



mental welfare
commission for scotland

Compulsory treatment for mental illness in the community – how is it working?

Themed report

February 2024



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

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Foreword – Julie Paterson, chief executive



When community compulsory treatment orders (CCTOs) were introduced 20 years ago they were expected to offer people with serious mental health conditions the opportunity to get full support and treatment at home as they recovered.

We'd last looked at the progress of these orders 10 years ago and wanted to check how they are working now, and if they are fulfilling their promise.

Rising numbers

Data showed us there had been a steady increase in the use of community compulsory treatment orders since their inception, with a 44% rise in the last decade, from 941 in 2013-14 to 1,356 in 2022-23.

We spoke to 92 people who'd been on these orders for over two years, and almost 30 family members. And we heard from over 300 medical and social work staff who worked with people subject to CCTOs.

Concerns over how they are used

We saw the law being used to make people take compulsory medication for many years, but little evidence of planning to support the person to come off the order or receive care and support that might lead to a more positive future – often all they get is medication.

We were really concerned to find that those responsible for reviewing community compulsory treatment orders don't always know the person on the CCTO very well or see them in person before renewing the order.

Family support

When we spoke to people on these orders and their relatives, they supported the situation because they said it guaranteed the individual would get help if there was a crisis. We understand that but don't think it's right – people should not have to live under a legal order just so they get care and treatment when needed.

CCTOs can be effective, but must work better

CCTOs remain a useful way of working in partnership with an individual and their family in their home surroundings rather than in a clinical environment. But we ask why so many people are on them, and for so long (up to 17 years according to our data), without therapeutic support leading to recovery and a better life.

We believe that CCTOs should not be defined by a threat of a return to hospital or removal of services, they should be in the context of a collaborative, comprehensive recovery oriented, inclusive approach.

And the renewal practices we found need to be improved. Change is needed to uphold the rights of those on CCTOs.

Our findings support the Scottish Mental Health Law Review's recommendation to Scottish Government on this issue, and we hope that government can use the detail of this report to further improve the management of these orders and improve the outcomes for this vulnerable group of people.

February 2024

Executive summary

Community-based compulsory treatment orders (CCTOs) were introduced by the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). It was thought that compelling care, treatment and support in the community for some people would be a better option than potentially multiple compulsory admissions to hospital. The positive intention of this approach was to provide stability, support and recovery at home in the community leading to voluntary care and treatment.

Data

The Commission's database confirmed that 1333 CCTOs were in place in August 2022. 821 of these orders were two years old or more. In 508 of these older orders, there had been no variation or return to hospital for the person but instead a continuous, apparently stable CCTO was evidenced from records. It was this group of people we were keen to learn more about to understand why the orders had been retained (for up to 17 years for some people) and why the intention to lead to voluntary care had not been realised for so many people.

We spoke with 92 people who have been subject to CCTOs for more than two years and 29 of their family members. We also heard from 322 staff working with them (community psychiatric nurses, specialist social workers known as mental health officers and psychiatrists).

Community compulsory treatment orders

We heard some positive reports of care and support, particularly involving social care support from third sector providers.

We heard that CCTOs were good because they ensured that the person had access to a psychiatrist, community nurse and mental health officer. There was a perception and indeed experience that this support would not be available without a CCTO. Family members particularly welcomed knowing mental health services were available should they be required.

People seemed to generally accept being on a CCTO believing it to be better than having to be in hospital. The threat of hospital appeared to be the main measure considered with expectation of recovery and hope rarely mentioned.

Those charged with implementing safeguards often failed to do so, with authority to provide medication either not in place, out of date or not understood fully by those administering it. Care planning and review processes were passive with little evidence of dynamic planning looking towards rehabilitation, recovery and supporting the person to claim their economic, social and cultural rights. There was a sense that CCTOs simply often 'trundled' on.

Scottish Mental Health Law Review (SMHLR)

Our findings from this themed work supports the Scottish Mental Health Law Review's recommendation to the Scottish Government:

Recommendation 9.29: The Scottish Government should commission substantial and innovative research:

- *To explain why the use of CCTO has continued to increase in Scotland;*
- *To understand the circumstances which make CCTO effective or ineffective;*
- *To show which groups of people CCTO tends to work for;*

- *To understand the experience of those who receive regular voluntary treatment in the community and who are not on CCTO.*

When someone is compelled by Scotland's Mental Health Act, the safeguards and underlying principles of that act (including providing the maximum benefit to the person and the provision of appropriate services) should be clearly evidenced. Our concern is that we did not always find this to be the case for those subject to CCTOs. We found that once someone is on a CCTO, there is little planning to get off it again. There is therefore a risk that therapeutic outcomes are being replaced with the extension of social control via CCTOs, many of which are remaining in place year after year.

Our work confirms that action needs to be taken now to understand the value or otherwise of CCTOs and to ensure that those who do require community-based orders benefit from them. We therefore look forward to the Scottish Government's response to the Scottish Mental Health Law Review's recommendation 9.29.

In the meantime, based on the current practice we have identified, we make the following recommendations to health and social care partnerships and their respective local authorities and health boards:

Recommendations

Recommendation 1:

The care programme approach or similar integrated framework should be used to support the dynamic care planning, review and revocation strategies for all people who are subject to CCTOs.

Recommendation 2:

Audits must be in place to evidence quality assurance of section 76 care plans completed by responsible medical officers.

Recommendation 3:

Audit processes must be in place to ensure that everyone subject to a CCTO has legal authority under Part 16 of the Mental Health Act in place with recorded dates for review and that treatment recorded on the statutory form remains accurate.

Recommendation 4:

Statutory obligations within section 25-27 of the Mental Health Act should be reflected within eligibility criteria and also the right to the four options of self-directed support.

Recommendation 5:

Social circumstances reports, taking account of economic, social and cultural rights, should be completed by mental health officers annually for those subject to CCTOs or statement given as to why this will serve little or no purpose.

Recommendation 6:

A training needs analysis should be undertaken to ensure a delivery plan to support key staff responsible for ensuring that:

- legal authority to provide treatment is in place, which is current and subject to regular review;
- carers' rights to an Adult Carer Support Plan are understood and upheld; and
- that carers are involved in decision making as far as possible.

Recommendation 7:

Individuals subject to CCTOs and their carers should have information regarding appropriate actions and contacts at times of crises.

Chapter 1: Introduction & methodology

Introduction

The Commission undertakes national themed visits and reports on the care and treatment of particular groups of people across Scotland. During 2022-23 we undertook a themed visit to people whose care was being provided in the community according to compulsory measures laid down in the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). These orders, known as community compulsory treatment orders (CCTOs), were first implemented in Scotland in 2005, they then became available in England and Wales in 2008 and extend to more than 75 jurisdictions worldwide. Whilst Scotland's legislation allows for people to be made subject to CCTOs from the community, other jurisdictions require that a detention in hospital must precede the community order.

In most of these countries, like Scotland, there had been a shift in the balance of care, that is, closure of long-term mental health inpatient beds towards delivery of mental healthcare in the community. It was in this context that CCTOs were regarded as less restrictive options for those people not wishing to accept care and treatment on a voluntary basis in the community; compelling treatment in the community was viewed as a positive alternative to potentially repeated compulsory hospital admissions. The intention was to bring stability, focus on recovery and ultimately voluntary care and treatment.

The Commission made CCTOs a monitoring priority when the Mental Health Act was implemented. In the first year following the implementation of the Act, we visited people subject to CCTOs. At that time, people had only been on the order for a few months. Five years later a more in-depth themed visit – *Lives Less Restricted*¹ – examined the care and treatment of almost 200 people who had been subject to CCTOs for more than two years. A number of recommendations for improvement were made, including the need to regularly consider the grounds for community compulsion at times between mandatory reviews and to develop “a revocation strategy that helps the person to recover to the point where compulsion is no longer necessary”. Our follow up visits in 2015 reiterated similar findings to previous visits and further emphasised the importance of participation of the person subject to the CCTO, ensuring the availability of advocacy support and physical health checks. We also asked local authorities to identify how they could more effectively discharge their duties under section 26 of the Mental Health Act to support people on CCTOs to secure and sustain employment.

In advance of our fourth themed visit in 2022-23, we were aware that the use of CCTOs and the research into their effectiveness over the years continues to cause much debate. Indeed, both the mental health law reviews in South Australia (February 2023)² and in Scotland (September 2022)³ expressed concern that practice was approaching the point where the growth of compulsion in the community was against a backdrop of evidence which suggests that the effectiveness of CCTOs is mixed and in many respects weak. Whilst neither review recommended ending the use of CCTOs, questions were asked about how they have developed and grown. Are they now vehicles of social control and coercion or genuine, individual drivers of therapeutic gain and personal outcomes?

¹ [Lives Less Restricted CCTO 10-11.pdf \(mwscot.org.uk\)](https://www.mwscot.org.uk/wp-content/uploads/2011/10/Lives-Less-Restricted-CCTO-10-11.pdf)

² [mental-health-act-review-final-report.pdf \(adelaide.edu.au\)](https://www.adelaide.edu.au/mental-health-act-review-final-report.pdf)

³ <https://cms.mentalhealthlawreview.scot/wp-content/uploads/2022/09/SMHLR-FINAL-Report.pdf>

And these questions, in turn, lead to the question of effectiveness. Research confirms that there is no one indicator of effectiveness although focus has regularly been on measurements relating to the reduction in psychiatric hospital admissions and the reduction in length of hospital stays.

In this themed visit report, the measurement of effectiveness was not about use of hospital beds but about direct reports from those subject to CCTOs; what difference did it make to their lives, what did it feel like being subject to this order at home, did resources follow these orders and lead to individual outcomes being met? We also aimed to gather information from family members/carers and those staff supporting the person, as part of a care management approach. In this report we therefore begin by reviewing CCTO data in Scotland and continue by providing qualitative information from those that know best about what it means to be on a CCTO.

Methodology

We accessed the Commission's database on 3 August 2022 and confirmed that there were 1333 community compulsory treatment orders (CCTOs) in existence at that time in Scotland. 821 of these orders were over two years old. For 508 of these older orders, there had been no variation or return to hospital but instead a continuous, apparently stable CCTO was evidenced from records. It is this group of people we wanted to speak with.

We chose a representative sample of 150 people from the group of 508 referenced above (representative of age, gender and geographical location). We designed questionnaires for the person, their family/carers and staff working with the person.

92 of the 150 individuals we approached agreed to speak to us directly and help us to complete the questionnaire information. We received 101 responses from community psychiatric nurses (CPNs), 106 from responsible medical officers (RMOs), 115 from mental health officers (MHOs) and 29 responses from carers/relatives. We found that other key professionals such as occupational therapists, speech and language therapists, psychologists and social workers rarely featured in the care and support of those subject to CCTOs.

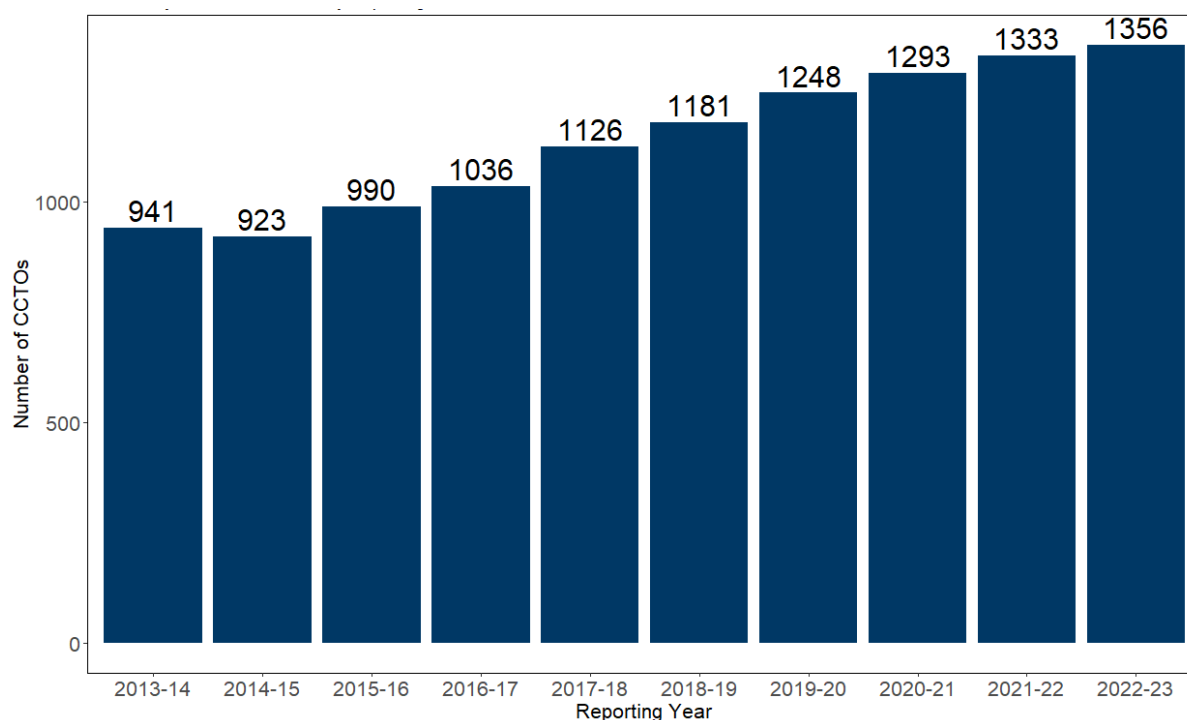
Analysis was carried out using Excel, R and NVivo.

Chapter 2: Data information

The King's Fund undertook early research in 2006 and estimated that there were about 160 people living in the community under a CCTO in Scotland as at 31 March 2006 and commented "the new community-based CTO arrangements seem to be reasonably well understood, and applied only to those for whom they were intended"⁴.

The Mental Welfare Commission's publication in 2022⁵, *Characteristics of compulsory treatment: an analysis to inform future law reform* showed that the number of CCTOs has increased in linear fashion over the years. There were more than twice as many CCTOs in 2021 than in 2007-8. The proportion of CCTOs that were continuing from the previous year was 45% in 2007 and 70% in 2020-21. In other words, the increase in CCTOs over the years is mainly down to more people staying on orders from the previous year.

Figure 1 – Community CCTOs in existence by reporting year



Over the last 10 years the number of people on CCTOs at any one time, has increased with a year-on-year increase from 2015-16 onwards. In 2022-23, there were 1356 people in Scotland on a CCTO, this is the highest figure seen in the last 10 years and represents a 44.1% increase compared to 2013-14.

While the number of CCTOs has increased over the years, the proportion by sex has stayed fairly consistent over the last 10 years since 2013-14, where approximately a third of CCTOs are for females and roughly two thirds for males.

⁴ [Community-based Compulsory Treatment Orders in Scotland: The early evidence - Simon Lawton-Smith - The King's Fund, 20 November 2006 \(kingsfund.org.uk\)](#)

⁵ [CharacteristicsOfCCTOs_June2022.pdf \(mwcscot.org.uk\)](#)

Further analysis of the 508 CCTOs that had been in place consistently for over two years, found the average length of the order was just over five years. However, there were a number of orders which had been in existence for considerably longer than this, see Figure 2.

When we stratified by sex, we found that while the pattern of two thirds of orders being male and one third being female remained consistent for those on orders up to seven years, the proportions were different for those on longer orders. Although the actual numbers of these orders are smaller, the ratio of male to female changes, with those on the longest orders exclusively male.

Figure 2 - Community CTOs longer than two years by length of order (n=508)

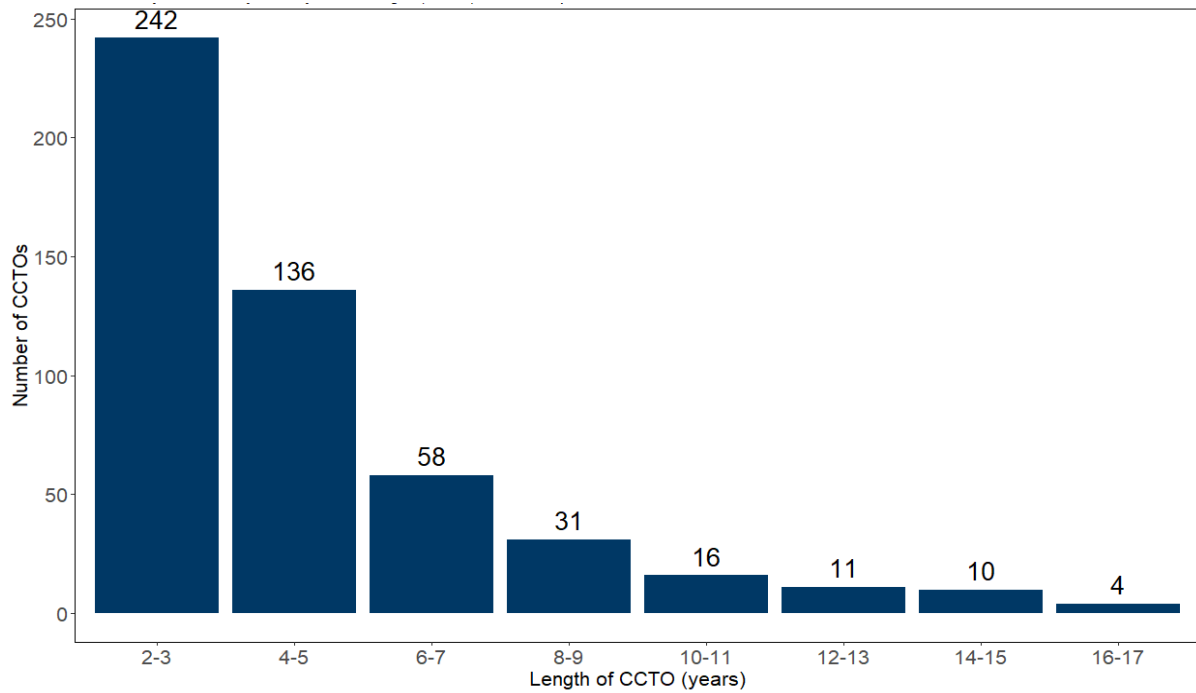
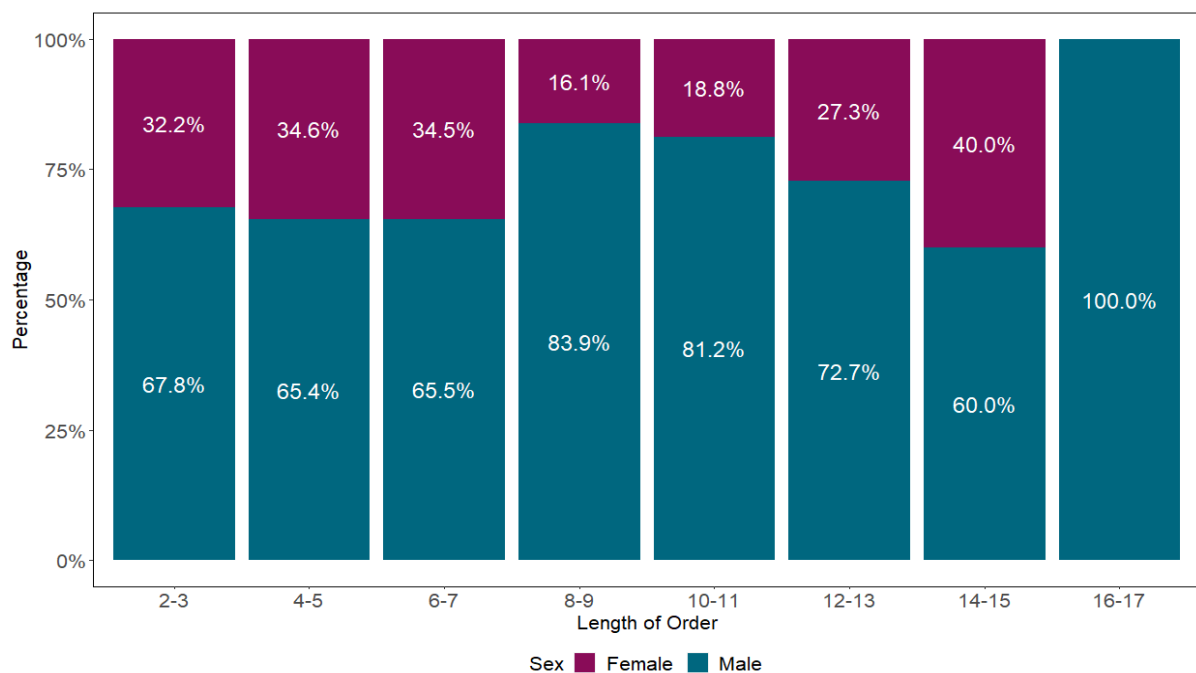


Figure 3 – Community CTOs longer than two years by length of order and sex (n=508)



The data confirms a level of use of CCTOs that is higher than was perhaps intended in 2003 when the Mental Health Act was introduced. Whilst it is acknowledged that treatment at home is preferable to treatment in hospital, if possible (least restrictive), CCTOs are still implemented against the person's wishes, compelling them to receive care, treatment and support and by definition are coercive. Scotland's Mental Health Law Review (SMHLR) report published September 2022 emphasises the need for law reform to reduce coercive practice and recommends enhanced research, monitoring, inspection and individual scrutiny of CCTOs. The Commission agrees and undertook this themed visiting programme to learn more about the impact of CCTOs on individuals, their families and those most important to them.

We sought to gauge the benefits of being subject to compulsory measures, how the order supported individual outcomes and recovery, how it performed in terms of the principle of reciprocity and if there was a commitment to supporting the person to work towards more informal care.

We also wanted to consider the quality of this statutory intervention measured against good practice and the application of the range of legal safeguards inherent in the legislation.

Importantly, we took the opportunity to consider the degree of attention given by professionals to the social, cultural and economic rights of the person, that is, those basic conditions needed to live a life of dignity to include rights to health, to social security, to food, to housing and so on. The chapters to follow therefore include what we heard from the key people affected and involved in the implementation of CCTOs in practice.

Chapter 3: The person

What we expected to find

We expected to find care, treatment and support delivered in line with the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) (see appendix 1). These principles are a set of guidelines informing how professionals should work when providing care and treatment under the Mental Health Act.

In line with these principles, we expected to hear from people who were aware of the conditions attached to their order and their rights associated with this and fully involved and participating in decisions about their care. Likewise, where appropriate, we expected to see carers and family fully included as critical partners in that care (see chapter 7).

We expected evidence of care and treatment delivered in a person-centred way with the full protection of available safeguards in place with a focus on recovery and what mattered to the individual. This might include flexible, creative self-directed care options, shifting control to the individual and ensuring a tailored response to assessed need.

Given our focus on those people who had been subject to a compulsory order in the community for more than two years, we expected that sufficient time would have elapsed to ensure prioritisation of their social, economic and cultural rights and that this would be demonstrated by living in an environment suitable to their individual needs and with the support necessary to work towards personal outcomes, promoting opportunities to participate in activity meaningful to them, including employment, where indicated. We expected to find that incomes had been maximised and where required, support was provided to manage finances to the benefit of the individual. Links with communities would also be a positive feature of well-being and recovery focussed support.

Whilst these components should form the basis of any intervention, this is arguably more of a requirement for a person whose life and choices are restricted by being subject to a CCTO, a legal order which is underpinned by practice principles and the principle of reciprocity in particular.

What we found

We spoke with 92 people who had been subject to a CCTO for two or more years (the average was a little over 5 years for those we spoke with). None of the people we met had been admitted to hospital during the course of the orders in place.

The breakdown of those interviewed is shown below:

Table 1 - Individual respondents' descriptive information

Variable	Category	n (%)
Gender	Female	30 (32.6)
	Male	62 (67.4)
Age range	25-44	24 (26.1)
	45-64	57 (62.0)
	65-84	11 (12.0)
Current service area	Ayrshire & Arran	7 (7.6)
	Dumfries & Galloway	2 (2.2)
	Fife	5 (5.4)
	Forth Valley	8 (8.7)
	Grampian	11 (12.0)
	Greater Glasgow and Clyde	21 (22.8)
	Highland	8 (8.7)
	Lanarkshire	8 (8.7)
	Lothian	12 (13)
	Tayside	10 (10.9)
Diagnosis*	Mental illness	91 (98.9)
	Personality disorder	2 (2.2)
	Learning difficulty	3 (3.3)
Named person	Yes	35 (38.0)
	No	54 (58.7)
	Missing	3 (3.3)
Important person	Yes	39 (42.4)
	No	42 (45.7)
	Missing	11 (12.0)
Interview	Face-to-face	71 (77.2)
	Virtual	10 (10.9)
	Not completed	7 (7.6)
	Missing	4 (4.3)

*some people will have multiple diagnoses so will add up to more than 92 or 100%

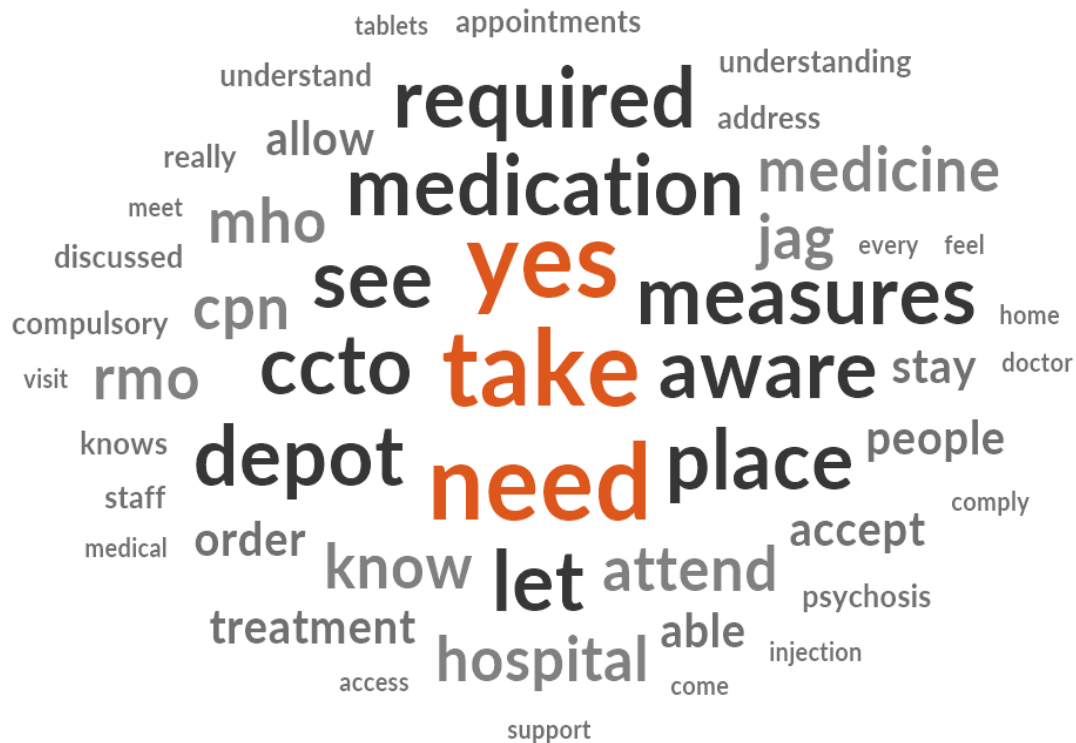
91 out of the 92 people we met with had a diagnosis of mental illness. 72% of people were diagnosed with a schizophrenic type illness and 7.6 % with a bipolar type illness. 64% of those we met told us they were receiving antipsychotic medication via a long-acting injection.

We asked people about their understanding of what being on a CCTO meant for them.

Just under half of those interviewed agreed that they understood the compulsory measures they were required to comply with as a result of being subject to the order while others demonstrated partial knowledge of the scope and limitations of the order as it pertained to

them. The most commonly quoted measure reported was compliance with treatment, with less knowledge of restrictions on where they should live, engagement with key professionals or consent required from the mental health officer (MHO) should they consider changing address. (See Figure 4)

Figure 4 – World cloud for awareness of measures



Generally, there were more negative feelings toward the imposition of the CCTO than positive. Acceptance or indifference was also evident. However, when compared with hospital admission 73% of the people we spoke with said they would prefer to be on a CCTO:

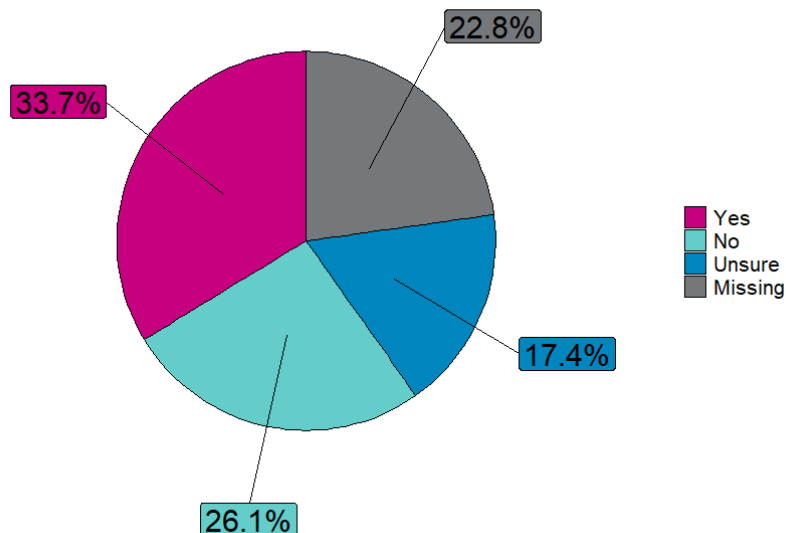
"Definitely better than hospital."

"[person] said that he would rather not be on any order however he would rather be living in the community than in hospital."

"I just don't want to be on any of it. Community based CTO is the best of two evils."

We asked people about any benefits of having been on a CCTO for two years or more. Only 33.7% of the people we spoke with were positive about the order's impact describing this once again in terms of staying home and out of hospital, but also that it enabled them to access support as well as giving structure and stability.

Figure 5 – Benefitted from CCTO



"It's given me more stability, kept me out of hospital and here in my home. The OT came and has given me a bath lift so I can get my baths independently. That's a benefit."

"I know I would stop taking my medication – I don't think I should be alive so I need it... I have a lovely life with it."

"Made me accept that I had to see people. Was scary at the start but now used to everyone and trust them."

Some people did not see any benefits:

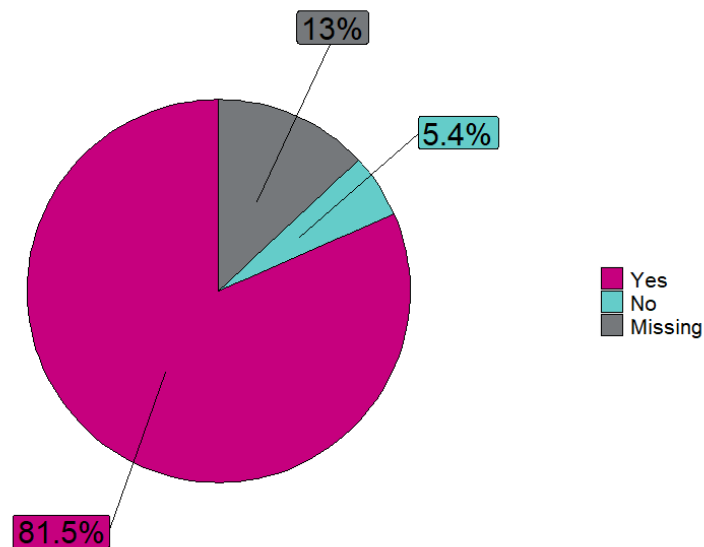
"Doesn't believe he has benefitted as is being forced to take Clozapine which has made him 5 stone overweight. Has been in and out of hospital in the past and thinks this is impacting what should be the best years of his life."

"No not at all."

"Can't really see any benefits, would still take medication and attend appointments without it."

We asked if people were aware of their right to appeal the CCTO:

Figure 6 – Aware of Right to Appeal



32 people had appealed their CCTO, 44 had not and 16 people did not answer.

When looking at the details of the CCTO appeal, there were some distinct themes including the support people had. Most said their appeal had failed, with only a very small number of people saying that they had previously won an appeal. Some people also made reference to having issues with the system.

"No chance against the professionals- they all stick together."

"I'm not sure how anyone wins if you've been on an order for a while."

"The meeting was ok, they were all friendly but felt like it was a foregone conclusion, they'd decided before it started."

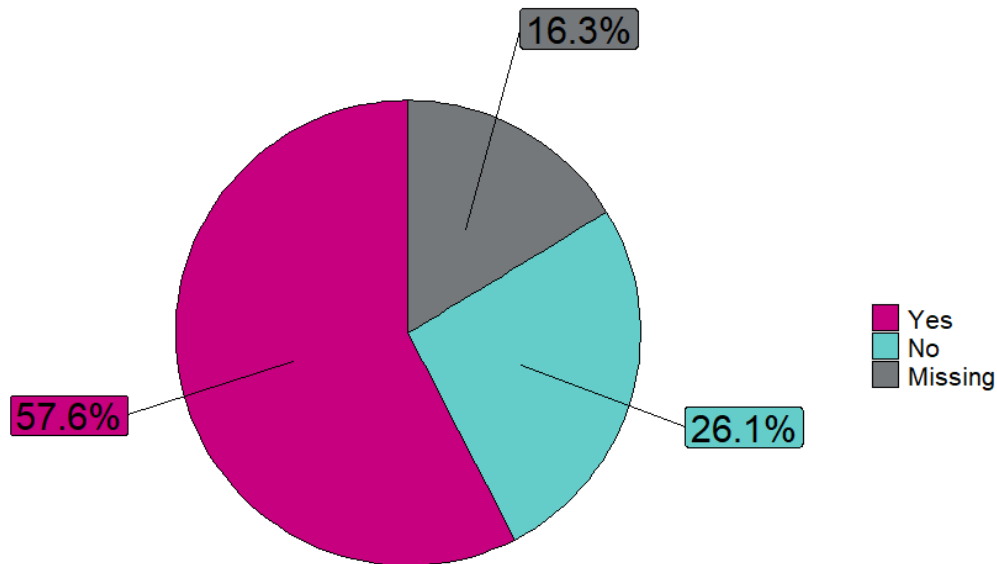
Community care and treatment

CCTOs are designed to ensure that those who need treatment but are well enough for that treatment to be delivered outside hospital get the care they need even if they are not willing to accept it voluntarily.

The principle of reciprocity "Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion" (appendix 1) dictates that those on CCTOs should receive particular support so that, over time, they will be able to choose to engage voluntarily.

We started by asking people how involved they felt in their care and treatment in the community; the graphic below shows the response we received:

Figure 1 – Involved in decision making



Almost 58% of the people we spoke with reported that they felt involved in decisions about their care and treatment with some good examples of collaborative working in response to concerns raised by the person.

"Feels he can talk about things that are part of his 'order' - money, activities, and his physical health. "

"She has told them that her medication was not working for her so her medication was changed."

"Involved in decisions about his care plan in the supported accommodation and meets with his keyworker regularly to review and chat about his support needs."

Others told us:

"Doesn't listen to me. Just says the jag keeps you well and I need to stay on it."

"It feels as if I have no control. I always ask for a reduction in aripiprazole but RMO isn't listening to me."

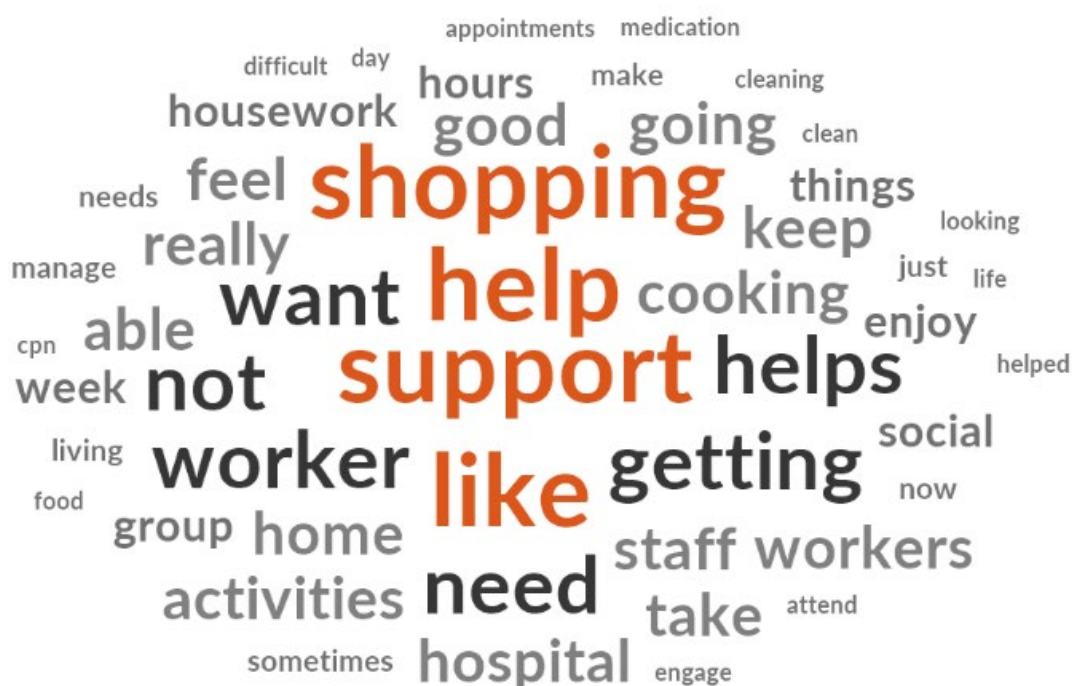
"He feels all of the professionals involved in his life make decisions for him."

A third of people who answered this question stated that they did not want family involved in decision making about their care and treatment.

We asked if people felt that they were benefitting from the care and support in place. 48 people said they were, 16 people said they were not benefitting, 16 were unsure and the remaining 12 did not answer.

We also asked if the support helped individuals to do the things that they wanted to do. 34 people said that it did help them, 20 people said it partially helped them and 12 said it did not help. 26 people chose not to answer the question. When asked about details of that support, we were told about examples of practical support and access to activities provided by highly regarded third sector professionals. Some people felt that they needed more support and some felt that they didn't need any support.

Figure 8 – Details of support



We asked whether people knew about the options available under self-directed support (SDS), only five people said they knew about SDS. Of those using SDS, reviews were regular and good creative outcomes reported:

“Community-based support. I take part in deciding what my needs are; then SW arranges the support.”

“Mainly social and recreational activities in the community. At present I have my hair done weekly, I attend slimming world and my weekly massage. However, I have used it more recently to install ring doorbell cameras. I am allocated an annual budget in accordance with my outcomes I want to achieve to enable me to live happy and safe in my own home. I don't manage the budget.”

We found that only 19 of the people we met with had a written crisis plan in place should support be required out of hours or at weekends.

As stated previously, we were also keen to hear from individuals about their social, cultural and economic needs and what was important to them to flourish and aim towards care and support on a voluntary basis.

Housing is a basic need and most reported positively stating that they liked their accommodation (this was supported by observations by Commission staff about the standard of accommodation), that it was in a good location, was near family or friends or that they had support, help and good neighbours or there were adaptations that helped.

Negative comments related to people wanting to move away, the accommodation being in a poor state, or that support was required.

We asked on a scale of 1 (not satisfied) to 5 (very satisfied) how satisfied people were with the range of employment or meaningful activities available to them. Most (60.8%) of those who answered gave a score of 4 or 5 indicating that they were satisfied or very satisfied with what was on offer to them. One person told us:

“The support has helped me to gain employment. Although this did not work out, he said he was pleased to have tried paid employment.”

19% scored 1 or 2 suggesting that they were not satisfied with what was available in terms of employment or meaningful activities.

Finance is also extremely important. 49 of the people we spoke with said they managed their own finances, whilst 22 people said they did not manage their own finances. Eight people weren't sure about the question (there were 13 responses missing).

Table 2 – Financial support for those who do not manage their own finances

Financial support*	n (%)
DWP appointee	15 (68.1)
Financial power of attorney	2 (9.1)
Part 3 - AWI	0
Part 4 – AWI	2 (9.1)
Financial guardian	7 (31.8)
Other	5 (22.7)

**some people will have multiple sources of support, therefore figures add up to more than 22 or 100%*

Other support included parents, spouse and support staff. People were also asked if they had had support to maximise the monies that they were entitled to. 47 people said that they had had support, eight had not, 19 people weren't sure if they had received support of this nature and 18 people chose not to answer this question.

When asked if they had any concerns about their financial situation, 11 people said they did whilst 65 people had no concerns. Seven of the people who had financial concerns said they had discussed this with someone, this included family, MHOs and support staff, while four people had not.

When asked about the outcomes of discussions, the following comments were given:

"Felt it was helpful - good to have someone to support me but not take over."

"They referred me to a food bank."

"Helped get my debts sorted out but still struggle."

We asked about overall satisfaction with the person's living situation, finances or support arrangements in place. Many people said they were satisfied, some mentioned that access to further support was needed whilst others spoke about accepting medication and being able to access activities.

"Happy with my lot - I feel settled now."

"Everything feels a bit more stable."

"I am satisfied with my living situation for the time being – I've lived here for a long time and get on well with most of the staff. I keep myself to myself. I wouldn't like to think I would be here for the rest of my life but I'm not sure how I would manage on my own."

There was a smaller proportion of references made to not being satisfied, with concerns relating to finance, limited opportunities to input to care, lack of activities, support having been withdrawn or not having access to physical health checks, and also isolation.

Even where people told us they were 'satisfied' or 'happy with their lot', we wondered what the benchmarks were. Commission visitors did not get a sense of hope, aspirational expectations or belief; the measure tended to be that the community arrangements were better than the threat of being in hospital.

Despite the principle of reciprocity, the reported approach to supporting people subject to CCTOs was not assertive but akin to those people not subject to compulsory orders, however it was noted that being on a CCTO was more likely to ensure named workers (nurses, mental health officers and psychiatrists) and where charges applied for care, for these to be waived.

Our interviews with individuals did not evidence commissioning of any additional community resources for people subject to CCTOs and appears to continue to reflect the King's Fund research of 2006: "Despite a Scottish Executive commitment to provide significant extra funding to implement the community-based CTO provisions, interviews suggest that there is little or no frontline awareness of any increase in resources".

Chapter 4: The role of the responsible medical officer (RMO)

What we expected to find

Section 230 of the Mental Health (Care and Treatment) (Scotland) Act 2003 requires the appointment of a responsible medical officer (RMO) “as soon as is reasonably practicable after the occurrence of an appropriate act in relation to a patient”. A CCTO is defined as an “appropriate act”. The RMO is appointed by the relevant hospital managers and is the medical practitioner who is responsible for the person’s care and treatment whilst they are subject to the order. We expected there to be an RMO in place for everyone we met with.

Like other professionals, the RMO is bound by the principles of the Act in any intervention carried out under the order. A key duty of the RMO is to review the community order regularly to consider whether the conditions of the Mental Health Act continue to apply. The order should be reviewed within set timescales and this review has a number of potential outcomes:

1. The order can be revoked;
2. The order can continue with the same conditions until the next statutory review period;
or
3. The order can continue but conditions attached to the order can be varied in light of changes in the person’s circumstances.

Section 76 of the Mental Health Act requires the RMO to prepare a care plan relating to the person and to ensure that this care plan is included in the person’s medical records. We expected to locate these care plans and find that they were comprehensive, setting out the medical treatment being given/proposed, describing all the person’s needs and wishes, including those referred to in an advance statement, thereby leading to the provision of an appropriate range of services. We expected to see section 76 care plans which were person-centred, recovery-focused, inclusive of the person and their family/carers and regularly and meaningfully reviewed.

We would suggest that it is also good practice for the section 76 care plan to incorporate the person’s main multidisciplinary working care plan, rather than be a stand-alone document. This can avoid unnecessary duplication and confusion. Statutory content that may not have been routinely included in the individual’s main care plan can be added.

The principles of the Mental Health Act also make it clear that the views of any carer of the individual should be taken into account when decisions are made about the person’s treatment and we expected evidence of carer involvement where appropriate. There is also a statutory requirement to consult the named person within these decision-making fora; the named person is nominated by the person subject to the order and has a right to be informed and consulted about aspects of the person’s care.

For those people with complex presentations and the involvement of a number of services, agencies or carers, we expected to see the use of the care programme approach (CPA). The CPA⁶ was originally developed for people with severe and enduring mental illness in 1996 via Scottish Office Circular SWSG 16/9. Unlike in England, where CPA was mandatory, this circular simply recommended CPA for use in Scotland. We however consider that the CPA should be

⁶ [Memorandum of Procedure on Restricted Patients \(www.gov.scot\)](http://www.gov.scot)

used for individuals with a mental illness and complex support needs. This helps to support effective, inclusive and well co-ordinated ongoing care.

Part 16 of the Mental Health Act contains special safeguards for any medicine given as treatment for mental disorder beyond two months. For these treatments the following is required:

Table 3 – Requirements for Part 16

Clinical situation	What Part 16 requires
Where a person is capable of consenting and does so	Written consent and certification on form T2B
Where a person is capable of consenting and refuses	Designated Medical Practitioner opinion on form T3B with statement as to why treatment should be given
Where person is incapable of consenting but does not resist or object	Needs Designated Medical Practitioner opinion on form T3B
Where the person is incapable of consenting and resists or objects	Needs Designated Medical Practitioner opinion on form T3B

During our themed visiting programme, we expected to see legal authority in place for all treatment given under Part 16 of the Mental Health Act and detailed within T2B and/or T3B forms as appropriate. We expected to find current T2B and T3B forms detailing the review period and certainly no older than three years. Where treatment had changed during this period, we expected to see this updated by the RMO.

What we found

All of the people we visited said they had a designated RMO although we heard that there was often a different RMO for each review. We were told that this lack of consistency impacted on relationship building which is important to individual outcomes. People who were subject to CCTOs reported that they often did not see the same medical practitioner twice and that routine appointments tended to be undertaken by junior doctors on behalf of the RMO and that the junior doctors changed on a very regular basis; this made it difficult to establish a working relationship and often resulted in individuals we spoke with having to explain their circumstances repeatedly.

106 RMOs engaged with us in this piece of work. We asked them how often they met with individuals and the results of this are shown below in Table 4.

Table 4 - Frequency of visits

Frequency	n (%)
Weekly or fortnightly	3 (2.8)
Every 1-2 months	6 (5.7)
Quarterly	34 (32.1)
Less often	52 (49.1)
As required	3 (2.8)
Info yet to be established or missing	8 (7.5)

Almost half of the RMOs who responded confirmed that they did not meet with the person on a CCTO very often (less often than four times per year) around a third saw them quarterly. Only a very small proportion of RMOs saw the person more often than four times per year; analysis of frequency of contact with the RMO highlights that this contact is likely to be based on mandatory review timescales.

A person who is subject to an equivalent hospital-based CTO, is likely to be seen by the RMO or a doctor reporting to the RMO on a weekly basis, so the parity of access to the RMO for someone in the community is significantly different. Whilst it can be argued that clinical need will dictate the regularity of contact with a doctor, that same assessment of clinical need should also inform the requirement for a CCTO to continue or not.

Similarly, we asked how often RMOs spoke with the named person and the results of this are shown in Table 5.

Table 5 – Frequency of named person contact

Frequency	n (%)
Weekly or fortnightly	1 (0.9)
Quarterly	8 (7.5)
Less often	31 (29.2)
Not spoken to named person	5 (4.7)
As required	1 (0.9)
No named person	32 (30.2)
Info missing	28 (26.4)

Of the 46 people we met who had nominated a named person, contact with the RMO was again sporadic. The named person role is an important safeguard under the Mental Health Act but unless it is afforded the full range of rights and responsibilities, we would argue that the effectiveness of the role is significantly reduced.

Care plans

Implemented well, and in accordance with the principles of the Mental Health Act, care plans and care planning provide a participatory framework for agreeing and reviewing the benefits of a given programme of treatment and care, together with an individual and their carers, as appropriate, in the context of their recovery.

Practice in section 76 care planning is guided by regulations⁷ which set out the information that must be contained in the section 76 care plan and in the Mental Health Act's Code of Practice⁸.

⁷ <https://www.legislation.gov.uk/ssi/2005/309/contents/made>

⁸ <https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-of-practice-volume-2-civil-compulsory-powers-parts-5-6-7-20/pages/5>

The Commission's good practice guidance⁹ also details the components of a good section 76 care plan and we used this good practice guide to assess the quality of the care plans we scrutinised.

We saw very few examples of care plans which evidenced consideration of all recommended elements of a person's care, most focussed predominantly on the delivery of treatment under Part 16 of the Mental Health Act.

Where section 76 care plans were assessed by Commission visitors as "good" and evidenced some detail over and above Part 16 treatment, these were generally compiled as part of a care programme approach (CPA) process.

We heard that some areas had adopted a policy of implementing CPA for all care planning in relation to CCTOs and we deemed this to be best practice as it ensured effective multi-disciplinary engagement, maximised opportunities for good communication between all parties and triggered a good record of discussion and crucially, decisions made. This, in turn, generated a revised current care plan and ensured intervention, both as part of a compulsory measure or delivered on a voluntary basis, and was targeted and working towards a recovery focus.

In some areas we saw the use of section 76 care plan templates which clearly drew on the Commission's good practice guidance, and where these were in operation we did see more care plans evidencing consideration of the wider holistic intention of the legislation. However, this was by no means consistent as we also noted that where the templates were used, there was still a tendency for many RMOs to concentrate only on the provision of the delivery of treatment under Part 16 of the Act and the wider considerations were either left blank or recorded as "not applicable".

Advance statements are powerful ways of allowing the voice of a person who may require mental health care, treatment and support to be heard at times when they may be so unwell that, despite support, they cannot fully express those wishes. We found that this section of the care plan template was left consistently blank by RMOs. Good practice would suggest that where there is an advance statement this should be attached and where there is no advance statement, confirmation recorded that this has been offered and/or that plans are in place to support the person to consider this safeguard in future.

Whilst we found section 76 care plans for the majority of the people we visited, not only did we find that many were only partially completed, we also found that a number of the care plans remained the same as when the order had been originally granted some years ago, simply attached again and again to subsequent applications to extend orders.

Of the 92 people we visited, the average duration of compulsory measures was just over five years; it would be difficult to accept that the needs of the person had remained constant over such a significant period of time leading to the same care plan year on year.

In 2010, the Commission recommended "a revocation strategy that helps the person to recover to the point where compulsion is no longer necessary". However, over a decade later, we still found a lack of consideration of planning towards either revocation and/or what would need to occur for revocation to be considered; in other words, there seemed to be a passive acceptance of continuation of the order. During our visits we noted that one person had

⁹ [Preparation-CarePlans-PeopleSubjectToCompulsoryCareTreatment_October2021.pdf \(mwscot.org.uk\)](https://www.mwscot.org.uk/Preparation-CarePlans-PeopleSubjectToCompulsoryCareTreatment_October2021.pdf)

formally requested that they be treated on an informal basis and a plan was put in place to work towards this goal. This was led by the person themselves and fully supported by the RMO and the multidisciplinary team.

It would seem from our visits that CCTOs are often extended on a year-to-year basis, with no dynamic review or planned exit strategy, leading to CCTOs potentially being used as an additional control in situations which might have been managed informally in the community prior to the Mental Health Act. From what we learned it was not clear that this was intended but, instead, it was a default position because of failure to actively consider the CCTO and its powers in the spirit intended by the Mental Health Act.

Medical treatment under Part 16 of the Act

The Mental Health Act includes a unique criterion for the use of compulsion in the delivery of mental health care and treatment. In Scotland, a person must exhibit “significantly impaired decision-making ability” before they are deemed eligible for detention or involuntary treatment. This is referred to by the acronym “SIDMA”. For both emergency and short-term detentions under the Mental Health Act, the RMO must believe that the person is likely to have SIDMA but for compulsory treatment orders (CTOs) the person must be shown to have SIDMA.

RMOs are required to evidence not only the presence of SIDMA but also require to show that SIDMA is caused or explained by the person’s mental disorder or impairment. Whilst there is both a Code of Practice¹⁰ and a Training Manual¹¹ available to practitioners for guidance in the assessment of SIDMA, the Mental Health Act offers no definition of SIDMA. Consequently, this can lead to considerable variation in evidencing SIDMA in practice. This is not a new issue and previous studies have highlighted an over-reliance on impaired insight, often without a clear link between impaired insight and how this affects the person’s decision-making ability.

The Mental Welfare Commission published guidance on the assessment of SIDMA in the context of eating disorders. In this document we deemed the SIDMA field to be formally complete only if it met all three of the following conditions:

- (a) It reported on specific symptoms of a mental disorder;
- (b) It indicated which component(s) of the overall decision-making process was impaired;
and
- (c) It indicated that there was a link between these first two elements.

During our themed visit to people on CCTOs, we saw further evidence of the variation in the quality of assessment and evidence of SIDMA as recorded in the statutory form CTO3a, Determination to Extend a CTO. We noted that few would satisfy the above conditions detailed in our guidance. Some examples are given below:

“Continues to lack insight.”

“His thought process is disordered.”

“Ability to make decisions is significantly impaired.”

¹⁰ Scottish Executive Mental health (care and treatment)(Scotland)Act 2003.Code of practice. Volume 2- civil compulsory powers.2005 <https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-of-practice-volume-2-civil-compulsory-powers-parts-5-6-7-20/>

¹¹ Scottish Executive Approved medical practitioners. Mental health (care and treatment)(Scotland)act, 2003 training manual.2005. <https://www.gov.scot/publications/approved-medical-practitioners-mental-health-care-treatment-cotland-act-2003-training-manual>

More detailed evidence was available in some instances:

“X has long term fixed delusional beliefs as a result of her diagnosis of schizophrenia which leads her to believe that she does not have a mental illness and she is therefore unable to contribute meaningfully to decisions about her treatment.”

Where the person had been subject to a CCTO on a longer term, often CTO3a forms simply repeated the rationale for SIDMA from previous extension paperwork on subsequent extensions, often despite this being completed by a different RMO and without any reference to any interventions that may have been put in place to try to address the grounds for SIDMA.

In most of the paperwork we reviewed, SIDMA seemed to be a static element of a person’s presentation where, in reality for some, it is a far more dynamic assessment and one which has potential to change as a result of appropriate intervention.

This landscape was further complicated by the relationship between SIDMA and the ability of the person to consent to medicines/treatment under Part 16 of the Act.

As described earlier, Part 16 of the Mental Health Act contains special safeguards for any medicine given as treatment for mental disorder beyond 2 months (T2B/T3B forms). During the visit, we reviewed the legal authority for this treatment to ensure that this was in place, current and appropriate to the particular needs of the person subject to the order.

Table 6 - Findings in relation to T2B/T3B forms (total 103)

Status	n* (%)
T2 - Valid	29 (28.2)
T3 - Valid	44 (42.7)
T2 - In place but requiring review	6 (5.8)
T3 - In place but requiring review	16 (15.5)
Expired	8 (7.8)

**there were 103 forms relating to 102 people*

The findings detailed above demonstrated that 71% of people who were receiving treatment under Part 16 as a compulsory component of the CCTO had the appropriate legal authority in place, whilst 29% were receiving treatment which was not properly authorised or reported under the Act. This was as a result of the T2B/T3B form having expired, in some instances for lengthy periods or indeed where they were absent. In addition, there were a number where the medication authorised had either changed or been discontinued and a different treatment commenced without forms being amended to reflect the change, therefore these forms required review.

There were also a number of T2B forms which we questioned and this highlighted some anomalies within the application of the legislation.

As described previously in table 3 above, the T2B form is used where a person is capable of consenting and does so, providing written consent and certification on the T2B. During the course of the visits, Commission visitors had the opportunity to review the range of legal documentation relevant to each person and this highlighted tension between information provided on the CTO3(a) - the Determination to Extend the CTO and the T2B.

Within the CTO3(a) there is a requirement that the RMO evidences the criteria for ongoing detention, one of which is that the person's "ability to make decisions about the provision of such medical treatment is significantly impaired", known as the SIDMA test, discussed above. Commission visitors noted that often the evidence given as evidence of SIDMA was contrary to the use of a T2B which confirmed that the person was capable of consenting to treatment under Part 16 of the Mental Health Act and did so.

Practical examples might be helpful here to illustrate the complexities at play.

Case 1

CTO3(a) records Y's "ability to make decision is significantly impaired. They have no understanding of their diagnosis. They do not believe that they have a mental illness and do not see the need for either medication or indeed the CCTO2.

Y has a section 47 certificate in place to authorise treatment for a range of treatment for physical health conditions as they have been deemed to lack capacity to consent to this.

Y has signed a T2B consenting to oral anti-psychotic medication, oral benzodiazepine and an anti-depressant."

While it is argued that SIDMA under the Mental Health Act and capacity under the AWI Act are not the same, this combination of the use of different legal safeguards is confusing and potentially difficult to understand and justify.

We were pleased to see a care plan in place where the person was consenting to the treatment – the most recent section 76 care plan noted that whilst this consent was in place, staff should revisit this prior to any administration of treatment as consent had in the past fluctuated depending on the person's mental state at any given time. We regarded this as a dynamic response which promoted self-determination but was subject to ongoing review to ensure consent remained informed and valid.

During our visiting programme we were concerned to find a number of T2B/T3B forms had expired and in one area we found 80% of the people we visited did not have appropriate authorisation in place. We followed this up and have been assured that this is a practice within the area which has been subject to an audit and an action plan is now in place to promote improvement to ensure that this legal authority is current and accurate.

Case 2

On checking records for Z, it was noted that the T3B had expired in 2021 although Z had continued to receive treatment under Part 16 of the Mental Health Act. At the time of our visit, Z's care was being reviewed by the RMO and consideration was being given to recall as a consequence of non-compliance with compulsory measures of the order (Z had not been taking prescribed oral medication). This action could have been subject to legal challenge and was duly addressed and resolved.

Whilst we were assured that there were administrative processes in place to ensure timeous review of this safeguard (T2/T3), it was important to remind RMOs of their statutory responsibility to complete this information and indeed for the community psychiatric nurse (CPN) to be aware of what authority was in place when they administer medication (see chapter 6).

Chapter 5: The role of the mental health officer (MHO)

What we expected to find

A mental health officer (MHO) is a social worker who has special training and experience in working with people who have a mental illness, learning disability, dementia or related condition. Under the Mental Health Act, local authorities have a statutory duty to “appoint a sufficient number of persons for the purpose of discharging, in relation to their area, the functions of mental health officers under the Mental Health (Care and Treatment) (Scotland) Act 2003, the Criminal Procedure (Scotland) Act 1995 and the Adults with Incapacity (Scotland) Act 2000”.

We expected to find designated MHOs for the people we met, with responsibility to support, promote and protect the rights of the individual subject to the CCTO. In order to provide continuity of care, we expected to see best practice whereby the MHO who was designated after the making of the CTO, was the same MHO who made the original CTO application. Indeed, our expectation is that local authorities seek to minimise the number of changes in the designated MHO throughout the period which the person is subject to compulsory powers.

We expected the MHO, like the RMO, to have regard to the principles of the legislation (appendix 1). We expected to find clear evidence of the MHO’s commitment to ensure that the person on the CCTO was able to participate as fully as possible in the processes involved in applying for and determining the CTO and providing such information and support to the person, as necessary, to facilitate that participation.

Importantly, we expected MHO practice to reflect the code of practice. The code of practice¹² states that it is important that the MHO’s input to the person’s care does not lapse immediately or shortly after the CTO is made only to be revived at the time of a mandatory review several months later. That is, the MHO requires to be an active participant in the person’s care and not simply a passive recipient of information. This could necessitate, among other things, regular liaison with the person’s key workers and care managers, where appropriate. We therefore expected an MHO, participating in a mandatory review of a CTO, to have a well-informed and, preferably, first-hand view of the person’s recovery and progress since the CTO was made. This could be through periodic assessment and review of the care plan ideally integrated with the RMO’s responsibility to review the CTO ‘from time to time’.

Finally, the Mental Health Act defines the ‘relevant events’ (section 232(1)) that trigger the requirement for an MHO to prepare a social circumstances report (SCR) for the person’s RMO and the Mental Welfare Commission. The making of a CTO is deemed to be a relevant event and should, therefore, trigger an SCR. Our good practice guidance on *Social circumstances reports*¹³ recommends that an annually updated SCR should also be provided by the designated MHO for all people subject to long term orders. Exceptions to this would be where there are agreed alternative review arrangements in place e.g. care programme approach reviews that involve MHOs.

Given that the average duration of CCTOs for the people we visited was approximately five years we expected to find SCRs in place, updating and analysing the interaction between the

¹² [Chapter 4 the compulsory treatment order and the interim compulsory treatment order in operation \(part 7 chapters 2, 3 & 7 or sections 72 to 76 and 127 to 129\) - mental health \(care and treatment\) \(scotland\) act 2003 code of practice volume 2 ?civil compulsory powers \(parts 5, 6, 7 and 20\) - gov.scot \(www.gov.scot\)](#)

¹³ [SocialCircumstancesReports_GoodPracticeGuide_2022_1.pdf \(mwcscot.org.uk\)](#)

person's health and social circumstances, providing information instrumental at the point of consideration of extending or otherwise compulsory measures. We expected that MHOs understood the importance of an SCR and the different purpose of an MHO section 86 determination report (see glossary).

The MHO role and arguably the SCR could be viewed as important vehicles in the overall recovery agenda, looking beyond the medical model of care to encompass the social, economic and cultural needs and rights of the person and, in so doing, promoting a longer-term recovery platform reducing the element of coercion. We therefore expected the role of the MHO, trained to take a holistic approach, viewing all major facets of a person's life, to feature strongly in the care and support of the people we met on CCTOs.

What we found

During the course of this themed visiting programme we made contact with 115 MHOs who were designated MHOs for the purpose of the CCTO.

We asked how often MHOs were in contact with the person subject to the order. The responses are detailed below.

Table 7 - Frequency of visits

Frequency	n (%)
Weekly or fortnightly	3 (2.6)
Monthly	19 (16.2)
Every 1-2 months	3 (2.6)
Quarterly	32 (27.8)
Less often	46 (40.0)
As required	2 (1.7)
Yet to be established or missing	10 (8.7)

Around 21% of MHOs were in contact more often than quarterly, 27.8% quarterly, with half of those we asked visiting less often. Further analysis showed that these contacts were likely to relate to formal review process timescales, contrary to the code of practice.

MHOs advised us that their involvement was predominantly around reviewing the CCTO and liaison with other professional services, rather than direct involvement with the person subject to the order. It is difficult to know on what basis decisions were being taken at these key review stages without direct involvement with the person to elicit their views of how the compulsory measures were impacting on their lives, their recovery and the need for these measures to continue.

This low level of direct contact by the MHO and RMO (noted in the previous chapter) calls into question the degree to which decisions are made collaboratively with the person themselves as opposed to a model of decision making which is predominantly professional. The practice we found reinforces concerns about CCTOs in practice being a coercive model of being 'done to'.

There were instances where we found involvement of both the MHO and an allocated social work care manager with distinct roles of overseeing the statutory element of the intervention and the day-to-day management of the care plan and contact with the individual. However, this dual allocation was only evident in 32% of all the cases we visited. Where this arrangement

was in place, contact was more regular and offered a more intensive intervention for a person whose life was restricted by being subject to compulsory measures. In these cases, we determined that this level of involvement was more in line with the principle of reciprocity and offered a more holistic overview of how the compulsory measures addressed the person’s identified needs.

Given that, in most cases we looked at, there was involvement only at the point of review/extension, our view is that this MHO practice risks becoming perfunctory and a means to an end, with practitioners tasked with providing information to justify the extension per se rather than a comprehensive review of the person’s holistic circumstances and the ongoing need for compulsion.

We asked MHOs if there was a current social circumstances report (SCR) which detailed the relevant circumstances of the person subject to the order. From reported responses and cross checked on the Mental Welfare Commission’s information system we found that 44% of the people we visited did not have a SCR on file.

56% of those we visited did have a SCR on file however most could not be described as current. Table 8 shows when these SCRs were completed.

Table 8– Year last SCR was completed

Year	n
2023	2
2022	5
2021	3
2020	4
2019	12
2018	10
2017	4
2016	4
2015	1
2014	7
2013	5
Older than 10 years	7

We discussed the reasons for not completing an annual SCR with MHOs and the reasons given for this were varied.

The most prevalent response was that compiling an SCR was seen as a duplication in activity as this information had been recorded in a report by the MHO under section 86 – determination to extend a CTO. Practitioners should be mindful of the different purposes of these two reports and MHOs and their managers should consider if the information provided in the section 86 report fulfils the requirements of a good SCR, thereby triggering a notification that a further SCR “would serve little or no practical purpose”. The Commission has previously noted that the decision that an SCR “would serve little or no practical purpose” is often not measured against MHO National Standards or indeed any local practice guidance but rather left to an individual MHO to assess and as a result is inconsistently applied.

Some MHOs advised that there had been no relevant changes in the person’s social circumstances since the last SCR had been completed. Given that almost 50% of SCRs we saw were more than five years old, it would be difficult to accept that there had been no

material changes in a person's life over this period. Additionally, if there were no changes, as a result of being subject to compulsory measure of care and treatment over this period, then it could be argued that the care plan might not be achieving the outcomes for which it was designed.

As part of this themed visit, we looked further at those cases where it was reported that there was no material change and found numerous examples of the person having moved house to supported accommodation or a care home, had children, lost a significant other, diagnosis of life limiting illness and being made subject to a welfare guardianship order under the Adults with Incapacity (Scotland) Act 2000 legislation. While these may have been recorded within a person's notes or indeed within a section 86 report, the opportunity to consider such life changes, their impact and any adjustments or support required is lost if an SCR is not updated on a regular basis.

One recurring reason we heard for the non-completion of an SCR was that no "relevant events" had occurred since the last SCR. Technically this is true as the legislation does not include the extension of a CTO as a relevant event. The Commission considers this an omission as we see people subject to long term orders, particularly within the community, and extension of such orders, as relevant events due to the ongoing impact and restrictions on the person's life.

We asked MHOs about the care plans which were in place for those people we met with. Just over half of the people we met (50.4%) had a care package in place as part of their care plan; the package was predominantly focussed on help within the home and support with medication or finance management. We asked MHOs if they thought that the care plan met the person's wider social, economic and cultural needs and there was a varied response to this. Most felt that social and economic needs were addressed but found it more difficult to consider the cultural needs of the person. No MHOs identified any unmet need.

We were disappointed to see very few examples of a self-directed support approach to personal outcomes being met for the people we spoke with. Self-directed support is a way of providing social care support that empowers individuals to have increased choice, flexibility and control over the care and support they receive. The Social Care (Self-directed Support)(Scotland) Act was passed in 2013 and there was a view that this might offer adults with mental illness, learning disability and other related conditions more options in how they would receive their support.

First, we were told by both the individuals we met and the staff groups we spoke with that the processes to implement self-directed support were long and convoluted and this resulted in a reluctance from both to progress this means of service delivery.

We also heard that duties under sections 25 and 26 of the Mental Health Act did not meet the critical thresholds of national eligibility criteria, meaning that it was difficult to prioritise finite resources to promote, for example, well-being, social development and assistance with travel in the context of reducing budgets and focus on high risk only.

Where we did see examples of innovative, self-directed support options, we saw an improvement in outcomes for the person e.g. the purchase of a laptop, initially to address social isolation which progressed to enrolment in online further education with the aim of employment at a future stage.

We were interested to hear the views from some MHOs that those who were subject to CCTOs were often reluctant to accept support in any form and that this led to them perhaps living in less than ideal housing environments, with little in the way of social interaction or meaningful activity and that this was said to be a direct choice the person was making.

In considering this last point, it is important to reflect on what we know are the five key constructs of the negative symptoms of schizophrenia which was the primary diagnosis for 72% of the people we spoke with: blunted affect, alogia (reduction in quantity of words spoken) avolition (reduced goal directed activity due to decreased motivation), asociality and anhedonia (reduced experience of pleasure). Experiencing these symptoms limit the choices people with severe and enduring mental illness make or are able to make, yet it is interesting that only 24% of those we visited were subject to the compulsory measure (d) under section 66 of the Mental Health Act which would require them to attend with a view to receiving community care services, relevant services or any treatment, care or service, in sharp contrast to the extensive use of compulsory measure (b) the giving of medical treatment.

Finally, we asked MHOs about the continued benefit of the CCTO remaining in place (figure 9). Most described how the person had benefitted from having regular medication that keeps them well and prevented an inpatient hospital stay. MHOs also made reference to the CCTO providing a legal framework for ongoing treatment and said that the order gave the person rights to review and access to the mental health tribunal as an independent review body. However, MHOs, trained in social work to take a holistic approach, trained to work in partnership to support the person to maximize their strengths and abilities to achieve desired outcomes, failed to reference this invaluable aspect of their role and how this could effect change and recovery and ultimately potential less reliance on compulsory measures.

Figure 9 - Continued benefit word cloud



It would therefore seem that CCTOs have developed in a way which predominantly delivers compulsory medical treatment in the community without the same regard for the wider, holistic, social, economic and cultural rights of the person.

The perceived CCTO benefits identified by MHOs were similar to those reported by RMOs; these were primarily illness and treatment focussed and did not reflect a recovery agenda nor a move away from coercion as an alternative.

Chapter 6: The role of the community psychiatric nurse (CPN)

What we expected to find

Unlike the professional involvement of both the RMO and the MHO which is guided by a range of regulations and codes of practice specifically relating to the management of a compulsory treatment order, the role of the specialist mental health nurse in this process is not detailed or specified in guidance. Community psychiatric nurses (CPNs), therefore, rely on their Code, *Professional standards of practice and behaviour for nurses, midwives and nursing associates* published by the Nursing and Midwifery Council¹⁴ to guide their interventions in the widest sense rather than specifically in relation to their involvement in a CCTO.

We expected to find CPNs having consistent, regular, planned and where required, unplanned, responsive contact with people subject to a CCTO. We expected to find evidence of the provision of specialist mental health nursing care and treatment which was collaborative, person-centred and human rights based.

We have seen the Commission's 2019 good practice guidance on care planning¹⁵ increasingly adopted by inpatient services as an improvement tool for care planning activity and we expected to see a similar focus on this important element of care and treatment in the community, particularly when delivered as part of a compulsory intervention.

The Commission's good practice guidance highlights that "treatment is not just about the nursing care and medical treatment which is proposed. An individual's physical health, social and recreational, spiritual and financial needs may all have a bearing on their recovery... The focus should be on the person and not just on their condition" and we expected to see care plans which reflected this wider consideration of treatment.

During our themed visiting programme we also expected to see accurate, timeous records of interventions with their effectiveness measured against mutually agreed goals with the quality of both care plans and records subject to an audit process to ensure that both internal procedural requirements and good practice standards were met.

Where interventions included the administration of treatment, we expected to see evidence of informed consent, either by the person where possible or by the legal safeguards provided by the legislation in the form of T2B or T3B certificates.

We know that people with the most severe and enduring forms of mental ill health experience some of the most profound health inequalities of any section of society. Life expectancy is reduced by between 15-20 years and long-term medical conditions such as diabetes, respiratory illness and cardiovascular disease are much more common.¹⁶ Consequently we expected to find care plans which addressed these physical health inequalities and included strategies to help close this health gap wherever possible.

Finally, we expected to see contact between CPNs and families and carers, where appropriate. The Triangle of Care¹⁷ is an important therapeutic alliance between individuals, staff and carers and promotes safety, supports recovery and sustains wellbeing. Given our focus on people who had been subject to a CCTO for two years or more, we expected that the CPN

¹⁴ [The Code \(nmc.org.uk\)](https://www.nmc.org.uk)

¹⁵ [PersonCentredCarePlans_GoodPracticeGuide_August2019.pdf \(mwscot.org.uk\)](https://www.mwscot.org.uk)

¹⁶ [Closing the Gap theme page - Research, University of York](#)

¹⁷ [Triangle of Care - Caring for our carers Caring for our carers \(oxfordhealth.nhs.uk\)](https://www.oxfordhealth.nhs.uk)

would have built up strong relationship-based practice with both the person and the person’s family, reflecting the importance of that important ‘triangle’.

What we found

We received 101 completed CPN questionnaires, 97 (96.0%) of the nurses described themselves as the allocated CPN in the person’s care whilst the others either did not respond to this question or said they were not the allocated CPN.

We asked CPNs how often they met with the person subject to the order. Figure 10 shows the regularity of CPN contact, 18% saw the person weekly, with a further 65% meeting fortnightly or monthly. 5% said they saw the person less often than quarterly and 8% said that they had some other arrangement. It is clear from this information that the CPN is the most regular professional contact when compared to the MHO and RMO.

Figure 10 - Frequency of CPN contact with the person on a CCTO

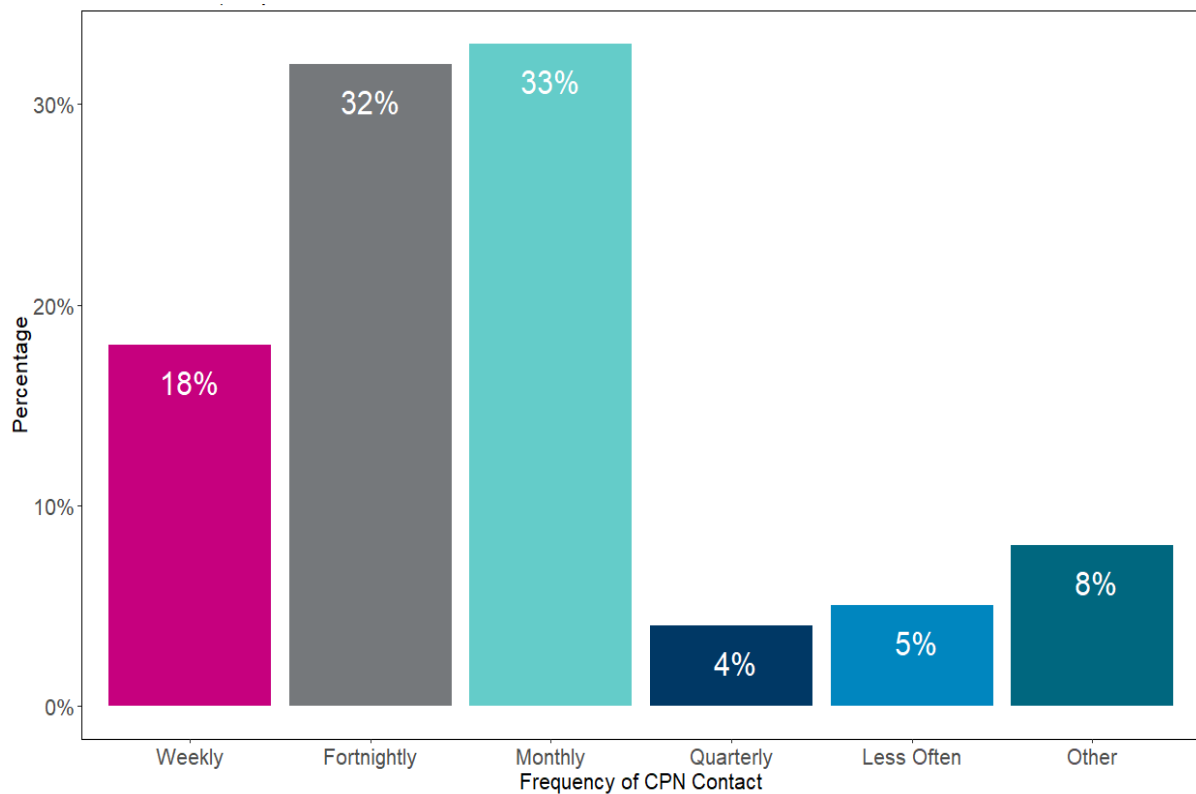


Figure 11- Main reasons for CPN contact



Figure 11 shows a variety of reasons for CPN contact however the main interventions were monitoring the person’s mental state and administering medication.

We heard from people who were subject to the orders that 59% met with the CPN at home while 22% attended a clinical setting/depot clinic with a range of other venues for the remainder e.g. day centres.

Whilst nurses told us that depot clinics were seen as an effective and safe means of administering medication, we would suggest that, for the CPN to conduct a full assessment of the person’s mental health, it is important that CPNs visit a person’s home, where possible, to gauge their functioning within their home environment and not only in a clinical setting.

Indeed, we heard that people subject to CCTOs welcomed CPNs visiting at home and spoke about this approach facilitating respectful relationships. Attending depot clinics seemed to be more common post the Covid-19 pandemic and we were told a different nurse might be on duty each time.

One person told us that:

“During Covid, it was jag only, no talk” and it “feels like the task is to find out how not to help you”.

Another person said that nurses don’t really know you at the depot clinics (unlike when visits were made to the home).

“Nurses there don’t know you...it’s the walk of shame...sterile...hate it”.

We were concerned to hear this feedback. Those we spoke with clearly valued having a dedicated CPN with whom they could build a therapeutic, trusting relationship to discuss goals and fears.

We were also keen to hear about the interaction between the CPN and the named person and/or families and carers, where appropriate.

Whilst the duty of confidentiality to the person subject to a CCTO is generally understood, we were keen to find out if there was also clear understanding of the importance of hearing the carer's perspective and their valuable insight about how the person subject to the CCTO is managing (good practice guide on *Carers and Confidentiality*¹⁸).

It was on this basis that we asked how often the CPN was in contact with the named person in the course of carrying out their role. The majority of CPNs (68%) said they would either not be in contact or chose not to respond to this question.

We found that 54% of those people we visited had copies of their nursing care plan but for the remainder, it was unclear if the person did not want a copy of their care plan or the care plan was not available. There were wide variations in the quality of the care plans we saw with some excellent examples evidencing involvement of the person and their family or carers and addressing the holistic needs identified collaboratively. And others where the care plans were solely focussed on the administration of medication. For many there was no evidence of regular review.

Our Commission visitors highlighted care plans which considered the broader needs of the person:

"Care plan outlines person's strengths, as well as takes into account person's future goals. [The person] lives independently and is able to attend to all activities of daily living independently as well as maintain household. They are an active part of their local community, they regularly attend 3rd sector groups run within local community as well as attends church and volunteers to maintain the church on a monthly basis. Care is arranged around the above to enable [person] to actively engage in same."

However, in other cases where we asked about a person's broader social, cultural and economic needs, some CPNs had not considered these.

"Don't know - this is not part of my remit."

"Don't know what this is about - I am only responsible for [person]'s mental health care."

The move towards a human rights enablement (HRE) approach noted as part of the Scottish Mental Health Law Review will require professionals to consider all of a person's relevant human rights and this includes economic, social and cultural rights. Our findings during this visit would suggest that practice has some way to go to incorporate this rights-based

¹⁸ [2018_update_carers_confidentiality_final_draft_16_oct_2018.pdf \(mwcscot.org.uk\)](#)

approach and that training across professional groups will be required to shift the mindset of some that these duties are out with current remits.

The majority of CPNs reported no concerns about the person’s community care package but where concerns were noted, these related primarily to either concerns about the person’s engagement with supports or that there was insufficient support.

We looked further at the cases where these concerns were reported and noted that only in a minority of these cases were compulsory measures under section 66(d) used. Section 66(d) authorises “the imposition of a requirement on the patient to attend – (i) on specified or directed dates: or (ii) at specified or directed intervals, specified or directed places with a view to receiving community care services, relevant services or any treatment, care or service.”

We felt in these instances this additional compulsory measure may have ensured more engagement, in the same way as we saw in terms of the use of medical treatment delivered on a compulsory basis.

It was difficult to ascertain from records if the use of section 66(d) had been considered and discounted or whether the focus continued to be purely on the giving of medical treatment rather than a more holistic response to the broader care and treatment which the legislation promotes.

We were keen to learn more about CPN involvement within the review process given they reportedly had the most regular contact with the person on a CCTO.

We were told that the CPN contributed to the review of compulsion in a variety of ways. Table 9 details this activity:

Table 9 – Involvement in the review of the grounds for compulsion

Involvement	n (%)*
Discussion with RMO	81 (80.2)
Involvement in multidisciplinary team (MDT) discussion	75 (74.3)
Discussion with person subject to compulsion	69 (68.3)
Discussion with named person	20 (19.8)
Discussion with family/carers where appropriate	18 (17.8)

**these are not mutually exclusive*

While it is good to see these figures in terms of a positive contribution to the statutory review process, it is somewhat concerning that in almost 20% of the visits we conducted the CPN was not actively involved in discussion with the RMO, 25% were not involved in the multidisciplinary team discussion and perhaps more concerning is that in 31% of the cases we visited, the CPN had not discussed the review of the grounds for compulsion with the person subject to compulsion.

When considering CPN involvement in the review process in general, we learned that the CPN contribution was more likely to be sought and valued where the CPA process was in place for an individual.

Table 10 - CPN Involvement in the review process

CPN involvement	n (%)*
As part of a formal review meeting	64 (63.4)
Telephone contact with RMO	32 (31.7)
Confirmed in writing	16 (15.8)

**these are not mutually exclusive*

Although there was limited evidence of a robust framework for taking account of CPNs' views in the review process (the professional with the most regular contact with the person), 95% of the CPNs we made contact with thought the criteria for compulsion continued to be met for those included in this themed work; this was usually because compliance with medication was said to keep the person well and that because the person lacked insight, they would not comply with treatment and this would result in a relapse or deterioration in mental health and could lead to hospitalisation. Only one CPN felt the criteria were not met, 4% (n=4) did not answer.

"Lacks insight into her mental illness which could lead to her becoming unwell and at higher risk if she stopped taking her prescribed medications and engaging with support."

"Continues to suffer from psychotic symptoms which would be worse if not on medication. When unwell he can pose a risk to himself and others and would quickly disengage with treatment."

"Does not believe she is unwell and would refuse treatment if not on a CCTO."

We heard from CPNs that the main components of their involvement with the person subject to the order were monitoring the person's mental state and administering medication.

We asked about the legal authority in place for the administration of prescribed medication under Part 16 of the Act and we heard several examples of good practice where the required authorisation forms (T2B or T3B) were kept beside the medication Kardex records (or electronic equivalent) and were checked with the person prior to the administration of their treatment, particularly where the medication was administered with consent from the person. We heard from some CPNs that consent was a dynamic decision so required to be checked and verified on each occasion. 43.6% (n=44) told us they check the authorisation form before giving medication.

Conversely, we saw examples where the T2B or T3B form was either out of date or did not authorise the treatment being administered. In these cases, there was a view that T2B and T3B forms were the responsibility of the RMO and therefore nursing staff told us that they would assume that the paperwork was in place and valid as the responsibility for this lay with the doctor not the nurse giving the medication. 38.6% (n=39) said they did not refer to T2 or T3 forms and 17.8% (n=18) did not answer this question.

In other instances, there was a belief that the existence of the CCTO was in itself authority to administer treatment under Part 16 of the Act, even where the person did not consent to this treatment. There was little or no knowledge of the T2B or T3B authorisation forms in the case of some nursing staff.

When considering the benefits of the CCTO to the person, medication was seen, by CPNs, as key to keeping the person well and the CCTO was seen as a way to support the person in the community, through mental health support, physical support and practical support. Some CPNs spoke about the CCTO giving them the ability to respond quickly to any deterioration in the person's mental health. These inputs were seen to prevent the need for hospital admission and in turn were said to result in other outcomes, such as improved quality of life for the person and their improved relationships with not only staff involved in their care but also with their own family.

Chapter 7: Carers

What we expected to find

We expected that those working with individuals and their families according to the Mental Health Act would be fully familiar with the definition and rights of carers as noted in the Carers (Scotland) Act 2016¹⁹, including the right to the offer of an adult carer support plan and the need to update this based on support provided to achieve outcomes agreed by the carer.

The Scottish Government's most recent national carers strategy was published in December 2022 and reiterated that unpaid care is vital to how social care is provided in Scotland; the value of the dedication and expertise of carers cannot be overstated.

The strategy refers to the Triangle of Care²⁰ which promotes the core principle that carers, people who use services and professionals should work, in equal partnership, to promote safety, support recovery and sustain wellbeing.

During our visits, we expected to find inclusion of carers, involving them in decision making, support for carers, ease of access to professionals responsible for care delivered under the CCTO and consultation with carers in the formulation and delivery of care plans, particularly those care plans which included carer involvement as a fundamental component.

We also expected to see evidence of the offer and provision of carer support plans, taking account of all aspects of care (as detailed within section 6 of the Carers (Scotland) Act 2016) including impact on the social, economic and cultural aspects of carers' lives.

What we found

We asked the 92 people we visited for their consent to speak with anyone identified as a carer, as defined in the Carers Act. We spoke to 29 carers, 28 of whom were aged 64 years or younger. 20 out of the 29 carers we spoke with were the parents of the person subject to the order.

Out with the formal discussions with these 29 carers, we also had some informal feedback from others. We heard of a reluctance by others to identify themselves formally as a 'carer'. We heard from spouses that being badged as a 'carer' altered the dynamic of the relationship although some felt pressured to be viewed as a carer, at times, for financial reasons including accessing appropriate welfare benefits to support the family.

We heard that for some, connotations of the role of carer were of monitoring and supervising medication compliance and this impacted on the relationship in a way which neither they nor the person they were caring for wanted.

For others within the sample, we heard that the long term, and at times acute nature of the mental illness, had impacted on relationships over time and had resulted in carers withdrawing regular support as either they or the person they cared for could not sustain this dynamic on an ongoing basis.

¹⁹ <http://www.legislation.gov.uk/asp/2016/9/contents>

²⁰ <https://carers.org/downloads/resources-pdfs/triangle-of-care-scotland/triangle-of-care-a-guide-scotland.pdf>

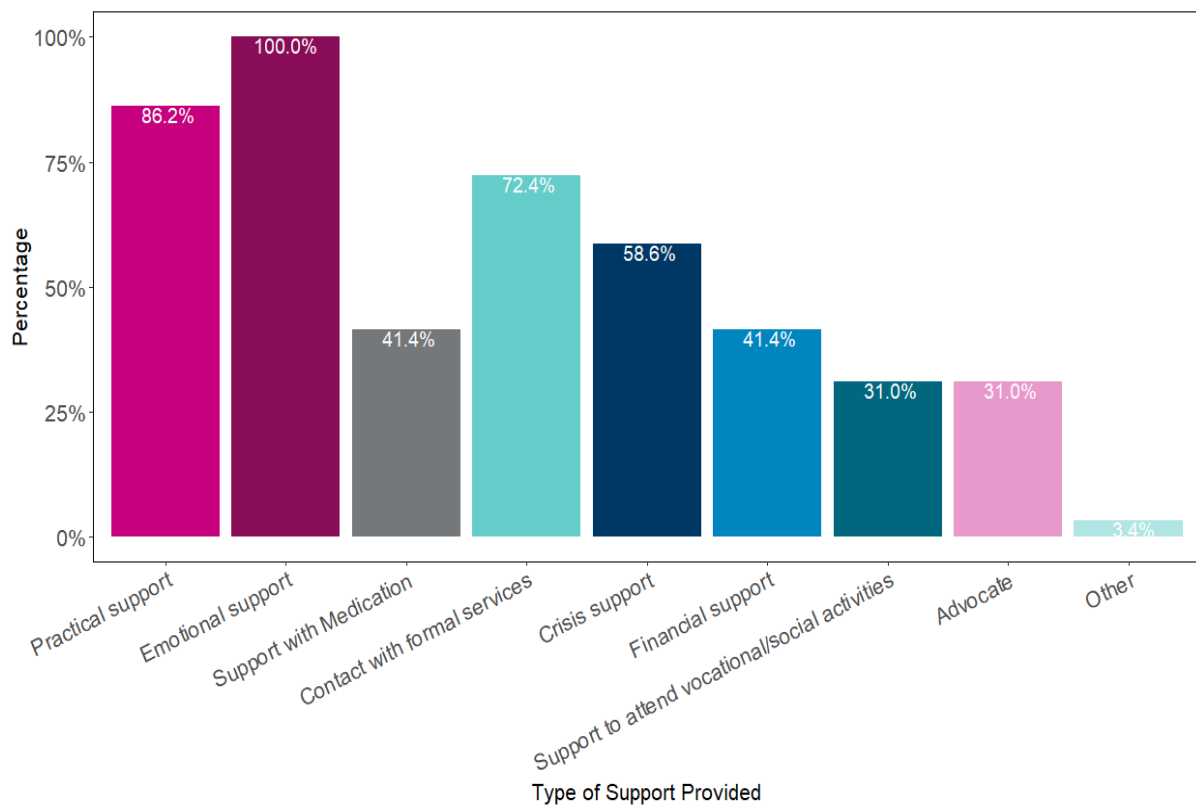
We asked the 29 carers who engaged with us, how many hours on average they spent in a week undertaking caring duties for the person subject to the CCTO; the table below illustrates this.

Table 11 – Average weekly carer hours

Average Hours	n (%)
1-4 hours	11 (37.9)
5-9 hours	5 (17.2)
10-14 hours	2 (6.9)
15-20 hours	2 (6.9)
Over 20 hours	9 (31.0)

In terms of the nature of the tasks and activities they performed, we heard that there were many types of support that carers provide and they are not mutually exclusive, so carers will provide different types of support at different times depending on need at any given time. The types of support can be seen in Figure 12.

Figure 12 - Types of carer support given



Note - Categories are not mutually exclusive so percentages will add up to more than 100%.

We asked carers how having someone on a CCTO impacts their life. For many there was an acceptance that this was just what they did for someone that they cared for, as illustrated below in direct quotes from some carers we spoke to:

"He is my son, I just do what needs to be done. Some weeks it can be more hours, we help with phones as he often loses them or they don't work, help paying bills, sort out electricity bills and make sure he's got electricity etc, run about and do errands for him. Do his laundry and clean house, change bed. In house every few days, make sure enough gas/electricity."

"It doesn't impact on my life as I am his parent and I will always do what is best for my son and have always done. He relies on me."

"It's just what you do."

However, there was also a proportion of carers who felt there was an emotional impact, through worrying about the person on the CCTO and their quality of life, having concerns about what will happen as the carer themselves ages or about how it impacts other family members, like children.

"I'm constantly worried about her safety."

"It causes me more anxiety than anything and worry that he is ok."

"It impacts on me emotionally as I'm nearly 70."

A proportion also felt their time was compromised as a direct result of their caring responsibilities and some reported that they had to reduce or give up work to accommodate care, including planning around medication, thus impacting on their ability to earn to their potential. Others said that they were unable to have a break or holiday due to their caring responsibilities. We were told that, over the years, this had impacted adversely on their overall quality of life and reduced their ability to do anything spontaneously.

"I took early retirement due to the demands on my time. I can't go away on holiday."

"Always have to think about [person] and make sure anything we do is planned so we are available to give him his medicine and check on him. Even if we go on holiday we need to time it so it isn't when he has his depot and then phone him twice a day to prompt him to take his medicine."

"Have not been able to pursue a normal career for 16 years."

A proportion of carers also mentioned that the caring role increased dramatically when the person was unwell, and at these times it helped if there was a degree of formal support around the carer to supplement their support.

Carers and the CCTO

We asked carers if they were aware of the compulsory measures which were included in the CCTO. While most people had some awareness, the largest proportion spoke about the order enforcing compliance with medication or treatment. Others were aware that the measures included having to meet with or give access to doctors, MHOs and other professionals and in some cases having to seek authority to change address.

Overall, 82% of the carers we spoke with had a good awareness of the conditions attached to the order with the remainder either not sure or unaware of the details.

The vast majority (93%) expressed a view that compulsory measures were appropriate and felt that there were positive benefits both for them as carers and for the person they cared for. This was mostly around ensuring the person took their medication that kept them well, or that the person had support and was safer than they would be without these measures. Some felt that the CCTO maintained the person in the community and reduced reliance on hospital admissions with a better quality of life and the opportunity to build better relationships with family.

"Think it's good that there is this condition in place which makes him go for his jag or he knows they'll take him back to hospital. He always says he'll take it but then won't and then he gets ill again."

There was a view from carers that when a deterioration in the person's mental health was becoming evident, there was a more timely response from formal services as a result of the CCTO being in place compared with previous experiences of seeking help at times of crises and that this alone was a benefit of a CCTO.

"Communication is really good between the professionals. I feel I can call the CPN or the Dr if there is an issue, feel supported."

Of the carers we spoke with, 44.8% reported that there was a crisis care plan in place which they found reassuring. Others felt that crisis care could be improved:

"Crisis plan is only the number of the crisis outreach team. Not really been much help when there has been any situation, we usually deal with it then they'll see him the next day. Would be good to have a more responsive service."

Overall, carers felt that the CCTO was a 'safety net' and that the person they cared for was benefitting from the care and support they received. Some recognised that although the person they cared for might not, at times, appreciate being subject to the compulsory measures, they offered the carer a degree of security with the knowledge that they had to take prescribed medication and that they would get a timely response from services when there were signs of relapse in symptoms. We also heard that the CCTO helped the person they cared for access services they might not have access to without compulsory measures in place.

"The CCTO has meant services have offered opportunities for [person] to attend psychology, have a CPN and support worker, I'm not convinced this would be in place if there wasn't the CCTO in place."

Where there was a formal care package in place, we asked carers if they had been involved in deciding what this care package would be. 70.6% said that they had been instrumental in this decision and particularly when the care was being overseen by the care programme approach (CPA).

We asked carers how involved they were in contributing to decisions about the care and treatment of the person they cared for. Most of those we spoke to reported that they did feel involved, particularly at key times e.g. CPA review, attendance at Mental Health Tribunal. This involvement was reported to be more meaningful when there was a degree of consistency in the staff team and where relationships had been established.

"I attend CPA meetings which are useful and sometimes Dr will phone me. He is good, he has been involved for years, which is good as he knows us and [person] really well."

"He has had the same Dr and CPN for years and this makes a difference. They really know him well and involve me as his mum, carer and named person."

The impact of caring on finance

Of those carers we met who were willing to discuss finances with us, we asked if their caring responsibilities had impacted on their finances.

Some told us that sustaining employment when the person they cared for was unwell was very difficult and that they relied on the goodwill of their employer to take time out, often at short notice to respond to caring needs. Ultimately, we heard that this was not sustainable.

"I had to stop working and this has made things harder. I used to work and do overtime if we were short of money. Cost of living has rocketed, and I now rely on benefits which can be difficult."

Of those we spoke to regarding finance (n=25) only two were in receipt of carer's allowance and there were a number of reasons for others not claiming this.

"Don't want to claim as I feel it will formalise role and then we won't ever get support for him but this gradually has impacted on finances with savings dwindling and cost of living rising."

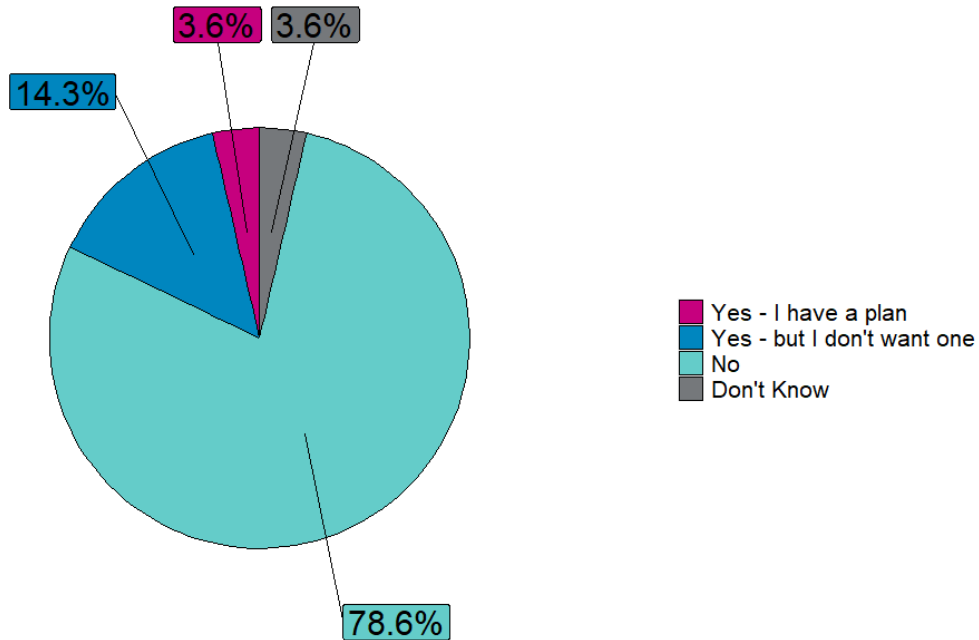
"I don't want carer's allowance as it would affect my benefits. I had to use my money when he got his new flat to cover moving costs."

As well as the impact on the carer's income, we heard of hidden costs, all of which impacted on finances; for example, travel costs to and from the carer's home to the person they cared for, to different appointments and often to subsidise and support household bills and costs.

Adult carer support plan

We asked if carers had been offered an adult carer support plan in line with the Carers (Scotland) Act 2016. Figure 13 below shows the results:

Figure 13 - Offered carer support plan



78.6% of carers we spoke with did not recall being offered an adult carer support plan. It is important to remember that the carers we spoke with cared for people who had been on CCTOs for two years or more. We would therefore assume that such a care plan would have been offered during this time. Given the presence of a CCTO and associated compulsory measures, it could be argued that those caring for individuals with this level of need should be prioritised and supported to ensure optimum outcomes for both.

Conclusion and recommendations

Community compulsory treatment orders have the potential to treat and support people with severe and enduring mental illness in the community rather than in hospital. Indeed 73% of the people we spoke with who are subject to such orders described this as a key benefit of a CCTO given their strong aversion to in-patient psychiatric care.

Both mental health officers and responsible medical officers perceived the benefits of CCTOs in terms of compulsory treatment of mental illness; there was little reference to recovery nor a proactive move away from coercion.

A positive right is the entitlement to care. We found that the community care and support afforded to people on CCTOs for two years or more did not seem materially different to packages of care and support offered to people receiving care and treatment on a voluntary basis.

There was no evidence of intensive care management, rehabilitation or drawing on the expertise of a range of mental health professionals (key allied health professionals' input was notably absent.)

Neither was there evidence of dynamic care nor planning and review to maximise the person's skills and abilities and aim towards mutually agreed outcomes, including care and treatment on a voluntary basis.

The question must be asked whether, had enhanced support been made available, would a CCTO be necessary for the people we met with? And are the growing numbers of CCTOs and indeed length of CCTOs a reflection of the failure to enhance community resources to support people towards recovery?

We learned that important legal safeguards authorising treatment in the community were not always in place, social circumstances reports were rarely completed by MHOs to inform future care planning and paperwork supporting CCTO reviews evidenced a lack of continuity of care and, in many cases, duplication of paperwork rather than active consideration of the need for the CCTO to remain or not. This begs the question of the purpose of a CCTO from a clinical perspective.

Some suggest that, as access to social care and support reduces, so reliance on enforced medication increases. There is also the suggestion that CCTOs may be continued because they make life easier for clinicians to bring people back to hospital without the bureaucracy of having to apply for another compulsory treatment order. However, the safeguard of the Mental Health Tribunal for Scotland should be in place to address this suggestion.

Family and carers felt somewhat reassured that the CCTO would ensure access to a psychiatrist or CPN or indeed admission to hospital should this be required. Their experience prior to the CCTO of having to provide support in crisis situations with the general practitioner trying to access secondary care had been challenging and sometimes frightening so there was a keenness not to be in this situation again.

Some of the people we spoke to who were subject to CCTOs acknowledged this:

"I would prefer to be on a CCTO than have [my partner's] role change to that of monitor/keeper of the tablets/reporter to the community mental health team. If I wasn't on a CCTO the dynamics of the relationship would change".

This themed work was informed by 92 people who are living with CCTOs (and have done for two years or more), 29 of their relatives/carers and 322 professionals involved in applying for the CCTOs and/or delivering community care and treatment according to the orders.

We continue to ask, do the reported benefits of CCTOs outweigh the coercive nature of CCTOs? Has the threshold for the use of mental health legislation in Scotland been lowered thus extending the net of social control? We did not have CCTOs prior to the Mental Health Act, why do we need them now and why are they continuing to rise and why are they lasting so long?

Whilst our work does not call for CCTOs to be abolished, our work does raise numerous questions which require to be answered and therefore supports the Scottish Mental Health Law Review's recommendation to the Scottish Government:

Recommendation 9.29: The Scottish Government should commission substantial and innovative research:

- *To explain why the use of CCTO has continued to increase in Scotland.*
- *To understand the circumstances which make CCTO effective or ineffective.*
- *To show which groups of people CCTO tends to work for.*
- *To understand the experience of those who receive regular voluntary treatment in the community and who are not on CCTO.*

We look forward to the Scottish Government's response.

In the meantime, based on the current practice we have identified, we make the following recommendations to health and social care partnerships and their respective local authorities and health boards:

Recommendation 1:

The care programme approach or similar integrated framework should be used to support the dynamic care planning, review and revocation strategies for all people who are subject to CCTOs.

Recommendation 2:

Audits must be in place to evidence quality assurance of section 76 care plans completed by responsible medical officers.

Recommendation 3:

Audit processes must be in place to ensure that everyone subject to a CCTO has legal authority under Part 16 of the Mental Health Act in place with recorded dates for review and that treatment recorded on the statutory form remains accurate.

Recommendation 4:

Statutory obligations within section 25-27 of the Mental Health Act should be reflected within eligibility criteria and also the right to the four options of self-directed support.

Recommendation 5:

Social circumstances reports, taking account of economic, social and cultural rights, should be completed by mental health officers annually for those subject to CCTOs or statement given as to why this will serve little or no purpose.

Recommendation 6:

A training needs analysis should be undertaken to ensure a delivery plan to support key staff responsible for ensuring that:

- legal authority to provide treatment is in place, which is current and subject to regular review;
- carers' rights to an Adult Carer Support Plan are understood and upheld; and
- that carers are involved in decision making as far as possible.

Recommendation 7:

Individuals subject to CCTOs and their carers should have information regarding appropriate actions and contacts at times of crises.

Appendix 1: Principles underpinning the Mental Health (Care and Treatment) (Scotland) Act 2003

- 1. Non-discrimination** - People with mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.
- 2. Equality** - All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national or ethnic or social origin.
- 3. Respect for diversity** - Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.
- 4. Reciprocity** - Where society imposes an obligation on an individual to comply with a programme of treatment or care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.
- 5. Informal care** - Wherever possible, care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.
- 6. Participation** - Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully. Information should be provided in a way which makes it most likely to be understood.
- 7. Respect for carers** - Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
- 8. Least restrictive alternative** - Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.
- 9. Benefit** - Any intervention under the Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.
- 10. Child welfare** - The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.



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