

The New Mental Health Act

Transitional Training Guide

Introductory Training for Mental Health Officers and Other Practitioners

Compulsory Treatment Orders and Related Matters

Reader 3

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

TRANSITIONAL TRAINING GUIDE

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

COMPULSORY TREATMENT ORDERS AND RELATED MATTERS

READER 3

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

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1. Introduction

This offers general introduction to the contents of the reader and advice to MHOs who will have worked through the previous materials and others using the reader who may not have had this opportunity.

This reader is offered to MHOs and their Approved Medical Practitioner colleagues. In particular it focuses on the:

- Process of application to the Tribunal for Compulsory Treatment Orders (CTOs);
- Medical recommendations (Mental Health Reports);
- MHO's report and Proposed Care Plan;
- Tribunal system;
- Compulsory powers that may be authorised in CTOs;
- Process of monitoring, administering and reviewing, varying and revoking Orders and appeals; and
- Treatment in relation to compulsion.

These will be examined in relation to the Principles and to related matters such as 'advance statements', the role of the 'named person' and the duty to provide advocacy.

1.1 Guidance for MHOs

The Reader presupposes the underpinning knowledge requirements for an MHO practising under the 1984 and the 2000 Acts and the grounding of knowledge in the 2003 Act at a level given in Readers 1 and 2 of this series.

1.2 Guidance for Medical Practitioners and others who have not worked through the transitional training to date

For approved medical colleagues, the Reader may be used with a lesser level of detailed knowledge of the Act. However, it is important to have an understanding of the function of the named person, the broad outline of advance statements and the general provisions of Emergency and Short-term Detention. In particular, this Reader assumes a reasonable knowledge of the Principles as set out in Part 1 of the 2003 Act. If you are uncertain whether or not your knowledge is sufficient to the task we refer you to Reader 1 and advise you to use the first self-administered test of knowledge attached to it.

This reader prepares you for the case study attached to it. This gives the framework and exercises for the third group study session in this sequence of transitional study. The reader does not seek to replicate or substitute knowledge of the Act itself but is intended to expand upon and explain in broader terms certain key matters contained in the Act. It also draws from the draft Codes of Practice¹.

¹ As with previous material in this sequence, we advise you that we have been unable to work to the final versions of the Civil and Criminal Procedures Codes of Practice. However, care has been taken to work to the most currently available drafts.

2. Compulsory Treatment Orders

This section addresses CTOs, the powers of compulsion they offer and the process of application to the Tribunal in order to obtain them.

While it may be helpful to gain an initial impression of CTOs by likening them to section 18 of the 1984 Act, they only share common superficial details:

- The granting of both section 18 and the CTO rests upon application to an independent body, the Sheriff Court for section 18 and the Tribunal for CTO;
- Both may last for initial periods of up to six months, renewable in the first instance for a second period of up to six months and, there after, annually;
- Both may be applied for in continuance of Short-term Detentions (in so far as one can refer to section 26 of the 1984 Act as a Short-term Detention);
- Both may be applied for in their own right, in respect of a patient already informally in hospital or a person living in the community; and
- Both rest on reports written by two Medical Practitioners, one of whom must be approved by the Health Board.

There the similarities begin to peter out. Significant differences are:

- The MHO alone may be the applicant for CTO;
- There is no role for the nearest relative or any other person to apply for CTO;
- The process of dealing with applications both administratively and in terms of procedure will develop in ways that differentiate Tribunals from Sheriff Court;
- The intervention of advocacy, which is now elevated to the patient's statutory right, may make the process of hearings very different;
- The same may become true in respect of the role of the named person and the function of advance statements;
- The scope of authority to compel the patient is far broader under CTO than section 18; and
- The process of application, monitoring, review and variation of the powers of a CTO are very different.

2.1 Powers of the CTO

The Tribunal may authorise and vary a wide range of powers for both care and treatment in hospital or in the community. These powers rest upon a care plan submitted by the MHO, indicating which aspects of delivery of care and treatment require delivery by compulsion of the Order. These powers range across the boundary between hospital and community and mean that there is no need to rely on the equivalent for Leave of Absence in the 2003 Act.

2.2 Routes to CTO

A CTO may be applied for in respect of either a person already living in the community or for an inpatient. A hospital patient who is the subject of consideration for application may either be informal or already subject to Short-term Detention.

While there is nothing in law to preclude application for CTO in respect of a patient who is subject to Emergency Detention, in practice there would never be time within the 72 hours to make the application and it would be unlikely that the proper assessments for a CTO could be made under these circumstances.

2.3 Application for CTO in respect of a formal patient

In the situation where there is not enough time remaining of a Short-term Detention to make a CTO application Section 47 allows an AMP to grant an extension to the 28 days. For the AMP to grant a section 47 extension the following must be fulfilled:

- The original conditions of Short-term Detention still prevail;
- There has been an unanticipated deterioration in the patient's mental health, such as would necessitate application for a CTO; and
- The MHO gives consent.

This authorises extension of detention for 3 working days (i.e. not counting Saturdays or Sundays or bank holidays) starting on the expiry of the Short-term Detention, for the exclusive purpose of making an application.

2.4 Section 68: Extension of Short-term Detention

Where an application has been made in respect of a patient who was subject to Short-term Detention or its section 47 extension and that detention period has expired before the Tribunal is able to determine the application, section 68 would authorise an extension for 5 working days to allow a tribunal hearing to determine the application.

It should be noted that these extensions must be viewed in relation to the Principle contained in section 1(4), 'the least restriction in relation to the freedom of the patient'. The implication here is that either of these extensions would only be applied in exceptional cases of absolute necessity and, as with any detention, for the minimum necessary period, never for the full term allowable simply for the sake of opportunity and never for the convenience of those administering the detention. In ordinary circumstances where the subject of an application is a patient already detained in hospital, multidisciplinary discussion should identify the need to make the application in good time for it to be managed before the expiry of the 28-day period.

2.5 The process of application for CTO

It should be said at the outset that the process of making an application is complicated and a great burden of work rests upon the MHO. The Draft Code of Practice emphasises that the process should be multidisciplinary and should involve in-depth consultation of all parties from early in the planning stage, throughout the entire process. It especially emphasises that the MHO must be central to the process and that the authors of the two Mental Health reports must have regard for the time-scale in relation to the MHO's task. The Draft Code advises that, to do otherwise would be to jeopardise the application.

The application must be made on the prescribed form. It must be accompanied by the following:

- Two Mental Health Reports (the reports by Medical Practitioners);
- The MHO's Report; and
- The MHO's Proposed Care Plan.

All of these must be submitted within a given time-scale, on prescribed forms.

2.6 Outline summary of the process of making an Order

The powers of a CTO, those measures that it may enforce- are proposed in the application and, if the application is granted, they are authorised by the Tribunal. While potentially wide ranging, these powers are drawn from a restricted menu contained in section 66, under the heading '**measures that may be authorised**'. In summary, these measures may compel the patient:

- To be detained in hospital;
- To receive medical treatment in or out of hospital;
- To receive community-care services or other services;
- To reside in a specified place;
- To afford access to MHO, RMO and various others; and
- To get permission from the MHO to change place of residence.

For the precise and detailed list of these measures, see 3.3 below.

What gives the CTO its breadth of scope is not just that the Tribunal may draw from this list of measures when it makes the Order. It must also detail what the Act refers to as **recorded matters**. These recorded matters are an itemised list of essential elements of a care plan. The measures of compulsion authorised in the CTO may be used to enforce delivery of these elements. For example, if it were considered essential that the patient be compelled to live in a particular scheme of supported accommodation and receive a weekly depot injection, these would be recorded as recorded matters in the Order. However, in order to compel the patient to receive them, the CTO would also have to contain the appropriate measures of compulsion drawn from the menu of powers contained in section 66(1), for example, 'the giving to the patient, in accordance with Part 16 of this Act, of medical treatment; the imposition of a requirement to attend...specified places with a view to receiving medical treatment; and the imposition of a requirement on the patient to reside at a specified place (section 66(1)(b), (c) and (e))'.

The two medical reports upon which the application rests, referred to as 'mental health reports' (section 57(4)) must explain the nature of the mental disorder and the symptoms it manifests. They must propose which measures of compulsion are necessitated by the patient's condition. The MHO's report (section 61) must provide the MHO's view of the relationship argued in the mental health reports, between the mental disorder, its symptoms and the required measures of compulsion. The MHO's proposed care plan (section 62) must detail the essential elements of care that are required for the patient. If accepted by the Tribunal, these elements may become the recorded matters in the Order.

When the application is submitted to the Tribunal it determines whether to include all of the proposed measures in the CTO and whether it will include all the proposed essential

elements of the care plan in the list of recorded matters in the Order. In doing so it may reject the application outright or vary the proposed measures and/or the elements of the proposed care plan by removing or adding to them as it thinks fit.

2.7 The Mental Health Reports

As noted above, the CTO application rests upon the two mental health reports by Medical Practitioners one of whom must be an AMP. The Code of Practice emphasises that this should be the RMO, where one has already been appointed to the patient. The Code also indicates an expectation that the other report would be made by the patient's GP, or at least a GP from the patient's practice. Where the patient has no GP, the second report should be written by another AMP, not from the same clinical team as the first and not working directly with the first or under his or her jurisdiction.

The purpose of the first report is to provide an expert knowledge of the patient's treatment needs in relation to mental disorder. Ideally, the second report should furnish more extensive knowledge of the patient's history and an understanding of any relevant physical health matters, such as a GP would have.

The reports are based upon medical examinations of the patient, which should be made independently of each other. You are directed to the Code of Practice for a more detailed discussion of the sorts of situations in which these examinations might be jointly undertaken, what ought to constitute an examination and how it may be undertaken in less than ideal circumstances, who may or should be present and other such issues.

If these reports constitute the start of the process of application, their basis is in the conditions that must be satisfied for a CTO to be granted. Therefore, central to each report is a statement that its author is satisfied that the conditions set out in section 57(3) are met, giving reasons why she/he believes the conditions to be met (see 'Conditions upon which the application rests' below).

The mental health reports must also agree upon the 'type' or 'types' of mental disorder (section 57(4)(c)). By this, the Act does not intend that the reports need to agree upon a specific diagnosis. 'Type' of disorder is given in reference to section 328(1), i.e. '(a) mental illness, (b) learning disability or (c) personality disorder'. However, section 57(4) (d) also requires the reports to give the symptoms of mental disorder and the ways in which the patient is affected by this disorder.

A further requirement of the mental health report is that the Medical Practitioner states the measures that should be authorised in the Order. These should relate to the elements of care and treatment proposed in the MHOs care plan. This requires close discussion between all parties *before* the MHO begins to make the application.

In summary the mental health reports must articulate how the symptoms of mental disorder affect the patient to such an extent as to necessitate the use of specific measures of compulsion. In relation to this point let us consider the definition of medical treatment given in section 329 of the Act, 'Interpretation':

'medical treatment means treatment for a mental disorder and... includes:

- a) Nursing;
- b) Care;
- c) Psychological intervention;
- d) Habilitation (including education, and training in work, social and independent living skills); and
- e) Rehabilitation...’.

Even setting aside that a CTO may authorise a broad range of compulsory measures other than medical treatment (for example, requiring the patient to reside at a specified place), the authority to provide medical treatment alone covers a wide range of interventions. Given that interventions such as care and rehabilitation blur the boundaries between the medical expertise that must be reflected in the mental health report and the expertise of the MHO in relation to the social antecedents and consequences of mental disorder, we can begin to see the need extolled in the Code of Practice that the entire process must be characterised by close interdisciplinary working. This is underpinned by the requirement that the MHO will comment upon the contents of the mental health reports.

Upon receipt of the mental health reports, the MHO has a duty to make the application, whether or not s/he agrees with the need for it.

2.8 Conditions upon which the application rests

In the conditions, set out in section 57(3) you should begin to recognise another variation on the theme we encountered when discussing conditions for Emergency and Short-term Detention:

The Medical Practitioners must be satisfied:

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

We can note several things from comparison with the conditions for Emergency and Short-term Detention. In the case of CTO, it is not merely likely that the patient has a mental disorder; it must be proposed as a certainty. To establish this certainty, either the patient will have to be well known to the Medical Practitioner, the patient will have to have had a period of assessment in hospital (for example under Short-term Detention) or the medical examination for the mental health report will have to have been very thorough indeed.

The condition that there is a mental disorder is tied to the availability of treatment and the likelihood that such treatment will prevent deterioration or alleviate the patient’s condition. Here is an indication that the purpose of a CTO is to provide such treatment

and secure the circumstances of care under which it may be provided in order to prevent deterioration or alleviate symptoms. This inter-relationship between the disorder, its treatability and the availability of such treatment must be carried in mind when considering the proposal of CTOs for individuals for whom there seems to be no effective treatment. There is discussion of this point in relation to personality disorder and Criminal Procedures in Reader 4.

The prevention or reduction of significant risk to health, safety or welfare, or safety of others is also directly connected to the availability and provision of care and treatment. With reference to our discussion of risk assessment in Reader 2, this clause demands a solid risk assessment in relation to the mental disorder and the proposed provision of treatment.

A test of the patient's capacity to make decisions in relation to this treatment is included in these conditions. As in the conditions for Emergency and Short-term Detentions, it is stated that the only valid reason for considering the patient to lack capacity in this narrow regard is by reason of the mental disorder. In other words, there is no reason for considering the patient to lack the ability to determine treatment decisions solely on the basis that we disagree with the decisions being made. For example if we think it seems unwise to attempt to treat schizophrenia with faith healing, this alone does not constitute an inability on the patient's behalf to make such a choice. Similarly, we may not deduce that the patient is incapable of making such decisions because of any factors, other than the mental disorder itself, for example on the sole grounds that the patient appears to be making unwise decisions because s/he is drunk or has ingested too much cannabis.

2.9 Time-scale for application

The medical examinations upon which the reports are based must take place within five days of each other. From the date of the last medical examination the MHO has a fourteen-day period in which to lodge the application with the tribunal. The Draft Code of Practice strongly emphasises the need for the Medical Practitioners to be aware that this 14-day time-scale does not begin with the MHO's receipt of the reports or with the completion of the reports, but with the completion of the latter medical examination. In emphasising this, the Draft Code outlines the heavy workload for the MHO between receiving the reports and submitting the application.

The need for close interdisciplinary planning is again emphasised here. Best practice would allow for the MHO and Medical Practitioners to forward-plan the entire process. There is no valid way of using any of the extensions to Short-term Detention discussed above as means to manage the bureaucratic process of making the application. The principle (section 1(4)) of the least restriction to the patient's freedom is given to ensure that a person is not needlessly deprived of liberty for any period of time, for any reason.

2.10 Who ought to be the MHO applicant?

Section 229 of the Act makes reference to the designated MHO in relation to the MHO role in Short-term Detention, CTOs and other Orders, described and defined as 'relevant events' in section 232. This imposes a duty on local authorities to designate an MHO for the purpose of the tasks prescribed in any of these interventions. While section 229 allows for the designated MHO to be replaced by another, for example in

the event of annual leave or ill-health or in the event of the designated MHO leaving the authority's employment, this implies a fixed and continuing role for that MHO, wherever practicable, for the duration of the intervention.

The Code of Practice suggests that, best practice is for the role of the designated MHO to stretch beyond the application process into the monitoring and review of the Order, once granted. It also suggests that 'where an MHO has already been designated as having responsibility for that patient's case, then that MHO, wherever practicable, should prepare the application'. Thus, where there is previous MHO involvement, for example in any Short-term Detention preceding the application, best practice would be for that designated MHO to continue the role, making best use of previous knowledge and established relationship.

This is an indication of a more extended role for MHOs under the 2003 Act than the brief role focused on minimal points of statutory contact that has often evolved in practice under the 1984 Act. This possibility that MHOs may need to hold long-term MHO cases will require a rethinking of the role both by practitioners and their employers.

2.11 The process of application and MHO Reports

By way of emphasising the need for strong communication the Draft Code of Practice advises that a 'high level of detail (in the mental health reports) gives the patient's MHO the widest scope possible within which to prepare the application. Similarly it allows the Tribunal to make as informed a decision as possible with respect to the application. It is important to note that the MHO should not have to rely solely on the evidence provided in the mental health report when it comes to his/her knowledge of the patient's medical state: the function of a mental health report... is to **reflect** the communication between the Medical Practitioner and the MHO which has already taken place prior to the report being prepared, not to **serve** as the communication between the two of them.' (The bold print is our emphasis).

Upon receipt of the reports the MHO must interview the patient unless it is impracticable to do so. The Code of Practice rightly indicates that it is unlikely that it will ever be completely impracticable for the MHO to conduct this interview. The MHO may need to make several attempts to conduct the interview. The Code suggests exceptional circumstances in which the interview may be severely restricted- for example where there is immediate risk of physical assault from a patient who is grossly psychotic. In such cases these circumstances must be noted in the application and the relative lack of interview should be compensated for by discussion with the named person and significant others.

The Code also advises that the focus of the interview should be 'on points of contention between what the two Medical Practitioners have proposed in their mental health reports and the views of the patient.' The substance of the interview may be augmented by other sources such as any advance statement.

2.12 The MHO report

The MHO Report accompanies the application and Mental Health Reports. It should be noted that there will be considerable duplication of information between the mental

health reports and the various reports and documents submitted by the MHO. The purpose of the MHO Report is to provide the Tribunal with the following information:

- The patient's name and address;
- The names and addresses of the named person and primary carer;
- The steps made to try to identify these people. In pursuit of the principle that regard must be had for the views of the named person, any carer etc, it is important that these views are represented in the report. The Code advises that, within the bounds of confidentiality, a broader regard should be had for the views of those involved in informal support networks;
- Steps taken by the MHO to inform the patient of his/her rights in relation to the application and the availability of independent advocacy services;
- Steps taken to ensure that the patient has had opportunity to access these services; and
- If it has not been possible to advise of and/or ensure access to advocacy services, reasons must be given. Such circumstances, however, would be exceptional, for example, in a minority of cases of the most severe dementia where the imparting of such information might be meaningless. Extra care should be taken in such cases to impart such information to relevant others such as named person, advocate, primary carer, wherever appropriate.

The MHO must give his or her views (including diverging opinions) on the mental health reports. These views should not be presented as a simple agreement or disagreement with the mental health reports. They must be presented in reasoned and evidence-based arguments that either strengthen or refute all or any aspect of the mental health reports. (See **Disagreement between MHO and Medical Practitioner**, below.) At its heart, the MHO's report is an assessment of the needs arising out of mental disorder.

The reasoned line of argument should reflect the principles. For example consideration of 'the least restriction to the freedom of the patient' and 'consideration of 'the range of alternatives available' would both be important in deducing the appropriateness of any proposed measures of compulsion. As the Draft Code of Practice suggests, in order to consider such matters properly, the MHO may need to request a report by (for example) a clinical psychologist. Assessment by a service provider may be sought to offer the fullest information on whether or not a particular residential service is suitable in consideration of a measure requiring the patient to reside at a specified place. This would be particularly important where a community-based Order is being considered.

If known, the MHO must also provide details of any advance statement made by the patient, as long as s/he has not competently withdrawn it. Comment should be made regarding the steps that have been made to accommodate the wishes set out in any advance statement in terms of the proposals for care and treatment.

An assessment should be made of the patient's ability to accept informal treatment and this should include an assessment in relation to the test of impaired ability to make treatment decisions. As the Draft Code advises 'It is therefore crucial that the MHO addresses the appropriateness of each of the compulsory measures...recommended in the mental health reports.'

In relation to this and to any advance statement, it is important that the patient's 'past and present wishes and feelings' are reflected. In the past, some service users have

reflected that their views were lost or dismissed as irrelevant in the process of detention. This principle (section 1(3)(a)) ensures that this cannot be the case anymore.

The report may give any other information that the MHO considers relevant to the determination of the application.

In a minority of cases the law allows for the Medical Practitioners to withhold from the patient notice that an application is being made, for example in certain cases of severe dementia or in cases where the patient is likely to abscond. In this case the MHO must comment upon this. However, as the Draft Code of Practice suggests the withholding of such notice from the patient may place the MHO in conflict with the duty to inform the patient of his/her rights and the rights in relation to advocacy. As the Draft Code suggests, this would be a situation in which close collaboration between MHO and RMO would be advisable to determine how best the MHO might discharge this duty.

2.13 Disagreement between MHO and Medical Practitioner

MHOs and Medical Practitioners bring different perspectives to any situation. While this may strengthen assessment when these perspectives are brought together, there will be occasions in which the different perspectives cannot be resolved in a unified assessment. In assessment for CTO, the MHO still has a duty to make an application where s/he disagrees with any or every aspect of the mental health reports. In our discussion of the mental health reports above we briefly touched upon the requirement that the MHO will give an opinion on the contents of these reports. As you will see, when we look at forms on the study day relating to this reader, this requirement is set out for the MHO to address in Part 5 of the prescribed form for MHO reports. This ensures that the MHO's independent assessment is contained within any application.

Where an MHO concludes that the criteria for compulsory measures has not been satisfied (where the conditions set out in section 57(3) are not met), the Draft Code informs us that 'the assessment should include an analysis of the likely impact on the patient's health, safety and welfare and the safety of any other person, if the care and treatment does not proceed on a compulsory basis.' It advises that such dissent should only be articulated following detailed discussion with the authors of the mental health reports. Where such disagreement exists, it is placed in the hands of the Tribunal to resolve it in determining the application. Therefore, the better all the reports are articulated, the stronger will be the basis upon which the final outcome rests.

2.14 The Proposed Care Plan

It is already emerging from our discussion above that there will be a complex interweaving of information, discussion and sometimes argument in the process which informs the writing of the Mental Health Reports and the MHO Report. The Proposed Care Plan is a means of pulling together from this complex weave all this material in a form that articulates the care and treatment elements which it is proposed should be provided. If the focus of the reports is on assessment of need and how care and treatment are to be delivered by means of measures of compulsion, the Proposed Care Plan is about what care and treatment is to be given to meet the assessed needs.

As we get into the discussion of the purpose of the Proposed Care Plan, we will explore the relationship between its contents and these measures of compulsion that can force

the patient to accept aspects of it. In this regard, the mental health reports and the MHO's report contain the factual information and arguments for proposing compulsory measures. These are recommended to the Tribunal as necessary means to the end of delivering those essential aspects of the Proposed Care Plan which the patient is unable to accept voluntarily. If this distinction between measures of compulsion and elements of the care plan still confuses you, we advise you to cast your eyes over **3.3 Measures that may be authorised**, below.

The MHO needs to be aware of the broad potential for compulsion in a CTO. While 'medical treatment' for mental disorder is given a very wide meaning in section 329, 'care' is left undefined in the legislation. Thus, care could consist of almost any aspect of service provision that ameliorates the patient's condition or prevents its deterioration, in regard to health and safety and particularly in regard to welfare.

If you had begun by associating the term 'care plan' in this Act with the familiar usage of the term in care management, you may now perceive significant differences between the two in the following discussion. Notable amongst the differences is that the Proposed Care Plan of section 62 includes proposals for the administration of medical treatment.

The Draft Code of Practice advises that while the MHO is the proposer of the Care Plan, the devising of the plan should be a multidisciplinary venture. For example, where 'treatment' includes 'nursing care or 'psychological intervention', those disciplines ought to contribute to the design of the plan. This then begs the question of how the MHO may articulate dissent to aspects of the plan that she/he is proposing if it rests on the pulling together of multidisciplinary views. The Draft Code advises that it is imperative that such differences of opinion are articulated within the plan.

To go further, it may be relevant for the MHO to articulate the differences of opinion of others within the clinical team to any aspect of the plan, in so far as they are relevant. Consider, for example, a plan that proposes a programme of behaviour modification to which the psychologist agrees, but s/he does not agree about the priority this should be accorded and places the patient on a three-month waiting list. Clearly this would be a significant matter in relation the statement in section 57(3)(b) of the conditions for an Order, 'that... the treatment is available'.

The Act sets out **the content for the Proposed Care Plan**. The four key factors are:

- The needs of the patient;
- The actions proposed to meet those needs;
- The objectives of those actions; and
- The parties who undertake responsibility to carry out the actions.

This structure is laid out on the form on which the proposed care plan should be recorded (see appendix V). Helpfully, the form contains a grid, which could not be completed without these matters being fully discussed. The proposals must differentiate those aspects of care and treatment that are essential from those which are non-essential. This is a point that will become significant when we discuss 'recorded matters' below, as the Tribunal will only elevate elements of the care plan to the status of recorded matters if they are satisfied that these elements are essential. The Proposed Care Plan must also indicate which of the essential elements are likely to be accepted by the patient

and therefore, which elements might be offered to the patient on a voluntary basis. The measures of compulsion sought in the application should strongly relate to those aspects of the plan about which the patient does not agree.

It must be borne in mind that it is important to make a record of unmet need in the Proposed Care Plan.

2.15 Summary of the Process of Application for CTO

Informal Patient Formal Patient Detained by Short-term certificate or extension



**Examination by two Medical Practitioners (one must be AMP/preferably RMO)
The completion of the latter examination starts the 14-day period in which the application must be completed and submitted to the Tribunal.**



Preparation and submission to designated MHO of the two Mental Health Reports by the two Medical Practitioners.



MHO interviews the patient; notifies of rights to independent advocacy; ensures access to advocacy; determines named person.



MHO prepares Application and MHO report, including views on the application and the matters set out in the Mental Health Reports.



MHO prepares the 'proposed care plan' in consultation with RMO and others.



Submission of application to the Tribunal within 14-days of last medical examination.



Hearing Convened

3. Tribunals

This section explains the role of the Tribunal in determining matters in relation to CTOs. It explains the powers that may be authorised and the function of ‘recorded matters’.

At the time of writing we do not yet have the detail of how Tribunal panels will go about their business. On top of this, it is even less possible to second guess how the system will develop in local areas let alone to predict how case based precedent will influence practice.

What we do know is that tribunals will deal with applications having regard for the principles at every step of the way. We can also imagine how tribunal hearings will accommodate and interact with the named person and with patient’s advocates. However, it is difficult to foresee whether the impact of legal representation at hearings will develop to make the process more adversarial or whether the relative informality of the process, compared to the Court setting, will have an effect upon how hearings are conducted.

3.1 What criteria will the Tribunal use to determine an application?

The Tribunal will use the same criteria as should be used by the applicant and the authors of the mental health reports - namely the conditions set out in section 64(5)² considered in conjunction with the principles. In considering these matters, the Tribunal may take evidence from a wide variety of sources. A range of parties³ (detailed in section 63(3) must be allowed to make either oral or written representation. The Tribunal has powers to compel any party to give evidence and it has power to take oaths.

The powers of the Tribunal, in determining an application are:

- To grant it;
- To refuse it;
- To grant an interim Order for a shorter period, if the Tribunal thinks the initial six-month duration is too long;
- To vary measures; and
- To add new ones.

3.2 Recorded matters

In granting an Order the Tribunal must specify such essential medical treatment, community care services and other relevant services as will be contained in the Order. It is the purpose of the Proposed Care Plan to enable the Tribunal to make an informed

² The conditions are- the existence of mental disorder; the availability of treatment likely to alleviate or prevent deterioration of the condition; the risks to health, safety and welfare; the impairment of ability to make treatment decisions because of mental disorder and the necessity of the Order.

³ These include the patient, his or her named person and main carer, the MHO applicant, the authors of the mental health reports, any welfare proxy, any curator ad litem appointed by the Tribunal and (the catch-all category) any other person appearing to the Tribunal to have an interest in the application.

decision in this regard. These essential elements are referred to in the Act as 'recorded matters'. They are elements which the Tribunal feels are essential aspects of the patient's care and treatment.

It does not appear that it is necessarily the case that all 'recorded matters' need be delivered by compulsion. As we have suggested, the MHO's care plan should be as full as possible and should focus holistically upon the needs of the patient, not just those needs about which there is disagreement with the patient. Some of them may relate to essential elements of the Proposed Care Plan to which the patient readily agrees.

The purpose of elevating their status to that of recorded matters reflects what is referred to as 'reciprocity' (see Millan in the Reader 1)⁴. Whether, at any given time, they require to be delivered by compulsion or not, 'recorded matters' are invested with some sort of guarantee that their delivery will be scrutinised by the Tribunal. At least, where an element that is a 'recorded matter' is not being provided to the patient during the course of the Order, the RMO has a duty to bring this fact to the attention of the Tribunal. The Commission also has powers to bring the non-delivery of recorded matters to the attention of the Tribunal.

Upon such notification from either the RMO or the Commission, the Tribunal must decide whether to vary the compulsory powers authorised by the Order or to vary the Order by removing the recorded matter from it. Consider, for example, a patient who is subject to a CTO which contains a compulsory measure authorising detention for treatment in hospital. While disagreeing about the need to be in hospital and to receive treatment, this patient is able to agree to accept independent living skills training and, this voluntary training is a recorded matter. If, during the course of the Order, the training becomes unavailable, the RMO has a duty to take matter back to the Tribunal. The Tribunal then has to consider whether there is a need to alter the Order to contain an alternative service to replace the unavailable service and to compensate for its loss.

While the Tribunal has no ultimate power to force any body, Health Board or Local Authority, to provide care or treatment, it has this authority to oversee the delivery of recorded matters and may call upon these bodies to account for non-delivery.

As an alternative to varying an Order, the Tribunal may decide to revoke it completely, if this lack of delivery appears to invalidate the entire Order. Consider for example, that it was a recorded matter for a patient to receive a depot injection in the community and the CTO authorised administration of the injection by compulsion. However, through avoidance and non-compliance, this patient has managed to avoid treatment for a significant period and has managed his mental disorder without it. This may show that the continuance of the Order is not in keeping with the conditions of the Order (section 57(3)) and principles, because events have shown that the measure of compulsion was not in fact necessary.

Recorded matters that are finally contained in an Order need not be drawn from those elements detailed in the MHO's Proposed Care Plan. In determining the application the Tribunal may find that some of the proposed elements in the care plan are not merited or it may identify others that are not contained in the plan but ought to be. The Tribunal

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

may similarly add to, remove or vary any of the measures of compulsion proposed in the application (in the Mental Health Reports and the MHO's report).

3.3 Measures that may be authorised

The Tribunal has authority to require compulsion in relation to the following matters.

- The patient may be detained in a specified hospital (section 66(1) (a)).
- The patient may be subjected to the administration of medical treatment in accordance with the Act, whether in or out of hospital (a matter we will discuss below). However, if the treatment is to be given in the community it may not be enforced in the patient's place of residence (section 66(1)(b)).
- From this there follows a requirement upon the patient to attend specified places at specified times, for treatment to be administered (section 66(1)(c)).
- There is a similar requirement to attend for receipt of community-care services or other services (section 66(1)(d)).
- The patient may be required to reside at a specified place (section 66(1)(e)).
- The patient may be required to allow visits to be made to him or her in his or her place of residence 'by the MHO, RMO or any other person authorised by the RMO as having responsibility for providing medical treatment, care or other services (section 66(1)(f)(i),(ii) and (iii)).
- The patient may be required to obtain approval from his or her MHO for any proposed change of address. He or she may also be required to inform the MHO of that change before it takes place (section 66(1) (g) and (h)).

3.4 Authorising an Interim CTO

In certain circumstances the Tribunal may consider that it is overly restrictive or not appropriate at this stage to grant a CTO for the full 6 months. In such circumstances it may grant an **Interim CTO** of up to 28 days duration. A subsequent interim order can be granted upto a continuous period no more than 56 days. The conditions that must be satisfied for doing so closely echo the conditions for any full-term CTO. The exception is that, while it states 'that the making of the Order is necessary' (section 57(3)(e) of the conditions for a CTO), whereas for the interim Order it states 'that it is necessary to make an interim CTO' (section 65(6)(b)).

The Draft Code of Practice advises that circumstances where this might be the case are, for example, where the Tribunal feels it does not yet have the full information to grant a CTO of full duration. It may wish, for example, to postpone the decision on the granting of a full-term CTO in Order to obtain further evidence from another Medical Practitioner, or to see how the patient responds in a given set of circumstances.

In all other regards, an 'Interim CTO' may authorise the same range of measures and contain any recorded matters as may a full CTO.

4. Monitoring and review of the Order

This section outlines the mandatory and routine arrangements for review of Orders and explains the roles of the RMO, MHO and others in relation to them.

After an Order has been made, the responsibility for its maintenance falls in greater part on the RMO and in lesser part on the designated MHO. In emphasising the role of the latter, please forgive us if we seem to be labouring a point. However, we are at pains to communicate the very different meaning of the MHO's role under this Act relative to the role you will have been accustomed to under the 1984 Act.

4.1 The Responsibilities of the RMO

As soon as possible after the granting of the Order, the RMO must draft a full care plan including precise details of the plan for medical treatment. The Draft Code advises that the plan should be drawn from the MHO's proposed care plan from the application and it should list all recorded matters. Its details should be finalised in consultation with the designated MHO and multi-disciplinary team and, while respecting patient confidentiality, the named person, nearest relative and primary carer should receive copies when one is given to the patient. The Draft Code suggests that the current model of practice for CPA paperwork should be followed here.

4.2 The MHO Responsibilities

The first occurring responsibility is more attendant upon the local authority than it is upon the MHO. It is the duty to appoint a 'designated MHO' under section 229, as we have discussed above. While there is no explicit duty upon the local authority to ensure that the MHO who was designated to make the application is one and the same as the MHO designated to follow through the responsibilities after the Order has been made, the Draft Code of Practice emphasises the importance of such continuity, where practicable. It should be noted that the active and continuing role of the MHO for the duration of the Certificate or Order is not a recommendation for good practice, it is a duty imposed under section 229(1)(b).

The Draft Code of Practice recommends that the MHO designated for the purposes of the continuing Order should make sure that the patient, the named person, the main carer and all other relevant, interested parties have his or her name and contact details.

The Draft Code of Practice advises of the importance for continuity of the MHO role. It is concerned that the MHO role does not vanish, only to reappear at moments required by law. It would be poor practice for example, if the MHO is only involved at the point of mandatory review of the Order, or the moment when MHO consent is required in the event of measures having to be taken because the patient is non-compliant with the Order.

The Draft Code also emphasises the need for all involved in the delivery of care and treatment under the Order to work in close multidisciplinary collaboration. In this way, the MHO and RMO will be kept informed of any changes in the patient's condition and

circumstances, in such a way that the criteria upon which the continuance of compulsion rests are under constant review.

It should be constantly borne in mind that, as long as the Order authorises compulsion, those administering care and treatment are discharging functions under the Act and therefore are continuously bound by the principles. Principles, such as the need to apply no greater restriction in relation to the freedom of the patient than is necessary, demand this process of constant review.

There is a duty under section 231, to provide an SCR within 21 days of the Order being made. We will discuss this and other requirements for an SCR in Reader 4.

4.3 Reviewing the Order

This process of constant review notwithstanding, the RMO is under a duty to review the Order 'from time to time' (section 80(2)) as well as making mandatory reviews at times specified by law (sections 77 and 78). 'From time to time reviews' may be seen as informal and may be incorporated into the RMO's continuing function of general oversight of the patient (ward-rounds, regular multidisciplinary meetings, out-patient visits etc). The mandatory review must take place within a two months prior to the Order expiring. This is to give time to consider whether or not to extend the Order upon expiry.

The criteria against which such reviews should be made are the conditions for a CTO- the existence of mental disorder etc, with which you should be familiar by now. The Draft Code of Practice advises that, in review, 'the presumption should always be in favour of revoking the Order unless the RMO is positively satisfied that the criteria are met'.

In mandatory reviews the RMO must examine the patient, consult with the MHO, with others providing care and treatment to the patient and with any other person whom the RMO deems to be appropriate. The Draft Code states that good practice is for the MHO to be continually involved in reviewing the patient's progress under the CTO. This relates directly to the duty upon the RMO to consult at mandatory review. The MHO should be well informed and have a current, first-hand view of the patient's condition in relation to the criteria for the continuance of the CTO. The Draft Code recommends a full case conference to be convened by the RMO for mandatory reviews.

4.4 Revoking, extending and varying Orders

As a result of reviews, the RMO must revoke the Order, if the criteria no longer apply. The RMO may also vary the terms of the Order or extend it upon expiry of its term of duration. It should be noted that the Commission also has powers to revoke an Order. The Commission would do this if it found that the conditions were no longer met and the RMO had not previously revoked the Order.

In the event that the Order is revoked, or the RMO intends to make an application to seek to have the Order varied or extended, s/he must inform a range of people and bodies including the MHO. Upon notification of intention to extend an Order, the MHO must:

- Interview the patient; inform him or her of the proposed extension of the CTO;
- Inform the patient of his/her rights in general and specifically in relation to the availability of advocacy;
- Ensure that the patient has access to advocacy services;
- Inform the RMO whether or not she/he agrees with the proposed extension; and
- Inform the RMO of any other relevant matters.

The RMO must have regard for these views and must prepare a record of his or her determination whether or not the extension is required.

Amongst others, this record is sent to the Tribunal who then decide whether or not they wish to review the determination to extend the Order. The Draft Code advises that the Tribunal would ordinarily only hold a review if there were significant reasons for doing so, for example if the RMO's record showed disagreement between the MHO and the RMO about the determination to extend the Order.

If the RMO wishes to vary and extend the Order s/he must make a specific application to the Tribunal proposing an updated care plan. Under these circumstances, while the MHO has the same duties as above, it is likely that s/he will also have to submit a report to the Tribunal giving a view on the updated care plan.

4.5 Suspension of Compulsory Measures

Section 127 gives the RMO power to suspend any CTO elements authorising detention in hospital and section 128 gives power to suspend any Order authorising any of the other measures given in section 66(1), attendance for treatment, residence at a specified place etc.

The effect of a suspension certificate is not unlike Leave of Absence under the 1984 Act in its proper usage. It allows the patient to test out life without any given measure of compulsion. While doing this, it provides a safety-net, in that the suspension certificate may be revoked if the patient does not comply with offers of care, treatment and support, provided the conditions for the Order still prevail.

A suspension of section 66(1)(a) (hospital detention) may be granted for a maximum period of 6 months in a year and, while it may be granted for shorter periods, they must add up to no more than 9 months in total over a year. Suspension of any measures contained in section 66(1) (b) to (h) (treatment in the community, residence etc) may be authorised for any consecutive period of upto 3 months . Suspension of these measures may relate to suspension of one or more conditions, which might not necessarily amount to suspension of the entire Order. For example, it would be possible to suspend the treatment requirements while still imposing the requirement to reside in a given place.

Where an RMO intends to make a certificate of Suspension under either section 127 or 128, she/he must first give notice to notify:

- The patient;
- The named person; and
- the MHO.

4.6 Non-compliance

This section discusses the powers conferred in situations in which the patient does not comply with an Order.

Leave of absence from section 18 of the 1984 Act and Community Care Orders became the only means of securing treatment in the community. This, however, has not been without difficulties in that leave of absence was never intended towards this end and Community Care Orders do not authorise compulsory treatment in the community. In the 2003 Act, the specific purpose of CTOs encompasses treatment in or out of hospital, although never in the patient's place of residence. However, if the hidden compulsion to accept treatment under leave of absence lay in the threat that failure to comply might result in recall to one's hospital bed, the question remains, where does a community - based CTO draw its compulsion from?

Of course, the CTO draws its compulsion from the law that requires anyone subject to a CTO to accept the measures contained in it. However, in practice this answer requires the patient to acknowledge the force of law. In terms of human rights, the proper process of law is enough to satisfy us that compulsion is justified, a properly convened hearing has determined that the criteria for compulsion are met, the patient's rights to advocacy etc have been addressed and the process of application and of putting the Order into practice have been mediated with the principles of the Act. However, none of this ensures that the patient will recognise that the law is upholding his or her right to protection from risks to health, safety or welfare such as would be present were the Order not enforced. Therefore, the Order must have teeth. It must have a means to enforce its ends if the patient is unable to comply.

The sections on Breach of Orders (Chapter 5, sections 112 to 123) make a distinction between breach by failure to comply with the requirement to attend for medical treatment and general non-compliance with the Order. It should be noted that all the following measures that may be taken in the event of non-compliance are addressed to patients subject to community-based Orders. This is because, provided certain conditions are satisfied, sections 239(4), 241(4) and 242(6) authorise the use of force to be applied in the administration of ECT or medicine to the patient in hospital where the CTO authorises the giving of medical treatment. In other words, where the patient's non-compliance has confounded attempts to enable treatment to be given in conjunction with care and other services in the community, the bottom line is that the treatment may be enforced by detention in hospital. For the patient who is subject to a CTO already authorising detention in hospital, the use of force under sections 239(4), 241(4) and 242(6) is already an implicit possibility.

4.7 Failure to attend for medical treatment

Where an Order imposes a 'requirement on the patient to attend on specified or directed dates or at specified or directed intervals, specified or direct places with a view to receiving medical treatment' (section 66(1)(c)), and that patient does not comply, the RMO, or anyone authorised by the RMO, may take the patient into custody and convey him or her to the required place for the purpose of receiving treatment. They may alternatively take the patient to any hospital to receive the treatment. If the Order also

authorises 'the giving of medical treatment' (section 66(1)(b)), the patient may be detained for up to 6 hours for the purposes of giving the treatment. In reality it is unlikely that one of these requirements would be contained in an Order without the other being there as well. Why would any Order place a requirement upon the patient to attend a specified place for treatment without requiring the patient also to receive that treatment?

This power conferred upon the RMO may only be exercised with the consent of the designated MHO (section 112(2)). That the MHO must be consulted in such cases is yet another instance strengthening the Draft Code of Practice's assertion that the designated MHO must have a continuing, hands-on role.

5. Non-compliance generally with the Order

Section 113 relates to non-compliance of a patient who is not already subject to detention in hospital. Where a patient has failed to comply with any of the measures of a community based Order the RMO or anyone authorised by him or her may take the patient into custody and remove him or her to hospital for a period of up to 72 hours of detention. In order to do this, certain conditions must have been satisfied:

- Reasonable steps must have been taken to contact the patient, following the failure to comply;
- If contact has been made with the patient, s/he must be given an opportunity to comply with the measure(s);
- Continued failure to comply would be reasonably likely to result in significant deterioration of the patient's mental health; and
- In a case of urgent necessity, the steps to contact the patient and allow the patient opportunity to comply need not be followed.

Where the patient is subject to such 72 hour detention, the RMO must examine him or her or arrange for another AMP to do so. All the measures contained in the original CTO or interim CTO are effectively suspended for the period of detention in hospital, other than the requirement to give treatment. If need be such treatments as are authorised in Part 16 may be given by force under sections 239(4), 241(4) and 242(6).

During this period of detention, if the RMO is either considering applying to the Tribunal to vary the Order, or is required to notify the Tribunal because of a failure to deliver an element of care that is a recorded matter, she/he may grant a certificate authorising detention of the patient for up to 28 days to enable the Tribunal to respond to the application or notification. This certificate, granted under section 114, must have the consent of the MHO. Again, its effect is to suspend all measures contained in the original Order, other than the requirement for the administration of treatment.

6. Application to revoke Orders and Appeals

This section sets out the processes of appeal against Orders and the people who may make appeals.

Given the duties upon MHOs to address the rights of the patient in Emergency, Short-term Detentions and in Orders, it is most important that you have a good understanding of the rights of the patient and named person in respect of applying to the Tribunal to revoke compulsory measures and the rights of a range of parties to appeal Tribunal decisions to the Sheriff Principal or Court of Session. (See also 6.3 in Reader 2.)

There is no statutory right of appeal for Emergency Detention. Either the patient or his/her named person may apply to the Tribunal under section 50 to revoke a certificate of Short-term Detention.

In the process of the CTO, both the patient and named person have rights to be heard and to give either oral or written evidence when an application is being considered by the Tribunal. They also have rights to have their views taken into account when the RMO is making a mandatory review. Sections 99 and 100 afford the patient and named person opportunity to apply to the Tribunal to revoke or vary an Order at the point when the RMO has applied for it to be varied and/or extended.

Under section 320:

- The patient;
- The named person;
- Any guardian or welfare proxy; and
- The MHO or RMO relevant to the proceedings of the Tribunal...

...may appeal to the Sheriff Principal against any decision made by a Tribunal in respect of Short-term Detention or an Order. If the Sheriff Principal considers 'that the appeal raises important or difficult questions of law' she/he may remit the appeal to the Court of Session.

Any informal patient who considers him/herself unlawfully detained in hospital may apply to the Tribunal for an Order under section 291, requiring the managers of the hospital to cease the detention. The following parties may also make such an application:

- Named person;
- The person who has parental responsibilities for the patient, if the patient is a child under 16;
- An MHO;
- The Commission;
- Any welfare proxy; and
- Any person having an interest in the patient's welfare.

This right would apply for example, where a patient feels that the door of a ward is locked against his leaving and his informal status is being jeopardised.

7. Legal Aid

Right to legal representation is not explicitly addressed in the 2003 Act. However, Tribunal rules and regulation will deal with this subject. The policy intention is for the situation in respect of the right to legal aid under the 1984 legislation to remain essentially the same under the 2000 Act.

8. Treatment in Relation to Compulsion

This section relates in as brief a manner as possible, the significant treatment positions in relation to compulsory powers. It also offers a short explanation of treatment in relation to the 2003 Act and the 2000 Act. We do not discuss certain major changes brought about by the 2003 Act, such as those to the provision for psychosurgery, since we deem these to be less relevant to MHOs.

Sections 233 through to 249 of Part 16 of the 2000 Act detail the all the treatment concerns of the Act.

Part 16 is ranked in terms of seriousness of the available treatments. It starts with a group of treatments including psychosurgery, the most invasive and lastingly irreversible of treatments. This is followed by a group including ECT, which is considered as relatively highly serious because of its invasiveness and the controversy that surrounds it. The next group includes hormone implants, artificial nutrition and other treatments that may be given 'for mental disorder or in consequence of the patient having a mental disorder.' Finally there is a group of treatments including those contained in the general definition given in section 329 (nursing care, psychological interventions, habilitation and rehabilitation). Part 16 is stratified in this way to allow greater safeguards against those treatments of greater seriousness.

Section 233 requires the Commission to keep a list of 'designated Medical Practitioners', specifically including some child specialists, who have appropriate qualifications and experience to perform the duties discussed below. These duties may generally be envisaged as the safeguarding duties of an independent, expert second opinion. In certain provisions, the designated Medical Practitioner must be a child specialist, where treatment is being given to a child.

Part 16 is not concerned with treatment given to informal patients, whether or not they are able to consent. For treatment of incapable informal patients you are directed to the 2000 Act.

Setting aside Emergency Detention, which does not, in itself, carry any authority to compel the patient to receive treatment, Short-term Detention authorises the same treatments as do both CTOs and interim CTOs provided they contain a measure of compulsion relating to the giving of medical treatment.

The treatment position for ECT is greatly revised so as to narrow down the context in which it may be given without consent. ECT may now only be given to formal patients who are either subject to the 2003 Act (with the exception of Emergency Detention) or the 1995 Act in the following circumstances:

Section 238 states that, if the patient is capable of giving consent to ECT and does not refuse to do so, the RMO or a designated Medical Practitioner must certify in writing that:

- Such a patient is capable of consenting;
- She/he has consented in writing;
- She/he is authorised to receive treatment by the 2003 Act (except Emergency Detention) or, as we will discuss in the final Reader, by the 1995 Act; and
- Such treatment is likely to alleviate his or her condition or prevent its deterioration.

For patients who are incapable of giving consent to ECT, the position is the same as that for other formal patients who are incapable of giving consent and are being treated with:

- Any medicine for reducing sex drive (other than that given by surgical implant of hormones);
- Provision of nutrition by artificial means (such as might be given to patients with eating disorders); and
- Other treatments that may yet be specified by regulations (section 240(3)).

These treatments may only be given where a 'Designated Medical Practitioner' who is not the RMO certifies in writing that:

- The patient is incapable of understanding the nature and purpose of the treatment and likely effects of the treatment;
- Giving of the treatment is authorised by the 2003 and/or 1995 Acts; and
- The giving of the treatment is likely to alleviate suffering or prevent deterioration of the condition (section 239(1)).

However, the Act makes a distinction between simply being incapable of consenting and resisting or objecting to the treatment. Where the patient resists or objects, it may only be given in terms of section 243(3) in Order to:

- To save the patient's life;
- To prevent serious deterioration of the patient's condition;
- Alleviate serious suffering on the part of the patient;
- Prevent the patient from behaving violently; and
- Prevent the patient from being a danger to self or others.

The use of force in giving treatment under any circumstances is not permitted other than for a patient who is in hospital.

The conditions above, for giving treatment where the patient resists or objects (to save the patient's life, to prevent serious deterioration of the patient's condition etc) also form

the conditions for giving treatment to any other formal patient, i.e. a patient who is subject to Emergency Detention in a situation of urgent necessity (section 243(1)).

Any other medicine for the treatment of mental disorder (other than that already discussed, to reduce sex drive) may only be given to formal patients who are incapable of consenting and who do not resist or object, for a consecutive period of two months. This clause (section 240(4)) applies to the more routinely prescribed psychiatric medications. You may recall that this period has reduced from the three-month period allowed under the 1984 Act.

At the expiry of the two-month period, the same conditions apply as for patients incapable of consenting to ECT etc 'that a designated Medical Practitioner' who is not the RMO certifies in writing that:

- The patient is incapable of understanding the nature and purpose of the treatment and likely effects of the treatment;
- Giving of the treatment is authorised by the 2003 and/or 1995 Acts; and
- Giving of the treatment is likely to alleviate suffering or prevent deterioration of the condition (section 239(1)).

As with other treatments already discussed, a formal patient who resists or objects to such medication may only be given it in situations of urgency where the treatment is likely:

- To save the patient's life;
- To prevent serious deterioration of the patient's condition;
- Alleviate serious suffering on the part of the patient;
- Prevent the patient from behaving violently; and
- Prevent the patient from being a danger to self or others.

In all the above matters regard must be had for the views contained in any advance statement.

8.1 A word about the treatment provisions of the 2003 Act in relation to those contained in the 2000 Act

There is much scope for confusion between these provisions, given that they deal with complicated overlapping areas. However, there are some simple rules of thumb that help to disentangle the Acts.

- Only the 2000 Act allows for provision of treatment for physical illness.
- The 2000 Act has a broader scope, being preoccupied not only with mental disorder, but with other physical conditions which may cause incapacity due to an inability to communicate.
- The 2003 Act's definition of mental disorder embraces personality disorder, learning disability, and mental illness. Concerns where the patient is in dispute over treatment for mental illness would best be met through the 2003 Act.

It could be argued that the principle in section 1(4)(a) of the 2000 Act, requiring account to be taken of 'the past and present wishes and feelings of the adult', is a soft means of deducing an advance statement. Furthermore, while it would be difficult to ignore any competently made advance statement and still be in keeping with this principle, the 2000 Act lacks the hard focus of sections 275 and 276 of the 2003 Act. These sections of the 2003 Act explicitly contain the advance statement.

Finally, the 2000 Act is exclusively directed at adults. Where there are issues of consent, anyone under 16 requiring treatment for mental disorder ought to be seen in reference to the 2003 Act. If the treatment is for a physical disorder the only recourse is to parental consent in relation to the 1991 Act.

9. What next?

Assuming that you are studying this reader in preparation for session 3 of the transitional study days, we advise you to test the fruits of your study against our third self-assessed test of knowledge. As per Readers 1 and 2, we advise you to read and reflect upon the attached case study if you have spare guided study time. Feel free to make notes of your reflections and compare them to your thoughts after the study session.

10. Study Materials for Session 3

By this third session you should require few general instructions. The self-assessed test of knowledge is provided to test your readiness for this session of study. The exercises for the day are all built around one case study, which requires you to:

- Examine matters relating to application for CTO against the conditions for an Order.
- Consider the forms for the Mental Health Reports, the Application, the MHO's Report and the Proposed Care Plan, making draft use of them.
- Consider the problems involved in making an application when the MHO and RMO are in disagreement.

As with previous self-assessed tests, 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.

10.1 The Third Self-Assessed Test of Knowledge

1. What are the time-scales for making the medical examinations for a CTO in relation to the deadline for the submission of the application by the MHO?
2. What are the maximum duration periods for a CTO and for an interim CO?
3. What measures may a Tribunal authorise in a CTO?
4. What reports and documents are required for a CTO application?

5. Does anyone have to be consulted if the RMO needs to remove the patient to a specified place for the purpose of giving treatment because the patient is non-compliant with a measure requiring treatment in a CTO?
6. If the patient is withdrawn into hospital under section 113, following a general failure to comply with measures of a community based Order, for how long may s/he be detained?
7. Who may apply to the Tribunal to revoke Short-term Detention or extension or variation of an Order?
8. May ECT be given to a patient who is authorised to receive treatment under the Act, who is incapable of understanding its nature, purpose and likely effects and who resists or objects to it?
9. To whom may appeals against Tribunal decisions be made?
10. What is a designated MHO?

The answers to these questions are found in Appendix A.

10.2 Introduction to the case study:

Reflecting on the Conditions for CTO, Process of making an application using the forms for the Mental Health Reports, the Application, the MHO's Report and the Proposed Care Plan and reflecting on the problems of managing disagreement between RMO and MHO.

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

Finally, before you engage with the case study, here is the abbreviated list of principles again:

'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 people have 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; and
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.

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:

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

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

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

While Toni poses no immediate risk to her own safety, she is increasingly preoccupied that her CPN, social worker and the supported accommodation staff all have doubles, discernible only by the subtly differing shades of their hair colour. In her belief, these doubles are all cloned by her psychiatrist as part of a plan to get her to recommence the mind-altering medication. She will only allow any of these people access to her flat if

she is satisfied that they are not the cloned version of themselves. Therefore it is becoming more and more difficult to maintain any contact with Toni, to monitor the care she is taking of herself and to keep an open dialogue with her. For example, no one knows how she is managing her finances, whether or not she is cashing her benefit cheques or doing shopping.

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

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

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

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

Questions:

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

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

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

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

- The MHO's Application;
- The Mental Health Reports by Medical Practitioners; and
- the MHO Report.

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

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

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

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

- a) There are numerous ways in which a CTO might be implemented to enable Toni to get back on track. Without wishing to restrict your discussion of these, salient amongst them would seem to be the issue of imposing a treatment requirement. This may be achieved by detention in hospital or requiring care and or treatment in the community.
 - (i) Consider the merits of both of these options.
 - (ii) Divide your discussion group into two sub-groups, preferably with all Medical Practitioner participants in the same sub-group.
 - (iii) We want one of the sub-groups to take on the view that Toni may be served best by treatment in the community and the other sub-group to take on the opposing view that a community-based order would fail her,

resulting in prolonged illness and an unenforceable order which would eventually have to be varied to detention.

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

(iv) How might the care-plan be structured in such a way as to reflect both the community based and hospital based plans for detention?

(v) Are there any other foreseeable difficulties in making an application under these circumstances of entrenched disagreement?

Answers to the third self-assessed test of knowledge (Reader 3):

1. **Q: What are the time-scales for making the medical examinations for a CTO in relation to the deadline for the submission of the application by the MHO?**

A: The medical examinations must be made within five days of each other and the 14-day period in which the MHO must complete his or her report and compile the MHO's Proposed Care Plan is triggered by the completion of the latter of these examinations. The application must be submitted to the Tribunal on or before the expiry of that 14-day period.

This is a crucial piece of knowledge and we would hope that you have these times firmly in mind by now.

2. **Q: What are the maximum duration periods for a CTO and for an interim CTO?**

A: CTO may last for up to 6 months in the first instance and is renewable for 6 months in the second instance. Thereafter it is renewable annually. An interim CTO is granted for up to 28 days.

We would hope that you know the duration of a CTO and its renewals from the old section 18, the time-scales for which it echoes. Consider the knowledge that an interim Order endures for up to 28 days as knowledge that gets you a bonus point.

3. **Q: What measures may a Tribunal authorise in a CTO?**

A: The detention of the patient in a specified hospital; the giving of medical treatment; the requirement to attend specified or directed places on specified dates or at intervals for the purpose of receiving medical treatment; the requirement to attend specified or directed places on specified dates or intervals for the purpose of receiving community care or other services; the requirement to reside at a specified place; the requirement to allow visits by the RMO, MHO or specified others involved in the delivery of services; and the requirements to obtain the MHO's permission to change address and to inform the MHO of that change before it takes place.

This is an extensive list and even as it appears here, we have paraphrased it from section 66. We do not anticipate that you will need to memorise such lists. If you have got the salient points correct (particularly detention, treatment, receipt of care services and the residence requirement) consider your answer good enough.

4. **Q: What reports and documents are required for a CTO application?**

A: The two medical reports by Medical Practitioners (one an AMP who is preferably the RMO), the Application by the MHO, the MHO Report and the Proposed Care Plan compiled by the MHO.

It is essential that you have this fixed in your mind as it is a starting point from which to quantify the process of application.

5. **Q: Does anyone have to be consulted if the RMO needs to remove the patient to a specified place for the purpose of giving treatment because the patient is non-compliant with a measure requiring treatment in a CTO?**

A: The RMO requires the consent of the MHO to do this.

You should have such knowledge of the structure of the Act by now that you should be able to guess the correct answer to this, based upon the assumption that virtually no restrictions may be imposed without MHO consent or application.

6. **Q: If the patient is withdrawn into hospital under section 113, following a general failure to comply with measures of a community-based order, for how long may she/he be detained?**

A: Up to 72 hours.

In a sense this is a question that requires you to have assimilated relatively small scale details of the Act. As such you might feel cause to be aggrieved that we expect you to have taken so much in so short a time. However, we would hope that you are beginning to do this. For example, if you confused the 72 hour period of detention under section 113 with the 6 hours that a patient may be held in order to comply with treatment under section 112, or the 28 days during which an order may be suspended in order to vary it under section 114, at least you are in the right ball park!

7. **Q: Who may apply to the Tribunal to revoke Short-term Detention or extension or variation of an Order?**

A: Either the patient or his or her named person.

8. **Q: May ECT be given to a patient who is authorised to receive treatment under the Act, who is incapable of understanding its nature, purpose and likely effects and who resists or objects to it?**

A: Yes, if it is urgently necessary to save the patient's life, to prevent serious deterioration in the patient's condition, to alleviate serious suffering, to prevent the patient behaving violently or to prevent the patient being a danger to self or others.

We deliberately asked a difficult question here to try and get at the differences between the treatment position here and in the 1984 Act. If you did not have the answer precisely correct do not worry. However, we would hope that you would be beginning to get the shape of these matters into your head. For example, if you answered 'no' to the question, out of an awareness that the treatment position for ECT in relation to consent and lack of capacity is more restrictive than it was in the old Act, you are still doing well in developing your knowledge.

9. **Q: To whom may appeals against Tribunal decisions be made?**

A: To the Sheriff Principal, who may remit the matter to the Court of Session.

10. **Q: What is a designated MHO?**

A: Under section 229, the local authority has a duty to appoint a designated MHO for the purposes of having responsibility for the patient's case, as long as the patient is subject to a certificate, order or direction.

We have threaded so many references to the continuing, hands-on role for MHOs through this reader that we would hope that you recognised this longitudinal role in the term 'designated MHO', even if you were unable to locate its source in section 229.

Comparison Between 2003 Act and 1984 Act

2003 Act Part 7 S57 – 129	1984 Act S18-23 and S27-34
MHO application, which specifies compulsory measures sought, medical treatment proposed, other services proposed, etc	MHO application which states need for Detention in hospital for treatment
2 mental health (medical) reports, 1 mho report and a Proposed Care Plan	2 medical reports, MHO application
2 Approved Medical Practitioners (AMP) or 1 AMP and 1 GP	1 approved (section 20) and 1 GP or previous acquaintance or, if exceptional, 2 approved
Both medical reports must specify at least one of the same types of mental disorder	Specify same mental disorder
Treatment likely to prevent mental disorder worsening or alleviate symptoms or effects	Treatment likely to alleviate or prevent deterioration in condition
Significant risk to health, safety or welfare of patient or safety of any other person and decision-making ability re medical treatment is significantly impaired and Order necessary	Necessary for health or safety of patient or for protection of other persons that he should receive medical treatment in hospital
Mental health reports must specify compulsory treatment measures	No measures specified
Dispense with notice to patient if notice is likely to cause significant harm to patient or other person	Dispense with service on patient if likely to prejudice health or treatment
No more than 5 days between mental health reports	No more than 5 days between medical reports
No conflict of interest in relation to medical examination	No pecuniary interest or relationship with patient
Separate medical examinations unless consent from patient(if capable) or named person/guardian/welfare attorney(if incapable)	Separate medical examinations unless consent
MHO must identify named person where reasonably practicable	
Notification by MHO to patient, named person and MWC	MHO informs nearest relative unless impracticable
Discretion if doctor thinks notice should be dispensed with	
Interview and report by MHO between mental health reports and application	
MHO informs patient of right to advocate and helps patient access these services	
MHO prepares Mental Health Officer's report. This includes details of the patient's social circumstances; the MHO's views on the mental health reports; details of any advance statement.	

MHO prepares proposed care plan. Specify medical treatment, community care services, details of hospital where patient to be detained or managers of hospital to appoint RMO where patient to stay in community, objectives of treatment and services	
Application to Tribunal within 14 days of second mental health report. For Detention in hospital or treatment in community	Application to Sheriff within 14 days of MHO interview and 7 days of later medical report. For Detention in hospital
Tribunal hearing. Right to attend for patient, named person, Guardian or Attorney, MHO, doctors, primary carer, curator ad litem, anyone else with an interest in the application.	Sheriff Court hearing. Right to attend for patient, nearest relative, patient's representative, MHO
Tribunal can make Order sought in whole or in part and can specify measures other than those set out in the application.	Sheriff can grant or refuse application
Emergency and Short-term Detention extension certificate extends Detention for 3 working days (from date of issue for Emergency Detention and from end of 28 days for Short-term Detention)	S26 extended for up to 5 working days
Detention under Short-term and/or extension certificate extended by 5 working days once application for CTO made. Tribunal decision before end of 5 working day extension period.	Sheriff court hearing within 5 working days (section 21). S 26 extended until application determined.
Removal to hospital or specified place of residence within 7 days of CTO	Removal to hospital within 7 days

2003 Act	1984 Act
Tribunal can make interim Order for up to 28 days. The total length of the interim Order may not exceed 56 continuous days.	No interim Orders but S26 extended until final determination
No interim Order without opportunity for patient to be heard	
Measures authorised by interim Order or full Order could include: Detention in hospital Giving of medical treatment Requirement to attend at specified places to receive medical treatment and/or community care services or other treatment, care or services. Requirement to reside at a specified address. Requirement to allow access to MHO, RMO, etc Approval of MHO to change of address, or, Inform MHO of change of address	Order authorises Detention in hospital but leave of absence with or without conditions possible later for specified maximum periods of time.
RMO duty to review interim and final CTO. Within 2 months of end of CTO. Duty to consult MHO and others.	RMO duty to review. Within 2 months of end of S18. Duty to consult those involved with treatment.
MWC power to revoke CTO	MWC power to discharge detained patients
RMO duty to make care plan (S76)	
RMO power to extend by 6 months and then by 12 months. Consent of MHO must be sought.	RMO power to extend by 6 months and then 12 months.
Appeal to Tribunal against extension	Appeal to Sheriff against renewal
Failure of a community-based patient to attend for treatment gives RMO or authorised representative power to take patient to hospital or specified place and keep them there for up to 6 hours to give treatment or to determine whether capable of consenting to treatment.	Absence without leave or failure to comply with conditions of leave of absence gives MHO, hospital staff, constable and persons authorised by managers of hospital power to take patient back to hospital
Failure to comply generally with CTO in community gives RMO or authorised person power to take patient to hospital for up to 72 hours for examination and for further 28 days if considering variation or application to Tribunal. MHO consent needed. Patient can apply to Tribunal to revoke.	
Transfer to another hospital	Transfer to another hospital (or guardianship) but what powers would Guardian have?

MENTAL HEALTH OFFICER DUTIES/ROLE UNDER 2003 ACT

Warrant to Obtain Entry

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

Emergency detentions

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

Short-Term Detentions

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

Extension of Short-Term detention

- Under **Section 47**, consent from an MHO must be obtained, wherever practicable, before an extension of a short term detention certificate pending an application for a compulsory treatment order can be granted. Under **Section 48** the RMO must notify the Tribunal of the extension and indicate whether the

consent of the MHO was obtained, and, if not, the reasons why it was impracticable to consult an MHO.

Revocation of Short-Term Certificates

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

Revocation of certificate suspending measure authorising short-term detention

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

Compulsory Treatment Orders

- Under **Section 57** a MHO must apply for a Compulsory Treatment Order when in receipt of the relevant mental health reports from two medical practitioners. MHOs play a key role in the decision to apply for a compulsory treatment order as well as the related process of making the application.
- The MHO applicant must prepare a report, a proposed care plan and an application based on these as well as the 2 accompanying mental health reports. They must coordinate all this within a very tight timeframe – within 14 days of the last medical examination for the purposes of the mental health report.
- In preparing the Mental Health Officer's report for the purposes of an application under **Section 61**, the MHO must interview the patient and inform them of their rights in relation to the application as well as the availability of independent advocacy services and must take appropriate steps to ensure that the patient has the opportunity of making use of these services. If meeting these duties proves impracticable, the MHO must state the reason why this was the case in the MHO report. The MHO must also, as soon as practicable after the duty to make the application arises and, in any event, before making the application, take such

steps as are reasonably practicable to ascertain the name and address of the patient's named person which is needed for the MHO report.

- Under **Section 62** an MHO must prepare a proposed care plan and in doing so must consult the medical practitioners who provided the mental health reports, and, where practicable, all relevant persons providing the medical treatment, community care services or other relevant services as outlined in the proposed care plan. Close attention must be paid to the considerable requirements in respect of proposed care plans outlined in **Section 62**.
- Under **Section 60**, the MHO must give notice in writing to the patient, the patient's named person and the Commission of their intention to make an application and they must do this as soon as practicable after that duty arises. The MHO can over-ride the RMO's decision not to give notice to the patient if they consider it appropriate to do so.
- The Tribunal before making a decision must afford the MHO applicant the opportunity of making representations either orally or in writing and of leading or producing evidence. The Tribunal system will result in closer scrutiny of the assessment and care planning process. This will result in a higher level of accountability for MHOs as well as others involved in the process.

Interim Compulsory Treatment Orders

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

Measures that may be authorised by the Tribunal

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

Hospital Direction or Transfer for Treatment Directions

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

Interim Compulsory Treatment Orders: Review and Revocation

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

Reviews, Extensions, Variations and Revocations of CTOs

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

Extension of CTO (a 'Section 86 determination')

- Under **Section 84**, the RMO must give notice to the MHO of the intention to extend a CTO. This triggers the MHO's duties under **Section 85** to interview the patient (wherever practicable) and to inform the patient in all cases of the RMO's intent, their rights in relation to this, and the availability of independent advocacy services. The MHO must also take appropriate steps to ensure that the patient has the opportunity of making use of those services.
- Following the interview of the patient when notified of the RMO's intent to extend the order, the MHO must advise the RMO of whether they agree with this decision and, if not, why not. The MHO must also inform the RMO of any other matter they consider relevant to the proposed extension. These views will then be expressed in the record made by the RMO of the extension which is forwarded to the Tribunal, the patient (unless the RMO feels that doing this would present a risk of significant harm to the patient), the patient's named person, the MHO and the Commission. The RMO must also record where the MHO failed to comply with their duties under **Section 85**.
- Where the MHO disagrees with the proposed extension of the order or has not advised the RMO of their views as required, the Tribunal must review the determination under **Section 101**. In such cases the MHO must be afforded the opportunity of making representations either orally or in writing and of leading or producing evidence.

- Similar procedures follow from the Tribunal's responsibility to review an order when they have not been involved in a determination in respect of the patient during the past two years.

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

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

Variation of CTO (a 'Section 95 application')

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

Failure to provide recorded matter specified in the CTO

- Under **Section 96** if it appears to the RMO that a service specified in a recorded matter is not being provided, they are under a duty to consult the MHO as soon as practicable and if satisfied that the recorded matter is not being provided must make a reference to the Tribunal, giving notice to the MHO when they do so.
- **Section 98** also gives the MWC the authority to make reference to the Tribunal where they feel it is appropriate.

- When a reference is made to the Tribunal under **Section 96 or 98**, the Tribunal can vary the CTO by modifying the measures or any recorded matter specified in the order, or can revoke the order. Before making a decision, the Tribunal must afford the MHO the opportunity of making representations orally or in writing and of leading or producing evidence.

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

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

Powers of Tribunal to require report from MHO

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

Breach of Orders Reports

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

Detention pending review or application for variation

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

Suspension of Detention

- Before an RMO under **Section 127** grants a certificate suspending the detention of a patient in hospital where this is a measure included in the CTO or Interim

CTO for a period of more than 28 days, s/he must give notice to the MHO (and others) before granting the certificate.

Suspension of Other Measures

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

Revocation of Suspension of Measures

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

Social Circumstances

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

Assessment of needs for community care services

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

Designation of Mental Health Officer

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

Consultation re certificates relating to Consent to Treatment

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

Named Person

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

Detention in conditions of excessive security

- When an application is made to the Tribunal under **Section 264** declaring that the patient is being detained (in the State Hospital) in conditions of excessive security, before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and to lead or produce evidence.
- Where a Tribunal makes an order under **Section 264** requiring a Health Board to transfer the patient to another hospital within 3 months and the Health Board fails to do so, **Section 265** requires that there be a hearing before the Tribunal and the Tribunal may decide if they feel that the patient does not require to remain in conditions of excessive security to specify that the Health Board transfer the patient to a suitable hospital within a period of 28 days. Before making such a determination, however, the Tribunal must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

- **Section 266** relates to situations where the Health Board again fails to transfer the patient and another hearing before the Tribunal requires to be held. Again, before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and to lead or produce evidence.
- Where an application is made by Scottish Ministers, a Health Board or (in certain cases) an RMO to the Tribunal to recall an order made under **Sections 264, 265 or 266**, before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and to lead or produce evidence.
- **Sections 268, 269, 270 and 271** outline processes which are the same as those outlined above except they relate to situations where the patient is detained in conditions of excessive security in a hospital other than the state Hospital.

Duty to minimise impact of compulsion on parent/child relationships

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

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

- **Section 289** gives authority for Regulations to be made in connection with the removal of a patient subject to a community-based compulsory treatment order to a place outwith Scotland. These Regulations can require the RMO to authorise a warrant in respect of such a transfer. The RMO in such circumstances must first notify the Mental Health Officer.

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

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

Applications to Tribunal in relation to unlawful detention

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

Warrant to enter premises for purposes of taking patient

- Under **Section 292** a warrant may be granted by a sheriff, or justice of the peace authorising any MHO (and any other duly authorised person) to enter the

premises specified in the warrant for the purposes of an authorised person taking the patient to any place or taking or retaking into custody the patient where the patient is liable to be taken or retaken. The authorised person in this context relates to a person who has already been authorised by another provision of the Act to take a patient into custody (for example, where the patient has absconded).

Removal Order

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

Nurses' power to detain pending medical examination

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

Absconding

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

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

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

False statements

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

CRIMINAL PROCEDURES ACT PROVISIONS

Assessment Orders

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

Treatment Orders

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

Interim Compulsion Orders

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

Compulsion Orders

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

Mandatory reviews of Compulsion Orders by RMO

- **Section 139** consultation with MHO by RMO required re first review of order.

- **Section 140** consultation with MHO by RMO required re further reviews.
- **Section 141** consultation with MHO by RMO required before making a determination during mandatory reviews that the patient no longer meets the criteria for continued detention and revokes the order.
- **Section 144** notification to MHO of revocation of order required by RMO.
- **Section 145** consultation with MHO by RMO required re mandatory reviews of order.
- **Section 146** consultation with MHO by RMO required where there is a proposed extension of order at first review.
- **Section 147** imposes duties on MHO triggered by above. MHO must interview the patient wherever practicable and must, in any case, inform the patient of the RMO's proposal, of their rights in relation to the proposed application, and of the availability of independent advocacy services. They must also take appropriate steps to ensure that the patient has the opportunity of making use of those services. In addition the MHO must inform the RMO as to whether the MHO agrees or disagrees with the proposed application and if they disagree, the reasons why this is the case and must inform them as well of any other matters that the MHO considers relevant. The RMO must inform the Tribunal in any subsequent application under **Section 149** of the MHO's views and why they disagree with the order if they do. They must also advise the Tribunal in the application where the MHO failed to comply with the duties imposed by **Section 147**.
- In any application to the Tribunal under **Section 149**, before making a determination the Tribunal must first afford the MHO the opportunity of making representation orally or verbally and of leading, or producing, evidence.
- **Section 150** consultations with MHO by RMO required in respect of proposed extension of order at further reviews.
- **Section 151** imposes duties upon the MHO triggered by above which are the same as those imposed under **Section 147**.
- **Section 152** imposes a duty on RMOs to consult with the MHO during further reviews of the order before making a determination.
- **Section 153** requires that the RMO give notice to the MHO (as well as the patient, the patient's named person, the Tribunal and the MWC) of the determination that the order is to be extended. The RMO must also advise the Tribunal of whether the MHO agrees or disagrees with the determination and if they disagree, the reasons for this. They must also advise the Tribunal where the MHO failed to comply with their duties under **Section 151**. Where the MHO disagrees the Tribunal has a duty under **Section 165** to review the determination.

- Before making a decision the Tribunal must afford the MHO the opportunity to make representations orally or in writing and of leading or producing evidence.

Extension and variation of Compulsion Order

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

Variation of Compulsion Order

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

Reference to Tribunal by MWC re Compulsion Orders

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

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

- **Section 163** relates to the Tribunal's duty to review a determination to revoke an extension of a compulsion order. Before making a decision, the Tribunal must afford the MHO the opportunity of giving evidence orally or in writing and of leading or producing evidence.

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

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

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

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

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

Non-compliance generally with Compulsion Order

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

Compulsion Orders and Restriction Orders

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

Review of Compulsion Order and Restriction Order

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

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

- **Section 185** relates to situations where an RMO has submitted a report to Scottish Ministers under **Section 183 (2)** that includes a recommendation that the Compulsion Order be revoked or has submitted a report under **Section 184**. In such circumstances Scottish Ministers must make a reference to the Tribunal and must as soon as practicable give notice to the Mental Health Officer that a reference is to be made.

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

Conditional Discharge of Person on Compulsion Order and Restriction Order

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

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

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

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

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

Hospital Directions and Transfers for Treatment Directions

- Under **Section 59B** of the **Criminal Procedure (Scotland) Act 1995** a report by an MHO is required for the court when a Hospital Direction is being considered.

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

Review of Hospital Direction and Transfer for Treatment Direction

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

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

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

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

- When no reference or application to the Tribunal has been made during a period of two years, **Section 213** requires Scottish Ministers to make reference to the Tribunal. In doing so they must as soon as practicable give notice to the MHO that a reference is to be made.

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

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

Assessment Order: Suspension of measure authorising detention

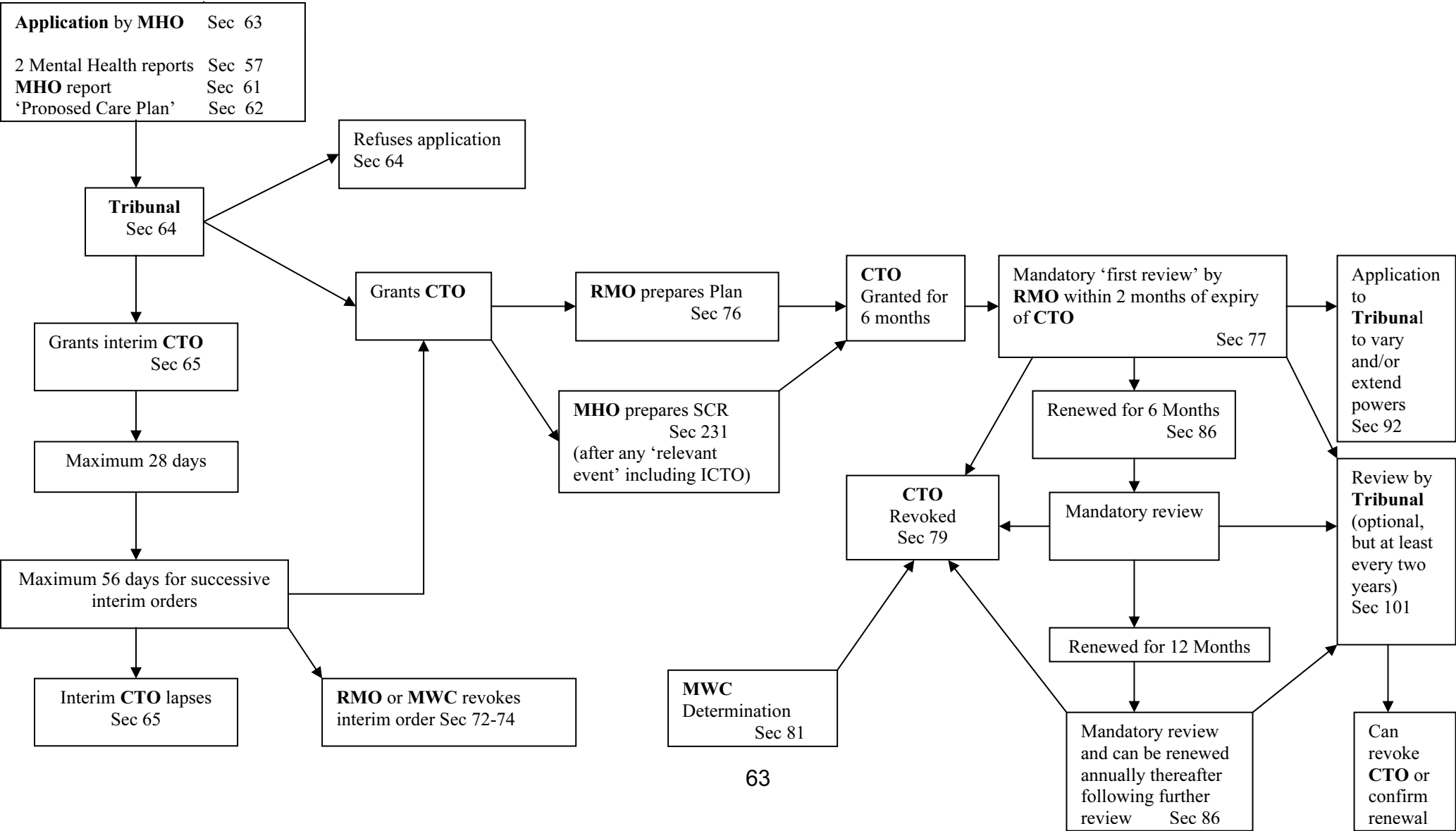
- Under **Section 221** the RMO may suspend the detention requirement of a patient on an Assessment Order and may include conditions seen as necessary in the interests of the patient. These conditions **may** involve the MHO, e.g. a condition

that the patient grants access to an MHO. If an MHO is authorised under this section, the RMO then has a duty under **Section 222** to give them notice when the order is revoked. Similarly, when Scottish Ministers revoke the order under **Section 223**, they must also notify the MHO if they had been authorised under **Section 221**.

Suspension of measures authorising detention after other relevant events

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

Please Note: This flowchart is for general guidance only and is not comprehensive. It should be used in conjunction with the Code of Practice and the Act itself.



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