mentalwelfare commission for scotland

dignity & rights ethical tre respect ca & equality

STATISTICAL MONITORING

Equality report 2012/13

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Equality report 2012/13

In undertaking our duties under mental health and incapacity law, we have also been mindful of the provisions of the Equality Act 2010, as well as the requirements for public authorities set out under the public sector equality duty. In particular with regards to our visit work we are required to have due regard to eliminate unlawful discrimination, harassment and victimisation and other prohibited conduct.

When we report on the overall use of mental health and incapacity legislation, we can only use the information which the law states we should receive. When we visit individuals, we are able to do more to assess attention to protected characteristics, especially race and religion. We have plans to improve our reporting further during 2013-14.

1. Monitoring data

Age and gender

We have published consistent findings over the last few years. These include:

- Women are generally more likely to be subject to brief orders such as the nurse's power to detain and emergency detention certificates (EDCs) (although almost as many men as women were subject to emergency detention in 2012-13).
- Men are more likely to be subject to long-term civil orders and to criminal procedure orders. Men aged 18 and over are more likely than women to be detained under short-term detention certificates (STDCs). For young people under 18, it is the other way round. This may be due to the higher incidences of eating disorders and self-harm in younger females.
- The use of the Act for individuals under the age of 18 remains higher than it was prior to 2011. We think this is because practitioners recognise that, for young people under 16, it is better that the young person has the safeguards of the Act. Previously, we thought that some practitioners placed too much reliance on parental consent.
- We have serious concerns about access to specialist young people's wards in some areas, notably Greater Glasgow, Lanarkshire, Forth Valley and Grampian. In some of these areas, there may be inequalities in access to intensive home treatment.
- Welfare guardianship tends to be used mostly for young people with learning disability and older people with dementia. In 2012-13, the number of indefinite guardianship orders fell for the third successive year. Individuals are now 50% less likely to be subject to indefinite guardianship that, for younger people, may deprive them of liberty without independent review. While we are still firmly of the view that the Adults with Incapacity (Scotland) Act 2000 requires amendment to become compliant with requirements of human rights law

through statutory review of welfare guardianship orders. It is good that practice is becoming more human rights compliant.

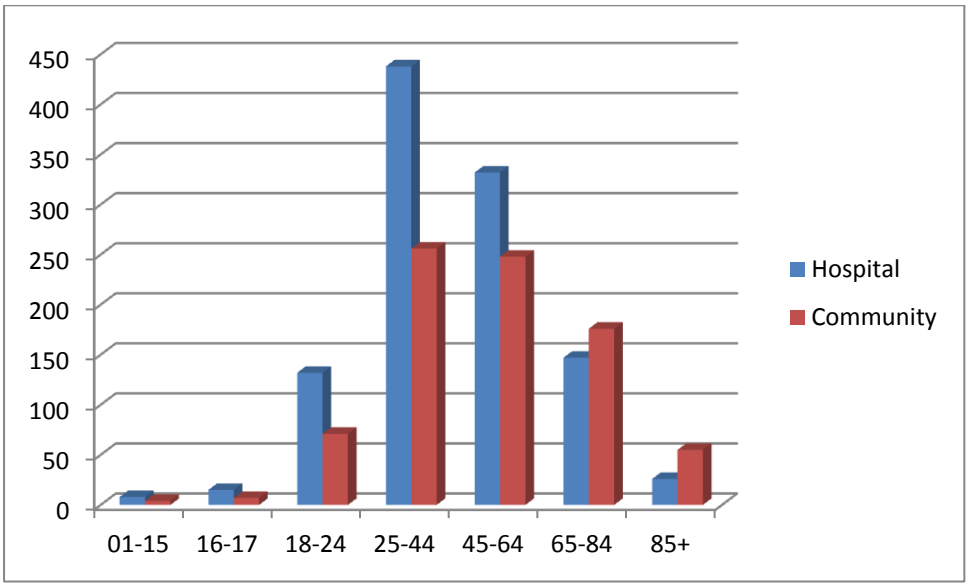
- Older people have a higher likelihood of being detained under mental health legislation although we have seen a decrease in the use of welfare guardianship in this age group. For individuals with dementia in hospitals and care homes, there is uncertainty as to when there is “deprivation of liberty”. We published updated guidance on this topic this year[1]

Because of the higher use of mental health legislation in older adults, we looked in more detail at differences among age groups in the pattern of use of mental health legislation. The most striking differences were in the use of emergency detention certificates.

Special report: emergency detention of older people

Emergency detention certificates can be granted for people in the community or for people already receiving care and treatment in hospital. We looked at the relationship between age and pre-detention status.

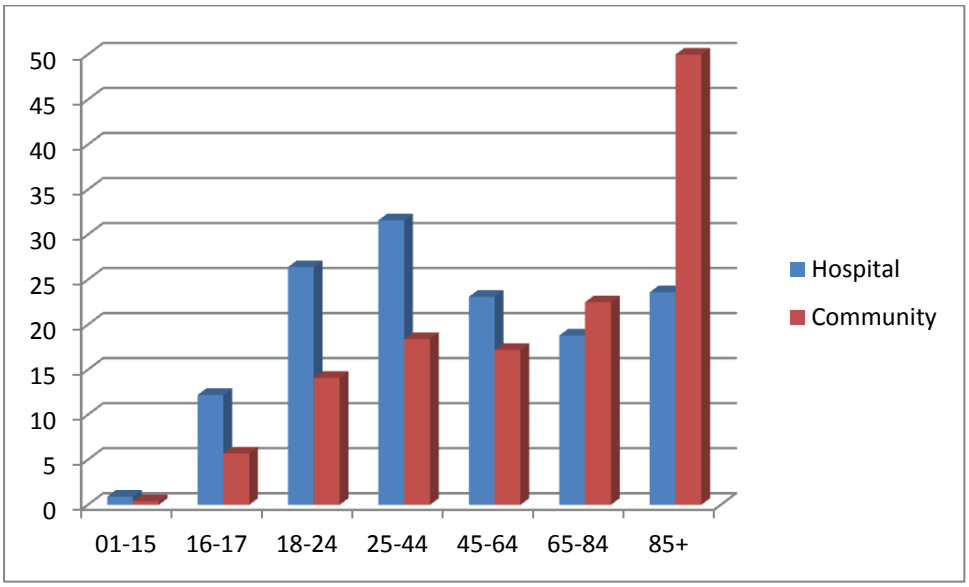
Figure 1: Emergency detention certificates granted 1st April 2012 to 31st March 2013: age and pre-detention status.



For most age groups, emergency detention is most often used for people already in hospital. Some of these may be for individuals presenting at accident and emergency departments. In contrast, emergency detention certificates granted for people aged 65 and over are more likely to be initiated in the community. We compared the relative rates of emergency detention across different age groups by population.

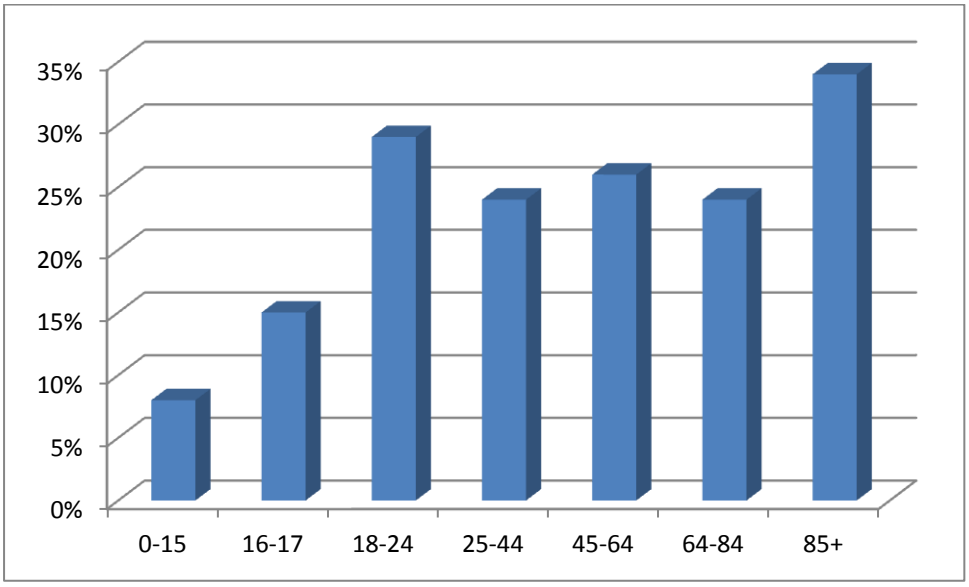
[1] http://www.mwcscot.org.uk/media/124856/mwc_deprivation_of_libertyanalysis-2.pdf

Figure 2: rates of emergency detention by age group per 100,000 population 2012-13



We found a much greater rate of use of emergency detention from the community for people ages 85 and over. We compared the way that compulsory episodes were initiated across different age groups. We wanted to see whether or not older people were more likely to have their compulsory episodes initiated by an emergency detention certificate.

Figure 3: percentage of compulsory episodes initiated by an emergency detention certificate by age group per 100,000 population 2012-13



Overall, 25% of all compulsory episodes start with an emergency detention certificate. This rises to 34% for people aged 85+. In contrast, very few compulsory episodes for young people under 18 start with emergency detention, although there is another smaller peak for people aged 18-24.

This is important. We have consistently stated that admission by short-term detention gives the individual the safeguards of expert mental health and social work assessment before being deprived of liberty and given compulsory care and treatment. This safeguard is not applied equally across age groups, with people aged 85 and over being most likely to be deprived of these assessments before admission. Because of these concerns, we looked into the circumstances of the 55 individuals aged 85 and over who were admitted from the community under an EDC. We examined the emergency detention certificates in more detail.

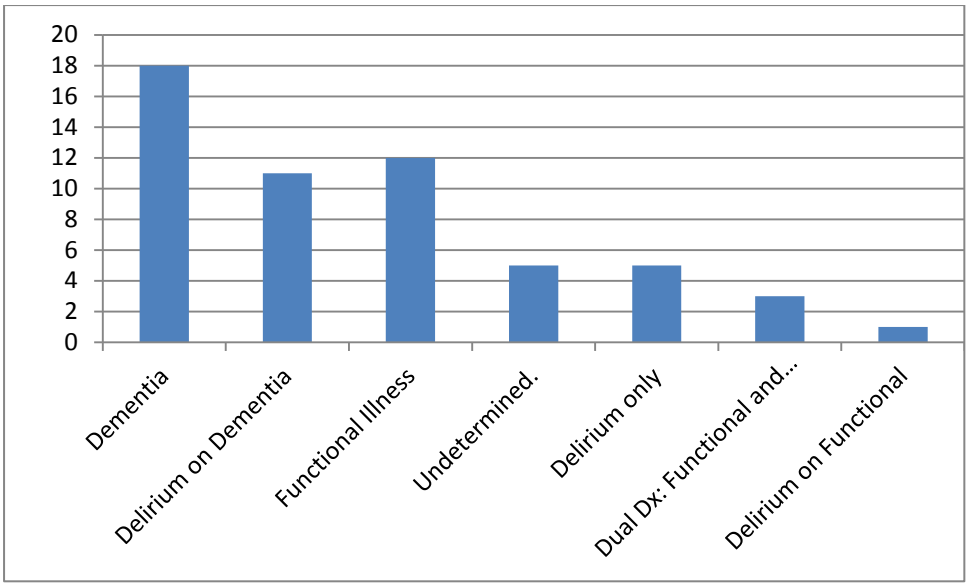
Emergency detention certificates for individuals aged 85+

The number of EDCs from the community for individuals aged 85 and over is relatively small. Although proportionately higher than expected, we warn against reading too much into these figures. However, we think there are some useful lessons from examining these episodes of detention.

General Findings

- Almost all of the certificates were granted by GPs (90%). This suggests that availability of approved medical practitioners is a problem.
- MHO consent was obtained in most cases (85%). It was good to see that MHO services were responsive, including out-of-hours services.
- More than half had a diagnosis of dementia (52%).
- Of those with dementia, 38 % (11 out of 29) had a superimposed delirium.
- 22% had a functional illness.
- Five had delirium without a pre-existing diagnosis of dementia. One of these had a previous functional mental illness.
- Of the five who had delirium, three went onto a STDC.
- Three had functional and organic illnesses which both seemed to contribute equally to presentation
- Five had an undetermined diagnosis (i.e. it was not clear on the EDC)

Figure 4: number of patients by diagnosis.



Time and location of granting EDC

- Half were granted during working hours. This contrasts with the general finding that most EDCs are granted outside working hours.
- Twenty were admitted from care homes. This is over a third of the number of people subject to EDCs. Many of these orders were granted outside working hours.

Risk

- All but two were recorded as requiring detention because of risk to their own health, safety or welfare.
- Of this group, half were also recorded as representing a risk to someone else.
- Only two were detained because they were placing someone else at risk rather than being a risk to themselves.

Reason for not doing a STDC

- 35% of referrers contacted specialist mental health services and were advised to complete EDC. Contact was with either Consultant old age psychiatrists or other specialist mental health service providers.
- 25% stated behaviour problems related to delirium or dementiua (aggression and/or agitation) as reason for not seeking STDC.
- 20% stated that a either psychiatrist or MHO was unavailable.
- 4% were additionally too medically unwell to await the completion of an STDC.

9% gave unclear or non-committal reasons. Some of these certificates may not stand up to legal challenge. Examples include:

- *"Has cognitive impairment", without further elaboration.*
- *"Offered GP follow-up and medications but refused."*
- *"I am a GP and not appropriate."*

There were four EDC forms where the reasons did not fit any of the above categories:

- One GP had not completed the box. This was identified by our system and we are following this case up.
- One GP stated when asked what efforts were made with respect to granting a STDC, "none."
- One GP stated a psychiatric review had been done earlier that day and at time of referral (out of hours) there was a reduction in community services available.
- The other individual had erotomanic delusions regarding her psychiatrist therefore it was thought inappropriate to request he complete a STDC.

The data we analysed is only as good as what is written. For example, a GP may have documented that a psychiatrist or MHO was 'unavailable' after having actually conferred with them. This is different from being *'uncontactable.'* Similarly, those who documented a patient as being too aggressive or agitated may have spoken to a psychiatrist but not documented this.

It seems likely that most individuals with dementia who had stressed or distressed behaviour presented in a way that was deemed too severe and distressing for themselves as well as family/other residents to make waiting for a STDC reasonable.

From examining EDCs for individuals aged 85 and over, we reached the following conclusions:

- The main diagnosis was that of dementia;
- Difficulties in management of stressed and distressed behaviour in care homes, especially outside "working hours" may lead to higher rates of emergency detention;
- Lack of ability of AMPs working in old age mental health services to respond to crises may result in more individuals being detained under EDCs;
- General medical practitioners often do not properly document the reasons for granting an STDC and may need more education and advice in this area.

NHS Boards and their partners may need to address these issues. Older individuals should not be disadvantaged by having relatively less access to specialist assessment before being detained under mental health legislation.

Disability

Other than the presence of mental illness, learning disability or personality disorder, we are not provided with specific information on disability. Most people subject to mental health legislation have mental illness. We are publishing updated census data on the use of mental health legislation for people with learning disability. One of the main findings is that they are on average detained for longer periods of time than people without learning disability.

Race

Table 1: Ethnicity of individuals as notified to the Commission on mental health act forms 2012-13

Ethnicity	Notifications to MWC 2012-13		Scottish population**
	Number of notifications	% of known total	%
White Scottish	3509	86.66	88.09
White British	252	6.22	7.38
White other	92	2.27	0.98
White Irish	19	0.47	1.54
Indian	11	0.27	0.30
Bangladeshi	7	0.17	0.04
Pakistan	43	1.06	0.63
Chinese	8	0.20	0.32
Asian (other)	20	0.49	0.12
Black (African)	49	1.21	0.1
Black (Caribbean)	2	0.05	
Black (other)	2	0.05	0.06
Mixed	15	0.37	0.25
Other	20	0.49	0.19
Total known	4049	100	
Not provided or unknown	1610	28.45*	
Total number of forms	5659		

**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 these figures

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.

There are problems in collecting and interpreting this information. We only have information on 72% of all forms submitted to us. Also, the ethnic composition of Scotland's population has changed since 2001. This data must be interpreted with great caution. Note that we have no data on the ethnicity of individuals for whom welfare guardianship is granted. There is no requirement to report this on any of the forms submitted to us.

What we found

We can only report on ethnicity if it is recorded on the forms sent to us. The data published here appears to indicate a substantially greater use of compulsory powers for individuals who describe their ethnicity as Black African.

For a much more detailed analysis of ethnicity, mental health and compulsory treatment see the study by Bansal et al[2]. This showed lower than expected rates of hospital admission for individuals from some minority backgrounds, but a proportionately higher use of compulsory powers. This suggests that people from some minority backgrounds do not use mental health services until they are so severely ill that compulsory treatment becomes necessary. We participated in this study and were co-authors of the report.

2. Information from our visits

Equality and diversity requirements: findings from our visits.

Our interest in this

We carried out our duties under the Equality Act 2010 and the general duty to record information on as many aspects of equality and diversity as possible. On our visits, we wanted to target people from minority ethnic backgrounds and/or those whose first language was not English. This included deaf people who used sign language.

On our visits, we assess whether or not individual care and treatment is in line with relevant legislation. We included aspects of the Equality Act when conducting this assessment. We wanted to find out whether or not people in this category were receiving culturally sensitive care and treatment. This included finding out about:

- Availability of interpretation, if needed;
- Family involvement and support;
- Religious requirements;
- Dietary requirements.

[2] Narinder Bansal, Raj Bhopal, Gina Netto, Donald Lyons, Markus F.C. Steiner & Sashi P. Sashidharan (2013): Disparate patterns of hospitalisation reflect unmet needs and persistent ethnic inequalities in mental health care: the Scottish health and ethnicity linkage study, Ethnicity & Health, DOI: 10.1080/13557858.2013.814764

What we found

We managed to record the ethnicity of 96% of all the people we visited, an increase on last year's recording. Around 2% were from black or minority ethnic groups, consistent with the Scottish population.

Table 2: Ethnicity of individuals visited by the Commission 2012-13

Ethnicity	Individuals visited by the MWC		Scottish population**
	Number of visits	% of known total	%
White Scottish	2262	92.5	88.09
White British	87	3.5	7.38
White other	20	0.82	0.98
White Irish	7	0.29	1.54
Indian	7	0.29	0.30
Bangladeshi	0		0.04
Pakistan	20	0.82	0.63
Chinese	5	0.20	0.32
Asian (other)	5	0.20	0.12
Black (African)	7	0.20	0.1
Black (Caribbean)	2		
Black (other)	1		0.06
Mixed	5	0.20	0.25
Other	16	0.65	0.19
Total known	2444		
Not provided or unknown	114		
Total number of visits	**2558**		

Interpretation: we found 13 people who required interpretation services. All had access to interpretation. In many cases, staff and family members also assisted with communication. Individual needs varied considerably and we were impressed with efforts made to assist communication.

Example – *We met Mark on one our visits to people receiving intensive community support. He has a learning disability and is deaf. He uses British Sign Language (BSL). All care staff are basic level BSL users and are trained to level 2 once working with Mark. Due to Mark's small thumbs his signing is unique to him so it needs his staff members or family to interpret what he is saying*

Family involvement: We found good family involvement. Where we were able to meet relatives, we found that they appreciated the support they received and the attention to cultural needs.

Example – *We met Asif on one of our hospital visits. He was detained in hospital and his mother visited regularly. His brother was his named person but lived some distance away. His brother told us that staff had paid attention to Asif's cultural needs. He is Muslim but is non-practicing. He has lived in the UK since early childhood and any cultural needs were being addressed by staff. He has a halal diet.*

Religion: for many people, the need for religious observance and support is very important. We specifically recorded this where the individual was from a minority ethnic background. Generally, we found that facilities were available to continue religious practices, but this was not always possible where individuals were detained in hospital, despite the best efforts of staff.

Example from one of our visitors – *Mohammed was attending local mosque before admission, cannot attend now because detained and no suspension of detention approved yet. I've discussed someone from the mosque coming in to see him though, and he does not want anyone to visit him while he is in hospital.*

Other individuals were able to continue religious practices.

Example – *Abda told us, "I get a private room for prayer and can also use the prayer room, there are prayers on a Friday in hospital which I go to."*

Diet: for some ethnic or religious groups, specific dietary requirements are important (e.g. Islamic or Jewish people). We found this to be complex, especially if the individual was diabetic or had other health issues. Despite this, we found that everyone we saw was receiving a culturally appropriate diet. Hospitals supplied Halal or Kosher food. In some cases, the individual wanted to prepare food him/herself and was helped to do so.

Conclusion

From our visits in 2012-13, we were generally satisfied that services were paying attention to the specific requirements of minority ethnic groups and also the needs of the one deaf person we visited. We did not record specific issues in relation to individuals with other protected characteristics.

In 2013-14, we are asking all individuals we visit, where possible, about any discrimination or disadvantage they have faced as a result of having one or more protected characteristic. We will report on our findings in next year's report.

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