2017 No. 176

MENTAL HEALTH

The Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2017

Made - - - - - 30th May 2017

Laid before the Scottish Parliament 1st June 2017

Coming into force - - 30th June 2017

The Scottish Ministers make the following Regulations in exercise of the powers conferred by sections 245(2), 246(1) and 325 of the Mental Health (Care and Treatment) (Scotland) Act 2003(a) and all other powers enabling them to do so.

Citation, commencement and interpretation

- **1.**—(1) These Regulations may be cited as the Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2017 and come into force on 30th June 2017.
 - (2) In these Regulations—
 - (a) "Form" means a Form set out in schedule 2; and
 - (b) any reference to a Form having a letter and a number is a reference to the Form having that letter and number in schedule 2.

Form of certificate

- **2.** Any certificate given under a section of the Mental Health (Care and Treatment) (Scotland) Ac 2003 which is specified in an entry in column 1 of schedule 1 is to—
 - (a) contain the particulars set out in the Form which is specified in the corresponding entry in column 2 of that schedule; and
 - (b) be in the Form which is specified in column 2 of that schedule and set out in schedule 2.

Revocations

3. The Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2005(a) and the Mental Health (Certificates for Medical Treatment) (Scotland) Amendment Regulations 2008(**b**) are revoked.

> MAUREEN WATT Authorised to sign by the Scottish Ministers

St Andrew's House, Edinburgh 30th May 2017

⁽a) S.S.I. 2005/443. (b) S.S.I. 2008/316.

SCHEDULE 1

Regulation 2

Column 1	Column 2
Section 235	Form T1
Section 236	Form T1
Section 238, where the treatment is that mentioned in section 237(3)	Form T2A
Section 238, where the treatment is that mentioned in section 240(3)	Form T2B
Section 239	Form T3A
Section 241	Form T3B

SCHEDULE 2

Regulation 2(b)

Form T1

Instructions																									١
The following form is t	to be us	ed:																							
where a certificate of cc (a) any surgical op (i) brain ti (ii) the fur (b) the treatment kr	eration ssue or actioning	for o	desti orair	royir n tiss	ig- iue;	and		g ty _l	oes	of m	edic	altr	eatr	nent	•										
This for	m is pres																				Act :	2003			
Where not completing th	his form	elec	tron	icall	y, to	ens	sure	acci	urac	y of	info	rmat	ion,	plea	se d	obse	erve	the.	follo	wing	co	nver	ntion	s:	
Write clearly within the boxe BLOCK CAPITALS and in BLACK or BLUE ink		ſ	_	exa	mpl		R	K	Е	Т		3 T	7			S	hade	e circ	cles Not	like Iike	this this	-> ->	×		1
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CHI Number																									_
Surname																									
First Name(s)																									٦
Other / Known As																									٦
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Γitle													(Ger	der		O N	1ale	!						
DoB ld/mm/yyyy]/]/							L				O F	em	ale						
Patient's home address																									_
	_																								4
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Postcode																									
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- Hospital																								П	
Ward / Clinic																_								\dashv	\dashv
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Patient's Nar	ne												CH	IIΝι	ıml	ber										
Patient's RMO (see not	e 1 k	elc	w)																							
Surname					Т									T												
First Name					1																					
Title											•		GI	MC I	Vui	mbe	r									
Hospital																										
Ward / Clinic (If appropriate)																										
l, the above named RMO	am a	арр	rov	ed u	nde	rse	ectio	n 2	2 of	the	Act	by:														
Health Board NHS																										ı
Where the patient is under the The above named RMC	_			speci	ialis	t	0	The	e ab	ove	nar	nec	l RM	10 is	s N	OT a	a cl	hild	spe	cia	list					
T1 / PART 1																			То	be	cor	nple	eted	by	the	DM
DMP Details (see note	2 b	elov	v)																							
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Surname																										
First Name																										
GMC Number															•					•						
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Postcode																										
Where the patient is under th	∟ e age	of:	18 -					J																		
O I am a child specialist				IOT a	a ch	ild	spec	iali	st																	
Certification																										
Complete the appropriate	opt	ion																								
A - complete where - F	atie	nt i	s C	apa	ble	of	Con	ser	nt to	Tr	eatn	ner	t													
I, the above named DMF																										
○ (a) the above named p												tme	ent													
(b) the patient has cons									_																	
(c) having regard to the in the patient's best interest interest.																n in,	the	e pa	itier	nt's	con	ditio	on, it	IS		
Details of the patient	's c	ons	ent	in v	vriti	ing	to t	he	trea	ıtm	ent															
O A copy of the patient's	cons	sent	in	writir	ng is	s at	tach	ed.																		
The patient signed this co	nse	nt o	n (c	late)]/]/															
B - complete where - P	atie	nt i:	s In	сар	able	e oi	f Co	nse	ent t	o 7	reat	tme	nt													
I, the above named DMP	con	firm	th:	at:																						
○ (a) the above named pa	atier	nt is	inc	apab	le c	of co	onse	ntir	ng to	the	e tre	atm	ent													
	Ш																									

- \bigcirc (b) the patient is not objecting to the treatment; and
- O (c) having regard to the likelihood of its alleviating, or preventing a deterioration in, the patient's condition, it is in the patient's best interests that the treatment should be given to the patient

Notes

- 1. Where the patient does not have an RMO, all references in this form to the patient's RMO will be taken to be the medical practitioner primarily concerned with treating the patient.
- 2. Where the patient is a child (under the age of 18) and the patient's RMO is NOT a child specialist, then the DMP must be a child specialist (where a child specialist is a medical practitioner who has such qualifications or experience in relation to children as the Mental Welfare Commission may determine from time to time)

Patient's Name		CHI Number		
T1 / PART 2			To be completed b	y the DMP
Treatment Details				
The treatment under section	234(2) is to consist of (shade as appro	priate) :		
(a) any surgical operation (i) brain tissue; or (ii) the functioning	r			
O (b) the treatment known a	as deep brain stimulation.			
Description of the treatment.				
Signature / Date				
Signed by the DMP				
Date	/ / /			

Form T2A

Instructions																								
The following form is to	o be us	ed:																						
where the patient's RMC				s that	the	pat	ient i	s ca	apab	ole of	cons	sen	ting	to t	reat	men	t an	d is	not	refus	sing	con	sent	for
treatment under section (a) electro-convulsion (b) vagus nerve stin (c) transcranial mag	∕e thera nulation	py (EC [*] (VNS);	Γ); and				wher	e th	e pa	'NS ai tient ent ai	is ca	pah	ole o	f co	nser									
This form is prescribed	d by regu			unde purpo													ct 20	003.	The	use	of a	ny ol	her 1	orm
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the box. Extension shee labelled with the appropried Patient Details															-,						-1			
CHI Number																								
Surname																								
Surname First Name(s)																								
Surname First Name(s) Other / Known As	'Oth	er / Know	n As' o	couldir	nclud	e any	name	· / ali:	as tha	at the p	patient	t wou	uld pr	efer	to be	know	n as.							
CHI Number Surname First Name(s) Other / Known As Title	Oth	er / Know	n As' o	couldir	nclud	e any	name	· / ali:	as tha	at the p	patient		uld pr Gen			know								
Surname First Name(s) Other / Known As Title DoB	Oth	er / Know	n As' o	couldir	nclud /	e any	name	/ali	as tha	at the p	patient				(ale	ale						
Surname First Name(s) Other / Known As Title DOB Marinm / yyyy Patient's home	Oth	er / Know	n As' (couldir	nclud	e any	rname	/ali	as tha	at the p	patient				(⊃ N	ale	hle						
Gurname First Name(s) Other / Known As Fitle DOB M/mm/yyyy Patient's home	'Oth	er / Know	la As' o	could ir	nclud	e any	r name	/ali	as tha	at the p	patient				(⊃ N	ale	hile						
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Ward / Clinic

Patient's Nai	me												С	HIN	uml	oer										
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RMO Details (where cer	rtific	cate	gra	ante	ed b	y tł	ne p	atie	ent's	s RI	VO)															
Surname																										
First Name																										1
Title													C	МС	Nu	mbe	er]
Hospital																										
Ward / Clinic (If appropriate)																										
Telephone No.																										
e-mail address								_					_			_	_	_			_			1		_
Approved under section 2	22 of	f the	e Ac	t by	_ <u> </u> :																				Ш	
Health Board NHS																										7
Where the patient is under the	age	of 1	8 -														-									_
O I am a child specialist;	or	0	l ar	n N	ОТ	a cł	nild s	spe	ciali	st	(see	no	tes)												
DMP Details (where cer	tific	ate	gra	nte	d b	y D	MP)																			
Surname																				T	7					
First Name																										
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Postcode									L GM:	СN	um!	L Der									1					
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Certification																										
Patient's consent to tre	atn	nen	t																							
I, the above named RMO	or [OMF	o co	nfir	n th	at:																				
(a) the patient is capable	of co	nse	ntin	g to	the	rea	tmer	nt;																		
○ (b) the patient has cons	ente	ed ii	n wr	iting	g to	the	trea	tme	ent (see	not	es)														
(c) the giving of medica (Scotland) Act 2003, or															ie M	ent	al H	ealt	h (C	Care	e an	ıd Tı	eat	me	nt)	
(d) having regard to the patient's best interests															atior	in,	the	pat	ient	's c	ond	ition	ı, it i	s ir	the	
Details of the patient's	cor	sei	nt ir	w	itin	g to	the	e tre	eatn	1en	t															
A copy of the patient's	con	ser	nt in	writ	ing	s at	tacl	ned								T2/	is:	sign	ed a	s th	e si	con gned lis c	cor	ıseı	it me	
The patient signed this con	sent	on	(dat	∋)]/]/						The	Coi	nmi	ssio	n ad	lvise	s tha	at the	e T2	Α	fter
Notes																						nsen			,	
Where the patient is under the If consent to treatment has bee	n wit																ild sp	ecia	list.							



	atient's Name	CHI Number	
		To be completed by	the DMP or RM
Details Of Tre			
he treatment	covered by this certificate is:		
	O ECT under section 237(3)(a)		
	O VNS or TMS (being treatments s	pecified in regulations under section 237(3)(b))	
Description of the stated.	the treatment(s) including frequency. The r	naximum duration of the course of treatment aut	horised must
1			
Certification	by RMO or DMP		
Certified by	O the RMO O the DMP		
Signature			
Date			

Form T2B

v7.0

The Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) Certificate Of Consent To Treatment	T2B (S240)
Instructions	
The following form is to be used:	
where the patient's RMO, or a DMP, certifies that the patient is capable of consenting to t treatment under section 240(3) of the Act: (a) any medicine (other than the surgical implantation of hormones) given for the purp (b) any other medicine given beyond a period of 2 months since the start of compulsor.	pose of reducing sex drive; and
This form is prescribed by regulations made under the Mental Health (Care and Treatment) (S	

This form is prescribed	by regu	lation		ade the														Act 20	003.	The	use	of a	ny ot	her f	orm
Where not completing this	form e	lectr	onio	ally,	toe	ensu	re a	ccui	acy	of in	form	atio	n, pi	leas	e ob	serv	e th	e foli	lowi	ng c	onve	entic	ns:		
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Patient Details																									
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Title														Ger	ıder		⊃ N	lale							
DoB dd/mm/yyyy] /] /							L) F	ema	ale						
Patient's home address																									
address																									
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Ward / Clinic

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																То	be d	con	nple	ted	by	the	e Di	/IP	or F	MC
RMO Details (where ce	ertific	ate	gra	ante	ed b	y tl	ne p	atie	ent's	s RI	/IO)															
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First Name	Ш							<u> </u>			L								_	_	L					
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Hospital																										
Ward / Clinic (If appropriate)																										
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Approved under section :	22 of	the	e Ac	t by	:																					
Health Board NHS																										
I am a child specialist;	or	0	l ar	n No					cialis	st	(\$	see	not	es)												
DMP Details (where ce	rtific	ate	gra	ante	d b	yυ.	ויויו																			
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DMP Details (where ce Surname First Name	rtific	ate	gra	ante	d b	<i>ע</i> ט. 											I									
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Surname First Name Address Postcode Where the patient is under th	he age	e of :	118 -								umb		m N	JOT	ac	hild	spe		list]]] (se	e no	tes)			
Surname	he age	e of :	118 -										m N	I I I I I I I I I I I I I I I I I I I	ac	hild	spe	ecia	list		(se	e no	tes)			

Patient's Name		CHI Number		
		To	be completed by th	e DMP or RM0
Certification				
Patient's consent to treatment				
I, the above named RMO or DMP confirm that:				
(a) the patient is capable of consenting to the treatment;				
\bigcirc (b) the patient has consented in writing to the treatme	ent (see notes)	i;		
○ (c) the giving of medical treatment to the patient is au (Scotland) Act 2003, or the Criminal Procedure (Scotland)			al Health (Care and T	reatment)
 (d) having regard to the likelihood of its alleviating, or patient's best interests that the treatment should be g 			the patient's conditio	n, it is in the
Details of the patient's consent in writing to the tre	eatment			
A copy of the patient's consent in writing is attached		T	B the patient cannot o 2B is signed as the sign xist at the time the T2B i	ned consent mus
The patient signed this consent on (date)	/	sl	he Commission advises hould not be issued mor he patient signs the cons	e than 7 days afte
Details Of Treatment				
The treatment covered by this certificate is:				
 Medication to reduce sex drive - hormones) given for the purpose of 	f reducing sex	drive		
Other medication beyond 2 mon the start of compulsory treatment (
If the treatment specified is other medication beyond 2 months, record the date any medication for mental disorder was first given in this period of detention. Note that this is required only for the first T2B or T3B form for medication issued, not for subsequent forms.		1	prior EDC, STD0 or orders under Procedure (Sco	

Patient's Name	CHI Number		
		To be completed by the	DMP or RMO
Details Of Treatment (cont)			
Description of the treatment(s) including frequency and d	uration of treatment		
Treatment can be authorised by this certificate until (date			
Note: - the potential period of treatment authorised should be than three years in line with Mental Welfare Commission			
Certification by RMO or DMP			
Certified by the RMO the DMP			
Signature			
Date / / /			
A copy of this form must be sent to the Mental Welfare Co	ommission within seven day	s of issuing the certificate	

Form T3A

Instructions																										٧
The following form is t	o be us	sed:																								
where a designated med consenting to treatment (a) electro-convulsiv (b) vagus nerve stim (c) transcranial magr	under s e therap ulation	ection by (E (VNS	on 23 CT) S); a	37(3 ; .nd) of			rovid	Not whe	e: E0	CT, V	/NS a	and tis (TMS	can ble c	not l	be gi	ven		pati	enti	is ind	сара	able o	of	
This form is prescriber	d by regi														nt) (S	cotl	and)	Act	2003	. The	e use	e of a	ıny o	ther t	form	
Where not completing thi	is form e	elect	roni	cally	, to	ensi	ıre a	еси	racy	of ii	nforr	natio	on, p	leas	e ol	ser	ve th	ne fo	ollow	ing o	conv	/enti	ons:			
Write clearly within the boxe. BLOCK CAPITALS and in BLACK or BLUE ink	s in		For	exa	imp	le						Ι				S	hade	e cir	cles Not	like Hike	this this	->	•	\	√	•
Where a text box has a rethe box. Extension shee labelled with the appropr	et(s) sho	ould	be c	lear	ly la	belle	ed w																			
Patient Details										_	,															
CHI Number														_												
Surname																										
First Name(s)																										
Other / Known As																										
Γitle	'Oth	er / Kr	nown	As' c	ould i	neluc	le any	/ nam	e/al	ias th	at the	patie	Г							-1						
DoB kd/mm/yyyy			/]			Ger	ider		0 N									
Patient's home																										
address																										
Postcode									l			l					I				L	_				
The patient is detained	in, or	und	er th	ne n	nana	age	mei	nt / d	care	of:																
- Hospital																										
Ward / Clinic Fappropriate																										
Patient's RMO												Ι														
Where the patient is under				Th	e R	MO	is N	TOI	ac	hild	spe	ecia	list		(se	ee r	ote	 1 - 8	oage	e 2)						

Patient's Nar	me	CHI Number	
		To be co	mpleted by the DMP
DMP Details			
Surname			
First Name			
Address			
Postcode	GMC Nui	nber	
1			
Where the patient is under the ○ I, the above DMP am a	=	MP am NOT a child specialist (se	e notes below)
, the above Divir aim a	orling specialist, or the above b	wir arrivor a crina specialist (se	s rioles below)
CERTIFICATION			
The treatment covered b	by this certificate is:		
ECT under section	-		
	eing treatments specified in regulations	under section 237(3)(b))	
(3			
	, not being the patient's RMO certify the		
	able of understanding the nature, purposel treatment to the national is authorised	,	
Act 1995; and	al treatment to the patient is authorised	by virtue of the Act, of the Chiminal P	rocedure (Scotiand)
0	4. f t		
Complete A or B as appropria	te for treatments under section 237(3)		
	resisting or objecting to treatment, an rioration in, the patient's condition, it is		
be given.	·, · p, ·		
OR			
B o the patient resists	or objects to treatment, and it is neces	sary to give treatment to the patient f	or the purpose of:
(a) saving the p	atient's life;		
O (b) preventing s	erious deterioration in the patient's cor	dition;	
(c) alleviating se	erious suffering on the part of the patie	nt.	
Notes			

where the patient's RMO is a child specialist, by a designated medical practitioner approved by the Mental Welfare Commission where the patient's RMO is not a child specialist, by a designated medical practitioner approved by the Commission who is a child specialist

Where the patient is not in hospital the above certificate does not authorise the giving of treatment by force to the patient



Patient's Nar	ne	CHI Number		
Details of Treatment				
Description of the treatm must be stated	ent(s) including frequency. The maximur	m duration of the course	of treatment authorise	ď
1				
Signature				
Signed by the DMP				
⊃ate dd/mm/yyyy				
A copy of this form must	be sent to the Mental Welfare Commiss	sion within seven days o	f issuing the certificate	•
	I			ľ
=	il.			

Form T3B

Instructions																									v
The following form is to be	us	ed:																							
where a designated medical p consent or incapable of conse (a) any medicine (other (b) any other medicine ((c) provision, without co	enti tha give	ng u in th en be	ınde e sı eyor	r se irgic nd a	ction al in peri	n 24 npla iod c	0(3) ntati of 2	of the ion common	he A of ho ths s	ct in rmo since	rela nes) e the	ation) giv e sta	to t en fo rt of	he foor for the cor	ollow e pu npuls	ing t rpos sory	trea e of trea	tmer red tme	nt(s) ucin	: g se			refus	sing	
This form is prescribed by	reg	ulati													nt) (S				2003	3. Th	ne us	se of	any (other	form
Where not completing this form	ne	lecti	onio	cally	, to e	ensu	ıre a	сси	racy	of ir	nform	natic	on, p	leas	e ob	serv	e th	e foi	lowi	ng c	onv	entic	ons:		
Write clearly within the boxes in		F	or	exa	mpl	le										Sł	ade	circ	les	like	this	->			,
BLOCK CAPITALS and in BLACK or BLUE ink		Γ		T	Ť			П					7						Not	like	this	->	×		9
Patient Details																									
CHI Number						Г					1														
Surname																									
First Name(s)	_																								
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○ The RMO is a child specialist ○ The RMO is NOT a child specialist

(see notes - page 2)

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where the patient's RMO is a child specialist, by a designated medical practitioner approved by the Mental Welfare Commission where the patient's RMO is not a child specialist, by a designated medical practitioner approved by the Commission who is a child specialist Where the patient is not in hospital the above certificate does not authorise the giving of treatment by force to the patient



Patient's Name			CHI Number		
				To be completed b	y the DMP
Details of Treatment				·	
If the treatment specified is beyond 2 months, record the medication for mental disor in this period of detention. Ne required only for the first T2 medication issued, not for second to the first T2 medication issued, not for second to the first T2 medication issued, not for second to the first T2 medication issued, not for second to the first T2 medication issued, not for second to the first T2 medication issued, not for second to the first T2 medication issued.	ne date any der was first given Note that this is B or T3B form for	/	/	Note: The period here in prior EDC, STDC, ICTO, or orders under the Crimir Procedure (Scotland) Act relate only to a single periodetention	CTO, TTD nal 1995 which
Description of the treatment(s) including frequenc	y and duration of tre	atment		
Treatment can be authori	•	e until (date) tificial means, duration of	treatment should als	to be recorded in	
the description of for certificates a	of treatment above, uthorising medication, th	e potential period of treat are Commission for Scotl	tment authorised sho	ould be no longer	
Signature					
Signed by the DMP					
Date dd/mm/yyyy	/ / / [
A copy of this form must be	sent to the Mental W	elfare Commission v	within seven days	s of issuing the certificate	

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations revoke and replace the Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2005 and the Mental Health (Certificates for Medical Treatment) (Scotland) Amendment Regulations 2008.

These Regulations prescribe the forms to be used, and the particulars of those forms, in giving certificates required under sections 235, 236, 238, 239 and 241 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

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£6.00

S201705318 06/2017 19585

1SBN 978-0-11-103593-1

http://www.legislation.gov.uk/id/ssi/2017/176