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

Section 244 Treatment Certificate

Safeguarding informal patients less than 16 years of age

T5

Instructions v7.1

The following form is to be used:

Where the following medical treatments are to be given to a patient who is under the age of 16:

(a) electro-convulsive therapy;
(b) transcranial magnetic stimulation; and
(c) vagus nerve stimulation,

when given as treatment for mental disorder or in consequence of the patient having a mental disorder

There is no statutory requirement that you use this form but you are strongly recommended to do so. This form draws attention to some procedural requirements under the Mental Health (Care and Treatment) (Scotland) Act 2003. Failure to observe procedural requirements may invalidate the Certificate.

Where not completing this form electronically, to ensure accuracy of information, please observe the following conventions:

Write clearly within the boxes in BLOCK CAPITALS and in BLACK or BLUE ink

For example

2	5		M	A	R	K	E	T		S	T

Shade circles like this ->

Not like this -> ⊗ ✓

Where a text box has a reference number to the left, you can extend your response on plain paper where there is insufficient space in the box. Extension sheet(s) should be clearly labelled with Patient's name and CHI number, and each extended response should be labelled with the appropriate text box reference number.

Patient Details

CHI Number

Surname

First Name(s)

Other / Known As

'Other / Known As' could include any name / alias that the patient would prefer to be known as.

Title

DoB
dd / mm / yyyy

Gender

○ Male ○ Female ○ Prefers not to say ○ Not listed

If not listed, please specify

Patient's home address

Postcode

<< Please enter NF1 1AB if no fixed abode

Patient's Name | CHI Number

Part 1 **To be completed by the Child Specialist or DMP as appropriate**

Details Of Medical Practitioner Primarily Reponsible For Treating The Patient

Surname

First Name

Address

Postcode

○ I, the above medical practitioner am a child specialist; or

○ I, the above medical practitioner am NOT a child specialist

Designated Medical Practitioner Details (if a DMP has visited and is completing Part 2b or Part 2c)

Surname

First Name

Address

Postcode GMC Number

○ I, the above DMP am a child specialist; or

○ I, the above DMP am NOT a child specialist

Patient's capability to consent to treatment

If the patient is capable of consenting, and does consent - **go to PART 2a**

If the patient is incapable of consenting to the treatment - **go to PART 2b**

Where it is necessary as a matter of urgency for medical treatment to be given to the patient, but the patient is incapable of consenting and resists to or objects to treatment - **go to PART 2c**

Patient's Name | CHI Number

Part 2: Certificate **To be completed by the Child Specialist or DMP as appropriate**

Part 2a: Patients capable of consenting and not refusing consent

I , the medical practitioner primarily responsible for the patient's treatment, am a child specialist, and I confirm that:

○ the patient is capable of consenting to the treatment;

○ the patient consents in writing to the treatment; and

○ 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.

Notes

i) If the patient withdraws consent to the treatment (in writing or otherwise) at any time before its completion, the remainder of the treatment will be deemed under regulations as a separate treatment requiring separate certification

ii) Where the patient is capable of consenting and does not consent to these types of treatment, then treatment is not authorised under the Act

Part 2b: Patients incapable of consenting to medical treatment

I am a DMP, and I confirm that:

○ the patient is incapable of understanding the nature, purpose and likely effects of the medical treatment;

○ 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 medical treatment should be given; and

○ a person having parental responsibilities and parental rights in respect of the patient has consented in writing to the medical treatment being given to the patient.

Notes

i) This does not authorise giving medical treatment by force to the patient.

ii) If the person with parental responsibilities and parental rights withdraws consent to the treatment (in writing or otherwise) at any time before its completion, the remainder of the treatment will be deemed under regulations as a separate treatment requiring separate certification.

Part 2c: Urgent medical treatment

I am a DMP, and I confirm that:

consent has been given by a person having parental responsibilities and parental rights in respect of the patient to the medical treatment being given to the patient; and

the patient resists or objects to the medical treatment, but

it is necessary as a matter of urgency to give the medical treatment to the patient for the purposes of:

○ (a) saving the patient's life;

○ (b) preventing serious deterioration in the patient's condition;

○ (c) alleviating serious suffering on the part of the patient.

Notes

For b) and c) above the medical treatment may only be given if it is not likely to entail unfavourable, and irreversible, physical or psychological consequences.

For c) above the medical treatment may only be given if it does not entail significant physical hazard to the patient.

Medical treatment is not authorised -

i) to be given by force to the patient, where the patient is NOT in hospital; or
ii) if the patient is capable of consenting but does not consent to the treatment

Patient's Name | CHI Number

Part 3 **To be completed by the Child Specialist or DMP as appropriate**

Treatment Details

Description of the treatment(s) including the frequency and duration of treatment

1	

Signature / Date

○ I am the medical practitioner primarily responsible for treating the patient

○ I am a Designated Medical Practitioner

Signature

Date / /

Patient's Name | CHI Number

Advance Statement - complete only where 2B or 2C on page 3 apply **To be completed by the DMP**

Complete A, B or C as appropriate

A ○ As far as is practicable to ascertain, the patient does not have an advance statement under S275 of the Act.

OR

B ○ As far as is practicable to ascertain: the patient has made and not withdrawn an advance statement under S275 of the Act; and all decisions to authorise or not authorise treatment I have made are NOT in conflict with any wishes specified in that advance statement.

OR ***NB Part C below is unlikely to be applicable if Part 2a has completed on page 2. If the treatment is in conflict with an advance statement, and the patient is capable of making a decision about the treatment and is consenting to it, it should be discussed with the patient whether they wish to withdraw the advance statement.***

C ○ Decision(s) I have made to authorise or not authorise treatment ARE in conflict with wishes specified in an advance statement made by the patient under S275 of the Act and not withdrawn. Please record in the box below:

- The date of the advance statement(s).
- Details of all treatment(s) authorised that are in conflict with the advance statement and how.
- Where a decision that conflicts with the advance statement is a decision not to authorise treatment, please provide details of this.
- Your reasons for authorising/not authorising these treatment(s), despite the conflict with the advance statement, with reference to your consideration of the Principles of the Act.

2	

Where the treatment is in conflict with the advance statement, a record of the above has been sent to:

○ the patient

○ the patient's named person (if any)

○ the Mental Welfare Commission (a copy of this form and any other record which has been sent to the patient/ others)