mentalwelfare
commission for scotland

Issue 5 March 2012

Chief Executive's Advice Note

I have collected some advice that we have given about the operation of mental health and incapacity legislation recently.
I hope you find it useful.

I would welcome any feedback by email to enquiries@mwcscot.org.uk

This is the latest set of advice notes that I have issued.
You can find the previous notes below.

Chief Executive advice note 1 - December 2010

Chief Executive advice note 2 - January 2011

Chief Executive advice note 3 - June 2011

Chief Executive advice note 4 – November 2011

Dr Donald Lyons, Chief Executive
Mental Welfare Commission for Scotland

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Mental Health (Care and Treatment) (Scotland) Act 2003

Can you detain someone who won't talk to you?

Ms X was known to have a mental illness and had a history of serious self-harm when unwell. Her relatives contacted the mental health services with serious concerns about her. The approved medical practitioner and mental health officer went out to see her. When they got there, they found that she was outside her house in a friend's car and refused to be interviewed. They tried to interview her through the car window but failed. Based on her appearance, previous history and worries from the family, they detained her under a short-term detention certificate (STDC).

While done with the best of intentions, this was wrong. The code of practice states quite clearly that the medical practitioner must undertake a detailed interview to determine the grounds for an STDC. It is important to conduct a full examination before someone can be detained for up to 28 days and treated without consent. We made this clear to the medical practitioner, Ms X and her solicitor, as she might be able to take legal action. We can't rule that the STDC was unlawful; only a court can do that.

If she had been in her home, the mental health officer could have applied for a warrant for entry under section 35 of the Act to allow for a medical examination. That was not possible in this case. The best course of action may have been to admit her under an emergency detention certificate. The code of practice states that this may be acceptable in exceptional circumstances where it is not possible to

examine the patient. Of course, if there were serious concerns about her safety, the police could have been alerted.

For more information, please refer to chapters 2 and 7 of volume 2 the code of practice.

Part 16 (medical treatment)

Some of these have come up before. We still find that many practitioners struggle with the requirements of part 16.

- We have heard of more problems where the patient is under 18, not under the care of a child specialist and judged able to consent to treatment. The certification on statutory form T2 must be from the responsible medical officer (RMO) or a designated medical practitioner (DMP) appointed by the Commission. The Act requires that a certificate for anyone under 18 must be from a child specialist. This is a problem if the RMO is not a child specialist. We think it may be acceptable for hospital managers to appoint a child specialist as RMO for the purposes of assessing capacity to consent. The legality of this has not been tested, however, so it is far safer for hospital managers to always appoint a child specialist as the RMO for any detained patient under the age of 18.
- I have previously pointed out that it is only the RMO who can certify consent on a T2 form. We still find that other medical staff complete these forms. They can only do so if hospital managers have formally delegated the powers of the RMO to them, e.g. if the patient's own RMO is on leave.
- We have had queries about giving medication via nasogastric or PEG tubes. Where medication is being administered beyond two months since first given during this episode of compulsory treatment, the specific route should be authorised on a T2 or T3 form. It is not "oral" medication. Also, we strongly recommend advice from a pharmacist before giving medication in this way. It may be acceptable to use this route if the patient is being fed artificially. It is not acceptable to insert a tube just to administer medication.
- A reminder: it is not appropriate to ask us to arrange a DMP opinion only to resolve uncertainty over the best treatment to offer. That is not the DMP's role. We advise asking a local colleague for an opinion in this situation.

S113 admission from a community order

I gave advice on the process of admitting people from community orders in issue 4. To clarify: recall under S113 requires the RMO to consider the grounds for detaining the patient in hospital because of non-compliance with the measures in the order. Form CTO8 is a notification that this has happened. It is completed after the patient has been admitted, not before. There is no form that actually authorises the admission. Practitioners should comply with the code of practice vol. 2, chapter 6.

Place of safety

McCaskill and colleagues[1] published an article in "The Psychiatrist" on this topic. It is a timely reminder that the police must report place of safety orders to the Commission. Form POS1 is not statutory but should be used for this purpose. Also, we heard of someone who was removed from his

[1] The Psychiatrist (2011), 35, 185-189, doi: 10.1192/pb.bp.110.030874

own home under a “place of safety order”. This would be ruled unlawful; only a person in a public place who appears to have a mental disorder can be dealt with by the police under this order.

Adults with Incapacity (Scotland) Act 2000

Cause of incapacity

The Act, when defining incapacity, states that it must be due to either mental disorder or inability to communicate because of physical disorder. There are important differences in how these separate disorders are managed. In particular, our safeguarding role only applies to people with mental disorder.

We have looked at the cases of people for whom welfare guardians were appointed, where the cause of incapacity was “inability to communicate because of physical disorder”. We found some people with severe acquired brain injury in this group. We found reports to indicate that the damage was much more widespread and affected many more brain functions than “communication”. They should have been classified as having a mental disorder.

The category of “inability to communicate” should only be used if that is the only apparent problem, e.g. language disorder after a stroke or “locked-in syndrome.”

“Section 47” certificates

Except in emergencies, the Act requires that medical treatment is authorised under a certificate granted (usually) by the medical practitioner. There may also be a welfare proxy (attorney, guardian or holder of an intervention order) with the authority to consent. If so, the section 47 certificate of incapacity is still required, as well as the consent of the welfare proxy. The code of practice makes this clear.

Also, a reminder that a section 47 certificate does not authorise transfer to hospital. See our guidance on this.

“Consenting Adults” guidance

We are always grateful for feedback on our guidance documents and we are reviewing many of them over the next year or two. Some people have misinterpreted some statements in the “Consenting Adults” guidance on rights and risks in sexual relationships. In our original document, we made it clear that any action to assist a person to procure the services of a prostitute is unlawful. We have revised the wording of our guidance to make this even clearer. We recommend you refer to our latest revision on our website when using this guidance as this will be more up-to-date than previous printed copies.

Some recent reports (in case you haven’t seen them)

http://reports.mwcscot.org.uk/web/FILES/MWC_RightToTreat_prf2.pdf

http://reports.mwcscot.org.uk/web/FILES/Powers_of_Attorney_and_their_safeguards.pdf

http://reports.mwcscot.org.uk/web/FILES/Publications/Hard_to_help.pdf

http://reports.mwcscot.org.uk/Visiting_monitoring/Mentalhealthofprisoners/Mentalhealthofprisoners.aspx

General Information

For more advice on applying best legal, ethical and professional practice to the care and treatment of people with mental health problems or learning disability, you can:

Visit: www.mwcscot.org.uk

E-mail: enquiries@mwcscot.org.uk

Phone: 0131 313 8777

Freephone - service users and carer line: 0800 389 6809

Typetalk users: dial 18001 before dialling