

# **The New Mental Health Act**

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## **Transitional Training Guide**

**Introductory Training  
for Mental Health Officers  
and Other Practitioners**

**Trainers' Guide**

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### **Introductory Training for Mental Health Officers and Other Practitioners**

#### **Trainers' Guide**

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

**TRANSITIONAL TRAINING MATERIALS**

**INTRODUCTORY TRAINING FOR MENTAL HEALTH OFFICERS  
AND OTHER PRACTITIONERS**

**TRAINERS' GUIDE**



## FOREWORD

This is part of a package of training materials commissioned by the Scottish Executive. It was developed by Mike Maas-Lowit of Robert Gordon University who was assisted in this process by a multi-disciplinary Advisory Group drawn from services across Scotland and chaired by the Scottish Executive.

The training material is geared primarily to assisting Mental Health Officers gain knowledge of their new statutory roles and duties which have been expanded considerably in the Mental Health (Care and Treatment) (Scotland) Act 2003. The material, however, is organised in such a way as to be of value to others involved in implementing the new legislation. Ideally, wherever possible, training will be delivered on a joint basis.

By necessity the material had to be developed before the Code of Practice, Regulations and Forms had been finalised. References made are generally to draft versions of each (e.g. Volume 1 of the Draft Code of Practice published in March 2004 and Volumes 2 and 3 in June 2004). This material should not be taken as a definitive, legal interpretation of statute. Practitioners should refer to primary legislation and the associated Codes of Practice and seek their own legal advice when questions on implementation and/or interpretation arise.

All should feel free to reproduce any of the material included in the Mental Health (Care and Treatment) (Scotland) Act 2003 Transitional Training Guide series, although the name of the author and the publication from which it came should always be clearly stated. All the material can be downloaded from the Scottish Executive's mental health law website: [www.scotland.gov.uk/health/mentalhealthlaw](http://www.scotland.gov.uk/health/mentalhealthlaw)



## Introduction

Welcome to this Trainers' Guide to the Transitional Materials. It is assumed that you fully understand the purpose and background of the Transitional Training materials. If you do not, we direct you to the foreword and introduction to Reader 1.

The purpose of the Guide is to enable you to implement the package of these materials. We propose a choice of two designs for the five study days. Set out and explained below, we call them Model A and Model B. However, there is as much scope within the overall design of the materials to bend them to your own style of delivery and your own particular use as you wish. We offer the materials in this way because there will be a range of trainers, who will exercise various preferences depending upon style of working and other factors such as demographic spread of the workforce. We also recognise that there will be a range of experience amongst the trainers, from those who feel as confident in the new legislation as any of us can be, to those who feel disadvantaged by lack of knowledge of it. Therefore, for example, some of you may already have designed your own package of training and may wish to use Readers 1 to 4 and the attached case studies in your own way.

This guide is written in anticipation that few of us are fully familiar with the words in the Act and none of us can yet know how it will work in practice. It is also written from the experience of having implemented a Pilot of the materials. The purpose of the Pilot was to:

Find out how the materials worked in practice and what required redrafting;  
Find out the best ways in which the materials may be implemented; and  
Obtain sample answers to the questions asked in the case studies, based upon the discussion of the cases by the participants in the Pilot.<sup>1</sup>

We therefore advise you that the following guide carries the weight of practical experience and that certain aspects of it should be adhered to very closely. We will flag these up as they occur.

Finally, by way of introduction, we acknowledge the complexity of the materials, this Guide included. This is because of the size, scope and complexity of the Mental Health (Care and Treatment) (Scotland) Act 2003, and the considerable task of putting it into action in the most effective and efficient way. The Pilot has demonstrated that the study of the Readers and the undertaking of the training are very taxing tasks for both participants and trainers alike.

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<sup>1</sup> The sample answers from this process are set out in this guide.



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## 1. Who should be a trainer?

The package of transitional materials is aimed primarily at MHOs. Therefore, from the experience of the Pilot, we are certain that it would not be possible for anyone who lacks extensive MHO practice experience to implement the training. It would also be impossible for anyone without extensive experience as a trainer to undertake the task. If your local authority lacks employees with these dual qualifications, we strongly recommend that you either buy them in or make partnership arrangements with another authority which has such employees.

We envisage the most appropriate group of people for the task of trainer to be tutors and co-ordinators of MHO training programmes as they have the joint expertise of MHO practice and training specifically focused upon the subject matter of Mental Health law.

It would be helpful to jointly undertake the implementation of the training. This would share the burden of understanding and introducing the materials and it would prove useful in managing group discussion and feedback (see below). In any case, we strongly advise that this training will not work unless you have a maximum relationship of one trainer to ten every participants.

## 2. What is required of trainers by way of preparation?

Obviously you will need to arrange the material circumstances of venue etc. You will need to co-ordinate numbers of attendees (and this may be complicated if session 1 is open to a wider group of multidisciplinary practitioners than the other sessions). The training is designed for fairly small optimum numbers, and this may require several runs of the event in larger, more populous areas.

However, perhaps the largest task for trainers is that they will have to be fully conversant with **all the materials in the Transitional Package** before they begin the training. We advise that you should make an early start on this task of reading and familiarising yourself with the didactic texts and the case studies well in advance of planning the training. It may be that you need to read core parts of the Readers more than once, in order to be at home with the content. You will need to pay particular attention to the case studies and consider the questions attached to them and the sample answers to them given in this guide. You will also have to read the Codes of Practice and the Act itself, if you have not already done so. You should approach this as a major piece of work.

We acknowledge that it has been impossible to devise a training of this scope and complexity without requiring you to make your own adjustments to it according to local need. It has been simply impossible to design an 'off the peg' product to meet so many specifications.

### 3. What is the optimum size of training group for the five-day event?

You will notice in the programme designs below that we speak of small group case study discussion and feedback to the larger group. This is in anticipation that, in most areas the complement of MHOs is so large that more would attend one 5-day event than could comfortably sit in a group and participate in the sort of detailed discussions that we expect our materials to generate. Therefore we suggest:

- **Sessions 2 and 4 (for MHOs alone)**, 30 participants, forming up to 3 small groups of 10 each, for the small group discussion;
- **Session 1**, (general overview of the Act), 50 to 60 participants: the 30 MHOs plus 20 to 30 colleagues, drawn from multidisciplinary settings (3 small groups of up to 20); and
- **Session 3**, (to which medical colleagues are invited), 40 participants: the 30 MHOs plus up to 10 medical colleagues. (3 small groups of maximum 14)

As we stated above, we strongly advise you from our experience of the Pilot that you will need:

- One trainer for each small discussion group; and
- A maximum of 10 participants per small discussion group for sessions 2 and 4.

We advise this because the newly acquired knowledge of the 2003 Act in conjunction with the practice experience of the participants will generate highly complicated and detailed discussion in the context of the case studies. This discussion must be carefully managed to keep it on track, being mindful of the purpose of the training:

- To give good understanding of how the 2003 Act will work in practice;
- To gather together questions and issues for continuing professional development and future training in working under the new Act; and
- To collect matters for policy and service development within the service as a whole.

This will not be achievable in larger groups or with less than one trainer per group.

## PROGRAMME DESIGN

### 4. General features common to Models A and B

Both models extend over a 5-day period.

Both models are complicated by our wish to build into the actual 5 days training as much **Guided Study** time as possible. This is to allow participants to:

- Read, reflect upon and assimilate the didactic texts;
- Undertake the self assessed questionnaires;
- Read and consider the case studies before small group discussion;
- To achieve all of this without having to find space in very pressurised work time or to have to do it in the participant's own spare time.<sup>2</sup>; and
- It is also so that the trainers may be reasonably assured that all participants will have read the materials before beginning to discuss the case study exercises.

Both models are also complicated by factors relating to the purpose of the training. The core purpose of getting MHOs up to speed for the implementation of the Act has been added to by the awareness that the general introductory session could benefit a broader multidisciplinary audience and that RMOs could benefit from the session in which CTOs are discussed. This also has obvious benefits for MHO participants. If the 2003 Act is underpinned by strong multidisciplinary work, then the wider invitations to attend selected parts of the training will enhance the experience for everyone.

Therefore, in both models:

- **Session 1** is a general introductory day on the 2003 Act, open to all relevant multidisciplinary colleagues;
- **Session 2** is exclusively for MHOs, on making inquiries, applying for warrants and considering consent to Emergency and Short-term detention;
- **Session 3** is for MHOs and RMOs, on Compulsory Treatment Orders; and
- **Session 4** is for MHOs on SCRs and matters relating to Criminal Procedures.

In summary, there are four sessions extending over 5 days. Each session lasts for a working day, the fifth day being given to the guided study of the texts. In both models, the only part of the reading we were unable to include in the allocation of guided study is the study of the text of the Reader 1 in advance of session 1.

**Note:** In inviting participants to the training, the letter will have to contain explicit instructions to arrive **having read Reader 1**. This letter should also ask participants to bring Codes of Practice and copies of the Act with them. All MHOs should have copies of these documents.

The difference in the models is in how the 5 days are broken up. The models are explained below and the relative merits of each discussed.

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<sup>2</sup> Note that we have placed a statement at the end of each reader advising participants to read and reflect upon the case studies if they have spare **guided study** time.

## **MODEL A**

This model integrates the guided study into the four sessions. Therefore, the sessions do not fit comfortably over the allotted 5 days.

### **Day 1: Session 1:**

**09.30 Introduction to the day: Trainer's introductory overview of the Act**

**10.30 Reading for first case study**

**10.45 Break**

**11.15 Small group discussion of the first case study**

**11.45 Feedback to large group**

**12.45 Lunch**

**13.45 Reading of second case study**

**14.00 Small group discussion**

**15.00 Break**

**15.30 Feedback to the large group**

**16.00 Trainer's general overview of session 1/ summary of major issues**

**16.30 Close**

## **Day 2: Session 2**

- 09.30 Introduction to the day: Trainer's overview of the materials for discussion: Duty to inquire, Warrants, Emergency and Short-term Detentions**
- 10.30 Guided study time: Individual study of the second Reader and Self-assessed questionnaire, taking such time for breaks as each individual requires.**
- 12.45 Lunch**
- 13.45 Reading for the first section of the case study**
- 14.00 Small group discussion**
- 15.00 Break**
- 15.30 Reading for the second section of the case study**
- 16.15 Brief feedback on issues to be picked up at the start of day 3**
- 16.30 Close**

## **Day 3: Session 2**

- 9.30 Trainer's brief introduction and review of previous day's discussion**
- 9.45 Reading of the third section of the case study**
- 10.00 Small group discussion, including a built-in break of 20 to 30 minutes at a convenient time**
- 11.45 Feedback to large group**
- 12.15 Trainer's general overview of session 2/ summary of major issues**
- 12.45 Close of session 2/ Lunch**

## **Day 3: Session 3**

- 13.45 Opening of session 3/ Guided study time: Individual study of the third Reader and Self-Assessed Questionnaire, taking such time for breaks as the individual requires**
- 16.15 Close.**

#### **Day 4: Session 3**

<b>9.30 Trainer's overview of the materials for discussion: Compulsory Treatment Orders and Treatment Matters</b>
<b>10.00 Reading for case study</b>
<b>10.15 Small group discussion, incorporating a built-in break of 20 to 30 minutes at a convenient time</b>
<b>12.00 Feedback to large group</b>
<b>12.30 Lunch</b>
<b>13.30 Continued discussion of case study and completion of the forms for CTO, including a built-in break of 20 to 30 minutes at a convenient time</b>
<b>15.45 Feedback to large group</b>
<b>16.00 Trainer's general overview of session 3/ summary of major issues</b>
<b>16.30 Close of session 3</b>

#### **Day 5: Session 4**

<b>09.30 Introduction to the session: Trainer's overview of the materials for discussion: Social Circumstance Reports under the Act and Criminal Procedures in relation to the Act</b>
<b>10.00 Guided study time: Individual study of the fourth Reader and Self-Assessed Questionnaire, taking such time for breaks as the individual requires</b>
<b>12.30 Lunch</b>
<b>13.30 Reading for case study</b>
<b>13.45 Small group discussion, including consideration of drafting report and allowing for a built-in break of 20 to 30 minutes at a convenient time</b>
<b>15.45 Feedback to large group</b>
<b>16.15 Plenary discussion and trainer's conclusions</b>
<b>16.30 Close</b>

### **Merits of Model A:**

This model allows for guided study to be undertaken in smaller chunks which some trainers may feel is more manageable and easier for participants to digest than model B, which contains a day-long period of guided study. The shorter periods of study also mean that the participants are not confronted with such a daunting pile of reading and that they approach each section of the study unburdened with the knowledge that is required for subsequent sessions. In this model, the knowledge base is acquired incrementally and this may be more conducive to reflection upon it.

### **The problems with model A:**

The model is slightly complicated and unwieldy in that session 2 is broken over two days and the second half of the session may feel light in content. There may also be difficulties in restarting the session after an over-night gap.

### **MODEL B**

This model separates out the guided study from the four sessions and places it in a unified day of its own. Therefore the sessions fit comfortably, each into one of the remaining 4 days.

#### **Day 1: Session 1**

**09.30 Introduction to the day: Trainer's introductory overview of the Act**

**10.30 Reading for first case study**

**10.45 Break**

**11.15 Small group discussion of the first case study**

**11.45 Feedback to large group**

**12.45 Lunch**

**13.45 Reading of second case study**

**14.00 Small group discussion**

**15.00 Break**

**15.30 Feedback to the large group**

**16.00 Trainer's general overview of session 1/ summary of major issues**

**16.30 Close.**

## Day 2

**Guided study: Individual study of all the Readers and their related Self-assessed Questionnaire, taking such time for breaks as each individual requires. It is envisaged that this would take place in a facility provided by the trainers, with lunch and refreshments provided.**

## Day 3: Session 2

**09.30 Introduction to the day: Trainer's overview of the materials for discussion: Duty to inquire, Warrants, Emergency and Short-term Detentions**

**10.30 Reading for the first section of the case study**

**10.45 Small group discussion of first section of the case study, taking such breaks as required**

**12.30 Lunch**

**13.30 Reading for the second section of the case study**

**13.45 Small group discussion**

**14.45 Break**

**15.00 Reading of the third section of the case study**

**15.15 Small discussion**

**16.15 Brief feedback on issues**

**16.30 Close**

#### **Day 4: Session 3**

- 9.30 Trainer's overview of the materials for discussion: Compulsory Treatment Orders and Treatment Matters**
- 10.00 Reading for case study**
- 10.15 Small group discussion, incorporating a built-in break of 20 to 30 minutes at a convenient time**
- 12.30 Lunch**
- 13.30 Continued discussion of case study and completion of the forms for CTO, including a built-in break of 20 to 30 minutes at a convenient time**
- 3.45 Feedback to large group**
- 4.00 Trainer's general overview of session 3/ summary of major issues**
- 4.30 Close of session 3**

#### **Day 5: Session 4**

- 9.30 Introduction to the session: Trainer's overview of the materials for discussion: Social Circumstance Reports under the Act and Criminal Procedures in relation to the Act**
- 10.00 Reading for case study**
- 10.15 Small group discussion, including consideration of drafting report and allowing for a built-in break of 20 to 30 minutes at a convenient time**
- 12.30 Feedback to large group**
- 13.00 Lunch**
- 13.30 Afternoon of general reflection: collecting matters for policy and service development and for continuing professional development and future training needs of participants. Breaks as required**
- 16.15 Plenary discussion and trainer's conclusions**
- 16.30 Close**

#### **Merits of Model B:**

Clearly, in the already complicated design of the entire package, this model has the comfort of relative simplicity. It avoids the complications of splitting

Session 2 over two days. It gives a unified study day to all of the reading and this then allows participants to get on with the discussion of cases in an unimpeded fashion.

In rural areas or areas where participants may be travelling over wide distances to get to the training, it avoids the problem of asking them to make the effort of coming to the third day which may be perceived as light in content in Model A.

While we advise you to convene the study day in a centralised setting, in dispersed rural areas it may be more economical to allow participants to undertake the guided study in their own locality.

As will be seen in 'Ways of delivering the 5-days' below, if your preference is to split the 5-days into smaller units, Model B is more easily devisable into stand-alone one-day units than is Model A.

### **The problems with Model B:**

These are all the converse of the merits of Model A:

It does not allow for assimilation of learning incrementally. It burdens the reader with all the material at once and with carrying all the knowledge through the 3 days of discussion.

### **Other Considerations:**

You will see from Model B that it results in a half day of extra time on the final day. This time is given over to gathering unanswered questions and matters to take forward for policy and service development and for further training requirements for the body of MHOs. This lighter half day, to which the facilitator may wish to invite the manager responsible for MHO services, may also be of advantage as a catch all, to clarify any issues arising out of the training.

In Model A these issues would have to be gathered by trainers as they progress through the programme, rather than in one unified session at the end of the training. This may either be perceived as an advantage or a disadvantage, depending on your perspective and your style as a trainer.

### **Ways of delivering the 5-days:**

The programme can be delivered in a unified block. This has advantages:

- It would be easy to arrange; and
- It takes participants away from work considerations for a unified period of time and allows them to give full attention to the training.

It, however, has disadvantages:

- There may be problems in delivering MHO and other services if large numbers of key mental health staff are taken out of practice for an entire working week;
- The programme is very condensed and intense and a wider spread of study days may make the study easier to assimilate; and
- For similar reasons, spread out delivery may allow for reflection time, which the 5-day block configuration does not.

We advise you to determine how to configure the study days in consultation with MHOs and their managers, as the problem is a mixture of operational, workload management and training-led considerations.

A broader spread configuration of the days would most easily be achieved for both Models A and B as follows:

**DAY 1 →→ DAY 2, DAY 3, DAY 4 →→ DAY 5**

In this way the first and last days become detached from a core 3-day block. There may be ways of further dispersing the days, for example, by using Model B above and making each day stand alone. However you resolve the matter we strongly recommend that the material is presented in the sequence of Readers 1, 2, 3 & 4.

## **5. Special use of Session 1**

It is possible to uncouple this general introductory day from the other three sessions and use it broadly, for multidisciplinary groups as induction into the Act. This option may be of particular interest to trainers who are devising training along with colleagues from Health Care and other agencies, in line with Joint Local Implementation Plans. This session may then take on the function of '*awareness training*' for a much wider audience, reflecting the larger numbers of staff for whom it is applicable.

## **6. Who might attend Session 1?**

Whether used in conjunction with the rest of the 5-days or delivered in its own right, session 1 would be of relevance to a wide group:

- Care Management Staff;
- Other Local Authority Staff, Non-MHO Mental Health Social Workers etc;
- General Nurse Managers (particularly in A & E settings);
- Psychiatric Nurse Managers;
- Psychiatric Nurses;
- GPs;
- Approved Medical Practitioners;

- Police;
- OTs, Physiotherapists, Speech and Language Therapists;
- Psychologists;
- Health Care and Local Authority Managers;
- Medical Records staff; and
- Health Centre Practice Managers.

This list is by no means inclusive. For example, while the materials are obviously focussed upon the statutory duties (principally of the local authority), they may be of use for voluntary organisation staff and those developing Advocacy services for the Act.

It would be most helpful for the person co-ordinating the training to encourage any RMOs who intend to come to session 3 on CTOs to also attend session 1. In this way they will be oriented to the format of the training and they will have received the general introduction in preparation for the more in-depth discussion of session 3.

## **7. Discussion of case the studies**

To give you the necessary advantage as trainer, we will replicate the questions asked in each case study and summarise some matters of significance by way of answers. However, throughout the case studies of Session 1 and those of other sessions you should bare in mind our instruction to participants: These discussions may generate questions to which we can have no answers as yet. These sorts of questions have a particular importance of focusing us on aspects of practice yet to be developed.

We would like to note some general matters:

- In reference to some issues/questions, these are by no means definitive answers. Nor can trainers anticipate the range of responses that will be generated in discussion amongst participants of the training.
- While we have advised participants not to be too restricted by the questions, there are several ways in which diversion from the questions may be unhelpful.
- Some questions may seem to invite divergence into discussion about the interface with the Adults with Incapacity (Scotland) Act 2000. While we accept the importance of developing this understanding, the purpose of this training is the narrower understanding of the 2003 Act. We therefore advise you to discourage such discussion.
- While much is made in these materials of the comparison of the 1984 and 2003 Acts, we would advise you to discourage too much discussion of the former Act, comfortable though knowledge of it may seem at this juncture.

- Various agendas may accrue to the advent of the new Act. For example, some practitioners may bring matters to the discussion in relation their workloads and the impossibility of undertaking the new MHO role in their current situation. While we have addressed such matters in the Briefing Paper for Health Service and Local Authority Managers, we worry that this will detract from this training, which is anyway a forum in which such issues cannot be answered. We therefore advise you to steer away from any such discussion.
- The experience of the Pilot is that a certain type of discussion is inevitable if you place like-minded MHO practitioners together. They tend to enthusiastically generate discussion of ethical matters in relation to practice. This is to their credit as it seems indicative of their shared interest in a very challenging area of practice. While some measure of it is inevitable and even desirable in the discussion of these case studies, we advise that it requires careful facilitation by the trainer to keep to the point of each case study. It is for this reason that we advise you to have one trainer per group.

We will clearly articulate the specific purpose of each case study in our discussion below. In some cases we will advise you of specific outcomes to which we wish you to direct the group discussion. To these ends we advise you to be open with the group and that you articulate the aims of each case study.

## **8. Small group discussion and large group feedback**

This device was introduced to enable you to hold larger training sessions than the level of group participation requires. The idea is that a number of small groups can simultaneously enter into detailed discussion of the case study and that they can then add to the learning process by giving condensed feedback of their discussions to the larger group of participants.

It may be that you are undertaking training of MHOs in insufficient numbers to warrant this strategy. If so, then you would have more time for small group discussion. However, assuming feedback to a larger group is required; you will have to consider how to manage it.

In collecting large group feedback we advise you to collect points of significance and unanswerable questions, and to undertake to circulate them after the training, as a means of reminding participants of the discussion. If some of the issues do relate to organisational or operational matters, it may be of help to undertake to address these to the lead manager for MHOs.

Since the experience of implementing the Pilot suggested that facilitating the small group discussion involves intense concentration on the task, we advise you to appoint a note taker in each group so as not to burden the facilitator with the added task of thinking, talking and writing at the same time.

## **9. Session 1**

### **Introduction:**

While the design of this package is prescriptive, we hope that, as a trainer, you will be able to deliver it in your own style. This begins with the session in which you introduce the materials. Therefore, we wish to give you some pointers and ideas which you may chose to adopt or which you may reject in favour of your own introduction:

Our proposed timetable is very tight (allowing one hour for introduction, from 9.30 to 10.30). You may wish to experiment with the timings, giving yourself more time for individual presentation if that is your style. By way of introduction to the first session we recommend a presentation that:

- Sets out the material for the day, in the context of the 5 days;
- Conveys the difficulty of the task with enthusiasm;
- Draws out the potential benefits of the 2003 Act; and
- Introduces the key themes of the Act.

### **Some of those key themes are:**

- A set of principles by which people given formal powers under the Act must go about their duties;
- A more focused regard for the needs of children and young people affected by serious mental disorder;
- The creation of the Mental Health Tribunal for Scotland, which largely replaces the function of the Sheriff Court in civil procedures of granting powers to detain and provide care and treatment on a compulsory basis;
- Expanded duties upon the local authority to provide a range of services for people affected by mental disorder in their area;
- Expanded roles and duties for other bodies such as the Mental Welfare Commission for Scotland;
- A revised framework of compulsory powers of detention in hospital for assessment, care and treatment of mental disorder;
- New powers to compel some individuals affected by serious mental disorder to receive care and treatment services in the community;
- Revision of the relationship between the criminal justice system, mentally disordered offenders and the powers to detain, treat and compel people to receive care;
- A better reflection of the Human Rights of people with mental disorder in relation to the Act;
- Statutory right of access to Advocacy Services for all people affected by mental disorder;
- Revision of the treatments that may be given to people without their consent and the conditions in which they may be given;

- Introduction of 'advance statements' whereby people may register the care and treatment they wish to receive should they become unwell; and
- Addition of new roles in support of people with mental disorder who require compulsion.

The Scottish Executive has made available a set of core PowerPoint slides for use in introducing the Act, which are available on their website at: [www.scotland.gov.uk/health/mentalhealthdivision](http://www.scotland.gov.uk/health/mentalhealthdivision) . These were developed by Karen Wiles, Principal Solicitor, the Moray Council. NES has also developed web-based learning which can be viewed at: [www.nes.scot.nhs.uk/mha](http://www.nes.scot.nhs.uk/mha) These may be of help in the introductions to all of the training days. We also draw your attention to the DVD/Video made by the Highland User Group (HUG), which serves very well as a means of communicating the voice of service users speaking about their experiences and their hopes for the Act, particularly in relation to the principles. This introduction might be a good place to air this voice.

### **Discussion of case study 1:**

We have produced some guidance on the purpose of the case studies so that you may keep discussion in the small groups on track, and some sample responses to the questions, so that you are fore-armed with likely points of discussion and so that you may re-energise any flagging or off-beam discussion in the groups. To enable you to distinguish these insertions, we have added them in **coloured type**:

#### **Case study 1: How may the Principles inform a case for Short-term Detention?**

It has to be borne in mind that this introductory day is for a broader audience than MHOs alone. This is one of the reasons that we begin with discussion of some issues that may seem self-evident to experienced MHOs. The intention here is not to patronise this body of practitioners, but to involve them in discussion with other colleagues to develop multidisciplinary discussion. Another reason that such matters are contained here is that questions such as 'how best to take account of a person's age, gender, cultural background etc' previously arose out of concern for good practice. MHOs must understand that these matters are now embodied in the **Principles** and that their elevation from 'good practice' to 'legally competent practice' changes the way that they are approached. This is a core point of significance that trainers ought to indicate through facilitation of the small groups.

As mentioned above, a presentation including a number of slides that will be useful are available from [www.scotland.gov.uk/health/mentalhealthdivision](http://www.scotland.gov.uk/health/mentalhealthdivision). At the Pilot it was suggested that the appropriate ones for any given case discussion could be displayed on the wall. Amongst them is the abbreviated list of principles.

**Please consider the principles in relation to the situation that is portrayed. In this scenario, take the conditions of detention to be given. This should not discount discussion of matters raised by the principles (having regard for the 'range of options available' for example) that may lead you to consider that detention is not the only course available. The specific purpose of the exercise is to get you to think about the principles in relation to the functions of considering whether to grant/give consent to Short-term Detention: a sort of amalgamated approved Medical Practitioner/MHO role. As this is the first exercise, we have listed principles we think are of significant relevance to help you answer the questions. You are also reminded of the abbreviated list of principles found at the start of the Reader.**

Michael's parents say that they need him to be removed from the home, at least temporarily. What Michael's father describes as 'the last straw' was the moment when he broke down his younger sister's bedroom door and stood there, screaming at Rebecca and her two terrified school friends who were doing homework. As a result Rebecca is tearfully refusing to go to school tomorrow. She says that it took her long enough to pluck up the courage to invite her friends round to her home where she had a 'crazy brother'.

Michael has just turned seventeen. He has had psychiatric involvement for a year now and in that time, he has scarcely attended school. Michael's psychiatrist is reluctant to pronounce any lasting diagnosis upon his condition but Michael says that he has heard voices since he was about six years old, the age at which he was traumatised in a house fire. Since adolescence Michael's behaviour has become markedly less predictable and more upsetting and difficult for his family to manage. Always a loner, he now spends most of his time in his room. From behind the door he can be heard talking, shouting and laughing through the night. He sometimes goes out late at night, and stands in the back garden, staring at the sky.

Michael's mother is now signed off her work as a travel agent. She is being prescribed anti-depressants and is in a state of anguish over his condition. She worries that he seldom seems to eat anything and that he has no relationship with any other members of the household, walking zombie-like past them should he ever encounter them in the house.

Michael's father, a bus driver, alternates between rage and pleading despair at Michael's behaviour. He seems to have more difficulty than Michael's mother has in understanding the psychiatrist's explanation that this behaviour is not wilful. However, the family has managed to keep a lid on things until very recently.

Michael has not been very compliant with services so far. He had reluctantly allowed his parents to take him to psychiatric appointments, refusing all other offers of services. He had reluctantly taken oral anti-psychotic medication, but he has recently becoming less and less compliant with this too. When he refused to attend his outpatient appointment last week, his psychiatrist suggested that he be admitted for the first time. Michael responded by

barricading himself in his room and, while his father thought admission was a good idea and would give them all a break, his mother tearfully pleaded for it not to happen. And so Michael stayed at home for one more tense week, until the incident in his sister's room.

**(a) How best to interpret and take account of Michael's present and past wishes and feelings?**

We do not have full enough information from the case study to allow us to deduce Michael's past wishes and feelings. Therefore any practitioner engaging with him would have a responsibility to find out as much as possible by establishing a relationship with him. However, Michael does seem to be closed in and blunted by his illness. Therefore, such information may have to be obtained from third parties.

Michael is certainly expressing some feelings which seem hard to interpret. For example, while he seems to feel the need to be left alone, he did attempt to communicate something to his sister and her friends. His present wishes are manifested in his reluctance to attend medical appointments and to take medication, but it must be noted that he has been persuaded to comply recently. Therefore, there may be some ambiguity in his wishes, or between his wishes and his feelings. Such ambiguity may be seen in the person who has *feelings* of fear of the dentist, but manages to overcome them in his *wishes* to get a sore tooth fixed.

Were this the case, it may be possible to reassure Michael that the frightening and isolating experience of his illness may be ameliorated with care and treatment. At the other extreme, we may acknowledge with Michael a divergence between what he wishes and the opinions of others in relation to what may be of benefit to him.

**(b) How best to have regard for the views of Michael's named person and carer?**

Michael's mother is currently his named person, in the absence of his having competently nominated one. (Being over 16, Michael is entitled to nominate his own named person.) His mother is expressing anxiety about how to cope, about Michael's wellbeing and about her family as a unit. She seems to be wavering between not wishing to hurt and betray Michael by securing treatment for him against his will and leaving him in what she sees as an intolerable situation.

**(c) How you would enable Michael to participate as fully as possible in the discharge of the function? (Function in this regard is the consideration of granting/consenting to Short-term Detention).**

What seems to be required is skilled imparting of clear information, given as carefully as possible and in a manner, which enables Michael to hear and understand. Facilitating Michael's right to access advocacy services may also be invaluable in this regard. It must also be remembered that there are a

broader set of rights in respect of Short-term Detention (rights to apply to the Tribunal to have the certificate revoked) and Emergency Detention (right to general information, as encapsulated in the principles).

While these matters are examples of things that may be self-evident to experienced MHOs, it is worth reminding them of something that they may have forgotten: It is a very challenging task to explain complicated legal rights to mentally disordered people in crisis. At one time it was probably even more difficult for any MHO to perform this task, when they were less familiar with the 1984 Act. They will now have to become as familiar with the 2003 Act to be able to perform the same task with the same comfortable skill.

**(d) What is the range of options available in the Michael's case?**

There are many options including attempting to introduce services into Michael's life at home on a voluntary basis. However, while that seems not to have been seriously tried so far, it may also be a bit late for it. Therefore, the following all seem to be worthy of consideration:

- Doing nothing;
- Considering Emergency Detention;
- Considering Short-term Detention; or
- Making an application for a Compulsory Treatment Order with powers to compel receipt of services at home or in hospital.

**(e) What is 'benefit' in Michael's regard, in respect of the importance of providing the maximum benefit to the patient?**

Serious consideration of 'benefit' here would seem to preclude doing nothing. Of justifiable benefit would be securing treatment:

- Because he seems to be at risk to health, safety and welfare; and
- Because Michael's support system, his family, is collapsing under the strain, which would exacerbate the above risks, especially the welfare risks. If the group do not pick up on this it may be advisable to ask them what the welfare risks might be for Michael, as welfare is a new condition for detention.

**(f) How can the functions of the Medical Practitioner and the MHO be discharged in a manner that involves the minimum restriction on Michael's freedom that appears to be necessary in the circumstances?**

Assuming the conditions for the various options of compulsion may be fulfilled, doing nothing may ultimately prove of greater restriction on Michael's freedom than taking action to compel him to receive treatment. It may also be the case that Emergency Detention proves to be more restricting than Short-term Detention. This is because Emergency Detention has severely limited rights and a lack of treatment powers. It also may proceed without the expert judgement of an Approved Medical Practitioner. Therefore, Short-term

Detention would most likely have to follow the imposition of an Emergency Detention Certificate.

It may be that a CTO is of greater restriction at the moment because the need for its longer duration and more intrusive powers has not yet been demonstrated. Short-term Detention appears to be the best means of assessing the need for the more restrictive CTO.

**(g) What regard should be had in relation to the importance of Michael's background and characteristics, including age, sex, etc?**

Here, we may see how the principles have added strength in their interlocking design. The important regard for Michael's age is echoed in the principle of primacy of the welfare of the young person. It also relates to **section 23**, which places a duty on Health providers to provide appropriate services for people of Michael's age. It may further relate to interviewing Michael in an age, gender and culture appropriate manner.

**(h) What are the needs and circumstances of Michael's mother as his carer and how may they best be addressed?**

Michael's mother appears to need support, advice and information in the first instance. In the longer term she probably needs a carer's assessment of need and respite services.

**(i) Most importantly, how can the function be discharged in a manner that best secures Michael's welfare? (From section 2: 'Welfare of the child.')**

In many ways we have already answered this question above. However, we have yet to acknowledge the duties of section 278, to 'mitigate adverse effects of compulsory measures on parental relations'.

**Discussion of Case Study 2: Reflecting on the Principles in relation to the Named Person and Primary Carer:**

**As in the previous case studies, please consider the principles in relation to the situation that is portrayed. In this scenario, take the conditions of detention to be given. Beyond the fact that it would be unlikely that a Compulsory Treatment Order would be considered in such a situation, it is not anticipated that the context of detention (Emergency or Short-term) is a question relevant to the exercise.**

It is important to note these points: At this stage in the training we need to focus on how the principles shape decision making, not upon the sort of decisions being made. There is ample opportunity for MHOs to consider the appropriateness of the conditions of detention and other matters later in the training sessions.

**The question has two parts to it, the second part introducing complicating factors in relation to the role of the named person. The specific purpose of the exercise is to get you to think about the principles in relation to the patient and the functions of the primary carer in the first instance and, in the second component of the question, the named person.**

While some of the questions between parts 1 and 2 may seem repetitive, it is worth asking them, because subtle shades of difference may come out in the answers, as the situation develops in the case study.

**In your discussion, make sure that you allow time for both parts.**

Reem Jiheli is a 29 year-old woman with a history of anxiety and depression dating back to her mid-teens. Reem describes herself as Scottish-Palestinian. She lives with her parents and, when well, has helped out in her father's business, a small Arabic printing service for local businesses. While she has managed reasonably well with CPN support and medication, she has also had severe stress-related bouts of illness in the past, during which Reem's mother has been identified as her main carer. She has required informal inpatient treatment on some of these occasions.

Within the family, Reem complains that both her parent's fuss too much over her and attempt to cushion her from any of life's potential hazards. Reem feels that they restrict her opportunities to form any adult relationships and she has consequently developed a close friendship with a man of her age without her parents' knowledge.

Reem met Duncan at a local mental health social-support drop-in service that her parents occasionally reluctantly allow her to attend. Duncan also has a history of mental illness. Reem and Duncan would eventually like to live together and he had been pressurising her to tell her parents about their relationship. Her CPN had offered to support Reem in the task. However, the pressure seems to have been too much for Reem's fragile mental health to endure. Superficially in agreement with the plan to tell her parents about Duncan, she had been more worried about it than she let on.

The current situation is that Reem has rapidly become increasingly anxious and depressed. Unable to tell any of those who support her of her deteriorating condition, she masked it as best she could until it was already profound. Once it was recognised by her parents, Reem's mother took on her customary, rather smothering caring role under which Reem has deteriorated to the point where she is mute and not eating. As she is now unable to consent to the hospital care that her CPN considers necessary, the CPN has advised her psychiatrist of a potential need for detention. An MHO has been advised accordingly.

**The views of others:**

While recognising from past experience that Reem ought to be in hospital, her mother is anxious that her daughter will not receive the personal care and attention she would receive at home. Reem's father is also anxious about her mixing with other mentally ill people in hospital.

Reem's CPN is concerned that Mr and Mrs Jiheli should not find out about Duncan's existence, as Reem was clearly more reluctant to let them know about him than she let on. Duncan, on the other hand, is angry about how Reem is smothered by her parents and he thinks this is the cause of all her mental health problems. He sees this as the perfect opportunity to confront Mr and Mrs Jiheli.

At first glance, Reem's situation appears to be sub-acute. At least, it does not appear to be a situation meriting consideration of compulsory powers, until the case study has developed to the point where Reem is profoundly depressed.

**(a) How can you best interpret and take account of Reem's present and past wishes and feelings?**

Reem's past wishes and feelings have been expressed ambiguously, in the fear of going against her parents' wishes on the one hand and in her own wish to assert her independence on the other. Her present wishes and feelings appear to be increasingly submerged in her depression and are therefore beyond expression.

**(b) How best to have regard for the views of Mrs Jiheli, as Reem's carer?**

There are complicated cultural issues attendant upon this. Mrs Jiheli seems to express her role as carer in a way that Reem finds smothering. As the case study develops, it also becomes apparent that Mrs Jiheli is mistrustful of the quality of care her daughter may receive elsewhere. It may be that she shares her husband's view that this care is culturally inappropriate or insensitive.

**(c) Given Reem's condition, is there any merit in attempting to engage her in participating as fully as possible in the discharge of the function?**

Even with severely depressed people, it is always worth attempting to engage them, if for no other reason than that they sometimes remember and appreciate the human contact in their mute state. It is also a duty of the MHO and others to communicate information about compulsory measures and one should therefore never assume that it is not worth while. Timing and the use of repeated and/or joint interviews with key others may assist.

**(d) What is the range of options available in the Reem's case not just in relation to the potential detention itself, but also in relation to the issues discussed above?**

These do not vary significantly from the options in Michael's case above, including attempting to introduce services into the home on a voluntary basis. However, while that seems not to have been seriously tried so far, it is also evidently too late for it. Therefore, the following all seem to be worthy of consideration.

- Doing nothing.
- Considering Emergency Detention.
- Considering Short-term Detention.
- Making an application for a Compulsory Treatment Order with powers to compel receipt of services at home or in hospital.

As with Michael, Short-term Detention probably comes out most favourably, with 'doing nothing' as the least justifiable option. It also seems evident that community based treatment is not viable at this stage.

**(e) How might you interpret the word 'benefit' in Reem's situation, in respect of 'the importance of providing the maximum benefit to the patient'?**

Reem's condition is life-threatening and this focuses benefit on providing services to prevent a deterioration. However, 'benefit' also may be interpreted not just in terms of what you do (for example securing urgent treatment if need be by compulsion), but also in terms of how you do it. In this sense, preserving confidentiality about Reem's boy friend would be of benefit to her.

**(f) How can the functions of the Medical Practitioner and the MHO best be discharged in a manner that involves 'the minimum restriction on the patient's (Reem's) freedom that appears to be necessary in the circumstances'?**

The question may be answered very much in terms of the response in Michael's situation above. However, it is also not just a question of what you do, but of how you do it. Again, breaking confidentiality about Duncan would be more intrusive than necessary.

**(g) What regard should be had in relation to the importance of Reem's background and characteristics, including age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group?**

Taking account of this reflects the problems of Reem's age, sex and sexuality, all of which seem to clash with her cultural background, ethnicity and (it may be implied) her religious background. Very careful regard should be had for all of this.

**(h) What are the needs and circumstances of Reem's mother as her carer? Given that, at least in Reem's eyes, she appears to be a rather smothering carer, is your consideration of Mrs Jehali's needs diminished?**

Clearly Mrs Jehali also requires the offer of a carer's assessment of need. She requires information and support and she needs to be listened to. Her views of services need to be accommodated and it needs to be borne in mind that considerations of culture reflected in the above principle should also be reflected in the provision of culturally sensitive services.

### **Case Study, continued....**

#### **The Named Person:**

Let us now complicate matters by adding a more challenging dynamic to the case: Before Reem became ill, she and Duncan attended a workshop for service users on the 2003 Act. Inspired by this, the couple resolved to make each other their respective named persons. This was competently done, witnessed by Reem's CPN, who had discussed the potential implications of their choice with the couple and now their respective choices of named persons have legal standing.

In securing treatment for Reem, clearly the multi-disciplinary team has to negotiate these difficulties. In doing this, it is important to consider the following facts: Sections 1(3)(b) (i) and (ii) require regard to be had for the views of the named person and carer. On top of these requirements, Emergency and Short-term Detention carry duties on the hospital managers to inform the nearest relative (in the case of Emergency Detention only) i.e Reem's father, and the named person (i.e. Duncan), of the detention. Short-term Detention also requires that the Medical Practitioner who is considering granting it must consult the patient's named person unless it is impracticable to do so. There is no duty upon anyone to notify the nearest relative or the carer of the existence of the named person. However, in thinking this through, it is possible that Reem's father will find out about Duncan. For example, the named person has rights of appeal against Short-term Detention and Mr Jiheli may find out about Duncan and his role, should he choose to exercise these rights.

The Draft Code of Practice enjoins the Medical Practitioner and MHO to undertake as much joint assessment and consultation as possible. It asks the MHO to 'find out as much as is possible under the circumstances about the person's personal and social situation.... Where practicable and where it would not cause undue pressure or concern to the patient, it would also be best practice for the MHO to discuss the situation with the family/carers etc independently of the patient.'

The purpose of the insertion of the second part of the case study is to focus thinking on the role, purpose and implications of 'the Named Person' in relation to the principles and to relatives and carers. The introduction of

Duncan as named person is a deliberate strategy to complicate the situation so that a stark contrast is created between the roles of named person and carer. It is also there in order for participants to consider that, even when 'the patient' exercises a competent and reasonable judgement in proposing a named person, it may create complications for them. On the other hand, the intention here is not to place a negative slant on the role of named person.

**Questions for case study 2, part 2: Does this information impact upon any of the following questions that we have already asked you above?**

**(i) How may you best interpret and take account of Reem's present and past wishes and feelings?**

In a sense, the revelation of Reem's nomination of Duncan as her named person only serves to emphasise her dilemma: whether to opt for independence while fearing to offend her parents, or to remain loyal to her parents' wishes. However, she has now elevated her boyfriend's status to one of legal standing and as such, it cannot be ignored.

**(j) How may you best have regard for the views of Reem's carer (and now her named person)?**

Mrs Jihali's views remain unchanged by events, as long as she does not know about Duncan. And, while one cannot realistically prevent Duncan from disclosing his relationship with Reem to her parents, his 'named person' status does not give him a right to do so. Therefore, while taking account of Duncan's views, it may be appropriate to point out to him that they represent his and not necessarily Reem's best interests, and that he may be actually harming her by his preferred course of action now.

Note, however, that there is no requirement in the Act for the named person to operate in a way that reflects the best interests of the patient. Free as they are from the binding principles, the onus is upon the patient to exercise judgement in nominating a person whose actions will be of benefit.

**(k) What is the range of options available in the Reem's case, not just to detention itself, but in relation to the issues discussed above?**

We have largely addressed this. Reem would seem best served by the immediate securing of Short-term Detention and thereby, obtaining treatment in the absence of Reem's ability to consent.

Other options are to consider that, while not being able to exercise a capacity to consent, Reem does not appear to be objecting to treatment and therefore her situation may be resolved with recourse to treatment under the Adults with Incapacity Act. Such issues may come up in discussion but they are needlessly complicating of our purpose here, the Adults with Incapacity Act better serves the needs of those who have physical treatment requirements and informality does not offer sufficient rights and safeguards. Therefore, paradoxically, it arguably may be seen as more restrictive of freedom.

Any discussion of treatment options risks going beyond the parameters of session 1. It would require more in depth understanding of Part 16 of the Act than participants yet have. For example, to give ECT without Reem's consent, but while she does not object or resist, would require a certificate from her Responsible Medical Officer or a Designated Medical Practitioner stating that she lacks capacity to understand the effects etc of the treatment but that it would be in her best interests as it is likely to alleviate or prevent deterioration of her condition (section 239).

## **10. Session 2**

### **Introduction:**

The sessions should become more challenging at this point, as they focus in greater detail on the letter of the law, specifically for MHOs.

The matters discussed above in the general introduction to the study days apply here as much as they do in Session 1. Your first task is to provide an overview of the material for:

- Making inquiries;
- Application for warrants;
- Consideration of consent for Emergency Detention; and
- Consideration of consent for Short-term Detention.

You may also wish to include other matters in you introductory overview that appear in the Reader 2. The most significant of these are:

- The framework for appointment and re-appointment of MHOs; and
- The material about risk assessment.

In this introduction to the material, we suggest several matters of primary concern:

- The arrangements for appointment of MHOs are very different from those under the 1984 Act and will require re-appointment to be based on evidence of continuing professional development. However, the specifications and framework for this are not yet known. We suggest that you mention it here as:
  - a) A way of making MHOs aware of an important fact; and
  - b) Introducing them to the expanded and more involved role of MHO under the Act.
- The designation of MHOs under section 229. This follows on from the point made above, that MHOs have a more involved, longitudinal role in the exercise of compulsory powers.

- The duty to make inquiries is a new one, probably yet to be fully configured by policy in your local area. However, if such local policy is available to you, it could be important to share it in outline.
- The 3 varieties of warrant available by application under section 35.
- The new arrangement whereby Short-term Detention is not dependent upon Emergency Detention.
- The fact that, Emergency Detention apart (where it is only required unless it is impracticable to obtain it), there is mandatory MHO involvement at the gateway to almost all compulsory powers.
- The significance of the new conditions for Emergency and Short-term Detention which now include ‘significant’ risk and ‘welfare’ in the criteria for risk assessment and significantly impaired judgement about the provision of medical treatment
- The specific test of capacity in making decisions about treatment
- The new duties of the MHO to give advice and access to advocacy
- The duties in relation to the named person
- The interaction of the MHO’s duties with the Principles
- The heightened focus on multidisciplinary consultation

It may also be of value to set all of this in context by linking it to the discussion of CTOs coming in Session 3.

As well as focusing on the content of Session 2, we advise that you give some time over to the discussion of the process:

**Built in study time:**

Unless participants have been adhering to Model B, there is a 2 hours and 15 minutes period given to guided study here. The intention is to:

- a) Make sure that participants do not hinder the discussion by not having done the reading; and
- b) Minimise the inevitable tendency for such preparation to be undertaken in the participants’ own time

However, the allotted time for the in-depth reading of such a lengthy text is limited. Therefore, it should be approached in what ever way best facilitates the needs of the participants. We recommend that:

- There are refreshments readily available throughout the study period;

- There are comfortable and quiet areas available for study; and
- There is scope for people to study individually in quiet privacy and for people to share discussion of the text if they find it easiest to study in small groups.

### **Discussion of case the studies:**

To give you the necessary advantage as trainer, we will replicate the case study and questions below. We will include extra guidance for trainers and summarise some of the points that came up in discussion in the Pilot of the programme. Again, to enable you to distinguish these insertions, we have added them in **coloured type**:

### **For trainers who have opted for Model A, a summary of discussion at the start of the second day:**

Because the session is broken over two days, you will have to give thought to how you provide continuity at the start of the second day. Our timetable allows for a 15 minute recap of the main points of discussion from the first case study. However, you may wish to use this time in some other way, to welcome participants back and re-energise the discussion at the start of the session.

### **The Case Study: Scenario 1**

The purpose of the case study is to focus participants' discussion on the mechanics of:

- Making Inquiries under section 33;
- Applying for warrants, in particular: under section 35(1), for entry to premises; and, 35(4), for making a medical examination without consent;
- Considering the conditions for Emergency and Short-term Detention; and
- Applying the principles to all of the above;

The PowerPoint presentation available from the Scottish Executive's website includes the following:

- The conditions for making inquiries and applying for warrants;
- The conditions for Emergency and Short-term Detention;
- The abbreviated list of principles; and
- Other prompts such as the conditions for CTO.

We advise you to make optimum use of this material during discussions.

In engaging with the scenario below, assume that the information set out has been gleaned from the medical records and from Eileen, the informant who has notified the local authority of the need to make an investigation.

Janice McLeod is a woman who has a history of depression in which low self-esteem is a chronic feature. She is in a bullying relationship with her husband John, a man who aggrandises his own self-esteem by dominating and humiliating her. Janice has a job as a school cleaner. She has little social life and keeps poor contact with her elderly mother. This is because John won't allow it, even though Janice is secretly desperately guilty and worried that her mother is increasingly in need of domestic help due to her failing eyesight and diabetes. In almost all decisions Janice defers to John, to the point where she feels she has no confidence to exercise choice in her own right.

Before she met John four years ago, Janice received in-patient treatment for depression following the death of her father. She was admitted to hospital following a suicide attempt by overdose. Admission was not by compulsion but Janice agreed to it with some reluctance. At the time she identified unresolved childhood issues of emotional abuse at her father's hands as largely causal of her depression. She has never discussed these events with John.

Janice is known to her GP surgery where she was treated for depression for eighteen months after her discharge from hospital. More recent contact with her GP has been for numerous minor physical complaints but she has had no contact in the last six months.

Over the last year Janice has been aware of sinking back into depression. However John will not allow her to seek help for it. He is acutely aware of the stigma of mental illness, having been mocked as a child for having a mother who spent periods in psychiatric hospital. Furthermore, John uses Janice's inability to 'snap out of it' as an excuse to further degrade her.

The situation has now developed to the point at which Janice feels too incapacitated by the weight of her low mood to get out of the house and go to her work. This has now happened for two weeks with Janice furnishing no medical certificate for her employer. Eileen, her friend from work, has called round to advise Janice that her work supervisor says that unless she responds to the letters that have been written to her or returns to work, she will lose her job.

Eileen was at first unable to get in to the flat to see Janice. John sent her away telling her Janice was out. However, Eileen thought it improbable that Janice would be out, since the time of her visit was 8.00am, following the end of Eileen's cleaning shift at the school. Eileen returned when John was at work. When she was eventually able to rouse Janice to answer the door by shouting through the letterbox, Eileen was shocked to see how painfully thin her friend had become. Having no experience of depression, she was equally shocked to see how deflated and empty Janice seemed: almost devoid of any will to go on living, was how she described it. What worried Eileen most was that Janice didn't even seem to have the emotional reserves to cry, in her desperate situation.

Janice brushed off Eileen's concerns and refused to go to the doctors, saying that John would never stand for it. She got rid of Eileen with a promise that she would be fine and she would see her at work next week. When Janice did not show at work, Eileen was yet again debarred from seeing her by John. Eileen has had contact with care management in the past and the only thing she could think of doing in this situation was phoning the social work department. However, she has not yet told Janice that she has made this referral.

### **The questions:**

- 1.1 Is this the sort of situation in which you would consider there to be a duty to make an investigation? In considering this, you may have to closely consider the circumstances in which such a duty arises (section 33 (2)(a) ): 'the person may be subject to or exposed to ill-treatment, neglect or some other deficiency in care or treatment...'**

In the Pilot, participants agreed that this was indeed the sort of situation in which they would find a duty to make inquiries. It is always likely that some participants may reflect that, under high workloads an MHO might not undertake this duty, or the local authority might not prioritise it. However, it could be appropriate to remind participants that this training is not about the limitations of resources and the pressures of workloads. It is about exploring how the new Act can be implemented as intended.

The Principles inform the initial response. While the progress of this referral may be determined by how it comes into the department (via intake team, non-mental health specialist care management team or via a telephonist for example) we ought to begin to expect all of these staff to have some grounding in the Act and to be aware of the duties of the local authority and the principles of the Act. It should also be the case, especially in the light of the SWSI and the Mental Welfare Commission Inquiries into the Scottish Borders Council<sup>3</sup>, that local authorities all have policies relating to Vulnerable Adults and are making careful use of them. It may also be argued that section 10(1)(d) of the 2000 Act applies here (duty to investigate).

It may be argued that, as long as an investigation/inquiry is being made, it does not matter from which source it flows. However, the probable presence of a strong mental health component here would suggest that the 2003 Act is the most appropriate umbrella under which to proceed.

Participants of the Pilot felt that a softly-softly approach would be best, gathering such information from medical records, the GP surgery and from a check of social work records on Janice, John and also Eileen, to rule out a malicious referral.

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<sup>3</sup> Report of the Inspection of Scottish Borders Council Social Work Services for People with Learning Disabilities, SWSI, April 2004 and Joint Statement from the Mental Welfare Commission and the Social Work Services Inspectorate, SWSI, April 2004.

It may be that the local authority is able to delegate its remit to inquire. For example, the GP or a practice nurse with previous relationship with Janice may have more luck than a new face in making initial approaches.

Care would need to be taken to proceed in ways that do not unnecessarily antagonise John. There would be much merit in proceeding in ways that attempt to include John. After all, he is the main carer, even if his care seems to be wanting.

All of these considerations suggest the need to highlight the very different mind-set that the new Act requires. If this matter does not arise at the instigation of the participants, the Trainer may have to point it out: This Act requires far more proactive practice than we are used to under the 1984 Act.

**1.2 If you agree that the conditions may have been met, what advantages are there in having an MHO make the investigation? Who else in the local authority might be competent to make such an investigation?**

MHOs are best placed to take such an inquiry forward because:

- As the first person to see Janice in this episode of depression, the MHO has a good knowledge of mental disorder;
- The MHO has superior knowledge of the 2000 and 2003 Acts;
- If it is required, the MHO has powers to take the matter forward (for example, applying for warrants);
- The MHO may have better access to medical records; and
- The MHO may have better access to medical colleagues and may have greater credibility in their eyes.

The Draft Code of Practice for Civil Procedures states that MHOs should make inquiries where possible. Were the inquiry not to be carried out by the MHO then:

- It could be undertaken by a CPN, but the CPN service might be reluctant to visit without the consent of the subject; and
- It could be the GP, but GPs often lack the resources for such a task.
- An experienced social worker may also be able to make such enquiries.

Who ever it was other than an MHO, they would have to have access to MHO advice and they would have to report back to an MHO for the matter to be checked out.

**1.3 If your answer to the first question was that there would be no duty in this case, what would you do with the information? If your answer was that there is such a duty, how would you proceed?**

If there were considered to be no duty to inquire, the decision would have to be justifiable in terms of the principles. In reality, it is difficult to foresee how

this could be justified in terms of the legal requirements of section 33 and the principles and in terms of the Code of Practice. However, were this the case, Eileen would have to be informed and the matter would have to be recorded. Both of these responses would need to be framed by the principles. Remember that section 1(7) states that ‘discharging’ in relation to a power, includes reference to the power by taking no action.’

Here too is passing reference to the Borders Inquiry: it found poor recording to be a factor in the failure to prevent abuse.

In the case of no further action, the GP would have to be notified of the situation, making it clear that no action was taking place from the local authority. However, participants of the Pilot all agreed that there was no apparent justification for taking no action on the information given in the case study.

Getting as much information from Eileen and the GP would be the first step. Prevailing on Eileen to let Janice know of the referral would be of help. However, participants recognised that Eileen may be fearful of John and therefore resistant to this.

Some participants reflected that it might be best to write to Janice first. Others felt that this would serve little purpose as John might well intercept her mail or she might be too depressed to bother opening a letter. There seem to be merit in two courses of action:

- Obtaining Janice’s phone number (if she has one) from either Eileen or the GP; and
- Jumping straight in with a visit.

One consideration was taking Eileen with you on a first visit. Questions of safety and responding in pairs were discussed.

#### **1.4 What considerations would there be in your plan of action, in relation to protecting Janice, given her fragile mental health?**

If the first response is made in a letter, enclosing leaflets about the Act and about depression may be of some use. However, in fact, we would not yet know that depression was the problem until we had visited.

Much of the discussion from participants in the Pilot focussed on avoiding making matters worse, incurring retribution from John and causing greater damage to Janice and John’s relationship.

In considering how to proceed, it became clear that an action plan was needed.

#### **1.5 What considerations would there be in relation to protecting Eileen’s confidentiality?**

This would depend upon whether or not Eileen had made Janice aware of the referral, whether she was prepared to do so or whether she had any objection to the MHO disclosing the source of the referral. Eileen may require protection from John and nothing should be done to place her at risk. However, while it is not helpful to have to protect the anonymity of a source, this does not diminish the duty to inquire.

## **1.6 Are there considerations in respect of John's rights?**

John's rights may be conceived of as twofold:

- 'Hard rights' (legal entitlements); and
- 'Soft rights', such as are contained in social work's value base and the professional ethics of other disciplines .

John's 'hard rights' as Janice's carer and nearest relative include:

- Right to a carer's assessment (section 228);
- The right to information that would assist him in his role as carer (section 1(5)(b)) (presumably this would include rights to be informed about inquiry under section 33 and any warrants under section 35);
- The right to having his views taken into account (section 1(3)(b) (ii)); and
- As her nearest relative John has a right to be informed within 12 hours of an Emergency Detention Certificate coming into effect.

Examples of John's 'soft rights' would be:

- The right to respect; and
- The right not to be cast as the source of all Janice's ills.

## **The Case Study: Scenario 2**

Having written to advise Janice and John of your intention to visit, you have called at their flat at the first available opportunity. John refused to allow you entry despite your explanations that you have a duty to make an investigation under section 33 and that you may have a duty to apply for a warrant under section 35.

John has told you in no uncertain terms that you are not getting in to the flat and that his wife is not available to speak to you. He has also told you that you may get a warrant, bring the police or whoever you want. This is his home and no one is getting in.

**The questions:**

- 2.1 Revisit section 33(2)(a), which now becomes the conditions for considering application for a warrant on the grounds that 'the person may be subject to or exposed to ill-treatment, neglect or some other deficiency in care or treatment...' Assume John's**

**refusal to be adamant. Assume also that you have made repeated attempts to obtain access over a period of days. Assume that, when John is out, the flat is locked and there is no sign of Janice. Assume also that the flat is on the second floor so you cannot even look in through the windows. Is the issue of such significance that you would apply for a warrant?**

At this stage, participants reflected that they **would** proceed. It would be important to explain the process of the application to John. Given that John's exhortation to 'bring the police or whoever you like..' may have been bravado or may have been made in the heat of the moment, it may be advisable to leave him with written information about warrants, obstruction and the duty to inquire, upon which he may reflect. It may also be advisable to leave him with 'thinking time', a clear time-scale for your return and an outline of likely actions and consequences.

**2.2 In applying for the warrant, section 35 (1) would only allow the authority to gain access to Janice. A warrant under section 35 (4) would allow you to obtain authority to enable a Medical Practitioner to carry out a medical examination of Janice, were you unable to obtain her consent to it. Under section 35 (5), a section 35 (4) warrant also carries potential authority to detain her for a three-hour period in order to facilitate the examination. Assuming that you do agree that a warrant ought to be applied for anyway, from the information you have above, do you consider that these additional powers may be necessary?**

**2.3 If you do agree that the wider scope of a warrant under section 35(4) is needed, how would the principles shape your plan for implementing such a warrant? (See the abbreviated list given above).**

In the Pilot, this question raised more questions about procedure than it could answer:

- Will there be a common form or template for warrants?
- Will it be necessary to go back to the Sheriff/JP to apply for a further warrant under section 35(4) if the process of gaining access to Janice under the 35(1) warrant proves it necessary?
- Would you require evidence that the request for medical examination has been refused before getting a warrant under 35 (4)?
- Conversely, could you obtain the two warrants simultaneously, as a matter of precaution?

It is hoped that some of these answers will be available by the time you are implementing the training.

The principles of benefit and the minimum intervention would suggest that it would be more stressful for Janice if the MHO had to go back to the Sheriff/JP to obtain further warrants, thereby protracting an awful situation.

The principle of minimum intervention also brings in to play practicalities such as:

- Getting a joiner or lock-smith to effect entry if force is required;
- Not having marked police cars at the door; and
- Encouraging a low profile approach from the police - removing hats etc.

In this way the principles should give shape to the action plan.

In the Pilot, much of the discussion here reflected good practice with which MHOs should be at home. However, in the light of the principles such good practice takes on the complexion of a legal duty.

**2.4 In having regard for the views of any carer, would you consider John to be Janice's carer? Consider also the Draft Code of Practice's direction that the MHO should consult as widely as possible with any people involved with the care of Janice in the situation.**

We already seem to have established that John is the carer: such is the overlapping nature of the questions. The task in his regard is to enable him to better direct his care. The case study hints that he has needs of his own, to come to terms with his own past and to manage his ambivalence about mental illness. He feels the stigma of it rubbing off on him because of his past and because he chose to marry a person affected by it.

There is the question of whether to contact Janice's mother. Balanced against this is the concern that such contact may worry a frail older person. Janice's employers may need to be contacted too, but this would breach her confidentiality. Eileen may be able to act as a less formal agent in contacting her work.

**The Case Study: Scenario 3**

**Assessment of risk in relation to Short-term Detention:**

You may recall that, at the end of the discussion of risk to welfare, in the Second Reader, we promised you a case study upon which to consider the balance between 'significant risk to health, safety or welfare etc' and the loss of liberty involved in detention. We also suggested that the principles should be guiding features in considering where the balance lay. In particular, in this regard, we highlighted the principles of having regards to benefit to the patient, equality and minimum restriction in relation to freedom.

We do not wish to assume that your discussion of the first two sections of the scenario took you in any given direction. Indeed, the design of the case study is intended to provide you with enough uncertainty that your discussion could travel in a number of directions. However, for the purposes of advancing the

discussion into the sphere of consideration of consent for Short-term Detention, please assume that you did successfully apply for warrants under section 35 (1) and (4).

You are now inside the McLeod's flat with a very angry John McLeod, who reluctantly opened the door to the police constable on production of the warrant. You have taken the precaution of discussing the entire process with a Medical Practitioner who has agreed to be on stand-by to make herself available within one or two hours, should you need her.

To enable you to discuss the merits and practical implications of Emergency Detention versus Short-term Detention, please consider the case to have two alternative possibilities at this point:

- a) that you have arranged for the GP (who is not an AMP) to attend. In this case it may be assumed that it is less than likely that an AMP would agree to attend such a situation for a patient unknown to the hospital for the last 4 years; and
- b) that you have been able to arrange the attendance of an AMP

Should detention be required, in the case of possibility a), Short-term Detention would not be possible.

The two possibilities of AMP and GP involvement should be highlighted by the trainer in the process of facilitating the discussion.

Upon your insistence, you are led to the sitting room where a dishevelled woman sits in dirty clothes. She does not acknowledge your presence at first, with her gaze frozen in front of her. When you ask Mr McLeod to leave the room she does speak to you in a halting whisper, asking you to leave and refusing to consider accompanying you to see a doctor. She acknowledges that she is depressed but she states that she does not wish any treatment, as she can manage her condition without it. She also states that to accept medical intervention would just anger her husband and make things more difficult between them. In her view it is, after all, her fault for being so miserable.

### Questions:

#### 3.1 What options would be available to you at this point? Do you consider it would be important to call in the AMP/GP for a medical examination?

Warrants under section 35(1) invite the MHO to make the application to include the names of 'any other persons so specified' for the purpose of gaining access to the patient (section 35(2)(a)(ii)). It would be important to have the AMP/GPs name on the warrant as a matter of course. The reality of this, displayed in the need for planning, is that the AMP or GP would need to be instructed to be on stand-by, if they did not intend accompanying the MHO on the visit.

### **3.2 Are there any circumstances in which you would not call in any Medical Practitioner at this stage?**

If, for any reason, there was no need to follow through with a medical examination, the options would be for informal admission or no action to be taken. It is difficult to see anything in the case study that would indicate these actions being justified. No further action under the Act would be indicated, for example, if the referral were a hoax or if Janice were physically ill rather than mentally ill.

At this stage you do call in the AMP. Having interviewed Janice, the AMP asks you to consent to Short-term Detention, based on her assessment that Janice is significantly impaired by her depression, that she is unable to make treatment decisions because of it and that the situation with Mr McLeod will deteriorate because of the intervention so far.

#### **The Case Study: Scenario 4**

##### **Questions:**

#### **4.1 From the information you have so far, do you agree that Janice's ability to make treatment decisions is significantly impaired by her mental disorder?**

Participants in the Pilot all readily agreed that there was ample evidence of Janice's lack of capacity to make treatment decisions and that the incapacity could be traced to her mental disorder. Discussion in the Pilot turned to the principle of regard for Janice's past and present wishes and feelings. Had there been any indication before this episode of illness that Janice had wished not to have treatment for depression, the clear view that she lacks capacity to make such choices might be obscured. The only hint of this in the case study is that she was reluctantly persuaded to accept informal admission four years ago. However there is no clarity on this point, as presumably she was already ill by then.

This in turn highlights the need for advance statements. There may be mileage in the trainer flagging up these issues for discussion if they do not occur naturally in the small group.

#### **4.2 Considering our discussion in the second reader about 'significant' in respect of 'significant risk to health, safety or welfare', do you consider that the risks to Janice's welfare outweigh considerations of loss of freedom entailed in any Short-term Detention? In this discussion please bear in mind the principles and particularly those relating to benefit to the patient, equality and minimum restriction in relation to freedom.**

It would be important to accept medical advice on the risk to health:

- Risk to physical health of not eating or taking fluids; and
- Risk to mental health of deterioration of depression.

Medical advice may also indicate risks to safety, for example from suicide. It is interesting to note when discussing these risks in practice that the welfare risks, being holistic, cannot be disentangled from the health and safety risks.

If Janice's long term relationship with John becomes more damaged by this action, this may be considered as a welfare risk. This is especially the case if the evidence is reviewed that partners frequently return to abusive relationships and that she is therefore likely to return to John, no matter how he jeopardises her mental health.

The only risk not felt to be evident was the risk to the safety of any other person.

### **4.3 Discuss the merits of Emergency versus Short-term Detention.**

These matters are well rehearsed in the reader: Emergency Detention might be more realistically practical, with the greater chance that a non - AMP would be available. However, it ought not to be considered as a matter of convenience.

Short-term Detention carries enhanced rights and safeguards such as the rights for Janice and John to apply to the Tribunal to revoke the detention and the greater security in having an AMP and MHO assess the service user before granting the certificate. However, it should be noted that Emergency Detention must be reviewed by an AMP as soon as practicable (section 38(2)). The Draft Code of Practice advises that an Emergency Detention ought to be converted to Short-term Detention as soon as practicable if this is required.

### **4.4 Assuming detention to have been proposed and consented to, what arrangements should be made for conveying Janice to hospital?**

The Code of Practice advises that it is the Medical Practitioner's responsibility to ensure that the patient is conveyed to hospital. The principles (such as least restriction to freedom) apply here to consideration of the manner in which the patient is conveyed to hospital.

## **11. Session 3**

### **Introduction:**

Session 3 on CTOs is the core of the materials, representing:

- Those facets of the Act with the most central role for MHOs; and
- Arguably, the most significant legislative developments in terms of care and treatment by compulsion.

We have time-tabled a brief 30 minute slot for introductions on the assumption that, by this stage, the process of sessions (issues relating to reading time, case discussion etc) will take less time. However we have to acknowledge that, at this stage, the session hopefully will include RMOs who are less familiar with these matters. It is also important to note that we have no way of guaranteeing that RMOs will have read the required materials. Even if they have, they are less likely to have the same level of knowledge of the Act as the MHOs who have by now worked through three Readers and two previous days of study.

We recommend the following as matters of significance for your introduction:

- CTOs represent opportunity to move on from the 1984 Act where the hospital was the only proper locus for compulsion;
- CTOs bring elements of care, and particularly receipt of community care services, into the orbit of compulsory powers;
- The process of application is complicated and rests heavily on a multidisciplinary approach;
- The role of the MHO is central to the process of application and success of the application may rest on early MHO involvement;
- Issues of timing of examinations and reports for applications will be key to success;
- The inclusion of the proposed care plan is a new element strongly relating to the MHO as pivotal in the multidisciplinary element;
- The role of the Tribunal in hearing applications will be a significant departure from that of the Court;
- The Tribunal may grant orders with varied and wide ranging powers;
- The Principles will form a guiding framework for practice in making, hearing, granting, implementing and monitoring applications;
- Other legislative innovations will impinge upon the process such as Advocacy, Advance Statements and Named Persons; and
- The long-term involvement of the designated MHO both changes working practices for MHOs and their relationship to RMO colleagues.

In presenting these issues, we consider that it is important to flag up two key themes:

- The longitudinal involvement of the designated MHO is quite unlike the sort of practice MHOs and RMOs have been generally used to; and
- The wide ranging scope of powers of CTO represents an opportunity to involve practitioners across all disciplines in consideration of more diverse means to meet the needs of the most vulnerable service users.

The exercises for the day are all built around one case study, which requires participants to:

- Examine matters relating to application for CTO against the conditions for an order;

- Consider the forms for the Mental Health Reports, the Application, the MHO's Report and the Proposed Care Plan, making draft use of them; and
- Consider the problems involved in making an application when the MHO and RMO are in disagreement.

### **The Alternative Case Study:**

Before looking at the case study we have selected for use, please note that we have included an alternative or additional case in **Annex C**. Our preferred case study, that involving Toni McRae (set out below), is targeted upon the process of application and in particular, the use of the forms. From the pilot, we estimate that it will take a group most of the study day to complete the exercise. However, no two groups work in the same way or at the same speed. Should a group complete the exercise in significantly less than the allocated time, you might wish to have some photocopies of the alternative case study to hand.

Another reason why you might wish to use the alternative case study is if discussion in a group is flagging or the discussion indicates that the group needs to discuss more ethical questions around the principles and the conditions for granting an application. A glance at the alternative case study will show that it poses some very challenging and, indeed, imponderable questions about these issues.

In particular, the Toni McRae case asks the group to explore the problems of making an application where opinion is divided. If the group requires a case study which produces more sharply divided views on a critical issue, the alternative case study will be of use.

You may even wish to copy the case study and give it to participants at the end of the day, for their own use.

**The Case study: The following is the text from the material attached to the Reader. Again coloured type denotes our insertions for the trainers' guide.**

**As in the previous case studies, please consider the situation portrayed in relation to the set of questions asked beneath it. This is the only case study for session 3. In it we want you to discuss the situation, considering the conditions for detention and then, in the afternoon, draft the reports on the prescribed forms. The training facilitator will have a timetable in which to pace discussions and create drafts of the forms throughout the day.**

To enable you to consider how the case study may be spread over the day, let us re-visit our proposed timetable:

### Session 3:

9.30	Trainer's overview of the materials for discussion: Compulsory Treatment Orders and Treatment Matters
10.00	Reading for case study
10.15	Small group discussion, incorporating a built-in break of 20 to 30 minutes at a convenient time
12.30	Lunch
13.30	Continued discussion of case study and completion of the forms for CTO, including a built-in break of 20 to 30 minutes at a convenient time
15.45	Feedback to large group
16.00	Trainer's general overview of session 3/ summary of major issues
16.30	Close of session 3

The 10.15 to 12.30 session is intended for use with questions 1 and 2. Questions 2 and 3, the form - filling exercises, may take considerable time and so the group will have to work in a focused way. It may be that some groups do not complete the Application and MHO Report forms by lunchtime, in which case you will have to decide whether or not to extend the work on question 2 into the afternoon. The 1.30 to 3.45 session is for discussion and drafting of the Proposed Care Plan and discussion of question 4, which will cause the group to re-visit their care plan. It may be anticipated that groups will find this a taxing session and it will require careful facilitation to keep it on track.

We would remind you of the PowerPoint slides which can be used with this guide.

Now in her mid-twenties, Toni McRae has had a diagnosis of paranoid schizophrenia since her late adolescence. She has had repeated spells in hospital, twice under section 18 of the '84 Act. Initially Toni was very rejecting of both the idea that she was ill and of medication, which tended to make her gather weight and feel lethargic. She also tended to socialise with people who smoked a lot of cannabis, which was inevitably counterproductive to a symptom-free life for Toni. In more recent years Toni has enjoyed maintenance on a more suitable regime of the new generation of anti-psychotic drugs. She has graduated to oral self-medication and she has benefited from a place in a hostel, from which she has progressed to supported accommodation. With CPN and social work help she has been able to reflect upon some of the hard lessons she has learned: loss of her own flat, loss of her career as an art student, alienation of friends and family: and she

has gained insight into her condition. With this insight has come a degree of ability to manage her life.

Strongly independent in spirit, Toni has rejected the conventional mental health social supports on offer. She favours the informal support of her circle of friends and fellow musicians and she is relatively successful in the local scene as the lead guitarist, singer and main songwriter for a progressive rock band called 'As Serious as your Life'.

However, a recent bout of gastric 'flu' seems to have knocked Toni out of equilibrium. Subsequently she covertly discontinued her medication and is refusing to take it anymore, denying that she is or ever was ill. In her opinion the illness was caused by her psychiatrist, who had experimented on her with mind-controlling drugs. According to Toni, these drugs had created an entire alternative reality for her, from which she has now awoken. If questioned about this, Toni sums up the situation with the phrase 'Which end of the worm sees the other?' In some sort of allusion to the two nerve-centres at opposite ends of an earthworm, her often repeated phrase seems to resonate with special significance for her.

While Toni poses no immediate risk to her own safety, she is increasingly preoccupied that her CPN, social worker and the supported accommodation staff all have doubles, discernible only by the subtly differing shades of their hair colour. In her belief, these doubles are all cloned by her psychiatrist as part of a plan to get her to recommence the mind-altering medication. She will only allow any of these people access to her flat if she is satisfied that they are not the cloned version of themselves. Therefore, it is becoming more and more difficult to maintain any contact with Toni, to monitor the care she is taking of herself and to keep an open dialogue with her. For example, no one knows how she is managing her finances, whether or not she is cashing her benefit cheques or doing shopping.

As far as can be ascertained she is eating but she has little food in the flat and her standard of hygiene is deteriorating. Toni will not speak to her psychiatrist or consider recommencing medication. In this she is not in anyway hostile but, with a superior air, she is quietly insistent that she alone knows what the doctor is doing.

The above two paragraphs are deliberately formulated to make the health and safety conditions rather vague and tenuous. As there is no tangible risk to the 'safety of any other person' the paragraph below is intended to give enough substance to the welfare condition that, in contrast to the life that Toni has shaped for herself before becoming ill again, it may arguably justify the imposition of compulsory measures.

This is because risks to health and safety are familiar territory to MHOs and RMOs in consideration of compulsion. The welfare condition is new and therefore deserves more discussion..

Some of Toni's friends have approached her support workers to ask for advice on how to manage their relationship with her. Since she has become ill they find it increasingly difficult to know how to cope with the things she says about her psychiatrist cloning other people. They do not always get into the flat when they visit and Toni is proving to be worryingly unreliable in her attendance at rehearsals and gigs. The band's drummer told staff that he was embarrassed when Toni launched into 'a long rant' about her psychiatrist over the PA system at a gig. Fortunately, most of the audience thought it was part of the stage show.

He claims that Toni is the band's driving force but it is getting to the point where they might wish to go it alone without her.

Toni's psychiatrist, her RMO, is convinced of the need for a CTO and has persuaded her GP of that need. While Toni keeps only occasional contact with her mother, she has made Mrs McRae her named person. Toni has never got round to making an advanced statement, having considered it unlikely that she would ever again be in a situation where she would not willingly comply with any treatment.

**1. Discuss the need for a CTO, bearing in mind both the conditions set out in section 57 (3) and the principals set out in section 1 of the Act. (While you may wish to look at the list of conditions in the actual Act, for ease of reference they are:**

- a) 'That the patient has a mental disorder;
- b) That medical treatment would be likely to:
  - (i) prevent the mental disorder worsening, or
  - (ii) alleviate any symptoms or effects of the disorder.
- c) That if the patient were not provided with the treatment there would be a significant risk':
  - (i) to the health, safety or welfare of the patient; or
  - (ii) to the safety of any other person.
- d) That because of mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired; and
- e) That the making of a CTO is necessary.

From the experience of having facilitated the Pilot, it was found to be helpful to systematically work through the conditions for an Order (section 57(3)):

**Is there evidence of mental disorder?**

Yes. There seems little need for discussion of this, given Toni's history and presentation.

**Would medical treatment be likely to prevent... or alleviate it?** Again there is ample evidence that it would and that, while well, Toni actively accepted treatment for this reason.

One participant in the Pilot hypothesised that, were there no indication in Toni's past that she had responded well to treatment, one would look to research and other empirical means to give evidence base to the matter.

**Are there risks to health, safety and welfare and safety of others?** It is easiest to rule out risk to safety of others. There is nothing in Toni's past or in her present behaviour to suggest such risks. There are risks to Toni's health: the questions of hygiene and eating do vaguely hint at physical risks. However, they are poorly substantiated. The risk to Toni's mental health is in sharper focus and it resonates with the welfare risks discussed below.

There does not appear to be a risk to Toni's **safety** but it is foreseeable that this might emerge if her condition deteriorates.

**Welfare** is the most clearly defined risk but, once we examine it, we see the problem of lack of definition in law. Welfare remains an holistic concept, such as we discussed in the Reader 2. If it relates to Toni as a person and the things she considers important in life, we can see that her friendships, her life in the band, her standing with the band's popular following and perhaps even the stability of her life and her tenancy are all threatened here. These all seem to be things that Toni values greatly and has worked hard to attain and maintain. If the question is: 'does the threat to these things outweigh the harm done to Toni's liberty by imposing compulsion?' then the answer could be a justifiable 'Yes'.

Conversely one could ask 'is it in the interests of a person like Toni, who had managed her illness with such care, for us to passively watch her descend into such upsetting illness?' The answer would probably be that it is not. This answer approximates the principle of regard for Toni's past wishes and feelings. It could be considered that her past wishes indicate a 'soft' advance statement, in the absence of any hard, legally constituted one.

Both here and in response to the discussion of the test of capacity below, it might be of interest for the facilitator to hypothesise what difference it would have made if Toni had made an advance statement, reflecting her wishes as encapsulated in the words of the case study: 'Toni has never got round to making an advance statement, having considered it unlikely that she would ever again be in a situation where she would not willingly comply with any treatment.'

**Is it the case that, because of mental disorder, the patient's ability to make decisions about the provision of such medical treatment is significantly impaired?** In the Pilot, participants reflected that this was a clearly indicated condition. There was a marked difference between Toni's willingness to accept treatment and to trust her psychiatrist before she became unwell and her reluctance to do so now.

**Is the making of a CTO necessary?** This condition causes us to review the range of options as required by the principles (section 1(3)(e)):

- It is unlikely that Toni could or should be persuaded to accept informal treatment;
- Doing nothing is a possibility at this stage if it is felt that the conditions are not yet strongly met. Against this consideration, Toni may be at no immediate risk, but the longer we wait, the more entrenched her illness may become;
- Using Emergency Detention seems inappropriate as there is no demonstrable urgency and since section 36 contains no authority to treat; and
- Using Short-term Detention is a possibility. However, the 28-day authority to treat may not give enough time for Toni to 'turn the corner'. Furthermore, the measures of compulsion in Short-term Detention are restricted to detention for treatment. It may be that authority to treat in the community would be preferable and there may be other powers that might be of use (requiring access to Toni for example).

**2. We are asking you to use the forms that will be available to create an application. You will have very limited time to do this and you should not get too drawn into matters of lesser importance such as inventing fictitious addresses for the various people involved.**

In asking you to perform this task we are aware that it is very much an artificial activity that will be undertaken in a very short time, based on very limited paper information. These parameters will scarcely approximate the real task of preparing a CTO. However, we offer it to get you to think about the process and the guidance/constraints of the forms. We have designed the task in the hope that, in your training group, you will have a mix of AMP/RMO and MHO colleagues. If you do not have this, you may have to draft a mental health report in absence of any medical colleagues.

**With reference to:**

- The MHO's Application;
- The Mental Health reports by Medical Practitioners; and
- The MHO's report.

**Consider what information you would wish to place in the various sections. In doing so, pay particular attention to the communication that is required between RMO and MHO. In considering what measures of compulsion ought to be recommended you will need to consider whether or not you feel that the problem can be managed by a community based order or detention in hospital.**

This question of community versus hospital detention as the locus for treatment becomes central to the following discussion and exercises in

questions 3 and 4. We advise you to begin to address it here, as suggested. However, we also advise you to steer group discussion away from getting bogged down with the issue at this point. In question 4 it will actually be of value to become entrenched in polar positions on the question.

**Note: it may not be possible for you to complete the lengthy forms in their entirety in the time given for this exercise. However, you may wish to jot notes on the various forms. At least, in considering the actual forms, you will get an idea of the scope of work involved in an application.**

This is a point in the process of group facilitation where you will be required to keep matters carefully on track. It may be that you have people in the group working on two tasks: Completion of the Mental Health Forms by RMOs and completion of the application, and the MHO Report by the MHOs. On the other hand it may be that the group wish to look at all the forms together. These are not points of great significance. What matters here is that the group examine the content of the forms and consider how the forms constrain and facilitate the passing of information. It is also important that the group consider the process recalled in the Code of Practice: that the Mental Health forms should reflect the discussion that has already taken place between Medical Practitioners and the MHO.

However the group use the forms two points are of great importance:

- The focus of the reports must be upon the arguments that will convince the Tribunal of the need to grant the order with the most useful powers to enable Toni to get her life back; and
- The limited time for the exercise means that only the barest sketch of these matters may be committed to paper and the actual application form will probably be the least used, containing as it does the factual details of name, address, dates etc.

If the group notice the repetitive nature of the information they have to commit to the various forms, so much the better. This is a fact of the application process. It will become even more evident when the group turns to the Proposed Care Plan.

Important factors of timing come into play here. The MHO report is dependent upon information from the RMO and, as the group examine the forms and consider how they will commit information on them, they should bear this in mind. They should also consider the constraints of the 5-day period within which the medical examinations must take place and the 14 days from completion of the last medical examination and the making of application to the Tribunal.

The artificial exercise of the case study means that we have all the information available to all parties at once. In the discussion about how to use the forms it may be valuable to hypothesise on how the flow of information might shape the process of the application in real life, where facts are neither as freely

available as they are on these pages nor are they as limited as they are in these few hundred words.

**3. Given that the Draft Code of Practice recommends that the MHO's Proposed Care Plan is draw up with close multi-disciplinary discussion, jointly consider a care plan and sketch it out on the prescribed form.**

At this point the arguments in favour and against hospital-based detention will become more sharply focussed. In reality it may be easier to take questions 3 and 4 together if the group cannot arrive at a clear decision of preference between hospital and community. Also, in reality, there is not enough information in the case study to determine whether it would be better to temporarily up-root Toni to hospital or whether it she might comply with treatment at a local health centre.

The group should not get too focused on the single issue of treatment. They must think widely about whether there are other matters that may be contained in the proposed care plan. They should be mindful that the care plan should be broadly focused not just on those aspects of care that require compulsion. This discussion should also reflect upon the multidisciplinary process of preparing the plan, including contributions from a wide range of people:

- CPN;
- The staff at the supported accommodation;
- The GP;
- Possibly care management; and
- Others.

The plan ought to accommodate the reasons why Toni became ill, difficult though it may be to legislate for catching bouts of flu. It should also consider learning from the way in which Toni's illness was not noticed sooner and whether or not it might have been prevented from deteriorating to this point.

**4. In order to get at the problem of preparing an application in a situation of entrenched disagreement between the views contained in the Mental Health Reports and those in the MHO's report, consider the following:**

**There are numerous ways in which a CTO might be implemented to enable Toni to get back on track. Without wishing to restrict your discussion of these, salient amongst them would seem to be the issue of imposing a treatment requirement. This may be achieved by detention in hospital or in the community.**

- a) **Consider the merits of both of these options;**
- b) **Divide your discussion group into two sub-groups, preferably with all Medical Practitioner participants in the same sub-group; and**

- c) **We want one of the sub-groups to take on the view that Toni may be served best by treatment in the community and the other sub-group to take on the opposing view that a community-based order would fail her, resulting in prolonged illness and an unenforceable order which would eventually have to be varied to detention.**

**It does not matter which view is ascribed to which group, but if you can be in a group that reflects your own view on the matter, so much the better. We have to suspend imagination at this point, as this is a case discussion about a fictional character contained in a few hundred words on paper, so either view is tenable. However, imagine that, were you to meet the real Toni in situ, it would be glaringly obvious to you that your view was correct.**

- d) **How might the proposed care-plan be structured in such a way as to reflect both the community-based and hospital-based plans for detention?**
- e) **Are there any other foreseeable difficulties in making an application under these circumstances of entrenched disagreement?**

Matters to consider here are:

- Is it likely that treatment could be sufficiently monitored in the community?
- How easy is it going to be to ensure Toni's compliance with community based treatment? Remember that treatment may not be enforced in her home. This would mean her attending a Health Centre or being taken there for treatment;
- If Toni fails to comply, what are the options? Force may not be used outside hospital. Under section 112 Breach of Orders, she may be escorted to the place of treatment and detained for up to 6 hours in order to give her the treatment. In cases of urgency, Toni could be conveyed to hospital and detained for 72 hours under section 113; and
- On the other hand, is it more restrictive to detain Toni, if she might respond to community based treatment? Is it of benefit to her to be removed from her home? Is the view that such treatment may only be monitored in hospital a view that truly takes account of the range of options? Could the order be tested in the community and then varied to detention if the first option fails?

It is important to leave the group time to revisit the Reports and Proposed Care Plan and consider how they could be used to reflect a divergence of opinion. It is also important to think about the process of working together collaboratively while in dispute.

## 12. Session 4

### Introduction:

It is to be anticipated that some MHOs will view Criminal Procedures as a specialised area of practice and will be resistant to engaging in it. There are plausible arguments in favour of this view:

- I lack previous expertise in this area under the 1984 Act;
- I lack experience in Criminal Justice work as a whole;
- There is too much pressure in my own job without taking on more; and
- The new MHO role will tax me beyond my limit in my existing remit without taking on more.

However, the overriding reason that we have included a session on the 1995 Act is that we anticipate that the directions from Scottish Ministers will indicate that appointment of MHOs under the 2003 Act will be dependant upon receiving the Mental Health Social Work Award which can only be obtained after demonstrating knowledge and competency in all areas of MHO practice. Furthermore, with the arrangements for funding and management of criminal justice services under review, it is not possible for anyone to foresee in what way local authorities will provide MHO services to the Court and so no practitioner can say with certainty that they will not be involved in Criminal Procedures.

It must also be borne in mind that work with people whose needs are encompassed within the governments policy for mentally disordered offenders (Mel5 1999), are in no way solely dealt with by specialised forensic mental health services, (where these exist.). Such people may be receiving services from general psychiatric services. Others may not be actively involved in criminal justice services but may (because of particular need and risk) be referred for care in conditions of special security, (e.g. referrals from local psychiatric hospitals still constitute the largest percentage of admissions to the State Hospital. )

In anticipation of these matters you may best manage them by addressing them in the introduction to the day. Related to this is the matter that many MHOs may feel themselves to be out of touch with the Criminal Justice system and so may feel less confident in the materials presented here. For this reason, the Fourth Reader has an important place (see below).

We suggest the following matters be raised in the introduction to the day:

- An outline of criminal procedures from arrest and charging with an offence, the pre-conviction and post-conviction stages to sentencing;
- A reiteration of the relationship between the 1984 Act and the 1995 Act (essentially that, under the 1995 Act, Courts could make hospital orders, which became synonymous with section 18, but for minor exceptions, via section 60 of the 1984 Act);

- An explanation of how the 2003 Act extends this relationship by adding new sections into the 1995 Act as below.
- Assessment and Treatment Orders as flexible orders of the Court, applicable pre: and post-conviction;
- Interim Compulsion Orders as a flexible power available post-conviction;
- Compulsion Orders as a new disposal available to the Court, with powers comparable to those contained in CTOs; and
- Compulsion Orders become the bridge to the 2003 Act as Hospital Orders were the bridge to the 1984 Act, in that, once received by the hospital the compulsion order is only slightly different from the CTO.

It may also be helpful to briefly introduce SCRs in the context of the new Act, as this constitutes the other half of the material in the Reader and features in the exercise below:

- Introducing the meaning of relevant event **Section 232**;
- Emphasising the similarities of SCRs under the 2003 Act and those under the 1984 Act;
- Outlining the purpose of SCRs; and
- The framework for reports.

### **Built in study time:**

If you are following Model A, the reading time of 2 hours and thirty minutes takes place after the introduction of the final day. If you have followed Model B, participants will already have had their Guided Study for the Reader. Again, the materials are crucial to a good understanding of the subject matter and must be read by all participants.

### **Discussion of case study:**

**Yet again we have marked our inserted comments in red, to enable you to track them and distinguish them from the text provided for participants.** Session 4 was not included in the Pilot Programme and so what is offered below is condensation of some issues we anticipate discussion of the case to generate.

We remind you of the PowerPoint slides made available by the Executive. These may be of use during small group discussion.

### **The Case Study:**

#### **History:**

Karen Rae is in her early thirties. She has a history of criminal convictions ranging from breach of the peace and petty theft to assault and dealing in Class A drugs. Resulting from this, Karen has received two custodial sentences, one following repeated breaches of probation.

Karen also has a psychiatric history stemming from her adolescence. She attended an adolescent psychiatric unit because of self-harm and behavioural difficulties with which her mother could not cope. At that time Karen disclosed that, from the age of 12 to 13 she had been routinely sexually abused by one of her brother's friends. Her psychiatrist from the unit believed that her behaviour was a post-traumatic stress response to the abuse. However, as her behavioural problems have developed into adult life, Karen has acquired the diagnosis of personality disorder.

Karen has no contact with her family. She has had numerous partners but is single at present. Karen has two children aged 3 and 7. Both are being looked after by the local authority and she has had little contact with them.

When under stress Karen, still cuts herself and, while in prison, she made several attempts to hang herself. She has a number of physical health problems resulting from prolonged abuse of heroin and crack cocaine.

Karen leads a chaotic life and is often homeless. Both social work and psychiatric services struggle to keep regular contact with her. Karen maintains her most consistent means of support is through her GP, because this affords her access to supplies of various medications. She is currently in receipt of anti-depressive and anti-psychotic medication from her GP, but it is thought doubtful that she takes either with the necessary regularity.

**Present circumstances:**

The local authority is in the process of obtaining a permanency order for both Karen's children, so that they may be placed for adoption. This is a source of considerable emotional stress for Karen. The tenancy of her council flat is also in jeopardy because she is in considerable arrears and her neighbours frequently complain about disturbances and fights in and around the flat.

**The offence:**

When Karen failed to appear in court on a charge of shoplifting she was arrested by warrant. On arrest she was found to be in possession of seven bags of heroin with a street value of £10 each. She claimed that they were for personal use in support of her heavy habit. However, the police attempted to strip-search Karen in custody.

While she was verbally abusive to the police up to this point, nothing in her baring forewarned them of the force of her violent outburst when they attempted the search. She managed to fracture a woman police constable's cheekbone and it took several officers to restrain her until the police surgeon could administer tranquillising medication.

In the cells Karen was considered unmanageable. She made repeated attempts to harm or kill herself by throwing herself off the walls. Upon her appearance in court, charged with both the original offence of shoplifting and

with assault of a police officer and possession of a Class A drug, the Procurator Fiscal applied for an assessment order upon the evidence of the police surgeon.

Karen is now detained in the forensic unit of the local psychiatric hospital for assessment.

Upon the making of an assessment order by the court, the MHO has 21 days to prepare an SCR.

### Questions:

- (1) **Were you the designated MHO, what issues would you wish to highlight from the case for the SCR and why? (Make a list of these issues. In doing so it may be of help to consider section 3.7 in the reader).**

Below, we will discuss some items from the framework for SCRs referred to in the question. It might be of help for the facilitator to appoint a note-taker to sketch a very brief draft of the SCR.

- **The reasons behind the use of the powers to which the patient is currently subject:**

Karen is subject to an Assessment Order, applied at the pre-conviction stage of Criminal Procedures. The reasons behind the use of the powers are that:

- She was considered likely to have a mental disorder upon medical evidence in Court;
- Medical opinion suggested that either she required a period of assessment to verify the mental disorder and quantify the need for treatment;
- There was treatment available that was likely to alleviate her condition or to prevent its deterioration; and
- She was unmanageable in custody being at such risk to:
  - a) Her own health and safety and her welfare; and
  - b) That there was evidence from the assault of the police constable, that she may be of risk to others such that she could not safely be released into the community on remand.

We have gone systematically through the conditions upon which a Court may make an Assessment Order. In doing so it might be useful to flag up to the group the absence of a test of capacity to make treatment decisions. It is likely that there is no such test because the Criminal Justice system places greater emphasis on issues of protection than it does on the patient/offender's right to determine treatment choices.

It should also be borne in mind that the alternative for the offender at this stage is likely to be remand in custody, and that therefore in relation to the

charge, a decision ( a 'criminal justice test' ) has already been made to deprive the person of freedoms and rights.

However, the principles still relate to the making of the Order and Karen's past and present wishes and feelings, the range of available options and the principles of 'benefit' and 'minimum restriction' would all apply.

- **The views of the patient with respect to these current powers:**

We do not have any detail of Karen's views. This flags up the importance of early involvement of the Designated MHO in order to establish a relationship with the patient, and of obtaining appropriate information.

- **The views of carers and family members on these powers:**

Karen appears to wish no contact with family other than her children and it is questionable that such contact is advisable at present. Liaison with the children's social worker may be of use here.

- **The patient's current state of mental health:**

Karen's mental health seems very poor just now. Even before her arrest, numerous stresses seemed to be aggravating her personality disorder. It would be important to emphasise the relationship of these social and psychological factors to the offences and the interaction of these with her established mental health problems and the physical problems of her substance misuse.

- **The patient's mental health history:**

This would be the place to acknowledge the perceived threat made to Karen by the police body search in relation to her history of abuse. If such a causal factor can be established it would be of great importance to share it with the RMO in relation to recommendations to the Court and in relation to future provision of direct care.

- **An assessment of risk to patient and any other person:**

It must be acknowledged that Karen has perpetrated a serious assault. As such there is a heightened risk that she may do so again, at least as long her aroused state of poor mental health endures. Any subsequent incidents that may have happened in hospital must also be acknowledged.

- **The patient's family situation, including children, dependants and caring responsibilities:**

This would be the place to locate a full discussion of the situation regarding Karen and her children. It may be appropriate to obtain information from the children's social worker to get the fullest picture.

- **The patient's ability to care for herself:**

Karen seems to be exercising very little ability to care for herself. Amongst other factors, low self-esteem may be implicated here. Her lack of compliance with both physical and mental health care provision would be an important factor under this heading.

- **Any matters which could prompt the local authority to inquire under section 33 of the Act:**

As chronic non-compliance seems to lie at the heart of lack care for Karen, there seems to be no indication of any need to inquire. However, nothing should ever be assumed and the process of preparing for the SCR may throw up some other matter necessitating inquiry. For example, someone in Karen's position would be very vulnerable to abuse and exploitation and if these had been issues in her life, it would be important to quantify them so as to protect her from them upon her return to the community.

- **The alternatives to detention, which were considered and ruled out:**

In SCRs for powers under the 1995 Act, the MHO has less of a direct role in considering alternatives to compulsion. In Karen's case the MHO would probably not have been involved at the making of the Assessment Order and could therefore only sum up the points made above in relation to the inappropriateness of custody and remand in the community, as discussed above.

- **The patient's history of substance misuse:**

Clearly Karen has an extensive history of substance misuse and it has a serious impact upon her life in relation to all of the offences, her mental health and her current situation.

- **The care planning which has been put into place to deal with any/all of the above issues:**

As yet there has been no viable care plan, largely because of Karen's non-compliance to date. However, the introduction of CTOs under the civil procedures of the 2003 Act does beg the question why was there no assessment of her need for compulsory measures of care and treatment before matters had degenerated to this point? Therefore, the beginnings of a forward-looking care plan might be well placed here.

This question highlights the principle of minimum necessary intervention: was it less restrictive of Karen's freedom to do nothing by way of civil procedures, in the face of her non-compliance, and to await the intervention of a mental health disposal from the Courts, after her life had deteriorated to such a point?

On the other hand, would such intervention be effective and of benefit, particularly if Karen's mental disorder is untreatable.

- (2) **Assuming that, following from conviction of the offences, the RMO intended to request a Compulsion Order from the Court, what issues would you wish to highlight in your report to the Court<sup>4</sup>. In particular, what would be your assessment of Karen's needs, what would you devise as a care plan and (assuming reasonable availability of services must be underwritten by the local authority) what services would you propose to meet those needs? (Make a list of the various matters you would wish to collect in this report. In doing so it may be helpful to consider the list under the heading 'MHO's Report for a Compulsion Order' under section 2.4 of the reader).**

If some of the following seems repetitive, it must be noted, as with the exercise for the reports in session 3, that the information crossing from report to report is repetitive, but carries different inflections and purposes. If the issue of repetitiveness does come up in discussion it would be helpful to reflect upon the following:

- To whom are these reports destined? and
- What is the different relevance of the information contained in them?

In the SCR the information is targeted upon the RMO, to inform him/her of matters in relation to fine-tuning the care and treatment offered and to better enable forward planning of that care and treatment. It is also targeted upon the Commission, to inform them of issues in relation to detention. In this case it may be that there is an issue to pick up in relation to why neither local authority nor health care providers had considered compulsion by civil procedures up to now.

On the other hand, the report for the Court is to advise it of the need and viability of the Order, or of alternatives which would best suit Karen's needs.

Section 2.4 of the Reader tells us that the report should discuss:

- **The personal circumstances of the offender, views of relevant others (Named person, carer and others):**

As discussed above, there do not seem to be any known 'relevant persons' and we do not know Karen's views: although, we would have become acquainted with them through the process of writing the SCR. This suggests that an informal spin-off from writing the SCR is that it is a means for the designated MHO to get to know the patient.

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<sup>4</sup> In reality it would be most likely that the Assessment Order would be replaced by a Treatment Order upon expiry of the 28 days, before Karen approached the sentencing diet of the Court.

- **The MHO's views of the suitability of the measures being sought by the medical reports:**

It is difficult to anticipate the range of views that may be generated in discussion of the case. However, clearly informal receipt of services has not been working for Karen. On the one hand, a Compulsion Order would offer opportunity to try enforced treatment in hospital or (more appropriately) compulsory measures in the community.

On the other hand, the risks are that Karen might be so forcefully non-compliant with services as to make any community based order unworkable. This would leave the option of detention in hospital as the only one. In this case the choice would be:

- To discharge a person who is at demonstrable risk;
- To detain Karen in hospital when this does not meet her needs; and
- To go on attempting to implement an unworkable order.

- **A proposed care plan:**

The stark choices above suggest the most careful analysis of needs is required. It might be easier to pose a series of questions rather than hypothesise a care plan:

- Would community based residential support be appropriate?
- If so, is there likely to be such a service available that could work with Karen?
- Are there drug rehabilitation services available that could work with Karen?
- Could these services be adapted to work with Karen under the compulsion of an Order from the Courts? (Remember that such an Order would be very different from the model posed by Drug Treatment and Testing Orders as piloted in Scotland, which impose the threat of a custodial sentence in the face of non-compliance.);
- What are Karen's treatment needs and how can they best be met by compulsion in the community? and
- How can Karen's broader mental health needs (for improved self-esteem, social development, employment etc) be met? Have compulsory measures anything to offer in this regard, or is compulsion incompatible with the development of such resources in a person?

- **Confirmation on behalf of the local authority of availability of community services that are to be delivered by compulsion:**

Are there potential areas of conflict between the local authority, which may wish to manage these resources and the MHO, who, while located within the employing authority, has a very different set of duties and responsibilities? While this question cannot be answered here, it is important to know that a question not dissimilar to this has been located in the *Briefing Paper for*

*Health Service and Local Authority Managers* to encourage the drafting of protocol.

This matter gets to the heart of the issue encapsulated in the SSSC's Mental Health Award competence 6.2.c: 'an explicit awareness of the legal position and accountability of MHOs in relation to the legislation and their employing authorities.' 6.2.c addresses the legal theory that MHOs have a capacity to make decisions autonomously from their employing authorities' line management systems. The autonomous MHO has a duty to provide a care plan and to verify to the Court the availability of resources to meet the needs contained in it. This has scope to create conflict between the MHO's duties as framed in the principles of the Act (for example, to consider the range of options and to provide resources for the least restrictive option) and the local authority's need to control and prioritise allocation of its resources.

- **A description of any alternative mental health disposals that the Court may wish to consider:**

It is always good to ponder the alternatives, especially in a case as fraught with complications as Karen's. Karen has so far lacked the ability to avail herself of help on a voluntary basis and it seems less likely that she would do so now. The question to be asked is 'would less restrictive measures of compulsion be of value?' For example, would probation with a treatment requirement be of use here?

The problem with probation is that, if it was breached, as would seem very likely, Karen would be brought back to court for sentencing for the original offences plus the breach, and she would, by then, be beyond consideration for care and treatment options. This makes probation seem likely to be a more restrictive option, given the seriousness of police assault.

On the other hand assault is a serious matter and a mental health disposal should not be seen as diminishing the seriousness or risks associated with the offence.

- **In what ways do the issues gathered your the SCR list differ from the issues gathered in list for the report to the Court for the Compulsion Order?**

The biggest difference is that much of the information in the SCR is retrospective of the current order and much of the material in the Compulsion Order Report is in anticipation of powers to progress the delivery of care and treatment. However, this is a matter of focus in which there will be grey areas of overlap: The SCR does require discussion of a care plan, and the CO report does require to be couched in a past history that justifies any recommendations.

- (3) What measures of compulsion would you wish to see contained in any order made by the Court?**

Discussion so far suggests that we are giving more serious consideration to community based options. Therefore, the more relevant powers (from **section 57A (8)** of the 1995 Act as inserted by **section 133** of the 2003 Act) are:

- Requirement to attend for treatment;
- Residential requirement;
- Requirement to attend to receive community care or other services;
- Requirement to allow access to the MHO, RMO and others concerned with giving of care or treatment; and
- Requirement to notify MHO of change of address and/or intention to change address.

Apart from the last two, we have fully discussed these above. While not conclusively opting for any (because paper exercise case studies always lend themselves to the inconclusive), we have been leaning towards residential requirements, community based treatment and receipt of community care services

**(4) In addressing this last question please debate the merits of a Compulsion Order which seeks to enforce order in Karen's chaotic life, where the best informal attempts at service delivery have so far failed:**

It is difficult for the answers to previous questions not to overlap with the question in hand. We have already acknowledged the risks of being saddled with an unworkable order. On the other hand, we have acknowledged the opportunity to impose order in Karen's chaotic life. The question cannot be determined in a paper exercise. However, as with most difficult, to answer questions, the principles provide a helpful framework:

In considering the 'range of options', what would be of most benefit and how might this be achieved with the least 'restriction on Karen's freedom', taking account of Karen's 'wishes and feelings' and her 'abilities and characteristics'?

**(5) Finally, while issues of availability of medical treatment are matters for the RMO, how might the case differ if the result of the Assessment Order was that there is no available medical treatment likely to alleviate or prevent deterioration of the patient's condition?**

We tagged this question on here because of the importance of the issue. In the case study there are hints that at least some Medical Practitioners have thought that Karen does respond to treatment. Why else would she be prescribed antidepressant and anti-psychotic medication? However, it is far from conclusive upon what grounds the case study bases the assumption that an Assessment Order will prove that Karen does respond to treatment well enough for us to interfere with her freedom to the extent of imposing treatment upon her.

Were it the case that the RMO did not think that Karen's condition was amenable to available treatments, the Compulsion Order could not be considered by the court, in which case the options would be for some non-mental health disposal such as a custodial sentence. Had Karen pled guilty to the offences, an SER might be requested at this point.

**Note: Annex A provides you with a template that you may photocopy. It contains the list of SCR headings and the list of subjects for a Compulsion Order Report, along with space for participants to take notes against each item.**

**What next?**

**In Annex C we have made available evaluation forms that you may copy and use. They are designed to cover the content of the Readers, the Case Studies, the Course Design and the quality of your input as a facilitator. They are designed to be easy to collate by simply adding up the numbered responses from the rating scales. It is easiest to do this on a blank copy of the form. The Scottish Executive would welcome collated feedback from the forms.**

**Now, over to you to put this training into action: Good luck.**

To contain participants' notes from the exercise in Session 4.

Notes for the SCR on Karen:

The reasons behind the use of the powers to which the patient is currently subject.

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The views of the patient with respect to these current powers.

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The views of carers and family members on these powers.

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The patient's current state of mental health.

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**The patient's family situation, including children, dependants and caring responsibilities.**

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**The patient's regular social contacts: e.g. supportive friends, involvement with voluntary organisations, attendance of religious group etc.**

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**The patient's ability to care for himself.**

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**The care being provided to the patient prior to detention taking place.**

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**Any matters which could prompt the Local Authority to inquire under section 33 of the Act.**

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**The alternatives to detention which were considered and ruled out.**

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**The patient's history of detention, including any consideration of victims and/or those affected.**

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**The patient's history of substance misuse.**

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**The care planning which has been put into place to deal with any/all of the above issues.**

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**Any ethnic, cultural and religious factors which need to be taken into account.**

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**Any language or communication issues which need to be taken into account.**

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**Notes for the Compulsion Order Report on Karen:  
The report should discuss:**

**The personal circumstances of the offender, views of relevant others (named person, carer and others):**

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**The MHO's views of the suitability of the measures being sought by the medical reports:**

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**A proposed care plan:**

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**Confirmation on behalf of the Local Authority of availability of community services that are to be delivered by compulsion:**

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**A description of any alternative mental health disposals that the Court may wish to consider.**

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Annex B

**THE MENTAL HEALTH (CARE & TREATMENT)  
(SCOTLAND) ACT 2003**

**TRANSITIONAL TRAINING MATERIAL EVALUATION FORM**

**Please rate the following statements by indicating with a cross on the scale from 1 to 10, where 1 is 'not at all' and 10 is 'extremely well':**

**About the readers:**

**The materials were easy to read:**

1    2    3    4    5    6    7    8    9    10

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**The materials aided my understanding of the principles  
of the 2003 Act:**

1    2    3    4    5    6    7    8    9    10

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**The local authority duty to inquire:**

1    2    3    4    5    6    7    8    9    10

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**Application for warrants:**

1    2    3    4    5    6    7    8    9    10

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**Emergency and short-term detention:**

1    2    3    4    5    6    7    8    9    10

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**Compulsory treatment orders:**

1    2    3    4    5    6    7    8    9    10

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**Assessment and treatment orders made by the court:**

1    2    3    4    5    6    7    8    9    10

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**Compulsion orders made by the court:**

1    2    3    4    5    6    7    8    9    10

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**SCRs under the 2003 Act:**

1    2    3    4    5    6    7    8    9    10

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**The case studies:**

**The case studies reflected MHO practice situations:**

1    2    3    4    5    6    7    8    9    10

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**The case studies were appropriately challenging:**

1    2    3    4    5    6    7    8    9    10

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**The case studies reflected the material from the readers:**

1    2    3    4    5    6    7    8    9    10

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**Course design:**

**The inclusion of guided study time helped me to manage the reading:**

1    2    3    4    5    6    7    8    9    10

**There was enough time given to case based discussion:**

1    2    3    4    5    6    7    8    9    10

**There was enough time given to reflection on the study materials:**

1    2    3    4    5    6    7    8    9    10

**The discussion of the cases aided my understanding of the 2003 Act:**

1    2    3    4    5    6    7    8    9    10

**Course facilitation:**

**There was enough time for the facilitator(s) to explain and present the programme:**

1    2    3    4    5    6    7    8    9    10

**The facilitator(s) managed the small group discussion:**

1    2    3    4    5    6    7    8    9    10

**The overall organisation of the programme assisted my participation:**

1    2    3    4    5    6    7    8    9    10

**The venue and facilities were comfortable:**

1    2    3    4    5    6    7    8    9    10

**Please give any other comments you wish:**

**Thank you for your participation.**

**Alternative/Additional Case Study:**

**Reflecting on a CTO and the Principles in Relation to an Advanced Statement:**

**As discussed in the text of the Trainers' Guide, we want to propose something more complicated, challenging and imponderable in this alternative case study. The specific purpose of this exercise is to get you to think about the conditions for a CTO in relation to the process of making an application. While it will inevitably be relevant to discuss the timing of the medical reports in relation to the MHOs report and the proposed care plan, we do not wish you to get too hung-up on the mechanics of the process. The aspects of the process we wish you to become more concerned with in your discussion are how the principles relate to the conditions for a CTO and how this articulates with the complicating factor of the advanced statement. In doing this, it may also be relevant to consider the broader Human Rights underpinned by the principles, especially Article 10 of the European Convention: the right to freedom of expression. This underpins our right to hold and express political views.**

**We also wish you to consider the potential for airing differences of opinion in the process of application and the ways in which those opinions may be expressed in the reports.**

For many years Mark Freeman has been an active figure in the Animal Liberation Front, an established national animal rights group. He has been involved in numerous demonstrations and direct action protests and he has been arrested on several occasions in relation to his cause. He works tirelessly for his local group and the cause is central to Mark's life. For all of his adult life Mark has been a vegan vegetarian to the full extent of not eating, using or wearing any animal products or products derived from testing on animals.

Mark has a ten yearlong history of bipolar affective disorder. He has a good understanding of the illness and the ways in which it has hampered his life in the past. He has developed many life skills as means of self-management of the disorder. While never liking the treatment, having a good relationship with his psychiatrist and the help of sound maintenance regime of medication, Mark has managed to keep free from any manifestation of his illness for three years now. However, while Mark was coming to terms with his illness, or in his words, while he was still learning the lessons it taught him, he was detained under the 1984 Act on two occasions.

Mark has recently discontinued his medication as he believes it to be derived from a process of animal testing. He has ordered his own supply of Tranquilibrium over the internet. Tranquilibrium is a form of Lithium that Natural Resort plc, the manufacturers claim is 'non-synthesised, naturally

occurring and incurring no harm to animals in its production or manufacture.’ However the result of this disruption in treatment is a resurgence of hypomania such that Mark seemed to be behaving in ways that posed risks to health and welfare and potentially to his safety. His sleep pattern had become progressively more erratic. During this time Mark had been energetically pursuing numerous plans and ideas, all of which he left in a half completed trail of chaos. Some of these ideas have taxed his slender income to the limit. For example, on a whim he determined that local wildlife was being damaged by the use of agricultural chemicals. He purchased an expensive metal cage and a flight to London, with the intention of collecting hundreds of specimens of wildlife, the idea being that he would release them in Downing Street. He did not collect and animals and he missed the flight because he had to attend a meeting of his local Animal Liberation group, at which he alienated many of his friends by suggesting that they should publicly torture a dog to show people how much animals suffer in laboratory experiments.

Mark was detained in hospital under a short-term certificate, granted by his RMO and consented to by an MHO. However, Mark has a properly authorised advance statement registering his wish that, should he ever require treatment by compulsion, nothing should be given to him that would cause, or have ever caused harm animals. In this he specified two matters in particular: his diet and his medication. In the first few days of Detention Mark did accept some treatment to alleviate his acute symptoms. However now, ten days into the 28:day period of the Short-term Detention, he is refusing to take any form of prescribed medication and because of his hypomania, his management is posing nursing staff considerable problems. Mark has a named person, his partner David. His advanced statement emphasises that David should be a full party to discussions about treatment matters. While less radically committed to the cause, David does share Mark’s concerns for animal liberation. He is supportive of Mark’s refusal, even though nursing staff have advised him of the risks to Mark’s mental and physical wellbeing, should his hypomania go untreated. In turn David points out that, while fully competent to make such decisions, Mark has taken considerable risks in support of his cause in the past, including getting himself arrested. Why should his choice to do so now be denied him just because he is mentally ill?

Even though the RMO has read up all she could find on the internet about Tranquilibrium (Mark’s preferred choice of treatment), her clinical opinion is that too little is known about the efficacy of the product. It also seems extremely unlikely that any form of maintenance medication would be effective in this crisis situation where the intervention of a major tranquilliser seems to be urgently indicated.

## Questions for discussion:

**In keeping with the complexity of the case study we intend to ask you some difficult questions. The overall point of this exercise is to consider the merits of making an application for CTO against the options of allowing Mark to remain untreated under the Short-term Detention or the merits of using the Short-term Detention to enforce treatment against the wishes expressed in the advance statement.**

- 1) In considering this complicated problem it will be necessary to ask whether Mark's current circumstances fulfil the conditions set out in section 57 (3)?**

In answering this, guidance may be obtained from the broad human rights perspective and the specific principles of the Act. Therefore, having asked you to satisfy yourself that the conditions may be met in this situation, we ask you to refine your thinking against the following:

- 2) Given that Mark's right of freedom to express his political opinions through refusal of medication is not an absolute right (it is, for example restricted by laws relating to civil order), how do you balance it with Mark's right to receive care, protection and treatment when unwell?**

You may discern that there are two very different perspectives on this rights issue. One is expressed by Mark's partner. It may be summed up in the following quote from the case study 'He is supportive of Mark's refusal, even though nursing staff have advised him of the risks to Mark's mental and physical wellbeing, should his hypomania go untreated. In turn David points out that, while fully competent to make such decisions, Mark has taken considerable risks in support of his cause in the past, including getting himself arrested. Why should his choice to do so now be denied him just because he is mentally ill?'

The other perspective is implicit in the nursing staff's concern for Marks wellbeing, regardless of his past wishes. This perspective assumes that Mark's wishes are invalidated by the seriousness of the risks he is facing.

While recognising the validity of both sides, it is difficult to reconcile them. We suggest that some practitioners are more likely to be oriented towards treatment by compulsion, knowing the risks of allowing someone's mania to go untreated. This perspective would uphold the person's right to receive treatment when too ill to recognise the need for it. On the other hand, while other professionals may not be comfortable accepting the gravity of risks in allowing Mark to remain untreated, they would uphold Mark's right to freedom of choice as a right that he is even entitled to die for.

**3) What problems may be posed in making an application where the RMO and MHO hold such irreconcilable views?**

Drawing from the Principles of the Act, consider:

- a) What is the importance of Mark participating as fully as possible in the discharge of the function? (The here function is to arrive at a decision about how best to resolve the treatment question.)
- b) How may 'benefit' be interpreted in Mark's case, in respect of the 'importance of providing the maximum benefit to the patient'?
- c) How can this function be discharged in a manner that involves the minimum restriction on Mark's freedom that appears to be necessary in the circumstances?

**4) What benefits do you perceive in the Tribunal's role in determining this application?**

This pack is one of a series of Training Guides detailed below developed for local authority mental health officers and related health and social care staff commissioned from Robert Gordon University by the Scottish Executive.

Reader 1

Introductory training for mental health officers and other practitioners

Reader 2

Emergency and short-term detention and related matters

Reader 3

Compulsory treatment orders and related matters

Reader 4

Provision of social circumstance reports and provisions for people with mental disorder within the criminal justice system and other related matters

Trainers Guide for Readers 1-4

Briefing Paper

For health service and local authority managers

Briefing Paper

For local authority elected members

This material is also available on the Scottish Executive's mental health law website

[www.scotland.gov.uk/health/mentalhealthlaw](http://www.scotland.gov.uk/health/mentalhealthlaw)

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