mentalwelfare
commission for scotland

Not properly authorised

Unannounced visits to people receiving treatment under the safeguards of part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003

Contents

Who we are and what we do

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health and incapacity law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have worked in healthcare, social care or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect.
- Have the right to treatment that is allowed by law and fully meets professional standards.
- Have the right to live free from abuse, neglect or discrimination.
- Get the care and treatment that best suits his or her needs.
- Be enabled to lead as fulfilling a life as possible.

Our work

- We find out whether individual treatment is in line with the law and practices that we know work well.
- Challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

Introduction

From April 2010 to March 2011, we conducted a series of unannounced visits to 45 hospitals where people were receiving compulsory treatment under the 2003 Act. We looked at the medication prescribed and administered in 672 cases and compared it with the treatment authorised on statutory forms. Where possible, we interviewed people to make sure that, when certificates stated it, they were giving informed consent to treatment.

The legal safeguards are designed to ensure that individuals receive medical treatment with their consent, or if they lack capacity, with authorisation by an independent "designated medical practitioner" appointed by the Commission. Our visits focussed on the following questions:

- Is there an appropriate treatment certificate?
- Does the certificate cover all the treatment actually administered?
- If the person's consent was obtained, does it appear to be valid?
- What processes and practices are in place in wards to ensure that the legal safeguards are observed?

We also took note of the existence of advance statements, and of Section 47 certificates which cover medical treatment for physical ailments when people lack capacity to consent.

Background

When the Commission conducted reviews of detention under the Mental Health (Scotland) Act 1984, we found problems with the medical treatment provisions. We found that legal safeguards for medication were not properly observed in about a fifth of the people we saw[1]. In all these cases we took action to make sure that treatment was in line with the law.

The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") has even stricter safeguards for medical treatment. In our visits to people treated under the 2003 Act, we have found some people whose treatment was not in line with safeguards. We decided to find out more about compliance with safeguards for medication for mental disorder.

[1] http://www.mwcscot.org.uk/web/FILES/A33825-MWC_AR_2005.pdf. See section 2.6.

Legal requirements

Part 16 of the 2003 Act covers medical treatment. While treatment is defined broadly, the special safeguards in part 16 relate to physical treatments such as medication, electroconvulsive therapy (ECT) and neurosurgery for mental disorder (NMD). The requirements of part 16 include:

- **The appointment of designated medical practitioners (DMPs)**
  We appoint independent practitioners as DMPs. We make sure that they have appropriate qualifications and experience to carry out this role and we require them to attend our training events so that they know what the Act requires. They provide independent opinions authorising certain treatments on the basis of their own clinical expertise.
- **NMD and related treatments, including deep brain stimulation**
  These treatments require opinions from a DMP and two other persons appointed by the Commission whether or not the person is subject to compulsory treatment. The DMP consider whether the treatment is in the person's best interests. All three assess the person's capacity to consent. These are highly specialised treatments, administered at a specialist centre. None of the people we visited had received or were being considered for these treatments.
- **ECT and related treatments including vagus nerve stimulation and transcranial electromagnetic stimulation**
  For people subject to compulsion, these treatments need either written consent or a DMP opinion from the start. Urgent treatment can be given before a DMP opinion is obtained. We did not set out specifically to look at these treatments but encountered some people receiving ECT. We made sure that legal documentation was in order if ECT was being given. We have no information to suggest that vagus nerve stimulation or transcranial electromagnetic stimulation has ever been administered under the 2003 Act.
- **Treatment given over a period of time**
  These are covered by section 240 of the 2003 Act and were the main focus for our visits. For medication for mental disorder, consent or DMP authorisation is needed if treatment continues beyond two months. This period starts with the first administration of any medication for mental disorder during the period of compulsory treatment. After two months, any existing or new treatment prescribed for mental disorder must have the patient's written consent or DMP authorisation. For artificial nutrition and medication to reduce sex drive, consent or DMP authorisation is needed from the start. Urgent treatment can be given under certain conditions.

There are five forms that are used to record or authorise treatment under part 16. They are:

- Form T1 to authorise neurosurgery.
- Form T2, completed by the responsible medical officer (RMO), to record consent to other regulated treatment.
- Form T3, completed by the DMP, to authorise other regulated treatment where the person cannot or does not consent.
- Form T4, completed by the RMO, to record administration of urgent treatment.
- Form T5 to authorise certain regulated treatments to young people.

We looked mainly at forms T2 and T3. These are statutory forms, prescribed by regulations, which must be completed. It is possible for a person's treatment to be covered by a T2 and a T3 form if he/she is able to consent to some treatments but not to others. If the forms are not properly completed or if they do not authorise all the treatment administered, then we consider that the person is receiving treatment without proper legal authority.

The 2003 Act only applies to treatment for mental disorder. Where a person lacks capacity to consent to treatment for physical illness, part 5 of the Adults with Incapacity (Scotland) Act 2000 applies. There is a statutory certificate to authorise these treatments (a "section 47 certificate"). This certificate might be needed along with a T2 or T3 form. We looked to see if these certificates were in place where required.

Our guidance document, "Consent to Treatment[2]", gives more detailed guidance on the requirements of legislation. It also gives guidance on the meaning of "consent" and assessment of capacity to consent to treatment.

How we carried out our visits

We identified hospitals and wards where people were likely to have been subject to compulsory treatment for at least two months. We visited a sample of these wards. For efficiency, we usually carried out these visits if we were undertaking other visits in or near the hospital. One of our medical or nursing practitioners visited the ward without prior warning. We examined medication prescription and recording charts for all people subject to compulsory treatment and, where relevant, compared them with T2 and T3 forms. We checked copies of these documents on site and on the Commission's files to make sure that we were reading the most recent forms. We asked nurses in charge of the wards about their procedures for making sure that treatment complied with the legislation. We also tried to interview people who were certified as capable of giving consent to determine whether, in our opinion, they were giving valid informed consent to the treatment they had been prescribed.

Where we had concerns about treatment that appeared to us to be unlawful, we raised this immediately with staff on the day of our visit and wrote to the person's RMO. We required the RMO to act to make sure treatment was properly authorised and to inform the person about any treatment that had been given without proper authorisation. We also gave advice to the RMO if we thought that a T2 form, while lawful, was not completed in line with our good practice guidance. We then entered all the information onto a database and conducted a thorough analysis.

[2] http://reports.mwcscot.org.uk/web/FILES/MWC_ConsentToTreatment_Web.pdf

Executive summary of findings and recommendations

Key messages

1. We considered that 12% of all the people whose cases we examined were receiving treatment that was not properly authorised or reported under the 2003 Act. Clinicians and managers must do more to make sure that everybody is treated lawfully.
2. We found situations where forms were absent, not completed lawfully or not giving authority for some of the medication that had been prescribed. Some forms were probably lawful but not completed in line with best practice guidance.
3. We considered that 15% of the people certified as giving informed consent to their treatment were either unable or unwilling to give consent. Clinicians cannot rely on previous written consent if the person no longer understands, or agrees to accept, the prescribed treatment.
4. Wards where all or most people were detained had significantly better compliance with part 16 of the Act. Greater familiarity with the Act seems to help compliance.
5. Training for nursing staff on part 16 of the Act helps compliance, but this was only significant if it had taken place within the previous year. Managers need to ensure that practitioners receive regular refresher training.
6. We were not able to demonstrate that good availability of treatment forms, alerts, audits, pharmacy input and our practice guidance were of benefit. All these measure are good practice but must be supplemented by sufficient training.

Recommendations

1. Training on part 16 of the Act must be regular and form a core part of relevant practitioners' personal development plans.
2. The Scottish Government and NHS Boards must ensure that training for approved medical practitioners addresses the shortcomings in practice that we have identified.
3. All relevant clinical staff should have access to, and follow, our best practice guidance on consent to treatment. They should pay particular attention to the guidance on completion of treatment plans (see appendix 2 of this report) and ensure that all regular and "as required" prescriptions are covered by T2 or T3 forms.
4. Hospital managers should ensure that they have local procedures to remind RMOs when treatment forms are due and to check that they have been completed timeously, properly and submitted to the Commission.
5. Managers should ensure that regular audits of prescriptions and treatment forms are thorough and undertaken by appropriately trained practitioners.
6. Clinicians should regularly check that people certified as giving consent on T2 forms are continuing to give valid consent to treatment.
7. Scottish Ministers should reconsider the validity of written consent over long periods of time.
8. Scottish Ministers should amend the 2003 Act to specify the length of time for which consent is valid.

General findings on the use of forms

We analysed the lawfulness of medical treatment of 672 people in 105 wards in 45 hospitals. The details of hospitals and number of people seen are shown in appendix 1. Of the 672 people:

- 465 (69%) were subject to compulsory treatment orders (CTO).
- 207 (31%) were subject to orders under the Criminal Procedures (Scotland) Act (CPSA).

We located 659 T2 or T3 treatment forms for these 672 people.

- 224 people had their treatment authorised by a T2 form (only).
- 411 people had their treatment authorised by a T3 form (only).
- 12 people had both a T2 and T3 form authorising their treatment.
- 25 people had neither. Most of these people were not receiving treatments that needed to be authorised on a T2 or T3 form. We found seven people who were receiving such treatment. We considered that their treatment was not properly authorised.

Table 1 shows a difference between people subject to CTOs and CPSA orders. As expected, a far higher proportion of people subject to CPSA orders were certified as giving informed consent to some or all of their treatment. This was highly statistically significant ($p<0.001$). The presence of significantly impaired decision-making ability (SIDMA) about medical treatment is an essential criterion for civil compulsion under a CTO but does not need to be present for people who receive care and treatment after committing an offence. While people who, in general, have SIDMA may be able to consent to individual treatments, it is more likely that they will lack capacity to consent and require an independent opinion for safeguarded treatments.

Table 1: Number of people seen by type of order and type of treatment form

Order	T2 form	T3 form	Both	Neither	Total
CTO	119 (26%)	319 (69%)	9 (2%)	18 (4%)	465
CPSA	105 (51%)	92 (44%)	3 (1%)	7 (3%)	207
Total	224	411	12	25	672

Advance statements

When capable, a person may make an advance statement stating how he/she would wish to be treated if no longer capable of making decisions. This can include advance refusals of certain treatments. If treatment is in conflict with an advance statement, the patient, named person and the Commission must receive a written explanation of the reasons.

We looked to see if the people we visited had made advance statements. Of the 62 people (9%) who had made advance statements:

- In 48 cases treatment complied with the advance statement.
- In 13 cases, treatment was in conflict with the advance statement and the appropriate notifications had been made.
- In one case, treatment was in conflict with an advance statement and the appropriate notifications had not been made. We regarded this treatment as not properly authorised.

Findings on authorisation of treatment

Key messages

We considered that 12% of all the people whose cases we examined were receiving treatment that was not properly authorised or reported under the 2003 Act. Clinicians and managers must do more to make sure that everybody is treated lawfully.

We found situations where forms were absent, not completed lawfully or not giving authority for some of the medication that had been prescribed. Some forms were probably lawful but not completed in line with best practice guidance.

We considered that 15% of the people certified as giving informed consent to their treatment were either unable or unwilling to give consent. Clinicians cannot rely on previous written consent if the person no longer understands, or agrees to accept, the prescribed treatment.

What we expect to find

We expect that all treatment administered to the person is properly documented on a statutory T2 or T3 form or reported as urgent treatment using a T4 form.

What we found

1. Authorisation of treatment

We examined treatment prescribed for regular use and treatment prescribed for "as required" use. We compared the medication prescribed with the medication authorised on T2 and T3 forms.

a) Treatment prescribed for regular use

We looked at all regular treatment that was subject to safeguards. This included oral medication, medication by depot injection of drugs, artificial nutrition and electroconvulsive therapy.

Of the 672 people we visited:

- 600 (89%) had treatment that was authorised by forms that were in line with the law and best practice guidance.
- 61 (9%) were being given treatment that was not properly authorised by treatment forms.
- 11 (2%) had treatment that was, on balance, probably authorised but not in line with best practice.

Of the 61 people whose treatment was not properly authorised:

- 26 people were treated under the authority of a T2 form that did not cover all the treatment the person was receiving. This represented 11% of all people treated under the authority of a T2 form.
- 28 people were treated under the authority of a T3 form that did not cover all the treatment the person was receiving. This represented 7% of all people treated under the authority of a T3 form.

- Seven people were treated with medication that needed either a T2 or T3 form but where neither form could be located.

b) "As required" treatment

In addition to regular treatment for mental disorder, many people had been prescribed treatment to be given "as required". This was usually given if the person was agitated, in distress or displaying aggressive behaviour. If not covered by a T2 or T3 form, we expect to receive notification of its administration on form T4.

Of the 672 people we visited:

- 564 (83%) were not receiving "as required" medication, receiving treatment that was properly authorised by T2 or T3 forms or receiving treatment notified to us on form T4. We were satisfied that treatment was being given lawfully in these cases.
- 38 (5%) had received "as required" treatment that was not properly authorised or reported to us. Sixteen of those people were also being given regular treatment that was not properly authorised by a T2 or T3 form.
- In a further 80 cases, we found prescriptions of "as required" treatment that were not consistent with treatment authorised on T2 and T3 forms but where the treatment had not, as far as we could determine, been administered. These people had not received unauthorised treatment but we do not consider this to be good practice. We comment further on this later in this report.

c) Totality of treatment not properly authorised by forms

We combined the results in a) and b). In total we found 83 people who were receiving treatment that, from our reading of statutory forms, was not properly authorised or reported. This was 12% of all the people whose treatment we examined. This included:

- Regular treatment (only) in 45 cases.
- "As required" treatment (only) in 22 cases.
- Both regular and "as required" treatment in 16 cases.

d) Validity of consent

We invited people who were certified as capable of giving informed consent (form T2) to meet with us. We wanted to satisfy ourselves that they had sufficient information and understanding about the treatments they were receiving and that they were continuing to agree to take the treatment prescribed for them. We were not able to see all such people. Our visits were unannounced and some people were not in the ward at the time of our visit. Some others declined the offer of meeting us.

We interviewed 117 people out of the 224 who were certified as giving consent to treatment on T2 forms. We found 17 people who, in our view, were not giving continuing informed consent to treatment. If this is representative, we consider it a matter of concern that 15% of all people who are regarded as giving informed consent to treatment may not be doing so.

e) Legality of additional treatment under incapacity legislation

We also looked at treatments for physical health problems. We would not expect treatment for physical illness, including treatment for the side effects of medication for mental disorder, to be documented on T2 or T3 forms. If the person cannot consent to these treatments, there should be a certificate in place to authorise treatment under section 47 of the Adults with Incapacity (Scotland) Act 2000.

We found 82 people who, in our opinion, required a section 47 certificate to authorise physical health treatments. Certificates were present for 61 of the 82 people (74%). This shows some lack of compliance with this part of the legislation but the percentage of forms completed is higher than we have found in care homes and medical wards for older people.

2. Common problems in complying with part 16

Our visitors made a record of the reasons why we considered treatment to be not properly authorised or not in line with best practice. The main categories of error were:

a) No form

Seven people had been receiving medication for more than two months but no T2 or T3 form was in place. One example was:

"T2/T3 was due 15/9/10. Visit was 7/10/10. No form in place. Is prescribed regular chlorpromazine, trazodone, sodium valproate (as mood stabiliser), fluphenazine decanoate. Is prescribed "as required" chlorpromazine, haloperidol and lorazepam orally and haloperidol and lorazepam by intramuscular injection." None of this treatment was properly authorised.

We were especially concerned when safeguarded treatment was being given to people who clearly did not have capacity to consent and where there was no independent opinion to authorise it.

"Patient is on Haloperidol. Patient interviewed – doesn't know about her diagnosis or treatment. Advised RMO to discuss with patient, reassess capacity and urgently arrange for a T3 to be completed if necessary."

Another example was a person with dementia.

"Prescribed donepezil 10mgs daily and trazadone 50mgs bd. There is no treatment certificate covering the above medication."

b) Forms not completed in line with the law

The T2 and T3 forms are statutory and must be submitted to the Commission. They must be used and must be properly completed. We found some forms that did not appear to comply with basic legal requirements. A few forms were not signed or dated. We found one person whose form was an old "form 9" from the previous Act (the equivalent of a T2 form under the 2003 Act). We consider this form no longer valid. In any event, it did not cover the person's present treatment.

c) Multiple medications, not all covered by forms

This accounted for most of the errors we found. There was a range of omissions. This was one of the most blatant.

"T2 covers medications including lamotrigine. Medications not covered by T2 – risperidone depot 25mg 2 weekly; risperidone 2mg daily; lorazepam 1-2mg O/IM "if required" for agitation max 4X/24hrs (has had on 15 occasions orally this admission, not IM); diazepam 5mg oral "if required" risperidone 2mg oral "if required" for agitation max 12mg/24hrs." Apart from lamotrigine (used as a mood stabiliser), we found that most regular and "as required" medication for mental disorder was being administered without proper authorisation. We were also concerned about the amount of "as required" medication. The person had been given significant doses of diazepam and lorazepam on the same day. This could have caused excessive sedation.

Other omissions included treatment with more than one drug of the same class. For example, the form will authorise a specific antipsychotic drug or an alternative from the same section for regular use. We sometimes found more than one. Also, we found people receiving treatment with oral and depot regular medication but where only one was authorised by the form.

"T3 authorises amisulpiride or other oral antipsychotic. Drug kardex has Flupenazine Decanoate 37.5mgs 1M."

"T2 states 1 oral antipsychotic from section 4.2.1 of the British National Formulary. Patient on both clozapine and quetiapine which are both from 4.2.1." See also our later comments on clozapine.

We found some people on more than one drug of the same class where it was clear that the intention was to change from drug A to drug B. Both drugs were administered together for a short time while the dose of A was reduced and stopped and the dose of B gradually increased. This is often good clinical practice. While the form only authorised one treatment, we thought that it would be unfair of us to regard this as improper. We recorded this as "properly authorised but not best practice".

Practice could improve in this area by better wording on forms. For example, if the form authorises drug A or an alternative drug from the same section of the BNF, there could be a statement such as "two drugs can be prescribed simultaneously for a period of X weeks during changeover".

In some cases, we found that the medication prescribed exceeded the doses authorised by the form.

"T3 authorises haloperidol maximum 10mgs but 15mg prescribed. T3 authorises chlorpromazine to maximum 300mgs but 400mgs prescribed."

We often found medication that had been recently prescribed but not consistent with the form. The prescriber may have omitted to check the form. We have encountered some practitioners who think that, when they start a new treatment, they can give it for two months before it needs to be authorised by a T2 or T3 form. This is wrong; the two months begins with the first administration of any medication for mental disorder. Examples were:

"Diazepam 5mg daily prescribed a week ago not covered"

"Recently prescribed regular haloperidol but only "as required" is authorised."

d) Clozapine

We looked specifically at prescriptions for the antipsychotic drug clozapine. Our guidance is that clozapine, while in the general class of oral antipsychotic drugs specified in the relevant section of the British National Formulary (BNF), requires to be specified along with procedures for blood monitoring. This is because of the particular risk of blood abnormalities and the need for monitoring to comply with the drug's product licence. We found several people who were receiving clozapine without the drug or monitoring being specified. This was of particular concern where the person was not consenting to treatment.

We found five people receiving clozapine with consent but without the drug being specifically mentioned on the T2 form. We thought this was not best practice but not necessarily improper as it was clear that the people were giving consent to the medication and associated blood tests.

Three people whose medication was authorised by a T3 form were receiving clozapine without specific authorisation. We regarded this treatment as improper and insisted on an independent opinion if treatment was to continue.

e) "As required" medication not specified

We found people who had been prescribed "as required" medication that was not authorised by a T2 or T3 form. Where medication had been administered, we regarded this as not properly authorised.

It is our view that medication prescribed "as required" should be authorised on a T2 or T3 forms. If it is prescribed, the medical practitioner must be considering that it could be needed at some point. In some wards, it appeared to be common practice for "as required" medication to be prescribed on a blanket basis for all or most people. We thought this might be common in the State Hospital and other secure units but we found this practice in non-secure wards as well.

We have considered whether it is acceptable to prescribe medication where there is neither consent nor an independent opinion and then to notify the Commission if it is administered as an emergency. We do not consider this to be good practice. Medication should be prescribed according to individual need.

Unforeseen situations arise in all forms of care. It would be more acceptable for the ward to have a general guideline on medication to be used in urgent situations and for the on-call medical practitioner to prescribe on a "one-off" basis, with advice from the person's RMO or a senior colleague. This should be reported to the Commission. If the situation is likely to recur, the treatment should be authorised by a T2 or T3 form.

A further issue arises for the person who consents in advance to "as required" sedation by injection. If, when the treatment is administered, the person is not consenting, then we do not regard the advance consent as valid (although, on a principle basis, it should be taken into account). The administration of this treatment should be reported to us on form T4. The RMO should reassess the person and consider whether an independent opinion on a T3 form is needed to authorise future "as required" treatment. Here is an example where we made comments and gave advice to the RMO about this:

"Intramuscular "if required" haloperidol 5mg and lorazepam 1mg were prescribed and covered by the T2 and on the consent form. I saw 3 occasions on 9/10/10 where IM "if required" lorazepam had been given (on the first occasion with IM haloperidol too). Patient had been restrained on each of these occasions. I discussed this with the RMO and advised him to consider DMP visit for IM "if required" psychotropic medication. T3 was later issued for "if required" psychotropic medication."

f) Invalid consent

A T2 form is only valid as long as the person is giving consent. Of 117 people interviewed, we found 17 people (15%) who did not appear to us to be giving valid informed consent. Some examples were:

"Mr A has dementia. I asked him about his medications. I asked about his antidepressant treatment, venlafaxine and mirtazapine. He said he had never heard of either. I asked if he thinks he needs any medication for depression and he said "I don't think so now". I told him he had just been prescribed venlafaxine yesterday and he said he had not known this. "They're just pills to me"." We advised the RMO to request an independent opinion.

"Mr B said that chlorpromazine makes him feel very sedated, lithium causes "brain side effects". He said he does not need lithium and does not want to take lithium or chlorpromazine. We advised him that he could not be required to take medication he did not consent to take unless authorised by an independent opinion." We asked his RMO to reassess the need for treatment, discuss options with Mr B and ask for a DMP visit if he still wished to prescribe treatment to which Mr B did not consent.

"Mr C says he does believe he has a mental disorder and that he needs the treatment he is prescribed. Agrees to all treatment except for depot risperidone – says he is not sure he will agree to have it again due to side effects. I did not have the impression he had not consented to have the 2 doses he said he has had so far. I explained his rights and said there is no authority for him to be required to take any medication he does not consent to at this time." We drew the RMO's attention to Mr C's views and asked him to reassess.

Findings on measures to aid compliance with legislation

Key messages

Wards where all or most people were detained had significantly better compliance with part 16 of the Act. Greater familiarity with the Act seems to help compliance.

Training for nursing staff on part 16 of the Act helps compliance, but this was only significant if it had taken place within the previous year. Managers need to ensure that practitioners receive regular refresher training.

We were not able to demonstrate that good availability of treatment forms, alerts, audits, pharmacy input and our practice guidance were of benefit. All these measure are good practice but must be supplemented by sufficient training.

What we expect to find

All wards with people detained under the 2003 Act should have proper procedures in place to make sure that treatment is in line with the Act. We expected to find that greater familiarity with the Act, good systems for auditing compliance, pharmacy input and training would have positive effects on compliance with the provisions of part 16.

What we found

a) Category of ward

We divided wards into two broad categories:

- "Secure wards" where all or most people are detained. This includes intensive psychiatric care units, low secure "forensic" wards, medium secure units and the State Hospital. We visited 190 people in these wards.
- All other wards. We visited 482 people in these wards.

We applied our assessment of whether regular treatment appeared to be properly authorised and in line with best practice. The results are shown in table 2.

Our data shows that people treated in secure wards are significantly more likely to be treated with proper authorisation than people treated in non-secure wards (p=0.003). Also, clinicians working in secure wards are more likely to act in accordance with good practice guidance. There are several possible reasons for this.

- It could be that the medical and nursing staff in secure wards are better at complying with the Act because they use it more often.

Table 2: Authorisation of treatment in secure v non-secure wards

Authorisation of regular treatment	Secure wards	Other wards	Total
Properly authorised	183 (96%)	417 (87%)	600
Not properly authorised	7 (4%)	54 (11%)	61
Authorised but not best practice	0 (0%)	11 (2%)	11
Total	190 (100%)	482 (100%)	672

- It could be that medical staff in those wards have more time to check that they are treating people in accordance with the safeguards in the Act.
- Many people in secure wards are subject to long term treatment and there are fewer changes. In more acute situations, treatment can change frequently and it can be more difficult to make sure that it stays in line with the authorisation on forms.
- In acute care, the requirement for treatment forms may coincide with other demands, especially in relation to Tribunal hearings. Clinicians and records staff may miss the fact that two months have passed and the form is now due.
- Greater external scrutiny by the Commission and the Tribunal might make staff more aware of their responsibility to make sure that treatment is given lawfully.

We also examined the authorisation of "as required" treatment. The results are shown in table 3.

Again, we found that secure wards are more likely to prescribe and administer medication on an "as required" basis with proper authorisation (p=0.004).

These results confirm our expectation that wards that are more familiar with the Act are more likely to comply with the safeguards in part 16.

b) Storage of documentation

We asked where the statutory treatment forms were kept. We thought that it might aid compliance if the treatment forms were stored alongside the prescription charts. Of the 112 wards that provided information to us:

- Most (90 out of 105) kept copies of the treatment forms within the medication kardex.
- A minority (7 out of 105) kept the forms in a separate folder and not in the kardex.
- A minority (8 out of 105) kept the forms in case records only.

We found no relationship between the storage of forms and the compliance with the Act. It appears that even when forms are stored along with prescription charts there is the same risk of error.

Table 3: Authorisation of "as required" treatment in secure v non-secure wards

Authorisation of "as required" treatment	People in secure wards	People in other wards	Total
Properly authorised or not prescribed	177 (93%)	387 (80%)	564
Administered without proper authorisation or reporting	3 (2%)	35 (7%)	38
Prescribed without proper authorisation but not administered	10 (5%)	60 (13%)	70
Total	190 (100%)	482 (100%)	672

c) Alerts and audits

In addition to the availability of forms within medication kardexes, we asked about two other mechanisms to aid compliance with legislation.

- Sticker systems. In some wards, staff put warning stickers on people's individual prescription charts to remind anyone prescribing and administering medication that there is a T2 or T3 form. Forty-eight of the 105 wards had such a system.
- Regular audits. We asked if the ward conducted audits to make sure that treatment was prescribed and administered in line with the authorisation on the forms. Forty-two wards told us that they conducted audits.

Sticker systems did not appear to reduce the risk of unlawful treatment. Regular audits had some effect. In wards where audits were carried out, the risk of unlawful treatment was slightly reduced for regular treatment (table 4) but this did not reach statistical significance. There was no effect on the occurrence of unlawful "as required" treatment. If treatment is subject to frequent changes, audits conducted on an infrequent basis may not be a sufficient safeguard.

d) Clinical pharmacy input

Regular clinical pharmacy input from an experienced pharmacist, familiar with the requirements of the legislation, could be helpful in ensuring compliance. Pharmacists conduct regular checks of medication prescriptions. They can alert medical staff when doses are above the recommended maximum and they often check whether the prescribed medication is in line with T2 and T3 forms. We heard that clinical pharmacy had regular input to 96 of the 105 wards. This varied from daily to monthly visits.

We could not find that the presence or frequency of pharmacy input had an effect on the occurrence of unlawful treatment. We visited 188 people in wards where pharmacists visited more than once a week and took part in clinical meetings. Seventeen people (9%) received unauthorised regular treatment and 15 (8%) received unauthorised "as required" treatment. This was no better than wards with no pharmacy input.

Some wards told us that the pharmacist audits the authorisation of medication on T2 and T3 forms. The effectiveness of this was variable.

Table 4: Effect of regular audit on authorisation of treatment

	Audits	No audits	Total
Number of people seen	189	294	483*
Unauthorised regular treatment	14 (7%)	31(11%)	45
Unauthorised "as required" treatment	12 (6%)	16 (5%)	28

* We were not able to get this information in some of the wards we visited, e.g. if the nurse in charge at the time of our visit was relatively new or inexperienced.

We found some wards with a high unauthorised treatment rate even with pharmacy audit. Again, audits may not have been frequent enough to capture changes in treatment.

e) Training

We asked the nurses in charge of the wards when we visited if they had had any specific training on the treatment provisions of the 2003 Act. In 59 of the 105 wards, some training had been provided. In some cases, training had been organised when the Act was implemented five years previously and never repeated. Also, we are aware that training for approved medical practitioners, when the Act was implemented, did not cover part 16.

Training on part 16 of the Act for nurses appeared to have some benefit. We visited 102 people in wards where nurses had received training within the previous year. Six people had unauthorised regular treatment and only three had unauthorised "as required" treatment. This did not reach significance level but tends to suggest that recent training is of value. When we included "as required" medication that had been prescribed but not administered, we found that training was of significant benefit (table 5).

f) Availability of good practice guidance

The Commission has published good practice guidance on consent to treatment. It contains detailed guidance on the requirements of the legislation, guidance on what constitutes valid consent and guidance on how to complete the statutory forms. Fifty-seven of the 105 wards had ready access to our guidance.

The presence of our guidance had no effect on the rate of unauthorised treatment.

Table 5: Effect of training on legality of treatment

	Recent training	No recent training	
Number of people visited*	102	381	
Unauthorised prescribed regular treatment	6 (6%)	39 (10%)	(P=0.1)
Unauthorised prescribed "as required" treatment	10 (10%)	75 (20%)	(P=0.02)

* We were not able to record this information in some wards.

Conclusions and recommendations

In our view, there is insufficient attention paid to providing lawful treatment under the 2003 Act. It is not acceptable that up to 12% of the people we saw were being treated without proper authorisation. Also, we are concerned that practitioners do not pay enough attention to people's ongoing capacity to consent to treatment.

All practitioners who prescribe and administer treatment should pay close attention to this report. Service managers need to take action to make sure that they have systems in place to improve compliance with the Act. National action is needed to make sure that appropriate mental health practitioners have sufficient knowledge to carry out their duties under part 16 of the Act.

Recommendations

- Training on part 16 of the Act must be regular and form a core part of relevant practitioners' personal development plans.
- The Scottish Government and NHS Boards must ensure that training for approved medical practitioners addresses the shortcomings in practice that we have identified.
- All relevant clinical staff should have access to, and follow, our best practice guidance on consent to treatment. They should pay particular attention to the guidance on completion of treatment plans (see appendix 2 of this report) and ensure that all regular and "as required" prescriptions are covered by T2 or T3 forms.
- Hospital managers should ensure that they have local procedures to remind RMOs when treatment forms are due and to check that they have been completed timeously, properly and submitted to the Commission.
- Managers should ensure that regular audits of prescriptions and treatment forms are thorough and undertaken by appropriately trained practitioners.
- Clinicians should regularly check that people certified as giving consent on T2 forms are continuing to give valid consent to treatment.
- Scottish Ministers should reconsider the validity of written consent over long periods of time.
- Scottish Ministers should amend the 2003 Act to specify the length of time for which consent is valid.

The Commission remains concerned about the risk of unlawful treatment. We will repeat this exercise in the near future to find out if there have been improvements.

Appendix 1: Hospitals and individuals visited

Ailsa	17
Argyll and Bute	15
Ayr Clinic	20
Ayrshire Central	1
Borders General	5
Borders NHS	4
Carseview Centre	7
Coathill	7
Crichton Royal	9
Crosshouse	9
Dr Grays	4
Dykebar	4
Galavale House	3
Gartnavel Royal	37
Hairmyres	10
Hartwoodhill	16
Herdmanflat	2
Kirklands	3
Leverndale	22
Lochview	6
Lynebank	5
Monklands	4
Murray Royal	30
New Craigs	14
Parkhead	21
Queen Margaret	5
Ravenscraig	3
Rowanbank Clinic	50
Royal Cornhill	40
Royal Dundee Liff	3
Royal Edinburgh	79
Royal Infirmary Of Edinburgh	1
Seafield	1
Southern General	4
St Johns	17
Stobhill	24
Stratheden	25
Strathmartine	5
Sunnyside Royal	9
Surehaven	5
The State	118
Whytemans Brae	4
Wishaw General	4
Grand total	**672**

Appendix 2: Reproduced from "Consent to treatment"

Treatment plans

This section provides some guidance on best practice in writing a treatment plan in relation to part 16 of the Act. We recommend separate plans for electroconvulsive therapy (ECT) and for artificial nutrition. Medication for mental disorder beyond two months and medication to reduce sex drive can be authorised on one form (either T2 if consenting to both or T3 if not consenting to both).

ECT

Treatment with ECT should be regarded as a course. However, where the person consents, this consent must be reviewed prior to each treatment. It would be best practice for the person being treated to confirm, either in writing or verbally, with a witness, that he/she is willing to continue with treatment. When documenting a course of ECT on a treatment plan, we recommend that the plan includes:

- Whether treatment will be administered as unilateral or bilateral (or that either method is acceptable).
- The maximum number of treatments per week that the person can receive (usually two).
- The maximum number of treatments authorised by the certificate (usually no more than 12).
- The duration of the authority of the certificate.
- The plan may include a statement on the maximum allowed intervals between treatments. This is not essential. However, we advise that a new certificate is required if the last treatment was more than 14 days ago.

Artificial nutrition

This is most likely to be used for people with eating disorders. It could be indicated for people with other forms of mental illness where the person is unwilling or unable to eat because of mental disorder. If the person needs artificial nutrition because of physical illness, it would be more appropriate to use the 2000 Act. The plan should specify the form of artificial nutrition, e.g. nasogastric or PEG tube. It should also specify duration of the authority to treat. Usually, this should be no more than three months. We do not think that giving fluids intravenously constitutes artificial nutrition. The Mental Welfare Commission has issued separate guidance on Artificial Nutrition.

Medication

Under the 2003 Act, only medication for mental disorder needs to be recorded on a treatment plan. Treatment for side effects of drugs for mental disorder does not constitute treatment for mental disorder. This might include treatment for drug-induced Parkinsonism or constipation. Also, it is not necessary to include drug treatment for epilepsy. Anti-convulsant drugs are often used to treat mental disorder and should be recorded on the plan if used for that or if used for both purposes.

Best practice in recording medication on treatment plans includes:

- Record the class or classes of drug treatment by referring to the section number in the British National Formulary (BNF). Responsible Medical Officers (RMOs) and Designated Medical Practitioners (DMPs) are best advised to have an up-to-date BNF available when completing a treatment plan. If naming a particular drug, use the British approved name.
- State the route of administration (e.g. oral or intramuscular injection).
- State the maximum permitted dosage; usually, referring to BNF maximum doses and frequency of administration does this best. It may be necessary to specify lower doses for some people. See below for high doses.
- Specify any drug treatment for "as required" use separately on the plan. Be especially careful about the dosage and frequency to ensure that treatment will not exceed BNF limits. Oral medication and medication by injection should be specified separately.
- For certain treatments, the plan may state that the administration of the drug should achieve a certain serum level.
- If medication authorised by the plan exceeds the recommended BNF maximum, the plan should state a requirement for special monitoring in accordance with guidance from the Royal College of Psychiatrists.
- Clozapine is a special case and should be documented by name. The plan should state that it also covers associated blood tests. (NB this is only the case for clozapine because of its product licence. Other drugs, e.g. lithium, also need blood tests but a treatment plan cannot authorise these. In both cases, practitioners will need to consider whether blood monitoring will be possible. In theory, it could be enforced to monitor clozapine although the distress this would cause the person might outweigh the possible benefits of treatment.)

Where the patient gives capable consent to treatment, it is best practice to specify the actual medication(s) on form T2, rather than give broad classes. It would also be good practice to record the purpose of the medication on the form. The form can be saved electronically and, with the patient's agreement, altered at a later date if necessary. If the patient does not consent, it is reasonable for the treatment plan to be broader by including classes of medication. The Mental Welfare Commission will provide a proforma for outlining a proposed treatment plan. A DMP will visit and will authorise an agreed treatment plan on form T3. The RMO and DMP will need to agree a plan that is broad enough to ensure that appropriate changes to treatment are possible without a further DMP visit. The plan must, however, be relevant to the individual. The plans should also only include treatment that is currently necessary, or likely to be needed, should present treatment be ineffective.

mentalwelfare
commission for scotland

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809

enquiries@mwcscot.org.uk

www.mwcscot.org.uk

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