Our Annual Monitoring Report 2008-09

mentalwelfare commission for scotland

Mental Welfare Commission for Scotland

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Director's introduction

This report gives an independent overview of the operation of the use of legislation to provide care and treatment for people with a mental illness, learning disability or other mental disorder. We have focused on our duties to monitor the **Mental Health (Care and Treatment) (Scotland) Act 2003**.

We also report on the use of the **Adults with Incapacity (Scotland) Act 2000** where there are significant interventions in the health and welfare of people with with a mental illness, learning disability or other mental disorder.

We provide statistical information on how each piece of legislation is used. We also use our knowledge and expertise to comment, where appropriate, on our findings. This has proved important in providing information for the review of mental health and incapacity legislation and the development of policy.

This year, we have found that the number of new compulsory orders continues to fall. We are pleased to see that fewer people are detained under emergency orders, although the fall is much greater for men than for women. The number of existing long-term orders is stable with about a third of people now being treated in the community instead of in hospital. We think this is good news and shows that the principle of least restriction is having an effect.

We have had an increase in reports of admissions of people under 18, especially males, to adult wards despite the Government's commitment to reduce such admissions. Also, we have concerns about young people with learning disability who are on indefinite welfare guardianship orders with no guarantee of a legal review.

We rely on information reported to us. We greatly appreciate the help we get from medical records departments in hospitals, local authority officers, the Mental Health Tribunal for Scotland and the Office of the Scottish Public Guardian. They all have legal duties to report orders and interventions to us and we acknowledge the work involved.

However, we know that there are some significant gaps in our information. In particular, we are missing information from the Tribunal on a significant number of cases where compulsory treatment orders have been granted. For this reason we have, where possible, relied on statistics compiled from Tribunal records and reported to us by them. We are grateful for their permission to reproduce these here.

The production of this report would not be possible without the expertise and diligence of our staff. I wish to record my thanks to all our administrative, information, database and communications staff for their assistance.

Our overview of the use of the Mental Health (Care & Treatment) (Scotland) Act 2003

The purpose of this part of the report is to give a national overview and our commentary on the use of the Mental Health (Care & Treatment) (Scotland) Act 2003 .

This report highlights

- variations in the use of the legislation across different geographical areas (NHS Board and Local Authority areas)
- issues in the use of legislation for particular categories of individual
- trends in the use of legislation over time

We have presented information on the use of the Mental Health (Care & Treatment)(Scotland) Act 2003 slightly differently this year. This part of our report is divided into four broad parts:

- new orders granted in 2008-09
- total number of orders in existence
- monitoring of priority areas
- additional findings from our monitoring programme

New orders granted

In this section of the report, we look at all the new orders that were granted over the year. We have looked at trends over time in how the Mental Health (Care & Treatment) (Scotland) Act 2003 is being used. As well as looking at total numbers, this year we have looked at whether the 2003 Act is being used differently for men and women.

We found a general fall in the numbers of new civil orders of all types.
The use of emergency detention for men is greater in the male population, but the fall in compulsory treatment orders (CTOs) is greater for women. There is a slight rise in the number of new orders for people with mental disorders who have been convicted of offences.

Table 1: Episodes initiated between 1 April 2008 and 31 March 2009 and comparison with 2007-08

Episode Sequence	Episodes 08-09	Episodes 07-08	%Change
Emergency detention to informal status	918	916	0%
Emergency detention to short-term detention	919	992	-7%
Direct to STDC	2211	2152	+3%
Direct to CTO (including interim orders)	95	132	-28%
Total episodes	**4143**	**4192**	**-1%**

Our interest in these figures

Short-term detention should be the usual route into compulsory treatment. We want to find out whether this is what happens. The use of short-term detention has gone up under the 2003 Act. We expected this but it means that, although fewer people are detained, those who are detained might be detained for longer.

This table shows how people enter a spell of compulsory treatment. We want to see how episodes start and what happens to people after they are first detained.

What we found

We were notified of 4,143 episodes of compulsory treatment during the year. This number has fallen consistently since the 2003 Act was introduced. It is slightly lower than last year and about 13% lower than the number of people detained each year under the 1984 Act. We believe that the more rigorous procedures, tighter grounds for compulsion and better expert assessment have reduced the need for compulsory treatment.

The shift toward short-term detention as the usual route into compulsion continues. The number of people detained under short-term certificates has risen by 12% since the 2003 Act was introduced.

This year there were 59 more people admitted directly under a short-term detention certificate. 79 fewer people were admitted under emergency detention certificates. 53% of people who are detained are now admitted under short-term detention certificates. We are pleased that this trend continues.

Since the 2003 Act came into force, fewer people have been given compulsory treatment than under the previous 1984 Act. We think this is because of tighter grounds for compulsion and because the procedure for admission is more demanding and needs greater expertise. More expert assessment should mean that compulsory treatment is only applied when absolutely necessary.

We remind psychiatrists to keep the need for short-term detention under review to make sure that people are not detained longer than is necessary and of benefit to them.

The use of emergency detention certificates

Table 2: Emergency detention by age and gender, 1 April 2008 to 31 March 2009

Emergency detentions	Female	Male	Totals (%)
0-15	2	7	9 (0)
16-17	12	11	23 (1)
18-24	109	108	217 (12)
25-44	436	362	798 (42)
45-64	257	240	497 (26)
65-84	146	124	270 (14)
85+	39	27	66 (4)
Totals	**1001**	**879**	**1880 (100)**

Our interest in these figures

Under the Mental Health (Care & Treatment) (Scotland) Act 2003, an emergency detention certificate (EDC) can be issued by an approved medical practitioner (AMP) in order to secure a psychiatric assessment, where there is grounds to believe that someone has a mental disorder. Mental Health Officers (specially trained social workers) should also give their consent to an emergency detention, if this is possible within the time available.

We collect information on the age and gender of people detained as an emergency, how the use of emergency detention varies depending on the area in which people live. We also look at what happens to people after a period of emergency detention. We look, for example at whether people go on to a short-term detention, or whether the person goes on to receive care and treatment on a voluntary basis.

What we found

The age distribution of people detained under EDCs is similar to previous years. We have however picked up an emerging difference in the gender of people detained as an emergency. The proportion of women detained under EDCs has risen steadily over the last three years. We have looked into the reason for this. Comparing 2008-09 with 2006-07, we found that:

- The total number of EDCs fell by 8%
- EDCs for men fell by 13%
- EDCs for women fell by only 3%

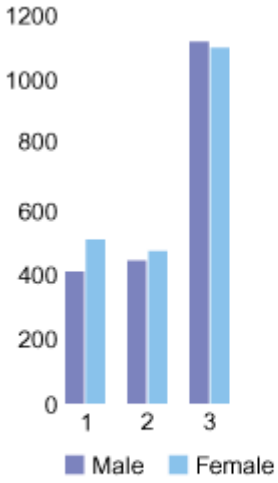
The difference is most evident in the 18-64 population. Compared with 2006-07, 20 (2%) fewer women in this age group were detained compared with 156 (18%) fewer men.

There is no increase in the number of men being detained under short-term detention, so the general fall in the use of the 2003 Act is evident for men but

not for women. General adult mental health services need to look at why this is the case. One possible explanation is that rates of deliberate self harm are higher in women. If so, there is a need to examine services for people who self-harm to make sure that there are services in place that will lessen the need for detention.

We shall look more closely at the characteristics of women detained under EDCs next year.

Figure 1: Episodes initiated between 1 April 2008 and 31 March 2009 displayed by gender



1: Emergency detention to informal status
2: Emergency detention to short-term detention
3: Direct to STDC

Our interest in this

Because of our findings in relation to gender and the use of EDCs, we wanted to look more closely at whether men and women were treated differently under emergency and short-term detention.

What we found

The striking finding is the number of women who are admitted for short periods under emergency detention but not detained further. The use of emergency detention certificates therefore appear to be responses to relatively brief mental health crises. The explanation for this is not clear - we have speculated about deliberate self harm, but we think this figure suggests mental health services need to look at how well they respond to women at times of crisis.

Table 4: Emergency detention certificates (EDCs) with and without MHO consent by NHS Board, 1 April 2008 to 31 March 2009

	No. of EDCs per 100K population	% of people in community before detention	No. of EDCs with MHO consent	No. of EDCs without MHO consent	% of EDCs with MHO consent
Ayrshire & Arran	39	42	71	74	49
Borders	11	54	19	3	86
Dumfries & Galloway	49	51	45	28	62
Fife	25	42	80	48	88
Forth Valley	35	53	83	19	81
Grampian	17	67	81	9	90
Greater Glasgow & Clyde	49	37	329	254	56
Highland	47	49	95	50	66
Lanarkshire	24	40	57	77	43
Lothian	38	51	256	53	83
Orkney	13	67	3	0	100
Shetland	36	38	6	2	75
Tayside	41	51	117	47	71
Western Isles	42	55	7	4	64
Scotland	**36**	**45**	**1249**	**631**	**66**

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Our interest in these figures

Emergency detention should only be used where granting a short-term detention certificate would involve too much of a delay for the individual. We look at the extent to which emergency detention is used to detain people who are already in hospital, or to admit individuals who have been admitted from the community.

We hear of anxiety from some people that, although they agree to be in hospital, they may be detained if they want to leave. We are concerned that this may constitute 'de facto' detention i.e. detention without the safeguards of law. Looking at the rates of admission from hospital helps us to identify where this might be happening. In previous years, around half of EDCs were granted for people who were already in hospital.

We place great importance in the role of the mental health officer (MHO) in the decision to detain a person. The MHO provides the important safeguard of looking critically at the proposal to detain the person and can help to look at alternative ways to support the person without needing to use compulsory admission. Where the person needs to be admitted, the MHO can help to explain the process and make arrangements to make admission easier and to safeguard the person's property and possessions. The 2003 Act requires either consent from an MHO, or an explanation of why this was not possible. We would like to see consent in as many cases as possible. We look to see whether there is more likely to be MHO consent in some NHS Board areas than others.

What we found

As in previous years, around half of EDCs were granted for people already in hospital. We found MHO consent for 66% of EDCs. This is the same proportion as last year and down from 72% in 2006-07. NHS Boards with proportions of MHO consent that are significantly lower than this should discuss the reasons with their local authority partners.

NHS Ayrshire and Arran has had low rates of consent in the past and is low again this year. This may reflect the rural nature of this area and the fact that out-of-hours MHO services cover a large area of the West of Scotland and might have difficulty attending in time (although the same argument might apply to NHS Highland where the rate of consent in much higher). NHS Lanarkshire has a low rate of consent but is a relatively low user of emergency detention.

NHS Greater Glasgow and Clyde should examine this data closely. They have a low rate of consent, a high use of emergency detention and a high rate of detaining people already in hospital (we know MHO consent is less likely in this group - see table below). We can help by providing the Board with data on which hospitals seem to use this power most.

Table 5: EDCs by pre-detention status and MH0 consent to detention 1 April 2008 to 31 March 2009

Status prior to emergency detention	Number of EDCs with consent	Number of EDCs without consent	Total EDCs	% with MHO consent
Informal in hospital	626	373	999	63%
From community	609	245	854	71%
Totals (%)	**1235(67%)**	**618(33%)**	**1853**	—

Notes: The table excludes 27 cases where there was no information about pre-detention status. This makes the percentage with consent slightly different from table 4.

Our interest in these figures

We usually find that detention of a person already in hospital is less likely to involve MHO consent. This is probably because the person is expressing an immediate wish to leave and the medical practitioner has conducted an examination, decided that the person should be detained but cannot wait for the MHO.

We have concerns that people can be detained for up to 72 hours without MHO consent.

What we found

As in previous years, a person who was already in hospital is less likely to have MHO consent for emergency detention. We have recommended possible changes to the 2003 Act to shorten the period for emergency detention under these circumstances, or to allow nurses the power to detain

until both the medical practitioner and MHO are able to attend and assess the person.

Table 6: EDCs by time of granting of certificate and MHO consent to detention, 1 April 2008 to 31 March 2009

Time of granting of certificate	% of total	% of total with consent	% of total without consent
Within office hours	30	21	9
Outside office hours	70	45	24

Our interest in these figures

While short-term detention should be the usual route into compulsory treatment, emergency detention is still used, mostly outside office hours. We think it is important that there is consent from an MHO wherever possible. The table above looks at the extent of MHO consent outside office hours.

What we found

We are pleased that it is still the case that most EDCs granted outside office hours have MHO consent. The exceptions appear to be NHS Lanarkshire and NHS Ayrshire and Arran. These areas were both served by the West of Scotland out-of-hours MHO service. It appears to us that this service is not providing the level of MHO cover necessary for these areas. We understand that North and South Lanarkshire councils have withdrawn from this service from April this year and we will study the coming year's data with interest. North and South Ayrshire local authorities should consider our data and examine other ways to provide a round-the-clock MHO service.

Table 7: Duration of emergency detention certificates granted, 1 April 2008 to 31 March 2009

	Within 24 hours of admission	24-72 hours after admission	Total (%)
EDCs revoked	208	271	479 (26)
EDC superseded by STDC	503	418	921 (50)
Order expired at 72 hours	n/a	n/a	448 (24)
Total number of emergency detentions (%)	**711(38)**	**689(37)**	**1848(100%)**

Our interest in these figures

Short-term detention should be the usual route for admission to hospital under the Act. This involves mental health specialists - an AMP and an MHO. EDCs can be granted for up to 72 hours. An AMP or MHO is not necessarily involved and there is no right of appeal.

The 2003 Act says that hospital managers should arrange for an AMP to examine the person as soon as possible after admission. We think this should happen within 24 hours. Usually, this should result in a decision to revoke the certificate or to detain the person under a short-term detention certificate. We do not think that the certificate should run for the full 72 hours and then expire.

We look at all EDCs and measure the time until they are either superseded or revoked to make sure that there is evidence of early expert assessment. If the person is admitted over a weekend, it might be acceptable for the AMP to assess, but not make a decision and wait for the team that knows the person best to assess the person on the Monday. This should only happen occasionally.

What we found

The table above shows that only 38% of people detained on an EDC had the order either revoked or superseded within the first 24 hours. We don't think this is what the 2003 Act intended and would like this figure to be much higher. Also, around a quarter of all certificates appear to run for the full 72 hours without being either revoked or superseded. We have found this consistently since the 2003 Act was implemented.

We think this is a problem. People should not be deprived of their liberty, for that length of time, on the basis of a certificate granted by one doctor who does not need to be a specialist and without the consent of an MHO. Of all EDCs that continued beyond 24 hours, 36% had no consent from an MHO.

We have recommended changes in the law to restrict the duration of emergency detention under those circumstances. Meanwhile, we remind hospital managers of their responsibilities and would like clear evidence of early assessment by specialists to make sure that detention is necessary.

Short-term detention under the Mental Health (Care & Treatment) (Scotland) Act 2008-09

Table 8: Short term detentions granted by age and gender, 1 April 2008 to 31 March 2009

	Short-term detentions		
Age group	Female	Male	Totals (%)
0-15	8	12	20 (1)
16-17	15	21	36 (1)
18-24	115	170	285 (9)
25-44	531	638	1171 (36)
45-64	478	420	898 (28)
65-84	392	314	706 (22)
85+	82	45	128 (4)
Totals (%)	**1621 (50)**	**1620 (50)**	**3244 (100)**

Our interest in these figures

One of the intentions of the Mental Health (Care & Treatment) (Scotland) Act 2003 is that short-term detention certificates (STDCs) should be the usual starting point for an episode of compulsory treatment for a mental illness or disorder. Being detained under a STDC provides better individual safeguards than admission under emergency detention; an STDC involves examination by an approved medical practitioner (AMP) and consent from a mental health officer (MHO). Short term detention can last for up to 28 days.

We are interested in whether this power is equally applied across geographical areas, across genders and for people of different ages. We also compare our data from 2008-09 with previous years to see if there are any emerging trends in the use of detention.

What we found

Unlike our findings for the use of emergency detention, we found the gender balance in the use of STDCs roughly equal and with very little change over the past few years.

Slightly fewer people under 18 were detained on STDCs - 56 this year compared with 66 and 67 in the previous 2 years.

The use of STDCs for older people has fluctuated in the last few years but we have seen a rise in the use of short-term detention for people aged 65-84. 706 people in this age group detained under STDCs this year, compared with 621 in 2006-07 and 675 in 2007-08. This is a rise of 14% over 2 years. The use of short-term detention appears to be similar for men and women and cannot be explained by a rise of that size in the number of older people in Scotland. We think this reflects a greater use of mental health legislation for people with dementia.

We have had concerns that many people with dementia are kept in hospital and deprived of their liberty without the law being used properly. Also, we have found cases where we thought a person with dementia should have been detained earlier in order to safeguard their rights and well-being. We will continue to monitor this and are visiting people in acute older people's wards across Scotland to make sure they are getting the care they need.

Table 9: Number and percentage of short-term detention certificates granted by type of mental disorder specified, 1 April 2008-31 March 2009

Type of mental disorder*	No	% of certificates
Mental illness	3167	98
Learning disability	144	4
Personality disorder	111	3
Not recorded	10	(0)
Total certificates	**3244**	

In many cases, people are diagnosed with more than one mental disorder.
*– each diagnosis is included separately in the table

Our interest in these figures

We are required to monitor the use of the 2003 Act. We need to know on what grounds people are being detained, to ensure individual detention is consistent with the letter and the principles of the law**.**

What we found

The majority of people subject to short-term detention have a mental illness diagnosis.

The number of people with a diagnosis of personality disorder receiving care and treatment under a STDC appears to have fallen slightly since 2007-08, from 133 to 111, although it is still higher than 2006-07 when only 42 people were recorded as having a personality disorder.

A small number of people who have a learning disability are detained under a short-term order. While the number is small we have recorded a significant increase in numbers of STDCs since 2007-08 (from 88 to 144 this year). Although the change in monitoring forms that took place in 2007 may have led to better recording and hence higher numbers, it is nevertheless a significant increase. Additional information regarding the use of mental health legislation for people with a learning disability will be available from our 2 yearly census. We will continue to monitor the use of mental health legislation for this group of people to ensure that people with a learning disability have the same freedoms, benefits and protections as other individuals under the law.

Table 10: Types and combinations of mental disorders recorded in short-term detention certificates, 1 April 2008 to 31 March 2009

Mental disorder	No	% of certificates
Mental illness	2935	90
Mental illness + learning disability	99	3
Mental illness + personality disorder	96	3
Mental illness + personality disorder + learning disability	7	0
Personality disorder	59	2
Personality disorder + learning disability	8	0
Learning disability	30	1
Not recorded	10	0
Totals	**3244**	**100**

Our interest in these figures

People frequently present with more than one diagnosis. It is important to recognise the relative contributions of each category of mental disorder in order to ensure that they are getting the appropriate care and treatment.

What we found

The revised STDC forms allow us to determine more clearly the number of people receiving more than one diagnosis. The number of people receiving a diagnosis of personality disorder alone is little changed from the previous year; in combination with mental illness or learning disability there are small increases.

The main finding is the doubling of those with a diagnosis of learning disability and mental illness, from 45 in 2007-08 to 99 this year. Overall, there has been a 64% increase since 2007-08 in the number of people with a learning disability detained under STDC. As we said above, some of this increase may be due to new monitoring forms. More information will be provided through our our 2008 census report on the use of mental health legislation for people with a learning disability.

Table 11: STDs granted where named person is recorded or consulted, 1 April to 31 March

	No.	% of all short-term detentions	
		2008-09	2007-08
Named person recorded	2558	79	74
Named person consulted	1618	50	46

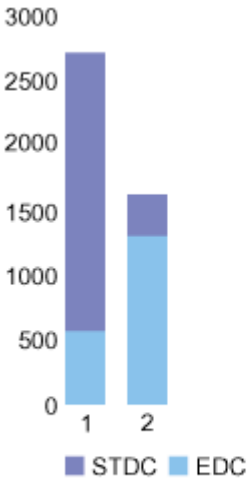
Our interest in these figures

The provision for individuals with a mental illness, learning disability or other mental disorder to have a named person was an important aspect of the 2003 Act. The appointment of a named person, trusted by the service user to take a specific interest in his or her care and treatment,was intended to provide a means by which a person's past and present views could be represented and could influence care and treatment decisions. Named persons should be consulted when an STDC is issued. We are aware that the implementation of this aspect of the 2003 Act has been less than complete.

What we found

There is a slight improvement in the consultation and recording of named persons. Nevertheless, as a clear requirement of the 2003 Act, it is disappointing that in 50% of cases, people treated under short-term detention received this treatment without the benefit of input from their named person. We will have more information about this aspect of the implementation of the 2003 Act in our 2009 monitoring report on short-term detentions.

Figure 2: Episodes of detention initiated by emergency and STD within and outside office hours 1st April 2008 to 31st March 2009



1: In Hours
2: Out of Hours

Our interest in these figures

The 2003 Act is clear that short-term detention should be the usual order used for compulsory admission. In previous years, we have found this is more likely to happen during office hours. At evenings, weekends and public holidays, emergency detention is more often used. We wanted to see if there was any change this year.

What we found

This year, around 80% of compulsory admissions during office hours are short-term detentions. Outside office hours, 80% are emergency detentions. As MHOs give consent for most out-of-hour emergency detentions, it appears that NHS Boards are not securing out of hours availability of AMPs who are required to carry out emergency assessments. We think that ensuring good availability of AMPs to review people within 24 hours of emergency admission is very important. NHS Boards that are not achieving this should look to see how the availability of AMPs can be extended.

Compulsory treatment orders

Table 12: Compulsory treatment orders granted by age and gender
1 April 2008 to 31 March 2009

Compulsory treatment orders	Female	Male	Totals	%
1-15 yrs	3	3	6	1
16-17 yrs	10	7	17	2
18-24 yrs	21	57	78	8
25-44 yrs	129	255	384	38
45-64 yrs	131	153	284	28
65-84 yrs	125	92	217	21
85+ yrs	20	17	37	4
Totals	**439**	**584**	**1023**	**100**

Our interest in these figures

Compulsory treatment orders (CTOs) are granted by the Mental Health Tribunal. They last for six months, can be extended by the responsible medical officer (RMO) for a further six months, and can then be extended annually. The Tribunal reviews CTOs at least every two years. CTOs can potentially restrict or deprive individual liberty for long periods of time.

We look at how these orders are used for people of different ages and genders to see if there are any key differences and trends. Over recent years, the number of new orders has decreased. We have also found that CTOs are usually used more for men than women. We have seen some increase in use for older people in recent years.

What we found

- The total number of new CTOs has fallen for the second year in a row. Until 2007-08, the number of new long term orders was rising. There were 15% fewer CTOs granted this year than there were 2 years ago.
- The number of CTOs for older people (65+) has not gone up compared with the last two years. This is in contrast to a rise in short-term detentions in this age group over the same time period.
- 57% of all new CTOs were for men. This is a slightly higher proportion than previous years.
- While the number of CTOs has reduced, the reduction has been greater for women that for men. Compared with two years ago, 21% fewer CTOs were granted for women, compared with 10% fewer for men.

The fall in the number of CTOs may reflect the stricter criteria of the 2003 Act and/or better ways of engaging people in informal treatment. It is possible that the procedure for granting a CTO, especially the likelihood of more than one Tribunal hearing, deters practitioners from applying. If so, it will be interesting to see what happens if the law is amended to streamline the procedure.

The gender difference in the use of CTOs is growing. The reduction in use of CTOs is more apparent for women than for men. We think this may be due to higher incidence of severe and enduring mental illness, complicated by use of drugs and alcohol, in the male population**.**

Table 13: Pattern of progression to compulsory treatment orders, 1 April 2008 to 31 March 2009

Status prior to CTO	Interim CTO only	Interim CTO to CTO	Direct to CTO
STDC	229	477	365
Informal	13	35	46
Totals	**242**	**512**	**411**

Our interest in these figures

When the Tribunal receives an application for a CTO, it must hold a hearing. Sometimes, hearings result in an interim order for up to 28 days. There can be a further interim order before a final decision is made. There has to be a hearing each time. Multiple hearings can be distressing for service users, time consuming for practitioners and expensive to deliver. We look at how many of the applications notified to us result in interim orders as opposed to full CTOs. Because of delays in transfer of information from the Tribunal, our data is not always complete. This should be kept in mind as you review this section.

What we found

Last year, we found that around 64% of all applications to the Tribunal resulted in an interim CTO. We found much the same this year. Despite everyone's desire to reduce the number of interim orders and multiple hearings, we find no evidence that this is happening.

It is very important that the Tribunal carefully considers the need for the CTO and for the measures that are sought. This must be done in a way that protects the rights of the individual, but also in the most efficient manner possible. When commissioning an independent limited review of the 2003 Act, the Scottish Government accepted the view that the process took too much time and was too expensive. Our information suggests that this continues to be the case.

Geographical variations in the use of mental health law in Scotland

Table 14: No and rate per 100k population of compulsory powers granted, by order type and NHS Board, 1 April 2008 to 31March 2009

NHS Board	Emergency detention	Rate per 100k	Short term detentions	Rate per 100k
Ayrshire and Arran	145	39	177	48
Borders	22	20	51	45
Dumfries and Galloway (HB)	73	49	82	55
Fife (HB)	91	25	209	58
Forth Valley	102	35	158	54
Grampian	90	17	280	52
Greater Glasgow and Clyde	583	49	978	82
Highland (HB)	145	47	190	61
Lanarkshire	134	24	233	42
Lothian	309	38	577	71
Orkney (HB)	3	15		0
Shetland (HB)	8	36	2	9
State	0	0	3	0
Tayside	164	41	287	72
Western Isles	11	42	17	65
Scotland	**1880**	**36**	**3244**	**63**

Our interest in these figures

Most people who are detained under the Mental Health (Care & Treatment) Scotland Act 2003 are held for up to 72 hours (if on an emergency detention certificate) or 28 days (on a short-term detention certificate). Each year, we look at how these orders are used in different NHS Board areas. We always find large variations and causes are not easy to explain.

Because people with severe and enduring mental illness tend to live in inner city areas, we would expect to find detention rates higher in these areas. Emergency detentions can be higher in rural areas, because it is less easy to get an approved medical practitioner (AMP) and a mental health officer (MHO) that would be required to complete a short-term detention certificate. These differences however do not explain the geographical variations in practice that we see.

We are concerned that areas with high use may be intervening excessively where there may be alternatives to depriving people of their liberty. Low use could mean that people are not being adequately treated or protected. It could also mean that people are being persuaded to be in hospital when they want to leave. This can mean they are effectively being "detained", but without the range of safeguards provided by the law.

What we found

We looked at this year's figures and compared them with those from the previous two years. Our main findings, shown in the table above are:

NHS Dumfries and Galloway and NHS Greater Glasgow and Clyde have highest rates of emergency detention. NHS Dumfries and Galloway was highest last year.

As with the last two years, the highest rate of short-term detention was in NHS Greater Glasgow and Clyde, but this year the rate is 14% higher than any other NHS Board area and 6% higher than last year. Tayside, Lothian and Highland have the next highest rates. This has been a consistent pattern over the last three years.

Lanarkshire and Borders have the lowest rates of all mainland NHS Boards.

The areas we have identified as especially high or low users of the 2003 Act should consider the reasons for this.

We think these differences raise a number of issues for example:

- the potential interaction of drug use with mental illness, especially in Glasgow and surrounding areas and the resulting impact on services there;
- the distinctive features and culture of mental health services in different parts of Scotland;
- the interaction between crisis services provision, crisis planning and individual detentions.

Table 15: Number and rate per 100k population of CTOs granted, 1 April 2008 to 31 March 2009 with three year average

Health Board	No. of CTOs	Rate per 100 k	Average in last three years (number)	Average rate in last three years (%)
Ayrshire and Arran	38	10	51	14
Borders	18	16	20	18
Dumfries and Galloway	34	23	33	22
Fife	76	21	94	26
Forth Valley	56	19	51	18
Grampian	92	16	102	19
Greater Glasgow & Clyde	258	22	267	22
Highland	63	20	76	25
Lanarkshire	77	14	76	14
Lothian	193	24	194	24
Orkney	1	5		
Shetland	1	5		
Tayside	106	27	102	26
The State Hospital	5	n/a		
Western Isles	5	19		
Totals	**1023**	**20**	**1066**	**21**

Our interest in these figures

Compulsory treatment orders (CTOs) are used to authorise long-term compulsory treatment. Each year, we look at how these orders are used in different NHS Board areas. We always find large variations and causes are not easy to explain. Because people with severe and enduring mental illness tend to live in inner city areas, we usually find rates higher in these areas. This does not explain the variations that we see. We are concerned that areas with high use may be intervening excessively where there may be alternatives to depriving people of their liberty. Low use could mean that people are not being adequately treated or protected.

We find that numbers and rates differ greatly from year to year, so we looked at the average use in each mainland NHS Board area over the last three years.

What we found

We think that it is best to look at the average figures for the last three years. These show that:

- NHS Lanarkshire and NHS Ayrshire and Arran have low CTO rates
- The highest CTO rates are in NHS Fife and NHS Tayside with NHS Highland and NHS Lothian not far behind
- Despite having high rates of emergency and short-term detention, NHS Greater Glasgow and Clyde has a CTO rate lower than many other areas and closer to the national average.

The NHS Board areas that we have identified should examine this data and look for possible explanations. They should also look at our point prevalence data. NHS Tayside, in particular, has a very high use of long-term compulsory treatment, especially in hospital.

Table 16: No. and rate per 100k population of short-term detentions granted by order type and local authority, 1 April 2008 to 31March 2009

Local Authority	Short - term detentions	Rate per 100k	CTOs*	Rate per 100k
Aberdeen City	145	69	63	30
Aberdeenshire	78	32	19	8
Angus	41	37	16	15
Argyll and Bute	47	52	15	17
Clackmannanshire	21	42	11	22
Dumfries and Galloway	79	53	36	24
Dundee City	123	83	50	34
East Ayrshire	37	31	13	11
East Dunbartonshire	36	34	3	3
East Lothian	63	66	26	27
East Renfrewshire	33	37	14	16
Edinburgh City	366	78	118	25
Eilean Siar	12	46	3	11
Falkirk	73	48	23	15
Fife	207	57	78	22
Glasgow City	671	115	143	24
Highland	153	70	48	22
Inverclyde	79	98	21	26
Midlothian	41	51	19	24
Moray	54	62	12	14
North Ayrshire	61	45	19	14
North Lanarkshire	84	62	33	10
Orkney	1	5	–	–
Perth and Kinross	122	85	42	29
Renfrewshire	79	47	28	16
Scottish Borders	52	46	23	20
Shetland	6	27	1	5
South Ayrshire	66	59	16	14
South Lanarkshire	174	56	61	20
Stirling	66	75	20	23
West Dunbartonshire	53	58	24	26
West Lothian	103	61	25	15
East of Scotland Standby Service	4	–	–	–
West of Scotland Standby Service	8	–	–	–
Local Authority not recorded	6	–	–	–
Grand Total	**3244**	63	**1023**	20

*CTO numbers provided by MHTS –

Our interest in these figures

Tables above show the variation in civil compulsory orders by NHS Board area. We also want to look for differences across local authority areas. There are differences and overlaps in boundaries, especially in Glasgow and

Lanarkshire. We do not examine figures for emergency detention because so many orders are outside office hours and the MHO may be from a different local authority as part of a regional standby service. For short-term detention and compulsory treatment orders, we usually find that inner city local authorities have highest rates.

What we found

Glasgow City and Inverclyde have very high rates of short-term detention. These are the major reasons why NHS Greater Glasgow and Clyde has such a high rate.

Rates are generally higher in inner cities and large towns such as Aberdeen, Dundee, Perth and Stirling.

Rates are generally low in rural areas such as Moray and Aberdeenshire or relatively affluent areas such as East Dunbartonshire and East Renfrewshire.

The use of nurses' power to detain

Table 17: Nurses power to detain pending medical examination, by hospital and gender, 1 April 2008 to 31 March 2009.

Hospital	Female	Male	Total
Aberdeen Royal Infirmary	0	1	1
Ailsa	1	0	1
Argyll and Bute	1	0	1
Borders General	0	1	1
Borders NHS	5	4	9
Cameron	0	2	2
Carseview Centre	4	5	9
County	0	1	1
Crichton Royal	7	3	10
Crosshouse	1	1	2
Dr Grays	3	0	3
Dykebar	6	2	8
Eilean Siar	1	0	1
Falkirk Royal Infirmary	0	1	1
Florence Street Day Hospital	1	0	1
Gartnavel Royal	6	2	8
Herdmanflat	1	0	1
Inverclyde Royal	1	0	1
Mackinnon House	2	1	3
Monklands	1	1	2
Murray Royal	1	1	2
New Craigs	4	2	6
Queen Margaret	3	1	4
Royal Alexandria	1	2	3
Royal Cornhill	2	2	4
Royal Dundee Liff	0	2	2
Royal Edinburgh	26	19	45
St Johns	2	0	2
Stratheden	0	1	1
Sunnyside Royal	1	0	1
Udston	1	0	1
Whytemans Brae	5	2	7
Wishaw General	0	1	1
Totals	**87**	**58**	**145**

Our interest in this

Nurses have the power to detain people in hospital pending medical examination, in situations where that person, or others, may be at risk. This is often known as 'nurses' holding power'. Last year we noted a marked variation in the use of this power around Scotland and a significant difference in the way that it was used with men and women. We wanted to see if there was any change this year.

What we found

We continue to find significant variation in the use of this power between hospitals across the country. As in previous years, the notifications received from the Royal Edinburgh Hospital indicate a higher use compared to similar services elsewhere.

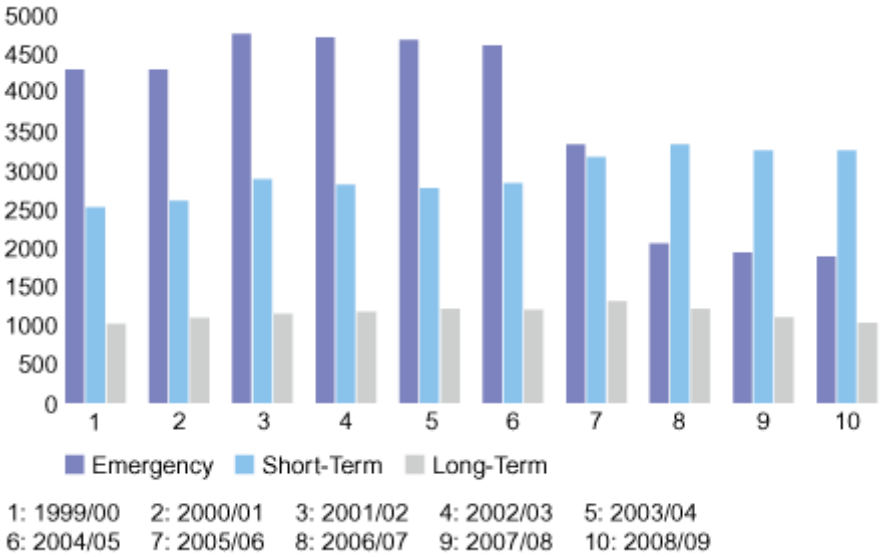
The use of the nurses' holding power to detain may be influenced by a number of factors such as local understanding of the power, variations in nursing practices and the availability of approved medical practitioners and mental health officers.

Since we started reporting on the use of this power, its use has been higher for women than for men. Nurses are perhaps more likely to restrain women.

Managers should examine the use of this power in their areas and ensure that nursing staff have a clear understanding about the appropriate use of their power to detain.

Trends in the use of civil compulsory treatment

Figure 3: Detentions under civil procedures in Scotland, 1999 to 2009



Our interest in these figures

We look at how the main civil compulsory orders in Scotland have been used over time. Over the years, we found an increasing use of long-term compulsory treatment. This was similar to other western European countries. We want to see what difference the Mental Health (Care & Treatment) Act 2003 has made to this trend.

What we found

Main findings are:

- The use of emergency detention is only 41% of the rate under the 1984 Act and is still falling. This is a tribute to the efforts of NHS Boards and local authorities to provide crisis services and intervene using short-term detention in most cases, especially within office hours.
- Short-term detention rates have gone up since the 2003 Act was introduced (midway through 2005-06) but have not changed much since then.
- The number of new long-term detention orders has continued to fall since the 2003 Act came into force. This year, there were 14% fewer new long-term orders than in 2006-07.

These figures need to be studied along with our figures on total number of orders in existence. While fewer people are subject to new orders, those who are on long-term compulsory orders seem to be staying on them for longer. Our visits to people who have been on CTOs for three years or more suggest that the need for the orders is not being reviewed often enough.

The use of compulsory care and treatment for mentally disordered offenders

Table 18: Compulsory treatment under criminal procedures, 2007- 08 and 2008-09

Order Type	No. of orders 2008-09	2007-08
Remand in custody or on bail for inquiry into mental condition (CPSA* 200)	3	7
Assessment order (CPSA 52D)	177	114
Treatment order (CPSA 52M)	74	80
Interim compulsion order (CPSA 53)	25	22
Temporary compulsion order (CPSA 54(1)(c)	12	5
Compulsion order (CPSA 57A (2))	59	41
Compulsion order (CPSA 57A (2)) Community	4	1
Compulsion order (CPSA 57(2)(a))	7	5
Compulsion order (CPSA 57(2)(a)) - Community	0	1
CORO** (CPSA 57A + 59)	9	10
CORO (CPSA 57(2)(b))	5	2
Transfer for treatment direction (MHSA (2003)*** 136)	29	30
Hospital direction (CPSA 59A)	0	1

* Criminal Procedure (Scotland) Act 1995

** Compulsion order with restriction order

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

Our interest in these figures

Each year, we report on the number of orders made for assessment or treatment under criminal procedures law. Many different orders can be made for the same person. For example, a person accused of a crime could be sent to hospital under an assessment order, detained further under a treatment order and, if convicted, treated under a compulsion order with or without a restriction order. We look to see if there are any variations compared with previous years.

We find some variation year on year but the only consistent pattern is that the use of long term orders after conviction (compulsion orders) had been falling for several years.

What we found

There are some differences from previous years but the main findings are:

- The number of compulsion orders without restriction has gone up from 48 to 60 this year. This is against a downward trend over previous years. We thought that better Court Diversion schemes were stopping people who had been arrested on minor charges from going through the criminal justice system. We will watch this figure in future years.
- The number of remands under Section 200 of the Criminal Procedures (Scotland) Act 1995 continues to fall. This is good news. We think there

are far more appropriate disposals available since the 2003 Act was introduced.

Table 19: Episodes of compulsion under criminal proceedings by age and gender 2008-09

Age Range	Female	Male	Totals
01-15	0	1	1
16-17	0	6	6
18-24	6	53	59
25-44	45	201	246
45-64	17	73	90
65-84	0	2	2
85+	0	0	0
Totals (%)	**68 (17%)**	**336 (83%)**	**404 (100%)**

Our interest in these figures

We look at the age and gender of people who have been treated under compulsory powers when accused or convicted of offences. Usually, these people are younger men. This differs from civil compulsory orders where the gender balance is more even.

What we found

As in previous years, there are far more men than women assessed or treated under compulsory powers via the criminal courts. We are seeing a slight shift in the age range, with proportionately more people aged 45 and over in this category. We will continue to monitor this.

Table 20: Community-based compulsion orders, 2008-09

	No. of orders
Full orders granted	4
Variations from hospital to community during period	21
Recalls from community to hospital during period (S113/ S114)	5

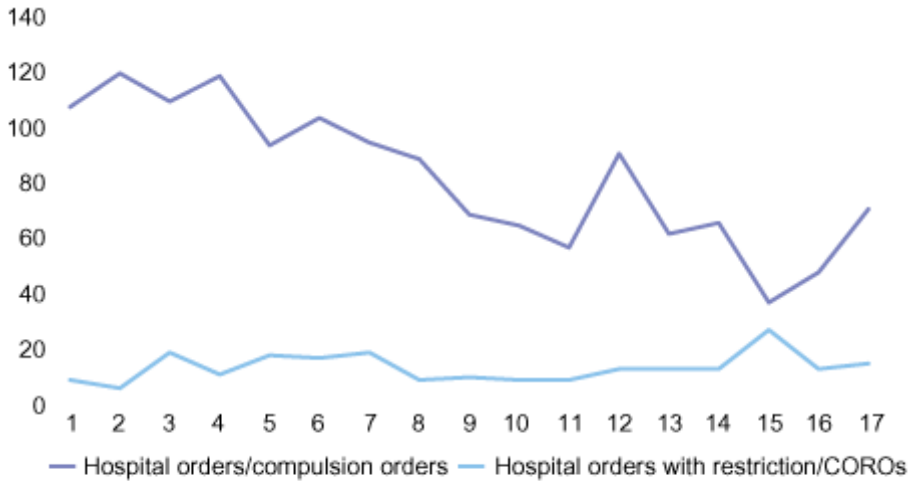
Our interest in these figures

Compulsion orders in the community are relatively uncommon but the number is rising. We look at how many new and varied orders there are each year.

What we found

This year, there were 25 new or varied orders authorising community treatment under a compulsion order. This is comparable with previous years. A very small number of people were recalled to hospital during this period.

Figure: Orders granted under Criminal Procedures Scotland Act 1992-2009



1: 1992/93 2: 1993/94 3: 1994/95 4: 1995/96 5: 1996/97 6: 1997/98
7: 1998/99 8: 1999/2000 9: 2000/01 10: 2001/02 11: 2002/03 12: 2003/04
13: 2004/05 14: 2005/06 15: 2006/07 16: 2007/08 17: 2008/09

Our interest in these figures

Criminal procedures legislation allows for long-term mental health "disposals" from court. Compulsion orders (formerly hospital orders) are granted by the court and are similar to compulsory treatment orders. Compulsion orders with restriction orders (COROs) are used where the crime has been particularly serious and where the person needs to be subject to special restrictions overseen by Scottish Ministers. We look at the number of new orders granted each year.

What we found

Over time, we had been seeing a reduction in the number of new compulsion orders (COs) while the number of new COROs had been relatively stable. We think that the 2006-7 figures are misleading - some of the forms had not been completed correctly due to misunderstanding of the new legislation. We are finding that the number of new COs has risen this year. We are pleased to see mental health care and treatment used as a disposal from court where there is a clear need. We would prefer to see fewer people with mental disorders getting involved in the court system in the first place. Good quality services, good crisis management and court diversion schemes all have a part to play

See also figures on trends in the use of legislation for mentally disordered offenders.

Total number of orders in existence

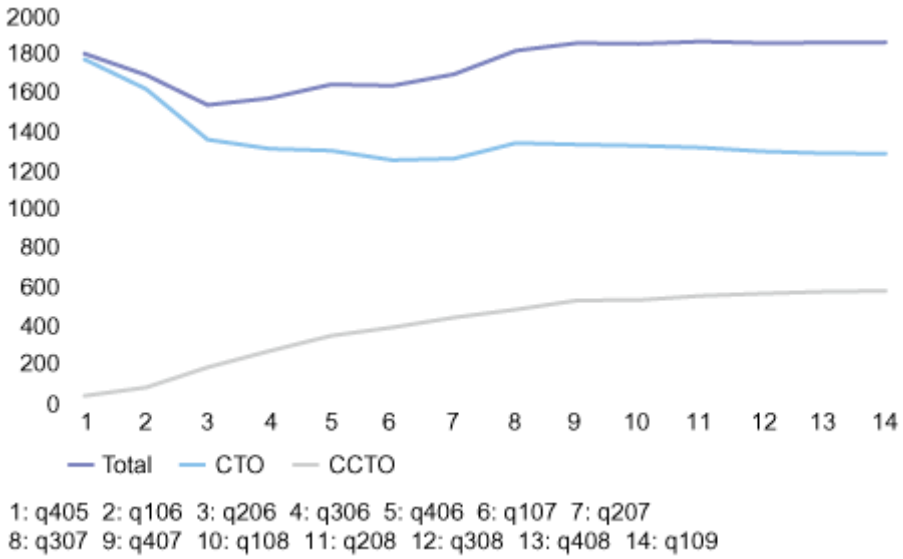
This section of our report deals with the "prevalence" of orders under the Mental Health (Care & Treatment) Scotland Act 2003. For long term orders, this can be more meaningful than looking at new orders. We have worked hard over the last year to improve our knowledge of all long-term orders and have revised previous years' data to give an accurate picture of how the new Act has been used since its introduction. We found that, after an initial fall, the number of people on long-term compulsory orders has risen to the same level as the previous Act. The big difference is that a third of people are now treated outside hospital. The number of people on criminal procedure orders has stayed stable over this time.

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

Order	2 April 08	2 July 08	2 Oct 08	7 Jan 09
Emergency detention	12	4	10	15
Short-term detention	225	221	206	210
Interim compulsory treatment order	70	61	64	72
Compulsory treatment order	1859	1851	1852	1854
Hospital-based	1312	1292	1283	1281
Community-based	547	559	569	573
Assessment order	5	10	9	9
Treatment order	11	14	14	10
Interim compulsion order	6	7	7	10
Compulsion order	168	163	172	173
Compulsion order with restriction order	253	251	249	246
Transfer for treatment direction**	64	65	67	68
Hospital direction**	0	0	0	0
Remand in custody or on bail for enquiry into mental condition	0	0	0	0
Probation order requiring treatment (s230)	0	0	0	0
Temporary compulsion order	0	1	3	4
Indeterminate status*	79	69	59	56

*In these cases, we have made improvements to the way forms are validated, resulting in a much higher rate of confidence in results hence a substantial reduction where status is indeterminate, compared with previous annual reports.

** For the 1984 Act, "Transfer for Direction with Restriction Orders" were originally interpreted as "Hospital Directions". This error was noticed in April 09 and they should have been interpreted as "Transfer for Treatment Direction". This explains changes to the figures.



Our interest in these figures

Here we show all the orders that are in force on four dates throughout the year. This is known as "point-prevalence" data. We think this is very important information, especially for long-term orders. It helps us to see how community compulsory treatment is used over time. We thought the numbers of people on community based orders under the 2003 Act would rise, at least for a while, when the Act was introduced in 2005. We thought that this might correspond with a fall in the number of people detained in hospital under long-term orders.

What we found

The graph shows that the total number of people on compulsory treatment orders (CTOs) has been remarkably steady over the past four quarters. The number of people detained in hospital is falling at the same rate that community compulsory orders (CCTOs) are rising. We saw little change in the number of people treated under long-term orders after being convicted of a crime.

We looked back to see what happened from the introduction of the 2003 Act. This is shown in the graph. We worked hard to get this data as accurate as possible, so this will look a bit different from the numbers we published last year.

Key points are:

- The number of people on CTOs fell sharply during the first year. Some orders may have been revoked because people did not meet the stricter criteria of the new Act. Others may have ended because practitioners were unfamiliar with new procedures.
- Over 2006 and 2007, the total number of people on CTOs climbed back to the previous level of just over 1800 at any one time. This number has been remarkably stable from mid 2007 until now.

- Long-term detention in hospital has fallen by around one third (about 600 people) since the 2003 Act was introduced. It appears that these 600 people would now be treated under community orders. We think this is in line with the principle of least restriction of freedom.
- The number of people on CCTOs rose sharply from the introduction of the 2003 Act and continues to rise. The increase has been slowing down and looks as if it will stabilise at around 600 people.
- We need to keep monitoring this. It is important that responsible medical officers remember their duty to review the need for the orders regularly. We don't think they do this often enough.

Table 22: Number of people subject to compulsory powers on 2 January 2009, rate per 100,000, by NHS Board in rank order.

NHS Board	Rate per 100K
Tayside	65
Greater Glasgow & Clyde	57
Lothian	55
Fife	51
Dumfries and Galloway	49
Forth Valley	46
Grampian	44
Highland	44
Ayrshire and Arran	41
Borders	36
Lanarkshire	31
Western Isles	15
Shetland	9
Orkney	0
Scotland	**53**

Our interest in these figures

We comment on the number of new orders in different NHS Board areas in other parts of this report. This table shows the total number of people in each area who are subject to compulsory treatment on one date during the year. In our experience, this is a good guide to the overall use of compulsion in each NHS Board area. We look to see which are the highest and lowest areas and try to explain the differences.

What we found

We consistently find that NHS Tayside has the highest use of compulsory treatment of all NHS Board areas in Scotland. This year is no exception. NHS Tayside's use of compulsion is 23% higher than the Scottish average. NHS Lanarkshire's use is 34% below the average, with NHS Borders also being low. These NHS Boards need to look at reasons for this. We have had useful discussions with NHS Lanarkshire. Factors which appear to affect use are:

- Urban versus rural populations

- Culture and attitudes of practitioners
- Availability of early intervention, treatment and support
- Use of alcohol and drugs

This is an area that needs more research. We need to understand why someone in NHS Tayside is more than twice as likely to be given compulsory treatment than someone in NHS Lanarkshire.

Our monitoring priorities

Each year, we decide on priorities for monitoring the Mental Health (Care & Treatment) (Scotland) Act 2003. We consult on what we should look at and build on our findings from previous years and other parts of our programme, for example visits to services and calls to our advice and information service.

In 2008-09 our monitoring priorities for care and treatment under the 2003 Act were:

- **the rights and welfare of people receiving community based compulsory treatment**

- **overrides of advance statements**
  We are still receiving very few notifications of advance statements being overridden. However, as we have no way of knowing how many advance statements have been produced we have no way of commenting.

- **the rights and welfare of younger people**
  We still have concerns about services for younger people and it is disappointing to see a rise in the number of young people admitted to adult wards, especially young males.

- **the rights and welfare of people on short-term detention certificates**
  We will be publishing an additional report from our programme of monitoring visits to people on short-term detention on this site very soon.

Overrides of advance statements

Table 23: Analysis of notifications of treatment that is in conflict with an advance statement, 1 April 2008 to 31 March 2009

	Total
Number of notifications	27
Notification made in error	1
Advance statement not compliant with Act	4
No override	4
Person agreed with treatment	3
Advance statement withdrawn	1
Continuation of override	1
*Actual overrides**	13
Refusal of depot injection	4
Refusal of any medication	1
Refusal of ECT	1
Request for/refusal of specific medication(s)	7
Refusal of artificial nutrition	1
Limits on dosage	2

* More than one category of override may arise in each Advance Statement

Our interest in these figures

Before the Mental Health (Care & Treatment) (Scotland) Act 2003 was introduced we consulted with stakeholders to identify those areas they felt we should monitor. Many people who had experience of using mental health services told us they were concerned that 2003 Act's provision for service users to influence their care and treatment through written advance statements, would be limited by practitioners overriding their expressed views.

In response to this concern, we committed to monitoring overrides of advance statements as part of our work to monitor the principle of participation which underpins the 2003 Act. It is difficult for us to know what proportion of advance statements are overridden as we currently have no way of knowing how many have been prepared.

What we found

We continue to receive a small number of notifications in respect of advance statement overrides. We follow up all notifications to determine the nature of the override. Not all are genuine overrides. In some cases the advance statement does not comply with the requirements of the 2003 Act. In others, the person agrees with the proposed treatment, despite what is set out in the advance statement.

We have not included those overrides where the only statement is the refusal of admission to hospital.

We have also become aware of a number of circumstances where patients are being encouraged to complete advance statements immediately prior to Mental Health Tribunal hearings. We do not think that this complies with the requirements of the 2003 Act.

Advance statements should be completed before treatment starts, at a time when the individual's capacity in respect of treatment for mental disorder is not significantly impaired. We think everyone involved should make sure that their practice does not encourage people to prepare advance statements when they aren't able to think clearly about what might be in their best interests. We do remind everyone of the importance of taking account of the person's present wishes when providing care and treatment.

Community based compulsory treatment

Table 24: CTO and CCTOs by NHS Board extant on point prevalence date on 7 January 2009

Health Board	CTO Community Based	CTO Hospital Based	Totals	% community based
Ayrshire and Arran	28	81	109	26%
Borders	12	15	27	44%
Dumfries and Galloway	18	42	60	30%
Fife	47	99	146	32%
Forth Valley	36	61	97	37%
Grampian	45	132	177	25%
Greater Glasgow and Clyde	156	310	466	33%
Highland	32	67	99	32%
Lanarkshire	42	92	134	31%
Lothian	112	213	325	34%
Shetland	0	2	2	
State	0	35	35	
Tayside	45	129	174	26%
Western Isles	0	3	3	
Totals	**573**	**1281**	**1854**	**31%**

Our interest in these figures

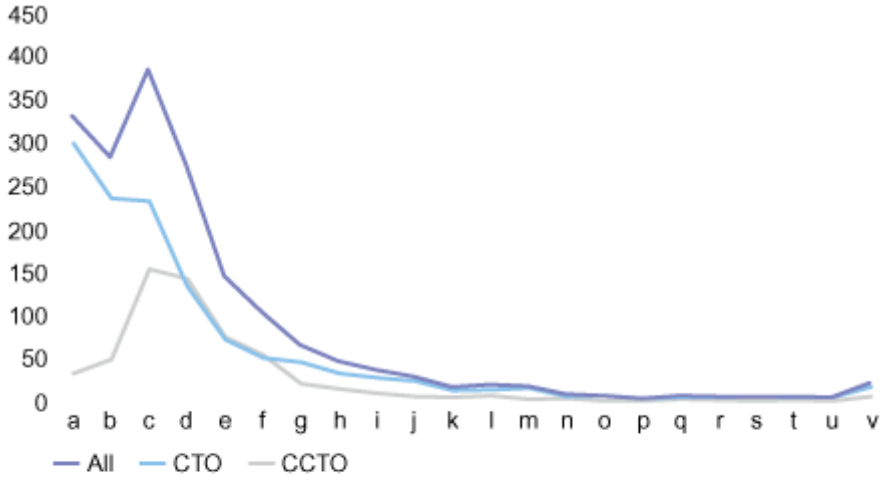
The Mental Health (Care & Treatment) (Scotland) Act 2003 makes provision for compulsory treatment to be delivered in the community. We know that the use of compulsory community treatment (CCTOs) is replacing long-term detention in hospital. Across Scotland, we found that around 30% of all compulsory long-term treatment is now in the community**.** We wanted to see if this varied across the main NHS Board areas.

What we found

We looked for NHS Boards that were obviously higher or lower than the national average. The important findings are:

- NHS Borders has a high proportion of compulsory community treatment orders. Given the relatively low use of the 2003 Act in that area, there are remarkably few people detained under compulsory treatment orders (CTOs) in hospital.
- Grampian, Ayrshire and Arran and Tayside have relatively low usage of CCTOs.
- Given the high use of the 2003 Act in Tayside, the number of people detained long-term in hospital is concerning. We think this NHS Board in particular should reflect on our figures and consider whether their community services are adequate.

Figure 5: Length of compulsory treatment by order type 2008-09



a: 0-6 months b: 6 months-1 year c: 1-2 years d: 2-3 years e: 3-4 years
f: 4-5 years g: 5-6 years h: 6-7 years i: 7-8 years j: 8-9 years k: 9-10 years
l: 10-11 years m: 11-12 years n: 12-13 years o: 13-14 years p: 14-15 years
q: 15-16 years r: 16-17 years s: 17-18 years t: 18-19 years u: 19-20 years
v: over 20 years

Our interest in these figures

We know that about a third of all CTOs are used to treat people in the community. We looked at all people who were treated under CTOs on one particular day to find out how long, in total, they had been subject to compulsory treatment. We looked at this for people on hospital and community treatment orders.

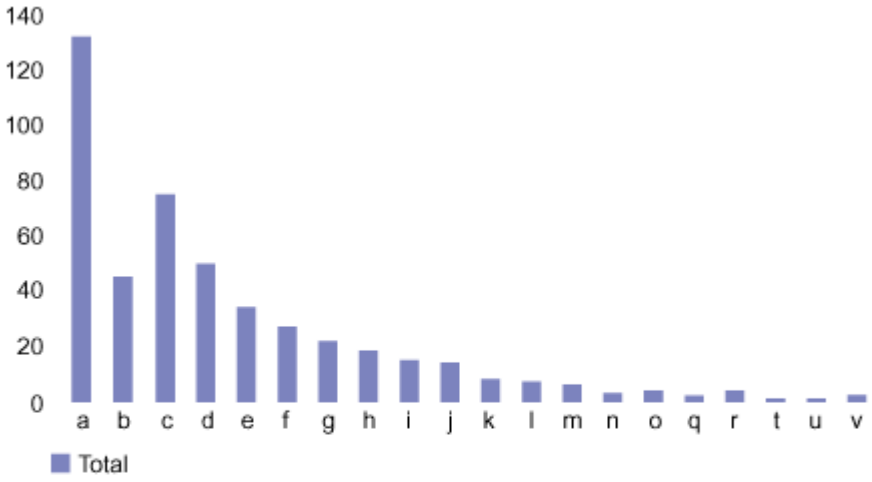
What we found

Most people are treated on CTOs for relatively short periods. We found that:

- After 2 years, the number of people still on CTOs drops quickly and very few people are on orders for more than five years.
- People treated for less than three years are more likely to be in hospital.
- For people whose episodes of treatment are longer than three years, the order is as likely to be community-based as hospital based.

We will repeat this survey on two dates over the next year to see if episode lengths change and if there is a greater shift to community orders

Figure 6: Length of episodes of all people subject to Compulsory Treatment Orders on 28th January 2009



a: 0-6 months b: 6 months-1 year c: 1-2 years d: 2-3 years e: 3-4 years
f: 4-5 years g: 5-6 years h: 6-7 years i: 7-8 years j: 8-9 years k: 9-10 years
l: 10-11 years m: 11-12 years n: 12-13 years o: 13-14 years q: 15-16 years
r: 16-17 years t: 18-19 years u: 19-20 years v: over 20 years

Our interest in these figures

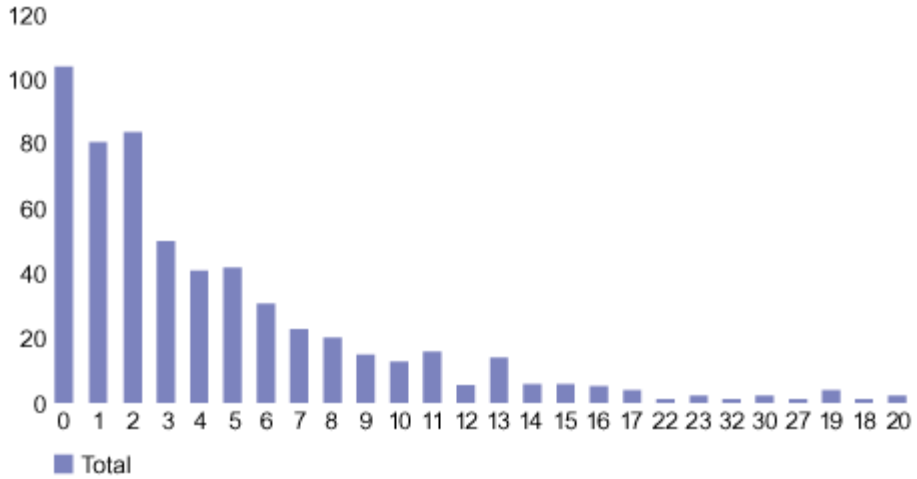
When the 2003 Act was introduced, some people were anxious that they would be placed on compulsory treatment in the community for long periods of time. For all people on CCTOs in January 2009, we looked to see when the episode of compulsory treatment started.

What we found

We found a lot of people whose order was less than six months old. There is a dip before another peak between one and two years. After that, we see fewer and fewer people whose orders have gone on for long spells.

This makes us think there are two populations. One group of people need a short spell of compulsory community treatment to help ensure recovery from an episode of illness. There is another group that needs longer spells of treatment. We want to find out more about these people and will be looking into this more over the next year.

Figure 7: People on community compulsory treatment orders - number of previous compulsory episodes



Our interest in these figures

We counted the number of previous episodes of compulsory treatment for all people who are on community CTOs at present. Under the 1984 Mental Health Act, nobody could be treated in the community under a civil compulsory order for more than a year. We expected to see community CTOs being used for people with several previous episodes and long spells of leave of absence under the 1984 Act.

What we found

Most CCTOs are used for people with few previous episodes. This was not what we expected. 18% of people had no previous episodes and almost half had fewer than three previous episodes. We think that the Mental Health Tribunal considers granting community orders wherever possible. This is in line with the principle of least restriction of freedom.

Table 25: Granting, recalls and revocations of community CTOs 1 April 2008 to 31 March 2009

	No. of people
New community orders granted	139
Variations of hospital to community CTOs	255
Variations of community to hospital CTOs	38
Recalls from community to period S112	10
Recalls from community to period S113	106
Recalls from community to hospital S114	79
Episodes of admission under EDC and/or STDC of people on community CTOs	78
Revoked/lapsed community based orders during period (including interim orders	252

Our interest in this

We take great interest in how compulsory community treatment works. We want to see how people come to be on CCTOs, how often these orders are revoked and whether people need to be brought back into hospital.

There are two reasons why a person on a CCTO might be compulsorily admitted to hospital. If people do not comply with the order (e.g. do not attend for treatment or allow support services into the house), they can be recalled under sections 113 (72 hours) then section 114 (28 days). There is a provision to take someone to hospital or some other place of treatment for 6 hours if he/she refuses to take medication (section112). People who comply with the order but become unwell can be admitted under emergency or short-term detention. Of course, people may agree to come to hospital voluntarily for treatment but we are not informed when this happens

What we found

The number of people on CCTOs continues to rise. Around 400 new or varied orders authorised community measures. Only 250 orders were revoked and some were varied back to hospital.

About a third of all people on CCTOs are taken into hospital under a compulsory order. This has been a consistent finding for the last few years. We still find a low use of section 112 to make sure the person receives medication but can still live in the community. It is possible that it is used more than we are aware of, but that this is notified on the wrong form.

We think section 112 is a useful provision and is less restrictive of the person's liberty than recall to hospital and we think it should be used more often.

Care and treatment of children and young people under 18

Table 26: Young people (under 18) admitted to non-specialist facilities, 1 April 2008 to 31 March 2009

	2008-09	2007-08
No. of admissions to non-specialist inpatient settings	149	142
No. of young people involved	138	122
No. of admissions where further information provided to MWC	139	127
No. of young people involved	131	115

Our interest in these figures

Monitoring the admission of young people to non-specialist settings such as adult and paediatric wards, for the treatment of mental illness has been one of our monitoring priorities since the Mental Health (Care & Treatment) Act 2003 came into force. We have raised concerns about the number of admissions for several years, and in Delivering for Mental Health published in 2006 the Scottish Government made a commitment to reduce the number of admissions of children and young people to adult beds by 50% by 2009.

In our monitoring of the admissions of young people under-18 years old across Scotland we look to confirm whether NHS Boards are managing to fulfil their legal duty to provide age appropriate services and accommodation. We expect to be notified of all formal and informal admissions to non specialist facilities. We have continued to ask Responsible Medical Officers (RMOs) to provide us with more detailed information once we have been notified of an admission.

Monitoring admissions of children and young people to non-specialist facilities will remain a priority for us in the coming year.

What we found

The figures in the table above show that in 2008-09 we were notified of 149 admissions, involving 138 young people under the age of 18 to non specialist wards.

Although this figure is lower than the figure for 2006-07 (when we were notified of 186 admissions), there is an increase in the number of admissions compared to 2007-08. We are concerned about this. This increase would suggest that NHS Boards are going to experience some difficulties achieving the specific commitment in Delivering for Mental Health to reduce the number of admissions by 50% by 2009.

Table 27: Admissions of young people to non-specialist facilities by NHS Board

Health Board	No of admissions	
	2008-09	2007-08
Ayrshire and Arran	15	9
Borders	9	9
Dumfries and Galloway	5	5
Eilean Siar	0	0
Fife	9	10
Forth Valley	4	12
Grampian	15	6
Greater Glasgow and Clyde	41	22
Highland	9	5
Lanarkshire	18	26
Lothian	15	28
Orkney	0	0
State	1	0
Tayside	8	10
Scotland	**149**	**142**

Our interest in these figures

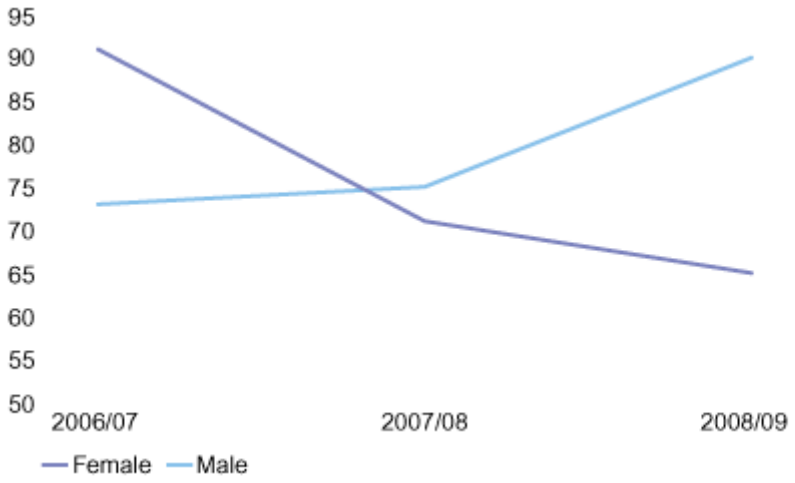
Our view is that when a young person needs in-patient treatment their particular clinical needs should be paramount. In comparing admissions to non-specialist facilities by NHS Board area we are looking to see whether there have been significant changes in the number of admissions within a specific area compared to figures from the previous year.

The 2003 Act is clear that the specific duty on NHS Boards to provide sufficient services for young people continues to their 18th birthday. We are aware that children and adolescent mental health (CAMH) services are configured differently and have different eligibility criteria in different areas. We are also aware that CAMH services are making strenuous efforts to admit under-16s to specialist facilities.

What we found

Figures in the table above compare admissions in 2007-08 and 2008-09 by NHS Board area. Comparison over these 2 years shows that in Fife, Forth Valley, Lanarkshire, Lothian and Tayside, there were fewer admissions this year than last year. However, there has been a significant increase in admissions in Grampian, Ayrshire and Arran, Highland, and in Greater Glasgow and Clyde. We are aware that in Greater Glasgow and Clyde the process of commissioning and building the new unit for young people may have influenced the number of admissions and that work is being undertaken to analyse the admission of young people to adult wards. We will be sharing information to assist this work, and also to clarify that we have been notified appropriately about all relevant admissions in this area.

Figure: Admissions of young people to non-specialist wards by gender three year trend



Our interest in these figures

Our analysis of non-specialist admissions identified an overall increase of admissions for young people to non-specialist wards. However we found that the number of admissions for young men has gone up, while admissions of young women have decreased. About half of the non-specialist admissions of young ment were for males aged 17.

What we found

This data shows that mental health services are treating young men and women differently. Possible reasons are that girls are admitted on an arranged basis, often for treatment for eating disorders, whereas boys are more likely to need urgent admission for other mental health problems when arranging a specialist placement is more difficult. There may be a tendency to regard 17-year-old males as less suitable for an adolescent mental health ward. The Scottish Government and specialist services for adolescents need to examine this finding and ensure that they do not discriminate on the basis of gender.

Table 28: Specialist health care for young people in non-specialist care, 1 April 2008 to 31 March 2009

Specialist medical provision	Age 0-15	Age 16-17	All	% of admissions
RMO at admission was a child and adolescent specialist	17	38	55	37
Nursing staff with experience of working with young people were available to work directly with the young person	15	37	52	35
Nursing staff with experience of working with young people were available to provide advice to ward staff	15	69	84	56
The young person had access to other age appropriate therapeutic input	14	42	56	38
None of the above	3	29	32	21

Based on number of admissions for 2008 – 2009 of 149

Our interest in these figures

When a young person is admitted to a non-specialist ward it is important that NHS Boards fulfil their duties to provide appropriate services. To enable us to monitor how this duty is being fulfilled we continue to ask RMOs to provide us with more detailed information once we have been notified of an admission, and some of the information we request is summarised in the table above.

We specifically want to see whether specialist CAMH service input is available, to ensure that appropriate care and treatment is being provided to the young person, and that relevant guidance and support is available for staff in non-specialist units who will rarely have experience of providing treatment and support to young people.

What we found

In 37% of admissions the RMO at the point of admission was a child and adolescent specialist. In 35% of admissions nurses with experience in the field were available to work directly with the young person and in 56% of admissions nurses with relevant specialist experience were available to provide advice to ward staff.

When compared with information collected last year this shows that the number of cases where the RMO at admission is a child and adolescent specialist continues to increase, but that the availability of nursing staff with relevant experience, either to work directly with the young person or to provide advice to ward staff, has decreased since 2007-08.

We have just completed a themed visit programme to CAMH services across Scotland. There will be further discussion in the national report, with reference to the information we gathered about local protocols for the management of

admissions and about CAMHS input, when the report from this programme is published later this year.

Table 29: Social work provision for young people in non-specialist care
1 April 2008 to 31 March 2009

Social work provision	Age 0-15	Age 16-17	All	%of admissions
Young person has an allocated social worker	21	44	65	44
If no allocated social worker, had access to a social worker.	11	51	62	42
Neither of the above	4	15	19	13

Our interest in these figures

We receive information on monitoring forms about social work input. Many young people admitted to a non-specialist facility will have had no prior involvement with social work, but our expectation would be that if social work input is felt to be necessary at the time when an admission is being considered, or after admission, then there should be clear local arrangements in place to secure that input.

What we found

Compared to the figures for 2007-08 fewer young people had an allocated social worker at the time of admission (44% compared to 52% in 2007/8). However a higher proportion of young people had access to a social worker after admission, according to the monitoring information we received (42% compared to 31%) and there has been a reduction in the number of young people who had no allocated social worker when admitted, and no access to a worker during the admission. We would hope this indicates that more integrated approaches to provide care and support when young people become in-patients are developing across the country, and again we will focus on this issue further in the national themed visit report to be published shortly, following our recent meetings with CAMH services across Scotland.

Table 30: Supervision of young people in non-specialist care
1 April 2008 to 31 March 2009

Supervision arrangements	Age 0-15	Age 16-17	All	% of admissions
Transferred to an IPCU or locked ward during the admission	8	18	26	17
Accommodated in a single room throughout the admission	30	82	112	75
Nursed under constant observation	28	59	87	58

All admissions = 149

Our interest in these figures

We ask for specific information about the supervision arrangements for young people admitted to non-specialist facilities to enable us to monitor whether the need for heightened observation is being carefully considered, and also so that we can arrange to visit any young person, if they are particularly vulnerable, to look at the care and support arrangements in place.

We would expect any issues about the safety and security of young people who may be vulnerable in non-specialist settings to be assessed and addressed by services. We have also previously highlighted the lack of an intensive psychiatric care unit (IPCU) for young people, and the situation with regard to this has not changed in the last year.

What we found

Significantly more young people were accommodated in single rooms throughout the admission than in the previous year, and we welcome this. A slightly higher number were nursed under constant observation and more were transferred to an IPCU or locked ward compared to last year, and one young person was admitted to the State Hospital in this period. There may be a number of reasons why constant observation or transfer to an IPCU were felt to be necessary, and this will probably reflect clinicians' views that young people can be vulnerable, and that risks and vulnerability are being carefully assessed during admissions.

Table 31: Other care provision for young people, 1 April 2008 to 31 March 2009

Other provision	Age 0-15	Age 16-17	All	% of all admissions
Access to age appropriate recreational activities	16	57	73	49
Access to education was discussed	16	27	43	29
Access to advocacy service	21	82	103	69
Young person has a learning disability	5	7	12	8

All admissions=149

Our interest in these figures

We ask for further information about access to other provisions to give us a clearer picture of how NHS Boards are fulfilling their duty to provide age appropriate services. Because a large proportion of admissions are for very short periods of time access to appropriate recreational activities and education may not be significant issues for many young people.

We want to know if independent advocacy services are readily available, given the important role advocacy can play in ensuring any patient's views are heard.

We also want to know how many young people with a learning disability are admitted to non-specialist facilities, because of the ongoing concerns about the lack of appropriate services for young people who have a significant learning disability and require in-patient admission for assessment and/or treatment, particularly where there are significant problems with challenging behaviour.

What we found

There has been a reduction in the number of young people who were reported as having access to age appropriate activities. In very few cases was access to education discussed. Again this may not have been appropriate if an admission was for a short period of time, but it is certainly the case that in the absence of specialist CAMHS or social work input, staff in adult wards will not know how to access continuing education services if this is appropriate while the young person is in hospital.

The overall number of young people reported as having had access to advocacy is exactly the same as last year, but it is concerning that almost a third of young people admitted were reported as not having access to advocacy during their admission.

Although the number of young people with a learning disability involved in these admissions is small, and has fallen from the previous year, it remains concerning that there is no specialist in-patient provision for this group. We are aware that in specific cases the admission of a young person to an adult

facility has had a very considerable impact on adult patients in a ward, because of the intensive care and support which has had to be provided to meet the care needs of the young person.

Table 32: Age of young person admitted to non-specialist settings by gender, 1 April 2008 to 31 March 2009

Age in years at last birthday	Gender		Total
	F	M	
12	0	1	1
13	1	1	2
14	4	3	7
15	11	13	24
16	22	26	48
17	23	44	67
Totals	**61**	**88**	**149**

Our interest in these figures

Monitoring the admission of young people to non specialist settings such as adult and paediatric wards, for the treatment of mental illness has been a priority for us since the 2003 Act came into force. We are interested in the figures for the age and gender of young people admitted, because they can indicate whether there are any trends, evident over a period of time, with regard to the admission of young people, and can suggest where services should be giving careful thought to arrangements in place to meet needs, or where there may be specific issues to address.

What we found

As was the case in the previous two years there were more 17 year olds admitted than any other age group, with 115 (77%) of admissions involving young people aged 16 to 17. This figure is fairly consistent with figures from the previous two years.

What is striking with the age and gender figures for 2008-09 is the shift in balance between the number of young males and females admitted. The trend over the past three years has been for the number of female admissions to non-specialist facilities to fall and the number of male admissions to rise, particularly in the 17 year old age group. In 2006-07 almost exactly the same number of young women and men age 17 were admitted. In 2008-09 90% more young men age 17 were admitted than young women. We are not sure why this is happening and will look at the figures for admissions to specialist facilities, to see if young women are more likely to be admitted to these in-patient facilities than young men.

We would also want to undertake a retrospective study of admissions over a specific period of time to try to establish if there are specific reasons why there has been such a marked shift in the in the gender ratio of young people admitted to non-specialist facilities.

Additional findings from our monitoring programme

We look at a number of aspects of compulsory treatment in this section. Some of the areas we choose to report on may emerge from our on going monitoring work, others will arise from our statutory monitoring duties.

Here you will find information on

- **the ethnicity of people who received compulsory treatment this year.** The forms used to record ethnicity are not always completed so please be aware that our data ethnicity is not complete. We are working with others on a research project that we hope will improve our knowledge of whether people from minority ethnic groups are treated differently under the 2003 Act.

- **the use of social circumstance reports**. You can find our good practice guidance on social circumstances reports in the publications section of www.mwcscot.org.uk .

- **the use of safeguarded medical treatments**

- **place of safety orders**.

Place of safety orders

Table 33: Place of safety orders notified to the Commission 1 April 2008 to 31 March 2009

	Was place of safety a police station			
Police Force	No	Unknown	Yes	Total
CENTRAL SCOTLAND	1			1
FIFE	13		1	14
GRAMPIAN	56	1	1	58
LOTHIAN AND BORDERS	9		1	10
NORTHERN	70	8	2	80
STRATHCLYDE	23		2	25
TAYSIDE	4			4
Grand Total	**176**	**9**	**7**	**192**

Our interest in these figures

Under section 297 of the 2003 Act, a police officer can take a person from a public place to a place of safety in order to arrange a medical examination. The person must appear to have a mental disorder and can be detained in the place of safety for up to 24 hours. The law is clear that a place of safety should be a hospital or other care establishment. Police stations should only be used in exceptional circumstances. We want to report on how often this power is used and to what extent police stations are used as places of safety.

What we found

Not all police forces have reported place of safety orders to us. We believe that there are many orders that we do not hear about. We remind the police that they have a statutory duty to inform us when a person is removed to a place of safety. Of the 192 orders notified to us, only seven involved removing the person to a police station. We would prefer if this figure was lower still and preferably zero. Local psychiatric emergency plans should identify appropriate places of safety for individuals.

Ethnicity

Table 34: Ethnicity of individuals as notified to the Commission on mental health act forms, 1 April 2008 to 31 March 2009.

Ethnicity	No.	% of known info.
White Scottish	3237	86%
White other	374	10%
Indian	18	<1%
Bangladeshi	8	<1%
Pakistan	26	1%
Chinese	13	<1%
Black-African/Caribbean	46	1%
Black (other)	10	<1%
Mixed	15	<1%
Total known	**3767**	
Not provided or Unknown	**1604**	**30%***
Total number of forms	**5371**	

**Percentage of forms where the information was not provided or is unknown is displayed as a % of total forms*

Our interest in these figures

We know that, in some parts of England, there is evidence of higher use of mental health legislation in some ethnic groups. Detention rates are higher amongst people of Black African or Caribbean ethnicity. We are interested to see if any ethnic group is over- or under-represented in Scottish data, so that the reasons for this might be explored and addressed.

What we found

We only have reliable information on ethnicity in 70% of cases. This is higher than last year but still not enough for us to be confident about findings. From the data available, we find no evidence of higher rates of compulsory treatment for any particular ethnic group. We are aiming to improve the information we have on this through a joint research project with the University of Edinburgh.

Social circumstances reports

Table 35: Provision of Social Circumstance Reports following short term detention in selected local authorities, 1 April 2008 – 31 March 2009

	Number of STDCs	Number of SCRs	% of STDCs triggering an SCR
Glasgow City	671	167	25
Edinburgh City	366	109	30
Fife Council	207	148	71
South Lanarkshire	174	105	60
Highland	153	20	13

Our interest in these figures

A Social Circumstances Report (SCR) is a formal report that draws together, into a single document, information about a person's mental disorder and how this interacts with their social circumstances. They are produced by a person's Mental Health Officer (MHO) when he or she is being considered for, or is subject to, compulsory measures under the Mental Health (Care & Treatment) (Scotland) Act 2003.

By setting out the strengths, personal history, the social supports available to the individual, SCRs are a valuable tool in assisting care teams in the assessment and future care planning of someone receiving compulsory care and treatment. We also find SCRs very useful to us, as they help us to ensure that the treatment being proposed or provided is in line with the principles of the 2003 Act.

The process of compiling a report gives the MHO the opportunity to apply their specialist social work skills and knowledge to help the individual to gain greater control over the management of their illness. As such, they fit in very well with the recovery approach to care and treatment.

What we found

We have commented in past monitoring reports on the difficulty MHOs are having in meeting the requirements of the 2003 Act, in respect of SCRs. Our report for 2007-08 showed only 29% of relevant events resulted in an SCR being provided. Notification of the reasons why the MHO felt that doing so would serve 'little, or no, practical purpose' was given in only 14% of the remaining relevant events.

In the past year the number of relevant events requiring an SCR increased by 3%, however, the percentage of SCRs completed following relevant events remained the same. This means that 4% more SCRs were completed and that more short-term detention certificates (STDCs) triggered SCRs.

Forty three per cent of STDCs resulted in SCRs in 2008-09, up from 39% last year. The total number of SCRs following STDCs increased considerably

from 1255 to 1389, an increase of 11%. This is good news as good SCRs include both the MHO's assessment and information on the individual's social circumstances which can help inform multidisciplinary planning. This is crucial at a time when a decision has to be made about whether to continue with a detention under the 2003 Act. Provision of SCRs following a compulsory treatment order, however, fell marginally from 11% to 9%.

The table above sets out provision of SCRs following STDCs and CTOs in selected local authorities. (It should be noted that there are discrepancies in some authorities where the local authority of the MHO who completed the SCR differs from that of the MHO who consented to the order).

It is evident that many authorities had a substantial increase in the percentage of STDCs which attracted SCRs. This was true in Moray (+133%), Argyll and Bute (+ 110%), Clackmannanshire (+90%), Dundee City (+57%), Perth and Kinross (+ 45%), Midlothian (+37%), and Aberdeenshire (+ 35%). There were, however, some authorities where there was a significant decrease in SCR provision following STDCs with Stirling Council (- 66%) and West Dunbartonshire Council (- 45%) showing the largest reductions.

Fife Council and South Lanarkshire MHO services appear to be among the most responsive to the statutory duty to provide an SCR following a STDC. Highland Council has the lowest rate of SCR provision.

Last year we reported that we were liaising with local authority MHO colleagues to draft further guidance on when we believe an SCR should be provided. This exercise was completed with the publication of Social Circumstances Reports - good practice guidance for MHOs and MHO managers**.** The report includes a number of recommendations for MHO service managers and MHOs which we hope will improve practice in this important area of local authority activity.

Consent to treatment under part 16 of the Mental Health (Care And Treatment) (Scotland) Act 2003

Table 36: Certificate of the designated medical practitioner (T3), 1 April 2008 to 31 March 2009

Treatment type	No.
ECT	120
Medication to reduce sex drive	2
Artificial feeding	19
Medication over 2 months	883
Total T3 certificates	**1017**

Note: T3 certificate may be for more than one treatment

Our interest in these figures

The 2003 Act is designed to provide safeguards for patients in general. Part 16 makes provisions for additional safeguards in relation to medical treatment particularly, but not only, where this is given without the patient's consent. There are specific safeguards for certain forms of medical treatment including electroconvulsive therapy (ECT) and procedures classified as Neurosurgery for Mental Disorder (NMD). Under the 2003 Act certain treatments can only be authorised by an independent doctor, known as a Designated Medical Practitioner (DMP).

Neurosurgery for Mental Disorder (Sections 235 and 236)

The 2003 Act requires that all patients (including informal patients) who are to be put forward for a procedure classified as neurosurgery should first be assessed by a Designated Medical Practitioner (DMP) and two other persons (not medical practitioners) arranged by the Commission. These three persons assess the individual's capacity to consent to neurosurgery and confirm this consent has been recorded in writing. In addition the DMP also assesses that the treatment is in the person's best interests. All three practitioners sign Form T1 if the treatment is approved. We seek to follow up progress reports on all patients having neurosurgical procedures at 12 months and again at 24 months from the team providing ongoing care for the person.

The Dundee Advanced Interventions Service (AIS) remains the only centre in Scotland providing neurosurgical treatment and has received referrals from Scotland, England and Eire. Although the 2003 Act has provision for treatment to be carried out without a patient's consent in certain situations, this has not happened since the Act was implemented. As the AIS only provides operations for people who are capable of giving informed consent this situation is very unlikely to occur.

Our Neurosurgery for Mental Disorder (NMD) Working Group met on three occasions this year and there was also a useful meeting with the Dundee AIS. The medical treatment known as Deep Brain Stimulation (DBS) is

classified for the purposes of the Act as Neurosurgery and requires the same safeguards under Section 234. With developments in research and the understanding of DBS we anticipate an increase in referrals to us for assessment and with this in mind the Working Group is in the process of recruiting additional members including DMPs.Additional training is required for all Working Group members to undertake their safeguarding roles in this respect.

Other safeguarded treatments (Sections 237 and 240)

Treatments covered by sections 237 and 240 include ECT, any medicine for the purpose of reducing sex drive, medicine given beyond two months and artificial nutrition.

In November 2007 Responsible Medical Officers (RMOs) were given notice that all patients' treatment should comply with procedures under the 2003 Act by the end of March 2008. In situations where there was still an old Form 9 or 10 under the previous Act this required to be replaced by Form T2 or T3 which have additional safeguards. Treatment given without consent is authorised by a DMP on Form T3.

In October 2008 new versions of T1, T2 and T3 were introduced (version 6.1) and we are confident that this has reduced some problems which were causing confusion with the completion of forms and rectified some minor errors. As a result the completion of forms has greatly improved. Focused audits on specific topics are used to identify training needs for the annual seminar for DMPs.

A number of T2 and T3 forms replacing Forms 9 and 10s were received after the specified date but as far as we are aware all hospitals are now complying with the correct procedures. The process has been greatly helped by liaison between our case work managers and medical records officers. We are also grateful to hospital pharmacists who have taken an interest in monitoring this area of practice.

Treatment given with the person's consent under the 2003 Act is authorised by Form T2 and the patient's consent in writing. Under the procedures of the 2003 Act we do not automatically receive these T2 forms and therefore cannot make comparisons with previous years or the 1984 Act. We have made a recommendation to the Scottish Government that it becomes a requirement of the 2003 Act that we are sent a copy of Form T2. In the meantime we are grateful to colleagues who continue to forward us copies of Form T2.

We received 755 T2 forms: 14 were for ECT, the majority of the rest were for medication beyond 2 months. The remaining forms were either for medication to reduce sex drive or the information provided was incomplete**.**

Treatment given without consent is authorised by a DMP on Form T3

The number and types of treatments authorised by a Certificate of the DMP is shown in the table above. The majority of treatments authorised were medication beyond two months. As in previous years about half of the patients

receiving ECT objected to it or were resisting the treatment. A third of these required treatment to save life, the rest to alleviate serious suffering and/or prevent serious deterioration.

Children and Young People

We received 14 form T2s for patients who were under 18 at the time of completion and consenting to treatment. There were 24 T3 forms for patients under 18 receiving treatment without consent. None of the T3s were for ECT, 9 were for artificial nutrition and 15 were for medication beyond 2 months. In all cases except one, either the RMO or the DMP was a child specialist.In the one case the first DMP was a learning disability specialist but it was quickly identified that the patient was also aged under 18 and we were able to send a second DMP with expertise in both learning disability and child psychiatry.

Designated Medical Practitioners

Seventy-three doctors were available to provide second opinions on safeguarded treatments during the year reported.We held an annual seminar for DMPs in October 2008 which was attended by slightly more than half of the DMPs. A summary of the issues discussed is sent to all DMPs. This meeting included an expert speaker on good practice in prescribing for the elderly and a DMP led discussion on ECT issues. The new version of Form T3 (version 6.1) was also introduced and a number of good practice points were highlighted.During the year a number of psychiatrists expressed an interest in becoming DMPs and two induction seminars took place in the Spring of 2009. We are grateful to those doctors who have provided second opinions often at short notice.We have noted that clinicians are finding their own jobs very busy and it is more difficult to identify DMPs willing to travel further afield particularly to the Grampian and Highland regions.

Our recommendations for amendments to Part 16 of the 2003 Act

Following review of the 2003 Act a number of minor amendments we have suggested the following:

- **Duration of Authority to Treat (Forms T1, T2 and T3)**

We have recommended to the Mental Health Review Group that each certificate of consent to treatment should have a statutory duration of authority, depending on the nature of the proposed treatment.

- **Section 244 (Additional Safeguards for Informal Patients)**

New and potentially controversial or relatively unevaluated treatments for mental disorder emerge from time to time. The MWC recommends an extension of Ministers' power to make regulations to prescribe conditions that must be satisfied before certain types of medical treatment specified in regulations are given to any patient regardless of age and regardless of whether the giving of medical treatment is or is not authorised by virtue of this Act or the 1995 Act.

As well as providing regulations for new treatments, this would correct an apparent anomaly whereby regulations pertaining to people under the age of 16, but where treatment is authorised by virtue of the 2003 Act, and who give consent to treatments specified under Section 237 could, in theory, be treated without the requirement for an independent opinion.

- **Neurosurgery for Mental Disorder (Sections 235 and 236):**

We were asked to assess two people being considered for NMD during the past year both of whom had experienced severe disabling depressive disorder and were considered to have had a full range of appropriate treatments without success. In both cases neurosurgery was considered to be in their best interests and the procedures took place within a few months of assessment. The NMD Working Group also considered reports on the progress of a number of people who had undergone procedures in previous years.

Our overview of the Use of the Adults with Incapacity (Scotland) Act 2000

Our monitoring duties are set out in the Adults with Incapacity (Scotland) Act 2000 and are focused on the welfare provisions of the Act.

We monitor the use of the 2000 Act, visit some people on guardianship, provide advice and good practice guidance in the operation of the Act and also investigate circumstances where an adult with incapacity may be at risk.

We are part of the framework of legal safeguards that are in place to protect people on welfare guardianship and intervention orders**,** or for whom decision making powers on welfare have been granted to someone else via a power of attorney.

Here you can review our findings from these monitoring activities.

Please use the red menu on the left to navigate to our key findings.

For details of our investigations, advice and good practice activities this year please see our Annual Report 2008-09.

Trends in the use of welfare guardianship

For the second year running we have seen a decrease in the rate of growth of new welfare guardianship orders under the Adults with Incapacity Act 2000.

In 2007-08 we recorded a 13% increase in new orders. During the past year this has slowed down even further to just over 9%. The increase in previous years had been 32% (2006-07), 32% (2005-06) and 45% (2004-05). This slowing down in the growth rate coincides with increasing use of Welfare Powers of Attorney - up from just under 20,000 being granted in 2006-07 to nearly 28,000 last year.

Last year we speculated that changes to the Social Work (Scotland) Act with the introduction of section 13ZA may have been partly responsible for changes in the trend. Local authority applications in approved orders had fallen by 20% in the year following its implementation. In 2008-09, however, local authority applications in approved orders actually increased over the previous year by 4%.

It remains to be seen whether this is a levelling out of local authority initiated orders. On the other hand**,** it is possible that this reversal in the downward trend may have resulted from the introduction of the Adult Support and Protection (Scotland) Act, which places a responsibility on local authorities in respect of vulnerable adults. It may be that these new statutory duties have resulted in tighter procedures for investigations into situations where an adult is vulnerable, which have ultimately led to decisions to seek welfare guardianship under the 2000 Act. Research into the outcome of case conferences held under the Adult Support and Protection (Scotland) Act could shed further light on this. As it stands, the slowing down in use of welfare guardianship is largely attributable to a slowing down in the rate of growth of private applications.

During the past year we have had greater success in harmonising our statistics with those reported by the Office of the Public Guardian. Last year's variance of 7% has been reduced to just over 2%. We will continue to seek consistency on data in future years.

Geographical variations in the use of welfare guardianship

Table 37: Guardianship orders granted by local authority area, 1 April 2008 to 31 March 2009.

	Private applications granted 2008-09	Local authority applications granted 2008-09	All applications granted 2008-09	Rate per 100k pop. Over age 16			
				Private rate	LA rate	Total rate	Recalled or lapsed**
Aberdeen City	32	15	47	18	8	27	11
Aberdeenshire	43	19	62	22	10	32	13
Angus	26	11	37	29	12	41	43
Argyll and Bute	9	4	13	12	5	17	16
City of Edinburgh	26	17	43	6	4	11	7
Clackmannanshire	6	0	6	15	0	15	10
Dumfries and Galloway	19	19	38	15	15	31	16
Dundee City	29	16	45	24	13	38	25
East Ayrshire	14	12	26	14	12	26	16
East Dunbartonshire	12	3	15	14	4	18	7
East Lothian	8	8	16	10	10	21	6
East Renfrewshire	9	6	15	13	8	21	13
Eilean Siar	4	0	4	18	0	18	0
Falkirk	13	16	29	11	13	24	13
Fife	73	43	116	25	14	39	30
Glasgow City	140	58	198	29	12	41	20
Highland	44	67	111	24	37	62	28
Inverclyde	6	5	11	9	8	17	12
Midlothian	15	3	18	23	5	28	9
Moray	18	5	23	25	7	32	14
North Ayrshire	26	6	32	23	5	29	7
North Lanarkshire	39	20	59	15	8	22	6
Orkney	1	0	1	6	0	6	61
Perth & Kinross	27	12	39	23	10	33	23
Renfrewshire	15	6	21	11	4	15	6
Scottish Borders	14	3	17	15	3	18	9
Shetland	0	0	0	0	0	0	6
South Ayrshire	11	16	27	12	17	29	16
South Lanarkshire	43	25	68	17	10	27	11
Stirling	8	3	11	11	4	15	14
West Dunbartonshire	13	7	20	17	9	27	12
West Lothian	22	10	32	16	7	24	12
Scotland	**765**	**435**	**1200**	**18**	**10**	**28**	**15**

6 joint applications are included with the local authority figures We use the term "private" to cover all applicants who are not Local Authorities.

Our interest in these figures

We have reported over the years on the variation in the use of guardianship from one local authority area to the next. The variation can be seen in both private and local authority generated orders. Local authorities have a duty under Section 57(2) to take forward applications for guardianship wherever

necessary when no-one else is, or is likely to make an application. While the reasons for these differences are complex, relevant local authority staff should review this data to help ensure that the Act is being used where necessary both to safeguard the welfare and property of adults with incapacity and to assist relatives and carers.

What we found

The above table shows the continuing variation in the use of welfare guardianship both by local authorities and private individuals in different council areas. Approved orders ranged from 4 per 100,000 in City of Edinburgh to 37 per 100,000 in Highland Council, with the Scottish average being 10 per 100,000. Private applications ranged from 6 per 100,000 in City of Edinburgh to 29 per 100,000 in Angus.

The dramatic change in the use of welfare guardianship (both private and local authority generated) compared with the previous year is very striking in certain areas. This was evident in West Dunbartonshire (+ 122%), South Lanarkshire (+110%), Highland (+68%), Dundee City (+67%), and Argyll and Bute (+63%). Edinburgh, however, had a fall of 33% in the number of new orders.

Such volatility has obvious implications for workforce planning, especially in respect of demand on Mental Health Officer resources within local authority areas. While there continues to be a fall in the percentage of orders where the local authority was the applicant, relative to private applicants, this is at a much smaller rate than in the previous few years. Although the actual number of local authority applications this year was higher than the previous year, they still accounted for only 36% of approved orders.

Causes of incapacity in guardianship

Table 38: Causes of incapacity in guardianship orders, 1 April 2008 to 31 March 2009

Types of incapacity	No. of people (%)
Learning disability	377 (31)
Dementia	663 (55)
Acquired brain injury	51 (4)
Alcohol-related brain damage	61 (5)
Inability to communicate due to physical disability	16 (1)
Mental illness	46 (4)
Personality disorder	4 (0)
Other	26 (2)
Totals	**1200**

Our interest in these figures

We have safeguarding duties in relation to people who fall under the protection of the Adults with Incapacity Act 2000. We examine the use of welfare guardianship for adults with a mental illness, learning disability or other mental disorder (including dementia) to determine how and for whom the 2000 Act is being used. This helps to highlight those individuals with certain mental disorders who might not be benefiting from the rights and protections that are set out in law. The table above sets out our analysis of approved welfare guardianship orders as related to the identified causes of the adult's incapacity.

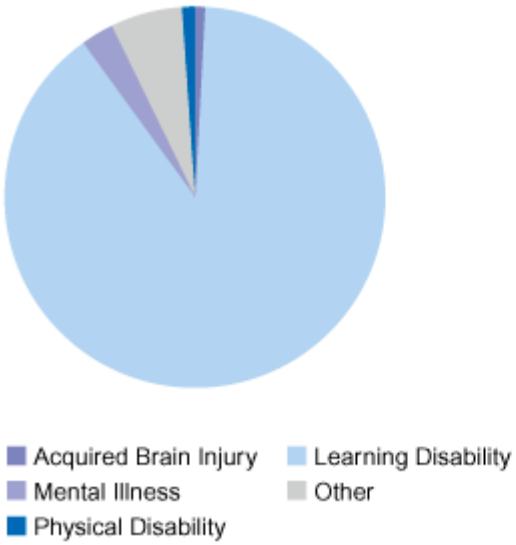
What we found

Each year dementia accounts for the great majority of orders, being specified as the cause of incapacity in 55% of the orders granted last year. The last three years, however, have seen a growth of 24% in the use of welfare guardianship for people with learning disability, relative to incapacity caused by other diagnoses. The number of orders approved for adults with alcohol related brain damage (ARBD) nearly doubled from 32 in 2007-08 to 61 last year but still only accounted for 5% of all orders.

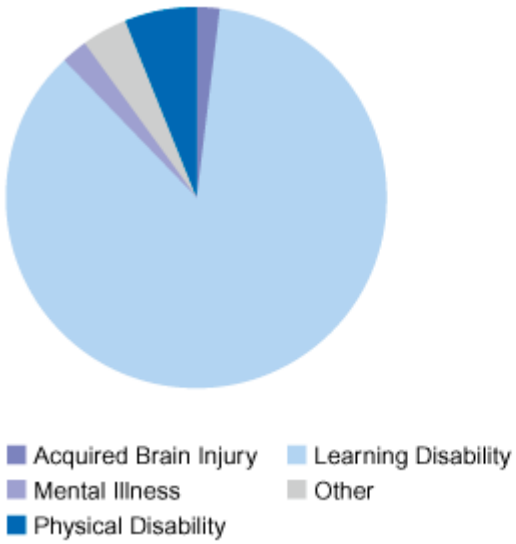
We think this is a surprisingly low rate given the difficulties faced by this group of individuals and the risks to their health and welfare.

Age at which adults are placed on welfare guardianship orders

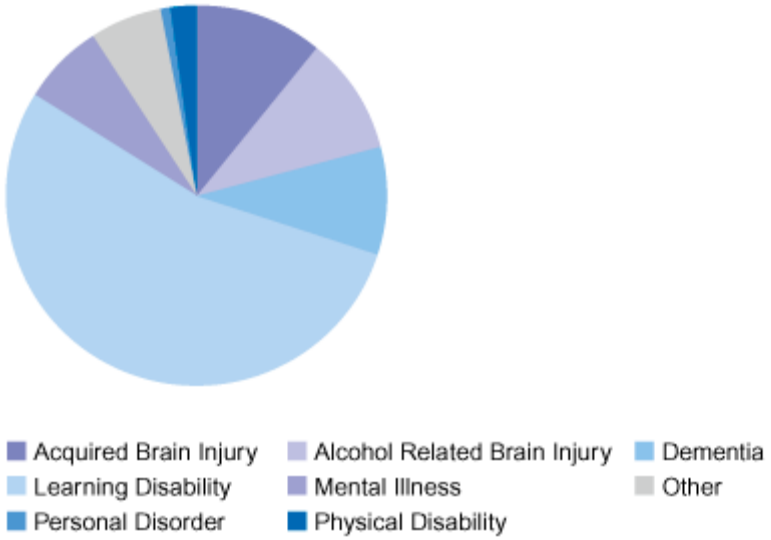
Adults aged 16-17 at point of guardianship order approval 2008-09



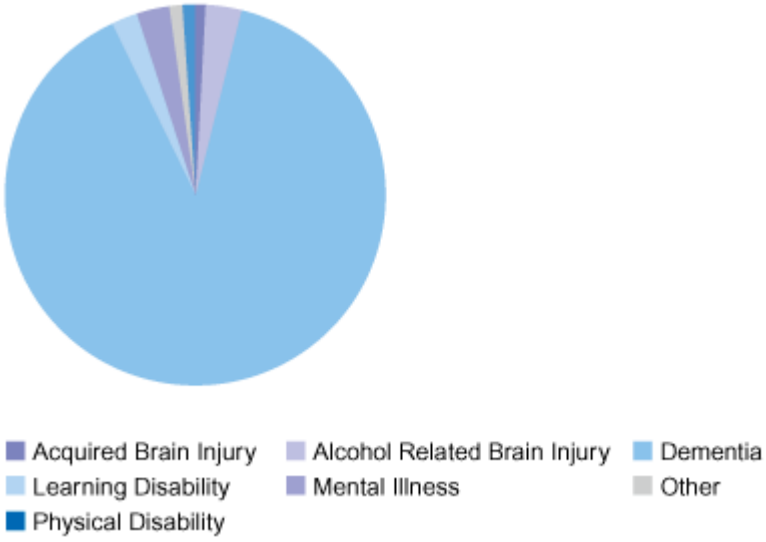
Adults aged 18-24 at point of guardianship order approval 2008-09



Adults aged 25-64 at point of guardianship order approval 2008-09



Adults aged 65+ at point of guardianship order approval 2008-09



Our interest in these figures

The above pie-charts show the considerable variance in the age at which adults with different causes of incapacity are placed on welfare guardianship orders under the provisions of the Adults with Incapacity Act 2000. This may not be surprising in itself, but has particular relevance when viewed in context of the length of time for which orders were granted.

What we found

Forty six percent of adults with learning disability were under 25 when their order was granted. This contrasts with only 9% of the orders for people with mental illness falling within this age range. With people for whom orders were granted where their incapacity was caused by dementia, 95% were over the age of 65 and 32% were over the age of 85 when the order was granted.

Length of welfare guardianship orders granted

Table 39: Duration and causes of incapacity in all guardianship orders, 1 April 2008 to 31 March 2009

Period granted/ Cause of incapacity	Learning disability No. (%)	Mental illness No. (%)	Dementia No. (%)	Other No. (%)	Total orders (%)
1 year or less	1 (25)	0 (0)	2 (50)	1 (25)	4 (100)
1-2 years	9 (36)	2 (8)	5 (20)	9 (36)	25 (100)
3 years	65 (31)	10 (5)	104 (20)	29 (14)	208 (100)
4 years	1 (100)	0(0)	0 (0)	0 (0)	1 (100)
5 years	42 (48)	6 (7)	24 (28)	15 (17)	87 (100)
6-20 years	15 (68)	1 (5)	4 (18)	2 (9)	22 (100)
Indefinite	244 (29)	27 (3)	524 (61)	58 (7)	853 (100)
Totals (%)	**377 (31)**	**46 (4)**	**663 (55)**	**114 (10)**	**1200 (100)**

Table 40a: Duration and causes of incapacity in guardianship orders, where the local authority is the applicant, 1 April 2008 to 31 March 2009

Period granted/ Cause of incapacity	Learning disability No. (%)	Mental illness No. (%)	Dementia No. (%)	Other No. (%)	Total orders (%)
1 year or less	1 (25)	0 (0)	2 (50)	1 (25)	4 (100)
1-2 years	4 (22)	2 (11)	6 (33)	6 (33)	18 (100)
3 years	31 (26)	8 (7)	61 (52)	17 (15)	117 (100)
5 years	11 (39)	3 (11)	7 (25)	7 (25)	28 (100)
6-20 years	6 (75)	1(13)	1(13)	0 (0)	8 (100)
Indefinite	52 (20)	17 (7)	164 (63)	27 (10)	260 (100)
Totals (%)	**105 (24)**	**31 (7)**	**241(55)**	**58 (13)**	**435 (100)**

Table 40b: Duration and causes of incapacity in guardianship orders, where the applicant is a private individual or representative, 1 April 2008 to 31 March 2009

Period granted/ Cause of incapacity	Learning disability No. (%)	Mental illness No. (%)	Dementia No. (%)	Other No. (%)	Total orders (%)
1 year or less	0 (0)	0 (0)	0 (0)	0 (0)	0 (100)
1-2 years	5 (71)	0 (0)	0 (0)	2 (29)	7 (100)
3 years	34 (37)	2 (2)	43 (47)	12 (13)	91 (100)
4 years	1 (100)	0 (0)	0 (0)	0 (0)	1 (100)
5 years	31 (53)	3 (5)	17 (29)	8 (14)	59 (100)
6-20 years	9 (64)	0 (0)	2 (14)	3 (21)	14 (100)
Indefinite	192 (32)	10 (2)	359 (60)	32 (6)	593 (100)
Totals (%)	**271 (35)**	**15 (2)**	**421 (55)**	**58 (8)**	**765 (100)**

Our interest in these figures

We have raised concerns in previous reports about the high percentage of orders granted on an indefinite basis. Our concern is that the lack of automatic, periodic judicial scrutiny of approved orders puts the onus on the individual to challenge an order. We don't think this is in keeping with accepted standards of justice. This is perhaps most evident in relation to how welfare guardianship is used for people with learning disability. We continue to discuss this with the Scottish Government.

What we found

The level of indefinite guardianship orders remained at the same level as last year at 71%. Last year, 65% of all orders granted for people with learning disability were granted on an indefinite basis. 76% of those with learning disability were under the age of 65 and 46% were under the age of 25. As the law stands, these are orders which need not be judicially reviewed during the lifetime of these adults. It is our view that this is an affront to natural justice which must be addressed.

One effect of the granting of orders on an indefinite basis is the impact on the number of extant welfare guardianship orders. While the growth in new orders was just over 9% last year, the growth in extant orders as of 31 March 2009 was 23%.

Consent to medical treatment

Table 41: Adults with Incapacity (Scotland) Act 2008, 1 April 2008 to 31 March 2009

Requests Types of treatment	Section 48/50
Medication to reduce sex drive	19
ECT	9
Second opinion in respect of disagreement between RMO and welfare proxy	3
Totals	**31**

Our interest in these figures

Part 5 of the Adults with Incapacity 2000 Act covers consent to treatment issues. It allows medical practitioners to provide treatment to people who lack the capacity to give informed consent to treatment. To do this the person has to be assessed as incapable of providing informed consent to the proposed treatment and a certificate has to be completed to this effect.

Part 5 ensures that people are not denied medical treatment because they cannot consent. It also requires second opinions to be provided for certain treatments, or where there is a disagreement between the clinical team and the person with welfare powers in relation to medical treatment. We are responsible for arranging these second opinions and for ensuring that people are treated lawfully.

What we found

We have continuing concerns about the widespread failure to comply with the requirements of Part 5 of the 2000 Act. We make recommendations on this issue in almost all of our reports on visits to care homes, and have also made national recommendations to service providers and Government, following our themed monitoring reports. This year we visited a number of dementia care homes alongside the Care Commission. A major finding from the visits was the lack of Section 47 certificates of incapacity and widespread failure of care homes and GPs to treat people lawfully. The detail of our findings and recommendations can be found in Remember, I'm Still Me. We have recommended that the Scottish Government review this part of the 2000 Act as a matter of urgency.

We continue to provide second opinions under Section 48 for people treated under the authority of the 2000 Act. Two thirds of these requests are for the authorisation of treatment to reduce sex drive. Of the total of 34 requests received, 21 were in respect of medication to reduce sex drive, one of these was cancelled and one resulted in agreement that the patient could and did consent. 10 were for electroconvulsive therapy with one being refused and a recommendation that the Mental Health (Care & Treatment) (Scotland) Act 2003 be used. The figures are little changed from previous years.

Unusually, this year we have been asked, on three occasions, to arrange second opinions where there has been a disagreement between the medical staff and a proxy with powers to consent to medical treatment. On one occasion, the disagreement was in respect of physiotherapy for a young woman with profound multiple disabilities where the welfare proxy did not wish there to be any such treatment. The second opinion doctor subsequently authorised the use of physiotherapy in line with the wishes of the clinical team. In the second, again within the learning disability field, the disputed treatment (antipsychotics and other related medications) was postponed until after a proposed move of residence to another area. In the final case, an elderly lady with severe dementia was admitted to hospital with distressing hallucinations and very disturbed behaviour. The welfare proxy did not agree with the decision to treat, as he regarded the symptoms as side effects of medication rather than requiring treatment. A carefully agreed treatment plan which took account of the differential diagnosis was agreed by the second opinion doctor in line with the wishes of the clinical team.

Our scrutiny of approved welfare guardianship orders and visits to adults on guardianship

In 2008-09 we scrutinised approved guardianship applications in 1,079 cases. This often involved asking specific questions or requesting information from:

- the MHO involved in the application;
- the supervising social worker, or the nominated officer carrying out the role of the Chief Social Work Officer where he or she was appointed as guardian;
- the adult;
- the adult's private guardian; and
- care providers.

As a result of this work we went on to visit 433 visits to adults on welfare guardianship. The purpose of these visits was to assure ourselves that the Adults with Incapacity Act 2000 is being implemented in accordance with the principles of the legislation.

The adults on guardianship we visited had incapacity caused by the following mental disorders:

- learning disability (including autistic spectrum disorder): 59%
- dementia: 29%
- acquired brain injury and alcohol related brain damage: 16%
- mental illness: 12%

As a result of our visits we followed up a number of issues in respect of individual cases. We recorded 216 separate issues which we followed up as a result of these visits. These were classified as relating to (in descending order):

- accommodation;
- activity levels;
- finances;
- level of social work input;
- legal concerns;
- protection/safety;
- physical health; and
- mental health.

Monitoring of use of welfare guardianship for adults under 25

Over the past several years we have witnessed an increasing use of welfare guardianship for young adults, most of whom have a learning disability. These orders are often granted for indefinite periods to private guardians with a larger number of powers being sought and granted.

Central to the safeguards built into the legislation, is the role of the local authority supervising officer. Over the years we have encountered a growing number of cases where we have been concerned about the quality of local authority supervision. In some cases, the statutory requirement placed upon the local authority to supervise guardians was not being carried out at all.

It was in this context that we felt it would be helpful to look in greater detail at the use of welfare guardianship for those under 25.

A local authority Mental Health Officer with considerable AWI experience was seconded into the Commission to take the lead on this project.

The exercise involved questionnaires and interviews with private guardians, local authority supervisors, local authority nominated guardians and social work managers. Following this exercise, a report was disseminated to Chief Social Work Officers and MHOs throughout Scotland. Areas covered in the report include communication between private guardians and local authority supervising officers; provision of information to private guardians; delegation of guardianship powers, recording of use of powers by guardians, recording of supervision visits by local authority officers; preparation, training and support of local authority staff in carrying out their statutory duties and the role of local authority management in the guardianship process. A number of recommendations have been directed at Chief Social Work Officers, Programme Leaders of Mental Health Officer Courses, the Social Work Inspection Agency, Scottish Ministers and the Mental Welfare Commission itself.

The detailed findings and recommendations of this report can be found in the themed reports section of http://reports.mwcscot.org.uk

A separate monitoring exercise was undertaken to look exclusively at local authority supervision of private guardians - focusing on adults over 25, but taking account of data collected in the under 25 survey in respect of the supervision of private guardians. We were pleased to have the services of another Mental Health Officer who was employed on a part-time basis to take the lead in this work. This report will be completed in 2010.

Our proposals for legislative change in relation to the Adults with Incapacity Act 2000

The Scottish Law Commission launched a public consultation exercise about plans for its future law reform work earlier this year. It sought views and suggestions about areas of the law that may require reform which should be included in its next Programme of Law Reform, due to start in January 2010.

In our response we urged the Scottish Law Commission to consider the working of the Adults with Incapacity Act 2000 in light of the decision of the Court of Human Rights in the *Bournewood* case and subsequent developments in human rights law. In particular, we thought the Law Commission should consider whether clarification of the Act would improve the rights and protections available for adults and could clarify the rights of their carers, attorneys and guardians to arrange care, bearing in mind the importance of both the right to liberty and the right to family life.

The key areas addressed in our submission include:

- **Deprivation of liberty:** Current Scottish Government guidance relates almost exclusively to deprivation of liberty of those who are being cared for in institutional settings. Many adults with incapacity have complex care needs which require care plans in the community, often their own homes, which may constitute a deprivation of liberty. It remains unclear whether a person who is unable to protect his or her own interests is deprived of his or her liberty if doors are locked for the individual's safety or if the person is not given free access to the outside world.
- **Carers:** Should a carer be able to make residential care arrangements for an adult lacking capacity where the adult is compliant and there is no perceived deprivation of liberty? A carer might argue that the right to family life in article 8 of the European Convention on Human Rights allows him or her to make arrangements on behalf of a family member in such circumstances.
- **Welfare attorneys:** Where a welfare power of attorney contains a specific power that allows the attorney to make arrangements amounting to a deprivation of liberty, it is unclear whether an attorney can consent to these arrangements if the adult appears to oppose or resist this.
- **Guardianship and deprivation of liberty:** The Scottish Law Commission should consider whether it would be helpful to clarify the limits of welfare guardians' powers in relation to deprivation of liberty. In particular:
    - Should additional safeguards come into play in such circumstances?
    - Is detention in the home acceptable under human rights law?
    - Given the majority of orders are granted on an indefinite basis, should the Act require regular review of orders?

- How long should guardianship last where an adult continues to be deprived of their liberty?
- Should a welfare guardian have the authority to consent to treatment in situations where there may be a need to intervene to promote or safeguard the physical health of an adult who lacks capacity and actively resists treatment?

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November 2009