mentalwelfare
commission for scotland

Short term detention

Monitoring the care and treatment of individuals receiving care and treatment on short term detention certificates

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Introduction

The Mental Welfare Commission has a duty in law to monitor and report on the operation of the Mental Health (Scotland) Act 2003 and promote best practice in relation to the principles or the Act. We do this in a number of ways; one of these is by visiting individuals who are subject to compulsory care and treatment.

This report provides an overview of our visits to a sample of individuals subject to short term detention certificates (STDCs) across Scotland. While a person is detained on a STDC their clinical team should carry out regular assessments and make appropriate care and treatment decisions. They should also start planning the individual's future care arrangements. For some people this may mean discharge from hospital, some may decide to remain in hospital on a voluntary basis, while others may need a longer period of compulsory treatment either at home or in the community.

We visited a total of 284 individuals who were receiving care and treatment in 34 hospitals across 11 NHS Board areas. We spoke to people about the care and treatment they were receiving; what they thought was working well and what could be improved.

During our visits we also reviewed individual care records and spoke with staff, carers and advocates.

We gathered information on:

- Care planning and reviews;
- Participation;
- Named persons;
- Access to advocacy;
- Advance statements;
- Consent to treatment;
- Right of appeal; and
- Level of contact with professionals.

About this report

Who we are

We are an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect;
- Have the right to treatment that is allowed by law and fully meets professional standards;
- Have the right to live free from abuse, neglect or discrimination;
- Get the care and treatment that best suits her or his needs; and
- Be helped to lead as fulfilling a life as possible.

What we do

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice information and guidance to people who use or provide mental health and learning disability services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

Why we visited people on short term detention certificates

Prior to the implementation of the 2003 Act, the most common route into hospital detention was under an emergency order. This involved assessment by a single doctor, not necessarily with any specialist training, often supported by a mental health officer. Emergency orders lasted for 72 hours and could then be followed by a 28 day short term order. There was no facility under the 1984 Act to admit someone directly to hospital on a 28 day order. Evidence from our monitoring programme found that just over half of emergency detentions led to 28 day orders under the 1984 Act.

We believed, along with other organisations and service-user groups, that a better planned and more multi-disciplinary community assessment would help to avoid unnecessary hospital admissions.

Where hospital admission is the most appropriate way to safeguard an individual's mental health and welfare, under the 2003 Act STDCs should be used in preference to emergency orders. The Code of Practice[1] highlights the advantages of this new procedure:

"A short term detention certificate is the preferred "gateway order" because, as compared with an emergency detention certificate, it can only be granted by an approved medical practitioner; the consent of an MHO to the granting of a short term detention certificate is mandatory; and it confers on the patient and the patient's named person a more extensive set of rights, including the right to make an application to the Tribunal to revoke the certificate"

The Code of Practice says it is essential for a mental health officer (MHO) to consider whether alternative forms of community based care and support are appropriate and available to be used as an alternative to hospital admission. It makes it clear that emergency orders should only be used in cases of genuine urgency. Assessment in the community should build on best practice and the principles of the 2003 Act. The process should be planned and multi-disciplinary as far as possible and should engage individuals, their carers and relatives in identifying alternatives to admission. One of the areas we routinely examine in the operation of the 2003 Act is whether this change of emphasis in the 2003 act is leading to changes in admission rates. Our monitoring confirms that individual admission on a STDC is now the most common route into compulsory treatment as envisaged by the Millan committee.

The intention of the 2003 Act was that EDCs should only be used where hospital detention is needed as a matter of urgency, and where there are significant risks which preclude the use of a STDC. There are a number of factors other than the availability of doctors and mental health officers which can impact on the use of EDCs prior to a STDC in an area:

- Geographical factors, such as lengthy travel times to access community mental health services in remote rural locations;
- The range and availability of community mental health services; and
- Availability of adequate social care resources to support people in the community; availability of resources out of hours.

Who we visited

The 284 people we visited represent about 21% of the 1380 individuals who were on a short term detention certificate during the period of our visit programme.

Nearly 60% of the people we visited agreed to be interviewed. Where an individual wasn't able to participate, or didn't wish to be interviewed, we still gathered information from their clinical notes and by talking to care staff.

Eighty per cent of the people we met had been diagnosed with a mental illness. 13% had a diagnosis of dementia; a small number had a personality disorder, others had alcohol related brain damage, or a learning disability.

Table 1: Individuals on STDCs visited, by diagnosis*

Diagnosis	No. of people visited
Mental illness (other than specified below)	235
Dementia	37
Acquired brain injury	3
Alcohol related brain damage	9
Learning disability	9
Autistic Spectrum Disorder	1
Personality disorder	19
Other diagnosis	6
Total of individual diagnoses	**319**

*Some individuals had more than one diagnosis and are therefore counted more than once in this table.

We are confident that our sample is representative of the total population of people on short term detention during the period in terms of age and pre-detention status. We found that women are slightly over-represented in the sample (56% of the total compared with 51% in the population) and men correspondingly slightly under-represented.

Table 2: Visits to people on short term detention by NHS Board, as % of total number on short term detention December 2008-April 2009

NHS Board	Sample size	All STDCs 02.12.08-15.04.09	Sample as % of all STDs in the period
Ayrshire & Arran	12	75	16
Borders	1	21	5
Dumfries & Galloway	3	35	9
Fife	16	92	17
Forth Valley	13	69	19
Grampian	14	117	12
Greater Glasgow & Clyde	97	409	24
Highland	11	85	13
Lanarkshire	32	95	34
Lothian	50	249	20
Tayside	35	126	28
Western Isles	0	7	0
Scotland	**284**	**1380**	**21**

From Table 2, it is clear that Glasgow, Lanarkshire and Tayside are slightly over-represented in the sample in relation to the total number of short term detentions in their areas. Borders, Dumfries & Galloway, Grampian, Highland and Western Isles are under-represented.

Routes into hospital

Forty per cent of the individuals we visited during this monitoring exercise were already in hospital informally before they became subject to a STDC. 29% were admitted from the community on a STDC; 27% of individuals had been on an emergency detention certificate (EDC) first – although there were some regional variations in relation to use of emergency detention. The proportion of men and women who were on EDCs prior to an STDC was about the same. A small number of the people we visited had been on community CTOs, or subject to English legislation before transferring to Scotland on a STDC.

In many of the cases we looked at, the circumstances which led to an EDC being used initially included:

- Absconding during the assessment process;
- Being found mentally disordered in a public place;

- Being thought at risk of self-harm/suicide; or
- A threat of harm to others.

In these situations an EDC is likely to be the appropriate option. Occasionally however it was recorded that there had been an awareness of the deterioration in someone's presentation, sometimes for a number of weeks, beforehand. It may be that where services are mainly hospital focussed and lack developed community early intervention procedures there can be an attitude of helplessness in the mental health service, waiting for the inevitable crisis to occur when detention in hospital becomes the only option. We believe that health and social care teams, their out of hours services and the community and social care resources available in an area, should be organised in a way that reduces the impact of these factors on whether an EDC or a STDC is sought.

Relatives can often be the first to notice and report changes and attempt to get assistance, as in this example:

"From reports in the file it was clear that M had been showing increasing symptoms of illness for a number of weeks. It came to a head when he was … full of grandiose plans. He was clearly unwell to his parents and they called the CPN service. The parents tried to prevent him going and called the police. When he left the house, the police intervened and took him to hospital, where he was detained on an EDC in the small hours"

In some of these cases, a more pro-active response to the concerns raised by relatives or others might have avoided an emergency admission. More and more areas of Scotland now have a community-based response team that can offer intensive support and intervention in a crisis, to avoid this leading to admission. It is acknowledged that, despite best efforts, hospital admission may still be necessary.

Care planning and reviews

Care plans are the way in which health and social care teams can document and share information about the care and treatment being provided for an individual. Care plan reviews are how multi-disciplinary teams can jointly review an individual's progress against the goals set in his or her care plan and make decisions about future care and treatment.

Care delivered under the 2003 Act should be in line with the principles of the Act, one of which is reciprocity. This means that where an obligation is placed on an individual to comply with a programme of treatment of care, there is a parallel obligation on the health and social care authorities to provide safe and appropriate services that are of benefit to the person. This includes ongoing care following a person's discharge from compulsory treatment. Delivering for Mental Health 2006[2] also refers to the need to look beyond the ill-health and focus on the full range of needs and capabilities of the individual. A social circumstances report written by the person's MHO should make a valuable contribution to this.

During this monitoring programme our practitioners reviewed individual care plans and used their professional skills and experience to make a judgement on whether these were satisfactory. We have previously issued guidance on care plans and we were keen to see to what extent this had been utilised in the preparation of care plans for people on STDCs.

We looked at 4 dimensions of care and treatment. These were:

- Meaningful involvement;
- Holistic care;
- Delivery of appropriate services; and
- Responsiveness to change.

Extracts from our guidance *Mental Health Act Care Plans: best practice guidance in the preparation of care plans for people receiving compulsory care and treatment* [3] are quoted at the beginning of each section.

Meaningful involvement

There are many ways of involving the person – even in situations where compulsion is required to ensure treatment is received, or participation appears to be difficult to achieve. The use of advance statements, where these have been made, the creation of "Staying Well" plans and the involvement of named persons, primary carers or independent advocacy are all pointers to the inclusion of the individual.

For 88% of the individuals we visited it was our view that they were appropriately involved in care and treatment discussions and decisions:

"Good admission notes and thorough physical examination on admission and good information re personal history. Care plans reviewed regularly, good record of multi-disciplinary input and patient has signed most of the care plans"

"Good notes on file by named nurse, indicating clearly when she has seen T, when she has sat down with her on a 1:1 basis to review care plans, and what the content of 1:1 contact was. T clearly felt that she was being involved in decisions taken and was happy with how she was being treated"

However this was not always the case:

"Mrs D complained that she did not know the result of a recent scan (which was reported clearly in her file) or whether a CTO application was being progressed. I brought the Charge Nurse in who told her the result of her scan and that a CTO was being progressed"

It is clear that services are trying to involve people in their care and treatment. However, inevitably the ability of the person to understand, make sense of and retain information about the complex processes surrounding compulsory treatment can be limited. We think services could make more effort to help individuals understand what is happening. We found that, when asked, only 57% of individuals said that they understood what was happening to them.

We also looked at whether all the appropriate people, such as carers, relatives and named persons appeared to have been involved in the assessment process.

We found that in 85% of cases relatives and carers had participated in assessments and reviews. In most of the other cases attempts were made but failed and the issue was addressed as soon as possible afterwards. In the very few cases where it appears this requirement of the legislation was ignored, we followed this up with the care team.

Holistic care

An individual's physical health, social and recreational, spiritual and financial needs may all have a bearing on their recovery. This is not to say that the care plan should cover all these aspects of an individual's life on all occasions, but there should be evidence that a broad approach has been taken to the creation of the care plan. The focus should be on the person and not just on the illness.

For 70% of the people we visited there was evidence of a holistic approach being taken and there was overwhelming evidence that the individuals we saw were receiving services appropriate to their needs such as in this case:

"Good admission assessments including learning disability specific health assessment, and thorough care plans in place – plan in place to increase community outings, re-integrate him gradually back into day activities with support staff fully involved in this plan."

Delivery of appropriate care

The principle that a person who is required by law to accept care and treatment against his or her will should be provided with appropriate care and treatment is not set out in absolute terms in the act. However, the legislation does require that persons who are discharging functions under the act "shall have regard to" the importance of providing appropriate services to patients subject to emergency and short term certificates and to patients on compulsory treatment and compulsion orders. This principle also applies to persons no longer subject to a certificate or order.

For nearly every person we visited we found evidence that appropriate care was being provided. Where no review of care had taken place this was mostly because the person had only recently been admitted.

"There is a good care plan in place, re-written with information from reviews held since admission. There is also a detailed description of circumstances prior to admission included in the assessment form completed by the doctor granting the STDC, including a brief personal history and family circumstances. There is a detailed letter on file sent to the GP to give an update following their referral".

Responsiveness to change

"Care plans should be evolving documents and an integral part of the recovery journey. The idea that care planning – and the production of required care plans at specific points in the journey – is a separate process from the day to day provision of care, support and treatment, is one which fundamentally fails to understand the concept of care planning and the recording of treatment and progress".

We found evidence in two out of three reviews of continuous planning that was responsive to the changes in the individual's mental health and future needs. It is essential that care teams are thinking about the person's future from an early stage in the admission, as decisions have to be made regarding whether a CTO is going to be needed. For some individuals it was apparent there had been more than one STDC since first admission to hospital due to a lack of careful planning.

For others we found evidence, even quite late on into the 28 day period, of uncertainty amongst nursing staff whether a CTO application was planned or not. In many cases this was due to the clinical complexity of an individual's presentation. Occasionally, applications for a CTO were being made so late it caused difficulties and anxiety for the person concerned. Best practice according to the code of practice is that the decision to proceed with an application should be taken after a multi-disciplinary case conference. The RMO should consult with the MHO well in advance of any such decision. The individual's case conference should also involve all relevant parties including multi-disciplinary health care staff, the patient's advocate, named person, relatives and/or carers. A more organised approach should lead to fewer delays in the Mental Health Tribunal process.

Participation

People who use mental health services are clear about the value they place on participation in care and treatment decisions.

"Service User involvement in Mental Health is clearly desirable both for those carrying out functions as part of their employment and for our personal development, knowledge, confidence and feelings of self worth"
(VOX May 2007)[4]

Under the principles of the 2003 Act each individual has a right to be fully involved, as much as possible, in all aspects of their assessment, care, treatment and support. Their wishes should be taken into account and they should be provided with information in a way which makes it most likely to be understood. The principles of the act also state that carers should receive appropriate information and have their views and needs taken into account.

Research commissioned by the Scottish Government and published in 2009 identified the need for further detailed investigation into the quality and inclusiveness of care plans for those under compulsory measures. Particular attention was paid to user participation[5].

"Across the range of positive and negative experiences of participation of the service users in this study, a key issue to emerge was the extent to which service users believed their views and opinions had tangibly influenced decision-making about their care and treatment. In other words, while they understood they had opportunities to voice their opinions and used them, they did not believe they were being heard".

Tait and Lester (2005)[6] have written about the benefits of service user involvement in care planning on the basis that service users:

- Are experts about their own illness and need for care;
- May have different but equally important perspectives about their illness and care;
- Can increase a possibly limited understanding of their mental distress;
- Are able to develop alternative approaches to mental health and illness;
- May find this therapeutic in itself; and
- May experience greater social inclusion as a result.

The researchers found that despite these benefits some health and social care professionals do not recognise the value of user participation and take advantage of it sparingly and with some reluctance. They speculated that asking people to participate in decision making about their care and treatment options may challenge the professional's notion of themselves being the sole experts, and may appear to them to lack scientific rigour. If a health team has this attitude it is likely that individual participation, when it is used, will not be listened to or valued.

On our visits we found some good examples of participation and the benefits that flowed from this:

"Following admission, Ms Y and her parents subsequently met with the RMO and MHO to reflect on the admission process, reasons for the detention, and to inform Ms Y of her rights etc. She remains unhappy about the process but confirmed that her views are listened to and she is entirely satisfied with the care and treatment she is receiving"

In some cases we were unable to find evidence of involvement either because the individual refused to engage, or was still too unwell at the time of our visit. In a small number of cases we recorded examples where the level of involvement was poor or non-existent:

"The STDC was lapsing on the day of the visit and no one on the ward had any idea about whether an application for a CTO was being made or not. Finally after a lot of information gathering, the staff confirmed to me that the STDC will be allowed to lapse. In view of this I would find it hard to believe that the patient had been adequately involved or understood her status"

The code of practice states that it is essential when deciding whether or not to proceed with a CTO application to do so only after all the relevant members of the patient's multi-disciplinary team have been consulted and that it is:

"essential to have regard to the views of the patient and the patient's carers and named person"

A recent article in the British Journal of Psychiatry noted that studies have shown that psychiatrists have "poor patient involvement abilities". It is our view that participation of individuals in their care is both beneficial to clinical outcomes and required by the legislation. The evidence from this visit programme is that this view is widely supported by the majority of health care teams. We found many examples of this:

"Unhappy with medication prescribed on admission but after discussion and negotiation re her reasons for wanting different medication she was started on Quetiapine and she has been significantly more settled in the couple of days prior to the visit. She clearly feels that her views have been listened to and that staff are treating her well"

The aforementioned Voices of Experience (VOX) guidance document, that aims to support services in Scotland to involve service users in a meaningful way, can be downloaded from http://www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/DFMH/crisistoolkitsupportvox.

Named persons

The 2003 Act says that individuals treated under the legislation should have a named person, who must be informed and consulted about aspects of their care. Individuals can nominate someone to be their named person when they are well; otherwise the responsibility falls by default to a person who is usually the main carer, or the nearest relative willing to be the named person. (This is defined in more detail in the Act). The doctor must, as far as possible and practical, have regard to the views of the individual's named person. He or she must discuss the care and treatment plan with the named person and afford them the opportunity to share their views about the individual's care and treatment.

We monitor the recording of named persons as part of our general monitoring programme. Our records for 2008-09 show that 79% of people on STDCs had a named person. Research conducted by the Scottish Government into the named person role and its operation[3] completed in July 2008 found that named persons were recorded by the Mental Health Tribunal in around 75% of STDC and CTO applications. It also found 74% of named persons identified at the STDC stage were default named persons. We found that 79% of the people on a STDC we visited had a named person and that 60% of these were by default. This might indicate that there has been an increase in the number of people choosing their named person as they become more familiar with their rights under the law.

About 21% of individuals we visited did not have a named person identified in their files. At the present time there are few circumstances in which it is possible for there to be no named person. The individual would have to either have no relatives or carers willing to act in this role, or have gone through the complex procedure of signing a declaration saying that they did not want any relative to act in this role. It must be taken into account that many of the people we visited had only been in hospital a few days and in some circumstances it is difficult for health and social care teams to identify exactly who the named person is.

However, some individuals and nurses remained unsure about the named person's provisions and were sometimes vague about being able to identify the named person even when the information was recorded in the notes. In one case, we were told the individual's mother was his named person even though there was a form revoking this, properly signed, on file. In another case an individual wanted her brother to be her named person and this wish was being granted even though she had not signed anything to revoke her son (who she felt was too young).

Sometimes, failure to understand the implications of the named person's provisions and not knowing where information about an individual's named person is kept can lead to potentially difficult circumstances, as the following cases illustrate:

- An ex-partner, formerly a named person on a previous admission, was recorded as the named person for this admission despite the individual nominating another named person in the intervening time. (We followed this up with the health team.)
- An individual was pressured into nominating a named person even though she was

> adamant she did not wish her confidential details or information about her distressing situation to be passed to anyone (she had no family). We advised her to sign a declaration regarding this and to include this information in her advance statement.

We have recommended to the Scottish Government that named person provisions should be made clearer and that named persons should have to be by nomination, not by default. The Scottish Government is considering these recommendations and others in their limited review of the 2003 Act.

Access to advocacy

Under section 259 of the 2003 Act all individuals with a mental disorder have a right of access to advocacy. There is a duty on NHS boards and local authorities to ensure that independent advocacy services are available. It would not be acceptable to meet this requirement simply by putting up a poster on the ward and expecting individuals to read and understand it. Information about advocacy services should be provided, both in writing and verbally, at different times during an admission to encourage uptake where appropriate.

We assessed access to advocacy by asking individuals and nursing staff whether advocacy services were readily available in the hospital. We also reviewed case notes for evidence that people had been informed of advocacy, or had used their services during this detention period.

We were pleased therefore to find that in the majority of care settings visited (85%) there was evidence that independent advocacy services were available. 21% of people reported that they had already accessed independent advocacy services.

We found that many of the people we saw were not ready, at this stage of their illness, to consider whether they would benefit from advocacy. We recognise that services generally have responded well to the change in the legislation and whilst advocacy is now widely available in most areas we will continue to monitor this important new requirement.

We found some variations in the ability to access independent advocacy for certain groups of individuals. We found that access was more difficult for people with dementia and people with acquired brain injury. Services need to ensure that advocacy is accessible in a meaningful way for people with all diagnoses. Specialist skills may be needed to work with particular client groups.

We have produced guidance on working with advocacy which may be of use. See www.mwcscot.org.uk for details.

Advance statements

One of the key provisions of the 2003 Act that aims to support participation in care and treatment is the right to make an advance statement. This is a statement, written when well, that says how the person would like to be treated if he or she becomes too unwell to make decisions about treatment in the future. Advance statements must be taken into consideration by the people involved in a person’s care and treatment. We believe that advance statements are a valuable way for individuals to influence care and treatment decisions that affect them. If professionals wish to override these wishes they must write and justify this decision to the individual, their named person, and to the Commission. We record and review all advance statement overrides and will challenge practitioners if we feel the decision to override has not been adequately justified with reference to the principles of the Act.

We had hoped that advance statements would – along with Mental Health Tribunals, the right to advocacy and the named person role – bring about an increase in individual participation in care and treatment decisions. We are disappointed that there has been much less uptake of this provision than expected. While it is an important factor, lack of awareness about how to make an advance statement does not appear to be the only reason that take up is limited. Scottish Government research has found that people often do not believe they have been ill and/or do not believe they may become ill again. In these circumstances an advance statement would seem to them to be redundant. Even those individuals who might accept that they have been unwell and may become unwell again, often do not see the point of making an advance statement. There is a level of cynicism that the doctor or other professionals will simply ignore or override an advance statement. This finding was demonstrated in the Scottish Government commissioned "The Cohort Study"[3]:

"Service users' perceptions and the continued low uptake demonstrate an underlying belief about a power imbalance in the clinical relationship in favour of consultants. That said some were completely satisfied and trusted the professional judgment of those involved in their care, seeing no need for an Advance Statement. There were indications however that Advance Statements are not promoted well enough, and that the support to make one is not always forthcoming."

We found from a previous visit programme to individuals receiving compulsory care and treatment on long term orders that 8% of patients had made an advance statement. However, out of all the people we visited during this programme we found that only six people (2%) had made an advance statement. Two of these advance statements had been overridden.

Many of the individuals we visited were too ill, at that point, to make an advance statement. We were concerned however that only 19% of people we visited were aware of their right to make an advance statement in future. It is our view that advance statements can be an effective way for people to ensure their views are taken into account when they are too unwell to express them. We would like to see a greater promotion of advance statements and more consideration of how services can support this – this might be part of a general approach to developing a culture of participation in services. We anticipate that this would lead to an increase in the number of individuals who have an advance statement. As well as health and social care staff, advocates may also have a role in encouraging take up.

The Principles into Practice website (www.principlesintopractice.net) provides access to a range of good practice resources to support professionals with understanding their role in encouraging and supporting advance statements.

Consent to treatment

People subject to CTOs and other longer term compulsory orders have specific safeguards in respect of their treatment. This includes a maximum time limit of 2 months for the giving of medicines for the treatment of mental disorder without consent. Treatment for longer than this requires an independent opinion from a “designated medical practitioner”. These safeguards would not be relevant to most of the people we saw as part of visits to people on STDCs. Only those people who had been recalled to hospital from a community based CTO, or those for whom particular treatments, such as electro-convulsive therapy or artificial nutrition for the treatment of anorexia were being considered, would be subject to the safeguards provided.

For those few individuals for whom part 16 of the Act was relevant, we found some evidence that the safeguards were not being wholly adhered to. Where our visitors identified specific concerns these were taken up with the care team and in particular the RMO.

“I am writing to the RMO as I have noted that there is no T3 in place, either in the patient’s file or on our records” (patient on CCTO)

We are aware that since the 2003 Act came into place there has been little or no training on consent provisions. We think this may be why adherence to the requirements is so variable around the country. It is our view that NHS Boards should now look at the training needs of their staff in respect of this part of the Act.

Treatment certificates (Section 47(1) Adults with Incapacity Act)

Under the Adults with Incapacity (Scotland) Act 2000 subsection 47(1), when a doctor (or other authorised person) decides that an adult is incapable of making a decision about their medical treatment it is good practice to make an assessment and complete a certificate of incapacity and a treatment plan. Under subsection 47(4) of the Act, “medical treatment” includes any procedure or treatment designed to safeguard or promote physical or mental health. Before completing the certificate of incapacity a doctor who wishes to treat an adult who lacks capacity in relation to their treatment should consider the views of any welfare attorney or guardian, and apply the general principles of the Adults with Incapacity Act.

Presence of mental disorder in itself does not mean that a person lacks capacity in relation to all matters requiring consent. A person’s capacity to make decisions can vary over time and in relation to the matters being considered, there is no automatic reason why a person subject to compulsory treatment should be assumed to lack capacity in relation to all treatment decisions regarding their physical and mental health.

We did, however, find a number of people in this monitoring programme who appeared to lack capacity in respect of consent to treatment for physical health problems and for whom there was no treatment certificate or treatment plan in place. We followed up with the doctor in these cases.

“Although MWC covert medication pathway completed no S47 certificate could be seen on file”

Right of appeal

If an individual does not consider themselves to meet the criteria for compulsory detention in hospital, the individual, or his/her named person can make an application to the Mental Health Tribunal to have the order revoked. Information about how to exercise the right of appeal should be provided by the individual’s social worker and nursing staff. This information should be provided at different times during the admission, both verbally and in writing.

We asked the individuals we saw whether they knew about their right of appeal and whether they had exercised this right. Many people were vague about whether this had happened even when notes recorded that information had been given.

Fifty-eight per cent of the people we spoke to said they were aware of their right to appeal. For 40% of these people we found no information that would confirm whether the individual had been given, or had understood, their rights. Only 10% of people of the people we visited were in the process of making an appeal.

The experience of compulsory admission can be highly distressing and, combined with the impact of the illness itself, a person’s capacity to understand and retain information can be severely limited. To help overcome this difficulty we recommend that individuals are made aware of their rights as soon as possible after admission and are reminded throughout their care and treatment. Staff should record in notes when they have given people the appropriate information. One way of facilitating people’s understanding may be the provision of a leaflet that explains their rights in a meaningful way that is appropriate to their needs. Some services for people with a learning disability, for example, have developed an easy read format for their information leaflets. This could be extended to include information on their right of appeal. Additionally, the role of independent advocacy should be fully utilised to ensure that people subject to the 2003 Act are as informed as possible and enabled to understand the appeals process as much as they can.

Level of contact with professionals

The level of support and monitoring individuals require will vary depending on individual need and may change over time as the person’s mental state and circumstances alter. It is important that individuals have adequate contact with their care team while on a STDC to ensure that services can identify and respond to changes in need. Our previous themed visit reports have highlighted the value that individuals place on therapeutic time spent with members of their care team.

On these visits, we looked at the level of contact people had with their health and social care team members. There were several difficulties in measuring the frequency of contact. Firstly, while there may be no record of contact in nursing notes or medical files, we cannot be sure that contact has not taken place. Sometimes staff and individuals reported contact, but we could find nothing in notes to confirm this. Where we were unable to find records of contact with particular professionals, (and even if we were assured the contact had taken place) we raised this as an issue with staff and stressed the importance of accurate recording. Secondly, 18% of the people we saw had been in hospital for a week or less which may affect our findings.

Contact with doctors

The number of recorded Responsible Medical Officer contacts with a patient during the first week after admission ranged from zero to four. The average contact was nearly once every four days. The average number of contacts with other types of psychiatrists (junior doctors/specialist registrars) during the first week ranged from none to seven contacts. On average, a patient would see a psychiatrist once every three days during the first week of admission.

Those patients who had been in hospital for over a week and less than 28 days had total recorded contacts with their RMO on average once every 10 days. The average number of contacts with other types of psychiatrists during this period was four.

This finding suggests that, following the initial assessment period when a patient might on average expect to see one of these more junior doctors twice, this reduces to once a week on average over the first 28 days.

While we recognise that there are significant pressures on medical staff, and that new training arrangements for junior doctors and the European Working Time Directive have significantly reduced the amount of time available for face to face contact with patients, we believe that people who are on STDC should be seen more frequently than is indicated by this report. The 2003 Act is clear that people should be regularly reviewed to ensure that care and treatment is of benefit and that the grounds for compulsory treatment are still being met.

The very nature of acute episodes of mental disorder means that an individual’s needs can change rapidly. Just as people may move from informal status to compulsion, then equally people can move in the other direction. We are concerned that a significant number of people on STDCs are subject to compulsion for longer than is necessary. For the people that we saw for this report 33% continued on their STDC until it lapsed, with only 19% being actively revoked; 48% progressed to a CTO.

Contact with named nurse

Many NHS Boards have a system that allocates a named nurse to each patient soon after admission. Many of our previous visit programmes have highlighted the value that individuals place on therapeutic time spent with their named nurse and the benefits both to the patient and the service where this arrangement works well.

We found in records reviewed for this programme, named nurses would see a patient on average three times in the first week following admission, and six times during the first 28 days. However, on some wards we found no written record of when the named nurse saw an individual, perhaps devaluing how important this contact is as part of the overall assessment. In the following case for instance we found an excellent level of support available to the person but we were unable to count the number of named nurse contacts:

“Named nurse usually sees the patient many times a day, as and when required and at least twice a week on a 1:1 basis. When the named nurse is away on leave or on a different shift, another nurse is always backing up for him or her”

Elsewhere we found:

“Recording is on [an electronic] system which is not completed necessarily by the named nurse. So it is unclear where the named nurse would record any discussion or interaction”

It was also not routine for named nurses to write in the notes when they had offered to see an individual but the individual had refused. We would recommend that NHS Boards look at these issues to ensure full and proper recording in a way which facilitates assessment and care planning.

Contact with the Mental Health Officer

The MHO has specific responsibilities following the granting of an STDC. They have a duty to explain to the individual about their rights, about the role of the named person and about how to access independent advocacy services. The code of practice suggests that the MHO should provide this information face to face, as well as in writing. The STDC also acts as a trigger for the completion of a social circumstances report (SCR). The SCR should reflect the views of the individual in relation to their detention and should be based on an interview with the individual. The importance of a comprehensive up-to-date report to the health care team cannot be overstated. We have provided good practice guidance for MHOs to assist them in preparation of SCRs. *Social Circumstances Reports: good practice guidance for mental health officers and managers* can be downloaded from www.mwcscot.org.uk.

The MHO must also be involved, as part of the multi-disciplinary team, in the assessment and care planning for the individual, in particular when considering whether an application for a CTO will be made.

While people told us that their MHOs visited more often than was routinely recorded in individual nursing and medical files, there was little evidence that individuals were being visited frequently enough to fulfil all of their MHO functions to the full.

We found recorded MHO contact with patients within the first week of admission for barely half of the people we visited. By the 28th day they had visited on average once, usually in relation to a CTO application. Often the MHO had not been involved since the admission, or had visited and had either been refused an interview by the patient, or no record of this interview existed in the notes. Sometimes we were told that although there had been no MHO contact another social worker had visited. Overall, it would appear that, once an individual is admitted to hospital, contact with social work, including MHOs, is infrequent.

Other concerns identified

General concerns

We followed up on care and treatment concerns for 25% of those individuals we visited. This section provides more detail about the issues that concerned us.

Quality of documentation

In most areas documentation of care and treatment was of a good standard. However, of all the problems we encountered issues with documentation were the most widespread. For some individuals there was no current care plan in place, or the standard of the care plan fell far short of what might be expected.

“There were very sparse nursing notes, with little of relevance to the person’s current needs. The only care plan I was able to identify was one dated 2004 for personal hygiene. When discussed this with the senior nurse at a follow up visit 2 weeks later everything was in place”

Other concerns included the lack of RMO entries in the case notes. Sometimes there was poor documentation of the names of the people attending weekly review meetings. This makes it impossible to identify who was involved in the decisions being made regarding a person’s care plan.

On occasion staff did not put their names after their signatures, although others had a system in place for identifying signatures. In some areas key (or named) nurses had not differentiated their one to one sessions with patients from general nursing notes, or had not recorded attempts to see a patient one-to-one when the session had been refused.

Our visitors noted that in some case notes routine assessments had not been completed long after they had been started. In other notes there was no way of knowing who had completed a form, or on what date, and although there was a place for the signature of the patient, they had not signed it, and there was no note to indicate whether the patient had refused.

We were pleased to find that most NHS Boards now have a comprehensive patient information sheet that provides easily accessible information about the individual’s status. These sheets record, for example, whether an individual is detained, if so when the order is due to expire, when and how the person’s rights were explained to them, who their named person is, whether they have an advance statement or an advocate, and so on. Some services however have not implemented this approach and information that is important for the wider care team to know is not readily available in an individual’s file. We found variation in practice, not just across Scotland but also within single NHS Board areas and within individual services. While one hospital or ward would be using a mental health act information form, in another this would not be the case. We recommend that all wards in all appropriate hospitals use a form that records all mental health act details in one easy to access place.

‘De facto’ detention

Where individuals meet the criteria for compulsory treatment in hospital they should be given the full safeguards provided by treatment under the 2003 Act. During our visits to people on short term detention we occasionally noted that staff have written "detainable if wishes to leave" or similar, in an individual's notes. In the worst cases, notes did not even identify whose decision this was, when it was to be reviewed, or whether it has been discussed with the patient.

Even with these details, it is our view that this type of statement is not acceptable. It increases the risk of a patient's rights being overlooked such that they become "de facto" detained (detained with no legal authority and without the safeguards of the law). If the RMO considers that compulsion may not be necessary and wishes to avoid continued use of the mental health act, but is still concerned that the individual may not always comply, then a written plan should be in place detailing what should happen if the patient expresses the wish to leave the ward. It may then be appropriate to record a statement in the notes such as:

"Requires to be reassessed if wishes to leave. Use of nurses holding power may be required".

This statement should be explained to the individual and, where appropriate, to his or her advocate. If the patient is unhappy with this situation, consideration should be given to whether their status as an informal patient accurately reflects their needs. If possible, the RMO should document his or her assessment of the grounds for detention at that time.

Unless an appropriately qualified nurse feels that the patient meets the criteria for the use of the nurse's holding power, an informal patient who wishes to leave the ward has that right. We will continue to review this aspect of patient care on their future visits.

"Specified person" regulations

The 2003 Act sets out the circumstances under which an individual can:

- Have regular restrictions placed on their use of a telephone and correspondence;
- Be subject to regular searches of their person and belongings;
- Have blood or urine samples taken to screen for drug and alcohol use.

The regulations, which cover these parts of the Act, give criteria which have to be met in order for the person's RMO to make them a "specified person". This is the essential step before any specific restrictions can be applied to an individual. For people who are detained in the State Hospital all these restrictions are in place automatically. For those in medium secure facilities – currently Rowanbank and The Orchard Clinic, the "safety and security" restrictions are in place automatically. Restrictions on telephones and correspondence still have to be individually applied.

In many situations, it is expected that hospital and ward policies will be in place to cover a number of issues such as whether mobile phones are allowed, and under what circumstances any in-patient can be searched. However, we found a number of examples of people on STDC being required to submit to routine urine screening without being made a specified person, particularly in NHS Greater Glasgow and Clyde and NHS Tayside.

"the person is subject to urine screening for possible misuse of drugs and alcohol. Not a specified person. This was raised with nurse

on the day but will be followed up with a letter to the RMO"

At the other end of the scale, we found wards where everyone who was detained was automatically a "specified person" and subject to random urine screening or searching without there being any evidence whatsoever to support the action of the staff.

We have contacted the relevant care teams to follow up on our concerns and will be issuing guidance on the operation of specified person regulations in 2010.

Other concerns that we raised during our visits, and which we have followed up on, have mostly been discussed earlier in this report. These were:

- Access to and awareness of advocacy;
- Lack of clarity on whether the STDC is going to progress to a CTO at quite a late stage in the admission;
- Environmental issues; and
- Lack of evidence that service users had been told of their rights.

Specific issues for individuals

There were also specific issues for individuals that our practitioners have followed up with the appropriate members. For example:

"Service user complained about lack of activity or time to go out for walks – she is used to being a very busy/active person. Also about the content and quality of food offered – she is a vegetarian. Have written to service manager about these"

"It is not clear why the STDC is still in place. Notes recorded by [junior doctor] state 'seems happy to stay voluntarily'. 'Review section on Monday'. Later notes state 'to allow the STDC to lapse'. When I raised this with nursing staff, the initial response was that it was too much hassle to have to get the doctor and complete the paperwork to revoke an order, hence the usual practice of allowing orders to lapse instead. When challenged, nurses then said that, in this service user's case, the decision may have been to continue the order because a depot was subsequently introduced. Letter to RMO re: this"

"Discussed with RMO who feels admission could have been prevented, but there was no cover for CPN on sick leave. To raise issue with the General Manager"

Summary of key findings

While we found evidence of early and active community interventions, we found some people who were admitted in crisis situations that could have been anticipated or prevented.

For most people, we were pleased to see good attention to the principles of giving information and encouraging participation. We found good examples of negotiation and attention to the views of individuals and carers.

In the vast majority of cases, we found that care and treatment was appropriate to people's needs and that a good range of options were considered.

In most cases, we found that care plans were being updated and were responsive to change in the person's condition.

We found cases where there were no clear decisions made about the grounds for a compulsory treatment order until very late in the 28 day period. This leads to late applications to the Mental Health Tribunal but also leaves the individual, relatives and ward staff in a state of uncertainty.

About a third of people detained on STDCs have a nominated named person. We had some concerns about the suitability of some “default” named persons, recording of named person information and people being pressured into choosing a named person when they did not want one.

There was very good evidence of advocacy provision although there was some evidence that access was more limited for people with dementia and acquired brain injury.

Doctors did not always follow correct procedure for medical treatment. They did not always notify us of urgent treatment or have proper documentation for people who were already subject to compulsory treatment in the community before detention. We also found poor compliance with part 5 of the Adults with Incapacity Act for treatment for physical health problems.

In nearly half of cases, we were not satisfied that people had been told of their right to appeal to the Mental Health Tribunal. They may have been given this information on admission, but had either not understood it or retained it.

We found good medical reviews during the first week of people’s detention. After the first week, we did not think that doctors reviewed people often enough, especially to look at whether the grounds for detention were still met.

Nursing contact was usually documented well, but it was not always possible to find out how often the named nurse saw the person. People seldom saw their mental health officers after admission.

We had other concerns, about quality of documentation, blanket use of searches and taking samples to test for drugs or alcohol, and the use of statements such as “detainable if wishes to leave” for informal patients.

Recommendations

Recommendations for health and social care managers

1. Health and social care managers should identify the factors that lead to the use of Emergency Detention Certificates in their area and determine what actions they can take to reduce the impact of these factors. This should be reflected in psychiatric emergency plans.
2. Health and social care managers should ensure that there are policies and procedures in place which support the accurate recording, in the health record, of all contacts and the presence or absence of key individuals at care and treatment reviews or other relevant meetings.
3. Health service managers must ensure that all relevant staff are familiar with consent to treatment provisions in both mental health and incapacity legislation and provide training to meet any identified need.

4. Hospital managers must ensure that people who are detained get information about their rights, including rights of appeal, and that they are given help to retain and understand this information.

Recommendations for psychiatrists

5. Psychiatrists who are responsible medical officers must make sure that the need for compulsion is kept under review and decisions about whether to apply for compulsory treatment orders are made in good time and communicated to patients.
6. Responsible medical officers must ensure that they are familiar with the requirements of part 16 of the 2003 Act and part 5 of the Adults with Incapacity Act.

Recommendations for the Scottish Government

7. The Scottish Government should examine the issues we have raised regarding named persons provisions when considering amendments to the 2003 Act. The issues are similar to those raised by the review committee.
8. The Scottish Government must ensure that training for approved medical practitioners addresses the requirements of part 16 of the 2003 Act and part 5 of the 2000 Act.

References

1 Mental Health (Care and Treatment) (Scotland) act 2003 Code of Practice Volume 2 Civil compulsory powers (parts 5, 6, 7 and 20) http://www.scotland.gov.uk/Publications/2005/08/30105347/53516

2 Delivering for Mental Health, 2006 http://www.scotland.gov.uk/Topics/Health/health/mental-health/servicespolicy/DFMH

3 An Assessment of the Operation of the Named Person Role and its Interaction with other forms of Patient Representation Research Findings No. 76/2009 http://www.scotland.gov.uk/Publications/2009/03/09103408/1

4 VOX, Good Practice in Service User Involvement, Guidance Notes, May 2007 http://www.scotland.gov.uk/Resource/Doc/924/0063945.doc

5 Research on poor uptake of advance statements reported in – Experiences of the Early Implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003: A Cohort Study, p14) http://www.scotland.gov.uk/Publications/2009/05/06155847/0

6 “Encouraging user involvement in mental health services” Lynda Tait & Helen Lester, Advances in Psychiatric Treatment (2005), vol. 11 p170 http://apt.rcpsych.org/

7 Goss et al “Involving patients in decisions during psychiatric consultations” British Journal of Psychiatry 2008; 193: 416-421 www.scie-socialcareonline.org.uk/profile.asp?guid=5cf281b3-6214-451e-bfa8-d98e47606770

Appendix

The Commission visited 284 people who were on a Short term Detention Certificate during a 4 month period. The sample size was not randomised in any way and there was no attempt to visit a representative sample of all people on a STDC. Generalisations from these statistics should be treated with caution.

Table 3: Use of EDCs before short term detention orders on people visited by NHS Board

NHS Board*	People on STDCs visited in period*		
	No. on EDC prior to STDC	% of total on EDC prior to STDC	Total
Ayrshire & Arran	0	0	12
Borders	0	0	1
Dumfries & Galloway	1	33	3
Fife	5	31	16
Forth Valley	1	8	13
Grampian	0	0	14
Greater Glasgow & Clyde	29	30	97
Highland	2	18	11

* Period: 22 December 2008-14 April 2009.

Table 4: Type of named persons by NHS Board

NHS Board*	% of people on STDCs visited			
	With a nominated named person	With a default named person	With no named person	No. of people visited
Ayrshire & Arran	9	73	18	12
Fife	38	50	12	16
Forth Valley	16	61	23	13
Grampian	31	23	46	14
Greater Glasgow & Clyde	41	42	17	97
Highland	63	0	47	11
Lanarkshire	25	66	9	32
Lothian	16	45	39	50
Tayside	35	59	6	35
Scotland	**32**	**47**	**21**	**280**

Table 5: Access to advocacy of individuals visited by NHS Board

NHS Board*	% with access to advocacy	% who had accessed advocacy	No. of people visited
Ayrshire and Arran	83	0	12
Fife	81	25	16
Forth Valley	92	30	13
Grampian	93	43	14
Greater Glasgow & Clyde	86	10	97
Highland	91	37	11
Lanarkshire	81	33	32
Lothian	94	20	50
Tayside	94	29	35
Scotland	**85**	**21**	**280**

* NHS Boards not showing did not have significant numbers of individuals visited.

Table 6: Access to advocacy of individuals visited by diagnosis

Diagnosis	% with access to advocacy	% who had accessed advocacy	No. visited with this diagnosis*
Mental illness	87	19	235
Dementia	78	13	37
Personality disorder	100	37	19
Alcohol related brain damage	89	44	9
Learning disability	78	33	9
Other diagnoses	70	0	10
Scotland	**86**	**20**	**319**

* Some individuals had more than one diagnosis and are therefore counted more than once in this table.

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