

Our overview of mental welfare in Scotland 2007-08

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

1 Director's introduction

This report gives an independent overview of the operation of the use of legislation to provide care and treatment for people with mental disorders. 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 mental disorders. We provide statistical information on how 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. Our findings and opinions have helped to change mental health practice for the better and this report contains information on significant improvements – for example, continued falls in emergency detentions, better consultation with named persons and improved services for younger people.

We rely on information reported to us. We greatly appreciate the help we get from medical records departments in hospitals, local authority officers, the Mental Health Tribunal for Scotland and the Office of the Public Guardian. They all have legal duties to report orders and interventions to us and we acknowledge the work involved. However, we know that there are some significant gaps in our information. In particular, we are missing information from the Tribunal on a significant number of cases where compulsory treatment orders have been granted. For this reason we have,

where possible, relied on statistics compiled from Tribunal records and reported to us by them. We are grateful for their permission to reproduce these here.

We believe that it would benefit everyone to have a single system to monitor the operation of the 2003 Act. We have recommended to the Scottish Government that the monitoring systems used by the Tribunal and ourselves are merged. This would improve reporting and reduce the time spent by both organisations on the transfer of information. It would also simplify reporting requirements for NHS Boards and local authority staff. Work has started on this and we await the outcome with interest.

This is the last overview report that we will publish in paper form. We will continue to publish an annual report. In future the information in this report will be published in a new area on our website. The MWC 'report hub' is available this year and will provide an easy point of access to future monitoring data. Visit <http://reports.mwscot.org.uk> to view data on-line.

None of this would be possible without the expertise and diligence of our staff. I wish to record my thanks to all our administrative, information, database and communications staff for their assistance in producing this report.

Table 1: Episodes initiated between 1 April 2007 and 31 March 2008 and comparison with 2006-07

Episode sequence	Episodes 07-08	Episodes 06-07	% Change
Emergency detention to informal status	916	991	-8%
Emergency detention to short-term detention	992	1038	-4%
Direct to STDC	2152	2217	-3%
Direct to CTO (including interim orders)	132	133	-1%
Total episodes	4192	4379	-4%

2 Overview of the operation of the Mental Health (Care & Treatment) (Scotland) Act 2003

2.1 Introduction

We have presented information on the use of the Act slightly differently this year. This part of our report is divided into four broad parts:

- New orders granted in 2007-08
- Total numbers of orders in existence
- Monitoring of priority areas
- Other data

The purpose of this part of the report is to give a national overview and our commentary on the use of the 2003 Act.

2.2 New orders granted in 2007-08

2.2.1 Accessing and exiting compulsory treatment – episode sequences

Table 1 shows all the episodes of detention reported to us in 2007-08. We have compared them with our figures for the previous year. Overall, the total number of episodes reported to us has fallen by 4%, compared with the previous year, the largest reduction being in the number of very brief episodes of emergency detentions. This continues the trend we have seen since the introduction of the 2003 Act. Strict grounds for emergency detention coupled with improved crisis services are the likeliest explanations for this particular reduction.

We also wondered whether the use of compulsory treatment in the community is reducing the number of episodes of hospital detention. Could it be that community measures are supporting people better, preventing relapse and reducing the number of emergency and short-term admissions?

Table 2: Emergency detention by age and gender, 1 April 2007 to 31 March 2008

Emergency detentions	Female	Male	Totals (%)
0-15	5	3	8 (0)
16-17	15	12	27 (1)
18-24	121	116	237 (12)
25-44	425	426	851 (44)
45-64	267	252	519 (27)
65-84	134	103	237 (12)
85+	41	14	55 (3)
Totals (%)	1008	926	1934 (100)

In addition to the episodes in Table 1 (page 3), we also found 107 admissions of people who did not comply with community measures (see page 31, Table 26). If all of these people would previously have been admitted under emergency and short-term detention under the old Act, the total number of episodes has actually fallen by just under 2%, rather than the 4% shown in Table 1. Therefore, we do not think we can say that compulsory treatment in the community is resulting in a significant reduction in the need for compulsory admission, but we will continue to monitor this closely.

2.2.2 Emergency detention

When the Act was implemented, a short-term detention certificate (STDC) was the expected route into compulsory treatment. STDCs carry greater safeguards, including a right of appeal. We were pleased to see a reduction of around 60% in the use of emergency detention since the implementation of the 2003 Act. Last year, we found that STDCs were the norm during office hours, but that

emergency detention certificates (EDCs) were still used in most situations where compulsory admission was necessary outside office hours. Our data for 2007-08 shows that little has changed.

The total number of EDCs fell from 2045 last year to 1934 this year. The rate of detention fell across all age groups except for people under 18 (up from 30 to 35). If we are correct in our belief that improved crisis services reduce the need for emergency detention, this could mean that crisis services for younger people need more attention.

We also wanted to find out how often Mental Health Officers (MHOs) gave consent as this is an important safeguard for the individual. The MHO needs to be sure that the grounds for the order are met and should explore alternatives to granting the certificate. However, under the 2003 Act, it is possible for one medical practitioner, not necessarily approved under the Act, to detain a person for up to 72 hours in hospital without the consent of a MHO. We have expressed

Table 3: EDCs with and without MHO consent by NHS Board, 1 April 2007 to 31 March 2008

	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	35	54	72	56	56%
Borders	12	62	11	2	85%
Dumfries & Galloway	56	55	56	27	67%
Eilean Siar	8	50	–	2	0%
Fife	35	43	86	40	68%
Forth Valley	41	48	102	15	87%
Grampian	24	62	105	24	81%
Greater Glasgow & Clyde	43	41	274	234	54%
Highland	55	41	81	87	48%
Lanarkshire	23	44	54	76	42%
Lothian	48	51	312	79	80%
Orkney	10	0	2	–	100%
Shetland	18	75	3	1	75%
Tayside	34	41	110	23	83%
Scotland	38	47	1268	666	66%

*In 34 cases there was no information provided about pre-detention status

concerns about this as part of the review of the Act.

In all cases the medical practitioner must either obtain MHO consent, or state why it was impracticable to do so. Table 3 (above) shows the proportions of EDC with and without consent in each NHS Board area. The main findings were:

- Good rates of consent in Forth Valley, Borders, Tayside and Grampian.
- Lanarkshire's low rate of consent must be balanced against a very low rate of emergency detention. However, the rate of emergency detention in Grampian was about the same, but with a much higher rate of consent.

Table 4: EDCs by pre-detention status and MHO consent to detention, 1 April 2007 to 31 March 2008

Prior status	Number with consent	Number without consent	Total	% with MHO consent
Informal in hospital	630	366	996	63%
From community	620	284	904	69%
Total (%)	1250 (66)	650 (34)	1900	–

Notes: The table excludes 34 cases where there was no information about pre-detention status.

Table 5: EDCs by time of granting of certificate and MHO consent to detention, 1 April 2007 to 31 March 2008

Time of granting of certificate	% of total	% of total with consent	% of total without consent
Within office hours	31	21	10
Outside office hours	69	44	25

- Greater Glasgow & Clyde, Ayrshire and Highland have comparatively low rates of MHO consent. Highland's figures are influenced by industrial action by MHOs for two months. During this time, there was almost no availability of MHO consent for detention. This gave rise to situations where several consecutive emergency detentions were used for some people. We made sure that the individuals realised that their detention was challengeable and expressed serious concerns to Highland Council and to the Scottish Government. Our greatest concern was the lack of a right of appeal, thereby contravening article 5 (4) of the European Convention for Human Rights.

Table 4 shows a slightly greater likelihood of detention without consent for people already in hospital. In many cases this is because the person is immediately wishing to leave and there is not enough time to obtain MHO consent.

Most EDCs are granted outside office hours. Even then, the majority have consent from an MHO. This shows a generally good provision of MHO services, both during and outside office hours. We compare this with the use of short-term detention and comment further in section 2.2.4 of this report.

We collect data on the duration of emergency detention. Where a person is detained under emergency powers, the Act requires an

Table 6: Duration of emergency detention certificates granted, 1 April 2007 to 31 March 2008

	Within 24 hours of admission	24-72 hours after admission	>72 hours after admission	Total (%)
EDC revoked, informal status	237	242	25*	504 (26)
EDC superseded by STDC	492	466	46*	1004 (52)
Order expired at 72 hours	n/a	n/a	n/a	426 (22)
Total (%)	729 (38)	708 (37)	71* (4)	–
Total number of emergency detentions				1934 (100)

*We have looked into these and believe that they are errors in recording information.

assessment by an approved medical practitioner (AMP) “as soon as practicable”. In our opinion, this assessment should take place within 24 hours of admission. Usually, the order should either be revoked or superseded by a STDC. Sometimes, it is reasonable to leave the EDC in place until the person is assessed by practitioners who know him or her best. It should be unusual for EDCs to expire at the end of 72 hours. Table 6 shows that 22% of emergency certificates run for the full 72 hours. We are pleased that this is lower than when we last examined this (29% in 2005-06) but we think it is still too high.

Overall, we are pleased to see that the use of emergency detention remains relatively low. However, we are concerned that a person can still be detained for up to 72 hours on the basis of one medical assessment, not necessarily from an AMP, without the consent of an MHO. We think the Act should be amended to reduce the duration of such a detention.

2.2.3 Short-term detention

We receive notification of all STDCs and make sure that they are legal. We agree that they should be the usual route into compulsory treatment because they require an assessment by an AMP and consent from a MHO. There should, if possible, be consultation with the named person. STDCs also provide a right of appeal – an essential requirement of human rights legislation. During the year, we found short-term detention certificates that were granted before the MHO gave consent. We took the view that these were not legal and issued guidance on the need for MHO consent before the medical practitioner signs the certificate.

The use of short-term detention has reduced slightly from 3313 last year to 3242 this year. There has been a significant fall in the use of short-term detention in older people. We comment on this further in section 2.4.3.

Table 7: Compulsory powers granted by age and gender, 1 April 2007 to 31 March 2008

Short-term detentions	Female	Male	Totals (%)
0-15	15	9	24 (1)
16-17	21	22	43 (1)
18-24	126	161	287 (9)
25-44	537	665	1202 (37)
45-64	462	438	900 (28)
65-84	374	301	675 (21)
85+	68	43	111 (3)
Totals (%)	1603	1639	3242 (100)

Table 8: Number and percentage of short-term detention certificates granted by type of mental disorder specified, 1 April 2007 to 31 March 2008

Type of mental disorder*	No.	% of certificates
Mental illness	3148	97
Learning disability	88	3
Personality disorder	133	4
Not recorded	4	(0)
Total certificates	3242	100

*More than one diagnosis may be specified – each diagnosis is included separately in the table.

The Scottish Government introduced new versions of the forms in August 2007. This led to major improvements in our data on the types of mental disorder. Tables 7 and 8 give an accurate picture of the use of the Act, especially for people with learning disability or personality disorder.

- Of the 88 people with learning disability, 52 (59%) had an additional mental disorder, usually a mental illness.

- Of the 133 people with a personality disorder, 83 (62%) had an additional mental disorder, usually a mental illness. 50 people had a diagnosis of personality disorder alone. We believe that most of these people had a diagnosis of “borderline personality disorder” and were at serious risk of self harm. If personality disorder was excluded from the definition of mental disorder under the Act, we would

Table 9: Types and combinations of mental disorders recorded on short-term detention certificates, 1 April 2007 to 31 March 2008

Mental disorder	No.	% of certificates
Mental illness	3024	93.3%
Mental illness + learning disability	45	1.4%
Mental illness + personality disorder	74	2.3%
Mental illness + personality disorder + learning disability	5	<1%
Personality disorder	52	1.6%
Personality disorder + learning disability	2	<1%
Learning disability	36	1.1%
Not recorded	4	<1%
Total	3242	100

Table 10: STDCs granted where named person is recorded or consulted, 1 April 2007 to 31 March 2008

	No.	% of all short-term detentions	
	2007-08	2007-08	2006-07
Named person recorded	2408	74	70
Named person consulted	1496	46	42

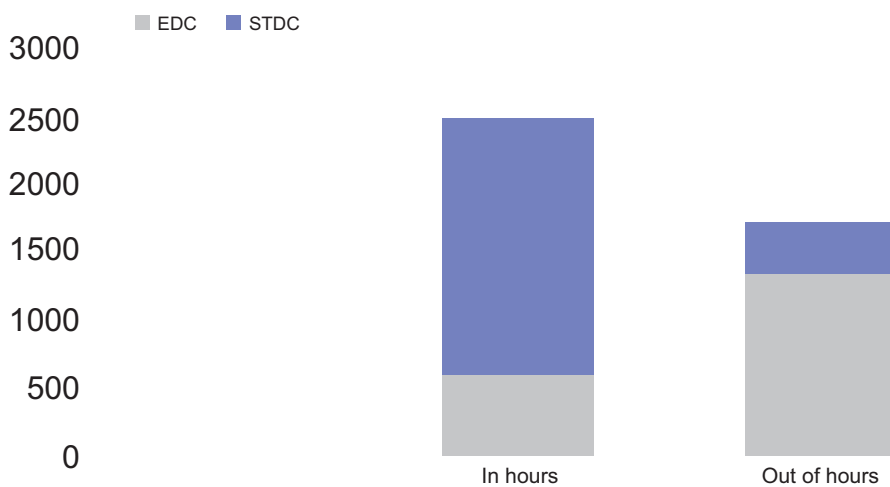
have serious concerns about the risks to these people's health, safety and welfare.

- Of the 3148 people with a mental illness, 118 (4%) had an additional mental disorder documented (personality disorder or learning disability).

Every two years, we conduct a census on the use of the Act for people with a learning disability. Our next one is due in September 2008.

The Act requires that an AMP completing such a certificate consults the named person unless it is impracticable to do so. There has been some improvement in the percentage of STDCs where the named person was consulted, see Table 10. There has been a continued improvement in the identification and recording of the named person. However, this is still less than 50% and continues to cause us concern. The views of a named person, especially when nominated by the individual, are an important factor

Figure 1: Episodes of detention initiated by emergency and short-term detention within and outside office hours, 1 April 2007 to 31 March 2008



in deciding whether to grant a STDC. We will be examining the reasons why named persons are not consulted in more detail in our focused monitoring of people on STDCs in the next year or two.

2.2.4 Comparison between the use of emergency and short-term detention

Figure 1 (above) shows all episodes of detention initiated by either an EDC or STDC. There is a marked contrast between certificates granted during office hours, compared with out-of-hours detentions. Most episodes are initiated within office hours and the great majority are initiated by STDCs. However, outside office hours, emergency detention is still the norm. Given the generally high rate of MHO consent, it is evident that the use of emergency detention outside office hours is because of a lack of availability of AMPs. At present, we think that NHS Boards should ensure that AMPs are available to assess people within 24 hours

of admission following emergency detention. However, they should examine opportunities to extend AMP availability to provide assessments for short-term detention outside office hours.

2.2.5 Compulsory treatment orders

There has been a slight reduction of new compulsory treatment orders (CTOs) granted – 1105 this year, compared with 1187 reported by the Mental Health Tribunal last year. The use of CTOs is highest in males between the ages of 18 and 44 with a greater representation of females at the extremes of the age spectrum. Of the 1105 new CTOs granted, 138 were community-based. See section 2.4.2 for more on compulsory treatment in the community.

Table 12 shows the information we have on progression to CTOs during the year. We have missing information on 61 CTOs reported in figures from the Tribunal. However, even without this information,

Table 11: Compulsory treatment orders granted by age and gender, 1 April 2007 to 31 March 2008

Compulsory treatment orders *	Female	Male	Totals (%)
0-15	6	2	8 (1)
16-17	9	6	15 (1)
18-24	39	65	105 (10)
25-44	158	253	411 (37)
45-64	151	149	300 (27)
65-84	119	110	229 (21)
85+	24	14	38 (3)
Totals (%)	506	599	1105 (100)

*Data obtained from the Mental Health Tribunal for Scotland and published with their permission

Table 12: Pattern of progression to compulsory treatment orders, 1 April 2007 to 31 March 2008

Previous status	Interim CTO only	Interim CTO to CTO	Direct to CTO
STDC	207	546	389
Informal	15	46	71
Total	222	592	450

we can say with confidence that the proportion of CTOs where an interim order has been granted has risen since the previous year. From the figures we have, it seems that interim orders are granted in 64% of all applications to the Tribunal for a CTO. This has risen from 54% last year. The issue of interim orders is being addressed by the present limited review of the Act. Service users, carers and independent advocates report the number of hearings as causing distress and practitioners have reported

concerns about the time involved. All agree that, for various reasons, interim orders are a problem. Our data shows that it is a problem that is getting worse. While it is right that the Tribunal examines the grounds for compulsory treatment, this should be done in a way that minimises distress for the service-user and maximises the time spent by practitioners on direct care and treatment.

Table 13: No. and rate per 100K population of compulsory powers granted, by order type and NHS Board, 1 April 2007 to 31 March 2008

NHS Board	Emergency detentions		Short-term detentions	
	No.	Rate per 100k pop	No.	Rate per 100k pop
Ayrshire & Arran	128	35	166	45
Borders	13	12	51	46
Dumfries & Galloway	83	56	86	58
Eilean Siar	2	8	11	42
Fife	126	35	225	62
Forth Valley	117	41	160	56
Grampian	129	24	293	55
Greater Glasgow & Clyde	508	43	922	77
Highland	168	55	194	63
Lanarkshire	130	23	231	41
Lothian	391	48	611	75
Orkney	2	10	1	5
Shetland	4	18	4	18
State hospital	0	n/a	2	n/a
Tayside	133	34	289	73
Scotland	1934	38	3242	63

2.2.6 Geographical variations in the use of the Act

Every year, we comment on variations in the use of the mental health Act across Scotland. This year, our observations are:

- The use of emergency detention is high in Dumfries & Galloway. This is similar to the previous year. The other area with a high rate of emergency detentions

was Highland where there was industrial action by MHOs. In the case of short-term detention, Greater Glasgow & Clyde, Lothian and Tayside have rates significantly above the national average.

- Borders and Lanarkshire are generally low users of emergency and short-term detention, joined this year by Ayrshire & Arran.

Table 14: Number and rate per 100K population of CTOs granted, 1 April 2007 to 31 March 2008.

NHS Board	CTO Orders Granted 2007-08	
	Number of orders*	Rate per 100K pop
Ayrshire & Arran	58	16
Borders	20	18
Dumfries & Galloway	35	24
Eilean Siar	1	4
Fife	96	27
Forth Valley	50	17
Grampian	101	19
Greater Glasgow & Clyde	280	23
Highland	85	28
Lanarkshire	86	15
Lothian	200	25
Orkney	–	–
Shetland	1	5
State Hospital	4	
Tayside	88	22
Total	1105	22

*CTO numbers provided by MHTS

- Highland and Fife have the highest rates of CTOs with Tayside, previously very high, now at the national average.
- Lanarkshire has a very low rate of CTOs. This has been a consistent finding over several years.

We are working with Audit Scotland and others to look at the possible reasons for

the large variations in the use of legislation. This may identify links with resources and availability of services. We believe that culture and attitudes also have a significant role. Areas with a high use of the 2003 Act may have a culture of legal intervention, perhaps more than is necessary. Low using areas could be using excessive persuasion to keep people in hospital, or engaged with

Table 15: No. and rate per 100K population of short-term detentions granted by order type and local authority, 1 April 2007 to 31 March 2008

Local authority	Short-term detentions		CTOs*	
	No.	Rate per 100k pop	No.	Rate per 100k pop
Aberdeen City	152	73	64	31
Aberdeenshire	77	32	22	9
Angus	43	39	15	14
Argyll & Bute	47	52	22	24
Clackmannanshire	30	61	9	18
Dumfries & Galloway	85	57	35	24
Dundee City	127	89	50	35
East Ayrshire	49	41	17	14
East Dunbartonshire	41	39	8	8
East Lothian	50	53	22	23
East Renfrewshire	33	37	8	9
Edinburgh City	412	88	140	30
Eilean Siar	8	30	1	4
Falkirk	85	57	30	20
Fife	225	62	96	27
Glasgow City	616	106	189	32
Highland	165	76	64	29
Inverclyde	61	75	14	17
Midlothian	43	54	11	14
Moray	59	68	12	14
North Ayrshire	38	28	17	13
North Lanarkshire	110	34	49	15
Orkney	0	0	0	0
Perth & Kinross	122	86	27	19
Renfrewshire	82	48	29	17

Table 15: continued:

Local authority	Short-term detentions		CTOs*	
	No.	Rate per 100k pop	No.	Rate per 100k pop
Scottish Borders	57	51	21	19
Shetland	5	23	2	9
South Ayrshire	63	56	25	22
South Lanarkshire	145	47	49	16
Stirling	38	43	12	14
West Dunbartonshire	38	42	19	21
West Lothian	91	54	26	16
Local authority not specified	45	–	–	–
Scotland	3242	63	1105	22

*CTO numbers provided by MHTS

treatment, where it might be more proper to afford people the legal safeguards of the Act. We challenge service providers when we find these extremes of culture and attitude.

We record the local authority that employs the MHO who gave consent to a detention. Most short-term detentions take place in office hours. 17% of STDCs are granted outside office hours. In the latter case, it is possible that the MHO was not employed by the local authority in which the person being detained is resident. This is due to arrangements where local authorities share responsibilities for out of hours cover. This should be borne in mind when interpreting this data.

Table 15 (above) shows that three of the four highest rates of short-term detention occur in city local authority areas (Glasgow, Edinburgh

and Dundee). Inverclyde, high last year, shows a rate closer to the national average. Perth and Kinross remains high. Of the areas with low rates, North Lanarkshire is remarkable; a person with a mental disorder is more than twice as likely to be detained in Perth and Kinross as in North Lanarkshire. Similarly, Dundee, Glasgow, Aberdeen and Edinburgh, in that order, have the highest rates for CTOs. Low rates in Angus and in Perth and Kinross, mean that the overall Tayside figures are lower than in previous years. While there are higher rates in urban areas, this does not explain high rates in Fife and Highland and low rates in North and South Lanarkshire. In our view, variations in practice must account for these differences.

Table 16: Nurses' power to detain pending medical examination, by hospital and gender, 1 April 2007 to 31 March 2008

Hospital	Female	Male	Total
Ailsa	4	2	6
Airbles Road Centre	0	1	1
Argyll & Bute	1	1	2
Bannockburn	1	0	1
Borders NHS	2	3	5
Carseview Centre	9	5	14
Crichton Royal	12	5	17
Crosshouse	1	0	1
Dykebar	4	0	4
Eilean Siar	0	1	1
Falkirk Royal Infirmary	1	1	2
Gartnavel Royal	5	4	9
Inverclyde Royal	1	0	1
Leverndale	1	0	1
Murray Royal	2	4	6
New Craigs	2	3	5
Queen Margaret	2	0	2
Rosslynlee	1	0	1
Royal Alexandra	3	0	3
Royal Cornhill	0	1	1
Royal Dundee Liff	2	0	2
Royal Edinburgh	24	25	49
St Johns	2	1	3
Stratheden	3	2	5
Whytemans Brae	1	4	5
Total	84	63	147

2.2.7 The use of nurses' power to detain

Nurses have the power to detain people in hospital pending medical examination in situations where that person, or others, may be at risk. We continue to find significant variation in the use of this power between hospitals across the country (Table 16). The notifications received from the Crichton Royal and the Royal Edinburgh Hospitals indicate a higher use compared to similar services elsewhere. Carseview Centre's notifications have markedly increased this year.

The use of the nurses' power to detain may be influenced by a number of factors such as local understanding of the power, how situations where people who are informal and at risk and who wish to leave hospital are managed, and the availability of medical practitioners and MHOs. Managers should examine the use of this power in their areas and ensure that nursing staff have a clear understanding about the appropriate use of their power to detain.

2.2.8 Trends in the use of civil compulsory treatment

Since the introduction of the 2003 Act, there has been a fall in the total number of episodes of compulsory treatment. We reported a further fall this year (see section 2.2 of this report). The messages from our examination of the trends over the last few years are:

- The Act envisaged that short-term detention would be the usual means by which a person would be first made subject to compulsion. This appears to be the case.

- Emergency detention continues to fall. We commend the efforts made by NHS Boards and local authorities to ensure the availability of AMPs and MHOs to achieve this.
- Short-term detention rates are higher than under the previous legislation. We expected to see this because it should replace many emergency detentions. There has been no further rise in 2007-08.
- This year, we have relied on data collected by the Tribunal on long-term orders. The data appears to show a reversal of the previous upward trend in the use of new long-term compulsory orders.

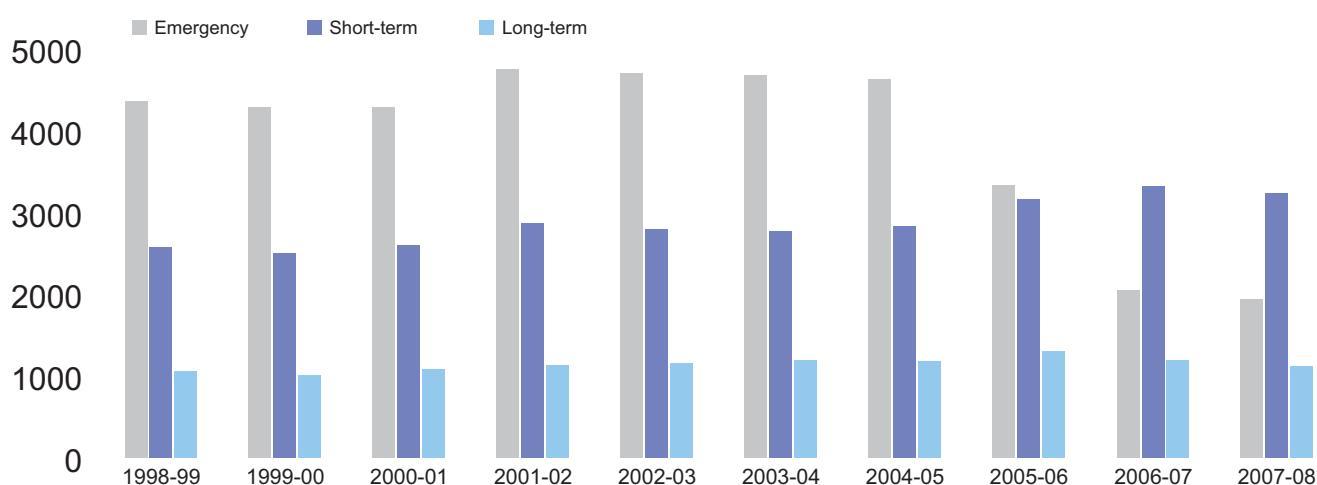
We can say with confidence that there have been fewer new episodes of compulsory mental health treatment in Scotland since the introduction of the 2003 Act. The stricter grounds for compulsion, changes in culture in line with the principles of the Act and improved service delivery could all play a part in this. However, see section 2.3 on the prevalence of compulsory treatment, as this shows a more complex picture than episode analysis provides.

Table 17: Civil compulsory orders granted, 1985 to 2008

	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	1187*
2007-08	1934	3242	1105*

*CTO numbers provided by MHTS

Figure 2: Detentions under civil procedures in Scotland, 1998 to 2008



2.2.9 The use of compulsory care and treatment for mentally disordered offenders

We report on the numbers of orders granted under the Criminal Procedures (Scotland) Act 1995 (CPSA) and under the 2003 Act for mentally disordered offenders (Table 18). The number of compulsion orders notified to the Commission this year continues a downward trend since 1996. Restriction orders remain within the range seen over the past few years (Table 20). Interim compulsion orders have fallen for the second year running since the implementation of the 2003 Act. This may be a reflection of extended renewal time from 28 days to 12 weeks. Post-sentence prison transfers are unchanged this year compared to last. Section 200(2) (b) allows for the committal to hospital of a person post-conviction but pre-sentence. The 2003 Act made improved provisions under S52 for the assessment and treatment of mentally disordered offenders before a final disposal was made by the

court. S200 of the CPSA continues to be used, albeit in reduced numbers. We believe that the provisions of S52 are more appropriate for mentally disordered offenders and render the use of S200 unnecessary. The number of convicted prisoners transferred to hospital for the treatment of mental disorder continues the general downward trend since 1995. We believe that lower use of CPSA for less serious offences suggests that other measures, especially court diversion schemes, make sure that people with mental health problems have access to care and treatment without the added distress of appearing in court.

Table 18: Compulsory treatment under criminal procedures, 2006-07 and 2007-08

Order type	No. of orders	
	2007-08	2006-07
Remand in custody or on bail for enquiry into mental condition (CPSA* 200)	7	16
Assessment order (CPSA 52D)	114	154
Treatment order (CPSA 52M)	80	74
Interim compulsion order (CPSA 53)	22	16
Temporary compulsion order (CPSA 54(1)(c))	5	9
Compulsion order (CPSA 57A (2))	41	35
Compulsion order (CPSA 57A (2)) Community	1	0
Compulsion order (CPSA 57(2)(a))	5	1
Compulsion order (CPSA 57(2)(a)) Community	1	0
CORO** (CPSA 57A + 59)	10	25
CORO (CPSA 57(2)(b))	2	1
Transfer for treatment direction (MHSA (2003)*** 136)	30	30
Hospital direction (CPSA 59A)	1	2

*Criminal Procedure (Scotland) Act 1995

**Compulsion order with restriction order

***Part 8 Mental Health (Care and Treatment)(Scotland) Act 2003

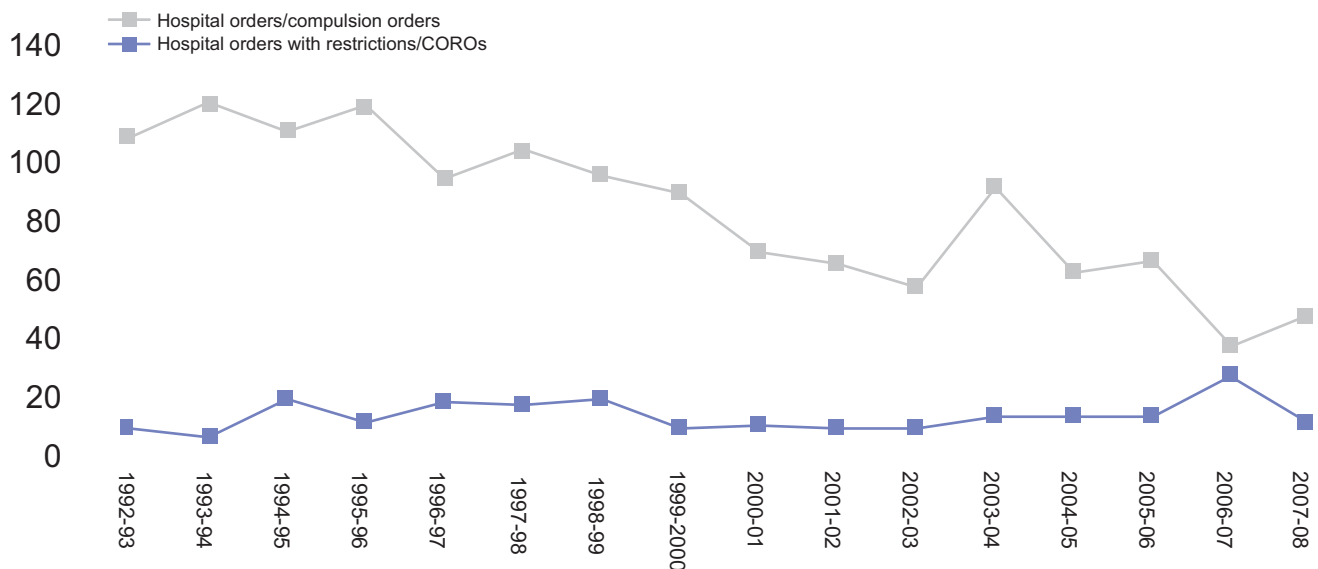
Table 19: Episodes of compulsion under criminal procedures, by age and gender, 1 April 2007 to 31 March 2008

Age Range	Female	Male	Totals (%)
01-15	0	0	0
16-17	0	3	3
18-24	8	52	60
25-44	28	162	190
45-64	15	49	64
65-84	0	2	2
85+	0	0	0
Totals (%)	51 (16%)	268 (84%)	319 (100%)

Table 20: Community-based compulsion orders, 1 April 2007 to 31 March 2008

	No. of orders
Full orders granted	2
Variations from hospital to community during period	17
Recalls from community to hospital during period (S113/S114)	1

Figure 3: Criminal procedure trends in Scotland, 1992-93 to 2007-08



2.2.10 Findings from our visits to individuals subject to long-term compulsion

We looked at a sample of 586 reports of visits we made to people on long-term compulsory treatment during 2007-08. This represents 83% of visits of this type undertaken in the year. This included 471 people who were subject to CTOs, 59 on compulsion orders and 34 people on compulsion orders with restriction orders (COROs). In 12 cases, the order type was not specified. For 198 of these visits the person was on a community based order. A further 84 people were out of hospital under suspension of detention. Many of the people we met as part of our programme of service visits were also subject to compulsory treatment of some form. Many others, while not detained, lacked capacity in relation to decisions about welfare and treatment. From this information, we have looked at how new safeguards in the Act are being used. We have also identified the greatest risks to proper detention, compulsion and lawful care and treatment. It is important that service-users, carers and service providers are aware of these risks.

Safeguards

Advance statements: Only half of the people we met were aware of advance statements. 10% had made an advance statement (an increase on last year) and a further 3% were thinking about making one. Grampian was the area with the highest number of people with advance statements – 12 of the 58 people we met. Advance statements are an important part of participation and an important indicator of the person's advance wishes.

Named persons: about two thirds of those visited were recorded as being aware of named person provisions. Just over half had nominated a named person. A further third of our sample had a default named person.

Independent advocacy: almost 90% of people had been offered advocacy. About half had used advocacy services at some point. When we visited services, we found that advocacy was not always well publicised. We made recommendations in seven cases where we felt services could do more to help people engage with advocacy.

Risks

Poor documentation: We don't think the important info in case records is as accessible as it ought to be for staff. We think it is best practice for case records to have easily accessible information on the type of compulsory order, as well as details of the RMO, MHO, named person, advance statement and independent advocate.

Information for individuals: Some people we saw could not recall being given information about their rights. Care staff must do all they can to make sure that people subject to compulsory treatment know their rights. Giving information at a single point in time, e.g. immediately after admission, may not be enough. It is important to do everything possible to make sure that the person retains and understands this information.

Consent to treatment: We identified numerous concerns about treatment in the absence of consent and without proper documentation. In relation to the 2003 Act, we found concerns about treatment in 20% of the people we saw. We looked for forms

documenting consent (T2) or certificate of independent opinion (T3). Commonest findings were:

- The treatment certificate was not available i.e. it was missing from the records or there was no record that it existed (29 cases) – in a few of these cases it was also established that the formal consent process had not been carried out. In one case the certificate did exist, (at the Commission) but the charge nurse did not appear to know of T2 and T3 statutory forms and did not know where to look for them.
- The certificate had been issued some time ago and did not correspond to the treatment current at the time of the visit (25 cases).
- The individual appeared not to be consenting to treatment covered by a T2 certificate of consent (3 cases) or they had not given written consent (5 cases).
- We found many examples of poor attention to this part of the Act. On our visits to services, we found many wards where these forms were not readily available. For example, in one ward T2 and T3 forms were not always present in either the Medicine Kardex or in the person's integrated case file. We were advised that they were kept in the Medical Records department. This leaves the person at high risk of receiving unlawful treatment.

Safety and security: while knowledge of the regulations in the 2003 Act on “specified persons”, searches and taking samples has improved, we had concerns about their use. We found some wards with “blanket” policies on searching people without clear justification in individual cases. This is only

acceptable in the State Hospital and in medium secure units. In other facilities, decisions must be based on individual risk and be in line with the principle of least restriction of freedom. We will look into this in more detail in 2008-09.

Knowledge and training: lack of knowledge is the greatest barrier to proper care and treatment for people who are subject to compulsion. Where there was poor compliance with legislation, this was usually because staff lacked knowledge. Service managers must make sure that there is a programme of training for new staff and refresher training for existing staff on important aspects of both the 2000 and 2003 Acts.

2.3 Total number of orders in existence

This part of our report addresses the prevalence rather than the incidence of compulsory orders. We assess this by reporting on the total number of people subject to any order on four dates throughout the year. While the number of new CTOs has fallen, the number of people who stay on CTOs is rising. Our data suggests that this is a result of compulsory community treatment and that the rate of new orders is higher than the rate that orders are revoked (see Table 21).

Last year, we found that the number of people subject to community orders rose, the number subject to long-term detention in hospital fell but there was no overall change in the total number of civil long-term orders. The position seems to have changed this year. Figure 4 (page 25) shows a rise in all CTOs. This is because the number of people on hospital based orders is no longer falling, while the number of people on community orders continues to rise. We need to be

Table 21: Number of people subject to compulsory powers, by type, at quarterly census dates

Order	4 Apr 07	4 Jul 07	3 Oct 07	2 Jan 08
Emergency detention	12	12	14	11
Short-term detention	212	230	193	179
Interim compulsory treatment order	75	54	73	52
Compulsory treatment order	1586	1676	1660	1668
hospital-based	1245	1312	1272	1270
community-based	341	364	388	398
Assessment order	10	9	5	7
Treatment order	8	7	8	9
Interim compulsion order	4	6	8	6
Compulsion order	137	141	130	133
Compulsion order with restriction order	244	242	240	236
Transfer for treatment direction	23	27	33	33
Hospital direction	36	35	37	34
Remand in custody or on bail for enquiry into mental condition	0	1	1	0
Probation order requiring treatment (S230)	0	0	0	0
Temporary compulsion order	–	–	–	1
Indeterminate status*	223	208	151	170

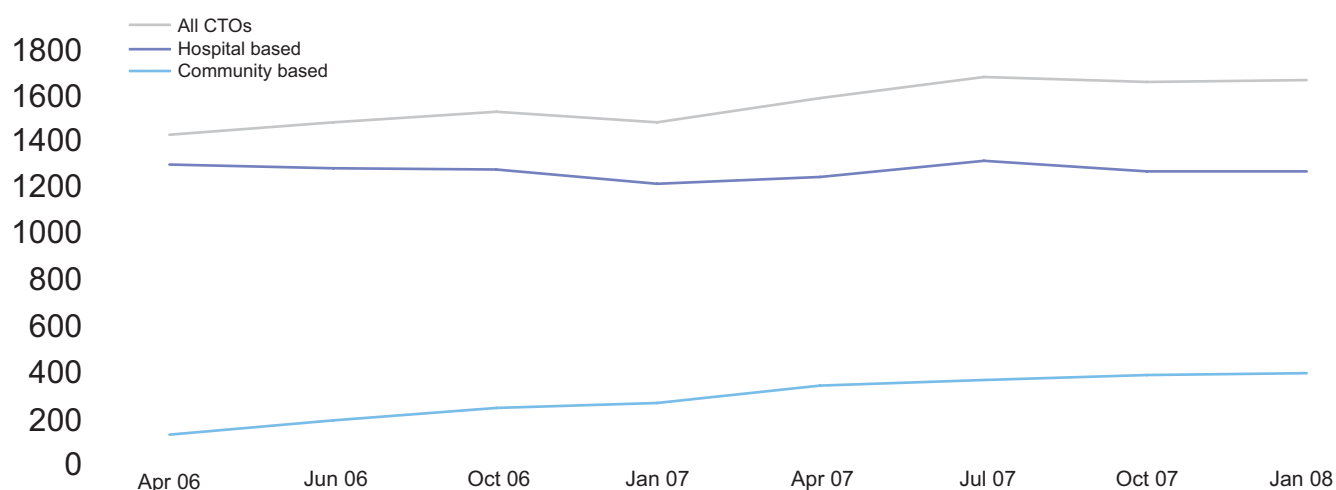
* In these cases we have low confidence in the person's status on this date, due to missing, or incomplete paperwork.

confident that these orders are still necessary, so we plan to prioritise people who have been subject to CTOs for three years or more for our monitoring visits this year. We will examine when the RMO last reviewed whether the grounds for compulsory treatment were still met and look at how the individual is being helped along the road to

recovery by taking greater control of his or her own treatment. We will report on this during 2008-09.

We have examined the number of people subject to any form of compulsory care and treatment by NHS Board area on one day of the year. This is shown in Table 21. Although this provides a sample of just one day, it is

Figure 4: Two year trend in prevalence of CTOs 2006-2008



Source: MWC quarterly census figures

remarkably similar to last year's data. Tayside had the highest number last year, but has been overtaken by Lothian and Fife which were second and third highest last year. Borders and (especially) Lanarkshire have very low rates of compulsory treatment. We find these differences hard to understand (see our comments in section 2.1 on geographical variations).

2.4 Monitoring of priority areas

We have continued to monitor the use of emergency detention, overrides of advance statements, compulsory treatment in the community and services for younger people. These were the priorities that emerged during stakeholder consultation over how the Commission should respond to the implementation of the Act. We reported on care plans last year. This year, because of rises in the use of the Act for older people, we have included a special section on our findings from our analysis of the use of the

Act for people aged 85 and over. We reported on the use of emergency detention in section 2.2.2 of this report. This section contains information on our other priority areas.

2.4.1 Overrides of advance statements

Preparation of an advance statement is one of the ways in which people can increase their participation in their care planning and treatment. Where a person receives treatment that is in conflict with an advance statement, it is important that this is justified, especially on the basis of maximum benefit. In the past year we have been notified of 28 potential advance statement overrides. This is a reduction from the previous year. Although this may appear to be an improvement, this has to be seen in the context of low uptake generally of advance statements. Of the 28 notifications, 18 came from the Tribunal. Medical practitioners providing, or authorising, treatment accounted for almost all the other notifications.

Table 22: Number of people subject to compulsory powers on 2 January 2008, rate per 100,000 population, by NHS Board in rank order

NHS Board	Rate per 100K
Lothian	56
Fife	54
Tayside	52
Greater Glasgow & Clyde	51
Highland	44
Dumfries & Galloway	43
Forth Valley	42
Grampian	41
Ayrshire & Arran	34
Borders	32
Lanarkshire	25
Shetland	14
Eilean Siar	4
Orkney	0
Scotland*	49

*205 people detained in the State hospital are included in the calculation of the Scotland rate.

When we receive notice of a potential override, we ask for a copy of the advance statement to check whether it is valid. We identify whether the person has had treatment that is in conflict with a valid advance statement and make sure that there were good reasons for this, based on the principles of the Act.

Table 23 summarises our findings:

On eight occasions, there was no override. This was because the RMO had agreed treatment with the person in line with their wishes, or that no advance statement actually existed.

Our enquiries also revealed that five of the advance statements appeared to us to be invalid. There were two main reasons for this. We found advance statements that were made without being witnessed, or without a statement from the witness as required by the Act (for example, by recording that the person making the statement had the capacity of properly intending the wishes specified in it). We also found statements that were so wide as to be unhelpful (for example, “not being made to do anything against my will”). This means that on 13

Table 23: Analysis of notifications of treatment that is in conflict with an advance statement, 1 April 2007 to 31 March 2008

	Total
Number of notifications	28
Notification made in error	8
Invalid advance statement	5
Person agreed with treatment and withdrew statement	2
Actual overrides	13
Refusal of depot injection	7
Refusal of any medication	4
Refusal of ECT	1
Request for one specific medication	1

occasions, that we are aware of, an advance statement was overridden. As we do not receive copies of all advance statements, we are unable to judge whether this is a significant proportion.

We found good explanations of why people were being treated in a way that conflicted with the advance statement. We also found good communication of the reasons for this with the person who made the statement. Even where the statement has been overridden, it still influences care and treatment through the principle of “regard to the past wishes of the patient”. The best example was the person who was treated with ECT despite an advance refusal. The designated medical practitioner who authorised the treatment determined that it could only be given when the person’s life was at risk (through refusing to drink). The responsible medical officer gave the person

a clear written explanation. We think this shows good practice in balancing the principles of benefit with the person’s wishes.

We believe that there is still a great deal of confusion with regard to advance statements. We have been told by people that they “do not see the point as they are always ignored” (we hope the above case gives some reassurance), or that they do not wish to contemplate the possibility that they may become ill again. It is also clear that people are encouraged to make advance statements at times when they may not be able to fulfil the requirements in the Act of “properly intending”. We have followed these up with the individuals who witnessed them where we are aware that this has happened.

Some services have good arrangements for encouraging the preparation of advance statements at the point of discharge and have involved advocacy services to support people.

Table 24: New CTOs granted by NHS Board, 1 April 2007 to 31 March 2008

NHS Board	New Community Orders	New Hospital Orders	CCTOs as percent of all CTOs
Ayrshire & Arran	13	45	22
Borders	5	15	25
Dumfries & Galloway	2	33	6
Eilean Siar	0	1	0
Fife	15	81	16
Forth Valley	8	42	16
Grampian	12	91	12
Greater Glasgow & Clyde	31	248	11
Highland	9	77	10
Lanarkshire	10	76	12
Lothian	27	173	14
Shetland	0	1	0
Tayside	6	83	7
The State Hospital	–	4	–
Western Isles	0	1	0
Scotland	138	970	12

Source: The Mental Health Tribunal for Scotland.

The principles into practice website shows good examples of advance statements. We think that some clarification regarding the content and scope of an advance statement and a requirement for it (and not just the override) to be notified to the Commission may be worthy of consideration by the Mental Health Act Review Group.

2.4.2 Community based compulsory treatment

In section 2.3, we reported that the number of people subject to compulsory treatment in the community at any one time is rising and is now approaching 400. In this section, we report on data on orders granted, varied and revoked during the past year. We also report on the number of people reported as having

Table 25: New CTOs granted by local authority, 1 April 2007 to 31 March 2008

Local authority	Community Orders Granted	Hospital Orders Granted	CCTOs as percent of all CTOs
Aberdeen City	8	57	12
Aberdeenshire	3	23	12
Angus	1	13	7
Argyll & Bute	3	19	14
Clackmannanshire	3	12	20
Dumfries & Galloway	2	33	6
Dundee City	2	43	4
East Ayrshire	6	13	32
East Dunbartonshire	2	13	13
East Lothian	1	23	4
East Renfrewshire	1	11	8
Edinburgh City	21	108	16
Eilean Siar	0	2	0
Falkirk	3	23	12
Fife	15	82	15
Glasgow City	21	140	13
Highland	5	54	8
Inverclyde	2	13	13
Midlothian	4	13	24
Moray	3	13	19
North Ayrshire	2	16	11
North Lanarkshire	7	40	15
Perth & Kinross	2	31	6
Renfrewshire	4	27	13
Scottish Borders	5	17	23
Shetland Islands	–	1	0

Table 25 continued:

Local authority	Community Orders Granted	Hospital Orders Granted	CCTOs as percent of all CTOs
South Ayrshire	5	19	21
South Lanarkshire	3	59	5
Stirling	3	7	30
West Dunbartonshire	–	24	0
West Lothian	1	21	5
Scotland	138	970	12

Source: The Mental Health Tribunal for Scotland.

been re-admitted to hospital from community orders.

Community-based CTOs now account for 12% of all new orders and almost a quarter of all existing CTOs. There is significant variation across Scotland in the ways that community compulsion is used (see Table 25). Numbers are quite low, so we are cautious about their interpretation, but the use in Borders and Ayrshire & Arran seem quite high while the use in Tayside (an area of generally high use of legislation) and Dumfries & Galloway is very low. This may reflect the availability of community services to support people on long-term compulsory treatment.

Table 26 shows the number of new community CTOs, variations, re-admissions and revocations. For existing orders, there is a trend towards community treatment, with many more variations from hospital to community than community to hospital. However, readmission to hospital is common, especially for short spells.

There are two broad reasons why a person subject to a community-based CTO might be admitted compulsorily to hospital. Firstly, the person might not comply with the order. The Act allows for the person to be taken to hospital for up to six hours (Section 112) because of non-compliance with medical treatment. Sections 113 and 114 apply to people who do not comply generally with the order. Secondly, despite compliance with the order, the person's mental health could worsen. This might result in emergency or STDC. These orders suspend all, or parts, of the CTO.

Table 26 shows how these orders have been used in the last year. There were only six Section 112 orders reported to us. Last year, there were only 12. We suspect that some people have been made subject to Section 112 orders but that these have been reported to us in error as Section 113 detention for 72 hours. Our data shows that 150 (37%) of the near 400 people who were subject to a community-based CTO during the year, were

**Table 26: Granting, recalls and revocation of community CTOs,
1 April 2007 to 31 March 2008**

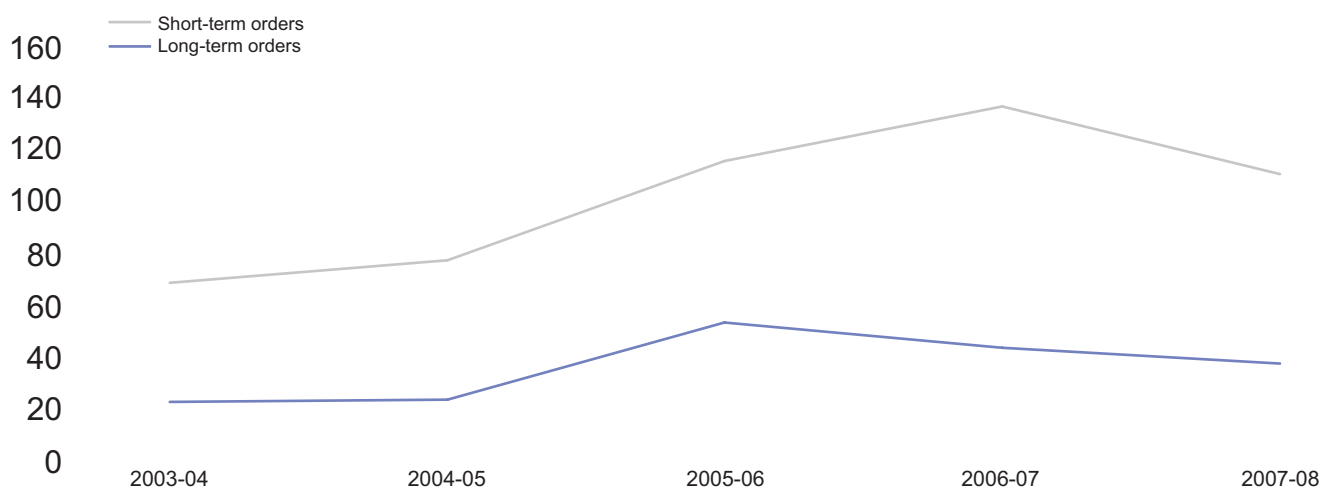
	No. of people
New community orders granted	138
Variations of hospital to community CTO	206
Recalls from community to hospital during period S112	6
Recalls from community to hospital during period S113	107
Recalls from community to hospital during period S114	77
Episodes of admission under EDC and/or STDC of people on community CTOs	43
Variations from community to hospital CTO	37
Revoked/Lapsed community-based orders during period (including interim orders)*	216

*Likely to be an underestimate. There is no requirement in the Act to inform us if an order expires.

re-admitted to hospital at some point. While readmission may have been necessary, there may be gaps in services to support people on community-based CTOs. We found some evidence of this when we visited these people. Our findings from an analysis of 198 visits were:

- **Appropriateness of order:** We found one order where we thought the grounds were no longer met. We raised this with the RMO who agreed and revoked the order. Even if we thought the grounds were met, we made sure people knew how to apply to the Tribunal to have it revoked.
- **Carers' involvement and support:** We found that almost all carers we met during our visits were satisfied with their level of involvement. We only found two situations where there was lack of support or involvement.
- **Crisis plans:** We reported our concerns about crisis plans last year and we remain concerned. We found 15 people who either had no crisis plan, or who had to rely on NHS24. In our opinion, this is inadequate. Service-users and carers should be able to obtain emergency mental health advice at any time if a crisis develops.
- **Legal documentation:** We found care plans that were missing or out of date (30 people), treatment safeguards were not properly used (14 people) and one person whose order was incorrectly documented.
- **Provision of appropriate services:** This is a principle of the Act and it was not always being observed. We found six people with unmet social care needs. In the most serious case, the Tribunal had made provision of supported accommodation a recorded matter twice, but it had still not been provided. Two people had poor physical health care.

Figure 1: Use of short-term and long-term compulsory treatment for people aged 85 and over, 2003-2008



Note: Data on long-term orders for 2005-06 is estimated. There was a general rise in long-term detention that year. Age-related data from October 05 to March 06 is missing. We reported 154 short-term detentions in this age group last year. The correct number was 137.

In all these cases, we took action to bring these matters to the attention of staff and we are following up on our recommendations.

2.4.3 Older people

In our annual report from 2006-07, we highlighted that the use of compulsory treatment under mental health legislation had almost doubled for people of 85 years and older, since the introduction of the 2003 Act. We identified 154 short-term detention certificates and 44 compulsory treatment orders in this age group. This compares with 78 and 24 respectively in the last full year of operation of the 1984 Act. We investigated this in greater detail to examine the reasons for the use of the Act and the outcome for people detained.

The trend over the last five years is shown in Figure 1. The rise in the use of the Act from 2004 onwards is likely to reflect concerns about treating people with dementia informally in the absence of informed consent. The fall this year (see section 2.3 of this report) could reflect a reduction in that concern. We provide further analysis of the care and treatment of people detained during 2006-07 here.

Short-term detention

Table 27 shows the use of short-term detention. While Tayside and Fife made relatively high use of short-term detention, the rates in Forth Valley and Grampian were relatively low. Numbers are generally too low to be able to comment in detail on the differences.

Table 27: Short-term detention for people aged 85 and over by NHS Board, 1 April 2007 to 31 March 2008

NHS Board	Number of orders	Rate per 100K population aged 85+
Ayrshire & Arran	7	91
Borders	4	160
Dumfries & Galloway	4	117
Eilean Siar	1	143
Fife	20	267
Forth Valley	4	80
Grampian	5	49
Greater Glasgow & Clyde	31	147
Highland	7	105
Lanarkshire	9	103
Lothian	21	141
Tayside	24	263
Total	137	139

Compulsory treatment orders

We examined the use of CTOs for this population in greatest depth. We examined all 44 case files we held for people aged 85 and over, who were made subject to CTOs between 1/4/06 and 31/3/07. Fife with 10 orders and Tayside with 7, were again relatively high. All orders except one authorised detention in hospital and medical treatment under part 16. The other authorised medical treatment, place of residence, access to health and social care practitioners and consent of MHO (place of residence was a care home. This is the only case where

ongoing management in a care home was authorised by a Tribunal order). Our main findings from examining all 44 people's cases in detail were:

- Most of the 44 people had dementia, either on its own or coupled with another pre-existing mental illness. Most were admitted from their own homes, but we found seven people admitted from care homes, usually shortly after admission to the home. We found little evidence of inappropriate use of the Act. Most people with dementia were detained after good attempts to provide care at home had been tried and failed.

Table 28: Young people (under 18) admitted to non-specialist facilities, 1 April 2007 to 31 March 2008

	2007-08	2006-07
No. of admissions to non-specialist inpatient settings	142	186
No. of young people involved	122	156
No. of admissions where further information provided to MWC	127	151
No. of young people involved	115	134

- Follow up of cases reveals a danger of “de facto” compulsory treatment without the safeguards of legislation. For example, we had been asked for advice about one person who became informal, but where the consultant wanted to sedate her by injection to move her to a care home. We made it clear that this was not lawful and it was not done.
- Better advance planning might reduce the need for admission under the Act. Only five of the 44 people had appointed a welfare power of attorney and none had made an advance statement. Three people had welfare guardians. Ten people progressed to welfare guardianship after their episode of detention. Earlier consideration of guardianship and the ability to intervene quickly under the Adults with Incapacity Act might have reduced the need for detention.
- The Tribunal is inconsistent in its approach to those people with dementia who cannot instruct legal representation. Sometimes, the main carer was thought to be able to represent the person’s interests. It is unfair to expect a stressed carer to do this objectively and we thought that independent representation would have been more

appropriate. However, we were impressed with the involvement of independent advocacy for most people and in the consideration given to recorded matters in three cases.

- We have concerns about medication. Most treatment certificate authorised antipsychotic medication despite concerns about its use for people with dementia. We also found certificates that authorised several different medications for the same individual. We thought this may not have been appropriate and brought this to the attention of the doctors concerned.

2.4.4 Services for younger people

Monitoring the admission of young people to non-specialist settings such as adult and paediatric wards, for the treatment of mental illness, remains a priority for the Commission. We have raised serious concerns for many years about this. In our monitoring of the admissions of under-18 year olds across the country 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 continued to ask

Table 29: Admissions of young people to non-specialist facilities by NHS Board

NHS Board	No. of admissions	
	2007-08	2006-07
Ayrshire & Arran	9	12
Borders	9	7
Dumfries & Galloway	5	3
Eilean Siar	0	1
Fife	10	7
Forth Valley	12	2
Grampian	6	14
Greater Glasgow & Clyde	22	43
Highland	5	20
Lanarkshire	26	23
Lothian	28	26
Orkney	0	0
Shetland	0	0
Tayside	10	28
Scotland	142	186

*GROS population estimate for mid-2007

RMOs to provide us with more detailed information once we have been notified of an admission.

In last year's annual report we welcomed the two commitments in 'Delivering for Mental Health' to improve mental health services being offered to children and young people, and to reduce the number of admissions of children and young people to adult beds by 50% by 2009. The figures in Table 29 for 2007-08 clearly indicate that the numbers admitted to adult wards have reduced, and that more specialist input is available when

young people are placed in adult wards. The 142 admissions we have been notified of in 2007-08 represents a 24% reduction in the number of admissions reported to us in the previous year.

We have been notified of 142 admissions involving 122 young people under the age of 18 to non-specialist settings. Of these, three admissions were to adult medical wards, three to adult learning disability units, two to eating disorder units, one to a mother and baby unit, and one to a paediatric ward. The remaining admissions were to adult

Table 30: Specialist health care for young people in non-specialist care, 1 April 2007 to 31 March 2008

Specialist medical provision	Age 0-15	Age 16-17	All	% of admissions
RMO at admission was a child and adolescent specialist	18	26	44	35
Nursing staff with experience of working with young people were available to work directly with the young person	17	40	57	45
Nursing staff with experience of working with young people were available to provide advice to ward staff	22	69	91	71
The young person had access to other age appropriate therapeutic input	17	49	66	52
None of the above	0	21	21	20
All admissions with info provided	26	101	127	100

mental health wards. We feel that notification of informal admissions has improved since the 2003 Act came into force, and are more confident that these figures are an accurate representation of the situation. The proportion of cases where services gave us more information has increased. We think this reflects the greater attention given to the care of younger people as a result of commitments.

We found that progress is being made in some NHS Board areas to fulfil legal duties to provide age appropriate accommodation. Table 29 shows the number of admissions by NHS Board area. Comparison of the past two years shows an improvement in Tayside, Greater Glasgow & Clyde, Highland, Grampian and Ayrshire & Arran, in terms of numbers of admissions, but an increase in admissions in the remaining areas.

We also received information on a monitoring form relating to 127 of these admissions, and tables 29 to 33 present the information provided on the monitoring forms. All percentages are based on the 127 cases where further monitoring information was provided.

When a young person is admitted to a non-specialist ward, it is important that NHS Boards fulfil their duties to provide appropriate services. Table 30 indicates that in 35% of admissions the RMO at the point of admission was a child and adolescent specialist, that in 45% of admissions nurses with experience in the field were available to work directly with the young person, and in 71% of admissions, nurses with relevant specialist experience were available to provide advice to ward staff. In all three of these

Table 31: Social work provision for young people in non-specialist care, 1 April 2007 to 31 March 2008

Social work provision	Age 0-15	Age 16-17	All	% of admissions
Young person had an allocated social worker	15	51	66	52
If no allocated worker, had access to a social worker	8	31	39	31
Neither of the above	3	19	22	17

Table 32: Supervision of young people in non-specialist care, 1 April 2007 to 31 March 2008

Supervision arrangements	Age 0-15	Age 16-17	All	% of admissions
Transferred to an IPCU or locked ward during the admission	2	12	14	11
Accommodated in a single room throughout the admission	21	67	88	69
Nursed under constant observation	19	55	74	58

areas the information, when compared with information collected the previous year, suggests that specialist clinical input is increasingly available when a young person is admitted to an adult ward – either to work directly with the young person, or to provide advice to ward staff. In over half of admissions we were also informed that the young person had access to other age appropriate therapeutic input, up from the figure of 42% of the previous year. We were pleased to see that everyone under 16 has at least some age-appropriate input. There were 21 people aged 16 and 17 who had no specialist input to their care. Eight of these people were in NHS Lanarkshire's area. We have already been in discussion with NHS Lanarkshire about this.

We receive information on monitoring forms about social work input, and this is collated in Table 31. Just over half of young people admitted to non-specialist facilities had an allocated social worker at the time of admission, with a further third of young people having access to a social worker, if they did not have an allocated social worker on admission. However, in almost a fifth of admissions though, the young person had neither an allocated social worker, nor access to a social worker on admission. We are unsure what lies behind this figure. It would be our expectation that if a young person does not have a social worker on admission and social work input is felt to be required, then there should be local

Table 33: Other care provision for young people, 1 April 2007 to 31 March 2008

Other provision	Age 0-15	Age 16-17	All	% of admissions
Access to age appropriate recreational activities	17	60	77	61
Access to education was discussed	9	19	28	22
Access to an advocacy service	18	85	103	81
Young person had a learning disability	3	11	14	11

processes in place though which referrals can be made. We will explore this issue further in 2008-09, when we undertake visits to child and adolescent mental health services (CAMHS) across Scotland.

The situation with regard to the lack of intensive psychiatric care units (IPCU) for young people again has not changed in the last year, with Table 32 indicating that in 11% of admissions the young person is transferred to an IPCU ward during the admission. There has also been a significant rise in the proportion of young people nursed under constant observation on admission. There may be a number of reasons why constant nursing observations are felt to be necessary, but this probably reflects clinicians' views that young people are particularly vulnerable in such settings. Our view would certainly be that the need for heightened observations should be very carefully considered when any young person, particularly any person under 16, is in a non-specialist setting.

Other care provision is shown in Table 33. We welcome the increase in young people's access to age-appropriate recreational activities (61% this year compared with

48% last year). We also view very positively the figures which state that 81% of young people had access to an advocacy service, an increase of 10% from the previous year's figures. However, we have serious concerns about poor access to education for young people admitted to adult wards. Our experience is that, without specialist CAMHS input, staff in adult wards do not know how to access continuing education services while the young person is in hospital.

Table 34 shows figures for the age and gender of young people who were admitted in 2007-08. As was the case in 2006-07 there were more 17 year olds admitted than any other age group, with 114 (71%) of admissions involving young people aged 16 to 17.

The information we received over the last year indicates that there have been some positive changes to the services provided to young people. We continue to have concern regarding the lack of appropriate services for young people who have a significant learning disability and who require admission for assessment and treatment of mental health problems, particularly where there are problems with challenging behaviour or

Table 34: Age of young person by gender, 1 April 2007 to 31 March 2008

Age in years last birthday	Gender		Total
	F	M	
12	–	1	1
13	3	2	5
14	4	1	5
15	9	8	17
16	25	24	49
17	29	36	65
Total	70	72	142

offending. The information provided to us suggests that fewer young people have been admitted to non-specialist facilities, and that liaison links between CAMHS and general adult psychiatry services are improving. Child and adolescent service input seems to be increasingly available either directly or on a consultative basis, when a young person is in an adult ward. Plans for the development of new units through regional networks are also progressing, with building already started in the West of Scotland. In conjunction with the information provided to us in the past year, this suggests that some NHS Boards are moving in the right direction to provide fully for the needs of young people who require hospital admission. As mentioned above, we plan to undertake visits to look at the provision of CAMH services in all areas of Scotland during 2008-09. During these visits we will want to look at how services for children and young people are being developed at a local level. Our information suggests that there may be specific local issues to address.

2.5 Additional findings from our monitoring programme

This section includes other important findings from our monitoring of the 2003 Act. We have analysed the use of social circumstance reports, data on ethnicity and information on medical treatment authorised under the Act.

2.5.1 Social circumstance reports

The preparation of a Social Circumstance Report (SCR) is an important part of the MHO's responsibilities under the Act. An SCR is a formal report drawing together into one document different strands of information about the interaction of a person's mental disorder and their social circumstances where a person is being considered for, or subject to, compulsory measures.

The SCR should include as much information as possible relevant to the current illness and the necessity for using compulsion. It should include social and family background; cultural circumstances;

the particulars of their illness, past and current; and the person's individual strengths and particular vulnerabilities. The report should describe the social supports available and highlight those areas which will require further attention in future, when care and support plans are being prepared. It should also include the person's view of their mental disorder as well as the proposed treatment, including how they would wish to manage it. It should then give the MHO's views on the rationale for statutory intervention, the proposed treatment and the factors that should influence the decision to apply compulsory measures. SCRs should also inform us of any concerns which we might wish to investigate further. The MHO should alert us to this in a covering letter.

Some MHOs have questioned the value of compiling SCRs, as much of this information is available in other forms. The Code of Practice advises on the differences between the SCR and information submitted in an application for a CTO. The SCR will often contain information which is not pertinent to the Tribunal deciding on whether the person meets the criteria for compulsory care. The SCR uniquely combines all the above information into one document. This becomes an invaluable record, not only throughout the period of compulsion, but also long afterwards.

The process of compiling the report helps communication and allows for full consideration of options in the context of that person's unique circumstances.

While the SCR document is an important record of the work and thinking that has gone on at the time of the compulsion, the process provides a key opportunity for MHOs to utilise their specialist knowledge, skills and training to assist the multi-disciplinary team in their assessment and care planning. It provides an opportunity for the MHO to discuss what has been happening with the individual and to provide professional support from a skilled mental health professional, outwith the medical and nursing team. It is a key time to discuss such matters as the principles of the Act which should inform their care, their legal rights and entitlements and the Tribunal process, the purpose and function of designating a named person or writing an advance statement and the role of the designated MHO. MHOs can also use this opportunity to help individuals take greater control over the management of their illness. Good professional MHO practice, in the process of preparing an SCR, fits very well with the recovery approach.

Many SCRs highlight the distress and very difficult personal circumstances people have to cope with when unwell. Families and carers also face real challenges at this time. MHOs can act as a bridge between NHS and local authority resources and are well placed to ensure that carers, as well as those subject to the Act, are given the appropriate support. Their link to local authority care management should guarantee that practical and emotional support complements the clinical care available for individuals.

Number of SCRs prepared this year

The Act requires SCRs to be prepared at various stages of compulsion unless doing so is seen by the MHO as 'serving little, or no, practical purpose'. These are referred to as 'relevant events' which, effectively, are all episodes of compulsion beyond the emergency detention (72 hr) stage. They are listed in Section 232 (1). The Code of Practice (vol 1 ch11) sets out good practice in the preparation of SCRs and Regulations (SSI NO 310) prescribe the information that should be included in an SCR. Where an SCR is not provided, the MHO is required to send an explanatory statement to the RMO and the Mental Welfare Commission. We feel the Act makes too many demands of MHOs as two, three and even four relevant events can follow each other in quick succession. It is difficult to see how a new SCR would serve a practical purpose in such circumstances. It is clear that MHOs are having great difficulty in complying with their statutory duties of notification where they are not providing SCRs. Of the 5384 relevant events we recorded for the year we received SCRs in 1583 cases. Of the remaining episodes where an SCR was not provided we only received notification in 521 instances, or just under 14% of cases.

It is unfortunate that these notifications are not being provided as it makes it difficult for local authority managers to determine whether SCRs are being provided by their MHOs in accordance with the law, the Code of Practice and local guidance. We are currently liaising with local authority MHO colleagues in devising further guidance on when we believe SCRs should be provided.

It is our view however, that this is an area in which the legislation could be amended to better achieve its intended effect. We would suggest that Section 231 be changed so that SCRs and/or notification of reasons for not providing SCRs are required after a freestanding relevant event, or a series of contiguous relevant events – not after every relevant event.

**Table 35: SCRs provided for STDCs and CTOs by local authority,
1 April 2007 to 31 March 2008**

Local authority	SCRs provided for STDCs	Total no. of STDCs	% SCRs per STDC events	SCRs provided for CTOs	MHTS data: total no. of CTOs	% SCRs per CTO events
Aberdeen City	39	152	26	3	64	5
Aberdeenshire	44	77	57	7	22	32
Angus	38	43	88	9	15	60
Argyll & Bute	5	47	10	3	22	14
City of Edinburgh	110	412	27	6	140	4
Clackmannanshire	15	30	50	0	9	0
Dumfries & Galloway	50	85	59	5	35	14
Dundee City	36	127	28	5	50	14
East Ayrshire	39	49	80	3	17	10
East Dunbartonshire	20	41	50	0	8	18
East Lothian	28	50	56	1	22	4
East Renfrewshire	28	33	85	3	8	37
Eilean Siar	5	8	62	1	1	100
Falkirk	46	85	55	0	30	0
Fife	147	225	65	10	96	10
Glasgow City	149	616	23	14	189	7
Highland	11	165	8	6	64	9
Inverclyde	27	61	44	1	14	7
Midlothian	23	43	46	5	11	45
Moray	9	59	15	0	12	0
North Ayrshire*	57	38	150*	0	17	0
North Lanarkshire	40	110	36	2	49	4
Orkney Islands	7	0	0	0	0	0
Perth & Kinross	35	122	29	6	27	22
Renfrewshire	19	82	23	4	29	14

Table 35 continued:

Local authority	SCRs provided for STDCs	Total no. of STDCs	% SCRs per STDC events	SCRs provided for CTOs	MHTS data: total no. of CTOs	% SCRs per CTO events
Scottish Borders	20	57	35	4	21	19
Shetland Islands	5	5	100	0	2	0
South Ayrshire	39	62	63	4	25	16
South Lanarkshire	79	145	54	24	49	49
Stirling	20	38	53	0	12	0
West Dunbartonshire	12	38	31	0	19	0
West Lothian	55	91	60	0	26	0
Scotland	1255	3242	39	126	1105	11

*We are looking in detail at the detentions in North Ayrshire consulting with the medical records officer and the MHO service manager to try to explain this unexpected figure.

In civil procedures the main relevant events are the making of a short-term detention (STDC) and the making of a compulsory treatment order (CTO). Table 35 shows the numbers of SCRs prepared by local authorities for STDCs and CTOs compared to the overall numbers of STDCs and CTOs in their area.

Figures indicate that shows that more emphasis is given to preparing a SCR for a STDC than for a CTO. This is understandable, as most people subject to CTOs will already have had a spell of short-term detention. In a number of cases an SCR is likely to have been provided recently. The preparation of SCRs for criminal compulsion orders largely matches that for civil orders, in terms of the proportion of relevant events which have triggered an actual SCR.

We expect local authorities to audit their own practice and that MHO managers will support frontline MHOs in decisions about which reports are necessary and which would serve little purpose.

Quality of SCRs

We are pleased to report that the quality of most SCRs remains high. We are well aware of the demands on MHOs time. We expect Local Authorities to give MHOs the time and resources they need to maintain high professional standards. We expect local authorities to be working towards full implementation of the MHO service standards. During the coming year we will be asking managers about their commitment to MHO services and we will liaise with the Social Work Inspection Agency over local authorities' compliance with meeting the National Standards for Mental Health Officer Services.

Table 36: Ethnicity of individuals as notified to the Commission on mental health act forms, 1 April 2007 to 31 March 2008

Ethnicity	No	% of known info
White Scottish	3053	85%
White other	406	11%
Indian	20	0.5%
Pakistani	38	1%
Chinese	20	0.5%
Black-African/Caribbean	0	0%
Mixed*	76	2%
Total known	3613	
Unknown**	2680	43%
Total number of forms	6293	

*Some of these could be incorrectly completed forms – interpret with caution

**Due to form not being completed, ethnicity recorded as unknown or ethnicity uncertain from information stored from scanned image of form

2.5.2 Ethnicity

There is evidence, from some parts of England, of relatively high use of mental health legislation for some minority ethnic groups especially black-African or Caribbean men. Also in England, the investigation into the death of David Bennett demonstrated evidence of racist attitudes among some staff. We therefore want to produce information on ethnicity of people subject to the Scottish Act to help ensure that there is respect for diversity.

We record data on ethnicity in two ways. Firstly, we receive records of ethnicity on forms submitted to us (EDC, STDC, CTO and nurses' power to detain). Completing

the ethnic monitoring section of forms is currently not mandatory. There are major problems with this information. It is usually collected when the person is first detained. This is likely to be when the person is unwell and distressed. The person completing the form is asked to describe how the "patient" describes his or her ethnicity. Many people cannot do this at the time, or refuse to co-operate. For many reasons, it may be difficult to obtain this information at that point in time. We have suggested that it is acceptable for practitioners to record how the person had previously described his or her ethnicity, if this information is available from other documentation.

Table 37: Ethnicity data from MWC visits to people on long-term compulsory treatment, 1 April 2007 to 31 March 2008

Ethnicity	Number
Scottish	469
Scottish/Other White	1
Irish	3
Other British	19
All White British	492
Other White	3
Pakistani	3
Scottish/Other Asian	1
Indian	4
Other Asian	2
Other Asian/Mixed	1
Chinese	3
All Asian	14
African	4
Other Black	1
All Black/African	5
Mixed	2
All Known	516
Unknown	74
Grand Total	590

Table 36 shows that we only have ethnicity information recorded on 57% of forms we receive. Of these, 96% of people were white and 2% were definitely from a minority ethnic group. The remaining 2% are recorded as 'mixed'. Some of these forms may have been inadequately completed, or could have been

misread by our information system. Due to legal advice received, we do not store ethnicity information in individual people's files and therefore cannot check it. The data is incomplete, but from the information we do have there appears to be no evidence of higher use of compulsory treatment for any

minority ethnic group, as compared with the white population.

Our second source of ethnicity data comes from our monitoring of long-term compulsory treatment. We collect data on ethnicity with the consent of the people we visit. For people from minority ethnic groups, we check that their cultural, religious and communication needs are being met. As we visited all people who became subject to long-term compulsory treatment within the previous year (or six months, if subject to community treatment), the information we collected from these visits accurately reflects the ethnicity of people subject to long-term treatment.

We have reliable ethnicity data on 87% of the people we met (see Table 37 on page 45). Of these, 95% were white British, less than 3% Asian and less than 1% Black. This suggests that there is little or no ethnic bias in the use of mental health legislation in Scotland.

We were satisfied with the respect shown by mental health services for the diverse needs of the people we met. Only one of the 590 people was unable to communicate in English. He received a very good translation service. We did not see anyone who communicated in sign language. We only found one instance where we felt that services could do more to meet the person's cultural needs. One person was unable to practice religious observance, but this was due to the severity of illness and not due to lack of sensitivity to religious needs.

Overall, for the people we met to monitor the use of the Act, we found no evidence of institutional racism and good respect for the diversity principle.

2.5.3 Consent to treatment under part 16 of the Mental Health (Care And Treatment) (Scotland) Act 2003

Neurosurgery for mental disorder (sections 235, 236)

Where a procedure classified as neurosurgery is proposed, the 2003 Act requires that the Commission arrange for a Designated Medical Practitioner (DMP) and two other persons (not medical practitioners) to carry out an assessment regardless of whether the person is detained under the Act. All three assess the individual's capacity to consent to surgery and that this consent has been recorded in writing by the individual. In addition the DMP also assesses that the treatment is in the person's best interests. At present the only centre providing neurosurgical treatment is the Dundee Advanced Interventions Service (AIS). During the past year four people were seen for assessment, three from Scotland and one from England.

All four people had severe incapacitating depressive disorder for many years and had previously received treatment with numerous medications, ECT and psychological therapy. Any improvement experienced had been short-lived. One person needed a second neurological procedure, because of continuing symptoms and a view that the initial operation had not fully achieved what was intended. Neurosurgery was considered appropriate in the four cases and was approved. Two people went on to have the procedure. One person had a change of mind and did not proceed to treatment. The fourth had surgery, which had been previously postponed due to a significant life event. The Act has provision

for treatment to be carried out without consent in certain cases. There has been no such treatment in these circumstances since the Act was implemented. At present this is considered unlikely, as the AIS only operates on people who give capable informed consent.

The Commission's Neurosurgery Working Group met on two occasions and we also had two useful meetings with the Dundee AIS. The working group has developed a programme to improve its administration, the knowledge of its members and to extend the monitoring period to two years after individuals have had their surgery.

We received two referrals from the AIS for Vagus Nerve Stimulation (VNS), a relatively novel treatment for depression. The Act only requires an assessment by a DMP for people who are subject to compulsory treatment and who are incapable of consenting. We did not have a statutory role in relation to these two people. However, we agree with the AIS that newer treatments need more safeguards. We advised them to seek appropriate independent opinions and will raise this issue as part of the review of the Act.

Other treatments (Sections 237, 240)

In November 2007 we gave notice to RMOs that any Form 9 or 10 documentation authorising treatment under the 1984 Act would be revoked by 31 March 2008. We decided that everyone should have treatment that complied with the requirements of the new Act. These new safeguards should be available to everybody on long-term treatment. This includes written explanations for treatment where the person resists or objects, taking account of advance

statements and consultation with named persons. This increased the number of requests for second opinions we received by 15% compared to the previous year.

Treatment given with the person's consent under the Act is authorised by Form T2. We do not automatically receive these forms and therefore it is not possible to make comparisons with previous years or the 1984 Act. We are considering suggesting that we receive the T2s as a requirement under the Act when the Act is reviewed. During the past year, we received copies of Form T2 giving notice of treatment with consent in 839 cases: 28 were for ECT, 14 for medication to reduce sex drive and 779 for medication beyond 2 months. There were also a number of forms with missing information.

Treatment given without consent is authorised by a DMP on Form T3. The number of treatments authorised is shown in Table 38.

The finding that about half of the people receiving ECT objected to or resisted the treatment was similar to the previous year. A fifth of people needed treatment to save life, the rest to prevent serious deterioration or to alleviate serious suffering. This was similar to 2006-07.

Audits of T3 certificates have identified a number of problems with completion of the forms and with the system for extracting information and these will be addressed over the next year. Improvements to the design of forms are also under discussion.

**Table 38: Certificate of the designated medical practitioner (T3),
1 April 2007 to 31 March 2008**

Treatment type	No.
ECT	142
Medication to reduce sex drive	4
Artificial feeding	27
Medication over 2 months	1026
Total T3 certificates	1178

Note: T3 certificates may be for more than one treatment.

The number of certificates is probably an underestimate.

Children and young people

We received 37 treatment forms for people under aged 18 at the time of completion, 30 of these were for treatment without consent. None were for ECT. 15 people received artificial nutrition and 22 received medication beyond two months. In all cases except one either the RMO or the DMP were child specialists. (In the one case the RMO was believed to be a child specialist in error.)

Designated Medical Practitioners

79 doctors provided second opinions on safeguarded treatments during the past year. We held an annual seminar for DMPs in November 2007 which was attended by just over half of the DMPs. The main focus of this meeting was on issues of consent to treatment, good practice guidance, prescribing issues and various matters concerning the correct completion of the T3 forms which had recently been revised (Version 6). During the year further induction seminars have been held for new DMPs.

We are grateful to those doctors who have provided second opinions throughout the year often at short notice and sometimes in addition to their own busy clinical jobs. A full list of these doctors can be viewed at www.mwscot.org.uk.

3 Use of the Adults with Incapacity (Scotland) Act 2000

Under Section 9 of the Adults with Incapacity (Scotland) 2000 Act (the Act), we have a responsibility to 'exercise protective functions' in respect of adults with mental disorder who are subject to intervention or guardianship orders under Part 6 of the Act where the order relates to the personal welfare of the adult. In this section we report on findings from our activities undertaken in carrying out this protective role.

**Table 39: Guardianship orders granted by local authority area,
1 April 2007 to 31 March 2008**

	Private* applications granted 2007-08	Local authority applications granted 2007-08	All applications granted 2007-08 (No.)	Rate per 100K pop. over age 16			
				Private rate	LA rate	Total rate	Recalled or lapsed**
Aberdeen City	22	23	45	13	13	26	12
Aberdeenshire	33	25	58	17	13	30	6
Angus	17	17	34	19	19	38	1
Argyll & Bute	7	1	8	9	1	11	3
City of Edinburgh	35	29	64	9	7	16	7
Clackmannanshire	7	2	9	18	5	23	3
Dumfries & Galloway	23	16	39	19	13	32	10
Dundee City	14	13	27	12	11	23	2
East Ayrshire	9	12	21	9	12	22	1
East Dunbartonshire	10	5	15	12	6	18	3
East Lothian	7	7	14	9	9	19	3
East Renfrewshire	8	4	12	11	6	17	4
Eilean Siar	0	1	1	0	5	5	1
Falkirk	7	20	27	6	16	22	2
Fife	94	36	130	32	12	44	37
Glasgow City	126	68	194	26	14	40	35
Highland	44	22	66	25	12	37	11
Inverclyde	3	6	9	5	9	14	1
Midlothian	10	4	14	16	6	22	–
Moray	17	5	22	24	7	31	5
North Ayrshire	18	3	21	16	3	19	11
North Lanarkshire	26	20	46	10	8	18	6
Orkney	1	0	1	6	0	6	–

Table 39 continued:

	Private* applications granted 2007-08	Local authority applications granted 2007-08	All applications granted 2007-08 (No.)	Rate per 100K pop. over age 16			
				Private rate	LA rate	Total rate	Recalled or lapsed**
Perth & Kinross	26	21	47	22	18	40	12
Renfrewshire	14	1	15	10	1	11	2
Scottish Borders	2	5	7	2	6	8	6
Shetland	2	0	2	11	0	11	–
South Ayrshire	6	12	18	6	13	19	2
South Lanarkshire	14	19	33	6	8	13	1
Stirling	10	3	13	14	4	18	1
West Dunbartonshire	3	6	9	4	8	12	–
West Lothian	14	11	25	11	8	19	12
Scotland	629	417	1046	15	10	25	225

*We use the term 'private' to cover all applicants who are not local authorities. 13 joint applications are included with the local authority figures.

**Includes cases terminated in period including where the adult died.

3.1 Trends in the use of welfare guardianship

During the past year, the use of Part 6 of the Act continued to rise but at a much slower rate than in previous years. Increases in approved orders in 2004-05, 2005-06 and 2006-07 were at a rate of 45%, 32% and 32% respectively. In the past year, however, the number of approved orders increased by only 13%. It is not clear why this is the case, or whether this trend will continue. It may be that the changes to the Social Work (Scotland) Act with the insertion of Section

13ZA brought about by the Adult Support and Protection (Scotland) Act 2007 in March 2007 is partly responsible for this. Local authorities made 22% fewer applications during 2007-08, though we cannot say that this was all in response to this change. Another contributing factor may be the increased number of orders being granted on an indefinite basis which is reducing the number of renewal applications. Also, the use of welfare powers of attorney may be having an effect. 83,700 welfare powers of attorney have been granted since the 2000 Act came into effect.

Table 40: Applicants for guardianship in orders granted, 1 April 2007 to 31 March 2008

Applicant	No (%)
Local authority	404 (39)
Relative/carer(s)	613 (59)
Joint	13 (1)
Solicitor	7 (1)
Independent advocate	3 (0)
Other	6 (0)
Total	1046 (100)

Our statistics are based on the date of the signing of the interlocutor, whereas the Office of the Public Guardian data is based on the date after registering the order following receipt of the approved application from the court. This, in part, is responsible for the fact that the Commission records approximately 7% fewer orders than the Office of the Public Guardian for 2007-08. We continue work on harmonising our statistics.

3.2 Guardianship orders by local authority area

There is still enormous variance in the use of welfare guardianship throughout the country (Table 39). Applications made by local authorities (which fell by 22% relative to the previous year) varied from 19 and 18 per 100,000 in Fife and Perth & Kinross Councils respectively, to 5 or fewer per 100,000 in Argyll & Bute, Clackmannanshire, North Ayrshire, Renfrewshire and Stirling Councils, with the Scottish average being 10 per 100,000.

There have been dramatic changes in the use of the legislation in certain local

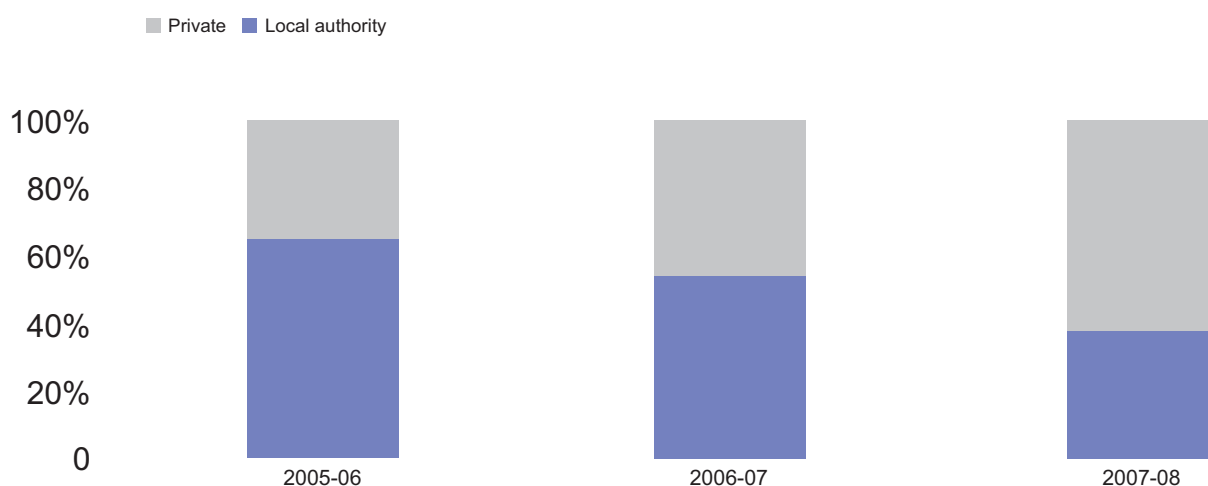
authorities. Fife Council applications fell from 107 in 2006/07 to 36 in 2007/08. Glasgow City Council fell from 110 to 68 during this period, Highland Council from 45 to 22 and West Lothian from 22 to 11.

Demographics of different local authorities will account for some of these differences and the closure of inpatient facilities in certain areas may increase rates in a few local authorities. Despite this, we would expect a higher level of consistency in the use of the legislation given that local authorities are all working to the same codes of practice and guidance. As in previous years, we ask local authorities to examine their practice when their use of the legislation is at considerable variance from the Scottish average.

3.3 Applicants for guardianship in orders granted

One of the most notable changes in the past year has been the shift in balance between local authority and private applications (Table 39). In 2005-06, 65% of all applications were made by a local authority. In 2006-07, this

Figure 6: Applicants for welfare guardianship 2005-08



stood at 55%. In the past year this reduced to just 38% of all applications. Figure 6 (above) shows the changing trend from local authority to private applications over the last three years.

Private applications varied from 32, 26 and 25 per 100,000 in Fife, Glasgow City and Highland Council areas respectively, to 5, 4 and 2 per 100,000 in Inverclyde, West Dunbartonshire and Scottish Borders Councils, with the Scottish average being 15 per 100,000. Glasgow City Council saw the most dramatic rise in the lodging of private applications, from 30 in 2006-07 to 126 in 2007-08. Such differences in the use of private applications are more easily understood. Factors such as local solicitors' awareness of the benefits of the Act and the resultant advice they give to clients will undoubtedly affect rates of private applications. The role that carer support groups might play in disseminating information about the usefulness of guardianship and how one can go

about making an application could be another contributing factor.

3.4 Causes of incapacity in guardianship orders

Table 41 is slightly different from last year's which used 'primary diagnosis' for counting the incidence of types of incapacity. Primary diagnosis is not recorded in guardianship applications and therefore this year we have counted the total incidence of each incapacity type.

Dementia is cited as the cause of incapacity in over 58% of all new orders granted – marginally down from 62% the previous year. Learning disability featured as a cause of incapacity in 28% of all applications, up from 25% in the previous year. Applications for people whose incapacity was caused by alcohol related brain damage (ARBD) rose from 3 to 5% of all orders granted, but still remains at a lower level than one might expect given the prevalence of the disorder and its obvious impact on a person's capacity to look

Table 41: Causes of incapacity in guardianship orders, 1 April 2007 to 31 March 2008

Types of incapacity	No. of people
Learning disability	296 (28%)
Dementia	609 (58%)
Acquired brain injury	37 (4%)
Alcohol-related brain damage	32 (3%)
Inability to communicate due to physical disability	12 (1%)
Mental illness	63 (6%)
Personality disorder	3 (0%)
Total	1046

after and/or promote their own welfare. Overall, this data shows little change from last year. The categories of mental disorder were generally similar in local authority applications and private applications. Mental illness was the cause of incapacity in 8% of local authority applications compared with 4% of private applications.

In the past year we noticed a significant difference in use of Part 6 of the Act for young people (under 21). As of 31 March 2008, there were 146 people under 21 who were subject to welfare guardianship orders. While the Scottish average was just under 13 per 100,000, Aberdeenshire, Aberdeen City and Highland Councils had rates of 44, 32 and 31 per 100,000 young people on welfare guardianship respectively. Angus Council, which adjoins Aberdeenshire Council, had fewer than 8 per 100,000 young people on guardianship. Glasgow City Council, North Lanarkshire, North Ayrshire and South Lanarkshire Councils, had fewer than 4 per 100,000 young people on welfare

guardianship. We intend to look more closely at the use of the Act for young people as we have become aware of cases where plenary powers (i.e. a full range of very broad welfare powers) are granted on an indefinite basis. We are perplexed as to the low use of the Act in some areas. We would expect that the question of whether legal authority is needed to implement key aspects of care plans be addressed in all assessments of young people making the transition to adult services.

3.5 Duration of guardianship orders

We are still concerned that the practice of seeking an order on an indefinite basis is becoming more commonplace, with 71% of all orders being granted on an indefinite basis in the last year. Private applicants sought orders on an indefinite basis at a much higher rate than local authorities – 78% compared to 60%. We believe it is essential that each case is looked at on its merits and with reference to principles of the 2000 Act, especially that of least restrictive intervention, in determining the length of

Table 42: Duration and causes of incapacity in all guardianship orders, 1 April 2007 to 31 March 2008

Period granted/ Cause of incapacity	Learning disability No. (%)	Mental illness No. (%)	Dementia No. (%)	Other No. (%)	Total orders (%)
1 year or less	5 (25)	2 (10)	13 (65)	0	20 (100)
1-2 years	5 (71)	0	2 (29)	2	7 (100)
3 years	55 (29)	20 (11)	87 (46)	33 (18)	188 (100)
5 years	37 (56)	5 (8)	15 (23)	9 (14)	66 (100)
6-20 years	15 (68)	1 (5)	4 (18)	2 (9)	22 (100)
Indefinite	179 (24)	35 (5)	488 (66)	51 (7)	743 (100)
Total (%)	296 (28)	63 (6)	609 (58)	97 (9)	1046 (100)

Table 43: Duration and causes of incapacity in guardianship orders, where the local authority is the applicant, 1 April 2007 to 31 March 2008

Period granted/ Cause of incapacity	Learning disability No. (%)	Mental illness No. (%)	Dementia No. (%)	Other No. (%)	Total orders (%)
1 year or less	5	1	7	0	13
1-2 years	3	0	1	2	4
3 years	43	14	51	22	123
5 years	15	2	3	5	25
6-20 years	2	0	1	0	3
Indefinite	48	18	163	23	249
Total (%)	116 (28)	35 (8)	226 (54)	52 (12)	417 (100)

time for which the order should be sought. We commented last year that we feel the lack of automatic review of approved orders after a set period of time is not in keeping with accepted standards of justice. The order continues without a judicial review unless the adult or another interested party objects.

This would appear to be at odds with human rights legislation and runs counter to the approach taken in the Mental Health (Care and Treatment) (Scotland) Act 2003. We remain of the view that this issue needs to be addressed by the Scottish Government. It cannot be right, for instance, that an 18 year

Table 44: Duration and causes of incapacity in guardianship orders, where the applicant is a private individual or representative, 1 April 2007 to 31 March 2008

Period granted/ Cause of incapacity	Learning disability No. (%)	Mental illness No. (%)	Dementia No. (%)	Other No. (%)	Total orders (%)
1 year or less	0	1	6	0	7
1-2 years	2	0	1	0	3
3 years	12	6	36	11	65
5 years	22	3	12	4	41
6-20 years	13	1	3	2	19
Indefinite	131	17	325	28	494
Total (%)	180 (29)	28 (4)	383 (61)	45 (7)	629 (100)

Note: rows do not sum to the final column because in a small number of cases the person had more than one cause of incapacity. In previous years, the corresponding table counted only one cause for each individual.

old with mild learning disability can be placed on a welfare guardianship order with plenary powers being granted to the guardian on an indefinite basis and the order need never again be judicially reviewed.

3.6 Our scrutiny of approved guardianship orders and visits to adults on guardianship

In 2007-08, we scrutinised welfare guardianship orders and reviewed existing orders in 1278 cases involving 1220 adults on guardianship. Often this involved corresponding with the adult, their guardian and/or social work supervisor with specific questions or requests for further information. We do this to assure ourselves that the Act is being implemented in accordance with the principles of the legislation. In some complex cases or where key interested parties have concerns we may decide it is necessary for

us to visit to best meet our responsibilities under the Act. In 2007-08 we visited 423 people on guardianship.

As reported last year, we have started to keep more detailed data on the nature of our actions taken as a result of our visits. This gives us a better idea of the type of issues which commonly emerge. It will also help us target our visits most effectively.

Our visits were made to adults whose incapacity was caused by the following conditions:

- Learning disability (including 16% with autistic spectrum disorder): 55%
- Dementia: 24%
- Acquired brain injury: 8%
- Alcohol related brain damage: 7%
- Mental illness: 6%

Comparing this with data on the use of welfare guardianship, we visited a much higher proportion of adults with a learning disability and a much smaller proportion of people with dementia. We did not visit people with dementia where the guardian was appointed to effect a generally agreed move to a care home and the adult appeared to be accepting and benefiting from the move. Adults with a learning disability tend to be younger and their orders are often granted on an indefinite basis and involve a full array of powers. In such cases we often feel it is important to make personal contact with the adult, their carer, guardian and/or local authority supervisor. This is to assure ourselves that the Act is being used in accordance with its principles as well as to give us the opportunity to personally explain the protective role of the Commission. We ask guardians to let us know of any difficulties or concerns about care arrangements, supports or the use of the guardian's powers in the future. In quite a few of these cases young people will be in the process of transferring to adult services. This is often a stressful and frustrating time for carers as well as the adult and the Commission is keen to see that this transition is handled well by those professionals involved.

We also visited a higher proportion of adults with acquired brain injury and ARBD. Providing appropriate services for adults with both disorders can prove difficult and with ARBD there is also the factor that, with abstinence and proper nutrition, an individual's mental capacity can improve.

Accommodation issues were those most often raised in our visits, followed by activity levels, protection issues, social work input, legal, physical health, mental health and financial issues. Accommodation issues were the most commonly identified issue for people with a learning disability. People seen with a diagnosis of ARBD, acquired brain injury and autistic spectrum disorder had on average more than one issue per person which we raised with the relevant parties.

3.7 Supervisory responsibilities

Local authority officers are required to visit the adult on guardianship as well as the guardian (or arrange for them to be visited) within the first three months of the order being granted and then at subsequent periods of no longer than 6 months. We reported last year on our efforts to secure updated information from local authorities. These have been largely successful. We still, unfortunately, come across a number of cases where there are delays in allocating a supervising officer or there is no evidence that these statutory visiting requirements are being met. We intend to look more closely at this in the coming year.

We reported last year on the information and guidance we developed and published – 'Working with AWI – Guidance for People Working in Adult Care Settings'. We continue to visit adults on guardianship in care settings where the carers know little or nothing about the guardianship. They are sometimes unaware that the person has a welfare guardian, who the guardian is, what powers they have and which powers are delegated to staff. Very often there is no

knowledge of the local authority supervising officer and what their role is. We feel that it is the responsibility of the local authority guardian/supervising officer to have a focused discussion with management about these issues whenever someone on welfare guardianship is placed in an adult care setting. Local authority staff should routinely use our publication as part of this process.

We have seen good examples of information leaflets used by local authorities to inform private guardians of the statutory duties of local authorities in supervising orders. We feel that use of such leaflets should be routine in all cases and that the content should include what the private guardian can expect of the supervising officer as well what the supervising officer will expect of the private guardian.

3.8 Developments in adults with incapacity legislation: renewal and recall procedures

The changes affecting renewal and recall procedures did not come into effect until April 2008. The Codes of Practice for Part 6 of the Act have been revised to take account of the new changes. Significant changes involve a streamlining of renewal procedures. Local authorities are now able to recall welfare powers where the chief social work officer is the guardian.

We have expressed our intention not to exercise our power to recall the welfare powers of a guardian other than in exceptional circumstances. We believe that the Sheriff Court is the appropriate forum for making such decisions when they are contested by any interested party. This is similar to procedures under the 2003 Act

where we believe that the Tribunal is the appropriate forum. The local authority must still inform us when they make or receive an application for recall. We will still be exercising our right to state an objection to the application where we believe it is warranted. In such cases the matter will be remitted to the Sheriff Court.

We are concerned that the Form AWI (15), used to intimate intention of the local authority to recall a welfare guardianship order, or the receipt of an application to recall guardianship powers, is not sufficiently detailed to provide the necessary information. The grounds on which the recall must be based under Section 73(3) are not specifically asked for in the form – merely the ‘reasons why it is intended to recall the powers relating to personal welfare’. It is important that these grounds are addressed when stating the reasons. We will monitor the use of this form in the coming year.

The Adult Support and Protection (Scotland) Act amendments also simplified renewal procedures for guardianship. For renewal of welfare guardianship applications the guardian must apply to the Sheriff Court by way of a minute. This application must be accompanied by at least one medical report (AWI 1) from an Approved Medical Practitioner. Two medical reports are no longer necessary. The application must be accompanied as well by a report provided by an MHO (AWI 3). The amended legislation says that the MHO’s report should contain an opinion as to the general appropriateness of continuing the guardianship, based on an interview and assessment of the adult carried out no more than 30 days before the lodging of the application; and the suitability of the

applicant to continue to be the adult's guardian. The form itself, however, requires only tick boxes on the outcome of the assessment followed by a text box which asks for 'Comments (if any)'. A sheriff may determine an application made under this section without hearing the parties although, if not satisfied by the information provided, can call for further reports and/or have a hearing.

We have concerns that the amended renewal requirements may not be sufficiently rigorous. Unfortunately, the amended Code of Practice offers very little additional guidance on good practice in relation to the renewal process. We intend to develop guidance for local authorities on good practice in the renewal of welfare guardianship orders to complement that available in the local authority revised Code of Practice. We would expect the local authority to exercise the same degree of care and attention in the renewal of guardianship that they undertook in relation to the original application. Some of these renewals might be requesting powers for a longer period than originally sought.

We would expect that the decision on whether to renew, or support the renewal of a guardianship application, should be made within the context of a multidisciplinary meeting. This should include input from the adult (as far as possible), nearest relative, carers and any other relevant person. The meeting should be informed by the review reports from the guardian/local authority supervising officer during the duration of the order. It should examine how the powers of the guardian have been used and which powers are still required to safeguard and/or promote the adult's welfare. The principles of the Act will guide decisions on the need for

guardianship and the exercise of powers. We would also suggest that a report detailing the MHO's assessment should be submitted to the Sheriff Court to accompany the required forms.

3.9 Part 5 of AWI Act – medical treatment

We found that compliance with part 5 of the Adults with Incapacity (Scotland) Act 2000 was poor. The lack of certification of incapacity under section 47 accounted for the vast majority of the 18 recommendations we made to hospitals and care homes about the operation of this Act. The most extreme example was:

"Not one person lacking capacity to consent to medical treatment in a particular care home had a section 47 certificate of incapacity. The manager and the trained staff appeared to be unaware of the law. The company provided guidance that referred to the law in England and Wales. They took immediate action to comply with the law as a result of our visit."

During 2008-09, we will be conducting joint visits to a sample of care homes along with the Care Commission. As part of this, we will provide more information on the use of part 5 of the Act. We suspect that it is widely underused and that many people are being treated without proper legal authority.

As we reported in our 2006-07 annual report, the Scottish Government has passed legislation modifying aspects of Part 5. This has now been implemented and provides for the provision of Section 47 certificates for periods of up to 3 years in situations of severe or profound learning disabilities, severe neurological disorder or severe dementia where there is no prospect of

Table 45: Adults with Incapacity (Scotland) Act 2000, 1 April 2007 to 31 March 2008

Requests Type of treatment	Section 48
Medication to reduce sex drive	20
ECT	10
Total	30

Figure 7: Second opinion assessments for treatment under Adults with Incapacity legislation, 2003-04 to 2007-08



recovery. The provisions also allow for other health professionals, who have been appropriately trained, to complete certificates within their own sphere of practice. This should enable dentists, ophthalmic opticians and nurses (at present), who undertake the approved training, to complete certificates in respect of their own interventions without the need to obtain a certificate from a medical practitioner.

We continue to arrange second opinions under Section 48 of the Adults with Incapacity Act. During the year we arranged 31 of these visits, of which two thirds were for medication to reduce sex drive. In three cases we do not

know the outcome of the request and in one case the request was refused and the RMO advised to consider the use of the Mental Health Act as the person was felt to be very unwell.

Of the 10 requests for authorisation to carry out ECT, 4 were not granted and the RMO advised to consider the use of the Mental Health Act. Most of the requests under both section 48a and b are in respect of people with dementia, only 8 were for people with a learning disability, 7 under section 48a and 1 under 48b. 3 were for people who had brain damage.



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