

# Our overview of mental welfare in Scotland 2006-07

Report on findings from  
our monitoring of the  
use of mental health  
and incapacity legislation





## 1 Director's introduction

This year, we have decided to separate our detailed reporting on the operation of legislation from the reporting of the Commission's work over the past year. The report 'Our Work and Our Views', shows what the Commission did over the course of 2006-07. This document focuses on the findings from our monitoring and visiting programme. It provides:

- Detailed reporting on the operation of legislation from the reporting of the Commission's work over the past year
- An overview of the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act)
- Findings on the priority areas of monitoring the 2003 Act
- Issues arising from monitoring the use of the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act)
- Detailed findings, recommendations and themes from our visits to individuals and to services
- A look into the future

The 2003 Act gives the Commission the general duties to monitor the operation of the Act and to promote best practice in its use. We monitor the operation of the Act by reporting on the notifications we receive and by visiting individuals. While we cannot be certain that we have received every notification that we should have, we are confident that our figures give a reasonably accurate picture of the way the Act is operating. From comparing our statistics with those of the Tribunal, we found that there are some differences. We may be missing information on some people's compulsory orders. For example, the Tribunal's statistics indicate that they granted 1187 compulsory treatment orders during 2006-07 whereas we only identified 1091. We have worked hard to harmonise our data with that of the Mental Health Tribunal and have suggested some amendments to the Act and to Tribunal Rules which would clarify the information that we should receive. In general, we have tried to avoid duplicating information available from the Tribunal, for example, appeals

against excessive security, applications for revocation of orders and references by Scottish Ministers for people with restricted status.

The Commission also has several other duties that provide safeguards for people subject to both the 2000 and the 2003 Acts. Visiting individuals and services provides important ways of learning about the quality of care that individuals receive. The experience of the service user is central to our findings and our recommendations to services. We counted well over 2000 visits to individual service users – probably an underestimate as we listened to the views of other users, either individually or in groups, and had a great deal of contact with independent advocates. We believe that using the experience of service users is essential to improving the quality of mental health care and treatment and we see our role as important in providing an independent and objective view.

## 2 Overview of the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003

### 2.1 Introduction

This year, we report on a full year of the new mental health legislation for the first time. In last year's annual report we reported on the use of the

2003 Act, but commented that the implementation of the Act half way through the year made interpretation of our findings difficult. This year, we can be more definite about the way legislation is being used and we have been able to draw firmer conclusions from our findings.

### 2.2 Accessing and exiting compulsory treatment – episode sequences

Figure 1: Emergency and short-term detention episodes initiated between 1 April 2006 and 31 March 2007

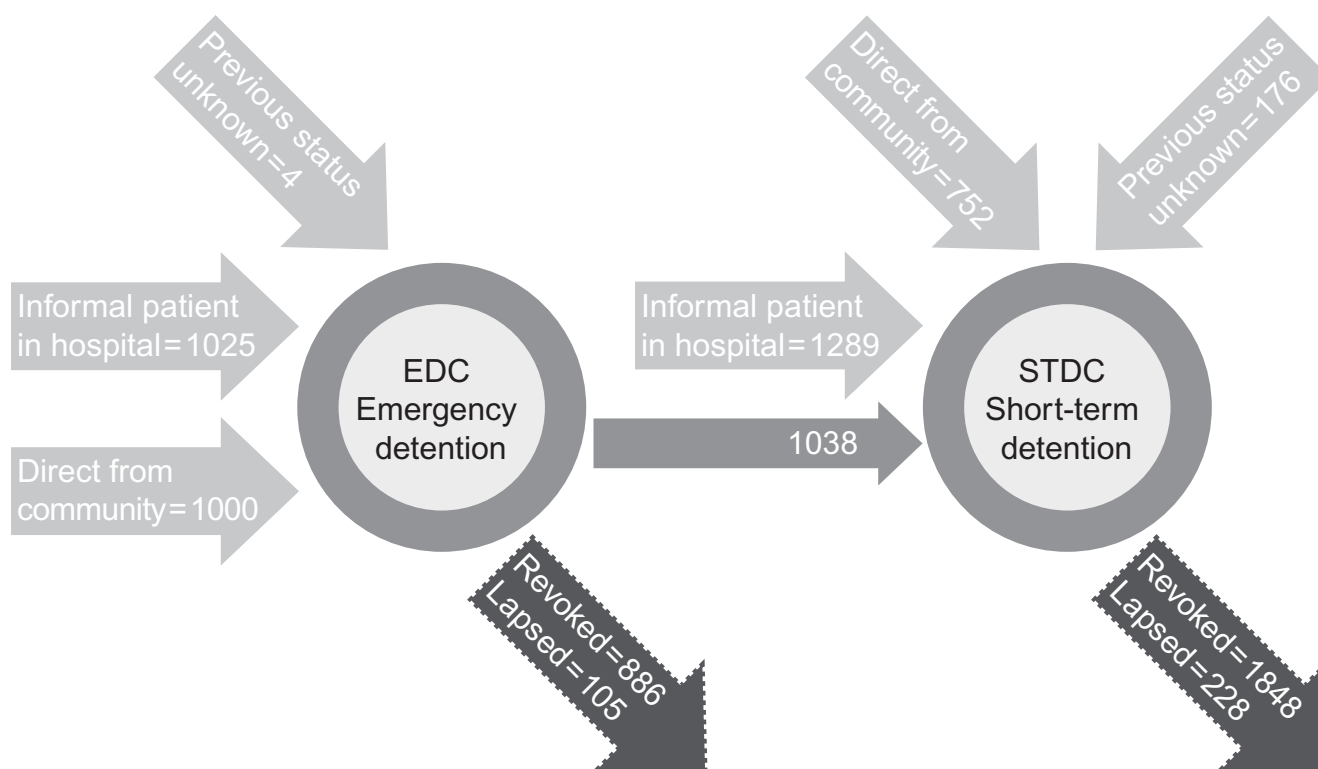
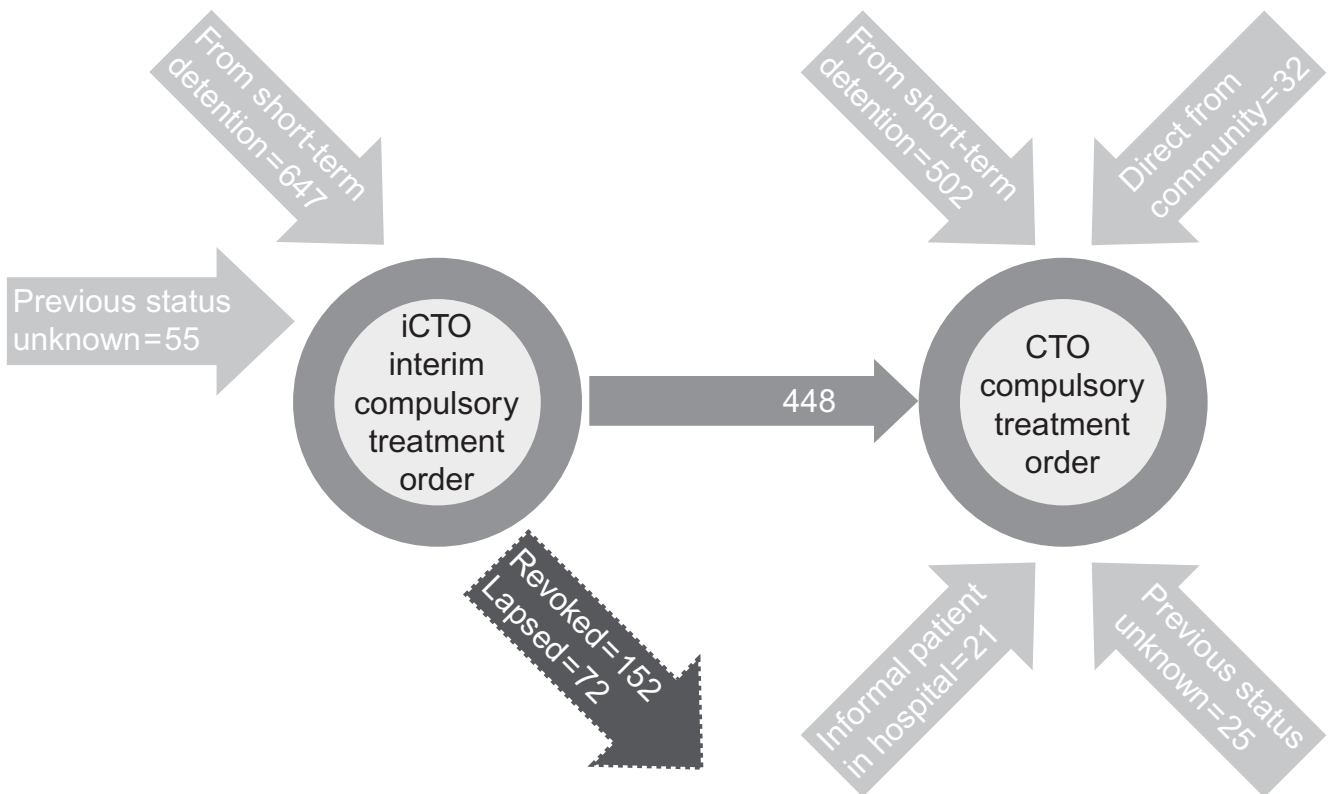


Figure 2: Compulsory treatment order episodes initiated between 1 April 2006 and 31 March 2007



Notes on the data: Report as at July 2007.

Table 1: Episodes initiated between 1 April 2006 and 31 March 2007

	Patients	No. of episodes
Emergency detention to informal status	915	991
Emergency detention to short-term detention*	658	683
EDC to STDC to interim compulsory treatment order*	73	73
EDC to STDC to compulsory treatment order	145	145
EDC to STDC to iCTO to CTO	137	137
Direct to short-term detention*	1364	1422
Direct to STDC to iCTO*	167	168
Direct to STDC to CTO	356	357
Direct to STDC to iCTO to CTO	270	270
Direct to iCTO*	14	14
Direct to iCTO to CTO	41	41
Direct to CTO	78	78
<b>Total episodes</b>	<b>4218</b>	<b>4379</b>

\*We believe that almost all of these orders expired and the people subject to them became informal. It may be that, in a few cases, we have not received information on subsequent orders.

The 2003 Act allows for more ways to initiate episodes of civil compulsion than the 1984 Act did. We have shown, in Table 1, the variety of ways in which episodes are initiated and how these progress. The key finding is the total number of episodes of compulsory treatment. From the year 2000 up to the implementation of the new Act, between 4700 and 4800 episodes of compulsory treatment were initiated

consistently each year. Our first data on the new Act, reported in last year's annual report, suggested a fall of around 8% in the number of episodes of compulsion. This year's figures confirm that figure and show that between 300 and 400 fewer people are being treated using compulsory powers under the 2003 Act.

Last year, we reported that the use of emergency detention had fallen by over

50% compared with the previous Act. We are pleased to see that this is proving to be a consistent trend. Short-term detention has become the usual route into compulsory treatment. Around 120 people became subject to CTOs directly from informal status. This is similar to the number of "straight to section 18" orders under the old Act. However, under the 2003 Act, 40% of these orders

are for community-based care and treatment.

We heard of many concerns about the numbers of interim orders granted by the Tribunal. This year, we were informed of 703 interim CTOs. Of these, 448 progressed to CTOs. There were 1091 full CTOs in total. Under previous legislation, people often remained subject to short-term detention pending a final determination by the Sheriff on applications for detention under section 18. We did not receive notification of these and we were concerned about cases that were continued for several weeks. Hearings where cases were continued did little to test the grounds for compulsion. Under the 2003 Act, the Tribunal tests the evidence for interim orders before granting them. We think this is correct but the consequence can be that two or three hearings are needed before the Tribunal makes a final determination. This can be distressing for service users, time-consuming for practitioners and expensive. Early applications for CTOs for people detained under short-term orders, a simpler process for appointing curators ad litem for

appropriate people, and prompt provision of independent psychiatric opinions would help. We make further comment on this in section 6.1.

### 2.3 The use of compulsory powers by age and gender

There are two notable features in the analysis of compulsory orders by age and gender. We are seeing a slightly higher number of young people treated under the Act. In a full year under the old Act, 18 people under the age of 18 were subject to long-term compulsory treatment and 56 were detained under short-term orders. This has risen to 26 and 66 respectively, the increase for girls being higher. This may reflect a greater use of compulsory powers for people with eating disorders.

We will explore this further in 2007-08.

There has been a significant increase in the use of compulsory powers for people over 85. Compared with the last full year of operation of the previous Act, the number of short-term detentions has risen from 78 to 154. Long-term orders rose from 24 to 44.

The rise may be due to a greater tendency to use compulsory powers for people with dementia following the European Court judgement on the "Bournewood" case. Again, women account for the majority of people detained in this age group, due to the higher proportion of women in the over-65 population

**Table 2: Compulsory powers granted by age and gender, 1 April 2006-31 March 2007**

Emergency detentions	Female	Male	Totals (%)
0-15	5	4	9 (0)
16-17	13	8	21 (1)
18-24	112	133	245 (12)
25-44	433	439	872 (43)
45-64	277	294	571 (28)
65-84	137	114	251 (12)
85+	54	22	76 (4)
<b>Totals (%)</b>	<b>1031 (50)</b>	<b>1014 (50)</b>	<b>2045 (100)</b>
Short-term detentions	Female	Male	Totals (%)
0-15	10	11	21 (1)
16-17	29	16	45 (1)
18-24	115	205	320 (10)
25-44	540	673	1213 (37)
45-64	487	452	939 (28)
65-84	350	271	621 (19)
85+	117	37	154 (5)
<b>Totals (%)</b>	<b>1648 (50)</b>	<b>1665 (50)</b>	<b>3313 (100)</b>
Compulsory treatment orders*	Female	Male	Totals (%)
0-15	7	4	11 (1)
16-17	9	6	15 (1)
18-24	38	86	124 (11)
25-44	161	270	431 (40)
45-64	120	139	259 (24)
65-84	116	91	207 (19)
85+	33	11	44 (4)
<b>Totals (%)</b>	<b>484 (44)</b>	<b>607 (56)</b>	<b>1091 (100)</b>

\*Includes community and hospital-based orders.

**Table 3: Emergency and short-term orders. No. and rate per 100K population of compulsory powers granted, by order type and Health Board, 1 April 2006-31 March 2007**

Health Board	Emergency detentions		Short term Detentions	
	No.	Rate per 100K pop	No.	Rate per 100K pop
Ayrshire and Arran	177	48	201	55
Borders	18	16	50	45
Dumfries and Galloway	77	52	88	59
Fife	124	35	247	69
Forth Valley	115	40	141	49
Grampian	142	27	288	54
Greater Glasgow and Clyde	583	49	942	79
Highland	147	48	220	72
Lanarkshire	125	22	250	45
Lothian	403	50	585	73
Orkney	2	10	0	–
Shetland	5	23	0	0
State hospital	0	–	3	–
Tayside	126	32	288	74
Eilean Siar	1	4	10	38
<b>Scotland</b>	<b>2045</b>	<b>40</b>	<b>3313</b>	<b>65</b>

#### 2.4 The use of compulsory powers by Health Board

Last year, we found that Ayrshire and Arran had a proportionately higher use of emergency orders compared with the number of short-term orders. This year, this is less evident (see Table 3) although, along with Borders and Dumfries and Galloway, their ratio of emergency to

short-term orders is higher than the national average. These Health Boards need to examine the reasons for this in conjunction with their local authority partners.

The use of short-term detention is highest this year in Greater Glasgow and Clyde, with Tayside, Lothian and Highland close behind. Long-term compulsory

treatment in hospital is highest in Fife and Tayside with Highland also showing relatively high rates. Looking back over previous years, Tayside has shown consistently high use of compulsory powers, although this dropped during 2005-06. Fife has shown a steady increase. Lanarkshire has been consistently low.

**Table 4: Interim and hospital-based CTOs. No. and rate per 100K population of compulsory powers granted, by order type and Health Board, 1 April 2006-31 March 2007**

Health Board	Interim CTO		Hospital-based Compulsory Treatment Order	
	No.	Rate per 100K pop	No.	Rate per 100K pop
Ayrshire and Arran	27	7	49	13
Borders	14	13	17	15
Dumfries and Galloway	17	11	27	18
Fife	51	14	93	26
Forth Valley	32	11	38	13
Grampian	44	8	101	19
Greater Glasgow and Clyde	238	20	213	18
Highland	43	14	73	24
Lanarkshire	40	7	61	11
Lothian	137	17	163	20
Orkney	0	0	0	0
Shetland	0	0	0	0
State hospital	0	–	4	–
Tayside	59	15	103	26
Eilean Siar	2	8	2	8
<b>Scotland</b>	<b>704</b>	<b>14</b>	<b>944</b>	<b>18</b>

We have commented in annual reports over the last few years on the possible reasons for these variations. They cannot be explained by differences in populations and must reflect differences in practice and, possibly, the ability of services to engage and support users without the need for compulsion.

The rate of interim orders appears highest in Greater Glasgow and Clyde.

**Table 5: Community-based CTOs. No. and rate per 100K population of compulsory powers granted, by order type and Health Board. Episodes initiated between 1 April 2006 and 31 March 2007**

Health Board	Community-based compulsory treatment order	
	No.	Rate per 100K pop
Ayrshire and Arran	7	2
Borders	4	4
Dumfries and Galloway	2	1
Fife	17	5
Forth Valley	8	3
Grampian	13	2
Greater Glasgow and Clyde	49	4
Highland	7	2
Lanarkshire	5	1
Lothian	26	3
Orkney	0	0
Shetland	1	5
State hospital	0	–
Tayside	8	2
Eilean Siar	0	0
<b>Scotland</b>	<b>147</b>	<b>3</b>

The numbers of people subject to community based CTOs are quite small and comparison between areas is difficult. Again, Fife shows a high rate. Otherwise, the rates appear highest where there are large urban populations.

## 2.5 The use of compulsory powers by local authority

**Table 6: No. and rate per 100K population of compulsory powers granted by order type and local authority, 1 April 2006-31 March 2007**

Local authority	Short-term detentions		Hospital-based compulsory treatment order	
	No.	Rate per 100K pop	No.	Rate per 100K pop
Aberdeen City	135	67	59	29
Aberdeenshire	89	37	23	10
Angus	34	31	15	14
Argyll and Bute	69	76	22	24
Edinburgh City	353	76	106	23
Clackmannanshire	21	43	10	20
Dumfries and Galloway	85	57	27	18
Dundee City	136	96	42	30
East Ayrshire	51	43	16	13
East Dunbartonshire	41	39	16	15
East Lothian	67	72	15	16
East Renfrewshire	29	32	7	8
Eilean Siar	7	27	2	8
Falkirk	80	53	22	15
Fife	246	69	92	26
Glasgow City	588	101	120	21
Highland	166	77	55	26
Inverclyde	74	91	17	21
Midlothian	32	40	15	19
Moray	58	65	20	22
North Ayrshire	55	41	19	14
North Lanarkshire	102	32	29	9
Local authority not specified	97	–	2	–
Orkney	0	0	0	0

Table 6 continued

Local authority	Short-term detentions		Hospital-based compulsory treatment order	
	No.	Rate per 100K pop	No.	Rate per 100K pop
Perth and Kinross	116	83	46	33
Renfrewshire	101	60	20	12
Scottish Borders	54	49	18	16
Shetland	2	9	0	0
South Ayrshire	87	78	17	15
South Lanarkshire	154	50	44	14
Stirling	41	47	7	8
West Dunbartonshire	45	49	20	22
West Lothian	98	59	21	13
<b>Scotland</b>	<b>3313</b>	<b>65</b>	<b>944</b>	<b>18</b>

Table 7: CCTO rates per 100K population

Local authority	Community-based compulsory treatment order	
	No.	Rate per 100K pop
Aberdeen City	9	4
Aberdeenshire	4	2
Angus	1	1
Argyll and Bute	4	4
Edinburgh City	18	4
Clackmannanshire	6	12
Dumfries and Galloway	2	1
Dundee City	3	2
East Ayrshire	3	3
East Dunbartonshire	3	3
East Lothian	1	1
East Renfrewshire	0	0
Eilean Siar	0	0

Table 7 continued

Local authority	Community-based compulsory treatment order	
	No.	Rate per 100K pop
Falkirk	3	2
Fife	16	4
Glasgow City	28	5
Highland	4	2
Inverclyde	5	6
Midlothian	3	4
Moray	2	2
North Ayrshire	1	1
North Lanarkshire	2	1
Orkney	0	0
Perth and Kinross	5	4
Renfrewshire	4	2
Scottish Borders	5	5
Shetland	0	0
South Ayrshire	3	3
South Lanarkshire	5	2
Stirling	1	1
West Dunbartonshire	4	4
West Lothian	2	1
<b>Scotland</b>	<b>147</b>	<b>3</b>

Local figures on the use of compulsory powers (Table 6) mirror the findings for Health Boards shown in Table 3. Glasgow City and Inverclyde have high rates for short-term orders, as do Dundee and

Perth and Kinross. The latter two also have high rates for long term hospital detention.

## 2.6 The use of nurses' power to detain

**Table 8: Nurses' power to detain pending medical examination, by hospital and gender, 1 April 2006-31 March 2007**

Hospital	Female	Male	Total
Ailsa	2	1	3
Argyll and Bute	1	3	4
Arrol Park Resource Centre	0	1	1
Borders NHS	2	5	7
Carseview Centre	1	3	4
Crichton Royal	15	10	25
Crieff	1	0	1
Crosshouse	2	0	2
Dr Grays	2	1	3
Dykebar	5	2	7
Falkirk Royal Infirmary	1	0	1
Gartnavel Royal	5	2	7
Hairmyres	1	1	2
Herdmanflat	1	1	2
Huntlyburn House	1	1	2
Inverclyde Royal	0	4	4
Leverndale	1	1	2
Mackinnon House	2	0	2
Monklands	1	0	1
Murray Royal	2	0	2
New Craigs	3	1	4
Parkhead	0	1	1
Rosslynlee	1	1	2
Royal Alexandra	3	2	5
Royal Cornhill	3	1	4

Table 8 continued

Hospital	Female	Male	Total
Royal Dundee Liff	1	1	2
Royal Edinburgh	19	23	42
Royal Infirmary Edinburgh	1	0	1
St John's	1	1	2
Stratheden	2	1	3
Western Isles	1	0	1
Whyteman's Brae	5	5	10
<b>Total</b>	<b>86</b>	<b>73</b>	<b>159</b>

The 2003 Act is clearer on the use of detention by nurses, pending medical examination, than the 1984 Act. It specifies that the authority to detain the person includes detention during the period of medical examination. We wondered if this might affect the way this power is used. On the basis of this year's data, it seems that little has changed. There is still a huge variation across the country. There are some hospitals where this part of the Act is used consistently often, whereas other hospitals use it rarely, if at all. There is no change in this pattern. Women are more likely to be detained in this way than men.

In our analysis of emergency detention on page 7, we note a significant number of emergency detentions without MHO consent for people already in hospital. Hospitals with high rates of emergency detention without consent have low rates of the use of the nurses' power. Section 299 of the Act states that the nurses' power is used where "it is not practicable to secure the immediate medical examination of the patient by a medical practitioner". If the medical practitioner is immediately present, the nurses' power would therefore not be used. We think it might be better for the nurse to detain the person for the two hour period to allow the medical practitioner to examine the person and consult a mental health officer

(MHO). This could reduce the number of emergency detentions without MHO consent but would require a change in the wording of section 299.

### 2.7 Short-term detention

Short-term detention is becoming the usual means by which people become subject to compulsory care and treatment. In last year's annual report, we analysed the way these orders were used. We examined some issues again this year.

### 2.7.1 Type of mental disorder

**Table 9: Number and percentage of STDCs granted by type of mental disorder specified, 1 April 2006-31 March 2007**

Type of mental disorder*	No.	%
Mental illness	3237	98
Learning Disability	27	1
Personality disorder	42	1
Not recorded	7	0
<b>Total</b>	<b>3313</b>	<b>100</b>

\*Only one type has been specified in nearly all cases.

We reported concerns last year about aspects of short-term detention certificates and are concerned that little has changed. Firstly, most certificates only specify one form of mental disorder (Table 8). This is probably inaccurate. We think it is likely

that there are more people with a learning disability who also have a mental illness than these results indicate. Our recent report on the use of mental health legislation for people with learning disability covers this in more detail (available from

[www.mwscot.org.uk](http://www.mwscot.org.uk)). New forms will be in use by the time this report is published. These should improve data collection in the future as they require the medical practitioner to be specific about all the forms of mental disorder that might co-exist.

### 2.7.2 Named person involvement

**Table 10: No. and % of all STDCs granted where named person is recorded or consulted, 1 April 2006-31 March 2007**

	No.	% of all detentions
Named person recorded	2313	70
Named person consulted	1403	42

We were also concerned that the named person was consulted over the proposed certificate in fewer than 50% of detentions. This year, identification of the named person has improved (70% compared with 60% last year)

as shown in Table 9. However, the proportion of orders where the named person has been consulted has not risen. The Act stipulates that the approved medical practitioner (AMP) completing the certificate shall consult

the named person unless it is impracticable to do so. Named persons are important safeguards for people and it is a concern that the rate of consultation is still low.

### 2.7.3 Time of granting of orders

**Table 11: STDCs granted, 1 April 2006-31 March 2007**

Local authority of MHO giving consent	STDCs granted in normal hours		STDCs granted out of hours		All STDCs	STDs per 100K population
	No.	%	No.	%		
Aberdeen City	107	80	27	20	134	67
Aberdeenshire	74	83	15	16	89	37
Angus	27	79	7	21	34	31
Argyll and Bute	44	64	25	36	69	76
City of Edinburgh	261	74	91	26	352	76
Clackmannanshire	18	86	3	14	21	43
Dumfries and Galloway	66	78	19	22	85	57
Dundee City	91	67	45	33	136	96
East Ayrshire	43	84	8	16	51	43
East Dunbartonshire	38	93	3	7	41	39
East Lothian	57	85	10	15	67	72
East Renfrewshire	25	86	4	14	29	32
Eilean Siar	5	71	2	29	7	27
Falkirk	64	80	16	20	80	53
Fife	202	82	44	18	246	69
Glasgow City	444	76	143	24	587	101
Highland	135	82	30	18	165	77
Inverclyde	67	91	7	9	74	91
Midlothian	28	88	4	12	32	40
Moray	35	60	23	40	58	65
North Ayrshire	52	95	3	5	55	41
North Lanarkshire	91	89	11	11	102	32
Perth and Kinross	95	82	21	18	116	83
Renfrewshire	93	92	8	8	101	60

Table 11 continued

Local authority of MHO giving consent	STDCs granted in normal hours		STDCs granted out of hours		All STDCs	STDs per 100K population
	No.	%	No.	%		
Scottish Borders	41	76	13	24	54	49
Shetland	2	100	0	0	2	9
South Ayrshire	83	95	4	5	87	78
South Lanarkshire	142	92	12	8	154	50
Stirling	29	73	11	28	40	47
West Dunbartonshire	44	98	1	2	45	49
West Lothian	72	73	26	27	98	59
Not recorded	20	21	77	79	97	–
<b>Scotland</b>	<b>2595</b>	<b>78</b>	<b>713</b>	<b>22</b>	<b>3308</b>	<b>65</b>

Note: In 5 cases the time of granting the STD is not recorded. This accounts for discrepancies in the totals.

Table 10 shows the number of STDCs consented to by MHOs employed by each local authority. In some cases the person was detained in a different Health Board area from the one where the MHO was based. However, given that most STDCs are granted

within normal working hours by MHOs employed in the person's home area, we think this is useful information for local authorities.

It is worth comparing the proportions of orders within working hours with the figure on emergency detentions on

page 8. Of 3308 short-term detentions, 78% were granted within normal working hours. In contrast, only 31% of emergency detentions are within working hours.

## 2.8 Risk and civil compulsory treatment

**Table 12: Category of risk for civil compulsory orders**

Type of order	Risk to own health, safety or welfare	Risk to own health/safety/welfare and safety of others	Risk only to safety of others
Emergency/short-term	58%	37%	4%
Hospital CTO	52%	47%	1%
Community CTO	46%	54%	<1%

We were interested to examine the use of civil compulsory powers in relation to risk. Table 11 shows the percentages of people on the main types of order who would present a risk to themselves or others without treatment. We found that people receiving compulsory community care and treatment were thought more likely to need treatment because of a risk to others, compared with people detained in hospital. Practitioners appear to be more likely to consider long-term compulsory community treatment if there is a risk to other people. Where the person's mental disorder would, without treatment, only result in a risk to his/her own health and safety, practitioners may be more inclined to accept a greater

degree of risk and have a higher threshold for using compulsion.

### 2.9 Social circumstance report

The social circumstance report (SCR) is an important document drawing together information on a person's social and family circumstances, their illness and their views. The SCR also records the proposed treatment and care plan. Many people who require compulsory treatment have complex needs and will benefit from carefully planned support, to allow them to experience the best quality of life possible. The SCR provides a useful tool for reflection, at any stage of recovery, on the rationale for the compulsion and the approach taken by the mental health team at a time of acute illness.

The increase in SCRs received by the Commission that we saw in 2005-06 has been maintained into 2006-07. In total, 2107 SCRs have been provided, 1955 of these for civil orders and 152 for orders made under criminal proceedings. Table 12 gives the numbers of SCRs provided by local authority for civil and criminal orders.

The substantial increase in the number of SCRs written this year reflects the importance placed on SCRs in the 2003 Act and the local authorities' endeavour to meet their responsibilities.

**Table 13: Number of SCRs provided for civil procedures, 1 April 2006-31 March 2007**

Local authority	SCR provided	Rate of SCRs provided per 100K population	Rate of relevant events* per 100K population
Aberdeen City	56	28	100
Aberdeenshire	72	30	49
Angus	44	40	45
Argyll and Bute	14	15	104
City of Edinburgh	196	42	103
Clackmannanshire	23	47	76
Dumfries and Galloway	52	35	77
Dundee City	84	59	127
East Ayrshire	41	34	59
East Dunbartonshire	32	30	57
East Lothian	46	50	89
East Renfrewshire	31	35	40
Falkirk	59	39	70
Fife	201	56	99
Glasgow City	274	47	127
Highland	26	12	105
Inverclyde	42	52	118
Midlothian	25	32	63
Moray	24	27	90
North Ayrshire	68	50	55
North Lanarkshire	57	18	41
Orkney Islands	1	5	0
Perth and Kinross	83	59	120
Renfrewshire	44	26	74
Scottish Borders	44	40	70
Shetland Islands	8	37	9

Table 13 continued

Local authority	SCR provided	Rate of SCRs provided per 100K population	Rate of relevant events* per 100K population
South Ayrshire	43	39	96
South Lanarkshire	147	48	66
Stirling	21	24	56
West Dunbartonshire	16	18	76
West Lothian	78	47	73
Eilean Siar	3	11	34
<b>Scotland</b>	<b>1955</b>	<b>38</b>	<b>84</b>

\*This column relates to 4305 relevant events (for 3977 people), including short-term detentions and compulsory treatment orders. In 803 other cases, local authority information was not available (e.g. for the 704 interim compulsory treatment orders).

Table 14: Number of SCRs provided for criminal procedures, 1 April 2006-31 March 2007

Local authority	SCR provided	Rate of SCRs per 100K population	Rate of relevant events per 100K population
Aberdeen City	3	1	9
Aberdeenshire	8	3	0
Angus	2	2	5
Argyll and Bute	0	0	2
City of Edinburgh	15	3	10
Clackmannanshire	0	0	2
Dumfries and Galloway	2	1	1
Dundee City	13	9	18
East Ayrshire	3	3	1
East Dunbartonshire	1	1	0
East Lothian	3	3	0
East Renfrewshire	3	3	3
Falkirk	1	1	12

Table 14 continued

Local authority	SCR provided	Rate of SCRs per 100K population	Rate of relevant events per 100K population
Fife	13	4	6
Glasgow City	20	3	9
Highland	7	3	7
Inverclyde	3	4	1
Midlothian	0	0	0
Moray	0	0	0
North Ayrshire	3	2	0
North Lanarkshire	10	3	8
Orkney Islands	0	0	0
Perth and Kinross	3	2	6
Renfrewshire	4	2	3
Scottish Borders	0	0	0
Shetland Islands	0	0	0
South Ayrshire	9	8	15
South Lanarkshire	21	7	23*
Stirling	0	0	1
West Dunbartonshire	0	0	0
West Lothian	5	3	0
Eilean Siar	0	0	0
<b>Scotland</b>	<b>152</b>	<b>3</b>	<b>7</b>

\*The number of relevant events in South Lanarkshire includes 68 at the State hospital from a total of 71. The above table relates to 338 relevant events (for 208 people).

There is a wide variation between the rates per 100K of SCRs and the rates per 100K for detentions. We continue to be concerned that provision of SCRs for people detained through the courts remains relatively low. The new Act asks for an SCR to be prepared for “every relevant event” within 21 days,

unless the MHO considers that providing an SCR would serve “little, or no, practical purpose.” Section 232 defines a relevant event as a short-term detention, an interim or a full compulsory treatment order and a number of orders under criminal proceedings. During the year there have been 5455 relevant events

relating to 3423 people. 2107 SCRs were sent to us and we received 457 notifications where the MHO believes that writing a SCR would serve little or no purpose. There are therefore a significant number of relevant events occurring where we receive no notification as to why an SCR has not been written.

**Table 15: Number of notifications that ‘SCR would serve little/no purpose’ by local authority, by civil and criminal orders, 1 April 2006-31 March 2007**

Local authority	Civil orders	Criminal orders
Aberdeen City	9	0
Aberdeenshire	23	1
Angus	4	0
Argyll and Bute	4	0
City of Edinburgh	43	4
Clackmannanshire	4	0
Dumfries and Galloway	1	1
Dundee City	28	3
East Ayrshire	14	1
East Dunbartonshire	4	0
East Lothian	2	1
East Renfrewshire	4	0
Falkirk	9	0
Fife	28	3
Glasgow City	85	3
Highland	6	0
Inverclyde	5	0

Table 15 continued

Local authority	Civil orders	Criminal orders
Midlothian	6	0
Moray	2	1
North Ayrshire	8	2
North Lanarkshire	11	1
Orkney Islands	0	0
Perth and Kinross	14	0
Renfrewshire	26	0
Scottish Borders	4	0
Shetland Islands	0	0
South Ayrshire	33	5
South Lanarkshire	17	0
Stirling	1	0
West Dunbartonshire	14	0
West Lothian	19	3
Eilean Siar	0	0
<b>Scotland</b>	<b>428</b>	<b>29</b>

Hard pressed MHOs may feel, at the stage when an SCR falls due, that the SCR duplicates information contained in detention certificates, CTO application papers or care assessments. However, none of these other documents record a rounded picture of the person on matters such

as their strengths, distinctive personality and individual circumstances, as well as their vulnerability and need for care and treatment. We expect that local authorities will audit their own practice in this area and that managers of MHO services support frontline MHOs to decide which reports are

necessary and which would serve little purpose. This is in line with the MHO standards published by the Scottish Executive in 2006.

**Table 16: SCRs received by the Commission between 1 April 2006 and 31 March 2007, by type of relevant event triggering the need to consider completing an SCR**

Relevant event	No.
The granting of a short-term detention certificate	1928
The making of an interim compulsory treatment order	87
The making of a compulsory treatment order	290
The making of an assessment order	64
The making of a treatment order	21
The making of an interim compulsion order	12
The making of a compulsion order	54
The making of a hospital direction	2
The making of a transfer for treatment direction	20
Other*	86
<b>Total SCR1s received</b>	<b>2564</b>

\*Other triggers included renewal/variation of a compulsory treatment order, renewal of a compulsion order, a cross-border transfer, an application for conditional discharge, and length of time in hospital.

Some MHOs have been concerned that the Commission no longer reads SCRs as soon as we receive them. However, we have decided to focus our effort when monitoring the implementation of the Act by visiting everyone on CTOs. SCRs provide us with invaluable information

for these visits. Although Table 16 shows that most SCRs are written in connection with a short-term detention and a minority at the time of making the CTO, the description of the background to the making of the order, recording practical problems and risks faced by the person at that time, remains very

relevant. The SCR helps us see whether the actual treatment provided meets the person's needs and that there has been benefit from the detention. We are encouraged that the standard of reports that we receive continues to be very high.

## 2.10 Trends in the use of civil compulsory powers

**Table 17: Detention trends under civil procedures, April 1985-March 2007 (EDC, STDC, CTO)**

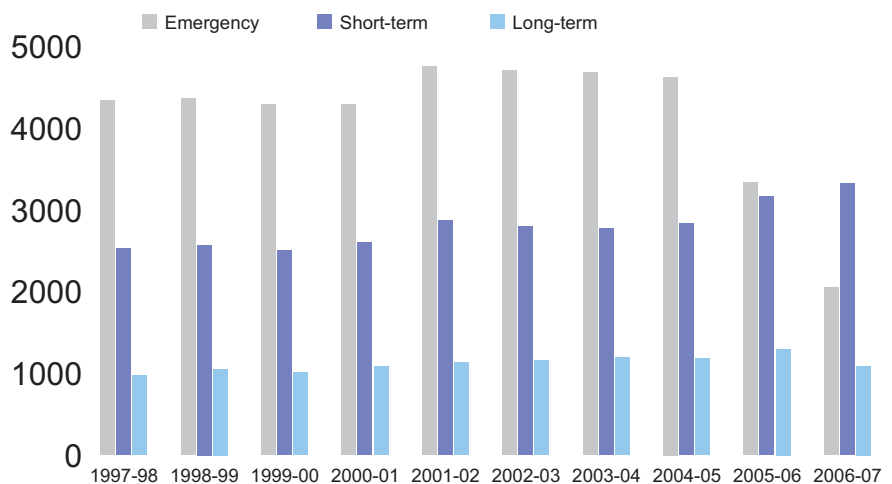
	Civil procedures*		
	Emergency	Short-term	Long-term
1985	3186	1395	349
1986	3224	1531	359
1987	3375	1613	422
1988	3443	1757	569
1989	3061	1601	510
1990	3271	1611	494
1991	3614	1927	664
1992	3632	1972	727
1992-93	3733	2080	745
1993-94	3696	2134	823
1994-95	3670	2197	877
1995-96	4149	2398	886
1996-97	4116	2416	887
1997-98	4333	2527	970
1998-99	4356	2566	1054
1999-00	4284	2500	1011
2000-01	4288	2597	1080
2001-02	4749	2872	1135
2002-03	4697	2795	1161
2003-04	4682	2763	1192
2004-05	4621	2834	1188
2005-06	3330	3158	1297
2006-07	2045	3313	1091*

\*NB: Tribunal reported 1187. No evidence of increasing use of long-term orders, even using the higher figure.

Each year, we examine the trends in the use of compulsory powers. There had been concern that the rate of use of long-term powers was rising over the years. While this seemed to show a “plateau” since the year 2001, there was a rise last year. It was important to see what has happened in the first full year following implementation of the 2003 Act.

As expected, we saw a reduction in emergency orders and an increase in short-term orders. This confirms the trend suggested by last year’s figures. The rise in the use of long-term orders last year could have been due to the transition between the 1984 and 2003 Acts. Another factor could be that practitioners were encouraged to make early applications for long-term orders under the old Act in order to allow the Tribunal to become established. This year, there has been no rise in the use of long-term orders. This contrasts with the previous trend of rising use of long-term compulsory powers, not just in Scotland but in many other countries in Western Europe. It will be interesting to see if this trend continues.

**Figure 3: Detentions under civil procedures in Scotland, 1997-98 to 2006-07**



Combined with the overall fall in numbers of people subject to compulsion, this may reflect changing attitudes to the use of compulsory powers in Scotland.

### 2.11 The use of compulsory care and treatment for mentally disordered offenders

It remains too early to identify any trends in the use of legislation for mentally disordered offenders since the introduction of the 2003 Act. We have included the figures from the last full year of the old legislation as a comparison with 2006-07.

This information is shown in tables 18 to 22.

There has been an increase in the number of episodes or orders that place people in hospital for assessment or treatment pre-trial and/or post conviction. We wish to carry out a more detailed analysis of these figures to identify how many episodes relate to transfers from prison or direct from court. We note that there were 16 episodes of the use of S200 and repeat our observation from last year that the new provisions under S52 render S200 unnecessary.

The total number of Compulsion Orders compared to old Hospital Orders has fallen from 61 to 52 and reflects a downward trend since 1996. Compulsion Orders with Restriction Orders (COROs) have reduced slightly but are within the

range we have seen over the past few years.

There has been a significant drop in the number of Interim Compulsion Orders (formerly Interim Hospital Orders) this year, from 55 to 39. This is likely to be a reflection of the

extended renewal time from 28 days to 12 weeks.

Post-sentence prison transfers have increased from 25 to 30. This is a slight reversal of a downward trend since 1995, when there were 60 transfers.

**Table 18a: Compulsory treatment under criminal procedures**

Criminal proceedings granted between 1 April 2004 and 31 March 2005

Order type	No. of orders
Remand to hospital before trial (CPSA 52)	118
Transfer order from prison before trial or sentence (MHSA (1984)**** 70)	24
Remand order (CPSA 200)	65
Interim hospital order (CPSA 53)	55
Temporary hospital order (CPSA 54(1)(c))	8
Hospital order (CPSA 58)	61
Hospital order with restriction order (CPSA 58 + 59)	12
Not fit to stand trial or acquitted (CPSA 57(2)(a))	12
Not fit to stand trial or acquitted with restriction order (CPSA 57(2)(b))	3
Transfer from prison without restriction order (MHSA 71)	8
Transfer from prison with restriction order (MHSA 72)	17

\*Criminal Procedure (Scotland) Act 1995

\*\*Compulsion order with restriction order

\*\*\*Part 8 Mental Health (Care and Treatment)(Scotland) Act 2003

\*\*\*\*Part VI Mental Health (Scotland) Act 1984

**Table 18b: Compulsory treatment under criminal procedures**

Criminal proceedings granted between 1 April 2006 and 31 March 2007

Order type	No. of orders
Remand in custody or on bail for inquiry into mental condition (CPSA* 200)	16
Assessment order (CPSA 52D)	154
Treatment order (CPSA 52M)	74
Interim and extension interim compulsion order (CPSA 53)	39
Temporary compulsion order (CPSA 54(1)(c))	9
Compulsion order (CPSA 57A)	52
Not fit to stand trial or acquitted (CPSA 57(2)(a))	2
CORO** (CPSA 57A + 59)	8
Not fit to stand trial or acquitted with Restriction Order (CPSA 57(2)(b))	1
Transfer for treatment direction (MHSA (2003)*** 136)	30
Hospital direction (CPSA 59A)	3

\*Criminal Procedure (Scotland) Act 1995

\*\*Compulsion order with restriction order

\*\*\*Part 8 Mental Health (Care and Treatment)(Scotland) Act 2003

\*\*\*\*Part VI Mental Health (Scotland) Act 1984

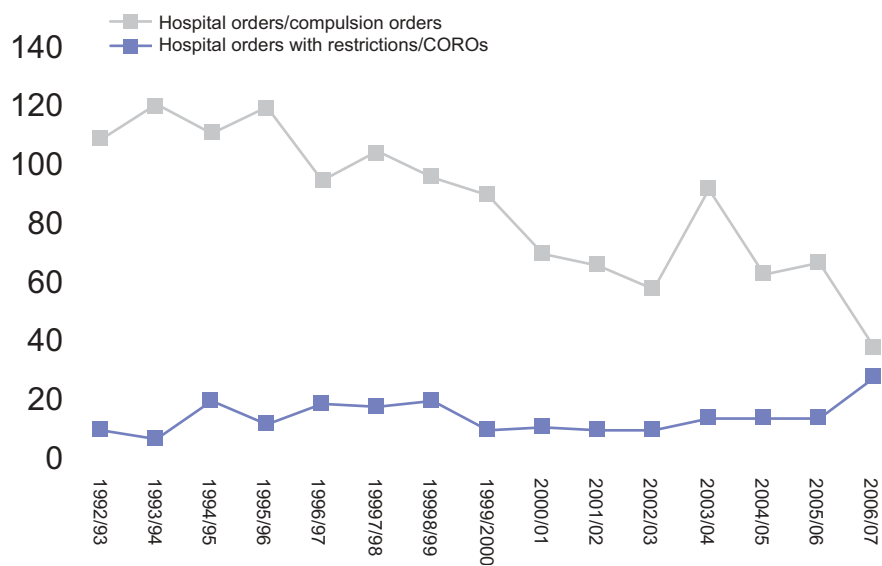
**Table 19: Episodes of compulsion under criminal proceedings, by age and gender, 1 April 2006-31 March 2007**

Age range	Female	Male	Totals (%)
01-15	0	0	0
16-17	1	0	1 (0)
18-24	3	32	35 (16)
25-44	25	111	136 (63)
45-64	4	35	39 (18)
65-84	0	4	4 (2)
85+	0	0	0
<b>Totals (%)</b>	<b>33 (15)</b>	<b>182 (85)</b>	<b>215 (100)</b>

Table 20: Community-based compulsion orders, 1 April 2006-31 March 2007

	No. of orders
Full orders granted	8
Variations from hospital to community during period	21
Recalls from community to hospital during period (S113/ S114)	7
Revoked/lapsed community-based orders during period	3

Figure 4: Criminal proceeding trends in Scotland, 1992-93 to 2006-07



## 2.12 Quarterly census data

**Table 21: Number of people subject to compulsory powers, by type, at quarterly census dates**

Order	On 5 Apr 06	On 5 Jul 06	On 5 Oct 06	On 3 Jan 07
Emergency detention	23	23	13	16
Short-term detention**	227	240	212	194
Interim compulsory treatment order	48	48	40	63
Compulsory treatment order	1430	1480	1525	1485
Of which, hospital-based	1299	1288	1280	1217
Of which, community-based	131	192	245	268
Assessment order	8	9	7	7
Treatment order	4	4	3	3
Interim compulsion order	12	5	8	3
Compulsion order	141	135	135	127
Compulsion order with restriction order	242	247	257	253
Transfer for treatment direction	11	13	17	19
Hospital direction	42	40	41	41
Remand in custody or on bail for inquiry into mental condition	1	1	0	0
Probation order requiring treatment (S230)	1	1	1	1
Indeterminate status**	212	226	187	223
<b>All people subject to compulsory treatment</b>	<b>2402</b>	<b>2472</b>	<b>2446</b>	<b>2435</b>

\*\*These are episodes that appear still open but where we are lacking notifications that we should have received.

For the first time, we have reported on the numbers of people subject to all forms of compulsory treatment on selected dates throughout the year (Table 22). These

reports are made available on our website as soon as we are confident that we have received all the notifications we should have. The main finding is a rise in the

numbers of people subject to community CTOs. While this was expected, we found that the number of hospital CTOs did not continue to fall after an initial reduction since

**Table 22: Number of people subject to civil compulsory powers on 3 January 2007, rate per 100K population, by health board area**

Health Board	Rate per 100K
Tayside	59
Lothian	54
Fife	49
Greater Glasgow and Clyde	48
Forth Valley	43
Grampian	41
Highland	41
Ayrshire and Arran	36
Dumfries and Galloway	35
Borders	27
Lanarkshire	24
Eilean Siar	15
Orkney	0
Shetland Islands	0
<b>Scotland</b>	<b>48</b>

October 2005. If this trend continues, the total number of people subject to compulsory treatment could rise. It will be important for practitioners to make sure that they review the need for continued treatment and revoke orders that are no longer necessary.

We looked at the prevalence rates for civil compulsory orders by Health Board on one of the census dates.

Table 22 shows the prevalence of civil compulsory orders in January 2007. These are consistent with the data on new orders on Section 2.5 and confirm that Tayside has the highest use of compulsory powers per head of population.

### 2.13 Place of safety orders

We now receive notification of all “place of safety” orders. Psychiatric emergency plans should identify appropriate establishments to use as places of safety. Out of around 130 orders, two of them identified the police station as the place of safety. We recommend that police stations are not used for this purpose. Notwithstanding that this happened on only two

occasions, it is our view that this should not happen at all. Services should examine any use of a police station in these circumstances and find better ways of responding.

#### 2.14 Ethnicity

We remain concerned about the under-reporting of ethnic information for people subject to the Act, with only 60% of forms containing this information. Based on this sample, between four and five per cent of people treated under the Act are from ethnic minority backgrounds. This is similar to the Scottish population as a whole and does not suggest that there is excessive use of mental health legislation for people from ethnic minorities. We are considering a special census on this during 2007-08. We also hope that new guidance on mental health Act forms will lead to improved information being gathered.

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

##### Neurosurgery for mental disorder (Sections 235, 236)

During the past year four people were referred for assessment. The Act requires the Commission to arrange for a Designated Medical Practitioner (DMP) and two other persons (not medical practitioners) to carry out the assessment, whether the person is subject to the Act or not. All three assess whether the person has the capacity to consent to surgery and has given consent. The DMP also assesses whether the treatment is in the person's best interests.

Treatment in Scotland is provided through the Advance Interventions Service in Dundee. Two of the four people seen in the past year lived in England and two in Scotland; none were detained in hospital. All four had suffered from depression for many years and had gained little benefit from medication, electro-convulsive therapy (ECT) or from psychological therapy. Two people had

undergone previous operations with definite, but temporary, benefit. Neurosurgery was considered appropriate in all four cases and has been carried out. Information about the outcome is not yet available. The Act allows treatment to be carried out without consent in certain cases, but there has been no treatment in these circumstances since the Act was implemented.

##### Other treatments (Sections 237, 240)

Treatment given with the person's consent is authorised by form T2. The Commission does not receive these forms automatically and, as a consequence, the data we have is not comparable with that previously available under the 1984 Act. During the past year the Commission received copies of form T2, which give notice of treatment with consent, for ECT in 13 cases, medication to reduce sex drive in 3 cases and medication beyond 2 months in 567 cases.

Treatment given without consent, authorised by a DMP on form T3, is summarised in Table 23.

**Table 23: Certificate of the DMP (T3), 1 April 2006-31 March 2007**

Treatment type	No.
ECT	122
Medication to reduce sex drive	19
Artificial feeding	25
Medication over 2 months	893
Total T3 certificates	1054

1054 certificates were issued during the year, compared with 475 in the first 6 months of the Act's operation; an increase of 11% over the comparable period in 2005-06. This reflects a long term trend.

The DMP considered that about half of the people receiving ECT objected to or resisted treatment. One fifth were considered to need treatment to save their lives, the others to prevent serious deterioration or to alleviate serious suffering.

#### Children and young people

The Commission received 26 treatment forms during the past year for people under eighteen. Nineteen of these were for treatment without consent. All the DMPs providing these second opinions were child specialists. Medication beyond two months was the treatment given in all cases.

#### Designated Medical Practitioners

70 doctors provided second opinions on safeguarded treatments during the past year. The Commission held a seminar in October 2006 to review the first year of operation of the new Act, which was well attended. The main focus of the meeting was on good practice guidance, which included the use of artificial feeding, and how to work with the new forms. A further seminar was held for new DMPs.

The Commission is grateful to those doctors who have provided second opinions throughout the year. A full list of these doctors can be viewed at [www.mwscot.org.uk](http://www.mwscot.org.uk).

### 3. Monitoring of priority areas

When we consulted with stakeholders, we identified five priority areas for monitoring the use of the 2003 Act. These were:

- Emergency detention
- Overrides of advance statements
- Compulsory community treatment
- Care plans
- Services for younger people

We report in detail on these five areas this year. During our visit programme in 2007-08, we will be consulting again with stakeholders to get their views on future priorities.

#### 3.1 Emergency detention

##### 3.1.1 Duration of orders

**Table 1: Duration of emergency detention orders granted, 1 April 2006-31 March 2007**

	Within 24 hours of admission	24-72 hours after admission	> 72 hours after admission	Total (%)
EDC revoked, patient informal	244	272	5*	521 (25)
EDC superseded by STDC	569	478	8*	1055 (52)
Order expired at 72 hours	n/a	n/a	n/a	469 (23)
<b>Total number of emergency detentions</b>				<b>2045 (100)</b>

\*We are following up on these notifications. They may be errors in recording information on forms. We are concerned that some people may be detained for longer periods than the law allows.

The durations of emergency detention certificates are shown in Table 1. The Act requires that hospital managers arrange for an examination by an approved medical practitioner as soon as practicable after admission. In some cases, it may be appropriate to allow the emergency order

to remain in place, especially where this allows a doctor who knows the person to make a decision. However, it seems that the order is allowed to expire at the end of 72 hours in almost a quarter of cases. This is similar to our finding last year. Health Boards should make sure that approved

medical practitioners are reviewing these orders. We would expect a review within 24 hours of admission.

**Table 2: Number and duration of episodes of detention initiated by emergency or short-term orders, 1 April 2006-31 March 2007: comparison with full year under previous legislation**

	No.	2004-5	% change under new legislation
All new episodes of detention	4246	4621	8% reduction
Episodes of detention lasting 72 hours or less	1025	1787	43% reduction
Episodes of detention lasting more than 72 hours	3221	2834	13% increase

A possible unintended consequence of the 2003 Act was the possibility of longer spells of detention under short-term orders. Because short-term detention should be the usual order to initiate a spell of compulsory treatment,

there is not necessarily the automatic review within the first 72 hours that there was under previous legislation. Table 2 confirms that this is the case. Responsible Medical Officers (RMOs) should keep the need for detention under review.

We believe it is especially important to review the need for detention carefully during the first few days as crisis situations can resolve quickly. People should not be detained for any longer than necessary.

### 3.1.2 Emergency detention certificates (EDCs) without consent

**Table 3: EDCs with and without MHO consent by Health Board, 1 April 2006-31 March 2007**

	No. of EDCs per 100K	No. of EDCs with MHO consent	No. of EDCs without MHO consent	% of EDCs with MHO consent
Ayrshire and Arran	48	107	70	60%
Borders	16	18	0	100%
Dumfries and Galloway	52	62	15	81%
Fife	35	88	36	71%
Forth Valley	40	106	9	92%
Grampian	27	129	13	91%
Greater Glasgow and Clyde	49	353	230	61%
Highland	48	122	25	83%
Lanarkshire	22	62	63	50%
Lothian	50	313	90	78%
Orkney	10	2	0	100%
Shetland	23	5	0	100%
Tayside	32	102	24	81%
Eilean Siar	4	0	1	0
<b>Scotland</b>	<b>40</b>	<b>1469</b>	<b>576</b>	<b>72%</b>

Before issuing an emergency detention certificate, the medical practitioner should either get the consent of a mental health officer (MHO) or state why it was impracticable to get consent. Table 3 shows the proportions of EDCs with and without consent in each Health Board area.

While Lanarkshire looks particularly low in percentage terms, it has a low rate of emergency orders and therefore the total numbers of EDCs without MHO consent is not high. Ayrshire and Arran and Greater Glasgow and Clyde have higher rates of EDCs and relatively more of them without MHO consent. We wanted to investigate this

more and broke the figures down by hospital and by the time the EDC was granted.

**Table 4: EDCs by Health Board, hospital, time granted and pre-detention status, 1 April 2006-31 March 2007**

Health Board	Hospital	Total No. of EDCs	% of people in community before detention	EDCs in working hours		EDCs out of hours	
				With/without MHO Consent	With/without MHO Consent	With/without MHO Consent	With/without MHO Consent
Ayrshire and Arran	Total	177	55%	29%	5%	32%	34%
	Ailsa	86	60%	30%	2%	34%	34%
	Arran War Memorial Hospital	1	0%	100%	0%	0%	0%
	Arrol Park Resource Centre	3	335	33%	0%	33%	33%
	Ayr	9	22%	0%	11%	11%	78%
	Ayrshire Central	12	92%	33%	17%	33%	17%
	Crosshouse	66	48%	29%	6%	32%	33%
Borders	Total	18	22%	28%	0%	72%	0%
	Borders NHS	16	19%	31%	0%	69%	0%
	Huntlyburn House	2	50%	0%	0%	100%	0%
Dumfries and Galloway	Total	77	52%	30%	5%	51%	14%
	Crichton Royal	65	56%	31%	3%	51%	15%
	Dumfries And Galloway Royal Infirmary	12	33%	25%	17%	50%	8%

Table 4 continued

Health Board	Hospital	Total No. of EDCs	% of people in community before detention	EDCs in working hours		EDCs out of hours	
				With/without MHO Consent	With/without MHO Consent	With/without MHO Consent	With/without MHO Consent
Fife	Total	124	45%	26%	10%	45%	19%
	Cameron	4	0	25%	50%	25%	0%
	Lynebank	1	100%	100%	0%	0%	0%
	Queen Margaret	36	37%	11%	14%	50%	25%
	Stratheden	32	50%	31%	13%	31%	25%
	Victoria Kirkcaldy	2	0	50%	0%	50%	0%
	Whytemans Brae	49	53%	31%	2%	53%	14%
Forth Valley	Total	115	55%	22%	3%	70%	5%
	Bannockburn	1	0	0%	0%	100%	0%
	Falkirk Royal Infirmary	78	61%	24%	3%	69%	4%
	Stirling Royal Infirmary	36	45%	17%	3%	72%	8%
Grampian	Total	142	55%	24%	4%	67%	6%
	Aberdeen Royal Infirmary	10	30%	0%	0%	100%	0%
	Dr Grays	15	73%	47%	0%	47%	7%
	Glen O Dee	1	0	0%	100%	0%	0%
	Inverurie Hospital	2	100%	50%	0%	50%	0%
	Maud Hospital	1	0	0%	0%	100%	0%
	Royal Cornhill	112	545	23%	4%	67%	6%
	Woodend Hospital	1	100%	0%	0%	100%	0%

Table 4 continued

Health Board	Hospital	Total No. of EDCs	% of people in community before detention	EDCs in working hours		EDCs out of hours	
				With/without MHO Consent	With/without MHO Consent	With/without MHO Consent	With/without MHO Consent
Greater Glasgow and Clyde	Total	583	43%	20%	9%	40%	30%
	Beatson Oncology Centre	2	50%	0%	0%	50%	50%
	Dykebar	52	48%	17%	19%	33%	31%
	Gartnavel Royal	115	47%	17%	8%	49%	27%
	Glasgow Royal Infirmary	5	25%	20%	0%	20%	60%
	Glasgow Royal Maternity	2	0	0%	0%	0%	100%
	Inverclyde Royal	35	34%	23%	3%	37%	37%
	Leverndale	57	38%	9%	16%	37%	39%
	Mackinnon House	51	45%	31%	6%	41%	22%
	Merchiston	1	100%	100%	0%	0%	0%
	Overtoun Court	1	100%	100%	0%	0%	0%
	Parkhead	75	63%	28%	8%	37%	27%
	Priory	1	0	100%	0%	0%	0%
	Queen Mothers	1	0	0%	0%	0%	100%
	Ravenscraig	1	100%	0%	100%	0%	0%
	Royal Alexandra	48	38%	19%	8%	48%	25%
	Southern General	83	32%	19%	6%	39%	36%
	Stobhill	22	48%	18%	18%	45%	18%
Vale Of Leven	13	42%	23%	15%	31%	31%	
Victoria Infirmary Glasgow	10	0	30%	10%	40%	20%	
Western Infirmary	8	0	13%	0%	50%	38%	

Table 4 continued

Health Board	Hospital	Total No. of EDCs	% of people in community before detention	EDCs in working hours		EDCs out of hours	
				With/without MHO Consent	With/without MHO Consent	With/without MHO Consent	With/without MHO Consent
Highland	Total	147	54%	28%	6%	55%	11%
	Argyll And Bute	33	71%	52%	12%	33%	3%
	Belford	2	0	50%	0%	0%	50%
	Caithness General	5	20%	0%	0%	40%	60%
	Campbelltown Cottage Hospital	1	0	0%	0%	100%	0%
	Dr Mackinnon Memorial Hospital	2	50%	50%	0%	50%	0%
	Islay Hospital	2	0	0%	50%	0%	50%
	Lorn & Islands	1	0	0%	0%	100%	0%
	New Craigs	92	55%	22%	3%	67%	8%
	Raigmore	8	57%	25%	13%	25%	38%
Lanarkshire	Town & County	1	0	0%	0%	100%	0%
	Total	125	45%	18%	9%	32%	42%
	Coathill	3	0	33%	0%	33%	33%
	Hairmyres	39	49%	18%	13%	23%	46%
	Monklands	38	54%	21%	8%	45%	26%
	Udston	3	25%	33%	0%	33%	33%
	Wishaw General	42	37%	12%	7%	29%	52%

Table 4 continued

Health Board	Hospital	Total No. of EDCs	% of people in community before detention	EDCs in working hours		EDCs out of hours	
				With/without MHO Consent	With/without MHO Consent	With/without MHO Consent	With/without MHO Consent
Lothian	Total	403	54%	22%	7%	56%	15%
	Astley Ainslie	3	0	33%	0%	33%	33%
	Herdmanflat	32	40%	44%	3%	50%	3%
	Rosslynlee	26	56%	27%	0%	73%	0%
	Royal Edinburgh	210	58%	20%	10%	53%	18%
	Royal Infirmary Edinburgh	50	39%	10%	10%	56%	24%
	Royal Victoria Edinburgh	8	25%	50%	0%	50%	0%
	St John's	70	65%	21%	4%	61%	13%
	Western General	4	0	25%	25%	50%	0%
Orkney	Balfour Hospital Total	2	100%	50%	0%	50%	0%
Shetland	Gilbert Bain Hospital Total	5	60%	60%	0%	40%	0%

Table 4 continued

Health Board	Hospital	Total No. of EDCs	% of people in community before detention	EDCs in working hours		EDCs out of hours	
				With/Without MHO Consent	Without MHO Consent	With/Without MHO Consent	Without MHO Consent
Tayside	Total	126	55%	33%	2%	48%	17%
	Carseview Centre	34	58%	38%	3%	44%	15%
	Murray Royal	43	61%	37%	5%	42%	16%
	Ninewells	5	0	60%	0%	20%	20%
	Perth Royal	2	0	0%	0%	100%	0%
	Royal Dundee Liff	18	56%	28%	0%	61%	11%
	Sunnyside Royal	24	55%	21%	0%	54%	25%
Eilean Siar	County/Total	1	100%	0%	0%	0%	100%
<b>Scotland</b>		<b>2045</b>	<b>50%</b>	<b>24%</b>	<b>7%</b>	<b>48%</b>	<b>21%</b>

Notes on the table: In 66 cases there was no information provided about pre-detention status.

Overall, 69% of EDCs are granted outside working hours. Because of this, the responsibility for MHO services lies with regional out-of-hours arrangements. It is therefore of little value to show this by local authority. Managers in health and local authority services responsible for these hospitals need to examine the reasons for this. However, a higher proportion of detentions without consent

are for people already in hospital (Table 4). In examining a sample of these, we found good explanations for this. Usually, the person was determined to leave hospital immediately, met the grounds for emergency detention and MHO consent was impossible to obtain in such an immediate situation. All the hospitals that had high rates of non-consent had higher than average rates of detention of people

already in hospital. They also had low use of nurses' power to detain. We think a change in the part of the Act on the nurses' power to detain might reduce the number of emergency detentions without consent (see page 37).

**Table 5: EDCs by pre-detention status and MHO consent to detention, 1 April 2006-31 March 2007**

	Informal in-patient (%)	From community (%)	Total (%)
With MHO consent	725 (50)	722 (50)	1447 (72)
Without MHO consent	337 (59)	231 (41)	568 (28)
<b>Scotland</b>	<b>1062 (53)</b>	<b>953 (47)</b>	<b>2015 (100)</b>

The figures are generally encouraging. Consent from a MHO is an important safeguard and we are pleased that over 70% of EDCs have MHO consent. While noting the likely reasons for non-consent for people already in hospital, we would encourage Health Boards with relatively low rates of consent, in conjunction with their local authority partners, to seek ways to increase their figures.

### 3.2 Advance statements

The principles underpinning the Mental Health (Care and Treatment) (Scotland) Act 2003 include having regard to the present and past wishes of the patient and the participation of the patient in the process of their care and treatment. The Commission believes that the making of an advance statement is an important part of the Act and demonstrates how these principles can be put into practice. Because we are only notified of those

circumstances where advance statements have been overridden, we are unable to say how many advance statements have been made. However, information gained from our visits to people subject to compulsion would indicate that the numbers are small, although beginning to increase. We are concerned about this. We think that patients should be helped to make advance statements and that it should form part of the care and treatment planning discussions at an appropriate point in the patient's recovery. This could be as part of a discharge planning process for example. Some patients have said to us that they do not wish to think about the possibility that they may become ill again and therefore do not wish to make an advance statement. We understand this but feel that patients should be encouraged to

participate in this way. Others have commented that there is no point in making one as it will be disregarded. We do not have enough information about the overall number of advance statements to be able to report on the proportions that are overridden.

We believe that advance statements are an important way in which individuals can participate in care and treatment decisions that affect them and carefully investigate those cases where a statement has been overridden. It is clear that the making of an advance statement is still an area of the 2003 Act which causes confusion and one which the Principles into Practice Network website ([principlesintopractice.net](http://principlesintopractice.net)) aims to address through the provision of resources and on-line discussion forums.

Between April 2006 and March 2007 we were notified of 44 patients whose advance statement appeared to have been overridden. Table 6 shows who made or notified the decisions to override these statements.

Where we are notified of a potential override we check first if there is a valid advance statement and also whether it has in fact been overridden. This is because we receive a number of notifications of potential overrides where there is either no advance statement, or there has been no override. In 13 instances there was either no override or no valid advance statement. In the 31 cases where there was clear evidence of an override, we checked the documents we received to assess whether they contained an adequate explanation of the reasons for the override and if the patient had been involved in the discussions. Where the Tribunal authorised an override we looked for evidence in the written judgement that discussion had taken place with the patient as far as possible.

**Table 6: Advance statement overrides, 1 April 2006-31 March 2007**

Source of notification	No.
Responsible medical officer	14
Mental health officer	2
Designated medical practitioner	6
Mental Health Tribunal	22
<b>Total</b>	<b>44</b>

Where RMOs or DMPs had authorised the override, we asked for further information if the reasons were not clear from the documents we already held. In the large majority of cases, we felt that the advance statement had been overridden after due consideration by the RMO or Tribunal. The majority of advance statements indicated either that the individual did not wish to receive psychotropic medication by injection or specific types of medication. Some also had comments about settings in which they did not wish to be cared for, others were very general. On only one occasion was an advance statement in respect of electro-convulsive therapy (ECT) overridden – in this case by the DMP.

We will continue to monitor this aspect of the Act and refine our processes with regard to this so that we have a better understanding of the number of valid advance statements that are being made and the reasons why they are overridden on occasion.

### 3.3 Community-based compulsory treatment

Table 7: Community-based compulsory treatment orders, 1 April 2006-31 March 2007

	No. of orders
Full orders granted	147
Interim orders granted	27
Variations from hospital to community during period	197
Recalls from community to hospital during period (S113/S114/emergency/short-term detention)	121*
Revoked/lapsed community-based orders during period	90*

\*Includes community-based interim orders.

In last year's annual report we indicated that we would be reporting on the use of Community-based Compulsory Treatment Orders (CCTOs) and we have published quarterly figures since then. Table 7 shows information on the numbers of community orders granted during the year.

The numbers are constantly changing: a point prevalence figure from 3rd Jan 2007 showed there were a total of 268 people on CCTOs compared to 1217 people on hospital based CTOs (see Table 5 in section 2.4). The number of community-based orders has risen steadily over the past year. However, they continue to represent a relatively small proportion of all CTOs at around 18%. At the same

time the number of hospital based CTOs has fallen, as has the total of all CTOs.

Because of the concern surrounding the use of community-based orders, we undertook to visit all those on CCTOs within 6 months of the order being granted or varied. In the past year we have carried out 273 visits to people who are on CCTOs.

One of our principal concerns was that CCTOs would be used inappropriately to ensure control over people who were seen only as a risk to other people as a result of their mental disorder.

Our review does not bear this out. For those CCTOs granted in the past year;

- 46% were on the grounds of "risk to their own health, safety or welfare",

- 54% also included "the safety of others" and
- less than 1% were on grounds of "safety of others" alone.

For people on hospital based CTOs (HCTOs);

- 52% were on the basis of risk to self and
- 47% had the added risk to safety of others.
- the use of (HCTOs) for reasons of safety of others alone was very low at 1%.

In both groups the majority of patients had mental illness as their main diagnosis.

The reasons for these differences are not clear and require further examination. Clearly, clinicians do not appear to be regarding a risk to others alone as a major factor in the decision to

provide compulsory treatment. It is reassuring to note that people have to be a risk to themselves first and foremost before any decision to treat on a compulsory basis, be it in hospital or in the community.

We also expected that CCTOs would be used in the main for people with multiple previous admissions, or a history of a long period of hospital detention, perhaps with multiple periods of suspension. Our monitoring suggests that people on CCTOs are more likely to have had previous episodes of detention than those on hospital based orders (45% with 4 or more previous episodes of detention compared with only 35% of those on hospital CTOs). In addition, although it is clear that people are detained for slightly longer overall than those on hospital CTOs, this is really only apparent for detention periods of greater than 12 months.

#### CCTO and admission to hospital

There are a number of ways in which people on CCTOs can be admitted to hospital if required.

1. An individual can be admitted informally
2. An individual may become too ill to be managed in the community and need compulsory admission under an emergency or short term certificate
3. An individual may fail to comply with the requirements of the order they can be admitted for up to 72 hours (S113) and then, if necessary, for up to 28 days (S114)
4. An order may be varied to include detention in hospital.

In addition, if medical treatment is a part of the order and a patient is not complying, they can be taken to a hospital for up to 6 hours in order to receive the treatment. We were notified of only four uses of a S112 which authorises this.

During the year we were notified of 121 occasions when people were recalled or admitted to hospital from CCTOs. We were notified of 19 variations, involving 17 individuals, from community to hospital CTOs.

#### What have we found on our CCTO visits

We carried out 273 visits to people on CCTOs in the last

year. We were particularly concerned to see if people were receiving all the care and treatment that had been stated in their CCTO. We asked to see care plans and looked at the compulsory measures in the CCTO to see if they were being adhered to. On some occasions people did not wish to speak to us in any detail and so we were unable to form a complete picture of their care and treatment.

In the majority of cases there was a care plan, and in most of these it was thought to cover all the person's needs. However, there were a number of cases where the care plan was either absent or insufficient. These cases were followed up with the appropriate care team. For example, some of the issues we followed up included: lack of crisis plans, inadequate community services such as no suitable accommodation and, in one case, the continued necessity for a CCTO. Following our intervention, the RMO revoked the order. Involvement of carers and advocates (where used) was generally good.

With regard to the measures specified in the CCTO, about

50% had their place of residence specified, attendance and access requirements were present in almost all cases and most, but not all, had been provided with the recorded matters which the Tribunal had placed on the order.

Commission visitors noted a considerable number of good practice issues, which is heartening. Specific comments were made about the involvement of service users in decisions about their care, about the use of Criminal Procedure (Scotland) Act 1984 (CPSA) and the communication between health professionals and service providers. However, there were also a significant number of concerns and the good practice picture across Scotland is variable.

Overall, the use of CCTOs in Scotland would appear to be associated with a positive outcome for patients and carers. However, it is too early to draw conclusions and the Commission will continue to monitor the use of compulsion in the community, in particular the quality of the care and treatment that is provided. We will refine our visiting

and information gathering to ensure that we obtain as good a picture as we can of CCTOs across the country. This information may assist in the debates regarding compulsory treatment in the community in other parts of the UK and elsewhere.

### 3.4 Care planning

Care planning is an integral part of health care and the 2003 Act has requirements for care plans to be completed in order to comply with specific parts of the legislation. Care plans are required with the application for a CTO where an MHO has to prepare a proposed care plan to submit to the Tribunal. Once the CTO has been granted and an RMO appointed, the RMO then has to prepare a Section 76 care plan which details the treatment plan proposed. During the period of treatment, there should also be a working care plan which should record more of the changing detail of the Section 76 care plan.

Regulations have determined the content of Section 76 care plans. In addition to medical treatment, the plan should include:

- Full details of the compulsory order and the day on which it was made;
- Objectives of the medical treatment;
- Details of any community care services, or other relevant services, and the objectives of these services;
- Name and other appropriate contact details of RMO;
- Name and appropriate contact details of MHO;
- The period of 2 months ending with the date by which the first mandatory and further mandatory reviews of the patient's compulsory treatment order have to be carried out;
- The dates on which these reviews have been carried out.

When we visit individuals, the Commission asks to see copies of the Section 76 care plans. These are not always forthcoming. We also look at the working care plan, if this can be found. The working care plan is not always easy to locate and may be comprised of a number of disparate pieces of paper located in various parts of the patient's case notes.

There are, however, a number of examples of excellent care plans which clearly document the care and treatment that is to be provided, the actual provision of that care and treatment and the involvement of the patient and any informal carers in the discussion and decision making process. Such care plans are often contained as a single document, held in one place in the patient's case notes, with copies held by patients themselves and carers. Good care plans show attention to the holistic range of treatments and supports which may be required by an individual, evidence of ongoing involvement from the patient and carers, as appropriate, and provide evidence of review on a regular basis. They are organic documents which are responsive to changing circumstances.

On our visits to individuals we ask questions about the care plans. During the last year we changed the way in which we gathered the information so it is not possible to give meaningful figures for the year. However, we have noted both good and poor practice in relation to care plans, for example;

“as well as medical treatment she is receiving support with financial issues, daily living tasks and other emotional and practical support”

“dietetics, speech and language therapy, occupational therapy, art therapy and pharmacy are all currently, or have been previously involved in, meeting his needs”

whilst on the other hand;

“her working care plan did not address the intended psychological support she was to be offered as stated in the proposed care plan... the working care plan was focused heavily on medication with little evidence of consideration or inclusion of other possible treatments”

“there did not appear to be much structure to X's life and input from the CPN and support worker seems to be limited to visits to cafes”

We are concerned about the quality and content of care plans and will be developing a Good Practice guideline during the next year. In addition we will continue to put additional information about Care Plans on our website.

### 3.5 Services for younger people

The Commission continues to focus on the admissions of young people to non-specialist settings such as adult and paediatric wards for the treatment of mental illness. In our monitoring of the admissions of under-18 year olds across the country in this position, we look to confirm whether Health Boards are managing to fulfil their legal duty to provide age appropriate services and accommodation. Medical records departments have improved their notifications of informal admissions to the Commission over the last year, ensuring that our figures are a more accurate representation of this population. We continue to ask RMOs to provide us with more detailed information once we have been notified of an admission.

Our information gathering in this format began with the introduction of the Act in October 2005. In the last annual report we provided figures for the first 6 month period from October 2005 to 31 March 2006. Information given in the tables below represents total figures from 1 April 2006 to 31 March 2007.

We have been notified of 186 admissions involving 156 young people under the age of 18 to non-specialist settings. Of these, 10 admissions were to paediatric wards, 3 admissions were to eating disorder units, 2 to adult learning disability wards and the remaining 171 to adult wards. Of the 186 admissions, 87 were detained under the mental health Act. The information received came from general hospital records departments as well as mental health services. Although reporting has improved we suspect there may still be some under reporting from general hospitals. In response to our requests for further information on each admission, we received a reply in 151 cases (Table 8).

Tables 9 to 12 present the information provided to us. All percentages are based on the 151 cases where information was provided on the monitoring form.

Table 13 shows figures for age and gender of young people who were admitted. There were more 17 year olds admitted than any other age group, with 16 year olds being the second highest age group. 118 (78%) admissions

involved young people aged 16-17. We believe services must continue to give careful thought to arrangements for the 16 and 17 year old group. The remaining 33 admissions (22%) involved children aged under 16.

In 13 admissions the young person had a learning disability. Two of these cases involved children aged under 16 years of age.

The 2003 Act is clear that the specific duty on Health Boards to provide sufficient services for young people continues to the 18th birthday. Consent to treatment provisions for children in the Act also apply to all those under 18. However, named person provisions and MHO responsibilities in the Act make distinction between those under 16 and those over 16. This reflects wider social and legal notions of the transition from childhood to adulthood. We are aware that children and young people's services are configured differently in different areas.

For example, some services will cater for young people up to the age of 18 and beyond, particularly on an out-patient basis.

Elsewhere, services may be

confined to those under 16, or to under-16s and 16 and 17 year olds still at school. Social work services have different responsibilities when the person is under 16. This may to some extent explain the young people we came across for whom it was reported there was no social work input.

Our view is that when a young person needs in-patient treatment for a mental health problem, his or her own particular needs should be paramount. Our guidance on the admission of young people to adult mental health wards reflects this. We are aware that child and adolescent specialist services are making strenuous efforts to admit under-16s to specialist facilities, responding flexibly to presenting need. We continue to encourage services to develop clear protocols for the management of such admissions and are of the opinion that the provision in the Act and our monitoring of this has unquestionably raised the profile of inappropriate admissions.

The Commission welcomes the commitment in the mental health delivery plan to reduce

admissions to non-specialist facilities by 50% by 2009 and the commitment to ensuring a named link person is available to every school, fulfilling the functions outlined in “The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care” (2005).

However, we continue to have concern regarding the lack of appropriate service for young people who have a significant learning disability and require in-patient admission for assessment and treatment of mental health problems, particularly where there are problems with challenging behaviour or offending. The situation in regard to the lack of intensive psychiatric care units (IPCU) for young people has not changed in the last year. We are, however, aware that the new build in the west

of Scotland for adolescent in-patient care recognises this shortcoming and plans to incorporate a sub-unit, where the needs of those who may have more disturbed behaviours can be catered for. We urge other areas to pay particular attention to this highly emotive and anxiety provoking service gap.

The information obtained from our monitoring over the last year indicates that, although there has been some positive change to the service provided to young people, Health Boards still have quite a way to go to meet their responsibilities to provide fully for the needs of young people who require hospital admission.

**Table 8: Monitoring of young people admitted to non-specialist facilities 2006-07**

	All
No. of cases of young people admitted to non-specialist in-patient settings 01.04.06-31.03.07	186
No. of young people involved	156
No. of admissions of young people detained under the mental health Act	87
No. of admissions where further information provided to MWC	151
No. of young people involved	134

**Table 9: Specialist clinical input\***

Age group	Age 0-15	Age 16-17	All	% of admissions
RMO at admission was a child and adolescent specialist	16	29	45	30
Nursing staff with experience of working with young people were available to work directly with the young person	16	37	53	35
Nursing staff with experience of working with young people were available to provide advice to ward staff	26	71	97	64
The young person had access to other age appropriate therapeutic input	18	46	64	42
None of the above	1	29	30	20
All admissions with info provided	33	118	151	100

**Table 10: Social work input\***

Age group	Age 0-15	Age 16-17	All	% of admissions
Young person had an allocated social worker	14	59	73	48
If no allocated worker, had access to a social worker	9	44	53	35
Neither of the above	10	15	25	17

**Table 11: Supervision arrangements\***

Age group	Age 0-15	Age 16-17	All	% of admissions
Transferred to an IPCU or locked ward during the admission	2	17	19	13
Accommodated in a single room throughout the admission	31	77	108	72
Nursed under constant observation	19	53	72	48

**Table 12: Other provision\***

Age group	Age 0-15	Age 16-17	All	% of admissions
Access to age appropriate recreational activities	21	52	73	48
Access to education was discussed	11	32	43	28
Access to an advocacy service	16	91	107	71
Young person had a learning disability	2	11	13	

**Table 13: Age of young person by gender\***

Age in years last birthday	Gender		Total
	Female	Male	
9	0	1	1
10	2	0	2
11	0	0	0
12	0	0	0
13	1	0	1
14	4	4	8
15	9	10	19
16	28	17	45
17	38	37	75
<b>Total</b>	<b>82</b>	<b>69</b>	<b>151</b>

\*Data based on the 151 admissions where information was provided on the monitoring form.

Table 14: Health Board where admissions took place\*\* (for all 186 admissions)

	No.	Population aged 0-17	No. admissions per 100K population aged 0-17
Ayrshire and Arran	12	75,880	15.8
Borders	7	22,787	30.7
Dumfries and Galloway	3	29,355	10.2
Fife	7	74,780	9.4
Forth Valley	2	61,767	3.2
Grampian	14	108,254	12.9
Greater Glasgow and Clyde	43	242,057	17.8
Highland	20	62,857	31.8
Lanarkshire	23	121,806	18.9
Lothian	26	157,600	16.5
Orkney	0	4,139	0.0
Shetland	0	5,047	0.0
Tayside	28	78,502	35.7
Western Isles	1	5,359	18.7
	186	1,050,190	17.7

\*\*Data based on information received for all 186 admissions.

## 4 Visiting

### 4.1 Introduction

Our visiting work remains an important source of information about the quality of mental health care in Scotland. We visit people who are treated under the provisions of mental health and incapacity legislation. We also visit all hospitals providing mental health care as well as community facilities, prisons, young offenders' institutions and the immigration detention centre. We visit in order to allow people to raise issues with us and to inspect facilities for their care. For people subject to compulsory care and treatment, these visits give us a good opportunity to see how the legislation is working. In this section, we report on our visiting work and on our findings.

In relation to people subject to powers under legislation, we consulted widely on who we should visit and when. We decided to visit all people on compulsory treatment orders (CTOs) or similar long-term orders. For people detained in hospital, we visited them after the first renewal – usually between the ninth and twelfth months of detention. We

decided to make people on community orders a priority and visited them within the first six months of the order being granted. This was in response to anxieties expressed by users and voluntary organisations about new provisions for compulsory community treatment. We asked individuals about their care and treatment and gathered information about the use of legislation, with particular attention to the principles of the Acts.

For people subject to welfare guardianship under the Adults with Incapacity (Scotland) Act 2000, we read all orders and visited selected people. We concentrated on people where there was disagreement about the welfare powers. We also visited people in selected care groups, for example younger people with dementia, people in transition between services and others who might be at risk from inadequate or inappropriate forms of care.

In our programme of visits to hospitals and other facilities, we wanted to have contact with as many service users as possible, either individually or in groups. We also made contact with independent

advocates and carers to seek their views on services. After each visit, we made recommendations based on what we found. In addition to our programme of visits, we undertook several unannounced visits and a major themed unannounced visit to wards for older people.

#### Who did we visit?

During 2006-07, our visit programme included:

- 111 arranged visits to hospitals and other care facilities
- Nine visits to the State Hospital
- Seven visits to prisons
- Nine unannounced visits to individual units and one major themed unannounced visit

We also visited individual people in hospitals, care homes and in their own homes by special arrangement. Table 1 shows details of the 2294 people we visited during the year. The number of visits to individuals in 2005-06 was 1835. This represents a 25% increase in visiting work since last year.

We continue to value the contributions of independent advocates and carers and made efforts to meet with them during our visit programme.

**Table 1: Visits to individuals, 1 April 2006-31 March 2007**

Reason for visit	No.
Compulsory treatment order (CTO)	
Hospital-based CTO	735
Community-based CTO	273
Compulsion orders (with/without restriction)	53
Conditional discharge	2
Possible MWC reference to Tribunal	5
Guardianship Order – initial visit	316
Guardianship Order – return visit	126
Intervention Orders	4
Service user seen by request	593
Other MWC-initiated visit	187
<b>Total</b>	<b>2294</b>

## 4.2 Findings from visits to people subject to compulsory care and treatment

When practitioner staff and Commissioners visited individuals, we asked them to examine whether care and treatment were in line with what the law intended. As well as recording our findings, we took action to try to improve compliance with the principles and procedures of the legislation. This section of our report gives details of this.

When we visited people who were subject to compulsory treatment under the 2003 Act, we wanted to know:

- Did they still need to be treated under the Act?
- Were new safeguards (e.g. advance statements, advocacy, named person provisions) being used?
- Was the part of the Act on medical treatment being used correctly?
- Were the principles being observed?

Throughout the year, we collected information on samples of the people we saw. Here are some of our findings.

### Was compulsory treatment necessary?

We were usually satisfied that the grounds for using the Act were still met. In fewer than 1% of cases, we did not think there was enough justification. In these cases, we contacted the Responsible Medical Officer (RMO) to voice our concerns and made sure the individual was able to apply to the Tribunal for the order to be revoked. Because of the principle of participation, we encourage and support individuals to take action themselves. We did, however, take one case to the Tribunal on behalf of the person concerned.

### Were new safeguards being used?

- **Advocacy:** almost all service users were reported as being aware that advocacy services were available, though in several cases the report was based on information in the service user's file rather than on what they said in interview. There were only 4 cases where the person did not appear to be aware of advocacy and their notes did not record that they had been

informed. Uptake of advocacy was only around 30%. We found a few people who wanted a service, but were unable to get an advocate. As well as supporting service users at Tribunals, advocates had been helpful in helping users to complain and to access financial help.

- **Named persons:** around 75% of people knew about named person provisions and had either chosen a named person or were satisfied with their "default" named persons. We heard of some problems. Some people and their named persons were unhappy that sensitive personal information had gone to the named person. This is an area of the Act that needs to be examined. The role of the named person is important but not at the expense of infringing the service user's right to privacy and dignity.
- **Advance statements:** about 60% of the people we visited had some knowledge of advance statements and it was clear that many staff were actively encouraging people to consider making one. However, only 2-3% of people actually had an

advance statement. We helped by giving information about advance statements when we visited. Even if the person lacked capacity at the time, he/she might wish to make an advance statement when able and we wanted to encourage this. A common concern was that advance statements could be overridden. Because of this, many service users believed that there was no point in making one. While it is sometimes necessary to give treatment that conflicts with an advance statement, clinicians are likely to try other treatment that complies with the statement at first. Also, we assured service users that we look carefully into any override to make sure that it is fully justified.

### Consent to treatment

We examined documentation on consent when we visited. We wanted to make sure that treatment was in line with what the documentation authorised. Where the person was documented as giving consent, we wanted to be sure that this consent was genuine and that the person had capacity. Our findings were:

- Treatment was in line with documentation in about 95% of cases. If not, we immediately raised the matter with the RMO. “As required” medication was sometimes not recorded properly, or given above the recommended maximum dosage. We are producing new guidance, in association with pharmacy colleagues, to address this.
- We had concerns about 50% of people who were documented as consenting to treatment. This was either because we did not think they were genuinely agreeing to all the treatment that was prescribed, or because we had doubts about capacity. Again, we drew this to the attention of RMOs and referred them to our guidance on consent to treatment (available from [www.mwscot.org.uk](http://www.mwscot.org.uk)).

### Observation of principles

We looked for examples of best practice and also practices that we thought needed to improve. Also, we specifically recorded issues of information and participation that we thought most important. Our findings were:

- Information: we found evidence that all people had been given an explanation of their compulsory order. However, about a quarter of the people we saw did not seem to have understood the information they were given. We reminded hospital managers that they have a duty to ensure that service users receive and understand information, including any right of appeal. We were not satisfied that they had done enough to help people understand.
- Participation: we looked at whether people had been involved in designing their care plans. About 70% had some involvement, but a significant number of people did not have a copy of their care plans, nor in some cases did they know where it was kept. People must be given the opportunity to participate in drawing up their care plans and must either have a copy or have ready access to it.
- Involvement of carers: where the individual had a carer, we found that there was good involvement in around 75% of cases. This is an encouraging finding. Carers should be involved and provided with as much

appropriate information and support as possible to help them in their caring role.

#### Other findings

- Almost everyone had a designated mental health officer (MHO) although about a quarter seemed not to know who the MHO was and what the role was. The MHO has an important role in contributing to the person's overall management and in securing appropriate community services.

- Some people were being subjected to searches and were required to give samples to test for alcohol or drugs. We found many cases where clinical staff were ignorant of the procedures in the Act for this and made sure that they either stopped or used the Act correctly. We found one person on a CTO who was not detained, but who was required to give samples for drug testing under the Tribunal's order.

We referred this back to the Tribunal and the order was amended.

#### Action taken by the Commission

Table 3 shows action that we took following our visits. Overall, we took some action in about two-thirds of cases. Our action resulted in service users being better informed and service providers being more aware of their responsibilities.

**Table 3: Action by the MWC following visits to individuals subject to compulsion**

Action taken	No.	% of cases
Advice to person visited to contact Tribunal	28	4
Other advice to person visited	115	16
Letter to person visited	46	7
Letter to named person/advocate	5	1
Written info to the person visited	26	4
Letter to RMO	175	25
Advice to care staff on the day	153	22
Letter to MHO	44	6
Issues raised with managers on the day	56	8
Letter to service manager	9	1

### Visits to people on welfare guardianship

We continue to visit people for whom the Sheriff Court has appointed welfare guardians. We report on their care, accommodation and professional support. In particular, we ensure that everyone involved is aware of the principles of the Adults with Incapacity Act and demonstrate that they observe them.

This year, we received and approved eight applications for recall of welfare powers. Usually, this was because the powers were no longer necessary. In most cases, local authorities asked us to recall the powers. Changes to the Act mean that we will make fewer of these decisions in future as local authorities will be able to recall the powers, even when they are the guardians.

### 4.3 Findings from service visits

When we conduct service visits, we provide feedback on our findings and observations. This usually involves making recommendations for improvements to services. In this section, we report on the recommendations we made and look at some

common themes that arose from the visit programme.

As a result of our 127 arranged visits to hospitals and prisons, we made 479 recommendations for improvements.

Common themes were depressingly familiar. As in previous years, we raised major concerns about some of the care environments and amenities we found. In addition, we looked at some issues being addressed by the Scottish Executive's Delivering for Mental Health plan.

#### Physical facilities

These remain a matter of great concern to us. A welcoming environment with privacy and dignity will improve progress towards recovery and is good for staff morale. Excluding concerns about smoking, we made 87 recommendations about poor physical environments. Common themes were:

#### Ageing and decrepit buildings

Moves towards closing old hospitals have adverse effects on people who remain in facilities scheduled for closure. Our visitors made frequent comments about bleak, dingy wards where

there was lack of personal space and natural light. People deserve privacy and dignity, especially in continuing care wards. We found little evidence of this in, for example, continuing care wards in Dykebar Hospital and Stratheden Hospital. Unfortunately, there is no commitment in the mental health delivery plan to set basic standards for physical accommodation. We will raise this with the Scottish Government and continue to report publicly on any conditions that we consider unacceptable.

#### Sites under development or derelict

We were very concerned about conditions we saw in the Royal Liff Hospital and Hartwoodhill Hospital. In the former, we visited a ward that was in the middle of a development area. Ward residents had their freedom significantly restricted as a result. Hartwoodhill Hospital contains many derelict buildings that are targets for vandals. We believe that these facilities are becoming increasingly unsafe and that the Health Boards must make strenuous efforts to find alternative accommodation for residents.

### Garden areas

Some wards need to have a degree of security for residents. A safe garden area adds greatly to quality of life in such situations. We made several recommendations about this.

### General upkeep and maintenance

Shabby décor and furnishings and poor maintenance do nothing for morale of residents and staff. We found poor maintenance in many places and will take further action if services do not act on our recommendations.

### Smoking

Mental health facilities are not exempt from the ban on smoking introduced by the Smoking, Health and Social Care (Scotland) Act 2005. Smoking is only permitted in designated rooms in mental health wards.

Designated rooms are strictly defined in the 2005 Act which includes a requirement for it to have a ventilation system that does not ventilate into any other part of the non-smoking premises in question. We made 23 recommendations where we found problems in implementing this. In 15

cases, we were able to smell cigarette smoke throughout the building. This was usually because of inadequate extraction and ventilation of smoking rooms; although experience in some wards in Ailsa and Murray Royal hospitals shows that it can be done. In contrast, when we visited one ward in Leverndale Hospital, we found that smoking was permitted in the main sitting area. The point of the Act is that non-smokers should not be exposed to passive smoking. Many mental health facilities are failing to do this. If our recommendations are not implemented we may inform environmental health departments, as they can give advice and may consider further action to enforce the legislation. We also found some facilities, for example the Royal Alexandra Hospital, where no smoking is permitted. Anyone who wants to smoke and who is too unwell to leave the ward unaccompanied must wait until a member of staff is available. In some areas, there was good assistance to stop smoking. While we believe that a total smoking ban in mental health care may not be practicable, we find that services are

struggling to accommodate smokers while complying with legislation. We will continue to monitor this closely and report further on the situation.

### Activities, amenities and treatments

We like to see good levels of activity and a range of treatment options available for people. Among our findings were:

- Gaps in provision of psychosocial interventions, especially cognitive behaviour therapy
- Lack of physical health checks for people in continuing care
- Low levels of social and recreational activity

Some of these issues will be addressed by commitments in the mental health delivery plan. Also, we received several comments about food (range, quality and temperature) that should be addressed by nutritional standards produced by NHS Quality Improvement Scotland. However, we are concerned about the quality of life for many people in continuing care. We highlighted this three years ago in our “Greater Expectations” report.

While we have seen some improvements, there is much more to be done.

#### Staffing and teamwork

Good mental health services are based on good multidisciplinary teamwork. Lack of input from psychology and occupational therapy were the most frequent concerns. We often found good input from social work to in-patient units and, where this did not happen, stressed its importance.

#### Use of legislation

During the visit programme, we wanted to know how the principles and procedures of new mental health legislation were working. We made 70 recommendations, our main findings being:

#### Poor documentation

One of our most frequent recommendations related to case records. For people subject to compulsion it should be easy to find documentation on their status and important information on named persons, advance statements etc. Some services, for example the forensic services at Leverndale Hospital, did this well and other services could learn from this.

#### Staff knowledge

We were concerned about lack of knowledge. Staff seemed particularly unclear about correct procedures to restrict communication and undertake searches and take samples to check for drug and alcohol use. We spent some time educating staff and recommended improved training.

#### Consent to treatment

We often found that important documents authorising medical treatment were either missing or hard to find. It is important that the appropriate forms are available at the point of giving medication. Without this, there is a greater risk that people will receive medication that is not authorised by law.

#### Other issues

- Ongoing concerns about younger people admitted to adult wards (see pages 49-54)
- A few gaps in advocacy provision and a need for more work to publicise advocacy services and help people to engage
- Use of residents' money for their benefit

#### 4.4 Visits to people on welfare guardianship

We continue to visit people for whom the Sheriff Court has appointed welfare guardians. We report on their care, accommodation and professional support. In particular, we ensure that everyone involved is aware of the principles of the Adults with Incapacity Act and demonstrate that they observe them.

This year, we received and approved eight applications for recall of welfare powers. Usually, this was because the powers were no longer necessary. In most cases, local authorities asked us to recall the powers. Changes to the Act mean that we will make fewer of these decisions in future. Changes to the Act mean that local authorities will be able to recall the powers, even when they are the guardians, providing there are no objections.

#### 4.5 Unannounced visits

This year we carried out 9 individual unannounced visits to 8 different facilities. We also carried out a simultaneous unannounced visit to 16 NHS continuing care wards for people over 65. The report of that visit “Older and Wiser” was published in June. We intend to continue to increase the proportion of our visits that are unannounced, with a target of 25% by 2012.

We have found through experience that unannounced visits help give a clear and uncluttered view of a care setting as it carries out its day-to-day operation. All 9 of the individual visits were initiated because of concerns that had been raised with us by service users, relatives or staff, alongside background information we already had from other visits. During these visits we were generally welcomed by patients and staff who were very willing and happy to give their views on the places we visited.

#### Examples of what we found

##### Maintaining standards during hospital closure

We visited a large 42-bed continuing care/rehabilitation ward in a formerly large hospital that is undergoing a closure programme. We were aware that the ward had been formed by its amalgamation with 2 other wards. We had not visited since the amalgamation and had some concerns that were reinforced by reports from the local patients’ council. When we visited we found a large ward in generally poor condition that was ill suited to its new function. In appearance it was grim, gloomy and impoverished. The ward was mixed and facilities for female patients were limited. There was little evidence of individual access to rehabilitation activities. A number of care plans said, “at least 15 minutes one to one contact with nursing staff per week.” We thought this was an indication of very low expectations of an appropriate level of therapeutic input by staff.

We reported our findings to the Health Board and discussed our concerns at a meeting with them. The Health Board took action and provided us with a plan of what they intended to do to remedy matters. Five months later we carried out another unannounced visit. While the ward itself remains unfit for its purpose there had been a marked improvement in cleanliness and décor. Care plans showed more evidence of being focused on rehabilitation and recovery. The Scottish Association for Mental Health were assisting in the preparation of patients for the eventual closure of the hospital. This episode emphasised to us the importance of maintaining the quality of care and environment while hospitals are undergoing closure programmes (this hospital is due to close in 2008). There is a danger that services can “take their eye off the ball” while focusing on reconfiguring the way they deliver care. There was recognition of this by the Health Board concerned, who responded promptly when the problems with their service were highlighted.

### Responding to concerns raised by a relative

The sister of a man who was a patient in a unit for younger people with dementia contacted us to express concerns about the standard of care he was currently receiving. She had already complained to the service but remained worried about his well-being. A visit by one of our medical officers confirmed some of her concerns. The visit also served to highlight ongoing concerns we had about the environment of this unit and the level of therapeutic activity there. We arranged a meeting on site with clinical staff and senior managers. Improvement action was agreed and the service has invested money and other resources in the unit. We were particularly pleased to see that the service sought advice on improvements to the environment of the unit from the Dementia Services Centre at Stirling University. We have visited the unit subsequently and saw considerable improvements in the environment and availability of therapeutic activity.

### Mixed wards, women and vulnerability

We visited recently-built, adult acute admission wards in one hospital, following concerns about staff attitudes and care that had been raised with us by a service user and a carer. An important objective of the unannounced visit was to observe the wards during the early evening and to speak to patients, and any relatives present, about their experiences. All of the patients spoken to had something positive to say about their care. They valued staff input but wanted more individual time with them. The staff on duty were clearly committed to delivering good care, at times in the face of limited community resources. There was one issue highlighted that can be a feature of acute services. About a third of the patients interviewed said that they felt unsafe at times. The new unit had individual rooms but 2 female patients reported pushing furniture up against their doors at night. We discussed this with the service. It is possible to allow patients to lock their doors to ensure privacy. Where there are concerns about safety, staff can override these locks

to gain access. Staff must be proactive in ensuring that their patients feel safe. As a matter of course, they should regularly ask their patients if they are experiencing any inappropriate behaviour or harassment on the ward.

### Older and Wiser

The full report of these visits is available on our website. During the visits to the 16 wards we met with patients, interviewed any relatives or carers who were present at the time and asked ward staff about improvements they would like to see for their patients. Patient files were reviewed to get a picture of the care and treatment being provided to individuals on the ward. Time was also taken to gain an impression of ward environments and their appropriateness for patients with severe dementia.

Our report draws particular attention to the need to improve the quality of physical environments provided for dementia patients and access to 'off ward' activities for patients. The review of patient files showed that several patients had not crossed the hospital threshold for over two years, many more had not been out in the last year.

With the number of people with dementia rising we, and others, believe that it is essential we can all feel confident that care in hospital will be provided in a pleasant environment, by staff who have the skills and resources necessary to provide kindly and sophisticated care. While adequate resources are essential, the quality of life for many of the patients we saw could be hugely improved by some small, inexpensive changes. Things like more accessible transport, better information for carers, improved signage and a deeper understanding of individual life histories would make an enormous difference.

We are very pleased that, in response to our report, the Minister for Public Health, Shona Robison, has said that she expects to see early improvements in respect of the privacy and dignity of patients. This includes greater participation in, and improved, physical and mental activities for patients and better access to information for carers, relatives and patients. The Scottish Executive has asked for an action plan from all Health Boards to address the issues raised by our report.

#### 4.6 Prison visits

This year we visited five prisons and the Immigration Reception Centre at Dungavel. We met with 20 prisoners who had either asked to see us or who had been drawn to our attention by health centre staff in the prison being visited. We followed up on care and treatment issues for seven of the prisoners we saw. The issues raised included transfer from prison to mental health services, access to mental health services on release and monitoring of treatment while in prison.

We met with a detainee at Dungavel after staff raised concerns about her mental state. She had been assessed by a psychiatrist who did not think that further assessment was necessary at that time. We shared the concerns of staff and she was seen by a medical Commissioner who felt that, given the circumstances, further assessment in hospital should be carefully considered. In the meantime she was moved to another Immigration Reception Centre prior to deportation. A medical officer at the new centre saw the letter from our Medical Commissioner

and agreed that a further psychiatric assessment should be carried out. We understand that the person concerned is now receiving treatment.

We were pleased to see developments in some prisons of access to advocacy services for people with a mental disorder. Increasingly we saw that prison staff are receiving mental health first aid training. This is a very welcome development in the identification of mental health problems and in the recognition of risk factors for prisoners.

A recurring issue brought to our attention was concern about the availability of prison nursing staff to escort prisoners being transferred to hospital. Reliance Prisoner Transport will provide a nurse escort but staff were concerned that this escort would not know the person being transferred and would therefore be less able to pass on information to the receiving service. We have been assured that steps have been taken to provide appropriate escorts who will be able to provide an effective transfer of care between prison and hospital.

The Scottish Prison Service has carried out an audit of patients made subject to the 2003 Act in the first seven months of its operation. The audit has raised a number of questions about the detection of mental disorder in people whilst in police or court custody, prior to reception into prison. We welcome this initiative and will focus on its findings in our forthcoming visits. We will also discuss the issues raised with the Forensic Network Board and others.

### 5 Use of the Adults with Incapacity (Scotland) Act 2000

In this section, we report on our findings from monitoring the use of the 2000 Act. We report on the use of welfare guardianship and of safeguards for medical treatment. We also report on guidance for care staff on the use of welfare powers and on the likely impact of changes to the Act, and of new guidance on when to invoke welfare guardianship.

### 5.1 Welfare guardianship

During the past year it became evident to the Commission that there was a discrepancy between our data for approved welfare guardianship applications and that of the Office of the Public Guardian for reporting years 2004-05 and 2005-06. While there will always be small differences in our respective statistics due to the timing of when we each receive and register applications, we recognised that there was scope for greater consistency

**Table 1: Guardianship orders granted by local authority area, 1 April 2006-31 March 2007**

	Private* applications granted 2006-07	Local authority applications granted 2006-07	All applications granted 2006-07 (No.)	All applications granted 2006-07 (Rate per 100K over age 16)	Recalled or lapsed** 2006-07
Fife	103	107	201	70	43
Glasgow City	30	110	140	29	28
City of Edinburgh	24	25	49	13	31
South Lanarkshire	20	23	43	17	18
Highland	26	45	71	41	38
West Lothian	13	22	35	27	30
Aberdeenshire	39	18	57	30	16
North Lanarkshire	20	14	34	13	16
Argyll and Bute	2	8	10	13	14

Table 1 continued

	Private* applications granted 2006-07	Local authority applications granted 2006-07	All applications granted 2006-07 (No.)	All applications granted 2006-07 (Rate per 100K over age 16)	Recalled or lapsed** 2006-07
Perth and Kinross	20	27	47	42	13
Dumfries and Galloway	14	20	34	28	14
Angus	20	5	25	28	9
Aberdeen City	25	18	43	26	20
North Ayrshire	3	12	15	14	17
East Ayrshire	6	19	25	26	17
Scottish Borders	2	9	11	12	10
Renfrewshire	6	2	8	6	10
East Dunbartonshire	8	1	9	11	4
Falkirk	5	9	14	12	3
East Lothian	4	8	12	16	4
Dundee City	14	10	24	21	3
Moray	7	3	10	14	4
South Ayrshire	5	7	12	13	5
East Renfrewshire	2	6	8	11	7
Stirling	4	6	10	14	2
West Dunbartonshire	3	5	8	11	10
Midlothian	3	3	6	10	6
Clackmannanshire	3	1	4	10	0
Inverclyde	3	1	4	6	3
Shetland Islands	0	0	0	0	1
Eilean Siar	2	3	5	23	3
Orkney	0	0	0	0	0
<b>Total</b>	<b>436</b>	<b>538</b>	<b>974</b>	<b>24</b>	<b>299</b>

\*The Mental Welfare Commission uses the term 'private' applicants for carers, relatives or their representatives making applications under the Adults with Incapacity Act. In all other cases the local authority is the applicant.

\*\*Includes cases where adult died.

between us. To address this, we undertook an exercise with the Office of the Public Guardian and the 32 local authorities to establish, as far as possible, a common, up-to-date, comprehensive list of existing welfare guardianship cases. The exercise proved valuable for all of us. The Commission now has strong confidence in our guardianship data and will resume detailed year on year comparisons next year, using 2006-07 as a new base line year for future comparisons.

#### 5.1.1 Trends in the use of welfare guardianship

During 2006-07, the use of welfare guardianship continued its strong growth with the Office of the Public Guardian reporting a 32% increase. In the first year of the Act there were 238 approved applications (2002-03). By last year, this had risen to just under 1000. What remains intriguing is the different profile of use of the legislation in the 32 local authorities (see Table 1). In the past year, four authorities

(Fife, Glasgow, Highland and Aberdeenshire) accounted for 48% of all applications, with Fife alone accounting for over 20% of all welfare

guardianship applications in Scotland. Even within these authorities, the percentage of applications which were made by the local authority,

**Table 2: Applicants for guardianship in orders granted, 1 April 2006-31 March 2007**

Applicant	2006-07 No. (%)
Local authority	538 (55)
Relative/carer(s)	419 (43)
Joint	11 (1)
Solicitor	6 (1)
<b>Total</b>	<b>974 (100)</b>

**Table 3: Duration of guardianship orders granted, 1 April 2006-31 March 2007**

Period granted	2006-07 No. (%)
1 year	7 (1)
2 years	5 (1)
3 years	237 (24)
5 years	54 (6)
Indefinite	659 (68)
Other	12 (1)
<b>Total</b>	<b>974 (100)</b>

as opposed to private parties, varied from 79% in Glasgow to 32% in Aberdeenshire (see Table 2). Despite an average growth in approved applications being at 32%, three authorities recorded fewer, and another three remained at the same level as in 2005-06. In Fife, the growth was well over 100%. In Aberdeen and Dundee, albeit starting from a lower base of extant cases, the growth was also well in excess of 100%.

**Table 4: Causes of incapacity in guardianship orders, 1 April 2006-31 March 2007**

Type of incapacity	2006-07 No. (%)
Acquired brain Injury	35 (3)
Alcohol related brain disorder	46 (5)
Dementia/Alzheimer's disease	606 (62)
Learning disability	245 (25)
Mental illness	57 (6)
Personality disorder	4 (0)
Multiple diagnosis	*
Other	5 (0)
<b>Total</b>	<b>974 (100)</b>

\*29 people have a multiple diagnosis. The table above shows the primary diagnosis.

One concerning trend, which we have commented upon in past reports, is the increasing tendency to seek guardianship orders for indefinite periods. In the past year 68% of all welfare Guardianship Orders were granted on an indefinite basis. In 2003-04, the first year of the 2000 Act, only 27% of Orders were granted on an indefinite basis. (See Table 5) The 2000 Act's default position for Guardianship Orders is three years although it states that they can be granted for other periods, including indefinitely.

This trend can be partially explained by the change in the balance of the causes of incapacity leading to orders being sought. In 2006-07, 62% of orders related to incapacity caused by dementia. In 2002-03, this stood at 51%. (Applicants for orders relating to adults with dementia seek these for an indefinite period in 66% of cases. This is a far higher ratio than orders that are sought on an indefinite basis for adults with any other primary diagnosis). The trend may have been influenced more by the growth of private

applications (up from 18% in 2002-03 to 43% in 2006-07). When we look at local authority approved applications, we see that only 61% were granted for an indefinite basis compared to 76% of private applications. It is clear, however, that in the course of both private and local authority applications, the trend has been to seek orders for an indefinite period more frequently.

There may be good reasons for seeking an order on an indefinite basis in certain

**Table 5: Duration and causes of incapacity in all guardianship orders, 2006-07**

Period granted/ cause of incapacity	Learning disability No. (%)	Mental illness No. (%)	Dementia/ Alzheimer's Disease No. (%)	Other No. (%)	Total (%)
1 year	1(14)	2(29)	4(57)	0(0)	7 (100)
2 years	1(20)	2(40)	0(0)	2(40)	5 (100)
3 years	55(23)	19(8)	128(54)	35(15)	237 (100)
5 years	23(43)	4(7)	16(30)	11(20)	54 (100)
Indefinite	157(24)	30(5)	435(66)	37(6)	659 (100)
Other	5(42)	3(25)	2(17)	2(17)	12 (100)
<b>Total (%)</b>	<b>242(25)</b>	<b>60(6)</b>	<b>585(60)</b>	<b>87(9)</b>	<b>974 (100)</b>

Notes on the data:

The Mental Welfare Commission is notified of orders where welfare powers are granted. This includes orders where both financial and welfare powers are granted. The Office of the Public Guardian publishes figures on orders containing financial powers only.

circumstances. The relative who applies might not wish to have to return to the Court with an application for renewal on an elderly relation with dementia when the incapacity itself will only worsen and the need for care and intervention grow over time. The potential cost of an application for renewal to the estate of the adult or the emotional strain may well be another consideration. The Courts themselves might not wish to be burdened unduly.

We believe, however, that each case should be looked at on its merits and with reference to the principles of the 2000 Act, especially that of least restrictive intervention. The Commission has expressed concerns in individual cases, such as young people with learning disability, where a wide range of powers are sought on an indefinite basis. It could be the case that even if, as individually assessed, the adult's clinical state is not likely to improve, the social circumstances of the adult can change over time. For example, relationships may be formed with service providers which result in the adult being able to be supported in making certain decisions

they would previously not have been able to make without such support.

A related issue is the real concern that the 2000 Act currently places the onus on the adult or another interested party to raise a judicial review. We do not feel this is in keeping with accepted standards of justice. The 2003 mental health Act has recognised this and has made arrangements for periodic reviews of compulsory orders which will be initiated by the Mental Health Tribunal for Scotland. We feel that this anomaly in the 2000 Act merits close attention by the Scottish Government.

#### 5.1.2 Scrutiny of applications and visits to adults on guardianship

In 2006-07, we scrutinised welfare guardianship applications and reviewed existing guardianship orders in 1055 cases. In doing so, we often corresponded and consulted with relevant practitioners, guardians, local authority supervisors and adults on guardianship for further information to determine whether we could best fulfill our duties by visiting the adult on guardianship. As a result

of this preliminary work, we decided to visit 442 adults on welfare guardianship which we carried out during the past year.

The Commission continues to be impressed, generally, with the professionalism of mental health officers (MHOs) and other local authority staff who appear to be using welfare guardianship in accordance with the principles of the 2000 Act to secure and enhance the welfare of people who are vulnerable due to their incapacity. There are instances, however, where we feel we must raise issues relating to the health, welfare and finances of individuals on welfare guardianship which arise from our contact with the adult and others with an interest. We have introduced a new reporting template within the Commission for people we visit on welfare guardianship. This will allow us to comment in greater detail in future reports on the nature of our activity on our visits as well as outcomes of these visits. We will be able to break down this information by individual local authorities. This information should be of interest and benefit to those who work within local

authorities managing adults with incapacity as well as to individual practitioners.

### 5.1.3 Supervisory responsibilities

We reported last year on the changes in regulations relating to duties and functions of local authorities in supervising welfare guardians. The minimum requirement to visit both adult and guardian following the initial visit was changed last year from three to six months for subsequent visits. What was apparent in the data-verifying exercise undertaken with the local authorities was that a number of local authorities were unaware of who in their authority was carrying out these supervisory responsibilities.

The relationship between the supervisor and the guardian can often be crucial in ensuring that the Act is being implemented as intended. It also provides a key local authority contact for private guardians who may require advice, guidance and assistance in carrying out their role and ensuring that the adult on Guardianship has access to all appropriate supports. The Commission is now asking for six monthly

updates from local authorities on those who remain on welfare guardianship, including contact details of the local authority delegated guardian or supervisor as well as private guardians. We feel this will help ensure local authority management have a firmer grasp on this key area of practice which is a requirement of the Act.

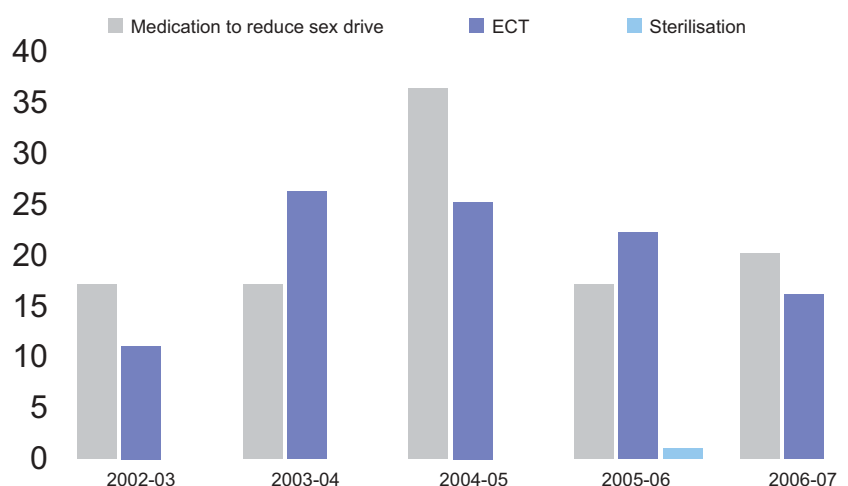
### 5.2 Treatment under Part 5 of the Adults with Incapacity (Scotland) Act 2000

Legislation modifying the 2000 Act has been passed but not implemented at the time of writing. This will change the duration of the

authority to treat in some cases and will allow dentists, nurses and physiotherapists to authorise certain treatments.

During the past year there have been no requests for second opinions under Section 50 of the Act. Second opinions under Section 48 have authorised ECT in 16 cases and the use of medication to reduce sex drive in 20 cases. A comparison of the number of requests for second opinions in recent years is given below.

Figure 1: Second opinion assessments for treatment under Adults with Incapacity legislation, 1 April 2002-31 March 2007



### 5.3 Information and guidance for people who work in adult care settings

Both from our visits undertaken to people on welfare guardianship and registered care services and from calls to our advice and information line, we have become aware of the need for clarity on roles and responsibilities regarding the use and implementation of welfare powers in care settings. Our visiting programme has also highlighted the need for improved record keeping where individuals are subject to welfare powers under the Adults with Incapacity Act. In the past year, the Commission has published guidance 'Working with AWI – Information and Guidance for People Working in Adult Care Settings' to help address this problem. This guidance has been distributed widely to local authorities and the independent care sector. This publication was distributed to all relevant registered services throughout Scotland.

This guidance offers particular advice for carers of adults subject to the 2000 Act. Because the Commission has legal duties in relation

to safeguarding the rights of people who are subject to welfare provisions of the 2000 Act, the guidance focuses on issues relating to welfare guardianship and welfare Powers of Attorney in care settings. While the guidance addresses some areas of financial decision making, this is only as far as this may have a bearing on the welfare of an individual.

Guidance advises staff to whom any questions or concerns about care arrangements should be addressed, and gives guidance on how the Act, and in particular the principles of the Act, can be used to resolve areas of disagreement. This guidance is available on the Commission's website.

### 5.4 Developments in adults with incapacity act legislation

The Commission had campaigned for a number of years for non-means tested legal aid for welfare guardianship applications. We reported in last year's annual report that we were pleased that from 1 August 2006, free legal aid for applications for welfare guardianship or joint financial

and welfare guardianship would be available without means testing.

We speculated last year that one unintended consequence of this would be a number of applications for welfare powers may be put forward when applying for financial guardianship, in order to gain access to this entitlement. It is not evident that these changes have influenced the use of the Act in this way. What has become evident, however, is that the Commission was not sufficiently sensitive to the complexity of the new arrangements for obtaining legal aid when seeking guardianship applications.

People seeking to become guardians may be eligible for a form of legal aid to pay for advice and assistance from a solicitor. The solicitor ignores an applicant's personal means, but must look at the disposable income and capital of the adult with incapacity. It allows a solicitor to give an applicant initial legal advice regarding their rights and legal duties, such as how to go about being appointed as a guardian, and can be used to make an application for civil legal aid.

The civil legal aid application is assessed by the Scottish Legal Aid Board (SLAB) and is designed for civil proceedings in the Sheriff Court. If the applicant wishes to be appointed as a guardian with either purely welfare powers, or a mix of welfare and financial powers, no means test is applied. If there is no welfare component (e.g. purely financial powers), SLAB has to look at the disposable income and capital of the incapable relative. No contribution from the applicant is due in a case where welfare powers alone are sought. A contribution may be payable in cases without a welfare component.

Before incurring any costs to an applicant, a solicitor should present them with all necessary information on fees and alert them to any possible costs due from their relative's estate. This is a complex area and prospective applicants should be referred to publications from the Scottish Legal Aid Board for fuller guidance.

### 5.5 When to invoke the Act

Last year we reported that, as well as proposed changes to the legislation, the Scottish Executive was reviewing comments on the draft guidance on when to invoke the Adults with Incapacity Act. This had already been issued for consultation and the Executive hoped to produce final guidance to assist professionals in complex judgements later in 2006. Guidance was eventually published in March 2007. Guidance aimed to:

- describe how the relevant duties and powers under the 1968 Social Work (Scotland) Act and 2000 Act sit alongside each other;
- promote and support good practice when major decisions require to be made on behalf of an adult with impaired decision-making capacity;
- promote and support good practice in assessing whether a proposed care intervention amounts to "deprivation of liberty" in terms of Article 5 ECHR;
- ensure consistency in the way the legislation is implemented.

The 1968 Act was amended so that where a local authority decided under section 12A of the Act that an adult's needs called for the provision of a community care service, and it appeared to the local authority that the adult is incapable in relation to decisions about the service, the local authority may take any steps which they consider would help the adult to benefit from the service. This includes moving the adult to residential accommodation if other circumstances, such as the accommodation, does not represent a deprivation of liberty, and there were no objections from any party to this move, prevailed.

The Commission is planning to produce more detailed guidance on whether any care arrangement provided amounts to a "deprivation of liberty" in terms of Article 5 ECHR to help local authorities make this assessment.

The Commission will monitor the effect that this change in the legislation has on delayed discharge from hospital.

### 5.6 Changes in Adults with Incapacity legislation

Since March 2007, doctors have been able to write treatment certificates under section 47 of the AWI, which last for three years in certain circumstances. Previously these certificates could only last one year. The adult who lacks capacity must be diagnosed as having a severe or profound learning disability, dementia, or a severe neurological disorder for this to apply.

Before the introduction of the Act in 2002, one way for people to obtain the authority to make decisions for an incapable adult was to apply to become a tutor dative. The suitability of the applicant was not assessed by a MHO, the powers sought did not need tailored to the individual and many were for an indefinite period without review. All tutors dative will need to consider applying for guardianship under the provisions of the 2000 Act, if they wish to renew their authority, two years from a date yet to be specified, but which is expected to be this autumn. Tutors dative may want to seek legal advice and will need to notify local

authorities of their intentions, if they wish to continue to be guardians, and it may be advisable to plan this well in advance of the 2 year end date.

In October 2007 the Adult Support and Protection (Scotland) Act will introduce a new procedure for local authorities to recall their own guardianships i.e. where the Chief Social Work Officer is the guardian. Local authorities have always had the right to recall private guardianships. They will have to let various parties know of their intention to recall guardianships, including the Mental Welfare Commission and the Office of the Public Guardian. Guardianship orders will be recalled if there are no objections.

## 6 Looking to the future

### 6.1 Challenges for legislation

As part of the monitoring of the operation of the 2003 Act, for 18 months we have listened to concerns about some of its provisions. Many aspects of the Act are a success. Notably, we believe that the principles have made a difference to the way that most practitioners undertake compulsory care and treatment. New safeguards such as advocacy and advance statements have had an impact and the Act has been successful in reducing the numbers of emergency orders. While anecdotal experiences of Tribunal hearings vary, we believe that there is general agreement the Tribunal process is preferable to the previous procedures in Sheriff Courts.

However, there have been some unintended consequences that have been less helpful in the way the Act has operated. While some of these have already been addressed, or are under consideration, we thought it would be helpful to set out the Commission's views in this section of our report.

The main problem areas have been:

- Restriction orders
- Tribunal process and interim orders
- Named persons
- Forms
- Suspension of detention

#### Restriction orders

Some psychiatrists brought this to our attention during 2006. Criteria for revocation of compulsion orders with restriction orders caused problems because there appeared to be no way to revoke the restriction order, even if it was no longer necessary. There were similar problems with other orders that carried restricted status, such as transfer for treatment directions. We were sure that this was unintended and were pleased that Scottish Ministers agreed with us. The Act was amended early in 2007 to bring the criteria for revoking the order into line with the criteria for granting it.

#### Tribunal process and interim orders

We received a lot of correspondence about the Tribunal. Practitioners and service users expressed frustration with the length of the process and the number of interim hearings. This could result in up to three Tribunal hearings to make a decision on a compulsory treatment order (CTO). This was often distressing to service users and costly to the time of Tribunals and practitioners attending them. The Scottish Executive has undertaken to review this situation. The causes need to be examined and include:

#### The requirement of the Tribunal to have interim hearings

Previously, Sheriff Courts allowed for the judicial process to be extended to allow for legal representation, independent opinions etc. We had concerns about this as it effectively extended short-term detentions with compulsory treatment, in the absence of a robust test of whether the grounds for the orders were met. The Tribunal must be satisfied that the grounds for interim orders are met and must afford a variety

of individuals to lead or produce evidence. The Tribunal's interpretation is that they cannot do this without a hearing and it is hard to argue against that view.

#### Access to legal representation

We know of some areas in Scotland where there are few solicitors willing and able to take on work relating to mental health legislation. This can cause delays in the process and makes it difficult for people to challenge their compulsory treatment. Article 5(4) of the European Convention for Human Rights requires the availability of such a challenge.

#### Curators ad litem

The Tribunal introduced a process for representing the interests of people who lack the capacity to arrange for legal representation. This has proved cumbersome and has led to delays in the process. At the request of Scottish Ministers, a group, convened by the Chair of the Commission, made recommendations for a more streamlined process. Although this was accepted by the Minister, it has not been implemented at the time of writing.

#### Independent psychiatric reports

Solicitors often try to obtain reports from independent psychiatrists on the application. We have heard of difficulties in getting reports. Other demands on psychiatrists' time, such as the demands of the new consultant contract, other work relating to the Act, and membership of Tribunals, reduce the time available for independent work.

There are no easy solutions to this. We believe that the duration of short-term orders, the nature of the Tribunal process and the roles of the Tribunal members need to be examined.

#### Named persons

We heard of many problems relating to the role of the named person, the most potent of which seemed to be the amount and nature of the information supplied to the named person. The 2003 Act and the Tribunal Rules require significant information to be given to the named person. This has resulted in named persons receiving some very sensitive personal information that may breach the service user's right to privacy and dignity. This is especially a problem where the named person responsibilities fall to the primary carer or nearest relative by default and the service user has not made a nomination.

While the Tribunal Rules would allow for some information to be withheld, this whole area needs further examination and probably a change in primary legislation and/or the Tribunal Rules.

#### Forms

We took on the work of designing the forms for the Scottish Executive. We heard of many concerns about the forms, notably length, complexity and repetition. We have redesigned the forms to address some of the problems. The 2003 Act requires much more information to be provided, so forms need to be longer. We designed the forms for electronic completion and it is important that practitioners have the skills and facilities to do this for all non-urgent situations. Ultimately, we believe that secure on-line completion and submission of forms is the way forward and will reduce the present bureaucracy and cost associated with the forms.

#### Suspension of detention

Practitioners have told us that they find the provisions for suspending detention confusing and cumbersome. Part of the problem will be addressed by amending forms. However, the requirement that accumulated suspension shall not exceed nine months in any 12 month period causes confusion. We have issued guidance and answered many questions on this. It is not clear to us what happens if this period is exceeded. Our general advice is to aim for variation of the order to remove the detention requirement at an early stage wherever possible – bearing in mind that the Responsible Medical Officer (RMO) must be satisfied that the grounds for compulsion are still met. However, we believe that the part of the 2003 Act on suspending detention needs to be reviewed for greater clarity and ease of use.

The Scottish Government has indicated that there will be a limited review of the 2003 Act later this year. We will be submitting suggestions to address these issues. We also intend to hold focus groups with psychiatrists and mental health officers to examine areas of concern and to help share best practice.

## 6.2 Challenges for delivery of mental health services

In December 2006, the Scottish Executive published “Delivering for Mental Health”. This document set out 14 commitments and three key targets. We welcomed the plan and believe that progress on the commitments will improve services. We have been closely involved in some of the commitments, especially in relation to acute in-patient services and the Scottish Recovery Index (SRI). It is unreasonable to expect the plan to cover all aspects of delivery of mental health services and we will use our visits to provide evidence of the commitments being achieved. In this year’s report, we have continued to highlight the lack of age-appropriate services for young people and some evidence of poor attention to physical health. We believe that the Executive and NHS Quality Improvement Scotland should examine our findings from visits when considering the content of care pathways and in implementing the SRI. However, it is important that we continue to use the experience of service users to highlight examples of best and worst facilities and care.

As part of a wider framework of inspection, we have made commitments to share our findings more with other agencies, notably the Care Commission and the Social Work Inspection Agency. During the past year, we consulted widely with stakeholders about how we should target our visit programme. Based on this consultation, we are making several changes to the way we visit services. We intend to:

- Conduct more unannounced visits
- Alter the frequency of visits to make them more responsive to stakeholders’ concerns
- Have greater contact with homeless agencies
- Make our findings and recommendation to services public and available on our website. This will include whether and how services have responded to our recommendations.







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