Our overview of mental welfare in Scotland 2010-11

mentalwelfare commission for scotland

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

Contents

Annual Monitoring Report 2010-2011

Chief Executive's introduction

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

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

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

Each year, we look closely at how the legislation is being used to provide care, treatment and support for people with mental health problems or learning disability. You can find detailed reports on our website. Here are the most important findings this year.

The Mental Health (Care and Treatment) (Scotland) Act 2003

This year, we found an increase in the number of new episodes of treatment under the 2003 Act. We were notified on 4304 new episodes compared with 4096 the previous year, a 6% increase. This was surprising because the number of new orders had been falling since the 2003 Act came into force.

Overall, the total number of people on long-term orders has not changed much. The number of people subject to long-term community orders continues to rise while the number of orders for treatment in hospital continues to fall. We think this is a good thing, although we have found that more people have been readmitted to hospital from community orders this year.

We found that the use of emergency and short-term detention certificates for people under 18 rose by 50% and 34% respectively, most notably for girls. Many of these young people were detained because of concerns about suicide risk. Publicity about recent suicides of young people may have resulted in practitioners using the Act more if there were concerns about possible suicide. There was a rise in the use of longer term compulsory treatment orders for young people of both genders.

We were pleased to see a drop in admissions of young people to non-specialist wards. These admissions had reduced in most NHS Board areas but had increased significantly in Grampian. The reduction is still a long way short of the commitment of 50% reduction in "Delivering for Mental Health".

We found that black people appear to be more likely to be treated under the Act. Our data on this is incomplete and we are comparing it with 2001 census data. We hope to provide better information in the future.

We look carefully for variations among NHS Boards and local authorities. This year, we found that:

- People in Dumfries and Galloway are more likely to be detained under emergency detention certificates without assessment by both a specialist doctor and specialist social worker. These orders should be used as seldom as possible.
- People in Ayrshire admitted under emergency detention certificates are least likely to have consent from a social work mental health officer (MHO). This is important because the MHO can help to look for ways to support the person without the need for emergency admission.
- People in Glasgow are more likely to be detained under short-term detention certificates. This could be explained by high levels of mental illness in deprived areas and availability of street drugs.
- People in Glasgow are also most likely to receive long-term compulsory treatment. The rate of compulsory treatment is more than double the rate in the Borders.
- Very few people in the Borders receive long-term compulsory treatment in hospital. They are more likely to be treated in the community than people in any other part of Scotland.

The Adults with Incapacity (Scotland) Act 2000

We found a 14% increase in the number of appointments of welfare guardians. The rise is due to the number of private individuals (as opposed to Chief Social Work Officers) appointed as guardians. Over half of these orders were for indefinite periods of time. This means that there is no automatic review by a court or tribunal. These orders may deprive people of their liberty for long periods of time. We are working closely with the Scottish Government and others to examine the human rights implications of indefinite orders.

Other findings on the use of welfare guardianship include:

- Glasgow city has the highest rate of new guardianship orders.
- Dundee City had the highest proportion of indefinite orders.
- The rise in the use of guardianship appears to be mostly for people with dementia.

New Orders Granted in 2010-11

This year, we were notified of 4304 episodes of compulsory treatment during the year. This number had fallen consistently since the 2003 Act was introduced. This is the first time it has risen since the Act was implemented. It is 6% higher than last year and higher than any year since 2006-7.

New episodes of civil compulsory treatment initiated 2006-2011

Episode Sequence	2006-7	2007-8	2008-9	2009-10	2010-11
Emergency detention to informal status	991	916	918	756	875
Emergency detention to short-term detention	1038	992	919	1029	912
Direct to STDC	2217	2152	2211	2201	2409
Direct to CTO* (including interim orders)	133	132	95	83	108
Total episodes	4379	4192	4143	4069	4304

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

NB: these are new episodes only. This does not include EDCs and STDCs for people already subject to community CTOs. The numbers of EDCs and STDCs reported elsewhere in our report are larger because they do include these additional people.

Our interest in these figures

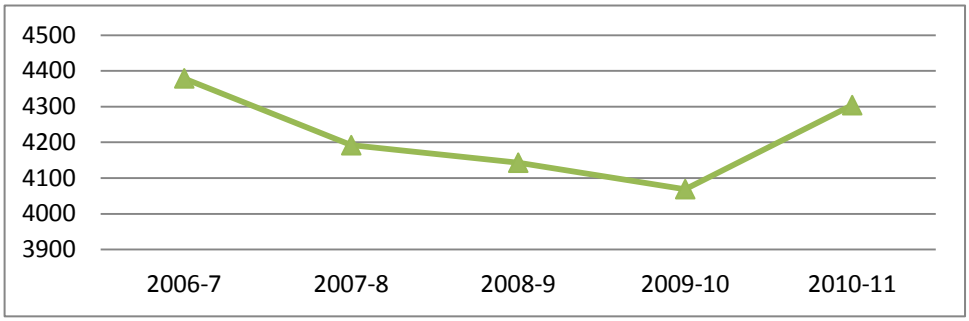
This table shows how people enter a spell of compulsory treatment. We want to see how episodes start and what happens to people after they are first detained. Short-term detention should be the usual route into compulsory treatment. We want to find out whether this is what happens. In previous years,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

We have looked at these trends from the first full year after the implementation of the 2003 Act.

What we found

We were notified of 4304 episodes of compulsory treatment during the year. This number had fallen consistently since the 2003 Act was introduced. This is the first time it has risen since the Act was implemented. It is 6% higher than last year and higher than any year since 2006-7. See figure below.

Figure: New compulsory episodes initiated 2006-11

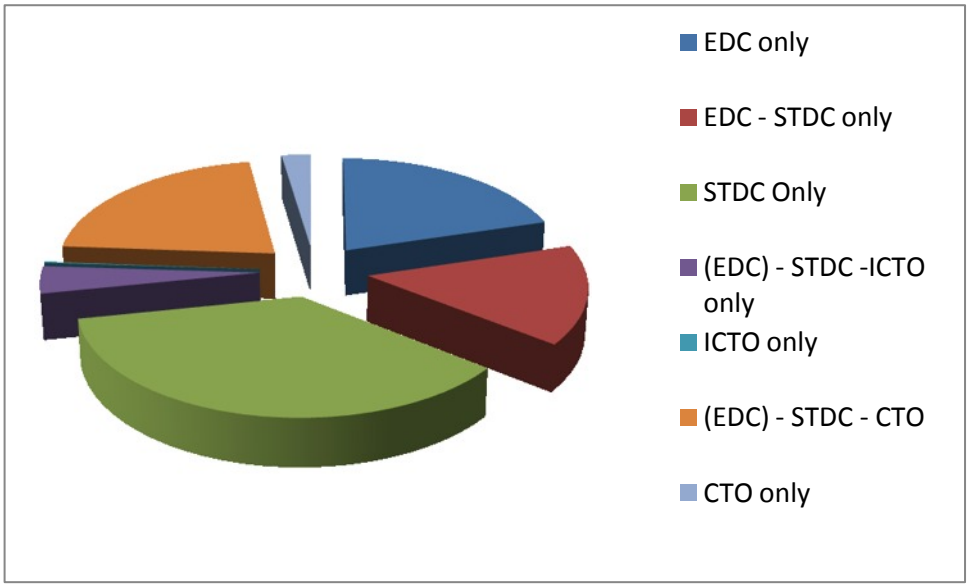


Almost all types of civil compulsory orders rose in 2010-11. The biggest increase was in the use of short-term detention certificates (STDCs). The part of our report on STDCs deals with this in more detail. We were concerned to see a rise in brief episodes of emergency detention. This type of episode had consistently fallen over previous years. We thought that quicker intervention, including crisis services, may have been responsible for the fall. If we were correct, this year's data suggests that crisis support has not been as effective as previously.

We had not expected to find a rise in the use of the Act, given our findings from recent years. We can only speculate on the reasons. Increased availability of street drugs, increased financial hardship and reduction in services due to financial pressures could all be playing a part.

We looked at the types of episodes of compulsory treatment that were initiated during the year. This is shown in figure below

Figure: Types of compulsory episode initiated 2010-11



Findings of note from this chart are:

- Only 24% of all episodes of compulsory treatment result in the granting of a long-term compulsory treatment order
- A further 4% of episodes progress to an interim CTO without a final CTO being granted.
- The remaining 72% or all episodes of compulsory treatment last for 28 days or less.

Where intervention under the civil powers of the Act appears necessary, it is reassuring that almost three-quarters of all people are given compulsory treatment for no more than 28 days.

The pattern of progression through the civil powers of the act is shown in the figure below

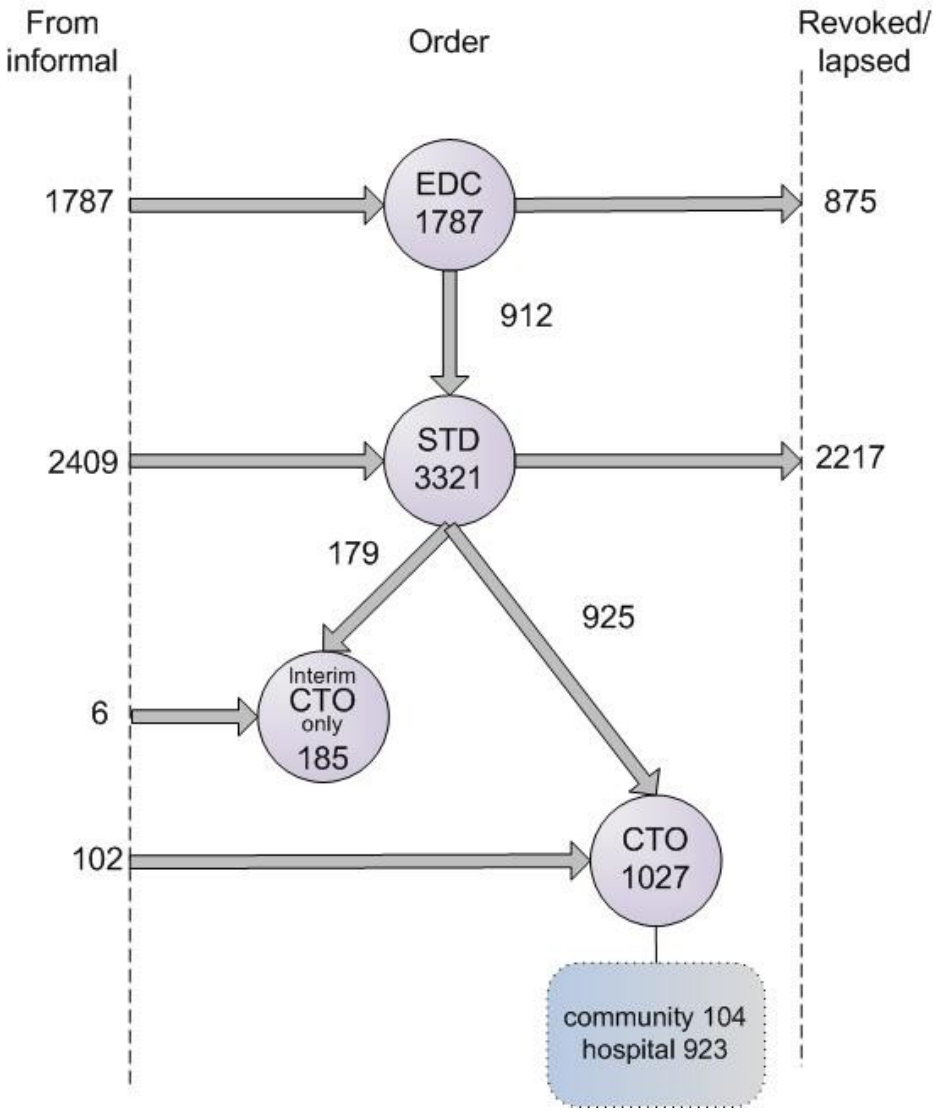


Table 2: Emergency detention by age and gender, 1 April 2010 to 31 March 2011

Age Range	Female	Male	Totals (%)
0-15	8	4	12
16-17	21	13	34
18-24	101	92	193
25-44	364	362	725
45-64	300	235	535
65-84	141	125	266
85+	39	21	60
Totals	**974 (53%)**	**852 (47%)**	**1826 (100%)**

Our interest in this

An emergency detention certificate (EDC) can be issued by any registered medical practitioner. There should be consent from a mental health officer if possible. We collect information on the age and gender of people detained in this way. We look for differences in the way EDCs are used for men and for women and any trends in the use of this power for different age groups. In previous years, we found that the use of EDCs was falling, especially for men. In contrast to the overall fall, the use of EDCs for people over 65 was rising.

What we found

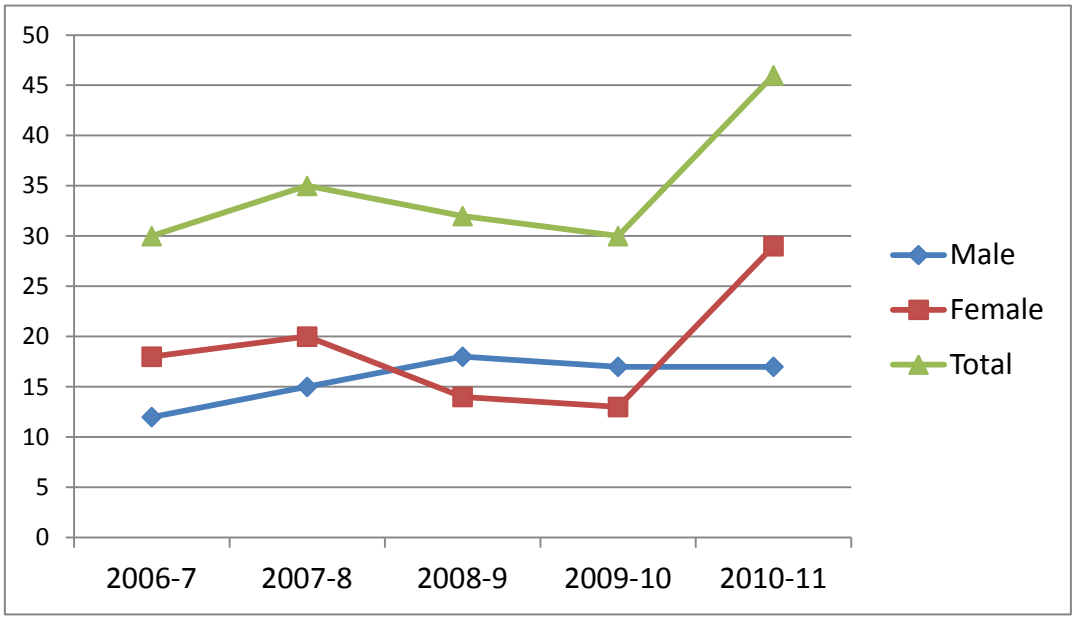
The total number of EDCs was almost the same as last year. This is the first year since the implementation of the 2003 Act that we have not seen a reduction in EDCs. The gender balance is about the same as last year, with more women than men detained under an STDC.

Age

- EDCs for people aged 65 and over fell by 6% this year. We will continue to report on this. There had been previous significant rises in the use of EDCs in this age group.
- There was a 50% increase in the use of EDCs for people under 18. We found 46 young people detained on EDCs this year, compared with 30 last year. This was an unexpected finding.

EDCs should only be used if it is not possible to secure assessments by both an approved medical practitioner and a mental health officer. It is likely to be used in crisis situations. We have found that it is often used for people who are in hospital on an “informal” basis. The rise in their use for young people is concerning. Figure (below) shows the numbers of EDCs for young people for the last five years.

Figure: admissions of young people under emergency detention certificates 2006-11



The rise is accounted for by admissions of females under the age of 18. Of the 45 young people detained under EDCs:

- 16 were detained in hospital in Greater Glasgow and Clyde
- 30 (67%) were already in hospital on an informal basis. This is higher than the figure for all age groups (57%).
- 29 were detained outside office hours
- Only five were detained in specialist units
- Only 19 detentions (42%) had MHO consent. This is lower than the figure for all age groups (62%).
- 29 people (mostly female) were detained because of suicide risk.
- 16 people (mostly male) were detained because of psychotic symptoms
- Two people had learning disability, one of whom also has autistic spectrum disorder. Both were detained because of behaviour that put themselves and others at risk.
- None of the young people detained on EDCs had eating disorders
- Four young people were in care. All of them were detained because of suicidal ideas and had histories of physical and sexual abuse.
- We wondered about the effect of drugs and alcohol. Few of the EDCs mentioned drugs or alcohol as a factor in the causes of the mental disorder.

We can only speculate on the reasons for the increase in the use of the Act for young people. There may be a tendency to detain young people with suicidal ideas, especially following public concern over the suicides of two girls in care. There may be a need to review service provision for young people who harm themselves. We have advised using the Act instead of relying on “parental consent” for young people unwilling to accept mental health treatment. As most of the increase is in 16 and 17-year-old people, this is unlikely to be the explanation for the rise.

Table 3: EDCs with and without MHO consent by NHS Board, 1 April 2010 to 31 March 2011

	No. of EDCs per 100K	% of people in community before detention	No. of EDCs with MHO consent	No. of EDCs without MHO consent	% of EDCs with MHO consent
Ayrshire & Arran	42	27	58	97	37
Borders	19	38	15	6	71
Dumfries & Galloway	62	34	53	39	58
Fife	28	53	86	16	84
Forth Valley	34	47	72	27	73
Grampian	19	64	68	35	66
Greater Glasgow & Clyde	43	39	268	244	52
Highland	48	49	102	47	68
Lanarkshire	38	40	125	86	59
Lothian	29	48	172	68	72
Orkney	5	0	1	0	100
Shetland	0	0	0	0	0
Tayside	35	44	117	23	84
Western Isles	4	0	0	1	0
Scotland	35	**43**	**1137**	**689**	**62**

Our interest in this

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

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

What we found

Of the mainland NHS Boards, Fife and Tayside have high levels of MHO consent. Local authorities in these areas appear to be providing a good MHO service. As with previous years, Ayrshire and Arran, Lanarkshire and Greater Glasgow and Clyde had relatively low rates of MHO consent to emergency detention. We have serious concerns about the very low rate of MHO consent in Ayrshire and Arran. Last year, it had Scotland's lowest rate of MHO consent (42% of all EDCs). This year, only 37% of EDCs in Ayrshire and Arran had MHO consent. This is at least partly explained by the finding that EDCs in this area are used far more often for people already in hospital (73% of all EDCs, compared with the Scottish average of 57%). We know from previous years that, in this situation, it is less likely that there will be MHO consent. The NHS Board should take note of our findings. This year, we are examining the treatment of people detained under EDC after informal admission. We will pay particular attention to this NHS Board area.

Table 4: EDCs by pre-detention status and MH0 consent to detention 1 April 2010 to 31 March 2011

Prior status	Number with consent	Number without consent	Total	% with MHO consent
Informal in hospital	574	454	1028	56%
From community	553	228	781	71%
Total (%)	**1127 (62%)**	**682 (38%)**	**1809 (100%)**	__

Notes: The table excludes 17 cases where there was no information about pre-detention status

Our interest in this

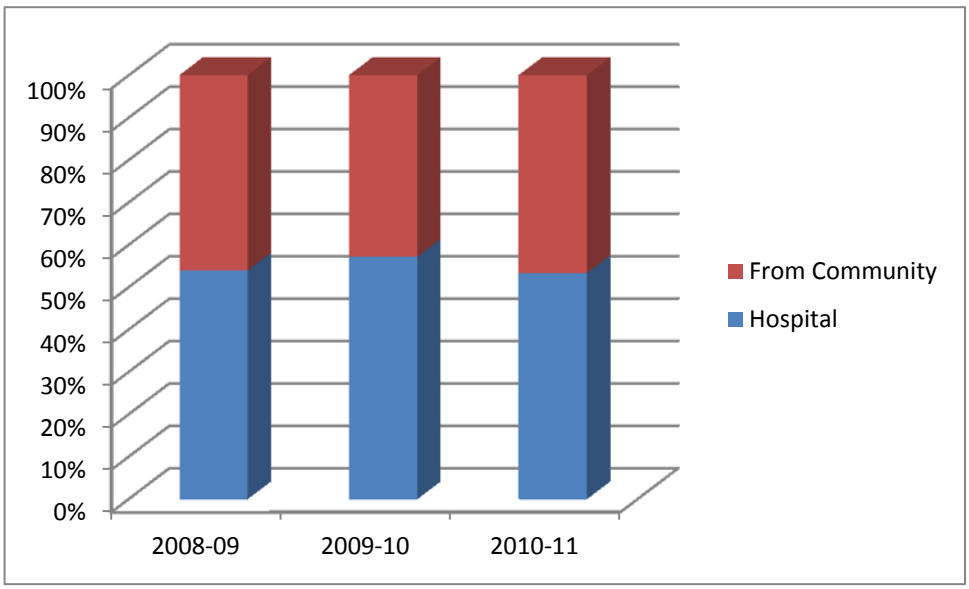
Consent for emergency detentions is very important. We usually find that detention of a person already in hospital is less likely to involve MHO consent. This is probably because the person is stating an immediate wish to leave and the medical practitioner has conducted an examination, decided that the person should be detained but cannot wait for the MHO. We have concerns that people can be detained for up to 72 hours without MHO consent.

What we found

Again, people who were already in hospital were much less likely to have consent from an MHO when detained under EDC. This year, only 56% of these EDCs had MHO consent, compared with 61% last year. This is a significant reduction (p=0.02). We remain concerned about this. We will argue strongly for amendments to the Act to reduce the need for emergency detention and/or make the period of detention without MHO consent shorter.

We looked at the use of EDC for people in hospital versus people in the community over the last three years. We had seen a steady drop in the use of EDCs, but proportionately more of them were for people already in hospital.

EDC for people in hospital versus people in the community 2008-11

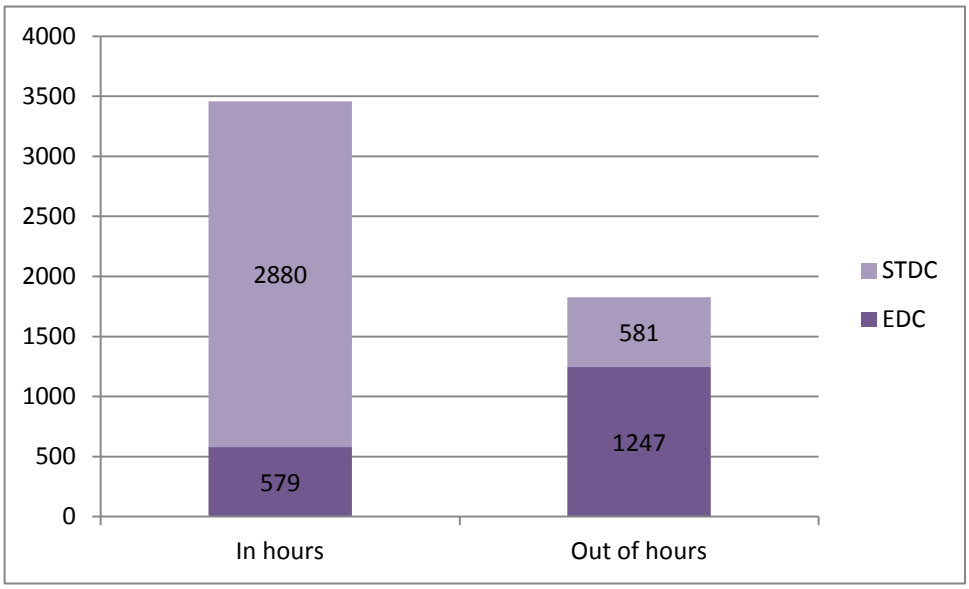


There was no significant change this year. There were more EDCs for people already in hospital, but the excess was less than previous years.

Table 5: EDCs by time of granting of certificate and MHO consent to detention, 1 April 2010 to 31 March 2011

Time of granting of certificate	% of total no. of EDCs	% of total with consent	% of total without consent
Within office hours	32	21	11
Outside office hours	68	41	27

Granting of EDCs vs STDCs, in hours and out of hours



Our interest in this

While short-term detention should be the usual route into compulsory treatment, emergency detention is still used, mostly outside office hours. We think it is important that there is consent from an MHO wherever possible. We want to find out if MHO consent is available outside office hours.

What we found

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

Table 6: Duration of emergency detention certificates granted, 1 April 2010 to 31 March 2011

	Within 24 hours of admission	24-72 hours after admission	Total (%)
EDCs revoked	251	286	537 (30)
EDC superseded by STDC	508	414	922 (51)
Order expired at 72 hours	n/a	n/a	332 (19)
Total (%)	759 (42)	700 (39)	-
Total number of emergency detentions			**1791 (100%)**

Notes – these figures include people admitted while on community-based compulsory orders but exclude 35 people where we have been unable to determine the duration of the EDC.

What we're looking for

Short-term detention should be the usual route for admission to hospital under the Act. This involves mental health specialists – an approved medical practitioner (AMP) and a social work mental health officer (MHO). Emergency detention certificates (EDCs) can be granted for up to 72 hours. An AMP or MHO is not necessarily involved and there is no right of appeal. The Act says that hospital managers should arrange for an AMP to examine the person as soon as possible after admission. We think this should happen within 24 hours. Usually, this should result in a decision to revoke the certificate or to detain the person under a short-term detention certificate. We do not think that the certificate should run for the full 72 hours and then expire. We look at all EDCs and measure the time until they are either superseded or revoked to make sure that there is evidence of early expert assessment. If the person is admitted over a weekend, it might be acceptable for the AMP to assess but not make a decision and wait for the team that knows the person best to assess the person on the Monday. This should only happen occasionally.

Table 7: Short-term detention certificates granted by age and gender, 1 April 2010 to 31 March 2011

Short-term detentions	Female	Male	Totals (%)
0-15	21	14	35 (1)
16-17	34	26	60 (2)
18-24	115	171	286 (8)
25-44	568	645	1213 (35)
45-64	515	447	962 (28)
65-84	405	350	755 (22)
85+	100	50	150 (4)
Totals (%)	**1758 (51%)**	**1703 (49%)**	**3461**

Our interest in this

Short-term detention certificates (STDCs) should be the usual start for an episode of compulsory treatment. An STDC involves examination by an approved medical practitioner (AMP) and consent from a mental health officer (MHO). It can last for up to 28 days. We look at how this power is used for people of different ages and genders to see if there is evidence of unequal treatment. We also compare this data with previous years to see if there are any trends. Last year, we noted a 3% rise in the use of STDCs. We commented on an increase in the use of STDCs in the previous three years for people aged 65 and over.

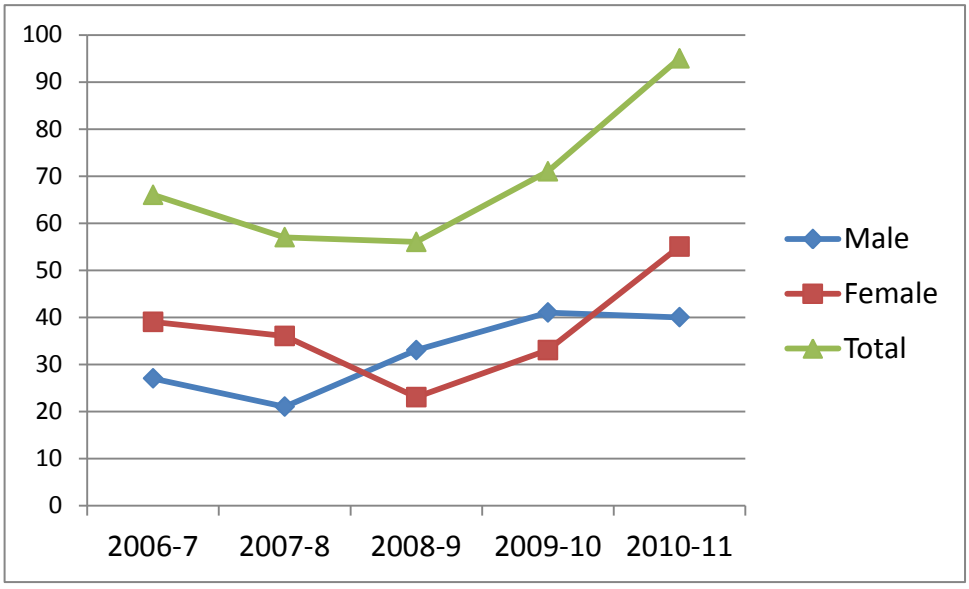
What we found

There has been a further 3% rise in the number of STDCs this year. Compared with 2008-9, there has been a 7% increase in the use of STDCs.

We looked at age and gender.

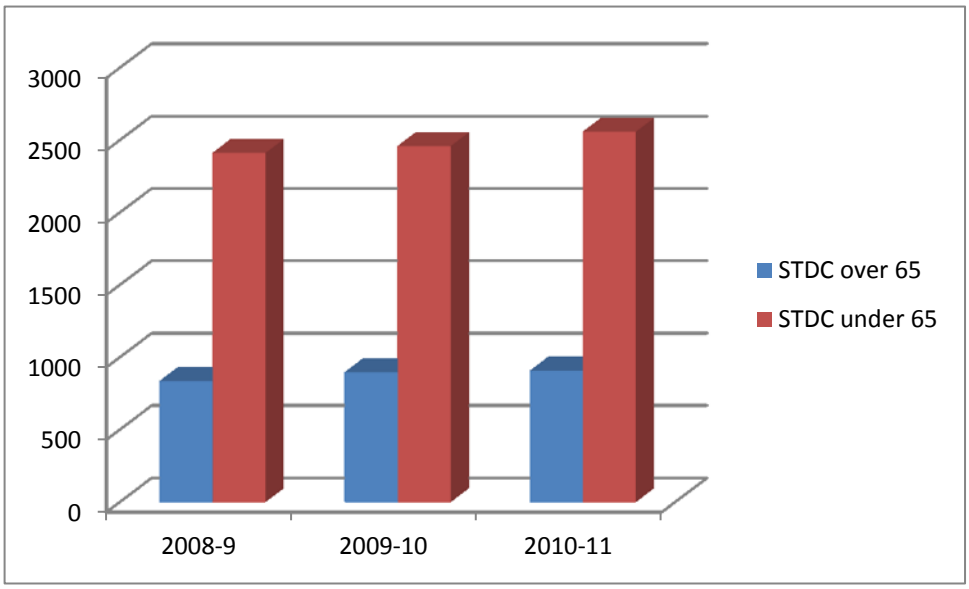
- Unlike previous years, there was no significant increase in the use of STDCs for people over 65 (900 STDCs this year compared with 895 last year).
- In pure numbers, the greatest increase was in people aged 25-54
- Proportionately, the greatest increase was in people under 18. We found 95 young people subject to STDCs in 2010-11. This was a 34% increase on last year and is a much greater number than any year since the 2003 Act was implemented.
- The balance between male and female detentions under STDC is roughly even, but the increase in young people seems to be for females. See figure below.

STDCs for people under 18: 2006-2011



We will continue to monitor the use of STDCs and look further into their use for young people. We considered the possibility that the rise may be due to reductions in community care services as finances become tighter for NHS Boards and, especially, local authorities. If that was the case, we would expect the bigger rises to be among older people and people with learning disability. They will need proportionately more social care support in the community. Unemployment, financial hardship and drug and alcohol consumption could be playing a part in the rise in detentions.

Three year trend in the use of STDC 2008-11 for people under 65 and people 65 and over



Last year, we commented on an increase in STDCs and other orders for people aged 65 and over. We found that more people with dementia were being admitted under compulsory powers. There has been no further significant rise this year, despite a rise in the use of STDCs for other age groups.

Table 11: Compulsory treatment orders granted by age and gender, 1 April 2010 to 31 March 2011

Compulsory treatment orders	Female	Male	Totals	%
1-15 yrs	4	4	8	1
16-17 yrs	14	13	27	3
18-24 yrs	30	66	96	9
25-44 yrs	156	200	356	33
45-64 yrs	153	146	299	28
65-84 yrs	128	108	236	22
85+ yrs	28	14	42	4
Total	**513**	**551**	**1064**	**100**

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

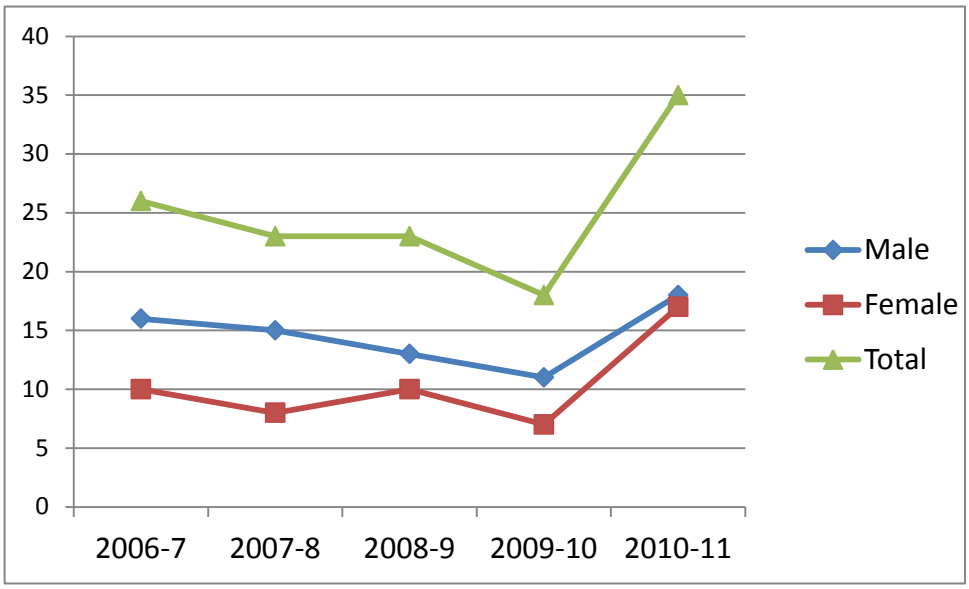
Our interest in this

Compulsory treatment orders are granted by the Mental Health Tribunal. They last for six months, can be extended by the responsible medical officer for a further six months and then extended annually. The Tribunal reviews them at least every two years. Therefore, they can restrict or deprive liberty for long periods of time. We look at how these orders are used for people of different ages and genders to see if there are any trends. Over recent years, the number of new orders has come down. They are usually used more for men than women. We have been examining the use of CTOs for older people as we had seen an increase in their use for people with dementia in previous years.

What we found

- The total number of new CTOs has fallen slightly this year. It appears to fluctuate year by year. There is no overall trend.
- The number of CTOs for older people (65+) has changed little this year, although there was a rise over the previous three years.
- The number of CTOs for young people (under 18), had fallen over previous years but rose sharply this year. We found 35 new orders for young people this year. This is much more than previous years and it mirrors the rise we have found in emergency and short-term detention.
- 52% of all new CTOs were for men and 48% were for women. This was a surprise. In previous years, many more men than women were subject to CTOs. The gap was much narrower this year. The difference from last year (56% were male and 44% female) is probably significant (p=0.02).

CTOs for people under 18: 2006-11



This figure shows a rise in CTOs for males and females under 18. We also found significant rises in the use of emergency and short term detention, although mostly for girls. We will look further into the reasons for this and discuss our findings with the Scottish Government and with specialists in child and adolescent mental health.

Table 12: Pattern of progression to compulsory treatment orders, 1 April 2010 to 31 March 2011

	Interim CTO only	Interim CTO to CTO	Direct to CTO
Total	**185**	**447**	**580**

Our interest in these figures

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

What we found

We have seen a further increase in the proportion of CTOs granted without an interim order. We think this reflects greater efficiency in the Tribunal process. We still think the Act should be amended to reduce further the number of interim hearings.

New Orders Granted – Geographical variations in the use of the Act 2010-11

Number and rate per 100k population of compulsory powers granted, by order type and NHS Board, 1st April 2010 to 31st March 2011

NHS Board	Emergency Detentions	Emergency Detentions Rate per 100k	Short Term Detentions	STDs Rate per 100k
Ayrshire and Arran	155	42	201	55
Borders	21	19	54	48
Dumfries and Galloway (HB)	92	62	109	74
Fife (HB)	102	28	215	59
Forth Valley	99	34	165	56
Grampian	103	19	350	64
Greater Glasgow and Clyde	512	43	964	80

Highland (HB)	149	48	220	71
Lanarkshire	211	38	285	51
Lothian	240	29	601	72
Orkney (HB)	1	5	0	0
Shetland (HB)	0	0	7	31
State	0	0	5	0
Tayside	140	35	281	70
Western Isles	1	4	4	15
SCOTLAND	**1826**	**35**	**3461**	**66**

Our interest in this

Most people who are detained under the Act are held for up to 72 hours (emergency detention) or 28 days (short-term detention). Each year, we look at how these orders are used in different Health Board areas. We always find large variations and causes are not easy to explain. Because people with severe and enduring mental illness tend to live in inner city areas, we usually find detention rates higher in these areas. Emergency detention can be high in rural areas because it is less easy to get an approved medical practitioner and a mental health officer to authorise short-term detention. This does not explain the variations that we see. We are concerned that areas with high use may be intervening excessively where there may be alternatives to depriving people of their liberty. Low use could mean that people are not being adequately treated or protected. It could also mean that people are being persuaded to be in hospital when they want to leave. This can mean they are to all intents “detained” but without the safeguards of the Act.

What we found

We looked at this year’s figures and compared them with the previous three years. Main findings are:

- Dumfries and Galloway has the highest rate of emergency detention for the fourth consecutive year. It is well above the national average and stands out at being much higher than any other mainland NHS Board area. We will specifically discuss this situation with them. We have previously suggested that they examine the availability of approved medical practitioners and crisis services.
- Greater Glasgow and Clyde has the highest rate of short-term detention. The rate has fallen slightly since last year but is still higher than any other NHS Board area. The overall rate of granting of STDCs in Scotland has risen slightly. Grampian and Lanarkshire had the greatest increases.
- Borders and Grampian had very low use of emergency detention. This was similar to last year

- There was less variation in the rate of use of STDCs across Scotland than in previous years. Among mainland NHS Boards, the range was 48 to 80 STDCs per 100,000. Last year, the range was 34 to 84.

The areas we have identified as especially high or low users should consider the reasons for this. We have some thoughts:

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

No. and rate per 100k population of short-term detentions and compulsory treatment orders by local authority, 1st April 2010 to 31st March 2011

Local Authority	Short -Term Detentions	Rate per 100k	CTOs*	Rate per 100k
Aberdeen City	158	73	56	26
Aberdeenshire	138	56	36	15
Angus	39	35	23	21
Argyll and Bute	71	80	11	12
City of Edinburgh	419	86	117	24
Clackmannanshire	22	43	6	12
Dumfries and Galloway (LA)	104	70	23	16
Dundee City	127	88	47	33
East Ayrshire	48	40	21	17
East Dunbartonshire	59	56	2	2
East Lothian	57	58	13	13
East Renfrewshire	50	56	1	1
Eilean Siar	3	11	1	4
ESWS**	2	0	n/a	n/a
Falkirk	78	51	28	18
Fife (LA)	215	59	93	25

Glasgow City	601	101	252	43
Highland (LA)	166	74	68	31
Inverclyde	68	85	4	5
Midlothian	29	36	9	11
Moray	50	57	13	15
North Ayrshire	64	47	9	7
North Lanarkshire	153	47	42	13
not recorded	9	0	n/a	n/q
Orkney	0	0	0	0
Perth and Kinross	118	80	36	24
Renfrewshire	83	49	18	11
Scottish Borders	58	51	14	12
Shetland (LA)	12	54	2	9
South Ayrshire	70	63	24	22
South Lanarkshire	163	52	44	14
Stirling	67	75	13	14
West Dunbartonshire	60	66	6	7
West Lothian	86	50	32	19
WSSS**	14	0	n/a	0
SCOTLAND	**3461**	**66**	**1064**	**20**

***CTO numbers provided in this table are from the MHTS.**

****ESWS and WSSS are out of hours services offered in the East and West of Scotland.**

Our interest in this

Tables above show the variation in civil compulsory orders by local authority area. We also want to look for differences across local authority areas. There are differences and overlaps in boundaries, especially in Glasgow and Lanarkshire. We do not examine figures for emergency detention because so many orders are outside office hours and the MHO may be from a different local authority as part of a regional standby service. For short-term detention and compulsory treatment orders, we usually find that inner city local authorities have highest rates. Some of this data may be skewed by "out-of area" placements (see our comments on NHS Board rates).

What we found

- Glasgow City has a high rate of short-term detention. The high rate in NHS Greater Glasgow and Clyde appears to be due to the high number of STDCs in the Glasgow City area.
- CTO rates are also highest in Glasgow. Dundee City, followed by other inner city areas, also had high use.
- Rural and more affluent areas have low use of mental health legislation. Highland council continues to have an unexpectedly high rate. Argyll and Bute, high last year, has a very low rate of new CTOs this year.

People with severe and enduring mental illness tend to move towards inner city areas. Variation of rates in rural areas may reflect the challenges in providing community services to a scattered population.

Number and rate per 100k population of CTOs granted, 1 April 2010 to 31 March 2011

NHS Board	No. of CTO Orders	Rate per 100 k
Ayrshire and Arran	53	14
Borders	13	12
Dumfries and Galloway	23	16
Fife	93	25
Forth Valley	47	16
Grampian	107	19
Greater Glasgow & Clyde	289	24
Highland	74	24
Lanarkshire	81	14
Lothian	175	21
Orkney	0	0
Shetland	0	0

Tayside	105	26
The State Hospital	2	0
Western Isles	2	8
SCOTLAND	**1064**	**20**

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

Our interest in these figures

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

When we looked at the average over a period of three years, we found that Fife and Tayside has the highest number of new CTOs granted over that time.

What we found

- NHS Borders continues to have low CTO rates, and has the lowest overall rate of use of the Act of all NHS Board areas.
- Tayside and Fife have the highest rates of new CTOs
- Some national or regional services might be skewing some of this data. For example, there are regional medium secure services in Glasgow and Lothian, an independent sector low secure facility in Ayrshire and learning disability facilities in Fife and Tayside that take people from outside their NHS Board area. We think the overall effect is relatively minor but could affect rates in smaller NHS Board areas.

For long-term orders, NHS Boards and local authorities should note our data on new orders but pay greater attention to our section on the total numbers of orders in existence.

The use of nurses holding powers by hospital and gender, 1 April 2010 to 31 March 2011.

Hospital	Female	Male	Totals
Ailsa	1	0	1
Borders general	1	0	1
Borders NHS	1	0	1
Carseview Centre	7	2	9
Crichton Royal	18	5	23
Crosshouse	4	2	6
Dr Grays	2	0	2
Dudhope House	1	0	1
Dykebar	4	2	6
Gartnavel Royal	4	1	5
Graham Anderson House	1	0	1
Hairmyres	0	1	1
Kirklands	0	1	1
Monklands	3	1	4
Murray Royal	2	1	3
Nairn Town and County Hospital	0	1	1
New Craigs	1	1	2
Queen Margaret	5	0	5
Ravenscraig	1	0	1
Royal Cornhill	2	1	3
Royal Liff Dundee	5	0	5
Royal Edinburgh	14	17	31
Seafield	0	1	1
Southern General	1	0	1
St Johns	2	3	5
Stobhill	1	0	1

Stratheden	1	4	5
Strathmartine	0	1	1
Whytemans Brae	3	0	3
Wishaw General	3	0	3
SCOTLAND	**88**	**45**	**133**

Our interest in this

Nurses have the power to detain people in hospital pending medical examination, in situations where that person, or others, may be at risk. This is often described as 'nurses' holding power'. Since the introduction of the 2003 Act we have commented annually on the marked variation in the use of this power across Scotland and the significant difference in the way the power is used with men and women. We looked closely at the figures this year to see if this pattern continued or if there was any change.

What we found

Overall, use of the nurses 'power to detain has dropped since last year's high of 162 reported uses and is lower than the 2008-9 figure of 145.

We continue to find significant variation in the use of this power between hospitals across the country. As in previous years the notifications received from the Royal Edinburgh Hospital indicate a higher use compared to similar urban services. The next highest usage is at the Crichton Royal Hospital. These two hospitals between them represent over 40 % of uses of the power across Scotland.

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

Since we started reporting on the use of this power, its use has been higher for women than for men. One explanation for this may be that nurses are more likely to restrain women. Last year, although the power was still used more with women than with men, we noticed a marked increase in the number of men detained by nurses pending medical examination which contributed to a noticeable overall increase in the total number of people detained by nurses. This year, the ratio of uses with women: men has reverted back to the previously noted pattern of approximately 2:1, with women representing 66% of the total and men 34%. There is no evidence in this year's figures to support any trend towards more equitable use.

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

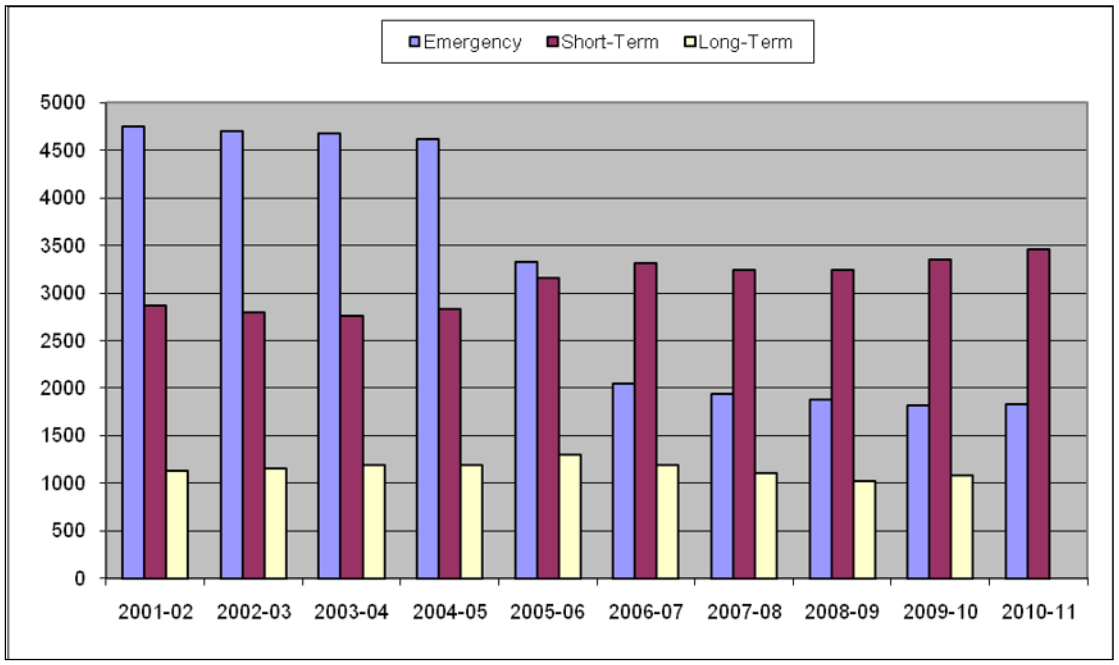
Table 17: Civil compulsory orders granted, 1985 to 2011

	Civil Procedures*		
	Emergency	**Short-Term**	**Long-Term**
1985	3186	1395	349
1986	3224	1531	359
1987	3375	1613	422
1988	3443	1757	569
1989	3061	1601	510
1990	3271	1611	494
1991	3614	1927	664
1992	3632	1972	727
1992-93	3733	2080	745
1993-94	3696	2134	823
1994-95	3670	2197	877
1995-96	4149	2398	886
1996-97	4116	2416	887
1997-98	4333	2527	970
1998-99	4356	2566	1054
1999-00	4284	2500	1011
2000-01	4288	2597	1080
2001-02	4749	2872	1135
2002-03	4697	2795	1161

2003-04	4682	2763	1192
2004-05	4621	2834	1188
2005-06	3330	3158	1297
2006-07	2045	3313	1091
2007-08	1934	3242	1105*
2008-09	1880	3244	1023*
2009-10	1822	3352	1085*
2010-11	1826	3461	1064*

*MHTS figure

Figure - 10 year trend in civil orders granted



Our interest in these figures

We look at how the main civil compulsory orders in Scotland have been used over time. Over the years, we found an increasing use of long-term compulsory treatment. This was similar to other western European countries. This trend has not continued under the 2003 Act. Emergency detention

has been falling, accompanied by an initial rise in short-term detention. We wanted to see whether these trends continued.

What we found

Main findings are:

- The use of emergency detention has not fallen this year. Again, the use of emergency detention for people already in hospital is high. We think that an amendment to the Act to encourage greater use of the nurses' power to detain would reduce the number of emergency detentions
- Short-term detention rates have gone up since the 2003 Act was introduced (midway through 2005-06). The rate of use has risen for the second consecutive year and is now at its highest ever rate. We continue to remind psychiatrists to review these orders frequently, especially during the first few days.
- The number of new long-term detention orders has fallen since the 2003 Act came into force. There has been some fluctuation since 2006-7 but no overall change.

Elsewhere in our report, we comment on an increase in the use of the Act for people under 18. We also found that the number of new episodes of compulsion has risen for the first time since the 2003 Act came into force. Data can vary from year to year, so we will examine the rate of new orders next year to see if there is a further increase.

Compulsory treatment under criminal procedures

1st April 2010 to 31st March 2011

Number of orders granted by order type, 2009/10 and 2010/11

	No. of orders	
Order Type	2010/11	2009/10
Assessment order (CPSA 52D)	139	130
Treatment order (CPSA 52M)	61	78
Interim compulsion order (CPSA 53)	17	12
Temporary compulsion order (CPSA 54(1)(c)	13	10
Compulsion order (CPSA 57A (2))	52	45
Compulsion order (CPSA 57A (2)) Community	1	1
Compulsion order (CPSA 57(2)(a))	8	10
Compulsion order (CPSA 57(2)(a)) - Community	1	0

CORO** (CPSA 57A + 59)	3	11
CORO (CPSA 57(2)(b))	0	0
Transfer for treatment direction (MHSA (2003)*** 136)	30	31
Hospital direction (CPSA 59A)	1	0

Our interest in this

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

What we have found

Episodes of compulsion under criminal proceedings, by age and gender, 2010-11

Age Range	Female	Male	Totals
01-15	0	0	0
16-17	0	1	1
18-24	2	37	39
25-44	37	159	196
45-64	21	60	81
65-84	0	8	8
85+	0	1	1
Totals (%)	60 (18%)	266 (82%)	326 (100%)

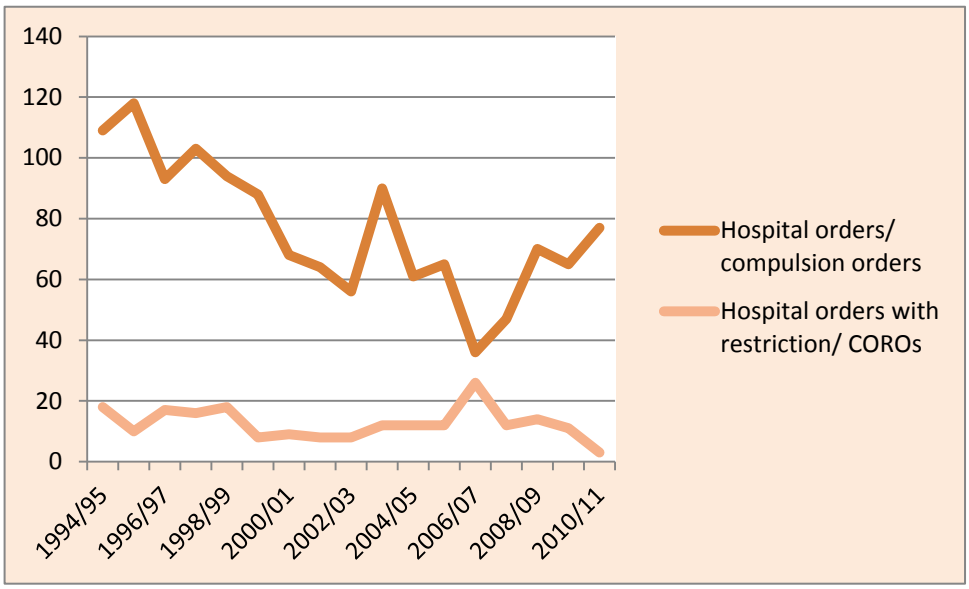
The use of CPSA orders continues to be stable with only small variations within order types. Gender differences remain the same with many more men than women being dealt with under CPSA, and the age peaking between 25 and 44.

A small number of people were placed on community orders either directly or as a result of variation from hospital based orders.

The implementation of the new Community Payback Orders may result in a reduction in the number of people placed on Community Compulsion Orders however numbers are so small that it is not possible to make any comment on this at the moment.

The Commission will only be advised about people on Community Payback Orders if there are significant concerns about their mental health.

Criminal proceeding trends in Scotland, 1994/95 to 2010/11



Length of compulsory treatment is longer for people who are on CPSA orders when compared with those on civil MHA orders. More people are subject to compulsory treatment for more than 10 years under CPSA.

Number of Civil Compulsory Treatment Orders current in 2010-11 by length of order.

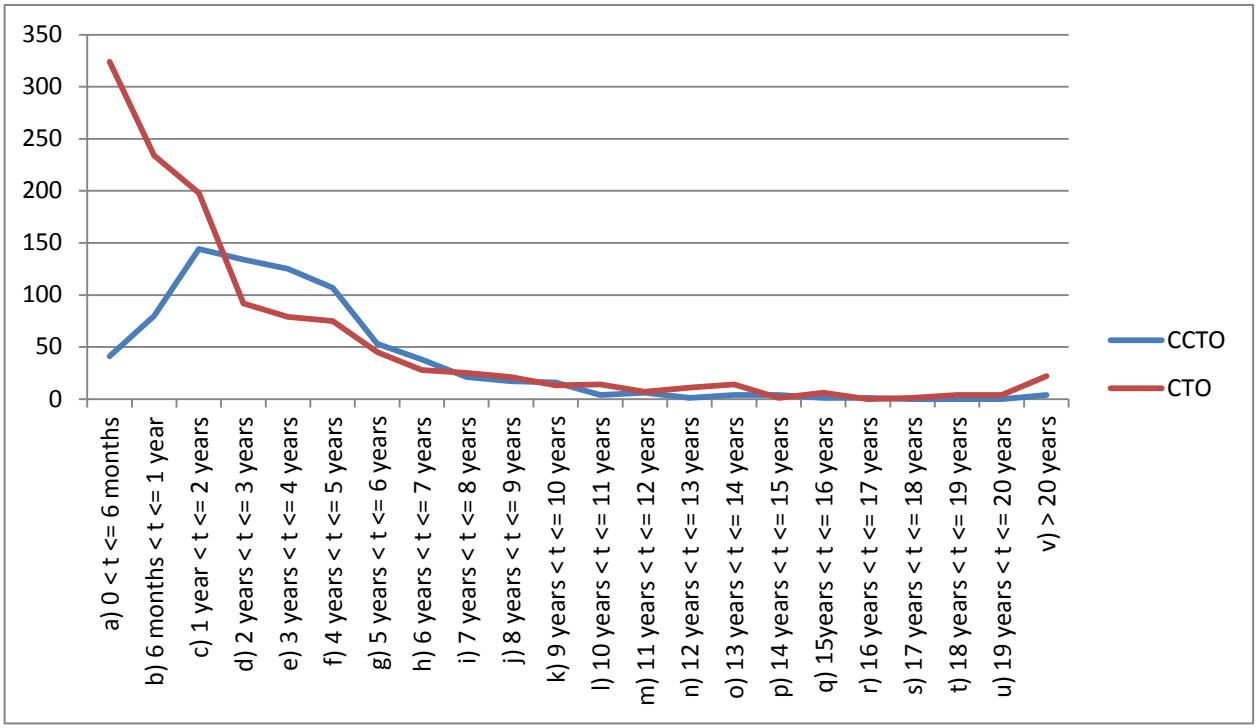


Figure created, July 2011

Number of Criminal Procedures Scotland Act (CPSA) orders current in 2010-11 by length of order

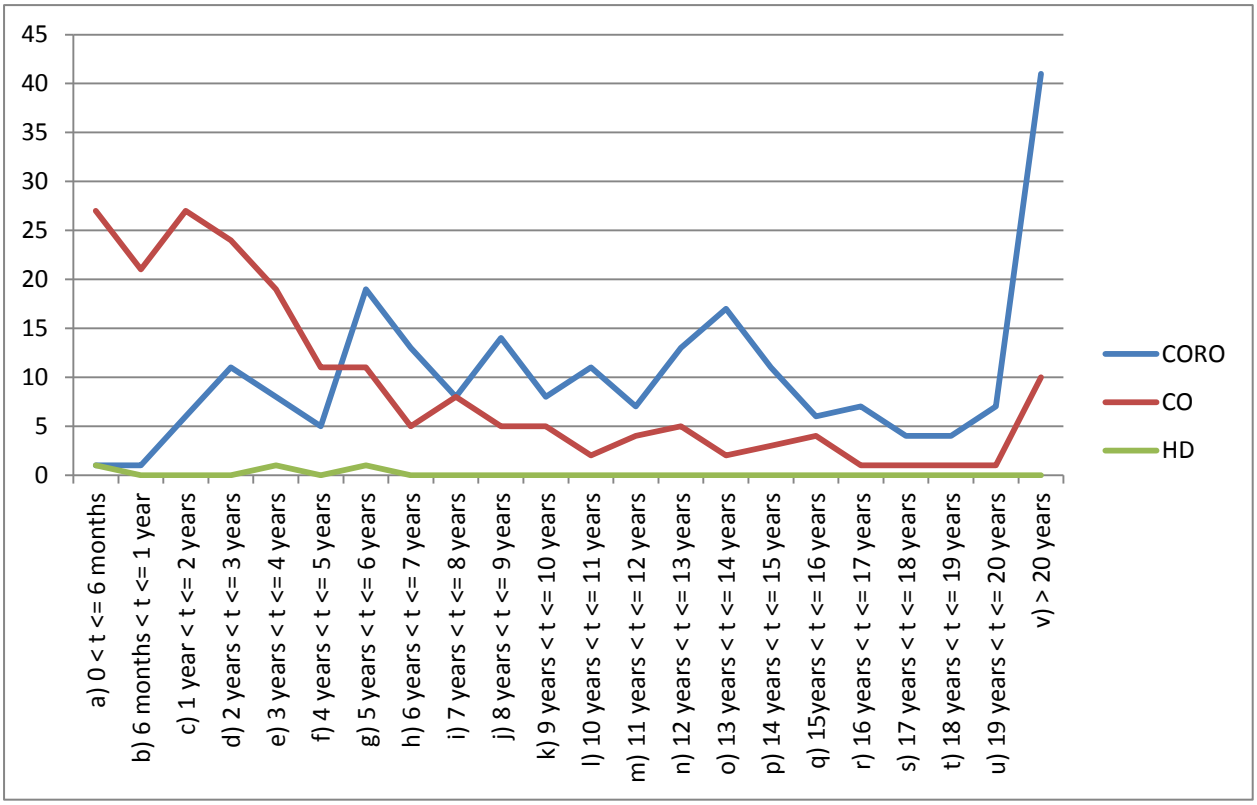


Figure created, July 2011

Point prevalence: the total number of orders in existence

This section of our report deals with the "prevalence" of orders under the Mental Health (Care & Treatment) Scotland Act 2003.

For long term orders, this can be more meaningful than looking at new orders. We have worked hard over the last year to improve our knowledge of all long-term orders and have revised previous years' data to give an accurate picture of how the new Act has been used since its introduction.

We found that, after an initial fall, the number of people on long-term compulsory orders has risen to the same level as the previous Act. The big difference is that a third of people are now treated outside hospital. The number of people on criminal procedure orders has stayed stable over this time.

Point prevalence

Total number of orders in existence

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

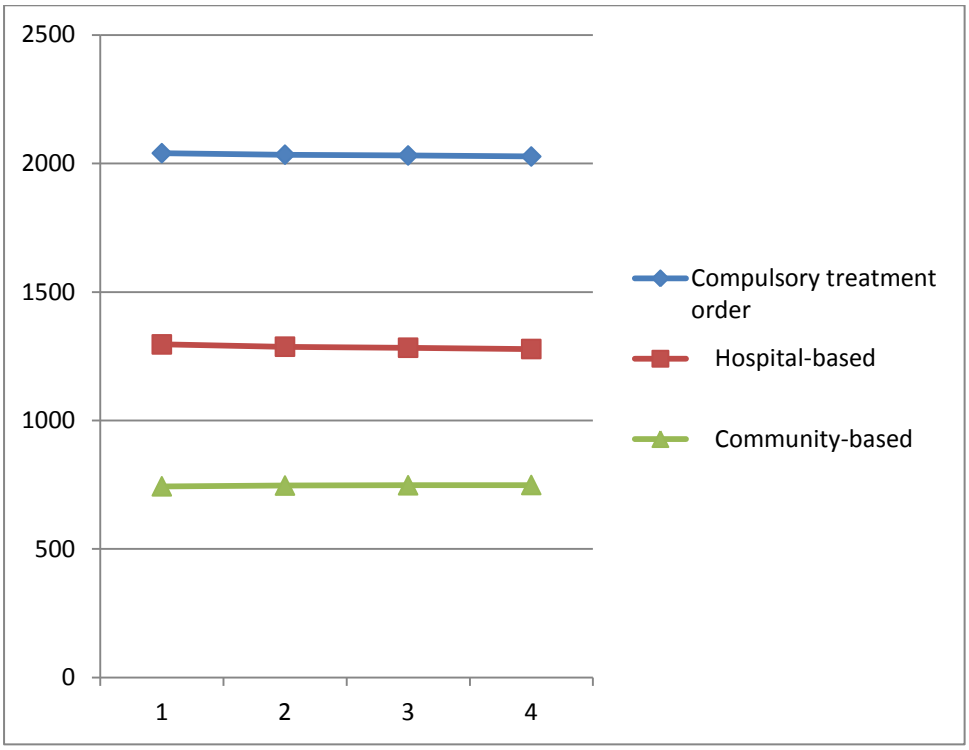
Number of people subject to compulsory powers by type at quarterly census dates, 2010-11

Order	April Quarter 1 2010	Jul Quarter 2 2010	Oct Quarter 3 2010	Jan Quarter 4 2011
Emergency detention	5	11	13	17
Short-term detention	237	244	239	211
Interim compulsory treatment order	54	45	47	38
Compulsory treatment order	**2040**	**2034**	**2031**	**2027**
Hospital-based	1296	1287	1283	1278
Community-based	744	747	748	749
Assessment order	12	14	9	5
Treatment order	11	7	12	13
Interim compulsion order	4	4	5	4
Compulsion order	190	189	193	195
Compulsion order with restriction order	239	233	231	227
Transfer for treatment direction**	58	56	62	55
Hospital direction**	2	2	2	3
Remand in custody or on bail for enquiry into mental condition	0	0	0	0
Probation order requiring treatment (s230)	0	0	0	0
Temporary compulsion order	0	0	0	2
Indeterminate status*	16	16	19	10

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

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

Point prevalence of compulsory treatment orders on four quarterly dates 2010-11



Our interest in these figures

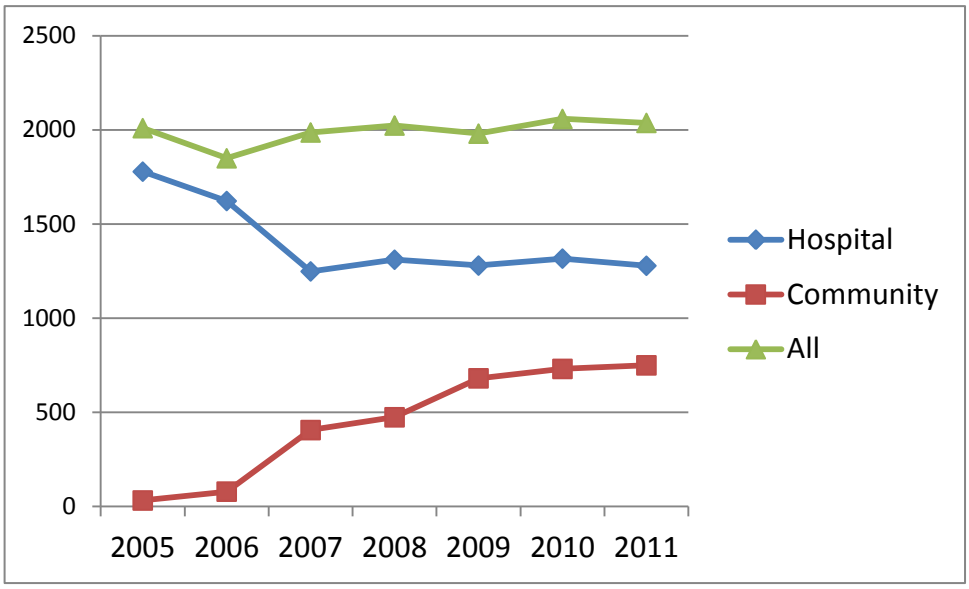
Here we show all the orders that are in force on four dates throughout the year. This is known as "point-prevalence" data. We think this is very important information, especially for long-term orders. It helps us to see how community compulsory treatment is used over time. We thought the numbers of people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

What we found

There are around 2000 CTOs in existence at any one time. Over a third of them are for people in the community. We reported on the care and treatment of people subject to "community" CTOs this year. Care and treatment was generally good. We thought that responsible medical officers should review orders more often and have a clear plan for working towards revoking the order. The lack of paid and voluntary employment were concerns.

We looked back at the use of CTOs since the 2003 Act was implemented.

Point prevalence of compulsory treatment orders 2005-2011



Note: in 2008, we implemented new systems for orders 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.

We found that around 2000 people were subject to CTOs (from long term "section 18" detention under the 1984 Act) in October 2005. There was a fall in the first year. Orders were not extended properly because clinician did not understand the review procedures. Since then, the total number has returned to around the previous level. People are more likely to be treated in the community than they were six years ago. This is in line with the principle of least restriction of freedom. There has been no significant rise in the total number of orders in place.

Number of people subject to compulsory powers on 5 January 2011, rate per 100,000, by NHS Board in rank order.

NHS Board	Rate per 100K population
Greater Glasgow & Clyde	59
Tayside	56
Highland	56
Lothian	55
Ayrshire and Arran	47
Fife	44
Forth Valley	43
Grampian	41
Dumfries and Galloway	35
Lanarkshire	30
Borders	26
Shetland	11
Western Isles	9
Scotland	**49**

These figures have been calculated including indeterminate orders.

Population used for calculation is over 16s by Health Board area.

Our interest in these figures

We comment on the number of new orders in different NHS Board areas in other parts of this report. This table shows the total number of people in each area who are subject to compulsory treatment on one date during the year. This is shown per 100,000 people. In our experience, this is a good guide to the overall use of compulsion in each NHS Board area. We look to see which are the highest and lowest areas and try to explain the differences. Factors which appear to affect use are:

- Urban versus rural populations

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

What we found

- The high numbers of new orders in Greater Glasgow and Clyde is also reflected in the number of total orders in existence. This area has the highest overall use of the Act in Scotland. It is a large area and some parts have significant deprivation and high rates of drug and alcohol use.
- NHS Borders has the lowest number of orders in existence this year. We also found the numbers of new order in the Borders to be low. Lanarkshire, always an area of low prevalence, is second lowest.

Our monitoring priorities

Each year, we decide on priorities for monitoring the Mental Health (Care & Treatment) (Scotland) Act 2003. We consult with stakeholders to help us identify these priorities. We also build on our findings from previous years and other parts of our programme, for example visits to services and calls to our advice and information service.

Care and treatment of children and young people under 18

Table 28: Young people (under 18) admitted to non-specialist facilities,

1 April 2010 to 31 March 2011

	2010-11	2009-10	2008-09
No. of admissions to non-specialist inpatient settings	151	184	149
No. of young people involved	128	147	138
No. of admissions where further Information was provided to MWC	135	168	139
No. of young people involved	115	140	131

Our interest in these figures

Monitoring the admission of young people to non-specialist settings such as adult and paediatric wards, for the treatment of mental illness, has been one of our monitoring priorities since the Mental Health (Care and Treatment) Act 2003 came into force. We have raised concerns about the number of admissions for several years. We are therefore pleased this year to see a marked drop in these admissions across the country. This will go some way towards reaching the aspiration of reducing admissions set by the Scottish Government. We have noted the increase in community teams in some areas and improvements to how admissions are supported by child and adolescent

clinicians in the non specialist areas which we see as having an impact on the numbers and length of stay of young people's admissions to non specialist settings.

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

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

What we found

The figures in the table above show that in 2010-11 we were notified of 151 admissions, involving 128 young people. These figures compare with 184 admissions, involving 147 young people, in 2009-10.

As mentioned in previous reports we anticipated last year that NHS Boards would experience difficulties meeting the commitment to reduce admissions by 50% by 2009, as last year's figures had increased slightly compared to 2007-8. The figures for 2009-10 increased again, significantly more than they did in 2008-9, and we were concerned about this. However we are pleased to see a decrease this year of 18 %. We continue to be concerned about the number of repeat admissions whilst acknowledging this has also decreased this year. The total number of young people admitted has dropped by 19 with15% of the admissions involving young people who were admitted more than once in the year compared to 20% in 2009-10. From the additional information gathered in the 135 returned questionnaires we received we can see that there are only a small proportion of admissions, 16, where social reasons and alcohol intoxication formed part of the reason for admission.

Table 29: Young people admitted to non-specialist facilities by NHS Board between April 2010 and March 2011

	2010 - 2011		2009 - 2010	
Health Board	No. of Admissions	No of young people involved	No. of Admissions	No of young people involved
Ayrshire and Arran	18	16	40	26
Borders	4	3	3	3
Dumfries and Galloway (HB)	10	7	9	4
Eilean Siar	0	0	0	0
Fife (HB)	6	6	6	5
Forth Valley	5	5	7	7
Grampian	30	23	13	12
Greater Glasgow and Clyde	34	28	41	29
Highland (HB)	7	7	7	5
Lanarkshire	29	25	30	25
Lothian	4	4	20	18
Orkney	0	0	0	0
Shetland	0	0	0	0
State	0	0	0	0
Tayside	4	4	8	6
Scotland	151	128	184	140

Our interest in these figures

Our view is that when a young person needs in-patient treatment their individual clinical needs should be paramount. In comparing admissions to non-specialist facilities by NHS Board area we are

looking to see whether there have been significant changes in the number of admissions within a specific area compared to figures from the previous year. In this year's figures we are also identifying not only the number of admissions in each area but the number of young people involved,.

The 2003 Act is clear that the specific duty on NHS Boards to provide sufficient services for young people continues to their 18th birthday. We are aware that child and adolescent (CAMH) services are configured differently and have different eligibility criteria in different areas. We highlighted this issue in our published report on the themed visit we undertook in 2009 to look at CAMH services, and we recommended there that all Health Boards should provide CAMH services to young people up to their 18th birthday, unless clinical need indicates otherwise in a particular case. We are also aware that CAMH services are making strenuous efforts to admit under-16s to specialist facilities, and that work is currently in progress nationally to develop agreed criteria for the admission to and discharge from specialist in-patient units. We would hope that when these admission criteria are in place this will impact on the numbers of admissions to non-specialist facilities.

What we found

Figures in the table above compare admissions in 2009-10 and 2010-11 by NHS Board area. In the majority of areas the number of admissions has been static or has reduced slightly. In Forth Valley there was a very small decrease, and in Dumfries and Galloway a small increase in admissions. There have been more significant decreases though in two board areas, in NHS Ayrshire and Arran, and NHS Lothian, with a significant increase in admissions in NHS Grampian.

In NHS Lothian there was an overall decrease of 16 admissions to 4. Of the 4 admissions 3 were 17 years old and 1 was under 16 years old. In all 4 admissions the psychiatrist in charge of the young person's care was a specialist in child and adolescent psychiatry with clear liaison between the adult and adolescent services noted. In one instance the young person was voicing suicidal ideation. We were informed in one admission there was no CAMHS bed available but the young person was supported to attend the specialist in-patient unit daily. We are aware that the in-patient unit for young people in NHS Lothian has undergone a review on how the young person's journey through the service is supported and managed along with an increase in community teams. We think this is having a positive impact on admissions to non specialist areas.

In Ayrshire and Arran there has been a marked drop in numbers of young people admitted to adult wards, from 40 in 2009-10, to 18 in 2010-11, involving 16 young people, compared with 26 the previous year. We know that NHS Ayrshire and Arran had been concerned about the relatively high number of young people in their area who were being admitted to adult wards, and had been seeking particularly to address work towards enhancing community supports for young people in crisis, and we encourage them in these efforts. The issue of self-harming ideation/actions in the context of alcohol or drug misuse, continues to cause concern, and again we encourage them in ongoing work on these issues with local authority partners. There are ongoing discussions about access to the regional specialist in-patient unit, and although we have been told that overall there has been progress, there has been concern about the admission of a small number of younger young people to an adult ward because the regional unit could not take them in the necessary timescale

There has been a significant increase in admissions in the NHS Grampian area in 2010/11. We are aware that local services have looked closely at this situation, and that there are no obvious significant factors influencing what is happening there. We have also looked closely at the monitoring information we have received, and can see that in almost all cases the individual young people have been acutely mentally unwell, and that a period of in-patient care and treatment has seemed very necessary. We can also see that considerable efforts have been made by local services to provide age appropriate services within the adult wards in Grampian. A CAMS psychiatrist will always be the RMO, and other CAMHS professionals are providing significant input into the adult ward. NHS Grampian has also designated a specific adult admission ward for admissions of young people, and has established a dedicated nursing team within that ward to provide nursing care to young people who have been admitted. We welcome these local responses, and think that they will help to ensure that the specific needs of young people who are in an adult ward will be addressed.

Table 30: Specialist health care for admissions of young people in non-specialist care, 1 April 2010 to 31 March 2011

Specialist medical provision	Age 0-15	Age 16-17	All	% of young people
RMO at admission was a child and adolescent specialist	23	38	61	**45%**
Nursing staff with experience of working with young people were available to work directly with the young person	16	44	60	**44%**
Nursing staff with experience of working with young people were available to provide advice to ward staff	26	72	98	**73%**
The young person had access to other age appropriate therapeutic input	13	39	52	**39%**
None of the above	1	23	24	**18%**

Percentages in the final column are based on all admissions where further information was provided to the Commission =135

Our interest in these figures

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

We specifically want to see whether specialist CAM service input is available, to ensure that appropriate care and treatment is being provided to the young person, and that relevant guidance and support is available for staff in non-specialist units who will rarely have experience of providing treatment and support to young people. Our interest in this issue has also been heightened as a result of the CAMHS themed visit we undertook in 2009 (the report of this themed visit has been published and is on our web-site) We were made aware in the course of this visit that access to specialist CAMH services when a young person is admitted to an adult ward varies across the country, with staff in several adult wards reporting a very limited access to CAMH support during admissions.

What we found

In 45% of admissions the RMO at the point of admission was a child and adolescent specialist a 20% increase from last year. In 44% of admissions nurses with experience in the field were available to work directly with the young person and in 73% of admissions nurses with relevant experience were available to provide advice to ward staff. This demonstrates an increase in nursing availability in both instances from last year which we welcome.

The number of cases where the RMO at admission is a child and adolescent specialist has increased following a drop last year. We are pleased to see that in many cases specialist child and adolescent consultants continue to provide advice and support during admissions. However we would hope that as increases to CAMHS workforce numbers occur that CAMHS clinicians will be more available to support non specialist services and child and adolescent specialist RMOs will be able to take on these patients from admission.

Table 31: Social work provision for admissions of young people to non-specialist care, 1 April 2010 to 31 March 2011

Social work provision	Age 0-15	Age 16-17	All	% of young people
Young person has an allocated social worker	22	56	78	**58%**
If no allocated social worker, had access to a social worker.	3	39	42	**31%**
Neither of the above	4	6	10	**7%**

Percentages in the final column are based on all admissions where further information was provided to the Commission =135

Our interest in these figures

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

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

What we found

Compared to the figures for previous years a significantly higher proportion of young people had an allocated social worker at the time of admission (58% compared to 49% in 2009/10 and 44% in 2008/9) A smaller number of young people, who had no social worker prior to admission, had access to a social worker after admission (42, compared to 67 in 2008/9) but there has been an overall reduction in the number and proportion of young people who had no social worker when admitted, and no access to a worker during admission – only 10 young people (7%) came into this category in 2010/11, compared to 22 (13%) in 2009/10. We hope that this indicates that more integrated approaches to providing care and support are continuing to be developed across the country, when young people are becoming in-patients and when discharges are being planned.

32: **Supervision of young people admitted to non-specialist care**,

1 April 2010 to 31 March 2011

Supervision arrangements	Age 0-15	Age 16-17	All	% of admissions
Transferred to an IPCU or locked ward during the admission	6	16	22	16%
Accommodated in a single room throughout the admission	32	79	111	82%
Nursed under constant observation	30	72	102	76%

Percentages in the final column are based on all admissions where further information was provided to the Commission =135

Our interest in these figures

We ask for specific information about the supervision arrangements for young people admitted to non-specialist facilities to enable us to monitor whether the need for heightened observation is being carefully considered. We also use this information to help us decide if we want to arrange to visit a young person. We will arrange a visit if the young person is particularly vulnerable, to look at the care and support arrangements in place.

What we found

There was a slight increase in the proportion of young people transferred to IPCU or locked ward last year (16% compared with 14% in 2009-10 and 17% in 2008-9), although the actual number was slightly less than in the previous year. Again, a high proportion were accommodated in single rooms (86%) and significantly more were nursed under constant observation (76%, up 13% on 2009-10)

We said in our last report that we hoped the increased use of single rooms and enhanced observation reflects a recognition that young people can be very vulnerable in an adult ward, and that risks and vulnerability are being carefully assessed and managed. This remains our position. However, we also recognise – because young people tell us this – that being nursed in a single room, on constant observations, often in isolation from other patients, and excluded from ward activities as a consequence, can be a lonely and boring experience, and may be perceived as punitive. So, while we welcome evidence that risk and vulnerability are being managed and assessed, it is essential that efforts are also made to mitigate against these adverse consequences. CAMHS input, and the expertise and contacts that can be built up when there is an identified adult ward which is used for young persons' admissions may be particularly helpful in this.

Table 33: Other care provision for young people, 1 April 2010 to 31 March 2011

Other provision	Age 0-15	Age 16-17	All	% of all admissions
Access to age appropriate recreational activities	14	46	60	**44%**
Access to education was discussed	13	35	48	**36%**
Access to advocacy service	25	85	110	**81%**
Young person has a learning disability	3	7	10	**7%**

Percentages in the final column are based on all admissions where further information was provided to the Commission =135

Our interest in these figures

We ask for further information about access to other provisions to give us a clearer picture of how NHS Boards are fulfilling their duty to provide age appropriate services.

We are aware that because a large proportion of admissions are for very short periods of time access to appropriate recreational activities and education may not be significant for many young people. We want to know if independent advocacy services are readily available, given the important role advocacy can play in ensuring that any patient's views are heard.

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

What we found

The information provided indicates a lower proportion of young people having access to age appropriate activities than in 2009/10 (44% compared to 51%), and almost the same proportion having access to advocacy services (81% compared to 80%) We welcome the availability of advocacy, although it is still concerning if all young people are not reported as having access to advocacy during their admission. We also understand that for many admissions, which are very brief, access to age appropriate recreational activities may not be relevant. We also appreciate that there may be a lack of clarity about what constitutes age appropriate recreational activities, and that this may be reflected in the information collected by our monitoring forms. Where beds have been designated in specific adult wards for the admission of young people we have seen examples of considerable attention being paid to providing age appropriate activities.

From the information provided access to education was discussed less frequently in 2010/11 than in the previous year (in 48 cases as opposed to 61 cases in 2009/10) It may not have been appropriate to discuss access to education if an admission was for a very short period of time. We have concerns though that in certain situations it clearly would have been appropriate to consider issues about access to education, when a young person was in a non-specialist facility. We have made a specific recommendation about this issue in our themed visit report mentioned above, and we remain concerned that in the absence of specialist CAMHS or social work input staff in adult wards will not know how to access education services if this is appropriate while a young person is in hospital. We have also started to ask for more specific details about how this issue is being addressed in our monitoring forms so that we will be gathering better and more consistent information about education provision in the future.

Table 33b: Age of young person by gender, 1 April 2010 to 31 March 2011

Age in years at last birthday	Gender		Total
	F	M	
12	0	0	0
13	2	2	4
14	9	3	12
15	9	7	16
16	22	16	38
17	37	28	65
Total	**79**	**56**	**135**

Percentages in the final column are based on all admissions where further information was provided to the Commission =135

Our interest in these figures

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

What we found

The data on the admission of young people to non-specialist wards had over the previous three years had shown that mental health services have been treating young men and young women differently, with the number of admissions for young men going up, while admissions of young women was decreasing. We looked at some possible reasons for this last year, suggesting that young women may be more likely to be admitted on an arranged basis, often for treatment of eating disorders, whereas young men may be more likely to need urgent admission for other mental health problems when arranging a specialist placement is more difficult. We also suggested that there may be a tendency to regard 17 year old males as less suitable for an adolescent mental health ward.

This year, we found a drop in admissions of young males to non-specialist facilities. It appears that there is more equitable access for young males and females to specialist facilities. It may be that

services have taken action on the basis of our concerns about young males. We will continue to report on the gender balance of admissions to non-specialist units.

Analysis of notifications of treatment that is in conflict with an advance statement, 1 April 2010 to 31 March 2011.

	2010-11	2009-10	2008-09
Number of notifications	**33**	52	27
Actual overrides	**18**	29	13
Refusal of depot injection	9	16	4
Refusal of any medication	3	5	1
Refusal of ECT	2	1	1
Request for one specific medication	4	7	7

Our interest in this

Advance statements are one of the ways of increasing patient participation in their care and treatment. Whilst we do not know how many advance statement have been made, we must be informed when one is overridden. It is important to understand the circumstances where an advance statement is overridden so when we are notified of a potential override we make inquiries to ascertain whether or not it is a genuine override, and if so, what steps have been taken to discuss this with the person concerned.

What we found

We were notified of 33 possible overrides this year of which 18 were actual overrides. This is a reduction on last year, both in the number of actual overrides but also in the number of potential overrides. There were far fewer errors of notification. For a small number of people, their advance statement is notified as overridden on each occasion that their compulsory treatment order is extended or otherwise reviewed by the Tribunal. Where advance statements refer to medication and the individual is clearly consenting to the treatment we encourage them to review their advance statements, when they are able, to take account of their changed circumstances.

Of the genuine overrides, half related to depot medication, where the advance statement indicated a wish for oral medication only.

As we noted last year, some “advance statements” had been made by the person at the time of their Tribunal hearing. Whilst these can and should be regarded as contemporaneous statements regarding current or proposed treatment; and may be appropriate advance statements at some point in the future, they cannot be regarded as advance statements at the time of the Tribunal. This

is because the wishes contained within an advance statement only come into effect if the person's ability to make decisions about their treatment for mental disorder becomes impaired.

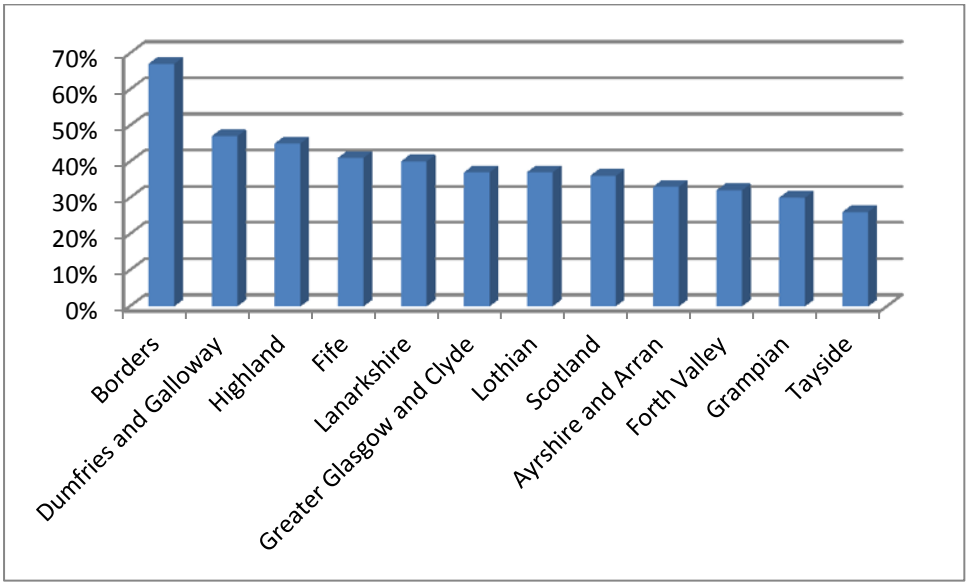
Community based compulsory treatment

CTO and CCTOs by NHS Board extant on point prevalence date on 5 January 2011.

Health Board	CTO Community Based	CTO Hospital Based	Totals	% community based
Ayrshire and Arran	46	93	139	33%
Borders	16	8	24	67%
Dumfries and Galloway	20	23	43	47%
Fife	53	76	129	41%
Forth Valley	32	69	101	32%
Grampian	56	129	185	30%
Greater Glasgow and Clyde	217	364	581	37%
Highland	64	78	142	45%
Lanarkshire	54	82	136	40%
Lothian	140	237	377	37%
Shetland	1	1	2	50%
State	2	19	21	10%
Tayside	48	136	184	26%
Western Isles	1	1	2	50%
Scotland	**750**	**1316**	**2066**	**36%**

(Note: Included are Community ICTOs, CCTOs, CTOs and ICTOs)

Percentage of CTOs that were community based on 5th January 2011: comparison among NHS Boards



Our interest in this

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

What we found

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

- NHS Borders has by far the highest proportion of compulsory community treatment orders. It is an even higher proportion than previous years. Given the relatively low use of the 2003 Act in that area, there are remarkably few people detained under compulsory treatment orders in hospital. Borders has a tradition of a community-based approach to treatment. NHS Dumfries and Galloway has the second highest proportion of CTOs that are community-based.
- Highland also has a high proportion of community compulsory treatment. Our data for this area shows that the rate of long-term orders is rising. Clinicians in this area should make sure they are reviewing the continuing need for these orders. This may be more difficult in remote areas.
- The use of community compulsory treatment is lowest in Tayside, followed by Grampian. These NHS Boards and their local authority partners should ensure that their community services are well enough developed. They may not be offering enough community support to people who need compulsory care and treatment. NHS Tayside should pay particular attention to this.

Granting, recalls and revocation of community CTOs, 1 April 2010 to 31 March 2011

	No. of people
New community orders granted (including interim orders)	125
Variations of hospital to community CTOs	*305
Variations of community to hospital CTOs	*90
Recalls from community to period S112	7
Recalls from community to period S113	113
Recalls from community to hospital S114	80
Episodes of admission under EDC and/or STDC of people on community CTOs	67
Revoked/Lapsed community based orders during period (including interim orders)	305

*We have introduced a new way of coding forms this year. The new code carries out more sophisticated checks which will account for changes in our reporting.

Our interest in this

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

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

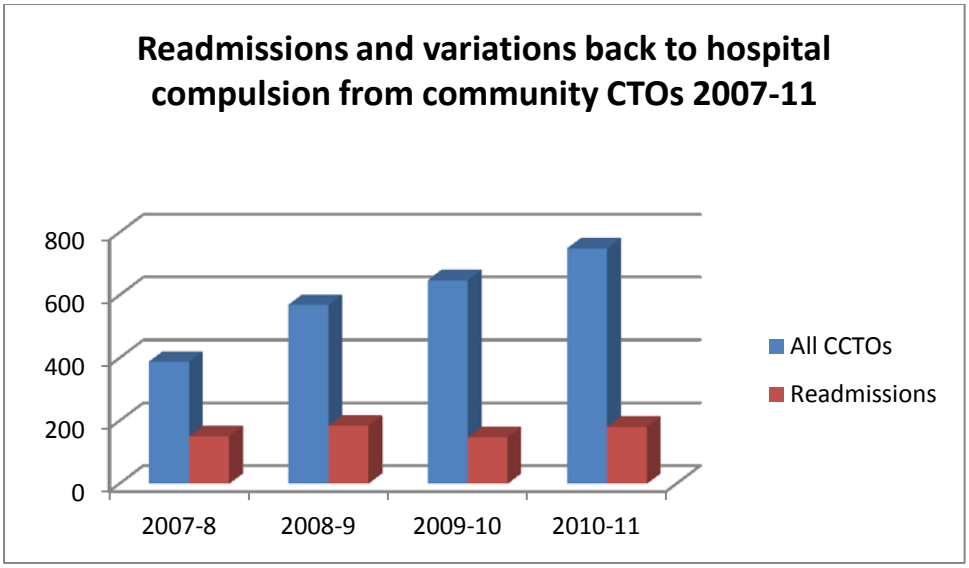
What we found

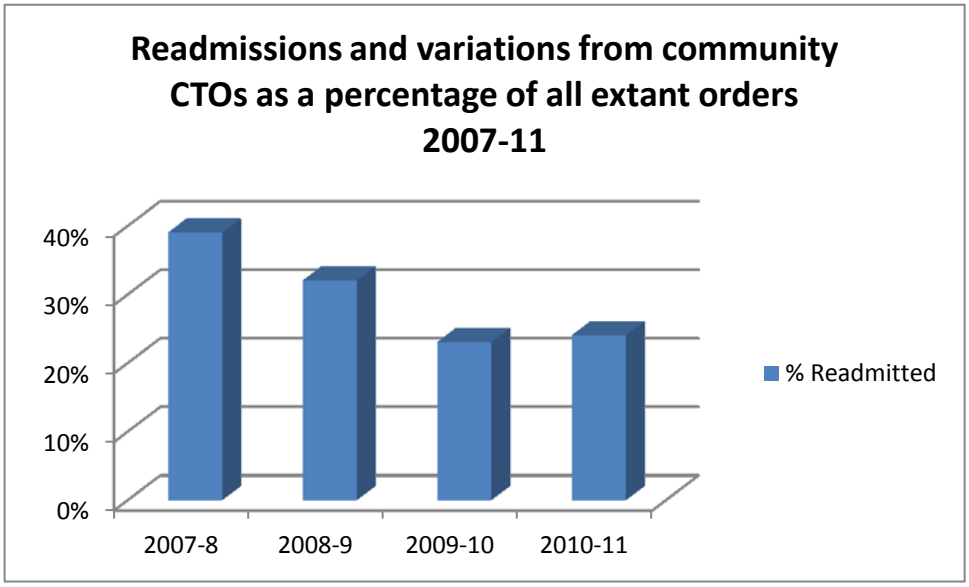
We have worked hard to improve our data on varied and revoked orders. While the number of variations back to hospital order appears higher than last year, this is partly because we are collecting this information better.

This year, 180 people on community orders were readmitted to hospital under compulsory measures (combination for S113/114 and EDC/STDC). This is higher than last year and is against a trend of fewer admissions over the previous three years. Taking this along with the rise in short-term detention orders, we have evidence that more people are being admitted to hospital under compulsory powers.

We still see very little use of S112. We think this section is a useful provision and is less restrictive of the person's liberty than recall to hospital. It should be used as an alternative to readmission to hospital where appropriate.

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

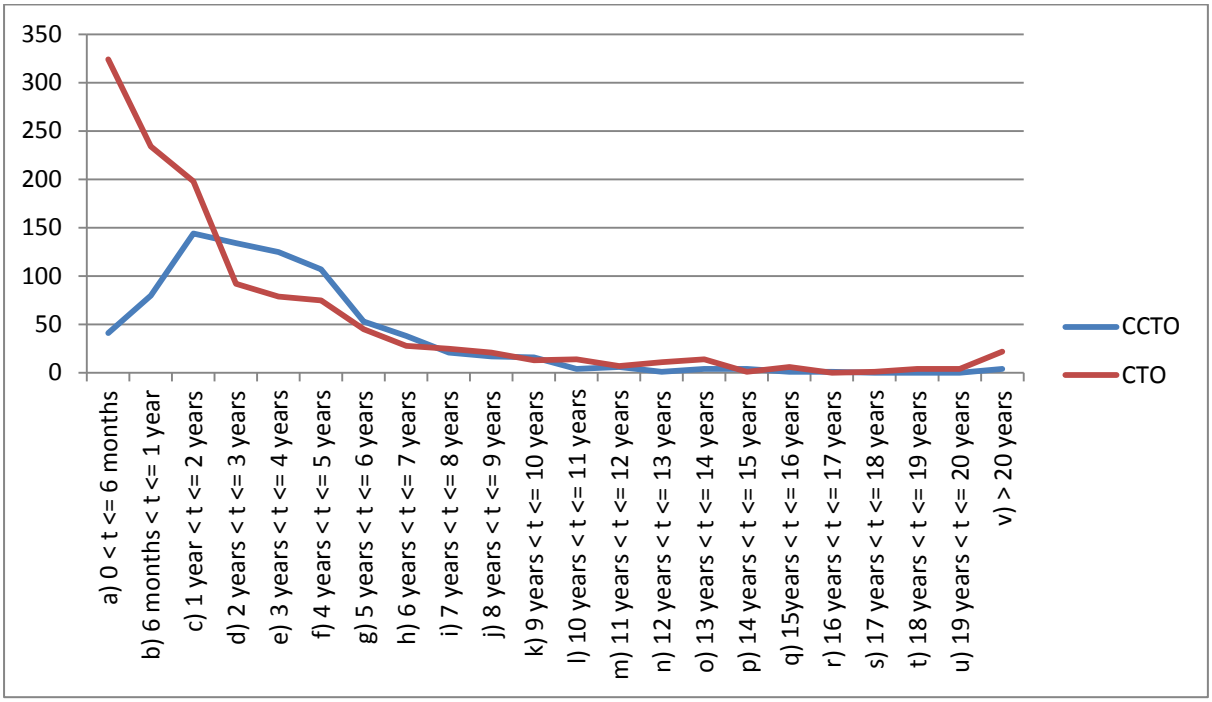




This year, the number of compulsory readmissions of all types rose. When seen as a percentage of all community CTOs, the percentage of people readmitted has not changed much. We still consider community compulsory treatment to be successful in many ways. Readmission is not necessarily a failure of community care. It can be an appropriate response to an episode of illness that occurs in spite of good community services.

Overall, more people admitted were to hospital under compulsory powers than last year. We will watch to see if this trend continues. We will also be interested to hear of people admitted because community services were unable to respond effectively or timeously.

Number of Civil Compulsory Treatment Orders current in 2010-11 by length of episode.



The figure above shows the total length of episode for all people subject to CTOs in July 2011. We have seen a trend towards community treatment for people whose episodes were longer than two years. This year, it is striking to see how many more people with episodes of compulsory treatment for more than two years are now being treated in the community.

Consent to Treatment

Certificate of the designated medical practitioner (T3), 1 April 2010 to 31 March 2011

Treatment type	No.
ECT	177
Medication to reduce sex drive	1
Artificial nutrition	27
Medication beyond 2 months	1012
Total T3 certificates	**1215**

Note: T3 certificate may be for more than one treatment

Our interest in this

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

What we found

1. Neurosurgery for Mental Disorder (Sections 235 and 236)

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

In Scotland the Advanced Interventions Service in Dundee is the only centre offering neurosurgical procedures and this year we assessed patients attending there from Scotland and England.

Five patients were seen for assessment during the reporting year. A further three referrals were received in February and March, and assessment dates were arranged after March 2011. These will be included in next year's report. Of those seen, four patients had treatment resistant depression, and one had treatment resistant obsessive compulsive disorder. In all cases the treatment was considered to be in their best interests and form T1 certificate of consent to treatment was issued. We also considered progress reports on a number of patients who had proceeded to neurosurgery previously. Training sessions were arranged for additional members of the teams who undertake these visits.

2. Other safeguarded treatments (Sections 237 and 240)

Treatments covered by sections 237 and 240 include ECT, any medicine for the purpose of reducing sex drive, medicine given beyond two months and artificial nutrition. Consent to treatment given with a patient's agreement is recorded on Form T2 usually by the RMO and by the patient's consent in writing. Treatment without consent is authorised by a DMP on Form T3.

We received 700 T2 forms, an increase one sixth from the previous year. The majority were for medication, 15 for ECT and 1 for artificial nutrition. The latter is likely to be significantly under-reported due to the wording of the MHA, section 240 (3), and we have recommended that this be changed in the revision of the act. Some RMOs may not be aware that the 2004 Modification Order of the MHA SSI/2004/533 requires copies of certificates under section 238 of the act (ie T2) to be sent to MWC within 7 days.

The number and types of treatments authorised by a Certificate of the DMP (Form T3) is shown in table 38 above. The majority of treatments authorised were medication beyond two months. 110 of the patients receiving ECT objected to it or were resisting the treatment. 14% of these required treatment to save life, the remainder to alleviate serious suffering and/or prevent serious deterioration.

The role of the DMP includes consideration both of the appropriateness of the treatment plan, and the requirements of the MHA. In some cases following discussion with the RMO the plan may be modified before approval. This is usually in relation to medication. In other cases the plan is not approved. For example, Dr A the DMP was asked to review a treatment plan for ECT. She agreed it was the treatment of choice for this person's illness and likely to be the most effective. However, the patient was objecting to this treatment. Dr A considered the views of the patient, the named person and the staff and the RMO. She concluded that the patient was incapable and refusing treatment. Her independent opinion was that the situation had not reached the point that treatment was necessary to save life, prevent serious deterioration or alleviate serious suffering as required for ECT where the patient resisted or objected. Dr A did not issue a form T3 and discussed the need for further trials of medication with the RMO who accepted this decision.

Children and Young People

We received 15 T2 forms for patients who were under 18 at the time of consenting to treatment all of which were for medication beyond two months. In 2 cases the RMO completing the form was not a child specialist and the need to remedy this was brought to the attention of the RMO and clinical team. Both were 17 year olds in adult wards.

There were 38 T3 forms for patients under 18 receiving treatment without consent. This was twice as many as the previous year. None were for ECT. 23 were for medication and 15 for artificial nutrition. In all cases either the RMO or the DMP were child specialists.

Designated Medical Practitioners

There were 82 DMPs on our register to provide second opinions on safeguarded treatments during the year. We held our annual DMP seminar in November 2010 and topics included capacity and consent, end of life issues, DMP presentations and prescribing in the elderly. Three induction sessions for new DMPs were held during the reporting year, and were also attended as a refresher session by some current DMPs. We are grateful to all our DMPs who undertake second opinion visits. Any Consultant who would be willing to undertake such visits is invited to contact the Commission for further information about this work.

Report on MWC unannounced visits to people receiving treatment under the safeguards of part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003

From April 2010 to March 2011, we conducted a series of unannounced visits to 45 hospitals where people were receiving compulsory treatment under the 2003 Act. We looked at the medication prescribed and administered in 672 cases and compared it with the treatment authorised on statutory forms. This is described in detail in our report entitled "Right to treat?" It included examination of T2 and T3 forms. Our findings included the following:

- We considered that 12% of all the people whose cases we examined were receiving treatment that was not properly authorised or reported under the 2003 Act. Clinicians and managers must do more to make sure that everybody is treated lawfully.
- We considered that 15% of the people certified as giving informed consent to their treatment were either unable or unwilling to give consent. Clinicians cannot rely on previous written consent if the person no longer understands, or agrees to accept, the prescribed treatment.

Our report has made a number of recommendations on training and best practice for clinicians and managers. The Commission has included Part 16 issues in our series of EIP (Excellence In Practice) seminars to start this autumn.

Ethnicity

Ethnicity of individuals as notified to the Commission on mental health act forms, 1st April 2010 to 31 March 2011

Ethnicity	No.	% of known information	% Scottish population**
White Scottish	3457	88%	88.09%
White British	236	6%	7.38%
White other	89	2%	0.98%
White Irish	17	0.4%	1.54%
Indian	17	0.4%	0.30%
Bangladeshi	3	0%	0.04%
Pakistan	30	0.8%	0.63%
Chinese	23	0.6%	0.32%
Asian (other)	10	0.2%	0.12%
Black (African)	39	1%	0.1%
Black (other)	1	0%	0.06%
Mixed	13	0.3%	0.25%
Other	15	0.4%	0.19%
Total known	**3950**	**100%**	**100%**
Not provided or unknown	1496	*27%	
Total number of forms	**5446**		

**Percentage of forms where the information was not provided or is unknown is displayed as a % of total forms*
***Taken from Analysis of Ethnicity in the 2001 Census - Summary Report (Scottish Government website)*

Our interest in this

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

so that the reasons for this might be explored and addressed. While our data was incomplete last year, we found some evidence to suggest that black people were more likely to be subject to the Act

What we found

We can only report on ethnicity if it is recorded on the forms sent to us. We have information from 73% of forms, an improvement on previous years. This is not high enough for us to be confident about our data. We have compared our figures with the most recent available census data. Since 2001, there have been several changes including a significant number of asylum seekers.

Our data suggests that, as in parts of England, black people are more likely to be subject to mental health legislation. This should be interpreted with caution. There is missing data and there has been reception of asylum seekers since the last census. We are working on research data in conjunction with the University of Edinburgh and others. Preliminary findings suggest that black people are more likely to be subject to long-term orders. However, even the best data we have is incomplete and the census data is out-of-date.

We are working with the Scottish Government and others to find better ways to report and collect information on ethnicity. If this is successful, and if the 2011 census data is published soon, we will be able to provide much more accurate information other the use of the 2003 Act for different ethnic groups.

Provision of Social Circumstances Reports following short term detention by local authority (where known) 1 April 2010 – 31 March 2011*

	Nothing received following STD (%)		"Serve no purpose" letter received following STD (%)		SCR received after STD (%)		Total Number of STDs in LA area (%)	
Aberdeen City	68	43	10	6	80	51	158	**(100)**
Aberdeenshire	32	23	5	4	101	73	138	**(100)**
Angus	4	10	3	8	32	82	39	**(100)**
Argyll and Bute	44	62	1	1	26	37	71	**(100)**
City of Edinburgh	318	76	19	5	82	20	419	**(100)**
Clackmannanshire	5	23	2	9	15	68	22	**(100)**
Dumfries and Galloway (LA)	48	46	6	6	50	48	104	**(100)**
Dundee City	29	22	25	2	73	57	127	**(100)**
East Ayrshire	14	29	6	1	28	59	48	**(100)**
East Dunbartonshire	20	34	4	7	35	59	59	**(100)**
East Lothian	26	46	0	0	31	54	57	**(100)**
East Renfrewshire	14	28	8	1	28	56	50	**(100)**
Eilean Siar	2	67	0	0	1	33	3	**(100)**
Falkirk	35	45	12	1	31	40	78	**(100)**
Fife (LA)	74	34	23	1	118	55	215	**(100)**
Glasgow City	414	69	44	7	143	24	601	**(100)**
Highland (LA)	143	86	1	1	22	13	166	**(100)**
Inverclyde	33	49	8	1	27	40	68	**(100)**
Midlothian	13	48	1	3	14	48	28	**(100)**
Moray	29	58	0	0	21	42	50	**(100)**
North Ayrshire	4	6	8	1	52	82	64	**(100)**
North Lanarkshire	77	50	8	5	68	44	153	**(100)**
Perth and Kinross	20	17	21	1	77	64	118	**(100)**
Renfrewshire	55	65	9	1	19	24	83	**(100)**
Scottish Borders	43	74	1	2	14	24	58	**(100)**
Shetland (LA)	4	33	0	0	8	67	12	**(100)**
South Ayrshire	16	23	5	7	49	70	70	**(100)**
South Lanarkshire	50	29	35	2	78	45	163	**(100)**
Stirling	37	55	1	1	29	43	67	**(100)**
West Dunbartonshire	41	68	4	7	15	25	60	**(100)**
West Lothian	17	20	12	1	57	66	86	**(100)**
SCOTLAND	**1729**	**50**	**282**	**9**	**1424**	**41**	**3435**	**(100)**

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

What we found

The number of short term detention episodes increased this year by about 3%, and the number of SCRs we received also increased by this same percentage. There were variations across Scotland,

with some local authorities increasing the percentage of SCRs completed (Aberdeen City produced a report in 51% of STDs, up from 32%, Glasgow produced a report in 24%, up from 17%) whilst others fell back (South Lanarkshire produced a report in 45% of STDs down from 62%).

Overall the level of compliance with the legislation regarding the completion of SCRs remains low at 41%.

We continue to look for alert letters from mental health officers when they have concerns about any aspect of the care or treatment of a person or how they came to be admitted to hospital. In one case this year we requested a critical incident review by the NHS Board as a result.

Our guidance on the completion of SCRs advises an annually updated SCR for long term compulsory treatment except where there are alternative, robust review arrangements in place such as CPA. In these circumstances there should be an SCR at least every two years which is in line with the necessity for the Tribunal to review long term orders every two years.

We made some recommendations regarding completion of SCRs in our programme of visits to people who were subject to compulsory treatment orders with community based powers (CCTOs). When we looked for an SCR in the 191 CCTOs on which the report was based 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.

It is worth repeating here that 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.

This mirrors our findings from *A Question of Balance*, our monitoring report looking at services for people with mental health problems receiving care and treatment after committing offences. Of the 306 people who were subject to a compulsion order or a compulsion order with restrictions, 223 (73%) had no SCR on file, and only 61 (20%), had an SCR dated after 2007. It also noted lower levels of contact than expected with MHOs. Designated MHOs should ensure that each individual has an SCR carried out as required by the 2003 act unless they can demonstrate doing so "would serve little, or no, practical purpose."

Managers of MHO services should audit compliance with the statutory requirement to produce social circumstances reports, and with our guidance that they be updated annually.

Place of safety orders notified to the Commission 1 April 2010 to 31 March 2011.

	Was Place of Safety a Police Station?			
Police Force	No	Not recorded	Yes	Total
CENTRAL SCOTLAND	9	0	0	9
FIFE	20	5	2	27
GRAMPIAN	115	7	2	124
LOTHIAN AND BORDERS	13	0	8	21
NORTHERN	51	4	2	57
STRATHCLYDE	39	1	2	42
TAYSIDE	4	0	2	6
Totals	**251**	**17**	**18**	**286**

Our interest in this

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

The Act places a duty on police officers to report to the Commission on any occasion that they convey people to a place of safety under section 297. We are aware that compliance with this part of the act is variable.

What we found

There was a slight increase in notifications this year, up from 209 in 2009/10 to 286 covering 255 individuals.

The Commission have been in discussion with the Association of Chief Police Officers (ACPOS) with a view to improving the recording and notification of incidents where people are removed to a place of safety. This has resulted in improved understanding and a somewhat higher rate of notification but has also identified practical difficulties in ensuring that notifications are made timeously and appropriately.

Until the Commission is confident that it is receiving notifications about the majority of occasions when section 297 is used we will be unable to form any reasonable judgements about its use.

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

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

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

We are part of the framework of legal safeguards that are in place to protect the rights of people on welfare guardianship and intervention orders, or for whom decision making powers on welfare have been granted to someone else via a power of attorney. We also to help ensure the Act is used in accordance with the Principles of the legislation.

Adults with Incapacity

Trends in the use of welfare guardianship

During the past year we have seen a 14% increase in the number of approved welfare guardianship applications. This is the highest percentage increase in the past four years. The number of applications put forward by local authorities has remained fairly static over this four- year period (417,435,423 and, for this past year,427). The increase is due to private applications which have risen by 74% during this period: up from 629 to 1094.

The Commission has been expressing concern about the high percentage of orders being granted on an indefinite basis and is heartened to see that there may be a change in practice underway. It remains to be seen whether this is sustained in future years. In 2008/9 and 2009/10, 71% of orders were granted on an indefinite basis. In 2010/11, this rate fell to 63%. While in the previous year 84% of orders granted for people with dementia were granted on an indefinite basis, this was down to 76% in 2010/11. For orders relating to adults with a learning disability, the rate fell from 60% to 48%. As in previous years, private applications are much more likely to be sought and granted on an indefinite basis than local authority applications. The proportion of indefinite orders sought fell by approximately the same amount for both types of application. Last year 68% of private applications and 51% of local authority applications were granted on an indefinite basis. This is discussed in more detail below.

Geographical variations in the use of welfare guardianship

Guardianship orders granted by local authority area, 1 April 2010 to 31 March 2011

	Private guardianships granted 2010-11	Local authority guardianships granted 2010-11	All applications granted 2010-11	Private Rate Per 100k Over 16 Pop.	LA Rate Per 100k Over 16 Pop.	Total Rate	Recalled*	Lapsed Without Renewal*	Service User Died*
Aberdeen City	38	11	49	21	6	27	0	0	7
Aberdeenshire	45	23	68	23	12	35	0	2	18
Angus	20	15	35	22	17	39	1	0	16
Argyll and Bute	23	1	24	31	1	33	0	0	6
City of Edinburgh	62	32	94	15	8	23	0	1	14
Clackmannanshire	15	2	17	37	5	42	0	0	2
Dumfries and Galloway	24	13	37	20	11	30	1	12	0
Dundee City	31	20	51	26	17	43	0	0	10
East Ayrshire	31	12	43	32	12	44	0	6	10

East Dunbartonshire	19	2	21	22	2	25	0		2
East Lothian	9	12	21	12	15	27	0	1	4
East Renfrewshire	19	2	21	27	3	30	0	1	5
Eilean Siar	9	3	12	42	14	56	0	0	4
Falkirk	22	21	43	18	17	35	0	0	7
Fife	85	30	115	29	10	39	5	0	47
Glasgow City	197	69	266	40	14	54	1	9	66
Highland	56	25	81	31	14	45	0	0	11
Inverclyde	7	3	10	11	5	15	0	0	2
Midlothian	7	3	10	11	5	15	0	0	4
Moray	23	3	26	32	4	37	0	2	12
North Ayrshire	39	5	44	36	5	40	0	1	6
North Lanarkshire	63	18	81	24	7	31	0	4	26
Orkney	5	4	9	31	24	55	0	0	0

Perth & Kinross	25	16	41	21	13	34	1	0	18
Renfrewshire	36	5	41	26	4	30	0	0	9
Scottish Borders	9	7	16	10	8	17	0	1	3
Shetland	0	1	1	0	6	6	0	0	0
South Ayrshire	25	25	50	27	27	54	0	3	6
South Lanarkshire	74	25	99	29	10	39	0	0	32
Stirling	12	8	20	17	11	28	0	0	0
West Dunbartonshire	29	6	35	40	8	48	1	1	4
West Lothian	35	5	40	26	4	30		0	7
Scotland	**1094**	**427**	**1521**	**26**	**10**	**36**	**10**	**46**	**373**

Our interest in this

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

Local authority managers will also wish to examine trends which might have implications for workload management and planning.

What we found

The above table shows the rate of approved orders per 100,000 population ranged from 6 in Shetland and 15 in Inverclyde and Midlothian, to 56, 55, 54 and 54 in Eilean Siar, Orkney, Glasgow City and South Ayrshire.

While there was a 14% increase in approved applications across Scotland, there were considerable variations across the country. Seven local authority areas saw increases in approved orders of 40% or greater. The number of approved applications in South Ayrshire more than doubled over the previous year and in West Dunbartonshire they experienced a 75% increase in welfare guardianship orders. In South Ayrshire this was down to increases in both private and local authority approved applications, with the local authority increase standing at 127%. In West Dunbartonshire this was as a result of private applications nearly doubling in the past year. It is clear that there must be difficulties in workload planning in local authority Mental Health Officer services when they have to respond to such dramatic and unanticipated increases in applications. Glasgow Council alone had to respond to 76 more applications in 2010/11 than they did in 2009/10; all but 2 of these being as a result of private applications.

There were, however, areas that experienced a decrease in approved orders: Perth and Kinross (27%), Angus (19%) and Inverclyde (17%). The decrease in Angus is down entirely to the fall in private applications, as approved local authority applications in Angus rose by 150% during the year.

The variations in approved local authority applications ranged from increases of 100% or over in Angus (150%),Scottish Borders (130%), South Ayrshire (127%), and East Lothian (100%), to decreases of over a third in East Renfrewshire (71%), West Lothian (62%), East Ayrshire (40%) and Renfrewshire (38%).

The number of orders recalled by local authorities remained extremely low. Only 10 orders were recalled, one being recalled by the Sheriff Court. Of the remaining 9, 5 were recalled by Fife.

Geographic variation in duration of orders

Duration of orders granted to Local Authorities, 1st April 2010 to 31st March 2011

Duration of orders granted by Local Authority	Up to and including 3 years	Greater than 3 but including 5 years.	Greater than 5 years.	Indefinite	Total Orders	% of total orders granted which are indefinite
Aberdeen City	4	1	0	6	11	**55**
Aberdeenshire	9	3	0	11	23	**48**
Angus	5	1	0	9	15	**60**
Argyll and Bute	1	0	0	0	1	**0**
City of Edinburgh	14	1	0	17	32	**53**
Clackmannanshire	0	0	0	2	2	**100**
Dumfries and Galloway (LA)	6	3	1	3	13	**23**
Dundee City	1	0	0	19	20	**95**
East Ayrshire	11	0	0	1	12	**8**
East Dunbartonshire	0	0	0	2	2	**100**
East Lothian	0	1	0	11	12	**92**
East Renfrewshire	1	0	0	1	2	**50**
Eilean Siar	0	0	0	3	3	**100**
Falkirk	11	6	1	3	21	**14**
Fife (LA)	6	5	0	19	30	**63**
Glasgow City	7	14	4	44	69	**64**
Highland (LA)	9	1	2	13	25	**52**
Inverclyde	1	0	0	2	3	**67**
Midlothian	2	0	0	1	3	**33**
Moray	2	0	0	1	3	**33**
North Ayrshire	2	0	0	3	5	**60**
North Lanarkshire	6	2	0	10	18	**56**
Orkney (LA)	3	1	0	0	4	**0**
Perth and Kinross	5	0	0	11	16	**69**
Renfrewshire	1	0	0	4	5	**80**
Scottish Borders	5	2	0	0	7	**0**
Shetland (LA)	1	0	0	0	1	**0**
South Ayrshire	22	2	0	1	25	**4**
South Lanarkshire	10	4	0	11	25	**44**
Stirling	2	1	0	5	8	**63**
West Dunbartonshire	2	0	0	4	6	**67**
West Lothian	2	2	0	1	5	**20**
Grand Total	**151**	**50**	**8**	**218**	**427**	**51**

Duration of orders granted to private individuals, 1st April 2010 to 31st March 2011

Duration of orders granted by Local Authority	Up to and including 3 years	Greater than 3 but including 5 years.	Greater than 5 years.	Indefinite	Total Orders	% of total orders granted which are indefinite
Aberdeen City	3	6	1	34	44	77
Aberdeenshire	3	0	3	33	39	85
Angus	1	2	1	16	20	80
Argyll and Bute	3	4	4	12	23	52
City of Edinburgh	3	5	2	52	62	84
Clackmannanshire	2	3	0	10	15	67
Dumfries and Galloway (LA)	6	7	3	8	24	33
Dundee City	1	0	0	30	31	97
East Ayrshire	10	7	0	14	31	45
East Dunbartonshire	1	4	2	12	19	63
East Lothian	1	1	0	7	9	78
East Renfrewshire	0	1	4	14	19	74
Eilean Siar	0	0	0	9	9	100
Falkirk	5	6	1	10	22	45
Fife (LA)	11	10	2	62	85	73
Glasgow City	9	48	10	130	197	66
Highland (LA)	9	6	4	37	56	66
Inverclyde	3	1	0	3	7	43
Midlothian	0	1	1	5	7	71
Moray	0	0	0	23	23	100
North Ayrshire	3	2	3	31	39	79
North Lanarkshire	32	6	0	25	63	40
Orkney (LA)	0	1	0	4	5	80
Perth and Kinross	4	0	5	16	25	64
Renfrewshire	2	6	4	24	36	67
Scottish Borders	3	0	0	6	9	67
Shetland (LA)	0	0	0	0	0	0
South Ayrshire	11	1	0	13	25	52
South Lanarkshire	9	16	1	48	74	65
Stirling	4	1	1	7	13	54
West Dunbartonshire	1	4	4	23	32	72
West Lothian	3	4		24	31	77
Grand Total	**143**	**153**	**56**	**742**	**1094**	**68**

Our interest in this

We are keen to see that the Act operates in accordance with its principles - among these are that interventions are to be undertaken on a least restrictive basis and that they benefit the adult. We believe that the necessity of keeping an order in place should be subject to routine review to determine that the grounds for continuation of orders still apply. We publish these tables so that managers, solicitors and the court service can be made aware of the variances across the country and examine the relevance for their own practice.

What we found

As reported above, there is wide variance in the length of time for which orders are sought and granted. In looking at applications put forward by local authorities where the Chief Social Work Officer is appointed guardian, the rate of indefinite orders sought ranges from 0% to 100%, with the average for local authority approved applications across Scotland at 51%. While the highest and lowest percentages are in areas where there are few local authority applications, for other areas the differences in the rates of indefinite orders sought are significant. Dundee City and Falkirk had nearly the same number of local authority applications, yet 95% of Dundee City local authority applications were sought on an indefinite basis, while only 14% of Falkirk Council applications were. South Ayrshire and Highland councils had the same number of local authority applications, yet 52% of Highland Council applications were sought on an indefinite basis, while only 4% of South Ayrshire Council applications were. East Lothian and East Ayrshire had the same number of local authority applications. In East Lothian, 92% were sought on an indefinite basis, where only 8% were in East Ayrshire.

There was noticeable variation as well in the lengths of time for which orders were sought by private applicants in different local authority areas, although these differences were not, generally, as pronounced as with local authority applications. There were some outliers, however, with 100% of Moray's private applications, 97% of Dundee City's and 85% of Aberdeenshire's being sought on an indefinite basis. The average was 68%. At the other end of the scale, 33% of private applications in Dumfries and Galloway, 43% in Inverclyde and 45% of private applications in East Ayrshire and Falkirk were sought on an indefinite basis.

There may well be reasonable explanations behind some of these variations. It may be that they can be explained in some instances by the age of the adults on whom orders are being sought. It is more understandable that indefinite orders are sought for an older person with moderate dementia than for a young person with mild to moderate learning disability. What is more concerning is the possibility that these variations may also be down to differences in the practice of solicitors, both private and local authority. The data needs closer examination of the circumstances of the individual cases to extract more useful information.

Duration of guardianship orders applied for by applicant

Welfare guardianships granted to Local Authorities between 1st April 2010 and 31st March 2011, by primary cause of incapacity and duration.

Cause of incapacity / Duration	Acquired Brain Injury	Alcohol related brain disorder	Dementia /Alzheimer's	Learning Disability	Mental Illness	Other	Totals (% of all orders)
Up to and including 3 years	9	20	58	57	8	4	156 (35)
Greater than 3 but including 5 years.	5	6	13	23	5	0	52 (12)
Greater than 5 years.	0	2	4	3	0	0	9 (2)
Indefinite	8	17	155	24	13	7	224 (51)
Totals (% of all orders)	22(5)	45 (10)	230 (52)	107 (24)	26 (6)	11 (2)	441 (100)

Welfare guardianships granted to private applicants between 1st April 2010 and 31st March 2011, by primary cause of incapacity and duration.

Cause of incapacity / **Duration**	Acquired Brain Injury	Alcohol related brain disorder	Dementia /Alzheimer's	Learning Disability	Mental Illness	Other	**Totals (% of all orders)**
Up to and including 3 years	8	8	65	54	2	1	**138 (13)**
Greater than 3 but including 5 years.	14	5	47	77	2	6	**151 (14)**
Greater than 5 years.	2	1	17	35	0	0	**55 (5)**
Indefinite	31	10	477	208	4	6	**736 (68)**
Totals (% of all orders)	**55 (5)**	**24 (2)**	**606 (56)**	**374 (35)**	**8 (1)**	**13 (1)**	**1080 (100)**

Our interest in this

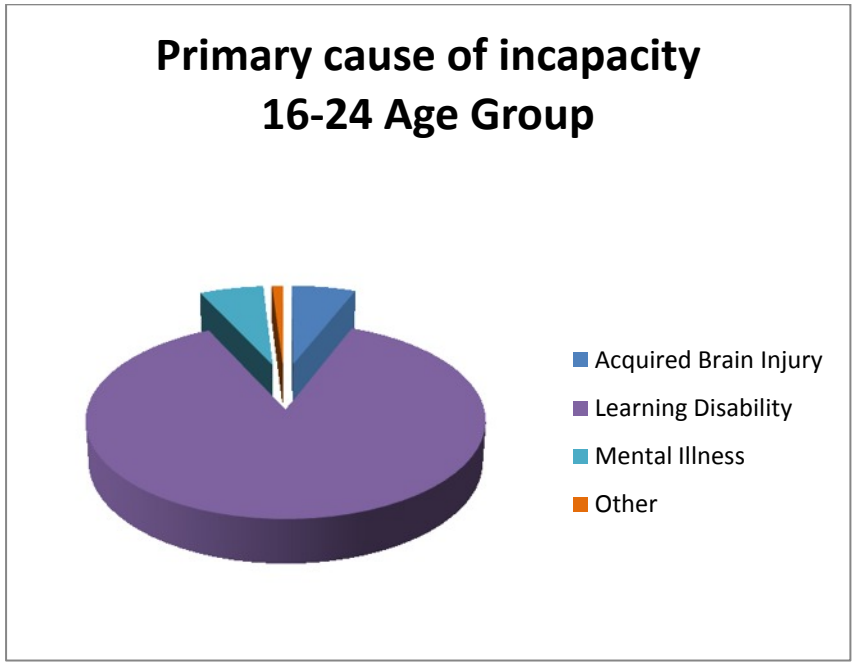
We have safeguarding duties in relation to people who fall under the protection of the Adults with Incapacity Act 2000. We examine the use of welfare guardianship for adults with a mental illness, learning disability or other mental disorder (including dementia) to determine how and for whom the 2000 Act is being used. This helps to highlight those individuals with certain mental disorders who might not be benefiting from the rights and protections that are set out in law. The tables above show numbers of approved welfare guardianship orders broken down by the identified causes of the adult's incapacity and the length for which the orders have been granted. We have raised concerns in previous reports about the high percentage of orders granted on an indefinite basis. Our concern is that the lack of automatic, periodic judicial scrutiny of approved orders puts the onus on the individual or other party with an interest to challenge the order. We do not think this is in keeping with accepted standards of justice. Particularly concerning, as we have reported, is the seeking and granting of orders on an indefinite basis for young adults with learning disability. We understand this issue will be addressed as part of The Scottish Law Commission's review of the legislation which began in September 2010.

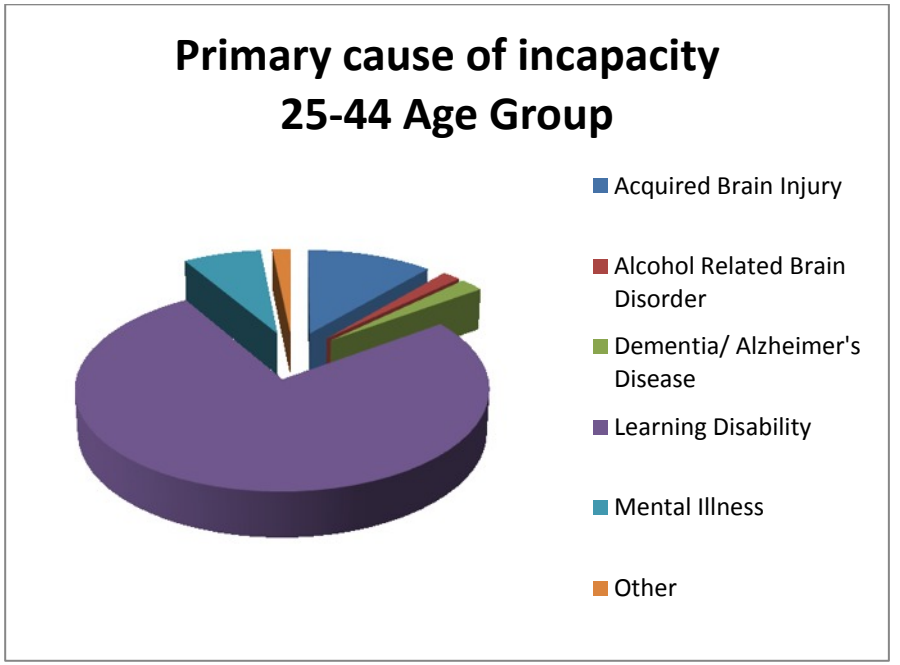
What we found

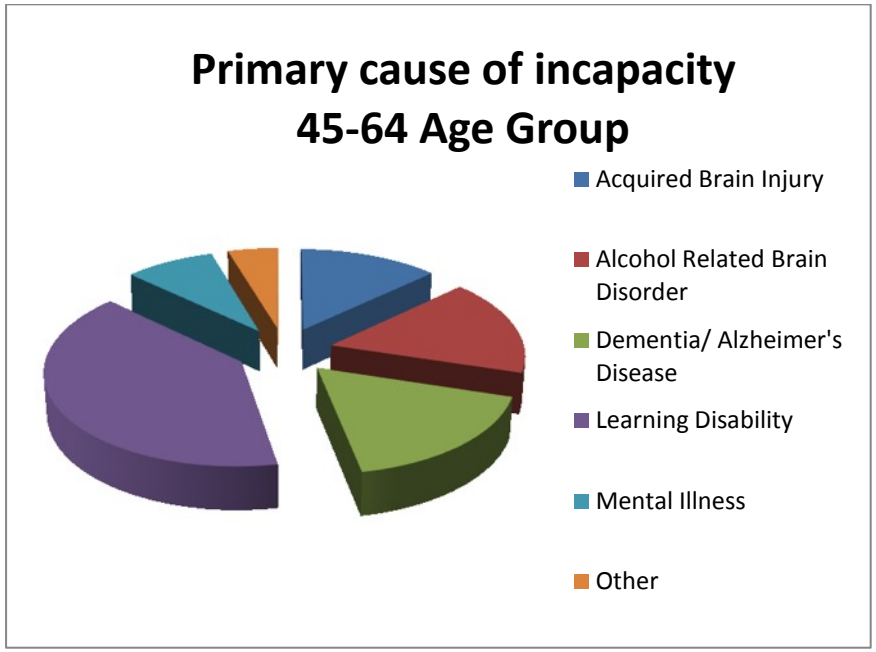
After gradual decreases in the percentage of orders granted during the past few years where the primary cause of incapacity was dementia, in 2010/11 this increased from 52% to 55% of all orders. There was, conversely, a small decrease in the granting of orders for adults where the cause of incapacity was learning disability. Gradual increases in the past few years were not sustained and the percentage fell from 34% to 32% of all orders.

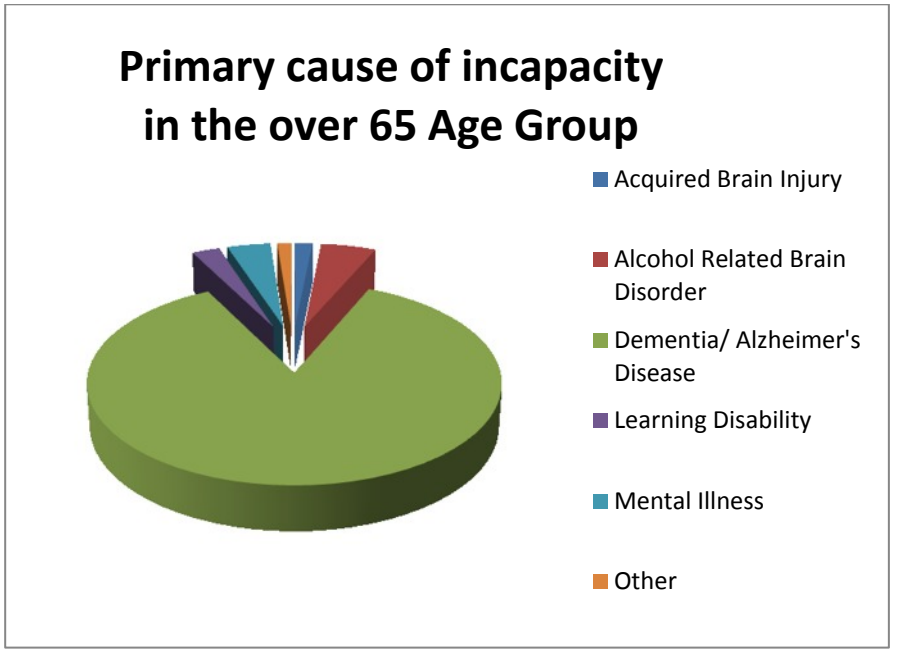
There were differences between local authorities and private guardians when looking at the cause of incapacity for the adults on whom welfare guardianship was granted. Basically, private guardians were more often appointed for people with dementia and learning disability than was the case with local authority guardians. Local authorities were much more likely to be guardians than private individuals when Alcohol Related Brain Damage or Mental Illness was the cause of incapacity.

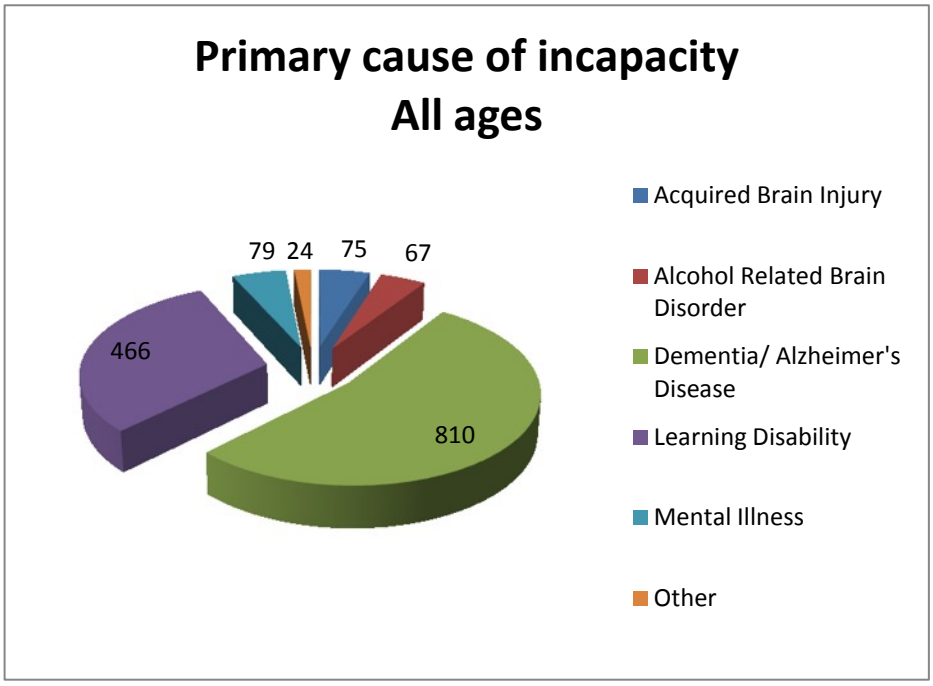
Indefinite orders, in general, were much more likely to be granted where there was a private guardian. This was true across all causes of incapacity except for mental illness. For private orders, 79% of adults with dementia, 56% with learning disability, 56% with Acquired Brain Injury, 42% with Alcohol Related Brain Damage and 50% with mental illness were placed on indefinite orders. This contrasted with the local authority percentages of 67%, 22%, 36%, 38% and 50%, the most dramatic difference being in relation to orders relating to adults with learning disability.


Primary cause of incapacity
16-24 Age Group
Acquired Brain Injury
Learning Disability
Mental Illness
Other


Primary cause of incapacity
25-44 Age Group
Acquired Brain Injury
Alcohol Related Brain Disorder
Dementia/ Alzheimer's Disease
Learning Disability
Mental Illness
Other


Primary cause of incapacity
45-64 Age Group
Acquired Brain Injury
Alcohol Related Brain Disorder
Dementia/ Alzheimer's Disease
Learning Disability
Mental Illness
Other


Primary cause of incapacity
in the over 65 Age Group
Acquired Brain Injury
Alcohol Related Brain Disorder
Dementia/ Alzheimer's Disease
Learning Disability
Mental Illness
Other



Our interest in this

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

What we found

In the past year there has been a significant change in the percentage of adults with learning disability under the age of 25 who were placed on welfare guardianship. For the two years previously, this stood at about 43% of all those with learning disability placed on orders. This past year this increased to 53%. In 2010/11 18% of adults with learning disability were in the 16-17 year old age group. This is up 2% on the previous year. This data is particularly concerning in one sense, as nearly half of all orders granted in respect of adults with learning disability were granted on an indefinite basis. There is no legal requirement for these ever to be reviewed again by the Sheriff Court once granted.

For people with dementia, the percentage of orders granted where the adult was over 65 remained at the same level as last year at 95%.

In the 25-44 age group, learning disability was the cause of incapacity in 76% of orders granted, with adults with acquired brain injury accounting for 11% of orders granted.

In the 45-64 age group, adults with learning disability was the cause of incapacity in 40% of orders, with alcohol related brain damage and acquired brain damage combined accounting for 30% of the orders granted.

Our visits to adults on guardianship

During 2010/11 we visited 379 people on welfare guardianship orders. The adults we visited had incapacity caused by the following mental disorders:

- Learning Disability: 45%
- Dementia: 25%
- Autism Spectrum disorders: 12%
- Alcohol Related Brain Damage: 8%
- Acquired Brain Injury: 6%
- Mental illness: 1%
- Not clearly established 3%

As a result of our visits we followed up a number of issues in individual cases. The issues raised fell into the following categories:

- Legislation: 25%
- Medication and consent: 22%
- Placement: 14%
- Activities: 11%
- Finances: 8%
- Behaviour which was difficult to manage: 7%
- Restrictions: 6%
- Communication: 4%
- Mobility: 1%

Adults with Incapacity (Scotland) Act 2008, 1st April 2010 to 31st March 2011, Section 48 (regulated treatments) and Section 50 (disagreements with proxy)

Requests Types of treatment	Section 48/50 Requests
Medication to reduce sex drive	21
ECT	24
Abortion	0
Dispute between welfare proxy and medical staff about treatment with antipsychotic medication.	1
TOTAL	46 requests for 45 people

Our interest in this

The Commission has a responsibility under the Adults with Incapacity Act to provide second medical opinions (nominated medical practitioners) for treatments that are not covered by the general authority to treat (Section 47). The specific treatments are noted above. In addition, where there is a welfare proxy with the power to consent to medical treatment and there is disagreement between then and the treating doctor, the Commission can be requested to provide a second opinion to resolve the dispute.

What we found

There were 45 requests under Section 48 and 1 under Section 50. Of the 24 requests for ECT, all except one were for separate individuals. There was one request for maintenance ECT. For authority to treat under Section 48 in respect of ECT the patient must not be resisting as well as being incapable of giving informed consent.

For treatment under Section 48a- medication to reduce sex drive, there were 21 requests.

In the case where there was a dispute between the welfare proxy and medical staff, the second opinion doctor authorised the continuation of antipsychotic medication against the wishes of the welfare proxy. In this case the need to use antipsychotics was very clearly linked to the distressing visual hallucinations and other symptoms experienced by the patient.

mentalwelfare
commission for scotland

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809

enquiries@mwcscot.org.uk

www.mwcscot.org.uk