SCOTTISH EXECUTIVE

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2 July 2004

Dear consultee

**VOLUME 2 OF THE DRAFT CODE OF PRACTICE FOR THE MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003**

Please find enclosed a copy of the volume 2 of the draft Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003. We are inviting written responses to this draft Code of Practice by **3 September 2004.**

**Contents of this consultation document**

This volume of the draft Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 deals with a range of issues relating to what can be termed civil detention procedures as well as certain issues relating to the general framework within which the Act operates. It therefore provides draft Code of Practice material on Parts 2, 4, 7 (Chapters 6 & 7), 17 (Chapter 2), 20 and 21 as well as sections 41, 42, 53, 54, 289, 290, 291 and 300 of the Act.

This volume does not look at the procedures surrounding the compulsory care and treatment of a person with mental disorder who has been involved in criminal justice proceedings. Those procedures are set out in Parts 8 to 13 of the Act and have been issued as a separate draft Code of Practice document issued for public consultation simultaneously with this volume.

**Accessing this consultation document**

If you wish to access this consultation online, go to the following website: http://www.scotland.gov.uk/view/views.asp. You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is.

If you have any queries or would like additional copies of this document, please contact Pamela Beer on 0131 244 3758.

**Responding to this consultation document**

We are inviting written responses to any aspect of this draft Code of Practice by **3 September 2004.** Please send your response to mentalhealthlaw@scotland.gsi.gov.uk or to the postal address at the head of this letter. When you are submitting your response, please make sure to include the respondee information form to be found in Annex 1 to this letter.

We would be grateful if you could clearly indicate in your response which questions or parts of the consultation paper you are responding to as this will aid our analysis of the responses received.

In addition to seeking written responses to this draft Code of Practice, we plan to organise some events which will both raise awareness of the publication of this draft Code of Practice and seek the views of interested parties on its contents. Further details about these events will be available shortly.

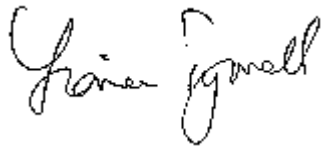
We regret that there is a reduced consultation period available for this second volume of policy proposals. We would usually issue documents for three months, but this consultation is only available for two months. This is because we wish to finalise both the Code of Practice and the Regulations policy before the autumn to ensure effective training and distribution of information in good time before the new Act comes into effect in April 2005. We apologise for any difficulties in responding this may present to you.

**Access to consultation responses**

We will make all responses available to the public in the Scottish Executive Library unless confidentiality is requested. All responses not marked confidential will be checked for any potentially defamatory material before being logged in the library or placed on the website. We draw your attention to the material in Annex 2 of this letter which sets out information on the consultation process used by the Scottish Executive.

Finally, thank you in advance for your responses to this consultation document.

Yours sincerely



**FIONA TYRRELL**

**ANNEX 1: RESPONDEE INFORMATION FORM**

Please complete the details below and attach it with your response. This will help ensure we handle your response appropriately:

**Name**:

**Postal Address**:

**Consultation title**: Volume 1 of the draft Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003

**1.** Are you responding as: (please tick one box)

| | |
|---|---|
| (a) an individual | □ (go to 2a/b) |
| (b) on behalf of a group or organisation | □ (go to 2c) |

**2a. INDIVIDUALS:**
Do you agree to your response being made available to the public (in Scottish Executive library and/or on Scottish Executive website)?

| | |
|---|---|
| Yes (go to 2b below) | □ |
| No, not at all | □ |

**2b. Where *confidentiality is not requested***, we will make your response available to the public on the following basis (please tick one of the following boxes):

| | |
|---|---|
| Yes, make my response, name and address all available | □ |
| Yes, make my response available, but not my name or address | □ |
| Yes, make my response and name available, but not my address | □ |

**2c ON BEHALF OF GROUPS OR ORGANISATIONS:**

Your name and address as respondees will be made available to the public (in the Scottish Executive library and/or on Scottish Executive website). Are you content for your response to be made available also?

| | |
|---|---|
| Yes | □ |
| No | □ |

**SHARING RESPONSES/FUTURE ENGAGEMENT**

3. We will share your response internally with other Scottish Executive policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for the Scottish Executive to contact you again in the future in relation to this consultation response?

| | |
|---|---|
| Yes | □ |
| No | □ |

## ANNEX 2: THE SCOTTISH EXECUTIVE CONSULTATION PROCESS

Consultation is an essential and important aspect of Scottish Executive working methods. Given the wide-ranging areas of work of the Scottish Executive, there are many varied types of consultation. However, in general Scottish Executive consultation exercises aim to provide opportunities for all those who wish to express their opinions on a proposed area of work to do so in ways which will inform and enhance that work.

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body. Consultation exercises may involve seeking views in a number of different ways, such as public meetings, focus groups or questionnaire exercises.

Typically, Scottish Executive consultations involve a written paper inviting answers to specific questions or more general views about the material presented. Written papers are distributed to organisations and individuals with an interest in the area of consultation, and they are also placed on the Scottish Executive web site (http://www.scotland.gov.uk) enabling a wider audience to access the paper and submit their responses. Copies of all the responses received to consultation exercises (except those where the individual or organisation requested confidentiality) are placed in the Scottish Executive library at Saughton House, Edinburgh (K Spur, Saughton House, Broomhouse Drive, Edinburgh, EH11 3XD, telephone 0131 244 4552).

The views and suggestions detailed in consultation responses are analysed and used as part of the decision making process. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

If you have any comment about how this consultation exercise has been conducted, please send them to the Mental Health Division Branch 3 at the address at the head of this letter.

# MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003

# DRAFT CODE OF PRACTICE

# VOLUME 2

# TABLE OF CONTENTS

# Introduction to Volume 2

## Coverage of this volume

1. Volume 2 of the draft Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 deals with a range of issues relating to what can be termed civil detention procedures as well as certain issues relating to the general framework within which the Act operates. It therefore provides draft Code of Practice material on Parts 2, 4, 7 (Chapters 6 & 7), 17 (Chapter 2), 20 and 21 as well as sections 41, 42, 53, 54, 289, 290, 291 and 300 of the Act.

2. This volume does not look at the procedures surrounding the compulsory care and treatment of a person with mental disorder who has been involved in criminal justice proceedings. Those procedures are set out in Parts 8 to 13 of the Act and have been issued as a separate draft Code of Practice document issued for public consultation simultaneously with this volume.

3. This volume, similarly, does not examine a range of other subjects for which provision is made in the Act. Volume 1 of the Code of Practice, issued for public consultation on 5 April 2004, dealt with Parts 1, 5, 6, 7 (Chapters 1 to 5), 14 to 16, and 17 (Chapter 1) of the Act as well as sections 33 to 35, 275 to 276, and 292 to 299. If you would like to receive a copy of any other volumes of the draft Code of Practice, please contact the Mental Health Legislation Team of the Scottish Executive at the address on the covering letter accompanying this volume.

## Structure of this volume

4. This volume is divided into 10 chapters.

5. Chapter 1 describes the power and duties of the Mental Welfare Commission for Scotland set out in Part 2 of the Act. It includes the role and functions of the Commission, and emphasises the importance of ensuring that notifications required by the Act are correctly made. Attached to Chapter 1 is an Annex setting out the notifications required, by whom, and the timing within which the notifications to the Commission must be made.

6. Chapter 2 sets out the powers and duties on Health Boards, under Part 4 Chapter 1. Health Boards have further responsibilities and functions under other parts of the Act, and those relevant sections of the Code of Practice should also be referred to where appropriate.

7. Chapter 3 sets out the powers and duties on local authorities, under Part 4 Chapter 2. Local authorities have further responsibilities and functions under other parts of the Act, and those relevant sections of the Code of Practice should also be referred to where appropriate.

8. Chapter 4 describes the provision of independent advocacy services as set out in Part 17 Chapter 2 of the Act. Two sections are still to be finalised and will be issued separately. These are: Independence in practice; and How to ascertain if a person who lacks capacity already has an independent advocate. Chapter 4 includes good practice guidance for mental health officers, hospital managers and general practitioners.

9. Chapter 5 examines the transfer of detained patients from one hospital to another whether that transfer be within Scotland or into or out of Scotland. These processes are outlined in sections 124 to 126 and 289 and 290 of the Act.

10. Chapter 6 describes what is meant at section 291 by 'unlawful detention'. It includes good practice guidance for the multidisciplinary team reviewing the restrictions on movement that may be considered appropriate for a patient in hospital.

11. Chapter 7 describes what is meant at section 300 of the Act by a "place of safety". It provides guidance on the issues which it would be expected that local agencies would agree upon when designating places of safety within their locality.

12. Chapter 8 examines the provisions of the Act relating to patients who abscond (that is, patients who take unauthorised leave). The chapter describes which categories of patients can be said to have absconded and which procedures must be followed upon their return from a period of unauthorised absence.

13. Chapter 9 focuses on the subject of "suspension". This is what was termed under the 1984 Act as "leave of absence". The chapter describes the Act's provisions with respect to the suspension of the hospital detention requirement of an emergency detention certificate or a short-term detention certificate. It then turns to the provisions of the Act relating to the suspension of any of the various compulsory measures which can authorised by a compulsory treatment order.

14. Chapter 10 examines offences including non-consensual sexual acts, and sexual offences where someone is providing care services for the person with mental disorder, to be found at Part 21 of the Act. Chapter 10 describes the offence of ill-treatment and wilful neglect of a mentally disordered person, and the offence of inducing and assisting a person to abscond, and provides best practice guidance.

15. Chapter 11, finally, provides a glossary of important terms which are commonly used throughout this volume and other volumes of the draft Code of Practice.

### Note on abbreviations

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

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

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

> **"the 1995 Act"**: Criminal Procedure (Scotland) Act 1995
> **"the 2000 Act"**: Adults with Incapacity (Scotland) Act 2000
> **"the Act", "this Act", or "the 2003 Act"**: Mental Health (Care and Treatment) (Scotland) Act 2003

**Mental Health Legislation Team**
**Scottish Executive Health Department**
**June 2004**

# CHAPTER 1
# MENTAL WELFARE COMMISSION
# (PART 2)

## *ROLE OF MENTAL WELFARE COMMISSION FOR SCOTLAND*

1. The Commission is an independent NHS body set up by Parliament which exercises protective functions in Scotland in respect of persons who may, by reason of mental disorder (including learning disabilities and dementia) be incapable of adequately protecting their persons or their interests, whether they be in hospital, care homes, the community, or institutions such as prisons. Its functions are discharged under the Mental Health (Care & Treatment) (Scotland) Act 2003 (the Act), the Adults with Incapacity (Scotland) Act 2000 and other relevant legislation.

2. Sections 5 and 6 of the 2003 Act place a duty on the Commission to monitor the operation of the Act and to promote best practice in relation to the operation of the Act. Under sections 10 and 19 the Commission may, publish information or guidance and gather and publish statistical or other information relating to the Commission's functions. The Commission also has a duty under section 7 to bring to the attention of Scottish Ministers, a local authority, a Health Board, or others, any matter of general interest or concern with regard to the welfare of any persons who have a mental disorder that the Commission considers ought to be brought to their attention. Under section 8, where certain relevant persons have the power to prevent or remedy some impropriety in relation to a patient's detention, or to prevent or remedy risk of harm to the patient or their property the Commission has a duty in certain circumstances to bring the facts of a patient's case to the attention of, and may make recommendations to those relevant persons. "Relevant persons" are defined in section 8(3) and include the Scottish Ministers, the Public Guardian, a local authority and health boards. Section 11 of the Act gives the Commission power to investigate deficiencies in a patient's care and to make recommendations to the relevant person as it considers appropriate.

3. In appropriate cases, the Commission's powers include the power to revoke short term detention and extension certificates under section 51, interim compulsory treatment orders under section 73 and compulsory treatment orders under section 81. Under the provisions of section 98, the Commission can make a reference to the Tribunal in respect of a compulsory treatment order to which the patient is subject. In the case of mentally disordered offenders, section 143 of the Act gives the Commission the power to revoke compulsion orders in appropriate cases. Under section 162, if it appears to them that it is appropriate to do so, the Commission can make a reference to the Tribunal in respect of compulsion orders to which a patient is subject. Under section 186, in cases where a patient is subject to a compulsion order and a restriction order, the Commission can require the Scottish Ministers to refer a case to the Tribunal, provided it gives reasons for requiring the reference to be made. Under section 209, where a patient is subject to either a hospital direction or a transfer for treatment direction, the Commission may similarly require the Scottish Ministers to refer a case to the Tribunal, provided it gives reasons for requiring the reference to be made.

4. The Commission has a central role in ensuring that the safeguards in place for patients receiving compulsory treatment are adhered to. Under section 233 the Commission has a duty to maintain a list of designated medical practitioners who may interview a patient, carry out a medical examination and require medical records to be produced for inspection, and who may authorise

treatment for patients who are either refusing treatment or unable to consent to it. The Commission also has the power, under section 248, to revoke certificates given under sections 235(2) or (3), 236(2) or (3), 238(1), 239 or 241(1), which certify that specified treatments may lawfully be given to a patient.

5. Under the Adults with Incapacity (Scotland) Act 2000, the Commission must also exercise a protective function in respect of adults who are the subject of Guardianship Orders or Intervention Orders in so far as the order relates to the personal welfare of the adult (see section 9 of the 2000 Act). The Commission has a duty to visit the adult as often as they think appropriate and to investigate any case where it appears a person may be experiencing ill-treatment, deficiency in care, or any risk to their property. Under section 73(3) of the 2000 Act, the Commission also has the power to release people from Guardianship orders.

### *NOTIFICATION TO THE MENTAL WELFARE COMMISSION*

6. In view of the Commission's statutory protective, investigatory and monitoring functions, it is essential that the Commission is provided with the required notifications under the Act and within the specified timescale.

7. A list of what should be notified, the person responsible for providing notification and the corresponding timescale is attached at Annex A.

**ANNEX A**

## NOTIFICATIONS TO MENTAL WELFARE COMMISSION

| Section | What | Who | Timescale |
|---|---|---|---|
| | **Emergency Measures** | | |
| **Section 35(10)** | Grant or refusal of warrant by sheriff or justice of the peace authorising detention for medical examination, entry to premises or production of medical records for inspection by a medical practitioner | MHO | As soon as practicable after the Warrant is granted or refused |
| **Sections 38(3)(a) and 38(4)(d)** | Grant of Emergency detention certificate | Hospital Managers | Before the expiry of the period of 12 hours beginning with the giving of the certificate to the hospital managers |
| **Sections 38(3)(b)(i) and 38(4)(d)** | Grant of emergency detention certificate | Hospital Managers | Before the expiry of the period of 7 days beginning with the day of being given notice under section 37 by the practitioner who issued the certificate |
| **Section 40(2) and 38(4)(d)** | Revocation of emergency detention certificate by an AMP | Hospital Managers | As soon as practicable after being informed of the revocation by the AMP |

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| **Section 42(4) and 38(4)(d)** | Revocation by RMO of suspension of authority to detain in hospital | Hospital Managers | As soon as practicable after being informed of the revocation by the RMO |
| | **Short-term Measures** | | |
| **Section 46(3)(b)** | Granting of Short-term detention certificate | Hospital Managers | Before the expiry of the period of 7 days beginning with the day on which the certificate is granted |
| **Section 48(2)(d)** | Granting of Extension certificate | AMP | Before the expiry of the period of 24 hours beginning with the granting of the certificate |
| **Section 49(4)(b)** | Revocation of short-term (ST) detention certificate or extension certificate | RMO | Before the expiry of the period of 7 days beginning with the day the certificate is revoked |
| **Section 54(3)(e)** | Revocation of certificate specifying a period during which a short-term detention certificate shall not authorise the detention of a patient in hospital | RMO | As soon as practicable after revoking the certificate |
| | **Compulsory treatment orders** | | |
| **Section 60(1)(c)** | MHO's intention to apply to the Tribunal for compulsory treatment order (CTO) | MHO | As soon as practicable after the duty to make the application arises and, in |

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| | | | any event, before making the application |
| **Section 74(1)** | Revocation of Interim CTO under section 72 | RMO | As soon as practicable after making the determination to revoke |
| **Section 82(1)** | Revocation of CTO under section 79 or section 80 | RMO | Before the expiry of the period of 7 days beginning with the day on which the determination to revoke is made |
| **Section 87(2)(c)(iv)** | Determination extending a CTO under section 86 | RMO | As soon practicable after the determination is made and, in any event, before the day on which the CTO will cease |
| **Section 91(f)** | Application to the Tribunal for extension and variation of CTO | RMO | As soon as practicable after the duty to make application arises and, in ant event, before making the application |
| **Sections 94 and 91(f)** | Application to the Tribunal for variation of CTO | RMO | As soon as practicable after the duty to make application arises and, in any event, before making the application |

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| **Sections 97 and 91(f)** | Reference to Tribunal by RMO, if recorded matter specified in CTO is not being provided | RMO | As soon as practicable after the duty to make the reference arises |
| **Section 116(3)(b)** | Detention of person on (community) CTO, under section 114(2), pending review or application for variation | Hospital Managers | Before the expiry of the period of 7 days beginning with the granting of the certificate |
| **Section 116(3)(b)** | Detention of person on (community) interim CTO, under section 115(2), pending further procedure | Hospital Managers | Before the expiry of the period of 7 days beginning with the granting of the certificate |
| **Sections 119(b) and 116(3)(b)** | (Section 117) Revocation of detention under section 114(2) – detention pending review or application for variation. | RMO | Before the expiry of the period of 7 days beginning with the revocation |
| **Sections 119(b) and 116(3)(b)** | (Section 118) Revocation of detention under section 115(2) – detention pending further procedure for Interim CTO | RMO | Before the expiry of the period of 7 days beginning with the revocation |
| **Section 124(12)** | Transfer to another hospital | Hospital Managers | Before the expiry of the period of 7 days beginning with the transfer |
| **Section 127(9)** | Suspension of detention under interim CTO or CTO, for a period of more than 28 days (the total days to include any other periods specified in other interim CTOs or CTOs) | RMO | Before the expiry of the period of 14 days beginning with the day on which the certificate is granted |

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| **Section 128(5)** | Suspension of other measures under (community) CTO | RMO | Before the expiry of the period of 14 days beginning with the day on which the certificate is granted |
| **Section 129(5)** | Revocation of suspension under section 127 or section 128 | RMO | Before the expiry of the period of 14 days beginning with the day on which the certificate is revoked |
| | **Criminal procedures** | | |
| **Section 130** | [Criminal Procedure (Scotland) Act 1995 {CPSA} section 52D (10)(e)] Making of an assessment order | Court | As soon as reasonably practicable after making the order |
| **Section 130** | [CPSA sections 52G(11) and 52D (10)(e)] Variation of assessment order, on review by RMO | Court | As soon as reasonably practicable after variation of the order |
| **Section 130** | [CPSA section 52M(9)(e) and section 52N(3)] Making of a treatment order | Court | As soon as reasonably practicable after making the order |
| **Section 130** | [CPSA sections 52Q(3) and 52M(9)(e)] variation of treatment order made under section 52Q(2)(b)(ii) | Court | As soon as reasonably practicable after variation of the order |
| **Section 131** | [CPSA section 53(11)(d)] Making of interim compulsion order (ICO) | Court | As soon as reasonably practicable after |

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| | | | making the order |
| **Section 134** | [CPSA section 60D(2)] Detention under CPSA section 60C (detention of acquitted persons by court) | Court | Before the expiry of the period of 14 days beginning with the day on which the order is made |
| **Sections 144(1) and 144 (4)(b)(i)** | Revocation of [Compulsion Order] by RMO | RMO | Before the expiry of the period of 7 days beginning with the day on which the determination is made |
| **Section 153(2) (c)(iv)** | Extension of CO by RMO | RMO | As soon as practicable after the determination is made and, in any event, before the day on which the CO will cease (unless extended) |
| **Section 157(f)** | Application to Tribunal for extension and variation of CO | RMO | As soon as practicable after the duty to make the application arises and, in any event, before making the application |
| **Sections 160 and 157(f)** | Application to Tribunal for variation of CO | RMO | As soon as practicable after the duty to make the |

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| | | | application arises and, in any event, before making application |
| **Sections177(2) and 116(3)(b)** | Detention of person on community based CO (cf. section 116 ) | RMO | Before the expiry of the period of 7 days beginning with the granting of the order |
| **Sections 177(3) and 116(3)(b)** | Revocation of detention under section 177(2) (cf. section 119) | RMO | Before the expiry of the period of 7 days beginning with the revocation |
| **Section 178 and 124(12)** | Transfer of person by authorisation of CO (cf. section 124) | Hospital Managers | Before the expiry of the period of 7 days beginning with the transfer |
| **Sections 179 and 127(9) and 128(5)** | Suspension of detention or other compulsory measures in person on CO (cf. sections 127 & 128) | RMO | Before the expiry of the period of 14 days beginning with the day on which the certificate is granted |
| **Section 185(2)(g)** | Reference of restricted patient by Scottish Ministers to Tribunal on recommendation from RMO | Scottish Ministers | As soon as practicable after receipt of report from RMO |
| **Sections 190 and 185(2)(g)** | Application by Scottish Ministers to Tribunal for an order under section 193 in respect of restricted patient | Scottish Ministers | As soon as practicable after the duty to make the application arises |

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| **Section 210 (4)(g)** | Reference to Tribunal by Scottish Ministers of patient subject to hospital direction or transfer for treatment direction | Scottish Ministers | As soon as practicable after they make reference to the Tribunal |
| **Section 224(10)** | Suspension of detention for a period of more that 28 days, for either a treatment order, interim compulsion order, compulsion order + restriction order, hospital direction, transfer for treatment direction | RMO | Before the expiry of the period of 14 days beginning with the day on which the certificate is granted |
| **Section 225(4)** | Revocation by RMO of suspension under section 224 ( for a period of more than 28 days) | RMO | Before the expiry of the period of 14 days beginning with the day on which the certificate is revoked |
| **Section 226(4)** | Revocation by Scottish Ministers of suspension under section 224 (for a period of more than 28 days) | Scottish Ministers | Before the expiry of the period of 14 days beginning with day on which the certificate is revoked |
| | **Social Circumstances Reports** | | |
| **Section 231(1)(b)(ii)** | Copy of Social Circumstances Report | MHO | Before the expiry of the period of 21 days beginning with the day on which the relevant event occurs (relevant events are listed at section 232) |

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| **S231(2)(b)(ii)** | Statement of reasons for non-compliance with section 231 | MHO | Before the expiry of the period of 21 days beginning with the day on which the relevant event occurs |
| | **Medical Treatment** | | |
| **Section 243(6)** | The giving of urgent medical treatment to a patient who does not consent/is incapable of consenting | RMO | Before the expiry of the period of 7 days beginning with the day on which the treatment is given (or first given) |
| **Section 245(5)** | Copies of certificates in respect of consent to treatment provisions, under<br>a)section 235 (NMD: consenting patients)<br>b)section 236 (NMD: incapable patients)<br>c)section 239 (ECT: incapable patients)<br>d)section 241 (other treatment: patients not consenting or incapable) | Person who gives certificate | Before the expiry of the period of 7 days beginning with the day on which the certificate is given |
| **Section 248(1)** | Report on treatment given under<br>a) section 235 (as above)<br>b) section 236 (as above)<br>c) section 238 (medication)<br>d) section 239 (see above)<br>e) section 241 (see above) | RMO | The next occasion after the giving of treatment that the RMO submits a record or applies to the Tribunal under section 87(2)(b) or section 92, or as required to do so by the Commission |

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| | **Named Person** | | |
| **Section 255(5)(b)** | Making a record where a patient does not have a named person or MHO unable to establish if they have a named person | MHO | As soon as practicable after making the record |
| | **Appeals against excessive security** | | |
| **Section 264(10)(j)** | Appeal to Tribunal against detention in conditions of excessive security in State Hospital | Tribunal | Before determining an application |
| **Sections 265(7) and 264(10)(j)** | Tribunal hearing in relation to an order under section 264 | Tribunal | Before making an order |
| **Sections 266(7) and 264(10)(j)** | Tribunal hearing in relation to an order under section 265 | Tribunal | Before making an order |
| **Sections267 (5)(a) and 264(10)(j)** | Recall of orders under sections 264(2), 265(3) or 266(3) | Tribunal | Before determining the application |
| **Section 268(10)(j)** | As section 264, in relation to hospitals other than State Hospital. Appeal to Tribunal against detention in conditions of excessive security | Tribunal | Before determining an application |
| **Sections 269(7) and 268(10)(j)** | Tribunal hearing in relation to an order under section 268 | Tribunal | Before making an order |
| **Sections 270(7) and 268(10)(j)** | Tribunal hearing in relation to an order under section 269. | Tribunal | Before making an order |
| **Sections 271(5)(a) and 268(10)(j)** | Recall of Orders under Sections 268(2), 269(3) or 270(3) | Tribunal | Before determining an application |
| | **Advance Statements** | | |
| **Section 276(8)(b)(v)** | Reasons for measures being authorised which conflict with wishes specified in advance statement | 1. Tribunal<br>2. Person having any functions under | Not specified |

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| | | the Act, or<br>3. Designated medical practitioner | |
| | **Communications** | | |
| **Section 282(2)** | Withholding of postal packet | Hospital managers | Before the expiry of the period of 7 days beginning with the withholding of the packet or anything contained in it |
| | **Cross border transfers** | | |
| **Section 289(2)(d)(iii)** | Regulations making provision for removal of community-based CTO/CO patient outwith Scotland | RMO | Before decision to authorise removal |
| **Section 290(2)(c)(iv)** | Regulations making provision for removal of detained patient outwith Scotland<br>(subject to regulations) | Scottish Ministers | At least 7 days before the date proposed for removal if within the UK or at least 28 days before the date proposed for removal if outside the UK |
| | **Place of Safety** | | |
| **Section 298(2)(b)** | Removal of a person to place of safety under section 297 | Constable | Before the expiry of the period of 14 days beginning with the day on which the person is removed to the place of safety |

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| | **Nurses' holding power** | | |
| **Section 299(8)** | Nurses' power to detain pending medical examination | Hospital Managers | Before the expiry of the period of 14 days beginning with the day on which the record is received from a nurse or person authorised by a nurse |
| | **Absconding** | | |
| **Section 310(2)(ii)** | Regulations making provision as to absconding or failure to comply with requirements imposed by orders or directions | RMO | Not specified (but may be added by way of Regulations) |

# CHAPTER 2
# HEALTH BOARD DUTIES
# (PART 4 CHAPTER 1)

This part of the Code of Practice addresses the duties which the 2003 Act places on Health Boards and hospital managers. Other duties and powers may be found additionally elsewhere in the Act, and Health Boards, hospital managers and relevant others should make reference to those further sections as appropriate.

## *GENERAL PRINCIPLES*

1. Sections 1 and 2 of the 2003 Act set out the principles as they apply to everyone with a function under the Act, including Health Boards and hospital managers. The Act imposes a duty on the Health Board and hospital managers (amongst others) to have regard to these principles in so far as they may be relevant to the performance of any function under the Act. Under section 1(11) discharging a function includes exercising the power by taking no action.

2. The principles which must be complied with when discharging certain functions are set out in section 1(3) and include the following:

- having regard to the present and past wishes and feelings of the patient;
- having regard to the views of the patient's named person, carer, guardian, or welfare attorney;
- having regard to the importance of the patient participating as fully as possible in the discharge of the function, including providing the patient with information and support to enable their participation;
- having regard to the range of options available in the patient's case
- having regard to the importance of providing the maximum benefit to the patient;
- having regard to ensuring the patient is not treated unfavourably; and
- having regard to the patient's abilities, background and characteristics.

3. The Act (section 2) contains a set of principles specifically relating to children, a child being a person under 18 years of age for this purpose. Subsection 2(4) requires the person to discharge the function in the manner that best secures the welfare of the child or adolescent patient, including having regard to the matters mentioned in section 1(3), and 1(5) and 1(6) where relevant, and discharging the function in the manner which appears to the person to be the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances.

4. In practical terms what this will mean is that Health Boards and hospital managers require to take account of these principles in all the policies, systems and structures that are put in place to enable medical practitioners, nursing staff, administrators and others to carry out their functions under the Act.

***SERVICE PROVISION***

5. It would be good practice for Health Boards to ensure that there are adequate resources to enable staff to have regard for the principles of the Act when carrying out their duties and functions under the Act. Resources in this matter relate to adequacy of staffing, for example to ensure that a person who is compelled to receive services under the Act is treated no less favourably than any other patient.

6. Resources may also imply physical resources, for example in making sure due regard is made to the patient's background including for example age, sex, sexual orientation, cultural and linguistic needs (section 1(3)(h)). This may mean, for instance, that an interpreting service is required.

**Approved medical practitioners**

7. Section 22 requires Health Boards and the State Hospitals Board for Scotland to compile and maintain a list of medical practitioners who have such qualifications and experience, and have undertaken such training, as may be specified in directions given by the Scottish Ministers, and are approved as having special experience in the diagnosis and treatment of mental disorder. Medical practitioners meeting these requirements and who are for the time being included in a list compiled under section 22(1) are referred to as 'approved medical practitioners'.

*Directions under section 22 which cover these issues will be consulted on separately by the Scottish Executive.*

8. It is important that the lists contain sufficient numbers of approved medical practitioners to cover the number of patients in the Health Board or State Hospitals Board area. Health Boards should ensure that their list is accurate and up to date, that any new medical practitioners who meet the criteria are added to the list, and that approved medical practitioners currently on the list continue to meet the criteria set out in the Directions.

9. Under section 17 a Health Board or Special Health Board amongst others must afford the Mental Welfare Commission, or a person authorised by the Commission, all facilities necessary to enable the Commission, or that person, to discharge the Commission's functions under the Act. The Commission may therefore request to see a copy of the list of approved medical practitioners at any time, and it would be good practice for Health Boards to provide an accurate up-to-date list within a reasonable time.

10. Approved medical practitioners perform many functions under the Act and they are fundamental to the workings of the compulsory treatment provisions under the Act. For example, an AMP must be involved with the detention process, including granting certificates for short-term detention (section 44), producing medical reports for CTO (Compulsory Treatment Order) applications (section 58) and acting as RMO (Responsible Medical Officer) to patients in hospital or in the community (section 230).

11. Hospital Managers are under a duty to appoint an RMO for a patient (section 230). If a patient already has an RMO who is an approved medical practitioner, best practice would be that that RMO continues to act as the patient's RMO. However, where the previous RMO was not an approved medical practitioner, it would be necessary to appoint a different RMO. Therefore it would be best practice for managers of an acute medical/ surgical hospital to ensure that arrangements are agreed and in place with acute psychiatric hospitals/ services to provide available approved medical practitioners, unless approved medical practitioners are already on the staff of the acute medical/ surgical hospital.

12. Hospital managers should ensure that where the patient's RMO is for any reason unavailable (e.g. through holiday or illness), they appoint another approved medical practitioner to perform the function of the RMO for as long as necessary on an interim basis.

*Further guidance is contained in the section of the Code of Practice on Appointment of Responsible Medical Officers. See Draft Code of Practice Volume 1, Chapter 11.*

### Provision of services and accommodation for certain patients under 18

13. Section 23 imposes a duty on a Health Board to make provision for any child or young person (up to the age of 18) where that person is either detained or voluntarily admitted to hospital for the purposes of receiving treatment for a mental disorder. In this regard, the provision of services and accommodation must be sufficient for the particular needs of the child or young person.

14. Health service providers have a duty under section 23 to provide services and accommodation sufficient for the particular needs of formal and informal patients under 18. Section 23 should be considered in conjunction with three further sections in the Act. Section 2 deals specifically with principles in respect of children and their welfare and in particular section 2(4) states that any function under the Act must be discharged in "the manner that appears to the person to be the manner that best secures the welfare of the child". Section 277 amends the Education (Scotland) Act 1980 by providing that education authorities have duties towards children who are subject to measures authorised by the 2003 Act or, in consequence of their mental disorder, by the Criminal Procedure (Scotland) Act 1995. Similarly, section 278 requires any person having functions under the act to take all reasonable steps to reduce any adverse effect on the relationship between a parent and child of either party being made subject to measures authorised by the 2003 Act or, in consequence of their mental disorder, by the 1995 Act.

15. Accommodation, care and treatment should be provided which best secures the welfare of the child (section 2). It is unlikely that a bed in an adult ward will be considered suitable for a child or adolescent patient.

### Provision of services and accommodation for certain mothers with post-natal depression

16. Section 24 places a duty on Health Boards in relation to "certain mothers with post-natal depression". Whether such a mother has been admitted to hospital voluntarily or not, and where her proximity to the child or children would not endanger the health or welfare of them, a Health Board

must provide suitable accommodation for both mother and her child or children under one year of age to ensure that the woman is able, if she wishes, to care for the child in hospital. Unlike section 23, "each Health Board shall collaborate with other Health Boards to whatever extent is necessary to fulfil this duty" (section 24(2)).

### Provision of services and charging for services

17. Under sections 25 to 26 a local authority has duties to provide, or to secure the provision of, care and support services, and services that promote well-being and social development, for those persons with a mental disorder in the community. Section 27 requires a local authority to provide facilities for, or assistance in, travel to such services for those persons. Under sections 25 to 27 a local authority has discretion to provide such services and travel, or secure provision of such services and travel, for persons with a mental disorder who are in hospital.

18. Section 28 amends section 87 the Social Work (Scotland) Act 1968 and sections 2 and 22(1) of the Community Care and Health (Scotland) Act 2002 to the effect that a local authority providing a service under sections 25 to 27 of the 2003 Act may recover such charge (if any) for it as it considers reasonable.

### Co-operation with local authorities

19. Section 30 requires local authorities to co-operate with any Health Boards, Special Health Boards or voluntary organisations that appear to the local authority to have an interest, power or duty to provide or secure the provision of those services mentioned in sections 25 to 27. Under section 31, the local authority can request assistance from these bodies who must comply with the request so long as the request is:

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

### Independent Advocacy Services

20. Under section 259 Health Boards and local authorities have a duty to collaborate with each other to secure the availability of independent advocacy services.

*Further guidance is contained in the section of the Code of Practice on Independent Advocacy. See Chapter 4 of this document.*

### *OTHER IMPLICATIONS OF THE ACT FOR HEALTH BOARDS AND HOSPITAL MANAGERS*

21. In addition to the sections already mentioned above, the Act contains a number of sections with implications for Health Boards and hospital managers. These include:

- Section 5: Mental Welfare Commission (the Commission) duty to promote best practice. It is likely that this will be done by the Commission regularly making hospital visits. *(See Chapter 1 in this document.)*
- Section 11: Commission's duty to make investigations into deficiencies of care.
- Section 13: Commission's duty to make visits to patients
- Section 16: Commission's authority to inspect medical or other records of the patient.
- Section 21: The Act creates the Mental Health Tribunal for Scotland, which largely replaces the Court as the forum for determining applications, granting orders and hearing appeals. It may well be that many Tribunals take place within the hospital.
- Section 22: Health Boards and the State Hospitals Board for Scotland have a duty to compile and maintain a list of approved medical practitioners. *(See this Chapter, above.)*
- Sections 30 and 31: The local authority has duties to provide care and support services, services that promote well-being and social development and to give assistance with travel to those with mental disorder in the community. They may also provide such services within the hospital. Sections 30 and 31 impose duties on health-care providers to co-operate with local authorities and to give such assistance in these matters as would be compatible with the discharge of their functions. *(See Chapter 3 in this document.)*
- Section 34: The local authority has specific duties to make inquiries into situations of apparent deficiency in care, neglect or ill-treatment in the community. Section 34 imposes a duty on various bodies including Health Boards to co-operate with these inquiries, in so far as compatible with, and not unduly prejudicial to, their functions. *(See Chapter 9 in Volume 1.)*
- Section 228: Where a written request for an assessment of the needs of a person with a mental disorder has been received by a local authority or Health Board, provided the circumstances referred to in section 228(2) are met, the local authority or Health Board is under a duty to respond to the request within 14 days, indicating whether or not they intend to carry out the assessment and, if not, why not. *(See Chapter 11 of Volume 1.)*
- Section 230 requires the managers of a hospital to appoint an RMO to any patient who is receiving services by compulsion in or out of that hospital. *(See Chapter 11 of Volume 1.)*
- Section 291 allows for various persons to apply to the Tribunal where it appears that a patient is unlawfully detained. This may mean that an informal patient is restricted from leaving the hospital, for example, where a ward door is locked and staff refuse to open it on request. It may also refer to an improperly made detention, for example one made without proper regard to the principles. Where the Tribunal find that a patient has been so detained, it will require the hospital managers to cease the detention. *(See Chapter 6 in this document.)*

# CHAPTER 3
# LOCAL AUTHORITY DUTIES
# (PART 4 CHAPTER 2)

This part of the Code of Practice addresses the duties which the 2003 Act places on local authorities. Other duties and powers may be found additionally elsewhere in the Act, and local authorities and relevant others should make reference to those further sections as appropriate.

## *LOCAL AUTHORITY PROVISIONS*

1. The 2003 Act places a number of duties on local authorities in relation to the provision of services for people with mental disorder (including services for mentally disordered offenders) and on Mental Health Officers.

2. The Act makes provisions relating to:

- mentally disordered children and young people requiring mental health services in their own right (including sections 2, 23, 252 and 277);
- their parents or those who have parental authority in relation to those children (section 278(1)(a) and (2));
- and children and young people with a parent who has mental disorder (section 278(1)(b) and (2)).

3. Sections 1 and 2 of the Act set out a number of principles as they apply to various persons who discharge statutory functions under the Act (or, in relation to section 2, any power or duty which may be discharged in more than one manner), including local authorities. The Act imposes a duty on the local authority (amongst others) to have regard for these principles in the performance of any function, duty or power under the Act (under section 1(11) discharging a power includes exercising the power by taking no action). The principles are set out at sections 1(2) and 1(3). They are that, in discharging a function by virtue of the Act, a person (including a local authority) shall have regard to the following matters in so far as they are relevant to the function being discharged:

- the present and past wishes and feelings of the patient;
- the views of the patient's named person, carer, guardian, or welfare attorney (unless it is unreasonable or impracticable to do so);
- the importance of the patient participating as fully as possible in the discharge of the function, including providing the patient with such information and support as is necessary to enable their participation;
- 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, unless it can shown that it is justified in the circumstances the patient is not treated unfavourably compared to a person who is not a patient;
- the patient's abilities, background and characteristics.

4. Sections 1(4) to 1(6), and sections 2 and 3 of the Act also set out principles relating to the way in which the function must be discharged. These require the person discharging the function to do so in a way which, for example:

- involves the minimum restriction on the freedom of the patient that appears to the person discharging the function to be the manner that is necessary in the circumstances;
- has regard, in so far as is reasonable and practicable to do so, to the needs
- and circumstances of the patient's carer which are relevant to the discharge of
- the function and of which the person is aware;
- has regard, in so far as is reasonable and practicable to do so, to the importance of providing information to the carer to assist them to care for the patient;
- has regard to the importance of providing appropriate services to the patient;
- encourages equal opportunities; and if the patient is a child, best secures their welfare.

5. In practical terms, this will mean that local authorities will require to take account of these principles (as set out in sections 1 and 2 of the Act) must be considered in all the policies, systems and structures put in place, for example to enable MHOs and others to fulfil their functions under the Act.

6. The Act places a duty on the local authority to cause inquiries to be made into deficiencies in care, treatment or support for people with a mental disorder living in the community (section 33). Best practice would suggest that structures should be in place to determine whether it should be an MHO's duty to make such inquiries or if care managers or other personnel may do so.

### Care and support services and services designed to promote well-being and social development

7. Under section 25, the local authority has a duty to provide or secure provision of care and support services for persons who have a mental disorder (or who have had a mental disorder) and are not in hospital. It may also provide, or secure the provision of such services to persons who have or have had a mental disorder and who are in hospital. The services include residential accommodation and personal care and support services, but not nursing services. There are a number of ways in which those people in informal need of services may come to be identified either by care management services, children and family services, or by MHOs in their role of considering people for compulsion (and possibly not finding they require this). Section 25 states that the care and support services provided shall be designed to:

- minimise the effect of the mental disorder on such persons; and
- give such persons the opportunity to lead lives which are as normal as possible.

8. Section 26 imposes a duty on a local authority to provide, or secure the provision of, services to promote the well-being and social development of persons with a mental disorder (or who have had a mental disorder) who are not in hospital. A local authority may also provide or secure the provision of such services for those persons in hospital.

9. These services include:
- the provision of social, cultural and recreational activities; and
- training and assistance in obtaining and undertaking employment for such of those persons as are over school age.

10. These duties are similar to the duties placed on local authorities by sections 7 and 8 of the 1984 Act. Best practice would suggest that due regard must be given to the principles of the Act in the planning and design of services.

11. Social activities in respect of enhancing the wellbeing of people with mental disorder might include those services (such as day care, drop-in centres and support services) that enable people to enhance their social networks. Cultural enhancement may be seen both in terms of services that reflect and support minority cultures and in terms of services that support and reflect the particular culture of an area.

12. Section 27 places a duty on a local authority to provide facilities for, or assistance with travel as the local authority may consider necessary to allow persons with a mental disorder (or who have had a mental disorder) and who are not in hospital to access such services. Local authorities may similarly provide assistance for persons in hospital who have or have had a mental disorder.

13. Section 28 amends section 87 of the Social Work (Scotland) Act 1968 and sections 2 and 22(1) of the Community Care and Health (Scotland) Act 2002 to the effect that a local authority providing a service under sections 25 to 27 of the 2003 Act may recover such charge (if any) for it as it considers reasonable.

14. The duties in these sections relate to all people with a mental disorder, or who have had a mental disorder, not just those subject to (or who have been subject to) compulsion by the Act.

### *Co-operation with Health Boards and others; assistance from Health Boards and others*

15. Section 30 requires local authorities, in providing services to persons under sections 25 to 27 to co-operate with any Health Boards, Special Health Boards or voluntary organisations that appear to the local authority to have an interest, power or duty to provide or secure the provision of those services. Under section 31, the local authority can request assistance from a Health Board or a Special Health Board and these bodies must comply with the request so long as the request is:

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

### Appointment of mental health officers

16. Section 32 places a duty upon local authorities to appoint a sufficient number of MHOs for the purpose of discharging, in relation to their area, the functions of MHOs under three pieces of legislation: The 2003 Act, the Adults with Incapacity (Scotland) Act 2000 and the Criminal Procedure (Scotland) Act 1995.

*The Scottish Executive will consult separately on the Directions to be made by the Scottish Ministers under section 32(2)(b) specifying the requirements for registration, education and training, experience, competence and any other matters.*

### Designated MHOs

17. Section 229 places a duty on a local authority, as soon as reasonably practicable after the occurrence of a relevant event (defined in section 232 as including the granting of a short-term detention certificate and the making of a compulsory treatment order and other orders), to ensure that an MHO is designated as the MHO having responsibility for the patient's case.

*Further guidance is contained in the section of the Code of Practice on Designated Mental Health Officers. See Draft Code of Practice Volume 1, Chapter 11.*

### Duty to inquire, and warrants

18. Sections 33 to 35 place a duty to inquire on local authorities.

*Further guidance is contained in the section of the Code of Practice on Duty to inquire, warrant and associated powers. See Draft Code of Practice Volume 1, Chapter 9.*

### Independent advocacy

19. Under section 259 Health Boards and local authorities have a duty to collaborate with each other to secure the availability of independent advocacy services.

*Further guidance is contained in the section of the Code of Practice on Independent Advocacy. See Chapter 4 of this document.*

### Section 279 Collation of data

20. Section 279 places a duty on local authorities, on being required to do so by the Scottish Ministers to provide them with such relevant information as is specified in the requirement which is needed by the Scottish Ministers for research purposes. The provision contains sufficient safeguards to protect the identity of patients in that the information should only be provided in a form so as not to identify or enable identification of the person.

21. Information need not be provided where:

- if, were it evidence which might be given in proceedings in any court in Scotland, the person having the evidence could not be compelled to give it in such proceedings; or
- it is, or refers to, information about a natural person and would identify or enable identification of the person; or

- the person required to provide the information is under a duty of confidentiality in respect of that information and they cannot provide the information requested without breaching that duty, unless the person to whom the duty is owed has given their consent to it being provided.

### Assessment of needs for community care services etc.

22. Sections 227 and 228 make provision in relation to assessment of needs for community care services by a local authority.

*Further guidance is contained in the section of the Code of Practice on Assessment of needs. See Draft Code of Practice Volume 1, Chapter 11.*

### Assessment of needs when under compulsion

23. Under section 227 of the 2003 Act, there are also specific times when MHOs must make assessments of people's formal needs for services when under compulsion. MHOs must prepare and submit care-plans along with any applications to the Tribunal for a CTO (section 62). Compulsion in the community may include compulsion to receive care services as described in section 25.

*Further guidance is contained in the section of the Code of Practice on Applying for a compulsory treatment order. See Draft Code of Practice Volume 1, Chapter 5.*

# CHAPTER 4
# INDEPENDENT ADVOCACY
# (PART 17 CHAPTER 2)

Chapter 4 describes the provision of independent advocacy services as set out in Part 17 Chapter 2 of the Act. *Two sections are still to be finalised and will be issued separately. These are: Independence in practice; and How to ascertain if a person who lacks capacity already has an independent advocate.* Chapter 4 includes good practice guidance for mental health officers, hospital managers and general practitioners.

## *RIGHT TO INDEPENDENT ADVOCACY*

1. Section 259 of the Act sets out the main provisions for independent advocacy. It places a duty on local authorities, Health Boards and the State Hospitals Board to secure the availability of independent advocacy services to people with a mental disorder and to take appropriate steps to ensure that they have an opportunity to use those services.

> "Every person with a mental disorder shall have a right of access to independent advocacy; and accordingly it is the duty of –
>
> each local authority, in collaboration with the (or each) relevant Health Board;
>
> each Health Board, in collaboration with the (or each) relevant local authority,
>
> to secure the availability, to persons in its area who have a mental disorder, of independent advocacy services and to take appropriate steps to ensure that those persons have the opportunity of making use of those services." (Sections 259(1) and (2))

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

### Who can access independent advocacy under the Act?

3. The right of access to independent advocacy under section 259 applies to anyone with a mental disorder. The term 'mental disorder' is defined in section 328 of the Act and means any mental illness, personality disorder or learning disability, however caused or manifested. In addition, section 328 specifically provides that a person is not mentally disordered by reason only of sexual orientation, sexual deviancy, transsexualism, transvestism, dependence on, or use of,

alcohol or drugs, behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person, or acting as no prudent person would act.

4. The right to access independent advocacy applies to any person who has a 'mental disorder' (as defined above):

- Regardless of age, disability, ethnic origin, culture, faith, religion, sexuality, social background or personal circumstances
- Whether or not they are subject to compulsion
- Whether or not they are ordinarily resident in Scotland.

### What is advocacy?

5. Section 259 (4) describes advocacy services for the purposes of the Act as:

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

6. Under the Act, an advocate might assist a person with mental disorder to express their needs and thoughts or to present their views. An advocate might help the person in their everyday dealings in relation to their healthcare and might speak on their behalf in their dealings with, for example, their MHO or hospital. Advocates can assist people to:

- make informed decisions,
- increase their decision making capacity, and
- communicate their views to others.

7. Local authorities and Health Boards should make arrangements to ensure that their staff are aware of the right to independent advocacy and the role of advocates. It is important that staff know that advocates may work with anyone with a mental disorder, including people with incapacity or communication difficulties.

### Usual role of the independent advocate

8. An independent advocate will support people to express their needs and thoughts and help them to make these known to others who need to be able to take the person's views into account in taking decisions under the Act. In this role, it is not part of an advocate's role to make judgements about what is in a person's "best interests", that judgement is made by others.

9. The involvement of an advocate does not change the level of responsibility on other professionals involved with the person with mental disorder. Those professionals still require to exercise their professional judgement about the person's case.

10. Advocacy organisations provides different types of advocacy, for example individual professional advocacy, citizen advocacy and collective advocacy. The Act is not specific about the type or types of advocacy services which a person should have a right to under the Act. Any or all of the various types might be appropriate depending on the circumstances of the person using the advocacy services.

11. In order to make the right of access to independent advocacy meaningful, it would be good practice, where the person has given consent, for an advocate to be permitted to:

- Attend, where practicable, a consultation, interview or meeting about the person's treatment or support in order that the advocate may support or represent the person there
- Have access to the person at any reasonable time to provide them with support and representation
- Correspond or communicate in any other way with the person on any matter relating to their role as an advocate
- Receive such information as would assist them to perform their role

12. Similarly, it would be good practice if people who are members of collective advocacy groups were able to:

- Receive assistance to attend the meetings of their collective advocacy group, where practicable,
- Correspond or communicate in any other way with their collective advocacy group

### Written communications with advocate

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

14. In order that it is clear to hospital managers that someone has an advocate, independent advocacy organisations should make arrangements to inform hospital managers of the advocacy organisation's contact details in respect of detained patients subject to the provisions of section 281 (withholding of mail).

15. Wherever possible, mail should be sent to or from the advocacy organisation's address as this will enable hospital managers to more easily identify mail to or from an independent advocate.

### Independent advocacy

16. The Act gives people with a mental disorder a right to *independent* advocacy. Independence is key because it is vital that the ability of advocacy organisations and advocates to carry out their

roles is not compromised in any way. For example, if an advocate was also a care provider and someone wanted to raise issues about their care, it is clear that the advocate's ability to support that person would be severely compromised. "Independence" is concerned with ensuring that the services that are provided are independent of the interests of those under a duty to provide the service.

17. Ideally, independent advocacy should be provided by an organisation whose sole role is advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy.

## *DUTY TO INFORM PEOPLE OF AND ASSIST THEM TO ACCESS INDEPENDENT ADVOCACY*

18. There is a legal duty on Mental Health Officers and hospital managers to inform people about independent advocacy and assist them to access it. However, it would be good practice for others involved in working with people with mental disorder to be aware of independent advocacy and let people know about it when appropriate.

### Mental Health Officer's duty to inform people of and assist them to access independent advocacy

19. Mental Health Officers (MHOs) have a duty at certain times to:

- Inform people with a mental disorder about the availability of independent advocacy services
- Take appropriate steps to ensure that those people have the opportunity of making use of those services

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

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

21. In addition, it would be good practice for Mental Health Officers to do so also at any other time where it appeared to the MHO that the person with mental disorder would benefit from information about, and assistance to access, independent advocacy services.

22. Information about independent advocacy organisations will need to be communicated to people in a way which they can understand and that takes account of any special communication needs they have. This will mean having in mind the needs of people who are deaf or hard of hearing, people who have a visual impairment, and people whose first language is not English. In addition, all written communication should be in clear and easily understood language. While it is important to leave the person with a permanent record of advocacy information, just handing over a leaflet will not be sufficient.

23. In recognition of the fact that it is not always possible to take in information at times of stress, it would be good practice for an MHO to discuss independent advocacy with the person on more than one occasion.

24. In addition to informing people about the availability of advocacy services, the MHO also has a duty to take appropriate steps to ensure that the person has the opportunity of making use of those independent advocacy services. The Act is not specific about the steps which the MHO should take and what is appropriate and these will depend on the circumstances.

25. Where the person would like an advocate, it would be good practice for an MHO to assist the person to contact an independent advocacy organisation. When a person would like an advocate, or already has one, it might be appropriate, unless the person says that they do not want assistance, for an MHO to contact the independent advocacy organisation on that person's behalf or to take the person to the advocate if the person would otherwise be unable to do so. The MHO should check with the person what information may be shared with the advocacy organisation.

26. Usual referral procedures for the relevant independent advocacy organisation should be followed.

27. It would be good practice for the MHO, where appropriate, to also provide information, using language that is easy to understand, about what an independent advocate is and how an advocate can help. It would also be good practice to record all steps taken to inform people of independent advocacy and where appropriate to access it, and to keep other people who support the person informed about the whether or not the person would like an advocate and any follow-up action required.

28. If a person would not like an advocate it would be good practice for the MHO to:

- Record the fact that the person was informed about advocacy and did not want an advocate
- Check with them again at a later date because people sometimes change their mind

29. Each Health Board and local authority will be expected to produce and maintain a list of independent advocacy organisations in their area. Officers with duties relating to advocacy under the Act should ensure that they can access this information. It will not be sufficient for anyone with a duty under the Act not to perform this duty fully on the grounds of ignorance.

### What happens if the MHO does not interview the person?

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

31. Sections 85, 89, 147, 151 and 155 place a duty on the MHO to inform the person about independent advocacy services, and to ensure the patient has the opportunity to use those services, as soon as practicable after receiving notice of a proposed extension and, where applicable, granted extension of an order notwithstanding that it may be impractical for the MHO to interview the person. It will depend on the circumstances when how soon is " as soon as practicable". It would be good practice for the MHO to record the steps taken in these cases.

**Hospital Managers' duty to inform people of and take appropriate steps to ensure that people have the opportunity to access independent advocacy**

32. Section 260 places a duty on the 'appropriate person' as defined in section 260(5) of the Act to 'take all reasonable steps' to:

- Inform people subject to any form of compulsion of the availability of independent advocacy services
- Take appropriate steps to ensure that those people have the opportunity of making use of those services

33. This duty must be carried out for people who are:

- Detained in hospital by virtue of the 2003 Act or the 1995 Act, or
- Are not detained in hospital but are subject to:
  - An emergency detention certificate
  - A short-term detention certificate
  - A compulsory treatment order
  - An interim compulsory treatment order
  - An assessment order
  - A treatment order
  - A hospital direction
  - A transfer for treatment direction
  - An interim compulsion order
  - A compulsion order

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

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

35. Information about independent advocacy organisations should be communicated to people in a way which they can understand and that takes account of any special communication needs they have. This will mean having in mind the needs of people who are deaf or hard of hearing, people who have a visual impairment, and people whose first language is not English. In addition, all written communication should be in clear and easily understood language. While it is important to leave the person with a permanent record of advocacy information, just handing over a leaflet will not be sufficient.

36. It would be good practice for information about advocacy to be displayed in public areas and on wards as well as in formats that can be given to people.

37. Under s260(2) the 'appropriate person' has a duty to take all reasonable steps to inform the person about the availability of advocacy services. Circumstances will dictate what is reasonable. It might be that when a person would like an advocate, or already has one, the 'appropriate person' should contact the independent advocacy organisation on a person's behalf, unless the person says that they do not want assistance, or support the person in doing this themselves.

38. It would be good practice for the 'appropriate person' to keep other people who support the person informed about whether or not the person would like an advocate and any follow-up action required.

39. The Act places a duty on the 'appropriate person' to inform the person with mental disorder about the availability of advocacy services, at certain times. In addition, it would be good practice for the appropriate person to:

- Inform people about what an independent advocate is and how an advocate can help, using language that is easy to understand
- Record all steps taken to inform people of independent advocacy and assist them to access it. This record should also state a person's response and any follow-up action needed.

40. If a person would like an advocate the 'appropriate person' should take appropriate steps to assist the person to make use of advocacy services. What will be appropriate will depend on the individual's circumstances. It might, for example, include contacting an independent advocacy organisation on the person's behalf, supporting the person to contact them or taking the person to the advocate. It would be good practice for the appropriate person to check with the person what information may be shared with the advocacy organisation. Where the person cannot give consent to the sharing of information the appropriate person may wish to seek legal advice on what information if any it might be appropriate to share in the circumstances.

41. If a person would not like an advocate, it would be good practice for an 'appropriate person' to:

- Record the fact that the person was informed about advocacy and did not want an advocate
- Check with them again at a later date because people sometimes change their mind

*See paragraph 48 below for guidance on what to do if a person is not able, for any reason, to state whether or not they would like an advocate.*

### Who is the 'appropriate person'?

42. The 'appropriate person' to carry out the duties under section 260 (described above) are:

- The managers of the hospital where a person is detained

- Where by virtue of a certificate granted under the Act the authorisation to detain is suspended, the managers of the hospital in which, but for the certificate, the person would be treated
- In any other case, the managers of the hospital specified in the order

43. In practice, this role may be carried out by other people on behalf of the hospital manager. However, it remains the hospital manager's responsibility to ensure that this happens. Hospital managers should ensure that processes for delegation of these responsibilities are clear. It should be made explicit who is to carry out these duties. Hospital managers should ensure that all relevant staff are aware of the patient's right to independent advocacy, the role of independent advocates and the legal and good practice requirements relating to independent advocacy provision under the Act. It is important that staff know that advocates may support anyone with a mental disorder, including people with incapacity or communication difficulties.

### What does 'as soon as practicable' mean?

44. Section 260(3) states that the duty on hospital managers to inform and assist people in relation to independent advocacy must be carried out:

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

45. The Act does not define what 'as soon as practicable' means. The timing will depend on what is reasonable in the circumstances.

### What constitutes a 'reasonable request'?

46. Section 260(3)(b) states that hospital managers will inform people of the availability of independent advocacy services "as soon as practicable after any occasion on which the person reasonably requests to be informed of those matters". It would be good practice to assume all requests to be reasonable and inform a person about independent advocacy whenever s/he asks to be so informed. It would also be good practice to record when and how the request for information was responded to.

### General Practitioners

47. General practitioners (GPs) are not specifically allocated duties regarding advocacy by the Act. However as a key point of contact for people who have a mental disorder their involvement is important to the successful implementation of the Act. It is expected that general practices will

have information about independent advocacy on display as well as in a form that people can take away with them. Where a person with a mental disorder requests information about independent advocacy, GPs would be expected either to provide this information themselves or to direct people to the appropriate person in the practice. Where the request for information comes within a consultation, it would be good practice for it to be recorded in the person's case notes.

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

48. Everyone with a mental disorder has a right to independent advocacy under the Act, including people who have communication difficulties or incapacity of any kind. It is important that these particularly vulnerable people are able to make use of this right. Where a person has incapacity, it should not be assumed that the person does not have capacity to make decisions on any subject at any time. A person's capacity may change over time and this needs to be taken into account.

### Speed of Response

49. When a referral is made to an advocacy organisation under the Act, it is expected that the advocacy organisation will respond to the person concerned as quickly as is appropriate and practicable in the circumstances. Following this initial contact, advocacy organisations will prioritise provision according to agreements with service commissioners based on local needs and national priorities. The prioritisation process will take account of whether any immediate action is required and whether or not a person is subject to compulsion under the Act.

### Tribunals

50. As part of their role in supporting and representing a person an independent advocate may wish to support a person in the time before and during any Tribunal hearing. The role of an independent advocate at a Tribunal would not replace any legal representation a person may have, though an advocate may support a person in communicating with their legal representative.

*It is anticipated that the Tribunal's Rules of Procedure which are currently being drafted will set out matters in relation to the conduct of Tribunal hearings.*

### Advance statements

51. Advance statements are described in section 275 of the Act as statements setting out the way the person making one wishes to be treated, or does not wish to be treated, for mental disorder, in the event of the person becoming mentally disordered and their decision making being impaired. Advance statements may be useful for people to indicate whether they would wish to have an advocate or not. Independent advocates may assist people to write an advance statement and keep it up to date. However, it would not be appropriate for an advocate to be a witness to an advance statement.

*Further guidance is contained in the section of the Code of Practice on Advance Statements. See Draft Code of Practice Volume 1, Chapter 2.*

### Independent advocates and named persons

52. A named person under the Act is any person 16 years and over nominated by an individual as such, or where there is no nominated named person, the primary carer, or the nearest relative.

53. An individual cannot be both independent advocate and named person for the same person. There are differences between the two roles which make them incompatible.

*Further guidance is contained in the section of the Code of Practice on Named Persons. See Draft Code of Practice Volume 1, Chapter 2.*

# CHAPTER 5
# DOMESTIC AND CROSS-BORDER TRANSFERS
# (PART 7 CHAPTER 6 AND SECTIONS 289-290)

This chapter aims to describe the processes attached to the transfer of certain categories of patients from one hospital to another.

Part 7 Chapter 6 of the Act deals with the transfer between hospitals in Scotland of a patient subject to a CTO. (Note that this chapter refers to transfers inside Scotland as "domestic transfers".) This chapter therefore outlines the basic procedures to be observed before moving on to a description of the process by which a patient or a patient's named person can appeal to the Tribunal against such a transfer.

The chapter then turns to sections 289 and 290 of the Act which deal with the transfer of certain patients outwith Scotland. It also examines the reception into Scotland of certain patients from other parts of the British Islands.

## *DOMESTIC TRANSFER OF A PATIENT SUBJECT TO A CTO (PART 7 CHAPTER 6: SECTIONS 124 TO 126)*

1. The Act makes provision at section 124 for the domestic transfer of a patient subject to a CTO. In terms of section 124(3) of the Act, a domestic transfer may only take place where the managers of the receiving hospital have consented to the transfer taking place.

### Does any prior notice have to be given before the transfer takes place?

2. Yes. The managers of the hospital in which the patient is currently detained must in terms of section 124(4) of the Act give at least 7 days' notice of the proposed transfer to the following parties:

- the patient;
- the patient's named person;
- the patient's primary carer.

3. Two caveats need to be added to the above notification requirement. The first is that this notification requirement can be waived in terms of section 124(7) of the Act if the patient consents to the transfer. The second is that the hospital managers can similarly dispense with the notification requirement in terms of section 124(5) of the Act if the patient has to be transferred urgently to another hospital. In both circumstances, the managers of the sending hospital must notify the patient and his/her named person and primary carer as soon as is practicable before the transfer takes place or else as soon as practicable after the transfer has taken place. In all cases, it is good practice to ensure that as much advance notice is given as is practicable under the circumstances.

### What happens if the transfer is delayed?

4. Nothing changes unless the proposed transfer does not take place within three months of the notice of the transfer being given to the patient, and his/her named person and primary carer. If this 3 month period has elapsed, then the transfer can only proceed where additional conditions imposed by section 124(10) of the Act are met. These additional conditions are:

- the managers of the receiving hospital continue to consent to the transfer of the patient;
- the patient and his/her named person and primary carer have been given at least 7 days' notice of the transfer. (However, if the patient continues to consent to the transfer or if the transfer must take place urgently, then this 7 days' notice requirement can be waived as long as the notifications take place as soon as is practicable before or after the transfer takes place.)

### Who must be notified after the transfer has taken place?

5. The managers of the hospital to which the patient has been transferred must in terms of section 124(12) of the Act notify the Commission of a range of matters within 7 days of the transfer taking place. These matters are:

- the date of the transfer;
- the name and address of the hospital to which the patient was transferred;
- whether 7 days' notice of the transfer had been given to the patient and his/her named person and primary carer (and if no such notice was given, why it was not given and why, if the transfer was urgent, it was necessary to transfer the patient urgently);
- whether notice was given under sections 124(6) or 124(10)(b) (this is the 7 days' notice of the transfer given to the patient, the patient's named person and the patient's primary carer) .

### Can an appeal be made against a domestic transfer?

6. Yes. Sections 125 and 126 of the Act make provision for an appeal to be made to the Tribunal against a proposed domestic transfer. Section 125 provides for an appeal where the transfer is to a hospital other than a state hospital while section 126 provides for an appeal where the transfer is to a state hospital.

7. The appeal rights under these sections can be exercised by either the patient or the patient's named person where the patient has already received notice of the proposed transfer or where the transfer has already taken place. It is therefore important to note that an appeal can be made to the Tribunal even after a transfer has taken place.

8. It will be important for all members of the patient's multi-disciplinary team to make sure that the patient and the patient's named person are fully aware of the fact that they have an appeal right against a domestic transfer. It would also be good practice for them to take the appropriate steps with respect to providing information and assistance so that the patient and the named person can exercise this appeal right.

### What are the timescales within which an appeal can be made?

9. The timescales are set out in sections 125(3) and 126(3) of the Act. Where an appeal is being made against a transfer to a hospital other than a state hospital, the timescales are as follows:

- if notice of the proposed transfer was given to the patient before the transfer took place, the appeal can be made at any point from the day on which notice was given up to 28 days after the transfer took place;
- if notice of the transfer was given to the patient on or after the transfer, the appeal must be made within 28 days of the day on which the patient was transferred;
- if notice of the transfer was not given to the patient, the appeal must be made within 28 days of the transfer taking place.

10. If the appeal against the transfer to a hospital other than a state hospital is being made by the named person, the timescales are as follows:

- if notice of the proposed transfer was given to the named person before the transfer took place, the appeal can be made at any point from the day on which notice was given to 28 days after the transfer took place.
- if notice is given to the named person on or after the transfer, the appeal must be made within 28 days of the notice being given.

11. Where an appeal is being made to the Tribunal against a transfer to a state hospital, the same timescales apply as those described in the two preceding paragraphs except that the period of 28 days is replaced by the period of 12 weeks.

### What are the possible outcomes of an appeal?

12. In terms of section 125(4) and section 126(4) of the Act, if an appeal is made against a domestic transfer, and if the transfer has not yet taken place, then the transfer may not go ahead unless the Tribunal gives its explicit approval in advance of the appeal being determined.

13. Where an appeal is made against a transfer to a hospital which is not a state hospital, the Tribunal can in terms of section 125(5) make an order that the transfer should not take place if it hasn't already. Where the transfer has already taken place, the Tribunal may make an order that the patient should be returned to the hospital from which the patient was transferred. In terms of section 125(4)(b) of the Act, the Tribunal may make an order that the patient be transferred as proposed pending the determination of the appeal.

14. Where an appeal is made against a transfer to a state hospital, the Tribunal can in terms of section 126(5) make an order that the transfer should not take place. Where the transfer has already taken place, the Tribunal may make an order that the patient should be returned to the hospital from which the patient was transferred. The Tribunal can make any such order if not satisfied that the conditions laid out in section 126(6) of the Act are met. The conditions are that:

- the patient requires to be detained in hospital under conditions of special security; and
- those conditions of special security can only be provided in a state hospital.

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

15. Careful planning should be given to any transfer well in advance of the day of the transfer. The range of issues which should be considered include:

- ensuring that the patient, and his/her relatives, carers and representatives have been informed of an agreed departure time in advance of the transfer, and that the patient is fully supported in preparing for the journey;
- providing an appropriate, swift and comfortable means of transport which is also suitable for the provision of medication, where necessary;
- ensuring that any difficulties relating to the required level of security and to possible absconding en route are foreseen (in as far as this is possible) and dealt with appropriately;
- ensuring that staff in the receiving hospital are properly prepared for the patient's arrival and that time is taken to ensure that the patient can settle quickly into the new environment.

### *TRANSFERRING OTHER CATEGORIES OF PATIENTS*

16. A patient who is subject to an emergency detention certificate, a short-term detention certificate or an extension certificate can be transferred from one hospital to another. However, there are no formal procedures in the Act for the domestic transfer of such a patient. This is because no hospital is specified in these certificates in contrast to a CTO where a hospital must be specified in the order by way of section 66(1)(a). The transfer of a patient subject to any of these detention certificates between two hospitals in Scotland can take place without the need to invoke formal procedures under the Act.

17. It would be good practice to ensure, where it is proposed to transfer a patient to another hospital who is subject to such a detention certificate, that:

- the transfer takes place, wherever possible, with the consent of the patient or the patient's named person;
- as much prior notice of the transfer as is practicable has been given to the patient, the patient's named person, the patient's MHO and other members of the multi-disciplinary team, and, subject to the patient's consent, any carers and relatives of the patient.

### *CROSS-BORDER TRANSFERS*

18. *Sections 289 and 290 of the Act provide for a range of regulation-making powers which can be exercised to make provision for the transfer into and out of Scotland of certain categories of patients. The Scottish Executive is currently consulting on the policy proposals informing these regulations. For further information on these policy proposals, please see the regulations policy proposals consultation document.*

# CHAPTER 6
# UNLAWFUL DETENTION
# (SECTION 291)

This section of the Code of Practice offers good practice guidance with regard to informal patients, who can be described as voluntary patients receiving care and treatment for mental disorder in hospital, and who are not subject to compulsion or detention under either the 2003 Act or the 1995 Act.

1. Section 291 conveys upon the following people the right to apply to the Mental Health Tribunal for an order requiring the managers of the hospital to cease to detain the patient:

(a) the patient;

(b) the patient's named person;

(c) if the patient is a child, any person who has parental responsibilities in relation to the patient;

(d) a mental health officer;

(e) the Commission;

(f) any guardian of the patient;

(g) any welfare attorney of the patient; and

(h) any other person having an interest in the welfare of the patient.

2. This provision effectively allows the patient or any of the other people listed in section 291 to ask the Tribunal to review the need for the patient to remain in hospital when not formally detained. An application could be made to the Tribunal on the patient's behalf under section 291 on the grounds that the patient is being detained in hospital unlawfully. Section 329 of the Act defines 'hospital' as any health service hospital, any independent health care service or any state hospital.

3. This provision might, for instance, be used to review the need for hospital care for a patient who had required hospital care and treatment for mental disorder, who had lacked capacity to consent to admission but who was not objecting to the care and treatment provided and therefore had not been detained compulsorily under either the 2003 Act or the 1995 Act. A patient with severe learning disabilities or dementia might come under this category. It might also be considered where a patient has been admitted to hospital as an informal patient but is being kept in a locked ward and denied free egress.

4. It is important that all patients, whatever their detention status, are provided with a safe, secure therapeutic environment. At times this might mean limiting the patient's egress from or access to parts of the hospital grounds, particularly for patients with dementia or learning disability who may be at risk to their own health by way of falling, or tripping on stairs or similar hazards.

5. It would be good practice for the multidisciplinary team to review on an ongoing basis any such limitations placed on an informal patient, as part of the ongoing review of the patient's care. This would ensure that the team gives active consideration as to whether the patient is being unlawfully detained. During such a review the multidisciplinary team may consider whether the patient's best interests would be served through detention and other compulsory measures under either the 1995 Act or the 2003 Act or the Adults with Incapacity (Scotland) Act 2000, rather than as an informal patient.

6. It would be good practice for members of the multidisciplinary team to inform the patient when they are admitted to the hospital of any limitations to be made to their egress from or access to parts of the hospital. A written summary or map or diagram suitable for the patient's needs may assist the patient's understanding of these limitations. Where limitations are altered after an incident or review it would be good practice for the multidisciplinary team to inform the patient of these changes within a reasonable time, and to update any written materials that may have been provided to the patient. What constitutes a reasonable time will depend upon the circumstances.

7. Under section 315 of the 2003 Act it is an offence for a relevant person who provides, or purports to provide, care and treatment to a patient to ill-treat or wilfully neglect that patient. The provisions of section 315 apply to informal patients as they apply to persons being treated under the 2003 Act and 1995 Act. Section 83 of the Adults With Incapacity (Scotland) Act 2000 has a related provision, whereby it is an offence for any person exercising powers under the 2000 Act relating to the personal welfare of an adult to ill-treat or wilfully neglect that adult. In some circumstances inappropriate use of restraint or limitations to an informal patient's liberty might contribute to or constitute ill-treatment or wilful neglect.

# CHAPTER 7
# PLACE OF SAFETY
# (SECTION 300)

The aim of this chapter is to describe what constitutes a place of safety as defined in section 300 of the 2003 Act. The chapter also points to some of the principles which underlie the provision of places of safety within a specific locality.

## *DEFINITION OF A PLACE OF SAFETY*

1. Section 300 of the Act provides a specific definition of a "place of safety" for the purposes of Part 19 of the Act. The following scenarios are dealt with in Part 19:

- where a warrant has been granted to enter a person's premises under section 292;
- where a removal order has been granted under sections 293 or 294;
- where a mentally disordered person has been removed from a public place under section 297;
- where a nurse has exercised the holding power under section 299.

2. The definition of a place of safety given in section 300 of the Act is:

(a) a hospital;
(b) premises which are used for the purpose of providing a care home service (as defined in section 2(3) of the Regulation of Care (Scotland) Act 2001); or
(c) any other suitable place (other than a police station) the occupier of which is willing temporarily to receive a mentally disordered person.

3. It should be noted that section 2(3) of the Regulation of Care (Scotland) Act 2001 defines a "care home service" as:

> a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need; but the expression does not include–
>
> (a) a hospital;
> (b) a public, independent or grant-aided school;
> (c) an independent health care service; or
> (d) a service excepted from this definition by regulations.

4. No such regulations have been made under section 2(3)(d) of the Regulation of Care (Scotland) Act 2001.

5. In light of the definition of a place of safety given in section 300 of the 2003 Act, it is important to emphasise that a police station may not be used as a place of safety in the scenarios described in Part 19 of the Act. The only exception to this rule is given in section 297(5) which states that a police station may be used where a mentally disordered person is removed from a public place under section 297 of the Act and where no place of safety is immediately available. On any rare occasion where a person is held in a police station instead of a place of safety, it would be expected that the person be moved on to a suitable place of safety as swiftly as is possible under the circumstances.

6. For further information on the use of police stations and other holding places subsequent to the granting of an emergency or short-term detention certificate in respect of a patient in the community, see the relevant chapters of volume 1 of the draft Code of Practice.

### *DESIGNATION OF A PLACE OF SAFETY*

7. All relevant local agencies should work closely together to ensure the provision of sufficient places of safety within their localities and to ensure that all parties have agreed upon and are fully aware of their location and use. It would be expected that these local agencies would designate an agreed preferred place of safety to which persons detained under Part 19 of the Act could be taken. It may be necessary for local agencies to designate an alternative place of safety to which those whose behaviour makes them unsuitable for the preferred place of safety could be taken (for example, where a person is particularly violent or disturbed).

8. When designating places of safety, it would be expected that local agencies have put in place policies which, among other issues, would:

- make clear who has responsibility for the transfer, reception and assessment of the patient and within which timescales;
- ensure that all staff potentially involved with the incidents described at Part 19 of the Act know how to access referral information for mental health specialists, where appropriate;
- address the training and awareness needs of such staff with respect to the needs of persons with acute mental disorder;
- put in place clear after-care arrangements where the person detained under Part 19 of the Act is not ultimately formally admitted to hospital;
- audit and regularly review the use and effectiveness of the locations designated as places of safety within their locality, looking at, for example, issues linked to absconding; the handling of episodes of violence; failures of communication; and users'/relatives' views and experiences.

9. No single solution to the issue of designating places of safety is likely to apply uniformly across all areas of Scotland (particularly in rural/remote locations). However, it is likely that the preferred place of safety would not usually be an A&E department. It could instead, where practicable and appropriate, be a specialised assessment unit closely linked to, or at least accessible to, a psychiatric facility. Any designated place of safety will need to be suitably equipped and staffed by qualified mental health staff who have experience in the management of acute mental disorder. Although it may be necessary to designate an A&E department as a place of safety, their use should not be standard practice and should, where practicable, be restricted to occasions where the person also has significant physical health problems related to, for example, self harm or substance misuse.

10. Where local agencies are designating places of safety within their locality, it would be expected that they would also develop contingency plans for occasions where a person is ultimately removed to an establishment other than a designated place of safety. Such contingency plans will need to focus on ensuring that the range of health and non-health professionals who may become involved with such a situation (for example, A&E staff, GPs, police officers etc) are as aware as is practicable of the issues outlined at paragraph 8 above.

11. The process by which relevant local agencies work together to agree on suitable designated places of safety should be carried out in parallel to their development of Psychiatric Emergency

Plans which would come into operation after the granting of an emergency or short-term detention certificate. For further information on Psychiatric Emergency Plans, see the relevant chapters of volume 1 of the draft Code of Practice.

# CHAPTER 8
# ABSCONDING
# (PART 20)

This chapter of the draft Code of Practice deals with the provisions laid out in Part 20 of the Act which relate to patients who abscond while subject to compulsory measures under the Act or the 1995 Act. (Under the Mental Health (Scotland) Act 1984, absconding was often referred to as "absence without leave".)

This chapter first describes which patients can be made subject to the Act's absconding provisions before moving on to describe the procedures to be followed once a patient has absconded. The chapter concludes with a discussion of the effect of a period of unauthorised absence on the expiry date of certain detention certificates and orders.

## *OVERVIEW OF ABSCONDING PROVISIONS*

1. The provisions of section 303 of the Act or paragraphs 7 to 12 of this chapter set out what must happen when certain patients abscond. The categories of patients who be made subject to these provisions are set out in sections 301 and 302 of the Act and in paragraphs 2 to 6 of this chapter.

## *PATIENTS WHO ABSCOND WHILE SUBJECT TO A CTO OR CERTAIN OTHER DETENTION CERTIFICATES AND ORDERS*

### Which categories of patients can be said to have absconded?

2. These categories are laid out in sections 301 and 302 of the Act. Section 301 sets out the various categories of patients who are subject to a CTO while section 302 describes the other categories of patients.

3. Section 301 of the Act lists the categories of patients subject to a CTO who can be said to have absconded and are therefore liable to be taken into custody and dealt with in accordance with the provisions of section 303. These categories are:

- where a patient who is subject to a CTO which authorises his/her detention in hospital absconds from that hospital or from any place where s/he is being kept while waiting for removal to hospital or while being transferred to another hospital in Scotland under section 124 of the Act;
- where a suspension certificate has been granted under section 127(1) of the Act and a condition has been added to this suspension certificate that the patient be kept in the charge of an authorised person or that the patient reside at a specified place either continuously or

for or at specified times. If that patient absconds from the charge of that authorised person or fails to comply with that residence condition, then the patient can be considered to have absconded or to have gone absent without leave.

- where a suspension certificate has been granted under section 127(1) of the Act and a condition has been added to this suspension certificate that the patient must, upon being recalled or upon the expiry of a specified period or upon or after the occurrence of a specified event, return to the hospital specified in the CTO or must go to some other specified place. If that patient fails to comply with this condition, then the patient can be considered to have absconded.
- where a patient who is subject to a CTO which specifies a residence requirement by way of section 66(1)(e) of the Act fails to comply with that residence requirement.
- where a patient who is subject to a CTO which specifies by way of section 66(1)(g) of the Act a requirement to obtain the approval of the MHO to any proposed change of address but who fails to comply with that requirement.

4. Section 302 describes the occasions when it can be considered that a patient subject to a range of other authorities to detain has absconded. As a result of this abscondence, the patient is liable to be taken into custody and dealt with in accordance with the provisions of section 303 of the Act, as described at paragraphs 7 to 12 of this Chapter. The occasions are where a patient absconds from any place where s/he is being kept while waiting for removal to hospital or from the hospital where s/he is detained while subject to any of the following authorities to detain:

- an emergency detention certificate;
- a short-term detention certificate;
- an extension certificate;
- section 68 of the Act (i.e. the 5-day period of detention subsequent to a CTO application being made);
- an interim compulsory treatment which authorises detention in hospital;
- detention under section 113(5) of the Act (i.e. the period of 72 hour detention which immediately follows non-compliance with a community-based CTO or interim CTO);
- a certificate issued under sections 114(2) or 115(2) of the Act (i.e. certificates which authorise the patient's detention in hospital after the patient has not complied with certain of the compulsory measures specified in a community-based CTO or interim CTO);
- section 299 of the Act (i.e. where a patient is detained in hospital subsequent to the exercise of the nurse's holding power).

5. Section 302(3) to (6) makes provision for further occasions where the patient is liable to be taken into custody and dealt with in terms of section 303 of the Act or paragraphs 7 to 12 of this Chapter. These occasions are as follows:

- where a patient who is subject to an interim CTO which imposes a residence requirement by way of section 66(1)(e) of the Act fails to comply with that residence requirement;
- where a patient is subject to a suspension certificate which in terms of sections 41(1), 53(1) and 127(3) of the Act suspends an emergency detention certificate, a short-term detention certificate or an interim CTO respectively. If such a suspension certificate includes a condition that the patient be kept in the charge of an authorised person, or that s/he reside at

a specified place continuously or for or at specified times, and if the patient does not comply with that condition, then the provisions of section 303 apply.

- where a patient is subject to a suspension certificate which in terms of sections 41(1), 53(1) and 127(3) of the Act suspends an emergency detention certificate, a short-term detention certificate or an interim CTO respectively. If such a suspension certificate includes a condition that the patient must, upon being recalled or upon the expiry of a specified period or upon or after the occurrence of a specified event, return to the hospital specified in the certificate/order or must go to some other specified place, and if the patient does not comply with any such condition, then the provisions of section 303 apply.

6. Sections 301 and 302 of the Act refer to situations in which "the patient is liable to be taken into custody" after having absconded. It would be expected that the decision as to the patient being liable to be taken into custody is recorded within the patient's medical notes with respect to issues such as who took the decision, who was consulted before the decision was taken, and on what evidence the decision was taken. This will be particularly important where the patient was subject to community-based measures when s/he was deemed to have been liable to be taken into custody. In such cases, the patient should be afforded as full an opportunity as possible to explain why, in terms of section 301(3) for example, s/he has failed to comply with the requirement to reside at a specified place before the decision is taken that s/he is liable to be taken into custody. It will also be important in such circumstances to have regard to the principles of the Act in sections 1 to 3 of the Act, particularly the principle stated at section 1(4) with respect to discharging functions under the Act in a manner "that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances."

### What actions can be taken subsequent to a patient absconding?

7. Section 303 of the Act sets out the procedures to be followed once a patient has absconded. In terms of subsection (1) of that section, the following actions may be taken:

- the absconding patient can be taken into custody;
- the absconding patient can be returned or taken to the hospital in which s/he was detained or was to be detained. If this is not appropriate or practicable, the patient may alternatively be taken to any other place which is considered appropriate by the patient's RMO.
- the absconding patient may be returned to or taken to any other place which s/he absconded from or where s/he failed to reside. If this is not appropriate or practicable, the patient may alternatively be taken to any other place which is considered appropriate by the patient's RMO.

8. The persons who are allowed to carry out the actions described in section 303(1) of the Act or paragraph 7 above are set out in section 303(3). They are:

- a mental health officer;
- a police constable;
- a member of staff of any hospital;

- a member of staff of the establishment where the patient is required to reside as a result of a residence requirement being specified in a CTO;
- any other person who has been authorised to carry out any of the above actions by the patient's RMO.

9. In a situation where a patient is subject to a suspension certificate granted under sections 41(1), 53(1) or 127(1) of the Act, and where a condition has been attached to that suspension certificate to the effect that the patient is to be kept in the charge of an authorised person, then that authorised person can carry out certain actions separately from those described in paragraph 7 above. Those actions are:

- to take the patient into custody;
- resume the charge of the patient. If this is not appropriate or practicable, s/he may take the patient to any place considered appropriate by the patient's RMO.

10. Subsection (6) of section 303 allows the use of reasonable force where the actions described at subsections (1) and (2) of that section or paragraphs 7 and 8 above are being carried out. Reasonable force should only be used as a last resort where all other appropriate approaches not involving force have been exhausted. It will be important for practitioners to have regard to the principle set out at section 1(4) of the Act with respect to discharging functions under the Act in a manner which "involves the minimum restriction on the freedom of the patient that is necessary in the circumstances".

11. It would be good practice for local agencies to include within their Psychiatric Emergency Plan ("PEP") contingency plans on the use of reasonable force with respect to absconding patients. (For further information on PEPs, see chapter 3 of volume 1 of the draft Code of Practice.) The issues relating to absconding to be agreed upon in a PEP could include:

- the parties best placed within any specific locality to exercise reasonable force;
- the use of physical restraint, including handcuffs, batons or even firearms, depending on the level of threat offered by the patient (it would be expected that agreement would be reached on such matters taking into account guidelines published by relevant organisations such as the Mental Welfare Commission, the General Medical Council or the Royal College of Nursing, among others);
- the extent of the involvement of the police in any case of absconding;
- suitable places where a patient may be taken into custody, where it is not immediately possible or appropriate to return the patient to hospital.

12. The timescales within any of the actions described at section 303(1) and (2) and paragraphs 7 and 8 above can be carried out are laid out in subsection (4) of that section. These timescales are:

- if the patient is subject to a CTO, those actions can be carried out within 3 months of the day on which the patient absconded or within 3 months of the patient becoming liable to be taken into custody;
- if the patient is subject to any other order, certificate report or provision, those actions can be carried out at any point before the expiry of that order, certificate or provision.

### How does a period of unauthorised absence effect the expiry date of a CTO?

13. With the exception of the scenarios outlined in sections 304(3) and 305 to 308 of the Act (these are described in paragraphs 14 to 17 below), the patient's unauthorised absence does not affect the expiry date of any certificate, order or provision of the Act to which the patient was subject when the unauthorised absence began.

14. Section 304(3) of the Act provides that if a patient's unauthorised absence lasts for more than 3 months, then the CTO to which s/he was subject ceases to have effect.

15. Section 305 of the Act provides for a scenario in which the period of unauthorised absence of a patient who is subject to a CTO lasts for more than 28 consecutive days but finished at least 14 days before the expiry date of the CTO. In such circumstances, the CTO ceases to have effect 14 days after the patient's period of unauthorised absence ends. During this 14 day period after the period of unauthorised absence has ended, the patient's RMO must carry out a mandatory review of the CTO in terms of section 305(2) of the Act. Such a review must be carried out in accordance with the provisions of section 77(3) of the Act. (See chapter 7 of volume 1 of the draft Code of Practice for information on such a review.)

16. Section 306 of the Act provides for a scenario in which the period of unauthorised absence of a patient subject to a CTO finishes either on the day on which the CTO was due to expire or within 14 days prior to the day on which the CTO was due to expire. In such circumstances, the CTO continues for 14 days from the point at which the patient's period of unauthorised absence ended. During this 14 day period after the end of the period of unauthorised absence, the patient's RMO must carry out a mandatory review of the CTO in terms of section 306(2) of the Act. Such a review must be carried out in accordance with the provisions of section 77(3) of the Act. (See chapter 7 of volume 1 of the draft Code of Practice for further information on such a review.)

17. Section 307 of the Act provides for a scenario in which the period of unauthorised absence of a patient subject to a CTO lasts for less than 3 months but finishes after the day on which the CTO was due to expire. In such circumstances, the CTO shall be treated as having continuing effect even after its expiry date and shall continue to have effect for a period of 14 days from the point where the patient's unauthorised absence ended. During this 14 day period after the end of the period of unauthorised absence, the patient's RMO must carry out a mandatory review of the CTO in terms of section 306(2) of the Act. Such a review must be carried out in accordance with the provisions of section 77(3) of the Act. (See chapter 7 of volume 1 of the draft Code of Practice for further information on such a review.)

### How does a period of unauthorised absence effect the expiry date of a short-term detention certificate or a certificate granted under sections 114(2) or 115(2)?

18. Section 308 of the Act provides for a scenario in which the period of unauthorised absence of a patient subject to a short-term detention certificate or a certificate granted under section 114(2) or 115(2) ends within 13 days of the date on which the certificate was due to expire. In such circumstances, the certificate continues to authorise the measures specified in it for a period of 14 days beginning with the day on which the patient's period of unauthorised absence ended.

### *PATIENTS WHO ABSCOND FROM OTHER JURISDICTIONS*

19. *Section 309 of the Act provides for regulation-making powers which would apply the provisions of sections 301 to 303 of the Act to patients who abscond to Scotland and are subject to corresponding compulsory measures in England, Wales, Northern Ireland, the Isle of Man or the Channel Islands. The Scottish Executive is currently consulting on policy proposals informing the regulations to be made under section 309. For further information on these policy proposals, please see the regulations policy proposals consultation document.*

### *PATIENTS WHO ABSCOND WHILE SUBJECT TO CERTAIN OTHER ORDERS*

20. *Section 310 of the Act makes provision for regulations to be made with respect to a patient who absconds or fails to comply with the relevant requirements imposed on him/her while subject to:*

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

*The Scottish Executive is currently consulting on policy proposals informing these regulations to be made under section 310. For further information on these policy proposals, please see the regulations policy proposals consultation document.*

# CHAPTER 9
# SUSPENSION OF COMPULSORY MEASURES
# (SECTIONS 41, 42, 53, 54 & PART 7 CHAPTER 7)

**Introduction**

An emergency detention certificate, a short-term detention certificate or a CTO can each be temporarily suspended. (Under the Mental Health (Scotland) Act 1984, this possibility was often referred to as "being granted leave of absence" or "being out on pass".) Suspension means that where a patient has been made subject to any of these compulsory powers, the requirement that the patient be detained in hospital which the certificate/order imposes can be temporarily lifted or suspended. Only the patient's RMO can suspend a certificate/order in this way.

In addition, any of the other compulsory powers specified in a CTO (for example, the requirement imposed on a patient to attend a specified place for medical treatment) can similarly be suspended by the patient's RMO.

This chapter therefore aims to describe the statutory processes to be observed before a certificate/order can be temporarily suspended as well as the best practice issues allied to any such suspension.

## *SUSPENSION OF EMERGENCY DETENTION CERTIFICATE (SECTIONS 41 AND 42)*

1. Where a patient is subject to an emergency detention certificate and is detained in hospital on the authority of that certificate, it is possible to suspend that certificate for a limited period of time (and thereby suspend the patient's detention in hospital) without revoking the certificate in its entirety. Under such circumstances, section 41 of the Act allows for a "suspension certificate" to be granted. Such a certificate can only be granted by the patient's RMO.

### How long can a suspension certificate last?

2. A suspension certificate can last for any period of time which the patient's RMO stipulates. In terms of section 41(2), this period may be the duration of an event or series of events with or without any associated travel. By implication, the time and date on which this suspension certificate is due to expire may not go beyond the time and date on which the emergency detention certificate is due to expire.

### Can conditions be attached to a suspension certificate?

3. Yes. The patient's RMO may attach conditions to the suspension certificate by virtue of section 41(3) and (4) of the Act. Such conditions can be:

- that the patient be kept in the charge of a person authorised in writing for that purpose by the patient's RMO; or
- any other conditions which the patient's RMO wishes to specify.

4. The patient's RMO can only grant any such conditions where, in terms of section 41(3) of the Act, s/he considers them to be in the interests of the patient or necessary for the protection of any other person. It should be noted that the RMO's giving of authority to another person to keep a patient in his/her charge can only be done in writing.

5. Examples of conditions which could be attached to a suspension certificate include that the patient live in a specified place under the care of a specified person; be kept in the charge of an escorting nurse; or that the patient accept visits from a medical practitioner or an MHO. It would be good practice for the RMO to ensure that the patient's MHO and other members of the multi-disciplinary team are informed of any conditions attached to the suspension certificate, and to ensure that procedures and contingency plans are put in place for any occasion where the conditions are not complied with.

### When would it be appropriate to grant a suspension certificate?

6. Given the brevity of a period of emergency detention, there are unlikely to be many occasions or events which would require a patient's attendance in person outwith the hospital in which they have been detained but which would not require the emergency detention certificate itself to be revoked. It would be expected, however, that before a suspension certificate is granted under section 41 the RMO would carry out as full an assessment as possible of the potential risk to the health and welfare of the patient and/or others of issuing the suspension certificate. Such an assessment should only be carried out after as full a consultation as possible has taken place with the other members of the multi-disciplinary team providing care and treatment to the patient. Practitioners are also reminded that they should have regard to the principles of the Act, as laid out in sections 1 to 3, when deciding whether or not to grant a suspension certificate. Particularly important among these principles in this connection will be that stated at section 1(4) of the Act which provides for any person discharging a function under the Act to discharge that function in manner which "involves the minimum restriction on the freedom of the patient that is necessary in the circumstances".

7. Before granting a suspension certificate (for example, for the purpose of allowing the patient to attend a funeral of a close relative), the RMO and the multi-disciplinary team will need to balance an acknowledgement of the social and emotional importance of attending such an event against the likely impact of attendance on the symptoms and behaviours related to the patient's mental disorder. This is particularly important given that these symptoms and behaviour had after all dictated that it was "necessary as a matter of urgency to detain the patient in hospital" when the emergency detention certificate was first granted. Similarly, cognisance will have to be taken of the views of others (family, carers, friends etc), who may also be involved in the event, on the patient's proposed attendance.

8. A suspension certificate should only be granted in relation to the assessed needs of the patient and not as a method of managing beds in wards which are running at or above capacity. A decision to suspend the power to detain the patient in hospital should only ever be taken where it is in the best interests of the patient.

**Who is responsible for the patient's care and treatment while subject to a suspension certificate?**

9. The patient's RMO remains responsible for the patient's care and treatment while the patient is subject to a suspension certificate. S/He must therefore ensure that appropriate arrangements are made or have been made for the patient's care and treatment while not in hospital. It should also be remembered that the duty under section 1(6) of the Act to provide "appropriate services" to the patient applies to any time where the patient is subject to a suspension certificate.

10. It is important that the patient's relatives and/or carers of the patient (especially where the patient is residing with them for the duration of the suspension certificate) and all the members of the patient's multi-disciplinary team should have easy access to the patient's RMO so that the patient's progress towards recovery can be effectively monitored and acted upon, where appropriate.

**What should happen where a patient requires emergency medical treatment in another hospital?**

11. There may be occasions where a patient detained in hospital on the authority of an emergency detention certificate requires to be transferred urgently to another hospital to receive emergency treatment for a physical disorder. (Note that only urgent treatment for mental disorder can be administered to a patient subject to an emergency detention certificate under section 243 of the Act: an emergency detention certificate does not give practitioners a general authority to treat under Part 16 of the Act.) A suspension certificate would not have to be issued in such circumstances as no hospital is specified in an emergency detention certificate. Best practice would suggest, however, that the RMO take steps to ensure that the patient's named person, primary carer, MHO and other relevant members of the multi-disciplinary team are informed of any such emergency transfer as soon as possible after it becomes apparent that the transfer may be necessary.

**Can a suspension certificate be revoked?**

12. It may be necessary for the patient's RMO to revoke a suspension certificate granted under section 41 of the Act. S/he may revoke the certificate where s/he is satisfied that it is necessary in the interests of the patient to do so or that it is necessary for the protection of any other person to do so. Where an RMO revokes a suspension certificate, s/he must in terms of section 42(3) of the Act inform a range of parties of the revocation as soon as practicable after it has taken place. These parties are:

- the patient;
- any person who had been authorised by the RMO to keep the patient in his/her charge for the duration of the suspension certificate;
- the managers of the hospital in which the patient is detained.

13. Those hospital managers must then in terms of section 42(4) of the Act inform a further group of parties of the revocation. These parties are:

- the patient's nearest relative;
- any person who resides with the patient assuming that the nearest relative does not live with the patient;
- the patient's named person assuming that the managers know who the named person is and that the named person is not the patient's nearest relative or a person who resides with the patient;
- the Commission.

## *SUSPENSION OF A SHORT-TERM DETENTION CERTIFICATE (SECTIONS 53 AND 54)*

14. Where a patient is subject to a short-term detention certificate and is detained in hospital on the authority of that certificate, it is possible to suspend that certificate for a limited period of time (and thereby suspend the patient's detention in hospital) without revoking the certificate in its entirety. Under such circumstances, section 53 of the Act allows for a "suspension certificate" to be granted. Such a certificate can only be granted by the patient's RMO.

### How long does a suspension certificate last?

15. A suspension certificate can last for any period of time stipulated by the patient's RMO. In terms of section 53(2), this period specified in the suspension certificate may be the duration of an event or series of events with or without any associated travel. By implication, the time and date on which this suspension certificate is due to expire may not go beyond the time and date on which the short-term detention certificate is due to expire.

### Can conditions be attached to the suspension certificate?

16. Yes. The patient's RMO may attach conditions to this suspension certificate. In terms of section 53(4) of the Act, such conditions are that:

- the patient be kept in the charge of a person authorised in writing for that purpose by the patient's RMO for the period specified in the certificate;
- any other conditions which the patient's RMO wishes to specify.

17. The patient's RMO can only grant such conditions where, in terms of section 53(3) of the Act, s/he considers them to be in the interests of the patient or necessary for the protection of any other person. It should be noted that the RMO's giving of authority to another person to keep a patient in his/her charge can only be done in writing.

18. Examples of conditions which could be attached to a suspension certificate include that the patient live in a specified place under the care of a specified person; be kept in the charge of an escorting nurse; or that the patient accept visits from a medical practitioner or an MHO. It would be good practice for the RMO to ensure that the patient's MHO and other members of the multi-disciplinary team are informed of any conditions attached to the suspension certificate, and to ensure that procedures and contingency plans are put in place for any occasion where the conditions are not complied with.

### When would it be appropriate to grant a suspension certificate?

19. The range of events and occurrences which might give rise to the granting under section 53 of a suspension certificate is likely to be greater than that which might give rise to the granting of a suspension certificate under section 41 of the Act suspending an emergency detention certificate. It may be necessary to suspend the short-term detention certificate in order to plan discharge and care

planning: for example, to allow the patient to visit and/or be assessed by a community care service provider; or to allow the patient to be gradually re-integrated into their pre-existing social circumstances in the community, including making visits and staying overnight at home, with relatives and carers, or in other care facilities. Before any decision is taken with respect to granting a suspension certificate, however, it would be expected that the patient's RMO consult with the MHO and other members of the multi-disciplinary team. The potential risk to the health and welfare of the patient and of others should be assessed as well as the extent to which the proposed suspension period will aid in the patient's recovery. Practitioners are also reminded that they should have regard to the principles of the Act, as laid out in sections 1 to 3, when deciding whether or not to grant a suspension certificate.

20. A suspension certificate should not be granted under section 53 of the Act as a means of managing beds in wards which are running at or above capacity. A decision to suspend the power to detain the patient in hospital should only ever be taken where it is in the best interests of the patient.

### Who is responsible for the patient's care and treatment while subject to a suspension certificate?

21. The patient's RMO remains responsible for the patient's care and treatment while the patient is subject to a suspension certificate. S/He must therefore ensure that appropriate arrangements are made for the patient's care and treatment while not in hospital. It should also be remembered that the duty under section 1(6) of the Act to provide "appropriate services" to the patient includes any time where the patient is subject to a suspension certificate.

22. It is important that the patient's relatives and/or carers (especially where the patient is residing with them for the duration of the suspension certificate) and all the members of the patient's multi-disciplinary team should have easy access to the RMO so that the patient's progress towards recovery can be effectively monitored and acted upon, where appropriate.

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

23. There may be occasions where a patient who is detained in hospital on the authority of a short-term detention certificate requires to be transferred urgently to another hospital to receive emergency treatment for a physical disorder. A suspension certificate would not have to be granted under such circumstances as no hospital is specified in a short-term detention certificate. Best practice would suggest, however, that the RMO should take steps to ensure that the patient's named person, primary carer, MHO and other relevant members of the multi-disciplinary team are informed of any emergency transfer as soon as possible after it becomes apparent that the transfer may be necessary.

### Can a suspension certificate be revoked?

24. Yes. There may be occasions where it is necessary for the patient's RMO to revoke a certificate suspending a short-term detention certificate. In accordance with section 54(2) of the Act, s/he may do this where s/he is satisfied that it is necessary in the interests of the patient to do so or that it is necessary for the protection of any other person to do so.

25. Where an RMO revokes a suspension certificate, s/he must in terms of section 54(3) of the Act notify in writing a range of parties of the revocation as soon as practicable after it has taken place. These parties are:

- the patient;
- the patient's named person
- the patient's mental health officer;
- any person who had been authorised by the RMO to keep the patient in his/her charge for the duration of the suspension certificate;
- the Commission.

## *SUSPENSION OF THE COMPULSORY MEASURES SPECIFIED IN A CTO OR AN ICTO (SECTIONS 127 TO 129)*

26. The patient's RMO can suspend any of the compulsory measures specified in a CTO. S/He can also suspend the hospital detention requirement specified in a ICTO. Section 127 of the Act and paragraphs 27 to 49 of this chapter deal with the suspension of the requirement to detain the patient in hospital while section 128 of the Act and paragraphs 50 to 55 of this chapter examine the suspension of any of the other compulsory measures specified in a CTO. Finally, paragraphs 56 to 60 examine the issue of revoking a suspension certificate which is addressed in the Act at section 129.

### Suspension of hospital detention requirement where a patient is subject to a CTO or an ICTO (section 127)

27. Where a patient is subject to a CTO or an ICTO which specifies that the patient be detained in hospital, it is possible to suspend that hospital detention requirement for a limited period of time (and thereby suspend the patient's detention in hospital) without revoking the order in its entirety. Under such circumstances, section 127(1) of the Act allows for a "suspension certificate" to be granted. Such a certificate can only be granted by the patient's RMO.

### How long does a suspension certificate last?

28. In terms of section 127(1) of the Act, the suspension certificate can last for any period of time as long as this period is not greater than six months if the patient is subject to a CTO. Where the patient is subject to an ICTO, the suspension certificate can last for any period of time, in terms of section 127(3) of the Act. In both cases, the expiry date of the suspension certificate must not go beyond the proposed expiry date of the CTO or the ICTO. In terms of section 127(4), the period specified in a suspension certificate may be the duration of an event or series of events with or without any associated travel.

29. There are additional considerations with respect to timescales where a patient is subject to a CTO. The RMO may not grant a suspension certificate if the period authorised in that suspension certificate, when taken together with any other suspension certificate granted in respect of that patient, would be greater than 9 months within the 12 month period which would end with the expiry of the proposed suspension certificate. This is to prevent a patient being subject to suspension certificates for unnecessarily long periods of time

### Can conditions be attached to the suspension certificate?

30. Yes. The patient's RMO may by virtue of section 127(5) and (6) of the Act attach certain conditions to the certificate irrespective of whether the patient is subject to a hospital-based CTO or ICTO. These conditions are:

- that the patient be kept in the charge of a person authorised in writing for that purpose by the patient's RMO;
- any other conditions as may be specified by the patient's RMO.

31. The reasons which must motivate the attaching of conditions to a suspension certificate are set out in section 127(5) of the Act. They are that:

- it is necessary in the interests of the patient to do so; or
- it is necessary for the protection of any other person to do so.

32. It should be noted that the RMO's giving of authority to another person to keep a patient in his/her charge can only be done in writing.

33. Examples of conditions which could be attached to a suspension certificate include that the patient live in a specified place under the care of a specified person; be kept in the charge of an escorting nurse; or that the patient accept visits from a medical practitioner or an MHO. It would be good practice for the RMO to ensure that the patient's MHO and other members of the multi-disciplinary team are informed of any conditions attached to the suspension certificate, and to ensure that procedures and contingency plans are put in place for any occasion where the conditions are not complied with.

34. When attaching conditions to a suspension certificate, the patient's RMO should also consider the extent to which it would be more appropriate to make an application to the Tribunal under section 95 of the Act seeking a variation of the CTO. For further information on this point, see paragraphs 42 to 44 of this chapter.

### When would it be appropriate to grant a suspension certificate?

35. A suspension certificate suspending the hospital detention requirement could be granted for a number of reasons including a compassionate visit or emergency treatment in another hospital, as described below. Its main purpose, however, will be to act as a tool in the process of planning a patient's discharge from compulsory measures and, more generally, from psychiatric services. For example, a suspension certificate could be granted to allow the patient to visit and/or be assessed by a place likely to be providing a community care service; or to allow the patient to be gradually re-integrated into their pre-existing social circumstances in the community. This could include allowing the patient to make visits to home or to stay overnight at home, with relatives and carers, or in other care facilities.

36. The patient's RMO should give full consideration to the need for a multi-disciplinary assessment of the impact on health and welfare of the patient and others of the proposed stay in the community. Any proposed suspension of detention and its objectives should concord fully with the patient's agreed care plan and its objectives. In coming to a conclusion on the appropriateness of the proposed suspension certificate, it will be vitally important that the RMO involve fully the patient's MHO and other members of the multi-disciplinary team. All practitioners involved in this process should also have regard to the principles of the Act, as laid out in sections 1 to 3, when

deciding whether or not to grant a suspension certificate. Particularly important among these principles in this connection will be that stated at section 1(4) of the Act which provides for any person discharging a function under the Act to discharge that function in a manner which "involves the minimum restriction on the freedom of the patient that is necessary in the circumstances".

37. It would be expected that the patient and the patient's named person be as fully involved as possible with the planning process preceding the decision to grant a suspension certificate. Subject to the patient's consent, detailed prior consultation will also need to take place with any appropriate relatives or friends of the patient (particularly where the patient is to reside with them once no longer detained in hospital) and with relevant community service providers. It would not be good practice to grant a suspension certificate where the patient does not consent to relatives or friends being consulted where they are to be involved in his/her care once no longer in hospital.

38. The patient's RMO, in consultation with the patient's multi-disciplinary team, will need to give careful consideration to whether the compulsory measures specified in a patient's CTO should in fact be varied under section 95 of the Act rather than temporarily suspended before taking the final decision to grant a suspension certificate. While there will undoubtedly be occasions when it is appropriate to grant a suspension certificate as a means of assessing the patient's likely recovery in a community environment rather than in a hospital, a suspension certificate should not be granted merely as a means of avoiding the need to make a section 95 application to the Tribunal to vary a CTO or of avoiding discharging the patient from compulsory measures altogether. For example, attaching a condition to a suspension certificate which stipulates that the patient reside at a specified place should not be used as a long-term alternative to applying to the Tribunal for an order which would vary a previously hospital-based CTO to a community-based CTO which specifies a residence requirement. Accordingly, a suspension certificate and the extent to which it is meeting its objectives should be kept under constant review by the patient's multi-disciplinary team with a view either to revoking the CTO or to making an application to the Tribunal to vary the compulsory measures specified in the order as soon as either option becomes appropriate.

39. Particular consideration should be given to the need for an application under section 95 of the Act where any of the conditions attached to the suspension certificate are equivalent to any community-based compulsory measures which were not discussed and considered by the Tribunal when the CTO was first made.

40. The decision as to whether to proceed with the granting of a suspension certificate as an alternative to an application under section 95 of the Act will ultimately depend on the extent to which the multi-disciplinary team is confident that the patient is ready to be discharged to the community. If the multi-disciplinary team have reservations about the patient's readiness to be discharged, it would be appropriate to grant a suspension certificate which would make the patient's stay in the community subject to an early review. Such a review should be undertaken sooner rather than later after the suspension certificate was granted with a view to making a section 95 application to the Tribunal.

41. A suspension certificate should only be granted under sections 127 or 128 of the Act where it accords with the assessed needs of the patient and not as a means of managing beds in wards which are running at or above capacity. A decision to suspend the power to detain a patient in hospital should only be taken where it is in the best interests of the patient.

**Who is responsible for the patient's care and treatment while subject to a suspension certificate?**

42. The patient's RMO remains responsible for the patient's care and treatment while the patient is subject to a suspension certificate. S/He must therefore ensure that appropriate arrangements are made for the patient's care and treatment while not in hospital. It should also be remembered that the duty under section 1(6) of the Act to provide "appropriate services" to the patient includes any time where the patient is subject to a suspension certificate.

43. It is important that the patient's relatives and carers (especially where the patient is residing with them for the duration of the suspension certificate) and all the members of the patient's multi-disciplinary team should have easy access to the patient's RMO so that the patient's progress towards recovery can be effectively monitored and acted upon, where appropriate.

44. Where a patient is on an extended period of absence from a hospital, it would be good practice for the patient's RMO to issue a written reminder to the patient to return to hospital shortly before the period of absence is due to end. If the patient does not return on time, then s/he can be said to have absconded and may be dealt with in terms of Part 20 of the Act.

**Who must be notified prior to the granting of a suspension certificate?**

45. There are a range of notification procedures attached to the granting of a suspension certificate under section 127 of the Act. These are set out in subsections (7) to (9) of that section. If the hospital detention requirement is to be suspended for a period of more than 28 days, the RMO must give notice of the proposal to suspend the CTO to the following parties:

- the patient
- the patient's named person;
- the patient's general medical practitioner;
- the patient's mental health officer.

46. It should be noted that the RMO must provide notification to these parties *before* the suspension certificate under section 127(1) is granted. The RMO must additionally give notice to the Commission of the granting of the suspension certificate within 14 days of it being granted.

47. It would be good practice to ensure that these parties receive similar notifications where a suspension period of less than 28 days is proposed.

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

48. There may be rare occasions where a patient who is detained in hospital on the authority of a CTO or an ICTO requires to be transferred urgently to another hospital to receive emergency treatment for a physical disorder. If there is insufficient time in such circumstances to effect a formal transfer of the patient under Part 7 Chapter 6 of the Act, it would be permissible to grant a suspension certificate suspending the hospital detention requirement of the CTO or the ICTO as this

would allow the transfer of the patient to take place urgently. It should be remembered, however, that the patient could not be detained in the second hospital (i.e. the patient could not be prevented from leaving that hospital) given that the first hospital will be explicitly specified in the CTO. The patient could only be detained in the second hospital where the patient's RMO has explicitly cited residence in the second hospital as a condition of the suspension certificate.

49. Best practice would suggest that the RMO should take steps to ensure that the patient's named person, primary carer, MHO and other relevant members of the multi-disciplinary team are informed of any emergency transfer as soon as possible after it becomes apparent that the transfer may be necessary.

**Can a suspension certificate be granted with respect to compulsory measures other than the hospital detention requirement? (section 128)**

50. Yes. Section 128 of the Act permits the patient's RMO to grant a suspension certificate suspending any compulsory measure specified in a CTO other than the hospital detention requirement. Compulsory measures other than the hospital detention requirement cannot be suspended where the patient is subject to an ICTO.

51. It should also be noted that a patient's RMO cannot attach conditions to a suspension certificate granted under section 128 which suspends any measure of a CTO other than the hospital detention requirement. This is in contrast to a suspension certificate granted under section 127 which suspends the hospital detention requirement where the patient is subject to a CTO or an ICTO.

52. The reasons for granting such a suspension certificate will be similar to those motivating the granting of a suspension certificate which suspends the hospital detention requirement of a CTO or ICTO. For further information on this point, see paragraphs 35 to 41 of this chapter.

53. A suspension certificate granted under section 128(1) of the Act may not last longer than 3 months. The RMO may not grant a suspension certificate if the period authorised in that certificate, when taken together with any other suspension certificate suspending compulsory measures other than the hospital detention requirement, would be greater than 3 months.

54. Before granting a suspension certificate under section 128(1) of the Act, in terms of section 128(4), the patient's RMO must notify the following parties of the compulsory measures to be suspended; the period for which they are to be suspended; and the RMO's reasons for suspending them. The parties to be notified are:

- the patient;
- the patient's named person;
- the patient's mental health officer.

55. The RMO must provide notification to these parties *before* the suspension certificate is granted under section 128(1). In terms of section 128(5), the RMO must additionally within 14 days of the suspension certificate being granted give notice to the Commission of the granting of

the certificate; the measures suspended by the certificate and the period for which they are to be suspended; and the RMO's reasons for suspending those measures. It would always be good practice to ensure that any such notifications are provided as soon as possible after the duty to provide them arises.

### Can a suspension certificate be revoked?

56. Any suspension certificate granted under sections 127(1), 127(3) or 128(1) of the Act can be revoked by the patient's RMO if s/he is satisfied that it is necessary in the interests of the patient to do so or that it is necessary for the protection of any other person to do so.

57. In terms of section 129(3), as soon as practicable after revoking a certificate which suspended the hospital detention requirement of a CTO or ICTO, the RMO must notify the following parties of the revocation. The parties are:

- the patient;
- the patient's named person;
- the patient's mental health officer;
- any person who was authorised to keep the patient in their charge during the period authorised by the suspension certificate;
- the patient's general medical practitioner.

58. It would be expected, however, that the RMO discuss with the patient and the other parties mentioned in the preceding paragraph any possible revocation of the suspension certificate before the certificate is suspended. The RMO should, for example, consider very carefully the reasons for revoking the certificate and, in particular, the effects this revocation might have on the patient's recovery.

59. In terms of section 129(4), as soon as practicable after revoking a suspension certificate which suspended any compulsory measure specified in a CTO other than the hospital detention requirement, the RMO must notify the following parties of the revocation and of the reasons for revoking it. The parties are the patient; the patient's named person; and the patient's mental health officer.

60. Where any suspension certificate is revoked, the patient's RMO must notify the Commission of the revocation within 14 days of it having taken place in terms of section 129(5).

# CHAPTER 10
# OFFENCES
# (PART 21)

**Introduction**

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

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

The chapter begins with a general overview of how it would be expected that situations where an offence is suspected would be approached. The remainder of the chapter sets down best practice points for those working with people with mental disorder where there are concerns that an offence may have been committed.

## *OVERVIEW*

1. There is now an increased awareness within the statutory services, the voluntary and private sectors, and the public domain, of the potential for abuse involving vulnerable people. This has been highlighted in the number of enquiries and inspections, and in the number of legal cases against people in positions of trust and responsibility, as well as members of the public.

2. The responsibility for the protection of vulnerable adults extends to all agencies who may be involved with a person who has a mental disorder as defined by section 328 of the Act. This includes local authorities, health boards and independent providers of care services. It would be expected that any response to concerns raised about the welfare of a mentally disordered person would be approached on a multi-agency basis, in line with locally agreed vulnerable adult protection guidelines and protocols.

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

### *BEST PRACTICE POINTS*

#### Non-consensual sexual acts (section 311)

4. Section 311 sets down the offence with which a person might be charged where that person engages in a non-consensual sexual act with a person who has a mental disorder.

5. Where there are concerns about the possibility of an inappropriate sexual relationship, it would be expected that these would be reported in line with locally agreed multi-agency procedures and a multi-agency assessment of the nature of the relationship taken forward. This would entail a meeting of all persons involved in the care of the person as well as the police to allow full information sharing and the issue of consent to be discussed; no assumptions should be made in the consideration of this matter. Local authorities and health boards will have protection procedures in place and recourse to these should be made available to all external providers from whom services are commissioned.

6. While respecting a mentally disordered person's rights to autonomy and self-determination, agency staff involved in the care of the person have a responsibility in accordance with locally agreed procedures and service agreements to report any concerns regarding relationships the person may have, particularly if exploitation or abuse is suspected.

7. Experience of the dynamics of the investigation of sexual abuse shows that allegations are often withdrawn if the person making the allegation is left unsupported through the assessment process. Agency staff would be expected to ensure that disclosures are recorded and acted upon promptly and, if necessary, interim protection measures taken, until the outcome of the investigation is known bearing in mind that no action should be taken which might compromise any future criminal investigation. If the level of risk is such that immediate action is required which cannot be achieved on a voluntary basis, it would be expected that legal advice would be sought to determine whether there are any statutory powers which required to be invoked.

8. Everyone who is involved in the assessment, care and/or treatment of the person, along with any other key people involved with the person, should be consulted and involved in the assessment and decision-making process. In the case of a person who is subject to compulsory powers under the Act, this would include all those with a statutory role in relation to the delivery of the person's care plan. (e.g. the RMO, the designated MHO, CPNs, other health and social care staff, and representatives of independent providers of services to the person).

9. Taking into account the nature of the concerns, it may be appropriate to consider the involvement of family and/or carers. The representation of an independent advocate in terms of section 259(1) may also be helpful to the person. Where it is clear that consent is an issue a multi-agency case conference should be convened and the police involved. It should be borne in mind that local authorities have a duty to assess need, to provide services and to protect, regardless of whether criminal behaviour has been established in accordance with a criminal standard of proof.

10. The Act supports statutory intervention in such scenarios through the local authority's duty to enquire into a mentally disordered person's case under section 33. Section 34 ensures the co-operation of key agencies in such enquires, supported by a warrant under section 35 if necessary.

These powers apply in relation to anyone with a mental disorder over the age of 16, regardless of whether or not he/she is subject to compulsory powers under the Act. For further information on these sections refer to Volume 1 Chapter 9 of this Code of Practice.

### *Persons providing care services: sexual offences (section 313)*

11. Section 313 sets down the offences with which a person might be charged where that person has a caring or professional relationship (as defined by section 313(2)) with a mentally disordered person and engages in a sexual act with him/her.

12. It would be expected that allegations involving persons defined by section 313(2) would be approached in the manner described in paragraphs 4 to 10 above. The police should be involved in all such cases in accordance with established vulnerable adults protection guidelines. Respective agencies' staff disciplinary codes will provide guidance regarding options for the deployment of the member of staff concerned during the investigation, but it would be expected that such a serious allegation would result in immediate suspension from duty until the investigation process had been concluded. During the investigation the primary focus and concern should always be the welfare of the mentally disordered person and so plans should be put in place to safeguard him/her during the course of the investigation.

13. Where an allegation has been made against a member of staff of an independent provider the identified person (as agreed and set down in the service agreement between the provider and the contracting agency) should inform the contracting agency and be involved in the investigation process. The Scottish Social Services Council and the Scottish Commission for the Regulation of Care should also be informed where the individual and/or service is registered with them.

14. Where allegations are made against volunteers used by contracting agencies in the provision of services to vulnerable adults, it would be expected that the action taken in response would be the same as that invoked in relation to a member of staff. Health boards and local authorities retain responsibility for services they commission whether directly or externally provided. It would be expected that, as a result of appropriate contracting arrangements, all independent agencies using volunteers will have comprehensive volunteer policies in place and will comply with disclosure procedures regarding criminal convictions.

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

15. Section 315 sets down the offence with which a person might be charged where that person is a carer (as defined by section 315(1)) and ill-treats or wilfully neglects a mentally disordered person.

16. It would be expected that allegations involving persons defined by section 313(2) would be approached in the manner described in paragraphs 4 to 10 above. Similarly, recourse to a local authority's duty to enquire in terms of section 33 should be considered.

**Inducing and assisting absconding etc (section 316)**
**Obstruction (section 317)**

17. Section 316 sets down the offences with which a person might be charged where that person induces or knowingly assists a patient to abscond, or harbours a patient who has absconded.

18. Section 317 sets down the offence committed where a person obstructs a person authorised by the Act in the manner described by section 317(1).

19. Where the collusion of anyone involved with the patient is suspected in relation to attempted or actual absconding, or where the functions of an authorised person are deliberately obstructed, it would be expected that the person or persons concerned would be made aware of these provisions and that their behaviour may be regarded as an offence under the Act. In order to avoid any unnecessary exacerbation of the situation this information should be conveyed in as neutral a tone as possible under the circumstances. It should be borne in mind by the professionals involved that the patient's family and/or others involved with the patient may to their mind quite legitimately disagree with their intentions or actions particularly where compulsory powers are being exercised or sought, (e.g. emergency detention under section 36 or a local authority's duty to enquire under section 33), and their behaviour should be carefully considered in this context.

# CHAPTER 11
# GLOSSARY OF COMMONLY USED TERMS

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

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

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

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

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

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

**Emergency detention certificate:** this is a certificate granted under section 36 of the Act. Where strict criteria have been met, it authorises the removal of a person to hospital within 72 hours and the detention of that person in hospital for a further 72 hours. An emergency detention certificate can be granted by any fully registered medical practitioner who has, where practicable, consulted and sought the consent of a mental health officer to the granting of the certificate.

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

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

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

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

**Multi-disciplinary team:** this is the team providing care, treatment and support to the patient while they are in receipt of mental health services. The membership and nature of the team will necessarily vary according to the needs and circumstances of the patient. It would, however, be expected that the team would be made up of, where appropriate and relevant, medical practitioner(s), a mental health officer and other social workers, nursing staff/Community Psychiatric Nurses, psychologists, occupational therapists etc. The team may also include community care service providers or voluntary organisations providing care and treatment. These components of the multi-disciplinary team would work together to co-ordinate and agree on all aspects of the patient's care and treatment. Multi-disciplinary working of a high quality will necessarily entail a genuine respect for the opinions of all members of the team; regular communication between all members of the team; and clearly defined information sharing processes.

**Named person:** this is someone nominated by a person in accordance with the provisions of Part 17 Chapter 1 of the Act to support them and protect their interests. The named person is entitled to receive certain information about the person and to act on behalf of the person in certain circumstances and at certain times set out in the Act.

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

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

**Proposed care plan**: this is a document drawn up under section 62 of the Act by the mental health officer who is making the application for a compulsory treatment order. It contains details of the

medical treatment for mental disorder, the community care services; and any other forms of care and treatment which it is proposed to provide to the patient if the compulsory treatment order is made. The "proposed care plan" should not be confused with the "care plan" which is prepared under section 76 of the Act by the patient's responsible medical officer subsequent to the making of a compulsory treatment order.

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

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

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

**Section 86 determination:** this is a determination made by the patient's responsible medical officer under section 86 of the Act to extend the compulsory treatment order without any variation of the compulsory measures or recorded matters specified in the order. A compulsory treatment order can be extended for six months, then for twelve months at a time thereafter. However, the Tribunal must review an order if it has not done so at any point within the previous two years. The Tribunal must also review section 86 determination if the mental health officer disagrees with this determination or if there is a difference between the type(s) of mental disorder stated in the section 86 determination and those in the compulsory treatment order.

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

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

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

**Section 293 warrant:** see "removal order".

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

**Social circumstances report:** this is a report prepared by a mental health officer under section 231 of the Act. It must be produced within 21 days of any of the following events taking place: the granting of a short-term detention certificate; the making of an interim compulsory treatment order; a compulsory treatment order; an assessment order; a treatment order; an interim compulsion order; a compulsion order; a hospital direction; or a transfer for treatment direction. However, an MHO does not need to complete an SCR where s/he is satisfied that an SCR would serve little or no practical purpose. However, a record must be produced stating why the SCR is not being prepared. This record must be sent to the Mental Welfare Commission and to the patient's RMO.

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