

**The New Mental Health Act**

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**Transitional Training Guide**

**Briefing Paper**

**For Health Service and Local  
Authority Managers**

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## **Transitional Training Guide**

### **Briefing Paper**

#### **For Health Service and Local Authority Managers**

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

**TRANSITIONAL TRAINING GUIDE**

**BRIEFING PAPER**

**FOR HEALTH SERVICE AND LOCAL AUTHORITY MANAGERS**

## 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)

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## 1. Introduction

In discussing the implications of Compulsory Treatment Orders (CTOs) under the Mental Health (Care and Treatment)(Scotland) Act 2003 (the 2003 Act), the analysis of the Scottish Executive Social Research Unit's consultation exercise on the programme of research for the 2003 Act (the Scottish Executive, 2004) made the point very eloquently. In discussing the implications of Compulsory Treatment Orders under the 2003 Act, it states that:

- 'The link between compulsion and buildings has been broken; and
- The idea that 'treatment' can only happen in certain places is overturned'.

For your purposes as a manager of local authority or health care services the implications that stem from this statement are wide ranging. In terms of social policy there is a simple equation that has developed over the age of community care:

'The more psychiatric hospital-based services have shrunk, the greater the need for mental health service delivery in the community'.

This suggests that there is a need for those who manage care and treatment services for those affected by mental disorder to view services holistically both in hospital as well as the community. The principles of the new legislation demand that use of compulsion should be on the basis of least restriction. Services and procedures will need to be in place to ensure that hospitalisation on a compulsory basis is there when needed but is not resorted to because of the lack of suitable community care and treatment alternatives. This will require closer relationships than ever between health, local authority, voluntary sector and other partners in the commissioning and delivery of supportive community services.

This Act must be viewed within the wider policy context in which it is emerging. The implementation of the Framework for Mental Health Services in Scotland, delivered in a way that embraces the Joint Future agenda will be essential to the successful introduction and operation of the 2003 Act in each area and across a range of service users. Community Health Partnerships will have an increasingly important role to play in this process.

A key feature of the 2003 Act is that it is complex legislation which demands a greater level of professional accountability for all those charged with its implementation than has been the case with the 1984 Act. It will be essential that there are clear, effective systems of communication in place to ensure that consultation and the sharing of key information between professions and agencies proceeds as smoothly as possible. Managers of health and social services will need to pay close attention to developing the administrative systems necessary to support staff in its implementation.

Our purpose in this guide is to draw your attention to certain key features of the 2003 Act and its relation to other legislation, in order for you to make informed decisions about how best to prepare to meet these new statutory demands.

This guide works its way through the salient points of the 2003 Act in relation to local authority and health service responsibilities. It should be emphasised that our undertaking here is not to advise you on how to meet your responsibilities under the 2003 Act. Our intention rather is to advise you of the extent of those responsibilities.

### **1.1 Scope of the Legislation:**

The new legislation has implications for a wide range of mental health service users and providers in a number of settings:

- Older people;
- Adults with learning disabilities;
- People with mental disorder caught up in the Criminal Justice System;
- Children and families affected by mental disorder;
- Accident and emergency services;
- General hospital services; and
- General practice surgeries.

The big picture has regard for mental health in the broad and more accurate sense of the term. Mental health relates to the mental wellbeing of the community and this has implications for everything from inpatient mental health services to issues of widespread community-based resources geared towards prevention, support and recovery.

In this sense there are sections of this guide that you will wish to share with colleagues more widely throughout your organisation.

## **2. The Significance of the Principles Contained in Sections 1, 2 and 3**

As with the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act) and the Regulation of Care (Scotland) Act 2001, the 2003 Act contains and is based upon a set of core principles. They have legal status in so far as they impose a duty on the health boards, hospital managers and their agents, local authorities and officers of local authorities (amongst others) to have regard for their contents in the performance of any function under the Act.

The principles of the 2003 Act are more complicated and involved than those in the 2000 and 2001 Acts. For a full discussion of the detail of the principles see the first reader in this sequence. However, for brevity here we will draw from the distilled version of these principles rendered in the Executive's Introduction to the 2003 Act (Scottish Executive, 2003). These include:

- The present and past wishes and feelings of the patient;
- The views of the patient's named person<sup>1</sup>, carer, guardian, or welfare attorney;
- The importance of the patient participating as fully as possible;
- The importance of providing the maximum benefit to the patient;

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<sup>1</sup> The named person is a function that can be read as replacing, to a large extent, the role of the nearest relative.

- The importance of providing appropriate services to the patient; and
- The needs and circumstances of the patient's carer.

The Act also sets out principles relating to the way in which the function must be discharged. These require the person discharging the function to do so in a way which, for example:

- Involves the minimum restriction on the freedom of the patient that appears necessary in the circumstances; and
- Encourages equal opportunities, and if the patient is a child, best secures their welfare.

Finally, the 2003 Act contains a set of principles specifically relating to children; a child being a person under 18 years of age for this purpose. This relates to a thread of regard that the Act has for children and young persons, emerging out of Millan's concern that children have been poorly served by acute psychiatric services to date.<sup>2</sup>

The significance of the principles for you as a manager is that they must be considered in all the policies, systems and structures that you put in place to enable all staff - MHOs, social workers, OTs, medical practitioners, nursing staff, administrators and others - to do their jobs. For example, we will discuss the various authorities to detain below. If your systems to respond to psychiatric crises, assessing quickly and as thoroughly as possible and providing alternatives to hospital admission where appropriate are not adequate, those practitioners within the services may not have the support and resources to do the job in a way that allows them scope to address the principles in practice. In this case whatever is done by a practitioner in discharging a function under the Act without proper regard to the principles could potentially be open to legal challenge subsequently.

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<sup>2</sup> New Directions, Report on the Review of the Mental Health (Scotland) Act 1984, Scottish Executive, January 2001, pp 224-228).

### **3. Implications of the Act for Health Service Managers**

**3.1** The implications of the Act for Health Service Managers fall into 4 broad categories:

#### **A. Workforce resources:**

Dr Sandra Grant's '*National Mental Health Services Assessment - final report*<sup>3</sup> suggests that the moves toward community based measures of compulsion will require acquisition of:

'new skills and competencies, always underpinned by a therapeutic relationship based on ethical principles'.

The report suggests staff groups for attention will include:

- a) Consultant Psychiatrists ;
- b) Clinical Psychologists ;
- c) Registered Mental Health Nurses;
- d) Allied health professionals, including dieticians, speech and language therapists;
- e) OT's and physiotherapists;
- f) GPs and primary care; and
- g) Pharmacists.

It advises that workforce considerations are not only about training and sufficiency of numbers, but also about service redesign and approach.

#### **B. Training:**

These principles have implications for any manager in relation to the staff of any health-care service in which such functions may be discharged. The first implication is that there is a duty to ensure that the staff have a sufficient working understanding of the principles to meet the requirement that they discharge their functions with regard to them. This, in turn has very pressing implications for the training of all key staff before the Act is implemented. The Scottish Executive in conjunction NHS Education Scotland (NES) and the Royal College of Psychiatrists is also developing training materials which aim to meet a broad range of training needs on the Act from awareness raising to specific procedures. These will be made widely available through NES.

#### **C. Material resources:**

The next implication is that there are adequate resources to enable staff to fulfil regard for the principles. Resources can be specific services and/or facilities (e.g. interpreting services, the ability to cater for a special diet or to provide special prayer facilities or a place of safety) or even adequate staffing. Such resources may be necessary to ensure that 'the patient is not treated in any way that is less favourable

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<sup>3</sup> <http://www.scotland.gov.uk/library5/health/mnhsaf-07.asp>

than the way in which a person who is not a patient might be treated in a comparable situation.’ This principle, coupled with the principle embodied in section 1(6) of ‘appropriate services’ including the provision of continuing care when the patient, or service user, is no longer subject to compulsion, amounts to Millan’s concept of ‘reciprocity’<sup>4</sup>:

‘Where society imposes an obligation on an individual to comply with a programme of treatment or care, it should impose a parallel obligation on health and social care organisations to provide safe and appropriate services...’

The resource implications of the Act, however, extend beyond the principles into other requirements imposed by other sections of the Act.

#### **D. Financial Resources:**

Resources also include financial resources. Each agency will have their own decisions to make on the investment to be made from their own general allocation to support a successful and ongoing implementation. In addition the Scottish Executive has provided local authorities with a total of £26.7m revenue and £4m capital to 2006. By 2005/2006, £13m in recurring revenue will be available to local authorities. An additional £1m in 2003/04 and £4.5m in 2004/05 will issue through NHS Boards for partnership spend on the implementation process and for attention to crisis services.

The Scottish Executive has indicated that further revenue and capital resources will issue next year under these arrangements and investment has and will continue to be made for national initiatives linked to the new legislation and general mental health services.

### **3.2 The Act demands close attention to and development of a broad range of services**

#### **A. Meeting the needs of children and young persons:**

**Section 23** imposes a duty on NHS Boards to make provision for any child or young person (up to the age of 18) where that person is either detained or voluntarily admitted to hospital for the purposes of receiving treatment for a mental disorder. In this regard, the provision of services and accommodation must be sufficient for the particular needs of the child or young person. This section is written out of specific consideration that most psychiatric services are designed for the treatment of adults.

Section 23 is strengthened by three further sources in the Act. **Section 2** deals specifically with principles in respect of children and states that any function under the 2003 Act must be discharged in ‘the manner that best secures the welfare of the child.’ **Section 277** requires education to be given to children who would otherwise be deprived of it by reason of mental disorder. **Section 278** further requires those

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<sup>4</sup> New Directions, Report on the Review of the Mental Health (Scotland) Act 1984, Scottish Executive, January 2001, pp19.

who have functions under the Act to have regard for the relationship between the child and those with parental authority for the child. The requirement is that in cases where either a child or a person with parental responsibilities is subject to the 2003 Act, every person discharging functions under the Act shall take such steps 'as are practicable and appropriate to mitigate the impairment or diminution' in the personal relations or direct contact between the parent and child.

The sum total of this is that health service providers will have to have facilities suitable for accommodating formal and informal patients under 18. They will have to provide education services for those patients under 16 years of age. Local authorities will also have responsibilities in this regard.

### **B. Post-natal depression:**

A second set of resource implications is created by **section 24**, in relation to 'certain mothers with post-natal depression.' Where such a mother has been admitted to hospital informally or formally, and where her proximity to the children would not endanger them, any NHS Board must provide suitable accommodation for both mother and child/ren, where the mother wants this service. Unlike section 23, 'each health board shall collaborate with other health boards to whatever extent is necessary to fulfil this duty' (section 24 2)). The wording of 24(2) implies that there may be collaboration to provide a few such national resources to meet the duties of all NHS Boards.

Guidance has been produced for NHS Boards, to facilitate the planning of this process. In anticipation of implementation of the 2003 Act, this guidance reflects the best available current advice on planning and provision of joint mother and child admission and care. It is available on the Scottish Executive's Mental Health and Well Being Support Group website at:

[www.show.scot.nhs.uk/mhwbsg/](http://www.show.scot.nhs.uk/mhwbsg/)

In relation to services for both children and their families and post-natal disorders we would encourage you to 'think local' and think in terms of broader access to the patient by their family.

### **C. Independent advocacy services:**

A third set of resource implications is created by **section 259**, which imposes duties upon each local authority to collaborate with its relevant NHS Board to ensure that mentally disordered persons living in their area have access to independent advocacy services. This is given sharper focus by the requirements upon Mental Health Officers to ensure that anyone detained under emergency or short-term detention or compelled by any order is informed of the right to advocacy and has access to the service.

## **3.3 Measures of compulsion**

The following is by no means a comprehensive discussion of compulsory powers and health-care managers' duties in relation to them. It serves only as a brief guide.

The 2003 Act substantially overhauls the framework of detention and introduces several new provisions which vary quite substantially from the 1984 Act. Among these are:

- **Nurses power to detain** for up to 2 hours, pending medical examination has been changed to include time for medical examination to take place and mental health officers to be involved where practicable;
- **Emergency detention** in hospital for up to 72 hours, with relatives no longer involved in giving consent and requiring, wherever practicable, the consent of a Mental Health Officer. The 2003 Act also introduces a requirement on hospital managers to make arrangements for an approved medical practitioner to carry out a medical examination of the patient as soon as practicable after their admission under the emergency certificate;
- **Short-term detention** in hospital for up to 28 days (no longer dependent upon the prerequisite of emergency detention) but requiring the consent of a Mental Health Officer in all cases; and
- **Compulsory Treatment Orders (CTOs)** - granted by the Tribunal for periods of up to 6 months in the first instance and renewable thereafter. All applications for CTOs will require in addition to medical and Mental Health Officer reports, a proposed care plan to which all parties contribute. The CTO may contain wide-ranging powers either to detain in hospital for treatment of mental disorder or to enforce compliance with measures of care and treatment in the community.

These are the main civil procedures. Below we will briefly discuss the measures afforded under criminal procedures.

### **3.4 Hospital managers' duties in relation to compulsory powers:**

**Section 38** sets out the duties upon hospital managers to:

- Make arrangements for an approved medical practitioner to examine the patient as soon as practicable after commencement of emergency detention;
- Give notification of the detention to: the nearest relative or any person residing with the patient, the named person if known and the Commission, within 12 hours; and
- Give notification to those listed above within 7 days of:
  - a) Reasons for granting the certificate;
  - b) Whether consent of an MHO was obtained;
  - c) Reasons for no MHO consent if it was not obtained;
  - d) Alternatives to granting of the emergency detention certificate; and
  - e) Why those reasons were determined as inappropriate;
- Give notification within 12 hours to the local authority within which the patient resides of the detention if no MHO consent was obtained.

The Draft Code of Practice for civil procedures is very clear that any medical practitioner considering granting an emergency or short-term detention certificate

should not attempt to 'shop around' for consent if the MHO withholds it. However, the Draft Code advises that local authorities and health-care partners should devise protocols for any medical practitioner who feels it is essential to obtain a second MHO opinion. Having such a system in place, responsive to need on a relatively speedy basis, would avoid placing undue stress upon doctor, MHO, patient, local authority and health services.

Duties similar to those under section 38 exist under **section 46** for short-term detention, to notify:

- a) The patient;
- b) The named person; and
- c) Any guardian or welfare attorney of the detention as soon as possible.

And within 7 days, to notify:

- a) The Tribunal; and
- b) The Commission.

### **3.5 Criminal justice and the mentally disordered offender:**

The 2003 Act provided an opportunity to overhaul the provisions for mentally disordered offenders under the Criminal Procedure (Scotland) Act 1995. As such the 2003 Act inserts sections into the 1995 Act giving greater flexibility to the disposals available to courts in meeting the needs of criminal justice and the needs of the mentally disordered offender, reflecting the 2003 Act's potential to compel care and treatment to be received either by detention in hospital or within the community. The 2003 Act also establishes ways in which these court orders may be managed by health and social care professionals within mental health services.

Significant among the newly inserted sections of the 1995 Act are:

- **Assessment orders:** 28 day detention in hospital for assessment and treatment either before conviction or between conviction of an offence and sentencing;
- **Treatment orders:** As per assessment orders but allowing for a prolonged period of assessment and treatment; and
- **Compulsion orders:** The wide-ranging detention or community based orders made by the Courts. Once received by the hospital, the patient is subject to powers much like the CTO.

In submitting a report to the court or to the RMO in respect of the above the MHO should address the availability of community based services which may be required to be delivered to the offender by compulsion. This highlights some of the problems of the fragmented service across the systems within the local authority and between health and social care services. While the MHO report to the Court should include a care plan, upon which these comments of availability are made, the order made by the Courts also requires recommendations to be made by two medical practitioners. These recommendations propose the measures of compulsion to be contained in the order. There is scope for conflict if the medical practitioners' recommend measures

of community-based compulsion contrary to the MHO's assessment of availability of services with which to meet these measures. Some of this conflict may be resolved at practitioner level by following the Draft Code of Practice's caution that such processes require very close interdisciplinary working. However, there would seem to be a need for managers of health and local authorities to establish a forum in which to discuss both the resource implications as well as the mechanics of consultation.

### **3.6 Detention in conditions of excessive security:**

**Section 264** provides for various parties to apply to the Tribunal where it appears that the patient is detained in conditions of excessive security in the State Hospital under a CTO, a Compulsion Order, a Hospital Order or a Transfer for Treatment Direction. This is reference to those patients who are detained in the State Hospital and who could receive services by detention in a hospital in their own area, but for resource implications.

Where the Tribunal finds that there is detention in conditions of excessive security, it will make an order requiring the relevant NHS Board to identify hospital provision into which the patient may be transferred. Where the Board fails in its duties to meet these requirements, it shall be subject to a Tribunal hearing.

**Section 268** makes similar provision for patients subject to CTO, a Compulsion Order, a Hospital Order or a Transfer for Treatment Direction who are detained in conditions of excess security in a hospital other than the State Hospital. In such a case the NHS Board must identify suitable provision of lesser security into which to transfer the patient.

These provision will not be implemented with the main provision of the Act in 2005 but must come into effect no later than 1 May 2006.

### **3.7 Other implications of the Act:**

This is not an exhaustive list. It is merely a list of some of the more explicit implications. This will give an idea of the need to be able to respond to a whole range of unforeseeable contingencies that practice under the 2003 Act will impose.

- **Section 5:** Mental Welfare Commission (the Commission) duty to monitor the operation of the Act and to promote best practice will require close attention by health and local authority managers to implementation issues ranging from data collection and storage, interagency communication, professional liaison, and shared protocols to a re-invigorated joint planning, resourcing and service development .
- **Section 11:** Commission's duty to make investigations into deficiencies in care or treatment, ill-treatment and neglect.

**Section 13:** Commission's duty to make visits to patients who are subject to compulsion under the 2003 Act.

- **Section 16:** Commission's authority to inspect medical records.
- **Section 21:** The 2003 Act creates the Mental Health Tribunal for Scotland, which largely replaces the Court as the forum for determining applications, granting orders and hearing appeals. Schedule 2, Part 2, Section 8(3) requires NHS Boards, local authorities and the State Hospital Board for Scotland to provide, as far as reasonably practical to do so, in response to a request by the President of the Tribunal, accommodation for the holding of hearings by the Tribunal.
- **Section 22:** NHS Boards and the State Hospitals Board for Scotland have a duty to maintain a list of approved medical practitioners.
- **Sections 30 and 31:** The local authority has duties to provide care and support services, services that promote well-being and social development and to give assistance with travel to those with mental disorder in the community. They may also provide such services for persons who are in hospital. Sections 30 and 31 impose duties on NHS Boards, Special Health Boards or a National Health Service Trust to co-operate with local authorities and to give such assistance in these matters as would be compatible with their functions where this is necessary to enable a local authority to perform any of their duties under section 25 or 26.
- **Section 34:** The local authority has specific duties to make inquiries into situations of apparent lack of care, neglect or ill-treatment in the community. Section 34 imposes a duty on various bodies including NHS Boards to co-operate with these inquiries.
- **Section 228:** Individual NHS Boards have a duty to respond to a request for an assessment of the needs of any person receiving services from it, should the person provide that request in writing. This also applies to an assessment of the needs of that person's primary carer. NHS Boards must respond to such requests within 14 days indicating whether they intend to undertake the assessment and, if not, why not.
- **Section 230:** Requires the managers of a hospital to appoint a Responsible Medical Officer to any patient who is receiving services by compulsion in or out of that hospital as soon as reasonably practicable.
- **Section 250:** describes a new and important role in the 2003 Act for the named person. In many regards it replaces the function of the nearest relative. The named person may be nominated while the patient has capacity to do so, and there after has rights to receive notification of detention and other compulsory powers, to make representation at Tribunals and to appeal against compulsion. As long as the patient has capacity to do so he or she may terminate the nomination of a named person or nominate a replacement.
- **Section 291:** Allows for various persons to apply to the Tribunal where it appears that an informal patient is being unlawfully detained. This may mean that an informal patient is restricted from leaving the hospital, for example,

where a ward door is locked and staff refuse to open it on request. Where the Tribunal find that a patient has been so detained, it will require the hospital managers to cease the detention.

#### **4. Implications of the Act for Local Authority Managers**

##### **4.1 Physical resource implications**

Sections 25 & 26 and 27 impose duties on local authorities relating to care and support services and services designed to promote well-being and social development and assistance with travel in accessing these services:

###### **A. Section 25**

Under section 25, the local authority has a duty to provide or secure provision of care and support services for persons who have a mental disorder and are not in hospital. It may also exercise discretion about the provision of such services to persons who are in hospital. As per our discussion of the principles above, where the local authority has a duty to provide such services, it must be able to say how the principles are reflected in the provision.

Section 25 circumscribes these services by stating that they:

'shall be designed to a) minimise the effect of the mental disorder on such persons; and b) give such person the opportunity to lead lives which are as normal as possible.'

It further states that such services shall include residential accommodation and personal care and support services.

###### **B. Section 26**

This section imposes similar duties to provide or secure provision of services to promote wellbeing and social development for persons with mental disorder outside hospital and discretion to provide such services for those in hospital:

These services are further described as including provision for social and cultural activities, training and assistance in obtaining and undertaking employment for those over school age.

###### **C. Section 27**

This section places a duty on local authorities to provide assistance in travelling to access such services for persons who are not in hospital.

###### **D. The interaction of section 25 and 26**

While all three sections largely overhaul and modernise section 7 of the 1984 Act in relation to residential accommodation, section 8 in relation to 'after-care' and section 11 in relation to education, they should not impose anything significantly new upon

any authority which has been meeting its responsibilities under the arrangements of the 'Framework for Mental Health Services in Scotland' and the disbursement of Mental Health Specific Grant moneys. What they do bring to the field of provision is a requirement that regard is had for the principles in the planning and design of services. They also bring new dimensions in respect of the requirements to facilitate access to employment and in the social and cultural dimensions of services that promote wellbeing.

Social activities in respect of enhancing the wellbeing of people with mental disorder may be thought of as those services (such as day care, drop-in and support services) that enable people to enhance their own social networks and build self-esteem and feelings of belongingness. Cultural enhancement may be seen both in terms of services that reflect and support minority cultures and in terms of services that support and reflect the particular culture of an area. For example, a service that offers support in culturally sensitive ways to the diverse range of minority ethnic cultures in an inner-city would fit this description. On the other hand, a service that offered to meet the particular cultural needs of Gaelic speaking people with mental disorder living on the Western Isles would also fit the description. It should be noted that these two aspects are in no way mutually exclusive.

So far, we have spoken about the general needs of the community for such services. These sections also raise the profile of individual need in respect of any person who may require support and care services or services that promote wellbeing. The 2003 Act is clear that these services relate to the broad community of people with mental disorder, not just the minority subject to compulsion. As we will discuss, there are a number of ways in which those people in need of services may come to be identified either by care management services, children and family services or by MHOs in their role of considering people for compulsion (and possibly not finding them needing of it).

There are also ways discussed below, in which MHOs must make assessments of people's formal needs for services by compulsion and must sometimes formally register proposed care-plans as part of the application to the Tribunal for a CTO. The Tribunal can specify which elements of the proposed care plan are to be 'recorded matters' which the Tribunal would see as essential components of the proposed care plan which must be delivered. The Tribunal itself may well play a role over time in driving forward the development of services in their response to applications for and reviews of CTO.

## **4.2 Workforce implications**

### **A. Section 32: Appointment of a sufficiency of MHOs:**

Section 32 places a duty upon local authorities to appoint a sufficient number of MHOs for the purpose of discharging their duties under three pieces of legislation: the 2003 Act; the Adults with Incapacity (Scotland) Act 2000; and, the Criminal Procedure (Scotland) Act 1995. We will go on to say much about the 2003 Act and the vastly expanded role for MHOs. (In order to give a precise illustration of the role, we have included a summary of all MHO duties under the 2003 Act in Annex A. A

quick read of this Annex will bring home to you the likely impact of the 2003 Act on existing MHO services ).

However, let us not forget that the body of MHOs in most local authorities is already taxed by the recently added weight of duties under the 2000 Act. For local authorities, the impact on MHO services will have the most important resource implications in actually implementing the Act; one that will be felt immediately in 2005 when the Act comes into effect.

The Scottish Executive commissioned research from the Scottish Development Centre for Mental Health on MHO Service Structures and Supports (Scottish Executive, 2003). This confirmed a wide variability in both quality and level of MHO service provision and the management structures in place for the support of these services. It confirmed a picture in which, in many places, these services have grown organically to meet need, rather than in planned and managed ways. With such matters in mind, Angus Skinner Chief Inspector of Social Work Services for Scotland, characterised the research as 'a wake-up call' for local authorities at a conference at Heriot Watt when the research report was launched. In support of this view the Scottish Executive is committed to developing a set of National Service Standards for MHO services as intimated in the policy statement which preceded the introduction of the Mental Health Bill. See Annex B for a copy of the Draft Standards which were sent out for consultation in August 2004.

These considerations are re-enforced in Dr Sandra Grant's 'National Mental Health Services Assessment: final report'.<sup>1</sup> The report raises concerns about the structure of MHO services, the sufficiency of MHOs and issues of retention of staff relating to the matters such as professional differentials in payment for MHO services.

### **B. Why is the number and arrangement of MHOs under the 1984 Act likely to be less than sufficient for contingencies of the 2003 Act?**

A clear understanding of the closely involved and long-term nature of MHO work under the 2003 Act requires us to look into some of the detailed mechanics of the Act.

Whereas the main route into compulsory detention under the 1984 Act was emergency detention, a route that involved scant role for the MHO and potential for the MHO not to be involved at all, the 2003 Act will work in very different ways. Apart from a small minority of cases, where the patient is introduced to compulsion by emergency detention and no MHO consent is practicably obtainable, the MHO will be involved in the assessment process associated with every route to compulsion under civil procedures in this Act.

The mechanics of the 2003 Act are very different to those of the 1984 Act, and it is difficult at this point to project the anticipated workload for MHOs from the basis of recent statistics from the old legislation. However, the Scottish Executive has been working closely with ADSW representatives in an attempt to reflect more accurately

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<sup>1</sup> <http://www.scotland.gov.uk/library5/social/MHOs/00.asp>

the potential statutory workload demand which will fall to MHOs from the 2003 Act as well as the 1995 Act and the 2000 Act. They have used projections based on a wide consultation with local authorities which estimate the average likely input from MHOs in respect of discrete statutory interventions under the legislation (e.g. consent for Emergency Detention, Applications for CTOs, compiling an SCR etc.). The estimates of the likely volume of the specific sections requiring the statutory activity were based on the most recent Mental Welfare Commission statistics and the projections being used for planning purposes by the Scottish Executive's Mental Health Law Team. The group also factored in a percentage for statute-driven work that does not result in use of the legislation. While the resultant figures are preliminary and must be viewed with caution, they represent the first attempt to quantify core statutory demand on the MHO workforce. The figures will be published by ADSW later this year. They are likely to conclude that the statutory workload falling to MHO as a result of these three pieces of legislation would amount to over 300 whole time equivalent MHOs across Scotland. This is dramatically in excess of current statutory input.

### **C. The role of Designated Mental Health Officer**

**Section 229** of the 2003 Act makes reference to the 'designated MHO' in relation to the MHO role in Short-term Detention, Compulsory Treatment Orders and other orders or 'relevant events' as referred to in **section 232** of the Act. This section imposes a duty on local authorities to designate an MHO for the purpose of the tasks prescribed in any of these interventions. While the section allows for the designated MHO to be replaced by another, for example in the event of annual leave or ill-health or in the event of the designated MHO leaving the authority's employment, this implies a fixed and continuing role for that MHO for the duration of the period of compulsion. In turn, this implies that your local authority will need to review, if they have not done so already, whether they have suitable policies and procedures for the adequate deployment of its MHOs. However this is determined, the implication of the word 'designated' is that an MHO will somehow be identified for the purpose in hand.

### **D. The continuing role for MHOs in cases of long-term compulsion:**

The legislation requires the role of the designated MHO to stretch beyond the application process into the monitoring and review of the order, once granted. The Draft Code of Practice suggests that:

'Where an MHO has already been designated as having responsibility for that patient's case, then that MHO, wherever practicable, should prepare the application.'

What is being suggested here is that, where there is previous MHO involvement, for example in any Short-term Detention preceding the application, best practice would be for that designated MHO to continue in the role, making best use of previous knowledge and established relationship. This is an indication of a more extended role for MHOs under the 2003 Act than the role focused on short-term statutory contact that has often evolved in practice under the 1984 Act.

The Act details numerous points in the maintenance of Compulsory Treatment Orders at which the MHO will be consulted by the RMO in respect of the review of orders, the extension and variation of orders, the imposition of additional measures of compulsion where the patient is non-compliant with an order, times at which the patient or others formally appeal against the order, etc.

#### **E. Implications of the extended role of the MHO for remote areas and the Island Authorities:**

The role for designated MHOs has particular implications for those dispersed and sparsely populated authorities, especially Orkney and Shetland. The reason we make special mention of these two authorities is because of their unique position, having no acute admissions facilities of their own. In their statutory capacities, their MHOs have been more used to short-term and crisis involvement. Long-term detention in hospital on a compulsory basis takes place on the mainland and many MHOs do not get the opportunity to engage in the practice and procedures associated with this. With its new focus on treatment in the community, the new Act may well provide new opportunities for compulsory care and treatment in the community rather than always having to resort to hospital based compulsory care and treatment. Managers in these areas will have to devise strategies for making CTO applications and implementing orders in situ, rather than dealing at arms length with hospital based orders at a considerable remove. Close attention will also need to be given to assuring that MHO staff in such areas receive sufficient opportunities to experience statutory MHO work to maintain confidence and competence to allow for reappointment as detailed in Ministers' Directions.

#### **F. Organisation and deployment of MHOs:**

The problem of how to make best use of MHOs poses several questions:

- If MHOs are a scarce resource, time consuming and costly to train and difficult to attract into either the onerous training or into your employment, is it best to maximise the resources by employing them exclusively as full-time MHOs?
- If MHO services have been arranged primarily by a rota system, how can such a system accommodate the complexities of picking up cases where the process of making an application may extend for days of work beyond the initial point of contact?
- How could a rota-ed MHO meet the competing requirements of their ordinary workload and the additional burden of making an application within a very short time-scale with an absolute, immovable and legally required deadline?
- Is it best for those MHOs who already work in multidisciplinary teams to service their teams, and where this is the case how do you ensure that such close working with the RMO does not jeopardise objectivity?
- How can work under the 2003 Act be balanced with the very different work of applying for Guardianship etc under the 2000 Act?
- If not all MHOs work in areas of the local authority central to mental health-criminal justice, child protection, Out of Hours/Emergency Duty Teams, etc. - how may best use be made of their availability?

This discussion also poses the converse consideration. Some local authorities have met their duties to provide sufficiency of MHOs to date by only allowing workers from core mental health settings to undertake the training. There is a wide dispersal of the MHO role through not just mental health, learning disability and older people services but also through criminal justice and now, children and families teams. The task for local authorities will be to capitalise upon this specialist knowledge and experience while ensuring that MHOs in non-mental health specialist teams have opportunities for statutory work, training and practice to ensure their ability to be re-appointed at regular intervals as set out in Ministers' Directions.

### **G. Attaining sufficiency of MHOs:**

There seem to be two lines of approach to these questions. Some authorities are thinking along the lines of attaining sufficiency by re-deploying their existing cohort of MHOs in ways that make greater use of them to the exclusion of other duties.

If one looks at the projected figures for the next intake of MHO training across Scotland, other areas are obviously beginning to encourage greater numbers of their workforce through the programmes<sup>6</sup>. There is no one solution which will fit the circumstances of all local authorities. It is likely most areas will need both to restructure existing services to better realise existing capacity as well as train and recruit additional MHOs.

### **H. MHO training as a means of increasing the workforce:**

MHO programmes are known to be amongst the most taxing of post-qualifying training in social work. A brief look at the transitional training materials alone suggests that the MHO task is arguably one of the most taxing roles in social work practice. And rightly so, as it should not be an easy task to make such huge decisions about people's basic civil liberties.

Across Scotland programmes vary in duration, some being of more condensed intensity than others, ranging from about 10 months to 18 months to completion<sup>7</sup>. They also have slightly varying progression rates<sup>8</sup>. They are all highly labour intensive, both of the candidates undertaking them and the expert staff (largely practising MHOs) who run them.

Some programmes struggle to encourage new candidates into them. This may be for a variety of reasons. Local authorities will need to examine their own situation in this respect. Recruitment and retention of an experienced and confident complement of MHOs is dependent on a number of issues. The SDCMH Research highlighted a number of issues related to job satisfaction of MHOs. The issue is directly related to the proper resourcing, support and management of the service as well as the health of the wider community service structure within which they practice. The training programmes are rigorous and demand considerable energy

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<sup>6</sup> Local Authorities have a total target of 96 MHO awards for 2004/05. The West of Scotland has the highest target of 30 new awards, increasing its intake by 10 from last year (SSSC figures).

<sup>7</sup> The mean progression time for programmes in 2003 was 11.9 months (SSSC figures).

<sup>8</sup> Out of 82 candidates registered on Scottish programmes in 2003, 51 have so far attained actual awards (SSSC figures).

and tenacity to complete successfully. Not all programmes are designed in ways that lend themselves to facilitating the candidate's progress by getting locum cover, and many local authorities expect their staff to struggle through the intense programme while having to continue to meet pre-existing work commitments. Resources available to local authorities to increase MHO workforce capacity to implement the legislation could be used creatively to establish such locum cover.

### **I. Retaining MHOs:**

With the anticipated directions from Scottish Ministers, MHOs will need to evidence their fitness to practice every 5 years. Some may simply chose not to do so without sufficient incentive. Some may even chose not to undergo the transitional training which will be necessary for MHOs who need to learn in detail the changes in the legislation and their roles and duties if they are to practice competently under the 2003 Act. Where few local authorities have issued MHO-specific contracts for basic grade staff, refusal to continue as an MHO may become a significant matter for employers. Recruitment and retention of MHOs is likely to remain a problem for authorities who do not organise their MHO and mental health services in such a way as to make it an attractive area in which to practice. At present, an uneven playing field in which service structures, pay and conditions vary considerably between authorities, serves to complicate the strategic approach to recruitment, retention and training for individual authorities. Some smaller authorities might have to look at joint services where they would otherwise lack the capacity, much as at happens with a number of out-of-hours services at present.

### **4.3 Financial Resource Implications**

Resources also include financial resources. Each agency will have their own decisions to make on the investment to be made from their own general allocations to support a successful and ongoing implementation. In addition the Scottish Executive has provided local authorities with total £26.7m revenue and £4m capital to 2006. By 2005-06 £13m will be available on a recurrent basis to local authorities. An additional £1m on 2003/04 and £4.5m in 2004/05 has issued through NHS Boards for partnership spend on the implementation process and for attention to crisis services.

Further revenue and capital resources will issue next year under these arrangements and investment has and will continue to be made for national initiatives linked to the new legislation and general mental health services.

### **4.4 Section 33 duty to inquire:**

This section relates to the duties upon local authorities to make inquiries in certain circumstances set out below. As the Draft Code of Practice advises:

'It would be best practice for local authorities to develop protocols which are consistent with their existing policies for the protection of vulnerable adults, and those currently in place in relation to' 2000 Act'.

As we have advised MHOs in the readers accompanying their transitional training, this suggests that any MHO may reasonably expect the local authority to produce a Framework of Guidance for practice. The purpose of the discussion here is not to anticipate this. It is for you to ensure that such policies are in place and that the policies reflect local need and circumstances. We only wish to draw some significant points to your attention.

The first point is the close link between section 33 of the 2003 Act and the section 10 duties in the 2000 Act, upon the local authority:

‘to receive and investigate any complaints relating to the exercise of functions relating to the personal welfare of an adult in relation’...to various proxies and, ‘any circumstances made known to them in which the personal welfare of the adult seems to be at risk’.

The second point is that both section 10 of the 2000 Act and section 33 of the 2003 Act relate to adults, meaning persons over the age of 16. The Children (Scotland) Act 1995 contains the authority for investigations in respect of persons under 16. The third point is that section 33 investigations may only be applied to persons living in the community, comparable concerns about hospital patients falling to the remit of the Commission. Finally, returning to section 10 of the 2000 Act, its remit is restricted to matters in relation to the personal welfare of the adult. Section 33 of the 2003 Act embraces a wider purpose, enumerated as follows:

- **Section 33(2) (a) (i)** ill-treatment; (ii) neglect; (iii) some other deficiency in care or treatment;
- **Section 33(2) (b)** because of mental disorder, the person’s property (i) may be lost or damaged; (ii) may be at risk of loss or damage;
- **Section 33(2) (c)** the person may be (i) living alone or without care; and (ii) unable to look after himself or his property or financial affairs; and
- **Section 33(2) (d)** because of mental disorder, the safety of some other person may be at risk.

The most significant differences to pull out of a comparison between the narrow section 10 and the wider section 33 are the latter’s remit for protection of property and financial affairs and the regard for the safety of others. This is an area of practice in which many difficulties have and will arise. Across Scotland there have been some imaginative ways for resolving these difficulties in managing adults’ finances and property under the 2000 Act and a case may be made for authorities finding a forum for sharing such practice, especially in the light of the extension to those duties under the new Act.

This poses the question, what actions may arise from an investigation under the 2003 Act? It may be that no further action is required. It may be that investigation indicates that the matter would best be dealt with through the 2000 Act, for example by application for welfare guardianship. It may be that some other broader remit is indicated, for example under section 12 of the Social Work (Scotland) Act 1968. Or it may be that investigation indicates a need to take other action under the 2003 Act, for example application for a Warrant of Entry, Emergency Detention or Short-term Detention, all discussed below.

So far in this discussion we have resisted pre-empting the policies that your local authority may draw up to advise its practitioners how to put section 33 into action. Indeed, it is far from clear at which stage in investigations MHOs will become involved. If the range of protocols for the 2000 Act is anything to go by, there will be a wide local variance in this matter. However, at the point of taking matters further into the 2003 Act, all routes require the involvement of an MHO. Therefore, any local policy must have good communication between MHOs and other systems such as care management.

While we have been at pains to guide rather than constrain your thinking on how to create policies and protocol on investigations, we would draw your attention to one matter. Between investigations under the 2000 Act and inquiries under the 2003 Act, the various routes to compulsion can be confusing. and generally speaking, the process would be greatly facilitated by the routine involvement of an MHO at an early stage in the process, if only to provide their specialist knowledge and experience. Therefore, careful consideration is required in your policies in relation to when to remit inquiry/investigation to MHOs and when to make it a general duty. As we have suggested, the demands that the 1995, 2000 and 2003 Acts impose upon MHOs are so great that this judgement needs to be balanced against the potential workload were you to determine that only MHOs may make any such investigations. What will be essential, however, is to ensure that the knowledge and expertise of an MHO informs individual inquiries if they are not driving the process themselves.

The other link to good communications lies in the section 34 duty on local authorities to co-operate with the Commission, the Public Guardian (because of the protection of property and financial affairs), the Care Commission (in respect of registered care homes etc) and NHS Boards.

#### **4.5 Further issues at the interface between MHOs and other systems:**

**Section 227** of the 2003 Act gives the MHO authority to notify the local authority of any situation in which a mentally disordered person appears to be in need of community care services. In such a case the person must become subject to an assessment of needs under section 12A of the 1968 Act. The 2003 Act further inserts a comparable power for the MHO to require the local authority to make an assessment of needs of a child into section 23 (3) of the Children (Scotland) Act.

These matters raise two issues. The first is the need to create a clear protocol to manage the interface between MHO and adult care/children and families services in relation to assessment of needs and provision of services.

The second matter is less clear cut but requires articulation. At one end of the spectrum, the MHO notifying the local authority under section 227 may also be the care manager who will make the assessment of needs. It is not unusual for MHOs to wear both hats even if at times there may be a potential conflict in these roles. The MHO, who is a mental health expert within the local authority, may find him/herself in conflict with the employing authority over the extent of need and the services required to meet the need of an individual service user. Local procedures and protocols should to be drafted in consultation with your body of MHOs to manage

such eventualities. Such protocols ought to acknowledge the MHO's duty to raise matters with the Commission, the Tribunal or the Court where s/he sees fit, even where such matters result from conflict with the employing authority.

This latter point hints at a matter about which some employing authorities may feel less comfortable. Section 227 clearly embodies the underlying legal principle that the MHO stands outside the normal line management authority in terms of making decisions and exercising powers under mental health law. While the local authority may instruct any care manager to determine the level of need they are able to meet in service provision, it has no such power should the extra-ordinary situation arise in which the MHOs judgement causes a dispute of opinions with the employing authority.

Under section 228, there is a similar extension to the duties on the local authority to respond to requests from users of services and carers for assessments of their needs in relation to the 2003 Act.

#### **4.6 The question of MHO autonomy:**

This question of the relative autonomy of MHOs is a point of legal theory that has long been considered by MHOs themselves. The 2003 Act places it in sharper focus in that MHOs are bound to make decisions, which in their expert judgement reflects the principles. While the local authority itself is no less bound by the principles, it has other priorities to juggle and it may not be placed in such close proximity to the principles in relation to any one individual case. It may therefore cause any of its MHO practitioners to justify a decision made in relation to the principles, but, unlike any other of its employees, it may not instruct the MHO to make a decision in any given way.

It is therefore to be anticipated that there is scope for conflict between MHOs and their employing authorities over resource implications of assessments of need and over services that ought to be provided for 'patients' subject to measures of compulsion.

Another factor to bear in mind, however, is that an MHO must be an officer of the local authority, and as such the local authority which appoints the MHO is accountable for ensuring the quality of service of individual MHOs. Under section 32, in fact, the local authority is under a duty to terminate the appointment of an MHO ( as an MHO, not as a social worker ) if the MHO does not satisfy any of the requirements stipulated in Directions by Scottish Ministers relating to education, training, experience, competence or any other matters that may be specified in Directions. The tension for local authority managers rests between monitoring and ensuring the quality of its Mental Health Officer service and the competence of its individual MHOs while respecting their autonomy and independence in respect of decision making under the relevant pieces of legislation. The tension for MHOs will be trying to implement the legislation as intended and trying to secure a full complement of services to meet the needs of individual service users while not disregarding the realities of resourcing issues in their authority. The recording of unmet need by MHOs should be addressed and may well be a helpful way of moving things forward.

In emphasising both the local authority responsibility for its MHO service provision and the need to achieve greater consistency in the level and quality of MHO services across the country, the Scottish Executive, as mentioned earlier, is developing National Service Standards for Mental Health Officer Services. A copy of the Draft Standards sent out for consultation is attached in Annex B in this paper.

#### **4.7 Section 35 warrants of entry:**

Good local guidance will also be required for MHOs and others on how to effect warrants of entry. The MHO is the applicant to a sheriff or justice of the peace for such a warrant if denied or obstructed access to a person who is subject to a section 33 inquiry. Those managers familiar with section 117 of the 1984 Act will be aware of certain issues. For example, while the warrant authorises the police to gain entry, if need be by force, it is not stated who will be responsible for repairing damage to property in such an eventuality. In guidance for section 35 warrants, the local authority may find benefit in devising protocols in conjunction with their legal advisors, the police and the sheriff clerk's office.

#### **4.8 Detention and compulsion under civil procedures:**

Were we to go into the detail of Emergency and Short-term Detentions and applications to the Tribunal for Compulsory Treatment Orders, this guide would be lengthy indeed. Relatively few managers will need to know the details of these matters. Should you be the exception to this case, we direct you to Annex A in this paper as well as Readers 1 to 3 of the transitional materials for MHOs in this series, to the Draft Code of Practice for the 2003 Act and to the 2003 Act itself. What we propose to do here is to give you the briefest outline of these powers and the duties that they place upon MHOs, so that you may understand the burden upon the MHO workforce as we have emphasised it in this guide so far.

While the largest number of people who arrived at receiving services by compulsion under the 1984 Act did so by the weakest route - Emergency Detention - that will not be the case under the new Act. The intention is that Emergency Detention for up to 72 hours will only be given in a minority of cases of true urgency. In a small minority of these cases where securing an MHO to assess for consent is not practicable, there will be grounds for granting Emergency Detention without MHO consent. In all other cases, MHOs will have to be involved in any measures of compulsion.

It should also be noted that MHO involvement will most likely be required shortly after the patient's admission under emergency certificate as it is a requirement that an Approved Medical Practitioner examine the patient as soon as practicable after admission on emergency certificate. The AMP will be considering the need for short term detention at that point which will require MHO input.

The Draft Code of Practice for civil procedures is very clear that any medical practitioner considering granting an Emergency or Short-term Detention certificate should not attempt to 'shop around' for consent if the MHO withholds it. However, the Draft Code advises that local authorities and health partners should devise protocols for any medical practitioner wishing to obtain a second MHO opinion.

Having such a system in place, responsive to need on a relatively speedy basis, would avoid placing undue stress upon doctor, MHO, patient, local authority and Health Services.

As an Interim route between 72 hour Emergency Detention and the more extensive CTO, the Act proposes Short-term Detention as the primary route of compulsory admission to hospital. Such detentions require the consent of an MHO in every case. It is valid for up to 28 days.

The CTO is an order made by the MHO's application to the Tribunal for wide ranging and extensive measures of compulsion that may be delivered in hospital or community. As we have already suggested, the workload for MHOs in its application and maintenance will be high.

#### **4.9 Criminal justice and the mentally disordered offender:**

The 2003 Act has been an opportunity to overhaul the provisions for mentally disordered offenders under the Criminal Procedure (Scotland) Act 1995. As such the 2003 Act inserts sections into the 1995 Act giving greater flexibility to the disposals available to courts in meeting the needs of criminal justice and the needs of the mentally disordered offender, reflecting the 2003 Act's potential to compel care and treatment to be received either by detention in hospital or within the community. The 2003 Act also establishes ways in which these court orders may be managed by health and social care professionals within Mental Health Services. For the purposes of the local authority, this places a burden on MHOs preparing Social Circumstances Reports to advise the responsible Medical Officer and in preparing reports for the court for specific applications that may be compared with the applications to the Tribunal for CTOs (as discussed above).

For your purpose as a manager, this carries a complexity of issues. Virtually all local authority criminal justice services are now managed separately from Adult Care Mental Health Services. It therefore poses significant questions:

- How may the two services relate, given that an offender dealt with in court may be compelled to receive services managed by adult care;
- Where services lack sufficient criminal justice workers who are also MHOs, how may the MHO services provide sufficient cover for courts; and
- In situations where criminal justice workers are managing cases which become subject to mental health matters arising out of the 1995 and 2003 Acts, how can the two services relate?

In the newly inserted sections of the 1995 Act in relation to Compulsion Orders, the wide ranging detention or community based orders made by the courts, there is an expectation that the MHO will advise the court of the availability of community based services required to be delivered to the offender by compulsion or otherwise. This highlights some of the problems of the fragmented service across the criminal justice/adult care divide. Presumably most adult care managers would strongly wish to devise protocols to avoid any MHO committing precious community care services without prior consultation and approval.

#### **4.10 Collation of data:**

The Scottish Executive Social Research Unit is undertaking a programme of research into the 2003 Act. The purpose is to get an overall picture of developing practice under the Act. This will contribute to the evaluation of services and the development of evidence based practice amongst other things. It will assist local authorities in monitoring costs and it will facilitate the general duties of a range of organisations and bodies to co-operate with each other. In furtherance of these goals, the Mental Welfare Commission hopes for a robust system for NHS Boards and local authorities to identify data such as ethnic background of patient's subject to compulsory measures.

National Service Standards for MHO Services are likely to address the need for local authorities to routinely collect and monitor data on all MHO activity as this is seen as information essential to the proper development, resourcing and day to day management of the service

## ANNEX A

### MENTAL HEALTH OFFICER DUTIES/ROLE UNDER 2003 ACT

#### Warrant to Obtain Entry

- Under **Section 35** there are three separate warrants which an MHO may seek in order to carry out the local authority's duty to inquire under Section 33: **Section 35(1)** is to provide access to premises; **Section 35(4)** is to detain a person for up to three hours for the purpose of facilitating a medical examination; and, **Section 35(7)** is to give access to a patient's medical records.

#### Emergency detentions

- Consent of relatives and / or nearest relatives no longer included in the Act in decisions about (**Section 36**) emergency (72hr) and (**Section 44**) short term (28 day) detentions.
- Consent of MHO required wherever practicable for emergency detentions.
- Under **Section 38**, an Approved Medical Practitioner must see patient as soon as practicable after admission under emergency detention certificate. This will lead to them requesting input from MHO re consent to short term detention in many cases.

#### Short-Term Detentions

- Under **Section 44** MHO consent is mandatory for short term detention. No longer is impracticability of securing consent able to be cited by medical practitioner.
- Under **Section 45** the MHO must, where practicable, interview patient prior to deciding whether to consent to short term detention. MHO also must ascertain the name and address of the patient's named person; inform the patient of the availability of independent advocacy services; and, take appropriate steps to ensure the patient has the opportunity of making use of these services.
- If it is impracticable for the MHO to interview the patient and ascertain the name and address of the patient's named person before consenting to the granting of the short-term certificate, the MHO must also record the steps taken in relation to these duties related to the process of consideration of short term detention and give a copy to the AMP within 7 days from when first consulted by the AMP re consent to short term detention.

## **Extension of Short-Term detention**

- Under **Section 47**, consent from an MHO must be obtained, wherever practicable, before an extension of a short term detention certificate pending an application for a compulsory treatment order can be granted. Under **Section 48** the RMO must notify the Tribunal of the extension and indicate whether the consent of the MHO was obtained, and, if not, the reasons why it was impracticable to consult an MHO.

## **Revocation of Short-Term Certificates**

- Under **Section 50**, the Tribunal must give the MHO who consented to the short term detention certificate the opportunity of making representation orally or in writing and of leading or producing evidence when a patient seeks to have the short term detention certificate revoked. The Tribunal may extend this right to any other MHO if the Tribunal feels that person has an interest in the application. This leaves it open for a designated MHO to be involved even if not the MHO who consented to the short term detention.
- Where an RMO revokes a short term detention certificate s/he must give notice under **Section 49** as soon as practicable to the MHO.
- Where the MWC revokes a short-term detention certificate they must give notice under **Section 52** to the MHO.
- Where the patient applies for a revocation of the short-term detention certificate, the MHO who consented to the short-term detention certificate would be given the opportunity to give evidence and may have to appear before the Tribunal.

## **Revocation of certificate suspending measure authorising short-term detention**

- Where an RMO grants a certificate specifying a period during which the short-term detention certificate is suspended, and subsequently revokes this certificate under **Section 54**, the RMO must as soon as practicable after doing so give notice to the MHO.

## **Compulsory Treatment Orders**

- Under **Section 57** a MHO must apply for a Compulsory Treatment Order when in receipt of the relevant mental health reports from two medical practitioners. MHOs play a key role in the decision to apply for a compulsory treatment order as well as the related process of making the application.
- The MHO applicant must prepare a report, a proposed care plan and an application based on these as well as the 2 accompanying mental health reports. They must coordinate all this within a very tight timeframe – within 14 days of the last medical examination for the purposes of the mental health report.

- In preparing the Mental Health Officer's report for the purposes of an application under **Section 61**, the MHO must interview the patient and inform them of their rights in relation to the application as well as the availability of independent advocacy services and must take appropriate steps to ensure that the patient has the opportunity of making use of these services. If meeting these duties proves impracticable, the MHO must state the reason why this was the case in the MHO report. The MHO must also, as soon as practicable after the duty to make the application arises and, in any event, before making the application, take such steps as are reasonably practicable to ascertain the name and address of the patient's named person which is needed for the MHO report.
- Under **Section 62** an MHO must prepare a proposed care plan and in doing so must consult the medical practitioners who provided the mental health reports, and, where practicable, all relevant persons providing the medical treatment, community care services or other relevant services as outlined in the proposed care plan. Close attention must be paid to the considerable requirements in respect of proposed care plans outlined in **Section 62**.
- Under **Section 60**, the MHO must give notice in writing to the patient, the patient's named person and the Commission of their intention to make an application and they must do this as soon as practicable after that duty arises. The MHO can over-ride the RMO's decision not to give notice to the patient if they consider it appropriate to do so.
- The Tribunal before making a decision must afford the MHO applicant the opportunity of making representations either orally or in writing and of leading or producing evidence. The Tribunal system will result in closer scrutiny of the assessment and care planning process. This will result in a higher level of accountability for MHOs as well as others involved in the process.

### **Interim Compulsory Treatment Orders**

- Where an application for a CTO is made under **Section 63**, anyone with an interest in the proceedings (therefore including an MHO) may apply to the Tribunal for an Interim Compulsory Treatment Order. Before making an interim order the Tribunal must afford any person having an interest in the application – which obviously includes Mental Health Officers – the opportunity of making representations either orally or in writing and of leading or producing evidence.

### **Measures that may be authorised by the Tribunal**

- The Tribunal may impose a requirement on the patient under **Section 66** to allow the MHO (or others involved in their care and treatment) to visit the patient in the place where the patient resides.
- The Tribunal may also impose a requirement on the patient to obtain the approval of the MHO to any proposed change of address.

- The Tribunal may further impose a requirement on the patient to inform the MHO of any change of address before the change takes effect.

### **Hospital Direction or Transfer for Treatment Directions**

- Following the imposition of Hospital Directions and Transfer for Treatment Directions, procedures in respect of CTOs and the involvement of MHOs will pertain as outlined in Schedule 3 to the Act.

### **Interim Compulsory Treatment Orders: Review and Revocation**

- Where an Interim CTO is revoked by either the RMO or the MWC they must under **Section 74 and** as soon as practicable after doing so, give notice of the determination and the reasons for it to the Mental Health Officer.

### **Reviews, Extensions, Variations and Revocations of CTOs**

- **MHO involvement is required in all reviews, extensions, variations and revocations of detention/compulsory treatment. Where the Tribunal makes any determination in respect of an order, they must first afford the MHOs an opportunity of making representation orally or in writing and of leading or producing evidence. The Tribunal may require the MHO to prepare and submit reports in relation to any determinations.**
- The RMO has a responsibility to consult the MHO in carrying out all first mandatory reviews of CTOs as outlined in **Section 77(3)(c)(i)**.
- The RMO must consult the MHO when carrying out further mandatory reviews under **Section 78**.
- Under **Section 82** the RMO and the MWC must notify the MHO whenever they revoke a CTO.

### **Extension of CTO ( a 'Section 86 determination')**

- Under **Section 84**, the RMO must give notice to the MHO of the intention to extend a CTO. This triggers the MHO's duties under **Section 85** to interview the patient (wherever practicable) and to inform the patient in all cases of the RMO's intent, their rights in relation to this, and the availability of independent advocacy services. The MHO must also take appropriate steps to ensure that the patient has the opportunity of making use of those services.
- Following the interview of the patient when notified of the RMO's intent to extend the order, the MHO must advise the RMO of whether they agree with this decision and, if not, why not. The MHO must also inform the RMO of any other matter they consider relevant to the proposed extension. These views will then be expressed in the record made by the RMO of the extension which is forwarded to the Tribunal, the patient (unless the RMO feels that doing this would present a risk of significant harm to the patient), the patient's named

person, the MHO and the Commission. The RMO must also record where the MHO failed to comply with their duties under **Section 85**.

- Where the MHO disagrees with the proposed extension of the order or has not advised the RMO of their views as required, the Tribunal must review the determination under **Section 101**. In such cases the MHO must be afforded the opportunity of making representations either orally or in writing and of leading or producing evidence.
- Similar procedures follow from the Tribunal's responsibility to review an order when they have not been involved in a determination in respect of the patient during the past two years.

#### **Extension and Variation of CTO ( a 'Section 92 application' )**

- Under **Section 88**, where an RMO is reviewing an order and feels that it needs to be extended and the order itself amended by modifying the compulsory measures, or any recorded matter, specified in it, the RMO must give notice to the MHO of the propose application. This then triggers off duties for the MHO which are the same duties as when an order is merely extended. The RMO's subsequent application under **Section 92** must indicate whether the MHO agrees or disagrees with the application, and, if the MHO disagrees, the reason for this. Alternatively, the RMO must state where the MHO has failed to comply with their duties under **Section 89**.
- Where any person having an interest in the above proceedings makes an application to the Tribunal or the Tribunal itself considers that it would not be able to determine the application before the CTO expires, it may grant an interim order under **Section 105** extending the order or extending and varying the order for a period not exceeding 28 days.
- The **Section 92** application will be reviewed by the Tribunal and, before making a decision, the Tribunal must afford the MHO the opportunity of making representations orally or in writing and of leading or producing evidence.
- Regulations under **Section 92(b)** require an MHO to prepare a report for the Tribunal

#### **Variation of CTO (a 'Section 95 application')**

- **Section 93** requires the RMO from 'time to time' to consider whether the CTO should be varied by modifying the measures in it. If it appears to the RMO that this is the case, they must consult the MHO. If the RMO subsequently applies to the Tribunal under **Section 95**, the same rules apply in respect of the MHO as was the case with an application under **Section 92**.
- Regulations made under Section 95(b) require an MHO to prepare a report for the Tribunal.

### **Failure to provide recorded matter specified in the CTO**

- Under **Section 96** if it appears to the RMO that a service specified in a recorded matter is not being provided, they are under a duty to consult the MHO as soon as practicable and if satisfied that the recorded matter is not being provided must make a reference to the Tribunal, giving notice to the MHO when they do so.
- **Section 98** also gives the MWC the authority to make reference to the Tribunal where they feel it is appropriate.
- When a reference is made to the Tribunal under **Section 96 or 98**, the Tribunal can vary the CTO by modifying the measures or any recorded matter specified in the order, or can revoke the order. Before making a decision, the Tribunal must afford the MHO the opportunity of making representations orally or in writing and of leading or producing evidence.

### **Application by patient for revocation of determination extending CTO or varying CTO**

- Under **Sections 99 and 100** a patient is given authority to apply to the Tribunal for an order under Section 103 revoking the RMO's determination to extend the order (**S.99**) or vary the order (**S.100**). Before making a determination on the application, the Tribunal must first afford the MHO the opportunity to make representation orally or in writing and of leading or producing evidence.
- The Tribunal can also approve interim extension and interim variation orders for a period not exceeding 28 days.

### **Powers of Tribunal to require report from MHO**

- Under **Section 109** the Tribunal is given the authority when considering applications under **Sections 92, 95, 99 or 100** to require an MHO in circumstances to be prescribed by Regulations to prepare and submit a report to the Tribunal.

### **Breach of Orders Reports**

- **Section 112** concerns situations where a patient subject to a compulsory order or interim compulsory treatment order which imposes an attendance requirement for medical treatment fails to comply with this, the RMO may take or authorise a person to take the patient into custody and convey them to any hospital or the place the patient is required to attend and detain them there for no longer than 6 hours only if the RMO consults the MHO and the MHO consents to this.

## **Detention pending review or application for variation**

- When a patient is detained in hospital under **Section 113** for up to 72hrs for general non-compliance with a community-based compulsory treatment order or community-based interim compulsory treatment order and when the RMO is considering whether the order should be varied by modifying the measures in it or is required to make an application to the Tribunal and when the RMO feels that if the patient did not remain in hospital there would be a significant deterioration in the patient's mental health, the RMO can under **Section 114** grant a certificate authorising the continued detention of the patient in hospital for up to 28 days but only if s/he first consults the MHO and the MHO consents to this.

## **Suspension of Detention**

- Before an RMO under **Section 127** grants a certificate suspending the detention of a patient in hospital where this is a measure included in the CTO or Interim CTO for a period of more than 28 days, s/he must give notice to the MHO (and others) before granting the certificate.

## **Suspension of Other Measures**

- Before an RMO under **Section 128** grants a certificate suspending any measure other than detention in hospital this is limited to a period of three months, s/he must first give notice to the MHO (and others) of the measures and the period that s/he proposes to specify in the certificate and the reasons for proposing to specify these measures

## **Revocation of Suspension of Measures**

- When the RMO revokes a suspension of measures s/he must as soon as practicable after doing so give notice to the MHO (and others).

## **Social Circumstances**

- **Section 231** requires MHOs to provide to the MWC and the RMO a Social Circumstances Report within 21 days of a 'relevant event' occurring, unless they formally state in writing to the patient's RMO and the MWC why doing so would serve little, or no, practical purpose. Regulations will prescribe the content of SCRs.
- Relevant events include:
  - The granting of a short term detention certificate and the making of:
  - Interim compulsory treatment orders;
  - Compulsory treatment orders;
  - Assessment orders;
  - Treatment orders;
  - Interim compulsion orders;
  - Compulsion orders;
  - Hospital directions; and

- Transfer for treatment directions.

### **Assessment of needs for community care services**

- **Sections 227 and 228** essentially state that when an MHO believes that a patient (i.e. anyone with a mental disorder) may be in need of community care services and requires a formal assessment of needs under **Section 12A** of the Social Work (Scotland) Act 1968, or believes that the needs of a child should be formally assessed under the Children (Scotland) Act 1995, they can request in writing to the local authority that this assessment takes place. This then places the local authority under a duty to respond within 14 days whether they intend to undertake the assessment, and, if not, the reason why this is the case. Similarly, if the MHO believes that the patient has need for services provided by a Health Board, they are given the authority to make a request for an assessment of these needs to the Health Boards who must respond within 14 days as to whether they intend to undertake the assessment, and, if not, the reasons why.

### **Designation of Mental Health Officer**

- **Section 229** requires the local authority as soon as reasonably practicable after the occurrence of a relevant event to designate an MHO who has responsibility for the case for as long as the patient is subject to the certificate, order or direction to which the relevant event relates. At any point in time the local authority can appoint another MHO in place of the designated MHO.

### **Consultation re certificates relating to Consent to Treatment**

- **Section 245** requires RMOs to consult with any person who appears to be principally concerned with the patient's medical treatment before granting a certificate under **Sections 235, 236, 239 and 241**. Given the definition of medical treatment in **Section 329**, this **may** involve an MHO.

### **Named Person**

- **Section 255** outlines the MHO's duties in respect of named persons, some of which have been referred to within the specific relevant event sections above. This section spells out that where an MHO either establishes that the patient has no named person, or is unable to establish whether they have a named person, they must make a record of the steps as were reasonably practically taken to determine whether the patient had a named person and who that person is. In doing so they must as soon as practicable give a copy of this record to the Tribunal and the MWC.
- **Section 257** gives the MHO the authority to make an application to the Tribunal requesting the appointment of a person named on the application to be appointed as the named person or the acting named person where they have established that the person does not have or appear to have a named

person or where the named person or apparent named person appears an inappropriate person to act as the named person.

### **Detention in conditions of excessive security**

- When an application is made to the Tribunal under **Section 264** declaring that the patient is being detained (in the State Hospital) in conditions of excessive security, before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and to lead or produce evidence.
- Where a Tribunal makes an order under **Section 264** requiring a Health Board to transfer the patient to another hospital within 3 months and the Health Board fails to do so, **Section 265** requires that there be a hearing before the Tribunal and the Tribunal may decide if they feel that the patient does not require to remain in conditions of excessive security to specify that the Health Board transfer the patient to a suitable hospital within a period of 28 days. Before making such a determination, however, the Tribunal must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.
- **Section 266** relates to situations where the Health Board again fails to transfer the patient and another hearing before the Tribunal requires to be held. Again, before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and to lead or produce evidence.
- Where an application is made by Scottish Ministers, a Health Board or (in certain cases) an RMO to the Tribunal to recall an order made under **Sections 264, 265 or 266**, before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and to lead or produce evidence.
- **Sections 268, 269, 270 and 271** outline processes which are the same as those outlined above except they relate to situations where the patient is detained in conditions of excessive security in a hospital other than the state Hospital.

### **Duty to minimise impact of compulsion on parent/child relationships**

- **Section 278** places a duty on MHOs as well as others exercising functions under the Act to take all reasonable and practicable steps to limit the effects of compulsory powers on the relationship and contact between a parent and child, whether it is the parent or the child who is subject to compulsion under the Act.

### **Cross-border transfer of patients subject to requirements other than detention**

- **Section 289** gives authority for Regulations to be made in connection with the removal of a patient subject to a community-based compulsory treatment

order to a place outwith Scotland. These Regulations can require the RMO to authorise a warrant in respect of such a transfer. The RMO in such circumstances must first notify the Mental Health Officer.

### **Cross-border transfer of patients subject to detention requirement or otherwise in hospital**

- Where Regulations make provisions under **Section 290** in respect of the cross-border transfer of certain patients, a warrant issued by Scottish Ministers is required authorising the transfer. Scottish Ministers are required to notify MHOs in such circumstances at least 7 days before the date proposed for the patient's removal. Regulations under **Section 290(1)** may require the provision of an MHO report following transfer of patient to Scotland.

### **Applications to Tribunal in relation to unlawful detention.**

- An MHO may apply to the Tribunal for an order requiring the managers of a hospital to cease to detain a patient who is in hospital on an informal basis.

### **Warrant to enter premises for purposes of taking patient**

- Under **Section 292** a warrant may be granted by a sheriff, or justice of the peace authorising any MHO (and any other duly authorised person) to enter the premises specified in the warrant for the purposes of an authorised person taking the patient to any place or taking or retaking into custody the patient where the patient is liable to be taken or retaken. The authorised person in this context relates to a person who has already been authorised by another provision of the Act to take a patient into custody (for example, where the patient has absconded).

### **Removal Order**

- **Section 293** gives MHOs the authority to apply to a sheriff for an order to remove a person to a place of safety where it is believed that the person has a mental disorder and is subject or exposed to ill-treatment, neglect or some other deficiency in care, or treatment or because of the mental disorder the person's property is suffering loss or damage or is at risk of suffering loss or damage, or where the person is living alone or without care and is unable to look after himself or his property or financial affairs. The removal order can authorise the MHO before the expiry of 72hrs to enter the premises, to remove the person to a place of safety and to detain the person in that place for a period not exceeding 7 days.
- **Section 294** allows the MHO to apply to a justice of the peace where making an application to the sheriff is impracticable or would cause a delay that would likely be prejudicial to the person who would be the subject of the application.
- **Section 295** stipulates that an application can be made to the sheriff to recall the removal order. Regulations stipulate that the sheriff before deciding on the

application must afford an MHO the opportunity to make representations and lead or produce evidence.

### **Nurses' power to detain pending medical examination**

- **Section 299** gives nurses of a prescribed class the authority to detain a patient in hospital for a period of up to two hours for the purposes of enabling arrangements to be made for a medical examination of the patient to be carried out and where they do to inform a mental health officer as soon as practicable after the holding period begins.

### **Absconding**

- Under **Section 303** an MHO is specified as a person who has authority to take into custody any patient liable to be taken into custody who has absconded. They are also given authority to return the patient to the hospital in which the patient was or was to be or if that is not appropriate, any other place considered appropriate by the patient's RMO detained. The MHO may also take the patient to such other place as they absconded from or at which they failed to reside, or, if not practicable, to any other place considered appropriate by the patient's RMO.

### **Long unauthorised absences ending more than 14 days before expiry of Compulsory Treatment Order**

- **Section 305** pertains where the unauthorised absence of a patient has lasted longer than 28 consecutive days and ceased before the beginning of 14 days ending with the day when the compulsory treatment ceases to authorise the measures specified in it. In such circumstances, the order ceases to have effect at the end of the 14 days when the patient's unauthorised absence ended. Within this 14 day period, the RMO must carry out a review in respect of the CTO and must consult the MHO in doing so.
- **Section 310** outlines procedures for patients on unauthorised leave who are liable to be detained or subject to compulsion under other procedures (Assessment Orders, Treatment Orders, Temporary Compulsion Orders under **Section 54**, Interim Compulsion Orders, and Compulsion Orders) and may involve an MHO.

### **False statements**

- **Section 318** makes it an offence for any person to knowingly make an entry or statement which is false in a material particular or with intent to deceive, makes use of any such entry or statement knowing it to be false.

## CRIMINAL PROCEDURES ACT PROVISIONS

### Assessment Orders

- **Section 52D of the CP(S) Act 1995 (Assessment Order)** is a 'relevant event' under Section 232 and as such requires the appointment of a 'designated MHO' (S 229) and the provision of an SCR unless the designated MHO states in writing to the RMO and MWC why providing such a report would serve little, or no, practical purpose.

### Treatment Orders

- **Section 52M of the CP(S) Act 1995 (Treatment Order)** is also a 'relevant event' and places the same responsibilities re the appointment of a 'designated MHO' and the subsequent provision of an SCR as under Section 52D.

### Interim Compulsion Orders

- **Section 53 of the CP(S) Act 1995 (Interim Compulsion Order)** is also a relevant event and imposes the same duties as above.

### Compulsion Orders

- Generally speaking, the duties placed upon MHOs and upon RMOs are the same after someone has been made subject to a Compulsion Order as they are after someone is made subject to a Compulsory Treatment Order.
- Under **Section 57C of the CP(S) Act 1995** a Mental Health Officer's report may be required by the Court when considering a Compulsion Order. In such cases an MHO is required to interview the offender wherever practicable and prepare a report stating the name and address of the offender; if known, the name and address of the offender's primary carer; in so far as relevant for the purposes of this section of the Act, details of the personal circumstances of the offender; and any other information the MHO considers relevant for the purposes of that section.
- Under **Section 232** a Compulsion Order is a 'relevant event' and as such requires the appointment of a designated MHO and the provision of a social circumstances report by a Mental Health Officer for the RMO and the MWC within 21 days after the order is imposed (unless the MHO states in writing to them why they feel providing such a report would serve little, or no, practical purpose).
- **Section 138** imposes a duty on MHOs as soon as practicable after a Compulsion Order is made to take such steps as are reasonably practicable to ascertain the name and address of the patient's named person.

## Mandatory reviews of Compulsion Orders by RMO

- **Section 139** consultation with MHO by RMO required re first review of order.
- **Section 140** consultation with MHO by RMO required re further reviews.
- **Section 141** consultation with MHO by RMO required before making a determination during mandatory reviews that the patient no longer meets the criteria for continued detention and revokes the order.
- **Section 144** notification to MHO of revocation of order required by RMO.
- **Section 145** consultation with MHO by RMO required re mandatory reviews of order.
- **Section 146** consultation with MHO by RMO required where there is a proposed extension of order at first review.
- **Section 147** imposes duties on MHO triggered by above. MHO must interview the patient wherever practicable and must, in any case, inform the patient of the RMO's proposal, of their rights in relation to the proposed application, and of the availability of independent advocacy services. They must also take appropriate steps to ensure that the patient has the opportunity of making use of those services. In addition the MHO must inform the RMO as to whether the MHO agrees or disagrees with the proposed application and if they disagree, the reasons why this is the case and must inform them as well of any other matters that the MHO considers relevant. The RMO must inform the Tribunal in any subsequent application under **Section 149** of the MHO's views and why they disagree with the order if they do. They must also advise the Tribunal in the application where the MHO failed to comply with the duties imposed by **Section 147**.
- In any application to the Tribunal under **Section 149**, before making a determination the Tribunal must first afford the MHO the opportunity of making representation orally or verbally and of leading, or producing, evidence.
- **Section 150** consultations with MHO by RMO required in respect of proposed extension of order at further reviews.
- **Section 151** imposes duties upon the MHO triggered by above which are the same as those imposed under **Section 147**.
- **Section 152** imposes a duty on RMOs to consult with the MHO during further reviews of the order before making a determination.
- **Section 153** requires that the RMO give notice to the MHO (as well as the patient, the patient's named person, the Tribunal and the MWC) of the determination that the order is to be extended. The RMO must also advise the Tribunal of whether the MHO agrees or disagrees with the determination and if they disagree, the reasons for this. They must also advise the Tribunal

where the MHO failed to comply with their duties under **Section 151**. Where the MHO disagrees the Tribunal has a duty under **Section 165** to review the determination. Before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

### **Extension and variation of Compulsion Order**

- **Section 154** requires the RMO to give notice to and consult with the MHO where the RMO is proposing extending and varying the order.
- **Section 155** imposes duties on MHO triggered by above which are the same as under **Sections 147 and 151**.
- **Section 157** places a duty on RMOs to give notice to MHOs where an application is to be made extending and varying a compulsion order. The application must state whether the MHO agrees or disagrees that the application should be made and if they disagree, the reasons why they do.
- **Section 158** requires that the Tribunal, before deciding on an application for an extension and variation of a Compulsion Order, must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

### **Variation of Compulsion Order**

- **Section 159** imposes a duty on RMOs to consult with MHOs as soon as practicable but before deciding to make an application when it appears to them that the compulsion order should be varied by modifying the measures specified in it.
- Any subsequent application under **Section 161** must include a statement as to whether the MHO agrees or disagrees with the application, and if they disagree, the reasons for this. The application must also indicate where the MHO failed to comply with the duties imposed under **Section 159**. Before making a decision the Tribunal must afford the MHO the opportunity of making representation orally or in writing and of leading or producing evidence.

### **Reference to Tribunal by MWC re Compulsion Orders**

- **Section 162** requires the MWC to give notice to the MHO when they refer a case to the Tribunal. In such circumstances the tribunal may make an order varying the compulsion order in respect of which the reference is made, or revoking the order. Before making a decision the Tribunal must give the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

### **Application to Tribunal by patient/named person for revocation of extension and/or variation of Compulsion Order**

- **Section 163** relates to the Tribunal's duty to review a determination to revoke an extension of a compulsion order. Before making a decision, the Tribunal must afford the MHO the opportunity of giving evidence orally or in writing and of leading or producing evidence.
- **Section 164** relates to situations where the patient or the patient's named person applies to the Tribunal to revoke a compulsion order or vary it by modifying the measures specified in it. When this happens, before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

### **Application for Interim Variation of Order by person with interest in proceedings**

- Under **Section 169**, an MHO would be considered to be a person with an interest in the proceedings under the above sections and as such could make an application to the Tribunal to make an interim order (for up to 28 days) varying the compulsion order by modifying the measures specified in it.

### **Failure to attend for medical treatment when attendance requirement is specified in Compulsion Order**

- **Section 176** effectively states that **Section 112** in respect of patients subject to Compulsory Treatment Orders and the consequent involvement of MHOs applies to same situation where patients are subject to Compulsion Orders.

### **Non-compliance generally with Compulsion Order**

- **Section 177** effectively states that the civil provision sections of the Act relating to non compliance generally with Compulsory Treatment Orders and the consequent involvement of MHOs applies to same situation where patients detained under Compulsion Orders.

### **Compulsion Orders and Restriction Orders**

- **Section 181** applies where a person is subject to a Compulsion Order and a Restriction Order and imposes a duty on the MHO to take such steps as are reasonably practicable to ascertain the name and address of the patient's named person.

### **Review of Compulsion Order and Restriction Order**

- **Section 182** requires the RMO to consult with the MHO in undertaking their mandatory annual review of patients subject to a Compulsion Order and a Restriction Orders.

## **Reference to Tribunal by Scottish Ministers re Compulsion Order and Restriction Order**

- **Section 185** relates to situations where an RMO has submitted a report to Scottish Ministers under **Section 183 (2)** that includes a recommendation that the Compulsion Order be revoked or has submitted a report under **Section 184**. In such circumstances Scottish Ministers must make a reference to the Tribunal and must as soon as practicable give notice to the Mental Health Officer that a reference is to be made.
- Under **Section 186** the MWC has authority to require Scottish Ministers to make reference to the Tribunal in respect of a person subject to a Compulsion Order and a Restriction Order. In such cases Scottish Ministers are required under **Section 187** as soon as practicable after receiving notice from the Commission to make reference to the Tribunal. When reference is made, Scottish Ministers must as soon as practicable give notice to the MHO that the reference is to be or has been made.
- Where an application is to be made to the Tribunal by Scottish Ministers under **Section 191**, Scottish Ministers must as soon as practicable after the duty to make the application arises give notice to the MHO that the application has been or is to be made.
- Before the Tribunal makes a decision in relation to any reference made to it under **Sections 185(1), 187(2) or 189(2)** or any application under **Section 191 or 191(2)** they must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.
- Regulations under **Section 191** will require a report from the designated MHO to accompany all applications under Section 191.

## **Conditional Discharge of Person on Compulsion Order and Restriction Order**

- Where a patient has been conditionally discharged by the Tribunal under **Section 193** and the Tribunal imposes conditions on that discharge, Scottish Ministers have the authority under **Section 200**, if satisfied that it is necessary, to vary any of the conditions imposed by the Tribunal and must in such cases notify the MHO as soon as practicable of that variation.

## **Appeal to Tribunal by patient/named person against variation of conditions imposed on conditional discharge where patient was subject to Compulsion Order and Restriction Order**

- When Scottish Ministers do vary conditions as stated above, **Section 201** states that the patient and/or their named person may appeal this decision to the Tribunal within 28 days. Before making a decision on this appeal, the Tribunal must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

## **Appeal to Tribunal against recall from Conditional Discharge where persons were subject to Compulsion Order and Restriction Order**

- Where an appeal is made to the Tribunal under **Section 204** by the patient or their named person, before deciding on the appeal the Tribunal must afford the MHO the opportunity to make representation orally or in writing and of leading or producing evidence.

## **Hospital Directions and Transfers for Treatment Directions**

- Under **Section 59B** of the **Criminal Procedure (Scotland) Act 1995** a report by an MHO is required for the court when a Hospital Direction is being considered.
- **Section 205** requires the MHO as soon as practicable after the direction is made to take such steps as are reasonably practicable to ascertain the name and address of the patient's named person.
- Hospital Directions and Transfer for Treatment Directions are both 'relevant events' under Section 232 and as such require both the appointment of a designated Mental Health Officer (under S.229) and the provision of an SCR by that MHO (under S.231) unless, in the latter, the MHO states in writing to the RMO and the MWC why the provision of an SCR would serve little, or no, practical purpose.

## **Review of Hospital Direction and Transfer for Treatment Direction**

- **Section 206** places a duty on RMOs to consult with the MHO as part of the review of Hospital Directions or Transfer for Treatment Directions.

## **Reference to Tribunal by Scottish Ministers or the MWC re Hospital Directions and/or Transfer for Treatment Directions**

- **Section 210** requires Scottish Ministers to give notice to MHOs as soon as practicable where, upon receipt of a report by the RMO following a review of a Hospital Direction or a Transfer for Treatment Direction the decision is taken not to revoke the direction and a reference is to be made, as required, to the Tribunal.
- **Section 211** outlines the process to take effect when a notice is given by the MWC to Scottish Ministers under **Section 209**. Scottish Ministers must make a reference to the Tribunal as a result and must give notice to the MHO as soon as practicable after receiving notice from the MWC.

## **Reference to Tribunal by Scottish Ministers re Hospital Direction or a Transfer for Treatment Direction**

- When no reference or application to the Tribunal has been made during a period of two years, **Section 213** requires Scottish Ministers to make

reference to the Tribunal. In doing so they must as soon as practicable give notice to the MHO that a reference is to be made.

### **Application by patient/named person to Tribunal to revoke Hospital Direction or Transfer for Treatment Direction**

- **Section 214** gives patients and /or their named person the right to apply to the Tribunal to revoke a Hospital Direction or Transfer for Treatment Direction. Before making a decision the Tribunal must afford the MHO the opportunity to make representation orally or in writing and of leading or producing evidence.

### **Assessment Order: Suspension of measure authorising detention**

- Under **Section 221** the RMO may suspend the detention requirement of a patient on an Assessment Order and may include conditions seen as necessary in the interests of the patient. These conditions **may** involve the MHO, e.g. a condition that the patient grants access to an MHO. If an MHO is authorised under this section, the RMO then has a duty under **Section 222** to give them notice when the order is revoked. Similarly, when Scottish Ministers revoke the order under **Section 223**, they must also notify the MHO if they had been authorised under **Section 221**.

### **Suspension of measures authorising detention after other relevant events**

- **Section 224** relates to situations in respect of; Treatment Orders; Interim Compulsion Orders; Compulsion Order and a Restriction Orders; Hospital Directions; and, Transfer for Treatment Directions where the RMO grants a certificate specifying the suspension of the detention requirement for up to three months. When the period for which detention is to be suspended would exceed 28 days, the RMO must give notice of the proposal to the MHO. When the certificate is revoked under **Section 225**, the RMO must also give notice to the MHO. Similarly, where Scottish Ministers revoke this certificate, **Section 226** requires that they give notice to the MHO.

**DRAFT****NATIONAL SERVICE STANDARDS FOR  
MENTAL HEALTH OFFICER SERVICES****AUGUST 2004****STANDARD 1: RESPONSIVE SERVICES**

Those who require a Mental Health Officer (**MHO**), including service users, carers and relatives affected by mental disorder, can expect an efficient and helpful response and a comprehensive service following requests for an MHO to undertake duties in accordance with the Mental Health (Care and Treatment) (Scotland) Act 2003 (**the 2003 Act**), Criminal Procedure (Scotland) Act 1995 (**the CP(S) Act**) and the Adults with Incapacity (Scotland) Act 2000 (**the AWI Act**).

**CRITERIA****The local authority ensures that:**

- 1.1 Information on how to access the MHO service whenever needed is available in appropriate languages and formats according to service users' and carers' needs. This information is widely distributed and available to the general public and all relevant mental health professionals, primary health care teams, the police, the court service, and independent sector care staff.
- 1.2 Service users and, wherever relevant, carers are given information which explains the role of the 'designated' MHO (as outlined in section 229 of the 2003 Act) and their relationship to the multi-disciplinary mental health service as well as other sections of the local authority social work service.
- 1.3 Service users and relevant others are given information on how to contact a 'designated' MHO appointed under section 229 following the start of a period of compulsion ('a relevant event' defined in section 232 of the 2003 Act). This includes 'designated' MHOs who are appointed on an interim basis (e.g. to cover out-of-hours or annual leave periods) in respect of individual service users.
- 1.4 All service users subject to compulsion or being assessed for use of compulsory powers under the 2003 Act, the AWI Act or the CP(S) Act and, where appropriate, their named person, carers and nearest relative are given accessible information in the appropriate language and format. This should include information on the relevant sections of the legislation, their associated legal rights and information and assistance in securing legal advice and guidance as well as advocacy services. Information should be communicated both orally as well as in written form.
- 1.5 All service users and carers in contact with the MHO service are given information in the appropriate language and format. This should clearly explain the

range of services available for people affected by mental disorder, systems for community care assessment and contact numbers for advice.

1.6 All service users who are, or have been, subject to or assessed for use of compulsory powers under the 2003 Act or the AWI Act have care plans and/or proposed care plans which draw upon a range of care and support services appropriate to their needs and preferences. This includes services which:

- Protect their interests where they are vulnerable or at risk;
- Enhance the quality of their lives (as outlined in section 25 in the 2003 Act);
- Promote their health and well being (as outlined in section 26 in the 2003 Act); and
- Lessen to the extent possible the need for use of compulsion (in accordance with the principles of the 2003 Act and the AWI Act).

1.7 The local authority, together with partner agencies, monitors the availability of services to implement 'Proposed Care Plans' submitted to the Mental Health Tribunal as part of the application for Compulsory Treatment Orders and uses this information to inform the joint planning process. This applies as well to services required to meet the assessed needs of service users for whom the local authority holds welfare powers under the AWI Act.

1.8 There is a system for workload management for MHOs which addresses the appointment of designated MHOs under the 2003 Act and the allocation of statutory work. This system should ensure quick allocation and limit, to the extent possible, the changes in the designated MHO for any one service user during the period in which they are subject to compulsion.

1.9 Processes are in place for inviting and analysing feedback from service users, carers, relevant statutory services and other stakeholders on the operation and effectiveness of the local authority's MHO service. The analysis of this feedback is accessible to all interested parties.

1.10 Information available from the local authority's formal Complaints Procedures relating to the department's mental health and MHO services is used to inform changes to and developments in these services.

## **STANDARD 2: REFERRAL, ASSESSMENT AND ADMISSION PROCEDURES**

Service users and carers and others making a referral can expect that the local authority makes clear arrangements for assessment of individuals under the 2003 Act, the AWI Act and the CP(S) Act and instigates actions to meet assessed needs.

### **CRITERIA**

#### **The local authority ensures that:**

- 2.1 MHO assessments take full account of the person's past and present views, to the extent possible, with the assistance of the service user's advocate and named person where appropriate. All assessments should include consideration of any available Advance Statements, as well as the views of users and carers.
- 2.2 MHOs make use of all appropriate methods of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise) in interviewing service users.
- 2.3 MHO assessments take full account of the service user's strengths as well as their vulnerabilities and any associated risks to the person or others in developing appropriate care plans and determining whether compulsory powers under the relevant legislation are necessary to implement these plans.
- 2.4 The outcome of MHO assessments is recorded in case files and is communicated, to the extent appropriate and within the bounds of confidentiality, to the service user, their named person, the medical practitioner(s) involved in the assessment, the person's nearest relative, and the person's keyworker (where one exists).
- 2.5 There is a system for receiving and acting upon referrals for comprehensive community care assessments made by MHOs to the local authority under section 227 of the 2003 Act as well as other relevant legislation where the MHO is not carrying out this assessment.
- 2.6 MHOs make appropriate, competent and timely applications to the Mental Health Tribunal and Sheriff Court where required following assessments under the relevant legislation.
- 2.7 Where an MHO assessment does not result in the use of compulsion, or where compulsion ends, the MHO or another specified worker continues to assist the service user and their carers where necessary in arranging the care they may be assessed as needing.
- 2.8 The local authority monitors the extent to which MHOs' views inform the assessment and management of how a person's removal to hospital can be effected in the safest and least disruptive manner when consent has been sought from an MHO to an emergency or short-term certificate, or where an MHO has made an application for a compulsory treatment order.

The same should apply in respect of the circumstances in which the person is cared for while waiting to be removed to hospital.

2.9 MHOs seeking and executing warrants under the 2003 Act involve all relevant parties in determining how this can be carried out in the safest, most sensitive and least restrictive manner.

2.10 There is monitoring of the implementation of procedures relating to the securing and protection of property by local authority staff when a person is admitted to hospital or care under the 2003 Act, the AWI Act and the CP(S) Act.

## **STANDARD 3: CARE PLANNING AND CARE MANAGEMENT**

Service users who are subject to compulsion under the 2003 Act, the AWI Act and the CP(S) Act can expect that they will benefit from care management and/or Care Programme Approach systems which provide support through keyworking, monitoring and review.

### **CRITERIA**

#### **The local authority ensures that:**

- 3.1 The MHO service is integrated into the care management and service commissioning infrastructure across all age groups.
- 3.2 MHOs evidence that care plans and/or proposed care plans involve the minimum restriction on the freedom of the service user that is necessary in the circumstances.
- 3.3 MHOs routinely contribute to the assessment of risk and vulnerability for people subject to compulsion, or for whom compulsion under the 2003 Act, the AWI Act and/or the CP(S) Act is being considered. Associated care plans identify risk, the management of it, and action to be taken in response to changes in circumstances which may affect the risk and its management.
- 3.4 MHOs consult with all relevant parties in compiling a 'Proposed Care Plan' as part of the application to the Tribunal for Compulsory Treatment Orders, and invite professionals with specialist knowledge and experience to contribute to the assessment, care planning and reviewing of service user's care plans where necessary.
- 3.5 MHO assessments and subsequent care plans take account of the local authority's duties under the 2003 Act and AWI Act to make enquiries where an individual with mental disorder and/or their finances or property, may be or may have been vulnerable and/or at risk.
- 3.6 Care plans for service users subject to compulsion in the community include alternative courses of action to be taken, and support to be made available in the event of the failure of essential components in the service user's care plan.
- 3.7 MHOs participate in regular multi-disciplinary reviews of care plans and the continuing need for use of compulsion for all service users subject to the 2003 Act, AWI Act or CP(S) Act.

## **STANDARD 4: INTER/INTRA-AGENCY COLLABORATION AND CO-OPERATION**

Service users who are, may be, or have been subject to compulsion under the 2003 Act, the AWI Act or the CP(S) Act can expect that the local authority social work service works closely with other agencies and other departments to ensure a co-ordinated approach to implementing the legislation and securing required services.

### **CRITERIA**

#### **The local authority ensures that:**

- 4.1 Agreed protocols are in place with health service colleagues, the police, the courts and the Tribunal service on implementing the 2003 Act, the AWI Act and the CP(S) Act.
- 4.2 Clear arrangements are in place to facilitate a responsive MHO service to the police, the courts and the Procurator Fiscal service to assist those service users with mental disorder who are involved in the Criminal Justice System.
- 4.3 The local authority, with partner agencies, commissions services which provide a range of alternatives to admission to psychiatric hospital.
- 4.4 The local authority, with partner agencies, is engaged in service development which identifies needs, including unmet needs, of service users affected by mental disorder and plans and commissions services appropriate to these needs.
- 4.5 There is social work expertise on mental disorder and the associated legislation available to social work criminal justice and child care services.
- 4.6 There is a clearly articulated strategy agreed with health service and voluntary sector partners which details joint working arrangements and where the MHO service sits within these arrangements. These arrangements include regular reviews, involving representatives of services users and their carers, of the effectiveness of these arrangements, so that arrangements may evolve as required.
- 4.7 There are formal arrangements with other local authorities on the implementation of the 2003 Act, the AWI Act and the CP(S) Act. These should address cross-boundary and other relevant issues such as out-of- area placements which require continued involvement of a 'designated' MHO. Authorities should also detail the arrangements for joint appointment of MHOs by more than one authority for carrying out specific pieces of work outside an MHO's employing authority, such as out-of- hours coverage in some areas.
- 4.8 There are agreed procedures/protocols with health service colleagues for resolving disputes concerning MHO assessments under the 2003 Act, the AWI Act and the CP(S) Act.
- 4.9 There is a system agreed with health colleagues for reporting, auditing and reviewing serious accidents and incidents involving service users with a mental

disorder so that, as necessary, practice may be changed to reduce the risk of any recurrence.

4.10 All relevant local authority departments are involved in service planning, development and delivery essential to the proper implementation of the 2003 Act, the AWI Act and the CP(S) Act.

4.11 There is clear guidance for staff on responding to the expectations of the Mental Welfare Commission for Scotland relating to the exercise of functions under the 2003 Act, the AWI Act and the CP(S) Act in which there is, or may be, a common interest, such as in the overlapping duties to make enquiries in certain cases. Liaison arrangements are regularly reviewed.

4.12 There is clear guidance for staff on responding to the expectations of the Public Guardian's Office relating to the exercise of functions under the 2003 Act and the AWI Act in which there is, or may be, a common interest. Liaison arrangements are regularly reviewed.

4.13 The local authority and partner agencies monitor the implementation of their Procedures for the Protection of Vulnerable Adults to ensure that the use of compulsion under the 2003 Act, the AWI Act and/or the CP(S) is considered wherever necessary to implement care plans designed to safeguard vulnerable individuals who have or appear to have a mental disorder.

## **STANDARD 5: EQUITABLE PROVISION AND ANTI-DISCRIMINATORY PRACTICE**

Service users and carers can expect that the local authority implements systems and processes for referral, assessment, care planning and service provision which respect the rights of people, especially those who are, have been, or may be subject to compulsion under the 2003 Act, the AWI Act and the CP(S) Act and which are provided in an anti-discriminatory way.

### **CRITERIA**

#### **The local authority ensures that:**

5.1 There is monitoring of whether ethnic origin, race, culture, religion, language, gender, disability, age and sexual orientation are fully taken into account in contacts with and assessments of people who are or may be subject to compulsion under the 2003 Act, the AWI Act or the CP(S) Act.

5.2 MHOs and other social work staff receive training in anti-discriminatory practice which addresses the knowledge and skills required to respond to and support the individual needs of each person with mental disorder referred to the service.

5.3 All MHOs have ready access to assistance in communication, whether through human or by mechanical aid, appropriate to individuals with mental disorder who are may be or have been subject to compulsion under the 2003 Act, the AWI Act or the CP(S) Act. Such assistance is also available to service users, Advocates, named persons and relevant others.

5.4 There is a local authority equal opportunity policy and action plan for recruitment, employment and service delivery.

5.5 There is a policy for dealing with harassment and abuse of service users and staff.

5.6 The needs of the population it serves have been assessed with partner agencies, and service use is monitored to establish patterns of under and over representation.

## **STANDARD 6: STAFF TRAINING AND DEVELOPMENT**

Individual MHOs can expect that their local authority provides appropriate opportunities for continuing professional development and structured specialist professional advice and guidance, as needed, from an experienced MHO.

### **CRITERIA**

#### **The local authority ensures that:**

- 6.1 There is a strategy for the recruitment, training and retention of adequate numbers of MHOs, including MHO staff with a variety of relevant specialist expertise, to meet the needs of their area.
- 6.2 The professional and practical support needs of individual MHO trainees are addressed in line with the recommendation of the training providers.
- 6.3 Newly qualified MHOs are supported in their role and given work appropriate to their experience and expertise.
- 6.4 There is a process for assessing the needs of individual MHOs and supporting them in developing individualised plans for continuing professional development to ensure they are able to gain sufficient experience to maintain their competence and confidence. This is tied to the requirements for re-accreditation and re-appointment as outlined in Statutory Directions.
- 6.5 All MHOs have been given training on the relevant procedures and protocols concerning implementation of the 2003 Act, the AWI Act and the CP(S) Act.
- 6.6 All MHOs have access to information and training which keeps them abreast of developments in mental health services, including psychiatric treatment and medication.
- 6.7 All MHOs have regular, structured access to advice and guidance from a designated, experienced MHO in respect of their MHO practice.
- 6.8 Arrangements are in place to assist MHOs in participating in regular local or supra-local MHO fora to discuss relevant matters relating to law, practice and service developments.
- 6.9 Opportunities are available for MHOs to access joint-training and continuing professional development with partner agencies.

## **STANDARD 7: ORGANISATION AND MANAGEMENT**

Individual MHOs can expect that the local authority provides proper managerial, administrative and technical support which enables MHOs to implement the legislation in accordance with the principles and codes of Practice of the 2003 Act, the AWI Act and the CP(S) Act.

### **CRITERIA**

#### **The local authority ensures that:**

7.1 There is a senior manager responsible for mental health and MHO services, including the co-ordination, development and monitoring of the MHO service and associated procedures and protocols.

7.2 There are clear policies and procedures on the allocation of referrals to the MHO service and for the appointment of 'designated' MHOs as outlined in section 229 of the 2003 Act, including those appointed to fulfil this role on an interim basis.

7.3 All service users subject to compulsion as well as relevant others involved in the service user's care and treatment are aware of how to contact the 'designated' MHO as needed.

7.4 There is efficient and effective communication between out-of-hours and daytime MHO services.

7.5 There is a system for reviewing the efficiency and quality of its MHO service, and its capacity to provide a quality service on an equitable basis. This includes monitoring how far the existing MHO service supports practice in accordance with the relevant Codes of Practice and the extent to which the service is delivered to the standards of the National Service Standards for Mental Health Officer Services.

7.6 Information on MHO referrals and response times is routinely monitored.

7.7 All MHOs are provided with sufficient, easily accessible administrative support to assist them in:

- Meeting deadlines for reports and statutory applications;
- Alerting them to renewal dates well in advance;
- Organising and minuting important multi-disciplinary case conferences; and
- Contacting relevant parties.

7.8 All MHOs have ease of access to personal computers, including Internet access, mobile phones and personal alarms.

7.9 All MHOs have access to specialist legal advice and support necessary in carrying out their statutory duties.

7.10 All MHOs have access to financial advice and support necessary in carrying out their statutory duties.

7.11 Each MHO has a personal copy of relevant legislation, the associated Regulations, Codes of Practice, the Memorandum of Procedures for Restricted Patients, all relevant local authority procedures and access to all Statutory Forms as needed.

7.12 All MHOs have up to date lists, including contact details of key service provision throughout the area as well as up to date lists of contact details for key personnel both within and outwith the Department.

7.13 All MHO activity is recorded and aggregate data is regularly monitored.

7.14 All MHOs are aware of policies and procedures to protect staff from violence or the threat of violence and to support staff who have been victims of violence.

7.15 Where local authorities serve communities in remote and rural areas there is a strategy which addresses issues of equity of MHO service response. Such strategies should also address the supervision and continued professional development of MHOs and be backed up by the investment necessary to implement this strategy.

7.16 There is a whistle blowing charter which specifically takes account of the statutory duties and professional responsibilities of MHOs.

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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