

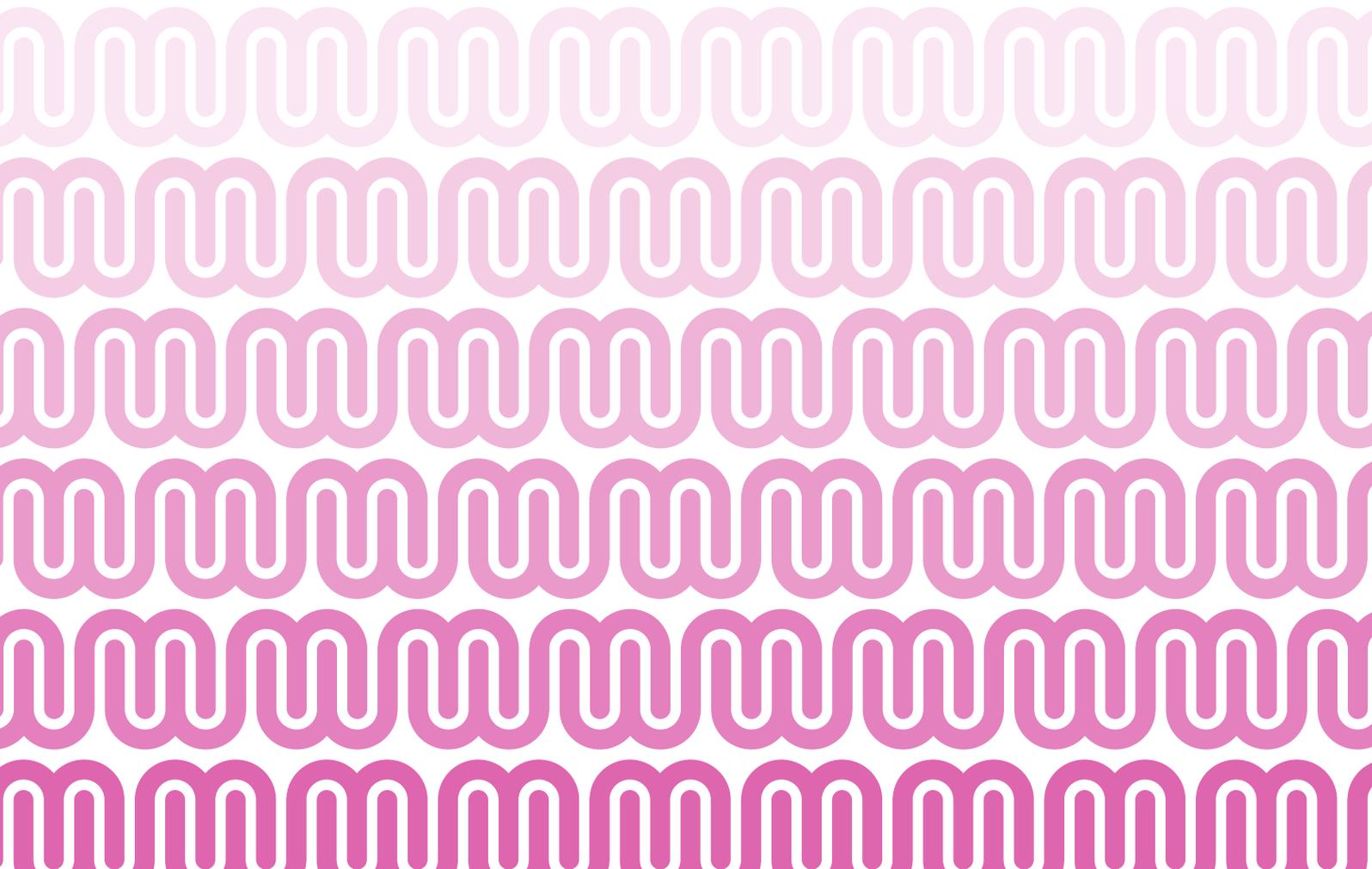


mental welfare
commission for scotland

Suspension of detention

Good practice guide

January 2022



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

This good practice guide was previously published in 2008 before being revised and updated in 2021.

Contents

Introduction	4
Scottish Government guidance on suspension of detention	4
What is suspension of detention?	5
Who suspends detention?.....	6
Granting suspension of detention – local leave plans and forms	7
Civil orders and COs	7
Restricted patients.....	7
Who must be notified?	8
Longer periods of suspension of detention	9
CTOs and COs.....	9
Restricted patients.....	10
Does suspension of detention under a previous CTO or CO count for the 200 day limit?	11
Suspension of detention in practice.....	11
Special situations.....	12
1. Suspension versus variation.....	12
2. Attaching conditions to suspension of detention	13
3. What if a patient is still in the community and the 200 day suspension of detention limit is reached?.....	15
4. What if a patient is in hospital, is ready for leave under suspension and the 200 day suspension of detention limit is reached?.....	16
5. Transfer to another hospital and suspension of detention	17
6. Revoking a suspension certificate.	18
7. What happens at the end of a period of suspension?	19
Conclusions	20

Introduction

This good practice guide contains guidance in the use of suspension of detention under the Mental Health (Care and Treatment) (Scotland) Act 2003¹. Most orders granted under this Act involve detaining an individual in hospital. A guiding principle of the Act is that individual care and treatment should be delivered in a way that is least restrictive of the person's freedom. Suspension of detention is a key provision that helps to achieve this. It is possible for the Responsible Medical Officer to suspend a person's detention to allow greater freedom and a better quality of life while still providing the care and treatment they need.

The Commission has the duty to promote best practice in relation to the principles of the Act. We believe that the appropriate use of suspension of detention is of benefit to the individual.

The Act's original provisions for suspension of detention were quite complex. In practice, they could be quite hard to understand and rather cumbersome to operate. Changes made by the Mental Health (Scotland) Act 2015² were implemented in 2017. These have improved things, particularly the simplification that only periods of suspension of detention that count as a full day are included in the maximum amount of suspension of detention that can be granted.

Scottish Government guidance on suspension of detention

The Scottish Government's initial guidance on suspension of detention was contained in the Code of Practice for the Act³, and also in HDL(2006)7⁴.

The government has published updated guidance covering suspension of compulsory measures specified in a compulsory treatment order (CTO) or an interim CTO (ICTO)⁵. This contains detailed information and good practice guidance, and we make reference to this. It is directly relevant also to compulsion orders (COs), as the same provisions apply.

¹ <https://www.legislation.gov.uk/asp/2003/13/contents>

² <https://www.legislation.gov.uk/asp/2015/9/contents>

³ Code of Practice

- Volume 1: <https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/>
- Volume 2: <https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-2-civil-compulsory-powers-parts-5-6-7-20/>
- Volume 3: <https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-3-compulsory-powers-relation-mentally-disordered-offenders/>

⁴ https://www.scot.nhs.uk/sehd/mels/HDL2006_07.pdf

⁵ <https://www.gov.scot/publications/mental-health-law---suspension-of-detention-guidance/>

What is suspension of detention?

HDL(2006)⁶ is clear on what constitutes suspension of detention:

“Any period outside the hospital grounds has to be authorised by a certificate under the relevant section of the Act. Time out of the ward but within the hospital grounds does not require a suspension of detention certificate.”

The relevant sections of the Act are:

Sections 41 and 42 - an emergency detention certificate (EDC);

Sections 53 and 54 - a short term detention certificate (STDC);

Sections 127 and 129 -

- a compulsory treatment order (CTO);
- an interim compulsory treatment order (ICTO);
- an interim order (extending, varying, or extending and varying a CTO under sections 105 or 106);

Sections 221 to 223 - an assessment order (AO); *

Sections 224 to 226 -

- a treatment order (TO); *
- an interim compulsion order (ICO);*
- a temporary compulsion order (TCO)
- a compulsion order with a restriction order (CORO);*
- a hospital direction (HD);*
- a transfer for treatment direction (TTD);*

Section 179 -

- an interim order (extending, varying or extending and varying a CO (sections 168 and 169);
- a compulsion order (CO)

(Section 179 says that sections 127, 128 and 129 apply to these orders so, in practice, the suspension of detention provisions are the same as for a CTO or ICTO)

(Suspension of orders marked with * need the permission of Scottish Ministers.)

⁶ https://www.scot.nhs.uk/sehd/mels/HDL2006_07.pdf

HDL(2006)7⁷ gives examples of situations where suspension of detention might be used. These are:

- rehabilitation including pre-transfer visits to another hospital;
- quality of life;
- compassionate visits;
- scheduled treatment in hospital;
- emergency treatment in hospital;
- attendance at court;
- attendance at Tribunal hearings held outside the hospital grounds.

The Scottish Government's recent guidance⁸ outlines how the main purpose of suspension of detention is to act as a tool in the process of planning a patient's discharge from compulsory measures and, more generally, from in-patient psychiatric services.

Generally, suspension of detention must be granted by the responsible medical officer (RMO) for any time the person spends outside the hospital grounds, regardless of the escort arrangements.

Who suspends detention?

The Act is clear that it is the RMO who authorises suspension of detention.⁹ It is important to note that, while a person can only have one RMO at any time, the RMO can be any approved medical practitioner who the hospital managers appoint to the role. Therefore, when the RMO is absent, off duty or on leave, the managers should appoint a substitute. Outside working hours, this would normally be the duty consultant.

During working hours, it would normally be a colleague, or a locum, who would cover short absences or longer periods of leave. The patient should always have an RMO available to grant suspension of detention, or make other decisions required by the Act.

⁷ https://www.scot.nhs.uk/sehd/mels/HDL2006_07.pdf

⁸ <https://www.gov.scot/publications/mental-health-law--suspension-of-detention-guidance/>

⁹ The only circumstance where a doctor other than the RMO could grant suspension of detention would be if the hospital managers appointed another approved medical practitioner under s230(3)(b) to act in place of the RMO and do that. This would be unusual.

Granting suspension of detention – local leave plans and forms

Civil orders and COs

There are no Scottish Government forms for certificates of suspension of detention where the period of continuous suspension granted is less than or equal to 28 days (i.e. consecutive days). This will always be the case for EDCs, STDCs and ICTOs.

The Act still requires suspension certificates for shorter periods of suspension of detention. These should be granted by the RMO on a local leave plan, and need to be signed by them to be proper suspension certificates. The RMO might authorise periods of suspension of detention per day, or per week, that may or may not actually be taken by the patient, depending on circumstances. The RMO can include conditions of suspension of detention as necessary (we cover this more below).

The Commission does not need to be notified of these shorter periods of suspension of detention.

The Commission needs to be notified (only) when a suspension certificate authorises a continuous period of suspension of detention of more than 28 days. Form **SUS1a**¹⁰ should be used for this.

(Form SUS1b is a form to suspend other measures – this is used to suspend measures in a community order.)

Restricted patients

For restricted patients, follow the Memorandum of Procedure on Restricted Patients.¹¹

The Commission needs to be notified (only) when a suspension certificate authorises a continuous period of suspension of detention of more than 28 days. Form **SUS3a**¹² should be used for this.

¹⁰ <https://www.gov.scot/publications/mental-health-law-forms/>

¹¹ <https://www.gov.scot/publications/memorandum-procedure-restricted-patients/>

¹² <https://www.gov.scot/publications/mental-health-law-forms/>

The expiry date of any suspension certificate must not go beyond the last date on which the MHA provision that the patient is subject to would currently authorise compulsion if not revoked. This should be particularly remembered for ICTOs.

Who must be notified?

The Act requires notification of periods of suspension where the cumulative time of short spells will be more than 28 days. The RMO must notify the patient, their named person (if they have one), general practitioner and the MHO. The RMO is required to make these notifications before they grant the suspension certificate. The code of practice suggests that it would be best practice to ensure that these parties receive similar notifications where a suspension period of less than 28 days is proposed. In practice, it is simpler to have a system of routinely giving all the above a copy of the leave plan.

For longer continuous suspension (more than 28 days), all the above need to be informed, as well as the Commission. It is perfectly acceptable to use the same leave plan and attach it to the completed SUS form when informing the Commission.

Longer periods of suspension of detention

Certificates; counting days; maximum suspension that can be granted; the “200 day rule”

(It is important to ensure that a single suspension certificate is never written such that it could breach any of the limits to suspension of detention described below, even if it is not certain that all the suspension of detention will occur.)

CTOs and COs

A suspension certificate may specify -

- a) a single period not exceeding 200 days, or
- b) a series of more than one individual period falling within a particular six-month period.

The maximum amount of suspension of detention that can be granted in a 12 month period is 200 days *wherever counted from*. This is a rolling 12 month period - there must be no day when, looking back from that day, the patient has had more than 200 days suspension of detention in the previous 12 months.

Any period of suspension of detention that lasts eight hours or less does not count as a day. This will include shorter periods of time spent by an inpatient outwith the hospital. Periods of more than eight hours but less than 24 hours count as a day toward the 200 day total (whether that period occurs within one calendar day, or spans two days).

The Scottish Government’s guidance contains examples of calculating how periods of suspension count as days, in paragraph 7¹³.

Calculating the maximum 200 days suspension of detention (and when that would be exceeded) can cause confusion. All days of suspension of detention that the patient has in a rolling 12 month period count towards this limit. This may include suspension of detention authorised on a number of certificates (local leave plans and/or suspension of detention notified to the Commission on SUS1a forms). It is important that a careful record of this is kept.

Our advice is to count back from the day in question. So for example if today is the 21 of March, the person can only continue to have suspension of detention granted if they have been on suspension for less than 200 days in total since the 21 of March last year.

When considering granting suspension of detention, the RMO should look forward to the last date of the suspension that they are considering granting. That date must

¹³ <https://www.gov.scot/publications/mental-health-law--suspension-of-detention-guidance/>

not be beyond the last date of the current authority for compulsion. Looking backwards from that date, the patient would need to have had no more than 200 days suspension of detention in the 12 months prior to that day.

The Scottish Government's guidance confirms in paragraph 8 that the maximum period of 200 days relates to the actual time that detention is suspended, not that specified or suggested on the certificate. So for example if suspension was granted for a period of two months on the 21 March but the person didn't actually go on leave from the ward on suspension until two weeks after this- i.e., it's the time away from the ward that counts not the dates on the form.

It is therefore not only best practice to keep accurate documentation of when the patient left and returned to the hospital; it is essential to keep a record of the days of suspension of detention they have had. It is important to make sure that suspension days are counted during periods when a patient has shorter periods of suspension authorised on a local leave plan (usually while still an inpatient).

When the RMO is considering granting a suspension certificate, they need to ensure that they do not complete this seeking to authorise suspension that would, when taken together with any other suspension the patient has had, exceed the limit of 200 days in 12 months. A certificate with this error is invalid from the outset and the patient will be on unauthorised absence from the hospital (this was confirmed in a Judicial Review in the Court of Session¹⁴). If they remain on unauthorised absence for three months, they will become informal.

Restricted patients

For orders covered by s224 – TO, ICO, TCO, CORO, HD, TTD –

a suspension certificate may specify:

- a) a single period not exceeding 90 days; or
- b) a series of more than one individual period falling within a particular three month period.

Otherwise, suspension of detention limits and our advice are as for CTOs and COs above. The maximum amount of suspension of detention that can be granted in a 12 month period is 200 days wherever counted from.

¹⁴ https://www.mhtscotland.gov.uk/mhts/files/Judgements/DC_petition_for_judicial_review.pdf

The best way to avoid any problems with the '200 day rule' is to apply at the earliest practicable stage for a variation to the order (or revoke it if no longer necessary). This may prove difficult during prolonged period of rehabilitation with a very gradual transition to community care, especially for people with restricted status.

Does suspension of detention under a previous CTO or CO count for the 200 day limit?

The wording of s127 was changed with the 2015 MHA revisions. We think the new wording restricts the counting of days on the suspension of detention to the current CTO or CO, so that any suspension of detention granted under a previous CTO or CO (that had been revoked/ended) would not count towards the 200 days maximum. However, the MWC's view is not a legal view. The RMO should seek their own legal advice on this in circumstances where this detail would be important.

Suspension of detention in practice

There are some general best practice points for all situations where suspension of detention is being considered:

- Where practicable, plans for suspension of detention should be discussed in advance with the detained person, their named person (if they have one), and any other carers who may have a role.
- Independent advocacy has an important role. The individual should always have access to advocacy and it is important for the advocate to assist the individual when suspension is being discussed.
- Discuss the suspension plan with the inpatient team and make sure it is prominently placed in the case record. It is particularly important that the nursing staff can refer to it easily.
- Any risks arising from suspension of detention should be documented. A risk management plan should be in place, where appropriate.
- In line with the principle of least restriction, any conditions to be attached to a period of suspension should be justified through reference to the risk assessment.
- Where suspension is used as part of rehabilitation to determine how the person can manage outside hospital, it is important to get feedback on periods of suspension from the person, carers and any professionals who have had contact with him/her during the period of suspension.

Special situations

1. Suspension versus variation

The process of transfer from in-patient to community care is often gradual, especially for people with severe and enduring mental illness. In general, we expect the difference between suspension and variation to be:

- Suspension is used for short, then gradually lengthening spells to assist rehabilitation and recovery. It should be used up to the point when the person appears able to live in the community with any appropriate support.
- Variation to an order that does not authorise detention should be used where the person appears capable of living outside hospital with appropriate accommodation and support, but where there is a need for some aspects of care and treatment to be provided on a compulsory basis.
- In all cases, RMOs must keep the need for compulsory treatment under review and be prepared to revoke the order if the grounds for compulsion are no longer met. In the case of COROs, the RMO should submit a report to Scottish Ministers if the grounds do not appear to be met.

Consideration should be given, in particular, to the principle of ensuring the minimum restriction on the freedom of the patient that is necessary in the circumstances.

In practice, the decision may not be easy.

Case example: *Mr B has a history of severe mental illness. He was admitted to hospital under the Act three months ago. Before admission, he was reclusive, living in squalor, refusing access to anyone and not eating. He believed his neighbours had him under CCTV surveillance at all times. He is subject to a CTO in hospital and has improved greatly on medication. He has been home on suspension of detention for short periods of time, most recently for a five day spell. He appears to care well enough for himself but is reluctant to take medication and only allows care staff to visit him at home because he has to. What would you do now?*

- a) Suspend his detention for a further period and review.*
- b) As above and initiate an application to vary the order.*
- c) Revoke the order.*

Our views: It would be a good time for the RMO to consider whether the grounds for the CTO are still present. The RMO was satisfied that they were. She has a full discussion with Mr B along with his advocate, his named person and the multidisciplinary team, using the principles of the Act to make the decision. Mr B wishes to be out of hospital permanently but his named person and other members of the team are concerned that he would neglect himself and might not let care staff into the house. On balance, the RMO decides on a longer period of suspension with the proviso that, if Mr B is recovering well over the next month, it would then be too restrictive for him to remain on a suspended CTO and that she would then apply to the Tribunal for a variation.

2. Attaching conditions to suspension of detention

Sections 41(4), 53(4), 127(6), 221(6) and 224(6) allow the RMO to specify conditions attached to the suspension of a detention, if they consider that this is necessary in the interests of the patient or for the protection of other persons. The conditions should be tailored to the needs of the patient and the circumstances and should be specified on the certificate.

Except for restricted patients, there is a significant difference between suspension and variation. Orders that do not authorise detention for example a Community based Compulsory Treatment Order can only authorise the specific measures in S66(1) (b to h). Therefore, when the RMO decides to apply to vary the order, they must remember that the varied order would not allow the RMO to impose conditions such as refraining from certain behaviours (e.g. taking alcohol and drugs or visiting certain people or places) which might be imposed under a suspension. While there may be situations where the RMO should issue strong advice to the person, there is no legal basis for imposing any sanction for a community-based order should the person disregard the advice, unless the person either:

- Fails to comply with the requirements of the order – in which case procedures for treatment under section 112 or admission under sections 113 and then 114 could be considered, or;
- Becomes mentally unwell and meets the grounds for admission under a short-term detention or emergency detention certificate.

Case example: *Ms D has a paranoid illness that is made worse when she drinks alcohol. She is on a compulsion order because she assaulted a stranger in the pub, believing that the stranger was talking about her. Her RMO suspends her detention to allow her to spend weekends at home but is worried that she might drink and get into the same difficulties that resulted in the initial assault. What conditions could the RMO attach?*

Our views: Use the principles of the Act and don't attach conditions that are not necessary or that are outwith the scope of the Act. Using principles of information and participation, it would be most important to engage her in staying well and safe. Practitioners should help her understand the risks to her mental health if she drinks. Suspending her detention is likely to be of benefit in helping her towards recovery and is likely to restrict her freedom less than being in hospital. The conditions attached should be no more restrictive than necessary. The views of others are important, especially informal carers who will be supporting her when she is at home. They need the information and support necessary to help them care for her.

In this case, the RMO documented the risks that might occur if detention is suspended. He put Ms D in touch with alcohol counselling services and impressed on her the need to avoid alcohol. He made sure that she and her carers had 24 hour contact numbers in case of emergency and advised the carers that Ms D should not drink. He arranged for staff to visit her on suspension to ensure she was well and was benefiting from her spell out of hospital. He attached conditions that she must

refrain from alcohol and must not go to a pub while on suspension. He had also wished to test her for alcohol during the period of suspension but realised that this would not be lawful. The specified persons provisions of the Act can authorise the taking of samples, but these only apply to patients who are detained in hospital – this would not include periods on suspension of detention or community orders. However, the RMO could, if necessary, ask her to provide a sample for testing on her return.

The RMO can only attach these conditions to a suspension. If he decides to apply for a variation, he could not impose either condition nor could he require her to provide samples. This emphasises the importance of encouraging Ms D's participation to make sure that her recovery is sustained.

3. What if a patient is still in the community and the 200 day suspension of detention limit is reached?

We are sometimes asked for advice in situations where a patient has been on suspension of detention, has reached the 200 day limit of suspension that can be granted, and there has been no application to the Tribunal for variation to a community-based CTO or CO.

In most of these circumstances, there has been an oversight on the part of the RMO, or the issue has arisen in the context of a change of RMO. It is important that there are clear processes for RMOs to be clear about amounts of suspension of detention that patients have been granted, and when an application to the Tribunal for variation is indicated.

If the 200 day limit has been reached, no further suspension of detention can be granted. If the person is in the community, and remains subject to the order, they will technically be on "unauthorised absence". However, we advise against applying the part of the Act that deals with this, as it was intended to be used for people who absconded.

If the person is in the community, the RMO should review their need for compulsory measures. If these are not required, the RMO should revoke the order. If the person does not need to be in hospital, the RMO should consider revoking the order as it is no longer necessary to detain the person. If there appear to be grounds for continued compulsion to receive care and treatment in the community, and the RMO revokes the current order, they can then apply to the Tribunal for a community-based compulsory treatment order.

We are aware that for some patients their RMO decides not to revoke the order, but to leave them on unauthorised absence and make an application to the Tribunal as soon as possible for variation to a community-based order. If this is done, the patient should be informed of their situation. It should be remembered that, if they are on unauthorised absence for three months, the episode expires and they will become informal.

If the RMO determines that a patient in the community requires compulsory admission to hospital, they can require them to return to hospital. This should be unusual in this situation, and only based on clinical need. We do not think that a patient should be returned to hospital simply because they cannot be granted further suspension of detention – that would usually be overly restrictive. However, in some cases there may be particular risks caused by suspension of detention ending that may necessitate hospital admission pending the outcome of an application for variation, e.g. if the patient has been engaging with community treatment only due to conditions attached to their suspension of detention, they disengage when the conditions are no longer there, and they cannot safely remain in the community without that treatment.

We wish to be informed of any occurrence of a person being recalled to hospital under these circumstances.

4. What if a patient is in hospital, is ready for leave under suspension and the 200 day suspension of detention limit is reached?

There is a problem if the person is still in hospital and needs compulsory hospital treatment.

Case example: *Mr F is subject to a CTO has been on suspension for 200 days but has had to come back into hospital. There had been an application to vary the order but, due to a mix-up, it wasn't sent to the Tribunal. He is improving and it would benefit him to get out of the hospital for short periods. According to the Act, his order cannot now be suspended. What should the RMO do? How can they follow the principle of least restriction and allow Mr F to have time outwith the hospital?*

- a. *Can they suspend the order, even though this is not allowed by the Act?*
- b. *Should they obey section 127 and not allow Mr D to leave hospital on suspension?*
- c. *Is there any other lawful solution?*

Our views: This is a situation where the principles may be in conflict with actions technically allowed by the Act. Firstly, the RMO should seriously consider whether the order is still necessary. The ideal solution would be to revoke the order. If the grounds are still met, based on the individual needs of the person, the RMO should ask for legal advice. We do not think that the RMO can grant suspension of detention in this situation, and we think that DC (Judicial Review) [2011] CSOH 193¹⁵ would confirm that. However, the Commission's view is not a legal view, and the RMO needs legal advice. The RMO should inform Mr F of the situation. We would consider that the principle of least restriction of freedom should apply, and Mr F should be able to be permitted to have some time outwith the hospital if suspension of detention would otherwise be granted and the Commission will support an approach that favours this. We would however expect such circumstances to be exceptional and would like to be informed if any situation such as this arises.¹⁶

¹⁵ https://www.mhtscotland.gov.uk/mhts/files/Judgements/DC_petition_for_judicial_review.pdf

¹⁶ We are writing to the Scottish Mental Health Law Review to highlight that we continue to hear of situations like this arising, and we think this merits particular consideration.

5. Transfer to another hospital and suspension of detention

If a person requires to be transferred to another hospital for treatment, it could be appropriate to use suspension of detention. However, if the authority to detain the patient is likely to be needed during their time in the other hospital, a formal transfer should be considered (under s124 for a patient subject to an iCTO, CTO or CO; or, for a restricted patient, under the applicable provisions with the consent of the Scottish Ministers). Unlike for patients detained under a CTO there are no formal procedures to follow for the transfer of patients subject to an EDC or STDC, although it is good practice to seek the consent of the patient and give notice as soon as possible.

Generally, if the treatment is part of ongoing mental health treatment, we recommend transfer. If it is for a coincidental physical problem, we recommend suspension in the first instance.

A transfer may be urgently necessary (for example to a general hospital) when no RMO is available to authorise a suspension of detention. In these circumstances, we think that lack of a certification should not delay urgent and necessary treatment. The on-call doctor should discuss the suspension with the RMO (or the acting RMO) and seek their verbal consent. This should be recorded in the case notes. The appropriate certificate should be completed by the RMO as soon as practicable.

Suspension of detention could be used to cover the period of a person's treatment in a general hospital. If it is in the interest of that person or necessary for the protection of other persons, the RMO can attach conditions to the suspension. These could include a condition that they stay in the designated ward, or a condition that they should be in the charge of a specified person (such as a doctor or nurse). However, if they are actually seeking to leave, and/or they require treatment for mental disorder with force, we think it would be preferable for the order to be transferred so that there is then authority to detain them in the general hospital under the order.

6. Revoking a suspension certificate

The RMO may revoke a suspension certificate if it is necessary to do so “in the interests of the patient or for the protection of any other person” (section 129). If suspension is recorded on a leave plan, it can be revoked by the RMO in writing on the plan (see below). If the suspension has been documented on form SUS1a, it can be revoked on SUS1c¹⁷.

For restricted patients suspension of detention can be revoked on SUS3b¹⁸.

Again, in revoking a certificate, the RMO has to consider the principles of the Act and be satisfied that the revocation is necessary. There is no right of appeal against revocation.

Case example: *In the previous case of Ms D, a member of staff informs the RMO that she saw Ms D in a pub, although apparently having a soft drink and enjoying herself. Although a breach of the conditions of suspension, the RMO did not consider that revoking the suspension was necessary and that it would limit her freedom more than necessary. However, he arranged to see Ms D urgently and remind her of the conditions. When she was seen in the pub again, this time drinking alcohol, the RMO considered that the risks to Ms D and others outweighed the restriction of freedom and that it would therefore be of benefit to her to revoke the certificate. He recorded the reasons for this in writing.*

Ms D was unhappy with this. Although she had no right of appeal against the revocation, she was reminded of her right to appeal the order and she obtained the services of an independent advocate.

Sometimes, the person whose detention is suspended may agree or want to return to hospital. In these circumstances it would not be appropriate to revoke the suspension of detention. They would be in hospital informally, and the days they spent there would count towards their 200 day suspension of detention allowance as the detention has indeed been suspended even though they are in hospital. Everyone must be clear that there is no authority to detain the person in that situation as the person wants or agrees to be in hospital. This might be for a short period e.g. to change medication. Depending on the circumstances, or if the informal admission is prolonged, the RMO should review whether an application for variation of the order is indicated.

¹⁷ <https://www.gov.scot/publications/mental-health-law-forms/>

¹⁸ <https://www.gov.scot/publications/mental-health-law-forms/>

7. What happens at the end of a period of suspension?

If the period of suspension granted on the SUS form has expired, the RMO should simply complete another SUS form if further suspension is to be granted. There is no need to revoke the previous certificate.

If the RMO has granted a period of suspension which has been revoked, or the conditions attached to the suspension have been changed, the RMO should revoke the previous certificate. The RMO could revoke a leave plan by writing "revoked", signing and dating it. SUS1c should be used for revoking longer periods of suspension (SUS3b for restricted patients). Another certificate can be granted if appropriate.

Conclusions

Where it is used appropriately, suspension of detention can enhance the quality of life of the individual. We have demonstrated examples of how this is best achieved by observing the provisions of the Act and by using the principles. Suspension of detention usually works well. However, some areas of difficulty can arise, particularly for some individuals whose 200 day suspension of detention limit has been reached. We will be commenting on this to the Scottish Mental Health Law Review that is currently reviewing mental health legislation.



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