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VISIT AND MONITORING REPORT

DECEMBER 2015

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What we do

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

We do this by:

- Checking if individual care and treatment are lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy and service development.

Why we visited

Policy context

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

The 2003 Act was introduced following the first major review of mental health legislation in Scotland since 1960. It included compulsory treatment orders, where an individual requires to be in hospital or is living in the community. It replaced the previous 'leave of absence' provisions with 'suspension of detention' for no more than nine months in any twelve month period. The intention was that orders should then be varied from hospital to community treatment orders in line with the principle of least restriction of freedom.

Previous visits

We made Community Compulsory Treatment Orders (CCTOs) a monitoring priority when the 2003 Act was implemented in 2005. At that point people had only been on community based orders for a few months, so in 2010 we looked at the care and treatment of people who had been on a CCTO for more than two years. We made a

number of specific recommendations in the monitoring report we published after completing this piece of work¹.

In our annual Mental Health Act monitoring report we look at the numbers and proportion of community orders². In 2013/14 we noted that community based orders now account for 41 percent of all Compulsory Treatment Orders (CTOs). Given the recommendations in our report in 2011, and the significant increase in the proportion of community based orders we felt that it was time to focus again on the care and treatment of people who had been subject to a CCTO for more than two years.

How we carried out the visits

In January 2015 there were 396 people who had been subject to a CCTO for over two years. We planned to look at the care, treatment and support of 100 of these (we actually looked at 101). We offered to meet all these people but some chose not to meet with us or were not available when we tried to meet them. We used a semi-structured interview to gather information and views from those we did meet (88) and to hear their concerns.

In addition we looked at case records and care plans for each person and interviewed their community psychiatric nurse (CPN) or mental health officer (MHO) or both by phone using a questionnaire.

What we examined

With particular regard to the principles of the 2003 Act, we examined:

- The views of people subject to CCTOs and their named persons about the care, treatment and support they received and their participation in their own care.
- Their care and treatment for mental health and physical problems to ensure they received maximum benefit and the range of treatments and services to meet their needs.
- The legality of their treatment, including proper authorisation of safeguarded treatments.
- The information people had about their treatment, their rights and the safeguards available for them.

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<http://www.mwscot.org.uk/media/53227/Livespercent20Lesspercent20Restrictedpercent20CCTOpercent2010-11.pdf>

² http://www.mwscot.org.uk/media/203499/mha_monitoring_2013_2014_3_final.pdf

- The frequency of reviews and strategies for reaching the point where the order is no longer necessary in line with the least restriction of freedom and the legal test of continuing necessity for the order.
- Progress towards recovery, with particular emphasis on help to manage finances and to obtain access to education and employment (reciprocity principle and the duties of local authorities).

Summary of Findings and Recommendations

About half the people we saw felt the order was of some benefit to them, though very few were clear under what circumstances the order would be revoked. Half had issues with the order, related either to medication or the requirement to accept care and support. We generally felt that practitioners carefully weighed up the benefits of the order, the risks of not being on an order and considered patients' views in extending the orders. However a number of people felt they were not listened to and there are challenges in trying to ensure they have meaningful participation in the review of their care and treatment and, where possible, an 'exit strategy' from compulsory treatment.

People were generally aware from their MHO of their right of appeal and the availability of advocacy. However, half of the people we saw told us they had not heard of advance statements.

We were disappointed to see very little evidence of clear revocation strategies in the majority of cases. We know that consideration of risk is central to the process of reviewing compulsory measures, and considering where criteria for compulsion are still met. The lack of evidence of consideration of how or whether support could be provided without compulsory measures suggests there is the potential for practice to become risk averse, and for CTOs to be continued on the basis of a preventative function alone, which the Code of Practice (CoP) says should not happen.

Most named persons were also contributing to care and support of their relative or friend. They generally appreciated and felt involved with the professional care and support being provided.

Care plans were in most cases appropriately addressing the person's needs and had a focus on recovery. There was evidence of good multi-disciplinary working. Whilst most practitioners involved people in decisions about their care and treatment, some were not offered the opportunity to attend the multi-disciplinary review of their care. In a small number of cases treatment was being given without proper legal authorisation. Consent and legal documentation should be considered at each medical review. It is best practice to renew all treatment certificates after three years and in a number of cases this had not happened.

Only a small number of eligible people were noted to have had physical health screening checks. Fewer than half had documented regular physical health monitoring.

Very few people had any negative comments about their accommodation.

No one was in full time employment and only eight were in part-time work.

Recommendations

Services should actively promote the use of advance statements, and individual practitioners should discuss the use of advance statements at regular intervals e.g. at review meetings.

Advocacy should be available for all patients who wish to use it.

Services should ensure that there is clear evidence of both time to time reviews and a revocation strategy in the case notes, the revocation strategy should be shared with the patient.

Local authorities should identify how they can more effectively discharge their duty under s26 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to support people on community-based CTOs to secure and sustain employment, and work with the Scottish Government to consider new opportunities to improve support for this group.

Services should ensure participation of the patient at review meetings, unless the patient does not wish to attend, when their care is being discussed.

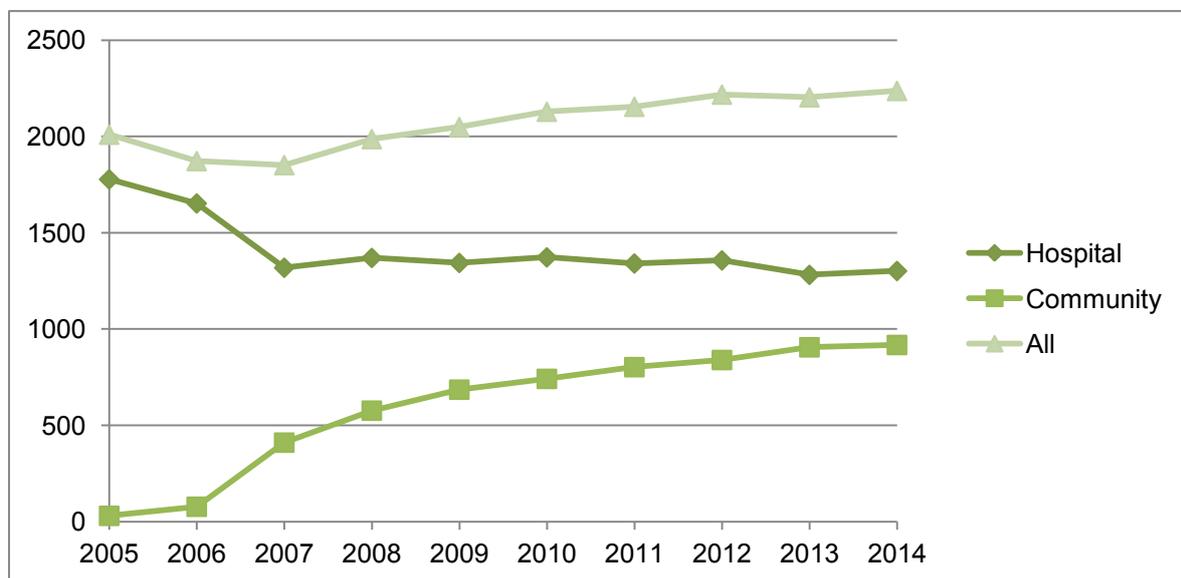
Mental health services should facilitate patients having physical health checks at least every 15 months, and access to relevant screening programmes.

Part 1: Use of community compulsory treatment orders

There has been a steady rise in the number of people subject to Compulsory Treatment Orders since the 2003 Act was implemented.

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 this might correspond with a fall in the number of people detained in hospital under long-term orders. However the rise in CCTOs has been greater than the decrease in hospital based CTOs, which has led to the slight overall increase in the use of compulsory treatment orders. These trends can be seen in [Figure 1](#) below.

Figure 1: Point prevalence of compulsory treatment orders (CTOs) 2005-2014

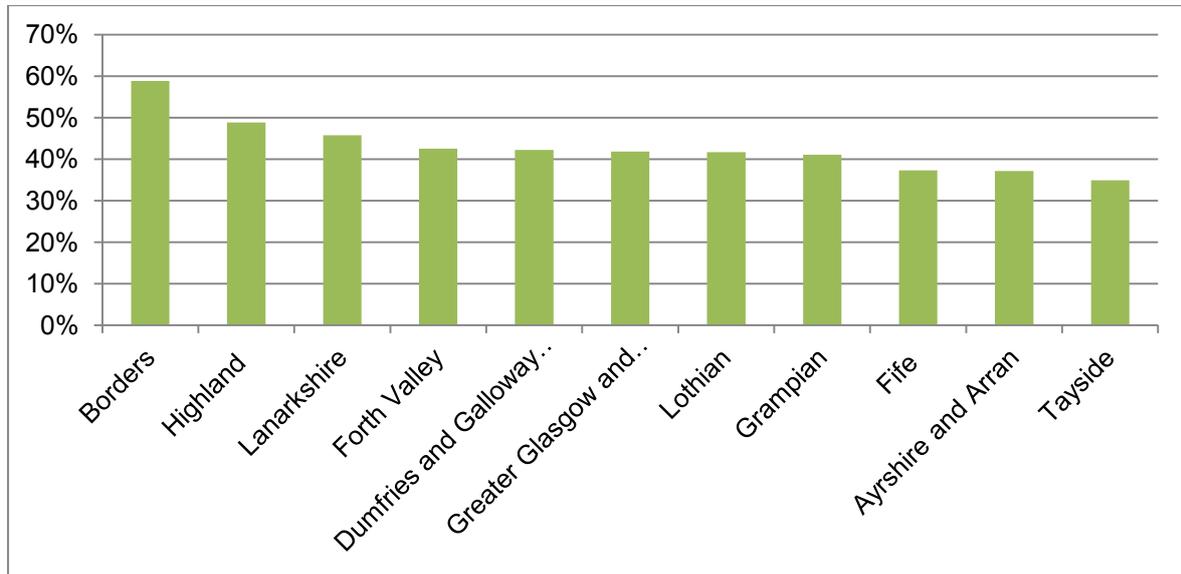


This has led to a narrowing of the gap between hospital and community CTOs with community orders accounting for 41 percent (916) of all CTOs (2180) at January 2014.

This is striking and shows the extent to which the balance of care has shifted to the community for people subject to compulsion.

The number of CCTOs as a percentage of all CTOs varies considerably between health boards, as shown in [Figure 2](#). NHS Borders is the only mainland board which makes more use of community CTOs than hospital CTOs, followed by Highland where almost half of the orders are community-based. Tayside, Ayrshire and Arran and Fife have a lower proportion of CCTOs.

Figure 2: CCTOs as a percentage of all CTOs in existence as at Mar 2014 - by NHS Board



There have been concerns since the inception of the 2003 Act about people being maintained on CCTOs for longer than necessary. In January 2015 we examined all extant CCTOs (910). We found that 44 percent (396) had been continuously in the community for the previous two years or more. The Mental Health Tribunal for Scotland reviews all orders every two years unless there has been a review for some other reason. This is to ensure the grounds for continued compulsory treatment are still met. Whilst this is an important safeguard, we are also keen to see that the grounds for compulsion are kept under regular review by the responsible medical officer (RMO) and that, where possible, there is a 'revocation strategy'.

Part 2: The people whose care we examined

We contacted 101 people in the mainland health boards who were subject to a CCTO and had been continuously in the community for the last two years or more. This implies that they are more likely to be chronically unwell.

Table 1: Individuals visited by NHS Board

Ayrshire and Arran	4
Borders	2
Dumfries and Galloway	7
Fife	8
Forth Valley	6
Grampian	9
Greater Glasgow and Clyde	21
Highland	10
Lanarkshire	9
Lothian	18
Tayside	7
Total	101

We looked at the diagnoses of the people contacted. The vast majority (97 percent, 98) had a mental illness. Of those:

- Eight people had an additional diagnosis of learning disability.
- Three had an additional diagnosis of acquired brain injury.
- One had an additional diagnosis of alcohol related brain damage.

There were two people who only had a learning disability and one person with a diagnosis of personality disorder. All three were subject to compulsion because of offending behaviour.

We looked at the case notes of all 101 people and obtained information from CPNs, MHOs, RMOs and support staff. We contacted all 101 people and interviewed 88 of

them. Twenty three people either did not want to be interviewed or were not available when we tried to visit.

Part 3: Findings

Individuals' views of the order

What we looked at

We were particularly interested in getting people's views of the CCTO, whether they felt it was of benefit to them or whether they had issues with it.

What we expected to find

Care and treatment should accord with the principles of maximum benefit and should have regard for the views of the patient.

What we found

Of the 88 people interviewed 20 made no comment on the benefits or otherwise of the order.

Of those who commented, just under a third were positive and identified benefits in being on the order. Many of these felt that the order had given them a period of stability by ensuring they accepted their medication and support. Mr A has a schizophrenic illness and a history of drug and chronic alcohol misuse which has impacted on his physical and mental health. He has had numerous hospital admissions. He was happy to be on the order and felt things were going well. He said *'I'm the best I've been all through last year and the beginning of this year'*.

Similarly Mr B has been in touch with psychiatric services since he was a teenager. He has a diagnosis of paranoid schizophrenia and has had numerous admissions to hospital. He has been on a community order for five years and he told us this was the longest period of time he has been out of hospital in his adult life. He gets support twice daily and sees his CPN twice a week. Without the support he knows he would end up back in hospital which has happened on numerous occasions in the past. He is very happy with his life at present and wants to keep things that way. He said he understands that the CCTO helps keep him well and he is *'happy just to go with the flow'*.

There were a further 13 people who said they preferred not to be on the order but recognised some of the positives of it. This usually related to the input they were receiving from their support workers.

Half of the people who gave us their views were unhappy about being on an order.

Six of these people were adamant that they were not mentally ill. For example Ms C told us she feels the order is completely unnecessary, she is not ill and when she has been off medication, she has " *had some quality of life*". She objects to the imposition of medication and the contact she has with the CMHT which she feels is punitive rather than supportive. She feels all they ever do is take her into hospital which she hates and she considers is detrimental to her wellbeing. She attends church and church groups but otherwise has limited outside interests, spending time watching TV, smoking, playing games and walking as well as doing her housework.

Staff have tried to increase input but she does not want this. She has had 10 admissions, some for quite extended periods of time, over 16 years, though has had a period of four years on a CCTO without readmission.

Mr D is diagnosed with a schizophrenic illness, and when he stops his medication he can be aggressive towards his family and has made suicide attempts. He has had numerous admissions to hospital over a 20 year period. He was clear that he does not believe he has mental illness - only a physical illness, which he maintains is caused by taking Clozapine over the past three years. He has been on a CCTO since 2009 and was clear he would not take medication if not on an order.

Of the remaining 28, 15 had issues with their medication - either having to accept a depot injection rather than oral medication, or the dosage they were having to take or the side effects. One person told us *'I'm not happy being on my CTO, I don't think at my age I need it anymore and I don't like having my injection, it's painful and I feel awful for hours after it. I'd rather have tablets to take.'* Others told us of side effects *'it dulls me'*, or *'I don't like taking medication, just having to have the injections, it makes my head feel 'funny''*

Several people were unhappy with other aspects of the administration of their medication. One told us *'I didn't like going to the local health centre to get my depot. I felt embarrassed because I was ill. I didn't like everyone knowing or thinking I was a nutter. For me it is a spiritual experience but people don't understand that.'*

People need to know their views on medication are taken seriously and administration of medication should be done in a way that respects their dignity as far as possible.

Five people said they had issues with the intrusion of support staff and three had issues with both their medication and their support.

What we looked at

We were interested in finding out if people knew about some of the safeguards in the Act.

What we expected to find

We expected that people would be aware of their right to appeal and the availability of advocacy, as these are a part of the MHO role. We hoped we might find an increase in the number of people who had advance statements, as part of the person's participation in their care and treatment.

Findings

The majority (76) of the people we interviewed (88) were aware of their right to appeal their CCTO. However, two people said they did not know they could appeal and 10 people either did not understand or did not respond to the question.

Sixteen had appealed their order at some point or were in the process of doing so; two were considering appealing and one had decided to withdraw their appeal. Four people told us they had thought of appealing but felt it was a '*waste of time*' or '*it would make no difference*'.

In terms of advocacy only two people said they had not heard of advocacy and 13 said they were unsure if they had. Under half the people we saw (39) told us they currently had an advocate and five said they would like one but did not have one currently.

Twelve people had advance statements and, as far as they were aware, these had not been overridden, though several people could not remember what was in their statement. A further six people told us they had heard of advance statements but did not want to make one.

We were disappointed that 39 people reported they had not heard of advance statements or, having discussed it with us, were unsure or not interested in having one. Six of these expressed the view that it would make no difference even if they had one. However twelve others said they would like to make a statement and a further two said they would think seriously about it.

We were told of a few examples of good practice where the person revisited their advance statement as part of their review or care programme approach (CPA) meeting to ensure it still reflected their wishes.

Reviews and revocation of orders

What we looked at

We looked at when cases had last been examined by a tribunal, either because the person had appealed or because the tribunal had not reviewed the order over the previous two years. We also looked at when MHOs and/or CPNs had been involved in reviewing grounds for compulsion, and at when the RMO had last reviewed the compulsory measures and where this was documented.

What we expected

The act requires that RMOs keep a CTO under general review and to review the grounds for continuing CTOs “from time to time.” This is in addition to their duty to carry out mandatory reviews when an order needs to be extended (every six months during the first year, and annually thereafter) or varied. We expected to find evidence in case files that the RMO had carried out “from time to time” reviews of the grounds for compulsion.

We also expected to see that individual people, carers, and professionals, understood:

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

The CoP (Vol 2, chapter 5, paras 01 -04)³ says that it is particularly important when someone is subject to a CCTO to look at progress towards recovery and review the extent to which care plan objectives are being met. It says clearly that orders should not be continued “on the basis of a preventative function alone.” We wanted to see if there was a clearly defined strategy towards revoking orders and considering whether compulsory measures were the least restrictive way to provide care and treatment.

Social Circumstance Reports (SCRs) provide helpful information for the RMO on wider aspects of a person’s life, and if up-to-date can help the RMO to decide whether or not an order continues to be necessary. MWC guidance⁴ advised an annually updated SCR for all people subject to long term compulsory measures, unless there were robust review arrangements in place which involved MHOs. We therefore looked at when the MHO had last completed an SCR, in each case.

³ <http://www.gov.scot/Publications/2005/08/30105347/53499>

⁴ http://www.mwcscot.org.uk/media/51846/Social_Circumstances_Reports.pdf

What we found

We were visiting people and reviewing records where the person had been subject to a CCTO for over two years, and therefore orders would have been extended at least twice in that period. Many people had been on a CCTO for a much longer period. Of the people we saw or whose notes we reviewed the CCTO started:

- In 2013, for one person
- In 2012 for 25 people
- In 2011 for 14 people
- In 2010 for 20 people
- Before 2010 for 41 people

We looked at the conditions in place in all CCTOs, and saw that:

- Giving medical treatment was authorised for everyone.
- Seventy seven people had one or more conditions relating to where they lived. This could involve requiring someone to live at a specified place, to get approval from an MHO or inform them of a change of address, or a combination of requirements.
- Eighty four people had a requirement to attend for medical treatment.

In 11 cases we noted that conditions had been changed at a recent tribunal, and in most of these cases tribunals had removed measures. This indicates that tribunals are considering whether certain conditions may be too restrictive when they review cases.

We looked at the records for all 101 people. As in our previous visit, practice varied across the country on where up to date information about the legality of compulsory treatment was kept. In all cases there was documentation that orders had been properly extended and that the person was still lawfully subject to compulsion.

We were satisfied that orders were being extended appropriately when mandatory reviews were needed. As before though we could see little evidence in files that psychiatrists are carrying out "from time to time" reviews. In several cases when we spoke to the MHO and/or the CPN they would tell us that there would be a discussion at regular reviews about whether the grounds for compulsion were still met, but this was not being clearly recorded. In 38 cases the care and support provided was being co-ordinated and reviewed within a CPA framework, in 30 case files we saw CPA documentation. Where the provision of support and treatment was being co-ordinated through the CPA review documentation tended to be much fuller and more detailed, suggesting that the review process was more structured. Even in

minutes of CPA meetings however there was minimal evidence of ongoing consideration of the need for compulsion.

When we looked for evidence of a revocation strategy we asked MHOs and/or CPNs about this issue. Again we could see little evidence in case notes about the circumstances in which a compulsory order would be revoked. In only eight cases the MHO or the CPN was able to confirm that there was a revocation strategy. This would almost always involve there being a sustained period when the individual was mentally well, and that there was a greater degree of confidence that the person would take medication on a voluntary basis.

Very few people could tell us that they understood when their psychiatrist and support team would feel confident they were recovering and that compulsory measures were no longer necessary.

We were disappointed to see very little evidence of clear revocation strategies in the majority of cases. We know that consideration of risk is central to the process of reviewing compulsory measures, and considering where criteria for compulsion are still met. The lack of evidence of consideration of how or whether support could be provided without compulsory measures suggests there is the potential for practice to become risk averse, and for CTOs to be continued on the basis of a preventative function alone, which the CoP says should not happen. We feel that RMOs and multi-disciplinary support teams should be looking at how risks are assessed and can be managed in partnership with individual people, exploring risk factors openly so that there is clarity about the circumstances in which treatment and support could be provided without compulsory measures being in place.

One issue which was mentioned by several MHOs as affecting decisions to revoke orders was the issue about charging for services. The COSLA charging guidelines for local authorities clearly indicates that people should not have to make a financial contribution to the cost of social care supports if they are subject to compulsory measures under the mental health act. Local authorities seem to be complying with this guidance, and no-one we saw was paying for services. In several cases we were told that there was no revocation strategy in place because the person would be assessed to make a financial contribution if they were not on a CCTO, and that there was an identified risk that they would refuse to accept support if they had to pay for part of. We feel that if this is an issue, this should be discussed openly with the person, as part of the process of assessing risks in partnership and trying to agree a clear revocation strategy within a recovery focussed approach.

Where there is evidence that a person may not access necessary support if they were required to pay for it, it would be more in keeping with the principles of the 2003 Act to use discretion to waive or reduce charges, rather than to continue to restrict the adult's liberty in order to avoid the charging regime.

When we looked for Social Circumstance Reports (SCRs) we found:

- In two cases an SCR had been prepared in the past year.
- In 17 cases an SCR had been prepared since 2010.
- In 37 cases an SCR had been prepared between 2005, when the new mental health act came into effect, and 2009.
- In 39 cases there was no copy of an SCR available.

Where SCRs were completed this tended to be after the granting of a short term detention certificate. As we have said in good practice guidance, we feel an SCR is an important document, in which an MHO can detail the interaction between a person's social and family circumstances and their mental health. We feel there is a role for updated SCRs to be completed, where people are subject to compulsory measures for extended periods. We did see good practice in specific local authority areas where the policy is that an MHOs completes a detailed review report at each CCTO renewal (West Lothian) This was however very much the exception.

Views of named persons

What we looked at

We contacted the named person, where the patient gave us permission to do so. We asked their views on the care, treatment and support of the patient and whether they felt they were appropriately involved by professionals.

What we expected to find

Care and treatment should accord with the principles of the 2003 Act and should have regard for the views of the named person.

What we found

Seventy six people had a named person, 50 of them were nominated by the person, 26 were default named persons.

With the patient's permission, we spoke to 23 named persons. Fifteen of these were very positive about the service the patient was receiving and felt appropriately involved in their care and support. The examples below reflect the overall views of this group.

His accommodation is ideal and I feel very positive about the hands on support from staff. They are excellent. They are very practical and friendly, they know him well, and they are very patient. I am involved with all the CPA meetings and attend

Tribunals. I visit him weekly and always speak to staff during visits and they will phone me to discuss any issue in between visits if necessary. I am 100 percent confident that compulsory measures were necessary and appropriate in my son's case. Without compulsory measures my son does not accept support, and his situation deteriorates very rapidly.'

Another commented 'I feel the team are fantastic, the support is really good and makes a difference. Staff know him well and are very supportive. I feel involved and that my views are listened to.'

Only two of the 23 named persons were unhappy about the care and support of their relative. Both felt little care and support was offered and both commented that they did not feel that professionals or the Tribunal listened to their views. One said '*No care or support being offered, even when she sees the psychiatrist, it's for 10 minutes. I am only consulted at the Tribunal, and they don't listen.'* The other named person told us of the poor condition of his son's flat and lack of social work support, which we followed up with the local authority.

The remaining people we spoke to were generally positive but qualified this with some concerns. One felt his wife could have more support during the day when he was at work and her anxiety increased, one was concerned about possible closure of the care home his relative was in, one felt more could be done by staff to address personal care issues, one felt communication between CPA meetings could be better and one was concerned about lack of employment opportunities.

Mental health care

What we looked at

We looked at people's care, treatment and support plans and how they were involved in decisions about their care. We asked the Commission practitioner to look at the quality of people's care and support and rate their satisfaction with the delivery of the care plans.

What we expected to find

We expected to find a number of documents outlining the plans for people's care and treatment which were outcome focussed and recovery-based. These include section 76 care plans, community mental health team (CMHT) care plans, CPA care plans and support provider care and support plans.

We would expect to see regular review of care, treatment and support plans with, as far as possible, clear partnership working between patients and professionals.

Where there are issues with accessing appropriate services, we would hope to see measures being taken to address these.

What we found

In summary the majority of care plans were good and most had a recovery-based focus. We only had concerns about a few care plans. Similarly we were satisfied with the delivery of nearly all the care plans. Sixty five percent of people felt they were participating to varying degrees in reviewing decisions on their care and treatment and staff were proactive in encouraging this. In some cases staff could provide more opportunity to increase the person's involvement in discussion and decision-making.

In every case section 76 of the 2003 Act requires that the RMO submits an up-to-date care plan when they are applying to the Mental Health Tribunal Scotland to vary and/or extend the order. In line with the principle of reciprocity, care plans should detail the support and services required and being provided to meet the individual's needs, where the individual has been required by legislation to comply with a programme of care and treatment.

In addition, where there is input from the multi disciplinary team, there may also be a more detailed working care plan. Fifty seven people had CMHT care plans and we looked at 39 of these. Where there is a support provider, they will have their own care plan detailing their objectives and service provision, which should relate to the overall multi disciplinary care and support.

Thirty nine people had support plans and we looked at 26 of these.

We also expected to see the use of the CPA for some people where there is a high level of risk and/or complex support needs. CPA is to ensure people are getting effective and well-coordinated care and support and are involved as much as possible in decisions about their care and treatment. CPA is not mandatory in Scotland. Thirty seven people's care and treatment was managed by CPA and we looked at 30 of these care plans.

Some people will have two or three care plans, depending on who is involved in their treatment and support. In addition to section 76 care plans we looked at 95 other care plans relating to 88 people. We considered 71 percent of people had good care plans and 27 percent had acceptable care plans. We only had concerns in two percent of cases. Similarly Commission visitors were satisfied or very satisfied with the delivery of the care plan in all but a few instances.

There were some examples of good recovery focused plans. For example a Commission practitioner commented as follows:

“G was diagnosed with schizophrenia at university. His mental health has improved over the past few years on Clozapine and he is relatively stable. He wants to get back to work and is involved with the mental health employment adviser and has done some training courses with a local project. He has few friends or social contacts and is very reliant on family. He is keen on physical exercise and the health care assistant is involved once a week in encouraging his interest in the golf range and tennis. He also goes to gym himself. His support is person centred and focussed on his choices.”

In some instances the practitioner was not fully satisfied with the delivery of the care plan. This generally related to difficulties in engagement with the care plan. This may have been due to symptoms of the person’s illness or that professionals have been unable to find meaningful activity which motivates the person’s involvement. For instance one of the Commission practitioners reported as follows:

‘M requires 24 hour supported accommodation and her needs are not being fully met where she is living. She could be provided with more support currently than she is willing to accept, but the support she is receiving is appropriate and delivered by support staff. She has a good relationship with them and also has particularly close support from her MHO. There have been efforts to support her to engage in social activities - she was supported to attend a women’s group last year but developed persecutory delusions about the other attendees and ceased going. She spends most of her time in the TV room smoking, watching TV and making phone calls.’

Review of care plan

We looked at people’s records to see if there was evidence of their participation in reviews of their care and treatment. Eighty percent of people attended reviews about their care and 20 percent did not. Of the 20 percent who did not, half were in one health board area and unless they are on CPA, their care and treatment is discussed at the CMHT meeting.

They are not invited to attend and their views are fed in from their ongoing contact with the RMO or CPN. This did not seem to maximise service user participation.

There were a number of examples given in the notes where it was clear that the person had been listened to. One practitioner wrote:

S has a mild learning disability, a bi polar affective disorder and a history of verbal and physical aggression towards women. He has a good package of care taking into

account his wishes. There is a good risk assessment and management plan in place with easy to follow with red, amber and green alerts. He asked for more time on his own in his flat and this was done (least restrictive). He volunteers at a gardening project in the local community and was very pleased with this. He discussed visiting arrangements and now has time with some of his family which is unsupervised.

We asked service users whether they felt involved in making decisions about their care and treatment. Seventy five people gave us their views of which 43 percent (32) were positive.

Some clearly showed the importance of support from CPNs, support workers, advocacy and MHOs. Comments included:

I always go to reviews, and they are often in my house anyway. I will always say what I want to say at these meetings.

S feels he is involved and attends all meetings. He feels his RMO has open discussions and is currently discussing medication and his sleep pattern. He is disappointed that his current RMO is only a locum.

Twenty one percent (16) of people however felt they were not listened to and 22 percent (17) had mixed views. For instance:

M feels he can talk but is not listened to in reviews. CPN supports him but he feels the doctors just make their minds up and that's that.

Six percent (four) of people choose not to go to their reviews for a variety of reasons, though in two cases their named person attends.

Eight percent (six) of people told us there were no review meetings that they could attend. CMHT reviews did not include the service user and, though their views may be fed back by the professionals involved, we felt this was not person-centred or in the spirit of the 2003 Act.

Compliance with treatment safeguards

What we expect to find

The provision of medical treatment for mental disorder is covered by Part 16 of the 2003 Act. There are safeguards for medication that is administered for more than two months. The person either gives signed consent (on form T2) or has treatment authorised by a designated medical practitioner (DMP) (on form T3). The relevant certificates should cover all the medical treatment prescribed.

Certificates under Part 16 should be subject to regular review. There should be evidence that the person's capacity to consent is reviewed regularly and the prescribed medication, including the use of 'as required' medication, properly authorised. We recommend that T2 and T3 forms should not last for more than three years, even where there has been no change in treatment.

What we found

Of the 101 people whose care we examined:

- Sixty five percent (66) had their treatment authorised by a T3 form.
- Thirty three percent (33) had their treatment authorised by a T2 form.
- Two percent (two) of people were not receiving medication as part of their treatment.

However there were some issues with consent:

- Two people had T2 forms but they were in fact not consenting to their medication.
- Two T3 forms and one T2 form did not authorise the treatment being given.
- Twelve percent of T3 and T2 forms were over three years old-some were eight or nine years old. Although this is not unlawful, we recommend that no certificate should last more than three years.
- There were no copies of forms for two people in care homes, though these were in their hospital records. It is important that care home staff have a copy so they are clear on their authority to administer medication.

These figures represent an improvement since our last CCTO visits in 2011. In 2011 treatment was not properly authorised in 13 percent of cases, compared with five percent in 2015.

In 2011 20 percent of T2s and T3s were over three years old, compared to 12 percent in 2015.

All these matters have been followed up by the Commission with the RMO or medical records staff.

Physical healthcare

What we looked at

We looked for documented evidence of physical health care reviews and appropriate investigations. We were not able to look at primary health care records but we

looked for information in the mental health notes. We also asked individual people how their physical health care needs were being met, and whether they had had a review of their physical health in the previous year.

What we expected

We know that people with mental health problems have greater risk and higher rates of a number of physical health conditions. Poor mental health is associated with an increased risk of physical illness, and a much higher mortality, with people dying on average more than 10 years earlier than the general population (Mental Health Strategy for Scotland: 2012-2015)⁵

The Scottish Government has made commitments to improve the physical health of people with a mental illness. In 'Delivering for Mental Health' (2006)⁶ the government said: "Commitment 5: We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months." In the "Mental Health Strategy for Scotland: 2012-2015"⁷ the government re-affirmed this and said: "Commitment 28: We will continue to work with NHS Boards and other partners to support a range of health improvement approaches for people with severe and enduring mental illness....."

In our last report into the use of compulsory community treatment in Scotland, in 2011, we said that we were concerned about the number of people where there was no documentation of regular health monitoring. This time we expected to find more evidence of work being done to improve physical health, and to see an increase in the number of physical health reviews.

What we found

Ninety eight people were registered with a general practitioner (GP) at the time we visited. Two people did not want to see us, and we could not confirm whether they were registered with a GP. One person was not registered. They were being seen by a specialist GP, and had been removed from their previous GP's list because of behaviour when they were mentally unwell. We followed this issue up, and confirmed that the mental health team was helping this person to register again with a GP.

Screening can help identify serious physical health conditions early, before symptoms emerge, and we looked at clinical notes to see if it was recorded that people were participating in breast, cervical, and bowel screening.

⁵ <http://www.gov.scot/Publications/2012/08/9714/8>

⁶ <http://www.gov.scot/Publications/2006/11/30164829/0>

⁷ <http://www.gov.scot/resource/0039/00398762.pdf>

Twenty nine women should have been offered a cervical screening test, 23 should have been offered breast screening, and 49 men and women should have been invited for bowel screening. Only a very small number of eligible people were noted to have accepted screening in the mental health notes: three people were noted as having had breast screening, four had cervical screening, and three had bowel screening. Slightly more people were noted to have refused screening, but in most files there was no information about involvement in screening. This does not necessarily mean that people had not been offered screening, or had not participated. We think it is important though that people are encouraged to participate in screening programmes, and that mental health services look at how they support physical health care, and encourage people to think about the benefits of screening. We visited several people who had taken up screening offers, where it was clear in the clinical notes that they had been supported to attend screening by workers, and that without this support they would not have attended.

Forty one people had documented regular physical health monitoring. This is almost exactly the same proportion of people as when we last visited people subject to community orders in 2010/11.

We did see good provision in certain areas for example CMHTs running health screening clinics. Some people were also having regular health monitoring for specific long term physical conditions, or were having regular blood tests if they were taking specific medication. Because we did not look at primary care health records, it may also have been the case that some people had had physical health checks, and this information had not been shared with mental health services. If this is so, checks may have limited usefulness if mental health practitioners are unaware of physical health problems which could have a bearing on the person's mental health and their treatment and support.

We continue to have serious concerns though that many people are not having regular physical health reviews. As we have said above, it is well known that people with severe and enduring mental illnesses have reduced life expectancy and poorer physical health than the general population. We feel the NHS could do more to support the health improvement approaches for people with severe and enduring mental illness in the way the Mental Health Strategy envisages.

We did look at how GPs were involved in the provision of mental health care and support, by asking mental health workers and the people on CCTOs we saw. In 38 cases mental health staff identified the GP as part of the system of support, and in 26 cases the GP was seen as one of the main supports. The same number of people we saw (38) also spoke of their GP as a support. Nineteen people saw their GP as one of their supports when mental health staff did not acknowledge the GP as a support. In total 57 people had the GP identified as a support, either by workers,

by the person themselves, or by both. We feel this is positive, and suggests that many GPs, who are the main point of contact for general healthcare, are seen as actively involved in supporting people in relation to their mental health care.

Accommodation and social support

What we looked at

We looked at the type of accommodation people were living in. We looked at whether residence was specified in the compulsory treatment order, at the housing support available, and how this was provided. We considered whether the accommodation met the person's own individual needs, and whether we felt the care and support provided to help the person maintain their accommodation was adequate.

What we expected

A settled home is vital for good mental health whereas poor accommodation can make mental health problems harder to manage. Housing support services can help people live as independently as possible in the community.

We therefore expected to find that people were living in accommodation which met their needs, and that housing support was being provided, where needed, to help people to manage their homes on a day to day basis.

The Social Care (Self Directed Support) (Scotland) Act 2013⁸, which came in to force in 2014, allows people to choose how social care support is provided. Local authorities must offer people four choices in how support can be provided, where a person's need for support is being assessed. We asked people therefore if they knew about the options for SDS, and if they were receiving SDS. We expected to find that information about SDS options was starting to be provided to a proportion of the people we saw, as SDS is now in the process of being rolled out across Scotland.

What we found

We got information about the type of accommodation all of the people were living in, from the individual interviews, or from file reviews. Of the 101 people:

⁸ <http://www.legislation.gov.uk/asp/2013/1/contents/enacted>

- Sixty six were living in their own homes or tenancies, either by themselves or with family or partners.
- Twenty five were living in a shared tenancy or supported accommodation.
- Six were living in group homes or hostels.
- Four were living in registered care homes.

No-one was living in temporary accommodation.

When someone is subject to a community based order certain measures can be authorised, including specific measures relating to accommodation. In 60 cases the person's address had been specified in the CCTO by the Tribunal. In 19 cases the person had to inform the MHO of any planned change of address, in 17 cases they had to get consent from the MHO to any proposed change of address, and three people had to do both, i.e. to let the MHO know and to get their consent to a change. In total 80 people had measures in their CCTO about their accommodation, and only 21 had no requirements about where they lived.

In line with the principle of maximum benefit the Commission would expect that if there are restrictions on where a person can live, then they should be living in accommodation which is suitable, and meets their needs. We were pleased that there was only one person living in accommodation which was unsuitable, and in this case the person had just received a large grant to re-furnish their house. In 11 cases we felt that accommodation was only partially suitable, and issues about accommodation were being dealt with by services. For example one person with mobility problems was due to move to a house on one level, and several people had identified that they wanted to move to smaller or bigger accommodation, and this was in hand.

Very few of the people we met had negative comments about their accommodation. Several people who were living in shared accommodation or group living situations did talk about how they would want in the future to move on. These comments re-enforce the fact that accommodation and support needs should be reviewed regularly, to ensure that people have the opportunity to move on, where appropriate, to good quality mainstream accommodation. Several people did describe problems with neighbours, and we would expect local authorities to try to help to find solutions to any problems. Several people also spoke about neighbours being very supportive, helping them feel settled in their local community. Feeling part of the community in their home was obviously an important part of feeling mentally well for many people.

We asked how people were being supported in their homes, and found that arrangements varied widely, as you would expect if supports provided are tailored to the needs of individual people. We found that:

- Of the 66 people living in their own homes 24 had visiting support workers as part of their main supports, and five had support workers on site as part of the accommodation.
- Thirty one people were living in shared, supported or group accommodation, and 15 people had support workers on site, with four having visiting support staff.
- Of the people we met and spoke to, 69 got support from family members/relatives, with 16 of that group also getting support from friends, and six having support from friends but not from family.

Some people were living in accommodation where support workers were on site 24 hours a day. They would all have planned periods when staff supported them individually, but staff would be available on site, or would be contactable on a 24 hour basis, if there was a crisis. Where support staff were not on site, the range of supports to help people manage their housing and to continue living in the community was varied and extensive. Some people had very intensive supports: we saw someone who had support workers with them for 13 hours a day, and other people who could have daily contacts with support staff for four hours a day, or would have two or three visits for shorter periods each day.

The focus of support again was variable, from very practical supports to helping people engage in activities in the community. Examples of supports provided were:

“Workers visit every morning to prompt with medication. The remaining support hours are flexible and to support with shopping, household tasks, and just provide social support.”

“She has 31 hours support from staff who assist with ... money/bills, managing her tenancy, checking food in the fridge is in date, attending appointments, activities.....”

Support could be for as little as two hours a week, and one person did comment that they felt that support provided in one hour slots was too short, because it took them time *“to get their head together to benefit from support.”* People we spoke to on visits were often very positive about the supports they received at home. Several of them attributed the fact that they had not been in hospital for some time to this support: *“he feels his support helps him stay out of hospital”* and *“the fact that I am not in and out of hospital is positive.”*

Some people did tell us that they did not feel they needed support at home, and that they felt this was unnecessary or interfering. One person who did not feel the need for support spoke about wanting to *“live without the intrusion of support staff”*, while someone else told us *“I don’t need support, I’m not harming anyone”* He clearly

wanted less input, and felt he had too many people visiting him. Sometimes people said that they did not feel they were ill and therefore did not need support.

Sometimes mental health staff clearly identified that there was a need for support at home, but the individual person was not willing to accept or engage with that support. In these situations we could see that there were significant problems arranging appropriate support, in the face of great resistance. We noted in one file that it was recorded for example that *“there is a delicate balance to be struck in providing support ascan be suspicious of the intentions of others.....Keeping her well and well supported is a finely balanced arrangement.”* In several cases we noted that support provided was the maximum the person was willing to accept, but was the minimum workers felt was needed, with one file stating that the minimal contact was allowing someone’s mental health to be monitored, and for them to be *“just maintained in the community.”*

We asked the 88 people we spoke to about whether they knew about self directed support and whether they had been assessed for SDS. We did not expect to find that significant numbers of people were receiving SDS, because the process of assessing people who were already receiving social care support before the new legislation came into effect will be a gradual one. We did expect to find that information about SDS was being provided to a number of people we met.

Of the 88 people who talked to us:

- Six said they were well informed or had some information about the SDS options.
- Fifty eight people knew nothing about SDS, with the remaining 26 people not answering this question.
- Four people had been assessed for SDS. Of these four people two were receiving SDS, and in one case arrangements were just being made to implement SDS.

The two people who were receiving SDS had both opted for the option of choosing their support, with the local authority making the arrangements: one person told us *“I didn’t like the council service, so they helped me get (service provider) in.”*

Finance, employment, and activity

What we looked at

During our visits we looked at whether people were in paid employment or were participating in voluntary work. We asked people to tell us how they spent their time.

Where people were prepared to provide information we also asked about the benefits they were receiving, and whether they had had any difficulties with benefits.

We also asked how people were managing their finances.

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

What we expected

There is evidence of links between debt and mental health problems, and we know that mental illness can restrict a person's educational and employment potential.

Being in work can be an important step to recovery and can help maintain good mental health, we also know though that there is a link between unemployment and poor mental health. The Royal College of Psychiatrists website⁹ contains information on the impact of mental health problems in employment and concluding that "mental health problems have a greater impact on people's ability to work than any other group of disorders."

People currently claiming welfare benefits are now experiencing the biggest change to the benefit system for many years. A number of new benefits are replacing existing benefits, with the aim of simplifying the benefit system, and reducing the overall benefit budget. Most people will move over to Universal Credit over the next few years: Disability Living Allowance (DLA) will be replaced by Personal Independence Payment (PIP) which will involve everyone currently getting DLA being re-assessed; Employment and Support Allowance (ESA) is being introduced gradually across the country, with work capability assessments being used as the test by the Department for Work and Pensions (DWP) to check if people are not well enough to work, and are eligible for ESA. Finding your way through the welfare system can be difficult and stressful and the benefit system is complex. There is also clear evidence that poor mental health is often associated with experiencing problems with the benefit system, and that benefit problems can impact on mental health (Reference: Centre for Mental Health report: Welfare advice for people who use mental health services, 2013¹⁰)

A number of voluntary sector organisations and professional bodies including the Royal College of Psychiatrists and Social Work Scotland have highlighted a range of concerns about the welfare reforms, including increasing sanctions (when benefits are stopped) and how work capability assessments are undertaken. There are

⁹ <http://www.rcpsych.ac.uk/usefulresources/workandmentalhealth.aspx>

¹⁰ <http://www.centreformentalhealth.org.uk/welfare-advice-report>

significant worries about the lack of understanding about mental illness in the benefit system, and about the impact this has on individual people claiming benefits.

We hoped to see support helping people to access employability services or education or training opportunities, where this was appropriate. This is a clear statutory responsibility of the local authority under s26 of the 2003 Act.

We also expected to find that people had good access to services to ensure that their income was maximised, and that support was available where there were issues about benefits, managing finances, or about personal debt.

The Scottish Recovery Network identifies that a key theme in recovery is finding a meaning and purpose in one's life, and being able to lead a satisfying life (Scottish recovery Network Discussion Paper Series: Paper 1, Elements of recovery)¹¹ We expected to find that people were engaged in activities in their communities which helped them feel they were leading a satisfying life.

What we found

Although we asked specific questions about benefits, we did not get a clear picture of how benefit changes may be impacting on the people we met. When we last visited people on CCTOs five years ago, we found that 80 percent of people were receiving DLA. On the recent visits we spoke directly to 88 people, and 50 people were willing to talk about their benefits and finances. Thirty seven people were receiving DLA, and four were now on the new PIP, so the proportion of people on benefits which aim to help with extra costs caused by long term ill-health or a disability is 82 percent, almost the same as in 2010/11. No-one identified that they were receiving Job Seekers Allowance (JSA), so no-one was in the group of people who are unemployed and actively looking for work. Sixteen people said they were receiving Income Support, and 20 said they were on the new ESA. Several people also knew that they were receiving pensions and pension credits. However it was also clear that many people did not know the specific benefits, and were unclear about the benefit changes to be introduced over the next two years. Twenty one people, out of the 50, told us about advice or support they had had in the past, to maximise their benefits and income. Support had been provided in different ways – by local advice centres, by CPNs or hospital staff before discharge, by social workers, MHOs, or local authority welfare rights workers, and by staff from support provider organisations. A few people also spoke about how issues about benefits are discussed at regular review meetings. We feel that is a useful approach, as it will make sure that any issues about maximising benefits, and potential changes in benefits, will be looked at routinely.

¹¹ <http://www.scottishrecovery.net/View-document-details/114-Elements-of-recovery-International-learning-and-the-Scottish-context.html>

We feel it is important that people continue to receive advice and support about benefits and their entitlements, particularly with the planned changes. The need for improved access to advice has been highlighted in a new report by the Scottish Mental Health Partnership, “Ticking all the Wrong Boxes: Mental Health and ESA” (April 2015)¹².

The majority of people who talked to us about their finances said they were able to manage their own money (29 out of 50 people) 12 people reported that they had difficulties managing their personal finances, and some people were unwilling to discuss this issue. Eleven of the 12 people who said they had difficulties with finances also said that someone was acting as DWP appointee, to manage their benefits.

One person did tell us that he would like to manage his own money, but also said he realised that there would be a risk he would be financially exploited. Several other people also spoke about how they have run up debts in the past, or have been taken advantage off financially. Where formal arrangements were in place to assist with managing money, the individual person generally was satisfied with the arrangements for them to access money for their personal use, and we did not find any major problems in how people were being helped to manage their personal finances. We also saw that where specific protection issues had been identified, appropriate steps were taken for example one person had been getting threats from a drug dealer about money he allegedly owed: the police had been involved, in addition to a DWP appointee being arranged.

Some people we met were not willing to talk about their finances in detail but did tell us a little about the support they received to manage their money, and we did gather information from contacts with staff providing support about how other people we were not able to talk to were supported to manage their finances. We saw that Part 3 of the Adults with Incapacity (Scotland) Act 2000¹³ (AWI) was being used in one case, and Part 4¹⁴ was being used in another. DWP appointeeship was in place for 30 people, including the 11 people who spoke to us about their finances and acknowledged that they had difficulties managing money. The Commission’s good practice advice, “Money Matters”¹⁵, has identified specific advantages and safeguards in relation to the use of DWP appointeeship. On these CCTO visits we could see that appointeeship is being used reasonably often, both by family members and local authorities. We did not pick up any concerns about the use of appointeeship, and in certain cases there was clear information about the reasons why this approach to managing finances was being used. However, it is important to

¹² http://www.samh.org.uk/media/439144/ticking_all_the_wrong_boxes_2_.pdf

¹³ <http://www.legislation.gov.uk/asp/2000/4/part/3n1>

¹⁴ <http://www.legislation.gov.uk/asp/2000/4/part/4>

¹⁵ http://www.mwscot.org.uk/media/216003/money_matters.pdf

recognise that there is no formal right of appeal when appointeeship is used, thus the need for appointeeship should be kept under review.

When we looked at employment we were disappointed with what we found, as we were in 2010/11. Out of 101 people no-one was in full time employment. Out of the 88 people we spoke to:

- Eight were in part time or voluntary work.
- Five were going to courses at college or university, with one person attending an art class, and two people in computing classes.
- One person was in a training course related to finding work –this was a confidence building course.
- Thirteen identified themselves as retired. Eleven of them were over 65, and two people under 65 said they were retired.

Of the eight people who were in part time or voluntary work seven were doing work which was unpaid (the other person did not tell us if they were in paid part time work) voluntary work placements were all with third sector organisations, and included gardening or outdoor conservation projects, fund raising, and working in charity shops.

As in our previous visits most of the people we saw had long standing mental health problems, and often had periods of acute mental ill health. For many of these people a return to some form of employment was not an option, and this is reflected in the fact that no-one was receiving JSA. Several people told us about how they had not been able to work for decades: one person in their 50s said they had only worked when they were 18. We know that being permanently unable to work affects your mental health (Scottish Health Survey Topic Report, Mental Health and Wellbeing, January 2015)¹⁶ We would therefore have expected to see more evidence of people being supported to access training and educational opportunities, or to think of this as an option for the future, as part of their individual route to recovery.

In addition to the existing statutory responsibility under s26 of the 2003 Act, we note that the Scotland Bill, currently before Parliament, gives the Scottish Parliament legislative competence in relation to creating employment schemes to assist those at risk of becoming long-term unemployed, and to help disabled people into work. We believe more needs to be done to assist people with long term mental health problems to secure and maintain employment, and we hope that the opportunities afforded by these new responsibilities will be seized.

We asked people to tell us how they spent their time generally during the week.

¹⁶ <http://www.gov.scot/Publications/2015/01/4163>

Some people described having very active lives, which they clearly felt were satisfying. One woman said *“I am happy with the way things are”* and spoke about the range of things she did, attending a therapeutic art group, having frequent contacts with extended family, going to women’s groups at her local church, and socialising with other church members.

Several people who had extended family living close by also spoke positively about the contact and support family members, and friends, provided. Other people told us about using day centres or drop in centres, about a range of physical activities they enjoyed, from curling to golf and fishing, or about informal social contacts they enjoyed, meeting friends for meals, for coffee, or in the pub.

However, when some people told us about things they did during the week, they clearly had very limited social contacts or community connections. We heard from people about how they spent much of their time in their homes, watching TV, when they went out it was often just to get shopping, or to have a coffee with a support worker. A number of the people we met were isolated and had very restricted contacts.

We did see that services were recognising that when someone was withdrawing from having social contacts, this could be a sign of relapse, and in several cases support staff were clearly trying to encourage and motivate people to participate in activities. Some people also prefer to spend time on their own. However we know that loneliness and isolation can affect your mental health and can become chronic problems, if the importance of having links with others in the community is not recognised (Mental Health Foundation: *The lonely society?* 2010)¹⁷

Conclusion

We were pleased to hear the views of so many people who have been on CCTOs for more than two years, being subject to a CCTO appears to help many people to remain out of hospital. The quality of care and support was generally good however much of the focus of care seemed to be mainly about medication rather than looking holistically at a person’s needs.

We were concerned at the lack of evidence of mental health services actively promoting physical health checks, this is important as people with long term mental health problems have an increased risk of physical illness.

¹⁷ <http://www.mentalhealth.org.uk/publications/the-lonely-society/>

Orders should be reviewed more frequently and there should be a revocation strategy. The use of advance statements should be promoted as a means of empowering patients.

Very few people had any form of employment. We believe that more opportunities for paid or voluntary employment would aid the recovery process.

We hope that services use the information and recommendations in this report to help people recover and have a good quality of life.





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