mentalwelfare
commission for scotland

# Lives less restricted

## A report into the use of compulsory community treatment in Scotland

# Contents

## Who we are and what we do

The Mental Welfare Commission is 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 and incapacity law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have worked in healthcare, social care 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 his or her needs;
- Be enabled to lead as fulfilling a life as possible.

## Our work

- 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 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.

## Our visits

One of the ways in which the Commission monitors individual care and treatment is through our visits programme. We visit people in a range of settings throughout Scotland: at home, in hospital or in any other setting where care and treatment is being delivered.

We have a duty to monitor the application of the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 and to promote best practice in their use. These principles should underpin the practice of all professionals working with an individual who is subject to compulsory measures under the legislation.

This report reflects our findings from a programme of visits to people who were subject to compulsory treatment orders with community based powers, i.e. who were not liable to be detained in hospital. We refer to these orders as Community Compulsory Treatment Orders (CCTOs). The visits took place between November 2010 and March 2011.

We examined many aspects of the care and treatment of people subject to CCTOs across Scotland. Most importantly, we wanted to hear people's views of the care and treatment they received. This will help services learn from good practice and respond to any issues that are identified.

## Why we visited

### Policy context

Community care is not a new idea in the provision of mental health services. From the 1950s onwards, there have been debates about how to make less use of long term hospital care. In the last twenty years there has been an increasing emphasis on shifting the balance of care from hospital to the community.

*The Framework for Mental Health Services in Scotland* (1997), was designed to provide impetus to the development of integrated community based services, and promote the shift in the balance of care. The (then) Scottish Executive's national plan for mental health services, *Delivering for Mental Health* (2006)[1], re-affirms this focus on shifting the balance of care, so that people wherever possible are "treated in community settings and with the minimum of disruption to their lives."

Before the 2003 Act was implemented, there were no provisions for compulsory treatment in the community, except under "leave of absence" from hospital, which was allowed by the Mental Health (Scotland) Act (1984). The Mental Health (Patients in the Community) Act (1995) restricted leave of absence to twelve months. This was consistent with human rights law, but it led to concerns that some people who needed longer term care and support in the community would not receive it.

The 2003 act was introduced following the first major review of mental health legislation in Scotland since 1960. This review, undertaken by the Millan Committee, reported to the Scottish Parliament in January 2001[2]. The report stated that, while service delivery had shifted to community care, mental health legislation had not. Following consultation, the committee recommended that a community order should be introduced, with specific safeguards. The 2003 act therefore allows compulsory orders to be granted where an individual is living in the community. It replaced the previous "leave of absence" provisions with "suspension of detention" for no more than nine months in any twelve month period. The intention was that orders should be varied from hospital to community treatment in line with the principle of least restriction of freedom.

While recommending compulsory community treatment, the Millan Committee heard concerns about:

- The imposition of treatment on a forcible basis and the possible infringement on an individual's rights;
- Community orders being a form of control without the commitment of resources to provide appropriate services;
- The possibility that such orders would discourage people from seeking help and support, or would be used as additional controls on people who may have accepted treatment informally before.

We took account of these concerns when we planned these visits.

## Our previous work on CCTOs

We made CCTOs a monitoring priority when the 2003 Act was implemented. In all of our statistical reports, we looked in detail at the numbers of people on CCTOs. Also, in the first year following the implementation of the Act, we visited people subject to CCTOs. At that time, people had only been on the order for a few months. In 2010 we thought that it was time to focus on these orders again. This time, we looked into the care and treatment of people who had been subject to a CCTO for more than two years.

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[1] http://scotland.gov.uk/Publications/2006/11/30164829/0

[2] http://www.scotland.gov.uk/health/mentalhealthlaw/millan/Report/rnhs-00.asp

## How we carried out the visits

On 1 November 2010, 247 people had been subject to a CCTO for over two years. We planned to visit as many of these people as possible between November and March 2011, to look at how care and treatment was being provided. A number of the CCTOs were revoked or had expired before a visit was organised. Despite this, and the severe weather, we arranged a total of 191 visits during this period. We examined clinical notes relating to these individuals. We offered to meet all of them, but some chose not to meet with us or were not available when we tried to meet them.

We sent letters to all the people we hoped to see, explaining the purpose of the proposed visit. We had a prepared semi-structured interview which was used to gather information directly from individuals. We also looked for evidence in case files. This allowed us to collect information consistently, and to be able to compare and contrast how orders are being used across Scotland. We gave individual people the opportunity in interviews to raise any particular concerns they might have with us. If we had concerns about the care and treatment an individual was receiving, we followed them up with staff. We used people's own views and our observations to produce this report.

## What we examined

With particular regard to the principles of the Act, we examined:

- The views of people subject to CCTOs (and their carers) about the care, treatment and support they received and their participation in their own care;
- Their care and treatment (for mental health and physical problems) to ensure they received maximum benefit and the range of treatments and services to meet their needs;
- The legality of their treatment, including proper authorisation of safeguarded treatments;
- The information people had about their treatment, their rights and the safeguards available for them;
- The frequency of reviews and strategies for reaching the point where the order is no longer necessary (least restriction of freedom and the legal test of continuing necessity for the order);
- Progress towards recovery, with particular emphasis on help to manage finances and to obtain access to education and employment (reciprocity principle and the duties of local authorities).

## SUMMARY OF FINDINGS AND RECOMMENDATIONS

There was much to praise in the way people subject to CCTOs were being treated. Generally, we commend NHS, local authority, voluntary and independent services for the care and support they offer. This is reflected in the key messages and, in particular, the views of the people we met during our visits. While we have recommendations to further improve the care of people on CCTOs, we hope that everyone reading this report takes away the impression that people receive good care and treatment under these powers.

### Key messages

1. Most people believed the order was of at least some benefit to them. Disagreements were usually about medication. Practitioners are generally good at documenting how they balance the principles of maximum benefit with having regard for the person's views.
2. Care plans were appropriately addressing the needs of people in almost all cases, with a large majority of people having information about who they could contact if they needed help and support in a crisis. There was evidence of good multi-disciplinary working and collaboration in most cases and practitioners are generally good at involving people in decisions about their care and support, in line with the principle of having regard to the person's views.
3. Some treatment for mental disorder was being given without proper legal authorisation. Consent and legal documentation should be considered at each medical review. It is best practice to renew all treatment certificates after three years.
4. Few people had made advance statements. Advance statements are a crucial aspect of patient participation. Individuals should be encouraged to complete advance statements where they are able and to keep them under review.
5. Most people subject to CCTOs are not receiving regular, documented physical health reviews. RMOs and GPs need to work together to ensure that all such people are registered and receive an annual review of their physical health. The outcome of the review should be available to the individual and the care team. Efforts need to be made to ensure that there is access to appropriate population screening programmes, and information on these programmes in accessible formats.
6. We found many people who had not had frequent enough reviews of the grounds for compulsion. We want to see more evidence that RMOs are reviewing the need for CCTOs in between mandatory reviews. Care plans should contain a “revocation strategy” that works towards a point where the order can be revoked.

7. Accommodation is a fundamental need for people with a mental illness, as for everyone in the community, and the accommodation and housing support needs of almost all the people we saw were being met appropriately.
8. Most people were receiving benefits and had access to good advice and assistance in managing money. Very few people were in paid or voluntary employment. Local authorities must take the lead, as per their statutory duties under the 2003 Act, in doing more to promote wellbeing and social development and, in particular, to help people obtain employment.

### Recommendations

1. Care should be co-ordinated. If the care programme approach is not used, integrated care pathways must ensure inter-agency coordination and communication and must ensure the involvement of the individual and his/her carers.
2. Services should offer people a choice of ways in which they might participate in review meetings or discussions about their care plans if they are reluctant to be involved.
3. Practitioners and service managers must conduct regular checks that medication is being administered lawfully. They should pay attention to the messages in our report on compliance with treatment safeguards[3].
4. When people are being discharged from hospital and/or when compulsory orders are revoked, this would be an ideal time for the person to consider making an advance statement. Care pathways should include a reminder to raise this with the person.
5. NHS Boards must comply with their responsibilities to assess and improve the physical health of people with severe and enduring mental illness.
6. Care pathway documentation should contain reminders to consider the grounds for compulsion at times between mandatory reviews. They should also require a “revocation strategy” that helps the person to recover to the point where compulsion is no longer necessary.
7. Managers of mental health officer services should audit compliance with the statutory requirement to produce a social circumstances report and with our guidance that it be updated annually.
8. Local authorities and NHS Boards should work closely with housing partners to secure the continued provision of a range of models of accommodation, designed to give people the opportunity to lead lives which are as normal as possible.
9. Accommodation and support needs should be reviewed regularly, as part of the routine review process, to ensure that people have the opportunity to move on where appropriate from intensively supported accommodation to good quality mainstream accommodation, with the necessary support.

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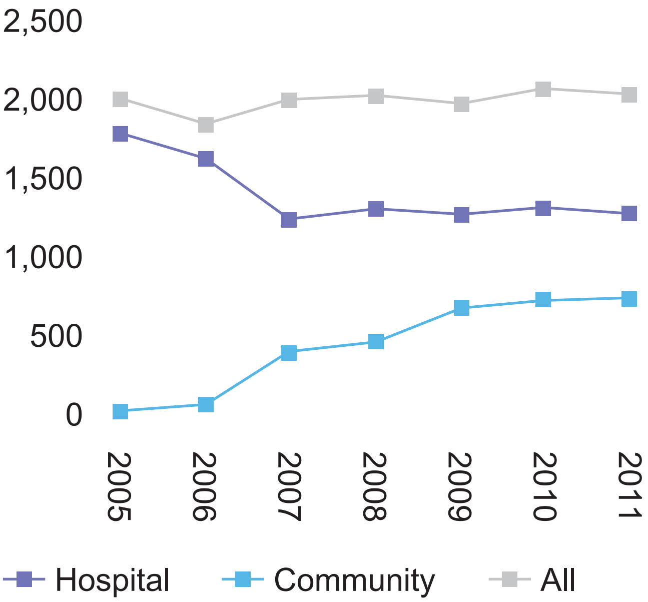
[3] http://www.mwcscot.org.uk/web/FILES/MWC_NotProperlyAuthorised_prf2.pdf

10. Local authorities should develop or review action plans indicating how they are implementing their duties under sections 25-31 of the mental health act, with particular reference to educational and employment opportunities. This should include developing employability services, volunteering and adult education opportunities.
11. Care plans should reflect the fact that finding employment can be a key theme of recovery for many people, and should cover employment and other meaningful occupation.

## PART 1: USE OF CCTOs

The overall number of people subject to compulsory treatment has remained stable at about 2000 since the 2003 Act was implemented, apart from a drop in the first year caused by errors in renewal procedures. We count all the people on CTOs on certain dates throughout the year. This is known as the "point prevalence" of CTOs (figure 1). Our data shows that fewer people are being treated in hospital; and more are treated in the community. This suggests that people who would previously have been detained in hospital are now being treated in the community. If this is the case, it appears that the principle of least restriction of freedom is being applied in practice.

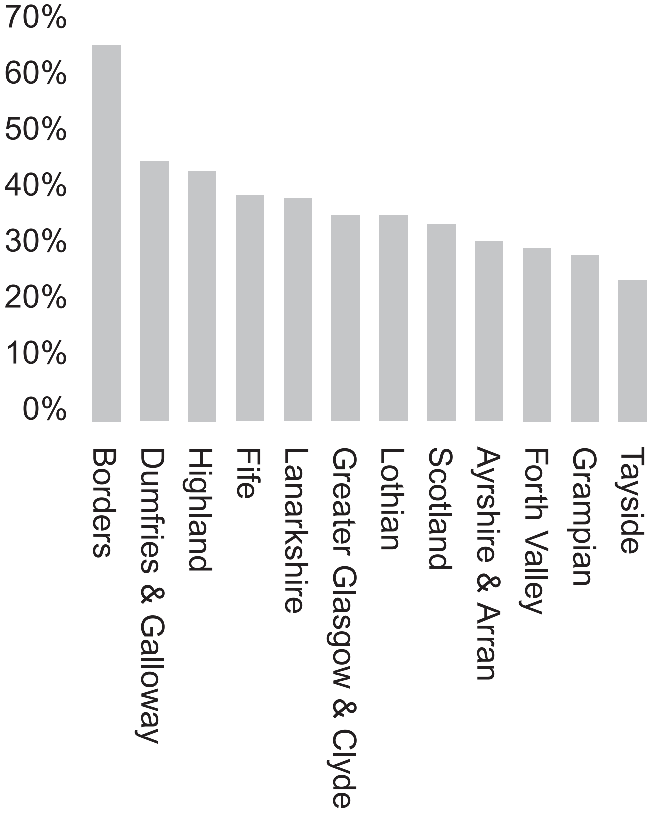
Figure 1: All people on CTOs at "point prevalence" dates 2005-2011



*Note: In 2008, we made improvements to the way we interpret notifications where the measures granted were unclear. Until then, we knew of around 200 orders where our system was not able to identify what measures were granted.*

The number of CCTOs as a percentage of all CTOs varies between 26% and 67% for all NHS boards (excluding island boards and the State Hospital). This is shown in figure 2. Very few people in the Borders are treated under CTOs in hospital. Tayside has the lowest proportion of community-based compulsory treatment. We have asked NHS Boards and local authorities to use these figures to reflect on how well they have developed their community services.

**Figure 2: Percentage of all CTOs that are CCTOs by NHS Board in 2011**



When the 2003 act was implemented, there were concerns that people would be maintained on CCTOs for longer than necessary. The Mental Health Tribunal for Scotland (MHTS) has a role in reviewing all orders which have been in existence for two years or more unless there have been reviews for other reasons within that period of time. This helps to ensure that the grounds for continued compulsory treatment are tested. If they are not met, the order is revoked.

## PART 2: THE PEOPLE WHOSE CARE WE EXAMINED

We contacted 191 people who were subject to CCTOs. We tried to contact people across all NHS Board areas. We were not able to contact people in Orkney, Shetland and the Western Isles, but we did manage to contact people in each mainland NHS Board.

Table 1: Individuals visited by NHS Board

| | |
|---|---|
| Ayrshire and Arran | 13 |
| Borders | 5 |
| Dumfries and Galloway | 5 |
| Fife | 16 |
| Forth Valley | 9 |
| Grampian | 6 |
| Greater Glasgow and Clyde | 57 |
| Highland | 11 |
| Lanarkshire | 14 |
| Lothian | 40 |
| Tayside | 15 |
| **Total** | **191** |

We looked at the diagnoses of the people we contacted. The vast majority of people (183) had a mental illness. Of those:

- Four people had an additional diagnosis of personality disorder;
- Seven had an additional diagnosis of learning disability;
- Two had an additional diagnosis of acquired brain injury.

The remaining eight people had a diagnosis of learning disability only (seven people) and alcohol-related brain damage (one person). Nobody had a diagnosis of personality disorder only. Nobody had a diagnosis of dementia or autistic spectrum disorder.

We examined the case notes of all 191 people and obtained information from care staff. Although we contacted all 191 people, we did not manage to visit them all. We actually met with 135 people. Some people declined the offer to meet with us or were not available when we tried to visit. Of the people we visited, seven were unable or unwilling to give us their views. We therefore have information from detailed interviews with 128 people.

## PART 3: OUR FINDINGS

### Individuals' views of the order

#### Key message

Most people believed the order was of at least some benefit to them. Disagreements were usually about medication. Practitioners are generally good at documenting how they balance the principles of maximum benefit with having regard for the person's views.

#### What we looked at

We were particularly interested to find out people's views of the CCTO. We wanted to know whether they thought the order was of benefit to them.

#### What we expected to find

Care and treatment should accord with the principles of maximum benefit and having regard to the views of the patient. We hoped to find that people subject to CCTOs thought that at least some of the measures were of benefit to them.

#### What we found

We obtained this information from 124 of the 128 people we interviewed. If we were not able to ask the person directly, we looked to see if the case notes contained any direct statements from the person about their views of the order. We found information in a further 17 cases.

Of the 124 people who gave us their views:

- 74 people (60%) believed that the order had been of benefit to them;
- 31 people (25%) had mixed views about the benefit of the order;
- 19 people (15%) thought that the order had been of no benefit.

We think it is reassuring that 85% of people thought that compulsory community treatment had been of at least some benefit. We were concerned that the people who agreed to meet with us might have particularly strong views, either positive or negative, about the order. We did our best to find out any views expressed by the people we were unable to meet. Of the 17 people whose views were recorded:

- Eight people believed that the order had been of benefit to them;
- Two people had mixed views about the benefit of the order;
- Seven people thought that the order had been of no benefit.

While it may be that the people who agreed to meet us were inclined to a more positive view of the order than people on CCTOs as whole, it is still reassuring that most people we met believed that the order has been of at least some benefit to them.

We looked at the positive comments from our visits. Medication can sometimes be a source of disagreement, but we found people who felt that medication was of benefit. For example:

*Mr A very happy with the level of support he receives. He said, "A lot of things have got a lot better. I am a lot less depressed and a lot less paranoid. I put that down to my change in medication. I am also willing to accept more help."*

*Mr B told me that he had very bad experiences of mental health services in the* *past and found them to be quite stigmatising. However, he did recognise that he benefitted from the depot medication and said that he found talking to his CPN helpful at times.*

There were several positive comments about support at home, especially from community psychiatric nurses and support staff. This came from a visit to a man with learning disability:

*Mr C was able to tell me he liked having the support of staff from the voluntary organisation. Certainly whilst I was there he appeared to have a good, close rapport with staff. Discussing his care, it was clear that all of the staff working with Mr C have known him for a long time and he benefits as a result. His aggression has reduced considerably which would indicate that he is happier now.*

And a woman with severe and enduring mental illness was especially pleased with the support from her CPN:

*Ms D told me that she enjoys visits from her CPN and is able to discuss any problems she has.*

It was good to find people whose lives had been transformed by being on the order. Ms E was an excellent example.

*It is evident from speaking with Ms E, her husband, support worker and RMO that the CCTO has changed her life. The RMO said that, up to 2008, she had been severely neglecting herself. Her hair was matted and full of lice. This was because, under the previous Act, she could not be compelled to receive ongoing community treatment. She has now been out of hospital for 3 years and has had no obvious symptoms of her illness. She has an excellent package of care which she is now willing to accept. Ms E told me that the CCTO was the best thing that had ever happened to her. Her husband was equally enthusiastic and said we should use her experience as a success story.*

Many people welcomed the availability of crisis support. In this particular case, Ms F thought that her support was of benefit. Her RMO believed that continued medication has helped but Ms F did not agree.

*Ms F appreciates the support. Professionals will respond to her calls when distressed. Wishes she was not subject to the order but is aware of the difference of opinion between her and her RMO in regard to medication.*

Ms F was one of several people with mixed views. They appreciated the benefit of care and support, but did not think that medication had been of benefit. Mr G was a good example. He accepted his medication by depot injection although he did not consent to it. We checked and found that it was properly authorised by an independent medical opinion.

*Mr G accepts that he has needed help and attends some care programme meetings and appointments. He clearly likes his CPN, but he would prefer to be off medication.*

Mr H had similar views. When unwell, there was a risk that he would commit offences, especially if also taking drugs. We thought that his care plan and risk management plan were very good. Mr H agreed but was still unhappy about his medication.

*Mr H advised me that he felt supported by his CPN and RMO but that he did not feel he required any medication for his illness. His* *hope was that he would be able to come off his medication now that he had not been smoking cannabis for two months.*

A few people with mixed views thought the medication was of benefit but that other supports were excessive and intrusive.

*Mr I was very positive about the medication he was taking and the benefits that it had provided him with. However, he was unenthusiastic about the other support and in particular the support workers. He said they came round too often and that he did not need their input and could manage by himself.*

Some people were adamant that the order had not helped them. Even so, we thought there was often evidence of benefit. Ms J denied that she had received any benefit at all. Despite this, she was still receiving treatment and support.

*Ms J completely refuses to recognise or accept that she may have an illness so is of the clear view that she does not need any support at all from mental health services and is very resentful of their input. Despite this she continues to attend for her depot and also engages reasonably well with her CPN. They chat about how things are going in general and she seems to quite enjoy this as long as the CPN doesn't delve too deeply.*

Mr K completely rejected the idea that anything was wrong with him and resented all input.

*He thinks everyone is interfering in his life and if this continues then he will go to Southern Ireland where there is no reciprocal arrangement (to return him to Scotland).*

## Mental health care

### Key message

Care plans were appropriately addressing the needs of people in almost all cases, with a large majority of people having information about who they could contact if they needed help and support in a crisis. There was evidence of good multi-disciplinary working and collaboration in most cases and practitioners are generally good at involving people in decisions about their care and support, in line with the principle of having regard to the person's views.

### What we looked at

We looked at how care and support was being provided and reviewed, and at how people were participating in the decisions about their care. We were interested in whether an adequate range of services was being provided, what peoples' views about the range of services were, and whether individual people knew what to do if they needed support in a crisis. We were also interested in seeing if people may be "drifting" on long term community orders, or if services were thinking in each case about when compulsory measures may not be needed. We look at this in more detail later under *"Continuation of orders"*.

### What we expected to find

The act requires that the mental health officer (MHO) submits a proposed care plan to the Tribunal when applying for a CTO. Where the responsible medical officer (RMO) applies to vary an order he/she must submit an up-to-date care plan. Where the application includes community measures, these plans should form the basis of the measures being sought. Also, the RMO has the duty to prepare and maintain a working care plan.

We expect the care plan to be comprehensive, describe all the person's needs and lead to the provision of an appropriate range of services. We have published guidance on best practice in constructing care plans[4]. Because of concerns expressed to the Millan committee, and in line with the principle of reciprocity, we expect to see good provision of community services to support individuals and to promote recovery.

We expected to see the care programme approach (CPA) used where risks and complexity are identified. CPA has been widely used across Scotland although it has never been made mandatory nationally. The purpose of CPA was to make sure that people with a mental illness and complex support needs were getting effective and well co-ordinated on-going care and support, and were involved as much as possible with their care planning decisions and arrangements. Some of our investigations have recommended more use of CPA[5] [6].

Integrated care pathways (ICPs) are being developed as prescribed by *Delivering for Mental Health*[7]. Standards for ICPs for mental health emphasise the importance of the individual being actively involved in the planning of their care, of undertaking a holistic assessment and providing care and support on the basis of assessed needs, and having a crisis intervention plan to prevent unnecessary hospital admissions[8]. We expected to see evidence of these standards being met for individual people.

## What we found

We obtained information about care plans for all of the 191 people whose care and treatment was looked at, and as described earlier, we were able to interview 128 people to ask questions directly about their care plan and to get their views.

In 81 cases (42%) the care and support was being provided within the CPA framework. Use of the CPA varies widely across NHS Board areas. In our sample:

- Almost everyone in Fife and Forth Valley was on CPA;
- In Lothian only 6 people (15%) were on CPA;
- In Dumfries and Galloway no-one on a CCTO was on CPA.

NHS Boards that are low users of CPA must make sure that care and support is well co-ordinated in other ways, e.g. via ICPs. Whether or not the person is on CPA it is important that their care plan is addressing their needs.

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[4] http://reports.mwcscot.org.uk/web/FILES/Publications/Mental_Health_Act_Care_Plans.pdf

[5] http://www.mwcscot.org.uk/web/FILES/Publications/Too_close_to_see_web.pdf

[6] http://reports.mwcscot.org.uk/web/FILES/Investigationsreports/Loss_of_focus.pdf

[7] http://scotland.gov.uk/Publications/2006/11/30164829/0

[8] http://library.nhsggc.org.uk/mediaAssets/dementiasp/mentalhealth_standardsforICP_DEC07%5B1%5D.pdf

Overall, care plans were describing the care being provided quite well. We were satisfied with the care plan in 181 cases (95%). Care appeared appropriate to the person's needs. We saw several care plans that were excellent, as our practitioners noted:

*"Care plans are very comprehensive, simple, and reflecting changing needs…"*

*"There is a care plan addressing all her needs, and she is very involved in decisions" (confirmed by interviewing the person herself)*

*"The care plan review included Mr A and his friend… The care plan is comprehensive and simple to understand. There is a record of discussion about providing care and treatment without the order…"*

Of the ten people whose care plan did not seem to be addressing needs, there were three cases where we could not find a care plan. We did see some cases where the care plan was very minimal, and we noted in one case the *"scant individualisation of the care plan."* In other cases, the care and support set out in the care plan (and being provided) was very minimal. This was often because individuals themselves did not see any need for services to be provided. Some people did not think they were mentally unwell and disliked the idea of having to accept supports, and some people did feel stigmatised as a result of previous contacts they have had with services. For example:

In Mr T's case it was noted that *"he is a very private man who will not tolerate any more input."*

In Mr S's case we saw that his care plan *"provides a limited amount of support, but this is all he is willing to engage with."*

We could see on these visits how workers were trying to balance the principle of least restrictive intervention against the principle of benefit, and how in a number of cases workers felt that more services would be a benefit if the person would accept them. In some cases there was a clear recognition that if an individual was willing to engage with a minimal level of support then this did at least allow their mental health to be monitored, so that more intensive input could be arranged if it was recognised that the person's mental health was relapsing.

We looked at the way in which care plans are reviewed, and again it was reassuring that in almost all cases there was evidence that reviews are taking place at least on an annual basis. There were only ten cases where we could not see any information about reviews. In seven of these cases, we still felt that the care plan was addressing the person's needs. We met five of them and were pleased to find that they agreed.

We also looked at whether there was multi-disciplinary involvement in reviews. We wanted to see if the range of workers who may be providing care and support to an individual were taking part in the review process. We were pleased to see that in 173 cases (91%) there did seem to be appropriate input from different professions when care plans were being reviewed.

We found evidence of people participating in their own review meetings in 149 cases (78%). We were able to ask 112 of those people about how they take part in reviews. Some people made very positive comments about how they feel involved in the review process. Mr B's case was a particularly good example:

*"He told us how his care provider has monthly meetings with him where he can make any comments he wants about his care plan and his support, that his comments are fed into his six monthly reviews with his multi-disciplinary support team, and how he can ask for any specific person to come to these meetings to support him."*

Ms C was very happy with her care plan and arrangements for review:

*She feels involved, doesn't feel she needs advocacy support now, and said to us "I just go along and say my bit" and that she is confident people listen to her and that they also "explain things well to me."*

Several people could also give us examples of the outcome of how their views are taken on board in reviews.

*Mr D told us that he knew his views were listened to because at his last review he had said that he felt he was doing well and didn't need as much support as he had been getting when he first moved from hospital into a new home. Workers at the review had agreed with him and his support was reduced to five hours a week, which he was very happy with.*

Some people are participating in reviews while clearly having a negative view of them. In Mr E's case:

*He only attends meetings to re-iterate that doctors are wrong.*

In 42 cases there was no evidence, either from the person themselves or from case files, of participation in reviews. It was often stated in files that people were invited to come to review meetings but chose not to attend, but in a small number of cases we could not see any record of the person being involved in decisions about their care, or actively choosing not to be involved. It was also clear that a number of people are choosing not to participate because they do not feel they are unwell, are unhappy having any care and support services provided, and don't want to engage with any review process.

*Mr F did not accept that he had a mental illness, he couldn't see any benefit from having a care plan or getting support, and could not see any reason to participate in discussions about his care and support.*

Mr G told us *"my views were not listened to when I went, so there is no point."*

It was good to see that some people could be helped to contribute to review processes, consistent with the principle of taking their views into account, even when they are not willing to attend meetings.

*Mr H is invited to care review meetings but chooses not to attend. We saw how care plans are discussed with him beforehand, and any new revised care plans are also written and discussed with him afterwards.*

Individuals and their carers must know what to do if they need help and support in a crisis. It was good to see evidence in case files that in a very large number of cases people had information about crisis supports. In 161 cases (84%), this information was available to individual people, and in 145 cases we were able to see that relatives and/or support workers also were aware of the crisis support arrangements. Sometimes we were only able to get this information from files. Of the people we met who gave us their views, 119 said that they knew how they could get support in a crisis, and only seven people did not know what they could do. Many people spoke very positively about the crisis supports they can use.

*Mr I was able to show us his relapse prevention/staying well plan which had contact details for the people supporting him and crisis numbers.*

*Mr J is able to telephone the local in-patient ward in a crisis – he said that often being able to speak on the phone, to a nurse who knows him, helps if he is feeling more agitated.*

We also heard of situations where having access to support in a crisis had helped to prevent the individual coming back into hospital.

*Ms K knew she could access her local crisis team by going to her health centre, and her community nurse felt that a hospital admission had been prevented last summer because Mrs K was aware of how to be put in touch with the crisis team.*

### Recommendations

Care should be co-ordinated. If the care programme approach is not used, integrated care pathways must ensure inter-agency coordination and communication and must ensure the involvement of the individual and his/her carers.

Services should offer people a choice of ways in which they might participate in review meetings or discussions about their care plans if they are reluctant to be involved.

## Compliance with treatment safeguards

### Key messages

Some treatment for mental disorder was being given without proper legal authorisation. Consent and legal documentation should be considered at each medical review. It is best practice to renew all treatment certificates after three years.

Few people had made advance statements. Advance statements are a crucial aspect of patient participation. Individuals should be encouraged to complete advance statements where they are able and to keep them under review.

### What we expect to find

The provision of medical treatment for mental disorder is covered by Part 16 of the Act. There are safeguards for medication that is administered for more than two months. The person either gives signed consent (on form T2), or has treatment authorised by a designated medical practitioner (DMP) (on form T3). The relevant certificates should cover all the medical treatment that is prescribed.

Certificates issued under Part 16 should be subject to regular review. There should be clear evidence that the individual’s capacity to consent is reviewed regularly and the prescribed medication, including the use of “as required” medications, properly authorised.

For those individuals who are unable to consent, there may also be a need for separate authorisation under section 47 of the Adults with Incapacity (Scotland) Act 2000 covering treatments for physical ill health.

Practitioners must take account of any advance statement. If any treatment is in conflict with the advance statement, the reasons for this must be given in writing to the individual, the named person and the Commission.

### What we found

Of the 191 individuals whose care we examined:

- 120 (64%) had their treatment authorised by a T3 form only;
- 57 (31%) had their treatment authorised by a T2 form;
- In two cases, there were both T2 and T3 certificates, reflecting the individual's capacity and/or agreement to consent to some aspects of their treatment and not others;
- There were five people where a certificate was required and could not be located;
- The remaining seven people were not receiving any medication for mental disorder.

Four people had other treatment authorised by a section 47 certificate, one of whom also had a T2 certificate indicating capacity to consent to treatment for mental disorder. We contacted the RMO to clarify this. It is, however, good practice to consider capacity for each individual treatment.

In 159 cases, the treatment prescribed was in line with that authorised by the certificate.

For 25 individuals, the treatment did not appear to be properly authorised. This includes the five people for whom no form could be located. The remaining 20 people were receiving treatment that was not authorised by the forms. Examples of our visitors' comments were:

*There is a T2 for diazepam, not used. No authority for her depot anti-psychotic, and she does not have capacity in my opinion.*

*There is a T3 dated 16/06/2006, which does not cover the prescribed medication. It authorises one depot antipsychotic, one regular oral anxiolytic and one "as required" antipsychotic. The patient is prescribed – Depixol 60 mgs weekly, Olanzapine 20 mgs daily (5/15), Diazepam 12 mgs daily (5/5/2), Temazepam 10 mgs nocte and Sertraline 150 mgs daily.*

In 39 cases where we had access to the certificates, the T2/3 form was more than three years old. Although this is not unlawful, we recommend that no certificate should last for more than 3 years. Where we found this we contacted the RMO to make them aware of our views.

Where possible, we tried to determine whether the people we met had the capacity to consent to treatment. In the cases of two people whose treatment was authorised by a T3 form, we thought that the individual was able and willing to consent. In the cases of five people who were certified as giving consent on form T2, we thought that a T3 would be more appropriate as the individual did not appear to us to be consenting. Some individual examples we raised with the RMOs were:

*Mr P is being given a depot injection which he would not agree to take if not on a CCTO and this is covered by T3 but he is also on olanzapine which he takes orally everyday* *and is willing to continue. This needs a T2 form. RMO agreed to do this.*

*Mrs R likes the security being on a CCTO gives her. She consents to her medication. A T2 may be more appropriate.*

We found only 24 advance statements (12% of the cases we studied). In 17 cases, the treatment prescribed was consistent with the advance statement. Five people had their advance statement overridden by a DMP. We had been notified of these and had found good justifications for the reasons for the overrides. In the other two cases, the individuals were clearly consenting to their current treatment. As they had capacity, the advance statement had no effect. We suggested that they should think again about the advance statement and possibly change it.

Our Principles into Practice website has examples of good practice in helping people to make advance statements.[9]

### Recommendations

Practitioners and service managers must conduct regular checks that medication is being administered lawfully. They should pay attention to the messages in our report on compliance with treatment safeguards.[10]

When people are being discharged from hospital and/or when compulsory orders are revoked, this would be an ideal time for the person to consider making an advance statement. Care pathways should include a reminder to raise this with the person.

## Physical healthcare

### Key message

Most people subject to CCTOs are not receiving regular, documented physical health reviews. RMOs and GPs need to work together to ensure that all such people are registered and receive an annual review of their physical health. The outcome of the review should be available to the individual and the care team. Efforts need to be made to ensure that there is access to appropriate population screening programmes, and information on these programmes in accessible formats.

### What we looked at

We looked for documented evidence of physical health reviews and appropriate investigations. Where possible, we asked individuals whether they had received a review of their physical health in the previous year.

### What we expect to find

We expect to find a review of physical health in patients subject to a CCTO at least once every 15 months (ideally annually). This was a commitment in *Delivering for Mental Health*[11]. The review should include a physical health assessment and the provision of health promotion advice. People receiving medication should have side-effects and any associated health risks assessed and managed.

The clinical record should indicate who is responsible for the physical health assessment (primary care or specialist services), and should provide evidence that results have been shared and acted upon. Dental, hearing and vision checks are also important.

CPA reviews should include a review of physical health needs and an agreed care plan to address identified needs. People should have access to appropriate community groups that support and encourage good physical health, e.g. walking groups, weight management and healthy living groups.

### What we found

- 185 people (96%) were registered with a GP at the time of interview.
- 79 people (41%) had documented regular physical health monitoring.
- 72 people (38%) had been seen by their GP, practice nurse or other clinical staff for review of their physical health and/or screening in the year prior to the interview.

Only a small minority of people refused a physical health check when it was offered, in one case due to delusional beliefs involving his GP.

We have serious concerns about these findings. It is well known that people with severe and enduring mental illnesses have reduced life expectancy and poorer physical health than the general population. Our findings appear to show that the NHS is still not doing enough to provide the level of care that *Delivering for Mental Health* envisaged. We were not able to examine primary care health records for all 191 people. It may have been the case that some physical health checks had been undertaken but not shared with mental health services. If so, the checks would have limited usefulness as mental health practitioners would be unaware of physical health problems that would have a bearing on the person's mental health and the treatment being undertaken.

### Recommendations

NHS Boards must comply with their responsibilities to assess and improve the physical health of people with severe and enduring mental illness.

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[9] http://www.principlesintopractice.net/

[10] http://www.mwcscot.org.uk/web/FILES/MWC_NotProperlyAuthorised_prf2.pdf

[11] http://scotland.gov.uk/Publications/2006/11/30164829/0

## Continuation of orders

### Key message

We found many people who had not had frequent enough reviews of the grounds for compulsion. We want to see more evidence that RMOs are reviewing the need for CCTOs in between mandatory reviews. Care plans should contain a "revocation strategy" that works towards a point where the order can be revoked.

### What we expect to find

The act requires that RMOs review the grounds for continuing CTOs "from time to time". It is not enough to only assess the grounds for a "mandatory review" when the order needs to be extended (every six months during the first year and annually thereafter) or varied. We expect to find evidence in case files that the RMO has carried out "from time to time" reviews of the grounds for compulsion.

We expect that individuals, carers and practitioners should understand:

- The reasons for continuing the order;
- The point at which the RMO would revoke the order;
- The steps needed to get to that point.

The Code of Practice (Vol 2, ch.5, paras.01-04) says that it is particularly important when someone is subject to a CCTO to look at progress towards recovery and review the extent to which care plan objectives are being met. The code says that an order should not be continued "on the basis of a preventative function alone". We wanted to see if there was a clearly identified "revocation strategy" towards revoking the order[12].

Social circumstance reports (SCRs) provide helpful information for the RMO on wider aspects of the person's life. If this information is kept up-to-date, it can help the RMO to decide whether or not the order continues to be necessary. We wanted to find out when the mental health officer had last updated an SCR. While not a legal requirement, our guidance advises an annually updated SCR for long term compulsory treatment[13]. Unless there are alternative, robust review arrangements in place such as CPA, then anyone subject to long term compulsion should have an up-to-date SCR at least every two years. This is in line with the necessity for the Tribunal to review long term orders every two years[14].

### What we found

We examined records of all 191 people. Practices varied on where up-to-date information about the legality of compulsory treatment was kept. In 186 cases, there was documentation that the order had been properly extended and that the person was still lawfully subject to compulsion. Of these:

- In 102 cases, the grounds for compulsion were documented in case notes or nursing notes;
- In 136 case files, the forms recording the extension of the order were readily available;
- We were able to track down the forms from hospital records departments or our own records for almost all the others.

It was good to see careful and detailed assessment of the need for continued compulsion. Here was a good example:

*CTO3a extending order has very clear care plan attached with specific reasons detailed why order was being extended. Also, the MHO has recorded very detailed reasons supporting the decision. All involved with the adult feel he has settled well since resettlement from hospital, and that the care home is managing psychotic symptoms well.*

There were only five cases where we could not find any information about RMOs' reviews in clinical notes or a form documenting the grounds for compulsion. It was not available in case notes and had not been supplied to us. Our view was that the order had lapsed. We gave the RMOs our views and asked that the individuals be informed.

We are satisfied that orders were being extended appropriately when "mandatory" reviews were needed. We did not see much evidence that psychiatrists are carrying out 'from time to time reviews'. It may be that the need for compulsory measures is being routinely considered at other regular meetings, for example at meetings to review care plans. If this is happening, it is not being well recorded in notes. It is difficult to say that the need for compulsory powers is being kept under general review, and that the RMO is consulting other people involved in supporting the person about whether or not compulsory powers continue to be necessary.

When we looked for evidence of a revocation strategy, we found that:

- In 68 cases (36%) we could see information about a revocation strategy;
- In 48 of these 68 cases we met the person and were able to confirm their views.

In some cases it was very clear to the person when their support team would feel confident that they were recovering and that the objectives of the care plan were being met. For example:

*"The psychiatrist has discussed with Mr L that a consistent period of compliance with medication will result in his CCTO being revoked".*

*"Ms M told us that she felt that compulsory measures had been needed but that she was "getting her life back together" and understands that if she continues to remain well and improve as she has done then compulsion will no longer be needed."*

Some people also said to us very clearly that they did not want a revocation strategy at present and that they felt having a CCTO in place felt like a safety net for them. Mr N for example was adamant that he did not want a revocation strategy, and saw the CCTO helping him avoid being back in hospital:

*"He told me that he has been out of hospital for six years now and wants it to stay that way."*

It was good to hear that some people understood very well the circumstances in which their compulsory order would be revoked, or that some people felt they were benefitting from being on an order and did not want to think about a revocation strategy at present.

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[12] http://www.scotland.gov.uk/Publications/2005/08/30105347/53563

[13] http://www.mwcscot.org.uk/web/FILES/Social_Circumstances_Reports.pdf

[14] http://www.mwcscot.org.uk/nmsruntime/saveasdialog.asp?lID=1504&sID=1082

It was disappointing though that in 108 cases there was no clear revocation strategy, or indication of the steps to recovery that people could take or that workers would hope to see, that would lead to care and support being provided without compulsory powers in place. It was clear that a significant number of people we saw were still mentally unwell, or would be unwilling to accept support without compulsory measures, but we do feel that having a clear revocation strategy can be linked to recovery journeys.

When we looked for SCRs, we found:

- In 95 cases there was no SCR available;
- In 84 cases there was an SCR but it was more than 2 years old;
- Only 12 people had an up to date SCR.

Of the 96 people for whom an SCR could be located, 11 were found to have been provided before the implementation of the 2003 act and the majority (66) were at least three years old. We do not think that this is acceptable, and it mirrors our findings from our monitoring of people receiving care and treatment after committing offences[15].

### Recommendations

Care pathway documentation should contain reminders to consider the grounds for compulsion at times between mandatory reviews. They should also require a “revocation strategy” that helps the person to recover to the point where compulsion is no longer necessary.

Managers of mental health officer services should audit compliance with the statutory requirement to produce a social circumstances report and with our guidance that it be updated annually.

## Accommodation and social support

### Key message

Accommodation is a fundamental need for people with a mental illness, as for everyone in the community, and the accommodation and housing support needs of almost all the people we saw were being met appropriately.

### What we looked at

We looked at the type of accommodation people were living in, and whether this was their own home, or a shared tenancy, or other group living situation. We looked at whether the residence was specified in the compulsory treatment order, the housing support available and how this was provided. We considered whether the accommodation met the person’s own individual needs, and whether we felt the care and support being provided within the accommodation was adequate.

### What we expected to find

People with long-term mental health problems should live in accommodation that meets their needs. They may need support to enable them to maintain their home and to be independent and feel secure in their community. Recent research also indicates that one in four tenants with mental health problems has serious rent arrears and is at risk of losing their home[16]. Accommodation is a priority when assessing people’s needs and helping people to live as independently as possible in the community. We expect people to be offered appropriate support to ensure that they maintain and retain their homes.

The Supporting People programme which began in April 2003 introduced significant changes to the way housing related support services were provided and funded. Across Scotland, new housing support services for people with a mental illness were developed, and more supports were available to allow people to maintain their accommodation and to have and to keep a stable place to live. There was a greater emphasis on the approach of providing floating housing support with a tenancy, with significant targeting of services to groups of people with particular needs, including people with mental health problems. The Supporting People programme in Scotland ended in 2008, when ring fenced funding was removed, but it is still government policy that local authorities should arrange for the provision of flexible housing support services to help people to feel safe, secure and self-reliant in their homes. The 2003 Mental Health Act also imposes a duty on local authorities to provide or secure the provision of care and support services, including residential accommodation.

### What we found

We obtained information about the type of accommodation all of the people we contacted were living in. Of the 191 people:

- 168 were living in their own homes or tenancies;
- 16 were living in a group home or hostel;
- Seven were in shared accommodation.

In 64 cases, the person's residence was specified in the CCTO. The Tribunal had imposed a requirement that the individual should stay at a certain address.

We looked at whether the accommodation was meeting peoples' needs, and were pleased that with almost everyone this seemed to be the case. In 169 cases we felt we were able to say that the accommodation was suitable. There were only nine people whose accommodation was, in our opinion, unsuitable. Two of them were waiting to be re-housed from temporary accommodation, one person had anti-social neighbours who created significant problems, and one person was in a tiny studio flat where we noted that:

*"Mr A sleeps, eats and spends all day in the same room."*

Mrs B also said to us that *"she feels unsafe in her house – she has had a number of break-ins recently."* We were pleased to see though that where accommodation problems were known about workers seemed to be taking steps to try to resolve the problems. Mrs B for example told us that a support worker was taking her to view several sheltered housing options where she lived, and that she had had visits from the police to give her advice about home safety after a break-in. It was also clear though that in areas where there is a limited supply of social housing it was difficult to find other options. We noted that several people were living in very deprived areas, and that one person waiting for a single bedroom flat was 150th on the housing list.

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[15] http://reports.mwcscot.org.uk/web/FILES/Visiting_Monitoring/CPSA_Monitoring_Report.pdf

[16] http://www.socialinclusion.org.uk/publications/Rentarrearsbriefing.pdf

We asked about how people were being supported in their homes, and found that this varied widely. Some people were living in group homes or shared accommodation where staff were available all the time. There were many different models of supported accommodation, and sometimes staff may also be there 24 hours a day, or be available on call if someone needs support. We were pleased to see that people received support to help them live as independently as possible in their own homes, and that this was available daily if needed.

People received help and support from different sources and in different ways. The range of supports helped people to continue living in the community. We found that:

- 30 people were getting 24 hour support in their accommodation;
- 139 people were getting support from workers who visited them;
- 116 people were getting support from family members;
- 16 people were getting other support, usually from neighbours or friends.

Examples were:

*Ms C has "daily contact with a housing warden."*

*Ms D "currently receives 18.5 hours support per week over six days."*

*Mr E lives in "core and cluster supported accommodation – 93 contracted hours support per week."*

*Ms F "lives in supported accommodation with daily support visits and staff are available by telephone 24 hours…"*

We did see or hear about a number of people who struggled to maintain their homes. Some did not seem to accept that support could help them with this task. It was good to see that care staff persevered in trying to offer help. We saw some people where considerable efforts were being made to stick with the plan to provide support in the home. In Ms G's case for example we made the following positive comments:

*"She has developed a rapport with one of the support workers so they are getting in much more regularly. This means that issues such as cleaning her flat are being worked on."*

We also met or read about a number of people who were very unwilling to accept support which everyone felt would improve their accommodation quality.

*Mr I did not accept he was ill, for example, and had refused housing association request to gain entry to upgrade his kitchen and bathroom and refused to agree to have his flat, which is filthy and chaotic, cleaned.*

In extreme situations the lack of housing support may place someone at risk of losing their tenancy, and it was reassuring to see that in such circumstances strenuous efforts were being made to get the person to accept support to maintain their home, in the face of great resistance.

*In Mr J's case we heard about the local authority housing department refusing to upgrade his home because of the state of the flat. His MHO spent several days clearing out the home to allow the work to be done, with the outcome that his living conditions improved greatly as a result.*

Some people were living in accommodation with very intensive support being provided. While this may be very appropriate people may, as they recover, be able to move to accommodation which has less support.

*In Ms K's case we heard about a plan for her to move from her current highly supported accommodation in the next year. Ms K had anxieties about the move, saying to us "how will new neighbours feel about me" and worrying about fitting in to a new community, but she was also pleased because she felt she would be managing with reduced support.*

We did not find a lot of evidence to suggest that many other people were able to move to appropriate new homes as part of a recovery journey. We thought they could have managed with less support and therefore could have greater privacy and dignity and a feeling of progress to recovery.

### Recommendations

Local authorities and NHS Boards should work closely with housing partners to secure the continued provision of a range of models of accommodation, designed to give people "the opportunity to lead lives which are as normal as possible." (Section 25 of the 2003 Act).

Accommodation and support needs should be reviewed regularly, as part of the routine review process, to ensure that people have the opportunity to move on where appropriate from intensively supported accommodation to good quality mainstream accommodation, with the necessary support.

## Employment and finance

### Key message

Most people were receiving benefits and had access to good advice and assistance in managing money. Very few people were in paid or voluntary employment. Local authorities must take the lead, as per their statutory duties under the 2003 Act, in doing more to promote wellbeing and social development and, in particular, to help people obtain employment.

### What we looked at

During our visits we looked at whether people were in employment, either full or part time, or were participating in voluntary work. We also asked about:

- The benefits people were receiving;
- Any difficulties with benefits;
- How people were managing their personal finances.

We recorded any concerns identified during the visits, and where appropriate we followed these concerns up.

### What we expected to find

There is a considerable amount of research information available focusing on inequalities in mental health. People with a mental illness are among the most excluded in our society and are nearly three times as likely to be in debt[17]. We know there is a link between unemployment and poor mental health. Mental illness can restrict a person's

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[17] "With Inclusion in Mind". http://www.scotland.gov.uk/Publications/2007/10/18092957/0

educational and employment potential. Paid employment and voluntary work are key parts of recovery, and of being able to live a meaningful and satisfying life[18].

We would expect to see evidence of some support being targeted at helping people access employability services or education or training opportunities where this is appropriate. We would also expect to find that people have good access to services to ensure that their income is maximised and that support is available where there are issues about managing finances, or about personal debt.

### What we found

We found that almost 80% of people were receiving Disability Living Allowance, mainly in addition to Incapacity Benefit and/or Income Support. Significant amounts of information have to be provided in support of a DLA application. This suggests that a considerable amount of support is being provided to help people maximise their benefits. A very small number of individual people, or family members, felt they should be receiving a higher rate of DLA.

The number of people reporting that they had difficulties managing their personal finances was very small, although some people were unwilling to discuss this issue. In a small number of cases formal arrangements were in place to assist with managing money, usually involving a family member acting as DWP appointee, or very rarely involving a financial guardian. In a few cases where the person was living in a care home, managers were managing their funds. In these latter cases we were satisfied with arrangements for the person to access money for their personal use.

In most cases where support was felt to be needed, this was being provided on an informal basis, with family and support workers assisting with budgeting or helping to pay bills. A small number of people had accessed financial advice outwith their network of care and support services. One person had used trading standards services to deal successfully with problems they had with excessive bank charges. Several people had received support from Citizens Advice Bureau or other money advice projects, and one person was going through the formal bankruptcy process at the time we visited.

From the information we collected on these visits we did not find major problems in helping people to manage their personal finances. We were satisfied that enough was being done to help people obtain money to which they were entitled and to manage it well. In two cases there were current concerns about the person being potentially vulnerable to financial exploitation, and in both cases we were satisfied that local services were looking at the available financial measures which could be used to protect the individuals concerned.

When we looked at employment, we were very disappointed with what we found. Out of 191 people, only 14 (7%) were undertaking any form of employment or education.

- Only two were in full time employment.
- A further four were in part time employment.
- Six people were in voluntary work.

- One person was attending college, and another one was doing an Open University course.

One other person told us that he would like to be involved in voluntary work. He had had a placement in a charity shop which was unsuccessful because there was no work for him to do. He was being supported to find alternative volunteering opportunities. Nobody else spoke about any options they felt were available to return to any form of work, despite the fact that paid or unpaid employment or voluntary work is generally better for mental health and wellbeing than unemployment.

A significant number of people seen on these visits had very long-standing mental health problems, and often had periods of acute illness. Some people were living in accommodation where support was provided or was available on a 24 hour basis, and some were attending day services or day hospitals for substantial parts of the week. For many people a return to some form of employment was not an option at present. We are also aware that UK-wide only 20% of adults with long-term mental health problems are in work.[19] In the present economic climate, it is unlikely that this will improve. Nevertheless we would have expected to see evidence of more people being supported to access appropriate training and educational opportunities, or of more people thinking about this as an option for the future, as part of their own individual route to recovery.

### Recommendations

Local authorities should develop or review action plans indicating how they are implementing their duties under sections 25-31 of the mental health act, with particular reference to educational and employment opportunities. This should include developing employability services, volunteering and adult education opportunities.

Care plans should reflect the fact that finding employment can be a key theme of recovery for many people, and should cover employment and other meaningful occupation.

[18] Scottish Recovery Network, Discussion Paper 5: Mental Health, Recovery and Employment.

[19] Office for National Statistics Labour Force Survey, Jan-March 2009.

## CONCLUSIONS AND FURTHER ACTION

We were pleased to meet so many of the people who were receiving compulsory community treatment. We were most grateful to them, their carers and practitioner staff for sharing their experiences and views with us. While there might be some bias to our findings because some people were unable or unwilling to meet with us, we think that our report shows that compulsory community treatment in Scotland works well.

- It appears to reduce the need for long-term treatment in hospital.
- People generally receive good care and support, but physical health needs more attention.
- Practitioners should review orders more frequently and show that they are helping the person to recover to the point where compulsion is no longer necessary.
- More opportunities for meaningful employment (paid or voluntary) would help people in the recovery process.

We hope that service providers use the messages in this report to help people to recover from serious mental illness. Good care, treatment and support must be accompanied by services to improve the person's overall quality of life.

We continue to regard compulsory community treatment as a priority for our attention. We will look further at our findings from this report and our forthcoming work on crisis support and intensive home treatment. As the balance of care continues to move away from hospital and into community settings, we will be an important safeguard in ensuring that people are given the care that meets their needs and respects their rights.

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