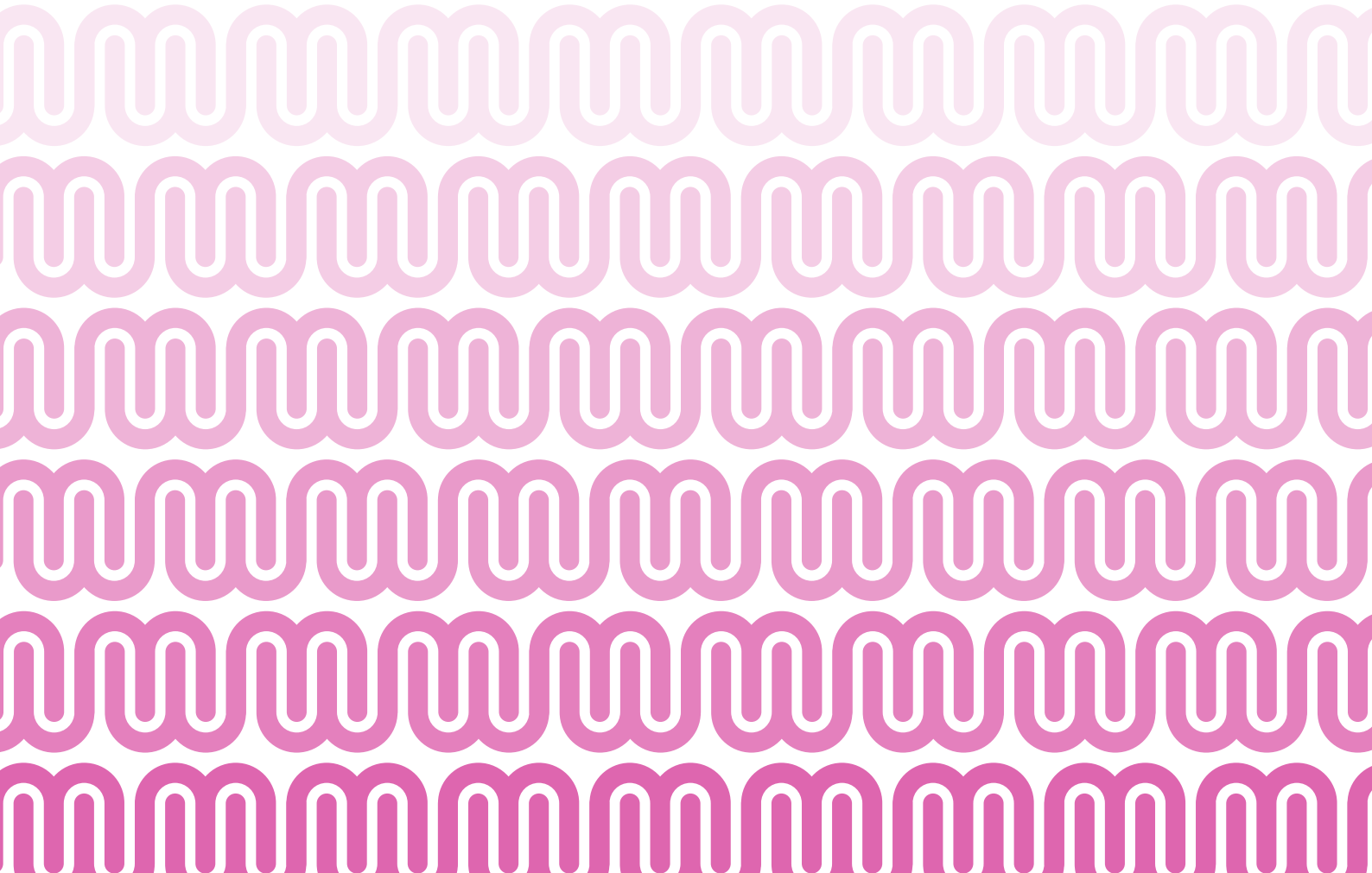
mental welfare commission for scotland

# Medical treatment under Part 16 of the Mental Health (Care and Treatment)(Scotland) Act 2003

## Good practice guide

**September 2025**



# 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 guidance was previously published as an advice note in 2014. It has been reviewed in 2021. The main changes are the addition of sections 3.4 on authorising IM clozapine and 3.5 on administering clozapine via a naso-gastric tube – expectations of clinical teams.

## Contents

# 1. About this guidance

The Mental Welfare Commission has the duty to give advice relevant to our functions. We also promote best practice in relation to the principles of mental health legislation.

We receive many calls for advice on the topic of medical treatment under the 2003 Act. We have used our answers to develop this guidance. It contains some guidance on parts of the law on medical treatment that cause the most difficulty. It also contains answers to some of the more difficult questions that have come our way.

We hope this guidance is helpful. You can call us for specific advice on 0131 313 8777 if this guidance does not answer your question. You may also find it helpful to refer to some of our good practice guides, especially Consent to treatment. We have provided a list of relevant guidance documents at the end of this document that may help you.

In this guidance, we use the term “patient” when interpreting the wording of the 2003 Act. Otherwise, we use the term “individual” to mean someone with a mental illness, learning disability or related condition. We use the term “mental disorder” when quoting directly from the Act.

We have divided this guidance into sections. You will find that some guidance in repeated in different parts of this guidance. This is intentional. For example, we have separate sections on electroconvulsive therapy (ECT) and urgent treatment. Where we have given advice on urgent ECT, our guidance appears in both sections.

# 2. General treatment safeguards

## 2.1. Introduction

This part of the guidance refers to the general treatment safeguards which apply under part 16 of the 2003 Act. It attempts to answer some of the questions we have been asked about this.

## 2.2. Treatment not mentioned in specific safeguards

This includes medication administered during the period of two-months from the first administration of medication under the 2003 Act. It also includes ongoing treatment that does not require safeguards such as care, nursing, psychological treatments, care, habilitation and rehabilitation.

The 2003 Act is not clear on this, but we think practitioners should follow the intention of section 242 in this case. Where treatment is not otherwise mentioned in this guidance, it can be given with the individual's consent. If the individual cannot or does not consent, it may be given under a test of "best interests". This means having regard to:

- The reason for not consenting;
- Any views expressed by the patient;
- Any views expressed by the patient's named person;
- Any advance statement made by the patient; and
- The likelihood of the treatment's alleviating, or preventing a deterioration in, the patient's condition.

## 2.3. Advance statements about medical treatment

See our good practice guide on advance statements[1] for full information. This guidance specifically addresses some issues that have come to our attention in relation to advance statements.

The 2003 Act allows an individual to make a written statement when they are well, with regard to how they would prefer to be treated (or not treated) should they become unwell, and unable to make treatment decisions in the future. This would cover only treatments for mental disorder given under the 2003 Act and has to be witnessed by certain classes of people in order to be valid. At present these are: chartered clinical psychologists, medical practitioners, registered occupational therapists, registered nurses, social workers, solicitors and people employed in the provision of (or in managing the provision of) a care service. An advance statement is not the same as a "living will" or an "advance directive" neither of which have any formal legal authority in Scotland and which are more often used in respect of treatment for physical conditions or end of life care. Although the 2003 Act does not state that an advance statement should be dated it should be standard practice for both the person and the witness to date their signatures.

[1] https://www.mwcscot.org.uk/node/224

**Making an Advance Statement: Key Points**
Must be:

- in writing.
- signed by the person making it.
- witnessed by someone from the prescribed class.
- made when the person, in the opinion of the witness, has the capacity to make the decisions referred to.
- dated

The existence and location of new advance statements must be registered with the Mental Welfare Commission.

An advance statement can be withdrawn by the person who made it at any time. The criteria for withdrawal are the same as for making an advance statement.

**What should be included in an advance statement?**
Our view is that only those aspects of medical treatment about which an individual would normally be offered some choice should be included. These are:

- Whether they are treated in hospital or in the community
- What medications and other forms of treatment regulated under part 16 of the 2003 Act they will receive
- What other therapeutic interventions they will receive.

**What should be done with an advance statement?**
It would be appropriate for copies of an advance statement to be given to the individual's consultant, so that it can be easily found in their medical record, and to the person who would be their "named person" should they be subject to compulsory treatment in the future. It might also be appropriate to give a copy to their mental health officer or solicitor.

**How often should an advance statement be reviewed?**
We recommend that individuals should review their advance statement after each episode of illness or at least every three years, providing they have the capacity to properly do so.

**The effect of an advance statement**
Anyone giving medical treatment under the 2003 Act must have regard to the views and wishes contained in a valid advance statement. However, advance statements can be overridden. The Tribunal, the responsible medical officer (RMO) and a designated medical practitioner (DMP) can all override an individual's advance statement.

Anyone thinking of overriding an advance statement should give careful consideration to the principles of the 2003 Act. When an advance statement is overridden a full explanation should be provided to the individual. The reasons

should be recorded in writing and a copy of this given to the person who made the statement, that person's named person, welfare attorney or guardian and to the Mental Welfare Commission. A copy of the record should be placed in the person's medical record. In practice, the Tribunal do this through their written findings, RMOs and DMPs should write a letter explaining their decision to the individual. This letter should be copied to the named person, any welfare attorney or guardian and the Commission.

In some cases, it may be possible by careful wording of a T2 or T3 form to avoid the need for an override and still respect the individual's wishes by being more specific about medications. For example using the phrase "except medication X or Y", (X and Y being the medications recorded as not wanted in the advance statement).

**When an advance statement is made about treatment already being given**
Sometimes individuals want to make, or are encouraged to make, an advance statement about treatment they are already receiving or that is being actively considered. The 2003 Act intended that advance statements would only have effect when a person's capacity to make decisions had been impaired by their mental disorder.

Our view is that whilst they may be valid advance statements they have not yet come into effect as there has been no change in the individual's capacity. They are however, useful contemporaneous statements about care and treatment and should be considered as such in any discussions.

## 2.4. The named person

An individual aged 16 or over can nominate an individual, also aged 16 or over, to be their named person. This can happen whether or not they are subject to compulsory powers at the time. The individual must have the capacity to understand the decision they are making and its effects, they must also not have been subject to any undue influence. A valid nomination must be signed by the person making it and witnessed by a prescribed person in the same way that an advance statement is. It would be advisable for the person to check, in advance, that their proposed named person is willing to act in that role. The nomination can be revoked at any time in the same way providing the person has the capacity to do so.

The nominated named person may refuse to act at any time. They should inform the person who nominated them and the local authority for the area where the nominator lives.

See the Scottish Government Mental Health Law in Scotland: Guide to Named Persons (2019)[2]

**What if there is no person nominated or the nominated person refuses to act?**
Section 257A (amended by the Mental Health (Scotland) 2015 Act) allows certain people to initiate an application or appeal to the Tribunal where there is no named person and the patient lacks capacity to do so. These listed initiators are the

[2] https://www.gov.scot/publications/mental-health-law-scotland-guide-named-persons/pages/1/

patient's guardian, welfare attorney, primary carer (if any), and nearest relative.

**What if the patient is under 16?**
In this case they cannot nominate a named person, even though they may be judged to have capacity. The person with parental responsibility, or the local authority where the child is looked after by that authority, would be named person.

**What is the role of the named person?**
Broadly speaking, the named person has similar rights to the patient to apply to the Tribunal, to appear and be represented at Tribunal hearings and to appeal. They also have the right to receive information about many compulsory measures which have been taken or are being sought where this is provided for in the 2003 Act. For example they should be consulted when a short-term detention is being considered or when certain medical treatments are prescribed. These duties apply unless "impracticable" to do so.

We have been asked if this includes where the individual objects to the named person being contacted. We think the duty to consult still applies and the individual should be informed that the practitioner has a legal duty to consult. Of course, if the individual is capable, they could decide to nominate a different named person.

**What if the individual does not want the named person to be consulted?**
There are several situations where there are statutory duties to consult the named person and/or take their views into account. In relation to medical treatment, this includes the RMO's duties in relation to the "best interests" test for general treatment under s242. It also includes the DMP's duty to consult the named person under s245 (see below).

In these situations, the statutory duty to consult the named person is clear in law and the individual cannot object to this. If the individual has capacity, he/she can change the named person or decide not to have a named person.

## 2.5. Designated medical practitioners (DMPs)

DMPs provide independent second opinions about certain medical treatments given under part 16 of the 2003 Act. We appoint the independent medical practitioners who provide opinions about treatment under this part of the 2003 Act. We make sure that all DMPs are up to date with clinical practice and that they understand the legislation. We are not, however, responsible for their independent clinical opinions.

The role of DMPs in specific situations is more fully covered in specific sections of this guidance. Broadly however, their role is as follows. Where an RMO wishes treatment to go ahead, in circumstances detailed in part 16 of the 2003 Act, and the individual is unable to consent or does not do so, they must seek a second opinion from a DMP. The DMP must consult with the patient, the named person and the people principally concerned with the patient's medical treatment. The DMP must have regard for any advance statement and also take into account the present and past wishes of the patient.

If the DMP considers that the proposed medical treatment is in the patient's best

interests, because it is likely to improve the patient's condition, or prevent it getting worse, then the DMP can sign a certificate authorising the RMO to give the treatment.

**Some issues regarding DMPs**

We are sometimes asked to arrange DMP opinions on informal individuals or to resolve uncertainty over diagnosis or treatment. This is not the role of the DMP. A local colleague should be asked instead.

We are sometimes asked to arrange a DMP opinion for medication much earlier than two-months after the start of treatment. This is often because the RMO is uncertain whether to proceed with treatment when the individual actively resists. There is no value in this request as the DMPs authorisation has no legal status until two-months have passed since the start of treatment. We suggest requesting a DMP opinion two weeks before the end of the two-month period.

# 3. Safeguarded medication

## 3.1. Medication beyond 2 months and medication to reduce sex drive

Please also consult our Consent to treatment guidance, especially the appendix on treatment plans. Part 16 contains special safeguards for:

- Any medicine as treatment for mental disorder given under the authority of Part 16 beyond 2 months
- Any medicine (other than the surgical implantation of hormones) given under the authority of Part 16 for the purpose of reducing sex drive.

For these treatments, the following is required:

| Clinical situation | What Part 16 requires |
|---|---|
| Where the patient is capable of consenting and does so | Written consent and certification on form T2 |
| Where the patient is capable of consenting and refuses | DMP opinion on form T3 with statement as to why treatment should be given |
| Where the patient is incapable of consenting but does not resist or object | Needs DMP opinion on form T3 and can be given if in the person's best interests |
| Where the patient is incapable of consenting and resists or objects | Needs DMP opinion on form T3 and can be given if in the person's best interests |

T2 and T3 forms are statutory forms. It is particularly important that they are correctly completed in all areas. Some errors or omissions would result in the form being invalid. It is unclear whether other errors, even those that may appear obvious or minor, could affect the validity of the form. These could result in the form being legally challengeable. Common errors include failure to shade all the circles at the bottom of page 2 of the form and failing to shade the correct circle at the top of page 3. The Commission will return these forms so that they can be properly completed.

We have previously provided guidance on the completion of treatment plans on T2 and T3 forms in Consent to treatment.

It should be noted that, when an individual consents to treatment, a T2 form can only be issued if the individual consents in writing to the treatment. Section 238 requires the RMO or DMP to certify this on the T2 form. The individual's written consent must be obtained and attached to the T2 form before the form is signed and dated. If the individual refuses or cannot consent in writing, a T3 form would be required to authorise treatment. Witnessed verbal consent would not comply with the legislation.

**When is a T2 or T3 form due?**

A T2 or T3 form needs to be in place before medication for the purpose of reducing sex drive can be given.

For other medication for mental disorder, a T2 or T3 form is required to authorise

**any** medication given after two-months since **any** such treatment was first administered during a continuous period of treatment under the 2003 Act.

When calculating two-months before a T2 or T3 form is needed, start from the first administration of any medication under the 2003 Act. This includes any urgent treatment given during emergency detention.

*Example:*

- *Emergency detention certificate granted 3 April.*
- *Lorazepam given IM as urgent medical treatment under Section 243 on 4 April.*
- *STDC granted on 5 April. Further doses of "if required" medication given.*
- *Regular antipsychotic commenced, mood stabiliser commenced 6 April.*
- *Interim CTO granted 4 May.*
- *Progressed to full CTO 18 May.*

*T2 or T3 form needs to be in place to authorise any medication for mental disorder from 4 June. This is two-months from the first administration of medication authorised by the 2003 Act.*

We have seen cases where RMOs thought that they could switch from oral to depot antipsychotic drug treatment where the person did not consent and then wait for two-months before asking for a DMP opinion. As above, this is wrong. After two-months has passed since **any** treatment was first administered under part 16 of the Act, a T2 or T3 form is needed to authorise the giving of medication in depot form.

We have been asked whether a new T2 or T3 form is required for short periods where the individual is prescribed two drugs of the same class when they are transferred from drug A to drug B with a small overlap (e.g. 1-2 weeks).

When the individual is capable of consenting to the treatment, and does so, it would be best practice to complete a new T2 form to authorise this.

Where the individual is being treated under the authority of a T3 that authorises one medication from that class, it would be inappropriate to ask for a DMP opinion – the individual is not having two treatments – this is merely the process of transferring from the first to the second. However, we think it is best practice for DMPs, when issuing T3s, to specify on the T3 that a period of transition is allowed.

In all other situations, a new T2 or T3 form is required to authorise any new treatments.

Note particularly:

- Clozapine needs to be separately specified with reference on the form to blood tests;
- Medication entries on T2 and T3 forms should always state the route of administration;
- When a change from an oral to a depot antipsychotic is planned, the depot cannot be commenced until a T2 or T3 form specifically authorising the depot is in place.

A T2 or T3 form is due two-months after the first administration of medication during any new period of detention. If there is a break in compulsory treatment, however short, any T2 or T3 form that was in place is no longer valid. The process starts again from the date of re-detention.

When an individual who is detained under the 2003 Act is then detained under the CP(S)A, or vice-versa, without any break in authority to detain, we consider that this is a continuous period of detention. Any T2 or T3 form in place prior to them being detained on the new certificate or order would still be valid.

In some cases it may be felt that the individual may be disadvantaged if they have been treated compulsorily for some time, become informal, and then been re-detained and further treated without having the safeguard of a T2 or T3 form. We have sometimes been asked to arrange a DMP visit in such cases early in the new period of detention. The same applies to individuals transferred into Scotland. There is no requirement for a T2 orT3 form within the first two-months following transfer.

But treatment may have been continuing for some time.

We understand the dilemma here. A DMP's authorisation carries no legal value until two-months have passed since the start of treatment. A DMP visit early in the period of detention is thus not appropriate. Where an individual will receive compulsory treatment without their consent during a longer period, without the safeguards of a DMP visit, it would be good practice for the RMO to arrange for another local approved medical practitioner to review their treatment.

**Can a person have both a T2 and T3 form if consenting to some treatments but not others?**
It can be perfectly appropriate for someone to have both a T2 and a T3 form. Capacity and consent should be assessed for each treatment offered. Obviously, the same treatment cannot be on both a T2 and T3 form.

An individual can only have one T2 for medication and one T3 for medication at any one time. When a new T2 or T3 form is required to authorise a new treatment, this supersedes any pre-existing form. All current treatments to be authorised under the T2 or T3 should be included on the new form.

**Who can complete a T2 form?**
A T2 form can only be completed by the responsible medical officer (RMO) or a designated medical practitioner (DMP) appointed by the Commission. Other medical staff can only complete T2 forms if hospital managers have formally delegated the powers of the RMO to them, e.g. if the individual's own RMO is on leave.

**T2 and T3 forms for people under the age of 18**
Please see the section on children and young people.

**Requesting a DMP visit**
If a DMP visit is needed please notify the Commission in plenty of time before the 2 month point is reached using the SOP1 form available from the Commission website. This form incorporates the previous Appendix E proposed treatment plan.

A DMP can visit and issue a T3 within 2 weeks before the 2 month date, although the T3 will not carry authority until then, We have found a situation where the responsible medical officer (RMO) consulted a designated medical practitioner (DMP) of his/her choice instead of contacting the Commission. The Commission appoints a DMP to provide an independent opinion on safeguarded treatment. In this case, the DMP had given a previous opinion.

When requesting an independent opinion, it is quite acceptable to inform the Commission that a particular DMP had given a previous opinion. But it is the Commission that chooses the DMP. Depending on circumstances, we may decide to appoint the same or a different DMP.

Please check that the individual is still actually detained before requesting a DMP visit as reminders are sometimes issued by medical records departments in error after an order has been revoked.

**Some points regarding the DMP's role**
We are sometimes asked to arrange DMP opinions on informal individuals. This may be to resolve uncertainty over the best treatment to offer. That is not the DMP's role, a DMP opinion carries no authority in these situations, and it is not appropriate to ask for one. We advise asking a local colleague for an opinion in these situations.

Sometimes, we are asked to arrange a DMP opinion for medication much earlier than two-months after the start of treatment. This is often because the RMO is uncertain whether to proceed with treatment when the individual actively resists. There is no value in this request. The DMP's authorisation carries no legal value until two-months have passed since the start of treatment. The best time to ask for a DMP opinion is two weeks before the two-month period expires.

**What is the situation after two-months if a T2 or T3 form is not in place to authorise treatment?**
There is no authority to continue medication for mental disorder after two-months if a T2 or T3 form is not in place. The exception is where the treatment falls within the criteria to be given as urgent medical treatment under S243. S243 includes provisions for giving treatment for preventing serious deterioration in the individual's condition.

In some cases, there may be a risk of significant deterioration if a regular medication was stopped (e.g. a mood stabiliser or oral antipsychotic medication). For some medications this could include risk of withdrawal syndromes.

We do not think there would be circumstances where continuing a depot antipsychotic could be justified under S243.

If medication is given under S243, the RMO should notify the Commission within seven days on a T4 form.

**What if the individual withdraws their consent to treatment under a T2?**
The individual can withdraw their consent to treatment at any time. If they do, the T2 form no longer authorises that treatment. There is no authority to continue the treatment until a T3 form is in place (unless it is urgent treatment falling within the

provisions of Section 243).

**What if treatment has been given after a T2 or T3 form was due and this was not urgent treatment under S243?**
We have come across situations where the need to complete a T2 form or arrange a DMP visit has been overlooked and treatment has been given after the 2 month point without legal authority.

If an individual has received any treatment outwith the authority of the 2003 Act, the RMO should inform them of this and of their right to speak to an independent advocate and to seek legal advice. Their named person and any involved advocate should also be informed. If the individual is incapable of understanding an explanation of what has happened, and later regains capacity to do so, there should be further discussion when he/she regains capacity.

**T2 and T3 forms need to be sent to the Commission**
A copy of the T2 form (documenting consent) must be sent to the Commission within 7 days. This is required following a modification to the 2003 Act. The DMP is responsible for sending the Commission a copy of the T3 form.

**A copy of the individual's signed consent form should be attached to the T2 form sent to the Commission (and any copies kept for reference clinically)**
The T2 is the certificate of consent. Page 2 refers to consent in writing being attached. We therefore think the individual's written consent is an integral part of the T2 form and should be attached to all copies of it.

**A copy of any T2 or T3 form authorising treatment should be kept with the medication prescribing sheet**
This is good clinical practice. Doctors planning to prescribe medication should always refer to the T2 and/or T3 form to ensure that there is legal authorisation for any medication prescribed for mental disorder. Nursing staff should check that any medication they administer is properly authorised under the law. Nursing staff should also check consent prior to administering medication that is authorised on a T2 form.

**Regard for advance statements**
See our section on general issues for more on advance statements.

The 2003 Act requires a "person giving medical treatment", or a DMP who is deciding whether or not to authorise treatment under Part 16 of the 2003 Act, to have regard for the wishes within any advance statement. If treatment authorised on a T2 or T3 form is in conflict with the individual's advance statement, the RMO or DMP who issued the form is required to make the notifications of the advance statement override as required in S276 of the 2003 Act (unless the form is a T2 issued by the RMO, and they have already made the advance statement override notifications regarding the treatment).

If the advance statement override concerns treatment on a T2 form (i.e. the individual is now consenting to receive treatment that they previously stated in an advance statement that they did not wish to have), the RMO should suggest to them that they may wish to review their advance statement.

**How long is a T2 or T3 form valid for?**
The 2003 Act contains no time limit at present. We advise renewing the forms no less often than every three years. In some situations, a DMP may specify a shorter timescale.

We advise shorter timescales for artificial nutrition and electroconvulsive therapy (usually three months). See the sections on those treatments for more information.

**Remember, medication cannot be given by force under the 2003 Act unless the individual is in hospital**
Part 16 of the 2003 Act states that, where the individual is not in hospital, the giving of medical treatment by force under the Act is not authorised.

(In a rare circumstance where medication for mental disorder required to be administered urgently in the community, without the consent of the individual, this would be under the common law principle of necessity). See notes on urgent treatment.

# 4. Some advice about particular circumstances or treatments

## 4.1. Clozapine

When clozapine is authorised on a T2 or T3 form, we recommend that a separate entry in the treatment plan should be made such as:

"Clozapine and associated blood tests to (either specified maximum dose or within BNF guidelines)".

It is a requirement of the licensing of clozapine that the individual is registered with a clozapine patient monitoring service. The drug will not be provided unless there is evidence that appropriate blood testing has been done before administration and continues to be carried out at regular intervals in order to reduce the risks of serious haematological side effects. Blood testing is therefore an integral part of the treatment.

The authorisation of treatment with clozapine on a T2 or T3 form must therefore include authorisation for the blood tests.

If an individual is refusing treatment with Clozapine, we believe the medication should only be given by reasonable persuasion. Oral medication cannot be given with force and, as we have covered elsewhere in this guidance, insertion of a NG or PEG tube solely for the purpose of giving medication is not appropriate.

If an individual refuses blood tests for Clozapine treatment, we advise against the use of force for the purpose of blood monitoring. Whilst the use of force to take blood may be legal, it is dangerous and highly distressing. If Clozapine treatment has already started and the individual, having previously agreed to blood tests, then refuses the tests, it may be necessary if clinically indicated to take blood (e.g. if there are signs of infection). We would recommend stopping Clozapine if the individual continues to refuse blood tests.

We have been asked how to proceed if an individual on Clozapine, who has a dangerously low white blood cell count and is clinically unwell, refuses to be examined. In this situation we would advise first assessing capacity to consent to or refuse examination. If the person has capacity to make this decision, examination cannot be carried out. If the individual lacks capacity, the necessity of the intervention must be determined. Authorising examination using a Section 47 Certificate under the Adults with Incapacity Act may be appropriate. All decisions and actions should be clearly documented, with reasoning for examination without consent. Persuasion and gentle restraint may be required to allow examination, guided by the necessity of the intervention and suspected severity and nature of the illness. Ultimately, duty of care may dictate that examination is necessary and urgent. Section 47 does not authorise force unless immediately necessary and only for as long as is necessary (i.e. if it is clinically "immediately necessary" to enforce the treatment, this is authorised).

We have also been asked whether treatment with Clozapine authorised by a T3 can be recommenced following an alert on blood tests. We advised that if a clinical decision is made that Clozapine therapy is the best treatment option the previous T3, if still valid and not superseded, could authorise the reintroduction of

clozapine treatment. However it would be best practice to request a further DMP opinion in this situation.

## 4.2. What are the procedures for authorising IM Clozapine

**Principles for safe treatment**
In consultation with the Mental Welfare Commission (the Commission), the Mental Health Pharmacy Strategy Group agreed a set of principles that services should follow to ensure each proposed use of intramuscular clozapine is subject to appropriate scrutiny at a local level and with the Commission.

**Treatment of last resort**
The standard accepted position with regards to unlicensed treatments is that they should be avoided where a licensed alternative exists. Clearly in this instance the oral formulations are licensed and clozapine is considered the treatment of choice for the patient but they won't accept oral therapy. A clear rationale for the use of clozapine should be agreed by the multi-disciplinary team supported by a detailed pharmacy medication history review and should indicate why other lower risk treatment options are inappropriate. This must be clearly documented in the patient's case record.

**Local approval from the relevant medicines governance group**
All Health Boards will have established processes for reviewing and approving requests to use unlicensed medicines. All requests to use intramuscular clozapine must be submitted to the relevant local governance structures for consideration.

**Bespoke patient care plan**
To support the approval process and ensure safe use, an individual care plan to support the use of intramuscular clozapine must be developed and agreed by the multi-disciplinary team. This plan must include the following information:

- Clinical rationale
- Initial dose & titration plan
- Monitoring – baseline & daily whilst on clozapine IM
- Proposed duration of treatment, including the possibility of 'rescue' administration to prevent treatment break after the patient has been established on oral treatment
- Responsibilities of clinical team members
- Review

**Designated Medical Practitioner approval**
In all likelihood intramuscular clozapine will be used in inpatient settings. Patients will be subject to compulsory treatment under mental health legislation, Part 16 MHA and be deemed incapable of decision making regarding their care and treatment (rather than competent and refusing of treatment). Second opinion approval by a Designated Medical Practitioner (DMP) appointed by the Commission is essential and must be in place before it can be prescribed.

**Minimum possible treatment period**
The purpose of using intramuscular clozapine is to establish treatment and then at the earliest opportunity transfer the patient to oral therapy. The likelihood is that patients will quickly agree to oral therapy as their mental state improves. Some NHS organisations e.g. The Maudsley have applied an arbitrary 14 day maximum treatment period for the intramuscular injection (with a caveat that clinicians may submit a case for extended treatment). Antipsychotic effect is probably minimal in that timescale and the hope is therefore that patients may opt to take oral as it is a more acceptable route. Therefore each patient's bespoke care plan must include an oral and an intramuscular titration schedule and nurses must always offer the patient oral treatment first before administering an intramuscular dose.

## 4.3. Administering clozapine via a naso-gastric tube – expectations of clinical teams

**Practical considerations**
Naso-gastric tubes are a commonly used intervention in many medical settings, most commonly to provide enteral feeding to individuals with swallowing difficulties. They may also be used to administer oral medicines. Use in mental health settings however is relatively uncommon with the exception perhaps of eating disorder units. Inserting a tube correctly is a relatively simple but skilled procedure that requires practice to ensure competence. This is likely to be more important in the context of patients who may resist the procedure and require to be restrained to enable the insertion of a tube. The challenges relating to the individual clinical situation and maintaining competence in use of NG tubes at a psychiatric treatment site may limit the viability of NG-administered clozapine as a treatment option.

As we have covered elsewhere in this guidance, insertion of a NG or PEG tube solely for the purpose of giving medication is not appropriate (see section 3.13).

**Pharmaceutical considerations**
Although there is a licensed clozapine suspension it is very viscous and is not appropriate for naso-gastric administration. Consequently, tablets should be crushed, mixed with water and flushed down the naso-gastric tube with an appropriate volume of water. Administering the tablets in this way constitutes off-label use and therefore unlicensed treatment.

**What is the significance of the unlicensed nature of crushed clozapine tablets by nasogastric tube?**
When crushed tablets are being given by NG tube the process is "off-label" and the treatment therefore unlicensed. As with IM clozapine, standards for practice guidance in the use of unlicensed treatments apply.

**Principles for safe treatment using the nasogastric route**
As in the use of IM clozapine, when treatment is given via the nasogastric route a clear rationale for this approach should be agreed by the MDT, supported by

pharmacy and reflected in a bespoke care plan available for the DMP to consider authorising.

**Treatment of last resort and only in an appropriate setting with a bespoke patient care plan**
Once a clear treatment rationale has been established, treatment should only be given by the NG route for the minimum treatment period necessary and oral treatment should be offered before each administration. The care plan must address the practicalities of passing NG tubes in a patient who may resist this practice and require restraint.

**Staff must have proven competencies for inserting NG tubes**
Although a commonly used nursing procedure in acute medicine, the use of NG tubes is not common in mental health settings. It is an important patient safety issue that staff who undertake this procedure maintain an appropriate level of competency.

**Local approval in place before the Commission second opinion**
As with the use of intramuscular clozapine, the administration of clozapine to an individual patient by NG tube should first be agreed within local governance structures for the approval of the use of unlicensed medicines before a request for DMP authorisation is made.

## 4.4. Can IM “if required” psychotropic medication be included on a T2 form?

The Commission has concerns about IM “as required” psychotropic medication being included on T2 forms in most cases. This is because any advance consent the individual has given is invalid if they have withdrawn their consent at a later time when the medication is given or if restraint is involved.

It is our view that IM medication prescribed “as required” should be authorised on a T3 form. If it is prescribed, the medical practitioner must be considering that it could be needed at some point. We have considered whether or not it is acceptable to prescribe IM “if required” medication where there is neither a T2 nor a T3 form in place and then to notify the Commission if it is administered as an emergency. We do not consider this to be good practice. Medication should be prescribed according to individual need.

Unforeseen situations arise in all forms of care. It would be more acceptable for the ward to have a general guideline on medication to be used in urgent situations and for the on-call medical practitioner to prescribe on a “one-off” basis, with advice from the person’s RMO or a senior colleague. This should be reported to the Commission on a T4 form. If the situation is likely to recur, the RMO should reassess the person and consider whether to request a visit from a DMP to consider authorising future IM “if required” psychotropic medication on a T3 form.

## 4.5. Should a medication be included on a T2 or T3 form if it is prescribed for two purposes, one of which is treatment for mental disorder?

Anticonvulsant drugs are often used to treat mental disorder and should be recorded on the plan if used for the mental disorder or if used for both purposes. Where the anticonvulsant is used for the sole purpose of treating epilepsy, there is no need to include it. Similar issues arise with propranolol (anxiety and hypertension).

## 4.6. Can medication authorised "as required" on a T3 form be given regularly?

No. If regular medication becomes necessary, the RMO should ask for a further DMP opinion. If the criteria are met for the medication to be given as urgent treatment under S243, it can be given and notified to the Commission on a T4 form.

## 4.7. Should high dose antipsychotic drug monitoring be included on a T2 or T3 form?

If medication authorised by the treatment plan on the T2 or T3 form exceeds the recommended BNF maximum, the plan should state a requirement for special monitoring in accordance with guidance from the Royal College of Psychiatrists.

It should be noted that this reflects and directs safe and best practice, but monitoring for side effects of medications (other than blood tests for clozapine) is not authorised under the 2003 Act. The Act provides no authority to require or enforce these investigations if the individual does not consent. High dose antipsychotic monitoring tests and investigations are medical treatments within the definition in the Adults with Incapacity Act ("any procedure or treatment designed to safeguard or promote physical or mental health"). If the individual lacks capacity to give informed consent to this treatment, a S47 certificate should be completed to authorise these.

## 4.8. Can medication prescribed "off label" be included on a T2 or T3 form?

Yes. Where medication is prescribed off-label (i.e. using a licensed drug for a different reason than those within the product licence), the RMO (and DMP, if applicable) should follow Royal College of Psychiatrists guidance. Off-label prescribing should only be used if licensed medication has failed or would be inappropriate. There should be a risk/ benefit analysis. If in doubt about whether to approve the medication, the doctor should consider whether a more specialist opinion in the area is needed. If the individual is giving consent, he/she should be told that the prescription is "off-label".

RCPsych guidance: https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2017-college-reports/use-of-licensed-medicines-for-unlicensed-applications-in-psychiatric-practice-2nd-edition-cr210-dec-2017

The GMC also has guidance on this: http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp

## 4.9. If an individual has been on a T3 form, then consents to treatment (documented on a T2 form), can the treatment be given under the original T3 if they withdraw their consent again?

We have sometimes been asked such questions, e.g. when an individual with schizophrenia was treated with a depot antipsychotic under a T3, then started to recover and consented to oral antipsychotic medication. The RMO completed a T2 form to authorise this, and asked if they could keep the T3 authorisation for treatment with depot as a fall back. The individual was still unwilling to consent to a depot antipsychotic.

In circumstances such as this, where the individual's condition has changed significantly since the T3 was issued, the previous DMP opinion may no longer be relevant. We advise that, when authorisation for treatment with a medication type moves from a T3 to a T2 form, it should be considered that the T3 would have no future validity in authorising that treatment in the future. If that treatment requires to be authorised under a T3 form in the future, a DMP visit should be requested.

## 4.10. Can medication be included on a T2 or T3 form in anticipation of the individual needing the medication in the future?

An example would be where an individual is likely to need a mood stabiliser, but is not prescribed one at present.

If the medication is part of the current treatment plan that, failing one medication working, another will be tried, it would be acceptable to include that in the T2 or T3 form. If it is simply a possible idea for future treatment, this should not be included. T2 and T3 forms should not be used as blanket authorisation for all possible treatments that might be needed, but should be tailored to present and foreseeable individual needs.

## 4.11. Medication given via NG or PEG tubes

Authorisation of artificial feeding does not in itself authorise administration of medication via a NG or PEG tube. However, if a NG or PEG tube is in situ, then this route is potentially available and it may be appropriate to administer medication this way. Medication given for mental disorder via NG or PEG is subject to the same safeguards under Part 16 of the 2003 Act as other medication. It is a considerably more invasive procedure.

After 2 months, medication for mental disorder to be given via NG or PEG must be authorised on a T2 or T3 form. This should be a separate T2 or T3 form to any form authorising artificial feeding (unless the medication is only sedation for the safe insertion of tubes). The specific NG or PEG route of administration should be stated in the entries on the T2 or T3 form. It is not "oral" medication. Of course, artificial nutrition, where this is required due to mental disorder, must be authorised before treatment starts.

We strongly recommend that advice from a pharmacist should be sought before

giving medication via PEG or NG tube (reasons include potentially different bio-availability via these routes).

The Commission is of the view that it is not appropriate to consider inserting an NG tube solely for the purpose of administering medication for mental disorder.

## 4.12. Other medications and whether they should be included on t2 or t3 forms

**Should hypnotics be included on a T2 or T3 form?**
If insomnia is a symptom of mental disorder the treatment of this with a hypnotic should be included on a T2 or T3 form.

If it is argued that insomnia is due to other factors – e.g. noise in the ward – then it is arguable that it is not for mental disorder and therefore authorisation not needed.

Generally, we advise inclusion.

**Should treatments for drug and/or alcohol dependence be included on a T2 or T3 form?**
We are commonly asked about treatments for drug dependency for example methadone for opiate dependence, benzodiazepines for alcohol withdrawal, or disulfiram and acamprosate for alcohol dependence.

Section 328 of the 2003 Act states that a person is not mentally disordered by reason only of "dependence on, or use of, alcohol or drugs".

If the individual is being treated for a mental disorder that is a consequence of alcohol or drug use then it is appropriate to include these treatments on T2 or T3 forms. Where drug/alcohol use coexist with an existing mental disorder, it may not be necessary to include them. It depends how close the link is between drug/alcohol use and worsening of mental disorder – the closer the link, the more the argument for inclusion.

For example, it would be appropriate to include medication on a T2 or T3 form that is part of the overall treatment plan for a drug induced psychosis. However, it would not be appropriate to include the treatment of straightforward drug dependency issues on a form T3.

If in doubt, it safest to include the medication on a T2 or T3 form.

**Should medication for physical health issues and psychotropic medication side effects be included on a T2 or T3 form?**
Most medications for physical health problems and side-effects from psychotropic medications (e.g. drugs to treat Parkinsonism) do not need to go on T2 or T3 forms. Medication to treat diabetes and thyroid hormone would not be included. However if the physical health problem is a direct cause of the mental disorder then it may be appropriate to include it e.g. thiamine in Wernicke's encephalopathy or alcohol-related brain damage.

Treatment for a physical disorder can only be given under the 2003 Act if it is a direct cause or consequence of the mental disorder. The giving of insulin to a

diabetic with an eating disorder would not be authorised or Granulocyte-Colony Stimulating Factor for side-effects of clozapine.

There will always be some occasions when it is debatable e.g. propranolol for both BP and anxiety. If in doubt, err on the side of including medication.

If an individual requires medications for physical disorders or symptoms and he/she lacks capacity to consent, these are not authorised under the 2003 Act. An Adults with Incapacity Act Section 47 certificate should be completed to authorise the treatment.

**Should thiamine be included on a T2 or T3 form?**
Where thiamine is used to treat a mental disorder, e.g. alcohol-related brain damage, then it is appropriate to include it. When used as a preventive measure, there is less of a need to specify its use on a T2 or T3 form.

**Should Fish Oil (Omega-3) be on a T2 or T3 form?**
If fish oil is being used as an adjunct treatment for schizophrenia by the RMO, then it can be regarded as a treatment for mental disorder and therefore may fall within part 16 of the 2003 Act. If the individual cannot or does not consent then a T3 form is needed. If it is being taken as a dietary supplement then it need not be included on the T3.

A T2 form would be completed if the individual is capable and consents. However, if the individual is consenting, we would not consider it a significant breach of the legislation if it is not included on a T2 treatment plan.

**Should homoeopathic and herbal remedies be included on a T2 or T3 form?**
We have come across circumstances where RMOs have felt pressurised by relatives to have this on the treatment plan.

In general, there is no evidence base for the use of this type of medication and it is not appropriate for this to be included on a T3 form for individuals who cannot or do not consent.

If an individual wishes it to be included on their T2 form we would not object, but do not regard it as necessary. Although it may be appropriate to include St John's Wort, as there is some evidence from a Cochrane review, doctors should be aware that the BNF advises it should not be recommended or prescribed for depression.

We have advised RMOs and DMPs to be wary of being asked to complete items on T2 or T3 forms to give legitimacy to inappropriate or alternative or complementary treatments for which there is not an evidence base (and/or for which they have no expertise), or as a way to get hospitals to pay for over the counter remedies.

**Should medication for ADHD be included on a T2 or T3 form?**
We have been asked if Methylphenidate and related medications for ADHD should be included on T2 and T3 forms. As these are medications for mental disorder, we now advise that they should.

## 4.13. Questions the Commission has received regarding validity of T2 or T3 forms when circumstances change

**Is a new T2 form required if the individual's RMO is changed?**
No. The T2 issued by the previous RMO remains valid. However, the new RMO should review the individual's consent to treatment, and there is nothing to prevent them from getting the individual to sign a new consent form and completing a new T2 if they wish to.

**Is a T3 form valid if the DMP who issued it later becomes the individual's RMO?**
Technically the T3 is still valid, but we firmly advise that a new DMP visit should be requested to supersede the T3.

**Is T2 or T3 form still valid if an individual is on a CCTO and has been admitted to hospital under STDC?**
Yes. The episode of treatment is continuous and the T2 or T3 form is still valid (unless it is a T2 form and the individual has withdrawn their consent to treatment it authorised).

**Is the T2 or T3 form still valid if the individual has been transferred to a different hospital?**
Yes. As long as there is no break in compulsory treatment.

## 4.14. Medicine for the purpose of reducing sex drive

**How should medication to reduce sex drive be recorded on the T2 or T3 form?**
In practice most individuals have learning disability, or dementia and a T3 form will be needed rather than a T2. We recommend specifying the individual medication on the form. More than one such medication should not be prescribed at a time without a very good reason and we would wish to be notified of these cases. Medication given to treat disinhibited behaviour associated with manic illness would not normally come under this category. Benperidol has some unpleasant side effects and should not normally be used. Long-acting injections for hormonal treatment are not regarded as surgical implants for the purposes of consent.

**A note on medication to reduce sex drive where the individual is not detained under the 2003 Act**
If an individual is not detained under the 2003 Act, and is unable give informed consent to this treatment, medication for the purpose of reducing sex drive can be authorised. The medical practitioner responsible for the individual's care must first complete a Section 47 certificate of incapacity. The Adults with Incapacity Act includes additional safeguards in respect of this treatment – the treatment cannot be given unless a doctor appointed by the Mental Welfare Commission issues an additional certificate under Section 48 of the Adults with Incapacity Act authorising the treatment. This authorisation only applies if the individual cannot consent, but does not resist or object to this treatment. Note that it has a maximum duration of one year.

If the individual resists or objects to treatment for the purpose of reducing sex drive, and the hypersexuality is due to mental disorder, assessment should take place regarding potential use of the 2003 Act.

# 5. Urgent treatment

Section 243 applies to urgent medical treatment given when an individual is detained in hospital under the 2003 Act or the 1995 CPSA, and does not consent or is incapable of consenting to that treatment.

The use of Form T4 (Record of Notification of Urgent Medical Treatment) is recommended as it ensures all relevant information is recorded. The notification is retrospective.

## 5.1. When does section 243 apply?

Urgent medical treatment may be needed around the time of admission when an individual is first subject to an emergency detention certificate (EDC) or at other times when there is a rapid change in the individual's mental state and the required therapy is not covered by an existing T2 or T3 form.

Section 243 would apply to individuals admitted under an assessment order (S52D CPSA) whilst awaiting a second opinion from another AMP.

The Commission has been asked whether or not urgent medication could be administered under section 243 during a period of detention by a nurse. This would be an unusual occurrence, but medication might need to be prescribed after a medical practitioner attends but before he/she can complete an examination and/or complete an emergency or short-term detention certificate. For example, medication may be immediately necessary if the individual is acutely unwell and violent.

We discussed this with the mental health law team in the Scottish Government and it was agreed that urgent treatment under section 243 may be given to someone who is detained in hospital. As section 299 gives a nurse of the prescribed class the power to detain we think therefore section 243 would apply. Our advice is therefore that the giving of medication during the use of a nurse's power to detain should be recorded and notified in the same manner as other urgent medical treatment.

## 5.2. When does section 243 not apply?

While section 243 applies to individuals detained under emergency detention certificates, the exception is the individual who is already subject to a community-based CTO. S243 It would then only apply to any treatment not covered by an existing T2 or T3 form.

Individuals on STDC do not normally require a T4 form for medication given in first two-months, unless they are also on CCTO and existing T2/T3 does not cover the proposed therapy or it is medication to reduce sex drive.

Section 243 does **not** apply to any emergency treatment given to an informal individual in hospital prior to the application of an EDC, or in the community prior to transfer to hospital on an EDC. In both situations common-law would apply and the clinician authorising treatment must carefully document the reasons and be prepared to justify their actions.

Urgent treatment for physical health problems is covered by the 2000 Act and

there is a common-law authority to treat in emergency situations. There is separate Commission guidance on physical treatment (Right to treat).

## 5.3. Section 243 Urgent medical treatment: the legislation

The 2003 Act states that where it is a matter of urgency for medical treatment to be given to individuals who do not consent or are incapable of consenting, it may be given for the purposes of

a) saving the patient's life

b) preventing serious deterioration in the patient's condition

c) alleviating serious suffering on the part of the patient

d) preventing the patient behaving violently or being a danger to the patient or others.

This is qualified by **b** to **d** not being likely to cause unfavourable and irreversible physical or psychological consequences, and by **c** or **d** not entailing significant physical hazard to the patient.

The RMO must notify the Commission within 7 days beginning with the day on which treatment was first given. The type of treatment and the purpose for which it was given must be recorded.

The Code of Practice volume 1 provides guidance on use of this part of the Act and in para 87 it states that 'Where treatment has been administered by force, it would be best practice to note this in the report to the Commission'.

## 5.4. Section 243 in practice

As this part of the 2003 Act authorises treatment to be given without consent or the special procedures elsewhere in the Act the clinician authorising the treatment must take particular care to form the best professional judgement in the circumstances.

Assessing if the criteria of preventing "serious deterioration" and alleviating "serious suffering" may be difficult to determine in individual circumstances, for example if treatment can safely be withheld until a second opinion is available. The RMO will need to keep in mind the principles of the Act and refer to the Code of Practice. The medical treatments safeguarded under the 2003 Act are medication, ECT and nutrition by artificial means.

**Medication**

Under part 16, medication to reduce sex drive requires authorisation from the start of treatment and we think it would be unusual for this to be given under urgent procedures.

For "other medication for mental disorder" the situation depends on which part of the 2003 Act applies.

For individuals on an EDC alone, all medication without consent for a mental disorder (for example emergency tranquilisation) should be notified on a T4 form.

For individuals on STDC or CTO, part 16 safeguards state that any other

medication for mental disorder given for a period beyond two-months requires consent or a second opinion. Section 243 may apply if such consent is not in place.

Medication given after a period of two-months following the first administration of any type of medication for mental disorder must be authorised by a T2 (certificate of consent to treatment) or T3 form (certificate of the designated medical practitioner). If a DMP second opinion is not arranged in time, the RMO may continue treatment if it meets the grounds of section 243 and it should be notified on form T4.

Sometimes during the course of treatment there may be a need to change medication for example from oral as required to oral regular, or from oral to depot. If this is not covered by an existing form, a new T2 or T3 is required and treatment could only go ahead before this is completed if urgent criteria are met. In this situation if there has been a delay in obtaining consent the clinician should consider the risks of discontinuing treatment as well as continuing. One of criteria under S243 is "preventing serious deterioration". This should be borne in mind when considering the effect of stopping medication as serious withdrawal reactions can occur. It may be appropriate to complete T4 and to continue treatment.

Reminder: **any** medication given for mental disorder counts towards the two-months including medication given on EDC. Changing the type of medication does not affect this timescale.

**Artificial nutrition**
Artificial nutrition given without consent under EDC requires a T4 notification.

For individuals on other orders artificial nutrition requires authorisation on a T2 or T3 form from the start of treatment.

An individual who is refusing to eat adequately as a result of an eating disorder or other mental disorder may be so physically unwell that the clinician cannot await a second opinion. Treatment may be given before a DMP opinion is provided, if clinically urgent, under section 243 and must be reported to the Commission on form T4.

If treatment continues for more than a few days then the RMO should submit a further T4.

We have not regarded administration of intravenous or subcutaneous fluid as artificial nutrition.

**Electroconvulsive therapy (ECT)**
Under no circumstances can ECT be given to an individual who is capable and refusing.

ECT given to an incapable individual during emergency detention requires notification on T4.

For other orders, ECT can be given urgently before a DMP opinion if the urgent grounds of S243 are met and if the individual is incapable of consenting. Each decision to treat must be tested against the grounds in S243 before each

application of ECT. In most services ECT is given twice a week and the Commission can usually arrange a DMP opinion within a week. In practice, it would be unusual if more than two urgent treatments are given but if the DMP has not visited and the individual has already had two or more treatments then ECT can still be given if the urgent grounds are met. (As a result of practice under the previous 1984 Act some clinicians believe wrongly that there is a limit of two ECT treatments).

ECT should be prescribed by the RMO and a T4 completed after treatment has taken place. It is a notification not an authorisation for treatment. (This is a common misunderstanding). Each decision to treat with ECT (i.e. each application of ECT) should be notified on a separate T4.

## 5.5. Notes on completion of form T4 (Record of Notification Following Urgent Medical Treatment)

**General issues**

- Part 16 of the 2003 Act states that the Commission must be notified of the giving of medical treatment by virtue of section 243 within 7 days beginning on the day on which treatment was first given.
- T4 is a non-statutory form. However, its use is recommended to ensure all the appropriate information is provided.
- Clinicians should remember it is a retrospective notification of treatment not an authorisation. (This is a common misunderstanding). In all cases, the reasons for urgent treatment should also be recorded in the case record.
- Do not complete form T4 for treatment administered before individual is detained under the 2003 Act. (See above note on common-law treatments).

**Form T4 Page 2 Details of Treatment**

- The T4 requires information about the type of treatment given.
- A separate T4 should be completed for each type of treatment (medication, ECT or nutrition) if more than one type is required.
- We are often asked how many treatments can be recorded on one form. There is no statutory guidance on this. However, we advise one T4 form for each administration of ECT.
- For other treatments a T4 may cover a course over several days. In the unlikely event that urgent treatment lasts more than one week, then a further T4 should be completed.
- Treatment not covered by Part 16 does not need to be recorded.
- Physical health treatments covered by the 2000 Act should not be included.
- It is not good practice to use the T4 form to authorise “as required” medication that has been prescribed for some time. This should be included on a T2 or T3 form.

**Form T4 page 2 Confirmation/Notification by RMO**

- Note that the certificate has two places requiring a signature.
- The person authorising the treatment (if not the individual's RMO) should sign the form at the end of the section on details of treatment. This means the person prescribing the treatment. If the prescriber is not the RMO this would be the on-call doctor, or in some cases a nurse prescriber.
- The T4 notification/confirmation section must be completed by the RMO (or in his/her absence the authorised RMO acting in their place. Other medical staff may only sign this confirmation part of the form if the hospital managers have formally delegated the powers of the RMO to them).

# 6. Electroconvulsive therapy (ECT)

## 6.1. Introduction

Electroconvulsive therapy is recognised as an effective treatment for certain conditions, especially depressive illness that is severe and/or has not responded to other therapies. It also has a role in catatonia and mania. There is insufficient evidence to recommend its use in schizophrenia[3]. This general guidance does not overrule the clinician's responsibility to make appropriate individual decisions based on individual circumstances and in consultation with the individual and carers.

In Scotland, the use, safety, quality and efficacy of ECT is monitored by the Scottish ECT Accreditation Network (SEAN). In several reports, SEAN data shows that ECT is highly effective for major depression. It also shows that individuals receiving ECT report adverse effects, the commonest of which is memory loss[4].

The Commission has the duty to provide advice and promote best practice in observing the principles of mental health legislation in Scotland. We also appoint independent medical practitioners to provide opinions where ECT is proposed under the terms of mental health or incapacity legislation. We make sure that all independent practitioners keep up to date with developments in professional practice and that they fully understand their responsibilities under the legislation, but we are not responsible for their independent clinical opinions.

## 6.2. ECT – consent and legal status

We cover this more fully in our guidance on Consent to treatment. The two Acts that apply are:

- The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act")
- The Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act").

A brief summary of the legislation is shown in the following table.

[3] https://www.nice.org.uk/guidance/ta59
[4] https://www.sean.org.uk/

| Capacity to consent | Legal status | Requirement |
|---|---|---|
| Capable and consenting | Informal | Written consent based on guidance from General Medical Council[5] |
| | Detained (2003 Act)* | Written consent with capacity certified on form T2 |
| Capable and refusing | Informal or detained | Cannot be treated with ECT, even in an emergency |
| Incapable | Informal** | Second opinion under section 48 of the 2000 Act. This is not used if the patient resists or objects.<br>Urgent treatment can be given and notified to the Commission in writing within 7 days. |
| | Detained – not resisting or objecting* | Independent 'best interests' opinion under the 2003 Act recorded on form T3 (referred to as 'T3A'). |
| | Detained – resisting or objecting* | As above but with indications limited to situations of necessity (referred to as 'T3B'). |
| | Urgent (including patients detained under emergency certificates) | Treatment given in advance of an independent opinion under the 2003 (urgent necessity under S243). Signed case note entry from prescribing practitioner that ECT is required as an emergency. T4 form (record of treatment) subsequently sent to the Commission. |
| Special situation –individuals under the age of 16 who are informal | | Independent opinion by child specialist certified on form T5 |

***** See S237-239 of the 2003 Act

** See regulations pertaining to S48 of the 2000 Act

[5] http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

In addition to these specific requirements practitioner should also bear in mind:

- The principles of the 2003 and 2000 Acts, in particular the right to information, regard for the views of the individual, maximum benefit, range of options and the views of carers.
- The right of access to independent advocacy. This is particularly important to ensure that the individual is able to express his/her views about the proposed treatment.
- The requirements of human rights legislation, especially the convention articles on the right to life, the right to be free from inhuman and degrading treatment, the right to liberty and the right to private and family life.

## 6.3. Guidance on specific situations

**Before treatment: which legislation to consider?**
For someone who lacks capacity and is informal, the decision on appropriate legislation depends on whether or not the individual resists or opposes the treatment. It is important not just to consider present statements.

*Example: The individual is assessed as having no capacity to consent but the clinical team is aware she would very much have resisted having ECT. It is clear that restraint is likely to be required during the ECT session. The RMO decides that detention and treatment under mental health legislation is the best way to proceed.*

This is correct. The use of force is addressed in the 2000 Act Part 5 Code of Practice. Sub-section 47(7) of the Act prohibits the use of force unless it is immediately necessary and only for so long as is necessary in the circumstances. The degree of force applied must be the minimum necessary. Where an individual shows continued resistance to treatment for mental disorder, consideration should be given to making use of options available under mental health legislation. We do not think it is appropriate for ECT to be given to an individual under the 2000 Act where it is known that the individual is likely to have objected to ECT and to very much resist having the procedure. In general the presumption is that, if force is required, ECT should be given under the 2003 Act.

Even if force is not anticipated, previous expressions of a wish not to have ECT should be regarded as opposition. Treatment under the 2003 Act is more appropriate. If there is no present or past evidence that the individual would resist or object to ECT, then treatment under the 2000 Act is appropriate.

**Before treatment: advance statements**
There are provisions in sections 275 and 276 for an individual to make an advance statement, but it can be overridden. A competent advance refusal of ECT is a very important statement and there are very few occasions where giving ECT in this situation is appropriate. In particular, we advise against ECT where the advance statement is made on the grounds of faith or belief.

We have been notified of very few situations where ECT was given despite an advance refusal. Anyone authorising ECT in this situation must put the reasons in writing and send this to the individual, named person, any welfare attorney or

welfare guardian and the Commission.

*Example: the individual made an advance refusal of ECT but became profoundly depressed and her life was at risk. She was detained under mental health legislation. The DMP authorised ECT, explaining in writing that the reason was to save life, but specified that it could only be given for as long as her life was at risk. The judgement was that her right to life was more important than any other consideration but that her advance statement should be respected as long as her life was not in danger.*

No two situations are the same. We advise wide discussion in any situation where ECT is considered despite a competent advance refusal.

**Before treatment: individual refuses investigations**
For safety reasons, physical health checks, including taking blood samples, are necessary before ECT. If the individual resists having blood taken, this could be authorised under S47 of the 2000 Act. Practitioners could use force for this if necessary and proportionate. They would need to consider, overall, whether or not the likely benefit from ECT justifies the use of force, and use the minimum force necessary.

**Authorising treatment on T2 or T3 forms**
If authorisation is needed for both ECT and medication, the RMO or DMP should record these on separate forms. This is because the treatments are covered by different sections of the Act with different requirements (section 237 for ECT, section 240 for medication). We also advise a separate form for artificial nutrition.

Also, if the individual receiving ECT is under 18, capacity to consent must be certified on form T2 by a child specialist. If the individual cannot consent, either the RMO or DMP must be a child specialist.

**Starting treatment: urgent situations**
We are often asked if a local second opinion is needed before ECT is given on an urgent basis. There is no legal requirement for a local second opinion but it is good practice. The RMO may wish a colleague's view, especially in cases of doubt or if there is significant opposition from the individual or others.

Some practitioners think that a maximum of two treatments can be given under urgent provisions before a T3 form can be completed. This is incorrect. In all cases, the decision to give urgent ECT depends on whether or not the criteria in S243 of the 2003 Act are met. Usually, the Commission can arrange a DMP visit within a week.

Therefore, it is unlikely that more than two treatments will be needed. But if there is a delay, further treatments can be given if the S243 criteria are met.

For each urgent ECT treatment, the RMO must record clearly in the case record why the S243 criteria are met. After each treatment, the RMO must report the administration of the treatment to the Commission. Form T4 is provided for this purpose.

**Starting treatment: no T3 form**
The DMP has visited and is believed to have agreed that ECT is appropriate but the form has not arrived yet. In this situation, the treatment cannot go ahead unless the RMO considers and records that the S243 grounds for urgent treatment are met. A fax or emailed copy of a T3 form is acceptable.

**Delays and gaps in treatment**
Some points about situations where ECT is delayed or suspended following authorisation under mental health or incapacity law:

- Unless otherwise specified by the form, treatment should start within two weeks of authorisation. If there is a delay, we advise a fresh authorisation.
- Likewise, if ECT is suspended for more than two weeks, e.g. because of physical ill-health, we advise a fresh authorisation before it is restarted.
- Maintenance ECT is a separate matter. While the NICE guidance identifies that maintenance ECT has no apparent advantage over other treatments, it may be the only option if other measures fail to prevent recurrence of major depression. In the very rare situations where this is administered under mental health legislation, the treatment plan on the statutory form will determine the frequency and the duration of the authority (usually either 6 or 12 months). This is the only situation where there can be a gap of two weeks or more without fresh authorisation.
- If there is a gap in detention, a fresh authorisation is needed.
  *Example: the individual is receiving ECT while subject to a compulsory treatment order. It expires because the RMO did not complete the extension form in time. The RMO then detains the individual under a short-term detention certificate. We consider that the authority to treat under the safeguards in part 16 of the 2003 Act expired when the CTO expired. Fresh authorisation is required.*

**Change in consent status**
Capacity to consent may change as a course of ECT progresses:

- An individual who consents at the start of a course of ECT may lose capacity or may change his/her mind. Any previous signed consent is invalid in this situation. The RMO must keep capacity and agreement to receive treatment under review.
- An individual who lacks capacity but does not, at first, resist or object may start to resist or object as treatment progresses. If the T3 forms states that the individual does not resist or object, the form is no longer valid. A further DMP assessment will be necessary to determine whether or not the stricter criteria are met.
- An individual may regain capacity to consent during a course of ECT. If the individual regains capacity, any form authorising ECT on the basis of incapacity is no longer valid. The RMO must reassess the grounds for continuing ECT and discuss this with the individual.
- In reassessing capacity, the RMO should bear in mind that, to be capable of

refusing, the individual understands the risks of refusing. It is important to assess whether or not the individual appreciates the risk of relapse if treatment is stopped too early. Also, it is important to remember that the return of capacity may only be temporary. Improvement after administration of any single treatment with ECT may not be permanent.

**During treatment: other procedures**

We were asked if, while anaesthetised, the individual could have a PEG tube inserted to feed her. This was because she was not eating as a result of her depression and her weight was dangerously low. This would constitute artificial nutrition without consent and would need an independent opinion by a designated medical practitioner, separate from the authorisation for ECT.

# 7. Artificial nutrition

## 7.1. Introduction

In addition to Consent to treatment and the relevant Codes of Practice, we advise reading our good practice guidance on artificial nutrition.

This guidance deals mostly with artificial nutrition for individuals with an eating disorder, although artificial nutrition is also prescribed for individuals with other diagnoses. Artificial nutrition refers to nutrition delivered by nasogastric (NG) feeding tube, percutaneous gastrostomy (PEG) tube or intravenous drip. Artificial nutrition for physical health problems, e.g. inability to swallow, is a separate matter. In all cases where an individual lacks capacity to consent, this would be authorised by part 5 of the Adults with Incapacity (Scotland) Act 2000.

This guidance does not discuss the clinical evidence and indications for artificial nutrition. Practitioners should be aware of the clinical literature relating to their area of practice.

## 7.2. The legal framework for providing nutrition by artificial means

Depending on an individual's circumstances, nutrition by artificial means can be provided under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 act), the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act) or on an informal basis.

## 7.3. Informal provision (i.e. not using the 2000 Act or the 2003 Act)

An individual who is judged to have capacity to make a decision about artificial nutrition can consent to its provision. Written consent should be obtained from the individual, observing the recommendations of the General Medical Council guidance "Consent: patients and doctors making decisions together".

## 7.4. Provision under the 2003 Act

Nutrition by artificial means is a safeguarded treatment under section 240 of the 2003 Act. This means that when artificial nutrition is provided under the 2003 Act the relevant requirements must be put in place from the start. This includes the situation where an individual under the 2003 Act is capable of consenting to artificial nutrition. We sometimes receive enquiries from practitioners who think that there is a periodof time where the individual can receive artificial nutrition under the 2003 Act without the necessary certificates being completed. This is incorrect – the requirements are necessary immediately when an individual is subject to the 2003 Act.

**Individual under the 2003 Act, capable of consenting to artificial nutrition and accepting treatment**

An individual who is under the 2003 Act, willing to accept artificial nutrition and capable of consenting should consent in writing. This written consent is attached to a T2 form (certificate of consent to treatment), completed by the Responsible Medical Officer (RMO). The T2 form is a statutory form, which means that only the currently specified form can be used. The RMO certifies that the individual is capable of consenting to the treatment. A copy of the form must be sent to the Mental Welfare Commission (the Commission).

**Individual under the 2003 Act, incapable of consenting or refusing to consent to artificial nutrition**

An individual who is under the 2003 Act and is incapable of consenting or refusing to consent to artificial nutrition must have the treatment authorised by a Designated Medical Practitioner (DMP) before the treatment goes ahead, unless urgent treatment is required, when the provisions of Section 243 of the 2003 Act are relevant.

A DMP will visit at the request of the individual's RMO. The DMP may then choose to issue a T3 certificate (certificate of the Designated Medical Practitioner) which authorises the treatment specified on the certificate.

Sometimes artificial nutrition must be provided to an individual in this situation before the DMP can visit. Section 243 of the 2003 Act specifies when urgent medical treatment can be given, for example to save the individual's life. If the RMO decides to provide artificial nutrition under section 243 then notification of this must be sent to the Commission on a T4 form within 7 days of starting the treatment.

## 7.5. Provision under the 2000 Act

There may be occasions when an individual who is not under the 2003 Act requires artificial nutrition and is incapable of giving consent. Artificial nutrition can be provided under the 2000 Act.

In this situation the treatment is authorised by a Section 47 certificate, issued by the medical practitioner primarily responsible for the treatment. We have heard of cases where practitioners are under the impression that artificial nutrition is additionally subject to section 48(2) of the 2000 Act (specified medical treatments) but this not the case.

The 2000 Act does not authorise the use of force unless it is immediately necessary and only for so long as it is necessary.

If an individual is subject to the 2003 Act, then artificial nutrition must be given under that Act rather than the 2000 Act.

## 7.6. The use of force

The Code of Practice for the 2003 Act states clearly that forcible feeding (putting food into an individual's mouth against their will) should never be used. Our full guidance on "Nutrition by artificial means" contains more detail on this subject.

## 7.7. Named persons and advance statements

There are provisions relating to both named persons and advance statements in the 2003 Act. When an individual is subject to this Act the treating professionals must consider the issues relating to these provisions. More detail is available in the Code of Practice to the 2003 Act and our full guidance.

## 7.8. Artificial nutrition for children and young people

Providing artificial nutrition to children and young people can raise further complicated issues. These are discussed in our full guidance document.

## 7.9. Specific questions about artificial nutrition

**An individual is subject to the 2003 Act. Does a T2 or T3 form authorising PEG tube feeding cover the actual insertion of the PEG tube (i.e. the anaesthetic and surgical procedure)?**
If the PEG feeding is required for the treatment of a mental disorder then the situation is analogous to nasogastric feeding for a mental disorder. The consent covers the medication and practical steps necessary for the insertion of the device. Under section 240 there must be a T2 or T3 form in place from the start of treatment.

**An individual has a T3 certificate authorising artificial feeding. Can medication be given for the mental disorder by this route (e.g. NG tube, PEG tube)?**
Medication for mental disorder requires separate authorisation (i.e. a separate T2 or T3 form). The route of administration must be specified - medication by NG or PEG tube would not be authorised by a certificate stating oral administration. In addition, specialist pharmacy advice should be obtained before giving medication by this route. It may be appropriate to use an NG or PEG tube to administer medication if the individual is being fed artificially in this way. It is not acceptable to insert a tube solely to administer medication.

**An RMO started a very ill detained individual on artificial nutrition but forgot to ask the Commission for a DMP opinion. What should the RMO do?**
If the grounds for urgent treatment are met, the RMO should record the urgent treatment given on a T4 and send it to the Commission. A DMP visit should be arranged as soon as possible. The individual should be informed about the delay in requesting a DMP opinion as the treatment given to date could be subject to legal challenge. If the RMO is continuing treatment until the DMP opinion is given then the urgent grounds specified in section 243 must continue to be met.

**An individual with anorexia nervosa is receiving NG feeding authorised by a T3 form. Her BMI is now 18 but there are concerns that she will not eat and will subsequently lose weight again. Can NG feeding without consent continue?**
Treatment can continue if it will prevent deterioration in the individual's condition. This must be interpreted in line with the principles of the 2003 Act. The RMO must consider whether NG feeding is the least restrictive option. In these circumstances, it would take some time for her BMI to fall to the level where her health is at serious risk. It may be hard to argue that continued NG feeding is justified.

**An individual has an unusual presentation of a first episode psychosis and is detained on a short term detention certificate. Among other features, she is refusing to eat. Is artificial nutrition in this situation covered by the 2003 Act?**
Yes. A DMP opinion should be requested for artificial nutrition from the start of treatment where refusal to eat is a symptom of a mental disorder.

**A 13 year old insulin dependent diabetic with anorexia nervosa is receiving nasogastric feeding with her consent. What might happen if she refuses to allow feeding?**
An informal individual can only receive treatment with consent. An individual may be able to consent between the ages of 12 and 15. Parental consent should be viewed with extreme caution if she says she is not willing to consent. Use of the 2003 Act ensures additional safeguards are in place. If a decision is taken to treat without consent this requires detention under the 2003 Act.

**How much artificial nutrition can be given under urgent provisions before a T3 certificate can be completed?**
This is a matter for clinical judgement. The RMO must assess the urgency of treatment by reference to the grounds in section 243 of the 2003 Act.

**How long are T3 forms for artificial nutrition valid for?**
The Act contains no time limit at present. Usually, we recommend a maximum of three months but it will depend on individual circumstances.

# 8. Medical treatment for individuals under 18

## 8.1. Introduction

This part of the guide applies to the medical treatment of children and young people under the age of 18. While other mini guides in the series address the issues relating to the treatment of adults, this guide focuses on those areas of the 2003 Act where there are particular differences in its use in children and young people. This mini guide will not review those aspects of administering medical treatment under the 2003 Act when there are no differences in approach between children and adults.

Practitioners should refer to the relevant sections of this guidance.

## 8.2. Definitions

In the 2003 Act any person under the age of 18 years is defined as a child. In order to avoid confusion this mini guide will retain this definition and use the term of child even though in clinical practice young person might be a more usual term when referring to young people in their teenage years.

In contrast, the Adults with Incapacity (Scotland) Act 2000 defines an adult as a person aged 16 years or over. While we refer to parental consent in this guidance, remember that a parent cannot consent to treatment for an individual aged 16 or over. However, if an individual aged 16 or 17 cannot consent to treatment for mental disorder but is informal and does not resist or object, he/she can be treated under the terms of the 2000 Act.

## 8.3. Children and consent to treatment: general issues

The Age of Legal Capacity (Scotland) Act 1991 gives particular rights to children, under the age of 16, to consent to medical treatment if the child has, in the medical practitioner's view, the capability of understanding the nature and possible consequences of the procedure or treatment. The Code of Practice of the 2003 Act recommends that practitioners should look for the capacity to consent to treatment from about 12 years old (Vol 1, Ch1, para 32).

When treating any child, the medical practitioner must consider whether the child has capacity to give valid consent to the proposed treatment. This is a matter for clinical judgement and depends on several things including:

- the age and maturity of the child
- the nature of the illness
- the complexity of the proposed intervention
- the risks and benefits of the intervention
- the quality of the doctor-patient relationship
- the nature of the parent- child relationship.

(Shaw, M. (2001) Competence and Consent to treatment in children and adolescents. *Advances in Psychiatric Treatment*, 7;150-159)

For consent to treatment to be valid it requires that the child can understand, retain, use and weigh the information about the proposed treatment provided by the practitioner and communicate their decision. Importantly it also requires that the child is not subject to undue pressure from any party in making the decision. When a child is capable of giving consent on their own behalf, best practice would suggest that parents should still be involved in the discussions where possible. Unless there are confidentiality issues, in most cases it would be reasonable to involve parents to assist the child in reaching a decision providing that the child is not so unduly influenced by that assistance that their consent becomes invalidated.

If the child is deemed capable of giving consent then the practitioner must seek consent of the child rather than of the parent.

If a child is not deemed to be capable of consenting to treatment due to immaturity then the practitioner should consider whether it would be appropriate to seek authority for treatment from that child's parents or an individual with parental rights and responsibilities.

The Children (Scotland) Act 1995 identifies those individuals who possess parental rights and responsibilities in relation to a particular child[6]. In Scotland a mother automatically acquires parental rights and responsibilities at a child's birth. The acquisition of parental rights and responsibilities of the father or same sex partner, however, varies according to a number of factors. A child's father possesses parental rights and responsibilities if he was married to the child's mother at the time of the child's conception or subsequently.

In same-sex couples there are parental rights and responsibilities for those:

- in a civil partnership or in a same-sex marriage with a woman at the time they have the egg donation, embryo transfer or donor insemination treatment which produces a child
- the partner of a woman undergoing egg donation, embryo transfer or donor insemination treatment, and you have completed the forms you need to get parental responsibilities and rights
- named on a child's adoption order
- named on a child's parental order after surrogacy
- the appointed guardian of a child whose parent has died and have consented to act as such.

An unmarried father will only acquire parental responsibility if he is recorded on the child's birth certificate (at registration or upon registration) from 4th May 2006 onwards. An unmarried father whose child's birth was registered before the 4th May 2006 or afterwards does not have parental rights and responsibilities unless he is recorded on the child's birth certificate even if he has lived with the mother for a long time. However, he can acquire parental responsibility by way of the court. Married step-parents and registered civil partners can acquire parental responsibility in a similar way. In certain circumstances people other than the

[6] https://www.mygov.scot/parental-responsibilities-rights/parental-responsibilities-and-rights/

parents may acquire parental rights and responsibilities in relation to a child e.g. appointment of a guardian in a will. Parents do not lose their rights and responsibilities if they divorce even if the parent without custody does not have contact with the child and does not make any financial contribution towards the upbringing of the child.

If there is any doubt about whether the person giving consent is legally entitled to do so, legal advice should be sought.

## 8.4. The use of compulsory powers in children

A child who is competent and informal cannot be compelled to accept treatment against their wishes or against the wishes of those who have parental rights and responsibilities towards the child.

When child who is informal is being treated on the basis of consent by a person with parental rights and responsibilities and the child appears to object to, or resist treatment, the RMO must consider whether or not it would be more appropriate to use the compulsory powers contained in the 2003 Act (Code of Practice Vol 1 Ch 1 para 34). This also applies where someone with parental rights refuses consent.

In the same way as an adult, a child under the age of 18 can be made subject to detention and the process for the granting of detention is the same in both adults and children. It is important for the clinician to consider the effects that detention may have on a child and ensure that all other options have been fully explored before determining that the use of detention is necessary.

The 2003 Act's Code of Practice states that best practice would be for a child's Responsible Medical Officer (RMO) to be a child specialist (i.e. with a certificate of specialist training in child and adolescent psychiatry on the General Medical Council's register).

Particular care is required to safeguard the rights of individuals under the age of 18 who are treated in adult general psychiatry or learning disability wards where the RMO is not a child and adolescent specialist. The Commission should be notified on the ADM2 form whenever a child under 18 is admitted to a non-specialist mental health unit or a medical or paediatric ward.

## 8.5. Welfare of the child

The 2003 Act has a number of principles that underpin how professionals should perform functions under the Act and Section 2 sets out a specific principle relating to children namely that anyone acting under the Act should do so in a manner so as to 'best safeguard the welfare' of the child. In determining what is in the best interests of the child the practitioner should take into account a number of factors including:

- The wishes and the feelings of the child past or present including any advance statements that have been made
- The views of the child's carers and/or named person
- The carer's needs and circumstances which are relevant to any usage of

the Act

- The importance of providing maximum benefit to the child whilst ensuring that any use of the Act involves the minimum restriction on the child's freedom
- The importance of providing the carer with information that might assist them in caring for the child
- The importance of providing the child with information and support to enable them to participate as fully as possible in the discharge of the use of the Act.
- Where the child is or has been subject to compulsory powers the importance of providing appropriate services to the child.

## 8.6. Compulsory treatment of individuals under 18

Part 16 of the 2003 Act is the part that outlines the provisions and safeguards in relation to medical treatment in those who are detained under the Act. It applies to children as well as adults and there is only one additional precaution that must be adhered to in implementing treatment under Part 16 when treating a child under 18.

## 8.7. Child specialists

If a child is subject to Part 16 of the Act and RMO wishes to treat the child without their consent, either the RMO must be a Child and Adolescent Psychiatrist or the DMP undertaking the second opinion must be a Child and Adolescent Psychiatrist.

If the usual RMO is not a child psychiatrist, hospital managers can appoint a child psychiatrist for the specific purpose of assessing and documenting capacity to consent to treatment (see S230 (3)) on form T2.

Note that this safeguarding applies to patients age 16 and 17 with learning disability and to any child including those age 16/17 who have been admitted to an adult ward.

## 8.8. Safeguarded treatments for informal children under the age of 16

The 2003 Act is designed to improve safeguards for individuals whether or not they are subject to compulsory powers under the Act. Although the Mental Health (Care and Treatment) Act 2003 mainly deals with compulsory treatment, because of concerns about certain treatments for children and young people, the Act introduced some treatment safeguards for informal individuals under 16 years of age. These are set out in the Mental Health (Safeguards for Certain Informal Patients) (Scotland) Regulations 2005 SSI 2005/401.

For informal individuals who are children under the age of 16, section 244 of the Act prescribes specific conditions that must be satisfied before certain forms of medical treatment can be given. The Mental Health (Safeguards for Certain Informal Patients) (Scotland) Regulations 2005 defines the following treatments as being regulated:

- Electroconvulsive Therapy (ECT)

- Transcranial Magnetic Stimulation (TMS)
- Vagus Nerve Stimulation (VNS)

The regulations make clear that, even though the child is an informal individual, it is not possible for any of these treatments to be given to a child unless consent for treatment has been obtained from either:

- The child, if the child is capable to consent and does so in writing, or
- A person with parental responsibilities gives consent and does so in writing when the child is deemed incapable of consenting to treatment.

When the child is capable of consenting to the treatment and does so in writing then certification must be given by either the medical practitioner primarily responsible for the child's treatment or a Designated Medical Practitioner (DMP) as defined by section 233 of the 2003 Act. Either the responsible medical practitioner or the DMP must be a Child and Adolescent Psychiatrist. The practitioner must certify that:

- The child is capable of consenting to treatment, and
- The child consents in writing to the treatment, and
- The treatment is in the child's best interests having regard to the likelihood of the treatment alleviating or preventing deterioration in the child's condition.

Once consent to the treatment has been given in writing, a copy of Form T5 must be sent to the Mental Welfare Commission within 7 days.

If a capable child withdraws consent to treatment and then changes their mind and consents once again, newly written consent must be obtained from the child and a further second opinion from a DMP is required.

When the child is incapable of giving consent to treatment and an individual with parental rights and responsibilities in relation to the child gives consent to the treatment in their stead a DMP who is not the medical practitioner primarily responsible for the child's treatment must certify that:

- The child is incapable of making the decision, and
- A person with parental rights and responsibilities for the child has granted consent, and
- The treatment is in the patient's best interests having regard to the likelihood of the treatment alleviating or preventing deterioration in the patient's condition.

Again in these circumstances a copy of the certificate of consent should be forwarded to the Mental Welfare Commission within 7 days.

Once again, if parental consent is withdrawn and then reinstated, a new written consent to treatment must be made and a further DMP opinion obtained.

If, at any time the child resists or objects to treatment, and the authority for treatment is provided by those with parental rights, then treatment on an informal

basis can only be given under section 243(3) (a)-(c) which relates to the giving of urgent treatment. A further DMP opinion is required and in these circumstances treatment can only proceed if the DMP certifies that:

- The child is incapable of making a decision;
- A person with parental rights and responsibilities for the child has granted consent; and
- The child resists and objects, and that urgent treatment is necessary to:
    - save the child's life; or
    - prevent serious deterioration in the patient's condition; or
    - alleviate serious suffering on the part of the patient.

Where a child receives treatment under section 243, either the responsible medical practitioner or the DMP who certifies treatment must be a child and adolescent psychiatrist. Once again the medical practitioner responsible for the child's treatment should notify the Commission within 7 days and detail the type of treatment given to the child and its purpose. The certificate in these circumstances does authorise the use of force if necessary in an urgent situation if the child is in hospital.

# 9. Physical healthcare and the 2003 Act

The issue of using the Mental Health Act to treat physical health problems is complex and uncertain. While the Act itself only refers to treatment for mental disorder, the Code of Practice states that a physical disorder that is a direct cause on the mental disorder can be treated under the Mental Health Act, as can "self-harm" resulting from the mental disorder.

The Commission has produced guidance *(insert reference)* on how this should be interpreted in a range of clinical situations. The issue of removing an individual to hospital and, where necessary, use force or restraint for physical healthcare is cover by the MWC guidance *Right to Treat*.

## 9.1. Specific situations

**Can a T2 or T3 form authorise treatment for physical illness?**
Not usually. See the MWC guidance *(insert reference).*

**An individual has schizophrenia. He needs urgent heart surgery but refuses. He appears to lack capacity and may die within days without surgery. How to proceed?**
The medical practitioner responsible for the surgery should assess capacity and certify under section 47 of the Adults with Incapacity Act 2000 if not capable. Use of the 2003 Act is not appropriate and there is no time to apply to court for an intervention order or welfare guardianship. Treatment can be given under the general authority of S47 with due observance of the principles of the 2000 Act. In view of the urgency and degree of risk to the individual, use of force or detention may be justified as being immediately necessary. The reasons should be properly documented.

**An individual is detained on a short-term certificate. She appears physically unwell but refuses to be examined. How to proceed?**
Assess capacity to consent or refuse examination. If she has capacity, nothing can be done. If she lacks capacity, need to decide necessity of intervention, a section 47 certificate may be appropriate.

Persuasion and gentle restraint might be needed to allow examination. The extent of examination needs to be guided by suspicion of severity and nature of illness.

Ultimately duty of care may dictate that examination is necessary and urgent under these circumstances. The medical practitioner must clearly record actions and reasons for examination without consent.

**Individual is on a CTO but has developed a serious physical illness that has caused paralysis. He can communicate via lip movements and has expressed a wish that treatment be withdrawn if the condition is unlikely to improve. What effect does the CTO have?**
CTO is not relevant here. There must be some attempt to assess his capacity and the presence of a mental disorder must be taken into account. Decisions to withdraw life-sustaining treatment must be made in line with GMC good practice guidance.

**Individual has taken an overdose not as a suicide attempt but to get rid of voices and help her relax. The doctor feels that she should have an ECG and bloods done to check her out physically but she is refusing.**
The RMO needs to assess her capacity to refuse. If she lacks capacity, action depends on urgency and necessity. If investigation is immediately necessary then it can be undertaken under the common-law principle of necessity. If she is detained under the 2003 Act then the Act can authorise intervention to investigate or treat deliberate self-harm. If not detained, a S47 certificate may suffice and force can be used if immediately necessary, although the RMO should consider the need for detention.

**Individual is on a community CTO and refuses personal care. He has infections in eyes and ears and refuses treatment. Can he be taken under Section 112 for treatment?**
S112 refers to treatment for mental disorder where measure 66c is authorised. This is more an issue of treatment for physical disorder. S47 of the 2000 Act is more appropriate. If he is neglecting himself then he might meet criteria for STDC in order to deal with this. If not complying with measure in the CTO more generally, admission to hospital under S113 may be appropriate.

**Individual repeatedly harms herself and needs urgent intervention sometimes using the 2003 Act. What are the roles of mental health, incapacity and common law in this situation?**
Emergency life-saving treatment can be given under the doctrine of necessity and does not necessarily need other legal intervention. The Code of Practice (Volume 1 page 15 sec 22) says that medical treatment under the 2003 Act can include the consequences of mental disorder, including self harm. We do not think it is necessary to detain somebody only to treat the consequences of self harm. A S47 certificate under the 2000 Act could be used for informal individuals. If the person tries to leave and meets the criteria for detention, then the 2003 Act should be considered. The service needs to look at an ongoing care plan to reduce the frequency of self harm and determine whether measures under the 2000 or 2003 Acts are needed to ensure compliance with the care plan. Refer to "Right to Treat" for more discussion on the options.

**Individual on STDC is accepting medication but is resisting nursing staff when they administer personal care (she is incontinent and requires help to maintain her hygiene and skin integrity). As this is not treatment for a mental disorder is it covered?**
Where incontinence is due to the mental disorder e.g. dementia, then it is reasonable to regard this as nursing care for the mental disorder. Physical problems that are not a cause or consequence of the mental disorder would be covered by part 5 of the 2000 Act.

# 10. Other sources of information and guidance

We hope this guidance document has been helpful. Other sources of guidance are available and may provide further assistance.

## 10.1. Mental Welfare Commission good practice guides

These can all be found in the good practice section of our website.

In specific situations, it may be helpful to consult:

- Consent to treatment;
- Right to treat? Delivering physical healthcare
- Advance statements;
- Nutrition by artificial means;
- Covert medication;
- Rights, risks and limits to freedom;
- Significantly impaired decision-making ability in individuals with eating disorders.

## 10.2. Codes of Practice

The 2000 and 2003 Acts have several Codes of Practice. Of these, the most relevant to medical treatment are:

- Volume one of the Code of Practice for the 2003 Act. Chapter ten covers medical treatment. https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/pages/11/
- The Code of Practice for part five of the 2000 Act: https://www.gov.scot/collections/adults-with-incapacity-forms-and-guidance/

## 10.3. General Medical Council

Medical practitioners should ensure they are familiar with the GMC's guidance on consent:

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent

## 11. Glossary

**Assessment order**: an order granted by the court under the 1995 Act remanding an individual to be detained in hospital after being charged with an offence

**AWI**: The Adults with Incapacity (Scotland) Act 2000 **CPSA**: The Criminal Procedure (Scotland) Act 1995 **ECT**: electroconvulsive therapy

**EDC**: emergency detention certificate granted for up to 72 hours under the 2003 Act

**CTO**: compulsory treatment order granted for up to six months in the first instance under the 2003 Act

**DMP**: designated medical practitioner appointed by the Mental Welfare Commission to provide independent opinions under the 2003 Act. The same group of practitioners also provide independent opinions under section 48 of the 2000 Act.

**GMC**: General Medical Council

**Informal**: not subject to compulsory measures under the 2003 Act

**NG tube**: a nasogastric tube used for artificial nutrition

**PEG tube**: percutaneous endoscopic gastrostomy tube providing artificial nutrition directly into the stomach

**RMO**: responsible medical officer appointed by hospital managers to undertake certain actions for individuals subject to the 2003 Act

**Section 47 certificate**: a certificate of incapacity to consent to medical treatment granted under the 2000 Act

**STDC**: short-term detention certificate granted for up to 28 days under the 2003 Act

**T2 Form**: a statutory form (certificate for medical treatment) which records an individual's consent to safeguarded treatments

**T3 form**: a statutory form documenting the independent opinion of a designated medical opinion (DMP).

**T4 form**: a form used to notify the administration of urgent treatment retrospectively

**T5 form**: a form used to record an independent DMP opinion in relation to certain treatments given to individuals under the age of 16

**The 2000 Act:** see "AWI"

**The 2003 Act**: The Mental Health (Care and Treatment) (Scotland) Act 2003.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