

# **The New Mental Health Act**

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## **Transitional Training Guide**

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

### **Emergency and Short-term Detention and Related Matters**

## **Reader 2**

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### **Emergency and Short-term Detention and Related Matters**

## **Reader 2**

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

**TRANSITIONAL TRAINING GUIDE**

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

**EMERGENCY AND SHORT-TERM DETENTION AND RELATED  
MATTERS**

**READER 2**



## 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

This reader in the series of transitional training materials is offered to MHOs alone. It focuses in detail on:

- Investigations that must be made by the Local Authority;
- Warrants of entry to premises;
- Emergency and Short-term Detention; and
- Related issues of Appeal and Treatment.

This reader assumes not only the underpinning knowledge requirements for an MHO practising under the 1984 and the 2000 Acts but also the grounding of knowledge about the 2003 Act at a level given in the introductory Reader 1 of this series. In particular, this reader assumes a reasonable theoretical knowledge of the principles as set out in Part 1 of the 2003 Act. It is preparation for the attached case study, which gives the framework for the second group study session.

## 2. Section 32 duties of the Local Authority in respect of appointment of MHOs

**This section of the reader examines the basis of the MHO's expanded role under the 2003 Act and places it in the context of the difference between the 1984 Act's section 9 and the 2003 Act's section 32.**

Section 9 of the 1984 Act imposed a duty on Local Authorities to appoint sufficient MHOs for the purpose of discharging their duties under the 1984 Act and later, the 2000 Act. It created a link to directions from the one-time Secretary of State and now, the Scottish Ministers, which set down the following:

- Two year post-qualifying criteria for MHOs;
- Approved training required by the SSSC within the framework of the post qualifying Mental Health Award; and
- Requirement of experience and competence in mental disorder as a prerequisite for MHOs.

Appointment as MHO was appointment for the practitioner's working life in that local authority. However, the 1984 Act will be totally repealed and therefore can offer no authority under which MHOs may be appointed in respect of their new duties under the 2003 Act. Therefore, section 32(3) of the 2003 Act provides transition for pre-existing MHOs from their authority under the 1984 Act to 2003 Act. Those of you who are practising MHOs under the 1984 Act will migrate to your authority under the 2003 Act at the point of implementation at midnight **4<sup>th</sup> of April 2005**. The transitional materials that you are reading are a requirement of that process.

The phrase 'A local authority shall appoint a sufficient number of persons for the purposes of discharging...the functions of MHO', which occurs in both Acts, is offered in the 2003 Act not just in terms of one piece of legislation, as it was in 1984. It now relates to the 2003 Act, the 2000 Act and the Criminal Procedure (Scotland) Act 1995 (or 'the 1995 Act' as it is referred to in the 2003 Act).

Given the expanded role of MHOs under these three Acts, it may therefore be reasonably deduced that local authorities should put greater resources into their MHO services or deploy these services differently, for example, in full-time MHO teams.

The prerequisites (section 32(2)(b)) upon which Scottish Ministers may give directions for appointment of MHOs now appear as follows:

- (i) 'Registration - MHOs will have to be registered social worker practitioners under the Regulation of Care (Scotland) Act 2001, who are officers of a local authority, although it is not clear at this point when this will be stipulated in Statutory Directions;
- (ii) Education and training - appointment will rest as before on a recognised professional qualification in social work and the SSSC award, including its English ASW equivalent with transitional training, the details of which will be addressed in Statutory Directions;
- (iii) Experience- post-qualifying social work experience is still set at 2 years. There is also an expectation that MHOs will provide evidence of their own continuing professional development (CPD) throughout their practising lives;
- (iv) Competence as respects mental disorder; and
- (v) Any other matters as may be specified by direction'.

The Directions arising out of section 32(2)(b) should be considered in conjunction with section 32(5)(b), whereby a local authority shall terminate the appointment of any MHO who ceases to satisfy the requirements. This means that we may expect Scottish Ministers to direct local authorities to appoint MHOs for time limited periods only. The most likely duration period for appointment is five years, after which the MHO will be required to re-evidence items (i) to (v) above. Re-appointment is likely to rest on evidence of continually developing competence in regards of mental disorder and CPD of MHO practice. This may appear onerous to some who are used to appointment for life. However, it is standard procedure in England and Wales and there are models for enabling practitioners to undertake this process with minimum additional work. It is to be anticipated that the Scottish Executive will work with the SSSC to provide a framework for this to happen within the next five years.

Increased powers of the MHO under the 2003 Act require extra safeguards. For example, Short-term Detention cannot be granted without MHO consent and, unless it is not practicable to do so, the same applies to Emergency Detention. The MHO now stands as the gate-keeper to all but a small minority of certificates that grant authority to detain.

Furthermore, in order to provide continuity, all compulsory powers<sup>1</sup> will now require the appointment of a 'designated MHO' who is expected to remain involved throughout all statutory involvement with the patient. Under the 1984 Act it was possible for an MHO to practice even though he or she only did so once every few years. Under the new system this would appear to be less than adequate.

### 3. Section 33 Duty to Enquire

**The following discussion of sections 33, 35, 36 and 44 is focused upon civil procedures, setting aside CTOs and consideration of detention and other forms of compulsion in relation to criminal procedures for the last two readers of the sequence.**

**The first of these matters is the duty upon the local authority to make inquiries in situations where it is concerned for the well-being of a person with mental disorder.**

**In the case where comparison between the 1984 and 2003 Acts is invited, we have placed a table in Annex 2, tracking the differences in the Acts.**

There is a close link between<sup>2</sup> section 10 of the 2000 Act (the duty of local authorities to make investigations) and section 33 of the 2003 Act. 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.

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. The Commission also has overlapping responsibilities to make inquiries in the community. However, it would only do so in exceptional circumstances, for example, where it wished to investigate deficiencies in the care provided by a local authority. Returning to section 10 of the 2000 Act, the remit is restricted to matters in relation to the personal welfare of the adult (see footnote 2). 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;

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You may already have noted in the text of the first reader that the phrase 'compulsory powers', sometimes also referred to as 'measures of compulsion' is used in relation to the CTO, as opposed to the narrower term 'detention', which is used in terms of Emergency and Short-term powers. This is because the CTO may compel its subject to accept a far wider range of measures than detention in hospital (whether for treatment or not).

<sup>2</sup> The section 10 duty in the 2000 Act is 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'

- 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.

It should be noted here that the Act states- 'where it appears that'... any of the above conditions are met, the local authority has a duty to investigate. The degree of certainty contained in it merely appearing to be the case is fairly low. The Draft Code of Practice describes this as a duty to investigate arising where it is 'suspected' that there is such a case.

The most significant differences to draw 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 raises questions about what actions may arise from an investigation. While the following is not a prescriptive list, these may be:

- No further action is required;
- Investigation indicates that the matter would best be dealt with through the 2000 Act, for example by application for welfare guardianship;
- Broader remit is indicated, for example under section 12 of the Social Work (Scotland) Act 1968; and
- 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.

The Draft Code of Practice contains a very good overview of practice matters in regard to section 33. It 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 the Adults with Incapacity (Scotland) Act 2000'. This suggests that any MHO may reasonably expect the local authority to produce a framework of guidance for practice.

In this discussion we have resisted pre-empting the policies that your local authority may draw up to advise you 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.

Section 34 confers a 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), Health Board and NHS Trust.

#### 4. Section 35 Inquiries under Section 33: Warrants

**This section deals with the various sorts of warrants of entry that may be obtained in pursuit of inquiries and other general situations.**

The significant similarities between sections 117 of the 1984 Act and section 35 of the 2003 Act are that both warrants require application to a Sheriff or Justice of the Peace (JP), with sworn evidence (The table in Annex 2 may facilitate tracking these comparisons). Both authorise entry to premises by force if need be. Both warrants authorise a police constable to force entry to lock-fast premises and both warrants may authorise time limited detention of the mentally disordered subject.

The differences are that a section 117 application could be made by either an MHO or a medical commissioner, while under section 35, application may be made solely by an MHO. The 117 warrant only authorised a named constable to gain entry while the 35 variant authorises 'any constable of the Police Force in the area in which the premises are situated' to do so. The 117 warrant authorised removal to a place of safety and detention therein for up to 72 hours, while the 35 warrant authorises no such removal.

There are actually 3 separate warrants authorised respectively under section 35(1), (4) and (7) respectively:

- Section 35(1) authorises entry;
- Section 35(4) authorises detention for up to 3 hours<sup>3</sup>, explicitly for the purposes of enabling a medical examination; and
- Section 35(7) authorises inspection of medical records.

The implication of 35(4) is that the apparently mentally disordered subject may be detained in situ in order to enable an examination for the purposes of either Emergency or Short-term Detention. The most likely use of a section 35(7) warrant is where the MHO is satisfied that for the purposes of inquiries under section 33..., it is necessary that a medical practitioner have access to the person's medical record, and that the MHO is unable to obtain the consent of that person to that matter.

The grounds of application for a section 117 warrant under the 1984 Act were that the person appeared to be ill-treated or neglected or 'kept otherwise than under control; or being unable to care for himself, is living alone or uncared for'. The conditions for application for a section 35 warrant under the 2003 Act rest upon the necessity to gain access to a person and possibly their medical records for the purposes of making inquiries under section 33. This implies that any of the matters enumerated in section 33(2)(a) to (d), discussed above, would be sufficient grounds for making an application for the warrant if they were coupled with any of the following:

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<sup>3</sup> Section 35 (4) is the power to require a medical examination without consent. The actual authority to detain the patient in situ for up to 3 hours is contained in section 35(5).

- An inability to obtain access to the person because the MHO is unable to obtain entry to the premises. The warrant remains valid for an 8-day period (with reference to a warrant under section 35(1));
- An inability to obtain the person's consent to a medical examination in furtherance of an inquiry under section 33 (with reference to a warrant under section 35(4)); and
- An inability to obtain consent from the person to gain access to medical records held by any person in respect of the subject of a section 33 inquiry (with reference to a warrant under section 35(7)) where the MHO feels it is necessary for the medical practitioner to have access to these records.

Once granted, the warrant will authorise the MHO correspondingly with powers either in relation to access to the premises, consent to medical examination or authority for the medical practitioner to access the person's medical records. The powers must be specified in the warrant.

It is likely there will be no statutory form for a section 35 warrant. You may expect the Scottish Executive to make available a non-prescribed pro-forma, but in some situations of urgency the application may be made orally. Therefore, it may be helpful to have some local guidance in relation to systems for locating a Sheriff or JP and in relation to local expectations in respect of applications.

It is worth noting that, during the 3-hour period of detention, in respect of 35(4), regard must be had for two potentially opposing poles: The principle of minimum restriction in relation to the freedom of the patient (section 1(4)) and the need to maintain the safety of all parties at all times. It is unlikely that practice in relation to section 35 warrants will differ from that under the old section 117 in that any application for a warrant presupposes a locked door or a steadfastly uncooperative person. Thus the implication that the application is necessitated by the process of section 33 inquiry having been thwarted. Therefore, it is likely that the application will be based on scant evidence that echoes the Draft Code of Practices choice of phrase 'where it is suspected that' the conditions for section 33(2) are met.

For this reason, the Draft Code of Practice suggests a fairly, but not too cautious approach, resting on the use of force as the last resort, a multidisciplinary assessment of risk (where possible) and mediation of the principles at all times. Because of the difficulties discussed above, there will be times when force is applied in situations where it was not required, where the outcome of the investigation is that no further action should be taken. In these cases best practice would be for local authority protocols to address the matter of who has the responsibility to pay for damage to property.

Whether or not a warrant is granted, the MHO applicant has a duty under section 35(10) to notify the Commission as soon as possible following the application.

Along with the specific warrant under section 35, in furtherance of section 33 inquiry, there is a general warrant that may be applied for by anyone who is authorised under the Act and who has encountered an inability to gain access to the patient (section 292). This authorises any constable of a given police force, the MHO or the RMO to gain entry in order to:

'Take the patient to any place (292(5)(a))' or to 'take (or re-take) into custody the patient where the patient is liable to be taken (or re-taken)' (292(5)(b)).

In other words, section 292 is for the purposes of removing a patient who is already subject to powers under the Act. For example, if a patient had absconded, or was refusing access following Short-term or Emergency Detention or a CTO, section 292 would be used.

Upon application to a Sheriff, section 293 authorises any MHO with powers to remove a person to a place of safety within 72 hours and to detain that person there for up to 7 days. (Note application is to a Sheriff only, unless, under section 294, it is a matter of urgency, in which case a JP may grant such an order.) If granted, this 'removal order' authorises entry into lock-fast premises, and the removal of the person by either the MHO, any other person specified in the warrant or any police constable of the police force in that area. The conditions for a 'removal order' are the same as the conditions for making Inquiries (section 33) and applying for section 35 warrants. A removal order (293) may be applied for only by an MHO.

Section 295 allows for anyone who has an interest in the welfare of the patient to apply to the Sheriff to have the 'removal order' varied or recalled.

Section 297 makes provision much like section 118 of the 1984 Act, for the police to remove a person who appears to be mentally disordered and detain them to a place of safety for up to 24 hours. (Note the change from section 118's authority to detain for up to 72 hours.)

It is also important to note that the seldom-used section 47 of the National Assistance Act still pertains.

In summary, there are a number of warrants and powers of removal and/or detention in place of safety:

- Section 35(1) MHO warrant from Sheriff or JP to obtain entry;
- Section 35(4) MHO warrant from Sheriff or JP to obtain medical examination without consent, (with power to detain for up to 3 hours- Section 35(5));
- Section 35(7) MHO warrant from Sheriff or JP to obtain access to medical records, by a medical practitioner;
- Section 292 application by any authorised person to Sheriff or JP to take or re-take a patient;
- Section 293 MHO warrant from Sheriff only, to remove to a place of safety for up to 7 days;
- Section 294 authority to apply for a section 293 warrant to a JP in situations urgency; and
- Section 297 police powers to remove from a public place to a place of safety for up to 24 hours.

## 5. Emergency Detention in relation to other forms of compulsion

**This section sets out the framework of Emergency Detention and discusses it comparatively with aspects of the 1984 Act.**

It is one of the oddities of writing this, before the implementation of the Act that it is impossible to know what common usage will develop to refer to various aspects of the Act. For example, we have begun to refer to Compulsory Treatment Orders in these texts as 'CTOs' without being able to know whether CTO will be the term of usage by professionals once the Act is under way. In this sense, we will continue to call Emergency Detention certificate by its full title, whereas, in practice, its working title may revert to 'EDC' or, if the old 'section 24' is anything to go by, 'Section 36'. (Note, as we are again making comparisons between the 1984 and 2003 Acts, Annex B may be a useful point of reference.)

Statistics indicate that most people introduced to detention in hospital under the 1984 Act were subject to sections 24 or 25. This was partly because the use of section 26 was precluded as an introductory route to detention and the use of section 18 as the preferred means of seeking powers of detention (as originally intended by the 84 Act) was rarely properly implemented in practice.

The 28 day Short-term Detention under the 2003 Act may be applied independent of the 72 hour Emergency Detention. This now provides two independent means by which a patient may be detained without considering application for a six-month Compulsory Treatment Order. Furthermore, each detention has its own implied specific purpose.

- Emergency Detention is restricted to situations of urgency and is for assessment only. In other words, the authority to give treatment under Part 16 of the Act is restricted to urgent situations where life is at risk, there is risk of serious deterioration, or treatment would alleviate serious suffering, prevent violent behaviour or a danger to any other person.
- In contrast, Short-term Detention is for a longer 28 day period of assessment and/or treatment under Part 16 of the Act. The CTO is for longer term, more planned compulsion to treat and enforce other measures, as authorised by the Tribunal, in or outside hospital.
- 'Emergency' in section 24/25 of the 1984 Act was characterised by any situation which was too critical to wait for the process of application for section 18. In contrast, emergency in the 2003 Act sense may mean any situation in which it is too urgent to await the arrival of an Approved Medical Practitioner (AMP) - (a Medical Practitioner approved by the Health Board under section 2 as having expertise in psychiatry.), and/or an MHO, and the clinical circumstances require very urgent action.

This is because Short-term, 28 day Detention may only be granted by an AMP, whereas Emergency Detention may be granted by any registered medical

practitioner. This having been said, there may well be a range of justifiable reasons for considering a situation to be an 'Emergency' other than the non-availability of an AMP. However, it should be noted that the presence of both AMP and MHO ensures the involvement of those with the best knowledge and experience to make such critical decisions.

It must be emphasised that emergency now means a situation of absolute urgency. The hope is that this will relegate the use of Emergency Detention to the gateway of least use, because it carries the least rights and protections for the patient. This having been said, there may be situations in which it appears to impose the least restriction upon the freedom of the patient (section 1(4)).

As will be seen, emergency may also be characterised by the non-availability of an MHO. This is because, in Emergency Detention, consent of an MHO is required only where practicable, while consultation with and consent of an MHO is an absolute requirement of Short-term Detention. In the case of non-availability of an MHO, Emergency Detention without consent may be the only option. The consequences of waiting for MHO availability have to be such that the criteria for Emergency Detention are met. National MHO Service Standards and local service redesign should seek to address the necessity for easy and quick access to an MHO where ever possible. However, the timing of Short-term Detention actually allows for a 3-day period within which the certificate may be granted, following from the AMP's examination of the patient (section 44(1)). There is therefore a considerable timeframe in which an MHO may consider giving consent. On the other hand, what is referred to as the 'appropriate period' for Emergency Detention (section 36(12)) is relatively short.

The term 'appropriate period' in relation to Emergency Detention refers to the period within which the certificate must be granted following the doctor's examination. In a rather difficult to read sentence in section 36(12) the appropriate period is given as the period starting at the end of the medical examination and ending at the end of the day on which the examination took place, or a period ending 4 hours after the completion of the examination. For example, if the examination was completed before 8.00pm on 07/04/05, the certificate would have to be signed by midnight and dated 07/04/05. If the examination ended after 8.00pm on the 7<sup>th</sup>, the appropriate period would end four hours later on 08/04/05, with the certificate having to be signed within that time. We are labouring this complicated point because the MHO would have to have considered and given consent within the appropriate period.

These requirements will more reasonably confine Emergency Detentions to acute situations of greater urgency than was the case with the old section 24. Since the 72 hour Detention carries the least rights for the patient (no formal right of appeal), this may better serve the patient's interests.

Under the 2003 Act, in most populous places, where the local authority has reasonably fulfilled its section 32 duties to appoint sufficient MHOs, there should be relatively few cases where an MHO is unable to attend within 4 hours (the minimum duration of the 'appropriate period', when it transverses 2 days). Such availability may be less easy to guarantee on the more remote of the Scottish islands for

example. There is also an additional problem of availability of AMPs in such remote areas.

## **5.1 Process of Emergency Detention**

Emergency Detention may be granted by any registered medical practitioner. The Draft Code of Practice suggests that this should be the practitioner within the clinical team currently responsible for the patient's care. However, it is also recognised that, by reason of it being an emergency, this may not be achievable in many cases.

Emergency Detention is non-renewable and it may not be used immediately following a Short-term Detention. There are various other extensions to detention immediately following which Emergency Detention may not be applied.

The patient may be either already informally in hospital or admitted to hospital from the community. In other words, while the 1984 Act distinguished section 24 (Emergency Detention from the community) from section 25(1) (detention of an in-patient), section 36 of the 2003 Act makes no such distinction, applying equally to both.

The certificate is also sufficient authority to remove a patient who has already been admitted to one hospital and take him or her to another. For example, it is sufficient authority to remove someone from an accident and emergency ward in a general hospital to which he or she has been admitted and take him or her to a psychiatric hospital. However, the Draft Code of Practice indicates that outpatient attendance at A & E should not be construed as admission.

A medical practitioner must have examined the patient. There must be no conflict of interest in relation to the medical examination. Ideally, examination should be face to face but, as the Draft Code of Practice suggests, there may be situations where it may have to be conducted in very restrictive circumstances. The purpose of the examination is to ensure that the conditions for detention have been met (see below). The authority of the certificate (to convey the patient to hospital within 72 hours and/or detain him or her for up to 72 hours) begins at the moment it is granted by the medical practitioner.

The Draft Code of Practice gives instances where it might be reasonable not to wait for an MHO: 'Immediate, serious or life-threatening danger to the patient and/or others or likelihood that the patient will abscond'.

The Draft Code indicates a minority of situations in which consent might be given over the phone, where the MHO has seen the patient a short time previous to the medical practitioner's call or where the MHO has a very close knowledge of the patient and has had contact within 12 hours.

It is worth noting that consent is solely the province of the MHO, with no remit for a relative, as was the case under the 1984 Act. The Draft Code states that a medical practitioner should not 'shop around' for consent where it has already been refused by one MHO. The implication here is that, while shopping around may not be strictly unlawful, it ought to be discouraged as poor practice and, where an MHO has

refused to grant consent, the certificate ought not be granted. The Draft Code advises that local authorities and health boards ought to agree a protocol outlining procedures for obtaining a second MHO opinion in particular cases.

The medical practitioner also has a requirement to 'consult' with the MHO. The Draft Code of Practice states that: 'It is imperative that as much joint assessment and consultation as possible takes place between the medical practitioner and the MHO, before the certificate is granted.'

With reference to section 1(3)(e) (the principle that regard should be given to the range of options available) the MHO should exhaust his or her thorough knowledge of the possible alternatives to the proposed Emergency Detention. Combining this with section 1(4), the minimum necessary restriction to the freedom of the patient, the MHO must ensure that every informal and less restrictive form of treatment has been explored. This should involve consultation both with the patient (as far as practicable) and the medical practitioner. It may also involve consultation with carers and relatives.

Once granted, the certificate must state the medical practitioner's reasons for believing that the conditions for detention (see below) are met and it must be signed by the medical practitioner. While the certificate should be completed on the appropriate form, the Draft Code of Practice advises that it may still be valid if it is written and signed on a separate sheet of paper, provided it contains all the necessary information.

Where the person is admitted to hospital under an Emergency Detention certificate, the detention period begins when the hospital managers receive the certificate. In the case of an inpatient, it begins with the granting of the certificate by the medical practitioner. In this case, the medical practitioner must give the certificate to the managers of the hospital as soon as practicable.

## **5.2 Authority and duration**

As with the old section 24 under the 1984 Act, the certificate contains sufficient authority to remove its subject to hospital within 72 hours of granting by the medical practitioner. It authorises detention for a separate period of up to 72 hours. While these are two separate 72 hour periods, the principle (section 1(4)) of least restriction to the freedom of the patient strongly implies that neither period should be allowed to endure unnecessarily to its full term.

The Emergency Certificate does not automatically confer a general duty to treat. We have already touched upon this point in several places, but to spell it out in a unified way, this poses several possibilities:

- Treatment for mental or physical disorder may be given with the patient's consent;
- Treatment for physical disorder may be given under Part 5 of the 2000 Act, where the patient lacks capacity to consent; and

- In the case of a child under the age of 16 years the Age of Legal Capacity (Scotland) Act 1991<sup>4</sup> states that a person under the age of 16 has legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment. In practice a medical practitioner would generally look for such signs of capacity from 12 years onward. It follows that a child deemed to have capacity could withhold consent as well. Where a child under 16 is unable to give consent, consent may be given or withheld by a person with parental responsibility. It should be noted, however, that the Millan Committee specifically noted the potential disadvantage to the child in this regard: Such a route to treatment does not offer the same rights as are afforded under mental health law<sup>5</sup>. Obviously the withholding of consent by a child with capacity can be overridden in the 2003 Act in the same circumstances that it may be with adults. Ideally, the principles of section 2 of the 2003 Act ought to be considered in this regard.

### 5.3 Conditions for Emergency Detention

There are two sets of conditions that must be satisfied by the examining medical practitioner. These are given in section 36(4) and (5). For those set out in subsection 4, the medical practitioner must be satisfied that it is likely that:

- The patient has a mental disorder;
- That, because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired; and
- (Section 36 (4) (a) and (b)).

It is stated that these need only 'likely' be the case. This is because the limited 72 hour Emergency Detention is intended as a period of urgently required assessment, during which the diagnosis should be more firmly established.

It is interesting to think of this 'likelihood' in the context of the meaning of mental disorder given in section 328, and the exclusions to the meaning in section 328(2). Exclusions include, for example, that a person may not be considered as having a mental disorder by reason only of 'use of alcohol' (section 328(2)(e)) and... 'behaviour that causes....harassment, alarm and distress' to others (section 328(2)(f)). On the other hand, there may be a situation in which a person exhibiting such behaviour while drunk may be detained on the basis that it is also 'likely' that he has a mental disorder. In such a case, consider the problems in establishing

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<sup>4</sup> Under the 1991 Act presumption of capacity to consent commences at 12 years old. Section 2 (4) states that '*a person under the age of 16 years shall have the legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.*' The implication of this section is any medical practitioner proposing treatment must have regard for a child under 16's views as long as the child appears to have capacity. Any person with parental responsibility may exercise the right to consent on behalf any child under 16 years-old, where it is the Medical Practitioner's opinion that the child lacks that capacity.

<sup>5</sup> New Directions, Report on the Review of the Mental Health (Scotland) Act 1984, Scottish Executive, January 2001.

sufficient likelihood of mental disorder amid the range of situations that may arise when the characteristics described in section 328(2)(e) and (f) occur together.

Section 36(4) also sets out an entirely new requirement regarding the likelihood that ability to make treatment decisions is significantly impaired because of mental disorder. This matter is echoed in the conditions for Short-term detention and CTO. It is an entirely new requirement, not featured in the grounds for detention in the 1984 Act. It suggests a very precise test of capacity that demands at least two questions:

**To what extent is the patient's ability to make treatment decisions significantly impaired?**

Note that this question does not include any reference to the patient making perfectly competent decisions in disagreement with those advised by the medical practitioner. No matter how unwise a decision may seem to others, we all have the right to make such choices provided we have capacity to do so. In this regard we may only be 'acting as no prudent person would act' (328(2)(g)).

**Is the patient's ability significantly impaired because of the likely existence of mental disorder?**

Note that any impairment may be by reason of other factors in the above case for example, it may be because the person has consumed a lot of alcohol. If decision making appears to be impaired, the important question to ask in relation to section 36(4)(b) is 'how is this impairment related to mental disorder'? For example, there would be a clear relationship between impairment and mental disorder where a person was unable to make treatment decisions because of disordered thinking caused by schizophrenia; or because the person was too withdrawn to make a decision because of depression.

The above questions may lead to an assessment that the person appears likely to have a mental disorder and does appear to be making an unwise choice in relation to treatment. However, it may be that something other than the mental disorder has distorted or affected judgement in this regard. This might be the case, for example, if it was established that, before the person ever became mentally disordered, his or her past wishes (section 1(3)(a)) consistently reflected treatment decisions that appeared unwise to the objective observer.

The second set of conditions, set out in section 36(5), require a greater degree of certainty in that the medical practitioner must be satisfied that:

- 'It is necessary as a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment requires to be provided to the patient;
- If the patient were not detained in hospital there would be significant risk...to the health, safety or welfare of the patient or to the safety of any other persons'; and

- 'Make arrangements with a view to the grant of a short-term detention certificate would involve undesirable delay'.

It is important to note some significant differences from the 1984 Act's section 24:

- The 2003 Emergency Detention has a specific purpose attached to it. It is for determining what medical treatment is required to be provided;
- The broader consideration of the welfare of the patient is now included along with the familiar considerations of health and safety; and
- The test is of significant risk, not simply risk.

The 2003 Act places these considerations in the frame of the medical practitioner's examination. We need to be absolutely clear here that MHOs do not have diagnostic skills or the accompanying knowledge. However, in consultation and consideration of giving consent in these circumstances, the MHO must be satisfied that detention on an urgent basis is appropriate in all regards. It has to be considered that the medical practitioner granting an Emergency Detention certificate need not be an AMP and therefore need not have special knowledge or experience of mental health law. Nevertheless, it is important that the MHO enter into a discussion with the medical practitioner as to why the medical practitioner feels the person is likely to have a mental disorder as well as why they feel the other criteria are met. Indeed, it is implicit in the role of the MHO that the MHO may have an important contribution to make to the decision making process. Consent should be neither given nor withheld by the MHO before engaging with the medical practitioner in such a focused discussion. While this will be standard, accepted practice for MHOs, the content of these discussions will have to be broadened to take account of the changed criteria for detention on an emergency basis.

#### **5.4 Other matters in relation to Emergency Detention**

If the medical practitioner is unable to obtain MHO consent because of impracticability (not refusal by MHO) he or she must state the reasons for this on the certificate. The certificate is given to the managers of the hospital and the managers, have a duty to inform:

- The nearest relative;
- The person who resides with the patient if it is not the nearest relative;
- The named person if the managers know who it is; and
- The Mental Welfare Commission.

Implicit in this latter requirement is that the Commission will take note of all Emergency Detentions that are granted without consent. In accordance with its remit in Part 2 of the Act the Commission would:

- Promote best practice;
- Draw matters to the attention of various parties; and
- Make enquiries, for example, should there be too many improperly explained detentions without consent, or should it be indicated that a local authority is chronically unable to provide adequate emergency MHO cover.

Where there was no MHO consent, the managers must notify the local authority within 7 days. Ideally, this will happen ASAP.

Section 38(2) requires hospital managers to arrange for an Approved Medical Practitioner to examine the patient as soon as practicable after the detention has begun. The implication of this is that, if the AMP is satisfied of the conditions for Short-term Detention and if MHO consent can be obtained, the patient should be moved to the 28 day order as soon as possible and not necessarily upon the expiry of the full 72 hours. This means that despite hospital managers having a duty to notify local authorities within 7 days of the start of the Emergency Detention, in most cases an MHO will be notified within 24 hrs and, ideally early enough to assess with the AMP. At this point consideration will have to be given to revoking the certificate or moving the person on to a Short-term Detention certificate. If the AMP is not satisfied that the conditions for Emergency Detention continue to be met, he or she has a duty to use the power to revoke the certificate. The AMP must then inform the patient and the managers of the hospital of this decision. The managers in turn have a duty to inform:

- The nearest relative;
- The person who resides with the patient if it is not the nearest relative;
- The named person if the managers know who it is; and
- The Mental Welfare Commission .

## **6. Short-term Detention**

**Short-term Detention is discussed in relation to the foregoing discussion of Emergency Detention and in relation to the 1984 Act.**

### **6.1 The process of granting a Short-term Detention certificate**

The distinctions between Emergency and Short-term Detention procedures may be summarised as follows:

- Both procedures rest upon certificates that may be granted by a medical practitioner, (an AMP in the case of Short-term Detention), following examination of the patient. However, while an Emergency Detention Certificate may only be signed within the 'appropriate period' following the medical examination as described above (See section 36(12), and this will always be less than 24 hours, the Short-term Certificate may be signed up to 3 full days after the examination.
- Both procedures require the consent of an MHO. However, while Emergency Detention requires consent only 'where practicable', if either no MHO consent is obtainable or no consent is given, Short-term Detention cannot proceed without MHO consent. As with Emergency Detention, the Draft Code of Practice advises that the Medical Practitioner may not shop around for consent, should the first MHO withhold it. Protocols, as stated above, should

cover situations where an AMP feels compelled in such circumstances to formally request a second MHO opinion.

Neither certificate is renewable.<sup>6</sup>

## 6.2 Conditions for Short-term Detention

In our discussion of Emergency Detention we emphasised that two conditions required a lesser degree of certainty than the others:

- It need only be 'likely' that there is a mental disorder; and
- It need only be 'likely' that 'because of the 'mental disorder', the 'patient's ability' to 'make decisions' about the 'provision of medical treatment is significantly impaired' (section 36(4)(a) and (b)).

These conditions are replicated in Short-term Detention (section 44(4)(a) and (b)). Thus, the AMP and the consenting MHO would have to be reasonably satisfied of the 'likelihood' of the existence of mental disorder and the test of significantly impaired decision making ability in relation to treatment.

As with Emergency Detention, there follow a set of conditions relating to risk:

- There 'would be significant risk to the health, safety or welfare of the patient or to the safety of any other person' were the certificate not granted (section 44(4)(d)).

It is important to note this difference between the conditions for Emergency and Short-term Detention in this point. Emergency Detention requires a different level of certainty in the facts, not just that it is 'likely' that there 'would be significant risk to the health, safety or welfare of the patient or to the safety of any other person', but that 'the Medical Practitioner is satisfied that the conditions... are met' (section 36(3)(c)). This implies a greater degree of certainty regarding the risk factors in Emergency Detention than in Short-term Detention, which requires only that 'it is likely' that these conditions are met. This is not surprising in that a greater certainty on the risk elements is required to proceed on an emergency basis which does not afford the same recourse to expert medical opinion or, perhaps, that of an MHO. Nor is there a right to appeal the decision.

The purpose of Short-term Detention is different from that of Emergency Detention. While, in the case of Emergency Detention 'it is necessary as a matter of urgency to detain the patient in a hospital for the purposes of determining what medical treatment requires to be provided...' (Section 36(5)(a)), a Short-term certificate is

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<sup>6</sup> Neither may follow on from the extension certificate that may be granted to prolong Short-term Detention beyond its 28-day's duration. This section 47 certificate is granted to facilitate application for a CTO, much like the section 26 A of the 1984 Act. Neither may be applied when the patient has had a community based CTO varied to a hospital based detention upon non-compliance with the terms of the order (sections 114 and 115) If these brief allusions to the intricate mechanics of CTOs seem confusing, do not worry. We will set them in a context that makes sense, in the third reader in the sequence.

made necessary in order to (i) ‘determine what medical treatment<sup>7</sup> should be given’ or (ii) ‘to give that treatment’ (Section 44(4)(c)). While the purpose of Emergency Detention it is to obtain assessment in situations of urgency; in the case of Short-term Detention the purpose is to secure a period of assessment and/or treatment that falls short of the longer term and broader compulsion of a CTO. Therefore, unlike Emergency Detention, Short-term Detention carries authority to give medical treatment in accordance with Part 16 of the Act.

The last of the conditions provides a safety-net in the statement that it is likely that ‘the granting of a Short-term certificate is necessary’ (Section 44(4)(e)). This relates to the principles that, before determining that a Short-term certificate is necessary, regard has been had to the range of options available, the maximum benefit to the patient (Sections 1(3)(e) and (f)) and the ‘minimum restriction on the freedom of the patient that is necessary in the circumstances’ (Sections 1(4)). As the Draft Code of Practice states, this would include both medical practitioner and MHO pausing to ‘discount that there is strong and reliable evidence that the patient’s treatment could be provided on a voluntary basis’.

### **6.3 Duration of Short-term Detention**

The Draft Code of Practice very clearly articulates that Short-term Detention ‘should be seen as the ‘gate-way order’ of choice. It should be granted in preference to an Emergency Detention certificate as it confers greater rights and protection’. Therefore we require a qualitative change in our thinking from the section 24/26 mind-set. Clearly, Short-term Detention ought to be considered as preferable to Emergency Detention unless circumstances dictate otherwise (e.g. the urgency of the clinical situation for the patient requires urgent action, rather than simply the non-availability of an MHO or AMP).

Once granted, the certificate is sufficient authority to convey the patient to hospital for detention within a 3-day period. The detention period of up to 28 days begins either once the certificate accompanying the patient to hospital is received by the managers, or, if the patient is already in hospital, at the moment it is granted. In the latter case, the AMP must give the certificate to the managers at the soonest practicable moment. The hospital managers have a duty to notify the following of the detention as soon as practicable:

- The patient;
- The named person;
- Any guardian or welfare attorney; and
- The Tribunal and Commission within seven days.

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<sup>7</sup> When we look closely at medical treatment in the third reader, we will see that it is broadly defined to include such things as nursing and social care, but in the definition (section 329) it is also restricted in application to the treatment of mental disorder.

## **6.4 Application to the Tribunal for revocation of Short-term Detention Certificate**

In addition to the increased rights conferred by the guaranteed consideration of MHO consent and the more expert scrutiny applied by an AMP than that of just any medical practitioner, both the patient subject to Short-term Detention and the named person have rights to apply to the Tribunal to revoke the certificate under section 50. While there is no limit on the number of times that such an appeal can be made against the detention, the Draft Code of Practice suggests that it would be unlikely that the Tribunal could practicably hear more than one per 28 day period.

## **6.5 The Role of the MHO**

The AMP must not only obtain consent but, as in the case of Emergency Detention, must also consult with the MHO. This is in keeping with the Draft Code of Practice's aims to promote close inter-disciplinary working and to enhance assessment by making it multidisciplinary.

Section 45 details the MHO's duties which are, where practicable, to:

- Interview the patient;
- Ascertain the name and address of the named person<sup>8</sup>;
- Inform the patient of the availability of independent advocacy (which, you may recall, is now a duty on both local authority and health board to supply - section 259);
- Take 'appropriate steps to ensure that the patient has the opportunity of making use of those services; and
- Record the steps taken to comply with these duties and to give a copy of this record to the AMP within seven days of the consultation. This is only required where it is impracticable for the mental health officer to interview the patient (45(2)(a) or ascertain the name and address of the patient's named person (45(2)(b).

In this latter regard, the principles 1(3)(c) and (d) are recalled - the importance of the patient participating as fully as possible in the discharge of the function and the importance of providing information and support to enable the patient to do so.

## **6.6 Section 47 Extension certificate**

Short-term Detention may be extended very much like the section 26A of the 1984 Act in circumstances where it appears to an AMP that the patient requires a CTO and too little time remains of the 28 day period to make an application to the Tribunal. By now you ought to know enough of the logic of the Act to predict that the consent of an MHO is required here, with no 'where practicable' exception.

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<sup>8</sup> Section 44 (10) requires the AMP, where practicable, to consult with the named person and have regard for his or her views. The Code of Practice underlines that it would be best practice for the AMP to consult as widely as possible 'with anyone who is directly involved with the care and treatment of the patient prior to hospitalisation or who might be expected to provide care and support upon discharge- e.g. staff at a supported accommodation project.'

To grant a section 47 extension certificate the AMP must be satisfied that the original conditions for Short-term Detention remain and that 'because of a change in the mental health of the patient, an application should be made...' for a CTO.

### **6.7 The Responsible Medical Officer's duty to review Short-term Detention**

Section 49 requires the RMO to review the authority to detain 'from time to time' and consider whether the conditions remain. If the criteria are no longer met, he or she has a duty to revoke the certificate and must notify the patient, the named person, any guardian or welfare attorney, and the Mental Health Officer who was consulted (originally) under section 44(3)(c) accordingly.

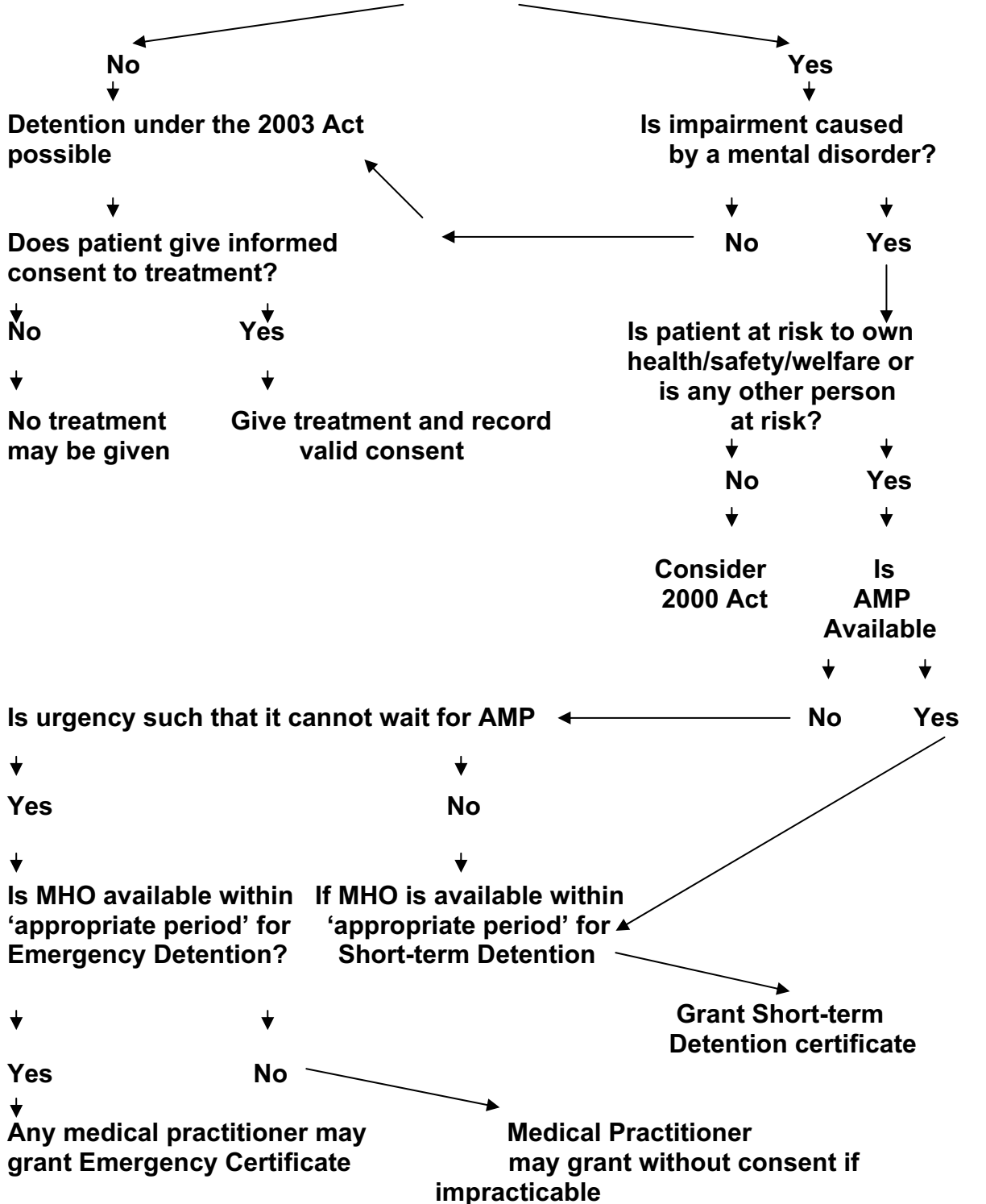
The Commission also has power to revoke a Short-term Detention, should it be satisfied that the conditions are not met. In such circumstances the Commission must also notify the same parties as described above when the RMO revokes an order. (section 52).

## When to use Emergency Detention or Short-term Detention

Patient appears to be suffering from a Mental Disorder

Patient may require treatment in hospital

Does patient may have significant impairment of decision making ability in relation to medical treatment?



## 7. Assessment of risk in relation to conditions of Detention

**In this section we give brief general consideration to risk assessment out of regard for the enhanced MHO role in detention processes and the more precise conditions of compulsion under the 2003 Act. Finally we relate risk assessment to the conditions of detention.**

The MHO now exercises considerably enhanced gate-keeping functions in relation to the various routes to detention and other compulsion under the 2003 Act. To put it bluntly, the fact that there will now be only extraordinary emergency circumstances in which any patient may be detained without MHO consent or assessment is a matter of great significance. It is therefore expected that MHOs will have to have well developed skills of risk assessment in acute and crisis situations involving mental disorder. It is for this reason that we offer you some words about risk assessment in this reader. However, this is not the place to propose any favoured models of risk assessment. It is rather our intention to discuss the general context of risk as it may arise in the framework of the Act and to highlight the ways in which some key features of assessment may fit into this framework. Having said this, it is a risky undertaking to propose discussion in which risk is generalised. The art of risk assessment is to be as precise and explicit as possible.

In the discussion we draw from some psychological sources, which have statistically quantified certain indicators of risk and proposed a clinical model for analysing risk. While we use these sources, our discussion keeps such a model in soft focus. This is because, however such measurements of risk may tend towards greater accuracy, they depend upon an ability to collate and analyse data. The opportunity to do such things is not available to MHOs, whose risk assessment must often be undertaken on the hoof, removed from clinically controlled settings and undertaken sometimes in situations of high stress and rapid action. This aside, O'Sullivan (1999) would stand in opposition to such attempts to scientifically quantify risk by indicating his view that precision in risk assessment is an illusory goal. He is also hesitant to recommend models of risk assessment, suggesting the danger that they may be mechanically applied.

### 7.1 What is risk?

Essentially risk can be described as the likelihood that something may happen. Risk assessment therefore implies an attempt to look into the future and quantify whether or not something good or bad may occur there. The 'assessment' part of the equation also implies that we marry together the likelihood of this event happening, with the desirability or undesirability of it happening.<sup>9</sup>

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<sup>9</sup> With our professional preoccupation to avoid catastrophe, it is easy to overlook the gamblers preoccupation that something good might happen. It is worth carrying in mind that risk assessment should also include assessment of positive risks.

Risk assessment cannot therefore be an exact science. The variables involved in the passage from present to future are so great (potentially infinite) that only the more outrageous and unlikely can be discounted.

This point is emphasised by Tony Zigmond, speaking on behalf of the Royal College of Psychiatrists in England and Wales, in discussion of dangerousness in relation to the draft Mental Health Bill. 'My ability to predict who might go on to commit a serious offence, if they haven't already done so, is very poor. With the best assessment currently available I would need to detain between 2000 and 5000 people unnecessarily to prevent one homicide' (Community Care 2003). This point echoes Thomas Szasz's contention that deprivation of liberty in mental health law rests not on what a person has done, as it would in criminal law, but on what a person might do (Szasz T. S, 1971.).

At the risk of pretending to make this conundrum more scientific than it ought to be, or making this seem like a standard grade maths paper, we may reduce risk assessment to the following sum:

**Risk assessment = X x Y**

- X** is the desirability/undesirability of a set of circumstances happening.
- Y** is the likelihood of it happening.

O'Sullivan (1999) proposes a diagrammatic form, not incompatible with our own:

<b>Present</b>		<b>Future</b>
<b>Hazards</b>	→ → →	<b>Dangers</b>
<b>Strengths</b>	→ → →	<b>Benefits</b>

In this model, hazards are the factors that increase the likelihood of danger happening. For example, an icy road is the hazard that increases the danger of a crash. The hazard is actual, in so far as it is observable in the present. The danger is potential, in so far as it may occur in the future.

In a similar way, strengths contained in the present situation may mitigate the negative risks that hazards indicate. Strengths may produce benefits rather than dangers in the future. If the icy road is the hazard that increases the likelihood of a crash, then a good driver and a safe car are strengths that may enhance the likelihood of a safe journey.

It should be borne in mind that the object of this equation is not to eradicate all undesirable or negative risks. A degree of negative risk is desirable or even necessary in life and any attempt to cushion a person by deleting all risk from their life will invariably be damaging in itself. 'The question is one of identifying an acceptable level of risk'.

## **7.2 Factors in the 'X x Y' equation**

It will not surprise any social worker to know that the 'X x Y' equation also represents a minefield of potential to get it wrong. There are, however, discernible sources of error that we may guard against. One of these may be caused by falsely attributing prejudicial characteristics to the subject of risk assessment. For the purposes of this discussion, the most obvious of these would be the sort of prejudice that popularly abounds regarding the dangerousness of individuals with mental illness per se. Any risk assessment would be hopelessly negatively skewed were the assessor biased by such an uninformed prejudice.

A second source of error may be caused by insufficient or inaccurate knowledge. The detailed knowledge base of MHO training and the new requirement that practising MHOs continue to develop this by CPD are safeguards against this. For example, even setting aside prejudice, any risk assessment of a person who has schizophrenia would be jeopardised if the assessor lacked sound current knowledge available on the disorder.

A third source of error comes from drawing false conclusions from linking two sets of correlation. For example, it is true that the suicide rate amongst men is significantly higher than it is amongst women in Scotland. It is also true that men tend to earn more through employment than do women. However, this does not mean that earning higher wages places one at greater suicide risk.

A fourth source of error might be the anxiety caused by high-profile media criticism of social workers. This is a well-known phenomenon in social work practice. More particularly in the sphere of child protection, it carries almost mythical status. For example, anxiety may cause us to overlook potential strengths in a situation and over-emphasise the dangers. Solid risk assessment requires a steady nerve that is not swayed by such considerations. While covering one's back is a natural concern, risk assessment ought to be focussed upon the subjects of the intervention, not upon the risks attendant upon the worker, except of course in respect of the actual risks to personal safety in the situation.

## **7.3 Enhance accuracy of assessment**

Not surprisingly, anxiety may be aroused by the context in which risk assessment arises. Sharing the assessment with a colleague may help to objectify it. Multi-disciplinary risk assessment broadens the base of knowledge upon which the assessment rests and introduces two or more perspectives to it. Assessment by one discipline alone is more one-dimensional than a multi-disciplinary assessment. The differing perspectives held by various disciplines may cause a practitioner to re-examine and justify the assessment.

Of course this works best where there is clear, unimpeded communication across disciplinary boundaries. It echoes the Draft Code of Practice's exhortation about interdisciplinary working. It should not be forgotten that this relates to one of the findings contained in the report of the Christopher Clunis Inquiry (Richie et al 1994), that an adequate safety net for the most vulnerable patients can only be provided by

close working across disciplinary boundaries. In O'Sullivan's model multi-disciplinary risk assessment is a strength that may produce benefit in the future.

It is well known that 'The best predictor of future behaviour is past behaviour' (Moor, B 1996), provided this predictor is placed in context of the situation in which the behaviour is triggered. This concept is underpinned by Hammond and O'Rourke (1997), who note that certain indicators in a person's behaviour and personal history can serve as the basic platform upon which risk analysis may be built.

It follows that past behaviour in a given context may be a hazard in the present. For example, where a person has, in the past, tended to self-harm because auditory hallucinatory voices have commanded it at times of emotional stress, it may be reasonable to be alert to the possibility of self-harming behaviour recurring if that person is now facing the break-up of a long-term relationship.

However, the hazard may be eroded by strengths such as insight into that behaviour. For example, attending a voice hearers' support group may enable the person to gain some insight into understanding the phenomenon of hearing voices and may assist in devising strategies for managing the voices.

Hammond and O'Rourke (1997) propose a cumulative model of risk analysis. This model entails psychometric testing and is not applicable in crisis situations or outside clinically controlled settings. However, it may assist in the application of risk assessment in practice. The model takes account of accumulated indicators of risk and places them in the context of the given situation in which risk is being considered. It is of value because it identifies different categories of risk:

- Dangerousness to others;
- Risk of self-harm and suicide; and
- 'The risk of mental deterioration and impending breakdown' (Hammond and O'Rourke, 1997 pp 2).

The value of this is that it seems to allude to the 'significant risk to health, safety or welfare, or the safety of any other person' given in sections 36 and 44 of the Act, even if it does not address the welfare requirement as explicitly as it does the others (see 7.4 below). Jeopardy to health, safety or welfare may be seen as the dangers the Act allows us to consider.

### **Risk factors of dangerousness**

The following cumulative factors to be aware of may be seen as hazards that may increase the likelihood of danger occurring. No single item may significantly heighten risk, but the more the items accumulate, the greater the risk.

- The person lives alone, in which case the person may have lower levels of support and early warning signs of deterioration may be missed. It may also indicate lower levels of domestic stability.

- Non-compliance with medication may indicate risk to the extent that medication alleviates symptoms that may be frustrating, upsetting or causing of fear, anger or other strong emotions.
- Past history of unpredictability may pose risk and may relate to an added factor: impulsiveness, which may indicate a disregard for the consequences of actions.
- Facing high levels of stress may predispose a person to act impulsively. It must be remembered that stress is not always caused by conventional sources.

For example, just because the rest of us do not share the reality of a psychotic experience, it does not make that experience less stressful. For example, the stress caused by a psychotic experience that one is being persecuted by the CIA is presumably as great as the real experience of such persecution. Perhaps it is greater, given that the subject will be hard pushed to find anyone to genuinely share the experience with.

- There is much research to indicate that problems with alcohol and certain other drugs may predispose a person to aggression or violence, whether self-directed or turned outwardly to others. They also cause disinhibition.
- History of high-expressed anger or evidence of it at the moment are indicators of risk. McGovern (1996) also gives a range of research to support this.

Hammond and O'Rourke give a range of factors that substantiate a history of dangerousness:

- History of criminal convictions for violent offences;
- Medical history of violence, aggression or self-harm;
- Record of suicidal ideation; past suicide attempts;
- Various histories that indicate specific risks such as carrying weapons, fire raising, predatory behaviours or hostage taking;
- Various indicators (such as head injury, low IQ) that suggest tendency to be frustrated;
- Factors such as cognitive or sensory impairment which may lead to unrealistic expectations of services; and
- History of child abuse indicates increased likelihood of self-harm, as do other factors that may lower self-esteem.

Both Hammond and O'Rourke and McGovern also note psychopathy as a potential risk factor, in that it embraces impulsivity, frustration and unrealistic expectations and is frequently linked to other indicators discussed above.

McGoven further noted feelings and expressions of hopelessness as being indicators of suicide risk especially amongst young people with the disorder. The strong link between suicide and depression should always be borne in mind.

The Sainsbury Centre for Mental Health has produced a very helpful and informative paper *Clinical Risk Management: A Clinical Tool and Practitioner Manual* written by Steve Morgan. The chapter on Risk Indicators alone is worth a read but, as above, it is stressed that these must be viewed within the proper context of the situation and the process of the assessment. The paper categorises the broad areas of risk indicators as: suicide; neglect; aggression/violence; and other risks.

Among suicide indicators it highlights the need to consider the following factors:

- Previous attempts on their life;
- Previous use of violent methods;
- Misuse of drugs and/or alcohol;
- Major psychiatric diagnoses;
- Expressing suicidal ideas;
- Considered/planned intent;
- Belief in having no control over their life;
- Expressing high levels of distress;
- Helplessness or hopelessness;
- Family history of suicide;
- Separated/widowed/divorced;
- Unemployed/retired;
- Recent significant life events;
- Major physical illness/disability; and
- Other (eg Age, sex, access to means, lack of positive social contracts/relationships/networks/cultural links).

#### **7.4 Risk assessment in the context of the conditions for detention**

The framework of the various sources of detention and compulsion under the Act give a useful shape to the assessment process. Discussion of risk assessment cannot be separated from the subject of the assessment, the nature of the attendant risks and the scope for allowing these risks to happen or taking steps to prevent them from happening.

Let us draft a generalised approximation of the conditions for Emergency and Short-term Detention, merging sections 36(4) and (5) with sections 44(4) such a hybrid might read as follows. The patient may be detained in hospital provided it is likely that:

- 'He or she has a mental disorder;
- Because of the mental disorder, his or her ability to make decisions about medical treatment is significantly impaired;
- Were the patient not detained there would be a significant risk to his or her health or safety or welfare;
- To the safety of any other person; and
- The detention is necessary'.

The subject of the risk assessment has to be either 'the patient' who has a mental disorder and impaired decision making ability in relation to treatment decisions or

‘any other person’ who may be exposed to risks that jeopardise his or her safety, or both of these.

The risks to the patient are confined to three broad areas health or safety or welfare and the risk to ‘any other person’ is restricted to consideration of safety. It is worth noting that ‘any other person’ in this case may actually be the MHO, or any other professional involved, should there be immediate risk to their safety. Therefore, risk assessment may call upon you to quantify and objectify a subjective feeling of personal danger from the patient.

Further risk of dangerousness to others, risk of self-harm and suicide and ‘the risk of mental deterioration and impending breakdown’ may arise here (Hammond and O’Rourke, 1997 pp 2). As we acknowledged above, this does not do justice to the condition of risk to welfare, which requires further discussion here.

### **The concept of welfare**

Under the 1984 Act, the term ‘welfare’ was sometimes criticised as too broad in consideration of the grounds for application for mental health guardianship. Moreover, section 329 of the Act 2003, which gives definition to how certain key terms in the Act are to be interpreted, does not give a meaning for welfare. So this remains a broad concept which, at best, may achieve sharper definition through decisions made by the Tribunal. On the other hand, welfare is also the province of social workers who may welcome the breadth of scope it offers.

Welfare is an holistic concept that, in the context of mental health, echoes the term ‘mental wellbeing’. For example, a person threatened with homelessness may be seen to be at risk to welfare because of the global effects that homelessness has upon a life. In the same way, a woman who is routinely humiliated by her partner to such a degree that it has a marked effect upon her self-esteem could be seen as having her mental health jeopardised because of the over-all effect that this experience may have upon other spheres of her life.

We do not suggest that such humiliation alone would constitute grounds for detention; however, it may be a contributory factor if that woman was prone to severe depression and other factors were present, such as inability to comply with treatment because her partner did not wish her to receive it. In this way too, the concept of welfare more accurately allows us to consider the effects of sexual or emotional abuse, the impact of which may fall short of jeopardising health or safety. In considering that a humiliating relationship alone is insufficient reason to consider compulsory measures, we are acknowledging that, in assessing risk, we have to take account of issues of degree of seriousness. There, of course, are other areas of risk to welfare associated with social exclusion, poor self-care, poor environment and the impact of the mental disorder on the individual’s ability to cope with the consequences of these.

The scope to take steps to minimise or prevent risk from happening is restricted by the duties given to anyone with a function under the Act ie in this case the medical practitioner and MHO.

The use of the word 'significant' in the phrase 'were the patient not detained there would be a significant risk to his or her health or safety or welfare; or to the safety of any other person' means 'significant' enough to merit the deprivation of freedom inherent in the authority to detain. This can require a balancing act: If the potential damage caused by allowing the risk to materialise or grow outweighs the loss of freedom caused by the detention, then the detention is merited. In weighing this up the principles become guiding factors, with regard for 'benefit to the patient, equality of opportunity and minimum necessary restriction all figuring large'.

One area in which MHOs can make a significant contribution to the assessment of risk in a crisis situation is by increasing the knowledge of those involved in assessing the risk collectively of the service responses available as well as other informal, but real, supports available to potentially manage and minimise the risky behaviour as it is thought likely to occur.

To illustrate the above, we have introduced to the accompanying hypothetical case study factors in relation to our discussion of welfare above.

## **8. What next?**

Assuming that you are studying this reader in preparation for session 2 of the transitional study days, we advise you to test the fruits of your study against our second self-assessed test of knowledge, attached to this reader. We advise you to read and reflect upon the attached case study if you have spare guided study time. This is because the case study is complicated and poses challenging questions. Your contribution to the discussion will be the better for having considered the questions beforehand. Feel free to make notes of your reflections and compare them to your thoughts after the study session.

### **8.1 References**

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## 9. Training Materials and Exercises for Session 2: The Second Self-Assessed Test of Knowledge

**In order to participate in session 2 of the transitional training a good and relatively detailed understanding of sections 32 to 56 of the 2003 Act<sup>10</sup> and related legislation must be assumed. The exercises are constructed with this in mind and you will not be able to engage in them without this understanding. Unless you are confident that you have acquired such an understanding from another source, you are asked to closely read the didactic material in the second reader before participating in the training event. If you are in doubt about your readiness, we propose the following brief test of knowledge. This should alert you to your fitness to undertake the training.**

**As with the first self-assessed test attached to the Reader 1, you may undertake the test on your own, do it in pairs or small groups or do it on your own and then compare/discuss your answers with fellow participants.**

1. What situations might invoke the local authority's duties to inquire (section 33)? If you feel like a more challenging variant on this question, are you able to address this comparatively, by articulating the ways in which section 33 covers a broader scope than does section 10 of the 2000 Act?
2. Who may make application for section 35 warrants and what potential powers can a warrant contain? Again, if you wish a challenge, are you able to say how section 35 warrants differ from those under section 117 of the 1984 Act?
3. How do the conditions for Emergency Detention under the 2003 Act differ from those contained in section 24 of the 1984 Act?
4. In what way does the person who may grant an Emergency Detention differ from the person who may grant a Short-term Detention?
5. How does the requirement upon the Medical Practitioner to obtain MHO consent differ between Emergency and Short-term Detention?
6. Who may appeal against Short-term Detention?
7. In what ways may Short-term Detention be revoked?
8. In what ways does Short-term Detention contain greater safeguards for the patient, relative to Emergency Detention?
9. In what ways is the local authority's duty to appoint MHOs changed from the 1984 Act to the position under the 2003 Act?

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<sup>10</sup> Sections 32 to 56 relate to appointment of MHOs, duty to make inquiries, application for warrants in relation to section 33 inquiries and matters in relation to emergency and Short-term Detention.

**The answers are found in Annex A.**

**A word about session 2:**

The exercises in this session are deliberately designed to have less conclusive outcomes than those in session 1. They are intended to generate discussion amongst experienced MHOs, who carry awareness of the complexities of real-life practice and should be able to bring this to bear upon the paper exercises in hand. To this end the discussion may very likely raise questions to which there are no answers as yet. Indeed, some of the following is almost designed to do so. Therefore, should you raise any of these questions, it is not a failure on anyone's behalf. Such unanswerable questions are very important and should be kept and used as material for you to reflect upon in practice.

While we do give quoted reference to the law where it is required in the exercises and we provide you with a copy of the abbreviated list of principles used in the Reader 1, you are advised to have a copy of the Act itself and the Codes of Practice to hand for reference during your discussion. This is because interpretation of the actual Act must be seen as the best preparation of all. This is your opportunity to try it out in a safe setting.

**Instructions for discussion of the case study:**

As per session 1, before beginning discussion, each discussion group is asked to appoint a note-taker and spokesperson. This is for the purpose of collecting feedback to the bigger group should it be required. Remember that the emphasis of this undertaking is the sharing of thoughts, concerns, anxieties and ideas, so the more collective contribution is facilitated, the better. You are advised to agree a small number of points from the case discussion. These may be answers to the questions, in so far as they have answers, considerations that you feel are relevant to the matters being discussed or unanswerable questions raised by your discussion.

As well as this generalised set of instructions, the case study has its own brief introduction, which is intended to focus you upon the specific purpose of your discussion. Take time to read the three sections of case study as the programme directs. Allow the questions at the end of the study's three sections to focus your discussion but do not be too constrained by them. While it is unhelpful to go off at irrelevant tangents, do not allow the questions to prevent your group from exploring relevant issues that may be useful in your area of practice. Contribute as fully as you can to the discussion.

Finally, unlike the exercises attached to Reader 1, those contained here are not inter-disciplinary in their focus. You are therefore expected to address them in your role as MHO. For this reason, when referring to the discharge of any given function under the Act, we have been precise so as to constrain you to the MHO task.

**Introduction to the case study:**

You will be working on one case study for the entirety of this second session. To enable you to deal with its complicated structure, it is best to think of it unfolding in

three sections, dealing respectively with inquiries, warrants and detention. Your training facilitator will have a programme prepared to enable you to pace your discussion of the sections of the case study over the day.

The 3 sections of the study direct you along a particular sequence of practice decisions which you may not have agreed to. This is a device to get you to consider various aspects of the Act - making inquiries, applying for warrants and considering emergency and Short-term Detention.

Finally, before you begin to engage with the case study, here is the abbreviated version of the principles to use as an aide memoir:

The principles place a requirement on those people who have what we have called a formal role to discharge any function under the Act. The requirement is that, in discharging his or her function, such a person has regard for:

1. The present and past wishes and feelings of the patient;
2. In so far as is practicable, the views of the patient's named person, carer and any guardian or welfare attorney;
3. The importance of the patient participating as fully as possible in the discharge of the function;
4. The importance of providing information and support for the patient, in the form that is most likely to be understood, to enable the patient to participate;
5. The importance of the range of options available in the patient's case;
6. The importance of providing the maximum benefit to the patient;
7. The importance of the patient's abilities, background and characteristics, including age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group;
8. The importance of providing appropriate services and continuing care to the patient;
9. The needs and circumstances of the patient's carer, providing such information as might be needed to assist in the care of the patient; and
10. The function must be discharged in a manner that involves the minimum restriction on the freedom of the patient that appears to be necessary in the circumstances, encourages equal opportunities and if the patient is a child (under 18 years old) best secures his or her welfare.

### **The scenario, section 1:**

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

Janice McLeod is a woman who has a history of depression in which low self-esteem is a chronic feature. She is in a bullying relationship with her husband John, a man who aggrandises his own self-esteem by dominating and humiliating her. Janice has a job as a school cleaner. She has little social life and keeps poor contact with her elderly mother. This is because John won't allow it, even though Janice is secretly desperately guilty and worried that her mother is increasingly in need of domestic help due to her failing eyesight and diabetes. In almost all decisions Janice defers to

John, to the point where she feels she has no confidence to exercise choice in her own right.

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

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

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

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

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

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

### **Questions:**

1. Is this the sort of situation in which you would consider there to be a duty to make an investigation? In considering this, you may have to closely consider the circumstances in which such a duty arises (section 33 (2) (a)) - 'the person may be subject to or exposed to ill-treatment; neglect or some other deficiency in care or treatment...'
2. If you agree that the conditions may have been met, what advantages are there in having an MHO make the investigation? Who else in the local authority might be competent to make such an investigation?
3. If your answer to the first question was that there would be no duty in this case, what would you do with the information? If your answer was that there is such a duty, how would you proceed?
4. What considerations would there be in your plan of action, in relation to protecting Janice, given her fragile mental health?
5. What considerations would there be in relation to protecting Eileen's confidentiality?
6. Are there considerations in respect of John's rights?

### **The scenario, section 2:**

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

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

### **Questions:**

1. Revisit section 33(2)(a), which now becomes the conditions for considering application for a warrant on the grounds that 'the person may be subject to or exposed to ill-treatment; neglect or some other deficiency in care or treatment...' Assume John's refusal to be adamant. Assume also that you have made repeated attempts to obtain access over a period of days. Assume that, when John is out, the flat is locked and there is no sign of Janice. Assume also that the flat is on the second floor so you cannot even look in through the windows. Is the issue of such significance that you would apply for a warrant?
2. In applying for the warrant, section 35(1) would only allow the authority to gain access to Janice. A warrant under section 35(4) would allow you to obtain

authority to enable a medical practitioner to carry out a medical examination of Janice, were you unable to obtain her consent to it. Under section 35 (5), a section 35(4) warrant also carries potential authority to detain her for a three-hour period in order to facilitate the examination. Assuming that you do agree that a warrant ought to be applied for anyway, from the information you have above, do you consider that these additional powers may be necessary?

3. If you do agree that the wider scope of a warrant under section 35(4) is needed, how would the principles shape your plan for implementing such a warrant? (See the abbreviated list given above.)
4. In having regard for the views of any carer, would you consider John to be Janice's carer? Consider also the Code of Practice's direction that the MHO should consult as widely as possible with any people involved with the care of Janice in the situation.

### **Scenario, section 3:**

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

You may recall that, at the end of the discussion of risk to welfare, in the Reader 2, we promised you a case study upon which to consider the balance between 'significant risk to health, safety or welfare' and the loss of liberty involved in detention. We also suggested that the principles should be guiding features in considering where the balance lay. In particular, in this regard, we highlighted the principles of having regard to benefit to the patient, equality and minimum restriction in relation to freedom.

We do not wish to assume that your discussion of first two sections of the scenario took you in any given direction. Indeed, the design of the case study is intended to provide you with enough uncertainty that your discussion could travel in a number of directions. However, for the purposes of advancing the discussion into the sphere of consideration of consent for Short-term Detention, please assume that you did successfully apply for warrants under section 35(1) and (4).

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

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

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

Should detention be required, Short-term Detention would not be possible in scenario a).

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

**Questions:**

1. What options would be available to you at this point? Do you consider it would be important to call in the AMP/GP for a medical examination?
2. Are there any circumstances in which you would not call in any Medical Practitioner at this stage?

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

**Questions:**

1. From the information you have so far, do you agree that Janice's ability to make treatment decisions is significantly impaired by her mental disorder?
2. Considering our discussion in Reader 2 about 'significant' in respect of 'significant risk to health, safety or welfare', do you consider that the risks to Janice's welfare out-weigh considerations of loss of freedom entailed in any Short-term Detention? In this discussion please bear in mind the principles and particularly those relating to benefit to the patient, equality and minimum restriction in relation to freedom.
3. Discuss the merits of emergency versus Short-term Detention.
4. Assuming detention to have been proposed and consented to, what arrangements should be made for conveying Janice to hospital?



## ANNEX A

### Answers to the second self-assessed test of knowledge (Reader 2)

In this appendix, as in the subsequent appendices giving answers to the other self-assessed tests, we give a set of answers and, in some places, a set of comments upon the answers. The comments are offered as 'marking criteria' by which to measure your answer against the one we give. For example, we ask some questions which are manifestly unfair in that the full answer is a list of legally correct points such as you would not know at this point. In such a case, we loosely identify within what scope a good-enough answer would lie and ask you to use your judgement as to how well your answer compares to this comment.

1. **Q: What situations might invoke the local authority's duties to inquire (section 33)? If you feel like a more challenging variant on this question, are you able to address this comparatively, by articulating the ways in which section 33 covers a broader scope than does section 10 of the 2000 Act?**

**A:** Section 33 of the 2003 Act embraces a wide 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.
- Section 33(2)(d) because of mental disorder, the safety of some other person may be at risk.

Compared to this, section 10 of the 2000 Act is restricted to matters in relation to the personal welfare of the adult.

The detailed answer given above is very precise. Unless you have memorised the 2003 Act, you are unlikely to have replicated it. If your answer states that section 33 relates to wider matters, for example, protection of property and of the safety any other person, it will pass muster.

2. **Q: Who may make application for section 35 warrants and what potential powers can a warrant contain? Again, if you wish a challenge, are you able to say how section 35 warrants differ from those under section 117 of the 1984 Act?**

**A:** In section 35 the MHO alone may make application. The powers contained in it allow for access to the patient, medical examination of the patient should he or she be unable to consent, detention for up 3 hours, to facilitate this

examination and access to medical records by a medical practitioner where it has been denied.

In section 117 of the old Act, the narrower grounds for application were simply that a person is suffering from a mental disorder and has been kept otherwise than under control, in any place; or being unable to care for himself, is living alone, uncared for in any place.

Section 117 could be applied for by either a medical commissioner or an MHO. 117 required execution by a named constable while 35 allows for any constable of the police force to effect the warrant. Section 117 also differs in that it allowed for removal to a place of safety and detention therein for up to 72 hours, whereas section 35 only allows for detention in situ for up to 3 hours, with no authority to remove the person.

Section 117 lasted for 72 hours, whereas a section 35 warrant to gain access lasts for up to 8 days.

Again this answer is more detailed than anything you are likely to be able to give. If you have been able to recall several items from it, your answer will do.

3. **Q: How do the conditions for Emergency Detention under the 2003 Act differ from those contained in section 24 of the 1984 Act?**

A: Section 36 of the 2003 Act requires it to be likely that the patient has a mental disorder and it is likely that, because of the mental disorder, the patient's ability to make decisions about the provision of medical treatment is significantly impaired (36(4)(a) & (b)). Compared to this, section 24 (1) bases its grounds on a presumption that the urgency to detain is by reason of mental disorder.

Section 36(5)(a) states that it is a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment is required. Section 24(1) gives no specific purpose other than the urgency itself;

Section 36(5)(b) states: were there to be no detention, there would be a significant risk to the health, safety or welfare of the patient or to the safety of other persons. Section 24 only gives risks of health, safety or protection of other persons.

The 2003 Act states that arrangements for Short-term Detention would involve undesirable delay. While there is a similar statement in 24(1), the implications are very different in that the undesirable delay of the 2003 Act would be a matter of hours, in order to effect Short-term Detention, while the delay in the 1984 Act would be days or even weeks to make an application to Sheriff Court.

The precision of the above answer assumes that by now you will be able to reproduce sections of the law accurately. It is unlikely that you will have memorised complete sections of the 1984 Act, let alone the 2003 Act. However we would hope that you have a picture of the salient differences

between these sections fixed in your mind by now. For example, if you did not note that the test for ability to make treatment decisions or the condition of significant risk to welfare are new and significantly different conditions that must be satisfied in the 2003 Act, we would not consider your answer to be adequate.

4. **Q: In what way does the person who may grant an Emergency Detention differ from the person who may grant a Short-term Detention?**

**A:** Any medical practitioner may grant Emergency Detention while only an Approved medical practitioner (approved by the Health Board under section 22) may grant a Short-term certificate.

We would hope that you had this question precisely correct.

5. **Q: How does the requirement upon the Medical Practitioner to obtain MHO consent differ between Emergency and Short-term Detention?**

**A:** The 'where practicable' clause stands in relation to MHO consent only in Emergency Detention. In Short-term Detention, no certificate may be granted without MHO consent.

As our answer suggests, the MHO consent position is fairly unambiguous and is a matter of great importance to MHOs.

6. **Q: Who may appeal against Short-term Detention?**

**A:** Either the patient or his/her named person may appeal to the Tribunal at any time and as many times as they wish during the detention period.

We would hope that you included both the named person and the patient here. If you only mentioned the patient, we will grudgingly let you consider it to be correct.

7. **Q: In what ways may Short-term Detention be revoked?**

**A:** The RMO has a duty to review the detention 'from time to time' and to revoke it if s/he is not satisfied that the conditions continue to be met. The Tribunal may revoke the certificate if not satisfied that the conditions are met upon appeal. The Commission may revoke the certificate if they are not satisfied that the conditions remain met.

You may consider your answer correct if you got any two of the above.

8. **Q: In what ways does Short-term Detention contain greater safeguards for the patient, relative to Emergency Detention?**

**A:** The MHO's gate-keeping scrutiny of the conditions of detention is strengthened by the absence of a 'where practicable' clause in respect of MHO consent in Short-term Detention. Short-term Detention is strengthened

by the greater expertise of an Approved Medical Practitioner in terms of understanding of mental disorder and knowledge of legislation. The right of appeal to the Tribunal in Short-term Detention strengthens rights for the patient and named person.

If you did not note that Short-term Detention is strengthened by the no consent = no detention clause, then your answer was not adequate. If you got the other two factors then your answer was very good.

9. **Q: In what ways is the local authority's duty to appoint MHOs changed from the 1984 Act to the position under the 2003 Act?**

**A:** The duty to appoint sufficient MHOs to their area now relates to three pieces of legislation the 1995, 2000 and 2003 Acts, whereas the 1984 Act's duty related only to the 1984 Act itself, in its original design. The 2003 Act makes specific reference to the registration of MHOs and to their education and training, while the 1984 Act only alluded to qualifications, competence and experience in dealing with mental disorder. Most importantly, appointment under 2003 Act is not 'for life', but is most likely to be for periods of 5 years only, renewable upon satisfying the original requirements for appointment as MHO in relation to continuing professional development.

This is another answer that would require you to have memorised the 2003 Act and probably been more acquainted with the detail of section 9 of the 1984 Act than most MHOs would need to be. Therefore, if you vaguely remembered that the 2003 Act involves greater complication across three pieces of legislation, entailing registration and being a time limited appointment, then you did well enough.

## Mental Health (Care and Treatment) Act Scotland 2003 comparison with Mental Health (Scotland) Act 1984

### Main Provisions

2003 Act	1984 Act
Principles S1	No Principles
Tribunal S21	Sheriff Court
Emergency and Short-Term Detention (No relative consent) (sections 36 and 44)	Sections 24 and 26. Relative /nearest relative or MHO consent required.
Compulsory Treatment Orders S63	S18 Orders
Assessment Orders S52D Criminal Procedure (Scotland) Act 1995 (the '95 Act), inserted by S130	S52, the '95 Act
Treatment Orders S52M, the '95 Act, inserted by S130	No direct equivalent
Interim Compulsion Orders S53, the '95 Act, inserted by S131	Interim Hospital Orders S53, the '95 Act
Compulsion Orders S57A(2), the '95 Act, inserted by S133	Hospital Orders S58, the 95' Act
Patient Representation/Named Person S250-254 and S257	Nearest Relative S53
Advocacy S259	No formal right to advocate
Advance Statements S275	No duty re Advance Statements
Local Authority Responsibilities S25-35 Plus!	Local Authority Responsibilities S7-11 and S92
Medical Responsibilities S22-24 Plus!	No specific Medical Responsibilities
Directions, Regulations, Code of Practice, Local Procedures	Directions, Regulations, Code of Practice, Local Procedures

### Principles

2003 Act	1984 Act
Principles s1	No principles - lack of reciprocity
Views of relevant others	Inform nearest relative
Participation in decision making	
Provision of information and support	Provision of information
Range of options	
Maximum benefit	
Patient not treated less favourably than someone who is not a patient	
Non discrimination	
Minimum restriction on freedom	
Carers needs	
Importance of service provision	

## Local Authority Responsibilities

<b>2003 Act S25-35, 227, 229, 259, 277</b>	<b>1984 Act S7-11, S92</b>
Provide and secure care and support services for people with mental disorder (section 25)	Broad duty to provide after-care services. (section 8)
Provide and secure services designed to promote well-being and social development (section 26)	Broad duty to provide after-care services (section 8). Specific duties re training and occupation for persons with 'mental handicap' only (section 11).
Provide assistance with travel (section 27)	No specific duty, except in relation to persons with a 'mental handicap'
Co-operate with Health Boards and others (section 30)	Similar
Request assistance from Health Boards (section 31)	
Appoint MHOs (section 32)	Similar (section 9)
Duty to inquire (section 33) where: Possible ill-treatment, neglect, or deficiency in care or treatment Property may have been at risk Person is living alone and unable to look after themselves	
Warrant can be used to further inquiries. Entry by MHO, any constable or other authorised person (section 35)	S117 warrant but not for inquiries Entry by named constable
Assessment of needs,(Part 14)	
Designation of mental health officer responsible for patient's case after each 'relevant event' (section 229 and 232)	
Social Circumstance Report required after each 'relevant event' unless MHO records why it would serve 'little, or no, practical purpose' (section 231)	SCR required only in certain circumstances and not where MHO consents to Short-term Detention (sections 22 and 26 and certain CPA orders)
Named person – MHO duties (section 255)	
Local Authorities and Health Boards must collaborate to secure the availability of independent advocacy (section 259)	
Entry, removal and Detention under Part 19 Education of persons who have mental disorder. (section 277)	S117 warrant, S118 place of safety (constable only)
Parental relations. (section 278)	

## Meaning of Mental Disorder

2003 Act	1984 Act
Mental illness or personality disorder	Mental illness including personality disorder
Learning disability	Mental handicap
However caused or manifested	However caused or manifested
	Mental impairment
	Severe mental impairment
NOT Sexual orientation Sexual deviancy Trans-sexualism Transvestitism Dependence on, or use of, alcohol or drugs Alarming or distressing behaviour Acting as no prudent person would act	NOT Promiscuity Sexual deviancy Other immoral conduct Dependence on alcohol or drugs
Eating disorders?	Eating disorders?

## Meaning of Treatment

2003 Act S329	1984 Act S 125
Medical treatment is treatment for mental disorder including nursing, care, psychological intervention, habilitation and rehabilitation including education, training in work, social and independent living skills.	Medical treatment includes nursing, and also includes care and training under medical supervision

## Emergency Detention - Conditions

2003 Act Part 5 (S36-43)	1984 Act S24-25
Mental disorder	Mental disorder
Decision-making ability significantly impaired	No mention of decision making ability
Matter of urgency to determine medical treatment	Admission to hospital urgent necessity
Risk to health, safety or welfare of patient, or safety of others if not detained	Risk to health or safety of patient or for protection of other people
Short-term Detention would involve undesirable delay	An application for admission would involve undesirable delay
Consent from MHO where practicable	Consent of relative or MHO where practicable
Certificate issued on same day as medical examination or 4 hours between examination and certificate	Recommendation on same day as examination

## Emergency Detention - Effect

2003 Act S36-43	1984 Act S24-25
Removal to hospital within 72 hours	Removal to hospital within 3 days
Assessment by AMP as soon as practicable after admission on emergency certificate.	
Detention for up to 72 hours	Detention for up to 72 hours
Detention ends when Short-term Detention imposed.	Detention lasts for 72 hours unless discharged prior to this.
Duty to inform nearest relative, person residing with patient, named person, MWC, Local Authority	Duty to inform MWC, nearest relative, and a person residing with the patient.
No new Emergency Detention immediately after expiry	No new S24/25 immediately after expiry
Power to suspend	
No appeal	No appeal
No compulsory treatment except where the treatment is urgently required (section 243)	No compulsory treatment

## Short Term Detention in Hospital - Conditions

2003 Act Part 6 (S44-56)	1984 Act S26
From hospital or community	From Emergency Detention in hospital
Approved Medical Practitioner (S22)	Approved Medical Practitioner (S20)
Mental disorder likely	Mental disorder
Likely that decision-making ability is significantly impaired	
To determine medical treatment needed, or give medical treatment under Part 16	Appropriate to be detained
Significant risk to health, safety or welfare of patient, or safety of others	Interests of patient's health or safety or with a view to protection of others
Consent from MHO required at all times	Consent from MHO or nearest relative, where practicable
Certificate issued within 3 days of examination	Examination within 72 hours of S24 Detention
Extension for up to 3 working days	Extension for up to 3 working days

## Short Term Detention in Hospital - Effect

2003 Act	1984 Act S26
Removal to hospital within 3 days	
Starts immediately and revokes Emergency Detention	Starts when Emergency Detention expires
Detention for up to 28 days (Plus 3)	Detention for up to 28 days (Plus 3)
Determine treatment	
Compulsory treatment, (subject to Part 16 )	Compulsory treatment, (subject to Part 10 )
Duty to inform named person, guardian, welfare attorney, Tribunal, MWC	Duty to inform MWC, nearest relative, Local Authority
MHO interview prior to consent	
LA must designate a MHO	
Social Circumstance Report, by MHO (unless it would serve little or no purpose)	Social Circumstance Report
RMO continuing duty to review	RMO duty to keep under review
MWC power to revoke	MWC power to revoke
Application by patient or named person to Tribunal for revocation.	Appeal to Sheriff (the exception)
Appeal to Sheriff Principal (if appeal to the Tribunal fails)	No further appeal

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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