mentalwelfare commission for scotland

Our overview of mental welfare in Scotland 2009-10

Key findings from our monitoring of mental health and incapacity legislation in Scotland

Contents

Annual monitoring reports

The Commission produces an annual independent overview of the operation of the Mental Health (Care & Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

In this section you can access our data and analysis for the period 2009-10. Please use the menu on the left to navigate your way to the information that interests you.

Director's introduction

Mental health and incapacity legislation - what we've found this year

Each year, we report on the use of the Mental Health (Care & Treatment) (Scotland) Act 2003 and on welfare guardianship under the Adults with Incapacity (Scotland) Act 2000. We look at new orders, existing orders and areas of the Acts that we think are particularly important for us to look at.

We spot trends and differences in the use of the Acts, paying particular attention to equality issues (e.g. age, gender and ethnicity). Here are the main findings from 2009-10.

New orders under the Mental Health (Care & Treatment) (Scotland) Act 2003

There has been a 7% fall in the number of new episodes of detention over the last four years. There have been fewer new episodes of compulsory treatment. The biggest drop has been in the number of emergency detentions, especially where the person is not detained further after 72 hours. We think one possible explanation for this may be that better crisis services have been put in place. Women are more likely than men to be detained under emergency powers.

While emergency detention from the community is falling, there are still a lot of people detained as an emergency when they are already in hospital.

The number of new short-term detentions and compulsory treatment orders are about the same as previous years.

Existing orders under mental health law

Around 2,000 people are subject to compulsory treatment orders at any one point in time. This is similar to the number of people detained under the previous Act.

About a third of these people are treated in the community without the need for detention in hospital. This is in line with the principle of restricting people's freedom as little as possible.

People who have been on a CTO for more than two years are now more likely to be in the community than in hospital. It used to be the other way round. The review by the Tribunal at the two year point might have something to do with this.

Geographical differences in the use of mental health law

Dumfries and Galloway has most emergency detentions per head of population. Greater Glasgow and Clyde has the highest rate of short-term detention.

Tayside and Greater Glasgow and Clyde have high overall rates of long term orders. Lanarkshire and Borders have low rates.

We think much of the variation is due to different practices and service provision, rather than differences between populations, in different geographical areas. High rates could mean that there are too few community services, or that practitioners are too ready to use compulsion. Low rates could mean that services are not responding to people's needs, or that people accept treatment under pressure that should really be subject the safeguards of the Act.

Equality issues

Older people (aged 65 and over) are more likely to be detained under all types of order. The rise appears to be for people with dementia. We think that this is because practitioners are more likely to use the Act and its safeguards, than to admit people with dementia informally when they do not consent and are voicing or showing some resistance. In these circumstances, we think the rise is probably a good thing.

Young people in hospital should receive facilities and services that are appropriate for their age (whether detained or not). The number of young people admitted to non-specialist wards has risen again and has not met the Government's target of a 50% reduction. Our biggest concern is that several young people are in adult wards with no input from younger people's mental health services.

Our data on the ethnicity of people subject to mental health law is not complete and the population of Scotland has changed since the last census. Despite this, our data may suggest that people of black-African origin are more likely to be detained in Scotland. This is similar to findings in some parts of England.

Other findings

There has been an increase in the number of people treated with electro-convulsive therapy who are unable to provide, or have refused to consent this year. This mirrors an increase in the use of ECT this year.
(see www.sean.org.uk for more information).

Adults with Incapacity (Scotland) Act 2000 use of welfare guardianship

There are now about 4,500 people subject to welfare guardianship - more than twice the number of people treated under mental health law.

The number of new welfare guardianship orders continues to increase. We have recorded a rise in the appointment of private individuals as guardians. The number of local authority applications has not gone up.

Most guardianship orders are for people with dementia or a learning disability. We are still concerned about indefinite orders for young people with a learning disability where there is no automatic review by a court or tribunal. This is not consistent with human rights law principles.

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:

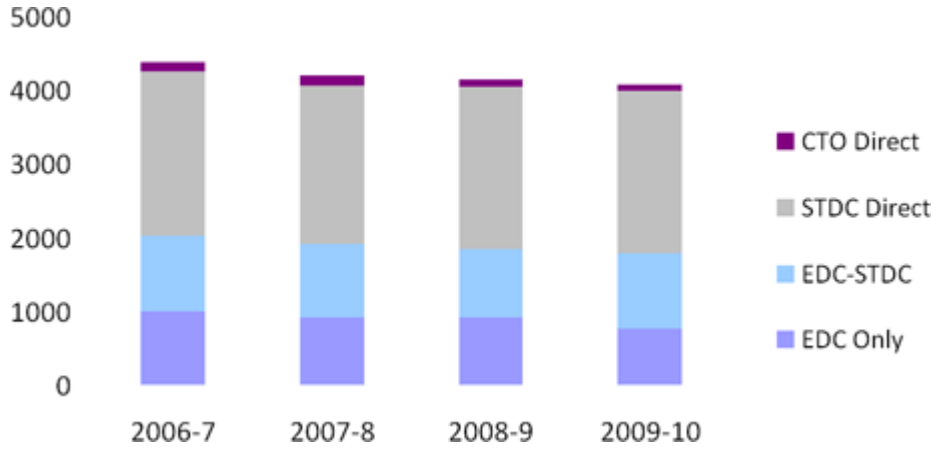
- new orders granted in 2009-10
- total number of orders in existence
- monitoring of priority areas
- additional findings from our monitoring programme 2009-10

New orders granted

Episode Sequence	2006-7	2007-8	2008-9	2009-10	Change from 08-09
Emergency detention to informal status	991	916	918	756	18% fewer
Emergency detention to short-term detention	1038	992	919	1029	12% more
Direct to STDC	2217	2152	2211	2201	About the same
Direct to CTO* (including interim orders)	133	132	95	83	13% fewer
Total episodes	4379	4192	4143	4069	2% fewer

*Taken from our information on hospital admissions. This may differ slightly from Tribunal figures.

New episodes of civil compulsory treatment initiated 2006-2010



NB These figures exclude people admitted to hospital from community based compulsory treatment

Our interest in this

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. Short-term detention should be the usual route into compulsory treatment. We want to find out whether this is what happens. In previous years, we found some general trends. The number of new compulsory episodes was falling, especially episodes initiated by emergency detention. Short-term detention, as a route into compulsion, had not been possible under the previous Act and looked to have been running at a consistent level since the 2003 Act was introduced.

This year, we have looked at these trends from the first full year after the implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003.

What we found

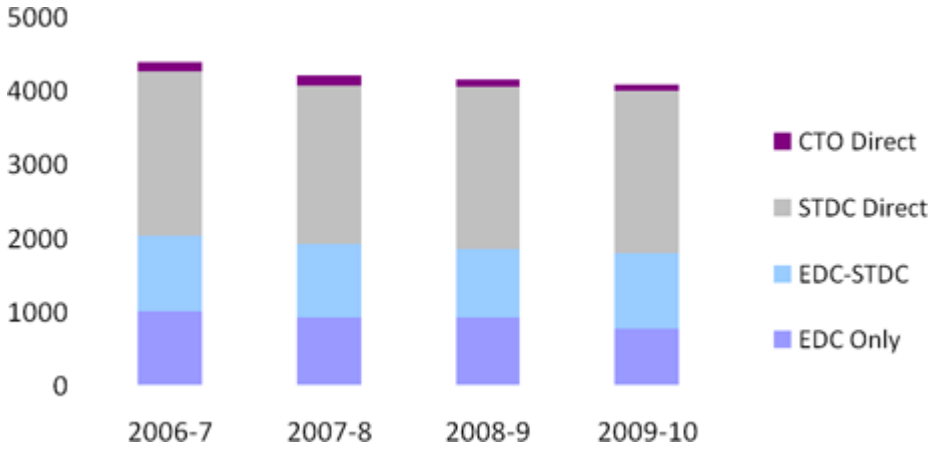
We were notified of 4,069 episodes of compulsory treatment during the year. This number has fallen consistently since the 2003 Act was introduced. Compared with the first full year of the 2003 Act (2006-7), 7% fewer people are being placed on compulsory care and treatment orders. Compared with the previous Act, the drop is 15%. We believe that the more rigorous procedures, tighter grounds for compulsion and better expert assessment, and possibly more responsive community services, have reduced the need for compulsory treatment and we are pleased that the number continues to fall.

The biggest drop this year was the number of people detained only under an emergency detention certificate. The drop of 18% suggests that services are finding better ways to respond to people in mental health crisis. The fact that

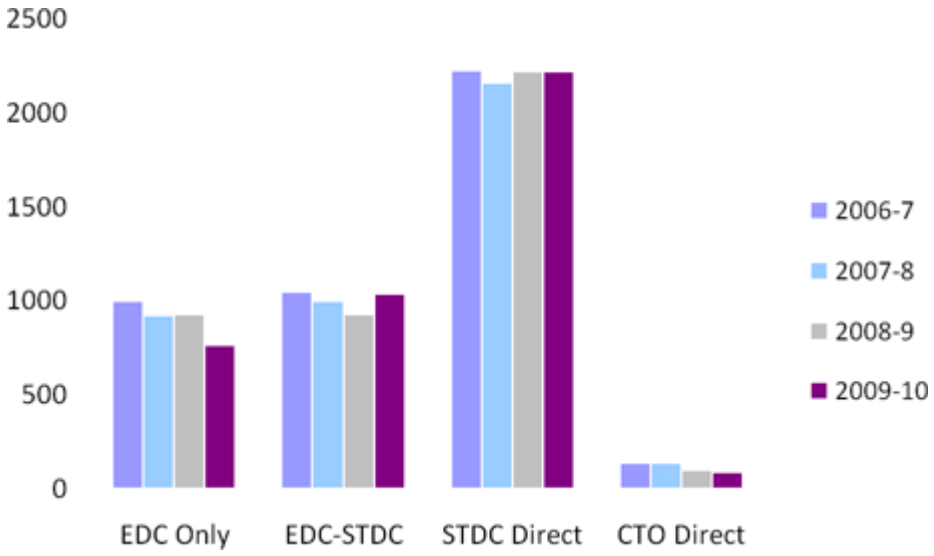
admissions under short-term detention certificates has not gone up, suggests that better crisis planning and management reduces the need for compulsory intervention. Also, despite a rise last year, the number of new orders under criminal procedures legislation has been relatively stable. This is reassuring as we would not wish to see people enter the criminal justice system when treatment under civil powers is appropriate.

There has also been a drop in the number of people who go straight onto a CTO. There is a higher percentage of community-based orders in this group. The two figures below show the trend in the use of new orders over the last four years.

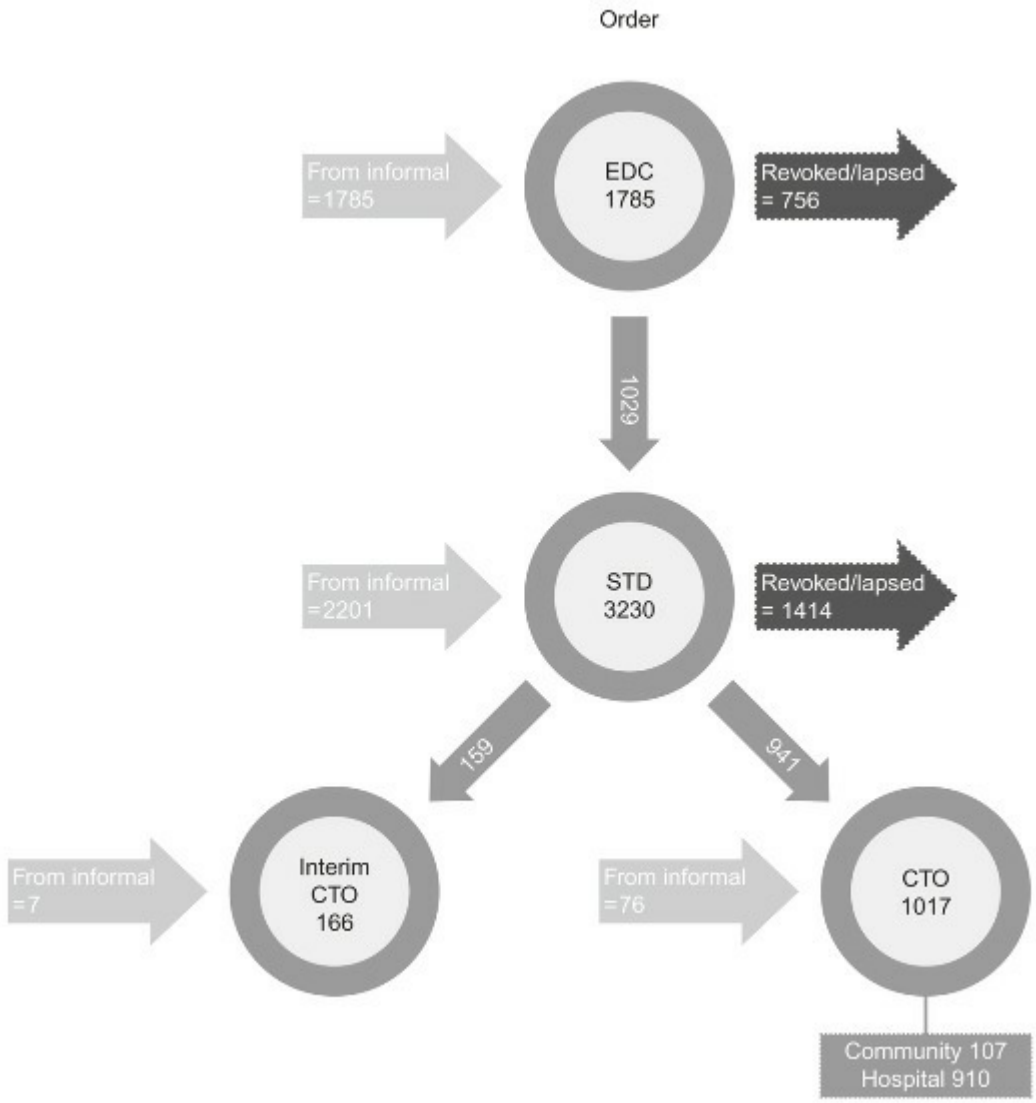
New episodes of civil compulsory treatment initiated 2006-2010



Trend in the initiation of compulsory treatment episodes 2006-10



Order sequencing 2009-10



Our interest in these figures

We want to see the pattern of how people progress from one order to the next. We also want to see the stages where orders lapse or are revoked. People should not be treated under compulsory powers any longer than is necessary.

What we found

- 42% of all emergency detention certificates are revoked or lapse at or before 72 hours.
- 72% of all short-term detention certificates are revoked or lapse at or before 28 days.
- 14% of all orders granted by the Tribunal following application for compulsory treatment orders are interim orders only and do not progress to a full CTO.
- 11% of all new CTOs are "community" orders, but 38% of people who go straight to a CTO from informal are being treated in the community.

Most people treated under the 2003 Act are detained and treated for short periods. We have reported on our visits to people on short term detention certificates and have commented on the need for frequent review of the need for the order. Most people who are detained each year will never have their cases reviewed by the Tribunal. The Commission has a vital role to visit these people and/or give advice and guidance to them and those caring for them.

The use of emergency detention certificates

Emergency detention by age and gender, 1 April 2009 to 31 March 2010

Age Range	Female	Male	Totals (%)
0-15	1	5	6
16-17	12	12	24
18-24	107	108	215
25-44	350	334	684
45-64	288	248	537
65-84	154	131	285
85+	43	28	71
Totals	955 (52%)	867 (48%)	1822 (100%)

Our interest in this

An emergency detention certificate (EDC) can be issued by any registered medical practitioner. There should be consent from a mental health officer (MHO) if possible. We collect information on the age and gender of people detained in this way. We look for differences in the way EDCs are used for men and for women and any trends in the use of this power for different age groups. Last year, we found a trend in the use of emergency detention: it fell for men but not for women. We were interested to see if this trend continued.

What we found

The total number of EDCs fell by 3%

Gender

- EDCs for men fell by 1%
- EDCs for women fell by 5%

More women than men are detained under an EDC, except in the 18-24 age group. This has always been the case but the gap has closed slightly since we reported reported on this last year. We will continue to monitor and report on gender differences in care and treatment.

Age

- EDCs for people aged 65 and over rose by 6%
- Since 2007-8, there has been a 22% increase in the use of EDCs in this age group
- The increase is proportionately slightly greater for men

Over the past three years, we have commented on an increasing tendency to use mental health legislation for older adults. The use of EDCs in this age group contrasts with a reduction in their use for younger people. As yet, the increase is not statisitically significant. We think the increased use of the 2003 Act for older people reflects the attention given to the rights of people with dementia. If the person cannot consent to hospital admission and is voicing or showing resistance, detention may be more proper than informal admission. Also, it may be that services are trying to manage people with dementia for longer in the community and need to intervene quickly when services are insufficient to deal with the risks faced by the person with dementia. The lack of a power to intervene quickly to provide emergency social care under the Adults with Incapacity (Scotland) Act 2000 may also be an issue here.

At the other end of the age spectrum, the use of EDCs for people under the age of 18 continues to fall.

EDCs with and without MHO consent by NHS Board, 2009-10

	No. of EDCs per 100K	% of people in community before detention	No. of EDCs with MHO consent	No. of EDCs without MHO consent
Ayrshire & Arran	40	31	62	86
Borders	8	33	9	0
Dumfries & Galloway	50	45	48	27
Fife	40	40	123	22
Forth Valley	36	31	75	28
Grampian	15	66	71	12
Greater Glasgow & Clyde	46	40	282	267
Highland	43	51	98	34
Lanarkshire	27	33	79	72
Lothian	31	51	211	43
Orkney	10	50	2	0
Shetland	5	100	1	0
Tayside	42	49	127	39
Western Isles	15	0	1	3
Scotland	**35**	**42**	**1189**	**633**

Our interest in this

Emergency detention should only be used where granting a short-term detention certificate would involve too much of a delay. We look at the extent to which emergency detention is used to detain people already in hospital or to admit them 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 want to find out how often this happens. In previous years, around half of EDCs were granted for people who were already in hospital.

We place great importance on 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 with previous years, Ayrshire and Arran, Lanarkshire and Greater Glasgow and Clyde had relatively low rates of MHO consent to emergency detention. These NHS Boards must work with their local authority partners to address this. Rural areas have significant challenges but the rate of MHO consent in Highland and Grampian show what can be achieved.

Fife and Lothian have very high levels of MHO consent, this suggests that they are providng a good 24 hour MHO service.

EDCs by pre-detention status and MH0 consent to detention 2009-10

Prior status	Number with consent	Number without consent	Total	% with MHO consent
Informal in hospital	629	403	1032	61%
From community	550	224	774	71%
Total (%)	**1179 (65%)**	**627 (35%)**	**1806 (100%)**	–

Notes: The table excludes 19 cases where there was no information about pre-detention status

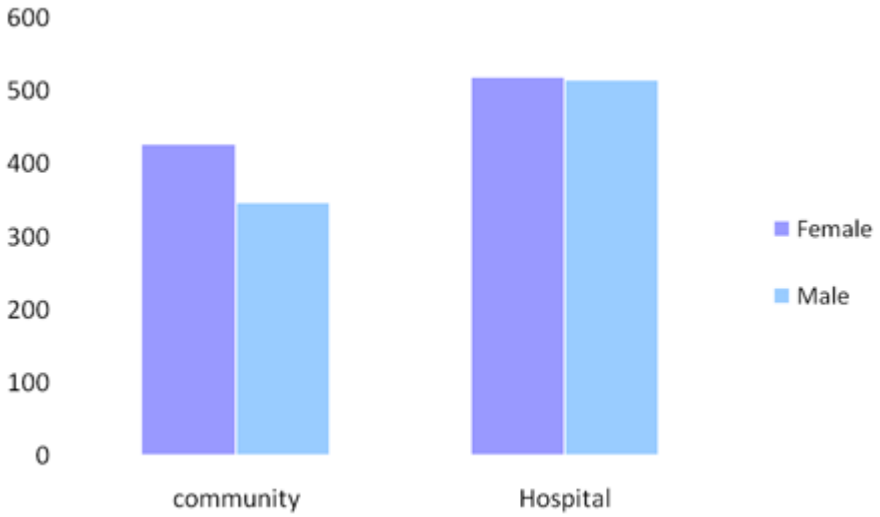
Our interest in this

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 stating 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

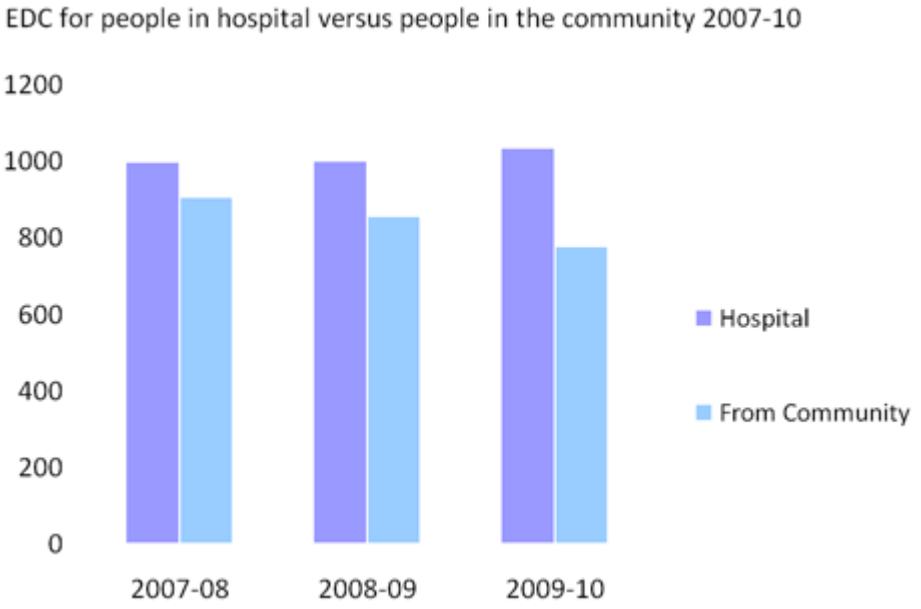
Again, people who are already in hospital are much less likely to have consent from an MHO when detained under EDC. Overall, it appeared that the use of EDC for people already in hospital was becoming progressively higher than the use for people in the community.

EDCs for people in hospital and from the community by gender 2009-10



Significantly more women than men are admitted from the community, compared with the gender balance of detention of people already in hospital (p=0.03). This reinforces our view that services respond differently to women in the community at times of mental health crisis. Possible explanations include response to deliberate self-harm by the use of emergency detention and the possibility that men may be even more likely to be dealt with by criminal justice procedures.

We looked at the use of EDC for people in hospital versus people in the community over the last three years.

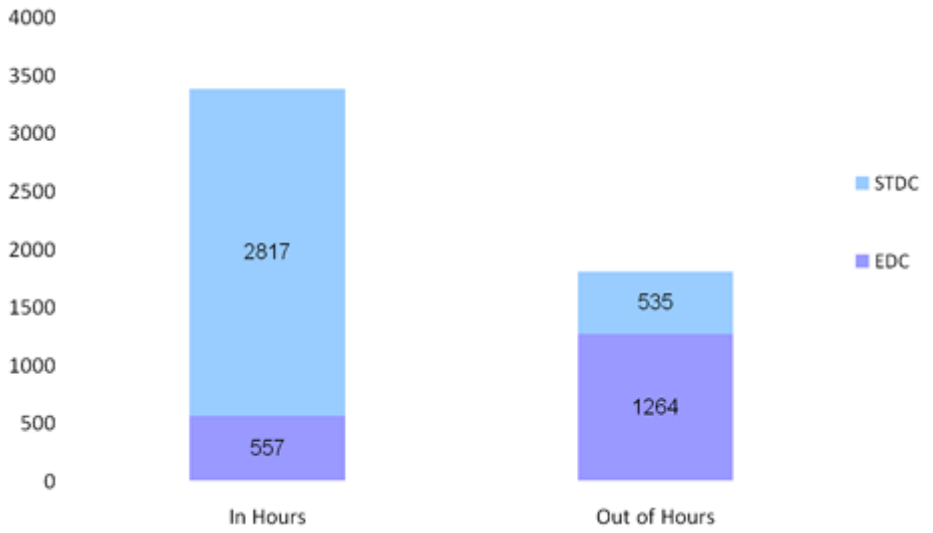


It is heartening that fewer people are admitted from the community under EDC. Since 2007 the overall drop in the use of EDC has been 16% for people who are admitted from the community. Its use for people in hospital actually rose slightly over the same time. This is highly significant (p=0.002). We think this is because the need to detain a person urgently in hospital may mean that it must be done before both an approved medical practitioner and MHO can attend. We have recommended changes to the use of nurses' power to detain and to the duration of EDCs as part of the review of the 2003 Act. Unless these changes are made, we expect that the use of EDC for people already in hospital will not fall. This is a matter of significant concern to us.

EDCs by time of granting of certificate and MHO consent to detention, 2009-10

Time of granting of certificate	% of total no. of EDCs	% of total with consent	% of total without consent
Within office hours	31	21	10
Outside office hours	69	48	25

Granting of EDCs vs STDCs, in hours and out of hours 2009-10



Our interest in this

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. We want to find out if MHO consent is available outside office hours.

What we found

Overall, most EDCs have MHO consent. There is no great difference in the rate of MHO consent for people detained within and outside office hours.

Duration of emergency detention certificates granted 2009-10*

	Within 24 hours of admission	24-72 hours after admission	Total (%)
EDCs revoked	202	233	435 (24)
EDC superseded by STDC	574	452	1026 (58)
Order expired at 72 hours	n/a	n/a	323 (18)
Total (%)	776 (42%)	685 (38%)	
Total number of emergency detentions			**1784 (100%)**

these figures include people admitted while on community based compulsory orders, but exclude 25 people where we have been unable to determine the duration of the EDC

Our interest in this

Short-term detention should be the usual route for admission to hospital under the 2003 Act. This involves mental health specialists - an approved medical practitioner (AMP) and a social work mental health officer (MHO). Emergency detention certificates (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 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 either 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 in such circumstances. 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.

What we found

This year, we found that only 18% of EDCs appear to run for the full 72 hours and then expire. This is much lower than in previous years. We are pleased to see this although we think the number should be lower still. It may be that we are not always notified if the order is revoked earlier.

Ideally, EDCs should be revoked or superseded by a short-term detention certificate within the first 24 hours. This happened for 44% of people subject to an EDC this year. This is an increase on previous years. Hospital managers must do their best to ensure that, where the order is not revoked or superseded, there is at least an assessment by an AMP within the first 24 hours.

Short-term detention under the Mental Health (Care & Treatment) (Scotland) Act 2003

Short-term detention certificates granted by age and gender 2009-10

Short-term detentions	Female	Male	Totals (%)
0-15	13	17	30 (1)
16-17	20	24	44 (1)
18-24	108	179	287 (9)
25-44	539	578	1117 (33)
45-64	513	466	979 (29)
65-84	405	357	762 (23)
85+	88	45	133 (4)
Totals (%)	**1686**	**1666**	**3352**

Our interest in this

Short-term detention certificates (STDCs) should be the usual start for an episode of compulsory treatment under the 2003 Act. An STDC involves examination by an approved medical practitioner (AMP) and consent from a mental health officer (MHO). It can last for up to 28 days. We look at how this power is used for people of different ages and genders to see if there is evidence of unequal treatment. We also compare this data with previous years to see if there are any trends. Last year, we commented on an increase in the use of STDC for people aged 65 and over

What we found

Overall, there has been a slight rise in the use of short-term detention in the last three years (about 3%). Unlike emergency detention, we found the gender balance in the use of STDCs roughly equal and with very little change over the past few years. Women over 65 are more likely to be detained on a short-term detention then men in the same age group. Men under 25 are more likely to be detained using a STDC than women of the same age.

As with emergency detention, we are seeing a rise in the use of STDCs for people aged 65 and over. Compared with 2007-8, there has been a 14% increase in the number of people aged 65 and over detained on STDC while the number of people under 65 in this category has remained stable. Over the past three years, we have commented on an increasing tendency to use

mental health legislation for older adults. The use of EDCs in this age group contrasts with a reduction in their use for younger people. As yet, there is not a significant overall rise in the older population. We think the increased use of the 2003 Act reflects the attention given to the rights of people with dementia. If the person cannot consent to hospital admission and is voicing or expressing resistance, detention may be more proper than informal admission. Also, it may be that services are trying to manage people with dementia for longer in the community and need to intervene quickly when services are insufficient to deal with the risks faced by the person with dementia. The lack of a power to intervene quickly under the Adults with Incapacity (Scotland) Act 2000 may also be an issue here.

The use of STDCs for people under 18 is higher this year than last. It fluctuates year by year with no overall trend.

Number and percentage of short-term detention certificates granted by type of mental disorder specified 2009-10

Type of mental disorder*	No	% of certificates
Mental illness	3232	96
Learning disability	147	4
Personality disorder	183	5
Not recorded	10	0
Total certificates	**3352**	

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

Our interest in this

We want to know the type of mental disorder(s) specified on STDC forms. The 2003 Act defines "mental disorder" as "mental illness, learning disability or personality disorder". A person may have more than one type of mental disorder. Generally, most people are detained because of mental illness.

What we found

We found an increase in the number of people recorded as having learning disability or personality disorder. This may reflect greater awareness of recording these conditions on the STDC forms. 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.

STDs granted where named person is recorded or consulted 2009-10

	No.	No.	% of all short-term detentions	
	2009-10	2008-09	2009-10	2008-09
Named person recorded	2670	2558	80	79
Named person consulted	1751	1618	52	50

All short term detentions 3352 (2009-10)

Our interest in this

The concept of each person having a 'named person', who would have an interest in the care and treatment of a person with mental disorder, was an important aspect of the 2003 Act. The right to be consulted over the proposed granting of an STDC is an important part of the named person's role. We have been disappointed that this has occurred in fewer cases than we wish to see.

What we found

There has been a steady increase in the number of STDCs where the named person has been consulted. This year, the named person has been consulted in more than half of cases. This is heartening but could be higher still. In most cases at present the person will have a designated named person, even if he or she has not nominated an individual to the role. The 2003 Act sets out who can act as a 'default' named person. It is the duty of the MHO to identify the named person. The MHO should also consult with medical and nursing staff to identify the named person and to ensure that everyone is aware of who that is. The AMP must consult the named person unless it is impracticable to do so.

Compulsory treatment orders

Compulsory treatment orders by age and gender 2009-10

Compulsory treatment orders	Female	Male	Totals	%
1-15 yrs	7	3	10	1
16-17 yrs	4	4	8	1
18-24 yrs	27	74	101	9
25-44 yrs	141	214	355	33
45-64 yrs	146	167	313	29
65-84 yrs	131	137	268	25
85+ yrs	20	16	36	3
Total	**476**	**615**	**1091**	**100**

These figures are supplied to the Commission by the Mental Health Tribunal Scotland.

Our interest in this

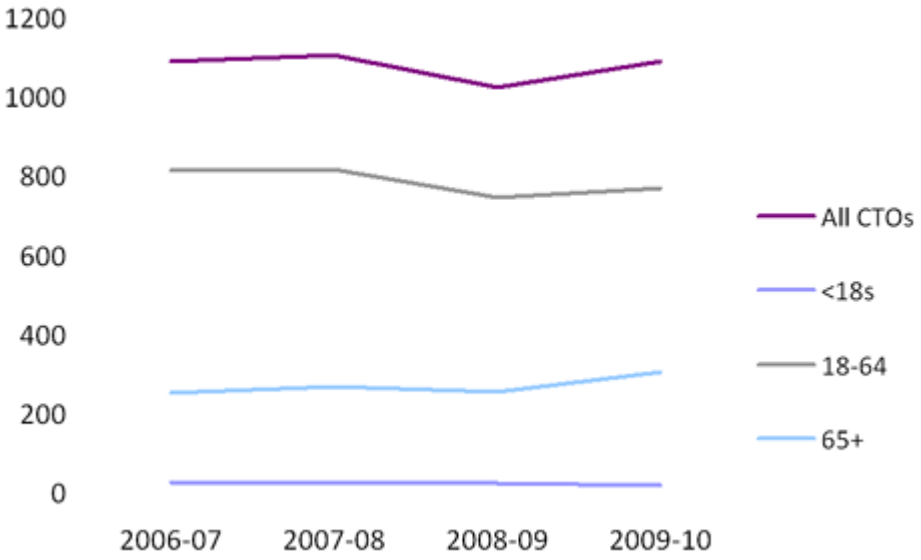
Compulsory treatment orders (CTOs) are granted by the Mental Health Tribunal. They last for up to six months, can be extended by the responsible medical officer for a further six months and then extended annually. The Tribunal reviews these orders at least every two years. Therefore, they can restrict or deprive 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 trends. Over recent years, the number of new orders has come down. They are usually used more for men than women. We have been examining the use of CTOs for older people as we had seen some increase in people aged 85 and over, although we did not find a consistent trend.

What we found

- The total number of new CTOs has risen this year. The nuber had falled last year and appears to fluctuate year by year. There is no overall trend.
- The number of CTOs for older people (aged 65 and over) has gone up compared with the previous three years. There were304 orders this year, compared with 254 last year - an increase of 20%. We are seeing an increased used of emergency, short-term and long term civil orders for older people that cannot be explained by a rise in the elderly population.
- There has been a steady fall in the granting of CTOs for young people (under 18). There were only 18 new orders this year compared with 23 for the past two years and 26 in 2006-7.

- 56% of all new CTOs were for men. We have consistently found that men are more likely to be subject to CTOs than women. There has been a big rise in the granting of CTOs for men in the 65-84 age group (137 compared with 92 last year).

New compulsory treatment orders granted 2006-10 by age group



This figure shows that the granting of new CTOs has reduced or at least been stable for most age groups. The rise this year is mainly due to an increased use of CTOs for older people. We are examining the characteristics of people who are subject to compulsory orders and are 65 or over.

Pattern of progression to compulsory treatment orders 2009-10

	Interim CTO only	Interim CTO to CTO	Direct to CTO
STDC	159	494	447
Informal	7	16	60
Totals	**166**	**510**	**507**

Our interest in this

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 when reading this section.

What we found

This year we found that nearly half of all CTOs are granted without an interim order. This is a much higher proportion than the previous two years. Everyone accepts the need to reduce the number of multiple hearings and appears that there is a reduction this year. We still think the 2003 Act should be amended to further reduce the number of interim hearings. We think this can be achieved while still fully respecting the rights of the individual.

Number and rate per 100k population of compulsory treatment orders granted 2009-10

Health Board	No. of CTO Orders	Rate per 100k
Ayrshire and Arran	62	17
Borders	13	12
Dumfries and Galloway	32	22
Fife	94	26
Forth Valley	38	13
Grampian	94	17
Greater Glasgow and Clyde	314	26
Highland	86	28
Lanarkshire	71	13
Lothian	182	22
Orkney	0	0
Shetland	1	5
Tayside	93	23
The State Hospital	1	0
Western Isles	3	15
Total	**1085**	**21**

CTO numbers provided by – Mental Health Tribunal Scotland. (MHTS)

Our interest in this

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. Although more people with severe and enduring mental

illness tend to live in inner city 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. There is also a risk that excessive persuasion is used to treat people in hospital. Practitioners must take care to make sure they are not unlawfully depriving people of their liberty.

Last year, we looked at the average over the previous three years and found that Fife and Tayside have the highest number of new CTOs granted over that time.

What we found

- NHS Lanarkshire and NHS Borders have low CTO rates. Borders has the lowest overall rate of use of the 2003 Act of all NHS Board areas.
- The highest rate of new CTOs is in NHS Highland. Fife remains high but Tayside was lower this year. NHS Greater Glasgow and Clyde has a higher use of new CTOs than previous years. This area has a very high use of all the main civil compulsory orders. The opening of Rowanbank Clinic, which receives transfers from the State Hospital, may have had a minor effect on the higher number of CTOs
- *S*ome national or regional services might be skewing some of this data. For example, there are regional medium secure services in Glasgow and Lothian, an independent sector low secure facility in Ayrshire and learning disability facilities in Fife and Tayside that take people from outside their NHS Board area. We think the overall effect is relatively minor but could affect rates in smaller NHS Board areas.

The NHS Board areas that we have identified should examine this data and look for possible explanations. They should also look at our data on the total number of mental health act orders in existence. NHS Greater Glasgow and Clyde in particular may need to examine the reasons for increased intervention under mental health legislation.

Geographical variations in the use of mental health law in Scotland

No. and rate per 100k population of compulsory powers granted, by order type and NHS Board 2009-10

NHS Board	Emergency detention	Rate per 100k	Short term detentions	Rate per 100k
Ayrshire and Arran	148	40	201	55
Borders	9	8	38	34
Dumfries and Galloway (HB)	75	50	102	69
Fife (HB)	145	40	254	70
Forth Valley	103	36	145	50
Grampian	83	15	289	54
Greater Glasgow and Clyde	549	46	1002	84
Highland (HB)	132	43	214	69
Lanarkshire	151	27	231	41
Lothian	254	31	581	71
Orkney (HB)	2	10	0	0
Shetland (HB)	1	5	3	14
State	0	0	1	0
Tayside	166	42	285	72
Western Isles	4	15	6	23
SCOTLAND	**1822**	**35**	**3352**	**65**

Our interest in this

Most people who are detained under the Mental Health (Care & Treatment) (Scotland) Act 2003 are held for up to 72 hours (emergency detention) or 28 days (short-term detention). 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 more people with severe and enduring mental illness tend to live in inner city areas, we usually find detention rates higher in these areas. Emergency detention can be high in rural areas because it is less easy to get both an approved medical practitioner and a mental health officer for short-term detention. 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. It could also mean that people are being persuaded to be in hospital when they want to leave. In some circumstances, this can mean an individual is, to all intents, "detained" but without the safeguards of the Act.

What we found

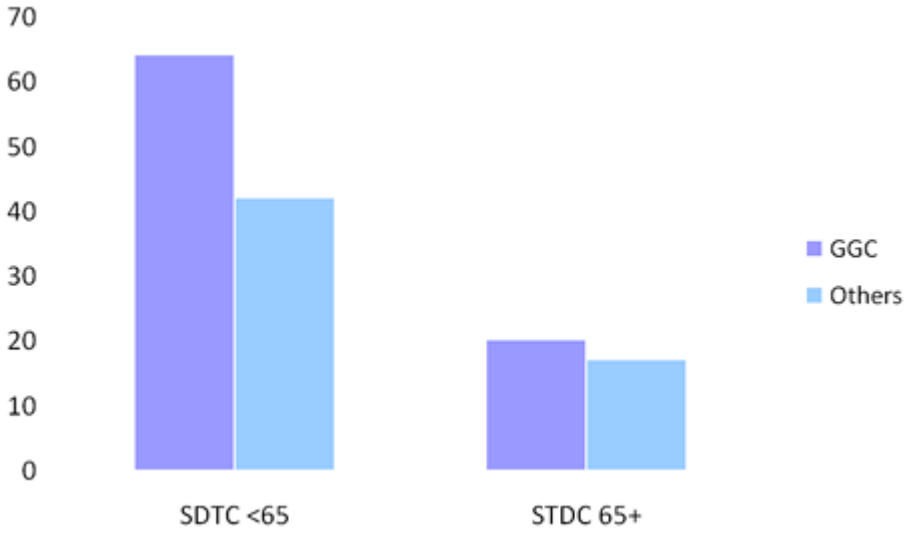
We looked at this year's figures and compared them with the previous three years. Our main findings are:

- Dumfries and Galloway has the highest rate of emergency detention for the third consecutive year. This should be a matter of concern for the NHS Board and the local authority. They should look into the reasons for this. Given that consent from mental health officers is around the national average, it may be that there is low availability of approved medical practitioners. Also, it may be that there are insufficient crisis services in these areas.
- Greater Glasgow and Clyde has by far the highest rate of short-term detention. This area also has a high rate of emergency detention, especially without mental health officer consent. While we expect to see high use of the Act in inner cities, there has been an increase in this NHS Board area of 9% compared with a 4% fall in other NHS Board areas. The excess in Glasgow appears to be mainly people under 65 (64 per 100k in GG&C, 42 per 100k elsewhere). See figure below.
- Borders and Grampian had very low use of emergency detention and Borders had the lowest use of short-term detention.

The areas we have identified as especially high or low users should consider the reasons for this. They may wish to consider:

- Are there distinctive features of the population in areas of high use of EDC and STDC? For example, is drug use, especially in Glasgow and surrounding areas, a particular problem causing or complicating mental illness?
- Are there distinctive features of mental health services in areas of especially high or low use? For example, do areas with high use of emergency and short-term detention have good enough crisis services?

Rates of short-term detention by age for NHS Greater Glasgow & Clyde compared with other NHS Board areas 2009-10



No. and rate per 100k population of short-term detentions and compulsory treatment orders by local authority 2009-10

Local Authority	Short -term detentions	Rate per 100k	CTOs*	Rate per 100k
Aberdeen City	147	70	56	26
Aberdeenshire	96	40	31	13
Angus	28	25	11	10
Argyll and Bute	72	80	28	31
City of Edinburgh	370	78	108	23
Clackmannanshire	18	36	7	14
Dumfries and Galloway (LA)	94	63	33	22
Dundee City	144	101	39	27
East Ayrshire	50	42	22	18
East Dunbartonshire	55	53	18	17
East Lothian	65	68	18	19
East Renfrewshire	31	35	12	13
Eilean Siar	5	19	5	19
ESWS	3	0	n/a	n/a
Falkirk	65	43	25	16
Fife (LA)	255	70	96	26
Glasgow City	696	119	195	33
Highland (LA)	160	73	65	29
Inverclyde	48	59	21	26
Midlothian	30	37	19	24
Moray	46	52	10	11
North Ayrshire	61	45	25	18
North Lanarkshire	125	38	37	11
not recorded	5	0	n/a	0
Orkney	0	0	2	10
Perth and Kinross	110	76	41	28
Renfrewshire	81	48	28	16
Scottish Borders	42	37	13	12
Shetland (LA)	8	36	2	9
South Ayrshire	62	56	20	18
South Lanarkshire	155	50	41	13
Stirling	62	70	7	8
West Dunbartonshire	38	42	13	14
West Lothian	113	67	37	22
WSSS	14	0	n/a	n/a
Grand Total	**3354**	**65**	**1085**	**21**

*CTO numbers provided by MHTS

Our interest in this

We have an interest in ensuring that people are getting the care and treatment they need regardless of where they may live. We therefore take an

interest in variations in the use of civil compulsory orders by NHS Board area. We also 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 the highest rates of detention. Some of this data may be skewed by "out-of area" placements.

What we found

Glasgow City and Dundee City have very high rates of short-term detention. Argyll and Bute Council has shown a particularly high rate this year, which is a new finding.

CTO rates are also high in Glasgow and Argyll and Bute. Highland Council also has a high rate of CTOs.

Other rural or more affluent areas have low use of mental health legislation.

The use of nurses' power to detain

Cases of nurses' power to detain pending medical examination, by hospital and gender of patient 2009-10

Hospital	Female	Male	Total
Ailsa	2	1	3
Borders General	1	2	3
Borders NHS	0	3	3
Cameron	0	1	1
Carseview Centre	6	4	10
Crichton Royal	12	12	24
Crosshouse	5	3	8
Dr Grays	1	1	2
Dudhope House	1	0	1
Dykebar	3	5	8
Falkirk Royal Infirmary	1	0	1
Gartnavel Royal	1	2	3
Haimyres	1	1	2
Huntlyburn House	1	1	2
Leverndale	3	1	4
Mackinnon House	1	1	2
Murray Royal	1	2	3
New Craigs	3	1	4
Parkhead	1	0	1
Queen Margaret	5	4	9
Royal Comhill	1	1	2
Royal Dundee Liff	1	0	1
Royal Edinburgh	24	14	38
Southern General	1	3	4
St Johns	4	3	7
Stratheden	3	1	4
Town & County (Wick)	1	0	1
Whytemans Brae	5	6	11
Grand Total	**89**	**73**	**162**

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 described as 'nurses' holding power'. Last year we continued to note a marked variation in the use of this power across Scotland and a significant difference in the way it was used with men and women. We looked closely at

the figures this year to see if this pattern continued, or if there was any change.

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

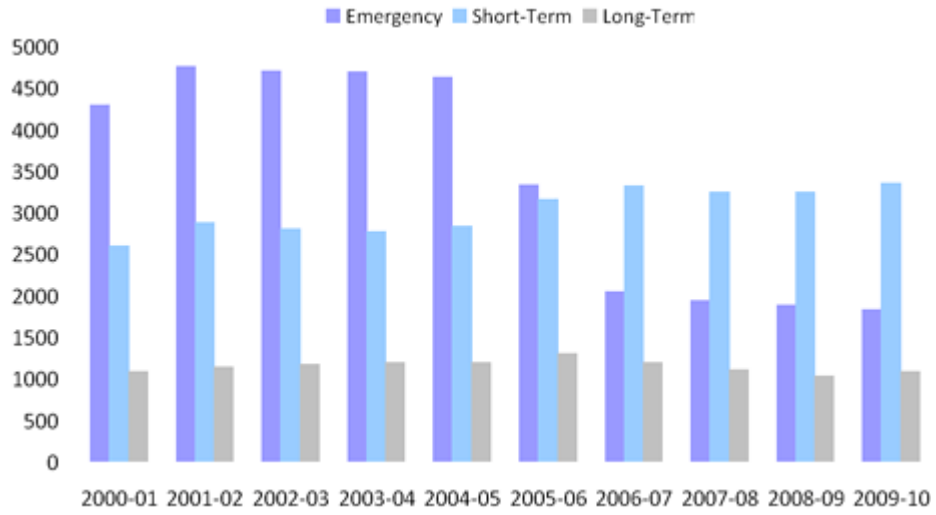
Since we started reporting on the use of this power, its use has been higher for women than for men. One explanation for this may be that nurses are more likely to prevent a woman from leaving. It may be that nurses do not prevent a man from leaving, but may consider futher action, for example involving the police if they think there is serious risk. This year however, although the power is still used more with women than with men, we have noticed a marked increase (25.9%) in the number of men detained by nurses pending medical examination which has contributed to a noticeable overall increase (11.7%) in the number of people detained by nurses.

We will continue to monitor the use of this power and in particular to see if this year's figures are a 'one off' or part of an indicative trend towards more equitable use.

Managers should examine the use of this power in their areas and ensure nursing staff have a clear understanding of the appropriate use of their power to detain. We are concerned that some people may be unlawfully deprived of their liberty where this power is not being invoked where it should.

Trends in the use of civil compulsory treatment

Detentions under civil procedures in Scotland, 2000-10



Our interest in this

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. This trend has not continued under the 2003 Act. Emergency detention has been falling, accompanied by an initial rise in short-term detention. We wanted to see whether these trends continued

What we found

Main findings are:

- The use of emergency detention continues to fall although mostly for people in the community (see table 4). We are encouraged by this although we have suggested changes to the Act that could reduce emergency detention further, e.g. by amending the use of nurse's power to detain for short periods or by shortening the period of emergency detention, especially where the MHO has not been able to consent.
- Short-term detention rates have gone up since the 2003 Act was introduced (midway through 2005-06). They are slightly higher this year than last year. We will watch to see if there are further rises. A rise in

these orders was a consequence of making this route the usual one into compulsory treatment. We continue to remind psychiatrists to review these orders frequently, especially during the first few days.

- The number of new long-term detention orders has fallen since the 2003 Act came into force. It seems to be around 1100 new orders each year on average and has shown slight fluctuation since 2006-7 but no overall change.

The total number of people on CTOs has changed little over the last year.

These figures need to be studied along with our figures on the total number of orders in existence.

The use of compulsory care and treatment for mentally disordered offenders

Compulsory treatment under criminal procedures 2008-09 and 2009-10

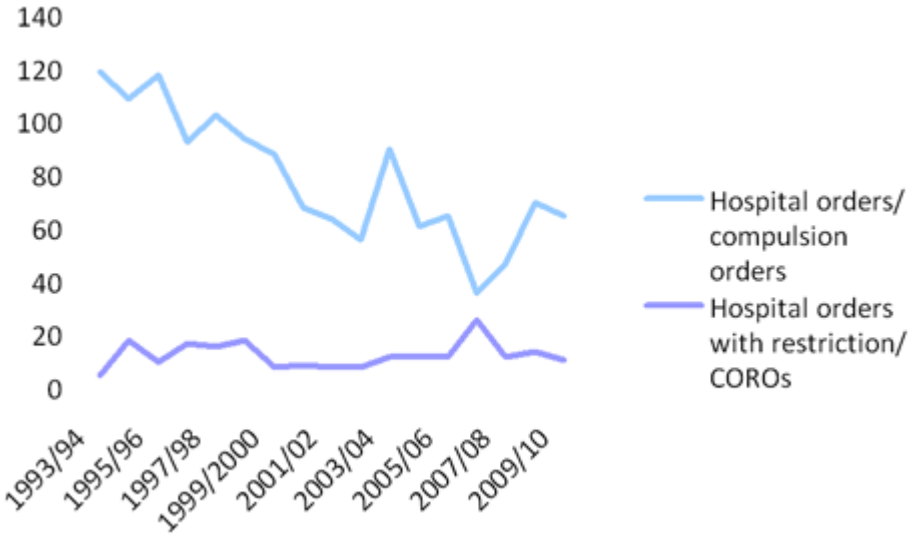
Order Type	No. of orders 2009/10	2008/9
Remand in custody or on bail for inquiry into mental condition (CPSA* 200)	0	3
Assessment order (CPSA 52D)	130	177
Treatment order (CPSA 52M)	78	74
Interim compulsion order (CPSA 53)	12	25
Temporary compulsion order (CPSA 54(1)(c)	10	12
Compulsion order (CPSA 57A (2))	45	59
Compulsion order (CPSA 57A (2)) Community	1	4
Compulsion order (CPSA 57(2)(a))	10	7
Compulsion order (CPSA 57(2)(a)) Community	0	0
CORO** (CPSA 57A + 59)	11	9
CORO (CPSA 57(2)(b))	0	5
Transfer for treatment direction (MHSA (2003)*** 136)	31	29
Hospital direction (CPSA 59A)	0	0
S200 Committal	1	0

* Criminal Procedure (Scotland) Act 1995

** Compulsion order with restriction order

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

Trends in the use of compulsory treatment under CPSA 2000-10



Episodes of compulsion under criminal proceedings, by age and gender 2009-10

Age Range	Female	Male	Totals
1-15	0	1	1
16-17	0	0	0
18-24	5	38	43
25-44	30	164	194
45-64	20	58	78
65-84	2	11	13
85+	0	0	0
Totals (%)	**57 (17%)**	**272 (83%)**	**329 (100%)**

Community-based compulsion orders 2009-10

	No. of orders
Full orders granted	1
Variations from hospital to community during period	11
Recalls from community to hospital during period (S113/ S114)	5

Our interest in this

People with mental disorder who are convicted of a criminal offence may be dealt with by being placed on an order under the Criminal Procedures (Scotland) Act 1995 (CPSA) which requires them to be treated in hospital or occasionally, in the community. In some cases, additional restrictions are placed on the individual and any lessening of their security status or suspension of detention has to be approved by Scottish Minister. An individual may be subject to a number of different orders before final disposal of the case which may be by Compulsion Order (CO) or Compulsion Order and Restriction Order (CORO).

What we found

There is a general downward trend in the use of mental health orders under the CPSA. The jump in the number of assessment orders that we recorded last year has not been repeated. Last year we wondered whether this would explain to some extent the gender difference in the use of emergency detention certificates (EDCs), with many more women than men being subject to EDCs and assessment orders being used almost exclusively for men. Whilst the difference is less this year, this is largely down to a fall in the use of EDCs for women.

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, as it allows us to look at the total number of people who are detained.

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 2003 Act has been used since its introduction (October 2005). We found that, after an initial fall, the number of people on long-term compulsory treatment orders has risen to the same level as the 1984 Act. The big difference, however, is that a third of people now receive long term compulsory care and treatment outside hospital.

The number of people on criminal procedure orders has stayed stable over this time.

Number of people subject to compulsory powers by type at quarterly census dates, 2009-10

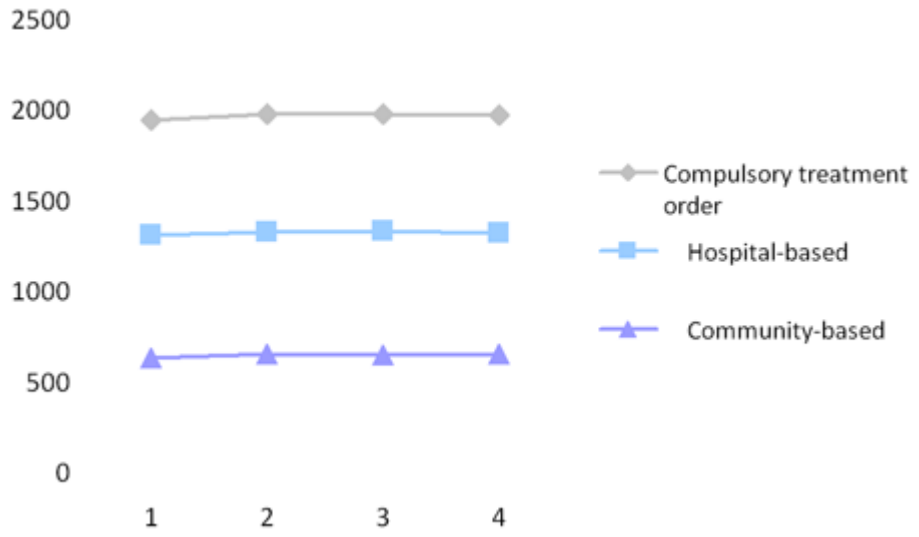
Order	8 Apr 09	8 Jul 09	7 Oct 09	6 Jan 10
Emergency detention	8	11	13	12
Short-term detention	245	234	213	199
Interim compulsory treatment order	79	56	41	57
Compulsory treatment order	**1940**	**1973**	**1975**	**1972**
Hospital-based	1309	1324	1328	1319
Community-based	631	649	647	653
Assessment order	7	13	7	5
Treatment order	11	8	15	12
Interim compulsion order	6	5	0	5
Compulsion order	190	177	174	176
Compulsion order with restriction order	243	239	237	239
Transfer for treatment direction**	61	58	57	55
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	2	3	0	1
Indeterminate status*	25	26	26	32

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.

***** 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.***

Point prevalence of compulsory treatment orders on four quarterly dates 2009-10



Our interest in this

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. 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 subject to compulsory treatment orders (CTOs) has been remarkably steady over the past four quarters. There are just under 2000 CTOs in existence at any one time. About a third of these orders are community-based.

The total number is about the same as the number of "section 18" long-term detentions under the old Act. More people are now treated in less restrictive ways, through the provision of compulsory treatment in the community. We are visiting as many people as we can on community CTOs this year to make sure that the orders are being used appropriately and reviewed often enough.

Number of people subject to compulsory powers on 6 January 2010, rate per 100,000, by NHS Board in rank order*

NHS Board	Rate per 100K
Tayside	63
Greater Glasgow and Clyde	63
Lothian	56
Fife	53
Highland	52
Dumfries and Galloway	51
Forth Valley	45
Ayrshire and Arran	43
Grampian	36
Lanarkshire	29
Borders	25
Western Isles	15
Shetland	9
Orkney	0
Scotland	**53**

Including indeterminate orders

Our interest in this

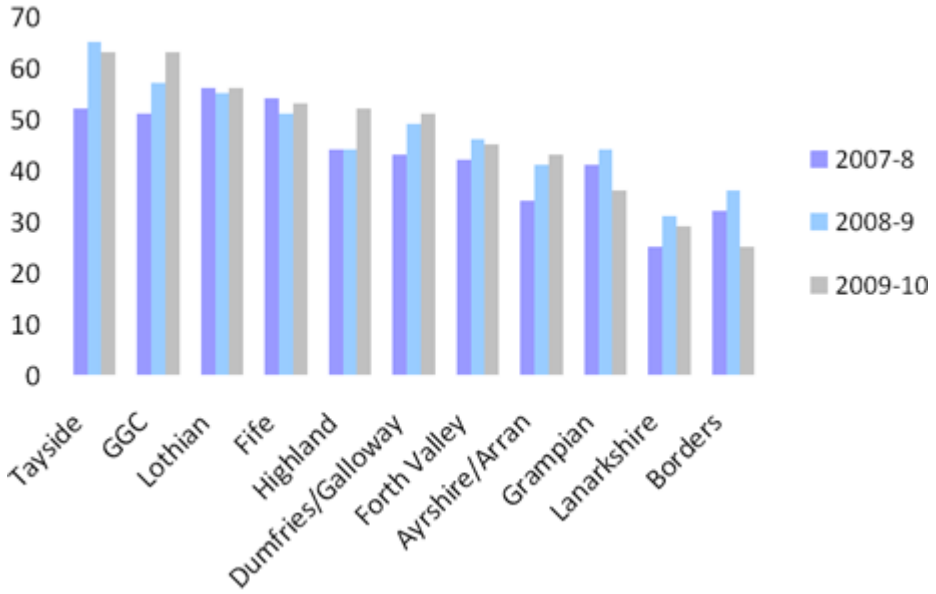
We comment on the number of new orders in different NHS Board areas in other parts of this report. This table shows the total number of people in each area who are subject to compulsory treatment on one date during the year. In our experience, this is a good guide to the overall use of compulsion in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

What we found

- The high numbers of new orders in Greater Glasgow and Clyde is also reflected in the number of total orders in existence. This year, GG&C has the joint highest number of orders along with NHS Tayside.
- NHS Borders has the lowest number of orders in existence this year. Lanarkshire, always an area of low prevalence, is second lowest.

Trend in prevalence of compulsory treatment per 100,000 population by NHS Board 2007-8 to 2009-10



We looked at the point prevalence of compulsory treatment over the last three years and compared the ten mainland NHS Board areas. There is a striking consistency to these figures. There are areas that always have a high or low use of the Act. We recommend that NHS Boards with either very high, or very low, use of the legislation examine their practice. High using areas might be using legislation too often and may need to do more to intervene and engage people earlier in treatment. Low using areas may be failing to detain people who need care and treatment or may be using excessive persuasion, rather than formal detention.

Some of the variations and changes in the use of the 2003 Act may reflect the numbers of people detained in regional units. For example, the Ayr Clinic and the low secure learning disability forensic unit in Lynebank Hospital, Fife will have significant numbers of detained patients, enough to skew the numbers per head of population in a small NHS Board area.

The increasing use of the Act in Greater Glasgow and Clyde is a matter of concern. While some of the increase may be due to the opening of Rowanbank Medium Secure Unit, this only explains a small fraction of the increased use of the Act. We will be discussing these figures with representatives of NHS Greater Glasgow and Clyde and will continue to report on geographical variations.

Our monitoring priorities

Each year, we decide on priorities for monitoring the Mental Health (Care & Treatment) (Scotland) Act 2003. We consult with stakeholders to help us identify these priorities. We also 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.

Advance statement overrides

Analysis of notifications of treatment that is in conflict with an advance statement 2009-10

	Total
Number of notifications	**137**
Actual overrides	**29**
Refusal of depot injection	16
Refusal of any medication	5
Refusal of ECT	1
Request for one specific medication	7

Our interest in this

Advance statements are one of the ways of that patients can participate in their care and treatment. Whilst we do not know how many advance statements have been made, we must be informed when one is overridden.

Participation is a key principle of mental health law and it therefore important to understand the circumstances in which an advance statement has been overridden. When we are notified of a potential override we make enquiries to find out whether it is a genuine override and, if so, what steps have been taken to discuss this with the person concerned.

What we found

We were notified of 137 potential advance statement overrides. Some of these came to us from the Tribunal, some from responsible medical officers MOs and some from 'second opinion' doctors, who had been asked to authorise treatments where people did not or were unable to consent. Out of this, we found 29 genuine overrides. The others were notifications in error, either because there was no advance statement, or because the particular treatment had not been specified in the advance statement. On a few occasions the person had subsequently agreed to their treatment and had decided to rewrite their advance statement.

Of the genuine overrides, the majority (16) were in respect of depot medication, where the advance statement indicated a wish for oral medication only.

We found some "advance statements" which had been made by the person at the time of their Tribunal hearing. We regard these as contemporaneous statements about care and treatment which anyone should be able to make at such a time and which should form part of the routine discussion about

individual care and treatment. As an 'advance statement' it would only have effect if the person then lost capacity.

Community based compulsory treatment

All existing compulsory treatment orders and community based compulsory treatment orders by NHS Board census date 6 January 2010

Health Board	CTO Community Based	CTO Hospital Based	Totals	% Community Based
Ayrshire and Arran	30	93	123	24%
Borders	10	15	25	40%
Dumfries and Galloway	23	39	68	34%
Fife	54	98	152	36%
Forth Valley	36	71	107	34%
Grampian	47	112	159	30%
Greater Glasgow and Clyde	190	361	551	34%
Highland	48	81	129	37%
Lanarkshire	50	78	128	39%
Lothian	111	252	363	31%
Shetland	2	0	2	100%
State	0	29	29	0%
Tayside	52	144	196	27%
Western Isles	1	3	4	25%
Totals	**654**	**1376**	**2030**	**32%**

Last year we reported on 1,854 CTOs. We didn not think this reflected the total number of CTOs. We have worked hard to make sure that we got better information this year. The number of people on CTOs has not, however, gone up significantly this year.

Our interest in this

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 being delivered in the community. We wanted to see if this varied across the main NHS Board areas. Unfortunately

we can't report this for local authority areas, because we don't always have up to date details of an MHO's employer.

What we found

We looked for NHS Boards where the use of community CTOs was obviously higher or lower than the national average. The important findings are:

- NHS Borders has the highest proportion of community based compulsory 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. Lanarkshire is not far behind.
- Ayrshire and Arran has the lowest use of community based compulsory treatment, followed by Tayside. The presence of independent sector hospitals with regional or national intake might skew some of this data.

A key principle of the 2003 Act is minium restriction of an individual's freedom. Areas that have relatively high use of compulsory treatment, but low use of community orders, should make sure that they have adequate services to provide community based compulsory treatment and that the use of community CTOs is routinely considered as an option for individual care and treatment.

Granting, recalls and revocation of community CTOs 2009-10

	No. of people
New community orders granted	119
Variations of hospital to community CTOs	296
Variations of community to hospital CTOs	28
Recalls from community to period S112	3
Recalls from community to period S113	89
Recalls from community to hospital S114	65
Episodes of admission under EDC and/or STDC of people on community CTOs	58
Revoked/Lapsed community based orders during period (including interim orders)	233

We have looked at the lengths of all CTOs and compared hospital and community orders. This year, for the first time, people who have been subject to a CTO for more than two years, but less than five years, are more likely to be treated in the community. This is an encouraging finding and is in keeping with the principle of least restriction of freedom.

Our interest in this

We take great interest in how community based compulsory treatment works. We want to see how people come to be on community based CTOs, how

often these orders are revoked and the reasons for people being brought back into hospital.

There are two reasons why a person on a community based CTO 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 attend for medical treatment (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

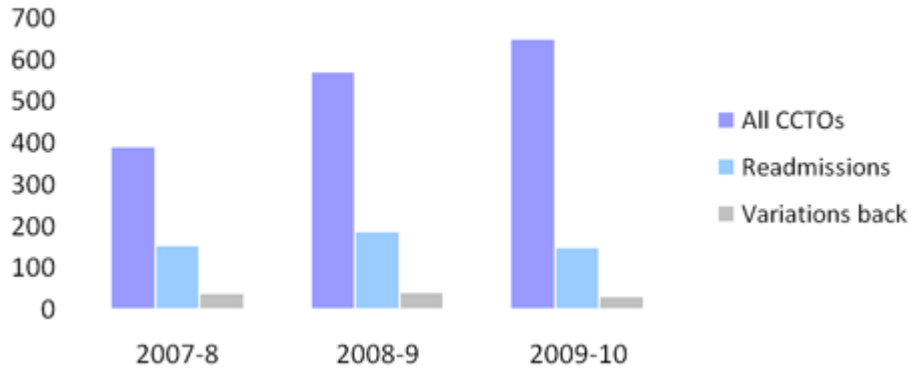
The number of people on community based CTOs has become stable over the last year. We may not yet have details on all revoked orders.

This year, 147 people on community orders were readmitted to hospital under compulsory measures (combination for S113/114 and EDC/STDC). Last year 184 people were readmitted. The number of variations from community orders to hospital orders has dropped from 38 to 28. These are encouraging figures. They suggest that compulsory treatment in the community is working better. We will visit people on community CTOs this year to satisfy ourselves that this is the case.

We still see very little use of S112 to provide care and treatment to people in the community. We think this legal provision provides a useful, less restrictive alternative to a hospital recall and should be used as an alternative to readmission to hospital, where appropriate.

The use of community compulsory treatment has gone up in the last three years. We wanted to see whether people were more or less likely to be readmitted from community orders over this time. This is shown in the figure below.

Readmissions and variations back to hospital compulsion from community CTOs, 2007-10



Readmissions and variations from community CTOs as a percentage of all extant orders, 2007-10

We are encouraged by the fall in readmissions from community CTOs. This year, the number of compulsory readmissions of all types has fallen, as has the number of variations back to hospital based orders. We are especially encouraged because the percentage of people readmitted from community orders has almost halved since 2007-8.

We aren't informed when people are readmitted informally while on community orders. Also, we need to be sure that people are getting good quality care and support in the community. We are arranging to visit people on community CTOs as part of our 2010-11 monitoring programme.

Care and treatment of children and young people under 18

Younger people admitted to non-specialist services 2009-10

	2009-10	2008-09
No. of admissions to non-specialist Inpatient settings	184	149
No. of young people involved	147	138
No. of admissions where further Information was provided to MWC	168	139
No. of young people involved	140	131

Our interest in this

Monitoring the admission of young people to non-specialist settings (such as adult psychiatric and paediatric medical wards) for the treatment of mental illness has been one of our monitoring priorities since the Mental Health (Care and Treatment) Act 2003 was introduced.

We have raised concerns about the number of these admissions for several years. We were pleased therefore with the commitment in Delivering for Mental Health, published in 2006, to reduce the number of admissions of children and young people to adult beds by 50% by 2009. We commented in our annual report 2008-09 that, based on our findings for that year, NHS Boards were likely to experience some difficulties achieving this specific commitment.

In our monitoring of the admissions of young people under 18 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

In 2009-10 we were notified of 184 admissions, involving 147 young people. These figures compare with 149 notifications of admissions, involving 138 young people, in 2008-9.

We anticipated last year that NHS Boards would experience difficulties meeting the commitment to reduce admissions by 50% by 2009, as last year's figures had increased slightly compared to 2007-8. The figures for 2009-10 have increased again, and significantly more than they did in 2008-9. We are concerned about this and are also concerned about the number of repeat admissions of young people. The number of young people admitted has risen slightly, by 9, but the total number of admissions has risen by 35. One fifth of admissions involve young people who were admitted more than once in the year.

A significantly higher proportion of young people were admitted more than once in 2009-10 compared to the previous three years, and we want to understand more clearly why this may be happening. We will be revising the monitoring form we use, to collect more helpful information about supports being provided when a young person is discharged following an admission. We hope this information will be useful in looking at the repeat admission figures in the future.

Admissions of young people to non-specialist wards by NHS Board

Health Board	2009-2010		2008-2009	
	No. of Admissions	No of young people involved	No. of Admissions	No of young people involved
Ayrshire and Arran	40	26	15	14
Borders	3	3	9	7
Dumfries and Galloway (HB)	9	4	5	5
Eilean Siar	0	0	0	0
Fife (HB)	6	5	9	9
Forth Valley	7	7	6	6
Grampian	13	12	15	14
Greater Glasgow and Clyde	41	29	41	36
Highland (HB)	7	5	9	7
Lanarkshire	30	25	22	17
Lothian	20	18	15	13
Orkney	0	0	0	0
State	0	0	1	1
Tayside	8	6	8	4
Scotland	**184**	**140**	**155**	**133**

Our interest in this

Our view is that when a young person needs in-patient treatment their individual 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. In this year's figures we are also identifying not only the number of admissions in each area but the number of young people involved. For comparison, we have looked at the figures for 2008-9 and identified the number of young people involved then.

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 child and adolescent (CAMH) services are configured differently and have different eligibility criteria in different areas. We have highlighted this issue in the on the themed visit report where we recommend that all NHS Boards should provide CAMH services to young people up to their 18th birthday, unless clinical need indicates otherwise in a particular case. We are also aware that CAMH services are making strenuous efforts to admit under-16s to specialist facilities, and that work is currently in progress nationally to develop agreed criteria for the admission to and discharge from specialist in-patient units. We hope that when these admission criteria are in place this will impact on the numbers of admissions to non-specialist facilities.

What we found

In the majority of NHS Board areas the number of notifications has been static, or has reduced slightly. In Forth Valley there was a very small increase, and in Dumfries and Galloway the higher number of admissions actually related to a smaller number of young people i.e. a few young people were admitted several times. There have been more significant increases though in three board areas, in Ayrshire and Arran, Lanarkshire, and Lothian.

In Lothian all admissions, apart from one, involved young people aged 16-17. Looking more closely at the information we received, we can see that in almost 75% of cases the young person had self harmed or was voicing suicidal ideation. In only three cases were we advised that no CAMHS bed was available. In Lanarkshire the CAMH service at present is only involved with young people up to the age of 16. We think this probably influences the relatively high number of admissions to adult wards in this area. In Ayrshire and Arran the Mental Health Directorate has advised us that they were already aware of these increases and had undertaken work to identify factors involved. As in Lothian there is a growing problem of self harm, or voicing suicidal ideation, in the context of alcohol or drug misuse, and consideration is being given to developing an intensive service response. In Ayrshire and Arran there is also an acknowledged lack of alternative crisis social care placements and discussions are taking place with service partners around addressing difficulties in accessing places in the regional in-patient unit.
We want to see progress in all these identified areas, to improve the access young people in Ayrshire and Arran have to age appropriate care and treatment.

Specialist healthcare for young people admitted to non-specialist wards

Specialist medical provision	Age 0-15	Age 16-17	All	% of admissions
RMO at admission was a child and adolescent specialist	14	30	42	**25%**
Nursing staff with experience of working with young people were available to work directly with the young person	16	53	69	**41%**
Nursing staff with experience of working with young people were available to provide advice to ward staff	25	95	120	**71%**
The young person had access to other age appropriate therapeutic input	14	57	71	42%
None of the above	6	26	32	**19%**

Percentages in the final column are based on all admissions where further information was provided to the Commission = 168

Our interest in this

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. 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.

Our interest in this issue has been heightened as a result of the CAMHS themed visit we undertook last year. We were made aware that access to specialist CAMH services when a young person is admitted to an adult ward varies across the country, with staff in several adult wards reporting a very limited access to CAMH support during admissions.

What we found

In 25% of admissions the responsible medical officer at the point of admission was a child and adolescent specialist. In 41% of admissions nurses with experience in the field were available to work directly with the young person and in 71% of admissions nurses with relevant experience were available to provide advice to ward staff.

This shows that, compared to last year, the availability of nursing staff with relevant experience to either work directly with the young person, or to provide advice to ward staff, has increased and we welcome this. The number of cases where the RMO at admission is a child and adolescent specialist has decreased. However, we are aware that in many cases specialist child and adolescent consultants are providing advice and support during admissions. This information may not be being captured consistently in our monitoring forms. We will therefore be asking specific questions about CAMH consultant input in individual cases as we introduce a revised monitoring form later this year. We would expect the information we report on next year to have more details about the level of CAMH consultant input into the care and treatment being provided when a young person is admitted. We hope that there is more significant input than the current available information suggests.

Social work provision for young people in non-specialist wards

Social work provision	Age 0-15	Age 16-17	All	%of admissions
Young person has an allocated social worker	20	63	83	**49%**
If no allocated social worker, had access to a social worker	13	54	67	**40%**
Neither of the above	4	18	22	**13%**

Percentages in the final column are based on all admissions where further information was provided to the Commission = 168

Our interest in this

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 to secure that input.

We also have an interest in the provision of services to looked after children. There is evidence that looked after children generally experience poorer mental health and there is now a national requirement that NHS Boards ensure that the health care needs of looked after children are assessed and met, including mental health needs. We would assume that any looked after young person admitted to a non-specialist facility will have an identified social worker.

What we found

Compared to the figures for 2008-09 more young people this year had an allocated social worker at the time of admission (49% compared to 44% in 2008-09).

A slightly higher number of young people had access to a social worker after admission (67 compared to 62 in 2008-09) but this represents a smaller proportion of the total than last year because of the higher overall number of admissions. There has been an overall reduction in the number and proportion of young people who had no social worker when admitted, and no access to a worker during admission.

We hope that this indicates that more integrated approaches to providing care and support are being developed across the country - both on admission and when individual discharge is being planned. It is not acceptable that 13% of young people admitted to specialist ward had no access to a social worker.

Supervision of young people admitted to non-specialist wards 2009-10

Supervision arrangements	Age 0-15	Age 16-17	All	% of admissions
Transferred to an IPCU or locked ward during the admission	4	20	24	**14%**
Accommodated in a single room throughout the admission	31	106	137	**82%**
Nursed under constant observation	31	74	105	**63%**

Percentages in the final column are based on all admissions where further information was provided to the Commission = 168

Our interest in this

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. We also use this information to help us decide if we want to arrange to visit a young person. We will arrange a visit if the young person is particularly vulnerable, to look at the care and support arrangements in place.

What we found

Fewer young people were transferred to an IPCU or locked ward compared to last year (14% compared to 17% in 2008-09). Significantly more young people were accommodated in single rooms throughout the admission than in the previous year (137 compared to 112 in 2008-09) and we welcome this. A higher number were nursed under constant observation this year (105 compared to 87) and we would hope that this reflects a recognition that young people can be very vulnerable, particularly in an adult ward, and that risks and vulnerability are being carefully assessed during their admission.

We aim to gather more specific monitoring information as a result of our revised monitoring form, and will be asking for more details about how decisions are taken about observation levels in future. We will therefore have more information about the supervision of young people in non-specialist facilities in next year's report.

We are aware, from our visits to CAMH services this year that many NHS Boards either have an identified adult ward which will be used when a young person is admitted, or are considering such an arrangement. Such arrangements can be very helpful in ensuring that single rooms are available for admissions and that the physical environment in a ward is as suitable as possible for the needs of a young person. Where such arrangements are in place we expect staff will be more aware of how to access age appropriate support for young people.

Other care provision for young people in non-specialist wards 2009-10

Other provision	Age 0-15	Age 16-17	All	% of all admissions
Access to age appropriate recreational activities	21	65	86	**51**
Access to education was discussed	17	44	61	**36**
Access to advocacy service	18	117	135	**80**
Young person has a learning disability	5	8	13	**8**

Percentages in the final column are based on all admissions where further information was provided to the Commission = 168

Our interest in this

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.

We want to know if independent advocacy services are readily available, given the important role advocacy can play in ensuring that 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 significant learning disabilities and require in-patient admission for assessment and/or treatment, particularly where there are significant problems with challenging behaviour.

What we found

The information provided indicates that slightly more young people are having access to age appropriate activities than in 2008-09 (51% compared to 49%), and significantly more had access to advocacy services (80% compared to 69%). We welcome this, although it is still concerning if all young people are not reported as having access to advocacy during their admission. We also understand that for many admissions, which are very brief, access to age appropriate recreational activities may not be relevant. We also appreciate that there may be a lack of clarity about what constitutes age appropriate recreational activities, and that this may be reflected in the information collected by our monitoring forms. Where beds have been designated in specific adult wards for the admission of young people we have seen examples of considerable attention being paid to providing age appropriate activities.

From the information provided, access to education was discussed more frequently in 2009-10 than in the previous year (in 61 cases as opposed to 43 cases in 2008-09). It may not have been appropriate to discuss access to education if an admission was for a very short period of time. We have concerns though that in certain situations it clearly would have been appropriate to consider issues about access to education when a young person was in a non-specialist facility. We have made a specific recommendation about this issue in our themed visit report. We remain concerned that, in the absence of specialist CAMHS or social work input, staff in adult wards will not know how to access education services should this be required.

We will also be starting to ask for more specific details about how this issue is being addressed so that we we receive better and more consistent information about education provision.

Age and gender of young people admitted to non-specialist wards 2009-10

Age in years at last birthday	Gender		Total
	F	M	
12	0	0	**0**
13	1	2	**3**
14	6	4	**10**
15	5	15	**20**
16	33	21	**54**
17	40	41	**81**
Total	**85**	**83**	**168**

Our interest in this

We are interested in the figures for the age and gender of young people admitted because they can indicate whether there are any evident long-term trends in the care and treatment of young people. These figures can suggest where services should be giving careful thought to the arrangements that are in place to meet needs, or whether there are specific issues to address in their services.

What we found

The data on the admission of young people to non-specialist wards over the previous three years has shown that mental health services have been treating young men and young women differently. While the number of admissions of young men is increasing, admissions of young women are decreasing. We looked at some possible reasons for this in 2008-09 and suggested that young women may be more likely to be admitted on an arranged basis, often for treatment of eating disorders, whereas young men may be more likely to need urgent admission for other mental health problems. We also suggested that there may be a tendency to regard 17 year old males as less suitable for an adolescent mental health ward.

As was the case in the previous three years, more 17 year olds were admitted to non specialist wards than any other age group. 80% of these admissions involved young people aged 16 to 17. This figure is very consistent with figures from the previous three years (for example 77% of admissions in 2008-09 involved young people aged 16 or 17).

The trend over the previous 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. This trend has not continued in 2009-10, and the number of male and female admissions for 17 year olds is almost exactly equal, with more 16 year old young women than young men being admitted. It is not clear why this has happened this year and we will continue to look closely at admissions by gender to see if the reversal of the previous trend is maintained.

Additional findings from our monitoring programme

Some of the areas we choose to report on annually will reflect particular issues that are identified in our on-going monitoring and visiting work and which we think require closer examination.

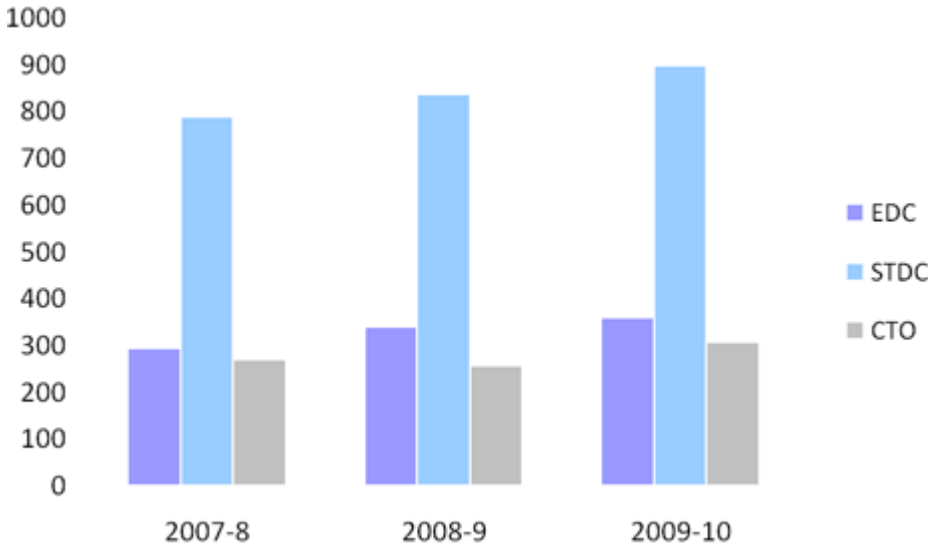
I

Compulsory treatment and the over-65s

Compulsory orders for people aged 65 and over, 2007- 2010

	2007-08	2008-09	2009-10
EDC	292	336	356
STDC	786	834	895
CTO	267	254	304

Compulsory orders for people aged 65 and over, 2007-10



***EDC - emergency detention certificate, STDC - short term detention certificate**
CTO - compulsory treatment order.

Our interest in this

Two years ago we identified that there was a big rise in the use of the Mental Health (Care& Treatment) (Scotland) Act 2003 for people aged 85 and over. This year, we found that all orders for people age 65 and over had risen substantially. We wanted to look into this more.

What we found

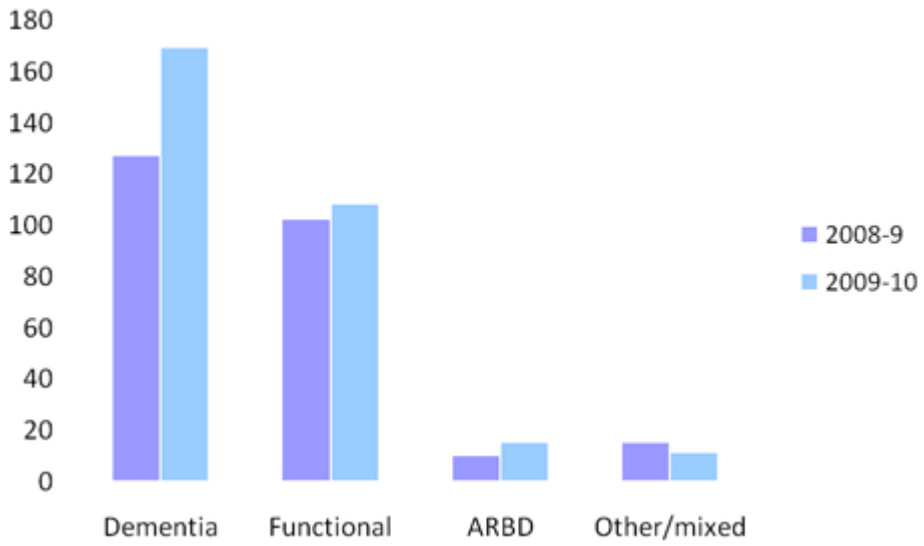
The table and figure above demonstrate the rise in the use of all three main civil orders for people aged 65 and over. We do not think that the over 65 population of Scotland has grown enough to explain this. We looked into the diagnoses of people whose detention progressed to a community treatment order (CTO).

We found data on all but one of the 303 people aged 65 and over who were subject to a CTO. We also found data on all 254 people who were made subject to a CTO last year. We looked at whether orders were being used for people with dementia, people with "functional" mental illness (e.g. depression, bipolar disorder or paranoid illnesses) people with alcohol-related brain damage (ARBD), or other diagnoses.

In the population aged 65 and over, CTOs are used most often for people with dementia. We have looked into the circumstances of these orders before and believe that the 2003 Act is being used appropriately.

We have had concerns that people with dementia who may not be consenting to their care and treatment were being deprived of their liberty without the safeguards in the 2003 Act and possibly in contravention of the Human Rights Act. We have also had concerns that the 2003 Act may be used too late and that people with dementia are left in situations of high risk to their own health and safety.

Diagnoses of people aged 65 and over where CTO was granted 2008-09 and 2009-10



ARBD - alcohol related brain damage

We have recorded a 33% increase in CTOs for people with dementia, but only a 6% increase for people with functional illness. Although numbers are low, we are also seeing an increase in CTOs for people with ARBD. This increase is below statistical significance, but still an interesting trend. We will analyse this information further to look for geographical variations.

Place of safety orders

Place of safety order notifications 2009-10

	Was place of safety a police station			
Police Force	No	Unknown	Yes	Totals
Central Scotland	1	0	0	**1**
Fife	23			**23**
Grampian	75	5	2	**82**
Lothian and Borders	10	0	5	**15**
Northern	43	9	1	**53**
Strathclyde	28	1	1	**30**
Tayside	5	0	0	**5**
Totals	**185**	**15**	**9**	**209**

Our interest in this

Section 297 of the Mental Health (Care & Treatment) (Scotland) Act 2003 provides authority for a police constable to remove a person from a public place where they reasonably suspect that the person has a mental disorder and is in immediate need of care or treatment. The order allows the person to be detained in the place of safety for up to 24 hours. Designated places of safety are normally a hospital and should not be a police station.

The 2003 Act places a duty on police officers to report to us when they convey a person to a place of safety under section 297. We are aware that compliance with this part of the Act is variable.

What we found

We received 209 notifications of place of safety orders this year. In 33 cases we were able to identify that the person had been detained in hospital under an EDC or STDC (28), admitted informally (4) or been subject to the nurses holding power (1). It was not possible to identify from the form or our records whether the remaining 176 people went on to receive treatment in hospital, or were discharged.

It is clear from the forms that the use of Section 297 is variable. On occasion, it is being used inappropriately, for example to record instances where police have assisted in the admission of a patient detained on an EDC in the community. We will look in greater detail at the forms that we receive and consider whether good practice guidance is required.

Ethnicity

Ethnicity of individuals as notified to the Commission on Mental Health Act forms 2009-10

Ethnicity	No.	% of known information	% Scottish population**
White Scottish	3258	86%	88.09%
White British	268	7%	7.38%
White other	100	3%	0.98%
White Irish	28	0.7%	1.54%
Indian	17	0.4%	0.30%
Bangladeshi	1	0%	0.04%
Pakistan	28	0.7%	0.63%
Chinese	17	0.4%	0.32%
Asian (other)	14	0.4%	0.12%
Black (African)	36	1%	0.1%
Black (other)	9	0.2%	0.06%
Mixed	15	0.4%	0.25%
Other	19	0.5%	0.19%
Total known	**3810**	**100%**	**100%**
Not provided or unknown	**1629**	***30%**	
Total number of forms	**5439**		

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

Our interest in this

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 can only report on ethnicity if it is recorded on the forms sent to us. We have information from 70% of forms, the same as last year. This is not high

enough for us to be confident about our data. We have compared our figures with the most recent available census data. Since 2001, there have been several changes in the Scottish population, including a significant number of asylum seekers.

About 3% of all forms identified people from ethnic minorities, compared with 2% of the last known population ethnicity data.

The main finding is the high number of people recorded as "black African". Census data suggests that black-African people make up a relatively small proportion of Scotland's minority ethnic population.

While acknowledging the limitations of the data on which we have based our analysis, it appears that people of Black-African origin are more likely to be subject to mental health legislation. This finding should be interpreted with caution. There is missing data and there has been reception of asylum seekers since the last census. It may also be that ethnicity forms are more likelty to be filled out for black people. It is worthy of further study and we will shortly have more research data that may give more information.

Social circumstances reports

Provision of social circumstances reports following short term detention by local authority 2009-10*

Local Authority	Nothing received following STD (%)		"Serve no purpose" letter received following STD (%)		SCR received after STD (%)		Total Number of STDs in LA area (%)	
Aberdeen City	87	(62)	8	(6)	45	(32)	**140**	**(100)**
Aberdeenshire	27	(28)	6	(6)	64	(66)	**97**	**(100)**
Angus	3	(7)	1	(2)	39	(91)	**43**	**(100)**
Argyll and Bute	42	(57)	3	(4)	29	(39)	**74**	**(100)**
City of Edinburgh	258	(72)	20	(6)	79	(22)	**357**	**(100)**
Clackmannanshire	4	(19)	3	(14)	14	(67)	**21**	**(100)**
Dumfries and Galloway	46	(46)	5	(5)	48	(48)	**99**	**(100)**
Dundee City	37	(30)	31	(25)	54	(44)	**122**	**(100)**
East Ayrshire	21	(35)	15	(25)	24	(40)	**60**	**(100)**
East Dunbartonshire	32	(56)	0	(0)	25	(44)	**57**	**(100)**
East Lothian	37	(53)	3	(4)	30	(43)	**70**	**(100)**
East Renfrewshire	13	(35)	3	(8)	21	(57)	**37**	**(100)**
Eilean Siar	3	(60)	0	(0)	2	(40)	**5**	**(100)**
Falkirk	15	(20)	15	(20)	46	(61)	**76**	**(100)**
Fife	94	(37)	8	(3)	155	(60)	**257**	**(100)**
Glasgow City	480	(74)	58	(9)	112	(17)	**650**	**(100)**
Highland	133	(83)	6	(4)	22	(14)	**161**	**(100)**
Inverclyde	15	(28)	7	(13)	32	(59)	**54**	**(100)**
Midlothian	15	(43)	7	(20)	13	(37)	**35**	**(100)**
Moray	28	(58)	1	(2)	19	(40)	**48**	**(100)**
North Ayrshire	6	(8)	6	(8)	60	(83)	**72**	**(100)**
North Lanarkshire	63	(50)	7	(6)	56	(44)	**126**	**(100)**
Orkney	0	(0)	0	(0)	2	(100)	**2**	**(100)**
Perth and Kinross	21	(18)	18	(16)	77	(66)	**116**	**(100)**
Renfrewshire	57	(66)	4	(5)	26	(30)	**87**	**(100)**
Scottish Borders	25	(57)	2	(5)	17	(39)	**44**	**(100)**
Shetland	3	(27)	2	(18)	6	(55)	**11**	**(100)**
South Ayrshire	9	(14)	7	(11)	47	(75)	**63**	**(100)**
South Lanarkshire	27	(17)	34	(21)	100	(62)	**161**	**(100)**
Stirling	31	(65)	3	(6)	14	(29)	**48**	**(100)**
West Dunbartonshire	28	(67)	0	(0)	14	(33)	**42**	**(100)**
West Lothian	35	(31)	7	(6)	72	(63)	**114**	**(100)**
Grand Total	**1695**	**(50)**	**290**	**(9)**	**1364**	**(41)**	**3349**	**(100)**

*It is difficult to attach a mental health act event to a local authority in some areas and difficult to link every SCR to a STD. If you wish to discuss variations in more detail please contact us.

Our interest in this

Social circumstances reports (SCRs) are an important source of information for a person's responsible medical officer (RMO) in assessing need and planning care and treatment. SCRs identify, at an early point, wider aspects of a person's health and welfare and can help identify the support needs of carers, which may also need to be addressed as part of the development of a person's care and treatment plans.

The SCR also provides us with a source of information about the the patient's circumstances prior to their being subject to compulsory powers. They can help us to determine whether any alternative courses of action might have been, or are being considered, and what these courses of action are.

SCRs can alert us to concerns about the person's care and treatment prior to admission, that we might wish to make further enquiries about. If mental health officers (MHOs) have concerns about an individual's circumstances, we ask them to draw these to our attention when they send us the report.

What we found

In nearly 50% of cases where a person was placed on a short term detention or a compulsory treatment order, and an SCR should have been provided, we received neither an SCR nor a notification that an SCR would serve 'little or no practical purpose' . This appears to be a high non-response rate. It may be that MHOs are either unaware of their duty or that they, or their managers, do not believe complying with this part of the legislation has priority. We have provided good practice guidance to assist mental health officers and their managers on the provision of SCRs. The granting of a short term detention certificate is a relevant event that should most often trigger an SCR.

Two years ago 39% of STDs resulted in an SCR. Last year this figure went up to 43%, but this year it fell back to 41%.

When we do not receive an SCR we are often unable to identify exactly which local authority is responsible for failing to comply with this duty. Where details are available, we can see that differences in the provision of SCRs ranges widely from one area to another. Those differences between areas are fairly consistently from one year to the next. From Highland Region we received nothing following an STD or subsequent CTO in over 80% of cases, whereas from North Ayrshire Council we receive an SCR or a letter in 91% of cases, with an SCR being provided for 83% of all relevant events.

Both Glasgow City and Edinburgh Council failed to provide either a letter or an SCR in about 70% of STDs. In Dundee City MHOs managed to provide a letter in 25% and an SCR in 44% of cases.

What we cannot tell is in how many of the cases of non-compliance the SCR would have served little or no purpose, and in how many cases the duty to write an SCR is being ignored.

We have consistently argued that the role of the MHO within Scottish legislation is to bring and present a valuable perspective to the care and treatment of people with mental health problems and we will continue to promote the writing of SCRs as one important element of this.

We aim to follow up on the recommendations made in our good practice guidance on the preparation of SCRs published in April 2009 with a focussed report in 2011.

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

Certificate of the designated medical practitioner 2009-10

Treatment type	No.
ECT	163
Medication to reduce sex drive	1
Artificial feeding	23
Medication over 2 months	936
Total T3 certificates	**1125**

Note: T3 certificate may be for more than one treatment

Our interest in this

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).

What we found

Neurosurgery for Mental Disorder (Sections 235 and 236)

The 2003 Act requires that all patients (including informal patients) who are to be considered 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 ask for progress reports from the team providing ongoing care for all patients at 12 months and again at 24 months after the procedure. In some cases we seek reports on subsequent progress as well.

The Dundee Advanced Interventions Service (AIS) remains the only centre in Scotland providing neurosurgical treatment and receives referrals from Scotland, England and Eire and we continue to liaise with them as needed.

The practitioners we appointed met with two patients and two T1 forms were issued. Both had severe treatment resistant conditions, obsessive compulsive disorder in one case and depressive disorder in the other. The treatment was approved for one patient. The other assessment involved a person with complex problems and a second visit was required after further investigations were arranged. The procedure was approved after the second assessment. We received two further referrals in March 2010, whose visits were arranged in the following months and will be included in next year's report. We considered reports on a number of patients who had proceeded to neurosurgery previously.

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.

Consent to treatment, given with a patient's agreement, is recorded on Form T2 usually by the responsible medical officer and with the patient's consent in writing. Treatment without consent is authorised by a DMP on Form T3. We received 591 T2 forms, substantially fewer than last year. Fifteen of the T2 forms were for ECT, the majority of the rest were for medication beyond two months. A number were either incomplete or incorrectly completed.We have recommended to the Scottish Government that it become a statutory requirement to send us these forms. In the meantime, we are grateful to those psychiatrists who send them to us and would like to remind all RMOs to use Version 6.1 of the form.

The number and types of treatments authorised by a Certificate of the DMP (Form T3) is shown in table 38 above. The majority of treatments authorised were medication longer than two months. 75 of the patients receiving ECT objected to it, or were resisting the treatment. One fifth of these required treatment to save life, the remainder to alleviate serious suffering and/or prevent serious deterioration.

We obtained data from the Scottish ECT Accreditation Network (SEAN) for a similar time period. SEAN data recorded a similar number of urgent treatments (42 in the SEAN data, 37 reported to the MWC). However, the number of people treated under the authority of a T3 form was, at most, 119 according to SEAN data. SEAN also recorded fewer people treated under the authority of the Adults with Incapacity Scotland Act 2000. It is likely that around 50 people for whom ECT was authorised by an independent opinion never received the treatment. This may have been because the patient improved without the need for ECT. Alternatively, there may have been other reasons to withhold ECT, e.g. physical illness.

The DMP does not always approve the treatment plan as it stands. For example the DMP may issue form T3, but recommend review after a few months. The DMP could ask for additional monitoring of physical health or a pharmacy review of medications. The treatment plan may be modified after discussion with the RMO or the DMP may occasionally disagree with the RMO.

Case example : Dr A was asked to approve a treatment plan which included clozapine. He reviewed the patient's history and previous doses of medication and did not feel there had been sufficient trial of other antipsychotics at high enough dose to justify this. After discussion with the RMO Dr B an alternative plan was agreed and the form T3 issued without clozapine.

Commission practitioners are undertaking unannounced visits to look at consent to treatment issues including an audit of T2 and T3 forms. We will be commenting on the findings in next year's report, but it appears there is a need for further guidance and training in the completion of T2 forms. Focused audits on specific topics are used to identify training needs for the annual seminar for DMPs. We note that hospital pharmacists continue to take an interest in monitoring this area of practice and have an important role in monitoring that the requirements of the act are being met.

Children and young people

We received 10 T2 forms for patients who were under 18 at the time of consenting to treatment all of which were for medication beyond two months. In one case the RMO was not a child specialist and the unit was contacted about this. Particular care is needed for patients under 18 who are in adult wards. The RMO assessing consent and completing the certificate must be a child specialist.

There were 19 T3 forms for patients under 18 receiving treatment without consent. One patient aged 16 received ECT and we requested further information from the RMO. Seven patients with a T3 received artificial nutrition and 12 medication beyond two months. In all cases, except one, the RMO or DMP was a child specialist. One patient seen in an adult IPCU was noted to be 17 when the initial DMP visit was undertaken, however the order was revoked before a second specialist DMP opinion could be arranged.

Designated Medical Practitioners (DMPs)

There were 78 DMPs on our register to provide second opinions on safeguarded treatments during the year. We held our annual DMP seminar in November 2009 which had expert speakers on eating disorders and artificial nutrition, and prescribing medication to reduce sex drive. We also reviewed good practice points for DMPs. Three induction seminars were held in spring 2010 which recruited 11 new DMPs and were also attended as refresher sessions by existing DMPs.

As in previous years, we are grateful to all those who undertake second opinions, often at short notice and sometimes out of normal working hours and at weekends to ensure people are seen as soon as possible. It remains difficult to find DMPs who are able to visit the Grampian and Highland regions.

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 matters have been granted to someone else via a power of attorney.

Here you can review our findings from these monitoring activities.

Trends in the use of welfare guardianship

During the past year we have seen an increase of 11.5% in the number of approved welfare guardianship applications. While approved orders are not increasing at the levels evidenced several years ago, they do continue to rise and appear to have levelled out at increases of between 9-13% over the past three years. This still represents a growth of over 27% in new orders in the past three years - mostly accounted for by the rise in private applications which have increased by 45% during this period.Clearly this rate of growth in private applications will be placing additional demands on statutory services both at the application stage as well as in the supervisory responsibilities which follow. While the percentage of local authority applications fell from 36% to 32% in the past year, the numbers have remained relatively static over the past three years (417,435 and 423).

Geographical variations in the use of welfare guardianship

	Private guardianships granted 2009-10	Local authority guardianships granted 2009-10	All guardianships granted 2009-10	Rate per 100k pop. Over age 16			
				Private rate	LA rate	Total rate	Recalled or lapsed**
Aberdeen City	38	18	56	21	10	31	11
Aberdeenshire	59	18	77	30	10	40	13
Angus	37	6	43	40	8	48	44
Argyll and Bute	10	4	14	13	5	19	16
City of Edinburgh	65	21	86	15	6	21	7
Clackmannanshire	8	4	12	20	10	30	10
Dumfries and Galloway	16	18	34	13	15	28	16
Dundee City	22	13	35	20	10	30	25
East Ayrshire	18	20	38	19	21	39	16
East Dunbartonshire	15	1	16	18	1	19	7
East Lothian	11	6	17	14	8	22	7
East Renfrewshire	11	7	18	16	10	26	13
Eilean Siar	4	7	11	19	33	52	0
Falkirk	14	20	34	11	16	28	13
Fife	79	35	114	27	12	39	30
Glasgow City	123	67	190	25	14	39	20
Highland	60	28	88	35	16	49	29
Inverclyde	8	4	12	12	6	18	12
Midlothian	5	2	7	6	5	11	9
Moray	26	4	30	37	6	42	14
North Ayrshire	32	7	39	29	6	36	7
North Lanarkshire	63	21	84	24	8	32	6
Orkney	4	0	4	25	0	25	0
Perth & Kinross	34	22	56	23	21	47	23
Renfrewshire	23	8	31	25	6	23	6
Scottish Borders	9	3	12	10	3	13	9
Shetland	0	1	1	0	6	6	6
South Ayrshire	13	11	24	14	12	26	16
South Lanarkshire	54	23	77	22	9	31	11
Stirling	12	6	18	17	8	25	14
West Dunbartonshire	15	5	20	20	7	27	12
West Lothian	25	13	38	19	10	28	12
Scotland	**913**	**423**	**1336**	**21**	**10**	**32**	**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 this

We have reported over the years the variations in the use of guardianship from one local authority area to another and from one year to the next. Anybody may apply to be a welfare guardian and most applicants are now private individuals. Local authorities have a duty under section 57(2) of the Adults with Incapacity (Scotland) Act 2000 to take forward applications for welfare guardianship wherever necessary when no-one else is making an application or is likely to do so. While the reasons for these differences are complex, local authority staff should review this data to help ensure that the Act is being used where necessary in their area both to safeguard the welfare and property of adults with incapacity and to assist relatives and carers. Local authority managers will also wish to examine trends which might have implications for workload management and planning.

What we found

The above table shows that the rate per 100,000 of approved orders in 2009-10 ranged from six in Shetland and 11 in Midlothian, to 49 in Highland, 48 in Angus and 47 in Perth and Kinross.

What is very noticeable is the dramatic variation in orders granted in specific areas from one year to the next. Approved orders increased by 100% in Edinburgh and Clackmannanshire in one year, and decreased by 61% in Midlothian, 22% in Dundee City and 21% in Highland compared to 2008-09.

While orders doubled in Edinburgh, Glasgow actually saw a decrease of 4%. The increase in Edinburgh was due to a large increase in the number of private applications. The local authority applications there increased as well but only by 24% (itself not an insignificant rise). The fall in the rate in Highland Council was due exclusively to a lower number of local authority applications - down by 58%. Private applications there actually rose by 36%.

Private applications accounted for 68% of all applications with the Scottish average being 21 per 100,000. The Scottish average rate per 100, 000 for local authority applications was 10. Leaving out the island authorities due to the low population numbers, the rates for local authority applications granted ranged between 1 per 100,000 in east Dunbartonshire to 21 per 100,000 in East Ayrshire and Perth and Kinross.

Guardianship orders should only last as long as they are necessary and local authorities are given the authority to recall them when they are no longer needed. There were, however, only 12 recalls of welfare guardianship in the past year: 11 from Fife and 1 from Glasgow.

It would appear that this is an area of practice and procedure which needs to be reviewed by local authority practitioners and managers.

Causes of incapacity in guardianship

Causes and duration of guardianship orders granted to local authorities 2009-10

Cause of incapacity / Duration	Acquired Brain Injury	Alcohol related brain disorder	Dementia/ Alzheimer's	Learning Disability	Mental Illness	Other	Totals (% of all orders)
>3 years	4	3	5	5	1	0	18 (4)
3 – 5 years	10	23	42	61	15	5	156 (37)
<5 years	0	0	1	1	0	0	2 (0)
Indefinite	3	12	164	54	8	6	247 (58)
Totals (% of all orders)	**17 (4)**	**38 (9)**	**212 (50)**	**121 (29)**	**23 (5)**	**12 (3)**	**423**

Causes and duration of guardianship orders granted to private individuals 2009-10

Cause of incapacity / Duration	Acquired Brain Injury	Alcohol related brain disorder	Dementia /Alzheimer's	Learning Disability	Mental Illness	Other	Totals (% of all orders)
>3 years	2	0	2	5	0	0	9 (1)
3 – 5 years	12	0	56	76	4	3	151 (16)
<5 years	3	5	15	49	1	0	73 (8)
Indefinite	31	7	423	217	9	11	698 (76)
Totals (% of all orders)	**48 (5)**	**12 (1)**	**489 (54)**	**334 (37)**	**14 (2)**	**16 (2)**	**913**

Note on the data: This information arrived at using guardianship status, private vs local auth not applicant status

Our interest in this

We have safeguarding duties in relation to people who come under the protection of the Adults with Incapacity (Scotland) Act 2000. We examine the use of welfare guardianship for adults with a mental illness, learning disability

or other mental disorder 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 tables above set out our analysis of approved welfare guardianship orders as related to the identified causes of the adult's incapacity and the length for which the orders have been granted.

We have raised concerns in previous reports about the high percentage of orders granted on an indefinite basis. Our concern is the lack of automatic, periodic judicial scrutiny of approved orders. This puts the onus on the individual or other party with an interest to challenge the order. We do not think this is in keeping with accepted standards of justice. We remain particularly concerned about the number of orders that are sought and granted on an indefinite basis for young adults with learning disability. We understand this issue will be addressed as part of The Scottish Law Commission's review of the legislation which is to begin in September 2010.

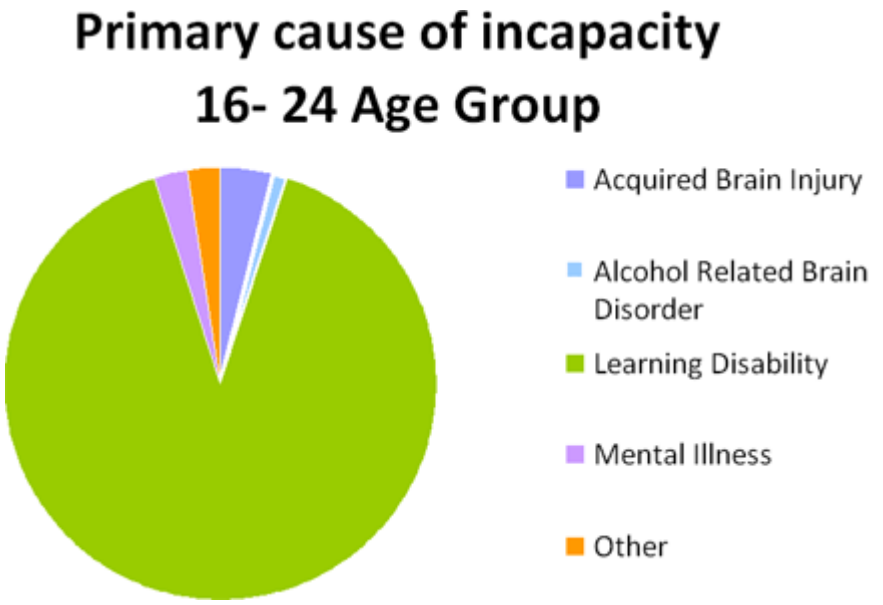
What we found

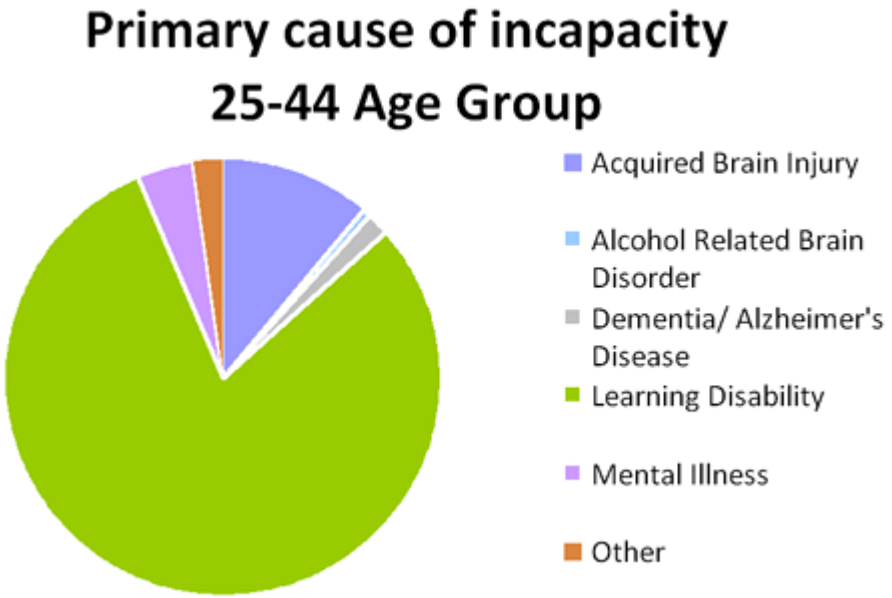
As with previous years, the majority of approved guardianship orders related to people with dementia. This stood at 52% of all orders. We had, however, reported last year a decrease in the relative use of guardianship for people with dementia and this trend continued in the past year. There has been a gradual increase in the use of guardianship for people with a learning disability. In 2006-07, 62% of all orders related to people with dementia and 25% were for people with learning disability. This has gradually shifted to 52% for people with dementia and 34% for people with learning disability.

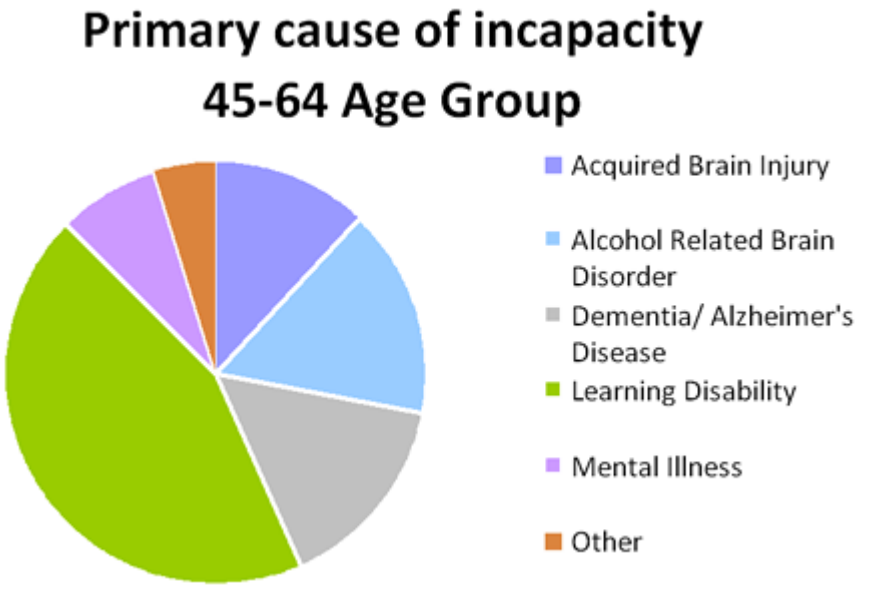
The length of time for which orders are granted remains high with 71% being granted on an indefinite basis. This is the same rate as last year. 84% of orders granted for people with dementia were granted on an indefinite basis. 60% of people with a learning disability had their orders granted on an indefinite basis. The differences between private and local authority applications are of interest. Private applicants are much more likely to be granted indefinite guardianship compared to local authority applicants (76% to 58% respectively). The gap is greatest for adults who have a learning disability.

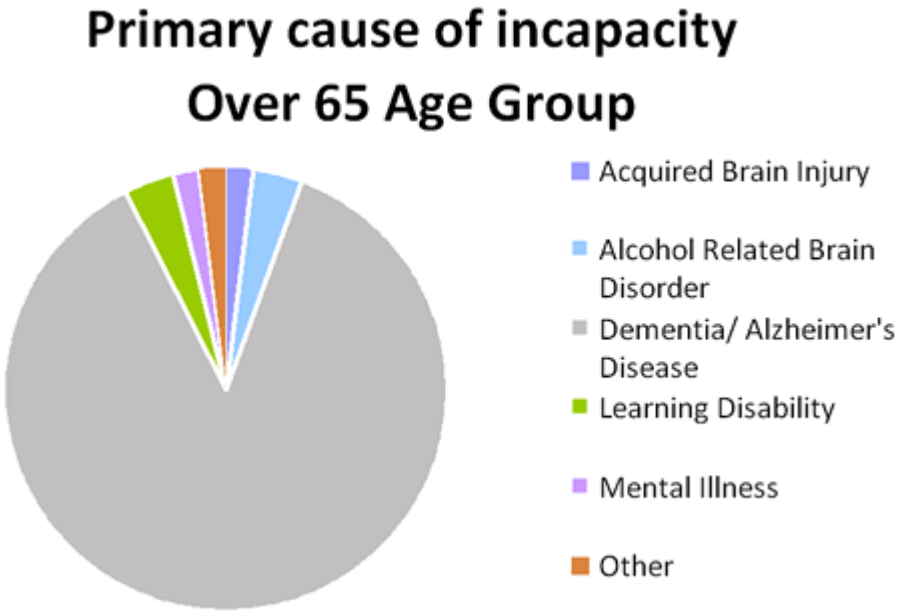
We found differing practices among local authorities in the length of time for which orders were sought and granted. Renfrewshire (at 100%), Dundee City Council (85%), Perth and Kinross (82%) and Falkirk Council ((75%) all had a relatively high percentage of orders granted on an indefinite basis. In other councils such as South Ayrshire (at 9%), East Ayrshire (25%), Argyll and Bute (25%) and North Lanarkshire (33%) the rates were much lower. It is not clear why there should be such disparities. The reasons are likely to be quite complex. Mental Health Officers and local authority service managers will wish to reflect on their practice to ensure it is in keeping with the principles of the legislation.

Age at which adults are placed on welfare guardianship orders









Our interest in this

The above pie charts show the age at which adults with different causes of impaired capacity are placed on welfare guardianship under the provisions of the Adults with Incapacity (Scotland) Act 2000. While some of this will be of no surprise, it has to be viewed in context of the length of time for which

orders are granted for adults whose impaired capacity is a consequence of different mental disorders.

What we found

The data is fairly similar to last year's in that 43% of all adults with learning disability who were placed on welfare guardianship last year were under 25 years of age when their order was granted. Just under 16% of adults with learning disability placed on welfare guardianship last year were in the 16-17 year old age group. For people with dementia, over 95% of them were over 65 when their order was granted.

It is interesting to see the diversity of mental disorders which have been the primary cause of impaired capacity for those between the ages of 25-44 and 45-64 when their order was granted. In the first group, learning disability was the cause of impaired capacity in over 80% of the orders granted and acquired brain injury was the cause of impaired capacity in 11%. In the 45-64 age group, acquired brain injury and alcohol related brain damage together were the cause of impaired capacity in 28% of the orders granted.

Consent to medical treatment

Adults with Incapacity (Scotland) Act 2000 S48 and Section 50 requests

Requests Types of treatment	Section 48/50 Requests
Medication to reduce sex drive	20
ECT	20
Abortion	1
Dispute between welfare guardian and medical staff about treatment.	2
Total	**43 requests for 38 people**

Why we are interested

We have a responsibility under the Adults with Incapacity Act (Scotland) 2000 to provide second medical opinions from nominated medical practitioners for treatments that are not covered by the general authority to treat (Section 47). The specific treatments are noted above. In addition, where there is a welfare proxy, such as a guardian or welfare power of attorney with the power to consent to medical treatment, and there is disagreement between them and the treating doctor, we have to provide a second opinion doctor to resolve the dispute.

What we found

There were 41 requests under Section 48 and 2 under Section 50. Of the 20 requests for electro-convulsive therapy (ECT), three people accounted for eight of these requests. For authority to treat under Section 48 in respect of ECT the patient must not be resisting, as well as being incapable of giving informed consent. Authority to treat was refused on four occasions, on two of these occasions treatment was subsequently carried out under the Mental Health (Care & Treatment) Act 2003, as it was refused on grounds that the person was resisting.

For treatment under Section 48a- medication to reduce sex drive, there were 20 requests and authority to treat was refused on 1 occasion.

Although consent to abortion was given under Section 48c, in fact the procedure was not carried out and the pregnancy continued to term.

The two instances where there was disagreement regarding the proposed medical treatment involved the decision to introduce a PEG tube to facilitate feeding. In both occasions, authority for the procedure was given.

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

In 2009-10 we scrutinised 1,423 approved welfare guardianship applications. This was an increase of 32% over the numbers scrutinised in the previous year. As well as reading the approved applications and subsequent orders very closely, this scrutiny often involved seeking further information from the following sources to help us determine how best to fulfil our statutory duties. Those from whom we sought information included:

- The mental health officer (MHO) involved in the application;
- The supervising social worker or nominated local authority officer carrying out the role of the chief social work officer where he or she was appointed welfare guardian;
- The adult with incapacity;
- The adult's private guardian; and
- Care providers for the adult with incapacity

As a result of this work we went on to visit 366 adults on welfare guardianship. The purpose of these visits was to assure ourselves that the Adults with Incapacity (Scotland) Act 2000 is being implemented in accordance with the principles of the legislation. It also allows all concerned an opportunity to meet with us, to raise any issues or concerns, and to ask us for information and advice.

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

- Learning disability: 51%
- Dementia: 18%
- Autism spectrum disorder: 10%
- Alcohol related brain damage: 8%
- Acquired brain injury: 8%
- Mental illness: 5%

As a result of our visits we followed up a number of issues in individual cases. We recorded 232 separate issues we followed up as a result of these visits. These were classified as relating to:

- Placement: 24%
- Activities: 16%
- Legislation: 13%
- Finances: 10%
- Social work input: 9%
- Communication issues affecting adult: 1%
- Adult's mobility: 2%

- Other (unspecified): 10%

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

Last year we wrote that we had submitted a response to the Scottish Law Commission's consultation on proposals for its Eight Programme of Law Reform running from 2010-2014.

We outlined the various areas we felt needed attention to help improve the rights and protections available for adults who fall within the scope of the legislation. We felt that clarification was needed on various issues such as "deprivation of liberty" and the length of time guardianship orders should last without routine judicial review.

The Law Society of Scotland and Enable Scotland supported our concerns. We were pleased to see that the topic of adults with incapacity was included as a project in the Scottish Law Commission's Eighth Programme of Law Reform.

The Law Commission intends to take forward this work in stages with the first stage concentrating on issues relating to welfare guardianship. We have been invited to take part in an advisory group to assist the Law Commission in this first stage. Research is currently being undertaken with the view to preparing a discussion paper.

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