NHS Education for Scotland

Learning Resource

Mental Health (Care and Treatment) (Scotland) Act 2003

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NHS
Education for Scotland

Designed in-house by the NES Corporate Communications team.

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Mental Health Act Learning Resource 2010

The Mental Health (Care and Treatment) (Scotland) Act 2003, (the Act) was passed by the Scottish Parliament in March 2003 and came into effect in April 2005. At that time the then Scottish Executive commissioned NHS Education for Scotland (NES) to facilitate the design of education/ training resources to help prepare frontline staff in Scotland to understand and work safely and effectively within the Act. NES developed an e-learning resource as well as a paper resource with an accompanying CD-ROM to ensure educational materials were easily accessible for all staff.

Since then the Scottish Government continued to monitor the operation of the Act and in 2008 set up an independent group to carry out a limited review of the Act. This group reported to the Scottish Government in 2009 and NES saw this as an opportunity to update the educational resource produced in 2005.

Although the outcome of the review has yet to be finalised this resource responds to the issues considered as part of the review and changes in practice since 2005.

Who is it for?

The main target audience for this revised version is Mental Health Nurses working with people with mental health problems, in recognition of the fact that they have specific statutory responsibilities as well as practice responsibilities under the Act. However, as the Principles of the Act apply to all staff it will be equally relevant, to a greater or lesser extent, for other nurses, AHPs and the wider workforce working with people who have mental health problems as well as patients and carers.

Content

The resource is in four study units:

- Unit 1 - Foundations of the 2003 Act
- Unit 2 - Safeguards, Rights and Appeals
- Unit 3 - Civil Compulsory Powers
- Unit 4 - People with Mental Disorder in the Criminal Justice System

The units can be studied in any order but to facilitate effective learning they are best completed in a progressive manner from unit 1-4. The length of time taken to complete each unit will depend on the student familiarity with the Act but should take approximately 4 hours to complete.

Unit 1

Foundations of the 2003 Act

Click **Here**

1

Principles, Roles, Responsibilities and Definition of Mental Disorder and Medical Treatment

Introduction

In this study unit we shall be considering the background to the 2003 Act, how it came about and what it says in relation to a number of key areas. The foundations of the 2003 Act are the principles upon which it is based. It is essential that anyone carrying out functions under the Act understands these principles and how to apply them in day to day practice. As well as knowing how to act it is also important to know whose responsibility it is to carry out various functions. We shall, therefore, discuss the role of the Mental Welfare Commission, the Mental Health Tribunal for Scotland and the specific professional roles defined in the Act as well as taking a brief look at the specific duties placed on NHS Boards and local authorities. In addition we will discuss the definition of "mental disorder" as it is defined for the purposes of the 2003 Act.

As you work through this unit you will find that as well as reading the text you are asked to undertake various activities.

The activities are designed to help you to develop your understanding of the areas under discussion and to think about how the 2003 Act will impact on your practice.

Learning Outcomes

By the end of Unit 1 learners should be able to:

- Appreciate the background and drivers to the Mental Health (Care and Treatment) (Scotland) Act 2003
- Critically examine the implications of applying the principles upon which the Act is founded for mental health services.
- Critically examine how the principles of the Act should promote and safeguard the rights of people who use mental health services and families and carers
- Integrate the principles with ethical and professional practice.

Patient, resident, patient or client?

No-one likes to be categorized in a way that detracts from their individuality. The emphasis now, quite correctly, is on staff, agencies and the people affected by mental illness or learning disability to work together in a collaborative manner towards the person's recovery. However, there are a number of terms used to describe people who are getting help and treatment. Throughout this document, in relation to people being treated under the provisions of the 2003 Act, we use the word patient because this is the term used in the legislation to define a person who has or appears to have a mental disorder.

Background to the 2003 Act

In the 1990s there was a growing and widespread recognition in Scotland that the then current mental health legislation (the 1984 Act) was increasingly outdated and in need of reform. This was not surprising given the 1984 Act was itself an update of the 1960 Act which was firmly based in a different era of mental health care where treatment was given in large hospitals and there was less emphasis on the rights of individuals. New legislation was needed that reflected developments in relation to the involvement of patients and carers, modern mental health practice and that, essentially, complied with human rights legislation.

The review of the 1984 Act began in 1999 with the setting up of a committee chaired by the Rt Hon Bruce Millan (the Millan Committee). This committee included mental health patients and carers as well a range of practitioners from both law and mental health practice. The Committee consulted very widely, commissioned research and ultimately published its recommendations in 2001.

During the two years that followed further debate and consultations were conducted on various draft Bills until on the 20th March 2003 the Mental Health (Care and Treatment) (Scotland) Bill was passed by the Scottish Parliament. It remains one of the largest (and arguably most complex) pieces of legislation to be passed by the Scottish Parliament to date.

On the day the Bill was passed Malcolm Chisholm (the then Health Minister) said: "This is an auspicious moment for the Parliament and for everyone with an interest in mental health in Scotland." (Scottish Executive News Release 20/03/03).

Activity 1 - Human rights and deprivation of liberty

Article 5 of the European Convention on Human Rights (ECHR) guarantees rights to liberty.

Take some time to read the publication written by Hilary Patrick (a specialist lawyer) for the Mental Welfare Commission about how the law and practices in Scotland in relation to the care and treatment of people with mental illness or learning disability respects article 5.

http://www.mwcscot.org.uk/web/FILES/Publications/Autonomy%2C_benefit_and_protection_FULL.pdf

Consider a situation in your own practice when a person may have been deprived of liberty and list the key factors which contributed to this deprivation and what steps you could take to prevent such a situation occurring in the future.

The new legislation has brought about major changes in mental health and learning disability care in Scotland. Not just in the introduction of mental health tribunals and the changes to compulsory powers. Arguably the most significant development has been the influence of the Act's principles on attitudes and behaviour in mental health and learning disability care in Scotland.

What are principles?

Principles are basic moral rules that we can use as a foundation for our judgements and actions, they can be a touchstone to test out our own attitudes and a buttress against our own prejudices. Principles can also provide a common language amongst groups of people who may have differing perspectives. This is particularly helpful in the complex world of mental health and learning disability care. Within medical ethics, there are often said to be four key underlying principles, namely justice, autonomy, beneficence (seeking to do good), and non-malificence (avoiding doing harm).

How did the principles of the 2003 Act come about?

The principles of the Mental Health Act are derived from the work of the Millan Committee which was specifically asked by Parliament to explore the ethical basis of compulsory treatment and to set out recommendations for new Scottish mental health legislation. In the process of its work, the Millan committee developed a clear commitment to consultation, openness and reciprocity and to legislation based on ethical principles. From that work came a set of principles now known as the "Millan Principles" They are as follows:

1. **Non discrimination** People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs.
2. **Equality** All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin.
3. **Respect for diversity** Patients should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.
4. **Reciprocity** Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.
5. **Informal care** Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.
6. **Participation** Patients should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Patients should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

7. **Respect for carers** Those who provide care to patients on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
8. **Least restrictive alternative** Patients should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.
9. **Benefit** Any intervention under the Act should be likely to produce for the patient a benefit which cannot reasonably be achieved other than by the intervention.
10. **Child welfare** The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

The Millan Committee recommended that mental health law in Scotland should be based on these principles and, while some of the clarity may have been lost in the process of drafting, these principles have nevertheless profoundly influenced the 2003 Act. These principles didn't just shape the recommendations they became the basis for the practicalities of the Act, for example:

- Participation led to rights to advocacy, provisions for advance statements and the appointment of a named person.
- Least restrictive alternative led to new arrangements around compulsory treatment orders and provisions to appeal against excessive security.
- Reciprocity led to requirement for care plans and the authority for the Tribunal to ensure particular aspects of care through 'recorded matters'.

How are the Millan Principles set out in the 2003 Act?

Compared to the Millan principles, the principles of the 2003 Act are, perhaps not surprisingly, set out in legal language which makes them a little less accessible. However, Volume 1 of the Code of Practice to the 2003 Act gives helpful guidance.

The principles, as set out in section 1 the 2003 Act, require that any person, other than those who are exempt (see below), 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
- 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.

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 them 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.

Activity 2 – Thinking about principles and practice

You may find it helpful to visit the Principles into Practice (PiP) website which is hosted by the Mental Welfare commission. PiP promotes care and treatment that is in line with the Principles of the Act. It gives practical guidance and useful examples of principles based care.

www.principlesintopractice.net

Activity 3 – Scenario
Using the principles in your practice

Drina is a Gypsy/Traveller in her 50's whose life is affected by a psychotic illness. The illness leads to her having beliefs that she needs to keep immersing herself in water which she does by going swimming. If she can't get to swimming pools she has, in the past, gone swimming in rivers and lochs, often putting herself at risk. She has been detained under the 2003 Act on a number of occasions.

Drina usually dresses in traditional clothing but her illness has led to her occasionally being more flamboyant in her attire which draws attention to her wherever she goes. She used to travel but now lives in a mobile home on a local authority site for travellers. She is well known and gets lots of support from her community but still regularly uses the swimming pool. The swimming pool management have become increasingly worried about Drina coming to the pool. This is not particularly because of any risks posed to her in the pool, it is apparently because of her 'unconventional' appearance and the unwarranted attention this generates from other patrons.

You are Drina's CPN. Think about how the principles could help you work out a strategy to support Drina.

Giving and sharing information and the constraints of confidentiality

It can be a challenge for staff to appropriately involve relatives and carers while at the same time protecting the confidentiality of the patient. This is a complex area that involves the rights of the patient, the appropriate involvement of relatives and the professional responsibilities of staff. The Mental Welfare Commission has provided a useful guide entitled “Carers and Confidentialty” that helps clarify the position for both carers and staff.

www.mwcscot.org.uk/web/FILES/Publications/Carers_Confidential.pdf

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.

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.

Why do you think that specific mention is made to the importance of providing the right kind of support to a person after the order he or she is being treated has ended?

It is fairly obvious that, for anyone, care and support should be given continuously and to the extent that it is required. However, when the 2003 Act was being developed some people voiced concerns that there could be a danger that services would mostly be directed at patients subject to an order. The worry was that as an unintended consequence services might not be made available to people who were not being treated compulsorily.

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.

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.

Who do the Principles of the 2003 Act apply to?

Any person performing functions under the Act, for example doctors, nurses and mental health officers, except:

- The patient
- Patient's Named Person
- Patient's primary carer

The Act does actually specify the individuals and organisations that must have regard to the principles these include those listed below.

- Scottish Ministers
- Mental Welfare Commission
- Mental Health Tribunal for Scotland
- Local Authorities
- Health Boards
- NHS Trusts
- Mental Health Officers (MHOs)
- Responsible Medical Officers (RMOs)
- General Practitioners (GPs)
- Nurses
- Police Officers

Note that this does not constitute a definitive list.
Adapted from Scottish Executive (2004) Introductory Training for Mental Health Officers and Other Practitioners Reader 1

Welfare of the Child

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.

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.

Section 278 deals with the impact on parental relationships if either a child or someone with parental responsibilities is affected by the 2003 Act in a way that might adversely affect the personal relationship or reduce contact between the child and the parent. A duty is placed on anyone with a function under the Act to take steps to mitigate against any adverse effects on parental relations.

Equal Opportunities

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.

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.

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.

The following are not bound by the requirements of section 3:

- Patient’s independent advocate
- Patient’s legal representative
- A curator ad litem
- Welfare Guardian or Attorney

Roles and Responsibilities

Broad description

Parts 2, 3 and 4 of the 2003 Act set out a number of special professional roles, makes provision for two organizations, the Mental Welfare Commission and Mental Health Tribunal, and list various duties to be undertaken by NHS Boards, Local Authorities and Hospital Mangers.

Mental Welfare Commission for Scotland

The Act sets out in Part 2 the purpose and function of the Mental Welfare Commission (the Commission). The Mental Welfare Commission for Scotland is an independent statutory organisation whose task is to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. As well as very specific functions set out in the 2003 Act the broad aim of the Commission is to promote the principles of the 2003 Act and to encourage best practice in its operation. It also has an important role to play regarding the welfare aspect of people who are being treated under the Adults with Incapacity (Scotland) Act 2000 (the AWI Act).

The Commission broadly describes its role as the promotion of the rights of people who are affected by mental disorder and to draw attention to what's good and what's bad in services and practice in Scotland.

Its strategic goals are:

- to help patients get the best possible care and treatment
- to help people working in mental health and learning disability services to provide the best possible care and treatment for patients
- to be independent experts in applying best ethical and legal practice in care and treatment.

The Commission achieves these goals by:

- visiting people who are affected by mental illness, learning disability or other mental disorder
- conducting inquiries and investigations
- monitoring the use of the Acts and promoting their principles
- appointing, training and monitoring the work of designated medical practitioners
- providing information and advice services
- influencing and challenging policy makers and service providers.

Activity 4 - The Mental Welfare Commission

The Commission's publications and information about the operation of the 2003 Act and the Adults with Incapacity (Scotland) Act 2000 are available on its useful website. Take some time to visit the site and familiarize yourself with the information there. Look at the publications section, in particular "Rights, Risks and Limits to Freedom", "Consent to Treatment" and "Covert Medication"

http://www.mwcscot.org.uk/newpublications/good_practice_guidance.asp

How may these publications support the provisions of the Act?

Mental Health Tribunal for Scotland

The Mental Health Tribunal for Scotland (the Tribunal) is an independent judicial body established by Part 3 of the 2003 Act. The Tribunal makes decisions about a wide range of situations on the care and treatment of people who are subject to the 2003 Act. The Tribunal service is headed by a President. Each Tribunal is made up of 3 panel members; legal, medical and general. The President and the tribunal members are appointed by Scottish Ministers. Certain decisions about restricted patients must be made by a tribunal chaired by a Sheriff. In summary the types of proceedings that a tribunal deals with are as follows:

- Applications to the Tribunal
- References to the tribunal
- Appeals to the tribunal
- Reviews by the tribunal
- Cases remitted to the Tribunal

Detail listing of all the types of proceedings are given in Volume 1 of the Code of practice to the 2003 Act (pgs 46 to 51))

Find out more about the Tribunal

Visit The Tribunal's website provides useful information on the operation of tribunals and is well worth familiarizing yourself with. www.mhtscotland.gov.uk

Health Boards

Health Boards have various duties including:

- Provide all necessary facilities to the Mental Welfare Commission to allow it to discharge its functions
- To maintain a list of Approved Medical Practitioners (see Special Professional Roles in the next few pages).
- To provide 'age appropriate' services for children and young people.
- To provide suitable accommodation and services for mothers with post-natal depression and their children.
- Co-operate with local authorities to provide care and support services, services to promote the well being and social development of those persons and facilities for traveling to allow access to such services

- Collaborate with local authorities to secure the availability of independent advocacy services
- Provide information to patients about compulsory treatment, appeals processes and access to advocacy
- Provide assistance to patients with communication difficulties
- Collate data on the use of the 2003 Act in their area of responsibility

Local Authorities

Local authorities have various duties including:

- Discharge their functions in a manner that best secures the welfare of young people under 18 years of age.
- Education authorities have a duty to make arrangements for the education of young people who are unable to attend school because they are subject to measures under the 2003 Act
- Provide care and support services designed to promote well-being and social development
- Co-operate with Health Boards and voluntary organizations to secure the provision of services for individuals
- The appointment and training of sufficient Mental Health Officers (see Special Professional Roles in the next few pages).
- To investigate any instance where it appears that a person with a mental disorder is being subject to ill-treatment, neglect, deficiency in care or treatment or whose property is at risk or they themselves are at risk or there is a risk to others.
- Carry out assessments of needs for community care services
- Collaborate with Health Boards to secure the availability of independent advocacy services
- 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 the child or the person being made subject to measures under the 2003 act

Hospital Manager

Hospital Managers have a number of duties in relation to a person subject to compulsory powers (these will be described in Study Unit 3).

Special Professional Roles

The Act sets out in some detail the roles and responsibilities of certain key professionals. As you move through the study units you will become increasingly aware of the detail of these roles. To aid your understanding the following pages contain a summary of these roles.

Approved Medical Practitioner (AMP)

An Approved Medical Practitioner (AMP) is a doctor with experience in the diagnosis and treatment of mental disorder. AMPs have a range of responsibilities including the authorisation of a period of short-term detention.

Responsible Medical Officer (RMO)

A Responsible Medical Officer (RMO) is a named AMP who is responsible for a particular patient's care and treatment. The RMO has various duties which will be described in Unit 3.

Mental Health Officer (MHO)

A Mental Health Officer (MHO) is a social worker with specialist training and experience in mental health. MHOs play a significant role in the 2003 Act including the preparation of reports, making applications for compulsory powers and consenting to certain forms of detention (see Units 3 and 4).

Designated Medical Practitioner

Designated Medical Practitioners are appointed by the Mental Welfare Commission and have a specific role in relation to certain medical treatments (see Units 3 and 4)

Nurses of the 'prescribed class'

Nurses of the 'prescribed class' are certain nurses who have the power (in specific situations) to detain patients for two hours pending medical examination. The class of nurse prescribed is a nurse registered in Sub-Part 1 of the Nurses' Part of the register established and maintained in accordance with article 5 of the Nursing and Midwifery Order (2001), whose entry includes an entry to indicate that:

(a) the nurse has a recordable qualification in mental health nursing or learning disabilities nursing;
(b) the nurse' s field of practice is mental health nursing or learning disabilities nursing.

Nurses of the prescribed class are defined in The Mental Health (Class of Nurse) (Scotland) Regulations 2005 which can be seen at the following website.
www.opsi.gov.uk/legislation/scotland/ssi2005/ssi_20050446_en.pdf

Definition of Mental Disorder

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.

Section 328 of the Act provides that "mental disorder" means any mental illness; personality disorder; or learning disability, however caused or manifested.

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.

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.

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.

Definition of "Medical Treatment"

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).

"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.

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.

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.

Part 16 of the 2003 Act which refers to medical treatment will be discussed in more detail in the next section

Activity 5 – Scenario
Defining Mental Disorder

Jake, a young man who has had serious relationship problems in his life, falling out with his family, getting into fights, not being able to sustain friendships, has increasingly been using GBL (gamma butyrolactone a once unrestricted “recreational drug”). His family are worried sick about him and are desperate for help. He has had previous contact with mental health services and was thought to have considerable personality difficulties, being diagnosed as having a personality disorder.

Jake’s GBL use has been escalating and adversely affecting his health. He has been receiving support from an addiction service who suggest that he is admitted into a psychiatric hospital for help in stopping using a drug which is seriously affecting his physical health and wellbeing. He agrees and starts a programme of withdrawal using benzodiazepine.

Quite quickly Jake’s behaviour changes, he becomes irritable and aggressive, refusing treatment and saying he wants to leave. It is highly likely that if he left he would start taking GBL again with serious risk to his physical health. Initially staff think that Jake’s behaviour is due to his personality and the stresses of withdrawal but increasingly there is evidence of psychosis in the form of paranoid ideas and beliefs. He is assessed by his psychiatrist who believes that Jake meets the grounds for a short-term detention certificate.

1. Imagine you are the doctor, what would you consider when deciding if Jake might have a mental disorder as defined by the Act?

2. What principles of the Act would the doctor be considering while deciding on Jake’s care and treatment?

3. How would you explain to Jake’s relatives why he had been detained?

Unit 2

Safeguards, Rights and Appeals

Click **Here**

2

Safeguards, Rights and Responsibilities

Introduction

In this study Unit you will learn about the safeguards, rights and appeals that are an essential part of the Mental Health (Care and Treatment) (Scotland) Act 2003 (The Act).

Following on from Unit 1 where you learnt about the principles which underpin the Act, these safeguards are intended to ensure that the principles are upheld, put into practice and that the patient will receive the best care possible under the Act.

The section gives an introduction to:

- Named persons
- Assessment of needs
- Advance Statements
- Rights of appeal
- Advocacy services
- Medical treatment

Learning Outcomes

By the end of Unit 2 learners should be able to:

- Assess the significance of the safeguards, rights and appeals contained in the Act and relate them to practice.
- Critically examine the provisions of each safeguard and explore their relationship to the principles of the Act.
- Explain the process of developing an advance statement and support people who use mental health services to write an advance statement.
- Differentiate between the role of independent advocacy and others representing the person using mental health services.
- Act as advisor to colleagues, people who use mental health services, their family and carers on additional safeguards relating to medical treatment under the Act.

Named Persons

Who is a named person?

The Act gives patients over the age of 16 the right to appoint a named person to protect his or her interests. This may be a relative or carer, but need not be. If a patient does not nominate anyone, the primary carer becomes the named person (sometimes known as the default named person), and if there is no primary carer, the nearest relative is assigned the role.

If the patient is under 16 then the named person will be either a person who has parental rights and responsibilities, as long as that person is over 16; the local authority, if the patient is being looked after under a Care Order (Children Act 1989) or in all other cases the main carer, as long as they are over 16.

What is the role of a named person?

The named person has various rights and responsibilities, aimed at providing safeguards for the patient if compulsory measures are used or contemplated. He or she receives notice at various stages of the compulsion process. Those considering the use of compulsory measures should consult with the named person and should consider the named person's views when making care and treatment decisions, if practicable. 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, for example, a Welfare Guardian appointed under the Adults with Incapacity Act (Scotland) 2000 would. Similarly, a named person is not the same as, nor replaces, an independent advocate.

The named person can appeal against compulsory orders (except emergency certificates) and any extension or variation of an order. The named person can also appeal against the patient's transfer to another hospital, including to the State Hospital. It is important to note that the named person can act independently of the patient and does not require his or her permission to exercise any of these functions.

The named person will generally receive full copies of all papers presented to the tribunal and is entitled to his or her own legal representative at the tribunal hearing. This is paid for on a free, non-means tested basis under the Assistance by Way of Representation (ABWOR) scheme.

The named person has one important right, which does not relate to the use of compulsion. This is the right to request

that the local authority and/or the NHS Board make a formal assessment of a patient's needs for social care or health services. (The patient and primary carer also have this right.) If the authorities refuse the request, they must give their reasons. It can sometimes be difficult for patients to access help when necessary and this is a way of ensuring that a patient's needs receive proper consideration.

Summary of Named Person rights

- To be consulted when certain things happen – such as when a short term treatment detention or an application for a compulsory treatment order (CTO) is being considered
- To be notified when certain changes to the patient's circumstances happen – for example if a detention certificate is revoked
- To receive copies of records if the treatment the patient receives is against the wishes made in an advance statement
- To make applications or appeals to the Mental Health Tribunal and to speak at a hearing
- If the patient cannot consent to a medical examination, the named person can do so if it is required for an application for a Compulsory Treatment Order
- To ask for an assessment of needs to be done for the patient by the Local Authority or the Health Board.

How is a named person nominated?

The nomination of a Named Person must be done in writing and must be witnessed by what is described as a person of the prescribed class. The witness is not endorsing the nomination but is certifying that, in their view, the patient understands the effect of making the declaration and has not been subject to any undue influence. The witness may not veto anyone that has been chosen by the patient.

The witness must be either:

- A doctor (a GP, psychiatrist or any other doctor)
- A registered nurse (need not be an RMN or RNLD)
- A solicitor
- A social worker
- A clinical psychologist
- An occupational therapist
- A social service worker (supervisor or manager of a care service, for example)

The witness should not be the named person even if they do fall into one of the above categories, as this may cause a conflict of interests.

Example of Nomination Form

NOMINATION OF NAMED PERSON MADE UNDER THE MENTAL HEALTH (CARE AND TREATMENT) ACT 2003

Name of person making nomination: wilma flintstone
Address of person making nomination: 22 Grantie Way, Bedrock

I hereby nominate Mrs Norma Rubble of 24 Granite Way, Bedrock to be my named person with regard to the Mental Health Act (Care and Treatment) (Scotland) Act 2003.

Signature: Wilma Flintstone

I hereby certify that I am of the opinion at the time of making this nomination, Wilma Flintstone understands the effect of nominating a person to be their named person and that she has not been subject to any undue influence. I hereby witness her signature.

Signature: B Bolder Date: 11 October 2010

Full name of witness: Barry Bolder

Address of witness: Quarry Solicitors, 35 Stone Road, Bedrock

Designation: Solicitor

The Named Person nomination does not have to be typed but it should be clearly written and if it is not in English then it should be accompanied by a translation to ensure that it is clearly understood.

What happens if the patient does not nominate a named person?

If no named person has been nominated (or the nominated person declines to act in the role) the primary carer of the patient unless that carer is under 16 years old becomes the named person. If there is no primary carer the patient's nearest relative (as defined by section 254 of the Act) becomes the named person.

Can a nominated named person decline to act in that role?

A person can decline to act as a named person, even if he or she becomes named person as a primary carer or nearest relative. There is, however, no procedure for ensuring that an individual receives notice that a patient has appointed him or her. Some people only find out that they are the named person when compulsory measures are being considered and they receive notification through the due processes of compulsory measures

Can a patient say that they don't want to have a named person?

There is no provision in the Act for a patient to say that they do not wish, in general, to have a named person. It is possible for the patient to revoke any nomination of a named person but this is on an individual basis. For example, the patient could make a declaration (signed by the patient and witnessed by a prescribed person) saying that they do not wish their nearest relative to be their named person.

What happens if a nominated named person is not thought to be appropriate?

If an MHO considers that a person is inappropriate to act as a named person then he or she is under a duty to apply to the tribunal for an order declaring that the person is not the named person and appointing someone else. The expectation is that the patient's right to choose their named person must be respected and that overriding those wishes should only take place when there are very clear reasons for doing so.

Can the Tribunal nominate a named person?

Yes, when the 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.

Difficulties with the role of Named Persons

The role of the named person was developed because of difficulties with the functions of the "nearest relative" set out in previous Scottish mental health legislation. However, there has been criticism of some unintended consequences of the new role. For example consultation carried out during the limited review of the 2003 Act indicated that the role of the named person was not fully understood, not just by patients and named persons, but also by professionals, including the tribunal.

Named persons are parties to any proceedings in their own right and must act in what they see to be the best interests of the patient. This may mean that sometimes a named person may disagree with the patient, and this can cause conflict. In addition there have been concerns about confidentiality. Named persons are "full parties" to a tribunal hearing and may receive information that the patient does not wish disclosed. Other issues about the role of the named person can be seen in the report of the limited review of the 2003 Act.

http://www.scotland.gov.uk/Publications/2009/08/07143830/4

Activity 1 – Examine The sample named person document given. Does this give all the information required?

Although there is no definitive document prescribed by the Scottish Executive the form given here has been made using the style suggested by them. The Named Person nomination does not have to be typed but it should be clearly written and if it is not in English then it should be accompanied by a translation to ensure that it is clearly understood.

It is also possible for the patient to revoke their declaration of the named person and for them to declare that there is someone they would not want to be their Named Person.

The Named Person must be 16 or over and should understand what would be expected of them. They also have to agree to undertake the role of the Named Person. We will look at what happens if they do not agree a little later in this section.

The Named Person should not be someone who has a professional role in the care and treatment of the patient, such as the GP, psychiatrist, CPN or the patient's mental health officer. The patient may ask advice as to who should be nominated as the Named Person, but there should be no undue pressure placed on them to nominate someone that the family or care staff think is suitable. It is important to realise that the choice must be the patients.

If the patient has not nominated a Named Person, or the person they have chosen is unwilling to act in that capacity, the 2003 Act states that the role will fall to the primary carer, provided they are over 16. If they are unwilling then it will fall to the nearest relative to be the named person. If all of this fails then the Mental Health Officer will apply to the Mental Health Tribunal to have a Named Person nominated to act on the patient's behalf, although this application can also be made by anyone who has an interest in the patient's welfare. The Mental Health Officer can also apply to the Tribunal to act if, in their opinion, the person nominated is unsuitable to be the Named Person.

Activity 2 - Named person and confidentiality

Named persons are “full parties” to the Tribunal hearing and as such receive the full application to the hearing. It could be difficult for the patient to ask for some material to be withheld. The information could relate to aspects of the patient’s life that he or she does not wish the named person to know about.

1. Think about the sort of information that a person may not wish their named person to know about.

2. How could you help the person with this situation?

Activity 3 – Identifying the named person

You have just been involved in admitting a 44 year old woman, Kate, who is very upset and disturbed. She has been admitted under a short term detention certificate It is hard to communicate with her as she is very suspicious of everyone around her. Its not clear if Kate has been in contact with local mental health services before but she does seem familiar with hospitals. She is more comfortable with you and appears reassured by your presence.

1. Who is responsible for identifying who the named person is?

2. Consider your role in the situation as described and think about what you could do to help identify the patient’s named person

Assessment of Needs

Earlier in this Unit it was mentioned that the Named Person may request the Local Authority or the Health Board to carry out an assessment of needs in relation to the person with mental disorder, but what is this?

Part 14 of the Act places a responsibility on the Local Authority or the Health Board to carry out an assessment of the patient's needs for services if they are requested to do so by the patient, their primary carer or the named person. If the request is made then the Local Authority or Health Board has 14 days to respond in writing stating whether or not they are going to carry out the request, and if not, why not. If the request is made by a Mental Health Officer the Local Authority has a duty to carry out the assessment within 14 days.

Advance Statements

What is an advance statement?

An advance statement sets out the way a person wishes to be treated, or not treated, for mental disorder in the event of becoming mentally unwell and unable to make decisions about their treatment. The purpose behind introducing advance statements was to improve patient participation, in accordance with the principles of the Act. The Act obliges tribunals and those providing treatment to take account of the past and present wishes and feelings of the patient and the advance statement is one potentially important way of recording these wishes.

Who can make an advance statement?

An Advance Statement can be made by anyone, even if they are under 16, providing they understand what they are putting in the statement and the effect it may have on their care and treatment in the future. In order for an Advance Statement to be valid it must be in writing, signed and witnessed by a person of the prescribed class. These are identified as the same class of people that are eligible to witness a named person nomination.

How should an advance statement be written?

The Scottish Executive (2004) has identified certain criteria that must also be met in order for the statement to be considered valid;

- At the time of making (or withdrawing) an Advance Statement, the person must have the capacity of properly intending the wishes specified in it
- The Advance Statement must be in writing
- It must be signed by the person making it
- The signature is witnessed by a person of the prescribed class and signed by them
- The witness certifies in writing on the statement that in their opinion the person making it has the capacity of properly intending those wishes

Can an advance statement be withdrawn?

An Advance Statement may be withdrawn if the person has the capacity of understanding the effect this may have. It is withdrawn by means of a written document which is signed and witnessed in the same way as the original document

Conflict of interest

As with the nomination of the named person, it may not be best practice for the witness of the Advance Statement to be someone who may be involved in providing the care and treatment for the patient in the future. This may lead to a conflict of interests if the patient were to become unwell and required care and treatment under the Act.

Where should an advance statement be located?

It is very helpful if a copy of any advance statement is held in the patient's medical records, hospital or primary care. A person giving medical treatment should ask the patient if he or she has an advance statement and where it is kept. If the patient is not able to say where their advance statement is it is best practice to check the their medical records.

What happens if medical treatment is given which conflicts with an advance statement?

Where anyone who is discharging functions under the Act makes a decision or authorises treatment which conflicts with the advance statement certain notifications must take place. If the Tribunal, the person having functions under the Act or a designated medical practitioner makes a treatment decision or authorises or gives treatment in conflict with the wishes of the patient set out in the advance statement then those persons must record in writing the reasons why and the circumstances surrounding the decision. A copy of this record must be sent to:

- The patient who made the advance statement
- The patient's named person
- Any welfare guardian or welfare attorney of the patient
- The Mental Welfare Commission

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

What is a personal statement?

An advance statement sets out a person's wishes in relation to their treatment for mental disorder. However, if a person becomes unwell there may be other matters that they wish to make sure people know about. A person can use a personal statement to set out what they would like to happen if they, for example, have to go into hospital. Things like what to tell their employer, care arrangements for pets and other domestic matters. It is helpful if a personal statement is signed and dated. However, there is no requirement for a personal statement to be witnessed. A personal statement can be attached to an advance statement but does not have the same effect in law. You may find the following example of an advance statement and a personal statement helpful.

Example of an advance statement

ADVANCE STATEMENT
MADE UNDER THE
MENTAL HEALTH (CARE AND TREATMENT) ACT 2003

Name: Wilma Flintstone
Address: 22 Grantie Way, Bedrock

I Wilma Flintstone wish the following views to be taken into account in the event of decisions about my care and treatment being made under the Mental Health Act (Care and Treatment) Act 2003, and my being unable to express my views about my care and treatment at that time.

I would like to receive the following treatments:

Before any other treatments are considered I would like someone to talk to, rest, relaxation and quiet for a few days.
In the event of the above not leading to an improvement then drugs can be considered preferably diazepam and/or Olanzapine but not Chlorpromazine as I have had bad reactions to it in the past.
Even if drugs are prescribed I would wish to continue having someone to talk to as part of my treatment, if possible a qualified counsellor.

I would not like to receive the following treatments:

See above regarding Chlorpromazine also under no circumstances do I wish drugs administered by injection.

Signature: Wilma Flintstone

Witness Certificate

I certify that in my opinion Wilma Flintstone has the capacity of properly intending the wishes set out above. I hereby witness her signature.

Signature: B Bolder Date: 11 October 2010

Full name of witness: Barry Bolder
Address of witness: Quarry Solicitors, 35 Stone Road, Bedrock
Designation: Solicitor

PERSONAL STATEMENT TO ACCOMANY ADVANCE STATEMENT

Name: Wilma Flintstone
Address: 22 Grantie Way, Bedrock

I Wlima Flintstone also wish the following views and preferences to be taken into account, in the event of my being able to express my views and wishes.

My daughter Pebbles is to be looked after by my mother Mrs Nora Chips.
My pet dog is to be looked after by my neighbours Mr & Mrs Barney Rubble.
My friend Norma Rubbles will collect my post and arrange for bills to be paid on my behalf.

I wish my mother to receive the Child Benefit Allowance and maintenance payments from my ex-husband for the care of Pebbles.

I do not want to have to share sleeping accommodation and therefore request a single room.

As a survivor of sexual abuse I would prefer a woman only environment, a female key worker and female Doctor.

Under no circumstance would I be prepared to eat red meat so I would request a red meat free diet.

Under no circumstances do I want any contact with my ex-husband Mr Fred Flintstone nor do I want any information about my whereabouts, my health or any other matter given to him.

I wish my daughter Pebbles to visit me every day.

Signed: Wilma Flintstone

Activity 4 - Benefit of an advance statement

Sean is about to go home after a period of time in hospital, he asks you about advance statements.

1. How would you describe the benefits of an advance statement?
2. What might make someone reluctant to prepare an advance statement?
3. Why might you want to have an advance statement?

Activity 5 - Overriding an advance statement

Imagine you are the keyworker to June who has a long term psychotic illness that has previously been successfully treated with depot anti-psychotic medication. She is on a compulsory treatment order. She hates the injections because she puts on weight and feel sluggish. She has written an advance statement which says that she does not want to be treated with depot medication.

There is concern that she won't comply with oral medication and that the consequences of becoming unwell might be another long spell in hospital. Her doctor overrides the wishes stated in the advance statement and prescribes depot medication again.

How would you explain why advance statements are of benefit, even if they are overridden?

Independent Advocacy

The 2003 Act defines 'advocacy services' as services of support and representation for the purpose of enabling the person to whom they are available to have as much control of, or capacity to influence, their care and welfare as is in the circumstances appropriate.

Independent advocacy supports a person's right to have their own voice heard in decisions made about their health and well-being. The Millan Committee noted in its support for the availability of independent advocacy services that any person can benefit from advocacy if, for whatever reason, they find it difficult to put their own case to service providers or do not feel in a strong position to exercise or defend their rights. It is particularly helpful for people who are at risk of being mistreated or ignored, or who wish to negotiate a change in their care, or are facing a period of crisis. Advocacy can be used by people with physical or mental disorders, or by people who simply feel overwhelmed and confused by institutions and care, or by their carers. It can be difficult, for a number of reasons, for patients to speak up for themselves. Advocacy can give a route by which this may be achieved.

Section 259 of the Act states that every person with a mental disorder shall have a right of access to independent advocacy. It places a duty on NHS Boards and local authorities in collaboration to secure the availability of independent advocacy services within their relevant Boards or authority.

The State Hospitals Board for Scotland has a duty to ensure advocacy services for those detained in the State Hospital. 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 Hospital is required to collaborate with the local authority and NHS Board for the area in which the former patient is now residing.

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/patient concerned.

What independent advocacy is and is not

(SIAA Code of Practice for Independent Advocacy, 2008)

Advocacy is:

- about standing alongside people who are in danger of being pushed to the margins of society.
- about standing up for and sticking with a person or group and taking their side.
- a process of working towards natural justice.
- listening to someone and trying to understand their point of view.
- finding out what makes them feel good and valued.
- understanding their situation and what may be stopping them from getting what they want.
- offering the person support to tell other people what they want or introducing them to others who may be able to help.
- helping someone to know what choices they have and what theconsequences of these choices might be.
- enabling a person to have control over their life but taking up issues on their behalf if they want you to.

Advocacy is not:

- making decisions for someone.
- mediation.
- counselling.
- befriending.
- care and support work.
- consultation.
- telling or advising someone what you think they should do.
- solving all someone's problems for them.
- speaking for people when they are able to express a view.
- filling all the gaps in someone's life.
- acting in a way which benefits other people more than the person you are advocating for.
- agreeing with everything a person says and doing anything a person asks you to do.

http://www.siaa.org.uk/content/view/124/46/

Activity 6 - Scenario Advocacy

John lives alone in his own home. He is very proud of his small flat and keeps it very clean and tidy. However, he has had long term mental health problems that partly contribute to a reluctance to go except to his local shop. He has one relative but apart from her rarely talks to anyone apart from his immediate neighbours. Frank has been his CPN for 4 years and has arranged, with John's rather passive agreement, a befriender and an independent advocate.

Frank has been transferred to another team and has been replaced by Brenda who has been getting to know John. She is concerned about John's social isolation and lack of activity so partly encourages and partly persuades John to attend a swimming group at the local pool.

A few days later Suzi, John's independent advocate, calls Brenda to say that John doesn't want to attend the swimming group and that John has asked her to be at Brenda's next visit. Brenda, with some irritation, agrees.

Sitting in John's small flat the three of them discuss John's activities. Or rather Brenda and Suzi discuss John's activities. He is quite passive and needs to be encouraged to participate. The discussion is frustrating, Brenda gets quite irritated and Suzi doggedly defends John's right not to do anything he doesn't want to do. They are stuck!

1. Why do you think Brenda is irritated?
2. What do you think Suzi thinks of Brenda's interventions as John's new CPN?
3. What do you think Brenda should do?

You may find it helpful to read the Mental Welfare Commission's guidance on working with independent advocates http://www.mwcscot.org.uk/web/FILES/Working_with_independent_advocacy

Rights of Appeal (Revocation)

The 2003 Act does not use the term “appeal”. However, it makes provision for the patients, or others acting on their behalf, to revoke or change most of the compulsory orders made in relation to the patient. The term appeal is commonly used when describing an application for revocation and, for ease of reference, we use the term throughout this section. The actual definitions and terms of the detention and Compulsory Treatment Orders will de dealt with in Unit 3 of this package but, as an introduction, we will deal with the rights of appeal in this section.

Emergency Detention (Section 36)

There is no appeal against an Emergency Detention Order. The Mental Welfare Commission also does not have the power to revoke this certificate.

An Emergency Detention Order can only be revoked by an Approved Medical Practitioner (AMP), when the patient arrives at hospital. On arrival the AMP may either revoke the certificate or will issue a short term detention certificate.

Short Term Detention Certificate (Section 44) or an extension certificate (section 47)

Under section 50 of the Act the patient and the Named Person have the right to appeal to the Tribunal for a revocation of these certificates. However before a decision is made the tribunal must allow representation from people acting on the patient’s behalf. The representation can be made orally or in writing and they may wish to produce evidence. The Mental Welfare Commission also has a power to revoke an STDC if the conditions for the certificate are no longer met.

Compulsory Treatment Orders (CTO) (section 64)

Under sections 99 and 100 of the Act, the patient or the Named Person can appeal to the Tribunal to have the CTO revoked or varied. This safeguard is in addition to all the mandatory reviews that are built into the system to ensure that the patient does not continue to be treated compulsorily when it is no longer required. The Mental Welfare Commission has the power to revoke a CTO under section 81 of the Act.

Interim CTO (Section 65)

There is no appeal against this. However an interim CTO cannot be in place for longer than 28 days and best practice would mean that this is reviewed by the Tribunal before it is due to expire. The Mental Welfare Commission can revoke an interim CTO under section 73 of the Act.

Determining an appeal

In determining the appeal the Tribunal must be satisfied that the criteria for the granting of the order continue to be met. It is also important to note that the onus is not on the patient to demonstrate that the criteria do not continue to be met. Rather the onus is on the professionals to prove the necessity of continuing compulsory powers.

Appeal against transfers within Scotland (sections 124 -126)

The patient or the Named Person can appeal against transferring the patient to either another hospital in Scotland or the state hospital. The patient or the Named Person can appeal to the Tribunal and must be done within 28 days of either the notice to transfer or the actual transfer taking place.

Appeal against cross border transfers (within the UK)

Where a patient is being transferred from Scotland to another part of the United Kingdom he or she may appeal to the Tribunal against the transfer. The appeal may be made any time between the patient being notified by Scottish Ministers and the transfer taking place. An appeal against the decision of the Tribunal can 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. In these cases the appeal is made directly to the Court of Session. No transfer may take place before an appeal is determined. There is no appeal after a transfer has taken place.

Appeal against detention in conditions of excessive security

A patient in the State hospital or a medium secure unit specified in Regulations, their named person, their guardian or the Mental Welfare Commission may appeal to the Tribunal against their detention in the state hospital or medium secure unit, declaring that they are being held in excessive security. If the appeal is upheld then the patient's Health Board must identify a suitable hospital for the patient to be transferred to. There are set time limits for the Health Board to respond to this order. There are also arrangements for the patient to be recalled to the State hospital if required.

Medical Treatment

Introduction

Being subject to compulsory powers does not mean that consent should not be sought for any treatment that is required, either for mental disorder or for any physical condition. Part 16 of the 2003 Act provides additional safeguards for patients in relation to medical treatment, particularly but not only, when treatment requires to be given without the person's consent. This section should be considered alongside the section that discusses advance statements.

Mental disorder, capacity and treatments for other conditions

It is very important to remember that Part 16 only applies to treatment for mental disorder of people who are subject to the provisions of the 2003 Act. Safeguards for the treatment of adults whose capacity is impaired are provided by the Adults with Incapacity (Scotland) Act 2000. You may wish to read the guidance to Part 5 of the 2000 Act to see the areas of treatment covered by that legislation. We discuss the 2000 Act later in this section.

http://www.sehd.scot.nhs.uk/mels/CEL2008_11.pdf
You should also familiarize yourself with the Mental Welfare guidance on consent to treatment which gives guidance for practitioners and a useful overview of the relevant legislation.

http://www.mwcscot.org.uk/web/FILES/Publications/Consent_to_Treatment.pdf

Any medical practitioner giving medical treatment must have regard to the principles of the 2003 Act, in particular taking into account the views of the patient and ensuring that he or she is given information about any proposed treatment and helped to understand its purpose and effects.

Part 16 covers general safeguards that apply to any person with a mental disorder in particular relating to consent. It also covers the arrangements for specific treatments such as long term treatment, ECT, neurosurgery and urgent medical treatment.

What is a Designated Medical Practitioner (DMP)?

The Act states that certain treatments, prescribed by a patient's own doctor, can only be authorised by another, independent doctor, called a "designated medical practitioner" (DMP). The Mental Welfare Commission is required to appoint DMPs to undertake these duties and to ensure that they undergo specific training. The Commission must include among these DMPs some who are specialists in child psychiatry.

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.

These powers 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.

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.

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.

It is 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.

Which measures do not give authority to treat
The following measures that 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 Criminal Procedures (Scotland) Act 1995, where an acquitted person may be detained for medical examination.

Any patient detained by these provisions must 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.

Which measures do give authority to treat?
Treatment may be given under part 16 of the 2003 Act if the patient is subject to one of the following 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.

Safeguards for Particular Treatments

Statutory forms

The Act requires that these provisions require formal certification. This certification is done using forms that are specified in regulations (statutory forms). The relevant forms are referred to throughout the following text. It is important to note that the Mental Welfare Commission recommends that copies of these forms are easily available to staff who are both prescribing and administering treatment.

Activity 7 - Knowing the mental health act forms

Anyone who may be administering treatment needs to know the consent status of a person who is subject to compulsory treatment. Study the statutory forms (at the links below) that are used to indicate a patient's consent status. Think about how best to make sure that the relevant people know the consent status of patients being treated under the 2003 Act.

http://www.scotland.gov.uk/Resource/Doc/924/0066822.pdf
http://www.scotland.gov.uk/Resource/Doc/924/0066823.pdf

All Part 16 forms can be viewed at the site below.

http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/treatmentfomsoct2008

Activity 8 - Find the forms where you work

Now you have studied the forms find out where they are kept where you work, either in hospital, clinic or community.

You might find it helpful to speak to your local medical records officer to find out how the consent to treatment forms are stored and monitored. Bear in mind the importance of the forms being available at the point of administration of treatment. It is very important that anyone prescribing or administering treatment to someone who is subject to compulsory powers is fully aware of the consent status of that person and which treatments are covered by the provisions of the 2003 Act.

Treatments given over a period of time (section 240)

This section applies to particular treatments where the patient is either:

- capable of consenting and not refusing consent (section 238); or
- incapable of consenting or capable of consent and refusing (section 241)

It applies to the following treatments given to a person subject to the measures noted above,

Immediately (as soon as someone is subject to an order) to:

- any medication (other than the surgical implanting of hormones) given for the reduction of sex drive
- the provision of nutritition by artificial means
- such other treatments specified in regulations made under section 240(3)(d)

This provision also applies to drug treatment for mental disorder after 2 months of compulsory treatment has elapsed.

Nutrition by artificial means

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. Passing a nasogastric tube can be particularly dangerous if the patient resists or struggles and force should not be used to insert a tube.

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 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.

Where a patient is capable of consenting and does consent

Treatment can be given only where the patient can and does consent in writing. Usually the Patient's RMO (or a DMP) must certify in writing that it is in the patients best interests (in relation to the treatment) to receive the treatment, that the patient is capable of consenting, the patient consents in writing and that the treatment is authorised by virtue of the 2003 or 1995 Act. This is recorded by the RMO on aT2 form.

Where a patient is incapable of consenting or is capable and refuses treatment

Where a patient is incapable or capable and refusing treatment the RMO must arrange through the Mental Welfare Commission for a DMP to examine the patient and consider whether the treatment should be authorised under section 241

The DMP must authorise in writing (on form T3) 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 the 1995 Act; and
- That the treatment is in the best interests of the patient

Where a patient is under 18, liable to compulsory treatment then the RMO or the DMP who approves the treatment must be a child specialist.

Safeguards for ECT and other treatments regulated under section 237

Section 237 sets out the safeguards for ECT and other treatments set out in regulations. These currently are vagus nerve stimulation (VNS) and transcranial magnetic stimulation (TMS). These treatments may only be given to a patient 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

This certification must be recorded on form T3.

It is important to note that the 2003 Act does not allow the giving of ECT to a patient who is capable of consenting and is refusing the treatment.
Where a patient is under 18, liable to compulsory treatment and can and does consent then the RMO or the DMP who approves the treatment must be a child specialist.

Surgical operations for mental disorder (section 234)
Section 234 applies to any surgical operation for mental disorder that “destroys brain tissue or the functioning of brain tissue” this is generally known as neurosurgery for mental disorder or NMD. Regulations specify that “deep brain stimulation” (DBS) is also included in these provisions.

These provisions apply to anyone regardless of whether or not they are subject to compulsory measures under the 2003 or 1995 Acts. NMD is a therapeutic process only offered after extensive assessment of patients who have intractable mental illness.

Where a patient is capable of consenting then they must do so in writing and two lay persons appointed by the Mental Welfare Commission must confirm that the patient is capable of consenting and has done so. In addition a DMP must make the same conformation. The patient may withdraw their consent at any time. Where a patient is incapable of consenting a DMP must certify that this is the case and that the patient does not object to the treatment and that it is in their best interests. Two lay people appointed by the Mental Welfare Commission must also certify that the patient is incapable of consenting and does not object to the treatment. In addition the RMO must make an application to the Court of Session and treatment may only be given if the court authorizes the treatment.

No patient who opposes the treatment, either by statement or resisting treatment may be given such treatment. The Mental Welfare Commission may revoke any of the certificates given by notifying the RMO. Certification must be recorded on Form T1

Urgent medical treatment

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 (the definition of medical treatment under the 2003 Act is given in section 1) 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 being 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.

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 for the following purposes:

- saving the patient's life
- 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.

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. Where treatment is given under this provision the RMO must notify the Mental Welfare Commission within 7 days using form T4.

When a decision is made to administer urgent medical treatment under this provision of this Act and is to be administered by force, it is important to ensure that such an intervention is undertaken only by staff who are fully trained (and updated) in appropriate control, restraint and resuscitation techniques. Where treatment has been administered by force, it would be best practice to note this in the report to the Mental Welfare Commission.

Adults with Incapacity (Scotland) Act 2000

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”.
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.

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.

Scenario 9 - Mental or Physical Disorder, What Legislation?

Abada is a 76 year old woman who lives with her extended family. She has a number of physical problems that have restricted her mobility and has had a number of urinary tract infections. She speaks some English but mostly communicates in her first language. Her family have noticed a deterioration in her memory over the past few months. One weekend she becomes very agitated and confused, the family are very concerned and call her GP. Abada appears to be in pain and looks very hot and physically distressed but won't allow the doctor to examine her. The GP is male and Abada is making it clear she doesn't want him anywhere near. The family say that she is talking in a very confused manner, is misidentifying her grandchild as her own daughter and appears to be very distracted. Abada is very restless, is not taking any fluids and although very hot refuses to take off any of her heavy clothing. The GP thinks she needs urgent treatment in hospital but Abada does not understand the situation and refuses to leave the house.

1. What strategies do you think might help Abada get the treatment she needs?

2. Given that Abada is refusing treatment what legislation do you think might be appropriate to use, the 2003 Act or Adults with Incapacity (Scotland) Act 2000

Unit 3

Civil Compulsory Powers

Click **Here**

3

Civil Compulsory Powers

Introduction

This study unit will examine the range of compulsory powers contained within the 2003 Act that are classed as 'civil' compulsory powers. The powers that apply where a person may have committed a criminal offence and has formal contact with the criminal justice system are described in Unit 4.

In undertaking this study unit it is very important that you have already completed Unit1 as you will need to be able to apply aspects of your learning about the principles of the Act from Unit 1 in this unit.

Learning Outcomes

By the end of Unit 3 learners should be able to:

- Describe emergency, short-term and long-term detention and/or treatment as described in the Act.
- Support colleagues, people who use mental health services, their family and carers in articulating the technical language of compulsory powers.
- Differentiate between the statutory duties to be performed by specified professions and organisations under the Act.
- Exercise appropriate judgement in the use of nurses holding power.

What are compulsory powers?

In Scotland, any medical intervention on a competent adult requires the consent of that adult. Treatment given without consent is potentially both a civil wrong, which could result in a claim for damages, and a criminal offence, such as assault. It would also be a breach of professional codes of practice. A competent adult is entitled to refuse treatment, for good or bad reasons, or for no reasons at all, assuming that the person has the necessary information to give consent and is capable of doing so. However, the 2003 Act allows that in certain circumstances a person who has been assessed as having a mental disorder can be detained and or treated with or without his or her consent. Such compulsory treatment must be given in the context of the safeguards set out in units 1 and 2 of this resource.

The Act also makes provision for entry into premises, removing persons to hospital or places of safety and detention there.

When can civil compulsory powers be used?

Very strict criteria must be met before compulsory powers can be used. The specific criteria for each of the powers are set out later in this unit. Generally, these criteria cover the presence of mental disorder, decision making ability, the necessity for treatment, risk to the health and safety of the person (or anyone else) and that it is necessary to use the powers. All of the decisions about the use of the powers must be considered in the context of the principles of the 2003 Act.

What types of compulsory powers are there?

The three main types of compulsory powers address particular circumstances:

- A Compulsory Treatment Order, for long term treatment, can only be granted by the Mental Health Tribunal.
- A Short Term Detention Certificate (STDC) that can last for up to 28 days and must be granted by an Approved Medical Practitioner.
- An Emergency Detention Certificate (EDC) that can be granted by any medical practitioner and lasts for up to 72 hours.

It is important to remember that the Code of Practice (CoP) to the 2003 Act emphasizes that the preferred entry to compulsory treatment is an STDC. The use of an SDTC ensures that a person has been assessed by a medical practitioner who is a specialist in mental health (an AMP). In addition there are greater safeguards associated with an STDC compared to an EDC.

Can a child be made subject to civil compulsory powers?

A young person or child under the age of 18 can be made subject to any of the civil orders. However, the CoP emphasizes that section 2 of the Act states that anyone discharging a function of the Act must do so in a manner that "best secures the welfare of the patient". In addition the CoP states that it it is best practice to admit young people to specialist facilities and that the Act places a requirement on Health Boards to provide such facilities. It is also best practice that a child's RMO should be a child specialist.

"De-facto detention" of patients already in hospital

Where an informal patient wishes to leave hospital against medical advice, he or she should not be placed in the position of feeling he or she must agree to stay in hospital purely because of the possibility of being detained under the Act. Such 'de facto detention' places restrictions on an informal patient without according him or her the protection of the rights that would be accorded if formally detained. It is important to remember that the patient's perception of the likelihood of detention if he or she does not comply with the medical practitioner's wishes is an important factor in deciding whether or not the patient is subject to 'de facto detention'. Great care must be taken by staff to explain the consequences of leaving hospital in way that is least likely to be construed by the patient as a threat of detention.

Activity 1 - Criteria for Mental Disorder

Imagine that you have been told that people are concerned about your behaviour. Your friends and family are worried because you have been staying out late, drinking a lot and spending money you can't afford on things you don't really need. You've met new people and have given them some money. You can't see what the problem is, you feel great, full of energy, don't need much sleep and life is a buzz. You have reluctantly agreed to go into hospital, not sure what all the fuss is about.

Your doctor has told you that everyone is worried about you and concerned that you are putting your self at risk with inappropriate relationships and reckless spending. She thinks you might be ill in a way that is affecting your mood and your judgement. You don't believe her but say that you will accept treatment although not in hospital. Your doctor says that if you try to leave you will be "sectioned" and will have to stay. You speak to nursing staff who explain that you can be prevented from leaving. They also tell you how an order would work and what your rights of appeal would be. You are also given information about the independent advocacy service.

1. How would you feel in this situation? Would you think you are being held against your will? What other information would you like to have?

2. If you were the doctor what would your concerns be? What options would be open to you?

3. If you were a nurse what would you do if the patient said she was leaving.

Emergency Detention Certificate (EDC)

This section will include the flow chart guide to medical practitioners on granting an EDC and the flow chart on when to use an EDC or an STDC

What is an EDC for?

An EDC is used when a person is not willing to be admitted to hospital but needs immediate admission for assessment of a possible mental disorder and there is not enough time, or no approved medical practitioner available, to use a Short Term Detention Certificate.

When may an EDC be granted?

An emergency detention certificate may be granted where the criteria at section 36 of the Act are met (see below). However, a STDC should be granted, wherever possible, in preference to an emergency detention certificate, where this is practicable and where the relevant detention criteria have been met.

A STDC is the preferred “gateway order” because, as compared with an EDC, it can only be granted by an approved medical practitioner. The consent of an MHO to the granting of a short-term detention certificate is mandatory (where consent had not been given with a prior EDC); and, very importantly it confers on the patient and the patient’s named person a more extensive set of rights, including the right to make an application to the Tribunal to revoke the certificate.

How long does an EDC last for and when does it start?

If the patient is already in hospital the period of detention starts when the EDC is granted. If the patient is in the community the EDC authorizes the transfer of the patient to hospital (within 72 hours of the granting of the certificate) and his or her detention there for up to 72 hours. The detention period begins on the admission of the patient to hospital. The certificate also gives authority to transfer the patient from one hospital to another within the 72 hour period.

What happens if an EDC is granted in an Accident and Emergency Department?

If a patient is in an A&E department and had not yet been admitted to hospital when the EDC was granted then he or she should be considered to have been in the community and the time scales for community admission (noted above) should be applied.

The Mental Welfare Commission has produced a short guide on the use of the mental health and incapacity legislation in general hospitals. This refers to the use of EDCs
It can be downloaded from the following site
http://www.mwcscot.org.uk/newpublications/good_practice_guidance.asp

Who may not be made subject to an EDC?

An EDC may not be issued if immediately before the medical examination the person is already detained under:

- An EDC
- A Short Term Detention Certificate
- An STDC extension certificate (Section 47)
- An STDC extension pending determination of a CTO (Section 68)
- A certificate granted under section 114(2) or 115(2). These certificates relate to non compliance with a CTO or interim CTO.

Who can grant an EDC?

Any registered medical practitioner (it is not necessary for the practitioner to be an AMP). It is important to note that an EDC may not be granted by a medical practitioner different to the one who carried out the medical examination.

What are the criteria for an Emergency Detention Certificate?
The criteria which must be met are laid out in section 36 of the Act. The medical practitioner must consider it likely that:

- the patient has a mental disorder; and
- because of that mental disorder, the patient's decision-making ability with regard to medical treatment for that mental disorder is significantly impaired.

The practitioner must also be satisfied that:

- it is necessary as a matter of urgency to detain the patient in hospital in order to determine what medical treatment should be provided to the patient for the suspected mental disorder;
- there would be a significant risk to the health, safety or welfare of the patient or to the safety of another person if the patient were not detained in hospital; and
- making arrangements with a view to granting a short-term detention certificate would involve undesirable delay.

What is the role of a Mental Health Officer in the granting of an EDC?

The medical practitioner must consult with and seek the consent of an MHO prior to the granting of a certificate. However, the urgency of the situation may make this impracticable and on such occasions the medical practitioner may grant the EDC without the consent of an MHO. When this happens the medical practitioner is required to notify the hospital managers who must then subsequently notify the Mental Welfare commission and the local authority of the reasons why it was not possible to consult an MHO.

The MHO has a very important role in considering the appropriateness of an EDC. He or she must be satisfied that there is no alternative to the use of an EDC and must also take into account the impact of the patient's family or carers if an EDC is not granted and if there are any appropriate alternative community based care options.

Where the MHO has given his/her consent to the detention, he/she will want to ensure that a range of actions take place. These actions are in addition to and complementary to any which ward staff may carry out but will necessarily vary according to the circumstances of the individual patient.

The MHO will wish to take all reasonable steps to ensure:

- that the patient is aware of his/her status and rights;
- that the patient has access to information on representation and advocacy and where necessary, provide assistance in making contact with these services;
- that the patient has access to interpretation and translation services, or services that address other communication needs;
- the safety of any children or other dependants or those in the patient's care;
- the safety of any pets;
- the security of the patient's premises and belongings if the patient has been detained at home and force was required to enter the premises;
- that the patient's named person and/or nearest relative has been informed and has the MHO's contact details;
- that the ward medical staff are aware of the patient's views on consent to treatment, including the existence and content of any advance statement made by the patient;
- that the ward medical staff have contact details of the MHO and of the patient's named person/carers, etc;
- that a written record of the MHO's decision to give consent is included in the patient's records, wherever practicable;
- that the patient and his/her carers and dependants have the MHO's contact details.

Activity 2 - What's the difference?

Think about the roles of an MHO, and independent advocate and the patient's keyworker. How would you explain the different roles to the patient?

What is the role of the patient's nearest relative or named person in an EDC?

The nearest relative plays no formal role in consenting to detention. However. a key principle of the Act involves having regard to the views of the patient's carers and their named person as well as any welfare guardian or attorney appointed under the 2000 Act with respect to functions being discharged under the Act. The views of such parties should be sought, wherever practicable, when an EDC is being considered.

What treatment can be given under an EDC?

An EDC is primarily an order to allow an assessment. Part 16 of the 2003 Act does not give general authority to treat under an EDC. The person subject to an EDC is in the same position as anyone else not subject to the Act, consent must be given for any treatment. However, urgent medical treatment may be given under the terms of section 243, but only where the patient is detained in hospital (See section 2).

In the case of a child the consent must be given in terms of the Age of Legal Capacity (Scotland) Act 1991 and the Children (Scotland) Act 1995.

Activity 3 - Urgent Medical Treatment

A young man has been brought to hospital by the police after being found inside the perimeter of an airport walking towards the runway. He has cuts all over his body that require treatment. Initially, he had been taken to a local general hospital where he refused treatment and tried to leave. He was placed on an EDC. He looks terrified and is hostile to anyone who comes near him. He appears preoccupied, distracted and the staff assessing him think it is highly likely that he is acutely psychotic. He has already tried to assault the police officers who found him.

The situation escalates when, despite efforts to engage with and reassure the young man, he makes a lunge for the door, lashing out at staff trying to restrain him. The doctor present instructs nursing staff to administer an injection of a major tranquilliser. This treatment was given under section 243 which relates to urgent medical treatment. Look at that section and consider whether the situation and the action taken met the criteria set out there.

Activity 4 - Providing Information

Find out how the hospital managers' duty to provide information about patients' rights is carried out where you work. Put yourself in the position of a newly detained patient, read the written information and see if you understand it. Is there anything else you would want to know?

Imagine that English was not your first language, how would you get the information you need to understand your rights if you were detained. Is there written information in other languages available, how easy is it to get translations? How would an interpreting service be accessed?

www.talkingmentalhealth.net is a resource which provides accessible information about rights for patients and carers.

Who must be notified of the admission?

The managers of the hospital have a duty to inform the following (normally within 12 hours):

- The patient's nearest relative
- Any person who lives with the patient (if the patient does not live with his or nearest relative)
- The patient's named person (if known)
- The Mental Welfare Commission

Can an EDC be suspended?

A patient's RMO may grant a suspension certificate that suspends the detention in hospital for a specified period. Suspension might be necessary for attendance at a general hospital for treatment or to collect something from home. Conditions may be attached such as escort arrangements (being "kept in charge of an authorised person") or any other conditions the patient's RMO wishes to specify.

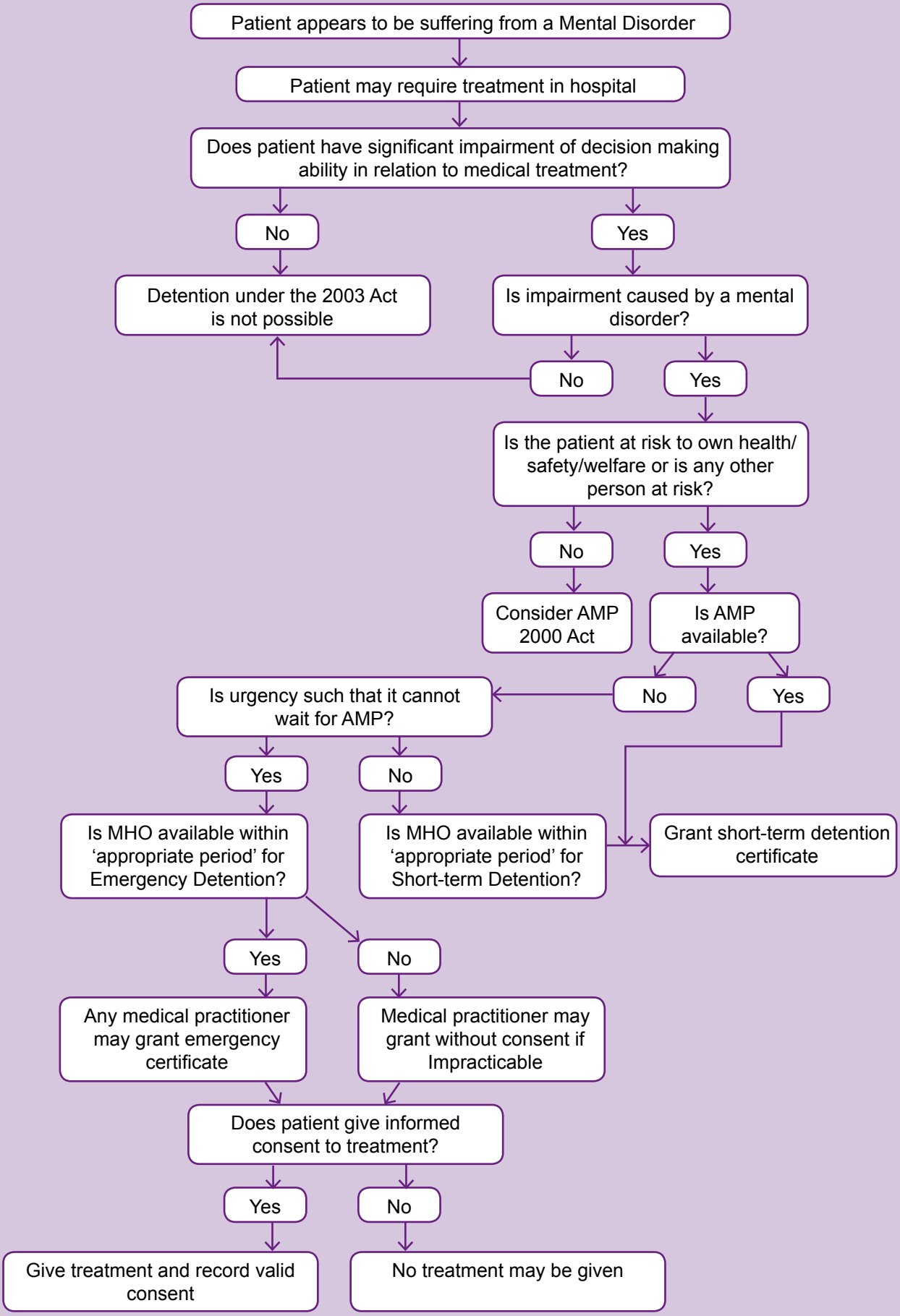
Is there a right of appeal against an EDC?

No, the patient has no formal right of appeal against the granting of an emergency detention certificate. However, the patient's rights are protected by a range of factors that include:

- An MHO must, wherever practicable, be consulted and his/her consent sought to the granting of the emergency detention certificate
- The medical practitioner who grants the certificate must provide on the certificate a justification of his/her reasons for granting the certificate
- The managers of the hospital in which the patient is detained must notify the relevant local authority of the reasons why it was impracticable to consult and seek the consent of an MHO to the granting of the certificate, where this was the case
- The Commission has the power under section 11 of the Act to investigate a case where a patient is subject to emergency detention (the Commission does not have a power to revoke an EDC)
- If it is deemed that ongoing detention would be appropriate, then the emergency detention certificate should be revoked as quickly as is practicable and a short-term detention certificate granted instead
- The patient may not be given medical treatment in terms of Part 16 of the Act while subject to an emergency detention certificate; and
- The patient has a right of access to independent advocacy services under section 259 of the Act.

Revoking an EDC

An EDC comes to an end after 72 hours. However an AMP may revoke the certificate if the practitioner is not satisfied the patient requires to be treated on a compulsory basis or that the conditions required for an EDC are no longer met.


Patient appears to be suffering from a Mental Disorder
Patient may require treatment in hospital
Does patient have significant impairment of decision making ability in relation to medical treatment?
No
Yes
Detention under the 2003 Act is not possible
Is impairment caused by a mental disorder?
No
Yes
Is the patient at risk to own health/ safety/welfare or is any other person at risk?
No
Yes
Consider AMP 2000 Act
Is AMP available?
No
Yes
Is urgency such that it cannot wait for AMP?
Yes
No
Is MHO available within 'appropriate period' for Emergency Detention?
Is MHO available within 'appropriate period' for Short-term Detention?
Grant short-term detention certificate
Yes
No
Any medical practitioner may grant emergency certificate
Medical practitioner may grant without consent if Impracticable
Does patient give informed consent to treatment?
Yes
No
Give treatment and record valid consent
No treatment may be given

What is an STDC for?

An STDC is used where a person is not willing to be admitted to hospital, where they may have a mental disorder that is affecting their judgement about treatment and admission is required for further assessment and/or treatment over a short period of time.

When may an STDC be granted?

An STDC may be granted when the criteria set out in section 44 of the 2003 Act are met (see below). It is not necessary for the patient to have been subject to an EDC prior to the granting of an STDC. An STDC should always be granted in preference to an EDC when the appropriate detention criteria are met.

How long does an STDC last for and when does it start?

If the patient is in the community the STDC authorizes the transfer of the patient to hospital (within 3 days of the granting of the certificate) and his or her detention there for up to 28 days. If the patient is already in hospital the 28 day period of detention starts when the STDC is granted. An STDC can only be extended in two ways:

- by an extension certificate granted under section 47 (in certain circumstances pending an application for a compulsory treatment order)
- by the 5 working days extension period permitted by section 68 where an application has been made for a compulsory treatment order

The certificate also gives authority to transfer the patient from one hospital to another within the 28 day period.

When can an STDC not be used?

An STDC may not be issued if immediately before the medical examination the person concerned is already detained under:

- An STDC
- An STDC extension certificate (Section 47)
- An STDC extension pending determination of a CTO (Section 68)
- A certificate granted under section 114(2) or 115(2) (detention pending review or application for variation of a CTO or detention pending further procedure of an Interim CTO)

Who has authority to grant an STDC?

An STDC may only be granted by an approved medical practitioner.

What are the criteria for an STDC?

The approved medical practitioner must consider it likely that the criteria which are listed at section 44(4) of the Act have been met before a short-term detention certificate can be granted. The criteria are that:

- The patient has a mental disorder;
- Because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired;
- It is necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient or giving medical treatment to the patient;
- If the patient were not detained in hospital there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person; and
- The granting of a short-term detention certificate is necessary.

What other steps must be taken by the approved medical practitioner before the STDC can be granted?

The approved medical practitioner must consult and obtain the consent of an MHO to the granting of the certificate and consult and have regard to the views of the patient's named person (where it is practicable to do so)

Where it has not been practicable for the approved medical practitioner to consult the named person in advance of granting the certificate, it would be best practice for him or her to attempt to consult the named person as soon as possible after the certificate has been granted.

In addition, the approved medical practitioner should take into account relevant information from the other members of the multi-disciplinary team who are providing care and treatment to the patient. The MHO and AMP should also remember that section 1(3) of the Act imposes on them a duty to have regard to the views of the present and past wishes and feelings of the patient which are relevant to the situation and to the views of the patient's named person, any carer, guardian and welfare attorney of the patient.

What is the role of a Mental Health Officer in the granting of an STDC?

As well as providing consent to the granting of an STDC the MHO has many duties (some of which are set out above in relation to an EDC) including the preparation of a social circumstances report within 21 days of the certificate being granted unless he or she is satisfied that it would serve little or no practical purpose (e.g. there is a recent report already available). The MHO has a key role to play in identifying the patients named person or providing information about the role of a named person and the process of nomination. The MHO must also provide an explanation of the role of independent advocacy.

What are the duties of the hospital managers?

Managers of the hospital have a range of duties following admission of the patient subject to a STDC. Section 46 places a duty on hospital managers to notify the following as soon as is practicable after they have received the certificate. The parties are:

- the patient;
- the patient's named person;
- any guardian of the patient under the 2000 Act; and
- any welfare attorney of the patient under the 2000 Act.

Within 7 days of the certificate being granted, hospital managers must also notify the Tribunal and the Commission that the certificate has been granted. They must also send them a copy of the detention certificate.

Section 260 of the Act places a duty on the managers of the hospital to which the patient is admitted to provide the patient with a range of information which principally relates to the patient's rights. Assistance must be given to the patient in overcoming any communications problems.

Detailed guidance on the duties of hospital managers to provide information can be found through this link http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/informationtopatient

Finally, section 230 obliges hospital managers to appoint an approved medical practitioner to act as the patient's responsible medical officer as soon as is practicable after the granting

of the short-term detention certificate. This should be, where reasonably possible, the same practitioner who examined the patient after admission to hospital.

What medical treatment can be given under an STDC?

A patient subject to an STDC may be given treatment for their mental disorder under the provisions of section 16 of the 2003 Act (see section 2)

Can a patient subject to an STDC be transferred to another hospital?

As no hospital is specified on an STDC a patient can be transferred to another hospital. This may be in emergency when urgent medical treatment is required. In such circumstances steps should be taken to notify the patient's named person, primary carer and MHO.

Can an STDC be suspended?

A patient's RMO may grant a suspension certificate that suspends the detention in hospital for a specified period. Conditions may be attached such as being escort arrangements (being "kept in charge of an authorised person") or any other conditions the patient's RMO wishes to specify.

Can an STDC be revoked?

There are three ways that an STDC can be revoked:

- By the RMO (if satisfied that the grounds are no longer met)
- By the Tribunal following an application by the patient or the patient's named person (this is the equivalent of an appeal)
- By the Mental Welfare Commission (Although the Commission has this power it does not provide an "appeals service" and would direct any request for revocation to the Tribunal)

Compulsary Treatment Order (CTO)

What is a CTO for?

A CTO is used for the treatment of a person with a mental disorder over a long period of time either in hospital or at home or other community setting. It is granted by the Mental Health Tribunal after a rigorous application process involving the patient, their named person, the RMO and MHO. It is likely that the patient will have legal representation and may also have an independent advocate.

When may a CTO be granted?

A CTO may only be granted by the Tribunal after it has considered a range of reports, and information arising from interviews at the hearing. Any application must be made, after careful consideration by the multi disciplinary team, by the MHO. Regard must also be given to the views of the patient, his or her carers and named person. There are strict time periods that must be complied with (see flow chart). The application must be accompanied by:

- two mental health reports
- the MHO's report; and
- a proposed care plan.

The application must also state the compulsory measures being sought, the medical treatment and services which it is proposed will be provided and the name of the hospital whose managers will appoint an RMO (this is only for community based CTOs). The Tribunal decides whether to grant the CTO after consideration of all of this information.

What is a mental health report?

The two mental health reports required must be completed by two approved medical practitioners or by an approved medical practitioner and the patient's general practitioner. The reports are written following separate examinations of the patient (the examinations can take place at the same time if the patient consents or the named person consents if the patient is not capable) of the patient. The examinations must consider the

current and past mental state of the patient, specify whether the patient has a mental disorder, what the symptoms are and whether he or she meets the criteria for a CTO. The measures that that should be authorised, in the medical practitioners opinion, should also be specified. The full requirements of the medical are given at section 57(4) of the Act. Its overall purpose is to provide the tribunal with as much information as is needed to make an informed decision about the need for a CTO.

What is an MHO's report?

The MHO's report provides a wide range of information which is vital to the Tribunal in determining whether a CTO is appropriate. Section 61(4) sets out the items that must be included in the report. As well as the patient's personal details and those of the named person and primary carer the MHO must set out the personal circumstances of the patient, the MHO's views on the medical reports, details of any advance statement made by the patient and any other relevant information. It is expected that this will include whether compulsion is necessary and whether any of the proposed treatment could be given informally. Another very important issue is what the impact of compulsion may be on the patients' personal finances, particularly benefits and housing support.

What is a proposed care plan?

A proposed care plan considers four factors, the patient's needs, the actions proposed to meet those needs, the objectives of those actions and who will carry them out. Information on those four factors are broken down into three further categories. The patient's needs with respect to medical treatment for mental disorder, community care or other relevant services and with respect to any other forms or treatment. The proposed care plan must also specify which of its elements are being provided with the patient's consent and which are being provided on a compulsory basis. An important element to be included is a description of the patient's unmet needs. All of this must be done in the context of the principles of the Act and taking into account any risk factors. The proposed care plan should not be confused with the care plan that the RMO must prepare if the application for the CTO is successful (section 76 care plan). See below for more information on the section 76 care plan.

Activity 5 - Proposed Care Plan

Follow the link below to the CTO application pack and find the sections relating to the proposed care plan that the MHO must complete. Explore how the form sets out the requirements for the proposed care plan.
http://www.scotland.gov.uk/Resource/Doc/924/0066914.pdf

Who must be allowed to give evidence at the Tribunal?

A wide range of parties must be allowed to give written or oral evidence at a hearing, they are:

- patient
- patient's named person
- any guardian of the patient
- any welfare attorney of the patient who has the relevant powers
- mental health officer
- medical practitioners who submitted the mental health reports which accompany the application
- if the patient has a responsible medical officer, that officer
- primary carer
- any curator ad litem appointed in respect of the patient by the Tribunal
- any other person appearing to the Tribunal to have an interest in the application (for example, the patient's nearest relative if they are not the primary carer; the patient's or the medical practitioner's lawyer; other medical practitioner or clinical psychologist called to give evidence; key worker or named nurse; the Commission, etc).

Can a nurse escorting a patient to a Tribunal be asked to give evidence?

The Tribunal takes the view that any escort nurse is there to look after the welfare of the patient and ensure their needs are addressed e.g. for toilet or meal breaks, and to ensure their comfort should they become distressed. The escorting nurse is not required to do anything else at the hearing, and should not give evidence at a hearing. A nurse who is required to give evidence should not perform the role of escort nurse in the same case.

What can the Tribunal authorise with respect to the CTO application?

The Tribunal has three options. It can refuse the application, it can grant the CTO or it can grant an interim compulsory treatment order.

What conditions can the Tribunal set?

If all the conditions set out in section 64(5) of the Act are met, then the Tribunal may make an order containing the elements outlined at sections 64(4)(a), 64(6) to (8) and 66(1) of the Act. These elements are described in the following paragraphs. In summary, they are:

- a series of compulsory measures;
- recorded matters;
- the type of mental disorder which the patient has; and
- the name of the hospital the managers of which are responsible for appointing the patient's RMO (where community-based measures have been authorised).

What compulsory measures can be authorised?

The compulsory measures which may be granted by the Tribunal include:

- the detention of the patient in hospital
- the giving of medical treatment to the patient in accordance with Part 16 of the Act
- imposing on the patient a requirement to attend certain places at certain times for the purpose of receiving medical treatment (this is sometimes called "an attendance requirement")
- imposing on the patient a requirement to attend certain places at certain times for the purpose of receiving community care services, or other relevant services or treatment (this is similarly sometimes called "an attendance requirement")
- imposing on the patient a requirement to reside at a specified place (this is sometimes called "a residency requirement")
- imposing on the patient a requirement to allow certain parties to visit the patient in the place where he/she lives (these parties could be, for example, the patient's MHO or RMO)
- imposing on the patient a requirement to obtain the approval of his/her MHO to any proposed change of address

- imposing on the patient a requirement to inform his/her MHO of any change of address before that change of address takes effect.

What are recorded matters?

In addition to the compulsory measures listed at section 66(1) of the Act, an order can specify "recorded matters". These are the particular types of medical treatment, community care services, relevant services or any other form of treatment, care or service which the Tribunal wishes to mark out as being essential to the care package. The Tribunal may wish to make something a recorded matter because where a recorded matter is not being provided to a patient over the course of the CTO, the patient's RMO is under a duty to bring this fact to the attention of the Tribunal. The Mental Welfare Commission also has this power. On being informed of a failure to provide a recorded matter, the Tribunal will decide whether it wishes to vary the measures or recorded matters specified in the CTO or else revoke the CTO entirely.

What is an Interim Compulsory Treatment Order?

The Tribunal may decide that it does not wish to grant a full 6 month CTO. It may instead grant a shorter order: an interim CTO. This outcome could happen where, for example, the Tribunal does not feel it has enough information on which to base their decision about the full CTO; where it wishes to seek further evidence from another party such as a medical practitioner, psychologist, social care provider, carer or relative; or where the patient and his/her representatives require further time in which to prepare their evidence. An interim CTO may also be granted where an application is made for one. The grounds for an Interim CTO are very similar to a CTO. The Interim CTO may last for up to 28 days and the Tribunal may grant more than one but the cumulative period must not exceed 56 days. The Interim CTO may authorise the same measures as those authorised by a "full" CTO.

Who does what happens after a CTO is granted?

The following parties duties are summarised below:

RMO – The patient's RMO must prepare a care plan which sets out the current care and treatment being given to the patient and what is proposed for the duration of the CTO. This is called the section 76 care plan and will largely be based on the proposed care plan which was submitted to the Tribunal as part of the CTO application. This care plan should be copied to the MHO, CPN and other members of the multi disciplinary team providing care and treatment to the patient. A copy should also be given to the patient and the patient's named person.

Although responsibility is placed on the RMO to draw up the section 76 care plan the MHO and the multi disciplinary team should participate fully in the preparation of the plan.

Local authority – the relevant local authority must designate an MHO to be responsible for the patient's case. This will usually be the MHO who made the application.

MHO – The designated MHO must ensure that all the relevant parties are aware of his or her appointment. This includes the patient, named person, independent advocate, family and carers as well as the multi-disciplinary team.

The MHO must prepare a Social Circumstances Report within 21 days of the making of the CTO unless he or she is satisfied that one would serve little or no practical purpose.

Those involved in the day to day operation of the CTO – the various members of the multi-disciplinary team (including nursing staff, allied health professionals, voluntary sector service providers etc.) should work closely to monitor the provision of the care plan. All concerned should keep in mind the continuing need for compulsory powers, the effectiveness of their application, whether the principles of the Act are being respected. In addition all should regularly review whether the objectives of the care plan are being met and whether the patient is being treated in the least restrictive manner.

What should a section 76 care plan contain?

The Mental Health (Content and amendment of care plans) (Scotland) Regulations 2005 (SSI No. 309) set out the information that must be contained in the care plan aside from the information detailed in paragraph 14 above. In general terms the regulations require that the following information must be detailed in the care plan;

(a) full details of the CTO and the day on which the order was made;
(b) the objectives of the medical treatment which it is proposed to give, and which is being given to the patient;
(c) details of any community care services or other relevant services and the objectives of those services which it is proposed to give, and which are being given to the patient;
(d) details of any other treatment, care or service (other than that described in section 76(2)(a) or in paragraph (c) above) and the objectives of that treatment, care or service which it is proposed to give, and which are being given, to the patient;
(e) the name and other appropriate contact details of the patient's responsible medical officer;
(f) the name and other appropriate contact details of the patient's mental health officer; and
(g) details of the 2 month period during which the statutory reviews under sections 77(2) or 78(2) are required to take place and the actual dates on which these reviews took place.

The full details of the CTO as referred to in paragraph 15(a) above would be the measures and any recorded matters authorised by the order.

With respect to the matters referred to in paragraph 15(g) above this simply means that when the care plan is first prepared under section 76(2) the RMO must detail on it the 2 month period during which the first statutory review must be carried out. When the first review has been carried out and the RMO is updating the care plan as mentioned in paragraph 18 below he/she must include the date on which the review took place and then detail the 2 month period during which the next statutory review must be carried out and so on.

How is a CTO kept under review?

The Act places a duty on the patient's RMO to review a CTO on two separate sets of occasions. The RMO must carry out "mandatory reviews" of a CTO and review a CTO "from time to time". A mandatory review must be carried out during the 2 month period which ends with the day on which the CTO is due to expire. It should be noted that a CTO lasts for 6 months from when it was first made, then for a further 6 months if extended, after which it may be extended for a further 12 months and thereafter every 12 months. In addition therefore to the mandatory review which must be carried out before the expiry of the first 6 month period of compulsory powers authorised by the CTO, the RMO must also carry out "further mandatory reviews". These must be carried out during the 2 month period which ends with the day on which the CTO is due to expire after having been extended or extended and varied.

The RMO should also carry out "from time to time" reviews as frequently as is practicable. Although it is difficult, by definition, to place a precise timetable on when such reviews should take place, they should not necessarily be seen as formal reviews which are separate from the simple day-to-day monitoring of the patient's progress towards recovery. Existing multi-disciplinary or multi-agency forums, such as ward rounds, planned out-patient visits to a day hospital or NHS resource centre could all, be seen as appropriate settings for a "from time to time" review.

What are the possible outcomes of a review?

Following a mandatory or a time to time review the RMO may do the following:

- revoke the CTO by way of sections 79 and 80;
- extend the CTO by way of a determination under section 86;
- apply to the Tribunal for extension of the CTO and variation of the compulsory measures or recorded matters specified in the order under section 92 of the Act where he/she has carried out a mandatory review;
- apply to the Tribunal under section 95 for variation of the compulsory measures or recorded matters specified in the CTO where he/she has carried out a "from time to time" review.

What treatment can be given under a CTO?

Treatment may be given under the provisions of part 16 of the 2003 Act (see section 2) when the Compulsory Treatment Order. A community based Compulsory Treatment Order may state that the patient is to attend a given location for the purpose of treatment. The Act does not, however, authorise the forcible administering of treatment in the home of an individual subject to an order.

What can happen if a patient is not compliant with community based compulsory measures?

If, after efforts have been made by the multi-disciplinary team, a patient does not comply with any attendance requirement of a community based CTO then there are a number of options available to the RMO.

Section 112 gives a power to have a patient taken into custody and conveyed to the place they were to receive treatment or to a hospital. The patient can be detained there for up to 6 hours and treatment administered under part 16 of the Act.

Where a patient fails to comply with any community based compulsory measure Section 113 provides two powers. The power to take the patient into custody and conveyed to hospital and the power to detain him or her there for up to 72 hours. This can only happen after all reasonable steps have been taken to allow the person to comply with the compulsory requirement.

Sections 114 (for a CTO) and 115 (for an interim CTO) give further powers to the patient's RMO where a patient has not complied with compulsory measures. If the patient has been detained under section 113 and following medical examination the RMO can detain the patient for up to 28 days. This can only be done if the RMO is considering whether any of the compulsory measures need to be modified or is satisfied that an application requires to be made to the Tribunal to vary the powers of the CTO. The RMO is required to consult with all relevant parties, including named person and MHO, before granting a certificate.

Can a CTO be suspended?

When a patient is subject to a CTO or an interim CTO which specifies detention in hospital it is possible to suspend the detention component of the order for a limited period of time. For a CTO this period of suspension can be for up to six months with the additional proviso that the cumulative period of suspension cannot be greater that 9 months in the 12 month period that would end with the expiry of the proposed suspension certificate. For an interim CTO the period of suspension cannot extend past the expiry date of the order (this is also true of a CTO).

Conditions can be attached to a suspension certificate such as the patient be kept “in the charge” of an authorised person or any other conditions specified by the RMO.

Suspension of detention may be used as part of a programme of rehabilitation or for attendance at other clinics etc. The RMO and clinical team must keep under review whether it would be more appropriate to vary the powers of the CTO and remove the detention component bearing in mind the principle of least restriction.

Suspension certificates can also be granted in relation to community based compulsory measures specified in a CTO (not for an interim CTO).

Activity 6 - Suspension of detention

The arrangements for suspension of detention are complex and can be difficult to explain. Read the guidance on suspension of detention prepared by the Mental Welfare Commission and think about how you would explain the arrangements to a person on a CTO who would like time away from hospital

http://www.mwcscot.org.uk/web/FILES/Publications/Suspension_of_Detention.pdf

What should happen if a patient requires emergency treatment in another hospital?

If a patient detained under a CTO or an interim CTO required emergency treatment in another hospital for a physical illness and there is insufficient time to undertake a formal transfer then it is appropriate that the detention is supended to allow the transfer to take place urgently. It is important to note that the patient could not be detained in the second hospital unless the RMO specifically states in the suspension certificate that residence is required there.

Can a patient subject to a CTO be transferred to another hospital?

Yes, a patient can be transferred to another hospital within Scotland where the managers of the receiving hospital have consented to the transfer. The patient or named person has a right of appeal to the Tribunal after they have received formal notice of any proposed transfer or were the transfer has already taken place.

Duty to Inquire, Entry, Removal and Detention Powers

Duty to enquire

Section 33 places a duty on local authorities to inquire into the situation of a person who appears to have a mental disorder and is living in the community. This inquiry is likely to be triggered if the person is suspected of being at risk of neglect or ill-treatment. If an MHO believes that entry to premises or access to medical records is required then he or she may seek a warrant from a Sheriff under section 35. Warrants under section 35 can be granted for entry, access to medical records and medical examination.

Removal order

An MHO can apply to a Sheriff for a “removal order” to take a person over 16 to a place of safety if it is believed the person is at risk of significant harm. The order authorizes the MHO, the police or anyone else specified to enter the premises specified with a 72 hour period, it authorizes the police to open locked premises, it authorizes the removal of the person to a place of safety and the person’s detention there for up to 7 days.

An authorised person's order

A section 292 warrant authorizes a person to enter premises where the person is already authorised by the Act to take a person into custody. For example to take a person into custody who is subject to detention and has absconded. The warrant also authorizes the police to break into locked premises. The authorised person must make the application for section 293 warrant to a justice of the peace or a Sherrif.

Removal from a public place

Sections 297 and 298 give powers to the police to take a person who appears to be suffering from a mental disorder and is in need of immediate care and treatment to a place of safety. The purpose of the detention is to allow a medical practitioner to examine the person and make any necessary arrangements for care and treatment. The person may be detained for up to 24 hours pending the outcome of examination.

Nurse's power to detain a patient pending medical examination (nurses holding power)

Section 299 gives a power to certain nurses to detain an informal patient, who is already in hospital, for the purpose of enabling a medical examination.

The patient can be detained for a period of up to 2 hours (the holding period). If the medical practitioner arrives to examine the patient at any point after one hour of the holding period the patient may be detained for a further hour from the time of the medical practitioner's arrival. This is to allow sufficient time for an examination. The nurses holding power should not be used consecutively.

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.

A nurse who has exercised the holding power should take steps to inform an MHO as soon as practicable. This is in anticipation of consent for further detention being required.

The nurse who has exercised the power is required to make a written record of the fact the patient was detained, the time the holding period commenced and the nurse's reasons for believing the necessary grounds for detention under section 299 have been met. The written record must be given to the hospital managers who must send a copy of the record to the Mental Welfare Commission. (Notification forms should be available in every ward).

Activity 7 - Proposed Care Plan

Download a copy of the notification form from the link below. Ask a colleague to give you a scenario where you may consider using the nurses holding power. If you decide that using the nurses holding power would be appropriate fill out the form and ask your colleague to give their opinion.

http://www.scotland.gov.uk/Resource/Doc/1094/0052163.pdf

Activity 8 - Why does the use of the nurses' power to detain vary so much?

The use of the nurses holding power varies greatly between hospitals around the country and even between units in the same hospital. Why do you think that may be? You might find it helpful to look at the section on the nurses' power to detain in Mental Welfare Commission's annual overview report.

http:// www.mwcscot.org.uk/web/FILES/Annual_reports/MWC_Overview_web.pdf

What is a place of safety?

The 2003 Act specifies a place of safety as a hospital, premises which are used for the purpose of providing a care home service or any other suitable place (other than a police station) the occupier of which is willing temporarily to receive a mentally disordered person.

It is important to note that while a police station is not specified as a place of safety it may be used when a constable has removed a person from a public place under section 293 and no place of safety is immediately available.

Correspondence, Telephones and Safety and Security in Hospitals

Sections 281 to 286 set out the provisions that relate to patients correspondence, use of telephones and safety and security. These provisions only apply to detained patients in any hospital. The provisions allow for, in strictly defined circumstances, the interception of patients' correspondence, access to telephones, the restriction of certain items, the control of visitors and the taking of specimens. Any restrictions or measures must be applied in a way which respects the patient's rights and dignity and are commensurate with any perceived risk to health, safety or welfare of the patient or any other person and, where applicable, to the safety and security and good order of the hospital. The Code of Practice provides guidance on the relevant procedures that must be followed. In addition, the Mental Welfare Commission has published guidance on the operation of these provisions.

http://www.mwcscot.org.uk/mwc_home/home.asp

http://www.scotland.gov.uk/Publications/2005/08/29100428/04380

Activity 9 - Scenario - Named person and tribunal representation

John and Frank, both in their late 60s have been partners for many years. They live together in a very supportive relationship. John has had a bi-polar type illness for a long time and recently had to be admitted to hospital under a compulsory order. A tribunal hearing is coming up, initiated by John who wants his CTO varied so he can be treated at home. John has specified Frank to be his named person. Frank is worried how the Tribunal will view the fact that he and Frank are gay and whether that will adversely affect the judgement on the suitability of the home environment.

1. How would you approach Frank's worries?

2. What information do you think he might find helpful?

Unit 4

People with Mental Disorder in the Criminal Justice System

Click **Here**

4

People with Mental Disorder in the Criminal Justice System

Introduction

This section describes what happens when a person, alleged to have committed an offence, comes into contact with the Scottish criminal justice system and where it is thought that he or she might have some form of mental disorder. At first sight these provisions appear complex, and to an extent they are. However, their purpose is straightforward, to ensure that a person with a mental disorder can be assessed, treated and appropriately cared for before, during and after the criminal justice process.

When someone breaks the law society expects that person will face some form of penalty as a consequence of his or her behaviour. However, our society also expects that people who are mentally ill or have a learning disability receive help, protection and treatment regardless of their circumstances. If we steal a car, break into a house or assault someone it is expected that we will be punished. However, what if someone who commits an offence clearly has some form of mental illness or learning disability? What if there is a possibility that their behaviour was as a result of some sort of mental disorder? What if the person who offended has a mental disorder but the offence appears to be unrelated? How can we make sure that an alleged offender who might have mental disorder gets properly assessed? How can we make sure that someone who has offended and is mentally ill or learning disabled gets the treatment they need at the right time in the right place? How can we be sure that the public is protected from high risk offenders who have a mental disorder?

Within the Scottish criminal justice system the 2003 Act, in conjunction with other legislation, provides the legal framework to allow for the assessment, treatment and protection, both of the offender with a mental disorder and the public at various stages of the legal process. The law does appear complex but its functions are clearer if broken down into its various stages.

Frontline staff working with people who are subject to these parts of the 2003 Act need to be know what the implications are

on aspects of care and treatment of matters such as consent to treatment, suspension of detention, timescales of compulsory powers and restricted status. Staff need to understand what these implications are so that they can make sure that patients understand their rights in relation to their treatment and detention.

In undertaking this study unit it is imperative that you have already completed Unit 1 as you will need to be able to apply aspects of your learning from Unit 1 to this unit. Please also remember as you read through the details of the various forms of compulsory powers that in carrying out any function under the Act practitioners must have regard to the principles of the Act (see Unit 1) and that in considering the use of compulsory powers the definition of "mental disorder' (see Unit 1 also) must be met.

Learning Outcomes

By the end of Unit 4 learners should be able to:

- Critically examine the key elements of provisions relating to people with mental disorder in the criminal justice system
- Determine when to access advice from specialists services for people with mental disorder in the criminal justice system
- Critically examine the implications for aspects of care and treatment resulting from the specific provisions of this part of the Act
- Support colleagues, people who use mental health services, their family and friends in articulating the technical language of the Act

Activity 1 - Is this section just for staff working in forensic services?

The answer to this question is a resounding no. Many people who have committed offences and then been made subject to compulsory care and treatment receive that treatment in general acute and old age services, both in hospital and in the community. While staff working in those services may not have frequent contact with patients who are subject to the provisions discussed in this section it is very important that all mental health and learning disability staff have a general overview and know where to get detailed information when required. Not least to ensure that the requirements of the legislation are adhered to but also to be able to discuss the implications with the people affected.

You may wish to find out how many patients in the service you are working in have been or are subject to mental health criminal justice procedures. Your local medical records department may be able to help. You can look at statistics on the use of mental health criminal justice procedures on the Mental Welfare Commission's website at this link:

http://reports.mwcscot.org.uk/annual_monitoring/overview2008-2009/annualreport2008-2009.aspx

Summary and Solemn procedures

In Scottish law, depending on the seriousness of the charges made against a person, summary or solemn procedures may be followed in either the Sheriff or District Courts or in the High Court. At the different stages of the procedures; in custody before a court appearance, during the court procedures and trial, sentencing and at final disposal the 2003 Act provides various options to allow for the person to receive appropriate assessment and treatment. Some of these options mean that the person concerned is subject to special restrictions which has significant implications on who can make decisions about discharge, transfer and suspension of detention.

Assessment in police custody (before any court appearance)

The police, prosecutor, court, criminal justice social work services, or the person's solicitor might be alerted to the possible presence of mental disorder from knowledge of previous psychiatric treatment, the person's behaviour and presentation, concerns expressed by others such e.g. relatives and from the nature of the alleged offence.

If this happens then a request for a mental health assessment is usually requested by either the police, prosecutor or court. This assessment is usually carried out by a forensic medical practitioner, formerly known as a police casualty surgeon who can, depending on the area, ask for an urgent assessment by a psychiatrist and if necessary by a Mental Health Officer. Although the person is not, as yet, within the remit of the court any findings at this stage might have an impact on any court appearance. It may be that the doctor who sees the patient at this stage makes recommendations to the court at the first appearance.

The outcome of this assessment and/or a report should be communicated to the police who will include this in their report to the prosecutor.

What could happen at this stage?

What happens now depends on the mental state of the person, their need for and willingness to accept treatment, the seriousness of the offence and the risk that they are thought to pose to themselves or to others. The options that are open are:

- Informal admission to hospital or referral to community based services
- Immediate admission under an Emergency Detention Certificate or a Short Term Detention Certificate (see unit 3)
- Non urgent application for a Compulsory Treatment Order (see unit 3)
- Recommendation for an Assessment Order (Section 52D) or a Treatment Order (Section 52M) to be applied by the court at the person's appearance in court on the next working day. This is the most appropriate option where the alleged offence is serious and/or the person poses a significant risk to others.

- No recommendation at present but a suggestion that a non urgent psychiatric assessment is sought while the person is on remand or bail.
- No further psychiatric involvement required

What are Appropriate Adults?

Appropriate Adult schemes do not arise from the provisions of the 2003 Act. However, Appropriate Adults are an important safeguard for potentially vulnerable people who have a mental disorder. Their main function is to ensure that a mentally disordered person is not disadvantaged during a police interview as a result of the disorder from which he or she suffers. The police should always have an Appropriate Adult present when they interview a person who appears to have a mental disorder.

Link to appropriate adults service guidance - http://openscotland.net/Resource/Doc/1099/0053903.pdf

What are Treatment and Assessment Orders?

These are the orders (sections 52 B to U) that are most frequently used to make sure that people, who appear to have a mental disorder are assessed and, if necessary, treated before the final disposal of the case by the court. They can be used before trial, after conviction, and before sentencing.

Assessment Orders

What is the purpose of an Assessment Order?

The key purpose of an Assessment Order is to allow the appropriate examination and assessment by an approved medical practitioner (AMP), of a person who is either awaiting trial or sentence.

What does it do?

It authorises the removal to, and detention in, a specified hospital for up to 28 days. The order can be extended for 7 days on one occasion only. It may also authorise the giving of medical treatment in certain circumstances (see effects of an Assessment Order for more details).

Who can apply for an Assessment Order?

The prosecutor can apply for an Assessment Order if the person has been charged with an offence, they appear to have a mental disorder, and the court proceedings have not concluded (section 52B). The court itself can also apply on its own motion (section 52E). If the person is remanded in custody Scottish Ministers may apply for an Assessment Order to be put in place (section 52C). This is appropriate in cases where waiting for the next court appearance would lead to an unreasonable delay or would not allow time for an adequate assessment pre-trial or pre-sentence.

Who are Scottish Ministers?

Scottish ministers are elected representatives (members of the Scottish parliament, MSPs) holding positions in the Scottish Government. They have a number of duties in relation to the 2003 Act and are referred to throughout this learning material.

How is an application for an Assessment Order made?

By the prosecutor – who will apply to the court for an assessment order having been alerted that a person may be suffering from a mental disorder by a medical practitioner who has previously examined the person or by the behaviour of the person in court. The prosecutor must have a report recommending an assessment order (as set out in Section 52D(2)(a). If alerted that a person may be suffering from a mental disorder, say by the police or by the person's conduct the prosecuter will instruct a medical practitioner (does not have to be an AMP) to assess the person and prepare a report.

By Scottish Ministers – where the person is in custody, if a medical practitioner carries out an examination and is of the opinion that the person should be transferred to hospital for assessment then the medical practitioner should prepare a report recommending an assessment order (as set out in Section 52D(2)(a)) and send this report to the prison governor who must notify Scottish ministers and an application may be made to the court that remanded the person for an assessment order.

By the Court – If the court has evidence from a medical practitioner recommending an assessment order it may make such an order. If the court suspects that a person appearing before it has a mental disorder it can instruct a medical practitioner to assess the person.

What are the criteria for an assessment order?

These are set out in Section 52D. In summary, a medical practitioner (not necessarily an AMP) must be satisfied there are reasonable grounds for believing that the person has a mental disorder, that detention in hospital is necessary to assess whether the conditions set out in section 52D(7) (the same as for a Treatment Order) are met. The conditions are that the person has a mental disorder; medical treatment for the mental disorder is available; and if the person did not receive treatment there would be a significant risk to the health, safety or welfare of the person or the safety of others. Also, is it likely that there would be a significant risk to the persons health safety or welfare or the safety of any other person if the assessment order were not made? The medical practitioner's recommendation must also state whether there is a suitable hospital placement available within 7 days and whether there is a reasonable alternative to making an assessment order (the expectation is that the opinion of an MHO is sought in considering alternatives)

Does the person have to appear in court?

It is expected that the person would appear in court for the assessment order. However, the order may be granted in the absence of the person. Under such circumstances the person's legal representative must be present and have an opportunity to be heard.

What happens after an Assessment Order is made by the court?

Within 28 days the responsible medical officer (RMO, who

will be an AMP) has a duty to report back to the court on the individual's mental condition and a view as to whether they meet the conditions of section 52D(7) so that the court can decide how to proceed. These conditions are:

- That the person has a mental disorder
- That medical treatment is available which would be likely to
  - Prevent the mental disorder worsening
  - Alleviate the symptoms, or the effects of the disorder

  and;
- That if the person were not provided with such medical treatment there would be a significant risk
  - To the health, safety and welfare of the person or
  - To the safety of another person

What is the effect of an Assessment order?

An Assessment Order can stipulate that the person be taken to a place of safety pending removal to hospital.

In terms of the 1995 Act (different to a place of safety as defined in the 2003 Act), a place of safety may be a section of the court, a police station, a prison, a young offenders' institution, or a general hospital. However best practice would suggest that in keeping with the principles of the Act, the most appropriate place of safety would be a hospital.

The person should be taken to the designated place by either:

- A police officer
- A person employed in or contracted to provide services in or to; the hospital and who is authorised by the managers of the hospital to remove the person to the hospital (this is likely to be a member of nursing staff)
- A specified person (any other person specified by the court)

Before the expiry of an Assessment Order the RMO should write a report to the court addressing;

- Whether the criteria for the Assessment Order are met
- Any other matters that may have been specified by the court as requiring to be included in the report when it made the assessment order or
- Whether a further 7 days are needed to complete the assessment (the assessment order can be extended for 7 days on one occasion only)

The RMO must produce the report before the 28 days are completed in order to address whether a Treatment Order is required. It is to be expected that the RMO would consult with the relevant MHO in the production of the report.

If the Assessment Order is at the pre trial stage of the court proceedings then it would be ended when court proceedings progress to the next stage or a treatment order is made.

If the Assessment Order is at the pre sentence stage of the process then it should also consider the relationship between the accused's mental state and the offence and the options for disposal.

If the Assessment Order is at the pre sentence or post conviction stage various options can be considered (See Appendix at the end of this Unit.)

Can medical treatment be given under an Assessment Order?

If the person is consenting medical treatment may be given. Treatment may be given without consent provided that the RMO obtains a second opinion from an AMP who is not involved in the patient's case and must consider that it is in the best interests of the patient.

Is there a right of appeal against an Assessment Order?

There is no right of appeal. Although if the person does not believe that they have mental disorder they should discuss this with their RMO. The RMO can make a report back to the court if it is thought that the person does not have a mental disorder.

Activity 2- Is someone on an assessment order allowed out of hospital?

A person who is subject to an assessment hospital is likely to have to attend court hearings. If the person is well known to the service through previous contacts it might be thought appropriate for access to activities away from the immediate hospital grounds. Events may occur that warrant leave on compassionate grounds.

A person on an assessment order is in the same position as someone who is on a restriction order. The full procedures set out in the Memorandum of Procedure on Restricted Patients apply.

You can read the information about the suspension of detention of restricted patients at the link below.

http://www.scotland.gov.uk/Publications/2005/10/0584334/43398

Activity 3 - Attending a funeral

Alex has been admitted to the medium secure unit where you work. He has been charged with assault and is being assessed to establish whether he has a psychotic illness. There was local press coverage of the alleged offence with a follow-up story about Alex's admission to hospital. Alex has been injecting opiates and has a long history of substance misuse. His uncle has recently died and Alex's family have asked if he can attend the funeral.

You are Alex's keyworker, how will you explain to Alex and his family how the decisions will be made about whether Alex can attend the funeral?

Treatment Orders

What is the purpose of a Treatment Order?

A Treatment Order is used to make sure a person who has a mental disorder and is awaiting trial or sentence receives appropriate treatment. It authorises detention in a specified hospital and the giving of medical treatment in certain circumstances.

How is an application for a Treatment Order made?

By the prosecutor – who will apply to the court for a Treatment order having been alerted that a person may be suffering from a mental disorder by a medical practitioner who has previously examined the person or by the behaviour of the person in court. The prosecutor must have a report recommending a Treatment Order (as set out in Section 52M). If alerted that a person may be suffering from a mental disorder, say by the police or by the person's conduct the prosecutor will instruct that the required assessments are carried out by medical practitioners.

By Scottish Ministers – where the person is in custody, if a medical practitioner carries out an examination and is of the opinion that the person should be transferred to hospital for treatment then the medical practitioner should arrange for two medical reports recommending a Treatment Order. These reports should be sent to the prison governor who must notify Scottish ministers and an application may be made to the court that remanded the person for a treatment order.

By the Court – If the court has evidence from two medical practitioners recommending a Treatment Order it may make such an order. If the court suspects that a person appearing before it has a mental disorder it can instruct that the required assessments are carried out.

What are the criteria for a Treatment order?

These are set out in Section 52M (1) to (5). In summary, the court must be satisfied on the written or evidence of two medical practitioners that the person has a mental disorder and that detention in hospital is necessary to assess whether the conditions set out in section 52D(7) are met. These are that the person has a mental disorder; medical treatment for the mental disorder is available; and if the person did not receive treatment there would be a significant risk to the health, safety or welfare of the person or the safety of others. Also, is it likely that there would be a significant risk to the persons health safety or welfare or the safety of any other person if the Treatment Order was not made. The reports must also state whether there is a suitable hospital placement available within 7 days and whether there is a reasonable alternative to making a Treatment Order (the expectation is that the opinion of an MHO is sought in considering alternatives)

Who gives the medical evidence?

The person must be assessed by two medical practitioners one of whom must be an AMP. One of the recommendations must be made by a doctor from the hospital where it is proposed to admit the person.

Does the person have to appear in court?

It is expected that the person would appear in court for the Treatment Order. However, the order may be granted in the absence of the person if the medical practitioner informs the court it would be detrimental to the person. Under such circumstances the person's legal representative must be present and have an opportunity to be heard.

What is the effect of a Treatment Order?

A Treatment Order can stipulate that the person be taken to a place of safety pending removal to hospital. In terms of the 1995 Act (different to a place of safety as defined in the 2003 Act), a place of safety may be a section of the court, a police station, a prison, a young offenders' institution, or a general hospital. However best practice would suggest that in keeping with the principles of the Act, the most appropriate place of safety would be a hospital.

The measures authorised by a Treatment Order are; that the person can be taken, within 7 days, to the designated

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The measures authorised by a Treatment Order are;
that the person can be taken, within 7 days, to the designated place by either a police officer, a person employed by the hospital and who is authorised by the managers of the hospital to remove the person to the hospital (this is likely to be a member of nursing staff) or a specified person; and
the detention of the person in the specified hospital and the giving of treatment under Part 16 of the 2003 Act.

Advance Statement

It is important to remember that staff who are giving medical treatment under the 2003 Act to a person subject to the 1995 Act (as in this case) then those staff must have regard to any advance statement made by the person.

What happens during a Treatment Order?

As soon as practicable after admission to hospital the patient and named person should be informed of their rights and of the availability of advocacy services.

If not already done an RMO and MHO should be allocated to the patient

During the Treatment Order the RMO, in consultation with the MHO will prepare a report that address the various statutory options available. If the Treatment Order is pre-trial these are:

- Insanity in bar of trial
- Insanity at the time of the offence
- Diminished responsibility
- What the appropriate disposal should be

If at the post conviction stage then the following should be considered:

- Whether an interim compulsion order should be made (this is expected to be done if a hospital direction or compulsion order with restrictions is being considered)

- Whether a final mental health disposal should be made which can be a:

  - Compulsion order
  - Compulsion order and a restriction order
  - Hospital direction
  - Guardianship order
  - Probation order with a requirement for treatment

Can a Treatment Order be varied?

A Treatment Order can be varied if the hospital specified in the order is not available within 7 days of the order being made. Also, if the specified hospital is no longer suitable because of a change in the person's mental state an alternative hospital may be proposed.

Can a Treatment Order be revoked?

If at any time during the treatment order the RMO no longer thinks the grounds are met then he/she must submit a report to the court. The court may then confirm, vary or revoke the treatment Order.

How does a Treatment Order end?

If the person is on a Treatment Order pre-trial, the order ends if:

- He/she is liberated in due course of law
- Proceedings are deserted
- He/she is acquitted
- He/she is convicted
- He/she is found insane in bar of trial

If the person is on a treatment order post-conviction but pre-sentence the order ends if:

- Sentence is deferred
- Sentence is imposed
- One of the following mental health disposals is made
  - Compulsion order
  - Compulsion order and a restriction order
  - Hospital direction
  - Guardianship order
  - Probation order with a requirement for treatment

Activity 4 - How long can a treatment order last for?

Consider the information above and work out how long a treatment could last for.

How would you explain the time limits on detention to a person who is subject to a treatment order?

Interim Compulsion Orders

What is the purpose of an Interim Compulsion Order?

Where a mentally disordered person has been convicted of a serious offence and may also pose a significant threat to themselves or to others an Interim Treatment Order allows for a prolonged period of assessment. This assessment has the aim of helping the court make the most appropriate final disposal. It may only be used where a compulsion order with a restriction order or a hospital direction is being considered.

What are the criteria for an Interim Compulsion Order?

The person must have been convicted of an offence punishable by a prison sentence (with the exception of cases where the sentence is set by law i.e. murder)

The court must also be satisfied that it is appropriate to make an Interim Compulsion Order having regard to the all the circumstances and the nature of the offence and any alternative available

There must be written or oral evidence from two medical practitioners, (one of whom must be an approved medical practitioner) that the grounds for detention are met.

There must be reasonable grounds for believing that the person's mental disorder is such that it would be appropriate to make a final disposal of a compulsion order and a restriction order or a hospital direction.

To assess these issues a suitable, specified hospital placement must be available within 7 days. A state hospital may be specified if the offender requires conditions of special security that cannot be provided elsewhere. (If within the 7 days of the order being imposed, it becomes clear that the hospital specified is unsuitable due to an emergency or other special circumstances so that the hospital is unable to admit the offender, this should be notified to the court or the Scottish Ministers and they may direct the offender to be detained in another hospital.)

How long does an interim Compulsion Order last for?

An Interim Compulsion Order may be made for a period of up to 12 weeks and can be extended by periods of 12 weeks at a time, to a maximum of 12 months.

Does the person have to appear in court?

Where the offender is unable to attend the court to hear the decision, due to their mental disorder or that they pose a significant risk in court, then the court may be able to grant the Order in their absence. In these circumstances, the offender's legal representative must be present and must be given the opportunity to speak.

Can an Interim Compulsion Order be revoked?

If it becomes clear to the RMO during the Interim Compulsory Order that the medical criteria are no longer met, the RMO may submit a report to the court containing a recommendation that the Compulsion Order is revoked. In seeking to have this done it is expected that the RMO would consult widely and work closely with the MHO, and take into consideration the social circumstances report provided.

What must happen after an Interim Compulsion Order is made?

Following the granting of an Interim Compulsory Order, the Local Authority has the duty to appoint an MHO to the person. The managers of the hospital the offender is detained in should ensure that the Local Authority is informed of the admission within two working days and an MHO should then be appointed within two days. The MHO must then complete a social circumstances report which is submitted to the RMO and the Mental Welfare Commission within 21 days of the Order being made.

An assessment must be carried out by the RMO and a written report must be submitted to the court before the 12 week period of compulsion comes to an end.

What issues should be addressed in the assessment?

- What is the nature of the person's mental disorder?
- What is the prognosis and likely response to treatment?
- What is the relationship between the mental disorder and the offence?
- What risk does the person pose and what part does the mental disorder play?
- What are the person's social circumstances and personal history relevant to understanding the mental health and social care needs and the assessment of risk

If the RMO is requesting an extension of the Interim Compulsory Order there needs to be only one report. However, if the recommendation is to be a Compulsory Order with a Restriction Order or a Hospital Direction then there would need to be two reports.

Although the usual outcome of an Interim Compulsory Order is a mental health recommendation to the court, a non mental health recommendation may be made. In this case the court would most likely impose a prison sentence on the offender.

Advance Statement

It is important to remember that staff who are giving medical treatment under the 2003 Act to a person subject to the 1995 Act (as in this case) then those staff must have regard to any advance statement made by the person.

Section 200 of the 1995 Act

This section's original purpose is to remand a convicted person in custody or on bail for assessment of their mental or physical condition. However, now that Assessment and Treatment orders are available it is expected that section 200 should not be used for assessment of a person's mental disorder.

Final Disposal of the Case

Broadly speaking, following conviction the court has a range of options to provide appropriate care and treatment in the right setting for that person. This includes hospital, community settings and options for further assessment. There are also options for non mental health disposals such as prison, probation a fine etc. In a few cases the mentally disordered offender may plead insanity. Insanity is a legal, not a medical term. There are special arrangements for people who are unable to participate in a trial or instruct legal representation or who were insane at the time of the offence. We discuss these arrangements later.

What options does the court have after conviction?

If further assessment or treatment is required:

- Assessment order (section 52D)
- Treatment order (section 52M)
- Committal to hospital (section 200)
- Interim compulsion order (section 53)

Where a final disposal can be made:
Hospital –

- Compulsion order (section 57A)
- Compulsion order with restrictions (section 57A&59)
- Hospital direction (section 59A)

Community –

- Compulsion order (without detention) (section 57A)
- Guardianship order (section 58(1)(a))
- Treatment as a condition of probation (section 230)
- Voluntary treatment

Non-mental health disposals –

- Custodial sentence in prison
- Probation order
- Community service order
- Fine
- Deferred sentence
- Admonished

The disposal recommended to the court should be the least restrictive option necessary in the circumstances.

- A hospital disposal should only be recommended where a community disposal is not appropriate due to the significant risk the offender poses to themselves or others

- A hospital disposal should be to a unit of no higher security than is necessary considering the risk the offender poses to themselves or others

- The recommendation for a mental health disposal must take the principles of the Act into consideration

Compulsion Order

What is the purpose of a Compulsion Order?

In general terms a Compulsion Order (CO) is almost identical to a compulsory treatment order (CTO) where a person has been convicted of an offence but has a mental disorder. The Court can authorize a range of measures in a CO including detention in hospital or community based treatment.

It is important to note, particularly for nurses working in prisons that the Code of Practice says that –
"For the avoidance of doubt under no circumstances should compulsory treatment for mental disorder by way of a CO (or a CTO) which authorizes compulsory measures in the community be appropriate whilst a person is serving a sentence in prison"

What are the criteria for a Compulsion Order?

The court may make a Compulsion Order where a person;

- Is convicted in the High Court or the sheriff court for an offence punishable by a prison sentence (other than for an offence where the term is fixed by law i.e. murder)
- Is sent to the High Court by the sheriff for sentencing for such an offence

There must be medical evidence from two medical practitioners – one of whom should be an approved medical practitioner stating that the following criteria for detention are met:

- the person has a mental disorder as defined by section 328 of the 2003 Act (section 57A(3)(a))
- medical treatment which would be likely to
  - prevent the mental disorder worsening; or
  - alleviate any of the symptoms, or effects, of the disorder is available for the person (section 57A(3)(b))
- In a case where detention in hospital is authorised that there is a suitable hospital available within 7 days of the order being made
- If such treatment were not provided there would be significant risk
  - to the health, safety or welfare of the person; or

- to the safety of any other person (section 57A(3)(c))

- the making of a CO is necessary (section 57A(3)(d))

- in a case where detention at a state hospital is to be authorised:
  - the person requires to be detained in hospital under conditions of special security; and
  - that such conditions of special security can be provided only in a state hospital (section 57A(3)(6))

Before making the order the court must have regard to the MHO report, all of the circumstances of the case including the nature of the offence the person's background and any alternative means of dealing with the person.

Are there any differences between the criteria for a CTO and a Compulsion Order?

The main differences in general terms between the criteria for a CO and those for a CTO are that for a CO there is no criterion relating to the person's ability to make decisions about medical treatment (see section 64(5)(d) of the 2003 Act in relation to a CTO), the person needs to have been convicted of an offence (other than murder) punishable by imprisonment, and the sentencing court must be satisfied that a CO is necessary taking into consideration the circumstances of the case (i.e. the nature of the offence and the antecedents of the offender) and the other sentencing options available.

What medical evidence is required for a Compulsion Order?

The medical evidence given in the case of a CO should be in writing and, while it can be given, oral evidence in the absence of a written report should be rare. Like a CTO two medical reports are required, one of which should be from an approved medical practitioner (AMP).

The two medical practitioners must agree that the offender suffers from the same category of mental disorder and should set out the conditions of the compulsion that they wish to be included in the Compulsion Order and provide evidence as to why a Community Order is not appropriate if they are asking for a hospital based Order. Measures which may be authorised by a Compulsion Order are the same as a civil CTO (see Unit 3)

What is the effect of a Compulsion Order?

- The person can be taken to a place of safety pending admission to hospital
- The person should be taken from the place of safety as soon as possible by a person listed in section 57(B). This includes nursing staff of the hospital where the person is to be admitted. There are arrangements to deal with a situation where the specified hospital is not available.

What measures can be authorised under a Compulsion Order?

Section 57A(8)sets down the measures which may be specified in a CO. Quoting from that subsection of the 1995 Act, these are:

(a) the detention of the offender in the specified hospital;

(b) the giving to the offender, in accordance with Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 Act (asp13), of medical treatment;

(c) the imposition of a requirement on the offender to attend-
(i) on specific or directed dates; or
(ii) at specified or directed intervals, specified or directed places with a view to receiving medical treatment;

(d) the imposition of a requirement on the offender to attend-
(i) on specified or directed dates; or
(ii) at specified or directed intervals, specified or directed places with a view to receiving community care services, relevant services or any treatment, care or service;

(e) subject to subsection (9) below, the imposition of a requirement on the offender to reside at a specified place;

(f) the imposition of a requirement on the offender to allow-
(i) the mental health officer; (ii) the offender's responsible medical officer; or (iii) any person responsible for providing medical treatment, community care services, relevant services or any treatment, care or service to the offender who is authorised for the purposes of this paragraph by the offender's responsible medical officer, to visit the offender in the place where the offender resides;

(g) the imposition of a requirement on the offender to obtain the approval of the mental health officer to any change of address; and

(h) the imposition of a requirement on the offender to inform the mental health officer of any change of address before the change takes effect.

How long does a Compulsion Order last for?

A CO lasts for up to 6 months and can be renewed for a further 6 months thereafter. After that the renewal periods are 12 months.

Variation, extension and revocation of a Compulsion Order

The procedures for the extension of a Compulsion Order, mirror those for compulsory treatment orders (see Unit 3). One important difference is at the responsible medical officer's first mandatory review of the Order at the six-month stage: if he or she wishes to extend the Order (which at the first review would be for a further period of 6 months), it can only be done by applying to the Tribunal irrespective of whether the measures in the Order need to be varied or not. For any subsequent renewals (which are then at 12-month intervals), the responsible medical officer can extend the Order unless the measures specified in the Order need to be varied when they would apply to the Tribunal. The offender can appeal to the court against the Order first being made and can subsequently apply for revocation of the Order to the Tribunal and against it being renewed or changed in any way.

RMO responsibilities – the Part 9 care plan

Unlike a CTO there is no requirement prior to the imposition of a compulsion order for the preparation of a care plan. However, after imposition section 137 requires the RMO to prepare a "Part 9" care plan which sets out care and treatment in the same manner as for a CTO. The only difference being that the part 9 care plan is also likely to address aspects of the patient's offending behaviour.

Restriction Orders

What is the purpose of a Restriction Order?

A Court can apply a Restriction Order (to a person who has been made subject to a Compulsion Order authorising detention in hospital) to a person who has offended, has a mental disorder and who may potentially pose a risk of serious harm to others. Its purpose is to protect the public from this risk. For a Restriction Order to be recommended to the court there should be a significant link between the person's mental disorder and the person's offence and/or any future risk that may be posed. In general terms it allows for greater scrutiny of the person concerned in the way their care is managed and the way decisions are made about their level of supervision, the general management of their care and their discharge.

The Scottish Government's primary role in the management of Restricted patients is to protect the public from harm. Detailed guidance is given to Responsible Medical Officers, MHOs and other staff in the Scottish Government's Memorandum of Procedure on Restricted Patients (MOP). This document is essential reading for staff working with restricted patients, it sets out the detailed guidance on the roles and responsibilities of all those involved in the care of someone subject to a Restriction Order.
Link to MOP

What are the criteria for a Restriction Order?

For a Restriction Order to be added to a CO which authorizes detention in hospital it must appear to the court that:

- Having regard to the nature of the offence which with he is charged;
- The antecedents of the person; and
- The risk that as a result of his mental disorder he would commit offences if set at large,

That it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of section 59, further the order that the person shall be subject to the special restrictions set out in part 10 of the 2003 Act without limit of time.

In most cases a Restriction Order would be made following extensive assessment under an Interim Compulsion Order.

What is the effect of a Restriction Order?

In general terms a Restriction Order made with a Compulsion Order means that:

- The person can be detained in hospital without limit of time
- None of the arrangements for review and renewal of a Compulsion Order apply. The person is detained in hospital until conditionally or absolutely discharged by the Tribunal.
- Suspension of detention can only be granted with the approval of Scottish ministers
- Transfer to another hospital can only be carried out with the approval of Scottish Ministers

How does a Restriction Order end?

If, after carrying out a review of a restricted patient's case and taking into consideration the opinion of the Mental Health Officer, the Responsible Medical Officer considers that there should be a change to the status of the patient, he or she must submit a report to Scottish Ministers with recommendations. Scottish Ministers must then refer the case to the Tribunal for assessment and any further action. The Scottish Minister can also make their own applications to the Tribunal. Detailed guidance on these arrangements are given in the MOP

The Mental Welfare Commission also has the power to require that Scottish Ministers refer a restricted patient's case to the Tribunal for review. The patient and the patient's named person can also apply periodically to the Tribunal to have the Order cancelled or varied.

Activity 5 - Patient or prisoner?

You are working in a low secure unit which is locked and can receive people who require treatment from prison. Transfers from prison are quite rare, the majority of the patients in the ward are subject to civil compulsory powers although there are two men who are on restriction orders.

John, a 30 year old man who is serving an 8 year sentence for robbery has been transferred to hospital on a Transfer or Treatment Direction. He has been in custody for 3 years and finds the change of environment quite difficult. He asks staff permission to for day to day things like going to the toilet or going to his room and is not used to the less structured life of hospital.

Two of the other patients start to make fun of John, commenting on his behaviour and calling him “The Prisoner”. This catches on in the ward and soon John is being called this by many of the other patients.

1. Think about John’s status. Is he a prisoner?

2. How would you explain to him what his position is in relation to the other patients in the ward who are on civil compulsory orders.

3. What would you do to stop John being singled out and picked on by some of the other patients

What is a Conditional Discharge?

The Mental Health Tribunal can order the conditional discharge of a patient who no longer requires to be detained in hospital for treatment or for the protection of others and to impose such conditions as it thinks appropriate.

In general, a restricted patient's discharge from hospital is subject to certain conditions (the exception being those restricted patients who are also life sentence prisoners.) The conditions usually imposed are those of residence at a stated address, supervision by a social worker and psychiatrist. However, additional conditions may be recommended either for the protection of the public or of the patient. Under the 2003 Act, a recommendation may be made to Scottish Ministers to vary these conditions at any time.

The purpose of formal supervision resulting from conditional discharge is to protect the public from further serious harm in two ways: firstly, by assisting the patient's successful reintegration into the community after what may have been a long period of detention in hospital under conditions of security; and secondly, by closely monitoring the patient's mental health for any perceived increase in the risk of danger to the public so that steps can be taken to assist the patient and protect the public. Conditional discharge also allows a period of assessment of the patient in the community before a final decision is taken on whether to remove the control imposed by the restriction order by means of an absolute discharge.

How does Conditional Discharge come to an end?

Conditional discharge comes to an end when the patient is given an absolute discharge by the Tribunal.

Multi-agency Public Protection Arrangements (MAPPA) and the Care Programme Approach (CPA) for Restricted Patients

While not part of the 2003 Act these arrangements are the basis of the way services manage the multi agency and multi disciplinary care and treatment of patients who are subject to restriction orders. There is comprehensive guidance available on the operation of these procedures.

www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/cel192008

http://www.forensicnetwork.scot.nhs.uk/documents/reports/CPA%20Consultation/Draft%20for%20Consultation%20_inc%20appendices_.pdf

What is the purpose of a Hospital Direction?

A hospital direction allows for a convicted mentally disordered offender to be given a hospital disposal along with a prison sentence. The person can receive appropriate medical treatment for mental disorder under the provisions of the 2003 Act and then to be transferred to prison to complete the prison sentence that was imposed at the time of making the hospital direction. The period of time that the person is subject to the Direction counts as time served in relation to the sentence. Unlike a Compulsion Order there is no exception where the sentence is fixed by law so a Hospital Direction can apply for a conviction for murder.

What are the criteria for a Hospital Direction?

The criteria for granting a Hospital Order as regards the medical evidence is the same as that for the granting of a hospital based Compulsion Order. However three additional factors should also be considered in these cases:

- It would be expected that an Interim Compulsion Order would be recommended first unless there was a very good reason for not doing so
- It would be expected that if a Compulsion Order were being considered due to the nature of the offence, then a Restriction Order would also be recommended
- The link between the specific mental disorder and the index offence and/or the potential risk of further serious harm would be expected to be weak in contrast to the Compulsion Order.

In the consideration of these matters and assessments the expectation is that the RMO and the MHO (who also prepares a report) would work closely together before a Hospital Direction recommendation is made to the court.

What is the effect of a Hospital Direction?

The effect in relation to removal to a place of safety and the arrangements for a change of hospital are the same as for a Compulsion Order. People subject to a Hospital Direction are subject to special restrictions as for those on a Restriction Order

What measures can be authorised under a Hospital Direction?

The measures that may be specified are;

- For an offender who is not already in hospital, their removal to a specified hospital within 7 days of the direction being made
- The detention of the offender in the specified hospital; and
- The giving of treatment in accordance with Part 16 of the 2003 Act

When does a Hospital Direction come to an end?

The Direction ceases to have effect when the person is released under Part 1 of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (section 217 of the 2003 Act). Under such circumstances the patient may be discharged or may remain in hospital as an informal patient or be detained under civil procedures (by way of a CTO in terms of section 64 taking into account the application provisions set out in section 71 of and schedule 3 of the 2003 Act)

Transfer for Treatment Direction

What is the purpose of a Transfer for Treatment Direction?

Many people serving prison services are affected by mental illness. A Transfer for Treatment Direction (TTD) allows for a sentenced prisoner (or a person detained under certain immigration legislation) to be transferred to hospital for care and treatment. All such patients are subject to special restrictions.

What are the criteria for a Transfer for Treatment Direction?

A TTD may be made by Scottish Ministers following consideration of two written reports from medical practitioners one of whom must be an AMP. The criteria are identical to those for a CTO except that, as with other procedures for mentally disordered offenders the impaired decision making ability criterion under section 65(5)(d) does not apply.

What measures are authorised by a Transfer for Treatment Direction?

- The removal to a specified hospital within 7 days of the direction being made
- The detention of the offender in the specified hospital; and
- The giving of treatment in accordance with Part 16 of the 2003 Act

Review of Hospital Directions and Transfer for Treatment Directions

The review procedures for a Hospital Direction and a Transfer for Treatment Direction are similar to those for a Compulsion Order and a Restriction Order. Important differences are:

- A person subject to either of these directions cannot be conditionally discharged.
- Scottish Ministers are under a duty, in certain circumstances, to cancel the Direction and return the person to prison without any requirement to apply to the Tribunal.
- The Tribunal can only direct Scottish Ministers to cancel the Transfer for Treatment Direction. Scottish Ministers must cancel the order when directed to do so by the Tribunal.

The Responsible Medical Officer has a duty to carry out an annual review of the direction (aside from keeping it under review on an ongoing basis), after which he or she submits a report to Scottish Ministers with any recommendations.

Scottish Ministers have a duty to keep a Hospital Direction and a Transfer for Treatment Direction under review. They also authorise the transfer of patients between hospitals whether or not the patient is detained in, or transferred to, the State Hospital.

Suspension of Detention

Section 224 of the 2003 Act sets out procedures for the suspension of detention, previously called "leave of absence", for patients who are on a compulsion order with a restriction order, a hospital direction, a transfer for treatment direction or any of the pre- disposal orders (with the exception of S200). Where a patient is subject to any of these orders, the RMO may grant a suspension of detention certificate for up to 3 months* (apart from for an assessment order which only lasts 28 days) provided that:

- they have obtained the consent of the Scottish Ministers; and
- it does not take the total period of suspension granted over 9 months in any 12 month period.

*It should be noted that the Memorandum of Procedure for restricted Patients states that approval for suspension of detention for up to 3 months would only be granted in exceptional circumstances, and any requests made by an RMO should be discussed with the Scottish Minister's Psychiatric Adviser before being submitted to them. The expectation is that the current good practice of gradually building up suspension of detention to 4 overnights and 5 days will continue with the prospect of the leave being further extended in exceptional circumstances.

Who is subject to special restrictions? – Summary of orders

A patient becomes subject to special restrictions as a result of one of the following orders made under the Criminal Procedure (Scotland) Act 1995 ("the 1995 Act"), as amended by the Mental Health (Care and Treatment)(Scotland) Act 2003 ("the 2003 Act"), or the 2003 Act itself. The orders are divided into pre and post-disposal for ease of reference:

Pre-disposal

- An assessment order under section 52D of the 1995 Act - a pre-disposal order made by the court authorising hospital detention for up to 28 days so that the patient's mental condition may be assessed. Compulsory treatment may also be given in certain circumstances (see section 242(5)(b). The order may be renewed once only for 7 days.

- A treatment order under section 52M of the 1995 Act - a pre-disposal order made by the court authorising hospital detention for treatment of a person's mental disorder. The order ceases at the end of the period for which the person is on remand or is committed.

- An interim compulsion order under section 53 or 57(2)(bb) of the 1995 Act - a pre- disposal order made by the court authorising hospital detention for 12 weeks (but can be renewed regularly for up to one year) so that the court can gather further evidence on whether the forensic criteria apply.

Post-disposal

- An order under section 57(2)(a) and (b) of the 1995 Act. This may follow a finding of insanity in bar of trial or acquittal on the grounds of insanity. Where there is a finding of insanity in bar of trial, an examination of facts will determine beyond reasonable doubt whether the offence(s) in question took place.

- A restriction order made by the court under section 59 of the 1995 Act at the time of disposal and is added to a compulsion order under section 57A of that Act. It means that the measures specified in the compulsion order will be without limit of time.

- A hospital direction order made by the court under section 59A of the 1995 Act following a conviction on indictment under the 1995 Act. In addition to receiving a prison sentence, a hospital direction is made. It allows the person to be detained in hospital for treatment of their mental disorder and then transferred back to prison to complete their sentence once detention in hospital is no longer required.

- A transfer for treatment direction - an order made by Scottish Ministers under section 136 of the 2003 Act which allows the transfer of a prisoner to hospital for treatment of a mental disorder.

Probation Order with a Requirement to Attend for Treatment

What is the purpose of a Probation Order?

The purpose of a Probation Order is for the medical or psychological treatment for a mental condition, but where the condition does not warrant a CTO or a CO,

What are the criteria for a Probation Order?

A court may grant a probation order based on the evidence of an AMP that the person has a mental condition; and this mental condition requires and may be susceptible to treatment; but a Compulsory Treatment Order or Compulsion Order is not warranted. Also, on the written or oral evidence of the registered medical practitioner or chartered psychologist by whom or under whose direction the treatment will be provided that the treatment is appropriate (section 230(3)(a)) and that arrangements have been made for the treatment, including reception in hospital if treatment as a resident in-patient in hospital is to be specified (section 230(3)(b))

A Probation Order cannot be made unless the court has received a social enquiry report from the MHO and they are satisfied that a local authority can make suitable arrangements for the supervision of the offender. The court must also have the agreement of the offender, the practitioner who will carry out the treatment and the probation officer.

What is the status of a person subject to a probation order?

A Probation Order does not provide any compulsory powers of detention or treatment. The offender may be treated as an in patient in any hospital except the state hospital and they will have the status of a voluntary patient in all respects, as a non resident patient at a specified place and that the treatment should be by or under the direction of a medical practitioner or chartered psychologist. Any other aspect of treatment need not be specified.

What happens if a Probation Order is not complied with?

If the offender does not comply with the treatment, or leaves the hospital that they are receiving in patient treatment in, the Act does not authorise detention. In this instance decisions would have to be made as to whether the circumstances and the person met the grounds for a STDC or an EDC

Insanity

What does insanity mean?

Insanity is used as a legal term and is not the same as the term mental disorder as defined in the 2003 Act. There are 3 different situations where insanity may determine the procedures followed and the outcome of the trial. These are; insanity in bar of trial, insanity at the time of offence and diminished responsibility (which only applies when the charge is murder). Both insanity in bar of trial and insanity at the time of the offence are used as a defense. Diminished responsibility is a plea of mitigation.

Insanity in bar of trial

If a person's mental disorder is such that he/she cannot participate adequately in the court process, (i.e. cannot understand the proceedings or instruct a legal representative as to a defence), then it has long been held that it is unfair for the person to be tried. If this is the case the court may find the person insane in bar of trial (or insane and unfit to plead) and there is no trial, or where the trial has commenced, it will be discharged (section 54(1)(a)) and orders an Examination of Facts

What is an Examination of Facts (EOF)?

An EOF is the procedure by which a court determines whether it can declare that the accused to be acquitted of the offence(s) on grounds of insanity. By way of the EOF the court determines whether the person committed the offence(s) and makes a finding to that effect. If the court finds beyond reasonable doubt that the person did not commit the offence then he or she will be acquitted. If it is found that the accused did commit the offences then the court will consider if there are grounds for acquittal, which includes insanity. The secondary purpose of the EOF is to identify an appropriate disposal for the person. Disposals available are:

- Compulsion Order
- Compulsion Order with Restriction Order
- Guardianship order
- Supervision and Treatment Order
- No order

However, if the court is not satisfied within reasonable doubt that the accused is responsible for the offence then he or she must be acquitted. In such circumstances the court may detain the person for a medical examination under section 60C.

Temporary Compulsion Order

When a person has been found insane in bar of trial, the court can make a Temporary Compulsion Order to allow the person to be detained in hospital for treatment of their mental disorder, while the court is holding an EOF to determine whether the person committed the offence. The court must be satisfied that:

- The accused has a mental disorder
- Medical treatment is available that will help alleviate the symptoms of the mental disorder or prevent the mental disorder worsening
- If such medical treatment were not given there would be significant risk to the accused or to any other person
- A hospital is available and suitable for the accused to be detained (this hospital would be specified in the Order)

The timescale and means of removal to hospital are the same as for a CO. The order authorises medical treatment under part 16 of the Act. Best practice would recommend that if the accused does not already have an MHO and an RMO, then these should be appointed and a social circumstances report should be drawn up. The Temporary Compulsion Order should be kept under review by the RMO and any change in the condition of the accused should be reported to the court. If the RMO feels there are grounds for a variation or revocation they submit a report to court and the order may be varied, revoked, or confirmed.

Insanity at time of offence

If a person was mentally disordered at the time of the offence then this may affect his/her legal responsibility for his/her actions. In some cases the court may find that the person's mental condition was such that he/she cannot be held responsible for his/her actions, he/she is then acquitted on account of insanity in terms of section 54(6) (also known as insanity at the time of the offence or not guilty by reason of insanity). A person may also be acquitted on the ground of insanity in terms of section 55(3) and (4), where the trial diet has been discharged and an Examination of Facts has taken place.

Diminished responsibility (only applicable where the charge is murder)

In murder cases, a person's mental condition may be such that although he/she cannot be acquitted on account of insanity, he/she may be found to be of diminished responsibility. The latter is a mitigating plea as opposed to a defense and therefore does not result in acquittal. The issue to be considered by the court is the extent of the effect of the accused's mental state on his or her actions.

Legal criteria

The legal criteria for insanity in bar of trial, insanity at the time of the offence and diminished responsibility are derived from common law. This means that the criteria are based on case law and could change. The current criteria are set out below.

Legal criteria for insanity in bar of trial:
In H. M. Advocate v. Wilson1942 JC 75 the court set out that there had to be:

a mental alienation of some kind which prevents the accused giving the instruction which a sane man would give for his defence or from following the evidence as a sane man would follow it and instructing his counsel as the case goes, along any point that arises.

Similar criteria were set out in Stewart v H. M. Advocate(No. 1) 1997 JC 183:

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

The test excludes amnesia for the circumstances of the alleged offence in itself, but inability to give instruction due to physical defects may be accepted with the exception of deaf mutism (HMA v Wilson1942 SLT 194).

Legal criteria for insanity at time of offence:
H. M. Advocate v Kidd1960 JC 61 (at page 70) is currently generally accepted and used as the basis of the insanity defence:

... in order to excuse a person from responsibility on the grounds of insanity, there must have been an alienation of reason in relation to the act committed. There must have been some mental defect … by which his reason was overpowered, and he was thereby rendered incapable of exerting his reason to control his conduct and reactions. If his reason was alienated in relation to the act committed, he was not responsible for the act, even although otherwise he may have been apparently quite rational.

Self-induced intoxication does not provide grounds for a defence of insanity.

Legal criteria for diminished responsibility:
These were set out in Galbraith v H. M. Advocate2001 SCCR 551 (2001 SLT 953 at page 966). The conclusions of the court were:

In essence, the judge must decide whether there is evidence that, at the relevant time, the accused was suffering from an abnormality of mind which substantially impaired the ability of the accused, as compared with a normal person, to determine or control his acts.

'Psychopathic personality disorder' (Carraher v HMA1946 SLT 225 and Kennedy v HMA1944 JC 171 both refer) and voluntary intoxication (Brennan v HMA1977 JC 3 refers) are excluded.

Detention on acquittal

Where there has been a medical recommendation for a Treatment Order, Interim Compulsion Order, Compulsion Order or a Hospital Direction for the accused, but they are subsequently acquitted of the alleged offence, it is possible for them to be detained for further medical examination (Section 60C). In the case of an Interim Compulsion Order, there need only be reasonable ground for believing that medical treatment would be of benefit.

Criteria for detention on acquittal

The Act allows for the Emergency Detention of a person acquitted of an offence under certain criteria;

The person has been acquitted
There must be evidence from 2 medical practitioners (one of the approved) satisfying the court that, the person has a mental disorder, medical treatment that would be likely to prevent the disorder worsening or alleviate any of the symptoms or effects of the disorder is available for the person and if f such treatment were not provided there is a significant risk to the person themselves or any other person. In addition the court must be satisfied that it is not practicable to secure the immediate examination of the person by a medical practitioner.

Effect of detention on acquittal

The person can be removed to a place of safety for a maximum of 6 hours and the most appropriate place would be the hospital that they were going to be admitted to or, if this is not possible, another hospital.

Ideally the subsequent examination should be done by one of the practitioners who made the disposal recommendation in case of conviction, but again time may not allow that, so it may be another medical practitioner who carries out the examination, and consults with one or other of the practitioners of the original report. It is also expected that the MHO would be involved with this assessment.

If the person requires to be detained longer than the 6 hours

consideration should be given to the use of an EDC or an STDC.

Medical treatment may not be given under the Act as the person is not detained. If the need for emergency treatment becomes evident, then the same grounds apply as is the case in civil detention.

Supervision and Treatment Orders

In general terms a Supervision and Treatment Order (STO) can be used where the court is of the opinion that the person requires treatment but can live in the community, with the supervision of health and social services.

Criteria for a Supervision and Treatment Order

The court must be satisfied:

- That, having regard to all the circumstances of the case, the making of such an order is the most suitable means of dealing with the person
- On the written and oral evidence of two approved medical practitioners that the person has a mental condition which requires and may be susceptible to treatment, but this mental disorder is not such that the person requires a Compulsion, with or without Restriction, or a Guardianship Order
- That the supervising officer intended to be specified in the order is willing to undertake the supervision of the person
- That arrangements have been made for the treatment specified to be given.

The court must also have a social enquiry report prior to considering an STO; this will ensure that the full assessment has been completed.

Treatment under a Supervision and Treatment Order

Unlike the Probation Order with treatment as a requirement, in-patient treatment cannot be given under an STO. The person can only be treated as an out patient although the place and the giver of the treatment should be specified in the STO. If the treatment was to be given by an approved medical practitioner,

then it is expected that they would be one of the reporters in relation to the STO. If however the treatment is to be given by another professional then their agreement should be sought and received before making the recommendation of an STO.

How long does a Supervision and Treatment Order last?

The duration of the Order may be for a period of up to three years. The person being supervised must comply with the recommendations set out in the STO, including if specified, a place of residence, but this cannot be a hospital. The person may move residence but this may mean making a variation to the STO if they are to be supervised by a different authority.

What happens if a Supervision and Treatment order is not complied with?

As the person has not been convicted on the grounds of insanity, the Order is not a sentence and cannot be breached in the same way that a Probation Order can.If the person does not comply with the order then it is expected that the supervising officer, the medical practitioner and relevant others should decide the next course of action.

If the mental condition deteriorates then inpatient treatment can be given with the person's consent as an informal patient.

If they do not consent then it may be necessary to instigate emergency detention procedures under the civil and not the criminal law. If any of the civil measures such as in-patient treatment, Emergency Detention or a CTO are instigated, then it would be expected that the STO will be revoked.

However this order does not allow the person to be taken forcibly for the treatment and part 16 of the Act concerning medical treatment does not apply to people with an STO.

Can a Supervision and Treatment Order be varied or revoked?

The medical practitioner can submit a report in writing to the supervising officer and apply to the sheriff court to revoke the order. In the case of a change of treatment the medical practitioner should apply in writing to the supervising officer and an application is made to the court to have the order changed.

When an STO is revoked the supervising officer will receive a copy from the court. It is then his responsibility to give a copy to the supervised person and the manager of any place that they have been required to reside. They must also send a copy to the Mental Welfare Commission.

Activity 6 - Scenario - Zero Tolerance

A young man is seeing his GP and is asking for medication to help with feeling generally unwell. He has had general pains about his body and thinks that his neighbours might be interfering with him. He is quite anxious and irritable. He is upsetting the surgery staff and the GP asks him to leave. As he is ushered out he turns and slaps the GP on the face. The GP is shaken but there is no physical injury as a result.

The GP practice operates a “zero tolerance” approach to violence and aggression. It is situated in an area of deprivation and there have been problems with drug addicts being intimidating towards staff.

The police are called, they arrest and charge the young man with assault. He is held in custody and when he appears in court the sheriff gives him a 12 month sentence.

The young man has a history of a schizophrenic illness, he has been in hospital and is currently subject to a community based CTO. He has had some minor brushes with the law resulting from behaviour associated with his illness. He had a history of substance misuse but this was currently under control. Psychiatric reports were called for and considered by the court before sentencing.

1. What options were open to the prosecutor and the court in this case?

2. What happens when someone subject to a CTO is sent to prison?

3. What are your views on a “zero tolerance” approach to violence when the perpetrator has a mental disorder?

Activity 7 - Scenario - Suspension of detention

Tension is building between two men who are detained in a mental health medium secure unit. One of the men has been granted a suspension of detention and is going to visit his home overnight. The other man, who has been in hospital the same length of time and whose mental state has improved considerably, has had no suspension of detention and none are in prospect. The second man is very angry and feels he is being treated unfairly.

Both men are subject to Compulsion Orders but the second man is also subject to a Restriction Order. They have different RMOs. The first RMO has assessed that his patient would benefit from the period of suspension and that it will provide an excellent opportunity for further assessment. The RMO of the second patient is cautious and she has not yet applied to Scottish ministers for permission for a suspension.

1. How do the arrangements for suspension of detention differ for a person subject to a CO and a person subject to a CORO?

2. Where would you find detailed information about the management of suspension of detention for someone who is subject to restrictions?

Appendix A

Suggested Answers to Activities

Click **Here**

Activity 3

There are a number of issues in this situation, not least that Drina may be being discriminated against on the basis of her ethnic background as a Gypsy/Traveller. To do so would be wrong. However, focusing on the principles of the 2003 Act at first sight you might think this is an issue about participation. The principle of participation relates to the involvement of the person as fully as possible in any decisions being made and the importance of providing appropriate information. The principles, of course, apply to people performing functions under the Act, not, as in this case the swimming pool management.

However, In this case it is probably best to use the principles as a guide to your own actions and to think of how they can help shape your involvement. Swimming appears to be of **benefit** to Drina and you would like to help her continue the activity. You will have to help the swimming pool managers with their anxieties about her attendance there. You could focus on the principle that a person's racial origin, cultural and linguistic background and membership of any linguistic group must be taken into account. Knowing this should help you in your discussions with the management of the swimming pool.

In addition Section 3 of the 2003 Act provides a duty on anyone carrying out a duty under the Act to ensure that the function is discharged in a way that encourages equal opportunities. Equal opportunities are set out in the Scotland Act 1998 and mean the prevention, elimination or regulation of discrimination between persons on the grounds of sex, or marital status; on racial grounds; or on grounds of disability; age; sexual orientation; language or social background.

Activity 5

1. As part of your medical assessment of Jake you would be thinking of what the appropriate course of action would be for his effective treatment. The treatment may involve the use of the 2003 Act so you would be assessing whether he had a mental disorder in terms of the Act. Section 328 provides that "mental disorder" means any mental illness, personality disorder

or learning disability, **however caused or manifested**. In Jakes case it appears highly likely that although his apparent psychosis has been caused by his drug misuse it is still a mental illness that requires treatment. Section 328(2) does specifically state that a person is not mentally disorder by reason only of a number of reasons which includes dependence on, or use of, alcohol or drugs. However, the Act is clear that its provisions can be used in respect of a person who has a mental disorder who also have drug and alcohol problems.

2. It is very likely that the doctor will be thinking of the importance of providing the maximum benefit to Jake balanced against providing treatment with the minimum restriction on his freedom. In addition the views of Jake's family as his carers are very important given their longer perspective on his behaviour.

3. In this situation it looks as if Jake's relatives will be very relieved that he is receiving treatment and is being looked after in a safe place. However, it is important that it is made clear that the use of the Act is in relation to Jake's treatment for his apparent psychosis. The Act can't be used **solely** to prevent a person from misusing drugs.

Unit 2

Activity 2

1. and 2. Having someone as your named person does not necessarily mean that you want that person to know all of your personal details. Some responses to the consultation on the limited review of the 2003 Act highlighted concerns that information about past abuse, the person's sexual history or details of past criminal offences could be disclosed which the person concerned did not wish their named person to have knowledge of. Some people were concerned that details of their financial history could be disclosed.

There are Tribunal rules of procedure that allow the professionals involved to request that sensitive information be withheld from one or more of the parties. If your patient is concerned about certain information being disclosed then you could help him or her to discuss their concerns with the MHO involved in the case.

Activity 3

1. The Act puts a duty on the MHO to take steps to find out if the person has a named person. If the MHO is unsuccessful in identifying a named person then they have to record the steps they have taken and inform the tribunal and the Commission. The MHO can then apply to the Tribunal for an order appointing a named person. However, if a member of the multi disciplinary team is better placed to find out whether a person has a named person then it would be best practice for that person to do so and communicate the information to the MHO.

2. Given that Kate appears to be comfortable with you then you are well placed to find out more about her background and history. You are well aware that when someone is suspicious it can take a little time to build up trust. However, with gentle questioning you are likely to be best placed to find out if Kate understands what a named person is and if she has one.

Activity 4

1. Hopefully Sean has been fully involved in the planning of his discharge from hospital and the care and support that he will be receiving at home. An advance statement would give him the opportunity to set down what his wishes are for his future care in a way that must be given due regard by those people who will be helping him. Although he has been able to get to know the staff who have helped him while in hospital and the community based staff who will be giving him support at home, these staff will change over time. An advance statement can be very helpful for new staff to be able to see what his wishes are if he were not able to tell them directly in the future. Sean may be feeling that he now can clearly express his wishes about his care and treatment but that could change. It can be tricky to discuss advance statements without sounding pessimistic about the liklihood of future periods of illness but the positive message is that an advance statement is Sean's voice put in a form that must be heard by the staff looking after him. Sean may be aware that advance statements can be overridden and be a little cynical about their usefulness to him personally. In practice figures from the mental Welfare commission indicate that very few advance statements are actually overridden (in 2007-2008 there were 13 overrides)

2. It can be very hard to think of the consequences of becoming unwell again. Especially just after having coming out of a period of illness, maybe with associated crises in one's life However, writing an advance statement while the experience of care and treatment is fresh in ones mind can help make those wishes for the future more relevant.

3. This is a very personal question, any of us can become unwell to the extent that our judgement is impaired and we are unable to state our wishes about care. Thinking of your own wishes in such a situation is not only of benefit to your own situation it can also help build your own understanding of the thoughts and wishes of those people you are helping towards recovery.

Activity 5

The potential benefits have already been discussed in the responses to the previous activity. For June it will be a hard task to accept that the medication she has to take is of benefit to her in the long term, particularly as she blames it for her lack of energy and inability to take much pleasure in her life. The team looking after her will be concentrating on improving her life and helping her with the negative thoughts she has in general. While the overriding of her advance statement may be adding to her feelings of helplessness it should be explained to her all the safeguards that are being applied to make sure that she is receiving appropriate treatment. She has been seen by a Designated Medical Practitioner who has agreed the treatment plan proposed by her Responsible Medical Officer. The override of her advance statement has been reported to the Mental Welfare Commission. Her RMO and clinical team must be carrying out frequent reviews of the need for compulsory powers in her care. It is also important that you make sure that June knows her concerns are clearly documented and taken into account whenever her treatment is being reviewed. She can, of course, apply to the Tribunal for a revocation of her CTO. June should have the support of an independent advocate in this situation to help her express her views to the clinical team.

Activity 6

1. Brenda has spent some time making arrangements for John to be involved in activities outwith his limited environment. Secretly she thinks that not enough has been done in the past to encourage him to get out more and engage with other people. She may be feeling that Suzi is not doing what is best for John, i.e. encourage him to get out more and form new relationships.

2. Suzi knows that she is there to help John express her views and is doing so in the way she thinks is most appropriate. However, she did get on well with John's previous CPN whom she thought paid due regard to John's wishes. She may be thinking that Brenda has been a bit heavy handed in her intervention and allowed herself to get into a position "fighting" John's battles for him.

3. Brenda believes her ideas for John are right and that she is acting in his best interests. What she may be missing is the extent of John's anxiety about and passive resistance to change. Perhaps it would be helpful if she addressed this with directly with John, who would have the support of Suzi to express his worries and assert his wishes in a more positive manner.

Activity 9

1. Abada is frightened and confused, the presence of strangers in her home is probably heightening her agitation. Calming the environment, having someone she trusts to help reassure her would be of benefit. It is very important to try and find out what Abada is frightened of and to reassure her Using family members to translate can present difficulties with clear and objective communication. Depending on the urgency of the situation having a professional interpreter can help the doctor communicate in an objective manner and assist in an assessment of Abada's capacity. However, given this is an emergency situation that may not be possible.

2. The first task for the doctor is to determine the most likely cause of Abada's condition. It seems very likely that she has an acute infection and that this is the cause of delirium. As a mental disorder this could be treated under the 2003 Act or under incapacity legislation. Given that the doctor believes that hospital treatment is required he can assess whether Abada meets

the grounds for a short term detention certificate and admit her to hospital compulsorily. However, if the doctor assesses the situation as an emergency in that Abada needs immediate attention to save her life or prevent a serious deterioration he can treat under the principle of necessity and use reasonable persuasion and restraint to allow the transfer of Abada to hospital.

Read the Mental Welfare Commission's guidance on consent to treatment when considering this scenario.
http://www.mwcscot.org.uk/web/FILES/Publications/Consent_to_Treatment.pdf

Unit 3

Activity 1

1. You might feel quite annoyed that your behaviour is being commented on and that people are trying to restrict your activities. You simply cannot see what the fuss is all about although a bit of you does recognize that people close to you are worried about your behaviour. You just think you have changed and that the old you was a bit "fuddy duddy" and you like your new freedom. You do think that you are being held in hospital against your wishes and feel very frustrated about this. You have been uncharacteristically irritated and angry with staff, sometimes shouting at them. You want to know what your rights are and to feel that someone is "on your side" given that your family, doctor and other staff all think you need protection and treatment.

2. As the doctor you have formed a view that this young woman's mood is elevated and that her judgement is impaired. She is behaving out of character and putting herself at risk. Third party information reinforces the view that she is doing things that she wouldn't normally do and is very vulnerable to exploitation. You would far prefer to form an alliance with her to make sure she gets the treatment you think she requires but have to accept that compulsory treatment is necessary at least in the short-term. You will make one last effort to treat her informally but recognize that the use of a short-term detention certificate may

be the best option to help her to recover. You are balancing the principles of benefit and least restriction in your consideration of what would be best in the circumstances

3. If she started to leave the ward against medical advice you would try to persuade her to stay and reinforce the message that people were worried about her. At the same time you would have to assess whether there was time to ensure a prompt assessment by a medical practitioner. If this could not be initiated immediately you would then assess the situation with the view of using the nurse's power of detention. You would consider the whether the following criteria were 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.

Also you would remember that a nurse who has exercised the holding power should take steps to inform an MHO as soon as practicable. This is in anticipation of consent for further detention being required.

In situations like this it is very important to ensure that the person concerned is kept safe while appropriate actions are taken. This will probably involve a raised level of observation. It is vital that staff stay engaged with the person, explaining everything that is going on and ensuring that she is aware of her rights.

Activity 2

An MHO is a specially trained social worker, appointed by the local authority, who has statutory functions under the 2003 Act. Those formal duties involve assessment, making applications for compulsory treatment and the giving of information. An independent advocate has no statutory duties but can provide help and assistance to the patient in communicating their wishes. The advocate should not work independently of the patient or express their own views on the situation. A keyworker

is the member of staff who has a coordinating role in the provision of the patient's care and treatment.

It is important to remember that particularly in the early stages of contact with services a person can be presented with a bewildering array of people and professionals. Being proactive in making sure the person knows what is going on is very important.

Activity 3

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. 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 in Part 16 of the 2003 Act.

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 for the following purposes:

- saving the patient's life
- 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.

In this case the young man is detained in hospital under an EDC, he is likely to deteriorate further if not treated, he appears to be suffering given his degree of apparent fear, he has already behaved violently and there is evidence from the physical injuries he has suffered that he is potentially a danger to himself.

On the face of it the actions taken do appear to meet the criteria set out in section 243.

Activity 9

1. Firstly it might be helpful to let Frank talk through his concerns and find out if his worries are based on past experiences of unhelpful attitudes and discrimination.

2. You could explain the principles of the Act, in particular those of benefit and least restriction in the context of John getting treatment and support to recover while at home. You could also describe the requirements of section 3 which refers to equal opportunities. Make sure he understands that the Tribunal has to adhere to the requirements of the Act so his and John's rights are protected by law. He might find it reassuring to speak to the MHO involved in John's case who would be able to explain the Tribunal processes in detail.

Unit 4

Activity 3

While recognizing the sensitivity of the situation you should think about explaining that Alex is subject to special restrictions and the Scottish Ministers' role in granting suspension on compassionate grounds. Clearly much will depend on the nature of Alex's relationship with his family and whether he consents to you discussing the situation with them. It may be appropriate to explain that the RMO has to make a report when making the application for suspension and that this report will include a risk assessment. You should also bear in mind that in the assessment of the appropriateness for suspension consideration swill be given to the impact this might have on other family members, the victim and their family, and the general public in the area. Suspension of detention for compassionate reasons will be given serious consideration by Scottish Ministers. However, it should be noted that such a request is more likely to be considered acceptable if efforts have been made to ensure a low profile, particularly, for example, where the media are already aware of the patient's background. The Memorandum of Procedure on restricted patients recommends that in some cases an alternative may be for the patient to visit the funeral

parlour or family home the evening prior to the funeral to view the deceased in the company of close family members.

Activity 4

Firstly you can explain that a treatment order comes to an end if the court accepts a recommendation for revocation made by the RMO when he or she no longer thinks the grounds continue to be met. The treatment order could also end in any of the circumstances set out in section 52R occur (see above).

Secondly, the prevention of delay in trials provisions of the Criminal Procedure (Scotland) Act 1995 place limits on the time an accused person can be held in custody prior to trial. These limits are:
40 days in summary proceedings
80 days for a person charged on indictment when the indictment has not been served.
140 days for a person charged on indictment where the trial has not commenced within that period of time.

Activity 5

1. While it is the case that John is serving a prison sentence and as such is a prisoner he is also a patient in hospital and should be considered as such.

2. Following on from the previous comment John needs help to understand that while he still has a sentence to serve he is now in hospital receiving treatment and is a patient there, the same as the others in the ward. Within hospital he is in the same position as everyone else except for the constraints of being a restricted patient. Explaining the effects of being restricted, being quite clear about what he can and cannot do may help him settle into his new environment. It is important that he understands what he can do as much as what he cannot.

3. Within the limits of his legal status he should be treated in the same way as the other patients in the ward. John needs help to adjust to the different environment and culture of hospital. At the same time other patients need help in understanding

the consequences of their behaviour. What may appear to be mild banter and practical joking can soon develop into or be perceived as bullying. Open discussion amongst patients may help as encouraging the others involved to reflect on their behaviour.

Activity 6

1. In this case it would be open to the Procurator Fiscal to divert the accused to mental health services and not pursue any charges.

2. The 2003 Act makes no specific provision for what happens when a person subject to a CTO receives a custodial sentence. Check with MWC what current guidance is

Activity 7

1. A person subject to a CO is in the same position as someone subject to a CTO. The RMO has authority to grant periods of suspension of detention. Best practice is that these decisions are made in consultation with the multi-disciplinary team. A person subject to a CORO is, by definition, restricted and while the RMO may make recommendations for suspension, authority lies with Scottish Ministers.

2. Detailed information about the arrangements for suspension of detention can be found in the Memorandum of Procedure on Restricted Patients.
http://www.scotland.gov.uk/Publications/2005/10/0584334/43398

Questions

Multiple Choice Questions Units 1 - 4

Click **Here**

Unit 1 - Multiple Choice Question

Which of the following is not a principle of the 2003 Act (although may be desirable):

1. The importance of providing the maximum benefit to the patient.

2. 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

3. The importance of the patient being able to choose where he or she will receive treatment to help towards recovery

Unit 2 - Multiple Choice Question

Which of the following are not rights of the named person as set out in the 2003 Act?

1. To be notified when certain changes to the patient's circumstances happen – for example if a detention certificate is revoked

2. To told what medication the patient is receiving

3. To receive copies of records such as if the treatment the patient receives is against the wishes made in an advance statement

Unit 3 - Multiple Choice Question

Who may not be made subject to an emergency detention certificate (EDC). A person subject to:

1. An EDC
2. 2. A Welfare Guardianship order with powers of residence
3. 3. A community based CTO

Unit 4 - Multiple Choice Question

Who cannot make an application for a Treatment Order?

1. The RMO
2. A Procurator Fiscal
3. Scottish Ministers

Q. Which of the following is not a principle of the 2003 Act (although may be desirable)

A.

Q. Which of the following are not rights of the named person as set out in the 2003 Act?

A.

Q. Who may not be made subject to an emergency detention certificate (EDC). A person subject to?

A.

Q. Who cannot make an application for a Treatment Order?

A.

NHS Education for Scotland
3rd Floor, Hanover Buildings
66 Rose Street
Edinburgh
EH2 2NN
tel: 0131 220 8600
fax: 0131 220 8666

www.nes.scot.nhs.uk

NHS
Education
for
Scotland