2003

Certain terms which are used regularly throughout this volume have a specific meaning in the context of the Act which it is important to note. Although these terms are defined in section 329 of the Act, it is worthwhile repeating some of them here.

“notice”/“notify”	notice in writing
“patient”	a person who has or who appears to have a mental disorder
“regulations”	secondary legislation made by the Scottish Ministers under the Act

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overview

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Introduction

This chapter begins with a discussion of the principles and other matters which underpin the legislation and which are laid out at sections 1 to 3 of the Act. It then describes two important terms used commonly throughout the Act: namely, “mental disorder” and “medical treatment”. The chapter

Principles of the Act

Taking account of the Principles of the Act

- 01 Section 1 of the Act sets out the principles according to which people performing functions under the Act must discharge those functions. The principles apply to any professional, such as a doctor, nurse, social worker or MHO who is carrying out a function or exercising a duty in relation to a patient. For example, any doctor, member of medical staff or MHO taking a decision concerning emergency or short-term detention of a patient, or applying for, renewing, or seeking to vary a compulsory treatment order is discharging a function under the Act. The Tribunal is bound by the principles when making decisions about a patient.
- 02 The following persons are not bound by the principles: the patient; the patient’s named person; the patient’s primary carer; a person providing independent advocacy services; the patient’s legal representative; a curator *ad litem* appointed by the Tribunal; and any guardian or welfare attorney of the patient. However, these principles may serve to guide such persons in their dealings with the patient, their carer and others.
- 03 The principles require that any person, other than those who are exempt, in considering a decision or course of action, takes into account the following matters:-
 - the present and past wishes and feelings of the patient, where they are relevant to the exercise of the function and in so far as they can be ascertained by any means of communication appropriate to the patient. Where the decision relates to medical treatment and the patient has an Advance Statement then this should be given due consideration (*For further information on advance statements, see Chapter 6 of this Volume of the Code of Practice*).

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- the views of the patient's named person, carer, and any guardian or welfare attorney so far as it is practical and reasonable to do so.
 - the importance of the patient participating as fully as possible in any decisions being made and the importance of providing information to help that participation (in the form that is most likely to be understood by the patient). Where the patient needs help to communicate (for example, translation services or signing) then these should be considered. Any unmet need should be recorded.
 - the range of options available in the patient's case.
 - the importance of providing the maximum benefit to the patient.
 - the need to ensure that the patient is not treated any less favourably than the way in which a person who is not a patient would be treated in a comparable situation, unless that treatment can be shown to be justified by the circumstances.
 - the patient's abilities, background and characteristics, including, without prejudice to that generality, the patient's age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background, and membership of any ethnic group.
- 04 Except where a decision is being made about medical treatment, the principles also require that the needs and circumstances of the patient's carer and the importance of providing such information to any carer as might assist the carer to care for the patient, so far as it is reasonable and practical to do so, must also be taken into account. What is practical and reasonable will depend on the circumstances. While in an emergency the time available to consult and provide information may be limited, in other circumstances the person making the decision or taking a course of action should be able to take time to do so.
- 05 When a person is considering the information to be shared with the carer, it would be good practice to consider in every case the patient's right to confidentiality about their private medical details and treatment options, before information is supplied. It should also be noted that the Community Care and Health (Scotland) Act 2002 amends the Social Work (Scotland) Act 1968 to give carers a right to have their carer needs assessed by the local authority. It would be good practice to bring this assessment right to the notice of any carer providing a substantial amount of care where the carer appears to have unmet caring needs.

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- 06 Where the person is discharging a function in relation to anyone who is, or who has been, subject to:-
- an emergency detention certificate under the Act;
 - a short-term detention certificate under the Act;
 - a compulsory treatment order under the Act; or
 - a compulsion order under the Criminal Procedure (Scotland) Act 1995.
- 07 The person must also have regard to the importance of the provision of appropriate services to the person, including continuing care, where the person is no longer subject to the certificate or order.
- 08 The principles require that, after taking into account the matters set out above and any other relevant circumstances, the person discharging the function must then carry it out in the way that appears to that person to involve the minimum restriction on the freedom of the patient that is necessary in the circumstances.
- 09 For the purposes of these principles, making a decision not to act is still considered as taking a decision and any such consideration is bound by the principles of the Act.

Welfare of the Child

- 10 Section 2 of the Act makes specific provisions to safeguard the welfare of any child in respect of whom a person is discharging a function under the Act which may be exercised in more than one way. For this purpose a child is any person under the age of 18 years.
- 11 A person discharging such a function must do so in the manner that appears to that person to best secure the welfare of the child. The person must also take into account the matters set out in section 1 of the Act. For example, the views of the child and any carers should be taken into account in making decisions regarding the child. The importance of acting in the manner which involves the minimum restriction on the freedom of the child must be considered.

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Equal opportunities (section 3)

- 12 Section 3 of the Act provides a duty which applies to specified persons who are exercising functions under the Act to ensure that the function is discharged in a manner which encourages equal opportunities and the observance of the equal opportunities requirements.
- 13 The Act refers to the meaning given to “equal opportunities” and “equal opportunities requirements” set out in the Scotland Act 1998. In terms of that Act, “equal opportunities” means the prevention, elimination or regulation of discrimination between persons on grounds of sex or marital status; on racial grounds; or on grounds of disability; age; sexual orientation; language or social origin; or of other personal attributes, including beliefs or opinions, such as religious beliefs or political opinions. “Equal opportunity requirements” means the requirements of the law for the time being relating to equal opportunities.
- 14 The persons who are bound by the requirements of section 3 are the Scottish Ministers; Mental Welfare Commission; a local authority; a Health Board; a Special Health Board; the managers of a hospital; a mental health officer; a patient’s responsible medical officer; a medical practitioner; and a nurse.

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Definition of “mental disorder”

- 15 The Act refers throughout to a “patient”. In terms of section 329 of the Act, “patient” means a person who has or appears to have a mental disorder.
- 16 Section 328 of the Act provides that “mental disorder” means any mental illness; personality disorder; or learning disability, however caused or manifested.
- 17 The definition of mental disorder has been drawn widely to ensure that the services provided for in the Act are available to anyone who needs them. A person with mental disorder will only be subject to compulsory measures under the Act if they meet the specific criteria for those measures. However, sections 25 to 27 of the Act also provide for a range of local authority duties in relation to the provision of services for any person who has, or has had, a mental disorder.
- 18 Section 328(2) of the Act specifically states that a person is not mentally disordered by reason only of any of the following:-
 - 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 any other person; or
 - by acting as no prudent person would act.
- 19 No person who suffers from mental disorder but also falls within any of the above categories should be excluded from consideration for assistance, treatment or services under the Act. For example, the provisions of the Act may be invoked in respect of people with mental disorder who also have alcohol problems or misuse drugs. Section 328(2) ensures that a person is not regarded as mentally disordered *by reason only* of their sexual orientation, deviancy, trans-sexualism, transvestism or dependence on drugs or alcohol, or by their behaviour.

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Definition of “medical treatment”

- 20 Section 329 of the Act defines “medical treatment” as “treatment for mental disorder”; and for this purpose “treatment” includes:-
- nursing;
 - care;
 - psychological intervention;
 - habilitation (including education, and training in work, social and independent living skills); and
 - rehabilitation (read in accordance with the paragraph above).
- 21 “Medical treatment” includes pharmacological interventions as well as other physical interventions (such as ECT) in addition to psychological and social interventions (including occupational therapy) made with respect to mental disorder. Any references to “medical treatment” in the Act and this Code of Practice should be read in light of the definition in section 329 as outlined above.
- 22 Medical treatment for an unrelated physical disorder is not authorised by the Act. However, medical treatment for a physical disorder which is directly causing the mental disorder would be authorised. For example, where a patient has delirium (as a mental disorder secondary to a chest infection), then the administration of antibiotics would be a medical treatment (indirectly) for the mental disorder and so authorised by the Act. Other medically induced mental disorders could include starvation-induced depression, or hypothyroidism-induced depression. Self-harm (including overdose) as a result of a mental disorder may also be treated under the Act.
- 23 Where medical treatment for an unrelated medical disorder is required, and the patient is an adult and incapable of giving consent, then treatment under the Adults with Incapacity (Scotland) Act 2000 should be considered.
- 24 *For further information on treating patients subject to an Emergency Detention certificate, see Chapter 7 of Volume 2 of this Code of Practice. For further information on “medical treatment”, see also Part 16 of the Act and Chapter 10 of this Volume of the Code of Practice.*

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Children and young people

Principles applying in the case of patients under 18: welfare of the child

- 25 Section 2 of the Act makes specific provisions to safeguard the welfare of any child. For this purpose, a child is any person under the age of 18 years.
- 26 Section 2 requires that any functions under the Act in relation to a child with mental disorder should be discharged in the way that best secures the welfare of the child. In particular it is necessary to take into account:-
- the wishes and feelings of the child and the views of any carers;
 - the carer's needs and circumstances which are relevant to the discharge of any function;
 - the importance of providing any carer with information as might assist them to care for the patient;
 - where the child is or has been subject to compulsory powers, the importance of providing appropriate services to that child; and
 - the importance of the function being discharged in the manner that appears to involve the minimum restriction on the freedom of the child as is necessary in the circumstances.

Can a child be made subject to civil compulsory powers?

- 27 Yes. A child under the age of 18 years can be made subject to an emergency or short-term detention certificate or a compulsory treatment order in the same way as an adult, and the procedures for granting or making such a certificate or order are the same irrespective of whether the patient is a child or an adult. Where it becomes apparent that it may be appropriate to grant, for example, an emergency detention certificate with respect to a child, special consideration should be given to the effects of detention on the child and to ensuring that all other options have been fully explored. While these points are, of course, also relevant to the detention of adults, they should be given particular consideration where a child is being detained.
- 28 Best practice would be for the RMO responsible for the child's care to be a child specialist.

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Consent to treatment under the provisions of the Act – under 18 years of age

- 29 The principles of consent apply to children suffering from mental disorder who are detained under the provisions of the Act. The treatment provisions and safeguards of Part 16 of the Act, including those relating to urgent treatment in emergencies, apply to child patients.
- 30 The medical practitioner attending the child must consider whether the child is capable of understanding the nature and possible consequences of the procedure or treatment. If the child is considered capable, the practitioner must seek the consent of the child rather than of the parent. Section 2(4) of the Age of Legal Capacity (Scotland) Act 1991 states:-

“a person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.”

- 31 Where a child is capable of giving consent on their own behalf, best practice suggests that parents are still involved in discussions where possible. Unless there are confidentiality issues, it would be reasonable to involve parents, advocacy workers or other appropriate persons to assist the child to reach a decision.
- 32 In practical terms, medical practitioners should look for signs that the child can consent on this basis from when the child is about 12 years old.

Consent to treatment for specified treatments for informal child patients – under 16 years of age

- 33 An informal child patient cannot be compelled to accept treatment against the child's wishes or those of a person with parental rights and responsibilities and rights towards the child. In the event of consent to proposed treatment being refused, consideration should be given to whether compulsory measures under the Act would be appropriate.

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- 34 Where an informal child patient is being treated on the basis of consent by a person with parental rights and responsibilities, and the child appears to object to, or resist, treatment, then again consideration should be given to whether it would be more appropriate to use the powers contained in the Act.
- 35 **The Mental Health (Safeguards for Certain Informal Patients) (Section 244) (Scotland) Regulations 2005** under section 244 of the Act have specified conditions that must be satisfied before the following treatments may be given to children under the age of 16 who are informal patients:-
- Electro Convulsive Therapy (ECT);
 - Transcranial Magnetic Stimulation (TMS);
 - Vagus Nerve Stimulation (VNS).
- 36 The safeguards are similar to those which apply to patients being treated formally under section 237 and its associated regulations. It should be noted that consent to treatment by either the child or a person with parental rights and responsibilities does not provide authority to treat in the absence of the additional safeguards. *(For further information on safeguards for certain treatments in relation to informal child patients, see Chapter 10 of this Volume of the Code of Practice.)*
- 37 Where a child patient is judged incapable of providing consent, due to either incapacity or their age, then consent must be obtained from a person with parental rights and responsibilities for the child under sections 1 and 2 of the Children (Scotland) Act 1995, or other person entitled to give consent on behalf of the child.

Legal measures for the protection of children at risk – under 16 years of age

- 38 The provisions of section 33, a local authority's duty to inquire, and section 293, application for a removal order, of the Act do not apply to children under 16 years of age. The appropriate provisions of the Children (Scotland) Act 1995 must therefore be used.
- 39 In some cases local authorities must take urgent action to protect a child from significant harm. A child's parents may agree to the local authority providing the child with accommodation and looking after him or her,

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until concerns about the child's safety, or allegations of abuse or neglect, can be clarified. The local authority might also consider whether others in the child's extended family or social network could look after the child while agencies carry out further inquiries or assessment. There will, however, be cases where the risk of significant harm befalling the child may make it necessary for agencies to take legal action for his or her protection. Any person may apply to a Sheriff for a Child Protection Order (CPO), or the local authority may apply for an Exclusion Order (EO).

- 40 The responsibility to take any urgent action to protect a child rests with the local authority within whose boundaries the child is located when such action is deemed necessary, even if the child does not normally live within that local authority's area. Other agencies or professionals may need to apply to a Sheriff for a CPO or to a Justice of the Peace, where a Sheriff is not available, for authority to remove a child where emergency protection is necessary.
- 41 The Children (Scotland) Act 1995 also makes provision for the local authority to apply for a Child Assessment Order (CAO) if it has reasonable cause to suspect that a child may be suffering, or is likely to suffer, significant harm and the parents or carers are refusing to allow the local authority to see the child. The CAO requires the parents or carers to produce the child and allow any assessment needed to take place to help professionals decide whether they should act to safeguard the child's welfare. The authority may ask, or the Sheriff may direct, someone else, such as a GP, paediatrician or psychiatrist, to carry out all or any part of the assessment. Professionals must assist in carrying out these assessments when asked to do so and local procedures should make provision for this.
- 42 Section 53 of the Children (Scotland) Act 1995 enables any person or agency with concerns about a child aged under 16, and where compulsion may be required, to refer the matter to the Children's Reporter. The Children's Reporter has the power to investigate the referral and where necessary convene a Children's Hearing. At a hearing the child may accept or deny the grounds. Where denied, the reporter may apply to the Sheriff for a finding as to whether the grounds are established. If accepted or established, the Children's Hearing is responsible for deciding whether compulsory measures of supervision are necessary and if so, what conditions should be attached.

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A child's named person – under 16 years of age

- 43 Where the patient is a child under 16 years of age, the Act makes provision at section 252 for the “relevant person” who has parental rights and responsibilities for the child to be the child’s named person. Where two or more “relevant persons” have such rights and responsibilities, then they must decide between them who is to be the named person. If they do not reach agreement, then the named person will be the person who is the child’s primary carer.
- 44 A “relevant person” must have parental responsibilities and parental rights as defined by sections 1(3) and 2(4) of the Children (Scotland) Act 1995. In addition, **The Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Enactments) Order 2005** has amended the Act to also provide that a “relevant person” must be:
- a local authority; or
 - a person who has attained the age of 16 years of age.
- 45 However, if a local authority has parental rights and responsibilities in relation to the child by virtue of an order under section 86(1) of the Children (Scotland) Act 1995, then the local authority shall automatically be the child’s named person.
- 46 Where a child is in the care of a local authority by virtue of a care order made under section 31 of the Children Act 1989, then the local authority shall be the child’s named person.

Parental relations

- 47 Persons discharging functions under the Act must be aware of the duties placed on them by section 278 of the Act. This section applies where a child or a person with parental responsibilities is subject to any provisions of the Act or the Criminal Procedure (Scotland) Act 1995. Persons discharging functions under these Acts must take all practicable and appropriate steps to mitigate any effects of the measures authorised by the Acts which might impair the personal relations or diminish direct contact between a child and a person with parental responsibilities. The patient’s designated MHO will play an important role in this process, particularly in relation to liaising closely with colleagues in the social work children and families teams.

chapter one

Provision of services and accommodation for certain patients under 18

- 48 Wherever possible, it would be best practice to admit a child to a unit specialising in child and adolescent psychiatry.
- 49 Practitioners are reminded of the requirement which section 23(1)(b) of the Act places on Health Boards to provide “such services and accommodation as are sufficient for the particular needs of that child” who is either detained or voluntarily admitted to hospital for the purposes of receiving treatment for a mental disorder. The provision of services and accommodation must be sufficient for the particular needs of that child patient.
- 50 A child should only be admitted to an adult ward in exceptional circumstances, for example, where no bed in a child or adolescent ward is immediately or directly available. If the detained child cannot be admitted to a unit specialising in child and adolescent psychiatry, special consideration should always be given to the environment to which they are to be admitted, and what impact that may have on the child concerned. Any risks to them should be identified in advance and a plan put in place to minimise such risks. For example, the allocation of a single room with en-suite facilities may be prioritised, or special arrangements put in place to monitor the child’s general well-being within the ward environment. Particular consideration should be given to the likely impact on the child of the behaviour of other patients on the ward and also the need to protect them from exposure to distressing experiences. Other ward policies, such as visiting, may also need modified to apply to children. Every effort should be made to provide for the child’s needs as fully as possible. Nursing staff with experience of working with children should also be available to provide direct input to care, support and guidance to ward staff.
- 51 In the event of a child patient being admitted to an adult ward, it would be best practice for the hospital managers to notify the Mental Welfare Commission to enable them to monitor the general provision of age-appropriate services under the Act.

chapter one

Education

- 52 Education authorities have a duty to make arrangements for the education of pupils unable to attend school because they are subject to measures authorised by the Act or, in consequence of their mental disorder, by the Criminal Procedure (Scotland) Act 1995. (Section 277 of the Act amends the Education (Scotland) Act 1980 to that effect.)

Please refer to the appropriate Volume and Chapter for further guidance on the remaining provisions of the Act.

chapter 2

mental welfare commission

chapter two

Role of Mental Welfare Commission for Scotland

01 The Mental Welfare Commission for Scotland (“the Commission”) is an independent organisation which carries out functions under the Act, the Adults with Incapacity (Scotland) Act 2000 and other relevant legislation.

General Duties

02 Section 5 of the Act places a duty on the Commission to monitor the operation of the Act and to promote best practice in relation to its operation. Specifically, it requires the Commission to promote the observance of the matters set out in Part 1 of the Act including the principles for discharging functions under the Act. These principles are discussed in Chapter 1 of this Volume of the Code of Practice and include giving patients information, taking account of their wishes and involving them in their treatment.

03 The Act does not empower the Commission to enforce these matters. However, it will have a significant role in highlighting situations where best practice is not being followed and making recommendations on how practice could be improved.

04 Section 6 of the Act requires the Commission to bring such matters concerning the operation of the Act as the Commission considers ought to be brought to the attention of the Scottish Ministers.

Particular Functions

05 Section 7 of the Act requires the Commission to bring to the attention of Scottish Ministers; a local authority; a Health Board; the Scottish Commission for the Regulation of Care; or others that the Commission considers appropriate, any matter of general interest or concern with regard to the welfare of any persons who have a mental disorder that the Commission considers ought to be brought to their attention.

06 Section 8 of the Act deals with the situation where it appears to the Commission in relation to a patient’s case that:-

- the patient is unlawfully detained;
- the patient may be, or have been, subject to ill-treatment neglect or some other deficiency in care or treatment;
- the patient may be living alone, or without care, and unable to look after himself, his property or his financial affairs;

chapter two

- because of the mental disorder, the patient's property
 - may be suffering, or have suffered, loss or damage; or
 - may be, or may have been, at risk of suffering loss or damage, or
 - the patient is detained in hospital under the Act or the Criminal Procedure (Scotland) Act 1995 and there may be some impropriety in relation to that detention.
- 07 If the Commission considers that a relevant person has or may have powers or duties which could prevent or remedy these circumstances or assist in doing so it must bring the facts of the case to the relevant person and, if it considers it appropriate, make recommendations regarding the case to the relevant person. "Relevant persons" are those listed in section 8(3) and include the Scottish Ministers, the Public Guardian, a local authority; and Health Boards.
- 08 Under section 9, the Commission has a duty to give advice on any matter arising from the Act to the following persons where that person has agreed that the matter should be referred to the Commission:-
- the Scottish Ministers;
 - a local authority;
 - a Health Board;
 - a Special Health Board;
 - the Scottish Commission for the Regulation of Care; and
 - the Scottish Public Services Ombudsman.
- 09 Under Section 10, the Commission may publish information or guidance about any matter relevant to its functions and its conclusions in relation to an investigation under section 11(1), an inquiry under section 12(1) or visits under sections 13(1) or (3) of this Act. It may also publish information which comes to light in the course of these investigations, inquiries or visits. The Commission may also publish any advice given to the persons listed in paragraph 8 if they are in agreement.
- 10 Section 11 of the Act gives the Commission power to investigate a patient's case and to make such recommendations as it considers appropriate where any of the circumstances listed in section 11(2) of the Act apply. Those circumstances include that the patient is unlawfully or improperly detained or may be or have been subject to ill-treatment or other deficiency in care or treatment.

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- 11 Section 12 gives the Commission the power to conduct an inquiry to investigate a case under section 11(1) of the Act. The Commission may appoint any person it considers appropriate to chair or conduct the inquiry and to report the findings. Proceedings in an inquiry under this section will have the privilege of proceedings in a court.
- 12 Section 13 provides that a person authorised by the Commission will visit as often as the Commission considers appropriate, patients who are detained in hospital under this Act or the 1995 Act. Visits may also involve patients who, though not detained in hospital, are subject to:-
- a compulsory treatment order;
 - an interim compulsory treatment order;
 - an emergency detention certificate;
 - a short-term detention certificate;
 - a compulsion order;
 - an interim compulsion order;
 - an assessment order;
 - a treatment order;
 - a hospital direction; or
 - a transfer for treatment direction.
- 13 The Commission also has a duty under this section to visit patients subject to certain provisions of the Adults with Incapacity (Scotland) Act 2000.
- 14 A person authorised to do so by the Commission under section 14, may, in connection with the discharge of any of its functions under this Act or the 2000 Act, interview in private, any patient or any other person whom the authorised person considers appropriate.
- 15 Under section 15, an “authorised person” may carry out in private, a medical examination of the patient in connection with the discharge of any of the Commission’s functions. The authorised person must be either a medical commissioner or a member of staff of the Commission who has such qualifications and experience as is prescribed in regulations. **The Mental Welfare Commission for Scotland (Authorised Persons) Regulations 2005 (SSI No. 205)** provide that an authorised person shall be a medical practitioner and either a member or a fellow of the Royal College of Psychiatrists or have a minimum of four years whole-time equivalent experience of providing psychiatric services.

chapter two

- 16 Section 16 provides that a person authorised by the Commission may, in connection with the discharge by the Commission of any of its functions under this Act or the 2000 Act, require any person holding a patient's medical records to produce them for inspection.
- 17 Section 17(1) makes provision for certain persons to afford the Commission all facilities necessary to enable them to discharge their functions under the Act. The persons are:-
- the Scottish Ministers;
 - a local authority;
 - a Health Board;
 - a Special Health Board;
 - a police force;
 - the managers of a registered care service;
 - the managers of:
 - a prison; or
 - a young offenders institution;
 - the Scottish Commission for the Regulation of Care; and
 - the Scottish Public Services Ombudsman.
- 18 Increasingly, services are provided by voluntary and other independent agencies. **The Mental Welfare Commission for Scotland (Prescribed Persons) Regulations 2005 (SSI No. 176)** have therefore prescribed the following to be included in the list of persons under section 17(1):-
- any persons who provide, under contract to, or by arrangement with, a Health Board, a Special Health Board or a local authority, services in connection with any of the functions of those bodies under that Act.
- 19 Under section 18, the Commission shall submit an annual report to the Scottish Ministers at the end of each financial year.
- 20 Under section 19, in accordance with directions given to it by the Scottish Ministers, the Commission shall provide the Ministers with, and publish, statistical or other information relating to the discharge of its functions.
- 21 Section 20 provides that for the purposes of the law of defamation, any statement made in pursuance of any of the sections 6, 7-10 and 18(1) of this Act by the Commission, or any of its employees, shall be privileged unless such statements are shown to be made with malice.

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- 22 The Commission has the power to make a reference to the Tribunal in the following cases:-
- under section 98 of the Act, in respect of a compulsory treatment order to which the patient is subject;
 - under section 162 of the Act, in respect of a compulsion order to which a patient is subject.
- 23 The Commission may require the Scottish Ministers to make a reference to the Tribunal in the following cases, provided that it gives reasons for requiring the reference to be made:-
- under section 186 of the Act, in cases where a patient is subject to a compulsion order and a restriction order, the Commission can require the Scottish Ministers to refer a case to the Tribunal;
 - under section 209 of the Act, where a patient is subject either to a hospital direction or a transfer for treatment direction.
- 24 The Commission may make an application to the Tribunal under section 291 of the Act for an order requiring the managers of a hospital to cease to detain an informal patient, that is a person who is not subject to the provisions of the Act or the 1995 Act.
- 25 Under section 162, the Commission has the power to make a reference to the Tribunal in respect of a patient who is liable to a relevant compulsion order.
- 26 In appropriate cases, the Commission's powers under the Act include the power to revoke short-term detention and extension certificates under section 51, interim compulsory treatment orders under section 73 and compulsory treatment orders under section 81. In the case of mentally disordered offenders, section 143 of the Act gives the Commission the power to revoke compulsion orders in appropriate cases.
- 27 The Commission has a central role in ensuring that the safeguards in place for patients receiving compulsory treatment are adhered to. Under section 233 it has a duty to maintain a list of designated medical practitioners who carry out the functions of designated medical practitioners set out in Part 16 of the Act. (*For further information see, Chapter 9 of this Volume of the Code of Practice.*) The Commission also has the power, under section 248, to revoke certificates given under sections 235(2) or (3), 236(2) or (3), 238(1), 239 or 241(1) relating to certain types of medical treatment.

chapter two

28 Under section 9 of the Adults with Incapacity (Scotland) Act 2000, the Commission continues to have general functions in relation to adults to whom that Act applies by reason of mental disorder. The functions under the Act include: to consult the Public Guardian and any local authority on any case of common interest; to receive and investigate complaints relating to the exercise of functions relating to the personal welfare of the adult in relation to welfare attorneys and guardians or persons authorised under intervention orders (where they are not satisfied by any investigation made by a local authority or where the local authority has failed to investigate); and to provide a guardian, welfare attorney or person authorised under an intervention order with information and advice in connection with the performance of his or her functions under the 2000 Act. Under section 73(3) of the 2000 Act, the Commission also has the power to recall the powers of a guardian relating to the personal welfare of the adult in the circumstances set out in that section.

chapter two

Notification to the Mental Welfare Commission

- 29 In view of the Commission's statutory protective, investigatory and monitoring functions, it is essential that the Commission is provided with the required notifications under the Act and within the specified timescale.
- 30 A list of what should be notified, the person responsible for providing written notification and the corresponding timescale is attached at Annex A.

chapter two

notifications to mental welfare commission

section	what	who	timescale
	Emergency Measures		
section 35(10)	Grant or refusal of warrant by sheriff or justice of the peace authorising detention for medical examination, entry to premises or production of medical records for	MHO	As soon as practicable after the warrant is granted or
Sections 38(3)(a) and 38(4)(d)	Grant of Emergency detention certificate	Hospital Managers	Before the expiry of the period of 12 hours beginning with the giving of the certificate to the hospital managers
Sections 38(3)(b)(i) and 38(4)(d)	Grant of emergency detention certificate	Hospital Managers	Before the expiry of the period of 7 days beginning with the day of being given notice under section 37 by the practitioner who issued the
Section 40(2) and 38(4)(d)	Revocation of emergency detention certificate by an AMP	Hospital Managers	As soon as practicable after being informed of the revocation by
Section 42(4) and 38(4)(d)	Revocation by RMO of certificate specifying a period during which an emergency detention shall not authorise detention of a patient in hospital	Hospital Managers	As soon as practicable after being informed of the revocation by
	Short-term Measures		
Section 46(3)(b)	Granting of short-term detention certificate	Hospital Managers	Before the expiry of the period of 7 days beginning with the day on which the certificate is granted

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section	what	who	timescale
Section 48(1) and (2)(d)	Granting of extension certificate	AMP	Before the expiry of the period of 24 hours beginning with the granting of the
Section 49(4)(b)	Revocation of short-term detention certificate or extension certificate	RMO	Before the expiry of the period of 7 days beginning with the day the certificate is
Section 54(3)(e)	Revocation of certificate specifying a period during which a short-term detention certificate shall not authorise the detention	RMO	As soon as practicable after revoking the
	Compulsory treatment orders		
Section 60(1)(c)	MHO's intention to apply to the Tribunal for compulsory treatment order (CTO)	MHO	As soon as practicable after the duty to make the application arises and, in any event, before making
Section 74(1)	Revocation of Interim CTO under section 72	RMO	As soon as practicable after making the determination
Section 82(1)	Revocation of CTO under section 79 or section 80	RMO	Before the expiry of the period of 7 days beginning with the day on which the determination to revoke is
Section 87(2)(c)(iv)	Determination extending a CTO under section 86	RMO	As soon as practicable after the determination is made and, in any event, before the day on which the

chapter two

section	what	who	timescale
Section 91(f)	Application to the Tribunal for extension and variation of CTO	RMO	As soon as practicable after the duty to make application arises and, in any event, before making
Sections 94 and 91(f)	Application to the Tribunal for variation of CTO	RMO	As soon as practicable after the duty to make application arises and, in any event, before making
Sections 97 and 91(f)	Reference to Tribunal by RMO, if recorded matter specified in CTO is not being provided	RMO	As soon as practicable after the duty to make the
Section 116(3)(b)	Detention of person subject to (community) CTO, under section 114(2), pending review or application for variation	Hospital Managers	Before the expiry of the period of 7 days beginning with the granting of
Section 116(3)(b)	Detention of person on (community) interim CTO, under section 115(2), pending further procedure	Hospital Managers	Before the expiry of the period of 7 days beginning with the granting of
Sections 119(b) and 116(3)(b)	Revocation under section 117 of detention under section 114(2) – detention pending review or application for variation of CTO	RMO	Before the expiry of the period of 7 days beginning with
Sections 119(b) and 116(3)(b)	Revocation under section 118 of detention under section 115(2) – detention pending further procedure for interim CTO	RMO	Before the expiry of the period of 7 days beginning with

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section	what	who	timescale
Section 124(12)	Transfer to another hospital	Hospital Managers	Before the expiry of the period of 7 days beginning
Section 127(9)	Suspension of detention under interim CTO or CTO, for a period of more than 28 days	RMO	Before the expiry of the period of 14 days beginning with the day on which the certificate is granted
Section 128(5)	Suspension of measures under (community) CTO	RMO	Before the expiry of the period of 14 days beginning with the day on which the certificate is granted
Section 129(5)	Revocation of suspension under section 127 or section 128	RMO	Before the expiry of the period of 14 days beginning with the day on which the certificate is revoked
	Criminal procedures		
Section 52D(10)(e) of the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act")	Making of an assessment order	Court	As soon as reasonably practicable after making the order
Section 52G(11) and 52D(10)(e) of the 1995 Act	Variation of assessment order, on review by RMO	Court	As soon as reasonably practicable after variation of the order
Section 52M(9)(e) and section 52N(3) of the 1995 Act	Making of a treatment order	Court	As soon as reasonably practicable after making the order

chapter two

section	what	who	timescale
Sections 52Q(3) and 52M(9)(e) of the 1995 Act	Variation of treatment order made under section 52Q(2)(b)(ii) of the 1995 Act	Court	As soon as reasonably practicable after variation of the
Section 53(11)(d) of the 1995 Act	Making of interim compulsion order (ICO)	Court	As soon as reasonably practicable after making
Section 60D(2) of the 1995 Act	Detention under section 60C of the 1995 Act (detention of acquitted persons by court)	Court	Before the expiry of the period of 14 days beginning with the day on which the order
Sections 144(1) and 144(4)(b)(i)	Revocation of Compulsion Order (CO) by RMO	RMO	Before the expiry of the period of 7 days beginning with the day on which the determination is made
Section 153(2)(c)(iv)	Extension of CO by RMO	RMO	As soon as practicable after the determination is made and, in any event, before the day on which the CO will cease (unless
Section 157(f)	Application to Tribunal for extension and variation of CO	RMO	As soon as practicable after the duty to make the application arises and, in any event, before making

chapter two

section	what	who	timescale
Sections 160 and 157(f)	Application to Tribunal for variation of CO	RMO	As soon as practicable after the duty to make the application arises and, in any event, before making
Sections 177(2) and (3) 116(3)(b)	Detention of person on community based CO (cf. section 114)	Hospital Managers	Before the expiry of the period of 7 days beginning with the granting of
Sections 177(3) and 119	Revocation of detention under section 177(3) (cf. section 117)	RMO	Before the expiry of the period of 7 days beginning with
Section 178 and 124(12)	Transfer to another hospital of person whose detention is authorised by CO (cf. section 124)	Hospital Managers	Before the expiry of the period of 7 days beginning with
Sections 179 and 127(9) and 128(5)	Suspension of detention or other compulsory measures in relation to a person subject to a CO (cf. sections 127 & 128)	RMO	Before the expiry of the period of 14 days beginning with the day on which the certificate is granted
Section 185(2)(g)	Reference of restricted patient by Scottish Ministers to Tribunal on recommendation from RMO	Scottish Ministers	As soon as practicable after receipt of report
Sections 190 and 185(2)(g)	Application by Scottish Ministers to Tribunal for an order under section 193 in respect of restricted patient	Scottish Ministers	As soon as practicable after the duty to make the application

chapter two

section	what	who	timescale
Section 210(4)(g)	Reference to Tribunal by Scottish Ministers of patient subject to hospital direction or transfer for treatment direction	Scottish Ministers	As soon as practicable after they make reference to the
Section 224(10)	Suspension of detention for a period of more than 28 days in respect of a treatment order, interim compulsion order, compulsion order and restriction order, hospital direction or transfer for treatment direction	RMO	Before the expiry of the period of 14 days beginning with the day on which the certificate is granted
Section 225(4)	Revocation by RMO of suspension under section 224 (for a period of more than 28 days)	RMO	Before the expiry of the period of 14 days beginning with the day on which the certificate is revoked
Section 226(4)	Revocation by Scottish Ministers of suspension under section 224 (for a period of more than 28 days)	Scottish Ministers	Before the expiry of the period of 14 days beginning with day on which the certificate is revoked
	Social Circumstances Reports		
Section 231(1)(b)(ii)	Copy of Social Circumstances Report	MHO	Before the expiry of the period of 21 days beginning with the day on which the relevant event occurs (relevant events are listed
Section 231(2)(b)(ii)	Statement of reasons for non-compliance with section 231	MHO	Before the expiry of the period of 21 days beginning with the day on which the relevant event occurs

chapter two

section	what	who	timescale
	Medical Treatment		
Section 243(6)	The giving of urgent medical treatment to a patient who does not consent/is incapable of consenting	RMO	Before the expiry of the period of 7 days beginning with the day on which the treatment is given (or first given)
Section 245(5)	Copies of certificates in respect of consent to treatment provisions, under <ul style="list-style-type: none"> • section 235 (NMD: consenting patients) • section 236 (NMD: incapable patients) • section 239 (ECT: incapable patients) • section 241 (other treatment: patients not consenting or incapable) 	Person who gives certificate	Before the expiry of the period of 7 days beginning with the day on which the certificate is given
Section 246(2)	Copies of certificates in respect of consent to treatment provisions, under <ul style="list-style-type: none"> • section 237(3) (ECT: consenting patients) • section 240(3) (Treatments given over a period of time etc: consenting patients) 	Person who gives a certificate	Before the expiry of the period of 7 days beginning with the day on which the certificate is given
Section 248(1)	Report on treatment given under <ul style="list-style-type: none"> • section 235 (as above) • section 236 (as above) • section 238 (medication) • section 239 (see above) • section 241 (see above) 	RMO	On the next occasion after the giving of treatment that the RMO submits a record or applies to the Tribunal under section 87(2)(b) or section 92 respectively, or as required to do so by the

chapter two

section	what	who	timescale
	Named Person		
Section 255(5)(b)	Copy of record made where a patient does not have a named person or MHO unable to establish if they have a named	MHO	As soon as practicable after making the
	Appeals against excessive security		
Section 264(9) and (10)(j)	Appeal to Tribunal against detention in conditions of excessive security in State Hospital	Tribunal	Before determining an application
Sections 265(7) and 264(10)(j)	Tribunal hearing in relation to an order under section 264	Tribunal	Before making an order under
Sections 266(7) and 264(10)(j)	Tribunal hearing in relation to an order under section 265	Tribunal	Before making an order under
Sections 267(5)(a) and 264(10)(j)	Recall of orders under sections 264(2), 265(3) or 266(3)	Tribunal	Before determining the application
Section 268(9) and (10)(j)	As section 264, in relation to hospitals other than State Hospital. Appeal to Tribunal against detention in conditions of	Tribunal	Before determining an application
Sections 269(7) and 268(10)(j)	Tribunal hearing in relation to an order under section 268	Tribunal	Before making an order under
Sections 270(7) and 268(10)(j)	Tribunal hearing in relation to an order under section 269.	Tribunal	Before making an order under
Sections 271(5)(a) and 268(10)(j)	Recall of Orders under sections 268(2), 269(3) or 270(3)	Tribunal	Before determining an application
	Advance Statements		
Section 276(8)(b)(v)	Record of circumstances in which measures, treatment or decision authorised which conflict with wishes specified in advance statement	1. Tribunal 2. Person having any functions under the Act, or 3. Designated medical practitioner	Not specified

chapter two

section	what	who	timescale
	Correspondence		
Section 282(2)	Withholding of postal packet	Hospital Managers	Before the expiry of the period of 7 days beginning with the withholding of the packet or anything
	Telephones		
Regulations made under Section 284	Making a patient a “specified person”	RMO	Before person can be treated as “specified person” AND
	Reviewing decision to restrict or prohibit a “specified person’s” calls	RMO	As soon as practicable
	Record of periods of restriction etc of telephone calls	Hospital Managers	As requested by the Commission
	Safety and Security		
Regulations made under Section 284	Making a patient a “specified person”	RMO	Before person can be treated as “specified person” AND
	Statement on incidence and circumstances of implementation of these regulations	Hospital Managers	As requested by the Commission
	Cross border transfers		
Section 289(2)(d)(iii)	In terms of any regulations made for the removal of community-based CTO/CO patient outwith Scotland	RMO	Before decision to authorise removal
Section 290(2)(c)(iv)	In terms of The Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005 which make provision for the removal of a detained patient outwith Scotland (subject to regulations)	Scottish Ministers	At least 7 days before the date proposed for removal if within the UK or at least 28 days before the date proposed for removal if outside the UK

chapter two

section	what	who	timescale
	Place of Safety		
Section 298(2)(b)	Removal of a person to place of safety under section 297	Constable	Before the expiry of the period of 14 days beginning with the day on which the person is removed to the
	Nurses' holding power		
Section 299(8)	Record in respect of detention of person under nurses' power to detain pending medical examination	Hospital Managers	Before the expiry of the period of 14 days beginning with the day on which the record is received from a nurse or person authorised by a
	Absconding		
Section 310(2)(ii)	The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005 make provision as to absconding or failure to comply with requirements imposed by orders or directions	RMO	When the RMO becomes aware that the patient has absconded or has been taken into custody after having absconded or has failed to comply with requirements imposed on

chapter 3

the mental health tribunal
for scotland (part 3)

chapter three

Introduction

This chapter introduces the Mental Health Tribunal for Scotland and provides information on the legislation governing its functions and duties. Information is also provided on the legislation with regard to the qualifications, training and experience required of the President and members of the Tribunal.

The chapter also identifies the types of proceedings and relevant section references for each type of case that the Tribunal will be required to consider.

The chapter provides information on the composition of a Tribunal, the Tribunal's decision making process and the form of intimating decisions of the Tribunal to each party.

The chapter also provides information on appeals to the sheriff principal or Court of Session against a decision of the Tribunal, location of Tribunal hearings, citation of a witness or production of evidence and payment of allowances and expenses.

The chapter ends with information on further secondary legislation made

Role of the Mental Health Tribunal for Scotland

- 01 The Mental Health Tribunal for Scotland ("the Tribunal") is a new independent judicial body, established by Part 3 and Schedule 2 of the Act. The Tribunal will be the body that makes the decisions in a wide range of situations on the care and treatment of patients who are subject to the Act. The Rules of the Tribunal are set out in **The Mental Health Tribunal for Scotland (Practice and Procedure) Rules 2005**.

chapter three

- 02 The Tribunal is headed by a President with the relevant qualifications, training and experience as prescribed by **The Mental Health Tribunal for Scotland (Appointment of President) Regulations 2004 (SSI No. 155)** and consists of three panels of members: legal members with the relevant qualifications, training and experience as prescribed by **The Mental Health Tribunal for Scotland (Appointment of Legal Members) Regulations 2004 (SSI No. 286)**, medical members with the relevant qualifications, training and experience prescribed by **The Mental Health Tribunal for Scotland (Appointment of Medical Members) Regulations 2004 (SSI No. 374)**, and general members with the relevant qualifications, training and experience prescribed by **The Mental Health Tribunal for Scotland (Appointment of General Members) Regulations 2004 (SSI No. 375)**. The President and the members of the three panels are appointed by Scottish Ministers. There is also a shrieval panel that will consist of individuals currently holding the office of sheriff principal, sheriff or part-time sheriff.
- 03 The types of proceedings that the Tribunal will deal with are:
- applications to the Tribunal;
 - references to the Tribunal;
 - appeals to the Tribunal;
 - reviews by the Tribunal; and
 - cases remitted to the Tribunal.
- and, for ease of reference, these proceedings are listed below under the relevant type of order.

chapter three

Short term detention certificate or extension certificate

Section 50	Application for revocation of short term detention certificate or extension certificate by patient or their named person
Section 255	Application by the MHO for an order appointing a named person or for an order declaring that the acting named person should not be the named person
Section 256	Application by various persons listed in sub-section (2) for an order appointing a named person or an order declaring that the acting named person should not be the named person
Section 290	Regulations made under this section (The Mental Health (Cross-Border Transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005) make provision for: <ul style="list-style-type: none"> a) reference by the Commission regarding proposed transfer from Scotland b) appeal by the patient against proposed transfer from Scotland

Compulsory Treatment Order

Section 63	Application by the MHO for a CTO
Section 92	Application by the RMO for an order extending and varying a CTO
Section 95	Application by the RMO for order varying a CTO
Section 96	Reference by the RMO where a recorded matter specified in an order is not being provided
Section 98	Reference by the Commission where it considers it appropriate
Section 99	Application by the patient or their named person for revocation of a determination extending an order
Section 100	Application by patient or their named person for revocation or variation of an order

chapter three

Compulsory Treatment Order – continued

Section 101	Review of a determination by RMO to extend an order under section 86
Section 120	Application by the patient or their named person for the revocation of a certificate under Section 114 or 115 authorising continued detention under CTO or ICTO
Section 125	Appeal by the patient or their named person against a proposed transfer, or transfer, to another hospital other than a state hospital
Section 126	Appeal by the patient or their named person against a proposed transfer, or transfer, to a state hospital
Section 255	Application by the MHO for an order appointing a named person or for an order declaring that the acting named person should not be the named person
Section 256	Application by various persons listed in sub-section (2) for an order appointing a named person or an order declaring that the acting named person should not be the named person
Section 264	Application by persons listed in sub-section (6) in relation to detention in excessive security
Section 267	Application for recall of an order relating to detention in excessive security by persons in sub-section (4)
Section 268	Application for an order, by persons in sub-section (6) declaring that patient is being detained in conditions of excessive security
Section 271	Application for recall of an order by Health Board, Scottish Ministers or the RMO
Section 290	Regulations made under this section (The Mental Health (Cross-Border Transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005) make provision for: a) reference by the Commission regarding proposed transfer from Scotland b) appeal by patient against proposed transfer from Scotland

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Compulsion Order

Section 149	Application by the RMO for an order extending a compulsion order
Section 158	Application by the RMO for an order extending and varying a compulsion order
Section 161	Application by the RMO for an order varying a compulsion order
Section 162	Reference by the Commission where appropriate
Section 163	Application by the patient or their named person for revocation of determination extending a compulsion order
Section 164	Application by the patient or their named person for revocation of, or variation of a compulsion order
Section 165	Review of a determination, where appropriate, by the RMO to extend a compulsion order under section 152
Section 177	(applying section 120) Application by the patient or their named person for the revocation of a certificate
Section 178	(applying Sections 125 & 126) Appeal by the patient or their named person against a proposed transfer, or transfer
Section 185	Reference by Scottish Ministers on a compulsion order and restriction order
Section 187	Reference by Scottish Ministers on notice from the Commission in respect of a compulsion order and restriction order
Section 189	Reference by Scottish Ministers where no reference or application has been made to the Tribunal within the preceding 2 years in respect of a compulsion order and restriction order
Section 191	Application by Scottish Ministers for an order to revoke a compulsion order, revoking the restriction order, varying the compulsion order or conditionally discharging the patient

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Compulsion Order – continued

Section 192	Application by the patient and their named person for an order to conditionally discharge the patient; revoke a restriction order; revoke a restriction order and vary a compulsion order or to revoke the compulsion order
Section 201	Appeal by the patient and their named person against variation of conditions imposed on conditional discharge
Section 204	Appeal against recall from conditional discharge by the patient and their named person
Section 219	Appeal by the patient or their named person against proposed transfer, or transfer, to hospital other than a state hospital where the patient is subject to a compulsion order and a restriction order
Section 220	Appeal by the patient or their named person against a proposed transfer or transfer to a state hospital, where the patient is subject to a compulsion order and restriction order
Section 255	Application by the MHO for an order appointing a named person or for an order declaring that the acting named person should not be the named person
Section 256	Application by various persons listed in sub-section (2) for an order appointing a named person or an order declaring that the acting named person should not be the named person
Section 264	Application by persons listed in sub-section (6) in relation to detention in excessive security
Section 267	Application for recall of an order, relating to detention in excessive security by persons in sub-section (4)
Section 268	Application for declaration, by persons in sub-section (6)
Section 271	Application for recall of order by Health Board, Scottish Ministers or the RMO

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Compulsion Order – continued

Section 290	<p>Regulations made under this section (The Mental Health (Cross-Border Transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005) make provision for:</p> <ul style="list-style-type: none"> a) reference by the Commission regarding proposed transfer from Scotland b) appeal by patient against proposed transfer from Scotland
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Hospital Directions and Transfer for Treatment Directions

Section 210	Reference by Scottish Ministers
Section 211	Reference by Scottish Ministers on notice from the Commission
Section 213	Reference by Scottish Ministers where no reference has been made for 2 years
Section 214	Application by the patient or their named person for revocation of a direction
Section 219	Appeal by the patient or their named person against proposed transfer, or transfer, to hospital other than a state hospital where the patient is subject to a compulsion order and restriction order
Section 220	Appeal by patient or their named person against proposed transfer or transfer to a state hospital, where patient is subject to a hospital direction or a transfer for treatment direction
Section 255	Application by MHO for an order appointing a named person or for an order declaring that the acting named person should not be the named person
Section 256	Application by various persons listed in sub-section (2) for an order appointing a named person or an order declaring that the acting named person should not be the named person

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Hospital Directions and Transfer for Treatment Directions – continued

Section 264	Application by persons listed in sub-section (6) in relation to detention in excessive security
Section 267	Application for recall of an order relating to detention in excessive security by persons in sub-section (4)
Section 268	Application for declaration, by persons in sub-section (6)
Section 271	Application for recall of an order by Health Board, Scottish Ministers or the RMO
Section 290	Regulations made under this section (The Mental Health (Cross-Border Transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005) make provision for: a) reference by the Commission regarding proposed transfer from Scotland b) appeal by patient against proposed transfer from Scotland

Informal Patients

Section 290	Regulations made under this section (The Mental Health (Cross-Border Transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005) make provision for: a) reference by the Commission regarding proposed transfer from Scotland b) appeal by patient against proposed transfer from Scotland
Section 291	Application relating to unlawful detention by persons listed in sub-section (4)

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- 04 Decisions on most individual cases are taken by a tribunal consisting of one member from each of the legal, medical and general panels. Each tribunal will have a convener who will be the President or a member of the legal panel. Where the Tribunal is considering proceedings (other than proceedings relating solely to an application under sections 255 and 256 of the Act) in relation to a patient subject to a compulsion order and a restriction order, a hospital direction or a transfer for treatment direction, the convener will be the President or a member of the shrieval panel.
- 05 The decision of the Tribunal, where made by more than one member, must be made by majority with the convener having a second casting vote in the event of a tie. The Tribunal must produce a written document containing the decision and a full statement of established facts and reasons for the decision. The Tribunal must notify each party of its decision and, on the request of one of the parties, a copy of the written document must be sent to each party.
- 06 *For further information on appeals against certain decisions of the Tribunal that can be made to the Sheriff principal or the Court of Session, see Part 22 of the Act and Chapter 13 of this Volume of the Code of Practice.*
- 07 Tribunal hearings will usually be held in the hospital where the person subject to the Act is an in-patient. If the person is not an in-patient, the hearing will usually take place at a venue as near as possible to where that person resides. To assist in the provision of accommodation for Tribunal hearings, NHS Boards, the State Hospitals Board for Scotland and local authorities have a duty under the Act, to provide hearing venues on request from the President, as far as it is reasonably practicable to do so.
- 08 The Tribunal has the power to require by citation any person to attend to give evidence at any hearing or to produce documents held by them. The Tribunal may require a witness to give evidence on oath or to affirm. Non-compliance with a citation without reasonable excuse is an offence, subject to specified penalties.

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- 09 The Tribunal can pay allowances or expenses to persons appearing at a Tribunal hearing. These may cover for example, travel and subsistence and loss of earnings. The Tribunal can also make payment to persons who have produced medical or other reports commissioned by the Tribunal under paragraph 10(2)(q) of Schedule 2 of the Act. In both cases the President determines the amount payable.
- 10 The President will submit an annual report to the Scottish Ministers on the performance of the Tribunal's functions. This report requires to be laid before the Scottish Parliament. The President will also provide to the Scottish Ministers, or other persons specified by them, such information about the Tribunal's operation as the Scottish Ministers may direct.
- 11 Further regulations have also been made under paragraphs 1(2)(c), 3(6) and 5(4) of Schedule 2 of the Act. **The Mental Health Tribunal for Scotland (Disqualification) Regulations 2004 (SSI No. 154)** were made under paragraph 1(2)(c) of Schedule 2 and provide a list of persons who are disqualified from appointment as, and being, a member of the Mental Health Tribunal for Scotland. **The Mental Health Tribunal for Scotland (Delegation of the President's Functions) Regulations 2004 (SSI No. 373)** were made under paragraph 3(6) of Schedule 2 and provide for the delegation by the President of the Tribunal of certain of the President's functions to any of the members of the Tribunal or its staff. **The Mental Health Tribunal for Scotland (Disciplinary Committee) Regulations 2004 (SSI No. 402)** were made under paragraph 5(4) of Schedule 2 and make provision for the procedure to be followed by and before a disciplinary committee constituted to carry out an investigation at the request of the Scottish Ministers in order to ascertain whether a member of the Tribunal is unfit for office by reason of inability, neglect of duty or misbehaviour.

chapter 4

health boards

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Introduction

This part of the Code of Practice addresses the main duties which the Act places on Health Boards and hospital managers (health bodies). Other duties and powers may be found elsewhere in the Act, and Health Boards, hospital managers and relevant others should make reference to

Health Board provisions

- 01 The Act places a number of duties on health bodies in relation to the provision of services for people with mental disorder, including services for mentally disordered offenders.

General principles

- 02 Sections 1 and 2 of the Act set out the principles and other matters which those who are performing functions under the Act require to take into account in so far as they are relevant to the function they are discharging. For those purposes, making a decision not to act is still considered as discharging a function and any such decision must be made taking the matters set out in sections 1 and 2 into account. Section 3 places a duty on specified persons exercising functions under the Act to discharge those functions in a manner which encourages equal opportunities and the observance of the equal opportunities requirements.
(For further information, see Chapter 1 of this Volume of the Code of Practice.)

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Service provision

- 03 It would be best practice for health bodies to ensure that there are adequate resources, including sufficient numbers of staff, to ensure, for example, that a person who is compelled to receive services under the Act is treated no less favourably than any other patient.

- 04 Due regard must be given to the patient's background including for example age, sex, sexual orientation and cultural and linguistic background (section 1(3)(h)). Consideration should always be given to whether physical assistance is needed, for example, whether patients would benefit from interpreting services, the provision of culturally sensitive in-patient accommodation and therapeutic activities, and appropriate services for those with sensory impairments. In carrying out their functions, health bodies should be aware of the need to eliminate unlawful racial discrimination; and to promote equality of opportunity and good relations between persons of different racial groups.

Duties to the Commission – section 17

- 05 Under section 17 a Health Board or Special Health Board amongst others must afford the Mental Welfare Commission, or a person authorised by the Commission, all facilities necessary to enable the Commission, or that person, to discharge their functions under the Act. Regulations made under section 17 have prescribed that any persons or agencies who provide a Health Board or Special Health Board with services under contract or other arrangement also have this duty.

Approved medical practitioners – section 22

- 06 Approved medical practitioners have specific duties under the Act in relation to, for example, assessing a patient in relation to short term detention, a compulsory treatment order or compulsion order under the Act. Section 22(1) of the Act requires each Health Board and the State Hospitals Board for Scotland to compile and maintain for its area a list of approved medical practitioners (AMPs).

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- 07 Section 22 confers power on the Scottish Ministers to give directions as to the qualifications, training and experience required of medical practitioners in order for them to be included in a list of AMPs. In May 2005 Scottish Ministers made a direction that specifies that the practitioner must:-
- be a Member or Fellow of the Royal College of Psychiatrists; or
 - be a medical practitioner with at least four years experience working in psychiatric services; and, in either case,
 - have successfully completed a training course in relation to the provisions of the Act which has been developed by the Scottish Ministers in consultation with the Royal College of Psychiatrists.
- 08 It is important that the lists compiled by Health Boards are regularly maintained, that new AMPs are added and that doctors no longer in the employ of the Health Board are removed promptly. It would be helpful for Health Boards to provide, when appropriate, to the Scottish Executive Health Department a copy of any updates to the list for their area. The Scottish Executive Health Department will publish these lists for information.
- 09 Doctors appointed on a short-term basis, for example 'locums', must meet the criteria specified in the directions made by Scottish Ministers before being added to a Health Board's list of AMPs. Similarly, GPs who wish to undertake duties as AMPs must meet the requirements of the directions before they can be appointed as AMPs by a Health Board. The Act makes no provision to bypass or circumvent the qualifications, training and experience specified in these directions.
- 10 A training course for qualifying doctors wishing to be appointed as AMPs has been prepared by the Scottish Executive in conjunction with NHS Education Scotland and the Royal College of Psychiatrists. This course will be available at frequent intervals to ensure that as far as possible doctors can undergo the necessary training for appointment as AMPs with the minimum of delay. (*For further information on appointment of responsible medical officers, see Chapter 9 of this Volume of the Code of Practice.*)

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Provision of services and accommodation for certain patients under 18 – section 23

- 11 Section 23 imposes a duty on a Health Board to provide sufficient services and accommodation to meet the needs of any child or young person under 18 (“the young patient”) who is either detained or voluntarily admitted to hospital for the purposes of receiving treatment for a mental disorder. *(For further information about patients under 18 years of age, see Chapter 1 of this Volume of the Code of Practice.)*
- 12 A young patient should only be admitted to an adult ward in exceptional circumstances, for example, where no bed in a child or adolescent ward is immediately or directly available.
- 13 If a detained young patient cannot be admitted to a unit specialising in child and adolescent psychiatry, special consideration should always be given to the environment to which they are to be admitted, and what impact that may have on the young patient concerned. Any risks to the young patient should be identified in advance and a plan put in place to minimise such risks. For example, the allocation of a single room, with en-suite facilities may be prioritised, or special arrangements put in place to monitor the young patient’s general well-being within the ward environment. Particular consideration should be given to the likely impact on the patient of the behaviour of other patients on the ward and also the need to protect them from exposure to distressing experiences. Other ward policies, such as visiting and smoking may also need to be modified to apply to young patients. Every effort should be made to provide for the young patient’s needs as fully as possible. Nursing staff with experience of working with young people should also be available to provide direct input to care, and support and guidance to ward staff. Best practice would be for the RMO to be a child specialist.
- 14 In the event of a young patient being admitted to an adult ward, it would be best practice for the hospital managers to notify the Mental Welfare Commission of this to enable the Commission to monitor the general provision of age-appropriate services under the Act.

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- 15 Section 23 should be considered in conjunction with the following sections of the Act:-
- section 2(4) states that any function under the Act which is being discharged in relation to a patient under the age of 18 must be discharged in the manner that appears to the person discharging the function to be the manner that best secures the welfare of the patient;
 - section 277 amends the Education (Scotland) Act 1980 to provide that education authorities have a duty to make arrangements for the education of pupils unable to attend school because they are subject to measures authorised by the Act or, in consequence of their mental disorder, by the Criminal Procedure (Scotland) Act 1995;
 - section 278 requires health bodies to take all reasonable steps to reduce any adverse effect on the relationship between a child and a person with parental responsibilities for that child, in the event of either the child or such a person being made subject to measures authorised by the Act or, in consequence of their mental disorder, by the 1995 Act.

Provision of services and accommodation for certain mothers with post-natal depression – section 24

- 16 Section 24 places a duty on Health Boards to provide “such services and accommodation as are necessary” to allow women with post natal depression to be admitted to hospital accompanied by their child under one year old.
- 17 This duty applies whether or not such a mother has been admitted to hospital voluntarily, and where her proximity to the child would not endanger the health or welfare of the child.
- 18 Health Boards must provide or arrange suitable accommodation for both the mother and any child, or children, under one year of age to ensure that the woman is able, if she wishes, to care for the child or children in hospital.
- 19 Best practice would be for hospital bodies also to be aware of persons, other than the mother, who have parental rights which may require to be accommodated. For example, a father with parental rights and responsibilities may be entitled to remove the child. It should also be borne in mind that legal advice may have to be sought when giving consideration to the mother’s wishes as to the involvement or otherwise of the extended family.

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20 The Act places a minimum duty on Health Boards to provide services and accommodation for mothers with post-natal depression. However, Health Boards may wish to extend such services to cover all women affected by perinatal and pre-natal mental illness, including conditions such as, psychosis, schizophrenia, etc that can occur in the weeks or months leading up to or following a birth.

21 Guidance has already been published to assist planners and providers.

Co-operation with local authorities – sections 30 and 31

22 Section 30 requires local authorities to co-operate with any Health Boards, Special Health Boards, or voluntary organisations that appear to the local authority to have an interest in, or power or duty to provide or secure, the provision of those services mentioned in sections 25 to 27. Those services are the provision for persons who are not in hospital and who have or have had a mental disorder of:-

- care and support services (section 25);
- services to promote the well-being and social development of those persons (section 26); and
- facilities for or assistance in travelling to allow access to such services (section 27).

23 Under section 31, the local authority can request assistance from a Health Board or Special Health Board to enable or help the authority to provide the services in section 25 or 26. The Board must comply with the request so long as the request:-

- is compatible with the discharge of its own functions; and
- would not prejudice unduly the discharge of those functions.

Independent Advocacy Services – section 259

24 Under section 259 Health Boards and local authorities have a duty to collaborate with each other to secure the availability of independent advocacy services, and to make sure that mentally disordered persons are able to make use of such services. *(For further information on independent advocacy, see Chapter 6 of this Volume of the Code of Practice.)*

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Provision of information to patient – section 260

- 25 Section 260 requires the managers of a hospital specified in an order, detention certificate, direction, or order, whether or not the patient is detained, to take all reasonable steps to:-
- ensure that the patient understands the relevant matters;
 - ensure that the patient is supplied with material appropriate to their needs (and in a form that is appropriate to their needs and permanent) to refresh the patient's understanding of those matters; and
 - inform the patient of the availability of independent advocacy services and to take appropriate steps to ensure that the patient has the opportunity of making use of those services.
- 26 "Relevant matters" means:-
- the provision of the Act or the 1995 Act by which the patient is being detained or the order has effect;
 - the consequences of the operation of that provision;
 - the powers that the patient's RMO and the Tribunal each has in relation to revoking that provision;
 - any right the patient has to make an application, or appeal, to the Tribunal by virtue of that provision;
 - how the patient may exercise such right;
 - how the patient may obtain legal assistance in respect of such right;
 - the powers the Tribunal may exercise in the event of the patient exercising that right; and
 - the Commission's functions that appear relevant to the patient's case.
- 27 The Act and regulations made under section 260 make provision in relation to the times at which hospital managers must provide such information. A full list of the times set out in the Act and in the regulations is found at the end of this Chapter.

For a full list of the prescribed times, please refer to end of this Chapter.

Provision of Assistance to patient with communication difficulties – section 261

- 28 Section 261 applies where:-
- a patient has difficulty in communicating or generally communicates in a language other than English; and
 - the patient is subject to the provisions of the Act listed in section 261(1), whether or not the patient is detained in hospital.

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- 29 In those circumstances, managers of the hospital are required to take reasonable steps to ensure that arrangements appropriate to the patient's needs are made or that the patient is provided with assistance or material appropriate to their needs to allow the patient to communicate at certain events.
- 30 The events are:-
- any medical examination of the patient carried out for the purpose of assessing the patient's mental disorder;
 - any review of the patient's detention under the Act or the 1995 Act; or
 - any proceedings before the Tribunal relating to the patient.
- 31 The managers of the hospital must make a written record of the steps taken as soon as practicable after they have been made.
- 32 To enable users with communication difficulties to interact with people effectively, reasonable adjustments should be made to support the patient's needs when identified. The onus is on the hospital manager to ensure that these steps are taken. Whenever possible, the patient should be asked which format he/she prefers. A record should be kept, with the patient's permission, if the patient uses technical aids to support communication or requires information to be interpreted, translated or adapted.
- 33 There are various aids and adaptations which can support and enable communication, as well as 'human aids to communication' such as British Sign Language (BSL) interpreters, lip speakers, Makaton, and deaf-blind communicators.
- 34 Where possible, materials should also be available in alternative formats such as large print, audio tape, Braille and computer disk. If they are not available, hospital managers should make reasonable adjustments to meet the request or to offer an alternative means of making the information accessible.
- 35 Hospital managers should have measures in place to support staff in making reasonable adjustments, thereby enabling them to respond accordingly.
- 36 If videos are offered to support users, these should, where ever possible, be purchased or designed by the Board with subtitles and if possible in

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BSL.

- 37 Consideration should also be given to the surrounding environment. This can affect communication due to noise levels, provision of loop systems, lighting, soft furnishings and décor.
- 38 There should be strategies in place to enable patients not only to receive and provide information but which also offer various means by which patients can contact services, including telephone, fax and text-telephone numbers and, where appropriate, e-mail addresses.
- 39 The above is not an exhaustive list of actions but provides examples of areas which hospital managers should take into consideration.

Collation of data - section 279

- 40 Section 279 places a duty on health bodies, on being required to do so by the Scottish Ministers, to provide them for research purposes with specified information as to the operation of the Act. The section contains safeguards to protect the identity of patients by specifying that if information from which a patient might be identified can be provided in an anonymous form then it should be so provided.
- 41 Information need not be provided where:-
 - if, were it evidence which might be given in proceedings in any court in Scotland, the person having the evidence could not be compelled to give it in such proceedings; or
 - the person required to provide the information is under a duty of confidentiality in respect of that information and they cannot provide the information requested without breaching that duty, unless the person to whom the duty is owed has given their consent to it being provided.

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Other implications of the Act for health bodies

- 42 In addition to the sections already mentioned above, the Act contains a number of sections with implications for health bodies. These include:-
- section 5: Mental Welfare Commission (the Commission) duty to promote best practice. It is likely that this will involve the Commission regularly making hospital visits. (*See Chapter 2 in this Volume.*)
 - section 11: Commission's duty to make investigations into deficiencies of care;
 - section 13: Commission's duty to make visits to patients;
 - section 16: Commission's authority to inspect medical or other records of the patient;
 - section 21: The Act creates the Mental Health Tribunal for Scotland, which largely replaces the Court as the forum for determining applications, granting orders and hearing appeals. It may well be that many Tribunals take place within the hospital;
 - section 33: The local authority has specific duties to make inquiries into situations of apparent deficiency in care, neglect or ill-treatment etc in the community. (*See Chapter 15 in this Volume.*)
 - section 34 imposes a duty on various persons including Health Boards to co-operate with these inquiries, in so far as compatible with, and not unduly prejudicial to, their functions. (*See Chapter 15 in this Volume.*)
 - section 228: Where a written request for an assessment of the needs of a person with a mental disorder has been received by a local authority or Health Board, provided the circumstances referred to in section 228(2) are met, the local authority or Health Board is under a duty to respond to the request within 14 days, indicating whether or not they intend to carry out the assessment and, if not, why not. (*See Chapter 7 of this Volume.*)
 - section 230 requires the managers of a hospital to appoint an RMO to any patient who is receiving services by compulsion in or out of that hospital. (*See Chapter 9 of this Volume.*)
 - section 274 states that any person discharging functions under the Act must have regard to the Code of Practice in discharging their functions.
 - section 291 allows various persons, including the Commission, to apply to the Tribunal where it appears that a patient is unlawfully detained. This may occur when an informal patient is restricted from leaving the hospital, for example, where a ward door is locked and staff refuse to open it on request. It may also include an improperly made detention, for example one made without proper regard to the

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principles. Where the Tribunal find that a patient has been so detained, it will require the hospital managers to cease the detention. (See *Chapter 8 of this Volume.*)

- sections 311, 313, 315 and 316 create offences in relation to non-consensual sexual acts; sexual offences; ill-treatment and wilful neglect; and inducing and assisting absconding in respect of persons providing care services, care and treatment, or employed by, providing services to or managing a hospital. (See *Chapter 16 in this Volume.*)
- section 317 creates offences of obstructing in relation to persons carrying out functions under the Act, for example, refusing access to premises to a person authorised by a warrant under sections 35 or 292 of the Act, or refusing to allow a person authorised under the Act to interview or examine a patient. (See *Chapter 16 in this Volume.*)
- section 318 provides for offences relating to the deliberate making of or using false statements in any application or relevant document required, authorised, granted, prepared, sent or given for the purposes of the Act. (See *Chapter 16 in this Volume.*)

Provision of information to patient – list of prescribed times – section 260

43 Where the patient reasonably requests such information.

- 44 Where the patient is detained in hospital, the beginning of the detention, or where not in hospital, the making of the following orders:-
- an emergency detention certificate under section 44(1) of the Act;
 - a short term detention certificate under section 47(1) of the Act;
 - a compulsory treatment order under section 64(4) of the Act;
 - an interim compulsory treatment order under section 65(2) of the Act;
 - an assessment order under section 52D of the 1995 Act;
 - a treatment order under section 52M of the 1995 Act;
 - a hospital direction under section 59A of the 1995 Act;
 - a transfer for treatment direction under section 136 of the Act;
 - an interim compulsion order under section 53 of the 1995 Act;
 - a compulsion order (with or without a restriction order) under section 57A of the 1995 Act;
 - a determination extending a compulsory treatment order (the making of a determination by a responsible medical officer) under section 86(1) of the Act;
 - the confirmation of determination and variation of a compulsory treatment order (the making of an order by the Tribunal) under section 102(1)(d) of the Act;

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- the making of an order by the Tribunal with respect to –
 - extension and variation by Tribunal of a compulsory treatment order under section 103(1)(a) of the Act;
 - extension by Tribunal of a compulsory treatment order under section 103(1)(b) of the Act;
 - confirmation of determination and variation by Tribunal of a compulsory treatment order under section 103(2)(d) of the Act;
 - variation by Tribunal of a compulsory treatment order under section 103(3)(b) of the Act; or
 - variation by Tribunal of a compulsory treatment order under section 103(4)(a) of the Act.
- the variation of a compulsory treatment order (the making of an order by the Tribunal) under section 104(1)(a) of the Act;
- the extension, or extension and variation, of a compulsory treatment order (the making of an interim order by the Tribunal) under section 105(2) of the Act;
- a variation of a compulsory treatment order (the making of an interim order by the Tribunal) under section 106(2) of the Act;
- the grant of a certificate by the responsible medical officer –
 - for continued detention in hospital for 28 days under section 114(2)¹ of the Act; or
 - authorising continued detention in hospital until the expiry of the authority in the order under section 115(2) of the Act.
- the giving of notice by the managers of a hospital –
 - notice of proposed transfer to another hospital under section 124(4)² or 124(6)(a); or
 - notice of transfer to another hospital having taken place under section 124(6)(b).
- the suspension of a requirement that a patient be detained in hospital (suspending for more than 28 days a measure specified in a compulsory treatment order or a relevant compulsion order) the grant of a certificate by a responsible medical officer under section 127(1)(b)³ of the Act;
- the suspension of other measures (suspending for more than 28 days other measures specified in a compulsory treatment order or a relevant compulsion order) the grant of a certificate by a responsible medical officer under section 128(1)(b)⁴ of the Act;
- the revocation of certificate suspending measure in compulsory treatment order or a relevant compulsion order (the revocation of a certificate by an RMO) under section 129(2)⁵ of the Act;

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- the duty to extend compulsion order (the making of a determination by a responsible medical officer) under section 152(2) of the Act;
- a confirmation of determination and variation of compulsion order (the making of an order by the Tribunal) under section 166(1)(d) of the Act;
- the making of an order by the Tribunal with respect to –
 - the extension of a compulsion order under section 167(1)(a) of the Act;
 - the extension and variation of a compulsion order under section 167(2)(a) of the Act;
 - the extension of a compulsion order under section 167(2)(b) of the Act;
 - the confirmation of determination and variation of a compulsion order under section 167(3)(d) of the Act;
 - the variation of a compulsion order under section 167(4)(b) of the Act; or
 - the variation of a compulsion order under section 167(5)(a) of the Act.
- the extension, or extension and variation, of a compulsion order (the making of an interim order by the Tribunal) under section 168(2) of the Act extending a compulsion order;
- a variation of a compulsion order (the making of an interim order by the Tribunal) under section 169(2) of the Act;
- a variation of a compulsion order (the making of an order by the Tribunal) under section 171(1)(a) of the Act;
- the making of an order by the Tribunal under-
 - variation of compulsion order under section 193(6) of the Act; or
 - conditional discharge and imposition of conditions under section 193(7) of the Act.
- the variation of any condition imposed by the Tribunal by the Scottish Ministers under section 200(2) of the Act;
- the recall of the patient to hospital by warrant by the Scottish Ministers (recall of patients from conditional discharge) under section 202(2) of the Act;
- the suspension of a requirement that a patient be in hospital – the grant of a certificate by the patient’s RMO under section 224(2) of the Act suspending for more than 28 days the detention in hospital for a patient subject to –
 - a treatment order;
 - an interim compulsion order;
 - a compulsion order and a restriction order;
 - a hospital direction; or
 - a transfer for treatment direction.

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- the suspension of authorisation for detention of patient in hospital – the revocation, by the patient’s RMO under section 225(2) of the Act, of a certificate granted by the patient’s RMO under section 224(2); and
- the suspension of authorisation for detention of patient in hospital – the revocation of a certificate granted by the patient’s RMO under section 224(2) by the Scottish Ministers under section 226(2) of the Act.

1 Section 114 is applied to a patient subject to a relevant compulsion order by section 177(2).

2 Section 124 is applied to a patient whose detention in hospital is authorised by a relevant compulsion order by section 178.

3 Section 127 is applied to a patient subject to a relevant compulsion order by section 179(1).

4 Section 128 is applied to a patient subject to a relevant compulsion order by section 179(2).

5 Section 129 is applied to a patient subject to a relevant compulsion order by section 179(3).

chapter 5

local authority duties

chapter five

Introduction

This part of the Code of Practice addresses the principal duties which the Act places on local authorities. Other duties and powers may be found additionally elsewhere in the Act and local authorities and MHOs should make reference to those further sections as appropriate.

Local authority provisions

- 01 The Act places a number of duties on local authorities in relation to the provision of services for persons with mental disorder (including services for mentally disordered offenders) and on Mental Health Officers (MHOs) appointed by those authorities.

General Principles

- 02 Sections 1 and 2 of the Act set out the principles and other matters which those who are performing functions under the Act require to take into account in so far as they are relevant to the function they are discharging. For those purposes, making a decision not to act is still considered as discharging a function and any such decision must be made taking the matters set out in sections 1 and 2 into account. Section 3 places a duty on persons exercising a function under the Act to discharge that function in a manner which encourages equal opportunities and the observance of the equal opportunities requirements. *(For further information, see Chapter 1 of this Volume of the Code of Practice.)*

Children and Young People

- 03 The Act makes specific provision in relation to patients under 18 years of age (“young patients”). Subsection 2(4) requires an authority in discharging functions in relation to young patients to do so in a manner that best secures their welfare.
- 04 Section 277 amends the Education (Scotland) Act 1980 to provide that education authorities have a duty to make arrangements for the education of pupils unable to attend school because they are subject to measures authorised by the Act or, in consequence of their mental disorder, by the Criminal Procedure (Scotland) Act 1995.

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Care and support services and services designed to promote well-being and social development – sections 25 to 28

- 05 Under section 25 of the Act, a local authority have a duty to provide, or secure provision of, care and support services for persons who have or who have had a mental disorder and are not in hospital. They may also provide, or secure provision of, such services to patients who have or have had a mental disorder and who are in hospital. Care and support services include residential accommodation and personal care and personal support, but not nursing care.
- 06 For these purposes “personal care” means care which relates to the day-to-day physical tasks and needs of the person (such as eating and washing) and to mental processes related to those tasks and needs (such as remembering to eat and wash). “Personal support” means counselling, or other help, provided as part of a planned programme.
- 07 There are a number of ways in which people in need of services may come to be identified either by care management services, children and family services, criminal justice social work services, or by MHOs in their role of considering people for compulsory measures under the Act (and possibly finding that these are not required). Section 25 states that the care and support services provided shall be designed to:-
- minimise the effect of the mental disorder on such persons; and
 - give such persons the opportunity to lead lives which are as normal as possible.
- 08 Section 26 of the Act imposes a duty on a local authority to provide, or secure the provision of, services to promote the well-being and social development of persons who have or who have had a mental disorder who are not in hospital. A local authority may also provide or secure the provision of such services for those patients in hospital.
- 09 These services include:-
- the provision of social, cultural and recreational activities; and
 - training and assistance in obtaining and undertaking employment for such of those persons as are over school age.

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- 10 Social activities aimed at advancing the well-being of people with mental disorder might include services such as day care, recreational opportunities, drop-in centres and support services. Cultural enhancement may be achieved both through services that reflect and support minority cultures and services that support and reflect the particular culture of an area.
- 11 Section 27 of the Act places a duty on a local authority to provide facilities for, or assistance with, travel for persons with mental disorder who are not in hospital as that authority may consider necessary to allow such persons to attend and participate in the services provided under sections 25 and 26 outlined above. Local authorities may similarly provide assistance for persons in hospital who have or have had a mental disorder. It would be best practice not to use a distinctive form of transport which may stigmatise the user.
- 12 Section 28 of the Act amends section 87 of the Social Work (Scotland) Act 1968 and sections 2 and 22(1) of the Community Care and Health (Scotland) Act 2002 so that a local authority providing a service under sections 25 to 27 of the Act may recover such charge (if any) for it as they consider reasonable. However, if a patient satisfies the local authority that they cannot afford to pay the charge for the service, the authority must only charge what the patient can practically afford. Scottish Ministers also have the power by regulations to exclude services from the charging regime.
- 13 The duties to provide services in sections 25 to 28 relate to all people, including children and young people, who have or who have had a mental disorder, not just those subject to (or who have been subject to) compulsory measures.

Co-operation with Health Boards and others; assistance from Health Boards and others – sections 30 and 31

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- 14 Section 30 of the Act requires local authorities, in providing services to persons under sections 25 to 27 to co-operate with any Health Boards, Special Health Boards or voluntary organisations that appear to the local authority to have an interest in the provision of services by the local authority or a power or duty to provide or secure the provision of services for the person. Under section 31, the local authority can request assistance from a Health Board or Special Health Board and these bodies must comply with the request so long as complying with the request:-
- is compatible with the discharge of its own functions; and
 - would not prejudice unduly the discharge of those functions.

Appointment of mental health officers – section 32

- 15 Section 32(1) of the Act requires a local authority to appoint a sufficient number of persons to discharge in their area the functions of Mental Health Officers (MHOs) under the Act, the Criminal Procedure (Scotland) Act 1995 and the Adults with Incapacity (Scotland) Act 2000.
- 16 Section 32(2)(b) of the Act provides that a local authority may only appoint under section 32(1) persons who satisfy such requirements as the Scottish Ministers may direct as to registration, education and training, experience, competence as respects persons who have or have had a mental disorder and any other matters that may be specified in the direction.
- 17 In May 2005 Scottish Ministers made a direction under section 32(2) specifying the requirements and to the matters mentioned in section 32(2)(b) of the Act which must be satisfied by a person seeking appointment as an MHO. These are:-
- registration as a qualified social worker;
 - a minimum of 2 years post-qualifying experience; and
 - having completed a specified amount of specialised training.
- 18 Social workers seeking appointment as MHOs must therefore undergo an approved MHO training course in addition to having the necessary registration and qualifying experience before they can be appointed as an MHO by a local authority.

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- 19 An MHO must be an officer of a local authority at the time of appointment as an MHO and must continue to be an officer of a local authority for the duration of the appointment. The Act does not prevent an authority appointing MHOs who are in the employment of another local authority, but that appointing authority will then be responsible for the training, etc, of any MHO appointed by them.
- 20 Section 32(3) makes provision that MHOs in post on the day prior to the coming into force of section 32 of the Act (on 5 October 2005) are deemed to have been appointed under section 32(1) of the Act. Section 32(4) and (5) makes provision in relation to the training of MHOs and the termination of appointment as an MHO and applies to persons appointed in this way as to new MHOs appointed on or after 5 October 2005. *(For further information on the designation of MHOs, see Chapter 9 of this Volume of the Code of Practice.)*

Duty to inquire, and warrants – sections 33 to 35

- 21 Section 33 of the Act places a duty on a local authority to cause inquiries to be made into deficiencies in care, treatment or support for people with a mental disorder living in the community. Section 34 applies where the local authority considers that assistance from specified persons is necessary or would assist in their inquiries under section 33, and allows the authority to request that assistance from those specified in the section. Section 35 makes further provision in relation to inquiries under section 33. It allows for a warrant to be sought by a relevant MHO if it is thought that entry to premises, access to medical records, or a medical examination is necessary but access has been or is likely to be denied. *(For further information, see Chapter 15 of this Volume of the Code of Practice.)*

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Assessment of needs for community care services – section 227

22 Section 227 of the Act deals with the situation where an MHO notifies the local authority that a patient in respect of whom the authority are under a duty or have a power to provide or secure the provision of community care services may be in need of such services. In those circumstances, the local authority must carry out an assessment of needs under section 12A of the Social Work (Scotland) Act 1968. Section 227 also amends section 23 of the Children (Scotland) Act 1995 to provide that where an MHO has responsibility for a child's case under the Children (Scotland) Act 1995 and the MHO makes a request, the local authority shall carry out an assessment to determine the needs of the child or of any other person in the child's family, so far as is attributable to the mental disorder. *(For further information, see Chapter 7 of this Volume of the Code of Practice.)*

Assessment of needs for community care services etc. – section 228

23 Where a written request for an assessment of the needs of a person with a mental disorder has been received by a local authority or Health Board, provided the circumstances referred to in section 228(2) are met, the local authority or Health Board is under a duty to respond to the request within 14 days, indicating whether or not they intend to carry out the assessment and, if not, why not. *(For further information, see Chapter 7 of this Volume of the Code of Practice.)*

Designated MHOs – section 229

24 Section 229 places a duty on a local authority, as soon as reasonably practicable after the occurrence of a relevant event in respect of a patient, to ensure that an MHO is designated as the MHO having responsibility for the patient's case. "Relevant event" is defined in section 232 and includes the granting of a short-term detention certificate and the making of a compulsory treatment order and other orders. *(For further information, see Chapter 9 of this Volume of the Code of Practice.)*

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Independent advocacy – section 259

25 Under section 259 Health Boards and local authorities have a duty to collaborate with each other to secure the availability of independent advocacy services and to make sure that mentally disordered persons have the opportunity to make use of the services. *(For further information, see Chapter 6 of this Volume of the Code of Practice.)*

Parental relations – section 278

26 Section 278 requires any authority exercising functions under the Act to take all reasonable steps to reduce any adverse effect on the relationship between a child and a person having parental responsibilities in the event of either the child or such person being made subject to measures authorised by the Act or, in consequence of their mental disorder, by the 1995 Act.

Collation of data – section 279

27 Section 279 places a duty on local authorities, on being required to do so by the Scottish Ministers, to provide them for research purposes with specified information in relation to the operation of the Act. The section contains safeguards to protect the identity of patients by specifying that if information from which a patient might be identified can be provided in an anonymous form then it should be so provided.

28 Information need not be provided where:-

- if, were it evidence which might be given in proceedings in any court in Scotland, the person having the evidence could not be compelled to give it in such proceedings; or
- the person required to provide the information is under a duty of confidentiality in respect of that information and they cannot provide the information requested without breaching that duty, unless the person to whom the duty is owed has given their consent to it being provided.

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The Act contains a number of other sections with implications for local authorities:

- Section 29 states that the duties of a local authority under sections 25 to 27 are without prejudice to the duties imposed on them by sections 12(1) (provision of advice, guidance and assistance on an appropriate scale), 13A (provision of residential accommodation with nursing), 13B (provision of care and after-care) and 14 (provision of domiciliary and laundry services) of the Social Work (Scotland) Act 1968 and by section 22(1) (duty to provide services for children in need) of the Children (Scotland) Act 1995.
- Section 252 states that where a child is in the care of a local authority by virtue of a care order made under section 31 of the Children Act 1989, the local authority shall be the child's "named person". Section 252 also provides that where two or more persons have parental rights and responsibilities in relation to a child and one of those persons is a local authority by virtue of an order under section 86(1) of the Children (Scotland) Act 1995, the local authority is also to be the child's "named person".
- Section 274 states that local authorities must have regard to the Code of Practice in discharging their functions under the Act.
- Section 292 provides that an authorised person may be granted a warrant by a sheriff or justice of the peace to enter premises, where they are unable to obtain access, or reasonably expect that they will not obtain access. An "authorised person" is a person already authorised under the Act to take the patient to any place, or to take (or retake) the person into custody, and may include an MHO. *(For further information on duty to inquire, warrants and associated powers, see Chapter 15 of this Volume of the Code of Practice.)*
- Section 293 makes provision for the application to the sheriff by an MHO for a removal order to authorise the removal of a person from premises to a place of safety. Section 294 allows such an application to be made in urgent circumstances to a justice of the peace. *(For further information, see Chapter 15 of this Volume of the Code of Practice.)*
- Section 300 specifies what constitutes a "place of safety". *(For further information on the provision of places of safety, see Chapter 15 of this Volume of the Code of Practice.)*

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- Sections 311, 313, 315 and 316 create offences in relation to non-consensual sexual acts; sexual offences; ill-treatment and wilful neglect; and inducing and assisting absconding in respect of persons providing care services, care and treatment, or employed by, providing services to or managing a hospital. *(See Chapter 16 in this Volume.)*
- Section 317 creates offences of obstructing in relation to persons carrying out functions under the Act, for example refusing access to premises to a person authorised by a warrant under sections 35 or 292 of the Act, or refusing to allow a person authorised under the Act to interview or examine a patient. *(See Chapter 16 in this Volume.)*
- Section 318 provides for offences relating to the deliberate making of or using false statements in any application or relevant document required, authorised, granted, prepared, sent or given for the purposes of the Act. *(See Chapter 16 in this Volume.)*

chapter 6

patient representation
(part 17, chapters 1 and 2)

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Introduction

This chapter describes three important issues relating to patient representation: named persons, advance statements and independent advocacy.

The chapter begins with a discussion of the right to nominate a named person in accordance with the provisions of Part 17 Chapter 1 of the Act. A named person is entitled to receive certain information about the patient who has nominated them and can act for them in certain circumstances, such as where the Tribunal is determining an application for a compulsory treatment order.

The chapter then turns to the subject of advance statements which can be made in accordance with the provisions of sections 275 to 276 of the Act.

Finally the Chapter describes the patient's right to access independent advocacy as set out in Part 17 Chapter 2 of the Act and includes best practice guidance for mental health officers, hospital managers and general practitioners.

The term "patient" has been used throughout this chapter to refer to the person nominating a named person or making an advance statement. It is acknowledged that a person who has no history of mental disorder may wish to implement one or both of these provisions, and that in this case "patient" as defined by the Act as 'a person who has or appears to have a mental disorder' would ordinarily be inappropriate. However, to

Named person

What is a named person?

- 01 In addition to their own rights to have their views heard, and to support and assistance, a patient's spouse or partner, relatives and carers may have an important role in mental health legislation in protecting the interests of a patient subject to compulsory measures, if they are appointed as a patient's named person under the Act.

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- 02 The Act creates a new role – the “named person” – who has particular powers and rights in relation to patients who become subject to compulsory powers, whether under the 1995 Act or the 2003 Act.
- 03 Broadly speaking, the named person has similar rights to the patient to apply to the Tribunal, to appear and be represented at Tribunal hearings (for example, concerning compulsory treatment orders, appeals against short term detention, review of compulsion orders etc.), and to appeal. The named person is also entitled to be given information concerning many compulsory measures which have been taken or are being sought, where this is provided for in the Act.
- 04 Although generally the role of the named person is to represent and safeguard the interests of the patient, the named person does not take the place of the patient in the way that, for example, a welfare guardian appointed under the Adults with Incapacity (Scotland) Act 2000 may be able to do so (depending on their powers). The named person and the patient are entitled to act independently of each other. For example, a named person can apply to the Tribunal for a review of the patient’s compulsory treatment order with or without the patient’s approval. Similarly, the named person is not the same as, nor does he or she replace, an independent advocate. The named person has the right to put his or her own view forward, even when the patient has a different view.
- 05 The principles of the Act require any person exercising functions under the Act (other than the patient and the parties referred to at section 1(7)(b) to (h) who might represent the patient) to take account of the views of the named person when making a decision or considering a course of action, where it is reasonable and practicable to do so. What is reasonable and practicable will depend on the individual circumstances of the case.
- 06 It is anticipated that where a patient with mental disorder comes under the 1995 Act or the 2003 Act, he or she will benefit from having a named person who will be kept informed of their status and can undertake certain functions for the patient. An exception is where the patient becomes subject to emergency detention. Their nearest relative must be informed and, if the nearest relative does not reside with the patient, any person who resides with them must also be informed. The patient’s named person must also be informed but only where the identity of the

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named person is known.

- 07 An MHO has a duty under sections 45 and 61 of the Act respectively to interview a patient when short-term detention or an application for a compulsory treatment order is being considered, unless it is impracticable to do so. Section 45(1)(b) of the Act states that the MHO must, where practicable, ascertain the name and address of the patient's named person before deciding whether to consent to the granting of a short-term detention certificate. Identifying the patient's named person may necessitate discussion with the medical practitioner who is considering granting the detention certificate and/or other relevant professionals as to whether the patient already has a named person, or where this is not the case, whether the patient has the capacity to nominate a named person. Section 61(2)(c)(i) of the Act states that the MHO must inform the patient of their rights in relation to the application for a compulsory treatment order. It would be best practice for the MHO, when undertaking either of these duties, to provide the patient with such information on the role of the named person as suits the patient's needs. It would be best practice for the MHO to discuss with the patient the process and effect of nominating and revoking a named person under section 250 of the Act as well as the process and effect of making and revoking a declaration stating who shall not be the named person under section 253 of the Act. The MHO might do this by explaining these issues to the patient orally and with a follow-up leaflet.
- 08 It would also be best practice for the MHO to explain to the patient what will happen if they do not nominate a named person. The MHO will consequently also need to explain the difference between the roles of the named person and the independent advocate. An independent advocate would enable a patient to have his or her voice heard and views taken into account, provide support and information to allow the patient to make informed choices, and assist the patient to put these views forward.

Who can be a named person?

- 09 The named person, if an individual, must have attained at least 16 years of age. While the Act does not prevent it, it is expected that the named person will not be someone with a professional relationship with the patient, such as a doctor/patient relationship, or anyone who works to deliver care or treatment to the patient, as it could create a conflict of interest. However, a person working in a related role but not responsible for the

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patient's care or treatment, for example a residential housing worker might be approached to act as named person and may feel reluctant to decline where the patient has made declarations stating that their carer and nearest relative shall not be their named person. A person working in such circumstances may feel that he or she has a duty of care and may wish to accept the named person role, to ensure the patient has a named person, but may also feel that a conflict of interest arises. For example, if an application for a community-based CTO were to be made specifying the service as part of the care plan, then the support worker acting as named person could feel that a conflict of interest had arisen between their work role and their role as named person. It may be that the patient would benefit from the assistance of an independent advocate, and this should be explored before agreeing to act as named person where a perceived conflict of interest may arise. It would be best practice for anyone working in a support role who wishes to undertake the named person role in circumstances like these to discuss the nomination with the patient's MHO with a view to identifying and preventing any potential difficulties. It would be best practice for a person in circumstances such as these to seek guidance and support from their employer before agreeing to act in the named person role.

When a named person should be given information

- 10 Once someone has been nominated, or becomes the named person under the provisions of the Act, it would be best practice for the MHO to ensure that they are provided with information about the role in a form which is helpful to them. This is likely to be presented both orally and in written form. This information should include an explanation by the MHO that the named person may decline to act by informing the patient and the local authority for the area in which the patient lives.
- 11 On all occasions where a named person is being nominated, the MHO should consider the impact on the nearest relative/primary carer where they are not nominated as the named person. This could be achieved by explaining to them the role of the named person and the rights of any relatives or carers who are not nominated as the patient's named person.

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The named person's role and powers

- 12 The Act confers on the named person certain powers and rights which will come into effect usually when the patient becomes subject to a short term detention order, a compulsory treatment order or a compulsion order under the Act. The named person also has rights under the Act to receive information where a patient has been made subject to an emergency detention certificate or detained by way of the nurse's holding power at section 299. In addition, section 1(3) provides that a person who is discharging functions under the Act should take into account the views of the named person where this is relevant to the discharge of those functions.
- 13 The MHO should make sure that the named person is fully aware that they have been nominated as named person or that they fail to be the named person under the primary carer or nearest relative provisions (where the patient has not nominated a named person). It would also be best practice for the MHO to ensure that the named person's identity is made known to all those who have functions under the Act which include a duty to notify the named person of certain events.
- 14 An MHO will need to be very familiar with the procedures regarding the nomination process of the named person. The MHO should explain to the patient that in the absence of their nominating a named person, their primary carer shall become their named person. If the patient has no primary carer or the carer declines to act, the patient's nearest relative will be the named person.
- 15 The MHO is required under the principles of the Act to take into account the views of the named person, any carer, any guardian and any welfare attorney. However, when ascertaining the identity of the named person, the primary carer or the nearest relative, the MHO should be careful to respect the patient's rights with respect to confidentiality.
- 16 Under section 255 of the Act, the MHO has a power to apply to the Tribunal for an order under section 257 to appoint a named person where the MHO cannot identify the named person or has established that the patient has no named person. The MHO is under a duty to make an application to the Tribunal where a named person has been identified but, in the opinion of the MHO, that person is unsuitable to act

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as the patient's named person. The application will be for an order to remove and replace an "apparent named person" (i.e. a person whom the MHO has deemed to be inappropriate to act in that role). A named person may be inappropriate to act for example if he/she bullies the patient or lacks capacity. A named person who is or has been a mental health services user is not to be automatically deemed inappropriate to act. The expectation is that the patient's right to choose whom they wish to have as a named person would be respected. The MHO has no power to veto the patient's choice at the time of nomination, nor should they apply undue influence on the patient. The MHO should intervene using the powers at section 255 only where there are clear and significant reasons for doing so.

Nomination of named person

- 17 Section 250 of the Act sets out the process for nominating a named person. A patient aged 16 or over may choose an individual to be their named person. The nomination may be made whether or not the patient is, at the time, the subject of compulsory measures under the 1995 Act or the 2003 Act. The patient must have the capacity to understand the decision they are making and its effects, and have not been subject to any undue influence. It may be that the patient is content for their carer or nearest relative, as the case may be, to act as their named person. Where this is the case, no nomination is required, and the patient should not be put under any undue influence to nominate someone else.
- 18 To be valid, a nomination must be signed by the patient making it and witnessed by a prescribed person. It would be advisable for the patient to check whether their desired named person is willing to act in that role, prior to making the nomination. The prescribed person must witness the patient's signature of the nomination and must certify that the patient making the nomination understands its effect and has not been subject to any undue influence. The Act does not define undue influence. However, helping a patient to understand the choices they have in relation to nominating their named person would be likely to be reasonable, whereas persuading a patient to nominate a particular person is unlikely to be so. A nomination remains valid if the patient who made it subsequently becomes incapable. Under section 250(4) of the Act, a nomination may be revoked by the patient who made it provided that the revocation is signed, and witnessed by a prescribed person who

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certifies that the patient revoking the nomination understands its effect and has not been subject to any undue influence. Where the prescribed person cannot certify that the patient understands the effect of their nomination or revocation, and/or has not been subject to any undue influence, the prescribed person may decline to act as witness. It would be best practice then for the witness, if the patient so requests, to assist the patient to identify another prescribed person to act as witness.

- 19 A person nominated may refuse to act as the named person at any time. Section 250(6) states that the person declining to act must notify their refusal to the patient who made the nomination and to the local authority for the area where the nominator lives.
- 20 It will be important that the patient's named person is identified, wherever practical, in a patient's case notes and on correspondence between general practitioners and hospital managers. Such case notes could include the patient's primary care notes held by his or her general practitioner, by secondary care services such as a community mental health team, or by hospital managers. The named person should be made aware of this and of the purpose of this record by the healthcare professional who includes the information into the patient's case notes. Where a named person is not identified in the case notes, and other care colleagues have indicated that they have no such record, the MHO should be contacted to ascertain whether they know who the patient's named person is or whether any further action to identify the named person is necessary.
- 21 Where the patient is a child under 16, the child cannot nominate a named person. The Act makes provision at section 252 for the person with parental responsibilities in relation to the child, or the local authority where the child is looked after by the authority, to be the named person. Where parental responsibility is shared, the relevant parties may decide between themselves who will act as the named person. In any other case the child's primary carer (who must be 16 years or over) shall be the named person.

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- 22 It is important that the information in the nomination is clear and reflects the patient's wishes, whatever language or form of communication is used. It would be best practice for any person discharging functions under the Act to offer assistance in contacting the relevant service where the patient appears to require interpretation and translation assistance.

Witnessing a nomination

- 23 The nomination by any patient of their named person must be witnessed by a prescribed person. The prescribed person must be able to assess and declare that in their opinion the patient making the nomination understands the effect of nominating a named person and has not been subjected to any undue influence in making the nomination. This is important to ensure the nomination is recognised as valid.
- 24 Regulations made under section 250 and 253 of the Act (**The Mental Health (Patient Representation) (Prescribed Persons) (Scotland) (No.2) Regulations 2004 (SSI No. 430)**) provide that any of the following persons may act as a witness:
- a clinical psychologist entered on the British Psychological Society's register of chartered psychologists;
 - a medical practitioner;
 - an occupational therapist registered with the Health Professions Council;
 - a person employed in the provision of (or in managing the provision of) a care service;
 - a registered nurse;
 - a social worker; and
 - a solicitor.
- 25 The role of the witness is to certify that the patient can make a valid statement, not to scrutinise, veto or endorse the nomination.

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The named person may decline to act

- 26 A person nominated to act as named person can decline to act at any time. If they consider that there might be a conflict of interest in continuing in this role then the person should give serious consideration to declining to act as the named person. For example, if the independent advocate has been nominated as named person (without consultation), the independent advocate should decline to act, as there are differences between the two roles which could cause confusion were the same person to fulfil both roles.
- 27 A person may decline to act as named person by giving notice in writing to the patient who nominated them and to the local authority for the area in which the patient who nominated them resides.
- 28 It would be best practice for any professional who is informed that the patient's named person is no longer acting in that role, to ensure that the patient's MHO (or if the patient does not have a designated MHO, the local authority for the area in which the patient lives) is notified of this, to enable an MHO to ensure action is taken to identify another named person.

Revocation

- 29 The patient may revoke a nomination at any time. Any revocation must be signed by the patient and witnessed. The witness, as with the nomination process, must certify that in their opinion the patient understands the effect of the revocation and that they have not been subject to any undue influence. Where an MHO is made aware that the patient has revoked their named person nomination, they should discuss with the patient whether they wish to appoint another named person. Where they do not, the MHO should explain the Act's provisions whereby the primary carer, or, if there is none, or they decline to act, the nearest relative, would now become the named person.

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Named person where no person is nominated or the nominated person declines to act

- 30 Where no named person is nominated under section 250, or the nominated person declines to act, section 251 determines who will be the named person (for a patient who is aged 16 or over). A person who is a named person by virtue of any of these rules may decline to act by giving notice, in accordance with the provisions of the Act, to the patient and to the local authority for the area in which the patient resides. Where a named person declines to act, the patient may nominate a new named person.
- 31 Where the named person declines to act and no new named person has been nominated, or no named person is nominated, the primary carer is the named person unless that carer is aged under 16 years. Where the primary carer is under 16, but the patient has one carer who is 16 or over, that carer is the named person. Where the primary carer is under 16, but the patient has 2 or more carers of at least that age, those carers may agree which of them is to be the named person.
- 32 Where a patient does not have a named person by virtue of any of the preceding rules (or if that person declines) the nearest relative, as defined by the list provided in section 254, is the named person.
- 33 Where a person has become the named person through the provisions of sections 251 or 254, it would be best practice for the MHO to ensure that the named person is aware of the role placed on them and the rights and responsibilities which it brings. It would be best practice for the MHO to ensure that the named person is made aware of their right to decline to act as named person and the process and effect of doing so.
- 34 It would also be best practice for the MHO to ensure that the named person's identity is made known to all those who have a direct interest and at least to the patient's RMO, carer, independent advocate and legal representative, if they have one. In addition, the MHO should ensure that the patient for whom the named person has been identified in this way is aware of the named person's identity and consequent role and powers, and what action they can take if they are not content with the person acting as their named person. For example, the patient could make a declaration stating that their carer or nearest relative, as may be the case, shall not be their named person.

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- 35 Where the carer and the nearest relative have both declined to act (or the patient has made a declaration stating that they shall not be the named person) then the patient does not have a named person.

Declaration in relation to named person

- 36 As well as the right to nominate a named person, a patient who is aged 16 or over also has the right under section 253 of the Act to specify someone whom he or she would not wish to be the named person. This right is to be exercised by making a declaration in a similar manner to nominating a named person. The declaration must be signed by the patient and witnessed by a prescribed person. The prescribed person must certify that, in their opinion, the patient understands the effect of making the declaration and that they have not been subject to any undue influence. Such a declaration remains valid even if the patient making it becomes incapable. It may be revoked by the patient at any time. Any revocation must also be signed by the patient and witnessed by a prescribed person. The prescribed person must certify that, in their opinion, the patient understands the effect of revoking the declaration and that they have not been subject to any undue influence.

- 37 Where an MHO is explaining to the patient the process and effect of making a declaration, it would be best practice to make the patient aware that the making of a declaration under this section does not prevent the Tribunal from appointing the person mentioned in it as the named person, where an application is made under sections 255 or 256 for an order under section 257.

Identifying a named person

- 38 Section 255 places a duty on a mental health officer, in certain circumstances, to take steps to find out whether a patient has a named person and if so, who it is. The circumstances are where the officer is discharging a function under the 2003 Act, or the 1995 Act, in relation to the patient and it is necessary for that purpose to establish whether the patient has a named person.

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- 39 If the MHO is unsuccessful in identifying a named person they are required under section 255(4) of the Act to record the steps taken to identify the named person. The MHO is then required to give a copy of the record to the Tribunal and the Commission as soon as is practicable. The MHO may also apply to the Tribunal for an order under section 257 appointing a specified person to be the named person.
- 40 On the other hand, in the process of discharging any function under the Act, the MHO may identify the named person but consider that that person is inappropriate to act as the named person. In that situation, the MHO is under a duty to apply to the Tribunal under section 255 for an order under section 257 declaring that the person is not the named person and appointing someone else.
- 41 In this respect, the MHO is under a duty to assess the appropriateness of the named person for that role. The expectation is that the patient's right to choose whom they wish to have as a named person would be respected. Proposals to override those wishes should only be made where there are clear and significant reasons for doing so.

Named person: application by patient etc to the Tribunal

- 42 In addition to the duties imposed on an MHO by section 255, certain other persons listed in the Act have a power to apply to the Tribunal for an order. This applies where the patient has no named person; the apparent named person appears to the applicant to be inappropriate to act in that role; or such other circumstances as may be prescribed in regulations made by the Scottish Ministers.

The Tribunal's powers in relation to the named person

- 43 The Tribunal has powers under section 257 to make certain orders about named persons, where an application under section 255 or section 256 has been made. Where a patient has no named person, the Tribunal has a power to make an order appointing a specified person to be the patient's named person. The Tribunal also has the power to make an order declaring that the acting named person is not the named person or specifying someone else to be the named person in that person's place. The Tribunal may make such order as it thinks fit. However, it cannot appoint a child under 16 to be a patient's named person.

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Advance statements

What is an advance statement?

- 44 Sections 275 and 276 of the Act enable a patient to make an advance statement. This is a written statement setting out how they would wish to be treated, or wish not to be treated, for mental disorder should their ability to make decisions about treatment for their mental disorder become significantly impaired as a result of their mental disorder. The duty to have regard to an advance statement is one aspect of the duty on doctors and other persons discharging functions under the Act as set out in section 1. These functions include having regard to the past and present wishes and feelings of the patient which are relevant to the discharge of the function. The advance statement is not the only means of ascertaining the patient's past and present wishes and feelings, and other relevant sources of information should be taken into account when decisions are being made about care and treatment (whether an advance statement exists or not).

The making and withdrawal of an advance statement

- 45 Section 275 of the Act sets out how a patient may make or withdraw an advance statement. In terms of section 275(2), an advance statement requires to be in writing, subscribed (that is, signed) by the patient making it and such subscription must be witnessed by a prescribed person. Furthermore, the patient making the advance statement must, at the time of making the statement, have the capacity to properly intend the wishes specified in it. The witness must certify in writing on the advance statement that in their opinion the patient making the statement has such capacity.
- 46 An advance statement may be withdrawn by the patient who made it. A withdrawal of an advance statement must comply with section 275(3) of the Act. Firstly, at the time of making the withdrawal, the patient must have the capacity to properly intend the withdrawal. Secondly, the withdrawal must comply with all the requirements set out in section 275(2), namely it must be in writing, subscribed (signed) by the patient making it and witnessed by a prescribed person. The witness must certify in writing that the patient has the necessary capacity to intend withdrawing the advance statement.

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- 47 Where a patient indicates that they wish to withdraw an advance statement, it would be best practice to halt decision-making about care and treatment until the patient has either withdrawn the advance statement (and possibly made another), or indicated that they are content to continue with their current statement.

The effect of an advance statement

- 48 Section 276(3) of the Act provides that where any person is giving medical treatment authorised by this Act or the 1995 Act, that person is to have regard to any advance statement which complies with the Act, made by the patient and not withdrawn. They must do this where they are satisfied that the patient's current decision-making ability is significantly impaired by reason of their mental disorder. There is an additional responsibility for any designated medical practitioner making decisions under section 276(4) to have regard to the wishes expressed in an advance statement.
- 49 In terms of section 276(1) of the Act, in making a decision in respect of a patient who has made and not withdrawn an advance statement, and where the Tribunal is satisfied as regards certain matters, the Tribunal must have regard to the wishes specified in the statement. The matters which the Tribunal requires to be satisfied about are that the advance statement complies with the requirements of the Act and that, because of their mental disorder, the ability of the patient who made the advance statement is significantly impaired.
- 50 Any person discharging functions under the Act (which will include those persons giving medical treatment authorised by the Act) shall have regard to the past and present wishes specified by the patient. Moreover, a responsible medical officer must, in terms of section 242(5)(a)(iv) of the Act, have regard to an advance statement, where one has been made and not withdrawn. To fulfil both these requirements, it would be best practice for the person giving medical treatment to undertake the following checks to ascertain whether the patient has made and not withdrawn an advance statement, in order to view a copy of that statement.

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Locating an advance statement

- 51 The person giving medical treatment should ask the patient if they have an advance statement, ask where it is stored, and explain that they wish to see it before making their decision regarding medical treatment. If the patient cannot or does not provide the person giving medical treatment with the advance statement or the name of any person holding a copy of it (for example because the patient is too ill to understand the request), it would be best practice, where the patient is in hospital, to check the patient's hospital notes for a copy of the advance statement or for any reference to an advance statement.
- 52 Where a copy is stored in the patient's records, it would be best practice for the advance statement to be prominently labelled to ensure it can be located quickly.
- 53 Where the patient is not in hospital, the person giving medical treatment should contact the patient's general practitioner to ascertain whether they have a copy in the patient's medical records. If the general practitioner holds a copy of the advance statement, the person giving medical treatment should request a copy. The general practitioner should treat this request in the same manner as a request for any other of the patient's medical records.
- 54 When trying to locate a patient's advance statement it would be reasonable to ask the patient's named person and/or the carer if they know of the existence and location of any advance statement.

Making decisions or authorising treatment which conflicts with those wishes

- 55 Where any person discharging functions under the Act makes a decision or authorises treatment which conflicts with the wishes specified in the advance statement, the Act requires certain procedures to take place (see section 276(7) and (8)). The Tribunal, the person having functions under the Act, or the designated medical practitioner, as the case may be, who makes a treatment decision or authorises or gives treatment in conflict with the advance statement, must comply with requirements set out in section 276(8) of the Act. This includes a situation where treatments or decisions which might have been authorised, given or made are not, with the consequence that there is a conflict with the wishes expressed in the advance statement.

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56 The requirements of section 276(8) of the Act are that those persons record in writing the circumstances in which the measures or treatment or decision were authorised, given or made or, not authorised, given or made. They must also record the reasons why the measures were taken or this treatment was given or decision was made. The Act also requires that a copy of this record is sent to:

- the patient who has made the advance statement;
- the patient's named person;
- any guardian or welfare attorney of the patient; and
- the Mental Welfare Commission.

57 A copy of this record must also be placed in the patient's medical records.

58 A competently made advance statement would be a strong indication of a patient's wishes about medical treatment but should not be considered in isolation. An advance statement cannot bind a medical practitioner or member of the care team to do anything illegal or unethical, nor can it bind a medical practitioner or member of the care team to provide, arrange or withhold specific services, medicines or treatments. A decision to act in agreement or in conflict with an advance statement should not be made on the basis of the costs involved. Where care or treatments requested in an advance statement are not available, it would be best practice to record that the patient has an unmet need.

What is included in an advance statement?

59 An advance statement may contain details setting out how the patient would wish to be treated for mental disorder should they become mentally disordered and their capacity to make decisions regarding medical treatment become significantly impaired. In the statement, the patient may also refuse particular treatments or categories of treatment for mental disorder.

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- 60 The advance statement might include a list of medical treatments which the patient has tried and have found to be beneficial, and a corresponding list of treatments they have found to be unhelpful. An advance statement might also contain information concerning early changes in symptoms, thinking and behaviour. This information might facilitate interventions aimed at preventing the need for treatment under compulsion. An advance statement cannot require that a service or medical treatment must be made available to the patient.
- 61 Only advance statements drawn up by patients in accordance with the provisions of the Act from 10 October 2004 (when the provisions in sections 275 and 276 dealing with advance statement were brought into force) will be considered as valid advance statements in accordance with the terms of the Act. It would be best practice to view any advance statement made before 10 October 2004 as an expression of the patient's wishes at the time of making the statement and to take it into account when considering the patient's past and present wishes and feelings about the treatment under consideration. In terms of section 1(3)(a) of the Act, persons exercising functions under the Act are required to have regard to the present and past wishes and feelings of the patient which are relevant to the discharge of such a function.
- 62 A pre-existing advance statement might be converted into an advance statement within the meaning of the Act by following the witnessing procedures now that the relevant provisions of the Act have been brought into force. It would be best practice for the medical practitioner or other relevant member of the multi-disciplinary team to advise the patient as to how they can 'validate' their pre-existing statement under the procedures set out in the Act.
- 63 It is important that the information in the advance statement is clear and reflects the patient's wishes, whatever language or form of communication is used. It would be best practice for any person discharging functions under the Act to offer assistance in contacting the relevant service where the patient appears to require interpretation and translation assistance.

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Preparation of an advance statement

- 64 The preparation of an advance statement provides the patient drawing up the statement with an opportunity to discuss their care and treatment with their care team, their MHO and perhaps their named person, carer(s) and independent advocate. It provides those consulted with an opportunity to give information about the process and effect of an advance statement, which may empower the patient to participate in care and treatment decisions. Whether or not a written, formally witnessed advance statement is produced, it is considered that such a dialogue would be in line with the principles of the Act and should be encouraged, where relevant and appropriate, as an ongoing part of the patient's care and treatment.
- 65 An advance statement cannot require that a service or medical treatment must be made available to the patient. Where a medical practitioner is assisting the patient to produce a list of preferred treatments to be included in an advance statement, it would be best practice to ensure that the patient making the statement is aware that clinical practice in the future might mean some medicines may be unavailable or less appropriate and substitutions might need to be used. Where care or treatments requested in an advance statement are not available, it would be best practice to record that the patient has an unmet need. Best practice guidelines should also be followed with respect to informing a patient of the possible benefits, risks and side-effects of receiving, or rejecting, each treatment.
- 66 Where a medical practitioner is assisting the patient to produce a list of treatments they would, or would not, wish to receive in future, it would be best practice to ensure the patient understands the relevant safeguards provided in Part 16 of the Act for treatments for mental disorder. If the patient understands such safeguards, they will be better able to make an informed decision about which treatments they do or do not wish to have in the future.

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- 67 It would be best practice for any person(s) assisting in the drafting of the advance statement to emphasise the importance of the patient being content that their advance statement reflects their wishes before having it witnessed. It would also be best practice to explain the process by which someone giving medical treatment under the Act must have regard for the advance statement under section 276(3); the process by which a health professional might act against the wishes of the advance statement; and the actions to be taken in such circumstances. The Act provides at section 276(8) a list of people who must be informed of such a decision to act against the wishes set out in the advance statement.
- 68 There will be no prescribed form for an advance statement, although it must accord with the requirements of the Act. However it is considered that it would be of use, and best practice, if the advance statement contained the name and address of the patient, the witness, and the patient's GP, and details of any named person, carer, guardian and welfare attorney.

Witnessing an advance statement

- 69 To be valid, the Act requires that an advance statement must be signed by the patient and witnessed by a prescribed person. The witness must sign the statement and certify in writing that in their opinion the patient making the statement has the capacity to properly intend the wishes specified in it.
- 70 The prescribed person witnessing the advance statement need not have been involved in the drafting of the advance statement. The role of the witness is to certify that in their opinion the patient has capacity to understand and intend the statement about the treatments mentioned. The witness has no power to edit, endorse or veto the contents of the advance statement, only to assess the patient's capacity to intend the wishes recorded in it. Where the prescribed person cannot certify that the patient has capacity to intend the wishes in the advance statement, the prescribed person may decline to act as witness. It would be best practice then for the witness, if the patient so requests, to assist the patient to identify another prescribed person to act as witness.

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- 71 A prescribed person acting as witness should not attempt to dissuade the patient from making an advance statement. However, if a witness is being asked to witness frequent changes to a statement, he or she may wish to suggest the patient seek assistance. It is important that the patient is content that their advance statement reflects their wishes before seeking a witness.
- 72 It would be best practice for the witness to check that the statement has been signed by the person making it before witnessing it. In witnessing the patient's signature on the advance statement, the witness must sign the document and must certify in writing on the document that, in their opinion, the patient making the statement has the capacity to intend the contents of the statement. As a matter of practice it is important that the statement includes the date it was witnessed to avoid ambiguity.
- 73 If the patient is making a personal statement about matters other than treatment for mental disorder in addition to an advance statement, the personal statement does not require to be witnessed. However, such a statement (which may include personal preferences, for example whom to contact about care of dependants or pets, or what their employer is to be told, if the patient is taken into hospital) should also be in writing and dated to avoid ambiguity about the patient's intentions. A personal statement may be attached to the patient's advance statement in their records but it will not have the same effect in law.
- 74 It would be helpful for the patient making the advance statement to identify, possibly in a separate document, a list of the people who will hold a copy of the advance statement and the personal statement described in the preceding paragraph, where one has been made. For example, a copy may be given to the witness, the patient's named person, carer, relatives, solicitor, independent advocate, MHO, GP, or RMO (if any) to place in their medical records. If the advance statement is later withdrawn, any person holding a copy will need to be notified.

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75 Regulations made under section 275 of the Act (**The Mental Health (Advance Statements) (Prescribed Class of Persons) (Scotland) (No.2) Regulations 2004 (SSI No. 429)**) provide that any of the following persons may act as a witness:

- a clinical psychologist entered on the British Psychological Society's register of chartered psychologists;
- a medical practitioner;
- an occupational therapist registered with the Health Professions Council;
- a person employed in the provision of (or in managing the provision of) a care service;
- a registered nurse;
- a social worker; and
- a solicitor.

Witnessing an advance statement: risk of future conflict of duty

76 A prescribed person acting as a witness may feel that there is a perceived risk of future conflict of duty if they witness an advance statement which they might, at some future time, have to override in order to provide care and treatment appropriate to the patient's needs. For example, a health professional witnessing an advance statement might subsequently be involved in authorising or administering treatment which conflicts with the wishes specified in a statement. This may be of particular concern for medical practitioners in rural or remote locations who may be not only the preferred witness (or only witness available) but also the person called upon to administer treatment measures compulsorily.

77 In such circumstances, it would be best practice for the prescribed person asked to witness it to discuss with the patient making the statement any potential risk of conflict of interest and to confirm with that patient that they still wish them to act as a witness. The prescribed person may decline to act as witness if, in their opinion, the risk of future conflict of duty is high. In declining to witness the advance statement the prescribed person may wish to help the patient making the statement to identify another prescribed person who is further removed from the risk of conflict, or another person independent of the care and treatment process, such as a solicitor, who could be asked to witness it.

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Storing and accessing an advance statement

- 78 To ensure that the advance statement can be considered at any future date, the patient making the advance statement will wish to make sure that other people are aware of its existence, and to ensure that it is filed in their relevant notes by the GP, RMO and MHO, where appropriate in the circumstances. These other persons could also be asked to hold a copy of the advance statement, or, at least, to be made aware of the details of the person who does hold a copy of the advance statement. This might include the patient's named person, carer and MHO and the hospital managers, if the patient is in hospital.
- 79 Where an advance statement is lodged in a patient's medical records, it should be treated as a medical record in terms of patient confidentiality. Best practice protocols for storing, retrieving, sharing, access by the patient, and destroying a patient record should be used when handling the advance statement.

Withdrawal of an advance statement

- 80 The process by which an advance statement may be withdrawn is similar to that for making one. The withdrawal may be witnessed by one of the same prescribed persons who can witness an advance statement. A witness should not attempt to dissuade the patient from withdrawing an advance statement.
- 81 After observing the patient sign that they are withdrawing their advance statement, the witness must certify that in their opinion the patient has the capacity of properly intending their wishes. They should also sign the statement. As a matter of practice it would also be helpful to date the statement.
- 82 The patient withdrawing the advance statement should ensure that all those who were given a copy or made aware of the existence of their advance statement are made aware of its withdrawal. These people should receive written notification from the patient that the advance statement has now been withdrawn. Notification that the advance statement has been withdrawn should also be given by the patient to their general practitioner, or, where the patient is in hospital, to the hospital managers. Notification that the advance statement has been withdrawn should also be given to the witness, the patient's named

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person, carer, relatives, solicitor, independent advocate, and MHO where any of these received a copy of the advance statement. It should be noted that the withdrawal is only valid where it complies with section 275(3). Therefore these people should not rely on being notified about the withdrawal in this way and to protect themselves they should see the withdrawal before relying on the fact of its withdrawal.

- 83 It is imperative that those involved with the care and treatment of the patient are made aware of the withdrawal of any advance statement. The patient withdrawing the advance statement may ask a member of their multi-disciplinary team to help them deal with these notifications, and where such a request is made, it would be best practice for the relevant professional to give such assistance as is appropriate in the circumstances.

Having regard to an advance statement: additional requirements for designated medical practitioners

- 84 Before making a decision under sections 236(2)(c), 239(1)(c) or 241(1)(c) of the Act, a designated medical practitioner should undertake checks to ascertain whether the patient for whom treatment is being considered has made and not withdrawn an advance statement, and to view a copy of that statement. The designated medical practitioner is required to do this in order to comply with the statutory requirement at section 276(4) to have regard to the wishes specified in such a statement.
- 85 The designated medical practitioner should ask the patient if they have an advance statement, ask where it is stored and explain that they wish to see it before making their decision. If the patient is unable to or does not provide the designated medical practitioner with the advance statement or the name of any person holding a copy of it (for example because they are unable to do so through illness), it would be best practice for the designated medical practitioner to check the patient's hospital notes for a copy of the statement or for a reference to a statement. If any advance statement exists, it ought to have been placed with the patient's medical records in accordance with section 276(8)(c) of the Act.

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- 86 Where the hospital notes do not contain an advance statement, it would be best practice for the designated medical practitioner to consider contacting the patient's general practitioner to ascertain whether they have a copy in the patient's medical records. The named person and/or the carer may know of the existence and location of any advance statement, and it would be reasonable to contact them to check.
- 87 A decision under sections 236(2)(c), 239(1)(c) or 241(1)(c) of the Act can only be made after these steps have been taken. Furthermore, under section 1(3)(a) of the Act, the designated medical practitioner must also have regard to the patient's past and present wishes and feelings (which may be expressed in a form other than an advance statement). Under sections 1(3)(b) and 1(9) the designated medical practitioner must have regard to the views of the patient's named person, any carer of the patient, any guardian of the patient, and any welfare attorney of the patient, unless it is unreasonable or impracticable to do so.

Acting in conflict with an advance statement

- 88 In terms of section 276(5) of the Act, the Tribunal must consider an advance statement (or a withdrawal of an advance statement) to be valid unless the contrary appears. If the Tribunal has considered an advance statement as valid, it should be presumed to be valid by any person giving treatment authorised by a decision of that Tribunal. Similarly, if medical treatment is being given otherwise than by virtue of a decision of a Tribunal, then the person giving that treatment must consider a statement (or its withdrawal) to be valid unless the contrary appears.
- 89 As mentioned above, where the Tribunal or a person giving medical treatment under the Act or a designated medical practitioner makes a decision which conflicts with the advance statement, section 276(8) of the Act requires that they record this in writing stating how the treatment conflicted with the patient's requests, and the reasons why this treatment decision was made. They must send a copy of this record to the patient, the named person, any guardian or welfare attorney and to the Mental Welfare Commission. This record must also be placed in the patient's medical records.

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Right of access to independent advocacy

90 Independent advocacy supports a patient's right to have their own voice heard in decisions made about their health and well-being. Independent advocacy enables vulnerable people to be heard and promotes social inclusion. Section 259 of the Act sets out the main provisions for independent advocacy.

“Every person with a mental disorder shall have a right of access to independent advocacy; and accordingly it is the duty of –

- (a) each local authority, in collaboration with the (or each) relevant Health Board; and
- (b) each Health Board, in collaboration with the (or each) relevant local authority, to secure the availability, to persons in its area who have a mental disorder, of independent advocacy services and to take appropriate steps to ensure that those persons have the opportunity of making use of those services.” (Sections 259(1))

91 For local authorities and Health Boards, the duty is a mutual one. Each local authority is required to collaborate with each Health Board in its area and likewise each Health Board is required to collaborate with each local authority in its area to secure the availability of these services. In the case of patients in the State Hospital, responsibility for securing the availability of independent advocacy services falls to the State Hospitals Board alone. However, in the case of a State Hospital patient who is granted a conditional discharge or for whom a compulsory treatment order has been suspended, the State Hospitals Board is required to collaborate with the local authority and Health Board for the area in which the former patient is now residing. This may be helpful in ensuring continuity of advocacy services to the patient.

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Who can access independent advocacy under the Act?

92 The right of access to independent advocacy under section 259 applies to anyone with a mental disorder, here referred to as the “patient”. The term “mental disorder” is defined in section 328 of the Act and means any mental illness, personality disorder or learning disability, however caused or manifested. In addition, section 328 specifically provides that a person is not mentally disordered by reason only of:

- sexual orientation;
- sexual deviancy;
- transsexualism;
- transvestism;
- dependence on, or use of, alcohol or drugs;
- behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; or
- acting as no prudent person would act.

93 This right applies to any patient:

- regardless of age, disability, ethnic origin, culture, faith, religion, sexuality, social background or personal circumstances;
- whatever their need for advocacy; and
- whether or not they are ordinarily resident in Scotland.

What is independent advocacy?

94 Section 259(4) describes independent advocacy services for the purposes of the Act as:

“services of support and representation made available for the purpose of enabling the person to whom they are available to have as much control of, or capacity to influence, that person's care and welfare as is, in the circumstances, appropriate.”

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- 95 Under the Act, independent advocacy might assist a patient to express their needs and thoughts or to present their views. An independent advocate might help the patient in their everyday dealings in relation to their healthcare and might speak on their behalf in their dealings with, for example, their MHO, RMO or members of hospital staff. Independent advocacy can assist patients:
- to make informed decisions;
 - to increase their decision-making capacity by helping them to understand the issues being discussed;
 - in communicating their views to others; and
 - in representing the patient's interests to enable those to be taken into account in decisions made relating to their care and treatment.
- 96 Local authorities and Health Boards should make arrangements to ensure that their staff are aware of a patient's right of access to independent advocacy and the role of independent advocates and advocacy groups, whether or not those staff have any specific duties corresponding to the patient's rights, as detailed below. It is important that staff understand that independent advocates may assist any patient with a mental disorder, including those with incapacity or communication difficulties, children and adolescents, or elderly patients.

The role of independent advocacy

- 97 Independent advocacy can enable a patient to express their needs and thoughts and to make these known to those who are making decisions about the patient's care and welfare. Many of those decision makers are required to take the patient's views into account and an independent advocate can play a vital part in ensuring that this can be done. The role of independent advocacy is to help a patient to understand their options and to convey their views. While it is not the role of an independent advocate to make decisions for the patient, he/she is there to offer support to facilitate the patient's decision-making.
- 98 The involvement of independent advocacy does not change the level of responsibility on other professionals involved with the patient. Those professionals still require to exercise their professional judgement in the patient's case. Nor does the involvement of independent advocacy affect a patient's rights with regard to seeking advice from a solicitor or access to legal aid.

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- 99 Independent advocacy organisations may provide individual or group advocacy. The Act is not specific about the type or types of independent advocacy services to which a patient should have a right of access. Any or all of the various types might be appropriate depending on the circumstances and personal preferences of the patient concerned.
- 100 Each Health Board and local authority should produce and maintain a list of independent advocacy organisations in their area.
- 101 As a matter of best practice, where the patient has chosen to use independent advocacy, the independent advocacy organisation or advocate should then be entitled to (where the patient agrees):
- be invited to attend, where practicable, a consultation, interview or meeting about the patient's treatment or care in order to support or represent the patient there;
 - have access to the patient at any reasonable time to provide any support or representation needed;
 - correspond or communicate in any other way with the patient on any matter relating to the patient's care and welfare; and
 - receive such information as would assist them to perform their role.
- 102 Independent advocacy organisations and its advocates must be clear about their obligations in respect of patient confidentiality. The patient should be asked to consent, where they are capable of giving that consent, before any personal information is passed on to a third party. The nature and amount of such information released to another person should be proportionate and relevant to the desired objective. Where it is not possible to obtain such consent, the independent advocate may consider that effective advocacy support cannot be provided if personal information is not shared. In those circumstances, the independent advocate must be alert to the need to respect patient's confidentiality and must only disclose information on a strictly "need to know basis" with appropriate safeguards. Otherwise, it will not be appropriate for an independent advocate to pass on information.
- 103 Independent advocacy organisations and advocates do not have an automatic right of access to the patient's medical records, although the patient may authorise them to have such access.

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104 Where the patient consents, it would be best practice for the MHO and hospital managers to help ensure that patients who are members of advocacy groups are able to:

- receive assistance to attend the meetings of their advocacy group, where practicable; and
- correspond or communicate with their advocacy group.

105 Where the patient consents, it would be best practice for MHOs and hospital managers to ensure that advocacy providers and groups are given:

- information from those planning or providing patient care or treatment which would assist the group to perform its role; and
- an opportunity to be involved, where practicable, in all stages of the decision-making process, including representation on planning and strategy groups.

Written communications with an independent advocate or independent advocacy organisations

106 Section 281 of the Act gives hospital managers the power to prevent certain detained patients (“specified persons”) from sending or receiving mail. However, mail to or from any person who is known by the hospital manager to be providing independent advocacy services, is specifically excluded from this provision under section 281(5)(n). Therefore a “specified person” has the right to send mail to or receive mail from their independent advocate, even where the patient is otherwise restricted in sending or receiving mail.

107 Any independent advocate or independent advocacy organisations should inform hospital managers responsible for a patient of their interest, and give their contact details. This is particularly important where the patient may be subject to restrictions in terms of section 281. Wherever possible, mail should be sent to or from the contact address notified to hospital managers. This will enable hospital managers to recognise more easily that mail is intended for, or is from, an independent advocate or organisation.

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What is meant by “Independent” advocacy

108 Independence is key in the patient’s right to advocacy, because it is vital that the role of independent advocacy is not compromised in any way. Independence ensures that the advocacy services provided are divorced from the interests of those persons concerned with the patient’s care and welfare. Conflict might occur for example, if a person providing advocacy services was also a care provider and a patient wanted to raise issues about their care. It is clear that in those circumstances, the advocate’s ability to support that patient would be severely compromised.

109 The Act, therefore, makes specific provision that to be “independent”, the advocacy services must be provided by persons other than a local authority or a Health Board responsible for providing services in the area where the patient is to receive care or treatment, or a member of those bodies or any other person involved in their care treatment or in providing services to them. Any independent advocacy organisation should have policies in place to identify and manage/minimise the risk of any conflict of interest.

110 Independent advocacy should be provided by an organisation whose sole role is independent advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy. If the independent advocacy service or advocate has a conflict of interest, they should inform all relevant parties of this, and should withdraw from acting for the patient.

Duty to inform patients of and assist them to access independent advocacy

111 Mental Health Officers (MHOs) have a duty under the Act at certain times to:

- inform patients about the availability of independent advocacy services; and
- take appropriate steps to ensure that patients have the opportunity to make use of those services.

112 MHOs are required by the Act to carry out this duty at each of the following times.

- when considering whether to consent to the grant of a short-term detention certificate (section 45);
- on application for, extension of and extension and variation of, compulsory treatment orders (sections 61, 85 and 89); and
- on extension of and extension and variation of compulsion orders (sections 147, 151 and 155).

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113 The 2003 Act has been modified by an order made under section 330 of the Act (**The Mental Health (Care and Treatment) (Scotland) Act 2003 Modifications Order 2004 (SSI No. 533)**) to include the following times when the MHO must inform the patient about the availability under section 259 of independent advocacy services:

- Application by RMO for variation of an order (section 94); and
- Application by RMO for variation of a compulsion order (section 160).

114 Regulations made under section 290 of the Act (**The Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005**) place a duty on the MHO to inform a patient of their right to access independent advocacy and to take steps to help them use such services where consideration is being given to the removal of the patient to a hospital outwith Scotland and on a patient's reception into a hospital in Scotland on removal from another part of the United Kingdom, the Isle of Man or the Channel Islands.

115 The “appropriate person” is under a duty in terms of section 260 of the Act to ‘take all reasonable steps’ to:

- inform patients subject to any form of compulsion of the availability of independent advocacy services; and
- ensure that those patients have the opportunity of making use of those services.

116 The “appropriate person” to carry out the duties under section 260 is:

- the managers of the hospital where a patient is detained;
- where, by virtue of a certificate granted under the Act, the authorisation to detain is suspended, the managers of the hospital in which, but for the certificate, the patient would be treated; or
- in any other case, the managers of the hospital specified in the order.

117 This duty must be carried out for patients who are:

- detained in hospital by virtue of the 2003 Act or the 1995 Act, or
- are not detained in hospital but are subject to:
 - an emergency detention certificate;
 - a short-term detention certificate;
 - a compulsory treatment order;
 - an interim compulsory treatment order;
 - an assessment order;
 - a treatment order;

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- a hospital direction;
- a transfer for treatment direction;
- an interim compulsion order; or
- a compulsion order.

118 In addition, section 260(3) states that the duty of the appropriate person to inform and assist patients in relation to independent advocacy must be carried out:

- as soon as practicable after the beginning of a detention order, where the patient is detained in hospital;
- as soon as practicable after the making of the order, where the patient is not detained in hospital;
- as soon as practicable after any occasion on which the patient 'reasonably requests' to be informed of those matters; and
- at such other times as may be prescribed by regulations.

119 Regulations made under section 260(3)(c) of the Act (**The Mental Health (Provision of information to patients) (Prescribed times) (Scotland) Regulations 2005 (SSI No. 206)**) require that, in addition to the times specified above, the managers of the hospital must also inform the patient about the availability under section 259 of the Act of independent advocacy services as soon as practicable after a number of other events. These events include:

- the making of an order by the Tribunal in relation to a CTO or a compulsion order;
- the making of a determination by the RMO in relation to such orders;
- the grant of a certificate by an RMO suspending detention for more than 28 days under an interim CTO;
- a CTO, a compulsion order (with or without restrictions) or a transfer direction and the revocation of such a certificate.

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- 120 In practice, the role of the appropriate person may be carried out by other hospital staff on behalf of the managers. However, it remains the appropriate person's responsibility to ensure that their duty is fulfilled. Where the duty is to be delegated, they should ensure that there are clear processes in place to ensure effective delegation, and in particular, that roles and responsibilities of members of staff or others who are to exercise delegated authority are defined.
- 121 All relevant staff should be made aware of the patient's right to independent advocacy and its role, the legal requirements relating to independent advocacy under the Act and of best practice. It is important that staff know that advocates may support any patient, including child and adolescent patients, patients with incapacity, and patients with communication difficulties.
- 122 It would be best practice for information on independent advocacy to be displayed in public areas and on wards as well as in forms which can be handed out to people, such as leaflets or cassette tapes. In addition, MHOs and hospital managers might provide such information at other times where it appeared to them that the patient would benefit from learning about, or how to access, independent advocacy services.
- 123 MHOs and the appropriate person should ensure that they are aware of the independent advocacy services that are available in their area. Claiming ignorance of these will not be sufficient excuse for a failure to comply with a duty under the Act.
- 124 Information about independent advocacy services will need to be communicated to patients in a way which each patient can understand, taking account of any special communication needs they may have. Such needs may arise, for example, where the patient is deaf or hard of hearing or has a visual impairment, a learning disability or where their first language is not English. In addition, any information provided in writing should be clear and in a style and language which can be easily understood by the individual patient. This is especially important for child and adolescent patients, as standard information may be presented using vocabulary which is too advanced or complex for them. While it may be considered to be important to give the patient information for their own future reference, perhaps in the form of a leaflet or a cassette tape, it will not be sufficient for the MHO or appropriate person to just

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hand over that leaflet or tape without making sure that the patient understands the information being given or has the means to play the tape.

- 125 The MHO and the appropriate person may need to explain what an independent advocate is and how an advocate or an advocacy group might help. It may be necessary for discussions on independent advocacy to take place on more than one occasion, as there may be factors such as stress, which make it difficult for the patient to fully absorb or understand the information being offered. The MHO or the appropriate person may wish to ask ward staff or other members of the multi-disciplinary team to assist them in this.
- 126 In addition to informing people about the availability of independent advocacy services, the MHO and the “appropriate person” also have a duty to take appropriate steps to ensure that the patient has the opportunity of making use of those independent advocacy services. The Act is not specific about the steps which they should take and what is appropriate and these will depend on the circumstances. Again, this may take more than one approach from the MHO or the appropriate person and other staff may be asked to assist and support to achieve this.
- 127 Where the patient would like independent advocacy, it would be best practice for an MHO and the appropriate person to assist the patient to contact an independent advocacy organisation. For example, they might contact the independent advocacy organisation on that patient’s behalf to make arrangements for the patient to meet with an independent advocate if the patient would otherwise be unable to do this. They should not at this stage be disclosing any personal information about the patient to the independent advocacy organisation. The patient should be asked for consent to disclose any information before it may be shared with the organisation. Where the patient cannot give consent to the sharing of information the MHO or the appropriate person should consult the RMO and members of the multi-disciplinary team to consider what information, if any, it might be appropriate to share in the circumstances, bearing in mind the patient’s right to confidentiality. It may also be appropriate to seek legal advice on the sharing of personal information.

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- 128 As a matter of best practice, the MHO and the appropriate person should record in the patient's medical records the steps taken to inform that patient of independent advocacy, how and where to access it. It would be best practice to keep other people who support the patient informed about whether or not the patient would like independent advocacy, and any follow-up action required, where a patient has consented to such information being shared. Where an independent advocate is involved, details of that advocate's involvement should be intimated to others concerned in the care and welfare of the patient.
- 129 If a patient has been fully informed about independent advocacy services, and chooses not to involve an advocate in their case, it would be best practice for the MHO and the appropriate person to:
- record in the patient's medical records the fact that the patient was informed about independent advocacy and did not want advocacy support; and
 - check with the patient again at a later date that they remain of the same view, in the event that they may have changed their mind.
- 130 If the MHO or appropriate person considers that the patient's decision to decline independent advocacy is due to their mental disorder, and also considers that independent advocacy would benefit the patient, then the MHO may wish to consult the RMO and other members of the multi-disciplinary team as to whether to refer the patient to independent advocacy services anyway.

What happens if the MHO does not interview the patient?

- 131 It is possible, in very limited circumstances, for an MHO to consent to a detention without having seen the patient in question. Section 45(1) states that the MHO has a duty to inform the patient about independent advocacy services before deciding whether to consent to a detention. If the MHO does not interview the patient for whatever reason, the MHO still has a duty to inform that patient about independent advocacy services and to take appropriate steps to ensure the patient has the opportunity of making use of those services. The MHO may have to visit the patient on more than one occasion.

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132 Sections 85, 89, 147, 151 and 155 place a duty on the MHO to inform the patient about independent advocacy services, and to ensure the patient has the opportunity to use those services, as soon as practicable after receiving notice of a proposed extension of an order to which the patient is subject and, where applicable, grant of such an extension, notwithstanding that it may be impractical for the MHO to interview the patient.

133 It would be best practice for the MHO to record in the patient's records the steps taken in these cases.

What does 'as soon as practicable' mean?

134 Section 260(3) states that the duty on the appropriate person to inform and assist patients in relation to independent advocacy must be carried out:

- as soon as practicable after the beginning of a detention order, where the patient is detained in hospital;
- as soon as practicable after the making of the order, where the patient is not detained in hospital;
- as soon as practicable after any occasion on which the patient 'reasonably requests' to be informed of those matters; and
- at such other times as may be prescribed by regulations.

135 Regulations made under section 260(3)(c) of the Act (**The Mental Health (Provision of information to patients) (Prescribed times) (Scotland) Regulations 2005 (SSI No. 206)**) require that, in addition to the times specified above, the managers of the hospital must also inform the patient about the availability under section 259 of the Act of independent advocacy services as soon as practicable after a number of other events. These events include the making of an order by the Tribunal in relation to a CTO or a compulsion order, the making of a determination by the RMO in relation to such orders, the grant of a certificate by an RMO suspending detention for more than 28 days under an interim CTO, a CTO, a compulsion order (with or without restrictions) or a transfer direction and the revocation of such a certificate.

136 The Act does not define what 'as soon as practicable' means, because it is a matter of what is reasonable in the circumstances of any particular case.

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What constitutes a 'reasonable request'?

137 Section 260(3)(b) states that the appropriate person will inform a patient of the availability of independent advocacy services “as soon as practicable after any occasion on which the patient reasonably requests to be informed of those matters”. Again, the question of what is reasonable depends on the facts and circumstances of the individual case. It would be best practice to consider all requests to be reasonable in the first instance, unless there is some unusual circumstance suggesting otherwise, and to inform that patient about the services available. It would also be best practice to record in the patient’s records when and how the request for information was responded to.

General Practitioners

138 General practitioners (GPs) are not specifically allocated duties regarding independent advocacy by the Act. However, as a key point of contact for patients their involvement is important to the successful implementation of these provisions. It is expected that general practices will have information about independent advocacy services on display, as well as having them available in a form that patients can take away with them. Where a patient requests information about independent advocacy, GPs and practice staff would be expected either to provide this information themselves or to direct the patient toward appropriate sources of information. Where the request for information is made during a consultation, it would be best practice for that request and the response to be recorded in the patient’s case notes.

What happens when a patient is unable to communicate whether or not they would like an independent advocate?

139 Every patient has a right of access to independent advocacy under the Act, as detailed above in paragraph 90. It is important that they are able to make use of this right, in view of their potential vulnerability. Where a patient lacks capacity to make a particular decision, it should not be assumed that the patient does not have capacity to make decisions on any subject at any time. A patient’s capacity may change over time and this needs to be taken into account. Where a patient appears to lack capacity to decide on making use of independent advocacy, the subject should be discussed again with them by those who have specific duties to bring the availability of those services to their attention, at a time when their capacity to understand the issue appears to have improved.

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140 Where a patient has a degree of incapacity, or cannot for any reason clearly say whether or not they would like an independent advocate, an MHO/hospital managers/appropriate person should consider how an independent advocate may be involved. MHOs/hospital managers/appropriate persons should pay particular attention to the patient's past wishes, the views of people supporting them and any advance statement or other record of a patient's prior comments on having an independent advocate. The right of access to independent advocacy is for each patient and is not limited only to those who are best able to articulate their needs.

Speed of Response

141 When a referral is made to independent advocacy, it is expected that the independent advocacy organisation will respond to the patient concerned as quickly as is appropriate and practicable in the circumstances. For example, priority may be required where some immediate action is needed and in particular where a patient is liable to be or is subject to compulsion under the Act.

142 It is recognised that independent advocacy organisations often work 'office hours' and that in certain circumstances, this may mean that there will be a delay in responding to the referral, at such times as weekends and holidays. Following initial contact, independent advocacy organisations should prioritise provision according to agreements with local authority and Health Board commissioners based on local needs and national priorities.

Tribunals

143 As part of their role in supporting and representing a patient, an independent advocate may assist a patient in the time before and during any tribunal hearing. The independent advocate would not replace any legal representative a patient may have, though an independent advocate may fulfil a useful role in helping a patient in communicating with their legal representative.

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Advance statements

144 Advance statements are described in section 275 of the Act as statements setting out the way the patient who has capacity to decide how they wish to be treated, or do not wish to be treated, at some time in the future, in the event that they become unable to make such decisions through mental disorder. Advance statements may be useful for patients to indicate whether they would wish to have an independent advocate or not.

145 Independent advocates may assist patients to write an advance statement and keep it up to date. Independent advocates are not one of the classes of persons authorised by regulations under section 275 of the Act to witness an advance statement. Where an independent advocate is qualified as a result of their professional qualifications (for instance, a nurse) to witness a patient's advance statement, then they will wish to consider carefully whether there may be a conflict of interest in doing so.

Independent advocates and named persons

146 Generally, a named person under the Act is any person 16 years and over nominated by a patient and the Act details the form in which this must be done. Independent advocates are not one of the classes of persons authorised by regulations under section 250 of the Act to witness a nomination but may assist a patient in writing out the nomination. Where an independent advocate is qualified as a result of their professional qualifications (for instance, a nurse) to witness a patient's named person nomination then they may wish to consider carefully whether there would be any conflict of interest in doing so.

147 Where there is no nominated named person, a patient may have as a named person, the primary carer, or the nearest relative where the patient is an adult, or the person with parental rights and responsibilities, the local authority, or the primary carer, where the patient is a child under 16.

148 As a matter of best practice, an individual should not act as both independent advocate and named person for the same patient. There are differences between the two roles which could cause confusion were the same person is to fulfil both roles.

chapter 7

assessment of needs

chapter seven

Introduction

This chapter offers best practice guidance in relation to the local authority's duty under Part 14 of the Act to assess the needs of an adult

Assessment of needs

- 01 Part 14 of the Act imposes a duty on local authorities to assess the needs of adults for community care services under Section 12A of the Social Work (Scotland) Act 1968 when notified by an MHO that the “patient” may be in need of such services. It also places a duty on local authorities to assess the needs of a child under section 23(3) of the Children (Scotland) Act 1995 when requested to do so by an MHO. In both cases the local authority must carry out an assessment. Furthermore, this Part of the Act places a duty on local authorities to consider whether an assessment of an individual's community care needs should be undertaken when this is requested in writing by the patient themselves, their primary carer or their named person. It would be good practice to consider a written request from the patient's independent advocate on behalf of the patient as if it were from the patient themselves.
- 02 The Health Board is placed under a similar duty when a request is made in writing by the patient, their primary carer or their named person in respect of the patient's perceived needs for services which are provided by the Health Board. In both cases, the local authority and the Health Board are required to respond to the person making the request within 14 days from when the request was received, indicating whether they intend to undertake an assessment, and if not, why not. It would be good practice for Health Boards and local authorities to ensure robust procedures are put in place for allocating, coordinating and processing any notification or request for an assessment of needs, including procedures for handling urgent referrals.

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Request for assessment of need by MHO

- 03 Section 227 of the Act relates to all people with a mental disorder with whom an MHO comes in contact in carrying out their duties under this Act. It gives an MHO authority to request an assessment of need for community care services and imposes a consequent duty on local authorities to undertake such an assessment. This duty may be triggered, for instance, when an MHO has assessed someone for the purpose of consent to emergency or short-term detention under the Act. It may even be that the MHO decides not to consent to detention but feels the person in question would benefit from a formal assessment of their need for community care services.
- 04 Normally, it will be for the designated MHO (following a ‘relevant event’ as defined in section 232 of the Act) to decide, based on their discussions with the rest of the multi-disciplinary team and the patient, whether the patient would benefit from such an assessment. Ideally, this will take place as soon as practicable after the patient becomes subject to compulsion. Information from a formal assessment may provide invaluable information to the designated MHO who will be assisting in the future care planning for the patient. There will also be cases in which the designated MHO will be preparing an application for a CTO and such information, if available, would greatly assist the MHO in devising a proposed care plan as part of that application. Where an MHO requests an assessment of needs, for example to inform a proposed care plan for a CTO application, it would be good practice to coordinate the timing of the assessment to ensure that the information is available to the MHO within the required timescales, where this is practicable.
- 05 In many cases it will fall to the designated MHO themselves to undertake a formal assessment of the patient’s need for community care services as an integral part of their assessment. There will be other situations, however, where the MHO might not be able to undertake a formal assessment for any number of reasons, such as the situation mentioned above where the MHO has assessed a person for detention which does not ultimately go forward. It may be that the patient is already known to another staff member in the local authority who has responsibility for assessment of his/her needs for community care services. The MHO should first establish whether the patient is known to a local authority colleague and whether such an assessment has already been

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undertaken, and if so, how recently. Where a patient is known and/or where their case is open to another colleague, this person should be consulted by the designated MHO in any case, regardless of whether an assessment has been undertaken already.

- 06 Another issue the MHO will have to consider is one of timing. There will be situations where there will be insufficient knowledge of the patient and the nature and course of their illness to justify proceeding with a formal assessment of their needs for community care services early in the period to which they are subject to compulsion. Perhaps the patient will not be well enough at an early stage, to actively participate in the assessment, something which is important in helping to secure the future success of any care plan based upon the assessment. The question of whether and when a patient should receive a formal assessment of their needs for community care services is something which should be kept under continual review by the designated MHO and the rest of the multi-disciplinary team. It would be good practice for local authorities to ensure robust procedures are put in place to fast-track and agree funding for the proposed care plans where applications are being pursued for CTOs.
- 07 All requests for an assessment of needs for community care services must be made in writing to the local authority. The request must be considered whether it “bears to be made” by the patient, their primary carer or their named person, or if it “appears” to be so made. Where a third party has helped the person to make the request, for example a family friend has written on behalf of the patient, named person or primary carer, then such a request would be considered valid. It would be good practice to consider a written request from the patient’s independent advocate on behalf of the patient as if it were from the patient themselves.

chapter seven

Requests of assessment of needs by patient, their primary carer, or named person

- 08 Section 228 of the Act requires the local authority and/or Health Board to consider the need of a person for an assessment of community care and/or health services when this is requested in writing by either the patient themselves, their primary carer or their named person. It would be good practice to consider a written request from the patient's independent advocate on behalf of the patient as if it were from the patient themselves. The local authority and/or Health Board must respond within 14 days of receiving the request, indicating whether they intend to undertake an assessment, and if not, why not.
- 09 Best practice would be for the local authority in responding to such a request to involve the designated MHO where one has been designated in respect of that person. There will, however, be cases where there will not be a designated MHO at the point of request. In such cases, it may still be prudent to involve an MHO wherever practicable to assist in the process of determining whether such an assessment should be undertaken. Whoever responds on behalf of the local authority should consult with other health and local authority colleagues in determining whether an assessment may be of benefit. Similarly, any health service colleagues who respond to such requests to the Health Board should liaise with all relevant health and local authority staff and relevant others in determining how to proceed.
- 10 Local authorities and Health Boards should ensure that their staff are aware of the rights of patients, primary carers and named persons to request such assessments and ensure to the extent possible that the wider public are also aware of the rights of people with mental disorder, their primary carers and named persons to request an assessment of their need for community care and/or health services. In publicising the rights of patients, carers and named persons, it would be good practice for local authorities and Health Boards to encourage staff to take a proactive approach in applying the principle of diversity, by taking a targeted approach to communicating with black and ethnic minority communities.

chapter 8

application to the tribunal in
relation to unlawful detention
(section 291)

chapter eight

Introduction

This section of the Code of Practice offers best practice guidance with regard to informal patients, who can be described as voluntary patients receiving care and treatment for mental disorder in hospital, and who are not subject to compulsion or detention under either the 2003 Act or the

- 01 Section 291 conveys upon the following people the right to apply to the Mental Health Tribunal for an order requiring the managers of the hospital to cease to detain the patient:
 - (a) the patient;
 - (b) the patient's named person;
 - (c) if the patient is a child, any person who has parental responsibilities in relation to the patient;
 - (d) a mental health officer;
 - (e) the Commission;
 - (f) any guardian of the patient;
 - (g) any welfare attorney of the patient; and
 - (h) any other person having an interest in the welfare of the patient.

- 02 This provision effectively allows the patient or any of the other people listed in section 291 to ask the Tribunal to review the need for the patient to remain in hospital when not formally detained. "Any guardian", at (f) above, includes any welfare guardian, and "any other person" at (h) above could include a relative, carer or independent advocate.

- 03 An application may be made where the patient has been admitted to hospital and is being given treatment for mental disorder otherwise than under the Act or the 1995 Act. Section 329 of the Act defines 'hospital' as any health service hospital, any independent health care service or any state hospital. The Tribunal must grant the application if it is satisfied that the patient is being unlawfully detained in hospital.

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- 04 This provision might, for instance, be used to review the need for hospital care for a patient who had required hospital care and treatment for mental disorder, who had lacked capacity to consent to admission but who was not objecting to the care and treatment provided and therefore had not been detained compulsorily under either the Act or the 1995 Act. A patient with severe learning disabilities or dementia might come under this category. It might also be considered where a patient has been admitted to hospital as an informal patient but is being kept in a locked ward and denied free egress.
- 05 It is important that all patients, whatever their detention status, are provided with a safe, secure and therapeutic environment. At times this might mean limiting the patient's egress from or access to parts of the hospital grounds, particularly for patients with dementia or learning disability who may be at risk to their own health by way of falling, or tripping on stairs or similar hazards. Where the patient is a child or adolescent, it may be appropriate for reasons of their personal safety to exclude them from certain areas of the hospital. Low staffing levels are insufficient justification for limiting reasonable, safe mobility by patients around the hospital. It would be good practice for the multi-disciplinary team to review any such limitations placed on an informal patient, as part of the ongoing review of the patient's care.
- 06 It would be good practice for members of the multi-disciplinary team to inform the patient of their rights while in hospital when they are admitted. For informal patients these include among others the right to leave the unit, to make their own decisions about whether to accept treatment, and in what form, and to choose whether to accept the restrictions on movement that may be prescribed for them. Where a patient has limited capacity to understand their rights, it may be appropriate to include the patient's carer or independent advocate in the discussion. Where restrictions on movement have been agreed, a written summary or map or diagram suitable for the patient's needs may assist the patient's understanding and recall of these limitations. Where limitations are altered after an incident or review it would be good practice for the multi-disciplinary team to inform the patient of these changes within a reasonable time, and to update any written materials that may have been provided to the patient. What constitutes a reasonable time will depend upon the circumstances.

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- 07 Under section 315 of the Act it is an offence for a relevant person who provides, or purports to provide, care and treatment to a patient to ill-treat or wilfully neglect that patient. The provisions of section 315 apply to informal patients as they apply to persons being treated under the Act and 1995 Act. Section 83 of the Adults With Incapacity (Scotland) Act 2000 has a related provision, whereby it is an offence for any person exercising powers under the 2000 Act relating to the personal welfare of an adult to ill-treat or wilfully neglect that adult. In some circumstances inappropriate use of restraint or limitations to an informal patient's liberty might contribute to or constitute ill-treatment or wilful neglect.
- 08 The Mental Welfare Commission may be contacted for guidance on restraint and restrictions to mobility.

chapter 9:

appointment of rmo
and designation of mho
(sections 230 and 229)

chapter nine

Introduction

This chapter examines the appointment and designation of two key members of the patient's multi-disciplinary team: that is, the appointment of the patient's responsible medical officer (RMO) under section 229 of the Act and the designation of the patient's mental health officer (MHO) under section 230. An RMO and an MHO must be appointed/designated

Appointment of RMO

- 01 Section 230 of the Act states that the relevant hospital managers must appoint an approved medical practitioner (that is, a medical practitioner approved under section 22 of the Act) to act as a patient's RMO. This appointment must be made "as soon as is reasonably practicable" after the occurrence of what sections 230 and 232 term an "appropriate act". These are:
- the granting of an emergency detention certificate;
 - the granting of a short-term detention certificate;
 - the making of an interim compulsory treatment order or a compulsory treatment order;
 - the making of a temporary compulsion order;
 - the making of an interim compulsion order or a compulsion order;
 - the variation of a compulsory treatment order or a compulsion order;
 - the making of an assessment order;
 - the making of a treatment order;
 - the making of a hospital direction;
 - the making of a transfer for treatment direction;
 - the transfer of the patient to another hospital under sections 124(2), 125(4)(b), 126(4), 218(2), 219(4)(b) or 220(4)(b) of the Act; and
 - the return of the patient to a hospital under sections 125(5), 126(5), 219(5) or 220(5) of the Act.

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- 02 The RMO must be appointed by the relevant hospital managers. This means:
- the managers of the hospital in which the patient is currently detained or which is specified in the order;
 - where a CTO or CO has been varied, the managers of the hospital which is specified in the order following modification under section 102, 103, 104, 106, 166, 167, 169, 171 or, as the case may be, 193(6) of the Act;
 - in the case where a patient has been transferred under the provisions of sections 124(2), 125(4)(b), 126(4), 218(2), 219(4)(b) or 220(4)(b) of the Act, the managers of the hospital to which the patient is transferred;
 - after receiving notice from the managers of the sending hospital that the transfer is to proceed and the patient is received in Scotland, the managers of the receiving hospital to which a patient has been transferred under the cross border provisions, prescribed by **The Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005**; or
 - the managers of the hospital to which a patient has been returned after an appeal against a transfer under the provisions of sections 125(5), 126(5), 219(5) or 220(5) of the Act.
- 03 The RMO must be appointed “as soon as is reasonably practicable” after the occurrence of “an appropriate act” in relation to the patient. It may be the case that it is possible for the RMO to be appointed the same day. However, in a situation where the RMO may have to come from a different hospital or service, “as soon as is reasonably practicable” could be interpreted as meaning within the next working day.
- 04 If a patient is made subject to compulsory powers and already has an RMO who is an approved medical practitioner in the terms of the Act, best practice would be for that RMO to continue to act as the patient’s RMO. Wherever a patient is made subject to compulsory powers but does not already have an RMO who is an approved medical practitioner in the terms of the Act, it will be necessary to appoint an RMO who is an approved medical practitioner. Arrangements must be such as to establish without delay or dubiety the RMO in respect of every patient after the occurrence of an “appropriate act”.

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- 05 Managers of an acute medical/surgical hospital will need to ensure that arrangements are agreed and in place with acute psychiatric hospitals/ services to provide available approved medical practitioners unless approved medical practitioners are already on the staff of the acute medical/surgical hospital.
- 06 There will therefore be occasions where, in effect, a patient has two RMOs: that is, an approved medical practitioner who is acting as the patient's RMO in terms of the Act and a medical/surgical consultant acting as an RMO, albeit not under the Act. In this situation, medical or surgical care should continue to be the responsibility of the medical/ surgical consultant while decisions about the treatment of mental disorder and the review of any detention procedures should be the responsibility of the approved medical practitioner who is acting as the patient's RMO appointed under the Act.
- 07 Where it is considered appropriate to discharge a patient from hospital, it should be noted that the RMO appointed under the Act will need to revoke the authority to detain the patient prior to a medical/surgical consultant discharging the patient from hospital. Where it is considered that the patient does not require to be detained in hospital but continues to satisfy the conditions for formal treatment under the Act, then the RMO should consider whether a suspension of detention or a CTO in the community would be more appropriate.
- 08 Hospital managers will need to ensure that arrangements are in place to cover the absence of an RMO: for example, through holiday or illness. Section 230(3) of the Act permits them to authorise any approved medical practitioner to act in place of the patient's RMO for a particular purpose or in particular circumstances.
- 09 The importance of ensuring that another approved medical practitioner is appointed swiftly to act as the patient's RMO in any circumstance where the patient's "usual" RMO is absent cannot be overemphasised. Hospital managers should have procedures in place to ensure that the patient, his/her relatives and carers, as well as the members of the patient's multi-disciplinary team, are always able to find out quickly who is acting as the patient's RMO.

chapter nine

Designation of MHO responsible for patient's case

- 10 A local authority must ensure that an MHO is designated as responsible for the case of any person in respect of whom a “relevant event” has taken place. The local authority must designate an MHO “as soon as is reasonably practicable” after a “relevant event” takes place. These “relevant events” are listed at section 232 of the Act. They are:
- the granting of a short-term detention certificate;
 - the making of an interim compulsory treatment order;
 - the making of a compulsory treatment order;
 - the making of an assessment order;
 - the making of a treatment order;
 - the making of an interim compulsion order;
 - the making of a compulsion order;
 - the making of a hospital direction; and
 - the making of a transfer for treatment direction.
- 11 The local authority must also designate an MHO where it receives notice of a proposed removal from Scotland under **The Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005** of a patient who is receiving treatment otherwise than by virtue of the Act or the 1995 Act.
- 12 It should be noted that an MHO does not have to be designated subsequent to the granting of an emergency detention certificate. However, best practice would nonetheless dictate that where an MHO consented to the granting of an emergency certificate, he/she (or another MHO, if necessary) would remain involved with the case for the duration of the detention. Where an MHO had not been involved in the granting of the emergency detention certificate, best practice would be for the local authority to allocate an MHO to the case as soon as practicable so that they are able to consult with the patient's RMO.
- 13 It should be noted that where a patient has been admitted to hospital on an emergency detention certificate granted without an MHO's consent, the managers of the hospital to which the patient has been admitted must give notice of the matters notified to them under section 37 of the Act by the medical practitioner who granted the emergency detention certificate to the local authority for the area in which the patient lives, or the local authority for the area in which the hospital is situated if the hospital

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managers do not know where the patient lives. Hospital managers must inform the relevant local authority within 7 days beginning with the day on which they receive notice under section 37 of the Act. This means that the hospital must be able to refer a case to the local MHO service as soon after admission as possible, even when admission occurs out of hours. *(For further information on the involvement of an MHO subsequent to the granting of an emergency detention certificate, see Part 5 of the Act or Chapter 7 of Volume 2 of the Code of Practice.)*

- 14 A local authority is required to ensure that the patient has a designated MHO for as long as that patient is subject to the terms of any relevant event. It would therefore be best practice for each local authority to maintain an up-to-date list showing which MHO is designated to the care of each patient to ensure that the designated MHO may always be speedily identified.
- 15 Local authorities will need to ensure that the arrangements also cover the absence of any MHO, for example, through holiday or illness. Section 229(2) of the Act permits them to designate an MHO to act as the designated MHO in place of the previously designated MHO either for all purposes or for a particular purpose or for particular circumstances.
- 16 Local authorities will also need to ensure the availability of a service out of hours, usually via an out of hours/emergency duty team service. The patient's designated MHO will, for the most part, be based in the day-time service and will therefore need to be able to pass on relevant and updated information to the out of hours MHO service. In effect, all local authorities will have to designate MHOs who staff their out of hours services to enable them to undertake designated MHO duties when required.

Can the role of designated MHO be transferred, once appointed, to another MHO?

- 17 Yes, under section 229(2)(a) of the Act but best practice would be for local authorities to limit the number of changes to the patient's designated MHO during continuous periods of compulsory powers to ensure consistency and to lessen confusion for the patient, his carer/relatives and members of the patient's multi-disciplinary team.

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Which local authority is responsible for designating the MHO?

- 18 Section 229(3) defines the “relevant local authority” in relation to designating an MHO. Where the patient is subject to hospital-based compulsion, then the relevant local authority is the local authority in which the patient was resident immediately before the relevant event occurred. Where a patient is subject to any form of compulsion in the community, the relevant local authority will be the authority in which the patient resides. Where a patient subject to detention in hospital was not resident in Scotland immediately before the relevant event occurred, the relevant local authority is the local authority for the area in which the hospital is situated. Although the Act does not require a new MHO to be designated after a patient has been transferred between hospitals within Scotland, it would be best practice for local authorities to liaise with each other to ensure that the patient continues to have a designated MHO.
- 19 Best practice would be for local health services to have procedures in place to ensure that local authorities are notified quickly of a relevant event. Similarly, best practice would suggest that local authorities will need to have processes in place to designate an MHO to the case of a particular patient and to communicate that designation and the MHO’s contact details swiftly, to relevant parties.
- 20 Local authorities are expected to have agreements with all relevant and/or adjoining local authorities in respect of the designation of MHOs on their behalf in certain circumstances. This would cover the needs of patients in the State Hospital, in medium secure units or those admitted outwith their area, for example, patients who may be at some distance from their place of domicile. This will be particularly important where a patient who is subject to a community-based compulsory treatment order was immediately beforehand subject to a hospital-based order but now resides in a local authority which is different from that in which the hospital is situated.

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What is the role of an MHO who is designated as responsible for a person's case?

- 21 The designated MHO must carry out specific functions and duties depending on which section of the Act the patient falls within. All relevant events for instance, require the MHO to complete a social circumstances report on the patient in terms of section 231 of the Act unless the MHO records why this would serve little or no practical purpose. *(For further information on SCRs, see section 231 of the Act or Chapter 11 of this Volume of the Code of Practice.)* In addition, there are other specific and general duties which the designated MHO should carry out. Examples of such duties include:
- assisting the patient in the process of nominating a named person; *(for further information, see Chapter 6 of this Volume of the Code of Practice)*
 - assisting the patient to access advocacy services, and perhaps legal representation, if required; *(for further information, see Chapter 6 of this Volume of the Code of Practice)*
 - consulting on the existence or drawing up of advanced statements; *(for further information, see Chapter 6 of this Volume of the Code of Practice)*
 - referring to the local authority for a comprehensive community care assessment when required and when the MHO themselves is not completing one. *(For further information, see Chapter 7 of this Volume of the Code of Practice.)*
- 22 Best practice would be for the designated MHO to play a key role in the ongoing assessment and care planning for the patient. The MHO should participate as a core member of the patient's multi-disciplinary team. Their role in this team is to be responsible for ensuring that the patient's social circumstances are fully considered by that team when the patient's care and treatment is being planned and delivered. To carry out this role effectively, the MHO should liaise closely with local authority colleagues to put in place the social care components of the patient's care plan as well as liaising closely with the patient's named person, carers, relatives and independent advocate as a matter of course. The MHO should remain easily contactable by them and the other members of the patient's multi-disciplinary team.

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medical treatment (part 16)

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Introduction

This chapter examines the provisions relating to the provision of medical treatment for mental disorder which are set out at Part 16 of the Act.

It looks at issues relating to the safeguards which are applied to treating any person with a mental disorder, including those linked to the Adults with Incapacity (Scotland) Act 2000, and the issue of consent. It then turns to safeguards which relate to specific forms of medical treatment, such as electro-convulsive therapy (ECT) and urgent medical treatment.

Medical treatment – safeguards

- 01 The Act is designed to improve safeguards for patients in general. However, there are some treatments for mental disorder where further safeguards are justified particularly, but not only, in the circumstances where the treatment is given without the patient's consent. Part 16 of the Act makes provision for such safeguards for treatment for mental disorder.
- 02 Any medical practitioner giving treatment for mental disorder must have regard to the principles set out in section 1 of the Act, and to any advance statement made by the patient in accordance with sections 275 and 276. In particular, the views of the patient should be taken into account, and the patient should be given information and assisted to understand the treatment and its aims and effects.
- 03 The safeguards in relation to neurosurgery for mental disorder (and to any other treatments regulated under section 234 of the Act) extend to any person with a mental disorder for whom this treatment is considered whether or not they are subject to compulsory measures under the Act. **The Mental Health (Medical treatments subject to safeguards) (Section 234) (Scotland) Regulations 2005 (SSI No. 291)** currently provide for the safeguards to also apply to the medical treatment known as “deep brain stimulation” (DBS). Although not precluded by the Act, it would not be expected that a patient under 20 years of age would be considered for neurosurgery for mental disorder.

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- 04 The safeguards in relation to ECT (and other treatments provided for in regulations made under section 237 of the Act) apply to anyone subject to compulsory measures under the Act. **The Mental Health (Medical treatment subject to safeguards) (Section 237) (Scotland) Regulations 2005 (SSI No. 292)** have prescribed that the safeguards should also apply to the medical treatments known as vagus nerve stimulation (VNS) and transcranial magnetic stimulation (TMS).
- 05 Section 243 applies to urgent medical treatment required by patients who are detained in hospital under the Act or the 1995 Act.
- 06 Under section 244 Scottish Ministers may prescribe specific conditions that must be satisfied before certain treatments are given to informal child patients **under 16 years of age, that is those children not being treated formally under the Act. The Mental Health (Safeguards for Certain Informal Patients) (Scotland) Regulations 2005** have prescribed ECT, TMS and VNS. *(For further information about child patients, see Chapter 1 of this Volume of the Code of Practice.)*
- 07 Section 249 provides a “child” is a person who has **not yet attained the age of 18** years of age where they are being formally treated under the provisions of Part 16 of the Act.
- 08 A “child specialist” means a medical practitioner who has such qualifications or experience in relation to children as the Commission may determine.

Measures which do not provide authority to treat

- 09 The following measures which authorise detention do not authorise treatment under Part 16 of the 2003 Act:
- an emergency detention certificate issued under section 36 of the Act;
 - a nurse’s power to detain pending a medical examination under section 299 of the Act;
 - the power to hold a person under the provisions relating to removal from a public place to a place of safety under sections 297 and 298 of the Act;
 - a warrant granted under section 35 of the Act;
 - a removal order under section 293 of the Act; and
 - an order under section 60C of the 1995 Act, where an acquitted person may be detained for medical examination.

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- 10 Any patient detained by virtue of the above provisions must therefore provide consent to any treatment for mental disorder. The exception is that a patient detained under an emergency detention certificate issued under section 36 of the Act may be given urgent treatment administered under the provisions of section 243, without their consent.

Authority to treat

- 11 The remaining treatment provisions in Part 16 and their safeguards apply to all patients who are subject to compulsory measures where medical treatment is specifically authorised under the Act or the 1995 Act. This includes patients who are subject to the following compulsory measures:
- a short-term detention certificate under section 44(1) of the Act;
 - an extension of detention, under section 47(1) of the Act;
 - an extension of short-term detention pending determination under section 68 of the Act;
 - a compulsory treatment order under section 64(4) of the Act;
 - an interim compulsory treatment order under section 65(2) of the Act;
 - an assessment order under section 52D of the 1995 Act;
 - a treatment order under section 52M of the 1995 Act;
 - a compulsion order (with or without a restriction order) under section 57A of the 1995 Act;
 - an interim compulsion order under section 53 of the 1995 Act;
 - a hospital direction under section 59A of the 1995 Act; and
 - a transfer for treatment direction under section 136 of the Act.

Adults with Incapacity (Scotland) Act 2000

- 12 Part 5 of the 2000 Act makes provision for medical treatment for adults who are incapable of giving consent as a result of incapacity, including incapacity caused by mental disorder. Section 1 of that Act defines the term “incapable”.
- 13 Section 47 of the 2000 Act allows the medical practitioner who is primarily responsible for the adult’s treatment to complete a certificate certifying that in his or her opinion the adult is incapable of making a decision on the medical treatment in question. Where the medical practitioner complies with the certification requirements set out in section 47 of that Act, he or she then has a general authority to do what is reasonable in the circumstances in relation to medical treatment to safeguard or promote the physical or mental health of the adult.

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- 14 For all patients, neurosurgery for mental disorder (and other treatments specified in **The Mental Health (Medical treatments subject to safeguards) (Section 234) (Scotland) Regulations 2005 (SSI No. 291)**) is safeguarded under the Act and may not be given to any person under the powers of Part 5 of the 2000 Act.
- 15 If a patient is subject to compulsory measures under the Act and is incapable in terms of the 2000 Act but also requires medical treatment for physical problems not related to the mental disorder, then the provisions of Part 5 of the 2000 Act may apply in relation to treatment of those physical problems.

Designated medical practitioners – section 233

- 16 The Act makes provision that certain treatments can only be authorised by an independent doctor, a “designated medical practitioner” (‘DMP’).
- 17 Section 233(4) confers powers on a DMP to:
 - interview the patient in private at any reasonable time;
 - carry out a medical examination of the patient in private, at any reasonable time;
 - require those holding the relevant medical records to produce them; and
 - inspect the records produced.
- 18 These powers will allow the DMP to consider and make a judgement on the benefit to the patient of the treatment proposed. Section 276(4) requires a DMP considering treatments under Part 16 to have regard to a valid advance statement made by the patient, if any, before making his or her decision about the treatment.
- 19 Although the Act allows for the DMP to interview the patient in private, the patient might request that their carer, relative, named person, independent advocate or other supporter attends the interview with them. In such circumstances it would be best practice for the DMP to allow a person requested by the patient to attend in support unless it is impracticable or contrary to the patient’s best interests to do so.
- 20 Where the patient is aged under 18 and medical treatment under Part 16 is being considered, either the RMO in charge of the treatment, or the DMP who approves the treatment, must be a specialist in child psychiatry.

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- 21 The Act requires the Mental Welfare Commission to appoint DMPs to undertake these duties and to ensure that they undergo specific training in their duties if required to do so by the Mental Welfare Commission. The Commission must include among these DMPs some who are specialists in child psychiatry.

- 22 It would be best practice that where the patient has a learning disability, either the RMO or the DMP is a specialist in learning disability treatment and care.

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Provisions and safeguards for particular treatments

Certain surgical operations for mental disorder under section 234

- 23 Where any treatment is being considered under the Act, section 1 (principles for discharging certain functions) and section 276 (advance statements: effect) must be taken into account.
- 24 Any DMP is required to take into account the principles of the Act and in particular the views of the patient and any advance statement made by the patient when considering whether the treatment should be authorised.
- 25 Section 234 specifies the treatments given to any patient, whether or not that patient is subject to compulsory measures under the Act, to which the special safeguards as set out in section 235 and section 236 of the Act apply. It specifies only one type of treatment, namely any surgical operation that “destroys brain tissue or the functioning of brain tissue” (generally known as neurosurgery for mental disorder or NMD). **The Mental Health (Medical treatments subject to safeguards) (Section 234) (Scotland) Regulations 2005 (SSI No. 291)** specify that the medical treatment known as “deep brain stimulation” (DBS) will attract the same authorisation conditions and safeguards as NMD. *(Regulations have also prescribed that statutory Form T1 must be used for certification by either the medical practitioner or DMP, as the case may be, for these treatments.)*
- 26 NMD is a therapeutic procedure offered after extensive assessment to patients with intractable illnesses. Where the patient is capable of consenting, they must consent in writing to the treatment, and two lay persons appointed by the Mental Welfare Commission must certify that the patient is able to consent and has done so. In addition, a DMP must confirm both that the patient is capable of consenting and has done so and that the treatment is in the patient's best interests. The patient can withdraw consent to the treatment at any time. If the patient does so, the remainder of the treatment or any future treatment of the same type would be viewed as a separate treatment which could not be given on the basis of the earlier consent.

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- 27 Where the patient is aged under 18 but capable of consenting, either the RMO in charge of the treatment, or the DMP who approves the treatment, must be a child specialist. Although the Act does not preclude this, it would not be expected that a patient under 20 years of age would be considered for neurosurgery for mental disorder.
- 28 For patients who are incapable of consenting, a DMP must certify that this is the case, that the patient does not object to the treatment and that the treatment is in the patient's best interests. Two lay persons appointed by the Mental Welfare Commission must certify that the patient is incapable of consenting and that the patient does not object to the treatment. In addition, the RMO must apply to the Court of Session, and the Court must make an order authorising the treatment specified. The Court of Session may only authorise the treatment if satisfied that, having regard to the likelihood of the treatment alleviating or preventing deterioration in the patient's condition, it is in the best interests of the patient, and the patient does not object.
- 29 Where the patient is aged under 18 and incapable of consenting, either the RMO in charge of the treatment or the DMP who approves the treatment must be a child specialist. As before, however, it should be noted that NMD is a therapeutic procedure offered after extensive assessment to patients with intractable illnesses, and that although the Act does not preclude this, it would not be expected that a patient under 20 years of age would be considered for NMD.
- 30 No patient who opposes the treatment, either by stating opposition or by resisting treatment, may be given such treatment. If the patient does not meet the conditions at any point, for example if they resist any part of the treatment, then the treatment cannot continue. This means that even where the Court of Session has made an order declaring that the treatment may lawfully be given, the treatment may not be given if the patient subsequently resists or objects.
- 31 The Commission may revoke any of the above certificates by giving notice to the patient's medical practitioner.

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Safeguards for ECT and other treatments regulated under section 237

- 32 Where any treatment is being considered under the Act, section 1 (principles for discharging certain functions) and section 276 (advance statements: effect) apply. (*Regulations have prescribed that statutory Forms T2 and T3 must be used for certification for these treatments.*)
- 33 Any DMP is required to take into account the principles of the Act and in particular the views of the patient and any advance statement made by the patient when considering whether the treatment should be authorised.
- 34 **The Mental Health (Medical treatment subject to safeguards) (Section 237) (Scotland) Regulations 2005 (SSI No. 292)** have prescribed the medical treatments such as VNS and TMS. As with ECT, these treatments may only be given to a patient who is subject to compulsion if:
- the patient can and does consent and that consent is given in writing; or
 - the patient is incapable of consenting and the treatment is authorised by a DMP.
- 35 Section 243(5) of the Act provides that it is not possible to give ECT to a patient who is capable of making a treatment decision and refuses the treatment, even where the treatment would otherwise meet the requirements laid out in section 243.
- 36 Where a patient who is liable to compulsory medical treatment can and does consent in writing to the treatment, then either the patient's RMO or a DMP (for example, where the RMO is unavailable) must certify that this consent has been given and that the treatment is in the patient's best interests, having regard to the likelihood of the treatment alleviating or preventing a deterioration in the patient's condition. The patient can withdraw consent to the treatment at any time. Any further treatment would not be authorised on the basis of the earlier consent.
- 37 Where the patient is aged under 18, liable to compulsory treatment and can and does consent, then either the RMO in charge of the treatment or the DMP who approves the treatment must be a child specialist.

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- 38 Where a patient who is liable to compulsory treatment is incapable of consenting, a DMP must certify that the patient is incapable of making a decision and that the treatment is in the patient's best interests having regard to the likelihood of the treatment alleviating or preventing deterioration in the patient's condition.
- 39 If the patient resists or objects to the treatment, the treatment can only be given if the DMP certifies that the patient is incapable of making a decision, that the patient resists or objects, and that the treatment is necessary under the urgent medical treatment provisions of section 243(3). These provisions are that the purpose of the treatment is:
- saving the patient's life;
 - preventing serious deterioration in the patient's condition;
 - alleviating serious suffering on the part of the patient; and
 - preventing the patient from behaving violently or being a danger to him/herself or to others.
- 40 No further treatment can be authorised under section 243(3) where the conditions of that section are no longer met.
- 41 Where the patient is given any of these treatments on the basis of urgent medical necessity, the RMO must notify the Commission, before the expiry of 7 days, of:
- the type of treatment given; and
 - the purpose for which it was given.
- 42 Where the patient is aged under 18 and resists or objects to the treatment, either the RMO in charge of the treatment or the DMP who approves the treatment must be a child specialist.
- 43 The Commission may revoke any of the above certificates by giving notice to the patient's medical practitioner.

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Safeguards for certain treatments in relation to informal child patients under the age of 16 - regulated under section 244

44 Section 244 provides for regulations to specify safeguards for specific treatments given to informal child patients under the age of 16. **The Mental Health (Safeguards for Certain Informal Patients) (Scotland) Regulations 2005** have prescribed that the following treatments should be regulated:

- ECT
- TMS
- VNS

(There is no form prescribed in regulations for these treatments but a pro forma may be found on the Scottish Executive's website at www.scotland.gov.uk/health/mentalhealthlaw).

45 Bearing in mind that the child is not being treated under the compulsory provisions of the Act, the regulations make clear that it is not possible to give any of these treatments to a child unless consent to treatment has been obtained, that is where:

- the child can and does consent and that consent is given in writing; or
- the child is incapable of consenting, a person with parental responsibilities grants consent in writing.

46 It should be noted that where a child is capable of consenting and does not consent to these types of treatment, then their right to refuse treatment cannot be overridden. Capable children should be treated in the same way as capable adults and be entitled to accept or refuse treatment for mental disorder.

47 Where the child can and does consent in writing to the treatment, then certification must be given by either the medical practitioner primarily responsible for the child's treatment or a DMP under section 233 of the Act. Either the medical practitioner or the DMP must be a child specialist. The practitioner must certify that:

- the patient is capable of consenting to the treatment, and
- the patient consents in writing to the treatment, and
- treatment is in the patient's best interests having regard to the likelihood of the treatment alleviating or preventing deterioration in the patient's condition.

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- 48 Where consent has been given in writing to the treatment, it would be best practice for the doctor who gives the certificate to send a copy of it to the Commission within 7 days.
- 49 A capable child can withdraw consent to the treatment at any time. Any further treatment would not be authorised on the basis of the earlier consent.
- 50 Where the child is incapable of consent, then consent must be obtained from a person with parental rights and responsibilities in relation to the child. If treatment is to proceed on the basis of this consent, then a DMP who is not the medical practitioner primarily responsible for the child's treatment must certify that:
- the patient is incapable of making a decision;
 - a person with parental rights and responsibilities for the child has granted consent; and
 - the treatment is in the patient's best interests having regard to the likelihood of the treatment alleviating or preventing deterioration in the patient's condition.
- 51 It would be best practice for the person who gives the certificate to send a copy of it to the Commission within 7 days.
- 52 Should consent subsequently be withdrawn, then any further treatment would not be authorised.
- 53 If, at any time, the child resists or objects to the treatment, then treatment can only be given under the provisions of section 243(3)(a) to (c), which relate to giving urgent medical treatment. Treatment can only be given if DMP certifies that:
- the patient is incapable of making a decision;
 - a person with parental rights and responsibilities for the child has granted consent; and
 - the patient resists or objects, and that urgent medical treatment is necessary to:
 - save the patient's life, or
 - prevent serious deterioration in the patient's condition, or
 - alleviate serious suffering on the part of the patient.

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- 54 Section 243 only authorises medical treatment if the treatment is not likely to entail unfavourable, and irreversible, physical or psychological consequences and if the treatment does not entail significant physical hazard to the patient.
- 55 Either the medical practitioner primarily responsible for the child's treatment must be a specialist in child psychiatry, or the DMP who certifies the treatment must be a child specialist.
- 56 No further treatment can be authorised under section 243(3) where the conditions of that section are no longer met.
- 57 Treatment cannot be administered by force where the child is not in hospital. However, it would be expected that where a child objects to or resists treatment, the medical practitioner would give further consideration as to whether it would be in the child's best interests to be treated under the formal provisions of the Act.
- 58 Where a child is treated on the basis of urgent medical necessity, it would be best practice for the medical practitioner primarily responsible for treatment to notify the Commission of the type of treatment given and the purpose for which it was given, within 7 days.

Treatments given over a period of time – section 240

- 59 For clarity, the undernoted treatments are not included within the provisions of section 240. These treatments have separate authorisation processes and safeguards as set out in the Act and described in the Code as follows. You should therefore refer to the appropriate parts of the Code and sections of the Act.
- neurosurgery for mental disorder (and other treatments specified by **The Mental Health (Medical treatments subject to safeguards) (Section 234) (Scotland) Regulations 2005 (SSI No. 291)** (paragraphs 23 to 31);
 - ECT (and other treatments specified by **The Mental Health (Medical treatment subject to safeguards) (Section 237) (Scotland) Regulations 2005 (SSI No. 292)** (paragraphs 32 to 43);
 - treatments given to informal child patients (specified by **The Mental Health (Safeguards for Certain Informal Patients) (Scotland) Regulations 2005** (paragraphs 44 to 58).

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- 60 Section 240 of the Act specifies the treatments which require the special safeguards as set out in sections 238 (patients capable of consent and not refusing consent) and section 241 (patients incapable of consent or capable of consent but refusing consent). These apply to any patient liable to compulsory treatment under the Act or the 1995 Act being treated for mental disorder or in consequence of having a mental disorder. *(Regulations have prescribed that statutory Forms T2 and T3 must be used for certification for these treatments.)*
- 61 The safeguards apply immediately for the following treatments:
- any medication (other than the surgical implantation of hormones) given for the purpose of reducing sex drive;
 - provision of nutrition to the patient by artificial means; and
 - such other types of treatment specified in any regulations made under section 240(3)(d).
- 62 Drug treatment for mental disorder attracts these safeguards after 2 months of compulsory treatment have elapsed.
- 63 Treatment may be given where the patient can and does consent in writing (section 238). The patient's RMO or a DMP must certify that having regard to the likelihood of it alleviating, or preventing deterioration in, the patient's condition, it is in the patient's best interests that the treatment should be given. The RMO or DMP must certify in writing that:
- the patient is capable of consenting to the treatment;
 - the patient consents in writing to the treatment; and
 - medical treatment is authorised by virtue of the Act or 1995 Act.
- 64 The Act has been amended by **The Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Enactments) Order 2005** to provide that a person who gives a certificate under section 238 (where the patient consents in writing to the treatment) must send a copy of it to the Commission within 7 days.
- 65 Where the patient is incapable of consenting or does not consent to the treatment, the patient's RMO is required to arrange through the Mental Welfare Commission for a DMP to examine the patient and consider whether the treatment should be authorised under section 241.

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- 66 When authorising any of the above treatments, a DMP must certify in writing that:
- the patient does not consent to the treatment; or
 - the patient is incapable of consenting to the treatment; and in either case
 - the giving of treatment is authorised by the Act or by the 1995 Act; and
 - having regard to the likelihood of its alleviating, or preventing deterioration in, the patient's condition, treatment is in the best interests of the patient.
- 67 The DMP is required to take into account the principles of the Act and the views of the patient and any advance statement made by the patient when considering whether the treatment should be authorised. In particular, the DMP should take into account the views of a capable patient who refuses consent. If that DMP agrees that the treatment should still be given, then the reason for that decision should be stated in the certificate.
- 68 Where the patient is a child under 18 years of age, either the RMO in charge of the treatment must be a child specialist, or the DMP who approves the treatment must be a child specialist approved by the MWC to give an opinion in relation to the treatments.
- 69 The Commission may revoke any of the above certificates by giving notice to the patient's medical practitioner.

Nutrition by artificial means – section 240

- 70 Artificial means of feeding might include feeding through a nasogastric tube, an intravenous drip or directly into the stomach through a gastrostomy. These methods of nutrition by-pass the patient's need to swallow food. They all carry risks and require an immediate second opinion by a DMP where the patient is capable of consent but does not consent to treatment. Passing a nasogastric tube can be particularly dangerous if the patient resists or struggles and force should not be used to insert a tube.
- 71 There is a difference between forcible feeding and these artificial means of feeding someone. Forcible feeding involves using direct force to make an individual swallow food. It may involve methods such as forcibly pushing food into the individual's mouth or forcibly holding his or her mouth open

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to receive food. Forcible feeding carries the risk of inhalation of food or asphyxiation and is not allowed under the Act and should never be used.

Consent – General provisions for treatment for mental disorder – section 242

- 72 Section 242 contains authority to give medical treatment where a patient is liable to be given such treatment compulsorily and the treatment is not specified elsewhere as requiring particular safeguards.
- 73 There is a general requirement under section 242 of the Act that where medical treatment is authorised under the Act or the 1995 Act with respect to a patient who is capable of consenting and does consent to treatment, then that consent must be recorded in writing and signed by the patient. The record of consent should be retained in the patient's medical notes. This provision is, however, subject to the specific requirements of sections 234(1), 237(2), 240(2), 243 and 244, which set out additional safeguards.
- 74 Any person who consents to treatment can withdraw that consent at any time. It would be best practice, where the person subsequently changes his or her mind and refuses a treatment, for a record of that refusal to be signed by the person and recorded in the patient's notes.
- 75 Where a patient who has previously consented to a treatment changes his/her mind and subsequently refuses treatment, further treatment cannot be authorised on the basis of the previous consent. The medical practitioner responsible for the patient's treatment must reconsider the appropriate safeguards for the treatment in question, once that consent has been refused.

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- 76 Where the patient is incapable of consenting, or is capable and does not consent, or consents but not in writing, then medical treatment for mental disorder may be given provided that the RMO determines that it is in the patient's best interest that the treatment be given, having regard to:
- the reason for a patient's non consent where they are capable of consent (if this has been disclosed to the RMO);
 - any views expressed by the patient;
 - any views expressed by the patient's named person;
 - any advance statement made by the patient; and
 - the likelihood of the treatment's alleviating, or preventing a deterioration in, the patient's condition.
- 77 Treatment must be given by, or under the direction of, the patient's RMO who must record the reasons for giving the treatment in writing.
- 78 It should be noted that medical treatment can not be given by force to a patient who is not in hospital.

Medical treatment for mental disorder where a patient is subject to an assessment order – section 242

- 79 Where the patient is subject to an assessment order and the patient is capable of consenting to the treatment but does not consent, consents other than in writing, or is incapable of consenting to the treatment, then another approved medical practitioner, who is not the patient's RMO, must determine that it is in the patient's best interest that the treatment be given.
- 80 To ensure the approval of the second medical practitioner is independent, while still observing timely and effective decision-making and treatment procedures, it would be best practice for the second medical practitioner to be based in a different medical clinical team, separate from the team which usually has responsibility for the patient's care and treatment decisions. To avoid any conflict of interest, best practice would also mean that the second medical practitioner could not be anyone who has a line-management relationship to the RMO.

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Urgent medical treatment – section 243

- 81 Section 243 applies to any patient who is detained in hospital under this Act or the 1995 Act. It describes the circumstances in which urgent medical treatment may be administered to a patient who does not consent, or is incapable of consenting to that treatment. It does not apply to patients who are liable to be treated on a compulsory basis as part of a CTO but who are not detained in hospital. Section 243(2) applies to any form of medical treatment for mental disorder, and authorises the treatment being given without consent or the special procedures set out elsewhere in the Act in specified circumstances.
- 82 It should be noted that section 243(5) explicitly forbids the giving of ECT to the patient under the authority of section 243 if the patient is capable of consenting to the treatment but does not consent.
- 83 Under section 243(3), treatment may be given without consent if it is both urgent and necessary to save life. Provided that the treatment is not likely to have any unfavourable, and irreversible, physical or psychological consequences, it may also be given in the following circumstances:
- to prevent serious deterioration;
 - to alleviate serious suffering by the patient;
 - to prevent the patient from behaving violently; or
 - being a danger to themselves or to others.
- 84 Under section 243(4), in the last two scenarios, treatment must not entail significant physical hazard to the patient. It would be expected that where urgent treatment is given under 243, the usual clinical guidance regarding best practice will also be taken into consideration.
- 85 Where urgent medical treatment is given under the authority of section 243, the patient's RMO must notify the Commission of the type of treatment given to the patient and the purpose for which it was given (i.e. in terms of the purposes outlined in section 243(3)) within 7 days of the treatment being given. This 7 day period begins at midnight of the day on which the treatment was given. *(There is no form prescribed in regulations for this notification however the non-statutory form T5 may be used for this purpose. It can be found on the Scottish Executive's website at www.scotland.gov.uk/health/mentalhealthlaw.)*

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- 86 While there will be situations when the need to administer urgent medical treatment is clear and unequivocal, it is recommended that practitioners exercise caution regarding recourse to the powers under section 243 of the Act. A decision to provide urgent treatment will be based on the best professional judgement available under the necessarily difficult circumstances of the case. However, it is important to recognise that the assessment of the likelihood of “serious deterioration” and “serious suffering” is a subjective process. A patient who is experiencing symptoms and behaviours as a result of mental disorder can be difficult to manage and may become oppositional or verbally aggressive or abusive. It would be expected that such behaviour would not, in itself, be seen as criteria for the giving of urgent medical treatment. On the other hand, it is recognised that verbal aggression may be a clear manifestation of a mental disorder which is causing the patient distress. The decision to administer urgent medical treatment will therefore need to be informed by the presence of a level of risk commensurate with the criteria listed at section 243 of the Act rather than as a means of managing a “difficult” patient. Best practice would dictate that recourse to the use of sedative medication would be restricted to the exceptional circumstances envisaged in section 243(3) and 243(4) and not as a way of subduing a patient who is difficult to manage or is demanding of staff time and attention.
- 87 Where a decision is made to administer urgent medical treatment under the authority of section 243 of this Act and this treatment is to be administered by force, it is important to ensure that such an intervention is undertaken only by staff who are fully trained in appropriate control, restraint and resuscitation techniques. As it is not expected that such intervention would happen often, it would be best practice for hospital managers to ensure that staff trained in these techniques are given regular opportunities to keep their skills current by taking refresher training from time to time. Where treatment has been administered by force, it would be best practice to note this in the report to the Mental Welfare Commission.

chapter 11

social circumstances
reports (section 231)

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Introduction

This chapter examines the preparation of a social circumstances report (“SCR”) under section 231 of the Act. It begins by describing the provisions of section 231 of the Act and the associated regulations which set out when an SCR must be prepared; what it must contain; and who it must be sent to.

The chapter then provides a range of best practice guidance with respect to, for example, the purpose of an SCR; when it would be acceptable not to prepare an SCR; and the difference between an SCR and a proposed

Overview of the statutory provisions

- 01 Section 231(1) of the Act states that wherever a “relevant event” occurs in respect of a patient, the patient’s designated MHO must prepare an SCR within 21 days of the “relevant event” occurring. Within those same timescales, the MHO must send a copy of the report to the patient’s RMO and the Commission. (There is no form prescribed in regulations for this but a pro-forma (SCR1) is available on the Scottish Executive’s website at: www.scotland.gov.uk/health/mentalhealthlaw.)
- 02 Where the MHO considers that providing an SCR would serve ‘little, or no, practical purpose’, the MHO must, in terms of section 231(2) of the Act, record the reasons for this and send a report to the patient’s RMO and to the Commission. (There is no form prescribed in regulations for this but a pro-forma (SCR1) is available on the Scottish Executive’s website at: www.scotland.gov.uk/health/mentalhealthlaw.)
- 03 Section 232 of the Act defines a “relevant event” as:
 - the granting of a short-term detention certificate;
 - the making of an interim compulsory treatment order;
 - the making of a compulsory treatment order;
 - the making of an assessment order;
 - the making of a treatment order;
 - the making of an interim compulsion order;
 - the making of a compulsion order;
 - the making of a hospital direction; or
 - the making of a transfer for treatment direction.

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- 04 Regulations made under section 231(3) of the Act (**The Mental Health (Social Circumstances Reports) (Scotland) Regulations 2005 (SSI No. 310)**) prescribe that the following categories of information must be provided in an SCR:
- the reasons behind the use of compulsory powers;
 - the views of patient with respect to the use of compulsory powers;
 - if the patient is unable to give a view, and only if available to the MHO, the views of the patient's named person, carer, guardian and welfare attorney with respect to the use of compulsory powers;
 - the patient's current state of mental health;
 - the patient's current state of physical health;
 - the patient's mental health history;
 - an assessment of risk of harm to the patient and to others;
 - the patient's personal history including details of employment, finances, and accommodation prior to the use of compulsory powers;
 - details of the family situation, including whether the patient has children, dependants and caring responsibilities;
 - details of the patient's regular social contacts: e.g. supportive friends, involvement with voluntary organisation, church attendance, etc.;
 - the patient's ability to care for him/herself;
 - the care being provided to the patient prior to the use of compulsory powers taking place;
 - any matters which would require the local authority to inquire under section 33 of the Act;
 - any alternatives to the use of compulsory powers which were considered and ruled out;
 - the patient's history of offending, including any consideration of victims and/or those affected;
 - the patient's history of substance misuse, if any;
 - any relevant ethnic, cultural and religious factors;
 - whether the patient has difficulty in communicating; and
 - the care planning which has been put in place to deal with any of the above issues.

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What is the purpose of an SCR?

05 The purpose of an SCR is to:

- provide the RMO with information which may assist in the assessment of the patient (including an assessment of potential risks) and in the planning of future care and treatment either on a formal or an informal basis;
- advise the RMO of the outcome of the MHO's assessment which should identify, at an early point, those aspects of a person's health and welfare as well as any support needs of carers which the MHO feels should be addressed in constructing future care plans;
- inform the Commission of the patient's circumstances prior to their being subject to compulsory powers and whether any alternative courses of action might have been considered or could be considered in the near future, and what these courses of action might have been or are; and
- alert the Commission to concerns with respect to any circumstances which fall within its remit and with respect to which it might wish to make further enquiries when carrying out its functions and duties under the Act.

06 An SCR should reflect the MHO's assessment and the information on which it is based. It should bridge the gap between specialist psychiatric services and local authority assessment and care management services, processes and resources. It should:

- bring together in one document relevant information from diverse sources, both historical and current;
- analyse the interaction between a person's mental disorder and their personal and social circumstances;
- comment on whether the MHO believes that compulsory powers have been used appropriately and on how and whether those powers should continue to be used; and
- propose recommendations for the future care and treatment of the patient.

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Whom should the MHO interview and/or consult in preparing an SCR?

- 07 The patient is the most important person in this process. It is essential that the MHO makes all reasonable efforts to meet with and interview the patient for the purpose of preparing an SCR. Interviews with the patient are fundamental to good professional practice in carrying out the assessment relevant to an SCR. Only in exceptional circumstances would an MHO be able to finalise an SCR without having interviewed the patient at least once. The MHO will need to exercise his/her communication skills and draw upon his/her knowledge and experience to establish a therapeutic relationship with the patient during the process of assessment. This will enable him/her to contribute good quality information to the RMO and the rest of the multi-disciplinary team in order to assist in their own assessment and decision-making about the future care and treatment of the patient. For this reason, it is important that local authorities, in responding to their duties under section 229 of the Act appoint a “designated mental health officer”, try to ensure continuity of care and limit changes of designated MHO to the greatest extent possible.
- 08 There may be occasions where a patient does not wish to or is not able to cooperate with the MHO in this process. When this is the case, it should be stated in the SCR. The MHO should, nevertheless, continue to prepare the SCR using all available information. It would be standard practice to interview involved relatives and/or primary carers, where appropriate, while preparing the SCR.
- 09 The patient might, however, state that he/she does not wish a carer or relative to be interviewed. In such cases, the MHO should weigh up the advantages and disadvantages of over-riding these wishes. This is a judgement call which should be discussed with the patient’s RMO and other members of the multi-disciplinary team. Decisions will be informed by the nature of the relationship between the patient and the carer or relative; the nature of the illness and the impact on the behaviour of the patient; and the perceived potential value of the views of the relative or carer. There may, for instance, be situations where the patient’s behaviour towards the primary carer or relative was a cause of major concern on their part prior to becoming subject to compulsory powers admission, and it may be that it would be difficult to assess and plan future care without their involvement. Where a decision is taken to over-

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ride the patient's wishes, the patient should be informed of this decision, the reasons for the decision; and the fact that the MHO will still be bound to protect the patient's confidentiality.

- 10 Persons who would normally be consulted by the MHO include all key members of the multi-disciplinary team involved with the service user; the patient's GP or other members of the Primary Care Team; any social work colleagues who have otherwise been involved with the patient and/or a close member of their family or their carer (e.g. in Community Care, Criminal Justice or a Children and Families Team), their primary carer; relatives and key staff involved in service provision in the voluntary sector.
- 11 The MHO should always discuss with the patient whether they would find it helpful to have their named person and/or independent advocate (where they have one) involved in any interviews with the MHO in the course of preparing the SCR.

In what circumstances might preparing an SCR serve "little, or no, practical purpose"?

- 12 As described in paragraph 1 above, section 231(1) of the Act states that an SCR must be prepared subsequent to the occurrence of any "relevant event". Administrative and workforce constraints alone do not absolve local authorities from this statutory duty. An MHO is only permitted not to prepare an SCR where he/she can demonstrate that preparing an SCR would serve little or no practical purpose. The effect of such a view is that the MHO does not believe that the processes allied to the preparation of an SCR (for example, interviewing the patient; consulting with relevant others; and pulling together all relevant information, including the MHO's assessment) will assist the RMO in the assessment and care planning of the patient or does not believe that information relating to the patient should be brought to the attention of the Commission.
- 13 There are situations, however, in which it will be evident that preparing an SCR would serve little or no practical purpose. An SCR, for example, may have been prepared following admission to hospital on the authority of a short-term detention certificate and the patient is subsequently detained under a CTO (i.e. a further "relevant event"). Similarly, a patient may be made subject to an assessment order for which an SCR is prepared and subsequently is made subject to a compulsion order.

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These situations will be generally fairly straightforward. Other situations require finer judgements. In some circumstances a patient will be admitted to hospital on the authority of a short-term detention certificate which is then revoked shortly afterwards. This could happen for any number of reasons. For example, the person may become well again quite quickly as in a case where the patient's mental state was considerably worsened by the effects of drugs or alcohol at the time of admission to hospital. In other cases, even though the certificate has been revoked, the person may still remain in hospital on a voluntary basis. In both these situations, it would be best practice for the MHO to discuss the situation with the RMO to determine whether it would be helpful to prepare an SCR. MHOs should also consider that there will be situations where they are not able to engage in constructive discussions with the patient and, sometimes, a carer or involved relative, despite efforts.

- 14 There may be occasions where the MHO's ability to prepare a thorough SCR will be in some way compromised. The MHO should always remember that, as a general rule, there will be value in putting together a report with limited information rather than not preparing an SCR at all. This could happen, for example, where a report had previously been completed, within the previous 3 to 6 months. It would be best practice to build upon the previous SCR and focus on the relevant information/developments in the intervening period and how this affects the assessment and care planning. Such an SCR should therefore focus on the factors which played a part in the breakdown of the previous care plan and how the care and support being given to the patient might be adjusted in future to take account of this. Even in such cases it would be best practice to repeat information from the first report (if necessary, by cutting and pasting) to ensure that all information is pulled together in the latest report so that it can stand on its own as a useful management tool.
- 15 Local authorities should set up systems to monitor the level and quality of its provision of SCRs. Such systems should monitor, on a routine basis, the reasons stated by MHOs as to why providing a report would serve little, or no, practical purpose.

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What is the difference between an SCR, a proposed care plan and a Mental Health Officer's report which both accompany the application for a Compulsory Treatment Order?

- 16 The MHO report for the CTO application should focus on the assessed needs of the individual and whether the MHO believes the criteria for compulsory powers are satisfied. A proposed care plan, while commenting on assessed needs, focuses almost exclusively on future care plans. Together these documents will contain much, but not all, the information included in an SCR. It should be possible to use much of the information from an SCR to help complete an MHO's report and a proposed care plan so that there should not be any wasted effort if the decision is taken to proceed with a CTO application well after an MHO has begun the process of completing an SCR. The main added value of the SCR is that it summarises information on the personal and social circumstances of the individual, as well as the care and treatment history of the patient and places this in the context of the current admission and future care planning.
- 17 The SCR should examine how the patient has managed his/her illness in the past; what has triggered acute episodes in the past; what has/has not worked, and why. The SCR may contain extraneous details which, while important historically in understanding the patient and his/her current situation, are not pertinent to the CTO application and the powers being sought. For example, there may be information on previous relationships, financial information, previous minor offences etc. which are not seen as relevant to the CTO application and in which it might be best to respect the patient's right to privacy and confidentiality. Personal information should only be shared with the Tribunal in applications when such information is relevant to the application. The SCR will also include information primarily for the attention of the Mental Welfare Commission which would not normally be included in these other reports.

What is the difference between an SCR and a report requested by the Sheriff Court in considering imposing a Compulsion Order?

- 18 The basic difference is the purpose for which the reports are being prepared. An SCR, as stated above, is prepared primarily to assist the RMO in assessment and care planning and to give relevant information to the Mental Welfare Commission. A report prepared in response to a

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request from the Sheriff Court when a Compulsion Order is being considered is to assist the court in determining an appropriate disposal: i.e. whether a Compulsion Order would be appropriate or an alternative mental health disposal. Such reports will have to address relevant social circumstances, assess risk and take account of the views of others and to this extent may well contain much of the material that would normally be found in an SCR. They would not, by their nature, contain all the information usually found in an SCR which is written, with a different purpose, for a different audience. Like an application for a CTO, the MHO should not include personal detailed information on the patient which is not relevant to the decision the court has to make.

Can an MHO trainee prepare an SCR?

19 The Act is structured in such a way to ensure that the specialist knowledge and expertise of the MHO is brought to bear in the assessment and care planning of persons subject to compulsory powers under the Act. The SCR should be a reflection of the MHO's assessment as well as a reference document which pulls together valuable, relevant information on the personal and social circumstances of the individual. As stated earlier, it should be founded on the basic professional practice of interviewing the patient and relevant others and consultation with the multi-disciplinary team. These are not activities that can be transferred to someone who does not as yet have the required expertise. MHO trainees do, of course, need to secure experience to be able to demonstrate the competencies necessary to receive the Mental Health Social Work Award and be appointed to act as an MHO. Ideally an MHO trainee should shadow an MHO who is interviewing and consulting others in preparing an SCR. The trainee might even, on their own, undertake further interviews and discussions with others in the multi-disciplinary team and use these as a basis for further discussions with the MHO preparing the SCR. The trainee might even gain useful experience from preparing a draft SCR based on the joint work which was undertaken with the MHO. The completed SCR, however, has to be owned and signed by the MHO. It is they who will remain accountable for both the content of the report and the practice upon which it was based.

chapter 12

correspondence, telephones,
and safety and security

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Introduction

This chapter sets out the procedures which must be followed when considering restrictions on or withholding of patients' correspondence and restricting or preventing use of telephones by patients and implementing any such restrictions or prohibitions. It also sets out the measures which may be taken to ensure the safety and security of hospitals and staff, patients and visitors within them and how those may be imposed.

These procedures apply to all hospitals. Any restrictions or measures must be applied in a way which respects the patient's rights and dignity and is commensurate with any perceived risk to health, safety or welfare of the patient or any other person and, where applicable, to the safety

Patient's correspondence

- 01 In general the mail of detained patients should not be withheld and they should be able to correspond with whoever they wish. However, sections 281 to 283 of the Act make provision for the managers of the hospital in which a "specified person" is detained to withhold that patient's correspondence in particular circumstances.
- 02 The Act recognises that on occasion it may be necessary to withhold mail sent to or from a patient. This may be because a person has requested in writing that the hospital managers withhold mail addressed to them by a particular patient. Alternatively mail may be withheld where the hospital managers take the view that mail sent to or by a "specified person" should be withheld on grounds of potential distress to the addressee or any other person not on the staff of the hospital, or cause danger to any person, or that a postal packet received by that patient might not be in the interests of the health and safety of the patient or might be a danger to any other person.

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- 03 Where the RMO considers restrictions on a particular patient's correspondence are necessary, then they must take the action set out in the Act and associated regulations made under section 281 (**The Mental Health (Definition of Specified Person: Correspondence) (Scotland) Regulations 2005**) and designate the patient a "specified person". Until this step is taken the patient's mail may not be withheld. A patient in a state hospital will be a "specified person" for these purposes, and otherwise, it will be for the RMO to make a clinical judgement in the circumstances of each case. While such a decision is ultimately a clinical decision for the patient's RMO it would be best practice for the RMO to consult with other members of the patient's multi-disciplinary care team and to take any views expressed into account.
- 04 The regulations referred to, provide that all patients in the State Hospital are "specified persons". This is commensurate with the level of risk which patients detained in that hospital are considered to present. For these patients the RMO need take no special action to record the fact that the person is a "specified person" in respect of their correspondence. While a patient in the State Hospital cannot ask for a review of the fact that they are a "specified person" for this purpose all the remaining protections and review procedures in these regulations apply to these patients as to patients in other hospitals who are "specified persons".
- 05 For all patients who are "specified persons" there will be no assumption that their mail may be inspected at all times. Any interception and inspection of such mail by hospital managers has to be commensurate with the risk presented by each such patient at that time.
- 06 The Act makes specific provision on mail from people listed in section 281(5). Mail addressed to such people or coming to a patient from such a person may not be withheld whether or not the patient concerned is a "specified person". The list includes those people who might be concerned with ensuring that the patient's rights are upheld, such as their advocate, legal adviser, MSP, etc. Regulations made under section 283 (**The Mental Health (Specified Persons' Correspondence) (Scotland) Regulations 2005**) have added the 'Scottish Freedom of Information Commissioner' to this list.

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- 07 For any patient who is a “specified person”, with the exception of mail to or from a “listed” person as mentioned above, mail addressed to or sent by or on behalf of that patient may be withheld by the hospital managers, if it is considered that this is necessary in the interests of the health or safety of that patient or for the protection of any other person.
- 08 The Act provides that the managers of the hospital may inspect and open any postal packet to enable them to determine whether it is addressed to any person who has requested that mail should be withheld and whether it should be withheld on grounds of health or safety of the “specified patient” or protection of any other person. Where these grounds are met, the hospital managers may withhold the mail or any item within it.
- 09 To enable the effective application of these procedures, it would be best practice if regular correspondents to “specified persons”, such as advocacy groups or legal representatives, were advised to mark correspondence clearly on the outside of the letter or packet with their name, address and the capacity in which they are corresponding. This would avoid the need for staff to open the mail to obtain this information.
- 10 If any mail or its contents is withheld then the hospital managers must make a record of this. Where mail sent to or from a “specified person” is withheld, the hospital managers must notify the Commission within 7 days. The notice must identify the “specified person” (ie the patient involved), the nature of the mail or the contents withheld and the reason for doing so. If mail is withheld the hospital managers must tell the patient that the mail was withheld, and, where mail addressed to a patient is withheld, the person who sent that mail (where known). The hospital managers must also provide the patient and the person who sent the mail (where known) with information about their rights to apply to the Commission to have the decision to withhold that item reviewed.
- 11 Regulations made under section 282 (**The Mental Health (Specified Persons’ Correspondence) (Scotland) Regulations 2005**) set out that when a patient’s mail is withheld, the hospital managers must take all reasonable steps to ensure that the patient is aware of their right to apply to the Commission for a review of that decision and to ensure the patient has the opportunity to make use of independent advocacy services in connection with any such application.

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- 12 There are no formal procedures by which the patient must apply to the Commission for such a review and a phone call by the patient or on their behalf may suffice. Any such application to the Commission must be made within 6 months of the decision to withhold mail being notified to the patient.
- 13 These regulations also provide that the Commission will give notice to the hospital managers of such an application. The hospital managers must produce the item withheld to the Commission within 14 days of a request to do so, to enable the Commission to inspect it. Where the Commission considers that the decision to withhold the mail was not appropriate, it may direct that the relevant item is released. The hospital managers must comply with any such direction.
- 14 It will be best practice to ensure that any patient who is identified as a “specified person” is made aware from the outset that their correspondence may be withheld, why this might be considered necessary and how to apply to the Commission for a review of any decision to withhold their mail.
- 15 Where a patient is a “specified person”, this does not in itself justify the withholding of all their correspondence. It is only in relation to those items which the RMO reasonably considers (to avoid distress to others, to protect the health of that patient, or the safety of others) should be withheld, that restrictions will be applied. Any decision to specify a patient will last for 6 months. The patient’s RMO must keep under review the decision that the patient is a “specified person”. Where the RMO considers that specification is no longer required it should be removed and the patient, their named person and the Commission informed.
- 16 Where after the 6 month period during which the patient is specified, the RMO considers it is still necessary for that patient to be a “specified person”, that will be recorded with the reasons for this decision. Again the patient, their named person and the Commission should be informed of this decision.

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- 17 References to mail or correspondence in this part of the Code, means any letter, parcel, packet or other article which may be sent through the post (whether by the Post Office or other carrier). The restrictions do not apply to e-mails or other electronic communications sent to or from a “specified person”.
- 18 When hospital managers withhold any item they must retain it for 9 months to allow time for the patient to request a review of their decision by the Commission and for the Commission to carry out this review.

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Patient's telephone calls

- 19 In general the telephone calls of detained patients should not be prohibited or restricted and they should be able to contact or be contacted by whoever they wish. Reasonable access to a telephone should be provided to patients (whether or not detained), subject to any general policy a hospital may have on the use of telephones by patients. Regulations made under section 284 of the Act (**The Mental Health (Use of Telephones) (Scotland) Regulations 2005**) set out the conditions under which a detained patient's telephone calls may be restricted or prohibited.
- 20 These regulations do not cover the use of mobile telephones. A patient's access to a mobile phone may be prohibited or restricted for reasons of safety and security in line with the conditions set out in regulations made under section 290 of the Act (**The Mental Health (Safety and Security) (Scotland) Regulations 2005**). (See paragraphs 33 to 66 of this chapter.)
- 21 All patients in the State Hospital are "specified persons" in relation to the regulations on the use of telephones and may therefore potentially have their telephone calls restricted. In any other hospital before a patient's calls may be restricted, the patient's RMO must record a reasoned argument that the patient is a "specified person" in respect of whom restrictions may be necessary. The patient, their named person and the Commission should also be told that the patient is a "specified person". The patient may ask for a review of the RMO's decision to specify once in each 6 month period. Other than for patients in the State Hospital, the specification lasts for a period of 6 months.
- 22 It would be best practice for the RMO, in consultation with the multi-disciplinary care team, to keep under review the decision that the patient is one whose calls may be restricted. The specification may be removed at any time where the RMO considers that it is no longer necessary.
- 23 The regulations provide that all "specified persons" shall have the right to make telephone calls subject to the conditions set out in the regulations and to their paying for these calls.

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- 24 The RMO may prohibit or restrict any call to or from a “specified person” where he/she is of the view that the call is likely to cause distress to that specified person or any other person not on the staff of the hospital, a significant risk to the health, safety or welfare of the specified person or to the safety of others. The RMO may also prohibit or restrict the use of telephones generally by a “specified person” for up to 3 months, if they have concerns for the above reasons. There may be other measures in place in relation to a particular patient which have to be taken into account, for example, there may be a court order which prohibits or restricts a patient’s ability to make contact with a particular individual. Any call by a patient to that individual would be unlawful if it breached the court order.
- 25 In making any decision on the use of telephones by a “specified person”, the RMO must have due regard to minimising the impact on that patient’s rights, and restrictions imposed must be proportionate in the particular circumstances.
- 26 The regulations provide that any person whose calls are restricted is entitled to ask their RMO for a review of this decision. Where the RMO has prohibited a specific call for a period of 7 days then the patient may ask for one review of that decision in that 7 day period.
- 27 On reviewing any such decision the RMO may remove or vary the restriction in any way they consider appropriate. Again, it would be best practice for the RMO to consult and take account of the views of the patient’s multi-disciplinary care team when reviewing that decision.
- 28 The hospital managers are required by the regulations to keep a record of any decisions to prohibit calls or restrict or prohibit the use of the telephone by any “specified person” with the dates and times of such restrictions. The managers must inform the patient concerned (unless to do so would be prejudicial to the patient’s health) and their named person of any such restrictions.
- 29 The regulations allow the managers of a hospital to intercept or arrange for the interception of any telephone call that has been restricted or prohibited or which would be unlawful. Any call would be unlawful if it breached a court order banning such a call.

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- 30 “Intercept” in the regulations has the same meaning as set out in section 284(7) of the Act. It would therefore include a nurse listening in to a telephone call where considered necessary. Only “specified persons” may have calls intercepted. The calls have to have been restricted or prohibited in advance of the interception. There might have been a restriction to the effect that a patient could only make one call a week to a relative or that a call would only last 10 minutes. The nurse could intervene if a second call was being made or to cut short the duration in accordance with what had already been decided. The nurse could not suddenly decide to intercept a call that was not the subject of a prohibition or restriction.
- 31 Section 284(6) of the Act provides that for any detained patient, phone calls to or from the list of people set out at section 281 may not be restricted. This is the same list of persons in respect of whom correspondence may not be restricted. The regulations referred to at paragraph 19 above add to the list ‘the Scottish Freedom of Information Commissioner’. However, there is an exception to the general exclusion of such calls from the ambit of the restrictions: if an individual on the list has requested that calls to them from a patient should be intercepted or where such a call would be otherwise unlawful, then such calls may be intercepted.
- 32 The regulations do not provide for covert monitoring of telephone calls which are being made to or received through the public telephone network.

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Safety and security in hospitals

- 33 Regulations made under section 286 of the 2003 Act (**The Mental Health (Safety and Security) (Scotland) Regulations 2005**) authorise a number of interventions in relation to patients detained in hospital on the grounds of safety and security, provided that these are carried out in accordance with the conditions laid out.
- 34 As part of their general management procedures all hospitals should have in place policies on safety and security in respect of all patients and their visitors. Such policies require to conform with these regulations.

Definitions of levels of security

- 35 At present mental health legislation provides no distinction between different hospitals providing treatment for mental disorder on the basis of security, other than “conditions of special security” which applies to the State Hospital. This means that the legislation making provision on security is equally applicable to all other hospitals.
- 36 The 2003 Act makes provision for further levels of security to be delineated in relation to appeals against being held in conditions of excessive security. Further consultation will take place on this in relation to the development of forensic services in the coming months with a view to developing regulations prior to the appeal provisions coming into effect in May 2006.
- 37 In the meantime, the regulations referred to in paragraph 33 above provide that all patients in the State Hospital and the Orchard Clinic will be treated as “specified persons” for the purposes of the regulations. In other hospitals, detained patients may be “specified persons” where their RMO decides that that is appropriate.
- 38 The regulations allow for measures to be applied to “specified persons” when considered necessary and appropriate, for example, the taking of samples from patients, restricting of articles which can be kept or brought in to the hospital, searching and surveillance in relation to patients and visitors, in line with conditions provided for in the regulations.

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Specified persons

- 39 The regulations provide that any patient in the State Hospital or the Orchard Clinic is a “specified person”. This reflects the high/medium secure conditions in which patients are detained in these hospitals. For patients detained in these hospitals, the RMO does not need to make and record a decision on whether a patient is a “specified person”. However, each patient must be informed of their status and the effect of it including their right to review and re-assessment. They may also request that the Commission consider any aspect of the application of the regulations.
- 40 For patients detained in other hospitals on an order under the 2003 Act or the Criminal Procedure (Scotland) Act 1995 the regulations provide that a patient may be a “specified person” where the RMO has, in the last 6 months, recorded the reason for their opinion that the person has or would seek to acquire any item which is likely to be prejudicial to the health or safety of any person or the security or good order of the hospital and informed the patient (unless to do so would be prejudicial to their health), their named person and the Commission. The patient and their named person must also be informed of the measures which may be taken and of their right to seek a review of the decision to specify them and a re-assessment of the need for any measures sought to be applied.
- 41 Identifying a person as a “specified person” means that the measures set out in the regulations in relation to safety and security may be carried out in relation to that person, subject to the conditions set out in the regulations. However, it must be stressed that the regulations do not require such searching, etc, to be carried out at specific intervals or indeed at all. Any searching and other permitted measures should be carried out only when considered necessary to ensure the safety and security of patients or of the hospital in general.

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General conditions

- 42 Any measures taken will be subject to the following general conditions:
- the patient's RMO considers that not to do so would pose a significant risk to the health, safety or welfare of any person in the hospital or to the security or good order of the hospital;
 - the RMO must at the request of the patient, or of their visitor where this is appropriate, review the risk and may reverse the decision or apply the measure in some other way;
 - the RMO must record the reasons and the outcome of taking the measure (ie a search) in the patient's records and in the hospital's records; and
 - the RMO must notify the "specified person" (unless to do so would be prejudicial to that person's health or treatment), their named person and the Commission.

Searching patients and their belongings

- 43 The regulations set out the conditions under which a search of a "specified person" and their belongings may be carried out, the types of search which may be carried out and the manner in which any search should be carried out.
- 44 The person's permission must be sought for each search. Where the person does not consent then the RMO on re-assessing the risk may decide that nonetheless the search should proceed. The regulations provide for two types of search: a "rub-down" search and a "removal of clothing search". It would be best practice to ensure that the type of search undertaken is commensurate with the level of risk perceived. All searches must be carried out by a person of the same sex and with due regard to the dignity and privacy of the person being searched. They should be witnessed by a person of the same sex, wherever practicable.

Authority for taking samples

- 45 The Act provides for the regulations to allow the taking of samples from a patient externally by swabbing from the mouth, samples of body tissue, blood or other body fluid or material and the taking hypodermically of samples of blood and the examination of all such samples under conditions as set out in these regulations.

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- 46 The taking of samples, etc, referred to in these regulations is for reasons of safety and security and can only be taken by authorised persons. It is envisaged that such samples may require to be taken, for instance, when the patient is suspected of having taken an illicit substance such as alcohol or drugs, perhaps during an outing to another hospital. The regulations would permit random sampling of “specified persons” where this is considered appropriate.
- 47 The “specified person’s” consent should be sought for the taking of each sample. Where the person does not consent, the RMO may reconsider whether the risk presented is such that the sample should be taken and may do so. Physical force should not be used when taking samples. It would be best practice to ensure that the patient understands the basis on which the sample is required, the consequences of not consenting or co-operating with the taking of the sample and how any continuing risk presented by the patient will be addressed by the hospital managers.
- 48 These regulations do not apply where samples, such as blood samples, are required in relation to a patient’s treatment. Where such samples are required these are subject to the treatment provisions of Part 16 of the Act.

Restrictions on patients’ belongings

- 49 The Act provides for the regulations to place restrictions on the kinds of things which “specified persons” may have with them while detained in hospital and the removal from them of articles kept in breach of such restrictions.
- 50 The condition on the placing of restrictions on having articles in hospital is that restrictions be applied in such a way as to minimise the impact on the patient concerned in so far as possible while considering health, safety or welfare of any person or the good order or security of the hospital. Articles or types of articles may be restricted either generally or in terms of their number, the access to or use of such article or type of article which the particular patient may have.

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- 51 Any articles removed should be retained and returned to the patient at the end of their period of detention in the State Hospital or Orchard Clinic or otherwise ceasing to be a “specified person”, unless the patient agrees to the article’s disposal before that time.

Restrictions on Visitors

- 52 The Act allows the regulations to provide for prohibitions or restrictions to be applied to visitors of “specified persons”. These are in relation to their entry to the hospital and their conduct, as well as on the kinds of things which the visitor might bring with them into the hospital. Visitors to “specified persons” may require to be searched and have their visits restricted or prohibited either as a consequence of such a search or where they refuse to co-operate. Items they carry with them may be searched and they may be refused entry to the hospital unless they agree to particular items being removed from them and returned to them at the end of the visit. (Illicit items such as drugs should be dealt with through the normal police procedures.)
- 53 These regulations provide that searches of visitors are authorised subject to conditions set out in the regulations. Where it is considered necessary that a visitor is searched, only a ‘rub down’ search is authorised. The visitor’s consent for the search must be sought. Where the visitor refuses then they may be refused entry to the hospital. Where the visitor is a child (ie under age 16) who is able to consent then that consent must be sought. Where the child is able to consent but refuses then no search may take place but the child may be refused entry. Where the child is unable to consent (for instance, due to age) then the consent of an adult with the child must be sought for the search. Any search must be carried out with due regard for the visitor’s dignity and privacy and, where the visitor is a child, with due regard for the welfare of the child.
- 54 For the State Hospital and Orchard Clinic all visitors may be searched. However, the regulations do not require such searching. Consent to a search may be a condition of entering the unit, as in the State Hospital, and visitors who do not submit to being searched may be refused entry.

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- 55 Restricting a visitor's access because the patient is ill should be a clinical decision and should be recorded in the patient's notes. The visitor should be told of the reason for the restriction (while observing appropriate medical confidentiality) and the length of the restriction. At the end of the period of restriction (or sooner where appropriate) the care team may extend it, as considered necessary in the circumstances or allow visits.
- 56 In either case, it would be best practice to inform the patient, their named person and known potential visitors of the continuance of the restriction or its end.

Surveillance of visitors

- 57 Some level of surveillance of visitors is likely in any hospital with security camera systems. Normal rules would apply to such surveillance – such as visitors and patients being informed of the surveillance and the reasons for it – and such surveillance is not subject to these regulations.
- 58 In addition, the care and treatment of many patients will include some level of direct observation by nursing staff depending on the circumstances. Such observation is not the subject of these regulations.
- 59 The Act provides that regulations will set out the conditions under which specific surveillance for reasons of safety and security takes place of a "specified person" and, where appropriate, his/her visitors. The type of surveillance envisaged by the Act is, for instance, video surveillance of a patient in their room or specific surveillance of a patient and his/her visitor. The conditions are that the consent of the "specified person" must be sought before any such surveillance takes place. In the absence of consent, the surveillance may only be carried out if, after re-assessment, the RMO considers it necessary in the circumstances. The surveillance of any visitors of a "specified person" shall only take place in visiting areas where conspicuous signs give notice of the surveillance.
- 60 Covert surveillance is not allowed under these regulations. Where a hospital wishes to undertake covert surveillance for any reason this will be carried out under the provisions of the Regulation of Investigatory Powers Act 2000 and authorisation for this should be sought in the normal way.

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Reports to Scottish Ministers

- 61 The regulations require that hospital managers report to the Scottish Ministers when requested to do so on the implementation of these regulations. Such reports should comprise a statement of the hospital policy on safety and security, and how the measures allowed for in the regulations have been used, including details of the effectiveness of the measures, the number of instances where they have been used, the outcome of that use, a record of any complaints and how those were resolved and any plans for review or update of the hospital policy arising out of its implementation or other issues.
- 62 Scottish Ministers' main interest will be to ensure that hospital managers are effectively implementing the regulations. Scottish Ministers would not expect to receive any patient-identifiable information in any such reports.

Mental Welfare Commission

- 63 The Commission's main interest in monitoring the implementation of these regulations will be to ensure the protection of patients' interests and rights while recognising that hospital managers must maintain safety and security.
- 64 The regulations provide that the records kept by hospital managers on the implementation of the regulations will provide to the Commission either by making those available to the Commission on inspection or by sending copies on request.
- 65 Regulations provide that the Commission may issue a direction that can require a hospital not to undertake searches or other security measures in relation to a particular "specified person" for up to 6 months, where they have identified and expressed concern about the use of such measure(s) in relation to that particular patient, except where the Commission gives its permission or supervises the search or application of the measure.
- 66 Regulations also provide that the Commission can issue a direction to hospital managers to inform the named person that the regulations are to be applied in respect of a particular "specified person" in a specified way.

chapter 13

appeals

chapter thirteen

Introduction

This chapter provides an overview of the provisions relating to appeals against decisions of the Mental Health Tribunal for Scotland to the sheriff principal or the Court of Session under sections 320(2) and 322(2) of the Act; and appeals to the Court of Session against decisions of sheriff principal under section 321(2) of the Act.

In particular it discusses:

- the appropriate sheriff principal to whom an appeal is to be made;
- the time limits for bringing an appeal;
- the grounds on which an appeal may be brought.

The chapter concludes with a summary of the powers that the court may

Appeal against a decision of the Mental Health Tribunal for Scotland and sheriff principal

Part 22 – Appeals

An appeal made under section 320(2)

- 01 The majority of appeals against decisions of the Tribunal are made to the sheriff principal under section 320(2). The decisions of the Tribunal to which section 320 applies are set out in section 320(1). Complex cases, where an appeal is made under section 320(2), may be remitted by the sheriff principal on his own initiative, or on the motion of any party to the appeal, to the Court of Session.
- 02 Section 320(3) makes provision about which sheriff principal an appeal under section 320(2) is to be made. Section 320(3) states-
- The appeal should be made to the sheriff principal of the sheriffdom in which the patient resides at the time the appeal is lodged;
 - Where the patient is detained in hospital at the time the appeal is lodged the appeal should be made to the sheriff principal of the sheriffdom in which the hospital is situated; and
 - In any other case the appeal may be made to the sheriff principal of any sheriffdom.

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- 03 Section 320(5) to (9) makes provision about the persons who have a right of appeal in particular cases.
- 04 The Act of Sederunt (Summary Applications, Statutory Applications and Appeals etc. Rules) 1999 (Statutory Instrument 1999 No. 929 (S.65)) lays out the form of application to the sheriff principal under section 320(2).
- 05 In terms of paragraph 2.6 of those Rules an appeal to the sheriff principal under section 320(2) must be lodged with the sheriff clerk within 21 days of the party being informed by the Tribunal of its decision.

An appeal made under section 321(1)

- 06 Section 321(1) provides a right of appeal against the decision of the sheriff principal on an appeal under section 320(2), to the Court of Session.
- 07 The Rules of the Court of Session lay out the form of application to the Court of Session under section 321(1).
- 08 Paragraph 40.4 of the Rules of the Court of Session provides that an appeal to the Court of Session against the decision of the sheriff principal must be made within 21 days after:-
 - the date on which the decision being appealed was given to the party;
 - where the sheriff principal issued written reasons for his decision later than the date on which the decision being appealed was given, the date on which the written reasons were issued to the party; or
 - where leave to appeal was granted by the sheriff principal or application for leave to appeal was made to the sheriff principal, the date on which leave was granted by the sheriff principal to the party.

An appeal made under section 322(2)

- 09 The decisions made by the Tribunal in relation to orders or directions made in the context of criminal proceedings listed in section 322(1) must be appealed directly to the Court of Session under section 322(2). Section 322(3) and (4) makes provision about the persons who have a right of appeal in particular cases.
- 10 The Rules of the Court of Session lay out the form of application to the Court of Session under section 322(2).

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- 11 The Mental Health (Care and Treatment) (Scotland) Act 2003 (Period for Appeal) Regulations 2005** provides that an appeal to the Court of Session against a decision of the Tribunal under section 322(2) must be made within 21 days after the date on which the party was informed of the decision appealed against; or if the party has requested a copy of the document mentioned in paragraph 13(3) of Schedule 2 to the Act within 7 days of being informed of that decision, the date on which the party received that document.

Grounds of appeal under section 320(2) or 322(2)

- 12** An appeal from the Tribunal to the sheriff principal or the Court of Session under section 320(2) or 322(2) can only be made on one or more of the following grounds:-
- that the Tribunal's decision was based on an error of law;
 - that there has been a procedural impropriety in the conduct of any hearing by the Tribunal on the application;
 - that the Tribunal has acted unreasonably in the exercise of its discretion;
 - that the Tribunal's decision was not supported by the facts found to be established by the Tribunal.

Appeal allowed under section 320(2), 321(1) or 322(2)

- 13** If an appeal is successful, the court upholding the appeal must set aside the decision of the Tribunal and will then either substitute its own decision for that of the Tribunal (where it is possible on the established facts to do so) or remit the case back to the Tribunal to consider afresh. Where a case is remitted to the Tribunal, the court can make directions that the Tribunal must be differently constituted from the original Tribunal that made the decision. The court can also issue directions about the consideration of the case as it considers appropriate.

chapter 14
cross-border transfer
of patients –
sections 289 and 290

chapter fourteen

Introduction

This chapter examines provisions in the Act which deal with the transfer of patients subject to a detention requirement or otherwise in hospital for mental disorder from Scotland, and the reception in Scotland, of patients subject to corresponding measures in England and Wales, Northern Ireland, the Isle of Man or the Channel Islands.

The Mental Health (Cross-border transfer: patients subject to detention or otherwise in hospital) (Scotland) Regulations 2005 specify the duties and roles of persons and agencies involved in the application process and

Overview

- 01 Regulations made under section 290 of the Act (**The Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005**) make provision for the following:
- the transfer from Scotland of a patient who is subject to any provision of this Act which authorises that patient's detention in hospital, or to the following provisions of the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act"): a compulsion order which authorises the patient's detention in hospital (with or without a restriction order) or a hospital direction;
 - the transfer from Scotland to a place outwith the United Kingdom of an informal patient who is in hospital for the purpose of receiving medical treatment for mental disorder. That is a person not subject to this Act or the 1995 Act. Note that subsection (1)(b) of section 290 does not provide for the transfer of an informal patient from Scotland to another part of the United Kingdom;
 - the reception in Scotland of a person subject to corresponding measures in England, Wales, Northern Ireland, the Isle of Man or any of the Channel Islands and removed from there.

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Removal of patients from Scotland

Duties of the RMO

- 02 Where an application is to be made to Scottish Ministers for the removal of the patient from Scotland, the duties of the RMO are set out in the regulations.
- 03 Where the RMO considers that it may be appropriate to make such an application he/she must, as soon as practicable, consult the designated MHO and such other persons as the RMO considers appropriate. In the case of an informal patient who is to transfer outwith the United Kingdom, the RMO must also inform the relevant local authority to allow an MHO to be designated responsibility for the patient's case.
- 04 If, taking into consideration the views of the parties mentioned in paragraph 3 above, the RMO considers that an application is appropriate he/she must give notice as soon as practicable to:
- the patient;
 - the patient's named person;
 - the patient's primary carer where the patient is in hospital being treated for mental disorder other than by virtue of the 1995 Act or the Act (i.e. an informal patient);
 - any guardian of the patient;
 - any welfare attorney of the patient; and
 - the MHO.
- 05 The RMO must allow these parties a period of 7 days to revert to him/her with their views.

Duty on the patient

- 06 Where the patient has a particular wish or preference that he/she would like the Scottish Ministers to take into consideration, the patient must inform the Scottish Ministers within 7 days of the day on which the notification was received (either directly or via their RMO).

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Responsibilities of the MHO

- 07 As soon as practicable after being notified, and in any event no later than 7 days after being notified, the MHO must comply with a number of requirements set out in the regulations, involving interviewing the patient and informing them of their rights in relation to the application. The MHO must inform the patient of the advocacy services provided by the Act, ensuring that the patient has the opportunity to use these services. The MHO must also inform the patient's RMO if he/she agrees or disagrees that the application should be made. If the MHO disagrees, a reason must be given along with any other relevant matters.

The Application

- 08 If, taking into consideration the views expressed by the MHO and those of the parties detailed in paragraph 4 above, the RMO is satisfied that an application should be made to the Scottish Ministers for a warrant for the removal of the patient he/she may make such an application. The specific information which must be included in the application is detailed in the regulations.

The role of Scottish Ministers

- 09 Scottish Ministers, when deciding whether to authorise an application, must consider a number of factors including the best interests of the patient, any wish or preference that the patient has notified to Scottish Ministers, the patient's security after being removed from Scotland and the treatment, care or services which will be available for the patient once transferred. Where Scottish Ministers decide that a patient should be removed from Scotland, they shall issue a warrant which authorises that removal. Regulations prescribe that no warrant shall be issued until consent has been obtained from the country or territory to which it is proposed that the patient be removed. Notice of the decision of the Scottish Ministers must be given to the patient, their named person, the RMO, the MHO, the Commission and the country or territory to which the patient is moving.

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- 10 The regulations specify an effective date for the patient's removal and a warrant issued under the regulations will only authorise removal of the patient within 14 days from the effective date. If the removal is authorised to a place in the UK, the effective date will be no sooner than 7 days before the date proposed for the patient's removal. In the case where removal is to a place outwith the UK, the effective date will be no sooner than 28 days before the date proposed for the patient's removal. However, where the patient consents to the move or it is considered of urgent clinical necessity to move the patient Scottish Ministers can waive the number of days specified. In such cases the effective date is a date no sooner than 3 days before the date of the patient's removal. The Commission must also be notified at least 3 working days before the proposed date of the patient's removal.

Right of appeal

- 11 A patient may appeal to the Tribunal against his/her proposed transfer at any time between being notified by the Scottish Ministers and the transfer taking place. The Tribunal may make or refuse to make an order that the proposed transfer go ahead. Thereafter an appeal against the decision made by the Tribunal may be made to the sheriff principal and thence to the Court of Session except where the patient is subject to a compulsion order and a restriction order or a hospital direction or a transfer for treatment direction. In these cases the appeal would be made direct to the Court of Session. Pending determination of an appeal, any warrant issued shall be suspended and removal shall not take place. There is no right of appeal once a removal has taken place.

Powers of escorts from other territories

- 12 The regulations also make provision for the powers of escorts from a country or territory to which the patient is being removed from Scotland who are:
- authorised to escort patients in that country or territory under the law of that country; and
 - authorised to escort the patient from Scotland under directions set out by the Scottish Ministers in the warrant;
- and the procedures to be followed should a patient abscond or attempt to abscond during the removal.

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Absconding patients

- 13 A patient who is subject to civil detention procedures and who absconds while being removed from Scotland under these regulations is liable to be taken into custody and dealt with in accordance with sections 301 to 303 of the Act subject to certain modifications. A patient who is subject to a compulsion order (with or without a restriction order), a hospital direction or a transfer for treatment direction (“the relevant 1995 Act provisions”) under these regulations is liable to be taken into custody in accordance with regulations made under section 310 (**The Mental Health (Absconding by mentally disordered offenders) (Scotland) Regulations 2005**). In general terms both sets of provisions provide that once the patient is taken into custody he/she may be:
- returned to the hospital where he/she was originally detained;
 - taken to the hospital in which he/she was to be detained; or
 - taken to any other place considered appropriate by the patient’s responsible medical officer.

Cessation of measures

- 14 Where a patient whose detention in hospital is authorised by the 2003 Act or the relevant 1995 Act provisions, is removed from Scotland under these regulations, the measures which authorised the patient’s detention in hospital in Scotland shall cease to have effect when the patient becomes subject to relevant measures in the country or territory to which the patient is removed.

Treatment of prison sentence with respect to certain patients

- 15 Where a patient whose detention in hospital is authorised by a hospital direction or a transfer for treatment direction is removed from Scotland under these regulations, his/her sentence is treated in the relevant territory as if it had been imposed in that territory.

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Transfer of patients from other jurisdictions into Scotland

- 16 The regulations made under section 290 of the Act (**The Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005**) also make provision where it is proposed to receive a patient into Scotland. These transfers require the consent of Scottish Ministers who will consider requests made by the person or authority exercising corresponding functions in a relevant territory. The information required by Scottish Ministers to be included in a request is:
- the patient's name and address;
 - the name and address of the patient's nearest relative or primary carer (if there is one);
 - the type of mental disorder the patient has;
 - details of the relevant measures to which the patient is currently subject; and
 - the name and address of the hospital in the relevant territory in which the patient is presently detained or is liable to be detained.
- 17 Where consent to the reception in Scotland is given, Scottish Ministers can consider any directions as to the patient's conveyance to their destination in Scotland which have been made by the sending person or authority and may give further directions as they think are required.
- 18 The regulations set out the process which will be put in place once the Scottish Ministers have consented to the reception of a patient into Scotland and the managers of the sending hospital have notified the managers of the receiving hospital that the transfer is to go ahead.

Appointment of an RMO

- 19 As soon as is reasonably practicable after being notified by the managers of the sending hospital that the transfer is to go ahead, the managers of the receiving hospital must appoint an RMO.

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Designation of an MHO

20 As soon as reasonably practicable after being notified by the managers of the sending hospital that the transfer is to go ahead, the managers of the receiving hospital must notify the relevant local authority of certain details relating to the patient. The local authority must designate an MHO responsible for the patient.

Powers of escorts

21 From the time when the patient enters Scotland until reaching his/her destination, the escorts have the following powers:

- where the patient is being escorted to their destination in Scotland by escorts authorised in the relevant territory under the law of that territory, the same powers in respect of the patient as they had in the relevant territory;
- where the patient is being escorted to their destination in Scotland by escorts authorised under or by virtue of the 2003 Act, the same powers to escort the patient as they would have if the patient was subject to the measure under the 2003 Act or the 1995 Act;
- where the patient absconds from the custody of escorts mentioned in that subparagraph, to immediately pursue and resume the custody of the person; and
- to restrain the patient if the patient has absconded, or attempted to abscond while being so escorted.

Absconding

22 The regulations provide that a patient who absconds within Scotland while being escorted to their destination in Scotland, will be taken into custody by an MHO, a constable, a member of staff of any hospital or any other person authorised to do so by the patient's RMO.

23 The regulations provide authority for detention and the giving of treatment in accordance with Part 16 of the 2003 Act, where patients are treated as if subject to a compulsory treatment order, an interim compulsory treatment order or a compulsion order.

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Reception into Scotland: general

24 On reception into Scotland, the patient is treated as if they are subject to measures under the 2003 or 1995 Acts which most closely corresponds or is most similar to those which the patient was subject immediately before the transfer. This includes where the patient had immediately prior to the transfer been subject to conditional discharge in the relevant territory. Where the patient is treated on reception into Scotland as if he/she is subject to a hospital direction or a transfer for treatment direction, his/her sentence is treated as if it had been imposed by a court in Scotland.

Duties of the MHO

25 The regulations specify that the MHO shall, as soon as practicable after being designated as the MHO having responsibility for the patient's case, in accordance with section 229 of the 2003 Act as applied by regulation 28, comply with the following requirements:

- to take such steps as are reasonably practicable to establish whether the patient has a named person;
- to notify the patient's RMO of the name and address of any named person;
- to comply with the requirements of section 231 of the 2003 Act subject to the modification that, in subsection (1) for the words "where a relevant event occurs in respect of a patient" substitute "patient is received in Scotland under **The Mental Health (Cross-border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005**";
- to inform the patient of the availability of independent advocacy services under section 259 of the 2003 Act; and
- to take appropriate steps to ensure that the patient has the opportunity of making use of those services.

Duties of the RMO

26 The regulations also specify the duties of the RMO. In particular, the RMO must carry out an assessment of the patient within 7 days of the reception of that patient in Scotland. A medical examination must be carried out in accordance with the regulations and the RMO must consider whether the measure which the patient is treated as if they have become subject to is appropriate.

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- 27 Following this assessment, the RMO has specific duties with respect to:
- The revocation of an emergency or short-term detention certificate;
 - The revocation of an interim compulsory treatment order, a compulsory treatment order or a compulsion order;
 - Reporting on and making recommendations to the Scottish Ministers following the assessment of patient;
 - Notification requirements post assessment;
 - Requirements post transfer; and
 - Care plans.

Care Plans

- 28 The regulations apply the relevant provisions of the 2003 Act to patients received in Scotland so that:
- care plans are prepared for those who are being treated as if subject to a compulsory treatment order or a compulsion order;
 - information is provided to such patients at specified times; and
 - assistance is given to patients with communication difficulties.
- 29 Within 6 months of the date on which the patient was received in Scotland, the Commission must ensure that an authorised person in terms of section 14 of the 2003 Act visits him/her.

What practical considerations should be taken into account when transferring the patient?

- 30 The transfer should be carefully planned well in advance. The range of issues which should be considered by members of the patient's multi-disciplinary team and by the managers of the sending and receiving hospitals include:
- ensuring that the patient, and his/her relatives, carers, named person, independent advocate and representatives have been informed of an agreed departure time in advance of the transfer, and ensuring that the patient is fully supported in preparing for the journey;
 - providing an appropriate, swift and comfortable means of transport which is also suitable for the provision of medication, where necessary;
 - anticipating any difficulties in relation to the required level of security and possible absconding en route (in as far as this is possible) bearing in mind the importance of caring for the patient in the manner which involves the minimum restriction on the patient's freedom that is necessary in the circumstances;.

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- ensuring that there is a clearly identified RMO in the receiving hospital;
- ensuring that the receiving hospital has been informed of any relevant dates with respect to the Act's provisions, for example for consenting to medical treatment, or renewing a CTO;
- ensuring that staff in the receiving hospital are properly prepared for the patient's arrival and that time is taken to ensure that the patient can settle quickly into the new environment;
- ensuring that, in the case of a patient aged under 18, services are available in the receiving hospital which are appropriate to the needs of that patient.

Can a patient on a community based order be transferred from Scotland?

31 Section 289 makes provision for regulations to set out the conditions and procedures for the transfer from Scotland to a place outwith Scotland of a patient who is subject to a compulsory treatment order ("CTO") or a compulsion order ("CO") which does not specify that patient's detention in hospital. It is very unlikely that a community based patient subject to a CTO or a CO would request a transfer to a jurisdiction outwith Scotland given that there will be no directly equivalent provision in other parts of the British Isles for community based patients. Regulations detailing the process of transfer for a community based patient will be made when equivalent provisions come into effect in the rest of the UK. Until then where a patient who is subject to a community based CTO or CO requests a transfer to other parts of the UK, the RMO should consider whether the patient may be discharged prior to an informal transfer or should become a hospital based patient and transferred under the provisions of section 290 of the Act.

chapter 15

duty to inquire;
other detention or removal
powers; the provision
of places of safety; and
nurse's power to detain
(sections 33-35; part 19)

chapter fifteen

Introduction

This chapter examines a range of powers and duties which the Act confers on, for example, local authorities, nurses and the police. It then looks at the provision of places of safety under Part 19 of the Act. The topics discussed in this Chapter are:

- a local authority's duty under section 33 to inquire into the situation of mentally disordered persons over the age of 16 who may be vulnerable to neglect or ill-treatment.
- the power of the sheriff under section 292 to grant a warrant to an authorised person authorising that person to enter premises.
- the power of the sheriff to grant a removal order under section 293 authorising the removal of a mentally disordered person to a place of safety and their detention there for a period of up to 7 days.
- the power exercisable by the police under section 297 to remove a mentally disordered person from a public place to a place of safety.
- a nurse's power under section 299 to detain an informal patient pending a medical examination.
- the definition and designation of a place of safety under section 300.

This chapter begins with an overview of the various powers being discussed followed by an exploration in detail of each of the powers in turn. This chapter concludes with the definition of a "place of safety" and the process by which such places of safety should be designated.

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Powers

		Statutory Form
Section 33	Duty on a local authority to inquire	
Section 35	Warrant for entry to premises	MHO1
Section 35	Warrant for access to medical records	MHO2
Section 35	Warrant for medical examination	MHO3
Section 292	Warrant for an authorised person, for the purposes for which they are authorised, to enter premises to take/retake a patient – sheriff/justice of the peace	MH04
Section 293/4	Order for patient's removal to a place of safety and detention for up to 7 days – sheriff/justice of the peace	MHO5/6
Section 295	Recall of variation of removal order	MHO7
Section 297/8	Police – removal from a public place to a place of safety	
Section 299	Nurse's power to detain	
Note: <u>All Warrants under Section 35 must be applied for separately</u>		

Overview of the powers available

- 01 Section 33 of the Act places a duty on a local authority to inquire into the situation of a person who appears to have a mental disorder who is living in the community. This duty to inquire is triggered, for example, where that person is suspected of being at risk of neglect or ill-treatment, where the patient is living alone or without care and where their property may be at risk of suffering loss or damage because of their mental disorder.
- 02 If it is thought that entry to premises, access to medical records, or a medical examination is necessary but access has been or is likely to be denied, the MHO should seek a warrant under section 35 of the Act. However, a warrant granted under section 35 does not authorise the removal of the person at risk to a place of safety. To remove a person at risk to a place of safety, an order under section 293 (or section 294, if urgently required) should be sought in addition to any warrant sought under section 35.

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- 03 An order issued under sections 293 or 294 of the Act only authorises entry to the patient's premises and the patient's removal to a place of safety. It does not permit access to a patient's medical records nor does it permit detention for the purpose of carrying out a medical examination.
- 04 When deciding which warrant or order to seek, the key considerations will be how much is known about the person's circumstances and the perceived level of risk. If the level of risk is thought to be high, and if it is thought that the person may need to be removed to a place of safety, then a section 293 or section 294 order should be sought.
- 05 The purpose of a warrant to enter premises issued under section 292 of the Act is to allow a person to enter premises where that person has *already* been given authority under another section of the Act or associated regulations to take (or retake) a patient to any place or into custody. An example of a situation in which such warrant may be sought is where a patient subject to a CO has absconded and a person authorised to take the patient into custody or return them to hospital requires entry to the premises where the patient has been found. Another example is where a CTO has been made in respect of a patient and that patient must be conveyed to a hospital or another residence but access cannot be gained to the premises where the patient is currently residing or has been found.
- 06 Under sections 297 and 298 of the Act, the police may take a person to a place of safety if that person is in a public place and appears to be mentally disordered and in immediate need of care or treatment and where they consider that it would be in the interests of the person or necessary for the protection of any other person to remove the person to a place of safety. The person may be detained there for a period of up to 24 hours. The purpose of this detention is to allow a medical practitioner to examine the person and to make arrangements for their care and treatment. Arrangements should be in place to ensure that police officers can rapidly ascertain the location of the places of safety.

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07 Under section 317, sanctions apply to any failure to comply with the Act.

A person commits an offence where he/she:

- refuses to allow a person authorised access to any premises;
- refuses to allow access to a mentally disordered person by a person authorised to have such access;
- refuses to allow the interview or examination of a mentally disordered person by a person authorised to interview or examine such person;
- persists in being present when requested to withdraw by a person authorised to interview or examine, in private, a mentally disordered person;
- refuses to produce any document or record to a person authorised to require the production of such document or record; or
- otherwise obstructs a person in the exercise of any functions conferred on them by virtue of this Act

The patient themselves will not have committed an offence should they do any of the above.

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A local authority's "duty to inquire" under section 33 of the Act

- 08 A local authority's duty to inquire arises in relation to any person aged 16 or over who has a mental disorder but is not subject to other detention provisions under the Act (in other words, where the person is not in hospital.) It is important to remember that the duty to inquire arises where it appears that the person or their property may be subject to ill-treatment, neglect or some other deficiency in care or treatment. The duty to inquire is therefore not restricted to situations in which it has already been shown that this has taken place. The local authority must inquire into a person's case where any of the following circumstances applies:
- where it appears to the local authority that the person may currently be, or may have been, subject to or exposed to ill-treatment, neglect or some other form of deficiency in care or treatment at a place other than a hospital;
 - where it appears to the local authority that the person's property may be suffering, or may have suffered loss or damage, or may be or have been at risk of suffering loss or damage because of their mental disorder;
 - where that patient may be living alone or without care, and may be unable to look after him/herself, or his/her property or financial affairs;
 - where the person is not in hospital and because of their mental disorder the safety of some other person may be at risk.
- 09 Local authorities have a function under section 10 of the Adults with Incapacity (Scotland) Act 2000 to investigate any circumstances made known to them where the personal welfare of an adult, within the terms of that Act, seems to be at risk. In order to comply with the statutory duty to inquire under section 33 of the Act, it would be good practice for local authorities to develop local investigation protocols. Such protocols should be consistent with the policies which should already be in place with respect to the protection of vulnerable adults, and, in particular, to their functions under the Adults with Incapacity (Scotland) Act 2000.

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Co-operation of other parties where the duty to inquire arises

- 10 The Act requires a range of parties and institutions to co-operate with the relevant local authority to ensure that that local authority is able to comply with its duty to inquire. The local authority may ask for such co-operation where it is necessary for the purposes of their inquiries or where it would assist with the inquiries. The parties required to co-operate with the local authority in terms of section 34 of the Act are:-
- the Commission;
 - the Public Guardian;
 - the Scottish Commission for the Regulation of Care; and
 - a Health Board.
- 11 These parties must co-operate with a request where it is compatible with their functions and where the request does not unduly prejudice the discharge of those functions. It would be expected that locally developed protocols on inquiry procedures would be drawn up in consultation and agreement with these parties. It would also be best practice to ensure that the police and other relevant services are involved in drawing up local protocols.

The next steps resulting from the duty to inquire

- 12 The local authority may decide that nothing further needs to be done within the parameters of this Act. It would be expected that this conclusion would only be arrived at after a range of functions have been carried out. These could include:
- the individual has been spoken to alone;
 - the individual's accommodation has been visited;
 - the views of all relevant professionals have been sought and considered; and
 - there is evidence that the individual's welfare will be safeguarded and promoted in future.
- 13 Where it has been decided that no further action under this Act is required, it would be expected that the MHO would produce a report on the circumstances which gave rise to the initial inquiries; the actions taken; and why they believed that no further action was required. The report should then be added to the person's case file. If there is no extant case file, the local authority should keep a record of the referral in line with their standard means of recording referrals.

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- 14 The next steps resulting from the duty to inquire could alternatively involve a wide range of voluntary or compulsory interventions. For example, care and support under the Social Work (Scotland) Act 1968 may be provided on an informal basis. Intervention under the Adults with Incapacity (Scotland) Act 2000 might also need to be considered. If intervention under the 2003 Act is required, consideration of an emergency or short-term detention certificate or even an application for a CTO may be appropriate.
- 15 In pursuance of the duty to inquire, the MHO may meet resistance from the person who is the subject of their enquiries or from others. For example, where investigations of allegations or suspicions of abuse or neglect are impeded by the threat of violence, care should be taken by the relevant local authority to ensure that staff are protected and supported when carrying out their duties. This could involve ensuring that visits are carried out in pairs or liaising closely with the police, where appropriate.
- 16 The MHO should always first consider how entry to the person's premises may be achieved without recourse to further legal measures. Where the MHO cannot gain entry or is confident that entry to the premises is not or will not be possible, he/she may need to seek a warrant under section 35 from a sheriff or a justice of the peace. An MHO may also seek a warrant for the purpose of detaining a person in order to carry out a medical examination; or to allow a medical practitioner to have access to a person's medical records. A warrant can be sought under section 35 to authorise any of these three courses of action (i.e. entry to premises; detention for the purpose of carrying out a medical examination; allowing access to medical records). However, a warrant which authorises, for example, entry to premises does not authorise access to the person's medical records. Each warrant must be applied for separately.

Making an application for a 'section 35 warrant'

- 17 The application must be made by an MHO. If a warrant is being sought to enter premises and open lock-fast places, the MHO making the warrant application must have been appointed by the local authority for the area in which the premises are located. An application for such a warrant must be made to a sheriff or justice of the peace of the sheriffdom or commission area in which the relevant premises is located.

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If a warrant is being sought for the purpose of detaining someone for the purpose of a medical examination or for allowing access to medical records, then the MHO making the warrant application must be appointed by the local authority making the inquiry. Similarly, an application for such a warrant must be made to a sheriff or justice of the peace for the sheriffdom or commission area where the person who is the subject of the duty to inquire is currently to be found. The MHO must provide evidence to the sheriff or justice of the peace and this evidence must be provided on oath. Local authorities will need to have in place protocols which address any cross-boundary issues which arise out of the application process.

- 18 The following statutory forms must be used for an application to the sheriff. (*The statutory forms are available on the Mental Health Law website at: www.scotland.gov.uk/health/mentalhealthlaw*)
 - application for warrant to enter premises: Form MHO1
 - application for warrant to detain person for the purposes of a medical examination: Form MHO2
 - application for warrant to access to a person's medical records: Form MHO3.
- 19 Note that an appeal cannot be made against the decision of the sheriff or justice of the peace to grant or refuse to grant a warrant.
- 20 Best practice would be for the MHO to inform the Commission of whether the application was refused or granted as soon practicable after the sheriff's determination has been made.
- 21 There are 3 separate warrants which can be issued under section 35. These are discussed in the following paragraphs.

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Warrant to enter premises

- 22 A warrant issued under subsection (1) of section 35 relates to an application to enter premises. (*Form MHO1 has been prescribed by regulations for this purpose.*) The sheriff or justice of the peace must grant a warrant where he/she is satisfied that the MHO's application meets the following conditions:
- it is necessary to enter the premises for the purposes of pursuing the local authority's duty to inquire; and
 - the MHO cannot obtain entry to the premises or reasonably believes that he/she will not be able to access the premises.
- 23 Where these conditions are met, the warrant authorises certain parties to enter the premises specified in the warrant within 8 days of the warrant being granted. (Note that the 8 day period begins with the day on which the warrant is granted.) The parties authorised to enter the premises are:
- the MHO specified in the warrant (this could be a different MHO from the MHO who made the warrant application);
 - any other person specified in the warrant (for example, a GP or CPN); or
 - any police constable of the force covering the area in which the premises are situated.
- 24 Note that the warrant also authorises the police constable to open lock-fast places on the premises specified in the warrant. It would be expected that the MHO who made the application for the warrant would take all reasonable steps to ensure the security of the person's premises and belongings if force has been required to enter the premises.
- 25 Wherever possible, entry to premises should first be attempted without force. It is important that a multi-disciplinary plan be prepared in advance on how to carry out the entry and removal of the patient. In order to minimise distress and risk to the patient, the procedure should be carefully planned and co-ordinated with all those involved in the process. The plan should also include contingencies in case the patient does not respond as expected. Care should be taken to use the minimum restraint necessary. Where it is anticipated that the use of force may be necessary to execute the warrant, a multi-disciplinary assessment of the risk should similarly be undertaken. However, there may be exceptional occasions where the subject of the warrant presents a considerable risk of violence.

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In such circumstances, management of the process should be passed on to the police to enable them to address the issue of safety of all parties concerned. Unfortunately, there may be isolated occasions when reasonable force, including restraint, may be necessary in order to fulfil these duties. However, all parties involved should bear in mind the principle of “least restrictive alternative” at all times.

Warrant to detain a person for the purpose of carrying out a medical examination

- 26 A warrant under subsection (4) of section 35 authorises the detention of a person for the purpose of carrying out a medical examination. (*The form prescribed in regulations for this purpose is Form MHO2.*) Where an application is made on these grounds, the sheriff or the justice of the peace must grant the warrant where he/she is satisfied that:
- it is necessary for a medical practitioner to carry out a medical examination of the person who is the subject of the local authority's duty to inquire; and
 - the MHO cannot obtain the consent of that person to the medical examination.
- 27 Under these circumstances, the warrant authorises that person's detention for a period of up to 3 hours. It should be noted that this 3 hour time period runs from the moment the patient is detained rather than from the moment the warrant is granted. Where an application for such a warrant is being considered, this should be discussed with the appropriate medical practitioner to ensure that they are in a position to attend.
- 28 When a person is detained pending a medical examination, all parties involved should keep in mind the principle of least restrictive alternative, while maintaining the safety of all the parties involved. Where practicable, any carers or family members of the person detained should be involved in discussions about how the situation can be managed safely and humanely. The roles and responsibilities of the parties involved should be as clearly defined in advance as is possible. It would be expected that roles and responsibilities would be defined within the context of the relevant, locally agreed psychiatric emergency plan.

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Warrant for access to a person's medical records

- 29 A warrant under subsection (7) of section 35 is for the purpose of allowing a medical practitioner to gain access to a person's medical records. (*The form prescribed in regulations for this purpose is Form MHO3.*) Where an application is made on these grounds, the sheriff or justice of the peace must grant the warrant where he/she is satisfied that:
- it is necessary for a medical practitioner to have access to the person's medical records; and
 - the MHO cannot obtain the consent of that person to accessing their medical records.
- 30 If granted, the warrant authorises access to the person's medical records. Any person who holds the person's medical records is required to produce them for inspection by the medical practitioner specified in the warrant, if that medical practitioner asks them to do so.

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Removal order (A “section 293 order”)

- 31 An MHO may apply to a sheriff under section 293 of the Act for a “removal order” which would allow a mentally disordered person over the age of 16 to be removed to a place of safety. The circumstances in which an MHO would make an application for a removal order with respect to such a person are where the MHO believes that the person is likely to suffer significant harm if not removed to a place of safety and if any of the following circumstances apply:
- the person is subject to or exposed to ill-treatment, neglect or some other deficiency in care or treatment;
 - because of the mental disorder the person's property is suffering loss of damage or is at risk of suffering loss or damage; or
 - the person is living alone or without care and is unable to look after him/herself or his/her property or financial affairs.

Making an application for a removal order

- 32 The application must be made by an MHO who has been appointed by the local authority for the area in which the premises are situated.
- 33 The application must be made to a sheriff of the sheriffdom in which the premises are situated. Section 294 of the Act provides, however, that an application for a removal order can be made to a justice of the peace if it is impracticable to make the application to the sheriff and if any delay in obtaining the removal order would be prejudicial to the person who is the subject of the application. It is therefore best practice to make an application to the sheriff wherever possible.
- 34 The MHO must provide evidence on oath to the sheriff or justice of the peace. The following statutory forms must be used for an application to the sheriff or a justice of the peace. (*The statutory forms are available on the Mental Health Law website at:* www.scotland.gov.uk/health/mentalhealthlaw)
- application to the sheriff: Form MHO5
 - application to a justice of the peace: Form MHO6.

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- 35 During the course of their inquiries, the MHO must ascertain, where practicable, the following persons prescribed under **The Mental Health (Removal Order) (Scotland) Regulations 2005**:
- any nearest relative of the person;
 - any guardian of the person;
 - any welfare attorney of the person;
 - any primary carer of the person.
- 36 Where the MHO considers that it would be prejudicial to the person's welfare for a hearing to be held by the sheriff, then the MHO may introduce a crave to the sheriff to dispense with intimation to the person who is the subject of the application and the prescribed persons listed at paragraph 35. The MHO should provide the sheriff with their reasons in coming to this conclusion to assist the sheriff in reaching his/her decision. (*This may be done by way of the statutory application MHO5.*)
- 37 Where the MHO considers that it would not be detrimental to the person's welfare, it would be best practice for the MHO to inform the person who is the subject of the application about the application for the removal order.
- 38 Where practicable, it would also be best practice for the MHO to advise any other persons who may have an interest in the person's welfare of the application. This would enable any parties to then enter the proceedings by way of a Minute.

Determining an application for a removal order

- 39 Where the application is being determined by a sheriff, he/she must give the person who is the subject of the application and the prescribed persons the opportunity to make written or oral representation and to lead or produce evidence with respect to the application. Where the sheriff decides to hold a hearing, then the sheriff will arrange for intimation of the date, place and time of the hearing to the person who is the subject of the application and the prescribed persons. However, a sheriff can dispense with this requirement if he/she believes that a delay caused by complying with this requirement would be prejudicial to the person who is the subject of the application.

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- 40 Where the application is made to a justice of the peace, the Act does not allow the patient or prescribed persons the opportunity to make representation or to lead or produce evidence. Where this is practicable, an application for a removal order must be made to a sheriff rather than to a justice of the peace.
- 41 The application can be granted if the sheriff or the justice of the peace is satisfied that:
- the person is aged 16 or over;
 - the person has a mental disorder;
 - the person is likely to suffer significant harm if not removed to a place of safety; and
 - any of the circumstances outlined in sections 293(2) of the Act as set out at paragraph 30 above applies.

What does a removal order authorise?

- 42 In terms of section 293(3) of the Act, a removal order confers several powers:
- it authorises the MHO specified in the order, any other persons specified in the order, and any constable of the police force for the area in which the premises are situated to enter any premises specified in the order within the period of 72 hours beginning with the granting of the order;
 - it authorises any constable of the police force maintained for the area in which the premises are situated to open lock-fast places on the premises before the expiry of the 72 hour period;
 - it authorises the removal of the person to a place of safety which was specified in the order within that 72 hour period; and
 - it authorises the detention of the person in that place of safety for a period which is specified in the order. This period may not exceed 7 days.
- 43 It should be noted that although the removal order authorises entry to premises and the removal of the person within a 72 hour period, the order should be executed as quickly as is safe and practicable in order to limit any potential for further harm to the person, or further loss or damage to their property. Similarly, although the person may be detained at a place of safety for a period of up to 7 days, the person should be moved as swiftly as possible from the place of safety to a more suitable care and treatment environment.

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- 44 It would be best practice for the MHO to notify the Mental Welfare Commission as to whether the application was granted or refused and to give an account to the Commission of the circumstances which led the MHO to conclude that an application for a removal order was appropriate.
- 45 Where a removal order is granted, it would be best practice for the MHO to inform the prescribed persons (see paragraph 35 above) of the outcome where a hearing was not held or the prescribed person(s) could not attend. The MHO may also wish to consider informing the person who is the subject of the removal order. It would also be best practice for the MHO to inform any other person who the MHO considers may have a legitimate interest in the person's welfare, setting out the procedure they should follow should they wish to exercise their right to apply to the sheriff under section 295 for an order to recall or vary the removal order.

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Recalling or varying a removal order (section 295)

- 46 An application can be made to a sheriff under section 295 of the Act which would 'recall' (i.e. cancel) the removal order. Similarly, an application can also be made to vary the removal order by specifying a different place of safety in the order.
- 47 The application must be made on Form MHO7. (*The statutory form is available on the Mental Health Law website at: www.scotland.gov.uk/health/mentalhealthlaw.)*
- 48 Such an application can be made by the person who is the subject of the removal order or by any person claiming an interest in the welfare of that person. The application must be made to a sheriff of the sheriffdom in which the premises to which the application for the removal order related are situated. Note that application cannot be made to a justice of the peace, unlike the initial application for the removal order.
- 49 Before the sheriff determines an application for such an order, he/she must afford the person who is the subject of the application and any person prescribed by regulations the opportunity to make written or oral representations and to lead or produce evidence. As the person who made the initial application, the MHO will be cited as the defender and will therefore receive intimation of such application.
- 50 Where the sheriff grants an order varying the removal order, this variation may authorise:
- the removal of the person to a new place of safety within 72 hours of the order varying the initial removal order being granted; and
 - the person's detention there for the remainder of the period specified in the original order.
- 51 Where the sheriff grants an order recalling the removal order, then the order may authorise the return of the person concerned to the premises from which they were originally removed, or to some other appropriate place chosen by that person.
- 52 No appeal is possible against a decision of a sheriff to make or refuse to make an order which would recall or vary a removal order.

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- 53 Best practice would be for the MHO to inform the Commission of those cases where the sheriff has granted a recall or variation of the order and the reasons for this.

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An authorised person's order – (A section 292 warrant)

- 54 The purpose of a section 292 warrant is to authorise a person to enter premises where that person has already been given authority by this Act to take a patient to any place or into custody. This could be, for example, a party authorised under the Act to return a patient who absconds while being transferred from one hospital to another. Another example would be where a person who is subject to the 1995 Act breaches a condition specifying that they reside in a specified place. A warrant can only be granted under section 292 where it is necessary to enter premises to enable that person to fulfil the purpose for which they had previously been authorised; and where the sheriff or justice of the peace is satisfied that the “authorised person” cannot obtain, or reasonably expect to obtain, entry to those premises.
- 55 The “authorised person” (i.e. the person who has already been given authority to take a patient to a place or into custody) must make the application to a sheriff or to a justice of the peace. (*Regulations have provided that statutory application form MHO4 must be used for this application. The statutory form is available on the Mental Health Law website at: www.scotland.gov.uk/health/mentalhealthlaw.)*
- 56 The warrant authorises specific parties to access the premises specified in the order. These parties are:
- the authorised person;
 - any MHO who has been appointed by the local authority for the area in which the premises are situated; and
 - any constable of the police force for the area in which the premises are situated.
- 57 Note that these parties may also be accompanied by a medical practitioner and any other authorised person.
- 58 The warrant also authorises any police constable for the area in which the premises are situated to open lock-fast premises, where required, for the purpose of gaining access to the premises specified in the order. Prior to the execution of a warrant, the relevant parties should discuss the best way to proceed which would maintain the dignity of the person who is the subject of the warrant as well as protect the patient and which would safeguard their own safety and the safety of others.

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Removal from a public place (sections 297 and 298)

- 59 Sections 297 and 298 of the Act confer on the police a power to take a person who appears to be mentally disordered and who appears to be in immediate need of care or treatment to a place of safety and to detain them there for a period of up to 24 hours. The purpose of this detention is to allow a medical practitioner to examine the person and to make arrangements for their care and treatment. The police may only exercise this power if the person is in a public place.
- 60 The grounds which must be met before the person may be removed from a public place are that a police constable reasonably suspects that:
- the person in the public place has a mental disorder; and
 - the person is in immediate need of care and treatment.
- 61 Before exercising the power the constable must also consider that it would be in the interests of the person or necessary for the protection of any other person to remove him/her to a place of safety.
- 62 If these grounds are met, the person may be detained at a place of safety for no more than 24 hours from the point of being removed from the public place. Note that the detention period under the Act is 24 hours, not 72 hours as was the case under section 118 of the 1984 Act. The purposes of the detention must be to allow arrangements to be made for a medical practitioner to examine the person and to make arrangements considered necessary by the medical practitioner for their care or treatment.
- 63 Section 297(5) of the Act permits a person to be removed to a police station when a place of safety is not immediately available. This is the only circumstance, in which a police station can be used as a place of safety. The person should be detained in a police station under this power for as short a time as is possible and, in any case, for no longer than it takes to make more suitable arrangements for the person's care and treatment.
- 64 Section 297(4) of the Act makes clear that the definition of a public place includes any place to which the public or any section of the public has or is permitted to have access, whether on payment or otherwise. It also includes the common parts of a building containing two or more separate dwellings.

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- 65 Section 298 places a duty on the relevant police constable to ensure that several parties are informed of a range of issues connected to the removal. These issues are:
- the name and address of the person removed to a place of safety;
 - the date and time at which the removal took place;
 - the circumstances giving rise to the removal of the person;
 - the address of the place of safety; and
 - if the person was removed to a police station, the reason why the person was removed there.
- 66 The parties who must be given information in relation to these facts are:
- the local authority in whose area the place of safety is situated. The local authority must be informed as soon as is reasonably practicable after the removal has taken place. Where the person's address is known, best practice would be to also inform the local authority for that place. Doing so would allow their mental health services to respond more quickly.
 - the nearest relative of the person. The nearest relative must also be informed as soon as practicable after the removal has taken place. If it is impracticable for the constable to inform the nearest relative or if the nearest relative is informed but does not live with the person removed, then the constable should ensure that one of the following is informed instead: a person who lives with or provides a care service to the person; or who is a carer of that person.
 - the Commission. They must be notified within a period of 14 days beginning on the day on which the person was removed to the place of safety.
- 67 A police constable will also wish to involve a medical practitioner once the patient has been removed to a place of safety. Police officers will need to be aware of how to contact police surgeons, CPNs, MHOs and other mental health professionals, where appropriate. Where a medical practitioner has been in attendance, the practitioner should check whether the relevant local authority has already been notified of the person's removal. If contact has not been made with the relevant duty MHO service, this should be done as quickly as possible to enable the patient to be interviewed jointly to facilitate the assessment and planning of an emergency or short-term detention certificate, where appropriate. *(There is no form prescribed in regulations for this application but a pro forma (POS1) is available on the Scottish Executive's website at: www.scotland.gov.uk/health/mentalhealthlaw.)*

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Nurse's power to detain a patient pending a medical examination (section 299)

- 68 Section 299 of the Act empowers certain nurses to detain an informal patient who is in hospital receiving treatment for a mental disorder but that treatment is not being given by virtue of the Act or the 1995 Act. There is only one exception to this general rule: that is where the patient is subject to a probation order with a requirement for treatment for a mental condition in terms of section 228(1) of the 1995 Act.
- 69 Regulations under **The Mental Health (Class of Nurse) (Scotland) Regulations 2005** provide that the nurse must be registered in Sub-Part 1 of the Nursing and Midwifery Order 2001 and their field of practice in mental health or learning disabilities nursing.
- 70 The patient can be detained by the nurse for a period of up to two hours ("the holding period") for the purpose of enabling arrangements to be made for a medical examination of the patient to be carried out. However, if the medical practitioner arrives to examine the patient at any point after 1 hour of the holding period has elapsed, the patient can be detained for a further hour from the point of the medical practitioner arriving to allow the medical examination to take place.
- 71 The nurse's holding power should not be used consecutively. If the nurse's holding period of 2 hours has elapsed without a medical practitioner attending, it would not be best practice to immediately re-detain the patient under section 299 of the Act.
- 72 A patient may only be detained by a nurse where it is not practicable to secure the immediate medical examination of the patient by a medical practitioner and if he/she believes that it is likely that the following conditions are met:
- that the patient has a mental disorder;
 - that it is necessary for the protection of the health, safety or welfare of the patient or for the protection of the safety of any other person for the patient to be immediately restrained from leaving the hospital; and
 - that it is necessary to carry out a medical examination of the patient to determine whether an emergency or short-term detention certificate should be granted.

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- 73 Before deciding whether or not to exercise this power, a nurse should weigh up the likely arrival time of a medical practitioner against the likely intention of the patient to leave. Many patients who express a wish to leave hospital can be persuaded to wait until a medical practitioner arrives to discuss the options further. The nurse should also assess the likely consequences of the patient leaving hospital immediately, taking into account factors such as, for example, the harm that might occur to the patient or others; any recently received messages from relatives or friends; any recent disturbances on the ward; or any relevant involvement of other patients. Where a nurse does exercise the power, he/she should attempt to communicate to the patient as clearly as the situation will allow what is happening and the implications for them of the power.
- 74 The nurse who has exercised the holding power must take all reasonable steps to inform an MHO of the patient's detention as soon as practicable after the holding period begins. Although there would undoubtedly be value in the patient being assessed by an MHO with previous involvement in the patient's case history, priority should be given to securing an MHO assessment as quickly as possible. Hospital managers and local authorities should work closely together to ensure that nurses have the contact information for the duty MHO service readily to hand both during the day and out of hours.
- 75 Although it would be best practice for the patient's existing RMO or another approved medical practitioner to carry out the medical examination, this may not always be possible. A pragmatic approach should therefore be adopted, particularly where the patient requires immediate medical attention. Should a more junior doctor carry out the medical examination, then the detention options, if detention is required, will necessarily be limited to the issuing of an emergency detention certificate.
- 76 The nurse who exercised the holding power must make a written record of the following facts as soon as practicable after the holding period begins:
- the fact that the patient has been detained;
 - the time at which the holding period began;
 - the nurse's reasons for believing it likely that the conditions of detention (see section 299(3)(a) to (c) of the Act as set out in paragraph 67 above) have been met.

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(There is no form prescribed in regulations for this purpose but a pro forma (NUR1) is available on the Scottish Executive's website at: www.scotland.gov.uk/health/mentalhealthlaw.)

- 77 The nurse must ensure that this written record is given to the managers of the hospital in which the patient is held as soon as practicable after the record has been made. However, the nurse may authorise another person to carry out this task. It would also be best practice for the nurse to make this record available to the relevant MHO. The managers of the hospital must send a copy of this record to the Commission within 14 days of their receiving it.

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Definition of a place of safety

- 78 Section 300 of the Act provides a specific definition of a “place of safety” for the purposes of Part 19 of the Act. The following scenarios are dealt with in Part 19:
- where a warrant has been granted to enter a person’s premises under section 292;
 - where a removal order has been granted under sections 293 or 294;
 - where a mentally disordered person has been removed from a public place under section 297; and
 - where a nurse has exercised the holding power under section 299.
- 79 The definition of a place of safety given in section 300 of the Act is:
- a) a hospital;
 - b) premises which are used for the purpose of providing a care home service (as defined in section 2(3) of the Regulation of Care (Scotland) Act 2001 (asp 8)); or
 - c) any other suitable place (other than a police station) the occupier of which is willing temporarily to receive a mentally disordered person.
- 80 It should be noted that section 2(3) of the Regulation of Care (Scotland) Act 2001 defines a “care home service” as:
- a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need; but the expression does not include –
- a) a hospital;
 - b) a public, independent or grant-aided school;
 - c) an independent health care service; or
 - d) a service excepted from this definition by regulations.
- 81 No regulations have been made under section 2(3)(d) of the Regulation of Care (Scotland) Act 2001.
- 82 In light of the definition of a place of safety given in section 300 of the Act, it is important to emphasise that a police station may not be used as a place of safety in the scenarios described in Part 19 of the Act. The only exception to this rule is given in section 297(5) which states that a police station may be used where a police constable has removed a mentally disordered person from a public place under section 297 of the Act and where no place of safety is immediately available. On any rare

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occasion where a person is held in a police station instead of a place of safety, it would be expected that the person be moved on to a suitable place of safety as swiftly as possible under the circumstances.

- 83 *For further information on the use of police stations and places of safety subsequent to the granting of an emergency or short-term detention certificate in respect of a patient in the community, see the relevant Chapters of Volume 2 of the Code of Practice.*

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Designation of a place of safety

- 84 All relevant local agencies should work closely together to ensure the provision of sufficient places of safety within their localities. They should designate agreed preferred places of safety to which persons detained under Part 19 of the Act could be taken and all parties should be fully aware of their location and use. It may also be necessary for local agencies to designate an alternative place of safety to which those whose behaviour makes them unsuitable for the preferred place may be taken (for example, where a person is particularly violent or disturbed).
- 85 When designating places of safety, it would be expected that local agencies have in place policies which, among other issues, would:
- make clear who has responsibility for the transfer, reception and assessment of the patient and within which timescales;
 - ensure that all staff potentially involved with the incidents described at Part 19 of the Act know how to access referral information for mental health specialists, where appropriate;
 - address the training and awareness needs of such staff with respect to the needs of persons with acute mental disorder;
 - put in place clear after-care arrangements where the person detained under Part 19 of the Act is not formally admitted to hospital; and
 - audit and regularly review the use and effectiveness of the locations designated as places of safety within their locality, looking at, for example, issues linked to absconding; the handling of episodes of violence; failures of communication; and users'/relatives' views and experiences.
- 86 It is unlikely that a single solution will apply across all areas of Scotland to the issue of designating places of safety (particularly in rural/remote locations). However, it is likely that the preferred place of safety would not usually be an A&E department. It could instead, where appropriate, be a specialised assessment unit closely linked to, or at least accessible to, a psychiatric facility. Any designated place of safety will need to be suitably equipped and staffed by qualified mental health staff who have experience in the management of acute mental disorder. Although it may be necessary to designate an A&E department as a place of safety, their use should not be standard practice and should, wherever possible, be restricted to occasions where the person also has significant physical health problems related to, for example, self harm or substance misuse.

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- 87 Where local agencies are designating places of safety within their locality, it would be expected that they would also develop contingency plans for occasions where a person is removed to an establishment other than a designated place of safety. Contingency plans will need to focus on ensuring that the range of health and non-health professionals who may become involved with such a situation (for example, A&E staff, GPs, police officers, etc) are aware as is possible of the issues outlined at paragraph 85 above.
- 88 The process by which relevant local agencies work together to agree on suitable designated places of safety should be carried out in parallel to their development of Psychiatric Emergency Plans, which would come into operation after the granting of an emergency or short-term detention certificate. *For further information on Psychiatric Emergency Plans, see the relevant Chapters of Volume 2 of the Code of Practice.*

chapter 16

offences (part 21)

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Introduction

Part 21 of the Act sets out offences in connection with sexual abuse, ill-treatment and neglect in relation to a person with mental disorder, and the obstruction of persons carrying out functions under the Act. It should be noted that Part 21 places no statutory duties on those working with people with mental disorder.

Best practice points

Given that there are no statutory duties contained in Part 21 this chapter simply provides guidance on a 'best practice' basis.

The chapter begins with a general overview of how it would be expected that situations where an offence is suspected would be approached.

The remainder of the chapter sets down best practice points for those working with people with mental disorder where there are concerns that

Overview

- 01 There is now an increased awareness within the statutory services, the voluntary and private sectors, and the public domain, of the potential for abuse involving vulnerable people. This has been highlighted in the number of enquiries and inspections, and in the number of legal cases against people in positions of trust and responsibility, as well as members of the public.
- 02 The responsibility for the protection of vulnerable adults extends to all agencies who may be involved with a person who has a mental disorder as defined by section 328 of the Act. This includes local authorities, health boards and independent providers of care services. It would be expected that any response to concerns raised about the welfare of a mentally disordered person would be approached on a multi-agency basis, in line with locally agreed vulnerable adult protection guidelines and protocols.

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- 03 Local authorities, health boards and independent agencies commissioned by them, all aspire to working with persons with mental disorder according to professional values and principles that ensure respect for individual autonomy and rights to self-determination. The pursuit of these aspirations should be balanced against these agencies' responsibilities to ensure that the person's rights to protection and the promotion of health and well being are also supported.

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Best practice points

Non-consensual sexual acts (section 311)

- 04 Section 311 sets down the offence with which a person might be charged where that person engages in a non-consensual sexual act with a person who has a mental disorder.
- 05 Where there are concerns about the possibility of an inappropriate sexual relationship, these should be reported in line with locally agreed multi-agency procedures and a multi-agency assessment of the nature of the relationship taken forward. This would entail a meeting of all persons involved in the care of the person as well as the police to allow full information sharing and the issue of consent to be discussed; no assumptions should be made in the consideration of this matter. Local authorities and health boards will have protection procedures in place and recourse to these should be made available to all external providers from whom services are commissioned.
- 06 While respecting a mentally disordered person's rights to autonomy and self-determination, agency staff involved in the care of the person have a responsibility in accordance with locally agreed procedures and service agreements to report any concerns regarding relationships the person may have, particularly if exploitation or abuse is suspected.
- 07 Experience of the dynamics of the investigation of sexual abuse shows that allegations are often withdrawn if the person making the allegation is left unsupported through the assessment process. Agency staff should ensure that disclosures are recorded and acted upon promptly and, if necessary, interim protection measures taken, until the outcome of the investigation is known bearing in mind that no action should be taken which might compromise any future criminal investigation. If the level of risk is such that immediate action is required which cannot be achieved on a voluntary basis, it would be expected that legal advice would be sought to determine whether there are any statutory powers which required to be invoked.

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- 08 Everyone who is involved in the assessment, care and/or treatment of the person, along with any other key people involved with the person, should be consulted and involved in the assessment and decision-making process. In the case of a person who is subject to compulsory powers under the Act, this would include all those with a statutory role in relation to the delivery of the person's care plan. (e.g. the RMO, the designated MHO, CPNs, other health and social care staff, and representatives of independent providers of services to the person).
- 09 Taking into account the nature of the concerns, it may be appropriate to consider the involvement of family and/or carers. The representation of an independent advocate in terms of section 259(1) may also be helpful to the person. Where it is clear that consent is an issue a multi-agency case conference should be convened and the police involved. It should be borne in mind that local authorities have a duty to assess need, to provide services and to protect, regardless of whether criminal behaviour has been established in accordance with a criminal standard of proof.
- 10 The Act supports statutory intervention in such scenarios through the local authority's duty to inquire into a mentally disordered person's case under section 33. Section 34 ensures the co-operation of key agencies in such inquires, supported by a warrant under section 35 if necessary. These powers apply in relation to anyone with a mental disorder over the age of 16, regardless of whether or not he/she is subject to compulsory powers under the Act. *(For further information on these sections refer to Chapter 15 of Volume 1 of this Code of Practice.)*
- 11 It should be noted that an offence under section 311(1) is a sexual offence for the purposes of Part 2 of the Sexual Offences Act 2003. Accordingly, a person becomes subject to the notification provisions of that Act (or "sex offender registration" as the requirements are sometimes known) if convicted of this offence or is found not guilty by reason of insanity.

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Persons providing care services: sexual offences (section 313)

- 12 Section 313 sets down the offences with which a person might be charged where that person has a caring or professional relationship (as defined by section 313(2)) with a mentally disordered person and engages in a sexual act with him/her.
- 13 It would be expected that allegations involving persons defined by section 313(2) would be approached in the manner described in paragraphs 4 to 10 above. The police should be involved in all such cases in accordance with established vulnerable adults protection guidelines. Respective agencies' staff disciplinary codes will provide guidance regarding options for the deployment of the member of staff concerned during the investigation, but it would be expected that such a serious allegation would result in immediate suspension from duty until the investigation process had been concluded. During the investigation the primary focus and concern should always be the welfare of the mentally disordered person and so plans should be put in place to safeguard him/her during the course of the investigation.
- 14 Where an allegation has been made against a member of staff of an independent provider, the identified person (as agreed and set down in the service agreement between the provider and the contracting agency) should inform the contracting agency and be involved in the investigation process. The Scottish Social Services Council and the Scottish Commission for the Regulation of Care should also be informed where the individual and/or service is registered with them.
- 15 Where allegations are made against volunteers used by contracting agencies in the provision of services to vulnerable adults, it would be expected that the action taken in response would be the same as that invoked in relation to a member of staff. Health Boards and local authorities retain responsibility for services they commission whether directly or externally provided. It would be expected that, as a result of appropriate contracting arrangements, all independent agencies using volunteers will have comprehensive volunteer policies in place and will comply with disclosure procedures regarding criminal convictions.

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- 16 It should be noted that an offence under section 313(1) is a sexual offence for the purposes of Part 2 of the Sexual Offences Act 2003. Accordingly a person becomes subject to the notification provisions of that Act (or “sex offender registration” as the requirements are sometimes known) if convicted of this offence or is found not guilty by reason of insanity.

Ill-treatment and wilful neglect of a mentally disordered person (section 315)

- 17 Section 315 sets down the offence with which a person might be charged where that person is a carer (as defined by section 315(1)) and ill-treats or wilfully neglects a mentally disordered person.
- 18 It would be expected that allegations involving persons defined by section 313(2) would be approached in the manner described in paragraphs 4 to 10 above. Similarly, recourse to a local authority’s duty to inquire in terms of section 33 should be considered.

Inducing and assisting absconding etc (section 316)

Obstruction (section 317)

- 19 Section 316 sets down the offences with which a person might be charged where that person induces or knowingly assists a patient to abscond, or harbours a patient who has absconded. **The Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Enactments) Order 2005** amended this section to include where the patient is being transferred to or from Scotland by virtue of the regulations made under section 290.
- 20 Section 317 sets down the offence committed where a person obstructs a person authorised by the Act in the manner described by section 317(1).
- 21 Where the collusion of anyone involved with the patient is suspected in relation to attempted or actual absconding, or where the functions of an authorised person are deliberately obstructed, the person or persons concerned should be made aware of these provisions and that their behaviour may be regarded as an offence under the Act. In order to avoid any unnecessary exacerbation of the situation this information should be conveyed in as neutral a tone as possible under the circumstances. It should be borne in mind by the professionals involved

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that the patient's family and/or others involved with the patient may to their mind quite legitimately disagree with their intentions or actions particularly where compulsory powers are being exercised or sought, (e.g. emergency detention under section 36 or a local authority's duty to inquire under section 33), and their behaviour should be carefully considered in this context.

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glossary of commonly
used terms

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Advance statement: this is a document drawn up in accordance with sections 275-6 of the Act. It is a written and witnessed document which is made when the patient is well and which sets out how he/she would prefer to be treated (or not treated) if he/she were to become ill in the future. The Tribunal and any medical practitioner treating the patient must have regard to the advance statement. A medical practitioner must also send to the Commission a written record of the reasons why the wishes set out in the advance statement have not been followed.

Assessment Order (section 52 of the 1995 Act): an order imposed by a criminal court prior to trial and/or after conviction before sentencing which authorises hospital detention for up to 28 days so that the patient's mental condition may be assessed. Medical treatment under Part 16 of the Act may be given to a patient in certain circumstances while subject to this order. It may be extended once only for a period of 7 days.

Approved medical practitioner: this is a medical practitioner who has been approved under section 22 of the Act by a Health 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; and at least one of the two mental health reports forming part of a compulsory treatment order application must be provided by an approved medical practitioner.

Authorised person's warrant/a "section 292 warrant": this 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.

Care plan: this is a document prepared by the patient's responsible medical officer under section 76 of the Act after a compulsory treatment order has been made. It lays out the forms of medical treatment and the other services the patient will be receiving while subject to the compulsory treatment order. 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

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compulsory treatment order.

Compulsion Order (section 57A of the 1995 Act): a final disposal imposed by a criminal court which authorises hospital detention or compulsory powers in the community for a period of 6 months, if not otherwise renewed. It may be renewed for 6 months and then annually thereafter. The procedures for the review of this order and for its renewal, variation and revocation are almost identical to those for a compulsory treatment order imposed under civil proceedings.

Compulsory treatment order: this is 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 6 months, if not otherwise renewed. The compulsory treatment order can be renewed for 6 months, then for 12 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: this is a certificate granted under section 36 of the Act. Where strict criteria have been met, it authorises the removal of a person to hospital within 72 hours and the detention of that person in hospital for a further 72 hours. An emergency detention certificate can be granted by any fully registered medical practitioner who has, where practicable, consulted and sought the consent of an MHO to the granting of the certificate.

Extension certificate: this is a certificate issued under section 47(1) of the Act. Where strict criteria have been met, it extends a period of short-term detention by 3 working days (not 3 calendar days) to allow for the preparation of an application for a compulsory treatment order.

Hospital Direction (section 59A of the 1995 Act): a final disposal imposed by a criminal court in addition to a sentence of imprisonment which allows the person to be detained in hospital initially for treatment for mental disorder and then transferred to prison to complete their sentence once detention in hospital is no longer required.

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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 funded or run by the Health 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: an order imposed by a criminal court after conviction and before sentencing which authorises hospital detention for assessment and treatment for a period of 12 weeks to allow further evidence to be obtained with respect to the person's mental disorder and the risk that they pose as a result of this disorder. It may be renewed regularly for up to 1 year.

Interim compulsory treatment order: this is an order granted by the Tribunal under section 65(2) of the Act. It authorises any of the compulsory measures listed at section 66(1) of the Act for a period of up to 28 days at a time. An unlimited number of interim orders can be granted as long as the total detention period authorised by the interim orders does not exceed 56 consecutive days.

Mental health officer's report: this is a report prepared under section 61 of the Act. It is prepared by the mental health officer as part of the application for a compulsory treatment order. It must detail background information on the person who is the subject of the application.

Mental health report: this is a report required under section 57(4) of the Act and prepared by a medical practitioner. Two such reports must form part of the application for a compulsory treatment order. The practitioner must lay out in this report the reasons why he/she believes that a compulsory treatment order is appropriate.

Multi-disciplinary team: this is the team providing care, treatment and support to the patient while they are in receipt of mental health services. The membership and nature of the team will necessarily vary according to the needs and circumstances of the patient. It would, however, be expected that the team would be made up of, where appropriate and relevant, medical practitioner(s), an MHO and other social workers, nursing staff/Community Psychiatric Nurses, psychologists, occupational therapists etc. The team may also include community care service providers or voluntary organisations

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providing care and treatment. These components of the multi-disciplinary team would work together to co-ordinate and agree on all aspects of the patient's care and treatment. Multi-disciplinary working of a high quality will necessarily entail a genuine respect for the opinions of all members of the team; regular communication between all members of the team; and clearly defined information sharing processes.

Named person: this is someone nominated by a person in accordance with the provisions of Part 17 Chapter 1 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.

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 where a person is removed to a place of safety. Section 254 of the Act sets out a list of the people who will be considered in identifying a person's nearest relative.

Nurse's holding power: this is a power which can be exercised by nurses of a prescribed class by way of section 299 of the Act to hold a patient for up to 2 hours while awaiting a medical examination.

Place of safety: Section 300 defines a place of safety as a hospital, premises which are used to provide a care home services 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.

Part 9 care plan: this is a document prepared by the patient's RMO under section 137 of the Act after a compulsion order has been imposed by a criminal court. It contains the same core information as the care plan of a patient who is subject to a CTO in that it sets out the forms of care and treatment for the mental disorder that the patient will receive while subject to the order but it also includes other information to take account of the status of the patient as a mentally disordered offender.

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Proposed care plan: this is a document drawn up under section 62 of the Act by the MHO who is making the application for a compulsory treatment order. 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 compulsory treatment order 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 RMO subsequent to the making of a compulsory treatment order.

Removal order/“a section 293 warrant”: an order granted by a sheriff or a justice of the peace under section 293(1) of the Act. It authorises certain persons to enter the premises of an individual at risk in order to remove them to a place of safety. It also authorises a constable to open lock-fast places and the detention of the person for 7 days.

Restriction Order (section 59 of the 1995 Act): an order imposed by a criminal court in conjunction with a compulsion order with the result that the measures specified in the compulsion order are without limit of time.

Section 35 warrants: these are warrants issued by a sheriff or a justice of the peace on an application from an MHO. The purposes for which these warrants can be granted are to enter premises; to detain a person in order to carry out a medical examination; and to allow a medical practitioner access to a person’s medical records. There is no right of appeal against a warrant being granted or not being granted under section 35.

Section 68 detention period: this is a period of detention which lasts for 5 working days (not 5 calendar days). This detention period occurs automatically once an application for a compulsory treatment order has been submitted to the Tribunal. It begins on the expiry of a short-term detention certificate or an extension certificate, depending on which certificate the patient is subject to. The Tribunal must determine the compulsory treatment order application by the end of this section 68 detention period.

Section 86 determination: this is a determination made by the patient’s RMO under section 86 of the Act to extend the compulsory treatment order without any variation of the compulsory measures or recorded matters specified in the order. A compulsory treatment order can be extended for 6 months, then for 12 months at a time thereafter. However, the Tribunal must review an order if it has not done so at any point within the previous 2 years. The Tribunal must

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also review section 86 determination if the MHO disagrees with this determination or if there is a difference between the type(s) of mental disorder stated in the section 86 determination and those in the compulsory treatment order.

Section 92 application: this is an application which the patient's RMO must make to the Tribunal under section 92 of the Act where he/she wishes to extend a compulsory treatment order with a variation of the compulsory measures or recorded matters specified in a compulsory treatment order.

Section 95 application: this is an application which the patient's RMO must make to the Tribunal under section 95 of the Act where he/she wishes to vary the compulsory measures or recorded matters specified in a compulsory treatment order.

Section 292 warrant: see "authorised person's warrant".

Section 293 warrant: see "removal order".

Short-term detention certificate: this is a certificate issued under section 44(1) of the Act. Subject to strict criteria, it authorises the conveyance of a person to hospital within 3 days of the certificate being granted, and then the detention in hospital of that person for a period of up to 28 days. A short-term detention certificate can only be granted by an approved medical practitioner with the consent of an MHO.

Social circumstances report (SCR): this is a report prepared by an MHO under section 231 of the Act. It must be produced within 21 days of any of the following events taking place: the granting of a short-term detention certificate; the making of an interim compulsory treatment order; a compulsory treatment order; 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/she is satisfied that an SCR would serve little or no practical purpose. However, a record must be produced stating why the SCR is not being prepared. This record must be sent to the Mental Welfare Commission and to the patient's RMO.

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Suspension certificate: this is a certificate granted under section 41, 53, 127 or 128 of the Act. A suspension certificate granted under sections 41, 53 or 127 suspends the hospital detention requirement of an emergency detention certificate, a short-term detention certificate or a CTO respectively. A suspension certificate granted under section 128 can suspend any measure authorised in a CTO other than the hospital detention requirement. Under the Mental Health (Scotland) Act 1984, “suspension” was sometimes referred to as “leave of absence” or “being out on pass”.

A suspension certificate may also be granted with respect to a patient who is subject to criminal justice proceedings. The processes involved in granting and revoking such a certificate are set out in Part 13 of the Act with the exception of a certificate with respect to a patient who is subject to a compulsion order without a restriction order; these are set out in section 127 as applied by section 179(1). Similar to CTOs, a suspension certificate granted under section 128 as applied by section 179(2) may suspend any measure in a compulsion order other than the hospital detention requirement.

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

Treatment Order (section 52M of the 1995 Act): an order imposed by a criminal court which authorises hospital detention for treatment for mental disorder. Section 52R of the 1995 Act sets out the circumstances in which this order ceases to have effect.

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forms

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All forms are non-statutory except where indicated

Form	Act reference	
Short-term and Emergency detention (Parts 5 and 6)		
DET 1	Sections 36 & 37	Emergency detention certificate
DET 2	Sections 44 & 45	Short-term detention certificate
DET 3	Section 45	MHO duties under section 45
DET 4	Sections 47 & 48	Extension of short-term detention certificate
Compulsory Treatment Order (Part 7)		
CTO 1	Sections 63, 64 & 66	CTO application pack
CTO 1a	Sections 63, 64 & 66	CTO and Interim CTO admission form
CTO 2	Section 58	Mental health report
CTO 3a	Sections 77, 78 & 86	RMO's mandatory review of a CTO and section 86 determination to extend a CTO
CTO 3b	Sections 77, 78 & 86	Review by the Tribunal of a section 86 determination
CTO 4	Sections 78, 91, 92 & 103	RMO's mandatory review of a CTO and a section 92 application to extend and vary a CTO
CTO 5	Section 94	RMO's application to the Tribunal to vary a CTO
CTO 6	Section 65	The making of an interim CTO by the Tribunal
CTO 7	Section 112	RMO's record of a patient having been taken into custody following failure to attend for medical treatment where this is a compulsory measure in the CTO (this form may also be used for compulsion orders)
CTO 8	Sections 113, 117	RMO's record of the patient's non compliance generally with a CTO which authorises compulsory powers in the community (this form may also be used for compulsion orders)

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CTO 9	Sections 114 & 177	RMO's certificate authorising continued detention of the patient pending review or application for variation; or interim compulsory treatment order detention pending further review
CTO 10	Sections 96 & 97	RMO's reference to the Tribunal with respect to the non-provision of a recorded matter and the Tribunal's determination with respect to such a reference
CTO 11	Section 98	Reference to the Tribunal by the MWC and the Tribunal's subsequent determination
CTO 12	Sections 105/106	Tribunal's determination where an interim extension and/or interim variation of the order is imposed
Admission following criminal justice proceedings		
ADM 1	Criminal Procedure (Scotland) Act 1995 (CPSA 1995)	Notification of admission of a patient following the imposition of an assessment order, a treatment order, an interim compulsion order, a supervision and treatment order, a compulsion order, a compulsion order and a restriction order, a hospital direction, a transfer for treatment direction or a probation order with a requirement for treatment for mental condition

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		Discharge of a patient subject to criminal proceedings
DISC 1	Criminal Procedure (Scotland) Act 1995	Record of the discharge of a patient who is subject to: an assessment order, a treatment order, an interim compulsion order, a supervision and treatment order, a compulsion order, a compulsion order and a restriction order, a hospital direction, a transfer for treatment direction or a probation order with a requirement for treatment for mental condition.
		Review of an interim compulsion order (Part 8)
CO 5	53B(1) of CPSA 1995	RMO's report to the court where he/she considers that an interim compulsion order should be extended
		Compulsion Order (Part 9)
CO 1	Sections 149 and 167	RMO's application to the Tribunal to extend a CO following first review and the Tribunal's order following application
CO 2a	Sections 140, 152, 153 & 166	RMO's determination to extend a compulsion order following further review
CO 2b	Sections 140, 152, 153 & 166	Review by the Tribunal of the RMO's determination to extend a CO following further review
CO 3	Sections 157, 158 & 167	RMO's application to the Tribunal to extend and vary a CO and determination by the Tribunal following an application to extend and/or vary a CO
CO 4	Sections 160, 161 & 167	RMO's application to the Tribunal to vary a CO and the Tribunal's subsequent determination

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CO 6	Sections 168/169	Tribunal's determination where an interim extension and/or interim variation of a CO is imposed
CO 7	Sections 163, 164	Application by the patient or the named person to the Tribunal to revoke or vary a CO and the Tribunal's subsequent determination
CO 8	Sections 162/171	Reference to the Tribunal by MWC and the Tribunal's subsequent determination
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CTO 8	Sections 113 and 117 as applied by section 177	RMO's record of the patient's non compliance generally with a CO (or a CTO) which authorises compulsory powers in the community
CO 9	Section 114 as applied by section 177(2)	RMO's certificate authorising continued detention of the patient pending review or application for variation of a CO
CO 10	Sections 141, 142, 144	RMO's record of the revocation of a CO; a record of the notifications made with respect to the revocation and record of termination of a CO
Compulsion Order and Restriction Order (Part 10)		
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CORO 2	Sections 191, 193	Application by Scottish Ministers to Tribunal under section 191 or 193

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CORO 3	Sections 193, 201 and 204	Tribunal's record of an application by the patient or named person against: <ul style="list-style-type: none"> – the variation by the Scottish Ministers of the conditions imposed by the Tribunal on the conditional discharge of the patient; – being recalled to hospital by the Scottish Ministers and the Tribunal's subsequent determination of the application
Hospital direction/Transfer for treatment direction (Part 11)		
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SUS 2	Sections 41, 42, 53 & 54	RMO's certificate granting the suspension of an emergency detention certificate, or a short-term detention certificate and any subsequent revocation or suspension (where appropriate)
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From September 2005, all Non-Statutory forms and Statutory forms may be found on the Scottish Executive's website at www.scotland.gov.uk/health/mentalhealthlaw

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