newsletter for mental health officers in scotland

from the Association of Directors of Social Work, The British Association of Social Workers, the Scottish Government, the Social Work Inspection Agency and Commmunity Care Works

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Moira Healy and **Alison Goodwin** of the Mental Welfare Commission discuss

financial interventions

Introduction

The Mental Welfare Commission has a major role in monitoring and safeguarding the health and welfare of those who lack capacity due to a learning disability, dementia, mental illness or other mental disorder. A new guide entitled 'Money Matters' has been produced by the Commission, in consultation with the Office of the Public Guardian (OPG), because of our concerns about the impact of financial management on the welfare of those who lack capacity. We regularly meet individuals whose quality of life could be significantly enhanced by effective management of their funds. Management of an adult's finances can be an integral part of providing for their health and welfare. It needs to be discussed as part of the care management role and appropriate measures considered, bearing in mind the principles of the AWI Act, such as benefit to the adult, the least restrictive option, maximization of the adult's residual skills.

Professionals need to feel confident in their knowledge of available financial measures when working with an adult with incapacity. Being able to give information and advice, or seek clarity about the range of roles and responsibilities of those dealing with the adult's financial affairs, is an essential part of the care management role. For example, professionals may need to give initial advice to relatives on the possible options for managing the adult's finances, or request confirmation on powers of attorney from the OPG to clarify the extent of powers when planning future care arrangements. They particularly need to be aware of the duties on the local authority conferred by the adult with Incapacity (Scotland) Act 2000 (AWI Act) and the amendments contained in the Adult Support and Protection (Scotland) Act 2007, as well as the scope of DWP appointeeship. We have been made aware of several cases where adults with a learning disability, for example, are leading chaotic lives, with bills unpaid, insufficient food and clothing and where they are open to exploitation. DWP appointeeship by the local authority or other body would have been a simple way of improving the adult's welfare. However, in the past a number of local authorities have decided not to act as corporate appointees and have failed to put any other measures in place. Hopefully the recent amendments of the AWI Act to allow organisations, including the local authority, to access funds under Part 3 will rectify such situations.

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contributors

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Julie Paterson qualified with a Masters in Social Work degree in 1995, became an MHO in 1997. She has worked in the field of mental health social work throughout her career. Julie's substantive post is Team Leader of the MHO Service in Fife but she is currently on secondment to the Mental Welfare Commission until Nov. 2009.

Moira Healy has been a qualified social worker since 1984 and an accredited mental health officer since 1995. Moira has extensive experience in both general adult psychiatry and in care of the elderly, spending most of her career working for the City of Edinburgh, latterly as District MHO. Moira has taught mental health law on the Edinburgh University MSW course and was a member of the south west Scotland MHO programme for many years. Moira joined the Mental Welfare Commission in 2005 as a social work officer.

Alison Goodwin has been a qualified social worker for over 27 years, spending most of her time working for Lothian regional Council and latterly City of Edinburgh

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financial interventions

Case study example

We came into contact with a woman with alcohol-related brain damage, who had separated from her husband. She had previously granted her husband Continuing/ Financial Power of Attorney (CPOA). This was activated in the event of her incapacity but he appeared to be unaware that these powers had been granted to him. These included the power to become her DWP appointee and the power to access her occupational pension. Effective management of the woman's money would have enabled her to have a nourishing diet and would have paid for the care services essential to her well being in the community.

The multi-disciplinary team, who supported her at home were aware of the CPOA arrangements and despite the obvious problems this was causing, chose not to challenge the husband's lack of use of these powers.

We have visited individuals in nursing homes where the home managers were acting as appointees for an adult's DWP benefits but did not access the adult's superannuated pension by using Part 4 of the adults with Incapacity Act. Nursing home fees were then taken from the person's benefits, leaving virtually no funds available for the adult's personal allowance. In such cases we would be concerned that the adult's pension is left to accumulate in a bank account and not used for his/her benefit. Such funds could be accessed by using the AWI Act (part 3, part 4 or part 6).

This guidance is intended to provide a useful overview for a range of practitioners tasked with safeguarding the welfare of adults who lack capacity. We hope that this will provide professionals with some confidence when advising on ways to effectively manage the finances of adults with impaired capacity. While it is not comprehensive, our guidance does cover the main options available for financial management. The information is presented in an easy to access table format, supported by more detailed guidance and links to relevant websites. A link to the guidance is provided below.

www.mwcscot.org.uk/newpublications/good_practice_guidance.asp

Colin Welsh and Ailsa Stewart

Community Out reach Team in West Fife

Fife, although geographically small, has NHS Mental Health services divided into three distinct areas, areas that have traditionally developed their own services to meet local need. North East Fife, including Cupar and St Andrews, Central Fife, including Kirkcaldy and Glenrothes and West Fife centred on Dunfermline. There are currently three admission hospitals, one for each area. This is currently under review with the option of locating to two sites, one in the East and one in the West.

The Community Outreach Team sits in West Fife and was established in March 2000 following the publication of research examining the type of services provided by Fife NHS to those with a diagnosis of schizophrenia. An outreach team approach was felt to be the best way to meet the needs of this group. The team is funded by NHS Fife and covers West Fife. The Team therefore meets the needs of a range of locations including mining villages, towns, coastline and rural communities. It works with one admission hospital in Dunfermline. The service operates seven days a week between 9.00am and 9.00pm (Monday to Friday) and 9.00am to 5.00pm (Saturday and Sunday). Offering support at the weekend is viewed very positively. Often staff use this period to meet up with people who they know are struggling by visiting, giving them a phone call or going out somewhere different to break a pattern of isolation.

The Team comprises six full time Care Managers, five from a health background and one from a social work background. The Team Leader is social work qualified. There are six Support Workers who are unqualified but have experience of working in mental health or learning disability services. Additionally, there is a Consultant Psychiatrist and a Staff Grade Doctor, an O.T, O.T. assistant and two full-time administrative staff. The team has access to psychology sessions from a Psychologist and a Psychology trainee. The Support Workers have access to training and have undertaken SVQs and OU courses. It is important to note that as the staff are employed by the Health Board, they cannot act as Mental Health Officers. The Team Leader however has worked as both an ASW and MHO in previous employment.

Referrals to the Team come from the four Consultants based within West Fife. Once a referral is made it comes to the team who discuss the individual's needs, gather any additional information required and then visit the individual to make an assessment of whether or not their needs can be met by the Team. The team work on an ongoing basis with a population of between 150 and 170, many of whom have been receiving services over a number of years. Input to service users will vary over time, depending on their needs.

The basis for referral is generally longer term mental illness, although the two groups within the population most likely to be referred are those with a diagnosis of schizophrenia or bi-polar disorder. Service users are generally between 18 and 65, although some people are now in their 70's.

Individuals referred to the Team commonly have a combination of issues surrounding their diagnosis and many have seen their illness adversely affect their social functioning, e.g. lifestyle, physical health, accommodation, employment and relationships. The population served by the team contains people who are in employment, undertaking training or college courses, voluntary work and those who are unemployed. The Team have started to explore the idea of appointing a Peer Support Worker in the future, involving someone with a lived experience of mental illness, to undertake a specific piece of work with the Team.

Once an individual has been referred and accepted by the Team the care management function is undertaken by one of the care managers. They will then involve the person in drawing together their care plan and agreeing on the areas needing addressed. For service users, there is the benefit of one location and one phone number that they can access for assistance, information and support on all aspects of their care.

Co-location and easy access to medical colleagues enables staff to provide quick responses. If, for example, someone requires their medication to be reviewed or changed this can happen on the same day. In addition if someone requires an assessment for admission, the Consultant within the team can arrange this very quickly.

There is significant opportunity for preventative work with individuals using this service. Team members meet with people when they are well and when they are ill so they are in contact with individuals at various points in their recovery journey. Staff can therefore support service users to identify the triggers to becoming unwell and patterns of behaviour that may precede this and agree strategies for people to avoid and/or work through these episodes.

The team are investigating using Wellness Recovery Action Plans (WRAPs) to support the above approach. Some staff have already been trained to use WRAPs*. This approach places responsibility for managing symptoms with the individual, whereas other methods such as Relapse Prevention, are geared towards staff responsibility. WRAPs can help service users identify what they should do when they feel they are relapsing. The detail of a recent evaluation of WRAPs can be found on the Scottish Recovery Network website at:

www.scottishrecovery.net/content/default.asp?page=s7_1&newsid=1283&newstype=n1_2

The type of activities undertaken by the team obviously varies from individual to individual but an example is provided below.

"We meet in town for coffee every week and discuss whatever is going on, it could be his gambling, it could be his medication or side effects, it could be me just checking how he is feeling about his life. A support worker takes him shopping every two weeks, or they might go to the pictures. There is also a worker from the local housing association, funded through supporting people, who goes in and does budgeting with him. He also attends appointments with our Consultant. We can get the prescriptions filled when necessary and ready for him to collect. Because this individual is subject to a CTO and is on a CPA he has an MHO who is also involved in his care. This MHO comes from the local social work team. This is one of the few times we need to access local social work services."

The Team promotes the take up of Advance Statements. By including information on issues out-with treatment, such as "what do you want to happen to your finances and pets if you have to be admitted?" or "who do you want to visit you?", they have encouraged take up of Advance Statements.

The nursing staff in the Team also operate three continuing care clinics primarily for depot injections. A physical health assessment is available to those on high dose prescriptions. An Affective Disorders Clinic is also provided which is principally for people with bi-polar disorders. The clinic can check their lithium levels and provide physical health screening.

Therapeutic work is undertaken on a one to one basis and staff use different psychological and psycho-social interventions. A key therapeutic element of the work being undertaken by staff is the long- standing relationships built up between staff and service users. The principles of recovery underpin the work of the team. They promote the importance of people identifying and using their own strengths to move forward rather than purely focussing on their needs and deficits. The Team believe that the person with the illness is very often the expert and this expertise should be central to care planning.

The Team appreciates the value of group work and have a well established programme of activity based group work.

The Team is involved in the National review of the Scottish Recovery Indicator (SRI) following their own work in using the original SRI which allowed them to create an action plan for Team development including developing an information leaflet and new documentation.

The team has a good relationship with the MHOs they work with regularly and can access them quickly if required for one of their service users. MHOs also attend CPA meetings with team members. Staff within the team do not attend Tribunals with service users preferring to keep themselves independent of the detention process, although the Consultant within the team will attend. Staff support service users through the admission process and continue to visit people throughout their admission to hospital. One MHO commented on their experience of working with the team.

As an MHO in the specialist MHO team, I have regular communication with team members of the Community Outreach Team and attend discharge planning and CPA meetings which COT members also attend. In the case of CPA meetings COT members are often care co-ordinators.

Communication with team members is extremely useful and invaluable with regard to exchanging information about service users who come to the attention of the MHO Team in relation to the need for possible compulsory measures and service users who are subject to Compulsory Treatment Orders. This enables an MHO to carry out an assessment with as much information as is available, taking into account service user circumstances. There are times when joint home visits to service users with a COT member are appropriate and beneficial.

In my opinion the COT offers a flexible needs led response to service users and is able to identify if there is a deterioration in a service users mental health that may require MHO intervention/involvement.

MHO Fife Council

The COT have been in existence for nearly 10 years and have over that time been able to assist many people who were labelled as having a "severe and enduring" mental illnesses to move on, take control and enjoy a greater quality of life than could have been imagined. Their experience has shown that giving people hope helps make expectations of recovery realistic.

* *www.scottishrecovery.net*

Electronic versions of the Newsletter

An electronic version of the newsletter can be downloaded from the website
www.strath.ac.uk/gssw/associatedcentres/communitycareworks/publications/mentalhealthofficernewsletter/
If you would like to recieve the newsletter electronically, please contact Ailsa Stewart at ailsa.e.stewart@strath.ac.uk

Julie Paterson of the Mental Welfare Commission discusses

The role of Social Circumstances Reports

The statutory responsibility for the preparation of social circumstances reports (SCRs)quite rightly (in my view) lies with the specialist, experienced social worker that is the local authority mental health officer. The Mental Health (Care and Treatment) (Scotland) Act (2003) confirms that where it is believed that an SCR 'would serve little or no practical purpose', an MHO need not comply with this requirement.

The Mental Welfare Commission has been monitoring practice in relation to when an SCR might be considered to 'serve little or no practical purpose'. It has identified the provision of SCRs as an area of practice where practitioners and managers are continuing to have difficulty in achieving consistency in the circumstances in which service users, Responsible Medical Officers (RMOs) and the Mental Welfare Commission (MWC) could expect a report to be prepared. As part of my role as social work officer within the Commission, I was therefore tasked with taking the lead on developing guidance which might usefully complement the information contained in Volume 1, Chapter 11 of the Code of Practice.

It is important to declare at the outset that, as a practising MHO and manager of an MHO service, I am indeed a fan of SCRs. As a practitioner I have found the process of preparing an SCR invaluable in engaging service users, carers and relevant others to examine the interaction of an individual's social and family circumstances with their mental disorder and thus inform future decision making. Have I always prepared SCRs where relevant events require that I should? No. Have I always recorded the reasons for not compiling an SCR and notified the Mental Welfare Commission and RMO accordingly? No. Did I think the Mental Welfare Commission read the report anyway? I wasn't sure.

Over the past eight months I have thoroughly enjoyed consulting with various stakeholders; RMOs, service users, Mental Health Officer Managers and MHOs themselves, both on an individual and group basis. The question of when an SCR would 'serve little or no practical purpose' produced a range of views from MHOs. Some MHOs confirmed that they would always prepare an SCR where a relevant event took place "it's like putting salt on my chips" as one MHO explained. Others suggested that they would not complete an SCR where a CTO application was being progressed (regarding this as duplication) and others explained that they would not complete an SCR unless a CTO was being progressed! The consultation process highlighted that, in many cases, MHOs were making these decisions in isolation. One thing that all MHOs had in common, however, was a very busy and pressured workload.

Given the wide variation and preparation (or not) of SCRs across and within local authorities in Scotland, the Mental Welfare Commission hopes that guidance on best practice for this extremely important document will give a steer towards a consistent and thoughtful approach to the interpretation of what constitutes an SCR which may 'serve little or no practical purpose'. It is hoped that this guidance will benefit MHO service managers with regards to their responsibility to monitor the level and quality of SCR provision and to target precious MHO resources effectively.

The Mental Welfare Commission's best practice guidance document is about to be published. As well as considering levels of SCR provision, it also takes the opportunity to re-visit the purpose (both process and product) and audience of an SCR. (Having worked at the Commission for the past 14 months now I can now confirm with confidence that the MWC officers certainly do read SCRs!) It then concludes with practice recommendations developed following the identification of key issues by relevant stakeholder. I would like to take this opportunity to thank everyone who has kindly contributed to the consultation process and attach the recommendations here for your information and interest:

Recommendation 1

- For a person who has no previous SCR on file, an SCR should always be completed within 21 days of initial detention (STD/Assessment Order/Treatment Order). This is irrespective of whether the person is known to mental health/learning disability services or not prior to detention. In the exceptional and unforeseen circumstances where this does not happen, reasons must be clearly recorded in the SCR1 form.

Recommendation 2

- Where the detention order is revoked at an early stage, an SCR should still be prepared using the information available. The SCR does not require to be a full, comprehensive report – information available and the context will still be useful.

Recommendation 3

- Where there is an earlier SCR on file for a previous episode of detention, only updated information need be provided. Explicit reference ought to be made to the original SCR and the circumstances that have changed. This updated SCR should be provided in the same format i.e. there should not be different paperwork for an updated SCR. (Relevant events following on from this should attract another updated SCR only when the RMO or MWC should be notified about significant changes or developments relating to the individual's social circumstances which have taken place since the last updated report). When making decisions about the provision of updated reports, priority ought to be given to reports for:
  - children up to age 18 years
  - people who have no permanent accommodation
  - people who have no informal network of support or relevant others involved in their care
  - circumstances involving offending behaviour
  - any child protection issues
  - contentious issues or concerns alerting the Commission to enquire further in line with its statutory remit
  - recent loss of employment
  - recent bereavement
  - breakdown or significant change in care/support arrangements
  - where there are caring responsibilities
  - victim of assault/exploitation.
  - Incidents of serious self-harm

Recommendation 4

- An annual updated SCR should be provided by the designated MHO for all people subject to long term detentions. Exceptions to this would be where there are agreed alternative review arrangements in place e.g. Care Programme Approach reviews involving MHOs, MHO reports prepared to support decisions to extend/vary order.

Recommendation 5

- Where decisions are made not to prepare SCRs, the reasons for this ought to be communicated to the service user in a format and at a time appropriate to the individual service user's needs.

The final two recommendations are directed at managers of MHO services in particular:

Recommendation 6

- Local authority managers of MHO services should have governance arrangements in place to ensure that they are aware of both the quality and content of SCRs as well as how SCRs are being prioritised within the service so that local MHO practice is in line with the law and the associated regulation on SCR content, the Code of Practice and this guidance.

Recommendation 7

- Leaflet information should be developed to inform service users and carers of the value, purpose and audience of SCR reports and when they are required under the Act.

Dale Meller Programme Manager – Mental Health and Race Equality NHS Health Scotland

Ethnicity Data Can Make a Difference – Ask the Question

Equality and diversity monitoring helps us to understand which individuals and groups access mental health services. It also enables us to promote equality by targeting services at groups who may encounter barriers using mental health services. In the context of decisions about compulsory treatment or incapacity, it is essential that mental health practitioners both record and understand the impact that a person's ethnicity may have in terms of intervention – not just in order to provide the most appropriate care and treatment but in order for analysis and future understanding about need and gaps in service provision.

Ethnicity relates to the group that a person belongs to, or is perceived to belong to, due to certain characteristics such as their 'race', religion, diet, appearance and language spoken. In the context of ethnic monitoring a person's ethnicity is self-defined. The Race Relations Amendment Act 2000 requires public services to provide equitable services to people irrespective of ethnicity. The legislation also requires public services to conduct ethnic monitoring with service users. Despite this legal driver, and the inclusion of ethnic monitoring within the forms used in connection with compulsory treatment under the Mental Health (Care & Treatment) (Scotland) Act 2003, we still have relatively poor completion of ethnicity forms. In its annual report in 2008, the Mental Welfare Commission reported that they had only received ethnicity information on 57% of the forms they received. This makes meaningful interpretation impossible. We are currently therefore, unable to interpret whether certain ethnic groups are over or under-represented in terms of compulsory treatment. A number of stakeholders, including the Mental Welfare Commission, believe that ethnic monitoring should be a mandatory part of the form filling process and have fed these views into the current review of the Act.

In England and Wales, ethnic monitoring has been routine across mental health services for over 10 years. The annual 'Count Me In' census of psychiatric hospitals reveals that African and Caribbean men are consistently over-represented in the numbers of detained patients and in secure wards as compared to their white counterparts. In Scotland, we know almost nothing about the rates or experiences of black and minority ethnic (BME) individuals and groups in our psychiatric hospitals or community mental health services. This is another reason why it is important to undertake ethnic monitoring in a consistent way.

There are a number of examples of good practice worth checking out:

1 The Mental Health and Race Equality Programme which is based within NHS Health Scotland and supports practitioner networks as well as learning resources and research. Contact Dale Meller at 0141 354 2900 or visit http://www.healthscotland.com/about/equalities/mentalhealth.aspx

2 'Happy to Ask, Happy to Tell' which is an information, DVD and training resource for frontline staff in diversity monitoring. Contact Christopher Homfray at 0141 354 2900 or visit http://www.isdscotland.org/isd/5652.html

3 The Ethnic Monitoring Toolkit which is a resource providing clear guidance on good practice in ethnic data collection. Visit http://www.isdscotland.org/isd/files/ETHNIC%20MONITORING%20TOOL.pdf

4 'What's Out There?' which is a research project looking at supports for BME individuals with learning disabilities and their families. Contact Jan Murdoch at 0141 418 5420 or visit http://www.scld.org.uk/

Update from the Scottish Government

MENTAL HEALTH DIVISION POLICY & LEGISLATION TEAM

Primary Legislation: review of the 2003 Act

An independent Review Group was appointed by the Minister for Public Health in January 2008 to conduct a limited review of the Mental Health (Care and Treatment) (Scotland) Act 2003. The remit of the Group was to: review the processes in respect of civil mental health detention; advise on changes that should be made to improve the efficiency of the operation of the legislation and experience of patients; report back to the Scottish Government with recommended changes to the legislation itself.

The Review Group has submitted a report for the Minister in March 2009.

The Mental Health Division are now carrying out an exercise to consider the Report's recommendations, and determine: which of the recommended changes in respect of civil mental health detention would require amendment of the 2003 Act itself; which might be achieved through secondary legislation (ie regulations, orders and the Tribunal Rules, all of which are made under the 2003 Act); and which might be achieved by changing existing practice.

If it becomes evident that primary legislation is required, ie a new Bill to amend the 2003 Act, Mental Health Division will also consider at the same time whether there are any other minor tweaks that might usefully be made to other parts of the Act to make it operate more effectively. In that regard, the 2003 Act was widely welcomed and continues to be viewed positively, but it is recognised that some further minor changes might be helpful to improve the operation of the Act .

It is unlikely though that any new Bill to amend the 2003 Act could be presented before 2010/2011 at least, as the necessary work in preparing for a new Bill, and getting a slot in the Parliamentary timetable for such a Bill, all takes time.

Secondary legislation: amendment of the Tribunal Rules

The Tribunal Rules are made under sections 21(4) and 326(2) of, and paragraph 10 of schedule 2, to the 2003 Act. The current rules are The Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005 (SSI 2005/519) as amended by SSI 2006/171.

A further set of amending rules (SSI 2008/396) were made to the original Tribunal Rules in November 2008, and came into force on 20 December 2008. The main changes:

- rule 42 (Disqualification) – to clarify as to when individuals would be disqualified from serving as members of a tribunal by reason of their being "employed by or contracted to provide services in or to the hospital". The intention is to reduce the number of individuals who might otherwise be deemed disqualified under rule 42 by virtue of their being employed to provide cover, when on call, to all hospitals within a health board area.;
- rules 46 & 47 (distribution & disclosure of documents) – to separate out the rules on distribution of documents from the provisions relating to non-disclosure, and to eliminate the previous requirement for the Tribunal to afford the parties an opportunity to make representations on documents which they have not seen such that the Tribunal may accept the reasons given on its own account;
- rule 72 (decisions of the Tribunal) – where a copy of a decision is sent to the MWC, the Clerk to the Tribunal will now also be required to send a copy of the application and accompanying medical reports and, in the case of a reference, send a copy of the reference to the MWC along with a copy of the decision.

Secondary legislation: cross border transfer regulations for community patients (s289)

The Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008 (SSI 2008/356) were made under section 289 of the 2003 Act and came into force on 3 November 2008.

The 2003 Act makes provision for community-based Compulsory Treatment Orders (CTO) and Compulsion Orders (CO). Section 289 of the 2003 Act is a power to Scottish Ministers to make regulations providing for cross-border transfer of patients subject to a requirement other than detention, which includes patients subject to community based CTOs and COs. Such regulations had not however been made under this power, to enable a patient on such a community-based order to transfer from Scotland to another country in the UK and be placed on a similar order. This is because there have, to date, been no orders comparable to CTOs or COs in those countries to enable Scottish patients to transfer to an equivalent statutory order, or to which patients in other parts of the UK are subject such that they could transfer to a community based order in Scotland.

However, the current situation is set to change. The UK government are planning to implement the main provisions of the Mental Health Act 2007 (which amends the Mental Health Act 1983), which, with accompanying regulations, will bring into effect from 3rd November 2008 provisions for Supervised Community Treatment Orders (SCTO) in England and Wales. This provision will only apply to England and Wales at present and not to other UK territories that do not have similar orders under their legislation.

To tie in with the introduction of these provisions in England and Wales the Scottish Government is introducing these regulations under section 289 of the 2003 Act. The order will now enable the cross border transfer of patients on community based orders to England and Wales and allow patients on SCTOs in England and Wales to transfer to Scotland.

These regulations are similar to those made under section 290 of the 2003 Act (SSI 2005/467 – "the s290 regulations") which enables the cross border transfer of patients detained in hospital. However, there are some significant differences.

Patients transferring from Scotland to England or Wales

- it is for the patient (or their named person where the patient does not have capacity) to initiate the request for a transfer (reg 3). This is in contrast to the section 290 regulations regime where the patient's Responsible Medical Officer (RMO) initiates and indeed requires the patient to transfer to another country (e.g for treatment).
- the patient's RMO is responsible for giving notice of the fact of the patient's wish to move to the patient's Mental Health Officer (MHO), primary carer and relevant others. (reg 3)
- the MHO must interview the patient and make their views on the transfer known to the RMO. (reg 4)
- the patient's RMO is responsible for satisfying him or herself through liaison with the receiving authorities that there are suitable arrangements in place in England or Wales to receive the patient, and may only authorise the transfer if so satisfied. (reg 5)
- where the patient's RMO is so satisfied that suitable arrangements are in place and has also taken account of: the best interests of the patient, the risk to the safety of any person, the views of those consulted, and has notified the receiving RMO and authorities of any recorded matter specified in the patient's order, he or she may agree to the transfer taking place. The RMO is then responsible for issuing the transfer warrant and notifying the patient's MHO and others. After the transfer has taken place the RMO must notify the MHO and the MWC. (Unlike the section 290 regulations regime for hospital based patients, there is no role for Scottish Ministers in making the decision about transfer or issuing the warrant for community based patients under these regulations). (regs 5, 6 ,7, 8)
- there is no provision for an appeal to the Tribunal against the decision to transfer the patient (because the patient, or, where appropriate, their named person, has initiated the request for transfer). However, regulation 8 and 9 provide for a right of appeal to the patient and the patient's named person to the Tribunal against refusal by the RMO of a request, and onwards from the Tribunal to the Court.
- the regulations make appropriate provision for the patient to be escorted to England or Wales where the RMO considers this is appropriate and for appropriate action to be taken by any such escort should the patient abscond or fail to appear at the agreed destination. (regs 11 and 12).

Patients transferring from England or Wales to Scotland:

- the managers of the receiving hospital are responsible for liaising with the managers of the sending hospital in England or Wales and agreeing (or not agreeing) to accept the patient on transfer. (Regulation 14)
- unlike the section 290 regulations regime for hospital based patients, there is no role for Scottish Ministers in approving transfers from England or Wales.
- the managers of the receiving hospital or the RMO appointed by them for the patient may make arrangements for the patient's transfer to their destination in Scotland where they consider this necessary. It is not essential to make such arrangements where the RMO does not consider them necessary. (reg15)
- the hospital managers are responsible for notifying the appropriate local authority of the details of the patient's planned transfer. (reg 16)
- the regulations make provision that an RMO and MHO should be appointed for the incoming patient and appropriate duties carried out (as for any patient who becomes subject to a new CTO or CO). (reg 18)
- any patient on an SCTO in England or Wales being transferred to Scotland will become subject to a CTO or CO (as appropriate) in the community under the 2003 Act on transfer and be subject to measures which most closely correspond or are similar to those in place while the patient was on the SCTO prior to transfer. (regs 19, 20, 21)
- provision is made for any escorts of the patient to have appropriate powers (although it is not essential that the patient is escorted). Should the patient abscond while being escorted then appropriate provisions are made for the patient to be apprehended. (regs 22 and 23)
- the patient's MHO, once appointed, must carry out the duties required by the Act to identify the patient's named person and inform the RMO. (reg 24)
- the new RMO when appointed must carry out an assessment of the patient within 7 days and take the appropriate action: –
  - to inform the hospital managers of the outcome of the assessment;
  - to discharge the patient where they consider the patient does not meet the criteria for compulsion; or
  - to draw up a care plan etc where they consider the patient does meet the criteria for compulsion. (regs 25, 26, 27, 28 and 29)
- the managers of the hospitals must notify the parties listed of the outcome of the assessment and whether or not the patient remains subject to the provisions of the 2003 Act. (reg 28)
- once transferred the patient becomes subject to the full provisions of the 2003 Act, including review and the MWC will be required to visit each transferred patient within 6 months. (regs 30 to 32)

Secondary legislation: Absconding regulations (s309 & s309A regulations)

The final package of regulations regulating absconding, the Mental Health (Absconding Patients from Other Jurisdictions) (Scotland) Regulations 2008 (SSI 2008/333), made under section 309 of the 2003 Act, came into force on 2 October 2008.

These regulations, along with the earlier Mental Health (Cross-border Visits) (Scotland) Regulations 2008†, deal with persons in Scotland who abscond or otherwise fail to comply with requirements imposed under mental health measures applicable in one of the other specified territories within the scope of the Scottish mental health legislation.

The regulations were made in tandem with the bringing into force in England and Wales of the final provisions of their Mental Health Act 2007, and replace the previous provision found in section 88 of the Mental Health Act 1983 (which extended to Scotland) in respect of absconding patients from England and Wales.

Secondary legislation: certificates for medical treatment

The Mental Health (Certificates for Medical Treatment) (Scotland) Amendment Regulations 2008 (SSI 2008/316) came into force on 12 October 2008, to amend the Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2005 (SSI 2005/443).

These new amending Regulations revise the wording and layout of the forms (T1, T2 and T3) to be used for giving certificates under sections 235, 236, 238, 239 and 241 of the 2003 Act in respect of the patient's consent to medical treatment and the patient's best interests with regard to giving that treatment. The aim of these

† SSI 2008/181, made under section 309A, which dealt specifically with leave of absence patients

continued on page 8

amendments is to make the forms clearer and easier to complete.

Practitioners should note therefore to use the new forms.

Directions under the 2003 Act – MHOs

The Mental Health (Care and Treatment) (Scotland) Act 2003 (Requirements for appointment as mental health officers) Direction 2009 was made in January under section 32(2)(b) of the 2003 Act. This 2009 Direction revokes The Mental Health (Care and Treatment) (Scotland) Act 2003 (Requirements for appointment as mental health officers) Direction 2005.

This Direction restates the terms of the 2005 direction and adds a new subparagraph 5(a) to include holding a Scottish Council Mental Health Officer Award as one of the ways of satisfying the requirements as to education and training in order to be appointed as a mental health officer.

Case law under the 2003 Act – test for revocation of restriction orders

In Scottish Ministers v Mental Health Tribunal for Scotland‡, the question of the approach by the Tribunal to section 193 of the 2003 Act (powers of Tribunal on reference under section 185(1), 187(2) or 189(2) or application under section 191 or 192(2)) was discussed in the Court of Session. The case had been brought by Scottish Ministers and is the first consideration by the Court of Session of section 193 and so is an important case.

The tests in section 193 for revocation of a restriction order are also repeated throughout the Act, for example, in terms of the tests that RMOs have to apply, so this case is of importance not just for the Tribunal in its approach to the tests for revocation of a restriction order under section 193 but also more widely by other practitioners as to the Courts' interpretation of the statutory tests.

The Court of Session:

- held that section 193 of the 2003 Act is a series of sequential tests (ie have to apply them all in order) – this means that if the patient meets the test in section 193(2) [has mental disorder and needs detention in hospital in order to protect the public from risk of serious harm] then the Tribunal can make no order at all under section 193.
- accepted Scottish Ministers' argument that the test for revocation of the restriction order in section 194(5) is in fact two tests. The two separate tests are: (a) whether the patient meets the serious harm test requiring detention in hospital; and (b) whether the patient otherwise requires a restriction order. The court must have already decided at s193(2) that patient does not meet test (a), otherwise they would not be considering any other order under section 193, so (b) is the only test left to consider for the test at 193(5) as to whether the restriction order should be revoked – ie is the restriction order still necessary.
- agreed that the serious harm requiring detention in hospital test found at s193(5) – ie test (a) above - is one of "risk of serious harm" rather than "serious risk of harm".
- noted that it is not defined in the 2003 Act as to what is meant by the second test for continued necessity for a restriction order - ie test (b) above – but, having given it consideration, agreed with Scottish Ministers that the starting point must be to look at why the restriction order was imposed in the first place. The Tribunal therefore needs to look back at the nature of the offence, the antecedents of the patient and the risk that the patient would commit further offences if set at large. Once it has considered these factors the Tribunal must then reach a conclusion (even if just to say that some of these aspects are no longer relevant)
- discussed within the judgment the purpose of a restriction order, which noted that Scottish Ministers have a statutory overseeing role under the 2003 Act in relation to restricted patients as a public risk protection.

The Scottish Ministers' appeal was therefore allowed by the Court of Session and the case remitted back to the Tribunal for a fresh hearing.

‡ *2009 WL 289345*

Other current mental health issues: future of the Mental Welfare Commission

In November 2008, the Cabinet Minister for Finance, John Swinney, issued a statement on scrutiny improvement, in which he indicated that a new health scrutiny body would be set up which would bring together the existing functions of NHS Quality Improvement Scotland and the Mental Welfare Commission. The new body would also take on the scrutiny of independent health, currently done by the Care Commission, and would ensure greater consistency of scrutiny. This would help the public better understand the standards of performance and delivery across a highly integrated universal public service. The body would also provide a stronger emphasis on the health needs and outcomes of vulnerable people, including older people, people with mental health problems and people with learning disabilities."

On 18 February 2009, however, Shona Robison MSP, Minister for Public Health and Sport, answered a Parliamentary Question on the future of the Mental Welfare Commission as part of the new scrutiny bodies for social care and health, as follows:

"I am aware of concerns expressed by stakeholders about this proposal, particularly about the perceived loss of independence for the MWC and the safeguarding role.

That is why Cabinet agreed earlier this week that while the MWCS will remain very much part of the simplification programme we will step back at this time from taking the MWCS' functions into either the new health or the new social care body.

We will discuss further with the MWCS and engage directly with mental welfare stakeholders on the way forward. At the same time we will review the operation of the MWCS over the next 4 to 6 months to establish how best to take the MWCS forward as part of the simplification programme.".

Over the next few months therefore, the Scottish Government Mental Health Division will discuss further with the MWC and engage directly with mental welfare stakeholders on the way forward. At the same time we will review the operation of the MWC over the next 4 to 6 months to establish how best to take the MWC forward as part of the simplification programme.

The Minister for Public Health and Sport will also host and chair a series of small stakeholder discussions as the starting point for discussion with and listening to stakeholders concerns.

(see page 9 for Mental Welfare Commission perspective)

Joanna Keating, Scottish Government Health Directorate, Mental Health Division

Head of Policy & Legislation Team (Branch 3), 3-ER St Andrews House, Regent Road, Edinburgh EH1 3DG

Mental Welfare Commission Update

Health and social care scrutiny reform

In November 2008 the Cabinet Secretary for Finance and Sustainable Growth announced the Government's proposed reform of the health and social care scrutiny system. The Mental Welfare Commission came within the remit of this proposal, which would have seen a merger with NHS Quality Improvement Scotland (NHSQIS) to create a new health scrutiny body. The Bill setting out these changes is due in Parliament in May. Following the announcement, there was much discussion about the status of the health scrutiny body and stakeholders expressed concern about the proposals. Ministers considered an alternative suggestion that placed the Commission's functions with the care and social work scrutiny body. The Minister for Public Health met with stakeholders on 2nd February to hear their views.

On 11th of February it was announced in Parliament that the Mental Welfare Commission would not be included in the proposals set out in the scrutiny Bill this May. The Government is still committed to including the Commission with the 'scrutiny simplification agenda' but the shape and terms of this will be agreed after a period of review and consultation over our functions. This will be led by the Mental Health Division within the Government and will involve the Commission and all stakeholders. The Commission has responded saying 'We are grateful to Ministers for taking account of the strong views of our stakeholders and for considering our submissions on the issue of reform of scrutiny bodies. We are pleased that Ministers recognise the important safeguards that we offer to people who are vulnerable through mental ill-health or learning disability. We will work constructively with Ministers and others to make sure that these safeguards continue in the most effective way possible.'

New publications

Greater expectations – revisited

The Commission has just completed its report from themed visits to people with severe and enduring mental illness. The report focuses on the care and treatment of individuals in rehabilitation and continuing care wards across Scotland and revisits some of the key themes identified in the Commission's 2003 report - 'Greater Expectations'.

The 2008 'revisit' finds progress in relation to some of the issues. One of the most striking findings however is the increase in concern about personal safety on wards. Half of the people interviewed on wards described either experience or fear of aggression, verbal and physical abuse. Fewer than half of these individuals said they had received help from staff to deal with the problem.

Staff who found themselves working in wards where individuals with widely different needs had been admitted, reported difficulties in maintaining their focus on individual recovery and discharge preparation.

A full copy of the report can be found at www.mwcscot.org.uk/newpublications/visit_reports_new.asp

Guidance on preparation of mental health act care plans

Following considerable consultation and discussion the Commission has produced guidance on the preparation of mental health act care plans. Individuals receiving treatment under the 2003 Act may have a number of care plans prepared during the period of his or her care and treatment. While a proposed care plan for an individual is prepared by the MHO, as part of an application to the Mental Health Tribunal, Section 76 care plans are the responsibility of the RMO and must be produced within the first two months of a compulsory treatment order. The Commission looks at S76 care as plans part of its duty to promote best practice under the act concerns over variability in quality. The guidance sets out what the statutory requirements are for a S76 care plan and to help pull these together with other care planning requirements.

Guidance can be found at:
www.mwcscot.org.uk/newpublications/good_practice_guidance.asp

Principles into Practice Network

This year the Principles into Practice Network set up an award scheme to recognise best practice in applying the mental health act principles in Scotland. We wanted to identify, celebrate and share the lessons from those services and projects that we knew were out there – working hard to respond to the challenge of putting the rights, needs and views of service users and carers at their heart. 68 nominations were received and reviewed by a multi-disciplinary judging panel. Four projects/services were selected from a shortlist of 14, with a further award winner being chosen by the delegates at the Principles into Practice Network Conference on 10th March. Category award winners were:

Beyond Barriers, Alzheimer Scotland for their work to involve and support carers

Health in Mind Information and Resource Centre/Edspace for demonstrating best practice in providing information for mental health service users.

Fife Child & Adolescent Mental Health Service Intensive Therapy Team for addressing the specific needs of children and young people who use mental health services.

NSF Lifeskills Project for developing innovative and flexible responses to meeting individual needs of mental health service users

The Orchard Centre run by Health in Mind won the 'people's choice' award for best practice in service user participation and influence.

Full details of all short listed and award winning projects can be found at www.principlesintopractice.net/awards

The **MHO** and **Ailsa Stewart**, Glasgow School of Social Work

The Removal of a Restriction Order – Experience in Practice

The following article details the process of removing the restriction element from a compulsion and restriction order. As usual the details of the individual at the centre of the case have been anonymised to protect their identity, however they have consented to having their story told in the newsletter and have approved the text.

Background

Alexander has a diagnosis of paranoid schizophrenia and presently lives in a long-term hospital ward. He has experienced mental health difficulties for more than a decade. Alexander was married with a child and ran his own business before his illness contributed to the break up of his marriage and the demise of his business. Alexander had a difficult childhood, most of which was spent with a violent, alcoholic parent. There is a view that long-term drug abuse triggered Alexander's paranoid schizophrenia.

Alexander has a history of being non-compliant with his medication, as his mental health improves he stops taking his medication as he feels it is no longer necessary. Due to his non-compliance Alexander has had a number of hospital admissions, some voluntary, some compulsory. A feature of Alexander's illness is that he sees the devil in people and in himself, which has led him to become violent, most often with himself.

The index offence that led to the Compulsion and Restriction Order occurred some 12-years ago when Alexander stabbed a female friend in whom he saw the devil who was torturing him. From the time of the index offence, Alexander has had visions of the devil coming to tell him he is going to hell because of the stabbing and for other reasons, e.g. treating a family pet badly. Alexander is haunted and tortured by what he perceives as his offences.

Since the index offence Alexander has remained in hospital except for the two periods of living in the community. Whilst living in the community, Alexander injured himself severely. One event led him to jump from a top floor flat onto a car in the street; he was seriously injured but recovered. On another occasion he mutilated his own sexual organs. However, since his index offence 12 years ago, Alexander has not attempted to harm anyone other than himself including during his extensive periods of hospitalization.

During both periods of discharge into the community the incidences of self-harm were directly linked to Alexander's non-compliance with his medication. He had begun reducing the doses of his anti-psychotic medication without alerting any of the professionals with whom he had contact. Whilst on the compulsion and restriction order he had regular contact with both his MHO and RMO. Alexander is able to talk insightfully about his illness and about what he would like in the future. He knows what makes him well and what worsens his symptoms although that has not prevented his non-compliance.

After a period in a medium secure unit following his last self-harming episode, Alexander was moved to a long stay ward where he has remained reasonably well for over a year. He has a number of groups and activities that he is involved in and he spends quite a lot of his time out of the hospital; four to five hours per day.

The Compulsion and Restriction Order

The Compulsion and Restriction order deals with both the safety of the patient and the safety of the public at large. The compulsion element deals with the safety of the patient, e.g. compulsory treatment and the restriction element deals with the safety of the public at large by restricting the patient's opportunity for interacting with the public.

Initially Alexander's restriction order limited him to a small number of hours outwith the hospital. The compulsion element of his order pertained to his medical treatment including his medication regime.

Any change to the compulsion and restriction order has to be agreed by Scottish Ministers. The process for changing the number of hours a restricted patient can be out of the hospital setting can take some time. This can cause delays to changes requested which can impact for example on whether or not the patient can attend particular classes or activities.

Recently both Alexander's RMO and MHO felt that the restriction order should be lifted, given that it had been so many years since his index offence and that there had been no other hints of offending behaviour against anyone else in that time. The only two incidents since the index offence have been very serious attempts on his own life which is why it was felt the compulsion order would be sufficient as this would require Alexander to continue to comply with his medication and for the next two years at least remain in the long term ward of the hospital. A clear discharge plan was prepared for any future discharge. The plan includes Alexander being discharged through the Community Rehabilitaiton Service and receiving 24-hour support for the foreseeable future.

In addition, Alexander now feels much more able to cope with his feelings of compulsion to respond to his thoughts about the devil, although he acknowledges these still happen on a weekly to fortnightly basis. He continues to see the devil in people's faces and feel overwhelmed by these images but instead of wanting to do something about it he now knows he does not have to do anything but that if he keeps active, these feelings will pass. The MHO and the RMO felt that by applying to have the restriction order lifted they were also acknowledging a staging post in Alexander's recovery.

The Tribunal

After six months an application was made to lift the restriction order, a Shrieval Tribunal was held. At this tribunal the MHO and the RMO spoke in detail about their reasons for lifting the restriction order. Alexander also contributed throughout the hearing and evidenced significant insight into the two self-harming events.

A detailed Scottish Government commissioned independent report on Alexander disagreed with both the RMO and MHO and felt that on no account should the order be removed. At the heart of the disagreement to remove the restriction order was the link between self-harm and the likelihood of harming others. The independent report noted that Alexander had made progress, but that there was a direct link between self-harm and the potential to harm other people and that on this basis the order should not be removed. The tribunal took detailed evidence and ran over a whole day.

At this point both the MHO and the RMO felt that the decision would go against them and they would be asked to apply again at a future date. The Tribunal members had pressed hard on the independent report writer about the detail of the link between self-harm and harming others, looking for research evidence to back up this perception. At one point the Sheriff asked for an explanation on how this man could still be a danger to other people when at present he spends 4/5 hours per day in the community, attending various groups, and there were no reports of anything of an anti-social nature, either outwith the ward or on the ward, which was recognized as a volatile environment.

The tribunal decision came back 2:1 for lifting the restriction order. The basis of the decision is laid out in some detail, however at the core of the decision was that Alexander did not meet the serious harm test and therefore they ordered that the restriction order be revoked in terms of Section 193(5) of the Mental Health (Care and Treatment) (Scotland) Act 2003.

The key elements which led to the outcome which Alexander wanted were that there had not been a single violent incident against others since the index offence some 12 years ago, the planned discharge through the Community Rehabilitation Team, Alexander's own evidence to the Tribunal and finally the principle of 'least restrictive option'.

At the heart of this case was also the failure of the independent report writer to make a direct link between self harm and the potential to harm others. In addition, the willingness of the tribunal members to consider the evidence within the principles of the Act and to listen in detail to Alexander, also affected the outcome.

At the end of the Tribunal the Government solicitor indicated that they would appeal, they had 21 days to lodge an appeal. However, the Government did not appeal the removal of the restriction order.

Experience of the MHO

For the MHO this was the first experience of a contested Shreival tribunal hearing. He found that the cross examination of his evidence was very detailed and took much longer than anticipated. Tribunal members also used old SCRs extensively in their deliberations. The independent report writer was also cross-examined for a significant amount of time.

The MHO felt that because it was this particular Sheriff's first experience of this type of Tribunal that they did not come with pre-conceived ideas and were willing to be open to weighing up the evidence presented fairly and transparently. In addition the Sheriff was very inclusive and open to all those present including Alexander and his named person.

The main learning points for the MHO have been around separating out the compulsion and restriction elements of the order and identifying what was actually required to maintain the safety of Alexander and the community at large. Being able to separate the restriction element out of the order meant that the RMO and MHO had the opportunity to acknowledge progress made by Alexander without compromising his safety or that of others, aiding his recovery.

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Council, where she was District MHO. Alison qualified as a MHO in 1995. She has extensive experience working with people with a learning disability. Alison joined the Mental Welfare Commission as a social work officer in 2005

Colin Welsh qualified as a social worker in 1980 and worked in England with Hereford and Worcester Council as an ASW and in Scotland as an MHO with Fife Council until 2000 when he moved to Fife NHS - Colin's current post. He has been a Commissioner with the Mental Welfare Commission since 2004.

Dale Meller came into post as the Programme Manager for Mental Health within the National Resource Centre for Ethnic Minority Health in August 2006 and since April 2008 has lead the Mental Health and Race Equality Programme within NHS Health Scotland. Dale has a social work background and was also a practicing Mental Health Officer. Previously she worked in a community mental health team in Clydebank for 8 years. Since June 2008 Dale has also been working as a part-time Commissioner (Equality and Diversity) with the Mental Welfare Commission.

Restricted Patients Branch - Meeting with MHOs working with MDOs

Rosie Toal, who heads up the restricted patient's branch in the Scottish Government, has enjoyed improving relations between her branch and MHOs working with mentally disordered offenders (MDOs) through a series of meetings held over the last eighteen months.

We understand that there are still MHOs and their managers who have not been able to attend.

She is therefore offering an invitation to MHOs working with MDOs and/or their managers to meetings with the branch in St Andrew's House, 2 Regent Road, Edinburgh EH1 3DG .

There are still some places available on 12th October 2009 from 11.00am until 14.00pm.

She will make a comprehensive and wide ranging presentation on the work of her branch and current issues and dilemmas with plenty of time for questions and debate. One of the Scottish Government lawyers will also make a presentation. This will be followed by lunch and an opportunity to meet informally with the members of her branch that your MHOs may be in contact with.

If you are interested in attending, speak with your line manager and ask them to advise Allan on allan.mitchell@scotland.gsi.gov.uk and he will notify you of your place. If the meetings are full further ones will be arranged.

Note: Articles in this MHO newsletter may not necessarily reflect the views of the advisory group or the organisations they represent.

An MHO discusses issues of equality and the law.

Compulsory Measures and D ementia

Introduction

Many MHOs will have experience of working with older people who are admitted to hospital in response to a deterioration in their mental health. Often, a dementia condition is at the root of these difficulties, and cognitive impairment can be a significant feature.

In common with the experience of those with a diagnosed functional disorder, compulsory measures will be warranted in certain circumstances to authorise the hospital admission of an adult with dementia. In a number of cases, it will be deemed appropriate for a longer-term statutory order to be pursued with a view to authorising continued detention. Again, one would imagine that this option would be considered in the context of all cases whereby an individual's circumstances are likely to meet the grounds for specific statutory interventions. In practice though, do we discriminate between certain individuals and service user groups based on their age and the nature of their disorder, when, by all measures commonly applied, the grounds could be equally applicable?

A recent case in which I was involved has served to highlight a concern that perhaps not everyone is treated equally at all times in terms of the application of the law.

The Case

I recently attended a tribunal on behalf of a colleague who had completed a Compulsory Treatment Order (hospital based) application in respect of an older adult who was an in-patient in an older persons psychiatry ward. The adult will hereafter be referred to as Mrs A.

Mrs A suffers from an advanced dementia condition with associated significant cognitive deficits. She had been living at home with her husband, but concerns had been increasing in respect of her mental health presentation and the extent to which Mr A was in a position to continue caring for his wife. Unfortunately, Mrs A's circumstances deteriorated to the extent that, following assessment by a psychiatrist and mental health officer (MHO), she was detained under Section 44 of the 2003 Act and admitted to hospital.

Mrs A received pharmacological and nursing care in hospital, and was deemed to have settled relatively well. Her responsible medical officer (RMO), Dr T, decided to revoke the short-term detention certificate, but failed to consult with the MHO or the Named Person (Mrs A's son) in advance. On learning of this development, the MHO expressed concern as to whether it had been appropriate to revoke the order, given that Mrs A continued to receive medication, and had endeavoured to leave the ward on at least two occasions. Given Mrs A's cognitive impairments, it was acknowledged that she could not provide informed consent in terms of the administration of medication, albeit she did not overtly object. It was also apparent that ward staff had been able to divert and distract her when she had attempted to leave the ward, but that medication had also, on occasion, been used as a sedating measure when she had become anxious and agitated.

The designated MHO was of the view that the measures being employed to maintain Mrs A within the ward in the absence of statutory authorisation might constitute a deprivation of liberty. This was discussed with the RMO and myself, and an agreement was reached to apply for a CTO under Section 57 of the 2003 Act. We were very much of the view that a tribunal should be afforded the opportunity to consider the circumstances of this case.

As noted above, the designated MHO was on leave on the date the tribunal convened to consider the CTO application, and I attended on her behalf. The position of both the RMO and myself was that Mrs A was unable to give informed consent as to the treatment that was being administered, and that she had consistently demonstrated a desire to leave. Nursing staff had employed various methods to distract and persuade Mrs A from leaving the ward. This use of trusted and often imaginative strategies to maintain an individual in hospital will come as no surprise to many of us whose practice brings us into contact with the field of older adult psychiatric care. Is this common practice replicated in adult in-patient settings? That is perhaps a question for another article or research study, but is no less worth bearing in mind for all that.

The tribunal was, not surprisingly, somewhat challenging. I was asked to draw a distinction between Mrs A's case and the many other similar situations whereby a patient with dementia is maintained in a hospital ward on an informal basis. The expectation, it appeared, was that I should highlight a distinguishing factor that might 'tip the balance' in Mrs A's case, and indicate that the test of necessity (Section 57 (3)(e)) was satisfied. I indicated that I did not deem it incumbent on myself for the purposes of presenting the current application to account for practices in place elsewhere. Indeed, I suggested that were I to have access to the detail of other cases of comparable circumstances, I might maintain a similar view to that being expressed in respect of Mrs A. That view being that a CTO was required in order to authorise the care and treatment plan, and ensure that Mrs A was not being unlawfully detained in hospital without the protection afforded by the legislation.

Mrs A's RMO presented a very measured and compelling argument in support of the application. Dr T acknowledged that he based the decision to revoke the short-term detention certificate on insufficient consideration of all the circumstances. He had reconsidered his position and was firmly in support of the requirement to seek authorisation to formally detain Mrs A in hospital. Dr T noted that should Mrs A remain an informal patient and opt to leave the ward (despite the efforts of nursing staff to prevent this occurring by whatever means) the associated risk factors would be of sufficient gravity as to warrant the granting of a further detention certificate. This was deemed to be contrary to the principal of the least restrictive option being preferred in all circumstances, and therefore inconsistent with the ethos of the 2003 Act. Mrs A's family supported this position, noting that any further detention from the community would be an extremely distressing experience for all involved.

The tribunal granted an interim compulsory treatment order, and Mrs A's status was changed to that of a detained patient (a subsequent tribunal granted a hospital based CTO). A curator had been in attendance and had requested a continuation in order to afford an opportunity to further consult all parties. He had been of the view that no compulsory measures were required, however, and therefore opposed the application.

To return to the question put to me by the tribunal, it is worth considering whether Mrs A's circumstances are significantly different to those of other dementia sufferers currently in numerous hospital wards across the country. While no two cases will ever share identical circumstances, the fundamental overarching issues that have been referred to above and that were considered in detail at Mrs A's tribunal are by no means exceptional. A passage from the tribunal's written determination is perhaps telling:

> 'The MHO confirmed that the patient was not able to understand the nature of her illness or reasons for being in hospital and accordingly could not give informed consent to the treatment being given. He advised that the order was necessary to ensure that the patient continues to receive the appropriate medical care and assessment.'

Conclusion

I would suggest that, as MHOs, we must ask ourselves if we are confident that the legislation is applied equally to all, at all times. Article 7 of the Universal Declaration of Human Rights, upon which much of our human rights legislation was based, is quite explicit:

> 'All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitment to such discrimination.'

Mrs A's case has potentially significant ramifications. These are already being experienced locally as borne out in my discussions with consultant psychiatrists working in the field of older persons psychiatry. Dr T, in particular, demonstrated a willingness and genuine commitment to re-evaluate his practice. Mental health officers have a significant role in influencing the extent to which practices are scrutinised and adapted to ensure that all are treated equally and are afforded protection by the law.

Gillian Adams

EARS Advocacy Service

EARS Advocacy Service covers Edinburgh, West Lothian, Midlothian and East Lothian and employs five full time advocates and a Service Manager. We provide independent professional advocacy. This is by issue-based advocacy partnerships to individuals over 65 years old. Service provision in Midlothian and East Lothian is to older people in care homes; those detained under the Mental Health Act; those in delayed discharge and older people in the community in receipt of health and or social care services. Advocacy services in Edinburgh and West Lothian are offered to older people in care homes and sheltered housing, those in delayed discharge and older people detained under the Mental Health Act.

Involvement with MHOs

All EARS advocates work closely with MHO teams in their respective areas. We receive referrals from MHOs for advocacy partners detained under the Mental Health Act. Advocates attend Mental Health tribunals supporting the service user's point of view and wishes. In doing so, as part of our service where an advocacy partner would like legal representation we have a list of solicitors from the Law Society. The advocacy partner then contacts their chosen solicitor or the advocate does so on their behalf. Often we hear of tribunals directly from MHOs. As advocates we also have a safeguarding role and are mindful of our partner's human rights. We may continue to work closely with MHOs where an advocacy partner is requiring support under Adult Support & Protection, and or Guardianship.

Main constraints

In spite of continual promotion of our service, our name can be confusing so that occasionally we have been asked to help with hearing aids, (although not by MHOs). Advocacy is not counselling nor do advocates have a duty of care. Advocates are not neutral; we are purely the mouthpiece of our partner. We do not have a view or opinion of our own or our organisation to express. Non-instructive advocacy comes in where there is proven incapacity although in practice we find that it is rarely that there is NO capacity to make decisions. The partner may not have the capacity to deal with finances but can be clear and consistent in their opinion about where or how they live or whether they wish to remain in hospital.

Possible service improvements

Communication with EARS will be greatly improved in the near future when our new telephone system will be up and running. This will include email and a website. Meanwhile each advocate has a mobile and visits wards where patients are likely to be detained. Regular promotion of our service is carried out in each area and where MHO teams would like an update we may be contacted to arrange a mutually convenient time and date. The service in each council area relies on funding from the NHS and local authority, and funding is generally time limited. Under the Mental Health Act advocacy is a right. The Adults with Incapacity Act does not state advocacy as a right but that it should be offered.

Value of role

Advocacy is a difficult concept to understand until it is explained. Then service users agree that it is a great idea to have someone purely on their side independent of care homes, the Local Authority and the NHS. There is occasionally suspicion of our role where people do not understand why an advocate is involved. Further information helps.

Discussion

We at EARS Advocacy Service occasionally have to pick up cases which would otherwise fall through the net. Although we usually work with people over 65, where someone under 65 has dementia and is detained in hospital, we will advocate for them when there is no other advocacy service. There are areas where there are competing advocacy services so EARS agrees protocols for referrals with these organisations.

Contributor

Gillian Adams East Lothian Advocate on behalf of the EARS Advocacy Service team.

Information and websites of interest

Trainee Mental Health Officers Attending Tribunal Hearings

Kate Pryde, Chair of the Mental Health Award Advisory Group of the Scottish Social Services Council, recently wrote to the Tribunal in respect of the attendance at and participation in proceedings before Tribunals. Ms Pryde explained the importance to the training and development of trainee mental health officers (MHOs) of observing Tribunal proceedings and, where appropriate, participating in those proceedings. For example, where a trainee MHO has undertaken the preparatory work for an application to the Tribunal under the supervision of a qualified MHO and then attends the Tribunal hearing along with that qualified MHO, it is of benefit for the trainee MHO to participate in the proceedings before the Tribunal as appropriate.

The Tribunal explained to Ms Pryde that decisions as to who may observe Tribunal proceedings are a matter for each individual Tribunal, taking into account the views of parties to the proceedings. However, where there is no objection from the parties there would appear to be no reason to prevent the trainee MHO observing proceedings. The President has expressed his personal desire that, where appropriate, Tribunals allow their proceedings to be observed by professionals who will come to play a regular role before Tribunals in due course.

With regard to the matter of who gives evidence in respect of an application made by an MHO, the Tribunal explained that those are matters for the applicant MHO. Where the applicant MHO has had preparatory work for an application carried out under his or her supervision by a trainee MHO then it appears to the Tribunal to be entirely appropriate that the MHO and the trainee MHO attend the Tribunal together with the trainee MHO giving such evidence as is appropriate.

Update on the Development of the Mental Health Officer Award (MHOA)

Progress is continuing on the development of the MHOA programmes across Scotland.

In the North, where RGU is the validating University, the programme was approved by the SSSC in October 2008 and is now running with its first cohort of students. Initial feedback from the programme staff has been positive albeit with a range of issues and learning arising from the first delivery of the programme.

In the West, where validation has been achieved through the Glasgow School of Social Work at University of Strathclyde in collaboration with Glasgow Caledonian University, the employer/university partnership received approval from the SSSC with a short action plan on 25th March 2009.

The East have formed a new partnership from the previous South East and Tayforth MHSWA programmes and have been working with the University of Edinburgh to develop the new programme which was approved by the SSSC in April 2009.

Both the West and East programmes will deliver their first programmes from Autumn /Winter 2009.

The development of these programmes has been funded by the Scottish Government, which has also provided money for the creation of new materials to support learning on the programmes. This work is being done on a cross- programme basis. A range of topics have been identified and this work will be advertised, through a variety of networks, for the attention of writers who have the knowledge and experience to deliver to the needs of the programmes. For further information about that aspect contact Karen.mclaughlin@sssc.uk.com.

New film helps children and young people understand mental illness

The Royal College of Psychiatrists has funded a short film to help children and young people better understand mental illness.

One in 12 children in the UK has a parent with a mental illness. However, it can be difficult to explain mental health problems in a way that is both easily understood by a young person, and acceptable as an explanation to their parents and relevant health professionals.

The new 16-minute film, called *When a parent has a mental illness*, can be watched for free on the Royal College of Psychiatrists' website. Dr Alan Cooklin, a consultant in family psychiatry, produced it with funds from the College's recent Images of Psychiatry campaign.

In the film, young people talk openly about their lives caring for a parent with mental illness. They talk about what they want from mental health professionals, as well as their concerns and worries.

Narrated by Chineye, a young carer herself, the film also explains in a very simple and visual way how the brain works and what happens when things go wrong.

Dr Cooklin said: "Children need a real explanation of mental illness. Children, even young children, can often think more complexly than adults if they are given a chance. This film gives young people the opportunity to begin discussions about mental illness in a more informed way, in partnership with professionals, family members and others."

For further information, please contact Liz Fox or Deborah Hart in the Communications Department.

Telephone: 020 7235 2351 Extensions. 298 or 127

E-mail: efox@rcpsych.ac.uk or dhart@rcpsych.ac.uk

Alternatively the video can be viewed on the website of the Royal College of Psychiatry on the link below.

www.rcpsych.ac.uk/mentalhealthinfo/youngpeople/caringforaparent.aspx

Forensic Network – Forensic Mental Health Services Managed Care Network.

The Forensic Network was established in September 2003 when Scottish Ministers invited Andreana Adamson to lead its development. The Network is multi-agency, with strong links with Scottish Prison Service, Social Work Services, Police and Criminal Justice agencies, The Scottish Executive and Carers amongst others. Below are some recent news items posted by the Network. Details of the work of the network including relevant news can be found on their website.

www.forensicnetwork.scot.nhs.uk/contact.html

If you wish to contact them directly please call them on 01555-842018 or by post at:

Forensic Network Team
The State Hospital
Carstairs
Lanark
ML11 8RP

General Enquiries should be directed to Sharon Bruce, Forensic Network Secretary at Sharon.bruce@tsh.gov.uk

Recent News from the Network

New Guidance - CEL 9 (2009)

The Scottish Government has produced new guidance for Patients Remanded to Hospital from Courts. Its primary purpose is to assist RMOs by clarifying the agreed procedure when seeking the required statutory consent from Scottish Ministers for any suspension of detention for remand patients (patients subject to an AO, a TO or an ICO); and to remind, following a few recent incidents, that there is no statutory authority to transfer ICO patients to another hospital.

IAFMHS Pre- Conference Workshops 23 June 2009, Edinburgh

The School of Forensic Mental Health is part of the Forensic Network who are local hosts for the 9th International Association of Forensic Mental Health Services Conference. As part of its ongoing programme of Educational events for professionals working within the field of Forensic Mental Health, the School is offering a number of half day and full day workshops on the day before the main conference. Half-day workshops cost £80 per delegate and the full day workshops cost £160.

Carers Network

Carers have decided on Saturday 31st October 2009 for their conference in Glasgow, most likely Glasgow Caledonian University. The Forensic Network continues to support them in developing an interesting programme including input from a drama group.

An Assessment of the Operation of the Named Person Role and its Interaction with other Forms of Patient Representation.

'The University of Stirling was commissioned by the Scottish Government to carry out research into the Named Person role and to consider its interaction with other forms of patient representation under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHSA) as part of its research programme into the operation of the Act. The study explored the Named Person role from the perspective of a range of stakeholders and made recommendations for the development of patient representation. The research was conducted from August 2007 to July 2008 and used quantitative and qualitative methods. The key findings are outlined below

Main Findings:

- The majority of Named Persons were default, comprising mainly carers and/or nearest relatives. Default Named Persons were seen as less active within the role. Named Persons were involved at the point of orders being made but were less so on an ongoing basis.
- The reasons for the high level of default Named Persons included a general lack of knowledge, information overload at a point when patients are least able to cope with it and reluctance to return to the idea of appointment once they were recovering.
- The Named Person role was in general viewed positively but there is a need to review how they are appointed and at which point, in order to increase the number of appointed Named Persons who are willing and able to actively undertake the role.
- Solicitors were observed to have varying styles. The better ones had an appropriate style for a Tribunal hearing and had an understanding of this area of law. There was patchy availability of solicitors across Scotland.
- The involvement of independent advocacy workers was viewed positively. Some independent advocacy services had to prioritise the Tribunal work and put other work on hold.
- Whilst there was potential for overlap in the three forms of patient representation, the respondents were clear about the differences.
- Representatives' participation in Tribunal hearings was seen to vary due to the style of the convenor.'

(Scottish Government 2009) An Assessment of the Operation of the Named Person Role and its Interaction with other Forms of Patient Representation

A full copy of the final report of the above research can be found on the Scottish Government website at: www.scotland.gov.uk/Resource/Doc/263258/0078745.pdf

Experiences of the Early Implementation of the Mental Health (Care and Treatment) (Scotland) Act, 2003: A Cohort Study

This evaluative research study was commissioned to explore the implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003 (MHCT Act). A team of independent researchers including mental health service users undertook the study, which lasted 2 years from September 2006. Using qualitative methods, the experiences and viewpoints of those subjected to compulsory care and treatment, of informal carers and families, and of a range of health and social care professionals and advocacy workers were explored in-depth. The findings should be read within the context of the research study undertaken, and care taken in generalising to different populations and areas.

Main Findings

- This study found evidence of positive shifts in practice, in service cultures, and in the approach to detention, as well as of scope for increased consistency and improvements.
- Mental Health Tribunals were viewed by all stakeholders as an improvement, which provided increased opportunity for participation, although personal experience did vary.
- Few service users had either made an Advance Statement or were considering making one, and many saw little point in doing so as they believed this would inevitably be overridden.
- The named person role was complex and often poorly understood by service users and many professionals. Although bringing about improvement for some carers, this was not universal.
- Challenges to implementing the Act's principles, particularly the 'least restrictive alternative' and 'reciprocity', were often linked to gaps in the range of community resources.
- There were indications that resourcing of new roles, responsibilities and processes arising from the MHCT Act was having a detrimental impact on the delivery of other mental health services and the de-prioritisation of those not under compulsory measures'
- Despite some efforts to address the difficulties, there was still confusion and uncertainty among many professionals about overlapping legislation regarding the notion of capacity.
- Although universally unwelcome at the time, just over half of the service user sample reflected up to one year later that compulsory care had been right for them at the time, even those detained in hospital.
- At the time of the research, new community-based compulsory orders appeared limited in use and scope, in some cases equating to medication orders.
- Although some service users had positive experiences, there were gaps in support for wellbeing and social development generally including little encouragement to take up employment.

Scottish Government (2009)

Research Findings:
http://www.scotland.gov.uk/Publications/2009/05/06155813/0

Update

Update from Office of the Public Guardian

Period from 1st April 2008 to 31st March 2009

The number of applications registered for each procedure is detailed for the periods 2007/08 and 2008/09.

Powers of Attorney

1 April – 31 March	Welfare	Continuing	Both	Total
2007/8	2,290	5,617	24,159	32,066
2008/9	1,351	3,059	26,327	30,737

The number of powers of attorney registered in 2008/09 is marginally less than the number registered in 2007/08.

Access to Funds

1 April – 31 March	Total
2007/8	197
2008/9	378

Although Part 3 of the AWI Act – Access to Funds was significantly amended in April 2008, the uptake of the new procedures has been lower than expected.

Investigations

1 April – 31 March	Total
2007/8	167
2008/9	151

The number of investigation referrals received was lower in 2008/9 compared to those received in 2007/08.

Intervention Orders

1 April – 31 March	Welfare	Finance	Both	Total
2007/8	11	255	5	271
2008/9	3	221	3	227

The number of intervention orders registered in 2008/09 was less compared to those registered in 2007/08. It could be deduced that section 13ZA of the Social Work (Scotland) Act has been used instead as it may have been a more appropriate method of intervention in certain circumstances.

Guardianship Orders

1 April – 31 March	Welfare	Finance	Both	Total
2007/8	615	223	510	1,348
2008/9	666	207	564	1,437

The number of guardianship orders registered in 2008/09 have increased compared to those registered in 2007/08.

Outreach service

The OPG has been raising awareness on the role of the Public Guardian and the Adults with Incapacity (Scotland) Act 2000 to groups throughout Scotland. Groups attending AWI sessions have included carers, social workers, MHOs, GPs, care home staff, members of voluntary agencies etc.

These sessions are offered free of charge and can be tailored to meet the information needs of the group.

If your team or department require a session on the AWI Act, please contact Amanda Kerr, Information & Outreach Manager akerr@scotcourts.gov.uk or telephone 01324 678334.

Adult Support and Protection Committees

The Public Guardian is unable to provide a representative to attend all ASP Committee meetings in each of the 32 local authority areas. However if attendance is required to discuss a particular issue, please contact Amanda Kerr, Information & Outreach Manager akerr@scotcourts.gov.uk or telephone 01324 678334 to make arrangements.

It would be helpful if copies of the minutes of the committee meetings were sent to opg@scotcourts.gov.uk

OPG publications and literature

A variety of publications on the financial procedures of AWI Act is available from the OPG. These can be viewed on our website www.publicguardian-scotland.gov.uk

Hard copies of the majority of the OPG publications are available on request by e-mailing opg@scotcourts.gov.uk or telephoning Lesley Feeney on 01324 77744.