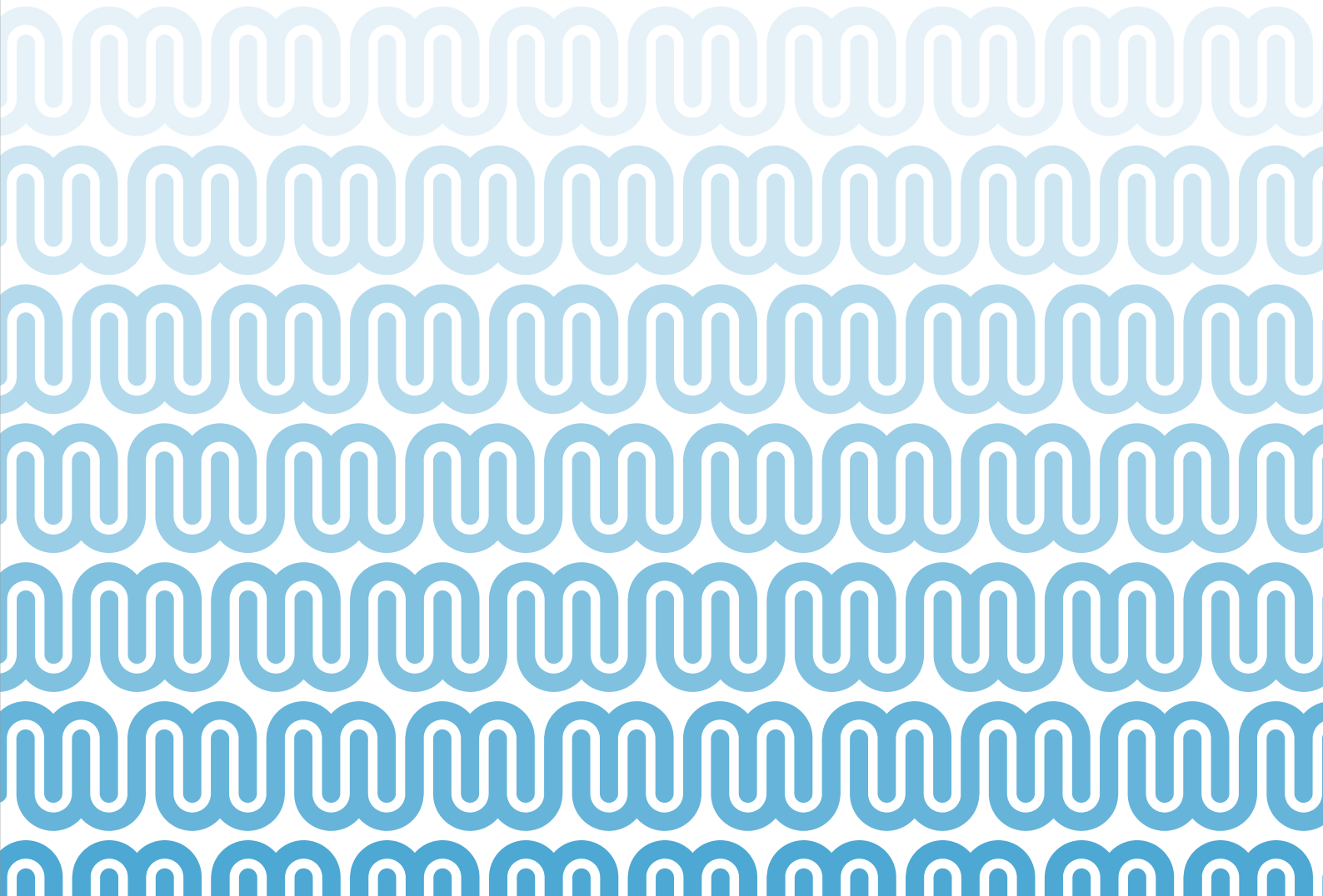
mental welfare commission for scotland

Adults With Incapacity Act monitoring report 2019-20

Statistical Monitoring

30 September 2020



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

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

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

Executive summary

Introduction

The Mental Welfare Commission has safeguarding duties in relation to people who are subject to the protection of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act).[1] We examine the use of welfare guardianship orders for adults with a mental illness, learning disability (LD), and related conditions (including dementia), to determine how and for whom the AWI Act is being used. This helps us to inform policy and practice. We also assist local area management in reviewing how and for whom Part 6 (Intervention Orders and Guardianship Orders) of the AWI Act is being used in their area and benchmark their use of the Act against other local authorities.

The Commission is part of the framework of legal safeguards to "exercise protective functions" in respect of adults on a guardianship order, an intervention order, or powers of attorney (S.9). Part of this function extends to investigating matters relating to the personal welfare of adults subject to a guardianship order. The Commission will from time to time undertake an investigation into the care and treatment of an individual subject to welfare guardianship, most recently in September 2019.[2] We also review the use of medical certificates where the adult is incapable of consenting to the treatment (s47), and where a guardian has been appointed but disagrees with the medical treatment. The latter can result in the Commission allocating an independent medical assessment (s50).

We report our function in monitoring the use of the AWI Act in two parts: 1) statistical monitoring of extant (existing) and granted guardianships, and 2) visits to individuals on guardianship orders to ensure their rights are upheld.

[1] Adults with Incapacity Act (Scotland) Act 2000 (asp 4) s 9
[2] Mental Welfare Commission, Investigation into the delayed discharge of Ms ST, 2019 https://www.mwcscot.org.uk/sites/default/files/2019-12/Ms_ST_investigation_FullReport_12September2019_.pdf

Part 1: Statistical monitoring

- In Scotland, 15,973 individuals were on a guardianship order on 31 March 2020, compared to 13,501 in 2018.
- A total of 3,199 guardianships were granted in 2019-20, seven percent higher than in 2017-18.
- Of all granted guardianships, 78% were new guardianships. Over time, there has been an increase in renewals of guardianships, from 6% in 2010-11 to 22% in 2019-20.
- The overall rate of granted guardianship orders was 70.4 per 100,000 population in Scotland, with the lowest rate in Inverclyde (32.2 per 100,000) and highest in South Ayrshire (102.1 per 100,000).
- Private guardianship orders accounted for 74% of all guardianships granted, which is similar to the past five reporting years.
- The most common primary diagnosis was LD (49%) and dementia/Alzheimer's Disease (36%). This is a change from 2010-11 when the most common primary diagnosis was dementia/Alzheimer's Disease. This appears to align with an increase in Power of Attorney (POA) and the inclusion of this measure in the dementia care pathway. We note the *5 Pillars Model of Post Diagnostic Support*.[3] A smaller proportion of granted guardianship orders were for Acquired Brain Injury (5%), Alcohol-Related Brain Damage (4%) or mental illness (4%).
- Almost half (46%) of granted guardianship orders were for a period of five years or less, while 47% were more than five years and 7% were indefinite orders. The proportion of orders granted that are indefinite have declined steadily over time. This is good news as our concern about indefinite orders is that the lack of automatic, periodic judicial scrutiny of approved orders puts the onus on the individual or another party with an interest to challenge the order- something which rarely happens. Furthermore, we feel there is the potential for a breach of Article 5 of the European Convention on Human Rights, where indefinite guardianship is used to authorise deprivation of liberty, since European case law makes clear the need for regular review. This is discussed further in the Commission's advice note on Deprivation of Liberty.[4]
- Decline in indefinite orders is driven by a shift in fewer people with LD being granted an indefinite guardianship order (from 48% in 2010-11 to 2% in 2019-20). As stated above this is a welcome trend.
- Requests for s48/s50 certificates were made for 62 individuals in 2019-20 and issued for 57 of those. Most common type of treatment for issued certificates was Electro-convulsive therapy (ECT) (72%) and medication to reduce sex drive (25%).

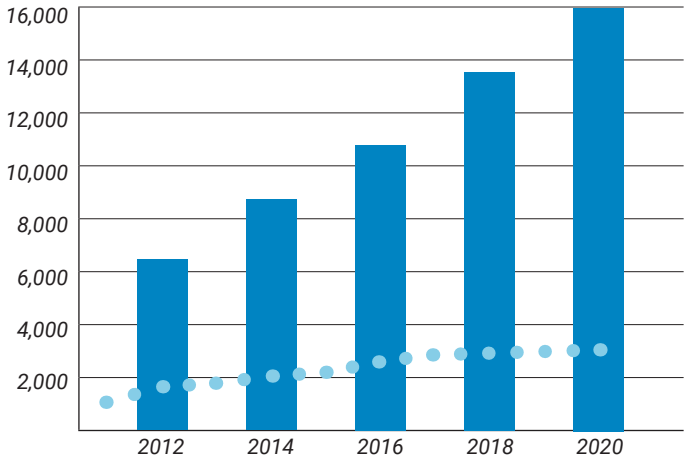
[3] Scottish Government, Scotland's National Dementia Strategy 2017-2020, 2017
https://www.alzscot.org/sites/default/files/2019-07/Third_Dementia_Strategy.pdf
[4] Mental Welfare Commission, Deprivation of Liberty, 2015
https://www.mwcscot.org.uk/node/172

Adults With Incapacity (Scotland) Act Monitoring 2019-20

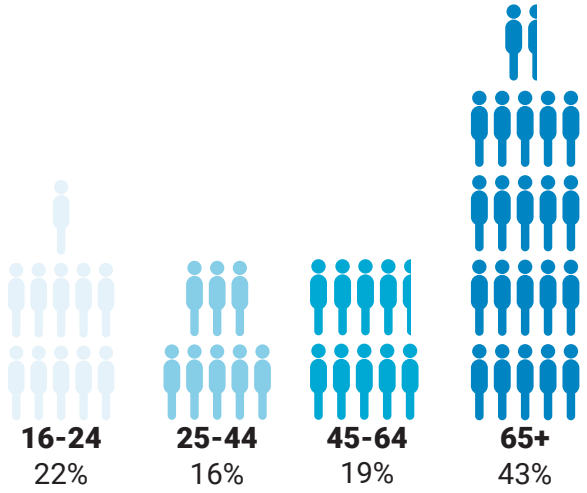
mental welfare commission for scotland

On 31 March 2020 there were 15,973 individuals on a guardianship order in Scotland. The number of people on a guardianship order in Scotland has increased over time. *(See bar chart, right)*

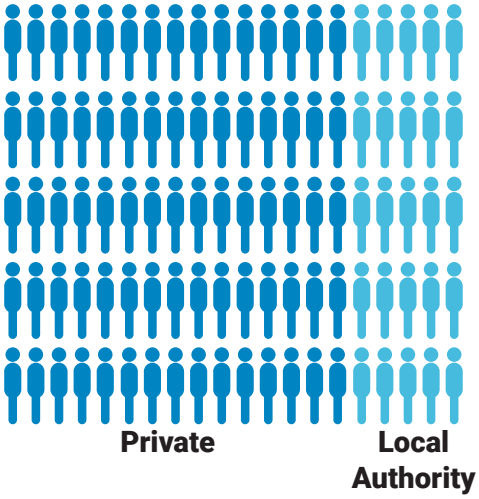
In 2019-20, there were 3,199 guardianship orders granted in Scotland. Of these, 78% were new, while the remaining were renewals of existing guardianship orders.
The number of new guardianship orders has also increased over time.
(See dotted line graph, right)



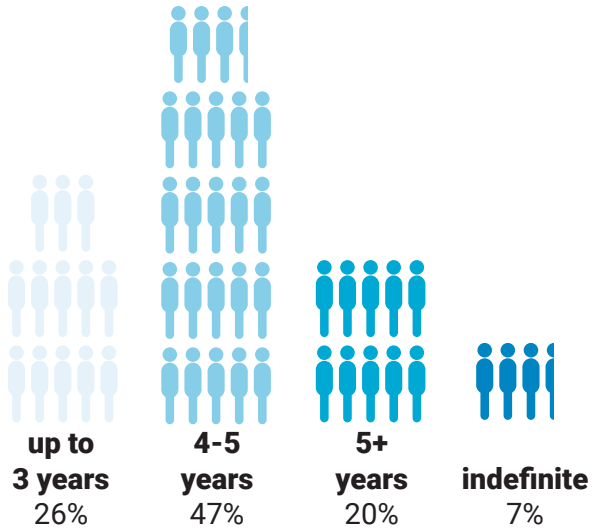
Of the guardianship orders granted in 2019-20, most people were 45 years or older.



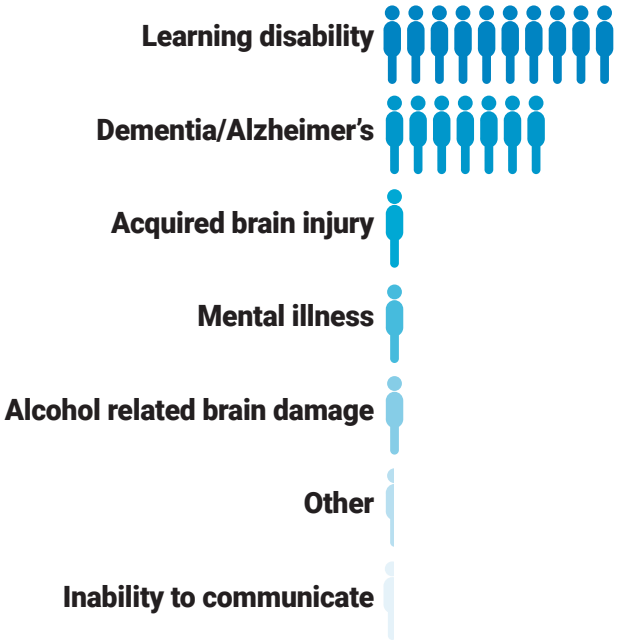
In 2019-20, three quarters of granted guardians were private individuals.



In 2019-20, fewer than one in ten individuals were granted an indefinite guardianship order.



The majority of people on a guardianship order in 2019-20 had a primary diagnosis of Learning Disability or Dementia/Alzheimer's Disease.



Part 2: Guardianship visits

By law, if an adult is unable to make key decisions or take necessary actions to safeguard their own welfare, a court can appoint a 'welfare guardian' to do this for them. With more people subject to guardianship orders and subsequently having their human rights restricted, ensuring that guardians are fulfilling their responsibility to uphold the principles of the AWI Act and using the powers to ensure individuals are appropriately protected with their rights upheld is increasingly important.

The AWI Act gives the Mental Welfare Commission a role in making sure that welfare guardianship orders work in a person's best interests and is in line with the principles of the Act. Each year we visit hundreds of people on welfare guardianship orders to ensure that the law is working in their best interests.

In 2019-20 we visited 311 individuals on guardianships and met 278 of their guardians. Overall, most visits we carried out showed that the guardian was complying with the principles set out in relation to the AWI Act. In the few cases where we had concerns about issues that needed to be addressed we followed up further.

Key gaps that we identified this year were the lack of support and supervision for private guardians; only 76% had received a visit from the supervising officer in the past six months. We also noted the continuing need for medical practitioners to ensure a s47 certificate is completed for their medical treatment, as only 76% of all individuals who required a s47 certificate had one in place. We are also concerned that for 67% of individuals with a Do-not-attempt CPR (DNACPR) it was either unclear if a medical practitioner had consulted with guardians or informed them that a DNACPR certificate had been signed by them. There were some individuals for whom restrictions regarding correspondence, restraint, social media, CCTV, and seclusion was happening despite powers not being in place. However, in most cases, the individuals were benefiting from the guardianship order and there were no issues to report.

Through our Advice Line we are sometimes notified of cases of particular concern. In this report, we have outlined several cases from our visits and calls that we have received as case studies; both good examples of alignment with the principles, but also how the Commission has got involved in cases of significant concern. For all case studies we provide learning points and specific points for care providers and for local authorities.

Guardianship Visits Monitoring 2019-20

mental welfare commission for scotland

We met with
311 individuals
278 guardians

Each year we aim to meet about 10% of all individuals who have had a granted guardianship order. We prioritise to meet younger individuals, those whose rights are very restricted by the guardianship order, and those with less common diagnoses. We do our guardianship visits to ensure that ensure that the law is working in their best interests.

What we learnt

Most common **diagnoses**:

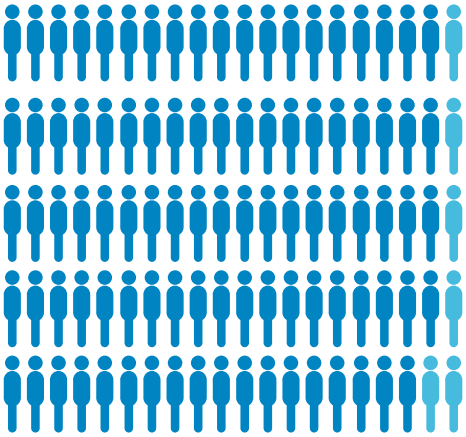
Acquired Brain Injury 10%

Dementia 20%

Learning Disability 53%

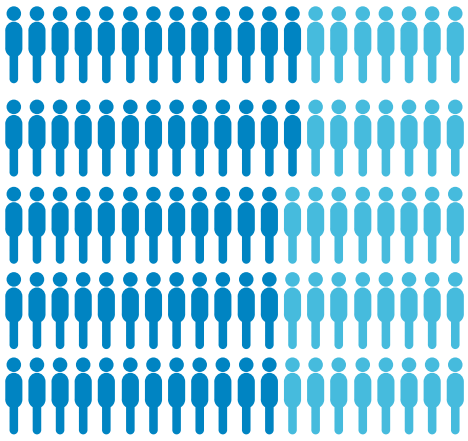
Less common diagnoses were: Alcohol-Related Brain Damage; mental illness; lack of communication due to physical condition; and 'other' conditions.

94% had **medical powers** granted in the guardianship order.



When a guardian has medical powers granted, they can make decisions on behalf of the individual.

The majority (62%) were **private guardianships.**



A private guardian can be a parent, relative, or friend who helps the individual make decisions relating to their welfare.

68% of guardianship orders fulfilled all **five criteria**:

- **Benefit**
- **Least-restrictive option**
- **Taking account of the wishes of the person**
- **Consultation with relevant others**
- **Encouraging the use of existing, and development of new skills**

Introduction

The Mental Welfare Commission for Scotland is part of the framework of legal safeguards in place to protect the rights of people on welfare guardianships orders, intervention orders, and powers of attorney (POA). We monitor the use of the welfare provisions of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act). We also monitor the use of Part 5 of the AWI Act relating to consent to medical treatment and research.

The Commission receives a copy of every application for welfare guardianship, including the powers sought, medical and Mental Health Officer (MHO) assessments, and a copy of the order granted by the sheriff. We visit people on guardianship orders and provide advice and good practice guidance on the operation of the AWI Act. When circumstances indicate that an adult with incapacity may be at risk, we make inquiries into their situation by including local authorities or make a formal referral for further investigations.

Where we think an adult might require adult support and protection procedures we always refer to the local authority, whose duty it is to investigate such matters under the Adult Support and Protection (Scotland) Act 2007 (the ASPA).

Welfare guardianship orders

The AWI Act introduced a system for safeguarding the welfare and managing the finances of adults who lack capacity to act, or to make some or all decisions for themselves due to a mental illness, learning disability (LD), dementia, or other conditions. It allows other people, called guardians or attorneys, to make decisions on behalf of these adults, subject to safeguards.

When an adult has capacity they can grant a Power of Attorney (POA) to someone to act on their behalf, should they become unable to make their own decisions. Welfare powers can only be used following the incapacity of the adult. Sometimes the adult's solicitor will write a specific clause in the document ensuring that this will be determined by a medical practitioner. Others do not have such clarity and are left to be determined by the proxy decision maker (attorney). The Commission would suggest the former is a better option, as the level of incapacity is then determined by an independent person.

When an adult no longer has capacity, an application may be made to the court and the sheriff may appoint a welfare guardian as proxy decision maker. The welfare guardian is then involved in making key decisions concerning the adult's personal and medical care. Decisions by attorneys or guardians should always be in line with the principles (see Box 1) of the AWI Act.

The majority of guardians are private individuals, usually a relative, carer or a friend. These are known as private guardians. The court can also appoint the Chief Social Work Officer (CSWO) of a local authority to be the person's welfare guardian, especially if private individuals do not wish to take on the role as guardian. This is known as a local authority guardianship.

Under the AWI Act, local authorities have a duty to make an application for welfare guardianship where it is required and no one else is applying. Local authorities also have a duty under the AWI Act to support and supervise all welfare guardians, and to visit the adult

and their guardian at regular intervals. In addition, local authorities can investigate issues relating to the welfare of an adult where a proxy decision maker (guardian or attorney) exists and there are welfare concerns under section 10(1) of the AWI Act.[5]

Adults with Incapacity Act law reform

Between January and April 2018, the Scottish Government carried out consultation on the AWI Act to seek views on changes to the legislation and practice around its use. The review addressed the need to reflect requirements of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)[6] and concerns that many of the processes within the legislation required to be reviewed.

In our last *Adults with Incapacity Act statistical monitoring report* we outlined that the Commission was working with the Scottish Government in working groups regarding law reform.[7] We continue to support this agenda with our response to the formal consultation on law reform. This was led by the Government, establishing the Scottish Mental Health Law Review[8]. The review will look at the current three acts (the Mental Health (Care and Treatment)(Scotland) Act 2003, the AWI Act; and ASPA) and consider the need for converging any or all of them. It is anticipated that this will generate considerable work for the Commission in the future[9].

This report

The Commission has safeguarding duties in relation to people who are subject to the protection of the AWI Act.[10] We examine the use of welfare guardianships for adults with a mental illness, LD, or related conditions (including dementia), to determine how and for whom the AWI Act is being used. This helps us to inform policy and practice. It also assists local area management in reviewing how and for whom Part 6 (Intervention Orders and Guardianship Orders) of the AWI Act is being used in their area and benchmark their use of the AWI Act against other local authorities.

Previously we have reported on the use of the AWI Act in two separate reports; statistical monitoring of the AWI Act and our visits to welfare guardians. This year, both aspects are reported in a combined report divided into two parts.

- In Part 1 we report on extant guardianship orders and granted guardianship applications for 2019-20. We focus on describing who were granted guardianships, who the guardian is and how long the order is for. We also report on geographical differences.

[5] Adults with Incapacity Act (Scotland) Act 2000 (asp 4) s 10(1)
[6] UN General Assembly, Convention on the Rights of Persons with Disabilities (adopted by the General Assembly, 24 January 2007) A/RES/61/106.
[7] Mental Welfare Commission, *Adults with Incapacity Act monitoring report 2017-2018,* 2018 *https://www.mwcscot.org.uk/sites/default/files/2019-06/10.09.2018_2017-18_awi_monitoring_report_0709_with_appendix_b.pdf*
[8] Scottish Mental Health Law Review, *About the review* https://mentalhealthlawreview.scot/about
[9] The Commission submitted a response to the call for evidence in phase one of the review, which is available at: https://www.mwcscot.org.uk/sites/default/files/2020-05/MHA-ReviewResponse_May2020.pdf
[10] Adults with Incapacity Act (Scotland) Act 2000 (asp 4) s 9

- In Part 2 we report on information collected during visits to individuals on a welfare guardianship order and their welfare guardians during 2019-20. In this part we focus on describing our assessment of how the principles of the AWI Act are used and adhered to, issues that we identified and examples of good practices where adults' rights are being respected and the order provides benefit to the individual.

Our data

AWI monitoring

When an application is made to a sheriff and a guardianship order is granted, the Commission is sent a record which is stored on our database. Every two years (previously annually) we report on the last year's number of granted guardianships for the period 1 April to 31 March. This year's report concerns all granted guardianship orders in 2019-20 and where appropriate trends from 2010-11 onwards are presented. We also report on extant guardianships, which includes all individuals in Scotland who were subject to a guardianship order as of 31 March 2020.

We are particularly interested in understanding the context and characteristics of the guardianship and our analyses therefore focus on: a) demographic characteristics (age, gender, diagnosis), b) guardianship status (new or renewed order), c) guardian (private or local authority), and d) length of guardianship.

We follow Public Health Scotland standards on data disclosure,[11] as data relating to mental health and vulnerable populations is considered sensitive. Measures to prevent identification should be taken and we therefore supress numbers of less than five where needed. Secondary suppression of additional cases is done where only supressing one case would allow for deriving the number through subtraction.

All percentages throughout the report have been rounded to the closest full number and in places the total may therefore not add up to 100%. Rate per 100,000 population were calculated using mid-2019 population statistics from National Records Scotland for the population aged ≥16 years.[12] For rate of guardianships per 100,000, 95% Confidence Intervals (CIs) are reported.[13] Local authorities with low numbers of granted guardianship orders have very wide CIs so comparisons of rates should be made with caution.[14]

Guardianship visits

Each year we aim to visit about 10% of all individuals who have been granted a guardianship order. In this year's report, we report on visits carried out in 2019-20. As our last report on our guardianship visits concerned 2017-18, and we now report on these visits bi-annually, a note about 2018-19 is needed. For the reporting year 2019-20, we implemented a new form for

[11] Public Health Scotland, *Statistical Disclosure Control Protocol v.1,* 2020 https://www.publichealthscotland.scot/media/2628/public-health-scotland-statistical-disclosure-control-protocol.pdf

[12] National Records Scotland, *Mid-2019 Population Estimates Scotland*. Retrieved from: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/mid-2019

[13] A CI indicates the likelihood of a value occurring within a range relating to a calculated value. For this report, this relates to the rate of granted guardianships. We use the confidence level of 95%, meaning for a rate of guardianship we provide the calculated range within which we are 95% certain that the true value lies within. The wider the CI, the less certain the rate. This is influenced by the overall number of guardianships, so for small local authorities with few granted guardianships this results in a wider CI and the calculated rate, therefore, is less certain in terms of being the 'true' value.

[14] Rate calculated from small samples (n<20) have higher relative standardised errors (RSE). The rate, therefore, is unstable and comparing it with other areas or with rates in previous years might lead to incorrect conclusions. More on RSE can be found at: https://www.health.ny.gov/diseases/chronic/ratesmall.htm

conducting the guardianship visits. Our 2018-19 data, therefore, was not comparable with 2019-20. We therefore only report on the most recent visit year. For our next report, planned for 2021-22, we will include two years' worth of data; 2020-21 and 2021-22.

During the end of this reporting year, the COVID-19 pandemic and subsequent lockdown in Scotland meant the target of 350 visits was not met. For 2019-20 we met 89% of our key performance indicator.

When we visit people on a guardianship order, there are five principles that we look to be fulfilled and complied with by those making decisions on behalf of individuals who lack capacity.[15] These principles are outlined in Box 1 and referred to throughout the report.

Box 1. Principles for guardianships of people who lack capacity

Principle 1 – Benefit

Any action or decision taken must benefit the person, and only be taken when that benefit cannot reasonably be achieved without it.

Principle 2 – Least-restrictive option

Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.

Principle 3 – Take account of the wishes of the person

In deciding if an action or decision is to be made, and what that should be, account must be taken of the present and past wishes and feelings of the person as far as these may be understood. Some adults will be able to express their wishes and feelings clearly, although they would not be capable of taking the action or decision which you are considering. For example, they may continue to have opinions about a particular item of household expenditure, without being able to carry out the transaction personally. The person must be offered help to communicate their views. This might mean using memory aids, pictures, non-verbal communication, advice from a speech and language therapist, or support from an independent advocate.

Principle 4 – Consultation with relevant others

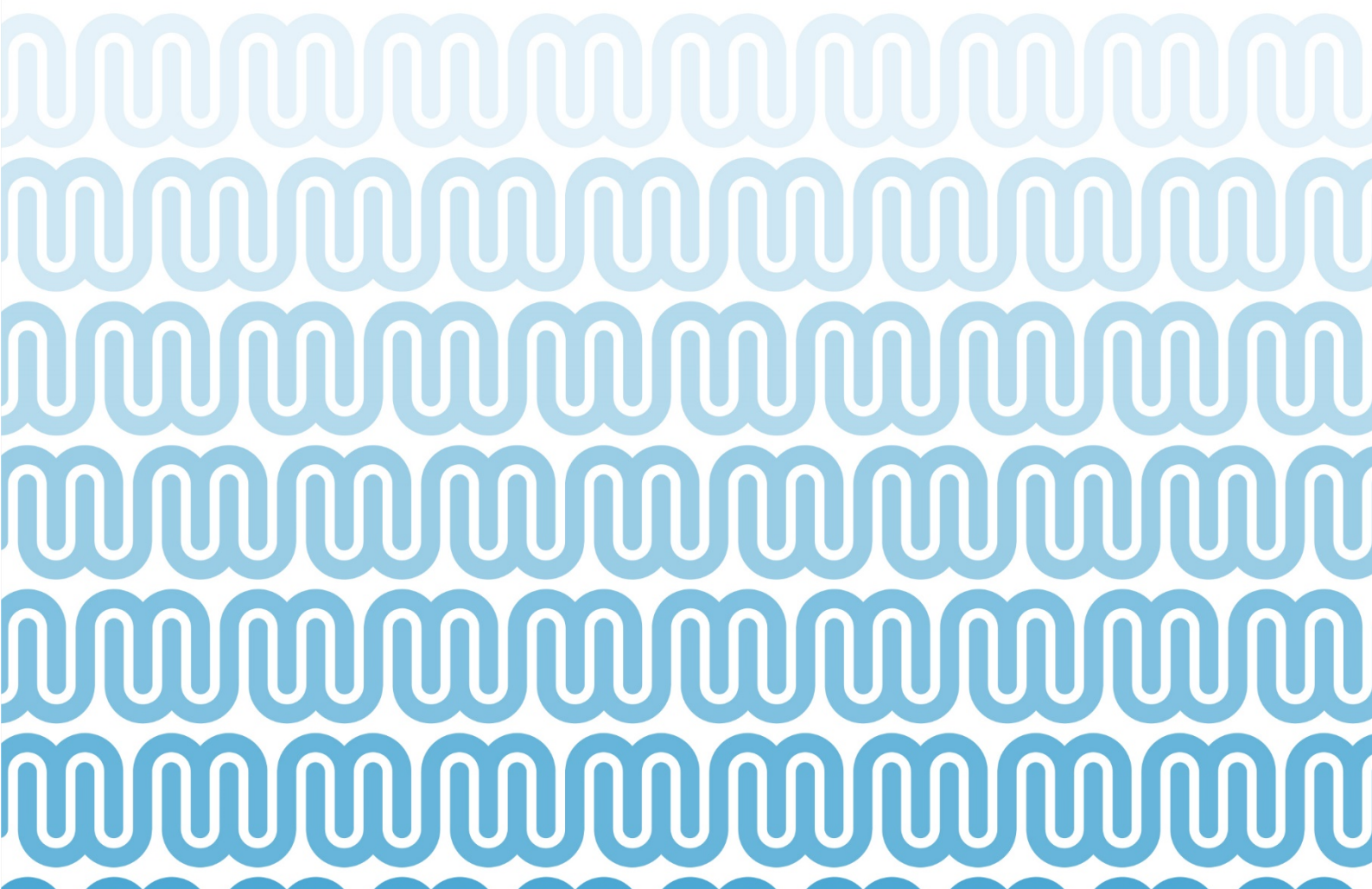
Take account of the views of others with an interest in the person's welfare. The AWI Act lists those who should be consulted whenever practicable and reasonable. It includes the person's primary carer, nearest relative, named person, attorney, or guardian, if there is one.

Principle 5 – Encourage the person to use existing skills and develop new skills

Encouraging and allowing the adult to make their own decisions and manage their own affairs and, as much as possible, to develop the skills needed to do so.

[15] Scottish Government, *Code of Practice For Local Authorities Exercising Functions under the 2000 Act*, 2008 p. 7 Retrieved from: https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-local-authorities-exercising-functions-under-2000-act/

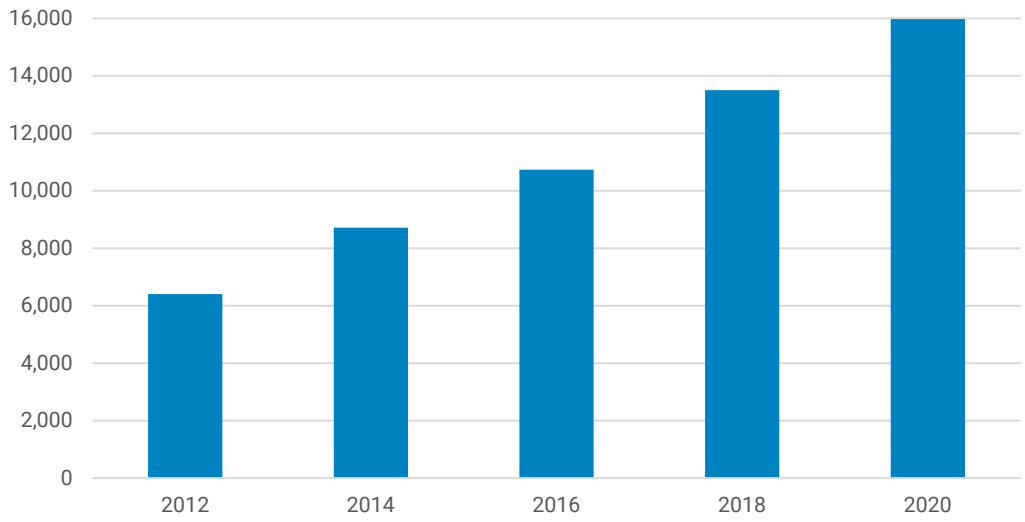
Part 1:
Adults with Incapacity Act statistical monitoring



Extant guardianships

On 31 March 2020 there were 15,973 individuals on a guardianship order in Scotland. The number of people on a guardianship in Scotland has increased over time (see Figure 1). A breakdown of characteristics of extant (or existing) guardianships is provided in **Table A1**, which shows that 62% of all people on a guardianship order are 45 years or older, a third (31%) are on an indefinite order, and the most common primary diagnoses are LD (51%) and dementia (36%).

Figure 1. Number of people on a guardianship order in Scotland as of 31 March



Granted guardianships

In 2019-20, a total of 3,199 new and renewed guardianships were granted. The number of granted guardianships was seven percent higher than in 2018-19. The number of granted guardianships has increased year-on-year since 2010-11 (Figure 2).

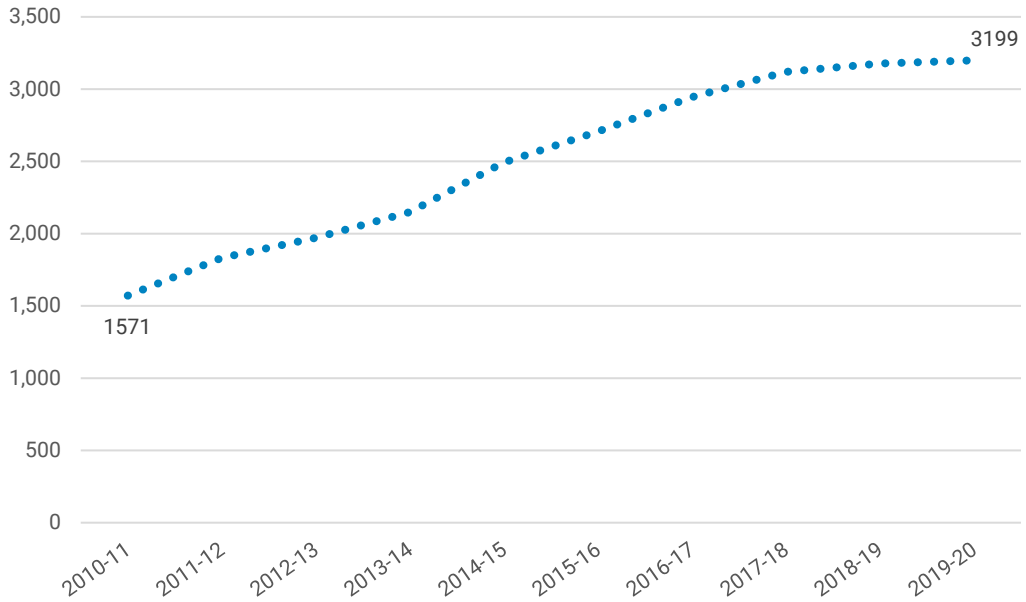


Figure 2. Total number of new and renewed guardianships granted, by year

For guardianship orders granted in 2019-20 there was an even gender split, and most (85%) of guardianships were for individuals with LD or dementia (see Table 1). Around half (47%) of orders were 4–5 years, and only 7% were indefinite. A total of 2,362 (74%) of guardianships were private and 837 (26%) were local authority – proportions which have remained similar over time (see **Table A7**). Those subject to guardianship tended to be older; 62% were aged 45 years or older. There are some differences in age of the individual depending on guardian status; a higher proportion of private guardianships were for individuals under the age of 24 years and slightly higher proportions were 45 years or older who were under local authority guardianships (see **Table A3**).

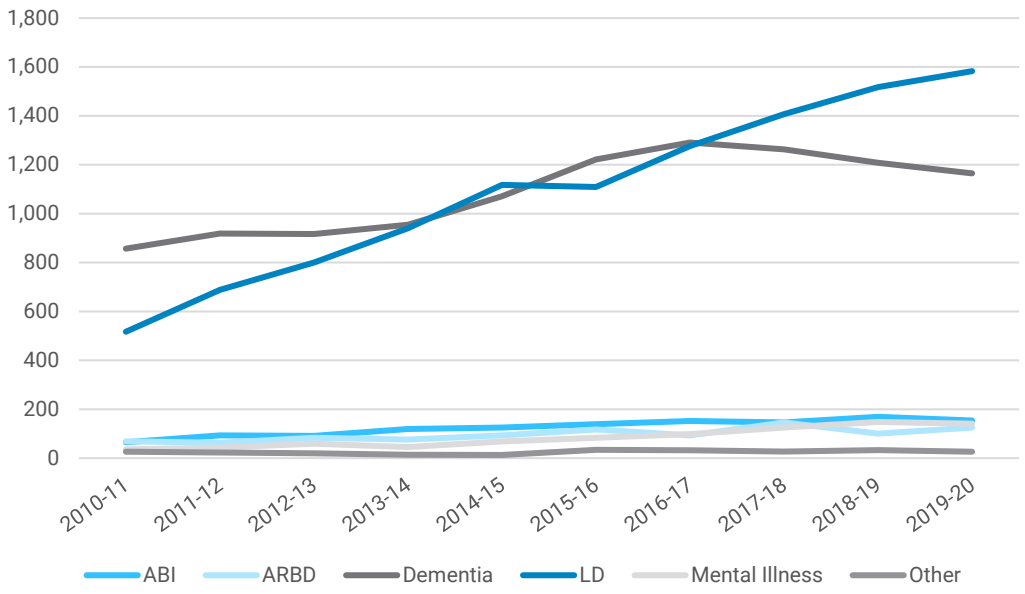
Table 1. Characteristics of granted guardianships 2019-20

Characteristic	n (%)
Age	
16–24	694 (22)
25–44	507 (16)
45–64	615 (19)
>65	1383 (43)
Gender	
Male	1651 (52)
Female	1548 (48)
Primary diagnosis	
ABI	154 (5)
ARBD	125 (4)
Dementia	1165 (36)
Inability to communicate[16]	5 (<1)
LD	1583 (49)
Mental Illness	141 (4)
Other	26 (1)
Length of guardianship	
0–3	846 (26)
4–5	1498 (47)
≥6	634 (20)
Indefinite	221 (7)
Guardian status	
Local authority	837 (26)
Private	2362 (74)

The number of guardianships has remained similar over time for all diagnoses apart from dementia and LD, for which the number of guardianships each year has increased since 2010-11. For dementia, however, the annual number of guardianships has tailed off since 2016-17 while for LD it has continued to increase (see Figure 3). This appears to align with an increase in Power of Attorney (POA), for which there was a 13% increase in POAs granted for those aged 65 years and older between 2016-17 and 2019-20, and a 63% increase since 2011-12.[17] The numbers of welfare guardianships applications for LD is increasing in line with them being for a shorter duration, since life circumstances and risks may require variations to their powers due to residing in the community. Some may involve restrictions which require to be legally authorised.

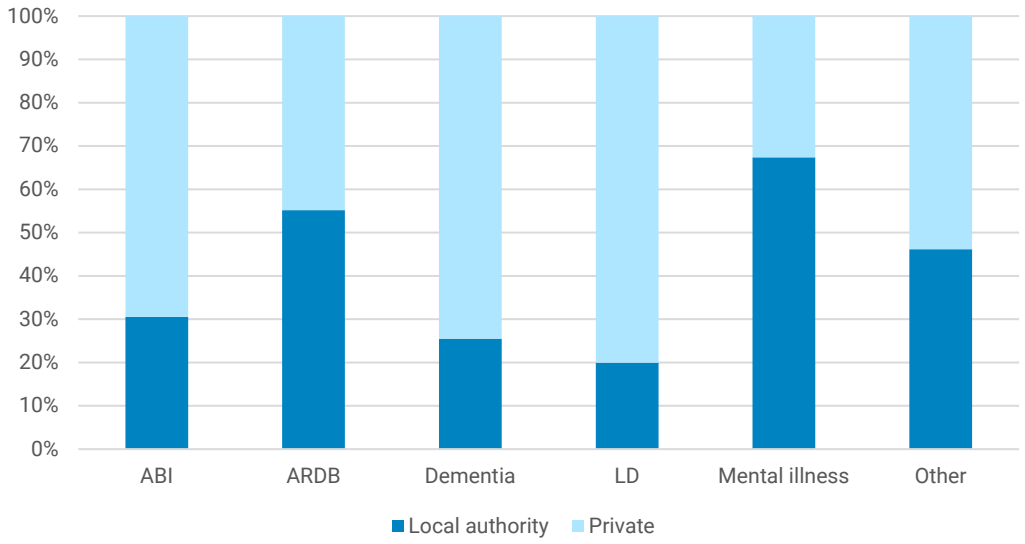
[16] Due to the small number of individuals with a diagnosis of inability to communicate due to a physical condition, this has been excluded from subsequent analyses.
[17] Personal communication with Elain O'Neill, Office of the Public Guardian Scotland 13 August 2020.

Figure 3. Number of granted guardianships by diagnosis and year



Type of guardian varies by diagnosis (see Figure 4); most individuals who were subject to an order with a diagnosis of dementia or LD were under a private guardianship, compared to mental illness and ARBD, where most guardians are local authority.

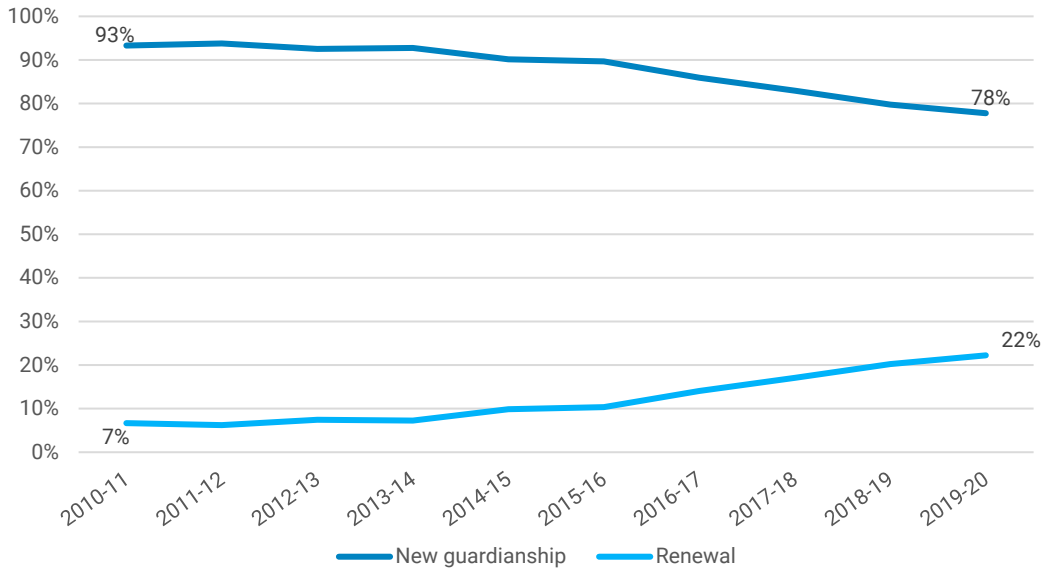
Figure 4. Proportion private and local authority guardianships, by diagnosis



Guardianship renewals

The majority (78%) of guardianship orders granted were new orders, while 22% were renewals of existing guardianships. Over time, a greater proportion of all the annual number of granted guardianships have been renewals of existing powers (see Figure 5), which appears to be explained by a decline in granted orders of indefinite length (see **Indefinite orders**). The Commission is content with this trend since it supports people's rights under UNCRPD by having their need for proxies judicially reviewed.

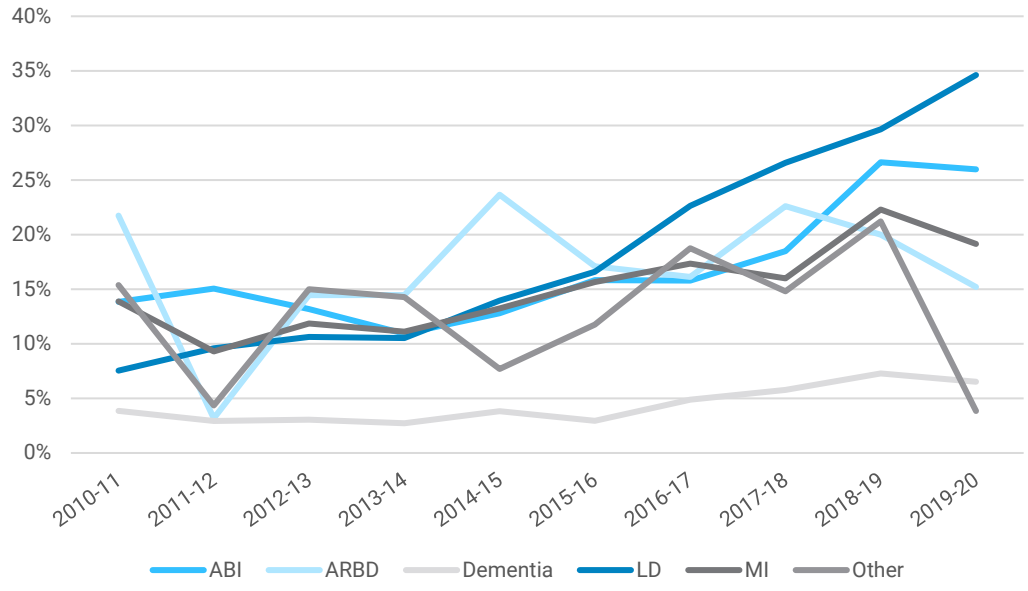
Figure 5. Proportion of new and renewed orders, by year



Guardianship renewals have increased year-on-year, from 7% in 2010-11 to 22% in 2019-20 (see Figure 2). A breakdown of characteristics of new and renewed guardianship orders for 2019-20 is provided in **Table A2**. This shows that 85% of renewals were in age groups younger than 65 years, a higher proportion were female (57%) and the majority were for individuals with LD (77%). A higher proportion of renewals than new guardianships were for three years or less (38% and 15%, respectively) and fewer were indefinite (2% and 8%, respectively).

Over time, there has been an increase in the proportion of guardianships that were renewals within each age group, with the largest increases among those under the age of 65 years (data not shown). Looking closer at diagnosis, the number of granted guardianships for the two main diagnoses (LD and dementia) increased steadily year-on-year until 2016-17, after which there has been a decrease in the annual number of guardianships for dementia (see Figure 3). Overall there has been an increase in renewals for all primary diagnoses (see Figure 6), which is particularly steep for LD and ABI, which we explore further in the **next section**.

Figure 6. Proportion of renewals by diagnosis and year



Indefinite orders

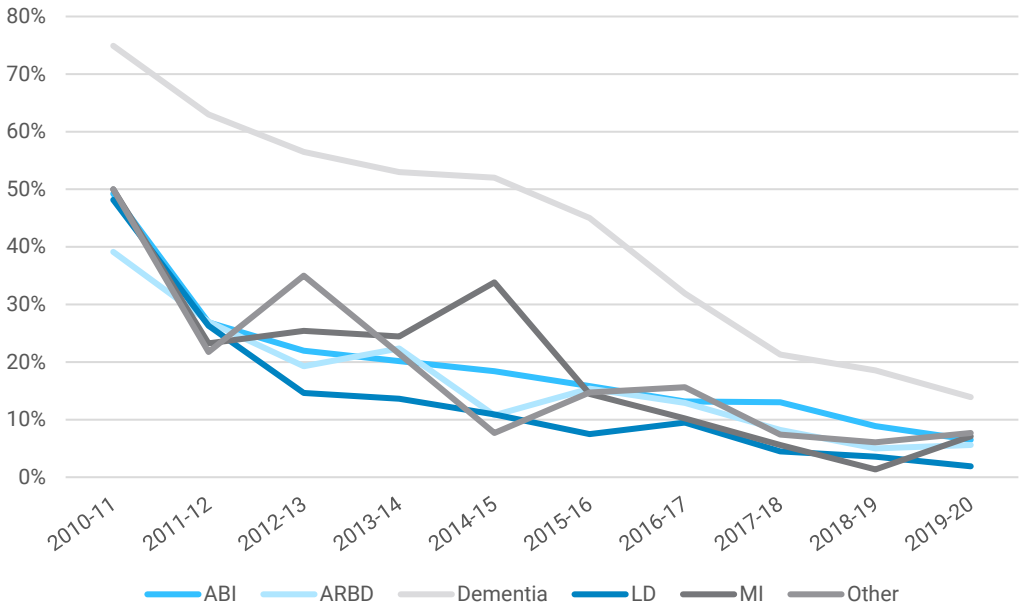
Over recent years, there has been significant progress in addressing the issue of the length of time for which guardianship orders are granted. Our concern is that the lack of automatic, periodic judicial scrutiny of approved orders puts the onus on the individual or another party with an interest to challenge the order if circumstances in relation to capacity change.

The Commission believes that an indefinite order may be appropriate in the case of, for example, an elderly person with advanced dementia. In other circumstances, we do not believe that indefinite orders are good practice or consistent with the principles of the AWI Act. Indefinite orders potentially breach Article 5 of the European Convention on Human Rights (ECHR),[18] where indefinite guardianships are used to authorise deprivation of liberty. European case law makes clear that there is a need for regular review of any restriction of liberty.[19]

Overall, the proportion of indefinite guardianships has declined, from 63% in 2010-11 to 7% in 2019-20. There has been a decline in indefinite guardianships across all age groups over time, but most starkly in the age group over 65 years (data not shown). This can be explained by a decline in proportion of indefinite guardianships within the age group over 65 years with dementia, from 76% in 2010-11 to 15% in 2019-20.

The proportion of indefinite guardianships for all diagnoses has declined over time (see Figure 7). The most significant change was for individuals with dementia (all age groups) for whom indefinite guardianships declined from 63% in 2010-11 to 14% in 2019-20

Figure 7. Proportion indefinite guardianships, by diagnosis and year

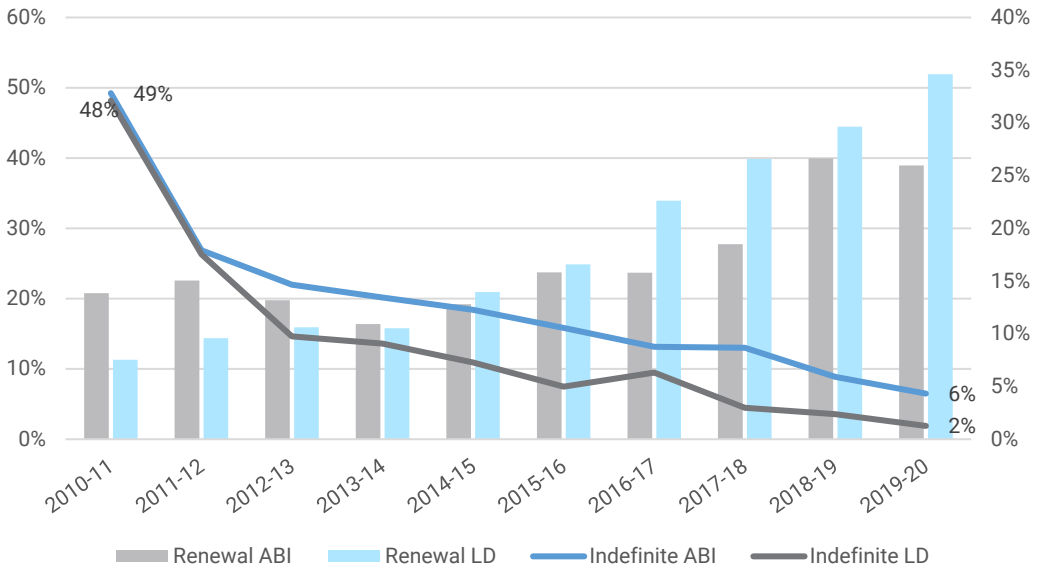


When considering the increase in renewals and indefinite guardianships, there have been drastic changes for ABI and LD in particular. Figure 8 shows that as indefinite guardianships

[18] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 5
[19] Mental Welfare Commission for Scotland, *Deprivation of liberty: Advice note*, 2015. Retrieved from: https://www.mwcscot.org.uk/node/172

for both diagnoses have decreased, from about half of all granted guardianships, there has been a subsequent increase in renewals. For LD in particular, renewals increased from 8% in 2010-11 to 35% in 2019-20. This is positive as more adults are subject to time-limited orders, which require review.

Figure 8. Proportion of guardianships for ABI and LD which were indefinite (left axis) and renewals (right axis), by year



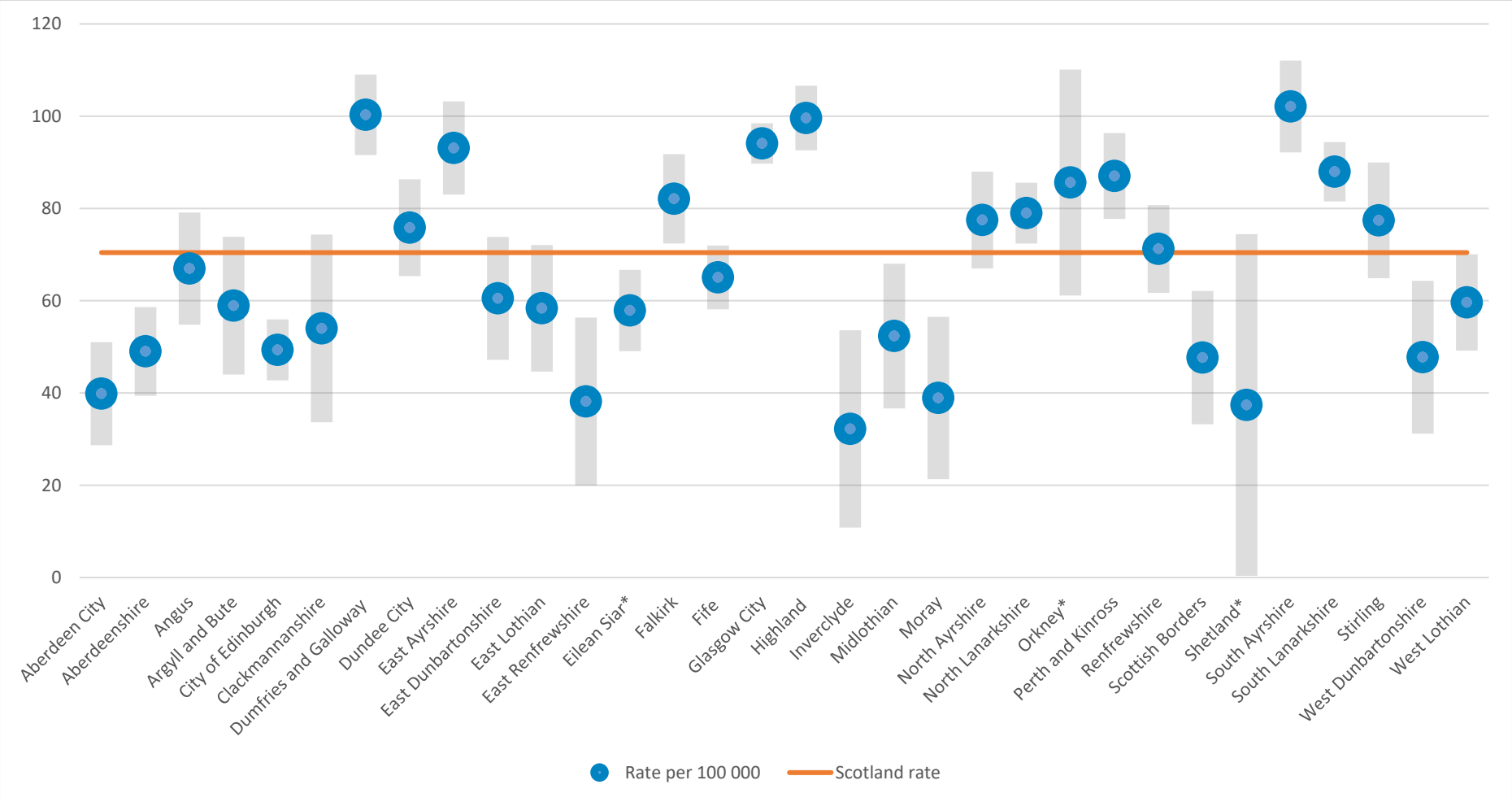
Geographical variation in number of granted guardianships

The number of guardianship orders granted in 2019-20 for each of the local authorities in Scotland are presented in **Table A5**. In order to make useful comparisons, we calculated the rate of guardianships granted per 100, 000 population with 95% CIs (see **AWI monitoring** for definition). The overall rate of granted guardianships was 70.4 per 100,000 population in Scotland, with the lowest rate in Inverclyde (32.2 per 100,000) and highest in South Ayrshire (102.1 per 100,000). We cannot comment on the reasons for this disparity. The rate of guardianships for each local authority is displayed in Figure 9 (see also **Table A5**). It should be noted that CIs for local authorities with low numbers of granted guardianships are wide and any comparison between rates for local authority areas with wide confidence intervals should therefore be made with caution. The wider the CI, the less certain the estimated rate per 100, 000.

The proportion of granted new guardianships ranged from 68% in North Lanarkshire to 100% in Eilean Siar and Shetland (see **Table A2**). The proportion of private guardians was highest in Eilean Siar, where all guardianships were a private guardian while the lowest proportion was in Inverclyde, where 57% of guardianships were private (**Table A6**). Table 2 shows the proportion with each guardian type by diagnosis for each local authority,[20] indicating a great variety across areas.[21]

[20] Excluding 'other' as the proportion was zero in most local authorities and in those where individuals were defined as 'other', the proportion was seven percent or less.
[21] For eight Local Authorities the absolute number of guardianships held by local authorities is less than ten, so the proportions need to be compared with this in mind.

Figure 9. Rate of new and renewed granted guardianship orders per 100 000 population (≥16 years) with 95% confidence intervals, by local authority area



The total number of granted guardianships is <20 and the RSE is therefore high. Comparisons of rates for local authorities with small numbers therefore need to be made with caution (see **Our data for further description)*

Table 2. Proportion of new and renewed guardianships by guardian and diagnosis, by local authority

Local Authority	Guardian	ABI	ARBD	Dementia	LD	MI
Aberdeen City	Private	4%	1%	35%	59%	1%
	LA	8%	11%	38%	31%	11%
Aberdeenshire	Private	5%	1%	33%	59%	1%
	LA	4%	7%	36%	43%	7%
Angus	Private	8%	1%	49%	40%	2%
	LA	5%	5%	40%	32%	18%
Argyll and Bute	Private	4%	1%	40%	50%	4%
	LA	6%	0%	52%	28%	13%
City of Edinburgh	Private	6%	2%	44%	45%	2%
	LA	4%	13%	37%	32%	10%
Clackmannanshire	Private	2%	3%	45%	48%	1%
	LA	9%	9%	40%	40%	2%
Dumfries and Galloway	Private	6%	2%	37%	54%	2%
	LA	5%	5%	36%	44%	9%
Dundee City	Private	5%	1%	51%	41%	1%
	LA	5%	4%	39%	39%	11%
East Ayrshire	Private	3%	2%	41%	51%	1%
	LA	4%	11%	33%	46%	5%
East Dunbartonshire	Private	3%	1%	43%	50%	2%
	LA	9%	11%	40%	22%	13%
East Lothian	Private	6%	1%	36%	56%	1%
	LA	6%	10%	39%	40%	4%
East Renfrewshire	Private	7%	0%	45%	47%	1%
	LA	7%	4%	41%	39%	6%
Eilean Siar*	Private	5%	2%	65%	26%	2%
	LA	5%	5%	48%	38%	0%
Falkirk	Private	4%	2%	42%	50%	1%
	LA	2%	8%	36%	48%	4%
Fife	Private	4%	1%	47%	45%	1%
	LA	5%	9%	39%	35%	10%
Glasgow City	Private	5%	3%	47%	43%	2%
	LA	6%	11%	55%	19%	6%
Highland	Private	3%	2%	49%	42%	3%
	LA	4%	7%	44%	36%	8%
Inverclyde	Private	8%	3%	40%	48%	2%
	LA	9%	16%	29%	32%	13%
Midlothian	Private	5%	3%	30%	57%	3%
	LA	2%	10%	25%	51%	8%
Moray	Private	7%	3%	42%	47%	0%
	LA	6%	0%	58%	30%	6%
North Ayrshire	Private	7%	2%	47%	42%	1%
	LA	10%	12%	37%	27%	10%
North Lanarkshire	Private	6%	2%	40%	50%	1%
	LA	7%	14%	33%	36%	10%
Orkney*	Private	8%	1%	35%	56%	0%
	LA	6%	0%	26%	35%	32%
Perth and Kinross	Private	4%	1%	44%	46%	3%
	LA	3%	8%	48%	30%	10%
Renfrewshire	Private	6%	3%	48%	41%	1%
	LA	7%	12%	42%	33%	5%
Scottish Borders	Private	4%	1%	27%	66%	1%
	LA	4%	3%	18%	61%	12%
Shetland*	Private	9%	0%	23%	66%	0%
	LA	10%	10%	70%	10%	0%
South Ayrshire	Private	6%	2%	51%	39%	2%
	LA	5%	8%	50%	23%	11%
South Lanarkshire	Private	5%	3%	45%	45%	1%
	LA	4%	14%	41%	32%	6%
Stirling	Private	4%	2%	44%	49%	2%
	LA	4%	16%	46%	28%	6%
West Dunbartonshire	Private	4%	3%	61%	31%	1%
	LA	8%	18%	53%	20%	0%
West Lothian	Private	6%	1%	38%	51%	2%
	LA	3%	5%	38%	45%	7%

**Total number of granted guardianships <20, proportions therefore relate to very small numbers which should be taken into account when making comparisons within and between areas.*

Medical treatment

The Commission has a responsibility under the AWI Act to provide independent medical opinions for treatments that are not covered by the general authority to treat (section 47; s47).[22] These specific treatments are regulated under section 48 (for example electro-convulsive treatment; ECT). In addition, where there is a welfare proxy with the power to consent to medical treatment, and there is disagreement in the treatment between the decision maker and the treating doctor, the doctor can request that the Commission nominate and arrange an independent medical opinion by an appropriate specialist to resolve the dispute (s50).[23]

In 2019-20, there were 61 requests for s48, for which a visit was conducted in 56 of those cases (see Table 3). There was one request for section 50 (s50) for which a visit took place. Compared to 2017-18, the number of requests was 36% higher and number of certificates issued was 38% higher. The proportion of issued certificates in relation to number of requests was however similar in 2019-20 as in the last reporting year. Twenty two (35%) of all individuals for whom a request was made had a s47 certificate in place.

The majority of requests and certificates issued were for electro-convulsive therapy (ECT) (71%) while a quarter were for drug treatment to reduce sex drive, and two were for other treatments.

Table 3. s48 and s50 requests and certificates issued for treatment, n (%)

Treatment	Requests	Certificates issued
Drug treatment to reduce sex drive	16 (26)	14 (25)
ECT	44 (71)	41 (72)
Other	2 (3)	2 (4)
Total	**62**	**57**

[22] Adults with Incapacity Act (Scotland) Act 2000 (asp 4) s 47
[23] Adults with Incapacity Act (Scotland) Act 2000 (asp 4) s 50(9)

Part 2:
Guardianship visits

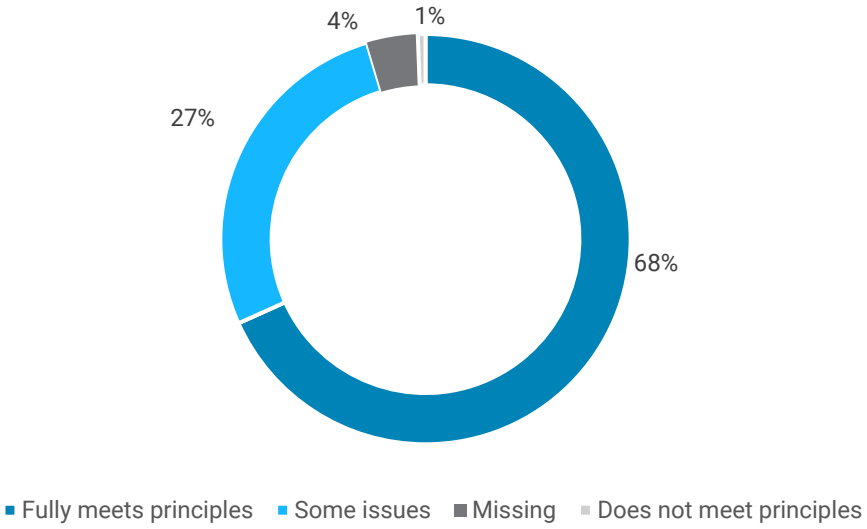
Our visits

During 2019-20, we visited 311 individuals on a guardianship order – a seven percent increase from 2017-18. Most were routine visits (76%), while a few were due to concerns that had been raised (13%) and through the Commission advice line (7%). **Table A8** provides an overview of the characteristics of those we visited.

We also met with 278 (89%) guardians, which was a higher proportion compared to 51% in 2017-18. We had contact with a higher proportion of private than local authority guardians (94% and 81%, respectively).

For each visit, we evaluated the individual's situation in relation to the overall principles of the AWI Act (see **Box 1**). We found that 68% fully met the five principles (see Figure 10), the remaining had some issues, and one case was considered not meeting the principles. In that case, we were concerned about the placement of the individual, which required intervention (see **Case Study: F**).

Figure 10. Evaluation of the individual's situation under guardianship



The most common issues that we identified and followed up on were: the need for a s47 certificate; ensuring that powers, delegation of powers and other information is kept on file; the adult's placement; support package or care plan/care record; supervision by local authority; and finances. Other, less common, issues included:

- Activities for the adult
- Personal items and personalised living space
- Physical health
- Psychiatric assessment or reassessment of needs
- Restrictions and powers
- Organise for visit from the Commission for opinion on current treatment
- Safeguards regarding contact with individuals that present risk to the adult
- Communication between care provider and guardian
- Review by social work.

What did adults tell us?

In our visits we seek to gain an understanding of the adult's views on the guardianship order, where we can obtain it. In 42% of visits the adult could engage fully or to some extent engage and answer questions about their situation. Of the individuals we could engage with, around half could clearly describe who their guardian was. In other cases, the adult was not aware of who their guardian was but was aware of who helps them with making decisions (which tended to be the guardian) and who to speak to if they were unhappy about any aspect of their care and treatment.

> *Although Y does not fully understand the guardianship, they said they are happy for the siblings to be helping out. Y said they feel involved in decisions about care but could not elaborate. Y feels they are doing fine and have everything they need.*

Overall, adults' views were positive and the adults we spoke to described feeling involved in decisions that are made about their care, living arrangements or other aspects of their life.

> *K knew their guardian was their parent. K felt consulted with and this was evidenced during discussion about activities and understanding of when K needs help and support. K feels comfortable talking to their parent about issues of concern, and also says they trust and would speak to support workers. K expressed that they were happy living at home and spoke fondly of their brother.*

In the very few cases where adults were unhappy, this often related to restrictions included in their order (further details in **Case study 3**). In these cases we could often see, however, that despite being unhappy about certain restrictions adults were consulted with and their wishes were, when possible, taken into consideration. We also asked adults if they had any concerns. Adults who raised concerns most commonly told us that they felt they did not need to be on an order, that they felt some restrictions (such as door monitoring or access to social media) were too restrictive, wanting more control over medication or money, or expressing not getting on with staff in their placement or wanting to live independently as they believed they were capable of doing so.

> *"I have contact with them (guardian and care manager) who deal with day-to-day things and can discuss things with them if I am unhappy about something. At the moment I am happy with my flat and the support that comes with it. I am not so keen on the door monitors I have on my door overnight to ensure I don't go out, but I understand the need for them at the moment. I have gone out of the window overnight but I got into trouble so probably wouldn't do that again. I did have support all of the time but I don't think I need this. I spoke to her (care manager) about this and she has agreed that I have an hour on my own in the morning before I go to my work placement and this might be increased depending on how I am doing. I am only allowed access to my phone when I have support and staff are allowed to see what I am accessing - this doesn't give me much privacy. I also like to play on my play station but I am not allowed to go online so that limits who I can play with."*

What did guardians tell us?

We also asked guardians about their views and if they had any concerns. Most did not raise any issues and reported that they were overall content with the guardianship order and the

care the adult was receiving. Specific issues were raised by 50 (18%) guardians and the most common concerns were about the level or quality of care provided to the adult (31%), the guardianship process or supervision from local authority guardian supervising officer (20%), or other issues (20%). Less frequently reported issues were:

- Physical health or medical issues
- Communication with care providers or others involved in the adult's life
- The adult's safety
- Accessing care and treatment
- Management of finances or financial guardianship
- Care and/or placement staff
- Family relations

Examples of what guardians told us included:

> *The guardian was not happy about the infrequent contact with the supervising officer and would like some further support and possibility for adult to get home care support.*
>
> *The guardian was very unhappy with the level of staff turnover and feels that there isn't enough skilled staff to ensure the adult gets out enough. There are also issues with weighted blanket not being allowed to be used despite providing the adult with comfort, until an Occupational Therapy assessment has been done and this has taken several months.*
>
> *There are uncertainties about financial contributions of adult, self-harm issues since adult moved in but guardian not always made aware or communicated with.*

Accommodation and living circumstances

Most individuals we visited lived in a care home, family home or in supported accommodation (see **Tables A11–A12** for detailed information). In the majority (84%) of visits we considered the adult to be appropriately placed and satisfied in their current accommodation, 10% were considered to be appropriately placed however the person was not happy with their accommodation and keen to move, while 5% were not considered appropriately placed. Of those who were considered inappropriately placed, there were plans to address placement with all but one individual. In this case, the individual was residing in hospital and we visited them as a result of the nurse manager raising concerns. The adult was in a delayed discharge situation and their discharge from hospital had been delayed for over three years. For the guardians, the issue was finding a suitable placement for the adult which appeared to be why their discharge was delayed, as described by the practitioner who visited the adult:

> *Initially I met with the joint guardians and they were accompanied by their carer advocate. We discussed that initially there had been some discord and disagreement between the guardians about the care needs for the adult, but they assured me that this was no longer the case and that they have worked through those issues and are now both in agreement with future needs. The adult has been on delayed discharge for over three years and has been living in (name of hospital). The lack of plans to address the adult's placement related to the local authority awaiting the outcome of a legal decision from the court.*

In one case we met with F, for whom we needed to intervene and advise on the arrangements of their placement as they had been placed in a temporary placement in an area away from friends and family and there was no evidence of ongoing involvement from the local authority guardian to address this (see Case study 1).

Case study 1. Stuck in temporary placement

We met with F during a routine visit to the care home where they live. The visit was selected on account of F's age, their complex diagnosis and a move from supported accommodation in their home area to a nursing home out with their home area. This visit concluded that the actions taken under the order did not fully meet the principles of the AWI Act – it was not least restrictive, did not take into account the adult's wishes and offered little benefit other than meeting their safety needs.

F has a diagnosis of LD and mental illness. They are currently housed in a different area to where they are from and usually reside. F describes missing people that they know and is unable to visit those who matter to them. The local authority guardian explained that the placement was in response to escalating risk factors for F in the community. The support F received in their own home was breaking down, with incidences of verbal and physical aggression towards staff. The current accommodation had always been viewed as temporary and the aim was to find F a similar placement in their local area, but no follow-up had taken place since admission. F told us:

> *"I like the people who support me here but I want to return to [home area] where I know the area and have friends. I can't go out here by myself or access my own money and I worry about this. I worry about being able to pay to stay here as I don't think I can afford it and I don't want to have any debt. I haven't seen my social worker for a long time but I speak to the care home manager here and she helps me to settle down. I also have an advocate who has just started to visit me, she says she will contact social work in [area] to see what is happening with my house."*

Our conclusion from the visit was that F's care could not be delivered without the use of the powers contained in the order. However, routine care management was lacking and this was all the more concerning given that their placement is a respite admission. F believed the placement to be temporary but was unaware of any activity around addressing this. This was unacceptable and added to the behaviours which challenged carers and other residents.

We discussed the situation with an advocate, who committed to progress their involvement to ensure that F's voice is heard. Delay in becoming involved appeared to be down to funding issues for this service, as this was a temporary out of area placement.

Following the visit, we contacted the care manager who recognised the delay in progressing an alternative and the lack of visits from the care manager to the adult, which was attributed to the distance involved. We recorded concerns about making temporary out-of-area placements without the safeguard of regular review. The care manager committed to arranging an urgent review and look for local alternatives. There was discussion around F returning to supported accommodation, with additional safeguards, but the risk involved in this plan was deemed to be unacceptable, following adult protection activity which led to the current placement. There was also discussion around ensuring that advocacy is accessible when the adult is placed out of area.

Following these interventions and engagement, a community placement was identified for F and plans were made for their transition to a more suitable environment.

Key learning points

- If an adult is placed out of area using welfare guardianship powers, there must be a commitment from the placing authority to monitor and review the suitability of the placement on an ongoing basis. This needs to ensure lines of communication between the adult and the guardian. Chapter 6 of the *Adults with Incapacity – Code of Practice for local authorities* highlights the duties of the local authority to hold regular review meetings, monitor the adult's personal welfare, and proactive exercise of the powers.[24] In this instance, these duties are important as the placement was a temporary arrangement and the adult was demonstrating distress and anxiety as a result of being placed in another area with limited access to family and friends.
- Ensure arrangements are in place for Advocacy provision which is a legal right enshrined in the AWI Act, the Mental Health Act, and ASPA and its provision is a local authority duty. As the adult had been placed out with their own local authority, it is incumbent on the local authority guardian to ensure this is in place, either from their own area or following a process of negotiation and/or commissioning from the receiving local authority.
- If appropriate, considerations should be made for transfer of the guardianship order to a new area. The adult was in temporary accommodation so this might not be appropriate in this instance. However, if distance was an issue for the guardian to maintain regular contact and review of the adult's circumstances, this might have offered a solution. The *Code of Practice* reminds us that habitual residence for guardianship should always be considered separately from issues of care management and in this case might have been a practical solution to the issues identified.
- Ensure a risk/benefit analysis is undertaken to inform proportionate intervention for the adult. It was clear that there were significant risks inherent in the adult's previous living arrangements and that placement in this setting reduced these risks. However, risk requires to be assessed in a personal context and take account of the benefit to the adult to ensure that actions are proportionate, fair and offer benefit to the adult. Standalone risk assessments which do not consider benefits to the adult can result in restrictive practices which offer little in the way of quality of life.

In some cases, we made notes of things that could be improved upon for the individual within their current living situation. While most individuals appeared to have surroundings that were well-decorated, personalised and providing a good environment we made note of cases where there was poor personalisation or decoration. One example was E, who did not have a social history (life story) in their file, which we believed might help with ensuring that their interests and past experiences are taken into consideration in their day-to-day life (Case study 2).

[24] Scottish Government, Code of Practice for Local Authorities Exercising Functions under the 2000 Act. 2008 https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-local-authorities-exercising-functions-under-2000-act/

Case study 2. Providing a social history

We met with E during a guardianship monitoring visit in the care home where they live. E has a diagnosis of a significant mental illness and dementia and their history of mental health issues goes back over 40 years. E previously lived in England but moved to Scotland in the last decade. During this time, E has had hospital admissions as well as been subject to compulsory treatment measures. E's situation was impacted by frequent moves during a period when it was not possible to engage with services. Three years ago, E was living in supported accommodation but was admitted to hospital due to further health complications and upon discharge came to live in the care home where they now reside. Due to both physical and mental health difficulties, E was assessed as needing care and support in a care home environment.

We reviewed E's care plan, which was reasonable and had good person-centred details about their needs and how these are met. We however identified that a social history was missing from this file. We felt that there were details about E's professional background that were relevant to their social history. There was a possibility that E has a brother that they do not have contact with, but the care home knows nothing else about their personal history or what has been important to them in the past. We knew from information in the application for a guardianship order that information about E's background was limited and that E could not provide any significant information. The Commission had some basic information about their past history, from a social circumstances report prepared by a Mental Health Officer (MHO) in 2011, following an episode of compulsory treatment then. After this visit, we spoke to the Local Authority guardian who agreed they would review E's file, and other information they held, to take out as much life history information as they could find, and share this with the care home.

Key learning points

- It is important that care providers have as much information as possible about a person's past life, and about what was important to them in the past. This will help encourage better communication and an understanding of the person's needs and wishes. It will help inform care and support, ensures that this is provided in a positive person-centred way, and develops a closer relationship between the person and carers. It also help carers to see the person behind the diagnosis.
- The general principles of the AWI Act state that "account shall be taken of the present and past wishes and feelings of the adult", and having as much personal life story information as possible will help put this principle into practice.[25]
- Having access to as much life story information as possible will help carers understand what might be important to an adult and relate to them, and to provide more person centred care and support.[26]

[25] Mental Welfare Commission, *Working with the Adults with Incapacity Act – for people working in adult care settings: Good practice guidance*. 2020 https://www.mwcscot.org.uk/sites/default/files/2020-07/WorkingWithAWI_July2020.pdf

[26] Alzheimer Scotland, *Standards of Care for Dementia in Scotland – A guide for people with dementia and their carers*. 2012 https://www.alzscot.org/sites/default/files/images/0001/2697/Guide_to_Standards_of_Care_for_Dementia_in_Scotland.pdf

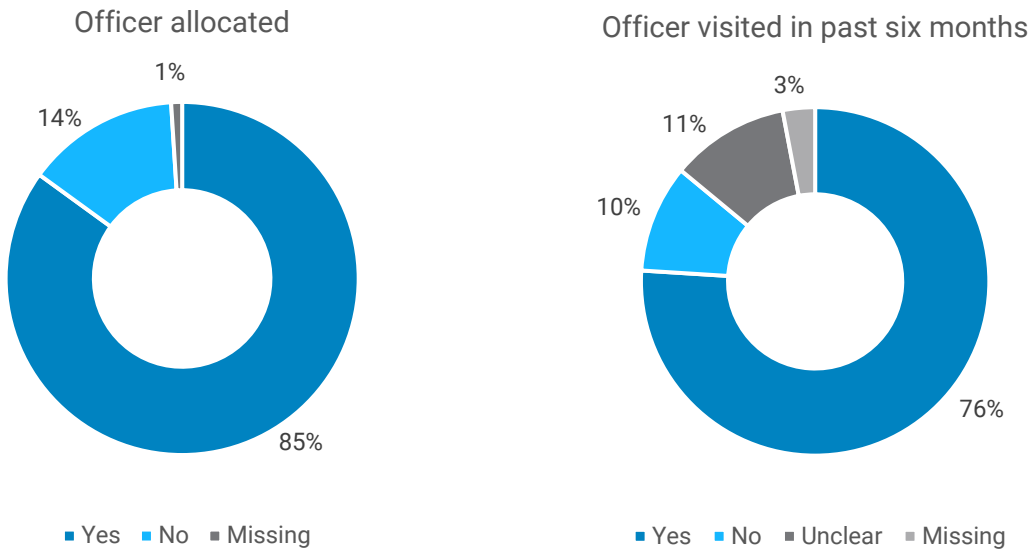
Guardian supervision and contact

Under the AWI Act, four public bodies are involved in the regulation and supervision of those authorised to make decisions on behalf of a person with incapacity. These are: the Office of the Public Guardian (Scotland), the Mental Welfare Commission, the courts, and local authorities. According to the AWI Act, local authorities must fulfil certain duties in relation to people who are on welfare guardianship orders:

> *"A local authority shall have the following general functions under this Act to supervise a guardian appointed with functions relating to the personal welfare of an adult in the exercise of those functions".*[27]

Of the 192 individuals who were on a private guardianship order, 86% had a supervising officer allocated. Where an officer was allocated, 76% had received a visit in the past six months (Figure 11).

Figure 11. Allocation and visits from supervising officer for private guardians



We note that while there is an improvement of supervising officers visiting the private guardian, which was 50% in 2017-18, it is still unsatisfactory that many private guardians have not had a visit in recent times.

The interpretation of supervision comes via codes of practice or statutory instruments which explain how powers should be used. Support and supervision requirements of private welfare guardians, changed in 2014, which allowed local authorities to consider reducing or ceasing visits where all parties were in agreement.[28] There is scope for private guardians and local authorities to reduce the statutory supervisory requirement in relation to individual circumstances, however the Commission needs to be formally notified of such an agreement.

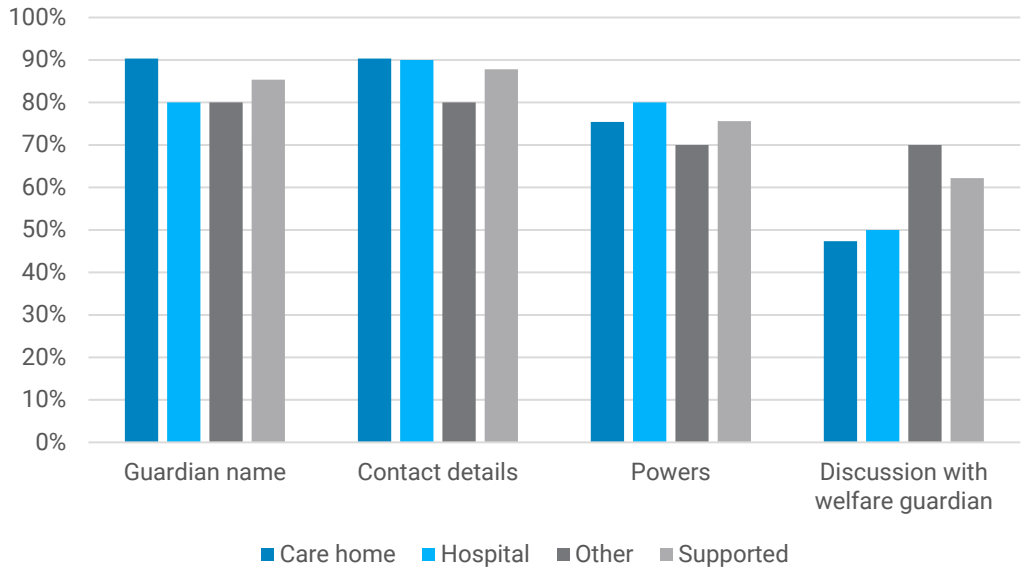
[27] Adults with Incapacity Act (Scotland) Act 2000 (asp 4) s 10(1)
[28] The Adults with Incapacity (Supervision of Welfare Guardians etc. by Local Authorities) (Scotland) Amendment Regulations 2014 SSI 123

An example of lack of supervision was W, an adult with LD, where we identified gaps in contact with the local authority for supervision:

> *This is a private order and requires supervision by the local authority. Neither W nor their parent were wholly clear on whether or not they had been supervised in recent months. They felt that this had not occurred for some time. They added that there had been a supervisor visit when the order was first granted. I advised them on the review of supervision that the local authority could employ, but it does not seem that this has happened and we have no documentation of this on the Commission record.*

For individuals on a guardianship order living in a care home, hospital, supported, or other type of accommodation we reviewed documents relating to the guardianship order that were held on the individual's file. Figure 15 shows that the guardian's name was recorded in over 80% of records in all types of accommodation. Distinct guardianship powers were documented in over 70% of records while fewer records indicated discussion about delegation of powers.

Figure 12. Documentation on individual's file



Most individuals (82%) had been visited by their guardian in the last six months. This was higher for private than local authority guardianships (86% and 76%, respectively). In 203 of the visits we took note of the accessibility and involvement of guardians or local authority supervising officers. For most individuals we could see evidence of regular contact and/or good accessibility of the guardian or supervising officer. In a very small number of cases we could not identify any contact in relation to the guardian or supervisor. In the case of L, an individual with dementia, we identified the following situation:

> *The care home staff had no knowledge of L's guardianship order and they did not think L was subject to guardianship nor who held the guardianship. The care staff assumed it was L's child, although it was the local authority. There was no evidence in the care record making reference to guardianship nor was there a copy of the guardianship order.*

Rights and restrictions

The UNCRPD is a comprehensive convention of human rights for people with disabilities. The Convention "adopts a broad categorisation of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms".[29]

During our visits, we look for examples of the principles of the AWI Act and of rights in line with the UNCRPD to demonstrate the adult is supported to exercise their rights in relation to all aspects of their lives. This might include elements of supported decision making to allow them to participate and make the decisions they are able to make for themselves. Proxy decision makers, like guardians have the power to make certain decisions in the absence of the adult but they must demonstrate they have taken the adult's will and preferences into account. Examples of rights we could see were upheld included:

- Respect for home and the family (Article 23, UNCRPD)
- Living independently and being included in the community (Article 19, UNRCPD)
- Access to and choice of activities to engage in (Article 30, UNRCPD)
- Support of advocacy (s259 of the Mental Health Act, 2.4 of the Health and Social Care Standards[30])
- Liberty and security of person (Article 17, UNCRPD)
- Protecting integrity of the person (Article 25, UNCRPD)
- Freedom of exploitation, violence and abuse (Article 16, UNCRPD)
- Health (Article 25, UNCRPD)
- Women with disabilities (Article 6, UNCRPD)
- Care plans regularly reviewed (1.15 of the Health and Social Care Standards[31])
- Adequate standard of living and social protection (Article 28, UNCRPD)
- Access to church and religion (Article 9, ECHR)

One good example of the standard of practice expected was an adult with cerebral palsy who lives with their parents, who are private guardians. The adult requires total support with all activities of daily living. The parents/private guardians advocate for the adult and where possible encourage shared decision-making. Our notes indicated that:

> *Least restrictive option – where possible the family actively encouraged shared decision-making in relating to social activities, holidays, clothing, diet and exercise. Parents balanced this well, ensuring good attendance with all medical appointments.*

As using the least restrictive option is an important principle of the AWI Act, we assessed restrictive practices used within the guardianship powers and where we had concerns addressed those. One example was an adult who was on a local authority guardianship order who resides in their own home with support 24/7. The adult has LD, autism spectrum disorder and a significant mental illness and we had concerns about restrictive practices that were in place and about appropriate use of powers.

---

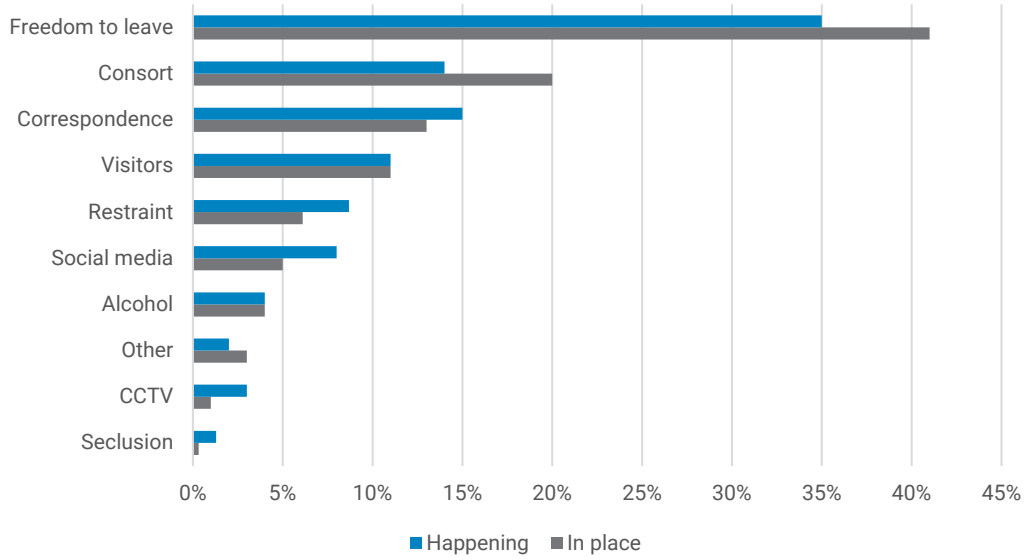
[29] UN General Assembly, Convention on the Rights of Persons with Disabilities
[30] Scottish Government, Health and Social Care Standards: my support, my life. 2017 https://www.gov.scot/publications/health-social-care-standards-support-life/pages/5/
[31] *Ibid.*

L has an earlier POA in place, and a recent welfare guardianship order in place to make additional welfare decisions on their behalf. The welfare guardianship powers in place authorise restrictive practices such as restraint as part of L's care plan. The welfare guardian is considering seeking further additional welfare powers particularly around seclusion and technology, as they felt this was required. The POA did not agree with them. Staff often have to remove themselves to the staff room or use seclusion to minimise risk and due to the layout of the house staff are unable to see if L is ok as they are often behind the staff door until safe to begin to work with L. The welfare guardian informed us that in terms of the seclusion protocol in place, staff can withdraw support or lock L in a specific area, however there are no powers currently in place authorising these measures of seclusion. Restrictive practices are in place which would suggest that L was non-compliant. L does have an advocate who visits regularly and attends the meetings. L at times engages and other times does not.

We recommended that additional powers were required in order to authorise decisions around seclusion and technology as part of L's care plan. Where the staff were considering installing technology such as CCTV we recommended that this would need to be based on a risk assessment and proportionate to L's needs, ensuring the least restrictive measures were taken into account based on the principles of the Act. This was taken forward and additional powers were authorised via court. We also recommended that a welfare guardianship would be the most appropriate legal framework for all of L's welfare decisions, rather than the POA, as where there is a deprivation of liberty and where an adult resists or opposes the arrangements a POA cannot enforce compliance.

Most individuals did not have specific restrictions within the order. Figure 17 shows the restrictions that had been put in place for individuals that we visited. The most common form of restriction in place and/or happening (without powers) was freedom to leave unassisted. We note a few areas where we observed discrepancy of powers in place and happening; for correspondence, restraint social media, CCTV, and seclusion we noted that there were some cases of restrictions happening despite powers not being in place.

Figure 13. Restrictions placed on the individual[32]



Several individuals were able to describe that they understood that the restrictions they have are there to keep them safe. One example was S, who was not happy about the restrictions their guardianship entails, but could acknowledge they do help keep them safe (Case study 3).

Case study 3. Benefits of restrictions

As part of the Commission's monitoring role we visited S, who is on a five-year welfare guardianship order. The adult has a diagnosis of borderline learning disability and paranoid personality disorder.

S has a complex psychiatric history and spent long periods in hospital under compulsory measures following breakdown in their community placements. S was involved in numerous community incidents and spent time in police custody. Following a period in prison, S was transferred to hospital on an assessment order granted under the Criminal Procedure (Scotland) Act 1995. The final disposal from the court was the granting of a welfare guardianship order and the CSWO of the local authority was appointed as the welfare guardian. Medical assessments indicated that S still required treatment within a hospital setting and was subsequently detained under the Mental Health Act.

Upon discharge, S moved into supported accommodation with a substantial care package that provided support 24 hours a day, seven days a week. The care and support plan was informed by S's physical and mental health needs and set out from the legal framework of the Community Compulsory Treatment Order (CCTO) and the guardianship order.

On our visit, the adult was able to tell us their views about the welfare guardianship order and the CCTO that was in place. The adult felt that the guardianship order in place was a waste of time, that they were unhappy being on the order, and that they did not want the guardian to be making legal decisions for them.

[32] In 20 of our visits, our old visit form were used on which alcohol, social media and consort was not included

We found that S was aware of the guardianship order and the restrictive consequences, but had poor overall understanding of why this was required. Restrictions specified within the order include accessing social media sites and freedom to leave unassisted. S told us that they felt restricted because they were not allowed go outside without staff support. We discussed this further during our visit and S was well aware of their rights and had advocacy support. S told us that they never want to go back to prison and later said that the order is keeping them safe. S recognised how much their life has improved since being discharged from hospital.

The powers in the order were aligned to the care plans and risk assessments that were in place. Regular multi-disciplinary meetings were taking place where care plans, needs assessment, and risk management plans were reviewed. Initially, S had a staff ratio of two-to-one and re-assessment concluded that the staffing could be reduced to one-to-one.

The delegated guardian had regular contact with S and was taking their views and wishes into account. S continues to be given the opportunity to make express wishes known to the care team. The delegated guardian has not delegated any welfare powers to the care staff that support the adult on a daily basis. The delegated guardian had made a decision due to the complexity of the adult care needs, that none of the welfare powers would be formally delegated to the care staff at this present time.

During our visit, we directed the care provider and the local authority guardian to our guidance on the AWI Act which includes a checklist for guardianship powers.[33]

S's treatment for mental disorder was being authorised under part 16 of the Mental Health Act. We saw a s47 certificate in place to authorise treatment for physical healthcare, however this was out of date. On speaking to the delegated guardian we were advised that the GP did not feel that a s47 certificate was required as a T3 was in place. A T3 certificate authorises treatment for mental disorder however does not authorise treatment for physical healthcare. The Responsible Medical Officer (RMO) and delegated guardian were following this up with the GP.

We were able to establish from our visit that the powers authorised within the guardianship order were of benefit to S and were tailored to their assessed needs. This enables S to be safeguarded and supported in an individualised way that provides opportunity for developing new skills and trying out new experiences, such as going on holiday. The benefit of the guardianship and CCTO to S is that they continue to be supported in the community as opposed to a hospital or prison setting, which is a positive outcome for S.

Key learning points:

- Present and past wishes of the adult shall be taken account of at all times. Adherence to the principles of the AWI Act is a key element in any decision making process and ensures that the adult's rights, will and preference are central to this decision making process. This principle must be applied whenever decisions are being made. A guardian must ensure that they involve the adult at all times where key decisions require to be made.
- In some situations a CTO and a guardianship order are both necessary measures

[33] Mental Welfare Commission, W*orking with the Adults with Incapacity Act: Information for people working in adult care settings*. 2020 https://www.mwcscot.org.uk/node/1480

- The AWI Act s47 certificates are required to authorise treatment for physical disorder where an adult lacks capacity.
- A guardian may arrange for some or all of his/her functions to be delegated (section 64(6) of the AWI Act). This provision is helpful in relation to welfare powers, and in a variety of situations, such as the example above, where the guardian is not the day to day carer.
- Delegating powers to support staff is a key concept of the AWI Act. Staff should be familiar with this and have a sound understanding of the legal powers, what they authorise, the parameters of this, and what discussion should take place if these are not able to be implemented. Supporting individuals to access advocacy input is also key.[34]
- Powers within a welfare guardianship order can be specific and restrictive in relation to aspects of the care plan. Applying the principles of the AWI Act are necessary in ensuring that restrictions are proportionate and benefit the adult.
- The principles of the AWI Act must apply to anyone carrying out the function or exercising a duty under the AWI Act.[35]

[34] Mental Welfare Commission, *Working with the Adults with Incapacity Act*
[35] Scottish Government, Code of Practice for Local Authorities Exercising Functions under the 2000 Act. 2008 https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-local-authorities-exercising-functions-under-2000-act/; Mental Welfare Commission, Rights in Mind – a pathway to patients' rights in mental health services https://www.mwcscot.org.uk/sites/default/files/2019-07/rights_in_mind_1.pdf

Medication and s47 certificates

The *Code of Practice*[36] and Mental Welfare Commission guidance[37] are clear in relation to the use of s47 certificates. Where an individual does not have the capacity to consent to the treatment they require, a doctor should formally assess their capacity and, on finding someone incapable of consenting, complete a certificate. Where this treatment is complex, they should complete a treatment plan. If a certificate is not done, then the treatment given is unlawful.

If there is a proxy decision maker, namely a welfare guardian or someone acting with a welfare POA, then the medical practitioner should also discuss the treatment with them. There is a clear space on the certificate for the doctor to put the name of the proxy decision maker. Care staff should assist the doctor in identifying the proxy decision maker from records and their knowledge of the adult.

Most individuals (87%) had medical powers granted within the guardianship order. A s47 certificate was required for 67% and of those the majority (76%) had one in place. The Commission will continue to remind medical practitioners and managers of health and social care services about the need for completing a s47 certificate. We raised during our visits where we noted that a certificate seemed to be missing:

> *There is a s47 certificate in place, which has been written by the GP who is the nominated link for the care setting. No consultation has taken place with the guardians. No treatment plan and I asked staff to raise this with a GP as s47 will be due for review.*

For individuals for whom a s47 certificate was in place, 99% were appropriate, however only 69% had a treatment plan and in 69% the guardian was informed about the s47 certificate.

In a couple of instances we noted that the s47 and treatment plan was not detailed or person centred, which the Code of Practice outlines.[38] In cases where no s47 was in place and this was required we advised about the need for making arrangements with a GP to get a s47 issued. In a few instances we identified certificates that were not kept on file and were also out of date.

> *There was no s47 certificate in P's file, however on asking the service manager she had a copy in her office. On reviewing this certificate, it was no longer valid and had recorded that the welfare guardians were consulted. The welfare guardianship order was not in place when this certificate was signed. The service manager agreed to liaise with the GP as P has changed practice due to moving, and to liaise with the welfare guardian regarding this and ensure a treatment plan was in place. I gave the service manager further advice and access to MWC guidance.*

[36] Scottish Government, *Adults with incapacity: code of practice for medical practitioners*. 2010 https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorised-carry-out-medical-treatment-research-under-part-5-act/

[37] Mental Welfare Commission, *Right to treat? Delivering physical healthcare to people who lack capacity and refuse or resist treatment*. 2011 https://www.mwcscot.org.uk/sites/default/files/2019-06/Right%20to%20Treat.pdf

[38] Scottish Government, *Adults with incapacity: code of practice for medical practitioners*

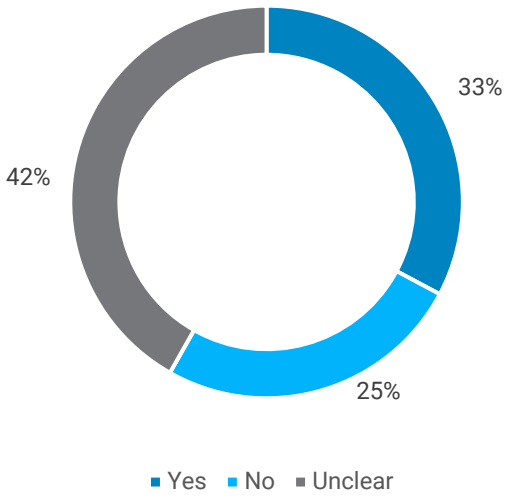
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

If an individual lacks capacity, the principles of the AWI Act apply. Intervention with Cardiopulmonary Resuscitation (CPR) should be considered if it is likely to be of overall benefit for the individual. If the clinical opinion is that there would be no benefit, then a Do Not Attempt CPR (DNACPR) decision is appropriate. The past and current views of the individual, if known, must be taken into account and there is a duty to consult relevant others and ask if there is any valid advance directive which should be assessed to see if it is applicable to the current situation. Proxy decision-makers, i.e. welfare attorney/welfare guardian/person appointed under an intervention order, must be involved in the process as they would have the same power to consent or refuse consent as a capable individual would.[39]

With the specific challenges that the COVID-19 pandemic have entailed, DNACPR for individuals who lack capacity was raised as a particular potential issue. The Chief Medical Officer of Scotland issued clear guidance that social care needs for individuals, who for example have learning difficulties, is not a reason to issue a DNACPR order.[40]

For about half (61%) the issue of guardians being informed about a DNACPR was not applicable, due to residing in the community or non-complex morbidity. Of the remaining 122 individuals visited, guardians had either not been informed or it was unclear if they had been informed for 67% of individuals for whom a DNACPR was applicable (Figure 14).

Figure 14. Guardian has been consulted of DNACPR



The issue of not being informed about DNACPR is important, as it can cause significant upset to family members as we found in one particular case.

[39] NHS Scotland, *Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) – Integrated Adult Policy.* 2010 https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2010/05/attempt-cardiopulmonary-resuscitation-dnacpr-integrated-adult-policy-decision-making-communication/documents/0098903-pdf/0098903-pdf/govscot%3Adocument/0098903.pdf

[40] Scottish Government, *Coronavirus (COVID-19): use of clinical frailty scale - letter from Principal Medical Officer*, 18 May 2020 https://www.gov.scot/publications/coronavirus-covid-19-use-of-clinical-frailty-scale---letter-from-principal-medical-officer/

A DNACPR form had been completed whilst A was a resident in a previous nursing home. This was done without involvement or discussion with the welfare guardians. When they found out, they were extremely upset and ensured that it was removed.

In other cases we found that documentation regarding choices for the adult regarding care had been arranged and documented, including a DNACPR.

A 'My anticipatory care plan' is in place which provides detailed information.

Finances

The AWI Act provides arrangements for making decisions and taking actions to safeguard the personal welfare, property, and financial affairs of adults whose capacity to do so is impaired. Part 6 allows for an application to be made to the court for:

- An intervention order authorising a person to take action, or make a decision, of which the adult is incapable.
- An order appointing a person or office holder as guardian in relation to the adult's property, financial affairs, and personal welfare.
- An order appointing a person or office holder in relation to a child who will become an adult within three months, but such an order will not have effect until the person's 16th birthday.[41]

Practical guidance around financial guardianship is outlined in our guidance *Money Matters.*[42] We review the management of an individual's finances on all our visits. Financial matters can impact on an individual's welfare. For most adults, a financial guardian (55%) or Department for Work and Pension (DWP) appointee (29%) were responsible for finances. In a few cases it was the care home or hospital (6%), adult themselves (4%), or other (3%). Only in a handful of cases were the finances handled by a financial (continuing) power of attorney or an informal arrangement.

The majority of individuals had sufficient access to funds (89%) while the remaining had some access to funds and in two cases problems with access to funds were identified; both related to difficulties with getting access to benefits due to not being a British citizen and due to a long hospital admission that influenced the benefits they were provided.

For most individuals we noted no concerns relating to their finances and in the instances where we did, these related to debts that the individual had accumulated, how money was spent, or queries regarding access to accumulated funds. We did note a few instances where we had significant concerns regarding the adult's finances, in the case of C this was in relation to their money being used for gambling.

We were concerned regarding the practice of staff putting on gambling bets for C. If this is deemed appropriate, then these need to be within their means and most certainly be fully

[41] Adults with Incapacity Act (Scotland) Act 2000 (asp 4) s 6
[42] Mental Welfare Commission, *Money Matters – Good practice guide,* 2019 https://www.mwcscot.org.uk/sites/default/files/2019-06/money_matters.pdf

receipted. The guardian told us that he had already asked the care home staff to cease this but it has persisted. When I spoke with the care home manager, they advised that this practice was going to cease with immediate effect and he appeared to understand the inappropriateness of the way this was occurring, i.e. against the wishes of the financial guardian and without obtaining receipts.

In another case we noted concerns about fraud from one of the adult's family members and the importance of those with welfare powers and those with finance related powers working in partnership in the best interests of the adult.

There is an issue about the fact that a substantial sum of money was apparently removed from a bank account by one of the extended family. The local authority guardian thought it may have been about £10K, but she said the police had informed her that the bank had refunded most of the money. The guardian has no authority to deal with finances (only welfare powers) and said that the local authority as the placing authority are appointees. A member of care staff who accompanied F to the local bank where they normally withdrew money alerted the manager to concerns recently – these were passed to the police who have investigated and charged someone with fraudulently taking money out of the account. The guardian has notified the local authority and been told that they will be looking to use access to funds to clarify how much F has as they don't seem to know and think they may have a private pension being paid into their account.

In most visits we noted that the adult had access to funds and that the money that was available to them was spent in a way that benefits the adult to pay for things they enjoy, such as leisure activities but also personal care. Financial arrangements were in many cases also set up to help the adult pay bills and debts that they would not have managed to do on their own. We also saw good examples of financial arrangements that not only ensured that the adult had everything they needed, but also made them feel in control of their money.

Excellent financial support plan in place. There is an understanding that J likes to feel 'financially independent' and with this in mind J is provided with money each day in order to purchase a newspaper and additional items they may wish to buy.

Guardianship interventions through the Advice Line

Our Advice Line provides a service for individuals and professionals to get advice on rights and good practice related to mental health and incapacity law, care and treatment. As such, we sometimes get calls from professionals or others involved in the care of an individual subject to the AWI Act. We regularly receive calls from guardians and care service staff about issues and practice around guardianship. This can generate more action from the Commission than merely giving advice over the phone, and sometimes leads to follow up by practitioners when they are planning guardianship visits.

In recent times, we have had two particularly complex cases that related to the use of the AWI Act where the Commission got involved to ensure that the welfare of the individual was considered. These are described below with learning points for those who may be involved in similar cases in the future. We also provide recommendations for actions that should be taken in these situations and what can be done to prevent similar issues from occurring again.

Case study 4. Addressing neglect in family home

O is an adult with a learning disability who was living with their parent, who was appointed as welfare guardian. Just over a year into the guardianship order, a social worker contacted the Commission's advice line to discuss concerns about O. Alarms had been raised by a former personal assistant to O indicating that they were not safe in the home environment that their parent was providing. Concerns about O's health and welfare due to severely neglected living conditions had led to the emergency removal of O to temporary respite care.

An investigation under the ASPA had also been instigated. Social work had then recommended that O be placed temporarily in independent accommodation with 24 hour support, pending their further enquiries, but O's parent did not agree. The local authority had received legal advice that there were not sufficient grounds to challenge the welfare guardian's decision making powers. They remained concerned and sought the advice of the Commission. Given the serious concerns about O, the Commission recommended that an application be made to the Sheriff under s71 of the AWI Act to replace, remove or recall the guardianship. The local authority made this application and a hearing took place within seven days. The Sheriff temporarily suspended the welfare guardian's powers to decide where the adult should live and transferred these powers to the local authority. The Sheriff directed that O be placed in temporary accommodation with 24 hour support at a place specified by the local authority and that O's social care needs also be determined. Recommendations for a period of supervised contact with the parent were also made.

The Commission followed up the case and were advised by social work that O settled quickly in their new accommodation and appeared happy there. Following further assessment, O continued to be cared for in this new setting, where reports indicated that O was thriving. O's parent remained in contact during this time. Other relatives subsequently made a successful application to become O's welfare guardians and supported O to continue to live in independent accommodation with 24 hour care.

During this process the Commission raised concerns about how the neglect of O appeared to have gone unnoticed for a long period before it came to the attention of social work. The lack of home visits by the social worker supervising the original guardian was highlighted. The absence of safeguarding around the contracting of personal assistants, who are independently employed through self-directed support, was also noted by the Commission as a concern.

Key learning points

- Social work has an important role in carrying out their supervisory duties for private welfare guardianships under the AWI Act and highlights the risks to individuals if failing to do so robustly. This case emphasises the importance of home visits to ensure that the adult's home environment is adequate and does not present a risk to their health and wellbeing.
- Under Section 10(d) of the AWI Act, a local authority has a duty to investigate any circumstances made know to them in which the personal welfare of an adult seems to them to be at risk
- Where an adult lacks capacity, the appointment of a proxy with financial powers is required to manage Option 1 of self-directed support on their behalf and to act as employer with inherent responsibilities attached.

Case Study 5. Delayed Discharge

C is a young individual who was diagnosed with a progressive, degenerative illness five years ago. The condition left C with significant physical difficulties and substantial psychological difficulties, including cognitive impairment, depression and suicidal ideation. This led to challenging and risk-taking behaviour and suicide attempts.

Three years ago, C was detained under the Mental Health Act and admitted to hospital in the health board area where they lived. Due to the degenerative and debilitating nature of C's illness, they were made subject to a welfare guardianship order, with the local authority named as guardian. After two years in hospital, C was transferred to a specialist facility in a different part of the country, a considerable distance away from their children and their family.

Shortly after the transfer, due to increasingly volatile behaviours and a significant suicide attempt, C was again detained under the Act and transferred to a psychiatric hospital, remaining out with their own health board.

When the Commission visited C in the psychiatric hospital last year, the care plan indicated C was awaiting transfer to return to their home area for continued care. We were however disappointed to find that five months after our visit, no bed had yet been identified and C was still in the same hospital, subject to a hospital-based Compulsory Treatment Order (CTO).

At the time of making the CTO, several health professionals and legal representation raised concerns about the suitability of this order, specifically that it would authorise detention in the hospital out with C's home locality, which resulted in C being far away from their children and family. In order for C's children to visit, a long journey had to be arranged and accompanied by social work, meaning that these visits were very limited. The concerns centred on the belief that being so far away from family, was understandably, causing additional distress and upset to C, evidenced in escalations in distressed and self-injurious behaviour. The children's social worker also attested that the situation was causing the children a great deal of upset.

The local authority, who was appointed as C's welfare guardian, made no representation during the CTO Tribunal process, despite the application being intimated to them.

The Mental Health Tribunal shared the concerns regarding the situation and made a recorded matter that C's home authority health board should arrange transfer to a general psychiatric ward in the home locality within 21 days. The recorded matter was not complied with and a subsequent s96 tribunal was scheduled.

In the interim, the Commission wrote to the services of C's home locality highlighting our concerns that given C's terminal diagnosis and ultimate progression towards the need for palliative care, coupled with the detrimental impact of the situation on C's mental health and the wellbeing of the children, it was imperative that a transfer to the home locality was instigated as a matter of urgency. Additionally, the Commission was concerned that the circumstances of C's detention were not compliant with the Millan Principles contained within the Mental Health Act, nor was it compliant with the core principles contained within the AWI Act and in direct contravention of Article 8 of the ECHR which, protects the right to respect for private and family life.

The Commission was delighted to be subsequently informed four days later that C had been transferred back to their home area, where they now receive care and treatment closer to loved ones.

Key learning points

- Under the Mental Health Act, a CTO can be varied by a tribunal.[43] Additionally, a tribunal can make a recorded matter, which is a treatment or service that the tribunal considers to be an essential part of the adult's care and treatment. In this case, a recorded matter was made that the home health board arranged transfer to a local hospital. This would have been consistent with the principles in the legislation of the least restrictive alternative and of maximum benefit. Where a recorded matter is not complied with, then the responsible medical officer must refer the case back to a tribunal.
- All parties to be compliant with the principles of the AWI Act (see Box 1).[44]
- The local authority made no representation during the tribunal process, which is not congruent with upholding the core principles of the AWI Act and their responsibilities as welfare guardians.[45]
- Under the AWI Act, local authority guardians have a statutory duty to monitor the adult's personal welfare. Where there is a change in circumstances a case review should be held. In this case, the adult's circumstances were changing, as C's mental and physical health were deteriorating and their frustration was increasing as a result of delays in transferring their care. This is an issue that should have been noted and acted upon by the guardians. The Code of Practice under the AWI Act states that:

  "Welfare guardianship should be used proactively to promote the personal welfare of an adult. While the guardian must be ready to react to events, he/she should also seek opportunities to improve the person's welfare within the scope of his/her powers and in applying the principles. Guardianship allows a flexible response to changing circumstances."[46]

- In this case, there was concern that the situation was in contravention of C's human rights, specifically Article 8 - the right to respect for private and family life. The Commission's guide *Human Rights in Mental Health Services* provides more information on human rights in mental health care.[47]

[43] Mental Health (care and treatment) (Scotland) Act 2003: Code of Practice Volume , Chapter 3 https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-1/pages/4/
[44] Adults With Incapacity (Scotland) Act 2000, Part 1, pages 1-2 https://www.legislation.gov.uk/asp/2000/4/section/1
[45] Scottish Government Adults with Incapacity Act: Code of Practice for Local Authorities, 2008 https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-local-authorities-exercising-functions-under-2000-act/pages/7/
[46] Scottish Government Adults with Incapacity Act: code of practice for Local Authorities, 2008, p.56 https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-local-authorities-exercising-functions-under-2000-act/pages/7/
[47] Mental Welfare Commission, Good practice guide: Human Rights in Mental Health Services, 2017 https://www.mwcscot.org.uk/sites/default/files/2019-06/human_rights_in_mental_health_services.pdf

Summary

This year we present monitoring of the AWI Act and our active assessments of the implementation of the AWI Act through visiting adults and guardians.

Ensuring that the principles of the AWI Act are applied and upheld are increasingly important given the steady increase in granted guardianships each year and the fact that almost 16,000 people in Scotland currently are on an order which is protective but also may restrict their liberty to a significant degree.

The Commission acknowledges that the AWI legislation is now 20 years old and welcomes the Scottish Government's Scott review considering all three key pieces of safeguarding legislation in Scotland.

For many years, we have highlighted the requirement of local authorities to supervise private guardianships. This year we note that whilst there is a welcome improvement of supervising officers visiting the private guardian, which was 50% in 2017-18 and now 76% in 2019-20, it is still unsatisfactory that private guardians have not had a visit in recent times.

We have already highlighted gaps in the existence of s47 certificates and we will continue to monitor medical practitioners' compliance with the legislation.

Over recent years our data has shown an increase in welfare guardianship orders granted for adults with a diagnosis of ARBD. In 2019 we produced Our Good practice Guidance (ARBD) and made specific recommendations for when working with adults who have ARBD. We therefore plan to undertake a themed visit specifically for this group of people who are subject to guardianship orders and will report our findings and recommendations in 2021.

The Commission is currently undertaking analysis of its functions and reporting with regards to Public Sector Equalities Duties as part of a themed project on the mental health needs of Ethnic Minority communities. The Commission aims to ensure recording of ethnicity as part of our various activities, including Guardianship reporting. This project, with recommendations, in regard to this function will be completed in early 2021; thus ensuring the Commission continues to meet the needs and protect the rights of individuals from all communities.

We look forward to following up on the findings of this report and the Commission's planned work, noted above, in our next monitoring year, which will be 2021-22. Until then we will work with local authorities in supporting individuals subject to guardianship orders to ensure that their rights are upheld and that practice continues to be informed by the principles of the AWI Act.

Appendix A - Glossary

ABI	Acquired Brain Injury
ARBD	Alcohol-related brain damage
ASPA	Adult Support and Protection (Scotland) Act
AWI Act	Adults with Incapacity (Scotland) Act 2000
CI	Confidence interval
CTO	Compulsory Treatment Order
CCTO	Community Compulsory Treatment Order
CSWO	Chief Social Work Officer
Dementia	Includes Dementia and Alzheimer's Disease
DNACPR	Do Not Attempt CPR
DWP	Department for Work and Pension
ECT	Electro-convulsive therapy
ECHR	European Convention of Human Rights
Inability to communicate	Inability to communicate due to physical impairment (e.g. Huntington's Disease)
LD	Learning Disability
Mental Health Act	Mental Health (Care and Treatment)(Scotland) Act 2003
MHO	Mental Health Officer
RSE	Relative Standard Error
s47	Certificate issued by a doctor where the adult cannot consent to the treatment being given
s48	Exceptions to authority to treat
s50	Medical treatment where guardian etc. has been appointed
POA	Power of Attorney
RMO	Responsible Medical Officer
UNCRPD	UN Convention of the Rights of People with Disability

Appendix B – Supplementary tables

Table A1. Extant guardianships in Scotland as of 31 March 2020

Characteristic	n (%)
Total	15,973
Guardian	
LA	3,639 (23)
Private	12,334 (77)
Local Authority	
Aberdeen City	587 (4)
Aberdeenshire	658 (4)
Angus	325 (2)
Argyll and Bute	195 (1)
City of Edinburgh	909 (6)
Clackmannanshire	169 (1)
Dumfries and Galloway	509 (3)
Dundee City	633 (4)
East Ayrshire	402 (3)
East Dunbartonshire	242 (2)
East Lothian	210 (1)
East Renfrewshire	207 (1)
Eilean Siar	86 (1)
Falkirk	471 (3)
Fife	1,240 (8)
Glasgow City	2,464 (15)
Highland	946 (6)
Inverclyde	94 (1)
Midlothian	202 (1)
Moray	258 (2)
North Ayrshire	404 (3)
North Lanarkshire	916 (6)
Orkney	59 (<1)
Perth and Kinross	582 (4)
Renfrewshire	586 (4)
Scottish Borders	238 (1)
Shetland	33 (<1)
South Ayrshire	399 (2)
South Lanarkshire	1049 (7)
Stirling	276 (2)
West Dunbartonshire	267 (2)
West Lothian	357 (2)
Age	
16–17 years	297 (2)
18–24 years	2,369 (15)
25–44 years	3,343 (21)
45–64 years	3,009 (19)
65–84 years	3,786 (24)
>85 years	3,169 (20)
Gender	
Male	7,913 (50)
Female	8,060 (50)
Length	
0–3 years	2,072 (13)
4–5 years	5,655 (35)
>5 years	3,266 (20)
Indefinite	4,980 (31)
Diagnosis	
Acquired Brain Injury	758 (5)
Alcohol Related Brain Disorder	553 (3)
Dementia/ Alzheimer's Disease	5,703 (36)
Inability to communicate	17 (<1)
Learning Disability	8,222 (51)
Mental Illness	545 (4)
Other	175 (1)

Table A2. Granted guardianships 2019-20 by guardianship status, n (%)

Characteristic	Total (n=3,199)	New guardianship (n=2,488)	Renewal (n=711)
Age			
16–24	694 (22)	484 (19)	210 (30)
25–44	507 (16)	304 (12)	203 (29)
45–64	615 (19)	427 (17)	188 (26)
>65	1,383 (43)	1,273 (51)	110 (15)
Gender			
Male	1,651 (52)	1,245 (50)	305 (43)
Female	1,548 (48)	1,243 (50)	406 (57)
Primary diagnosis			
ABI	154 (5)	114 (5)	40 (6)
ARBD	125 (4)	106 (4)	19 (3)
Dementia	1,165 (36)	1,089 (44)	76 (11)
Inability to communicate	5 (<1)	5 (<1)	*
LD	1,583 (49)	1,025 (42)	548 (77)
Mental Illness	141 (4)	114 (5)	27 (4)
Other	26 (1)	25 (1)	*
Length of guardianship			
0–3 years	634 (20)	365 (15)	269 (38)
4–5 years	846 (26)	760 (31)	86 (12)
≥6 years	1,498 (47)	1,157 (47)	341 (48)
Indefinite	221 (7)	206 (8)	13 (2)
Guardian status			
Local authority	837 (26)	663 (27)	174 (26)
Private	2,362 (74)	1,825 (73)	537 (74)

** n<5 or secondary suppression*

Table A3. Granted guardianships 2019-20 by guardian status, n (%)

Characteristic	Total (N=3,199)	Private (n=2,362)	Local Authority (n=837)
Age			
16–24	694 (22)	624 (26)	70 (8)
25–44	507 (16)	356 (15)	151 (18)
45–64	615 (19)	401(17)	214 (26)
>65	1,383 (43)	981 (42)	402 (48)
Gender			
Male	1,651 (52)	395 (49)	1153 (47)
Female	1,548 (48)	442 (51)	1209 (53)
Primary diagnosis			
ABI	154 (5)	107 (5)	47 (6)
ARBD	125 (4)	56 (2)	69 (8)
Dementia	1,165 (36)	868 (37)	297 (35)
Inability to communicate	5 (<1)	*	*
LD	1,583 (49)	1,267 (54)	316 (38)
Mental Illness	141 (4)	46 (2)	95 (11)
Other	26 (1)	*	*
Length of guardianship			
0–3 years	634 (20)	409 (17)	437 (52)
4–5 years	846 (26)	1,201 (51)	297 (35)
≥6 years	1,498 (47)	574 (24)	60 (7)
Indefinite	221 (7)	178 (8)	43 (5)
Guardianship status			
New	711 (22)	1,825 (73)	663 (27)
Renewal	2,488 (78)	537 (74)	174 (26)

** n<5 or secondary suppression*

Table A4. Granted guardianships 2019-20 by diagnosis, n (%)

Characteristic	Total N=3199	ABI N=154	ARBD N=125	Dementia N=1165	LD N=1583	MI N=141	Other N=26
Age							
16–24	694 (22)	*	*	*	680 (43)	*	*
25–44	507 (16)	*	*	*	447 (28)	*	*
45–64	615 (19)	65 (42)	56 (45)	74 (6)	352 (22)	57 (40)	8 (31)
>65	1,383 (43)	55 (36)	66 (53)	1087 (93)	104 (7)	60 (43)	10 (38)
Gender							
Male	1,651 (52)	54 (35)	35 (28)	739 (63)	640 (40)	68 (48)	11 (42)
Female	1,548 (48)	100 (65)	90 (72)	426 (37)	943 (60)	73 (52)	15 (58)
Length of guardianship							
0–3	634 (20)	41 (27)	56 (45)	279 (24)	391 (25)	66 (47)	11(42)
4–5	846 (26)	69 (45)	54 (43)	527 45)	787 (50)	787 (36)	8 (31)
>5	1,498 (47)	34 (22)	8 (6)	197 (17)	375 (24)	14 (10)	*
Indefinite	221 (7)	10 (6)	7 (6)	162 14)	30 (2)	30 (7)	*
Guardianship status							
New	711 (22)	114 (74)	106 (85)	1089 (93)	1025 (65)	114 (81)	*
Renewal	,2488 (78)	40 (26)	19 (15)	76 (7)	548 (35)	27 (19)	*
Guardian							
Private	2662	107 (31)	56 (55)	868 (25)	1267 (20)	46 (67)	14 (46)
Local Authority	837	47 (69)	69 (45)	297 (75)	316 (80)	95 (33)	12 (54)

** n<5 or secondary suppression; inability to communicate excluded from this table due to small n*

Table A5. Rate of granted guardianships with population figures, by local authority

Local authority	Rate per 100,000	Number of granted guardianships	Average population ≥16 years
Aberdeen City	39.9	77	193,247
Aberdeenshire	49.0	104	212,194
Angus	67.0	65	97,055
Argyll and Bute	58.9	43	72,964
City of Edinburgh	49.3	220	445,863
Clackmannanshire	54.0	23	42,594
Dumfries and Galloway	100.3	126	125,617
Dundee City	75.8	95	125,276
East Ayrshire	93.1	94	100,957
East Dunbartonshire	60.5	54	89,242
East Lothian	58.4	51	87,390
East Renfrewshire	38.2	29	76,005
Eilean Siar	57.9	13	22,466
Falkirk	82.1	109	132,778
Fife	65.1	201	308,998
Glasgow City	94.1	501	532,454
Highland	99.6	196	196,794
Inverclyde	32.2	21	65,197
Midlothian	52.3	39	74,507
Moray	38.9	31	79,675
North Ayrshire	77.5	87	112,272
North Lanarkshire	79.0	220	278,534
Orkney	85.6	16	18,688
Perth and Kinross	87.0	111	127,529
Renfrewshire	71.2	106	148,833
Scottish Borders	47.7	46	96,487
Shetland	37.4	7	18,722
South Ayrshire	102.1	97	95,002
South Lanarkshire	88.0	233	264,881
Stirling	77.4	61	78,793
West Dunbartonshire	47.8	35	73,283
West Lothian	59.6	88	147,606
Scotland	**70.4**	**3,199**	**4,541,903**

Table A6. Number of guardianships granted, by Local Authority and year

Local Authority	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Aberdeen City	53	62	58	78	61	78	85	78	94	77
Aberdeenshire	72	90	65	72	80	80	98	109	96	104
Angus	37	39	29	31	44	48	55	71	58	65
Argyll and Bute	23	29	26	26	33	42	37	39	41	43
City of Edinburgh	100	91	100	115	105	144	188	164	202	220
Clackmannanshire	17	11	20	9	20	33	36	30	28	23
Dumfries and Galloway	41	43	48	46	61	119	117	114	147	126
Dundee City	53	71	97	96	95	70	107	83	96	95
East Ayrshire	42	42	51	49	81	101	87	98	84	94
East Dunbartonshire	22	31	33	36	42	40	36	50	45	54
East Lothian	25	38	62	32	38	47	34	51	48	51
East Renfrewshire	22	32	24	21	35	37	29	45	35	29
Eilean Siar	12	8	10	*	5	16	29	16	19	13
Falkirk	43	39	38	54	81	92	79	99	90	109
Fife	115	144	145	161	181	215	204	262	226	201
Glasgow City	274	326	390	352	377	377	367	443	448	501
Highland	83	101	93	111	128	147	203	165	187	193
Inverclyde	10	11	12	21	21	20	38	31	30	21
Midlothian	11	10	20	18	25	32	33	53	54	39
Moray	27	31	21	15	33	44	55	38	43	31
North Ayrshire	44	52	48	62	83	66	87	80	89	87
North Lanarkshire	83	112	139	165	174	188	183	235	250	220
Orkney	13	7	9	13	9	18	8	8	9	16
Perth and Kinross	42	72	63	73	69	64	77	100	88	111
Renfrewshire	41	39	60	90	112	141	115	110	129	106
Scottish Borders	16	23	18	31	46	40	42	58	52	46
Shetland	*	*	*	*	*	6	8	7	7	7
South Ayrshire	52	40	32	57	84	98	90	117	115	97
South Lanarkshire	100	125	151	151	214	172	227	209	207	233
Stirling	20	30	27	51	34	33	63	49	58	61
West Dunbartonshire	37	39	41	38	51	57	46	32	39	35
West Lothian	40	43	41	69	65	41	81	75	62	88
Scotland	**1,571**	**1,833**	**1,971**	**2,149**	**2,491**	**2,706**	**2,944**	**3,119**	**3,176**	**3,199**

Table A7. Number of Local Authority (LA) and private (P) guardianships, by Local Authority and year

Local Authority	2010-11		2011-12		2012-13		2013-14		2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
	LA	P	LA	P	LA	P	LA	P	LA	P	LA	P	LA	P	LA	P	LA	P	LA	P
Aberdeen City	13	40	13	49	17	41	15	63	25	36	26	52	29	56	17	61	30	64	24	53
Aberdeenshire	23	49	25	65	14	51	9	63	24	56	21	59	20	78	23	86	29	67	29	75
Angus	15	22	11	28	12	17	7	24	15	29	13	35	26	29	26	45	26	32	25	40
Argyll and Bute	*	*	7	22	5	21	9	17	7	26	16	26	8	29	9	30	3	38	17	26
City of Edinburgh	33	67	23	68	19	81	27	88	22	83	49	95	59	129	45	119	69	133	82	138
Clackmannanshire	*	*	*	*	*	*	*	*	6	14	5	28	5	31	6	24	6	22	6	17
Dumfries and Galloway	15	26	19	24	19	29	13	33	20	41	47	72	32	85	27	87	45	102	29	97
Dundee City	21	32	27	44	35	62	39	57	29	66	21	49	32	75	25	58	28	68	38	57
East Ayrshire	12	30	18	24	23	28	22	27	28	53	24	77	24	63	35	63	25	59	36	58
East Dunbartonshire	*	*	*	*	*	*	*	*	5	37	*	*	6	30	5	45	9	36	8	46
East Lothian	12	13	15	23	23	39	10	22	19	19	17	30	8	26	11	40	16	32	16	35
East Renfrewshire	*	*	11	21	5	19	*	*	6	29	7	30	*	*	7	38	5	30	*	*
Eilean Siar	*	*	*	*	0	10	*	*	*	*	*	*	5	24	*	*	*	*	0	13
Falkirk	21	22	17	22	15	23	22	32	33	48	27	65	25	54	32	67	24	66	32	77
Fife	30	85	46	98	57	88	55	106	48	133	70	145	59	145	101	161	61	165	54	147
Glasgow City	72	202	50	276	61	329	45	307	44	333	54	323	43	324	55	388	55	393	61	440
Highland	26	57	37	64	48	45	32	79	46	82	46	101	88	115	66	99	66	121	67	129
Inverclyde	*	*	*	*	*	*	*	*	7	14	9	11	12	26	8	23	9	21	9	12
Midlothian	*	*	*	*	6	14	5	13	*	*	12	20	10	23	15	38	17	37	14	25
Moray	*	*	*	*	*	*	*	*	8	25	11	33	12	43	12	26	6	37	9	22
North Ayrshire	5	39	9	43	7	41	14	48	19	64	8	58	18	69	11	69	28	61	28	59
North Lanarkshire	18	65	27	85	29	110	25	140	34	140	41	147	30	153	59	176	57	193	49	171
Orkney	*	*	*	*	*	*	*	*	*	*	5	13	*	*	*	*	*	*	5	11
Perth and Kinross	15	27	14	58	19	44	12	61	17	52	16	48	27	50	39	61	25	63	36	75
Renfrewshire	5	36	8	31	11	49	21	69	23	89	36	105	25	90	25	85	20	109	26	80
Scottish Borders	7	9	9	14	5	13	8	23	10	36	12	28	13	29	10	48	15	37	14	32
Shetland	*	*	*	*	0	0	*	*	*	*	*	*	*	*	*	*	*	*	*	*
South Ayrshire	27	25	12	28	9	23	9	48	17	67	22	76	16	74	27	90	25	90	19	78
South Lanarkshire	26	74	28	97	38	113	34	117	35	179	38	134	46	181	53	156	36	171	46	187
Stirling	8	12	3	27	6	21	13	38	8	26	6	27	11	52	18	31	16	42	23	38
West Dunbartonshire	6	31	7	32	9	32	8	30	8	43	11	46	9	37	8	24	5	34	9	26
West Lothian	5	35	11	32	10	31	11	58	12	53	7	34	18	63	16	59	15	47	20	68
Scotland	**439**	**1,132**	**464**	**1,369**	**518**	**1,453**	**484**	**1,665**	**580**	**1,911**	**686**	**2,020**	**724**	**2,220**	**798**	**2,321**	**779**	**2,397**	**837**	**2,362**
Scotland (%)	**28**	**72**	**25**	**75**	**26**	**74**	**23**	**77**	**23**	**77**	**25**	**75**	**25**	**75**	**26**	**74**	**25**	**75**	**26**	**74**

* n<5 *or secondary suppression*

Table A8. Number of new and renewed granted guardianships, by Local Authority and year

Local Authority	2010-11		2011-12		2012-13		2013-14		2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R
Aberdeen City	*	*	62	0	*	*	71	7	56	5	*	*	79	6	*	*	80	14	63	14
Aberdeenshire	60	12	82	8	56	9	68	4	72	8	70	10	77	21	90	19	81	15	87	17
Angus	*	*	*	*	*	*	31	0	*	*	42	6	42	13	66	5	43	15	46	19
Argyll and Bute	*	*	*	*	26	0	*	*	*	*	*	*	31	6	*	*	34	7	35	8
City of Edinburgh	94	6	83	8	93	7	105	10	94	11	131	13	171	17	144	20	171	31	177	43
Clackmannanshire	17	0	11	0	20	0	9	0	*	*	*	*	*	*	*	*	*	*	*	*
Dumfries and Galloway	36	5	35	8	43	5	41	5	45	16	103	16	100	17	87	27	94	53	95	31
Dundee City	*	*	*	*	97	0	*	*	*	*	*	*	100	7	70	13	90	6	82	13
East Ayrshire	34	8	37	5	38	13	43	6	67	14	86	15	68	19	76	22	65	19	65	29
East Dunbartonshire	22	0	*	*	*	*	*	*	*	*	*	*	*	*	34	16	34	11	46	8
East Lothian	*	*	*	*	*	*	*	*	*	*	36	11	26	8	36	15	37	11	37	14
East Renfrewshire	22	0	*	*	*	*	*	*	35	0	32	5	*	*	39	6	*	*	22	7
Eilean Siar	*	*	8	0	10	0	*	*	5	0	16	0	29	0	*	*	*	*	13	0
Falkirk	37	6	*	*	*	*	*	*	64	17	80	12	66	13	85	14	81	9	79	30
Fife	*	*	128	16	134	11	149	12	165	16	201	14	177	27	231	31	175	51	166	35
Glasgow City	265	9	320	6	373	17	344	8	360	18	342	35	313	54	366	77	355	94	393	108
Highland	73	10	91	10	88	5	102	9	118	10	133	14	176	27	137	28	154	33	151	45
Inverclyde	*	*	*	*	*	*	*	*	*	*	15	5	31	7	23	8	24	6	*	*
Midlothian	*	*	*	*	*	*	18	0	*	*	24	8	26	7	45	8	42	12	30	9
Moray	*	*	*	*	16	5	*	*	27	6	*	*	*	*	33	5	37	6	*	*
North Ayrshire	*	*	52	0	*	*	55	7	77	6	61	5	72	15	65	15	77	12	63	24
North Lanarkshire	74	9	107	5	117	22	145	20	140	35	156	32	151	32	176	59	178	72	150	70
Orkney	*	*	7	0	9	0	*	*	*	*	12	6	*	*	*	*	*	*	*	*
Perth and Kinross	*	*	*	*	54	9	64	9	*	*	*	*	66	11	85	15	78	10	92	19
Renfrewshire	41	0	*	*	*	*	88	*	106	6	135	6	97	18	88	22	104	25	82	24
Scottish Borders	11	5	18	5	*	*	28	*	40	6	35	5	37	5	51	7	43	9	38	8
Shetland	*	*	*	*	0	0	*	*	*	*	6	0	8	0	7	0	7	0	*	*
South Ayrshire	*	*	35	5	*	*	51	6	73	11	87	11	73	17	95	22	89	26	70	27
South Lanarkshire	*	*	115	10	139	12	140	11	192	22	155	17	202	25	169	40	160	47	180	53
Stirling	*	*	30	0	26	*	44	7	*	*	28	5	*	*	44	5	45	13	46	15
West Dunbartonshire	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
West Lothian	*	*	*	*	*	*	64	5	55	10	35	6	59	22	61	14	43	19	63	25
Scotland	**1,466**	**105**	**1,719**	**114**	**1,824**	**147**	**1,993**	**156**	**2,247**	**246**	**2,426**	**280**	**2,530**	**414**	**2,587**	**532**	**2,534**	**643**	**2,488**	**711**

* n<5 *or secondary suppression;* N: new guardianship; R: renewal

Table A9. Characteristics of guardianship visits

Characteristics	n (%)
Gender	
Male	164 (53)
Female	147 (47)
Age group	
16–24	55 (18)
25–44	80 (26)
45–64	92 (30)
>65	84 (27)
Health board	
Ayrshire and Arran	29 (9)
Borders	16 (5)
Dumfries and Galloway	11 (4)
Fife	12 (4)
Forth Valley	11 (4)
Grampian	16 (5)
Greater Glasgow and Clyde	63 (20)
Highland	20 (6)
Lanarkshire	47 (15)
Lothian	47 (15)
Tayside	31 (10)
Western Isles	8 (3)
Diagnosis[a]	
ABI	30 (10)
ARBD	12 (4)
ASD	19 (6)
Dementia	62 (20)
LD	164 (53)
Other mental illness	27 (9)
Other	10 (3)
Length of order	
0–3 years	77 (25)
4–5 years	150 (48)
≥6	5 (16)
Indefinite	33 (11)
Guardianship status	
Renewal	88 (28)
New guardianship	223 (72)
Guardian	
Private	192 (61)
Local authority	118 (38)
Both	1(<1)

[a] *Some had more than one diagnosis recorded*

Table A10. Primary diagnosis by guardianship status, n (%)

Primary diagnosis	Total (N=311)	Local authority (n=118)	Private (n=192)
Dementia	62 (20)	24 (20)	38 (20)
ABI	31 (10)	11 (9)	19 (10)
ARBD	12 (4)	7 (6)	*
LD	164 (53)	56 (47)	108 (56)
ASD	19 (6)	*	15 (8)
Other mental illness	27 (9)	21 (18)	*
Other	10 (3)	*	9 (5)

**n<5 or secondary suppression; Other included: Huntington's disease, Landau Kleffer syndrome, Chromosomal abnormality, Multiple Sclerosis, Fragile X, Tuberous Sclerosis, cognitive impairment, CVA with expressive dysphasia, Down's Syndrome*

Table A11. Accommodation by guardianship status, n (%)

Accommodation	Total (N=311)	Local authority (N=118)	Private (N=192)
Care home	114 (37)	51 (43)	63 (33)
Family home	94 (30)	16 (14)	78 (41)
Supported	82 (26)	43 (36)	38 (20)
Hospital	10 (3)	*	6 (3)
Other	10 (3)	*	7 (4)
Missing	1 (<1)	1 (<1)	0

**n<5 or secondary suppression*

Table A12. Accommodation by diagnosis, n (%)

Accommodation	Diagnosis[a]						
	ASD	Dementia	ABI	ARBD	LD	Other MI	Other
Care home	*	52 (84)	11 (37)	9 (75)	35 (21)	9 (33)	*
Family home	10 (53)	6 (10)	12 (40)	*	57 (35)	7 (26)	*
Supported	*	*	*	*	60 (37)	9 (33)	0
Hospital	0	*	*	0	*	*	0
Other	0	0	0	0	0	*	0
Missing	0	0	0	0	*	0	0
Total	**19**	**62**	**30**	**12**	**164**	**27**	**10**

**n<5 or secondary suppression; [a] Some had more than one diagnosis recorded*

Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk