mentalwelfare commission for scotland

STATISTICAL MONITORING

Mental Health Act monitoring report 2016-17

Reviewed May 2018

Contents

The Mental Welfare Commission

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

1. Overview of the use of the Mental Health (Care and Treatment) (Scotland) Act 2003

We have a statutory duty to monitor the use of the Mental Health Act (Care & Treatment) (Scotland) 2003. We do this by checking that all relevant paperwork is correct and by publishing this monitoring report. This year we present data from 2016-2017, as well as some 10 year trend data. We have also included statistical analysis to allow significant outliers to be more easily identified. We will follow this information up with health boards and local authorities in our end of year meetings.

Key findings

In 2016-17 we were notified of 5422 new episodes of compulsory treatment during the year. This was an increase of 8.2% on the previous year. This is the highest number of new compulsory episodes since the 2003 Act was implemented, and is now above the level of new compulsory episodes under the 1984 Act in 2001-02 (4,849), having followed an upward trend since 2009-10. In the last ten years the rate has increased from 81.5 (2007-08) to 100.3 (2016-17) per 100,000 population. This represents a 23% increase.

Seventy three per cent of episodes of compulsory treatment lasted for 28 days or less.

The number of new episodes starting with an emergency detention certificate (EDC) has risen by 11.6% this year, with an increase of 25.5% since 2007-08. In the ten year period the rate has increased from 37.2 to 44.7 per 100,000 population.

The number of people put straight onto a short term detention certificate (STDC) has risen over the ten year period by 34% (2161 in 2007-08 to 2905 in 2016-17). The rate has increased from 41.8 to 53.7 per 100,000.

In the last year, the rate of use of EDCs was almost five times higher in Dumfries and Galloway than in Grampian.

Over the ten year period, the percentage of EDCs across Scotland with mental health officer (MHO) consent has fallen from a high of 68% in 2008/09 to 54% in 2016/17.

Mental illness accounts for the vast majority of people detained under a STDC. In 2016/17 only one per cent of STDCs were for people with learning disability alone, and three per cent for people with learning disability and mental illness. Similarly, only two per cent were for people with a personality disorder alone.

Over the ten year period, the prevalence of compulsory treatment orders (CTOs)* has increased by 20.6% from 37.8 per 100,000 at January 2008 to 45.6 per 100,000 at January 2017. This continues the upward trend.

*In this report, please note that CTOs are hospital orders only, community compulsory treatment orders (CCTOs) are not included (Amended 26/02/2018)

We have found large variations in the use of compulsory treatment across Scotland. We find this variation hard to explain and have made the following recommendation:

Recommendation

We recommend that the Scottish Government explores how to better understand the significant variations in the use of compulsory treatment through data linkage with other information sources.

The number of place of safety order notifications received (1133) has risen by 37% from last year (830). This is a 90% rise since 2011/12. We think this reflects better reporting by the police. The proportion of incidents where the place of safety was a police station has risen this year (5%, 58) but is still below the earlier high in 2011/12 (18%, 108).

2. New episodes of civil compulsory treatment

In 2016-17 we were notified of 5422 new episodes of compulsory treatment during the year. This was an increase of 8.2% on the previous year. This is the highest number of new compulsory episodes since the 2003 Act was implemented, and is now above the level of new compulsory episodes under the 1984 Act in 2001/02 (4,849), having followed an upward trend since 2009/10. In the last ten years the rate has increased from 81.5 (2007-08) to 100.3 (2016-17) per 100,000 population.

Table 2.1 New episodes of civil compulsory treatment initiated 2007-08 to 2016-2017

New episode starts with this order [y]	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16-17	16-17 % rise
EDC	1923	1859	1805	1805	1766	1878	1887	1969	2164	2414	11.6%
STDC	2161	2229	2232	2423	2421	2452	2529	2803	2755	2905	5.4%
Compulsory Treatment Order (CTO)* [xx] (includes interim orders)	131	99	78	101	95	102	113	89	94	103	9.6%
Total episodes	**4215**	**4187**	**4115**	**4329**	**4282**	**4432**	**4529**	**4861**	**5013**	**5422**	**8.2%**

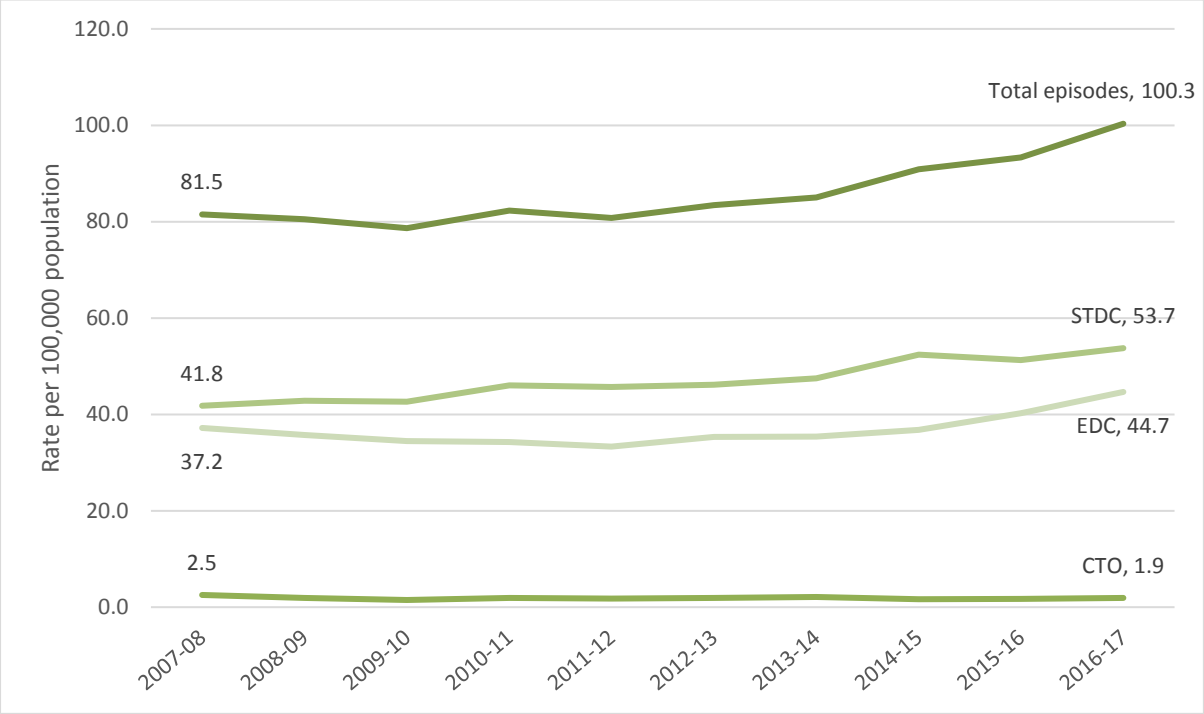
*In previous years data on CTOs has been taken from MHTS; this year all data has been taken from the Commission information management system.

[xx] Includes a small number of cases direct to ICTO only, or initially to ICTO then onto CTO.

[y] This is the starting order in a new sequence of one or more orders.

NB: these are new episodes only. This does not include EDCs and STDCs for people already subject to community CTOs. The numbers of EDCs and STDCs reported elsewhere in our report are larger because they include these additional people.

Figure 2.1 New compulsory episodes initiated 2007-08 to 2016-17 (rate per 100,000 population) by episode starting order



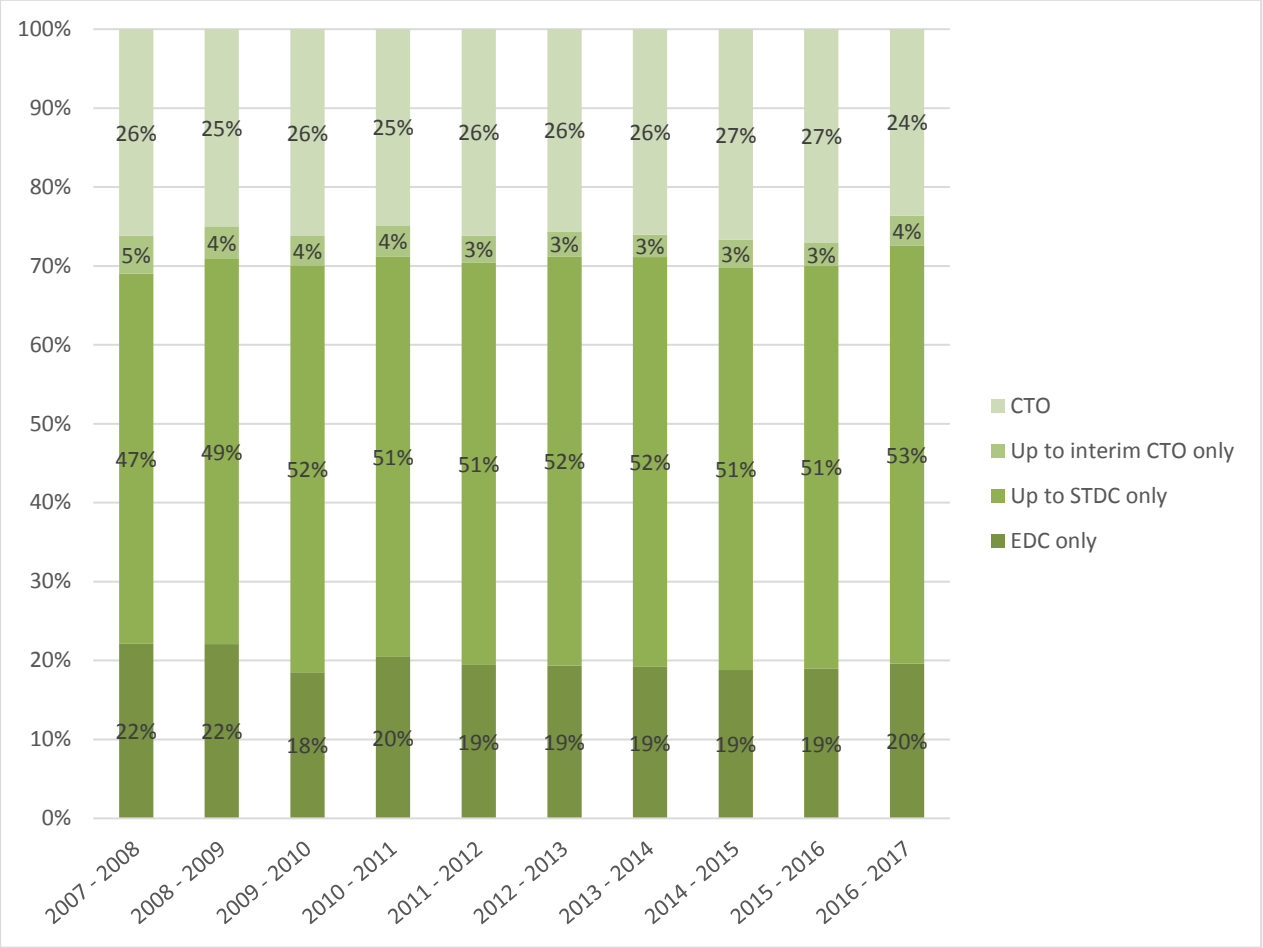
The number of new episodes starting with an EDC has risen by 11.6% this year, with an increase in numbers of 25.5% since 2007-08. In the ten year period the rate has increased from 37.2 to 44.7 per 100,000 population.

The number of people put straight onto a STDC has risen over the ten year period by 34.4% (20017-08, 2161 to 2016-17, 2905). The rate has increased from 41.8 to 53.7 per 100,000. This is the preferred route to compulsory treatment as it affords the patient more safeguards.

New episodes per year starting with a compulsory treatment order have varied from an initial high of 131 (rate 2.5) to 78 (rate 1.5) in 2009-10, to the current figure of 103 per year (rate 1.9 per 100,000).

We looked at the progression of episodes of compulsory treatment that were initiated during the year.

Figure 2.2 Progression of types of compulsory civil episodes 2007-08 to 2016-17



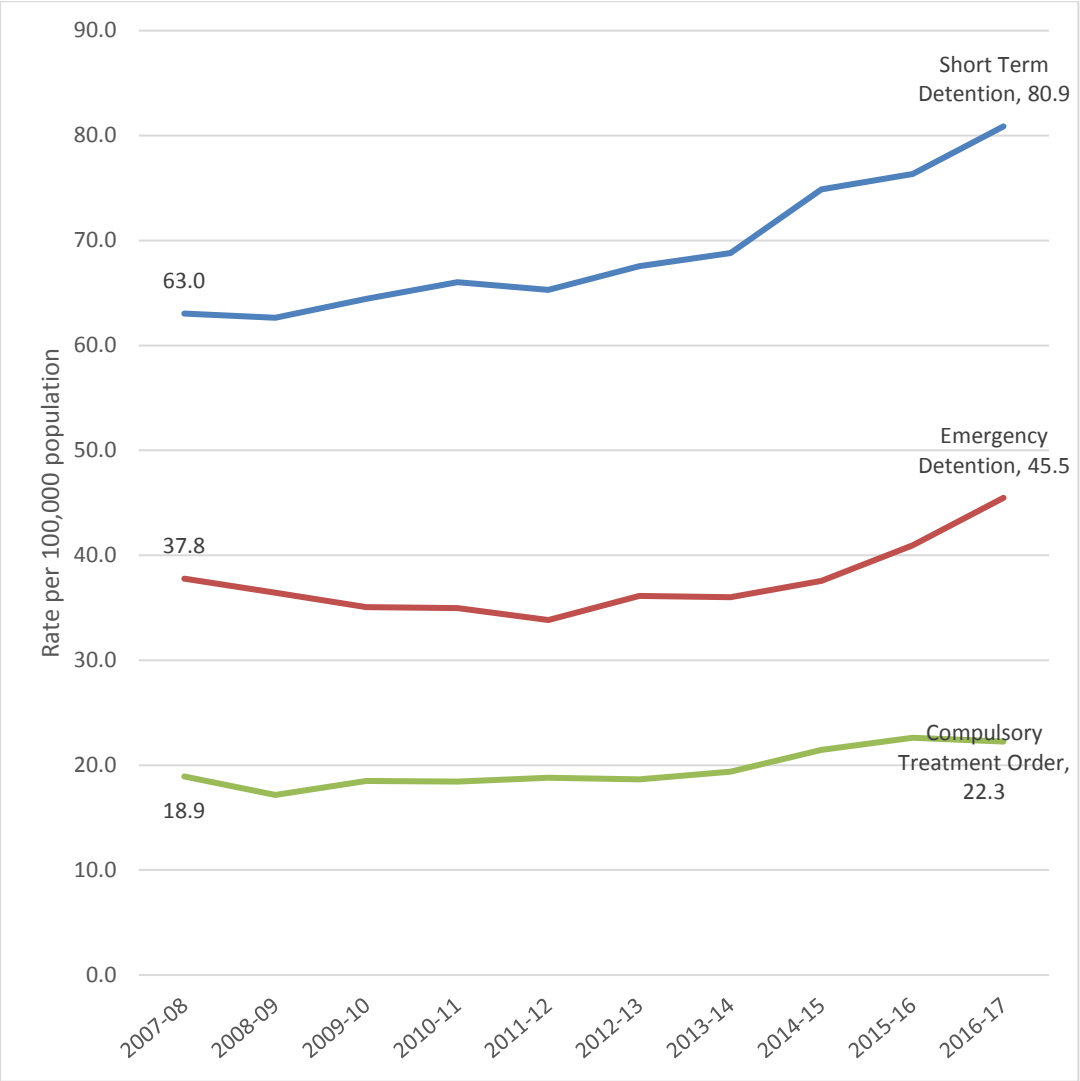
Findings of note from this chart are:

- Over the ten year period, around a quarter (24-27%) of all episodes of compulsory treatment resulted in the granting of a long term CTO. In addition, 3-5% of episodes progressed to an interim CTO without a final CTO being granted.

- The remaining 69-73% of all episodes of compulsory treatment lasted for 28 days or less. This percentage was highest in the last year (2016-17, 73%).

3. New orders

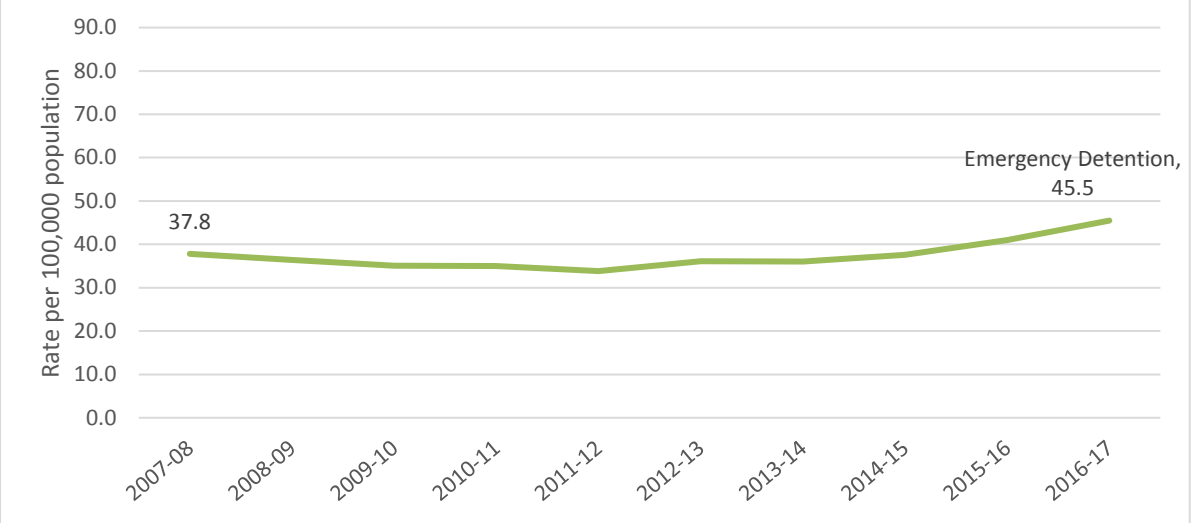
Figure 3.1 New orders across Scotland (rate per 100,000 population)



On the following pages we look at the different orders in more detail.

3.1 Emergency detention certificates (EDCs)

Figure 3.1.1 EDCs (rate per 100,000 population) 2007-17

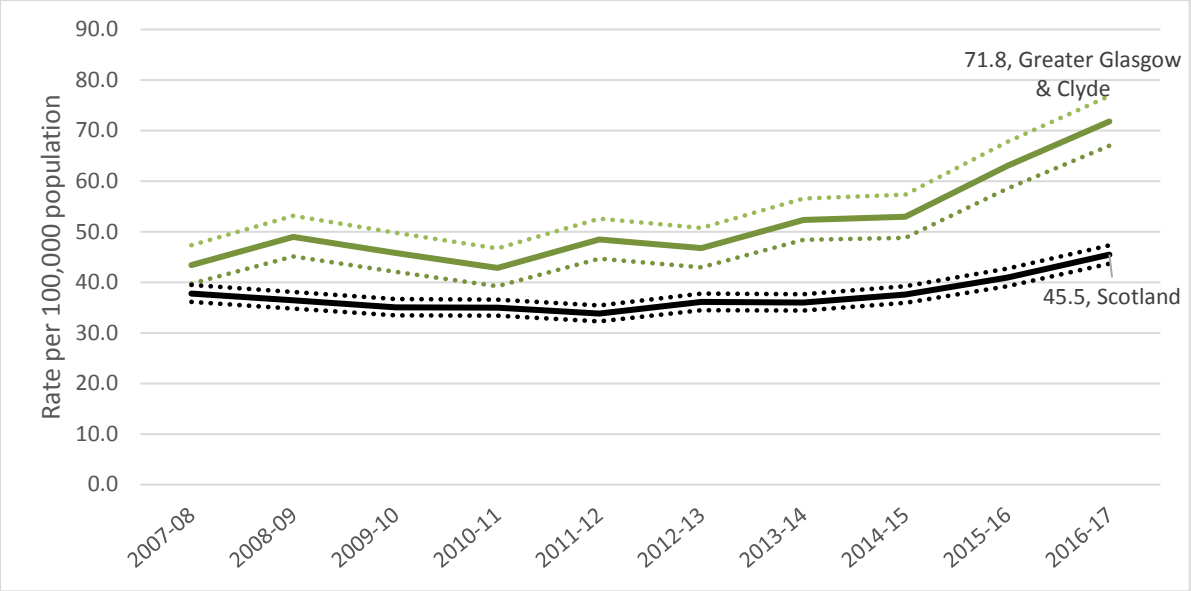


The number of EDCs completed per year has increased by 25.9% (1953 to 2458) over the ten year period.

The national rate has risen from 37.8 to 47.5 per 100,000 population. After a low of 33.8 in 2011/12 it has risen steadily, with a sharper increase in the last two years.

The following charts show the NHS boards which are significantly above or below the national average.

Figure 3.1.2 EDCs Greater Glasgow & Clyde (95% confidence intervals*)



* A confidence interval gives a measure of the precision of a value. It shows the range of values that encompass the population or 'true' value, estimated by a certain statistic, with a given probability. For example, if 95% confidence intervals are used, this means we can be sure that the true value lies within these intervals 95% of the time.

Figure 3.1.3 EDCs Dumfries & Galloway (95% confidence intervals)

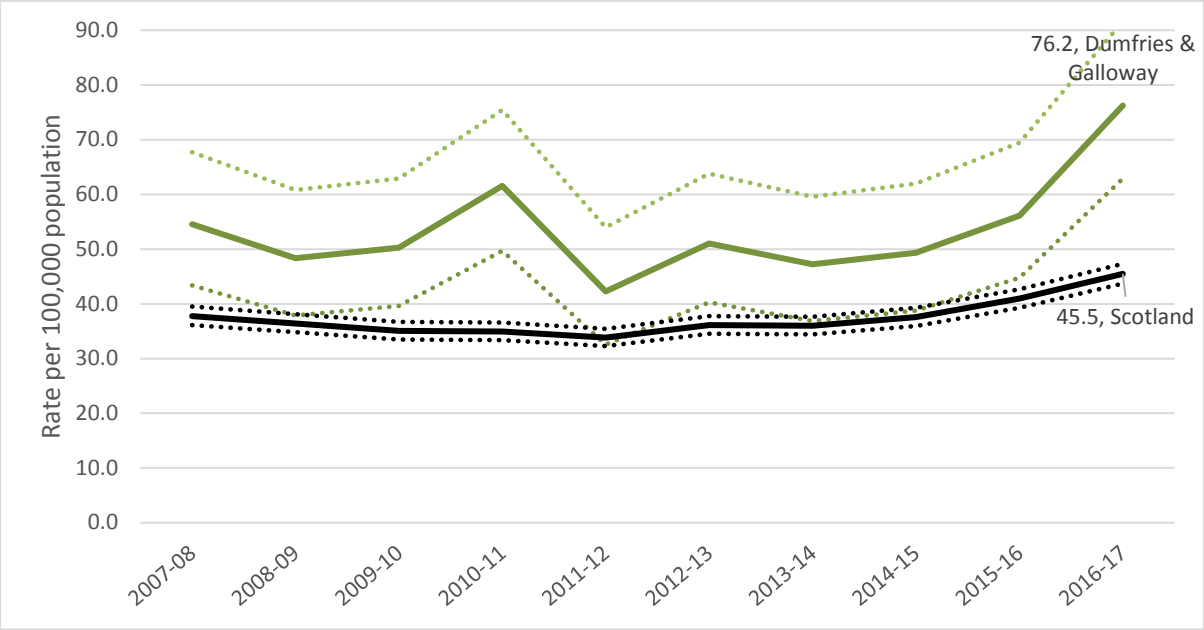
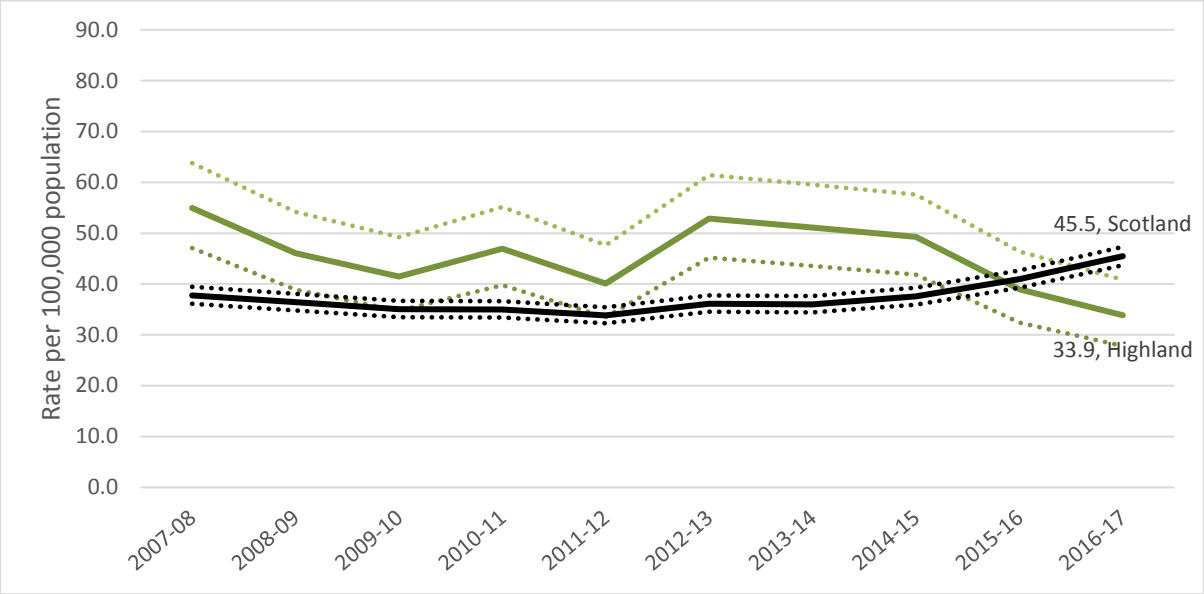


Figure 3.1.4 EDCs Highland (95% confidence intervals)



All health boards have shown considerable variation in rates per 100,000 population over the ten year period.

Over the ten years, two health boards have been consistently above the Scotland rate. Greater Glasgow and Clyde has risen from 43.4 to 71.8 per 100,000, and has shown a steep rising trend since 2012/13. Dumfries and Galloway has risen from 54.5 to 76.2 per 100,000. After falling to a low of 42.3 in 2011/12 it has continued to rise.

Highland health board has been above the Scotland rate for six out of the ten years but has been falling since a high of 52.8 in 2012/13.

Figure 3.1.5 EDCs Grampian (95% confidence intervals)

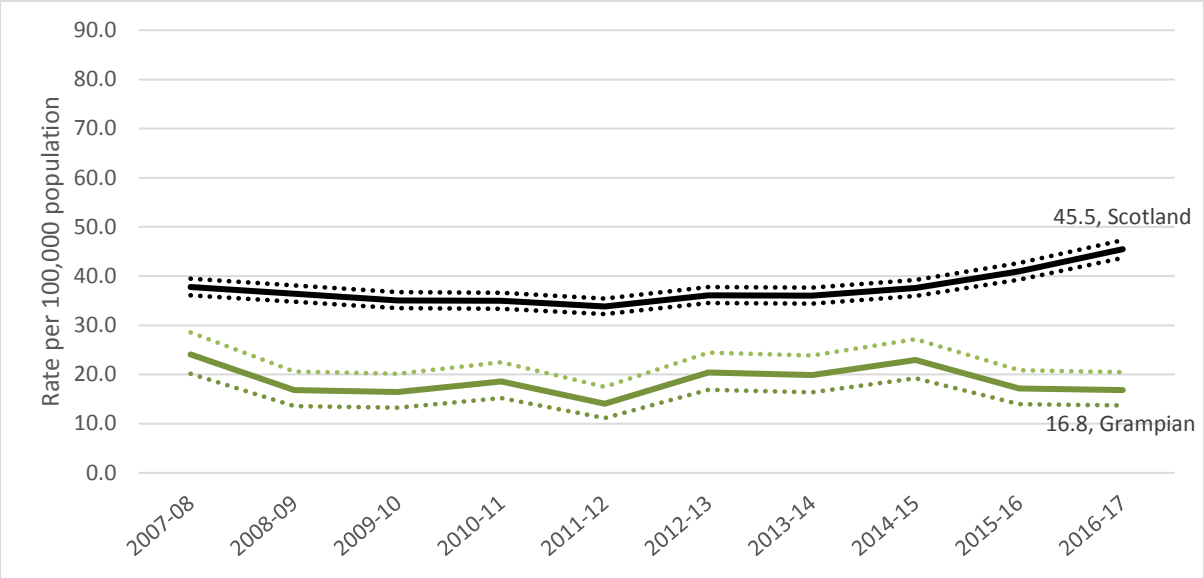
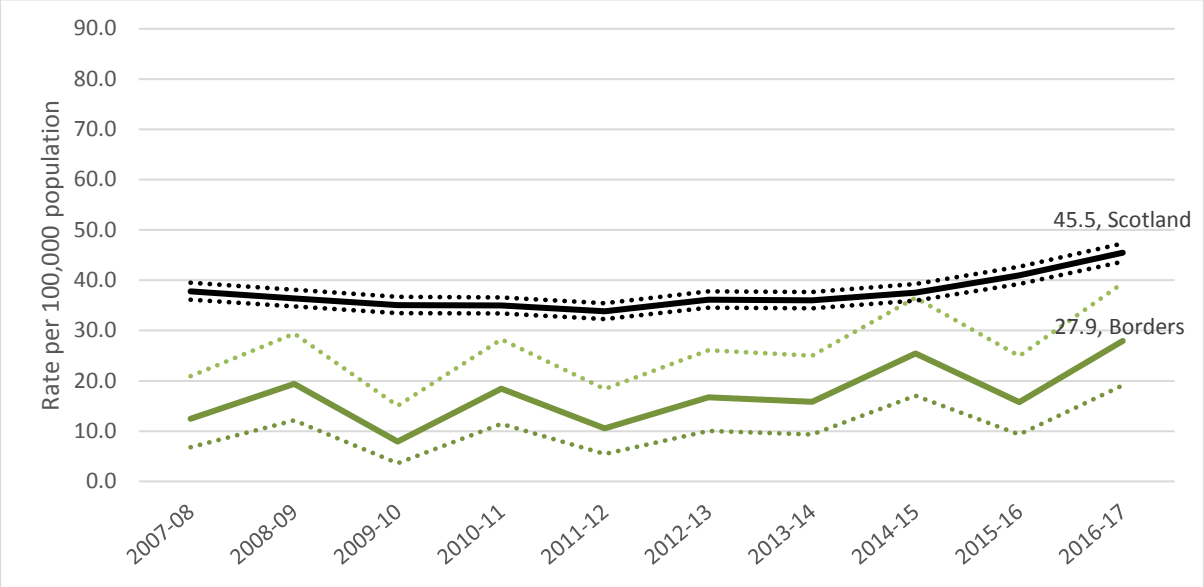


Figure 3.1.6 EDCs Borders (95% confidence intervals)

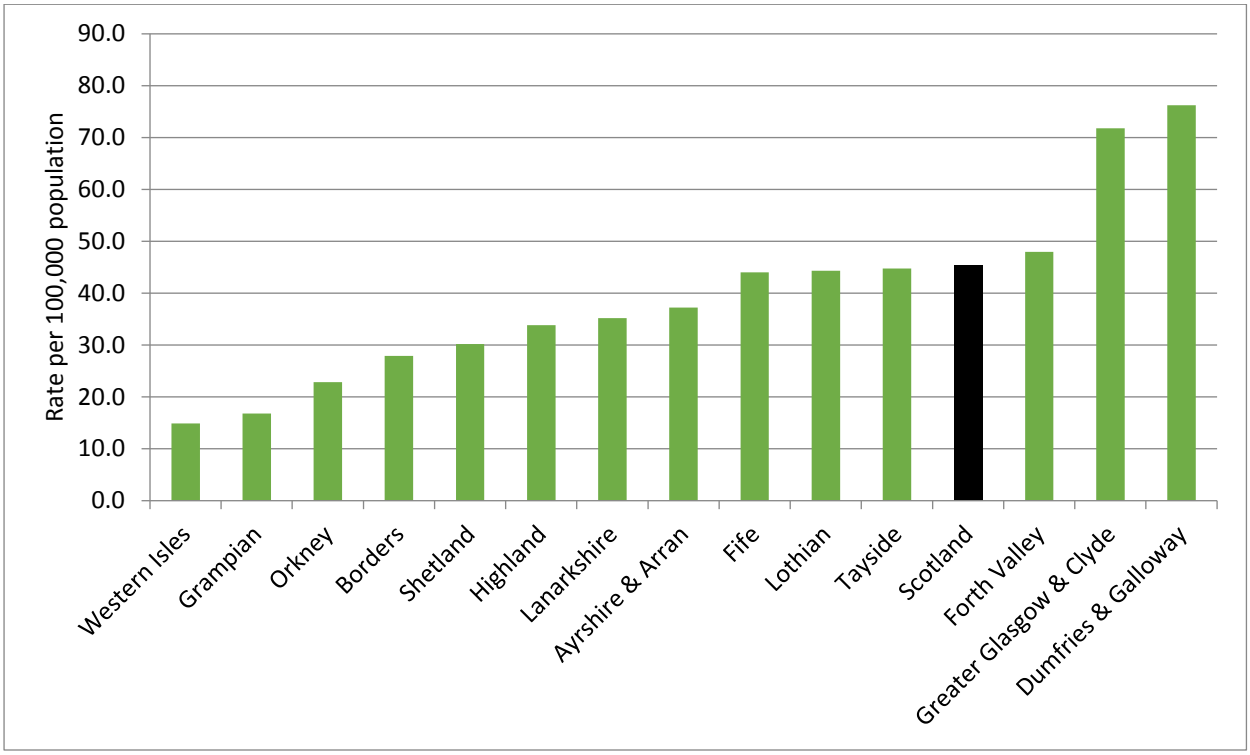


Grampian and Borders have been consistently below the Scotland rate; but whereas Grampian appears to be falling overall (24.1 to 16.8), Borders appears to be rising (12.5 to 27.9).

It can be seen that the rate of EDCs is almost five times higher in Dumfries and Galloway than it is in Grampian.

Emergency detention certificates by health board 2016/17

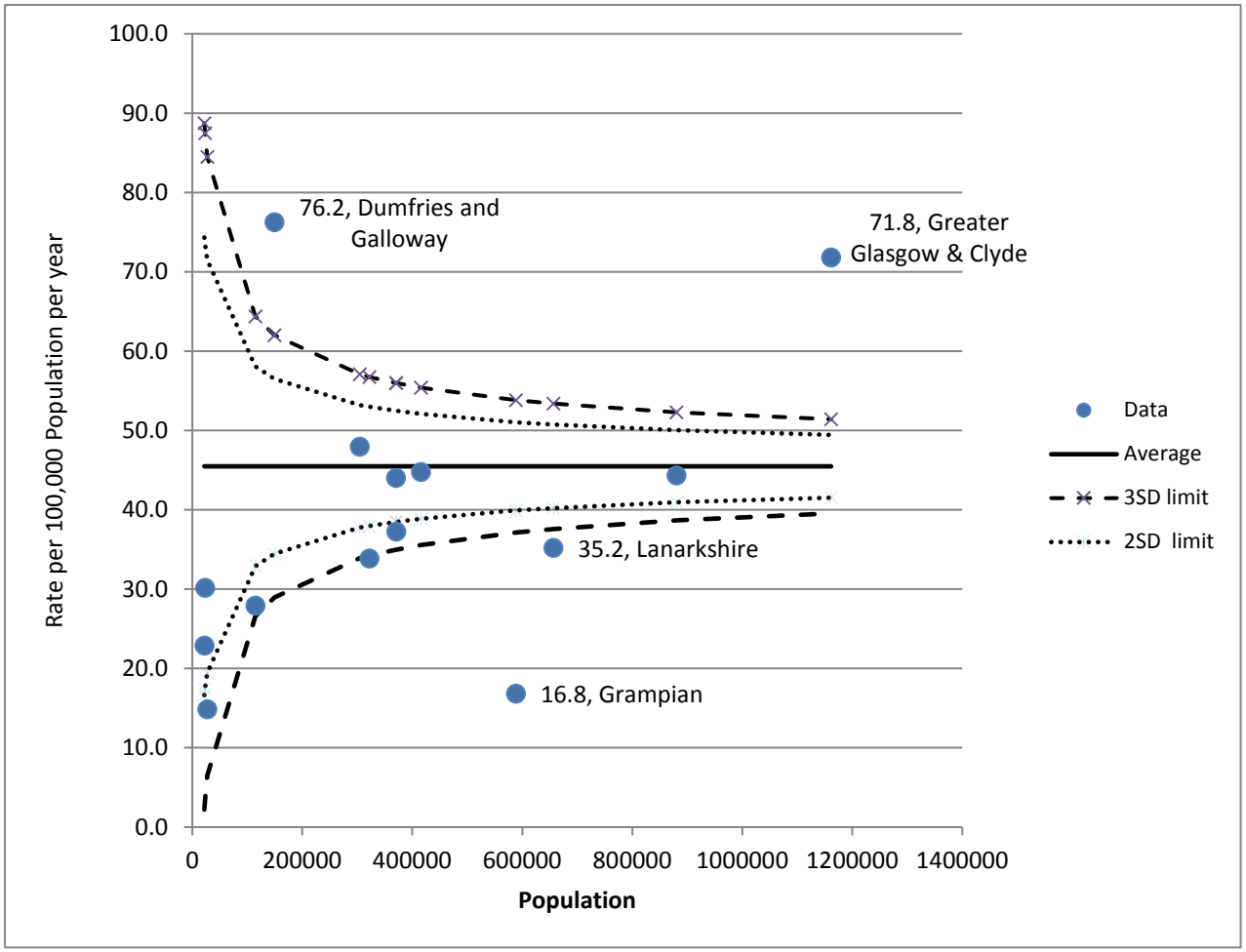
Figure 3.1.7 EDCs by health board 2016/17 (rate per 100,000 population)



In 2016/17 two local health boards continue above the Scotland rate (45.5; 95% CI: 43.7 to 47.3). Greater Glasgow & Clyde (71.8; 95% CI: 67 to 76.9), which has the largest population, has the second highest rate after Dumfries and Galloway (76.2; 95% CI: 62.9 to 91.6), which has one of the smallest populations.

In 2016/17 health boards below the Scotland rate (45.5; 95% CI 43.7 to 47.3) are Lanarkshire (35.2; 95% CI 30.8 to 40.0), Highland (33.9; 95% CI: 27.8 to 40.8), Borders (27.9, 95% CI: 19.1 to 39.4), and Grampian (16.8; 13.7 to 20.5).

Figure 3.1.8 Funnel plot* showing rates of EDCs at NHS board level 2016-17



Key

Rate per 100,000	Health board
76.2	Dumfries & Galloway
71.8	Greater Glasgow & Clyde
48.0	Forth Valley
45.5	Scotland
44.8	Tayside
44.3	Lothian
44.0	Fife
37.2	Ayrshire & Arran
35.2	Lanarkshire
33.9	Highland
30.2	Shetland
27.9	Borders
22.9	Orkney
16.8	Grampian
14.9	Western Isles

*A funnel plot is a type of control chart where an indicator is plotted against the denominator and shown in relation to a reference figure (e.g. the Scottish average). Control limits are set at three standard deviations from the average and get narrower from left to right on the chart as the size of the denominator increases. Data points that are outside these control limits are called 'outliers' and may be worthy of further investigation. More details on funnel plots and statistical process control methods can be found on the Quality Improvement Hub website. An example is given below.

https://www.isdscotland.org/Health-Topics/Heart-Disease/Publications/2015-09-22/2015-09-22-HeartDiseaseIndicators-Report.pdf?74964541197

Emergency detention certificates by gender and age group

What we found

The number of emergency detention certificates completed per year has increased by 25.9% (1953 to 2458) over the ten year period.

The national rate has risen steadily from 37.8 to 47.5 per 100,000 people.

The national rate for women has risen from 38.3 to 45.9, and for men from 37.2 to 45.0 per 100,000 people.

The following charts illustrate variances by gender and age group in rates per 100,000 population.

Figure 3.1.9 EDCs - Women by age group 2007-17

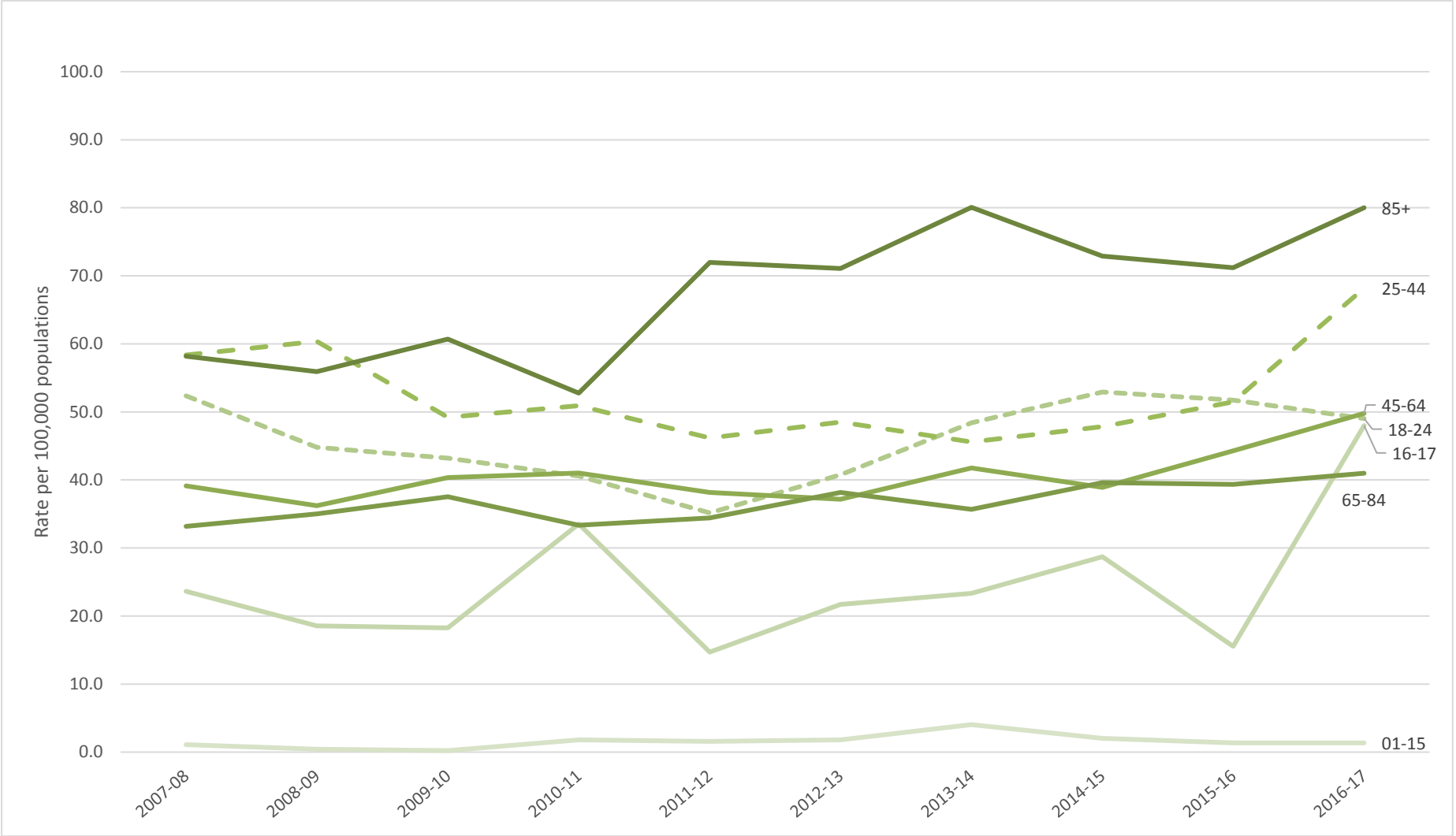
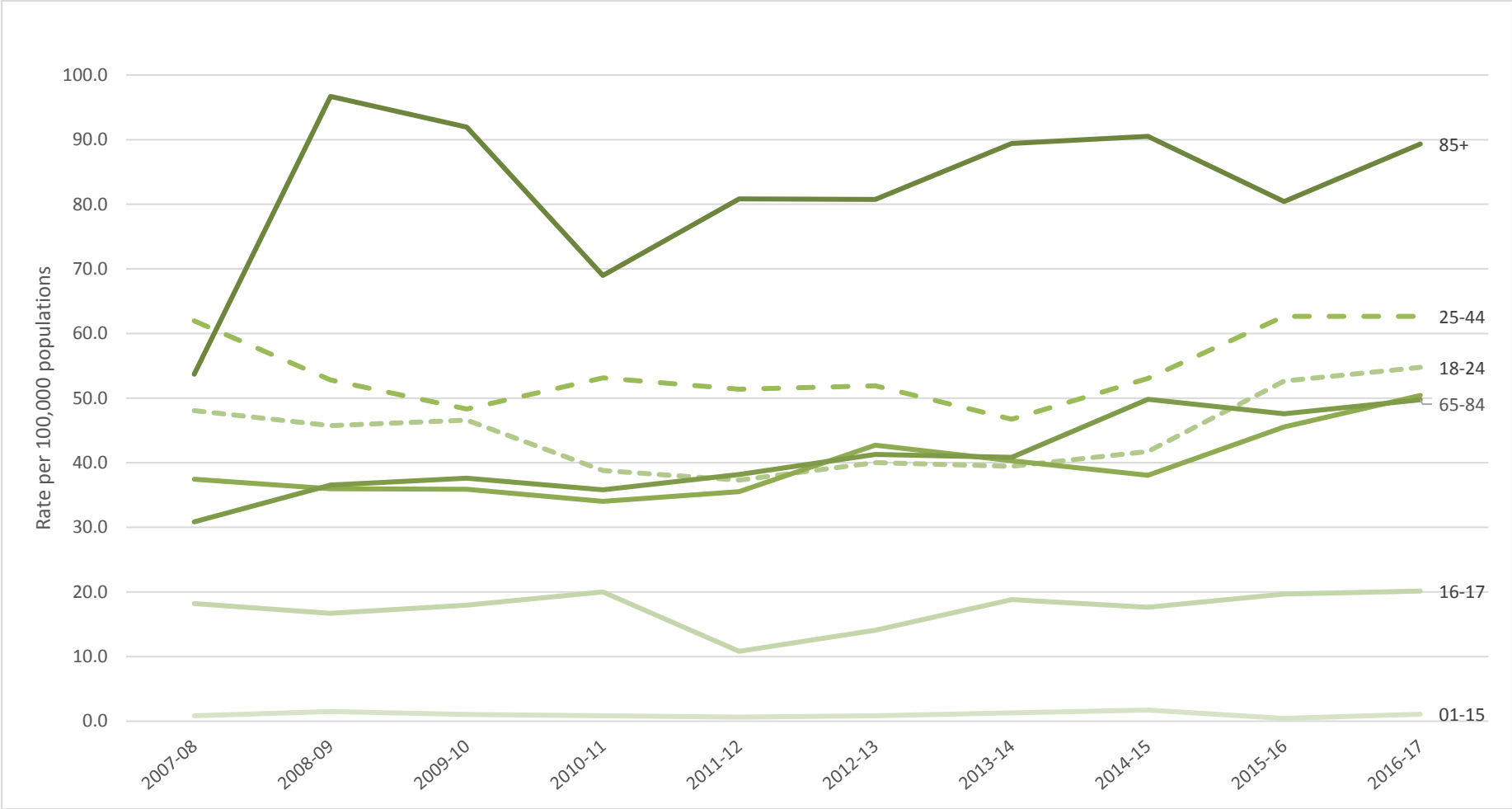
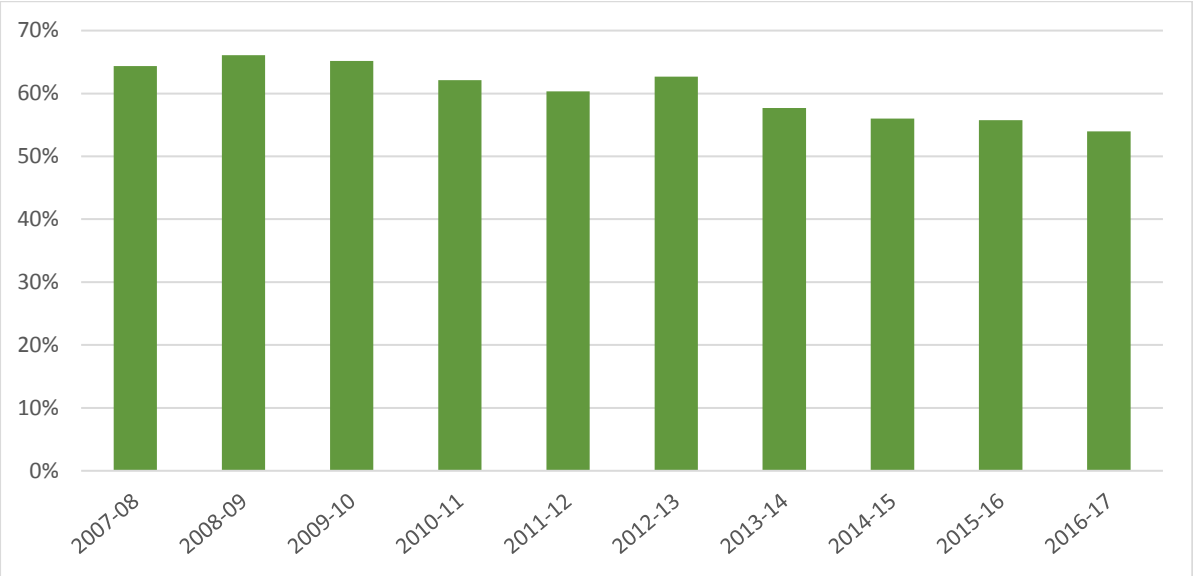


Figure 3.1.10 EDCs - Men by age group 2007-17



Mental health officer (MHO) Consent

Figure 3.1.11 Percentage of EDCs across Scotland with MHO consent



Over the ten year period, the percentage of EDCs across Scotland with MHO consent has fallen from a high of 68.1% in 2008/09 to the current percentage of 54% in 2016/17.

In 2016/17, of the 2,458 people across Scotland made subject to an EDC, we found that 46% did not have the consent of an MHO, similar to the previous two years (44-45%).

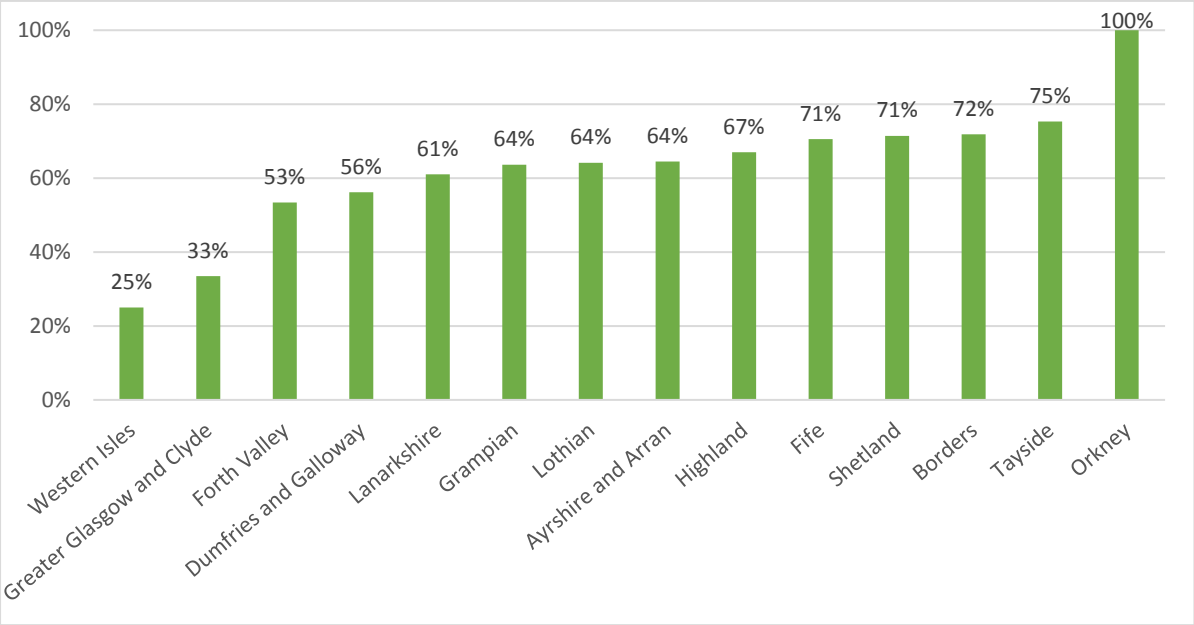
This year four health boards have made improvements in the percentage of consents: Dumfries & Galloway from 52% to 56%; Grampian from 61% to 64%; Highland from 57% to 67%; and Tayside from 73% to 75%.

Greater Glasgow and Clyde decreased slightly from 35% to 33% this year.

In 2016 we published a report which examines Scotland's high levels of emergency mental health detention without the consent of specialist social workers[1]. This continues to be an issue of concern to the Commission. We hope that it will be taken into account in the implementation of the commitment in the Scottish Government Mental Health Strategy to consider how to alleviate pressures on MHOs. It also requires local action, particularly in areas where the level of consent is low. We will follow this up with NHS boards, local authorities and health and social care integration joint boards (IJBs).

[1] Mental Welfare Commission for Scotland (June 2016) Emergency detention certificates without mental health officer consent http://www.mwcscot.org.uk/media/321062/edc_report_2016.pdf

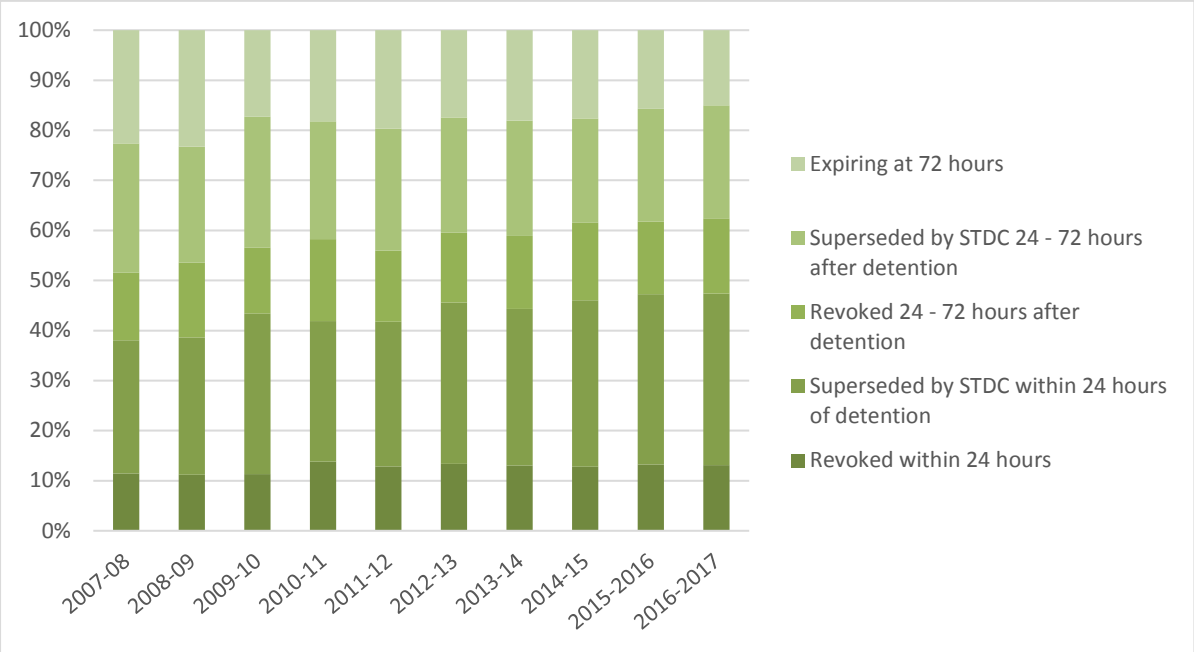
Figure 3.1.12 Percentage of EDCs with MHO consent for all NHS boards 2016-17



Duration of emergency detention

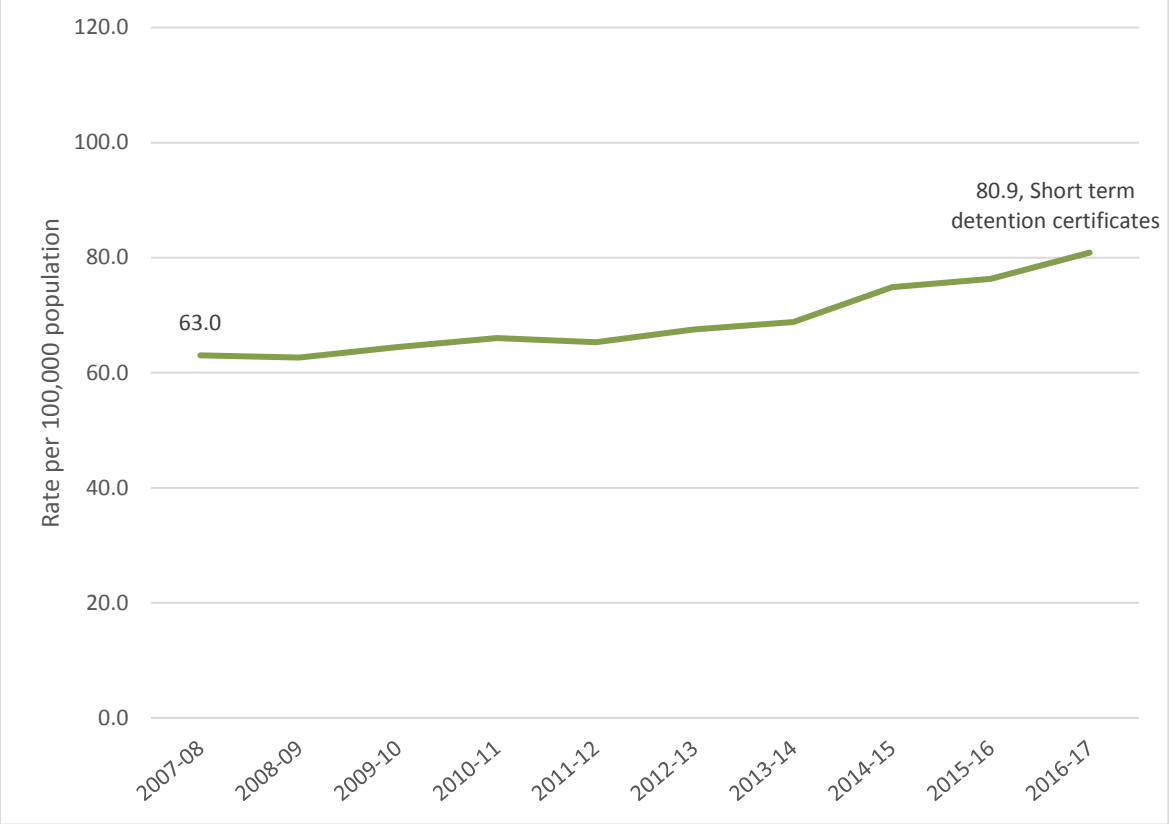
Over the ten year period, the percentage of individuals on an EDC who have had the order revoked or superseded by a STDC within the first 24 hours has increased from 38% (734) to 47% (1157).

Figure 3.1.13 Duration of emergency detention 2007-17



3.2 Short term detention certificates (STDCs)

Figure 3.2.1 STDCs across Scotland (rate per 100,000 population) 2007-17



The number of short term detention certificates completed per year has increased by 34.1% (3259 to 4371) over the ten year period.

The national rate has risen steadily from 63.0 to 80.9 per 100,000 population.

Figure 3.2.2 STDCs in Greater Glasgow & Clyde (95% confidence intervals)

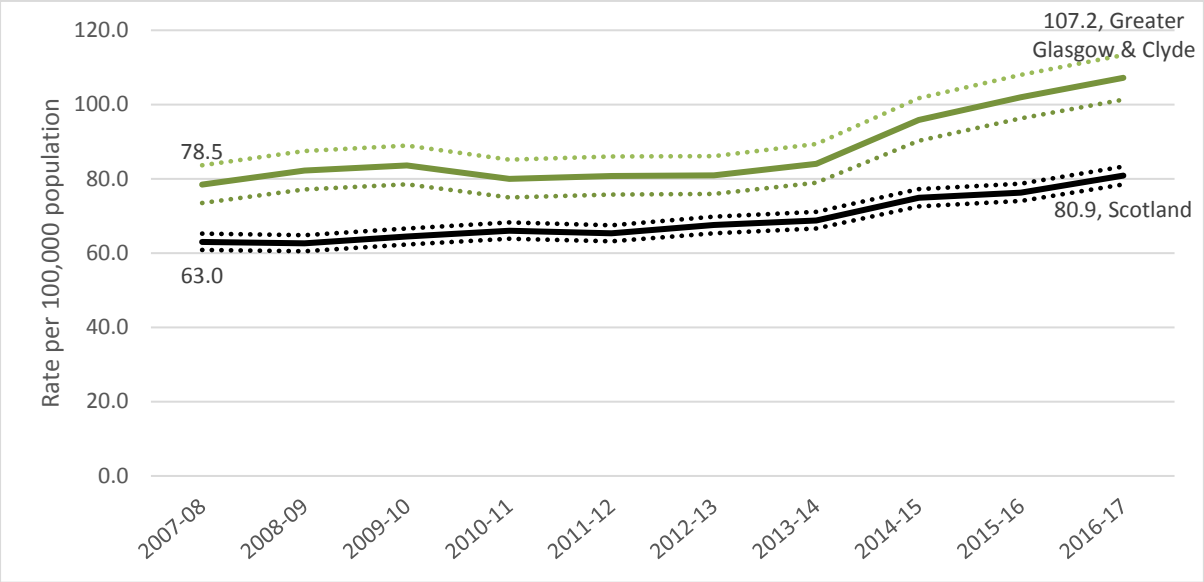
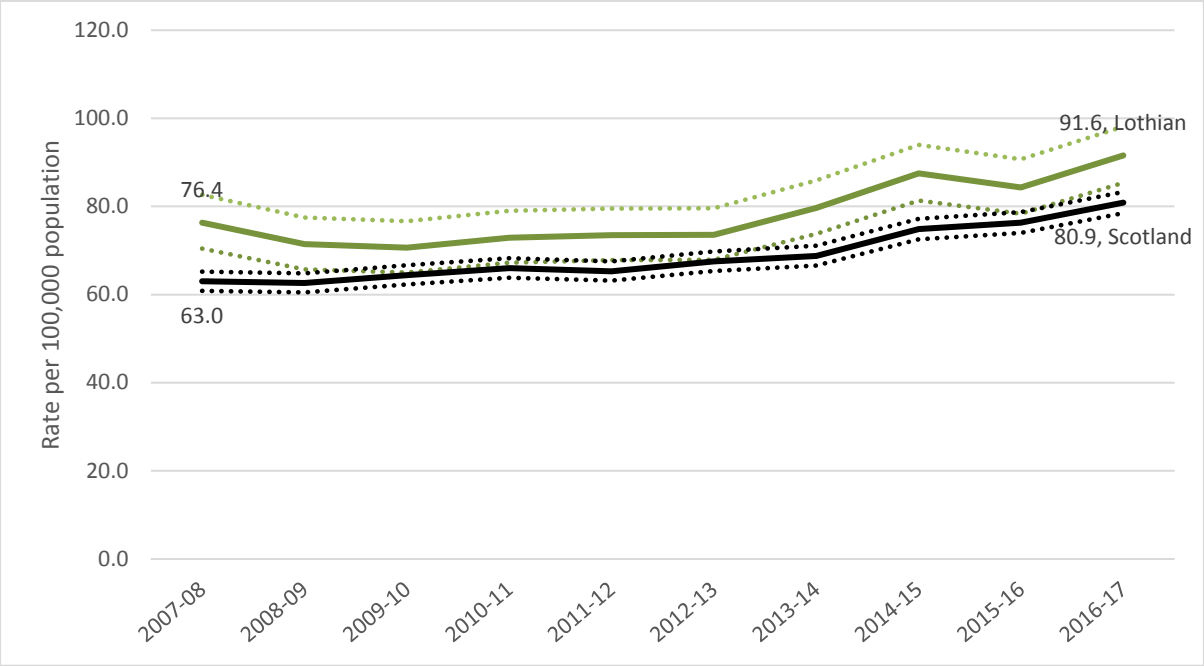


Figure 3.2.3 STDCs in Lothian (95% confidence intervals)



All health boards have shown considerable variation in rates per 100,000 population for short term detention certificates over the ten year period.

Greater Glasgow and Clyde and Lothian have had consistently higher rates than Scotland. GG&C has shown the largest increase in the rate (78.5 to 107.2), whilst Lothian has increased from 76.4 to 91.6 in the period.

Figure 3.2.4 STDCs in Lanarkshire (95% confidence intervals)

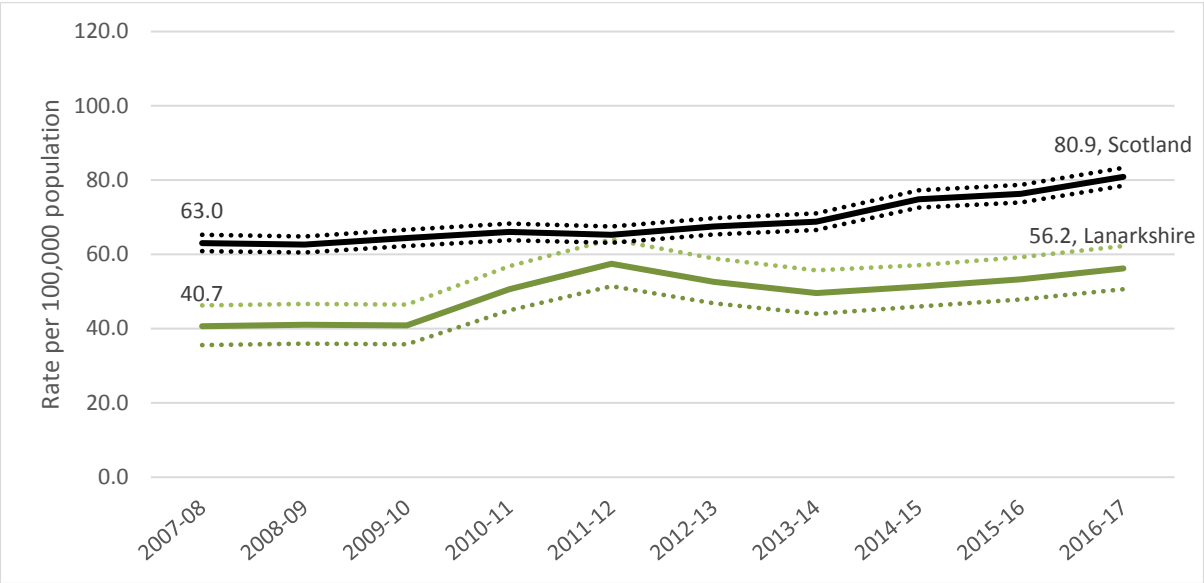


Figure 3.2.5 STDCs in Ayrshire & Arran (95% confidence intervals)

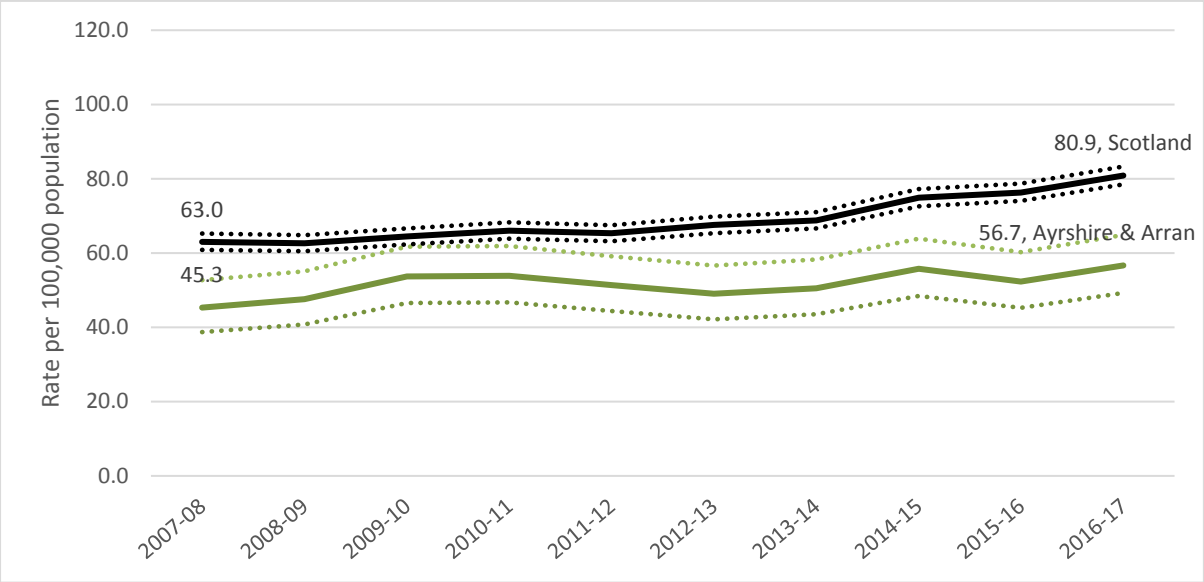


Figure 3.2.6 STDCs in Borders (95% confidence intervals)

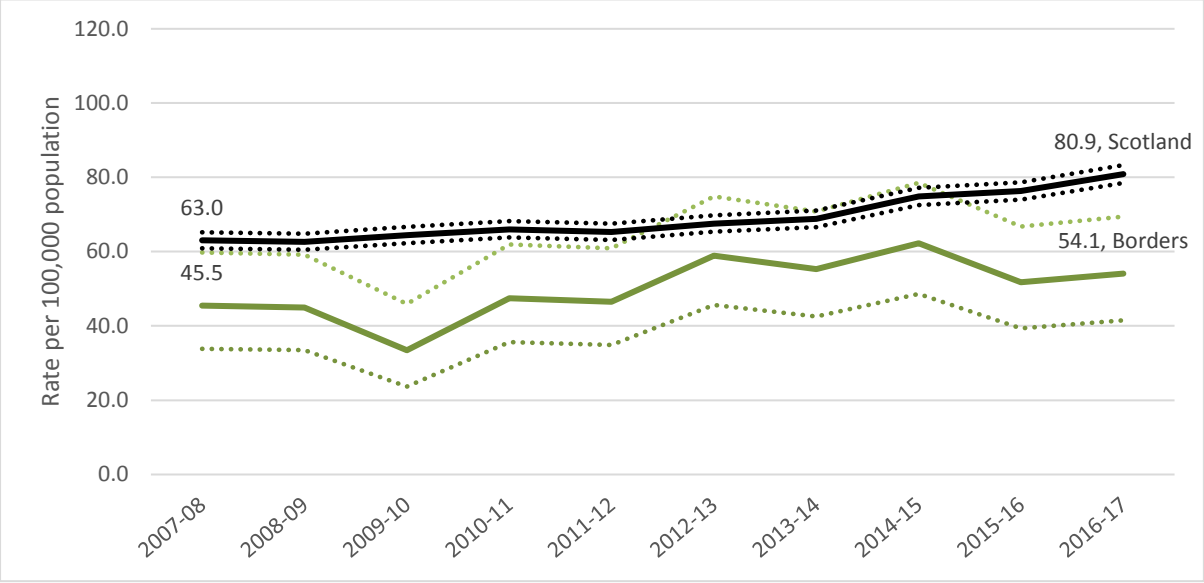
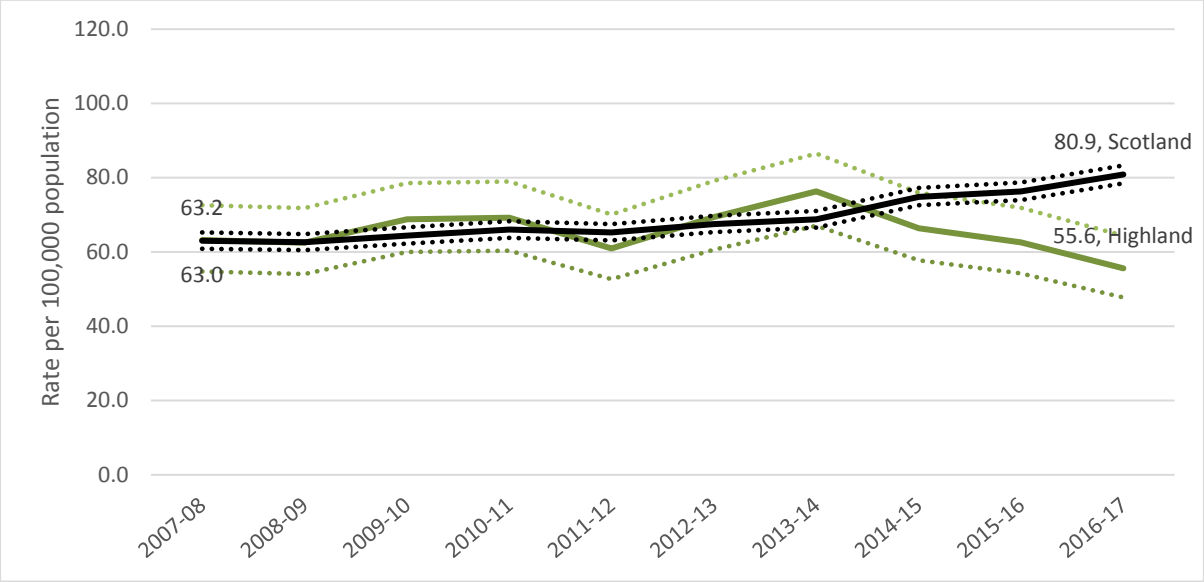


Figure 3.2.7 STDCs in Highland (95% confidence intervals)



Three health boards have been lower than the national rate over the ten year period Borders, Lanarkshire and Ayrshire & Arran. Borders has shown the most variability within that time, and like the other two is showing an upward trend. Highland has dropped below the national rate over the last two years.

Short term detention certificates 2016/17

Figure 3.2.8 STDCs 2016/17 (rate per 100,000 population)

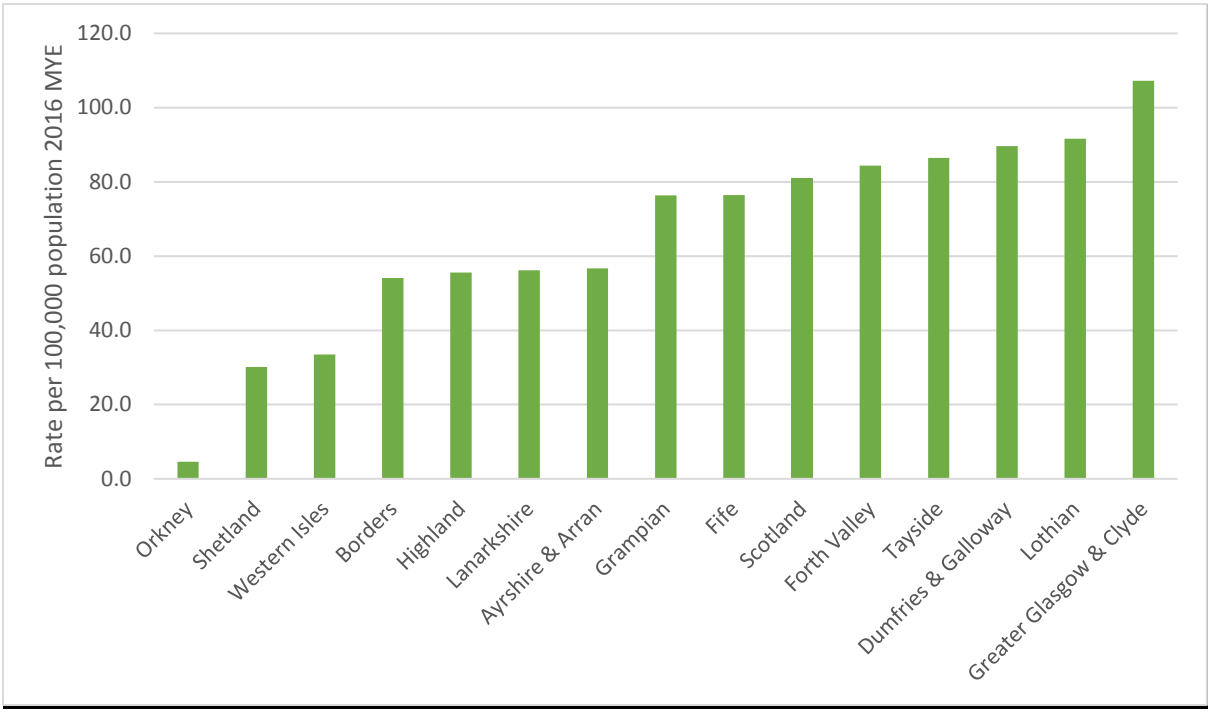
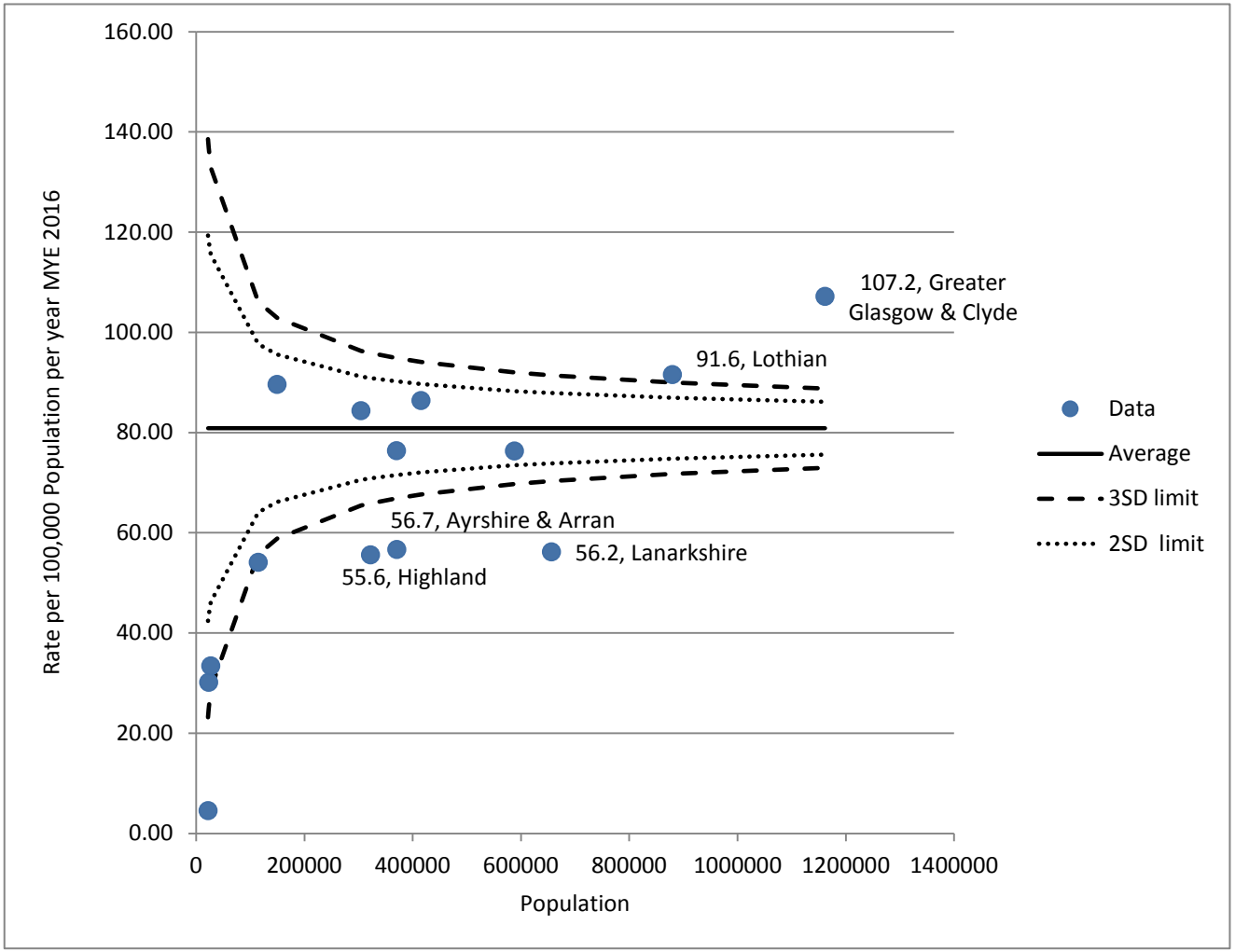


Figure 3.2.9 Funnel plot showing rates of STDCs at NHS board level 2016-17



Key

STDC 2016-17 Rate	Health Board
107.2	Greater Glasgow & Clyde
91.6	Lothian
89.6	Dumfries & Galloway
86.4	Tayside
84.4	Forth Valley
80.9	Scotland
76.4	Fife
76.3	Grampian
56.7	Ayrshire & Arran
56.2	Lanarkshire
55.6	Highland
54.1	Borders
33.5	Western Isles
30.2	Shetland
4.6	Orkney

In 2016-17 two health boards continue to be significantly above the Scotland rate (80.9; 95% CI: 78.5 to 83.3). Greater Glasgow & Clyde (107.2; 95% CI: 101.3 to 113.3), which has the largest population, has the highest rate; Lothian follows (91.6; 95% CI: 85.4 to 98.1).

In 2016/17 health boards below the Scotland rate (80.9; 95% CI 78.5 to 83.3) are Ayrshire & Arran (56.7; CI: 49.3 to 64.9), Lanarkshire (56.2; 95% CI 50.6 to 62.2) and Highland (55.6; 95% CI: 47.8 to 64.4).

STDCs by age and gender

The number of short term detention certificates completed per year has increased by 34.1% (3259 to 4371) over the ten year period.

The national rate has risen steadily from 63.0 to 80.9 per 100,000 people.

The national rate for women has risen from 65.4 to 87.1, and for men from 60.8 to 70.0 per 100,000 people.

The following charts illustrate variances by gender and age group in rates per 100,000 population

Young people

In 2016/17, for the third year running the number of young women in the 0-15 age group has remained at the higher level of 40. This year the number of young men in this group (16) has returned to the higher level last seen in 2013/14 (18).

In the 16-17 age group there were 44 female and 28 male.

Older people

In 2016/17 the 85+ age group is comprised of 115 women and 80 men.

Figure 3.2.10 STDCs – Women by age group 2007-17

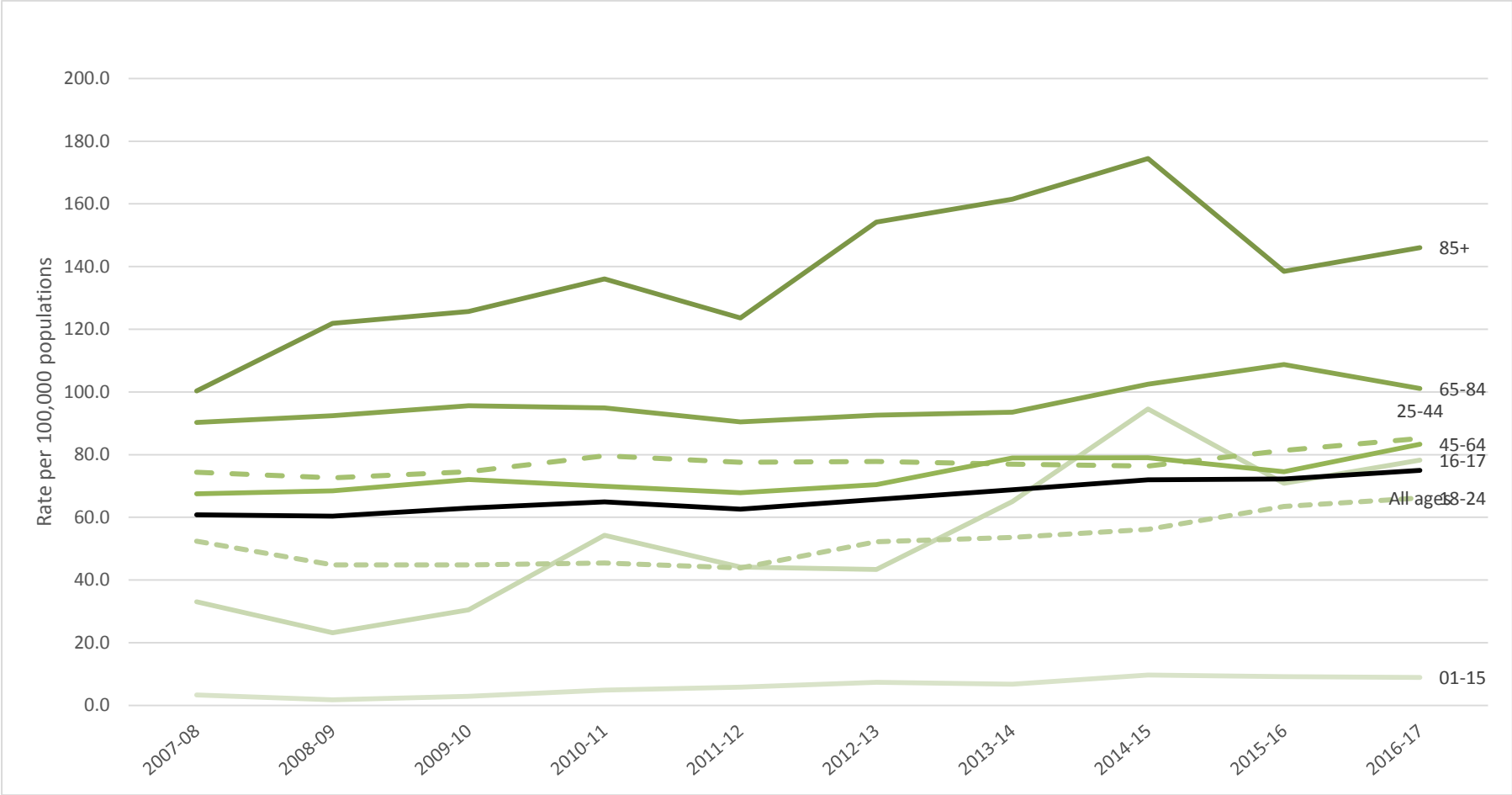
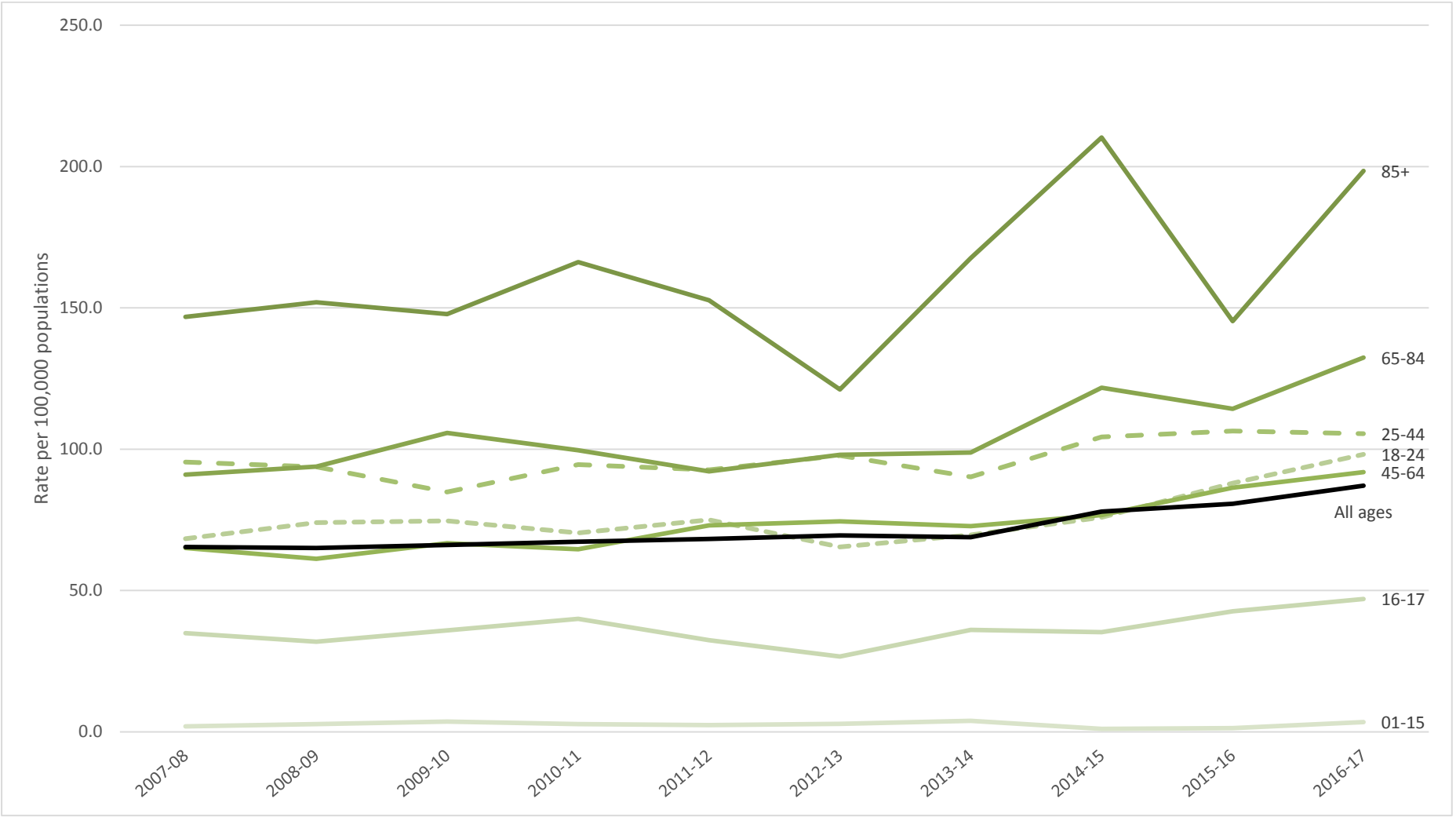


Figure 3.2.11 STDCs - Men by age group 2007-17



Diagnosis recorded

Our interest in this

We want to know the type of mental disorder(s) specified on STDC forms. The Act defines ‘mental disorder’ as ‘mental illness, learning disability or personality disorder’.

A person may have more than one type of mental disorder, so it is important to recognise the relative contributions of each category of mental disorder.

Table 3.2.1 Types and combinations of mental disorders recorded 2016/17

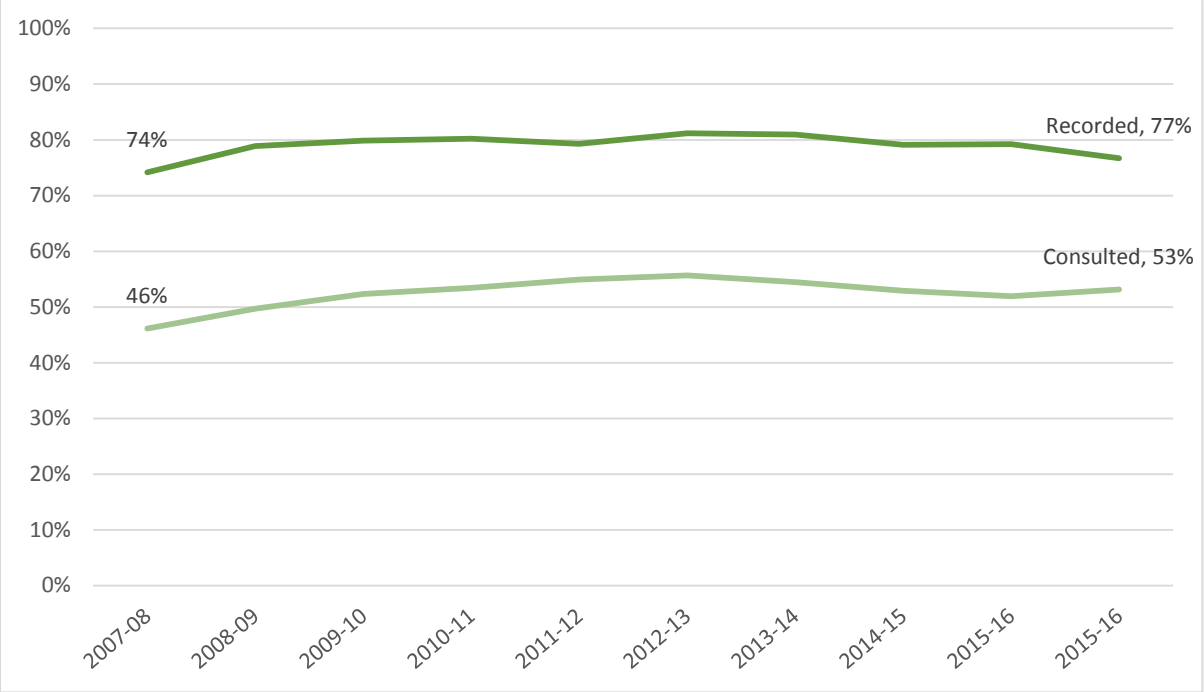
Mental disorder	STD Certificates	
	No.	%
Mental Illness	3891	89%
Mental Illness + Learning Disability	130	3%
Mental Illness + Personality Disorder	213	5%
Mental Illness + Personality Disorder + Learning Disability	9	0%
Personality Disorder	80	2%
Personality Disorder + Learning Disability	12	0%
Learning Disability	36	1%
Total	**4371**	**100%**

Mental illness accounts for the vast majority of people detained under a STDC. In 2016/17 only one per cent of STDCs were for people with learning disability alone, and three per cent for people with learning disability and mental illness. Similarly, only two per cent were for people with a personality disorder alone.

The proportions have changed little over the past 10 years.

Named person consultation

Figure 3.2.12 STDCs 2007-2017: Percentage where named person has been recorded and/or consulted



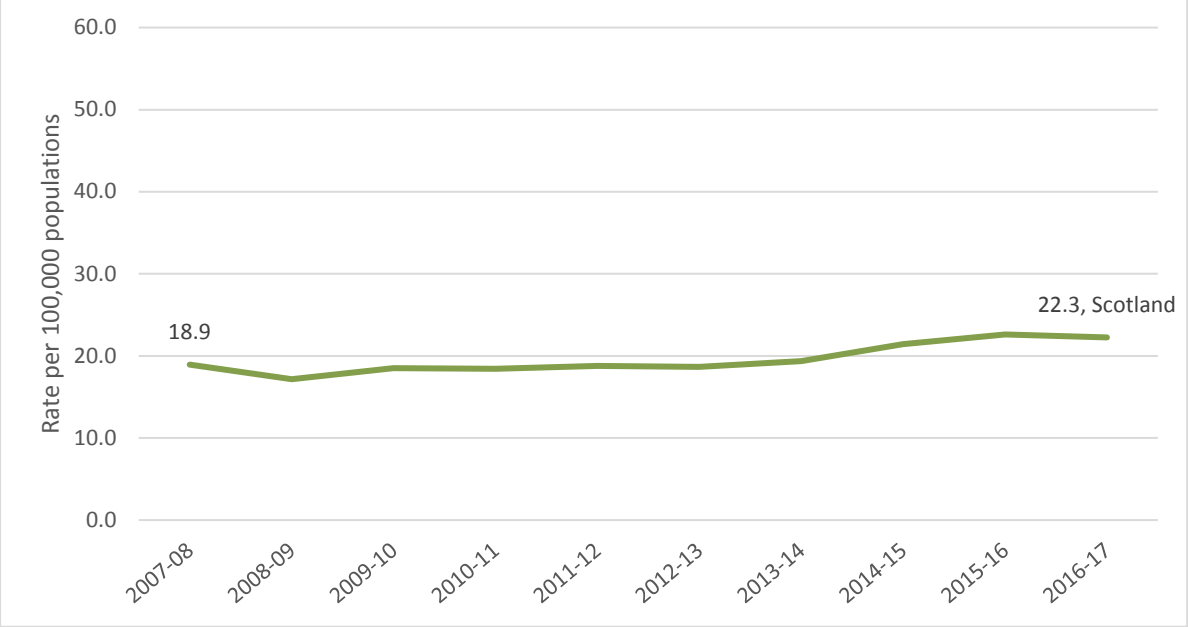
Over the ten year period the percentage of STDCs where the named person was consulted has risen (46% to 53%); the highest percentage was in 2012/13 at 56%.

The proportion of STDCs where the named person is recorded has risen over the period from 74% to 77%. However, since a high point of 81% over 2012 to 2014 there has been a slight downward trend.

The 2015 Mental Health Act may affect these figures in future as the role of default named person will be phased out. Apart from children, patients will only have a named person if they have chosen to do so.

3.3 Compulsory treatment orders (CTOs) *

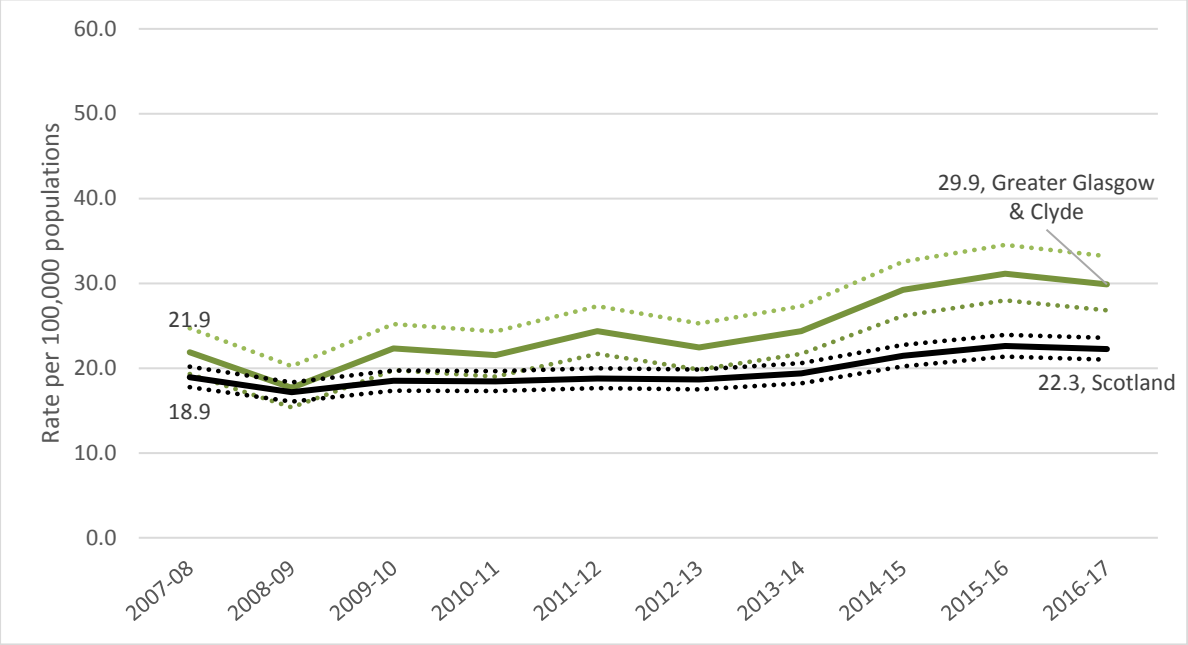
Figure 3.3.1 CTOs across Scotland (rate per 100,000 population) 2007-17



The number of compulsory treatment orders completed per year has increased by 22.9% (979 to 1203) over the ten year period.

The national rate for compulsory treatment orders has been rising steadily over the past ten years (from 18.9 to 22.3 per 100,000). The rate of increase is slower than for EDCs or STDCs.

Figure 3.3.2 CTOs in Greater Glasgow & Clyde (95% confidence intervals)



*In this report, please note that CTOs are hospital orders only, community compulsory treatment orders (CCTOs) are not included (Amended 26/02/2018)

The rate for Greater Glasgow and Clyde was higher in 2009 and for the last six years than the national rate. Over the period it has risen from 21.9 to 29.9.

Figure 3.3.3 CTOs in Ayrshire & Arran (95% confidence intervals)

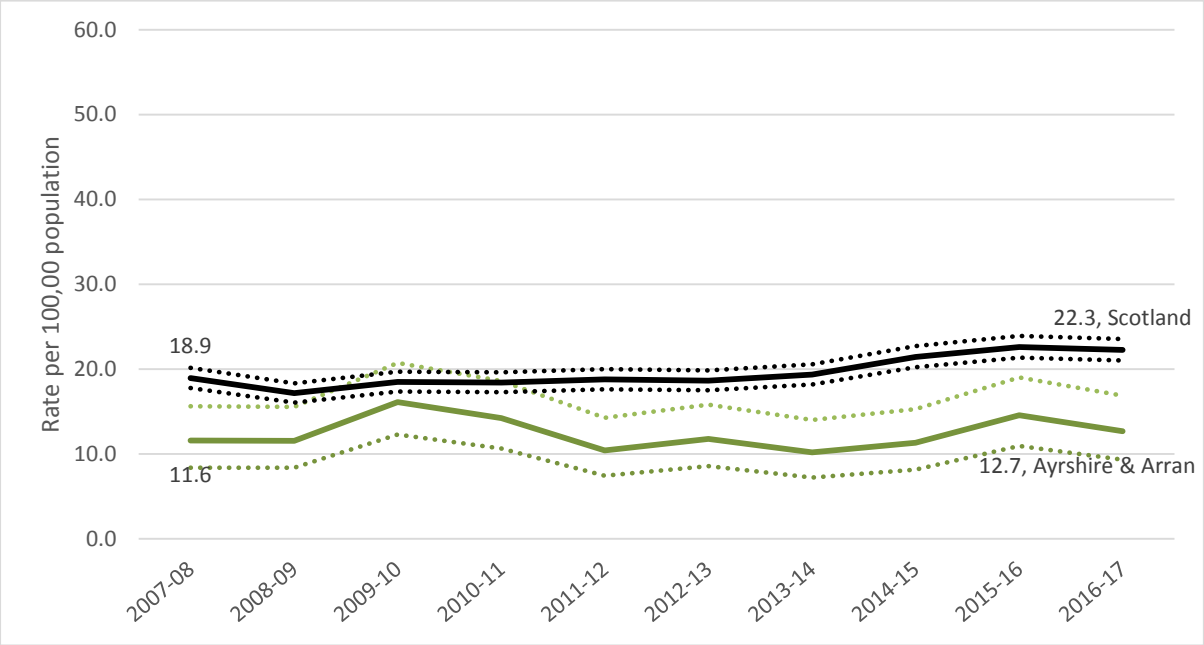
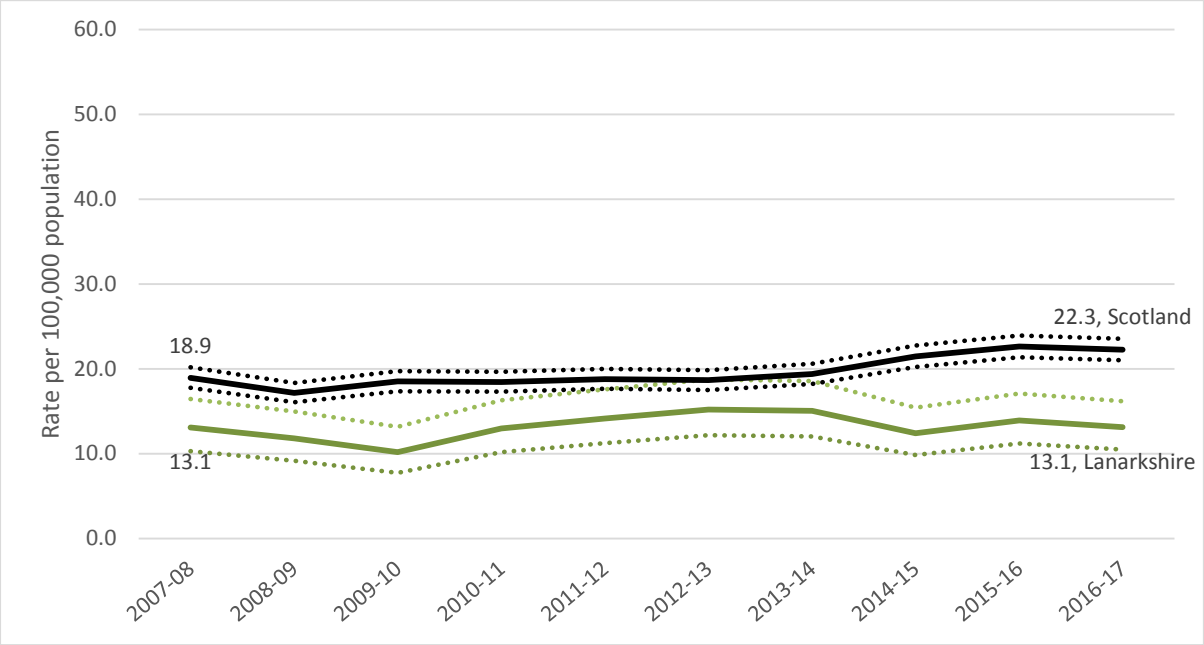


Figure 3.3.4 CTOs in Lanarkshire (95% confidence intervals)



Ayrshire and Arran and Lanarkshire have had a lower CTO rate than Scotland: Ayrshire and Arran has a slight upward trend, whilst the Lanarkshire rate has returned to its starting point after some increase in the middle years.

All other boards have not varied significantly from the national rate during the period.

Compulsory treatment orders 2016-17

Figure 3.3.5 CTOs (rate per 100,000 population) 2016/17

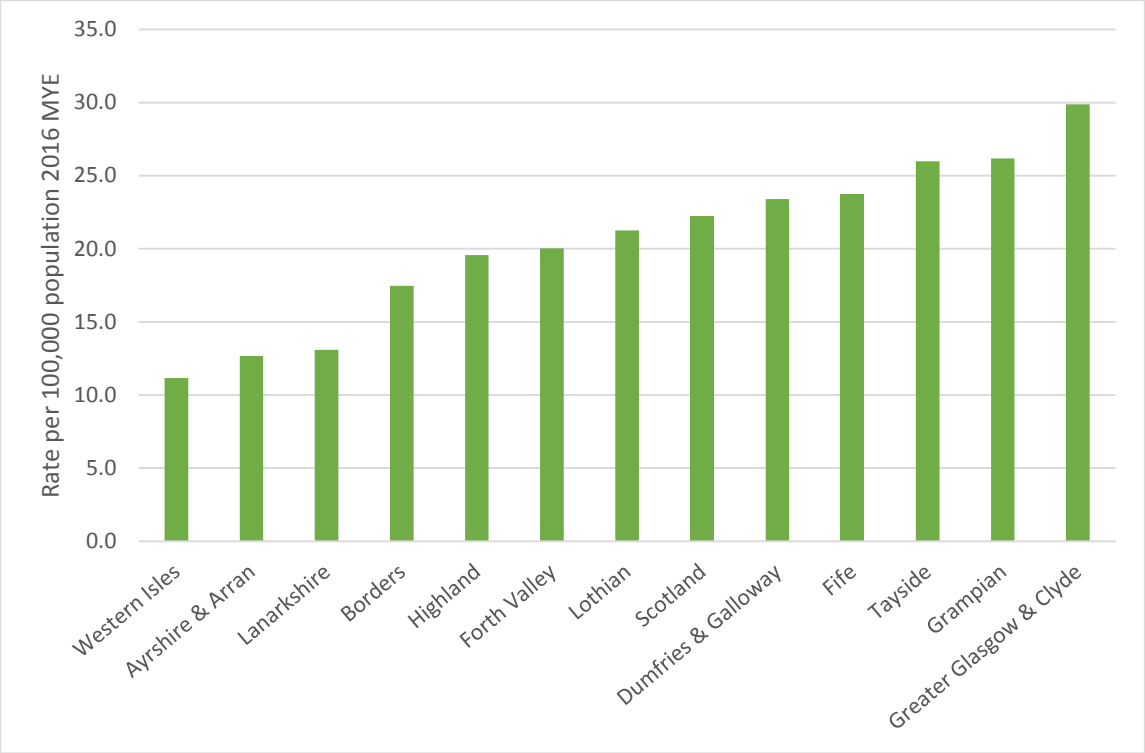
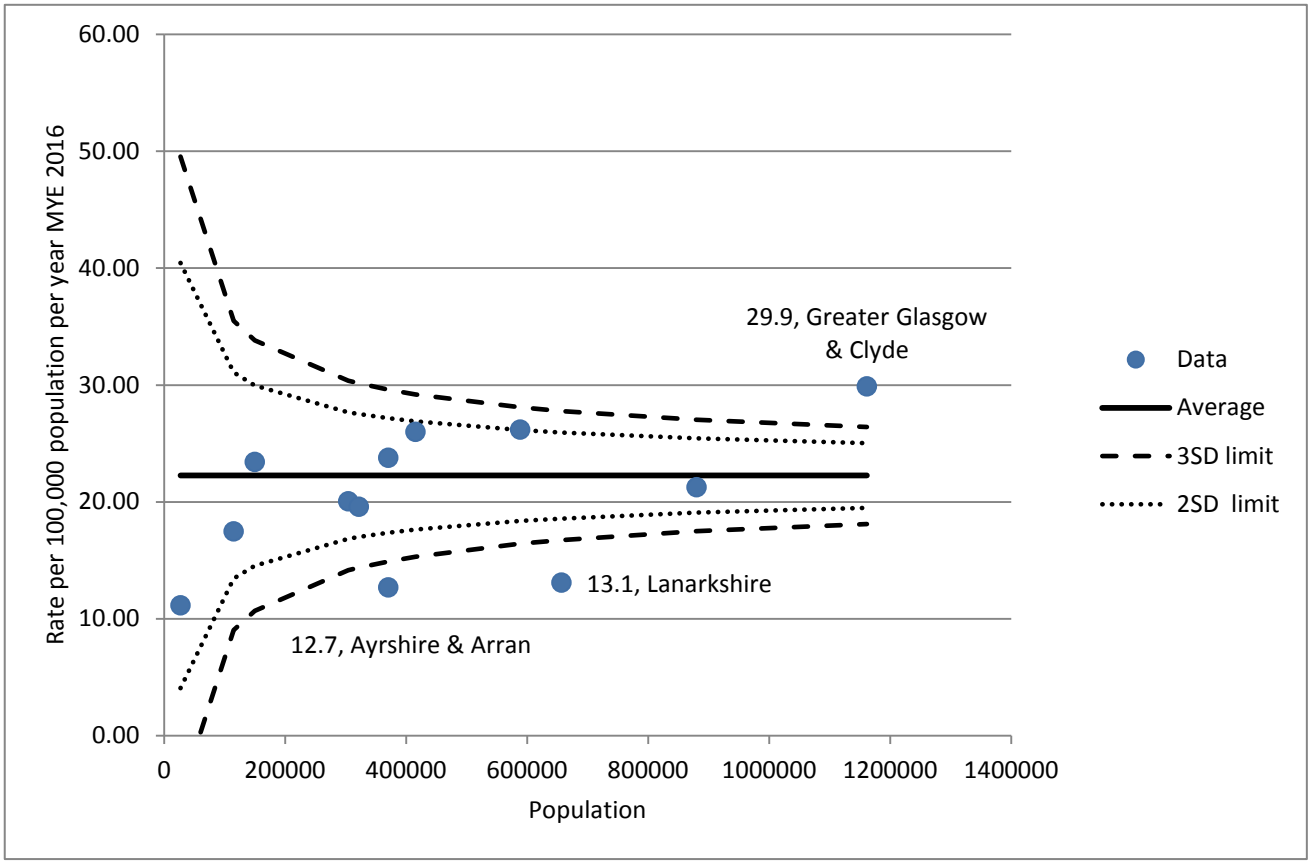


Figure 3.3.6 Funnel plot showing rates of CTOs at NHS board level 2016-17



Key

CTO 2016-17 rate	Health Board
29.9	Greater Glasgow & Clyde
26.2	Grampian
26.0	Tayside
23.8	Fife
23.4	Dumfries & Galloway
22.3	Scotland
21.3	Lothian
20.0	Forth Valley
19.6	Highland
17.5	Borders
13.1	Lanarkshire
12.7	Ayrshire & Arran
11.2	Western Isles

In 2016-17 only Greater Glasgow & Clyde (29.9; 95% CI: 26.8 to 33.2) continues above the Scotland rate (22.3; 95% CI: 21.0 to 23.6)

In 2016-17 two boards continued below the Scotland rate (22.3; 95% CI 21.0 to 23.6): Lanarkshire (13.1; 95% CI 10.5 to 16.2) and Ayrshire & Arran (12.7; 95% CI: 9.3 to 16.9).

3.4 Variations between local authorities

- Glasgow City, Aberdeen City, City of Edinburgh, Dundee City have the highest rates of short term detention this year.
- West Dunbartonshire and Aberdeen City have the highest rates for CTOs this year; followed by Perth & Kinross and Inverclyde.

Table 3.4.1 STDCs and CTOs by local authority 2016-17 – number and rate per 100k population

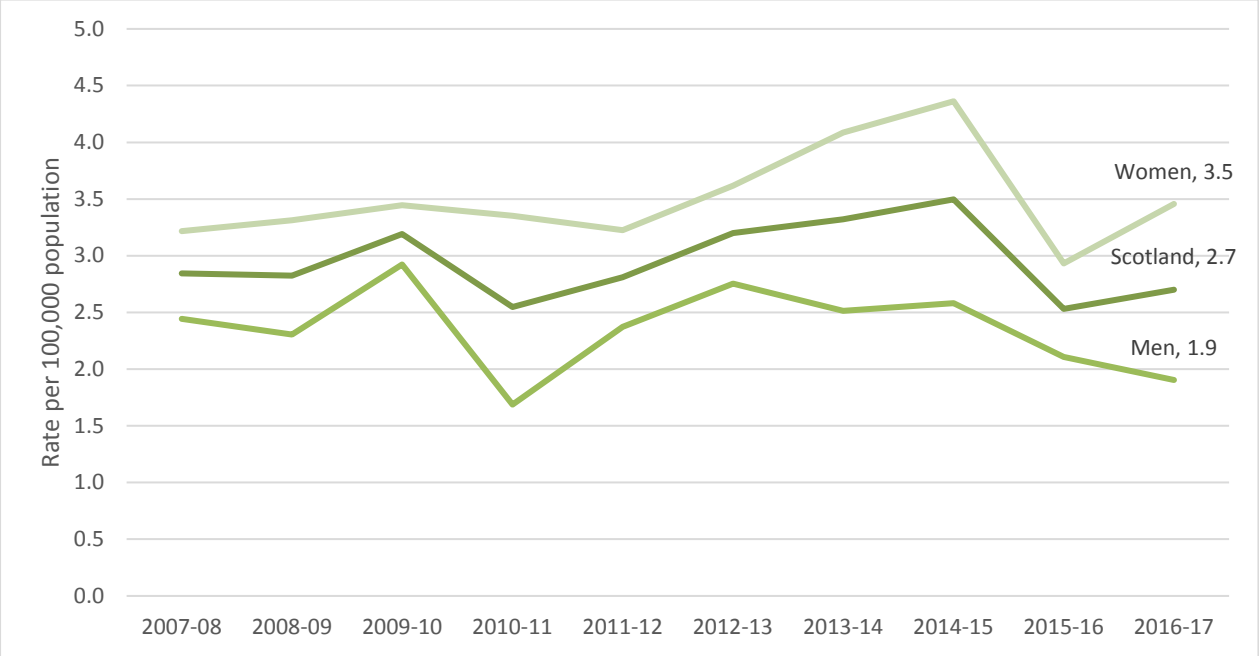
Local Authority	STDCs		CTOs	
	No.	Rate per 100K	*No.	Rate per 100K
Aberdeen City	259	112.7	92	40.0
Aberdeenshire	128	48.8	41	15.6
Angus	52	44.6	23	19.7
Argyll and Bute	46	52.8	13	14.9
City of Edinburgh	562	110.8	111	21.9
Clackmannanshire	47	91.5	13	25.3
Dumfries and Galloway	139	93.0	37	24.7
Dundee City	162	109.3	35	23.6
East Ayrshire	83	67.9	8	6.5
East Dunbartonshire	56	52.1	21	19.5
East Lothian	63	60.5	22	21.1
East Renfrewshire	57	60.8	14	14.9
Eilean Siar	9	33.5	3	11.2
Falkirk	152	95.4	38	23.8
Fife	286	77.2	85	23.0
Glasgow City	767	124.7	166	27.0
Highland	150	63.9	60	25.6
Inverclyde	79	99.8	25	31.6
Midlothian	50	56.4	15	16.9
Moray	64	66.6	13	13.5
North Ayrshire	81	59.6	17	12.5
North Lanarkshire	221	65.1	50	14.7
Orkney	1	4.6	7	32.0
Perth and Kinross	143	94.9	54	35.8
Renfrewshire	119	67.6	47	26.7
Scottish Borders	65	56.8	24	21.0
Shetland	7	30.2	2	8.6
South Ayrshire	56	49.8	23	20.4
South Lanarkshire	209	65.9	58	18.3

Stirling	62	66.1	12	12.8
West Dunbartonshire	71	79.0	38	42.3
West Lothian	125	69.4	36	20.0
Scotland	**4371**	**80.9**	**1203**	**22.3**

4. Nurse's power to detain

The Mental Health (Scotland) Act 2015 amends Section 299 of the 2003 Act. This means that a patient can be detained by the nurse for a period of up to three hours. The nurse exercising the power to detain must take all reasonable steps to inform a mental health officer (MHO) of the detention.

Figure 4.1 Nurse's power to detain - women and men (rate per 100,000 population)



Over the past ten years the number of nurse's holding powers across Scotland has varied between 134 and 187 per year. Overall, the rate is showing a downward trend, the highest rate having been in 2014/15 at 3.5 (per 100,000 population).

The use of the powers for women has varied between 81 and 120. Overall, the rate is higher for women than for men, and was highest in 2014/15 at 4.4 (per 100,000 population).

The use of the powers for men has varied between 43 and 74 per year. The rate was highest in 2009/10 at 2.9 (per 100,000 population).

Overall, there appears to be an upward trend in the rate for women and a downward trend for men. The current rate for women at 3.5 is approaching twice the rate for men at 1.9.

For both women and men, the highest numbers are in the 25-44 and 45-64 age groups. The 25-44 age group is showing a downward trend, while the 45-64 age group is showing an upward trend. However, the trends are stronger for women.

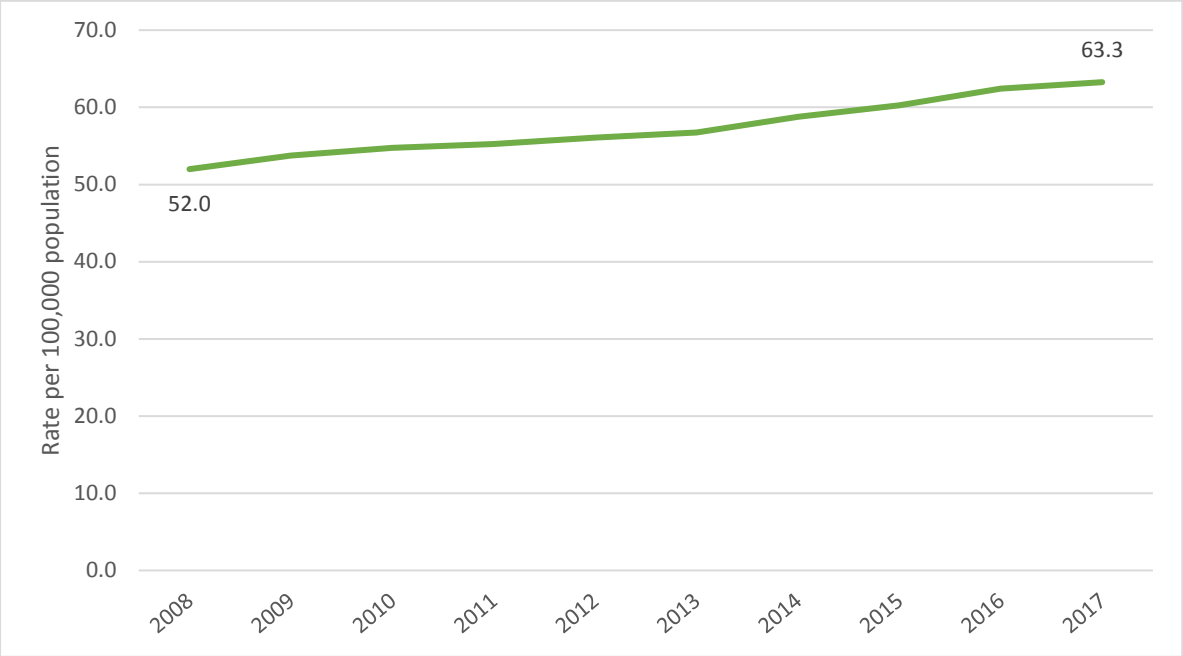
For men the rates per 100K are highest for the 16-17, 18-24 and, in recent years, the 45-64 age groups. The 16-17 year age group is showing an upward trend. The 18-24 age group is showing a downward trend.

5. Total number of Mental Health Act orders in existence

5.1 All orders

Over the past ten years the total numbers of orders in existence in Scotland has risen steadily, increasing by 27.2% from 2688 (January 2008) to 3419 (January 2017). The national prevalence rate of all compulsory orders has risen by 21.7% from 54.7 to 63.3 per 100,000 population.

Figure 5.1.1 Total number of Mental Health Act orders in existence (rate per 100,000 population)



The total number of people who are subject to compulsory treatment in each board area on one date during the year is shown in figure 5.1.1. This is shown per 100,000 people. This is a good guide to the overall use of compulsion in each NHS Board area. Factors which may affect use are:

- Urban versus rural populations
- Culture and attitudes of practitioners
- Availability of early intervention, treatment and support
- Use of alcohol and drugs

We found that:

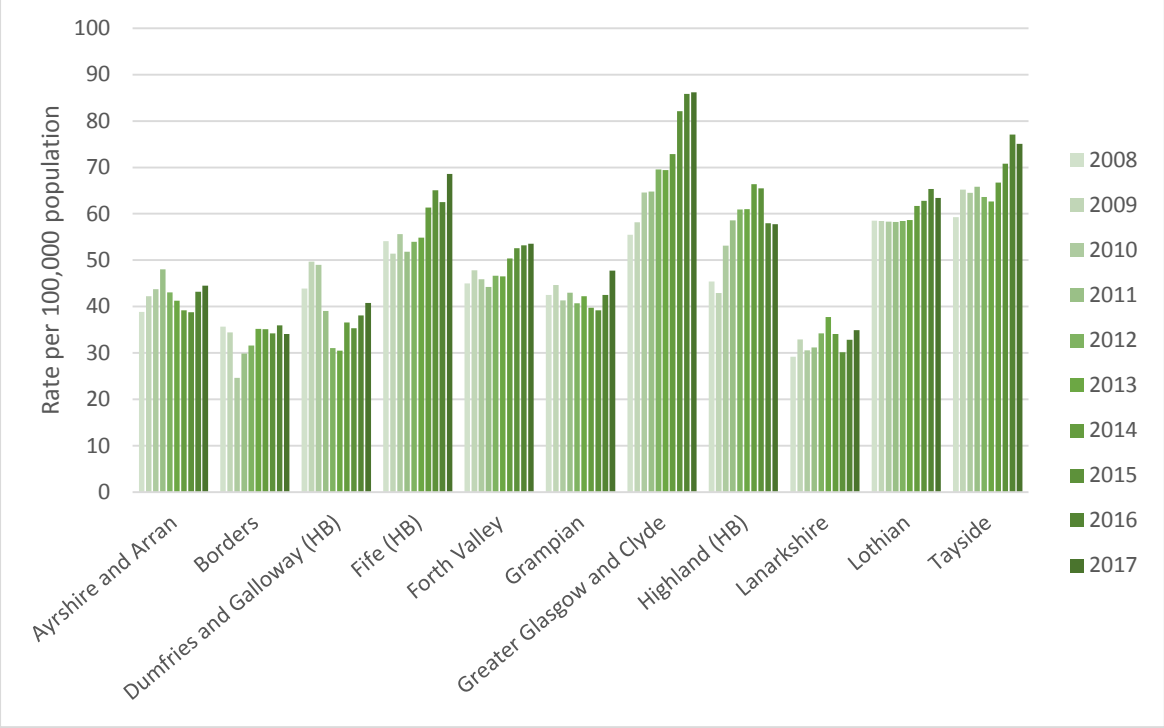
- Greater Glasgow and Clyde continues to have the highest prevalence of compulsory treatment (86.2 per 100,000). Tayside (75.1 per 100,000) and Lothian (63.4 per 100,000) are also high, reflecting significant numbers of deprived inner city areas where the number of people with major mental illness is likely to be highest.
- This year Fife is also high (68.6 per 100,000).
- This year, Highland, although having one of the higher rates, has maintained its 2016 level (57.8).
- Borders (34.1), Lanarkshire (34.9) and Dumfries and Galloway (40.8) have a low prevalence of compulsory treatment.

We still find this variation hard to explain.

Recommendation

We recommend that the Scottish Government explores how to better understand the significant variations in the use of compulsory treatment through data linkage with other information sources.

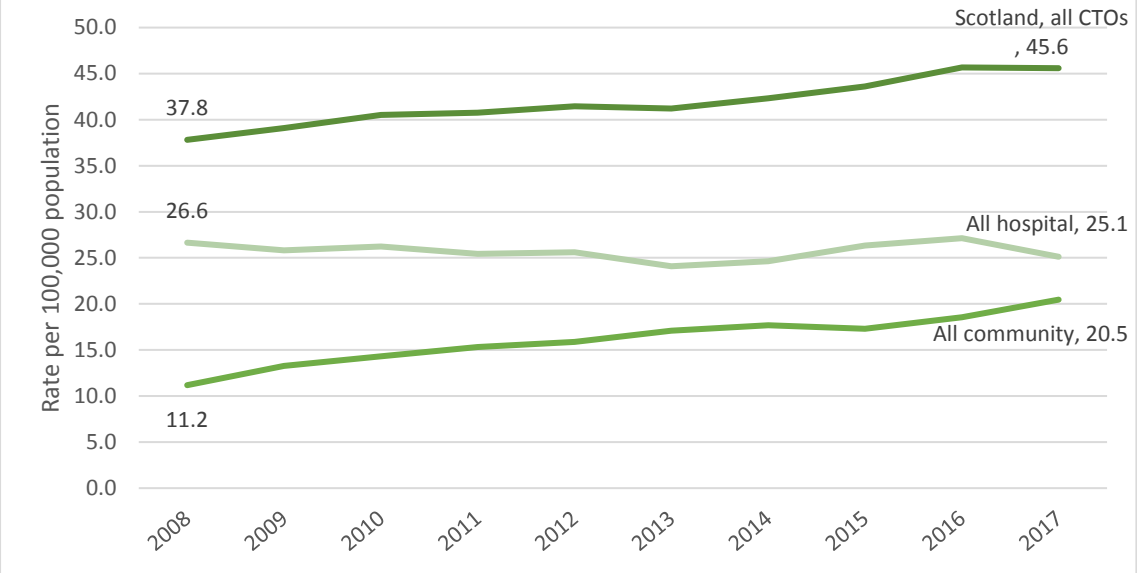
Figure 5.1.2 Ten year trends in prevalence of all compulsory orders per 100,000 population by NHS board (2008-17)*



*All prevalence data has been refreshed this year. Prevalence is taken at first week of January each year. GRO Mid-year population estimates by pre-April 2014 NHS Board areas up to 2013-14.

5.2 Compulsory treatment orders

Figure 5.2.1 Point prevalence of CTOs 2008-17* (rate per 100,000 population)



*All data has been refreshed back to January 2008

Over the ten year period the prevalence of all CTOs has increased by 20.6% from 37.8 (per 100, 000) at January 2008 to 45.6 (per 100,000) at January 2017. This continues the upward trend.

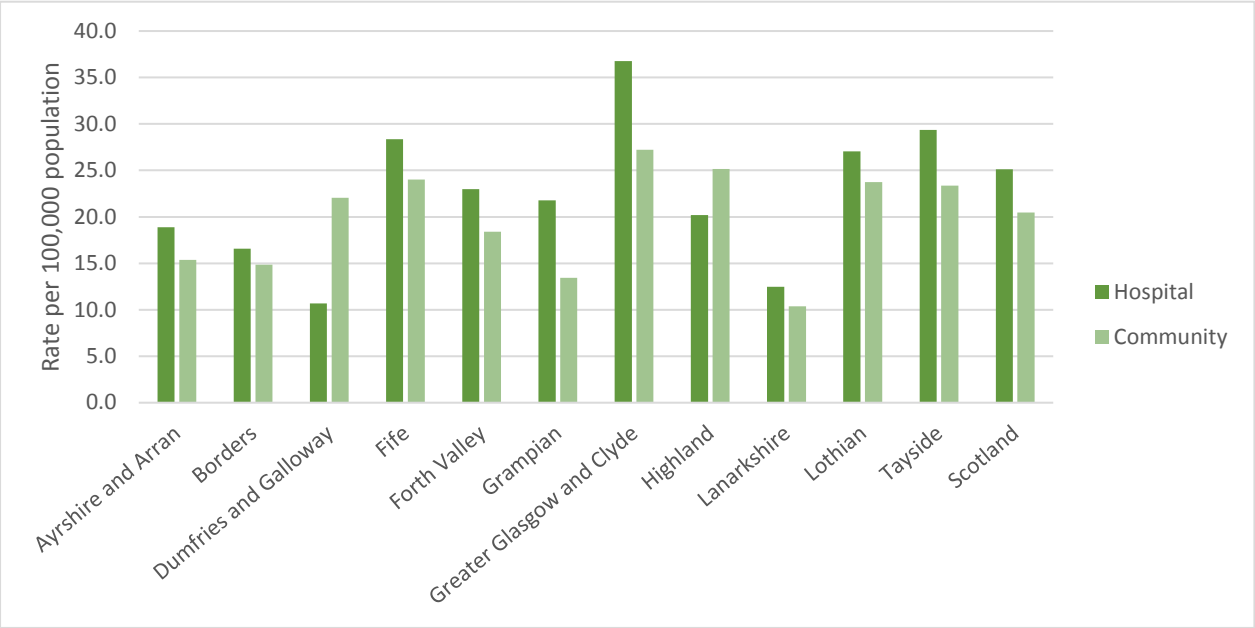
The proportion of community orders has continued to rise over the period, and at January 2017 accounted for 44.9% of all CTOs. In January 2006, they accounted for just four per cent and 23% by January 2007. This shows the extent to which the balance of care has shifted to the community for people subject to compulsion.

- The use of hospital-based CTOs is highest in Greater Glasgow and Clyde (36.8), followed by Tayside (29.4), Fife (28.4) and Lothian (27.0). Dumfries and Galloway (10.7) and Lanarkshire (12.5) have the lowest prevalence of hospital CTOs compared with other mainland NHS boards.

- Greater Glasgow and Clyde (27.2), Tayside (23.3), Fife (24.0), and Lothian (23.8) have the highest use of community compulsory treatment in Scotland.

- Dumfries and Galloway and Highland are currently the only mainland boards which make more use of community CTOs than hospital CTOs. Previously, this was the case in Borders, but the balance has changed this year.

Figure 5.2.2 All existing hospital vs community CTOs per 100,000 population by mainland NHS board Jan 2017



5.3 Advance statements

Table 5.3.1 Notifications of treatment that is in conflict with an advance statement by year 2009/10 to 2016/17

	2009/ 10	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/ 16	2016/ 17
Number of overrides	29	18	19	18	31	47	66	55
Refusal of depot injection	16	9	11	5	20	20	29	*20
Refusal of any medication	5	3	2	6	0	5	13	8
Refusal of or Request for one specific medication				4	6	10	12	*9
Refusal of ECT	1	2	1	1	0	3	2	0
Other	7	4	5	2	5	9	10	18

*One individual included in both categories

Advance statements are one of the ways of increasing patient participation in care and treatment. Although we do not know how many advance statements have been made, we must be informed whenever one is overridden.

When an advance statement is overridden, we expect the person authorising the override to have fully discussed this with the patient. The patient and their named person, if they have one, must also be notified in writing.

We recorded that 55 patients had their advance statement overridden in 2016-17. These included notifications from responsible medical officers (RMOs), designated medical practitioners (DMPs) and the Mental Health Tribunal for Scotland (MHTS). This figure does not include every patient for whom we received an advance statement notification from the MHTS. This is because we do not complete a new advance statement monitoring form for these if it is an ongoing override situation and we have recently completed a form.

One patient had different wishes in their advance statement overridden on different occasions. They are therefore included in the numbers in the table for both refusal of depot and refusal of one specific medication.

Of the 19 overrides not specified by type in the table, five related to other wishes concerning medication. Two of these patients had recorded a wish to receive particular lists of medications/doses and required medication in addition to this. One did not want a second mood stabiliser; one did not want medication for which blood monitoring was required; and the other did not want medication with weight gain as a side effect.

As a result of our advance statement monitoring, we contacted DMPs on three occasions. This was to seek further information about explanations provided for the patient or to advise on this.

We contacted RMOs on 15 occasions for a variety of reasons relating either to the advance statement or other aspects of treatment. Four of these contacts were about explanations to the patient about the override. On four occasions we suggested discussion with the patient about whether they might wish to review their advance statement, either because it had been written some time ago or it did not seem to reflect their current wishes. In two cases the patient was not consenting to treatment that was authorised on a T2 and, on discussion with the RMO, they agreed that a DMP visit was indicated.

The advance statement wishes that were overridden for eight people involved location of treatment, e.g. a wish for community rather than hospital treatment.

Advance statements: the legislation and the future

Following the implementation of the 2015 Act, NHS boards are required to notify us when a patient makes or withdraws an advance statement. We are required to keep a register with this information. A requirement has also been placed on NHS boards to publicise the support it provides for people to make or withdraw an advance statement.

Last year we published new advance statement guidance, templates and films with different patients' experiences about making and having advance statements.

We will be undertaking a review of our advance statement monitoring processes and how we report on this.

6. Compulsory treatment under criminal proceedings

People with a mental disorder who are accused or convicted of a criminal offence may be dealt with by being placed on an order under the Criminal Procedure (Scotland) Act 1995 (CPSA), which requires them to be treated in hospital or, occasionally, in the community. In some cases, additional restrictions are placed on the individual, and any lessening of their security status or suspension of detention has to be approved by Scottish Ministers. An individual may be subject to a number of different orders before final disposal of the case, which may be by compulsion order, compulsion order and restriction order (CORO), or hospital direction.

In 2016/17, 267 individuals were subject to a CPSA order, with the total number of orders amounting 463. This year, 230 individuals were subject to CPSA order, with the total number of orders amounting to 417. This total is very similar to 2014/15, when there were 398 CPSA orders.

6.1 Assessment and Treatment Orders

The key purpose of both assessment and treatment orders is to allow assessment of a person prior to trial, or after conviction but before sentencing. It allows courts to remand a person in hospital instead of custody, when it appears the person is suffering from a mental disorder. Both orders allow for the transfer of a person remanded in custody and awaiting court appearance to be admitted to hospital for assessment. An assessment order can last up to 28 days and be extended on one occasion by a further seven days. An assessment order may be followed by a treatment order.

Table 6.1.1 Number of Assessment and Treatment Orders

Order Type	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Assessment Order	115	178	132	145	131	159	134	133	145	128
Treatment Order	85	84	79	64	103	142	98	106	113	109

Our information management system records each treatment order received as a distinct order. For example, an individual may be recorded as having two or three consecutive treatment orders and then an interim compulsion order. The number of individuals who have been subject to treatment orders in 2015/2016 is 88.

6.2 Unfitness for trial and acquittal by reason of mental disorder

If a person's mental disorder is such that they cannot participate in the court process, the court may find the person unfit for trial. A temporary compulsion order (Section 54(1)(c)) allows for a person, found unfit for trial, to be detained in hospital prior to an examination of facts.

Unfitness for trial

Table 6.2.1 Number of Temporary Compulsion Orders

Order Type	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Temporary Compulsion Order	5	14	10	14	12	17	7	20	18	20

The use of the Temporary Compulsion Order (20) has been virtually the same as last year, after unusually low use in 2013/14 (7).

In addition, persons who suffer from a serious mental disorder that impairs their judgement can be acquitted by reason of mental disorder.

Where a person has been acquitted on account of insanity, or has been found unfit for trial, there are a number of disposals available to the court.

Table 6.2.2 Acquitted by reason of mental disorder and unfitness for trial: disposals

Order Type	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
S57(2)(a) Compulsion Order	6	10	13	11	7	12	15	21	26	28
S57(2)(a) Compulsion Order - community	1	0	0	1	0	0	1	0	0	0
S57(2)(b) Compulsion Order with Restriction Order (CORO)	3	5	1	2	5	4	9	5	3	5
Guardianship S57(2)(c)	0	0	0	0	1	0	0	0	0	0
Supervision & Treatment Order S57(2)(d)	0	1	0	0	0	1	0	3	0	3

As can be seen, all but three of the outcomes involved inpatient treatment. It is likely that this reflects the serious nature of the patient's mental condition. No individual was sentenced to a community based compulsion order.

6.3 Post-conviction predisposal

An interim compulsion order allows for a period of inpatient assessment before a final disposal is made with respect to mentally disordered offenders who have been convicted of serious offences. The interim compulsion order is recommended in cases where a restriction order is being considered, and can last up to twelve months to permit a comprehensive inpatient evaluation.

Table 6.3.1 Post-Conviction, Pre-Disposal

Order Type	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Interim Compulsion Order	24	26	17	22	19	26	32	21	23	27
S200 Committal	7	3	0	0	1	2	1	0	0	0

Section 200 is seldom used due to the more flexible use of assessment and treatment orders post-conviction.

6.4 Final mental health disposals by the court

There are three hospital disposals available, namely a compulsion order, CORO and hospital direction. A CORO is made by the court after consideration of the future risk to the public of serious harm. A hospital direction allows a person to be given compulsory treatment for mental disorder in hospital but, once they recover, to be transferred to prison to complete their sentence.

In addition, there are community disposals in the form of compulsion order, guardianship order, and a community payback order with a mental health treatment requirement.

Mental Health Disposals

Table 6.4.1 Number of mental health disposals

Order Type	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
S57A (2) Compulsion Order	55	60	53	51	46	60	57	44	45	61
S57A (2) Compulsion Order - community	2	5	1	3	0	1	1	1	0	0
S59 CORO	9	9	9	5	12	8	10	8	9	9
Hospital Direction	1	0	0	1	1	1	2	3	2	0
Guardianship Order S58**	0	1	1	1	(1)	1	1	2	1(1)	0

** Figures in brackets represent renewals in that year

The number of hospital directions remains low, suggesting that the remand provisions, including the interim compulsion order, allow careful evaluation prior to final disposal. The numbers of compulsion orders and COROs are very similar to last year.

Transfer for treatment directions

This provision allows for the transfer of a sentenced prisoner from prison to hospital for the treatment of a mental disorder.

Table 6.4.2 Number of transfer for treatment directions

Order Type	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Transfer for Treatment Direction	30	32	33	31	42	46	47	37	36	57

7. Place of safety orders

The number of notifications received (1133) has risen by 37% from last year (830) - this is a 90% rise since 2011/12. We think this reflects better reporting by the police. The proportion of incidents where the place of safety was a police station has risen this year (5%, 58), but is still below the earlier high in 2011/12 (18%, 108).

This year the latest version of the form (Version 7[2]) is being more fully utilised. This form captures changes of location of place of safety within the same incident. This year, five per cent (58) of occasions resulted in the initial place of safety being a police station. In addition there were 17 occasions where the second place of safety was a police station, usually due to discovery of a weapon or breach of the peace.

We published a more detailed monitoring report regarding place of safety orders in 2016[3], and are undertaking further research with the police in 2017-18.

[2] Version 7 of the form began to be implemented across Scotland from April 2016 and allows for recording of changes of place of safety in one incident

[3] Mental Welfare Commission for Scotland. (2017) *Place of Safety Monitoring report 2016.* http://www.mwcscot.org.uk/media/373113/place_of_safety_monitoring_report_2016.pdf

Table 7.1 Place of safety orders notified to the Commission

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Scotland	228	224	218	300	596	563	662	699	830	1133

Table 7.2 Was place of safety a police station?

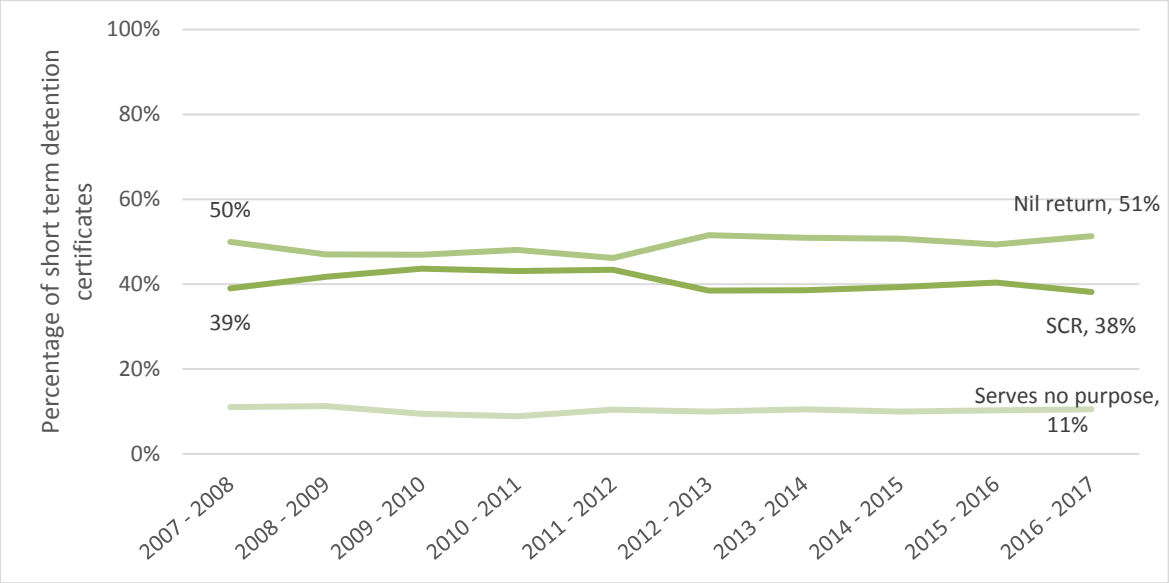
Was place of safety a police station?	2011/12		2012/13		2013/14		2014/15		2015/16		2016/17	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No	455	76%	454	81%	588	89%	638	91%	809	97%	1039	92%
Not recorded	33	6%	9	2%	14	2%	15	2%	8	1%	36	3%
Yes	108	18%	100	18%	60	9%	46	7%	13	2%	58	5%
Grand Total	**596**	**100%**	**563**	**100%**	**662**	**100%**	**699**	**100%**	**830**	**100%**	**1133**	**100%**

8. Social circumstances reports (SCRs)

There is a significant variation in the completion of SCRs across Scotland, with Edinburgh City, Glasgow City and West Dunbartonshire consistently completing the lowest percentage of SCRs following a STDC. (Average across ten years: Edinburgh City 26%, Glasgow City 20%, West Dunbartonshire 18%)

Over the ten year period, percentages of SCR completion in relation to STDCs have remained fairly static across Scotland as a whole.

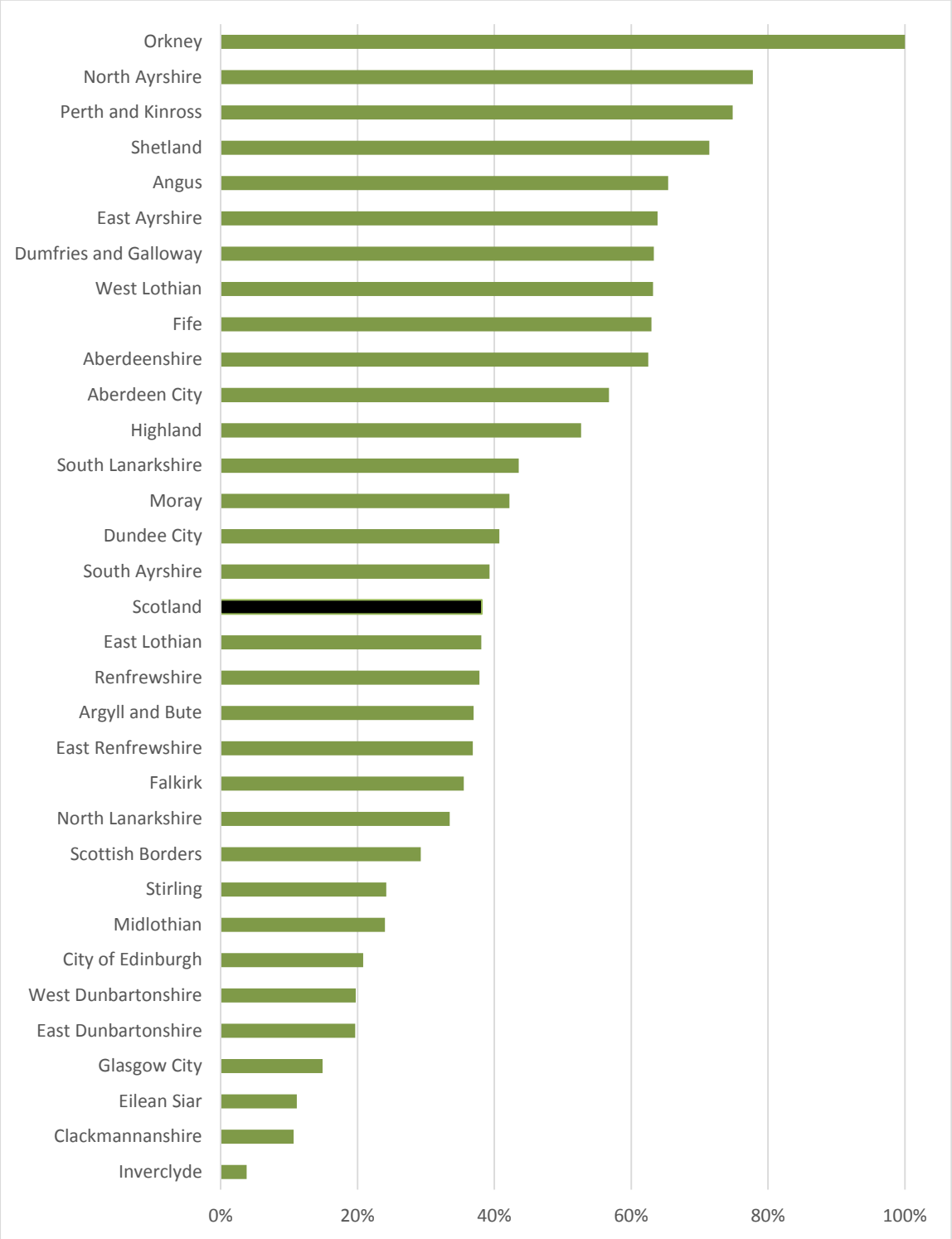
Figure 8.1 Percentage of SCRs completed across Scotland for STDCs



However, in real terms this accounts for an additional 1112 STDCs per year by 2016/17, generating an additional 396 SCRs and 100 serves no purpose notifications per year.

A number of local authorities have seen a substantial increase in completion of SCRs from the starting year 2007/08 to the current year 2016/17 – Argyll & Bute (10%-37%), Highland (9%-53%), and Perth and Kinross (32%-75%).

Figure 8.2 SCRs completed following STDC 2016/17 (%)



The percentage of STDCs that triggered the completion of an SCR in 2016/17 was 38%. This, again, was similar to last year, even though there was an increased number of STDCs (2016/17, 4371) (2015/16, 4098).

Table 8.1 Provision of SCRs following STDC – 2016-17

	Documents returned to MWC following STDC						STDCs in LA	
Local Authority*	**None**		**"Serve no purpose" letter**		**SCR**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Aberdeen City	92	36%	20	8%	147	57%	259	100%
Aberdeenshire	39	30%	9	7%	80	63%	128	100%
Angus	13	25%	5	10%	34	65%	52	100%
Argyll and Bute	26	57%	3	7%	17	37%	46	100%
City of Edinburgh	394	70%	51	9%	117	21%	562	100%
Clackmannanshire	39	83%	3	6%	5	11%	47	100%
Dumfries and Galloway	44	32%	7	5%	88	63%	139	100%
Dundee City	73	45%	23	14%	66	41%	162	100%
East Ayrshire	22	27%	8	10%	53	64%	83	100%
East Dunbartonshire	43	77%	2	4%	11	20%	56	100%
East Lothian	39	62%		0%	24	38%	63	100%
East Renfrewshire	31	54%	5	9%	21	37%	57	100%
Eilean Siar	8	89%		0%	1	11%	9	100%
Falkirk	88	58%	10	7%	54	36%	152	100%
Fife	79	28%	27	9%	180	63%	286	100%
Glasgow City	558	73%	95	12%	114	15%	767	100%
Highland	48	32%	23	15%	79	53%	150	100%
Inverclyde	65	82%	11	14%	3	4%	79	100%
Midlothian	17	34%	21	42%	12	24%	50	100%
Moray	35	55%	2	3%	27	42%	64	100%
North Ayrshire	6	7%	12	15%	63	78%	81	100%
North Lanarkshire	130	59%	17	8%	74	33%	221	100%
Orkney		0%		0%	1	100%	1	100%
Perth and Kinross	27	19%	9	6%	107	75%	143	100%
Renfrewshire	62	52%	12	10%	45	38%	119	100%
Scottish Borders	39	60%	7	11%	19	29%	65	100%
Shetland		0%	2	29%	5	71%	7	100%
South Ayrshire	22	39%	12	21%	22	39%	56	100%
South Lanarkshire	87	42%	31	15%	91	44%	209	100%
Stirling	42	68%	5	8%	15	24%	62	100%
West Dunbartonshire	45	63%	12	17%	14	20%	71	100%
West Lothian	31	25%	15	12%	79	63%	125	100%
Scotland	2244	51%	459	11%	1668	38%	4371	100%

9. Consent to treatment under Part 16 of the Act

Our interest in these figures

Part 16 of the 2003 Act makes provisions for additional safeguards in relation to medical treatment for detained patients, particularly, but not only, where this is given without the patient's consent. There are specific safeguards for certain forms of medical treatment, including electroconvulsive therapy (ECT) and procedures classified as neurosurgery for mental disorder (NMD).

Under the 2003 Act, certain treatments can only be authorised by an independent doctor, known as a designated medical practitioner (DMP).

Safeguarded treatments (Sections 237 and 240)

Treatments covered by sections 237 and 240 include ECT, any medicine for the purpose of reducing sex drive, medicine given beyond two months and artificial nutrition.

If a patient is considered to be capable of consenting, and does so in writing, the responsible medical officer (RMO) completes a Form T2 ‘Certificate of Consent to Treatment.’

If a patient is incapable of consenting, treatment may be authorised by a DMP on Form T3 ‘Certificate of the Designated Medical Practitioner.’ Section 240 treatment (medicine for the purpose of reducing sex drive, medicine given beyond two months, and artificial nutrition) can also be authorised by a DMP if a patient is capable but refusing consent, if the DMP certifies that the treatment is in the patient’s best interest.

The following tables show the trends over the last 10 years in T2 and then T3 forms for the various treatments.

Certificate of Consent to Treatment (Form T2)

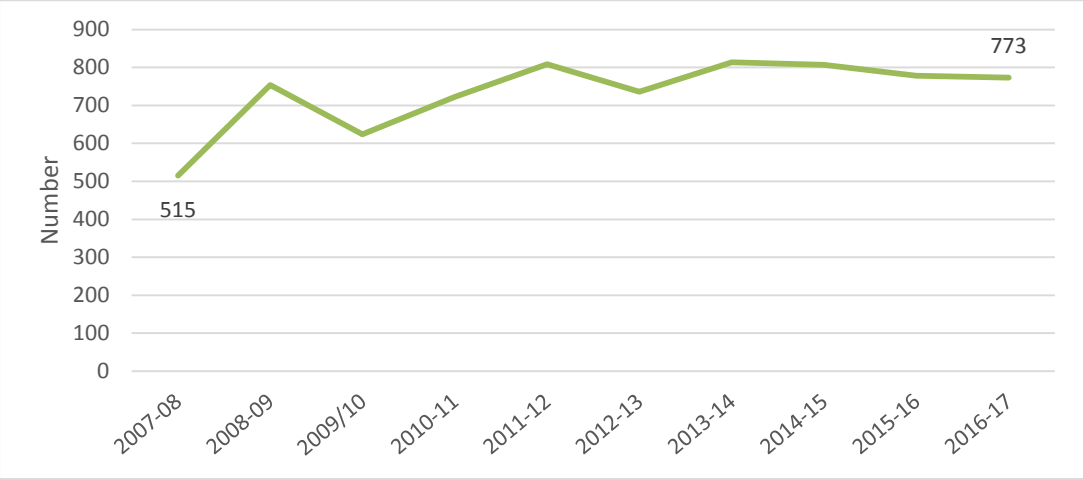
The majority of T2 forms relate to treatment with medication given beyond two months from the point of detention under the Act. T2 forms are rarely used in relation to medicine to reduce sex drive or artificial nutrition. It is more common for these to be given with DMP authorisation, or under the Adults with Incapacity (Scotland) Act 2000 in the case of medicine to reduce sex drive. The figures have been fairly stable over the last seven years, with significantly lower numbers of T2s received in 2007/8 and 2009/10.

Table 9.1 Certificate of Consent to Treatment (T2) 2007/08 to 2016/17

Treatment type	2007-08	2008-09	2009-10	2010-11	2011-12	20012-13	2013-14	2014-15	2015-16	2016-17
ECT	10	13	15	15	26	17	14	16	8	21
Medication to reduce sex drive	1	0	0	0	0	1*	0	2*	0	1
Artificial nutrition	0	0	1	1	0	2	2	5	1	0
Medication beyond 2 months	504	741	608	707	783	717	798	785	769	751
Total T2 certificates*	515	754	624	723	809	736	814	807	778	773

*One T2 certificate had medication to reduce sex drive as well as medication beyond two months

Figure 9.1 Certificate of Consent to Treatment (T2) 2007/08 to 2016/17



Certificate of the designated medical practitioner (Form T3)

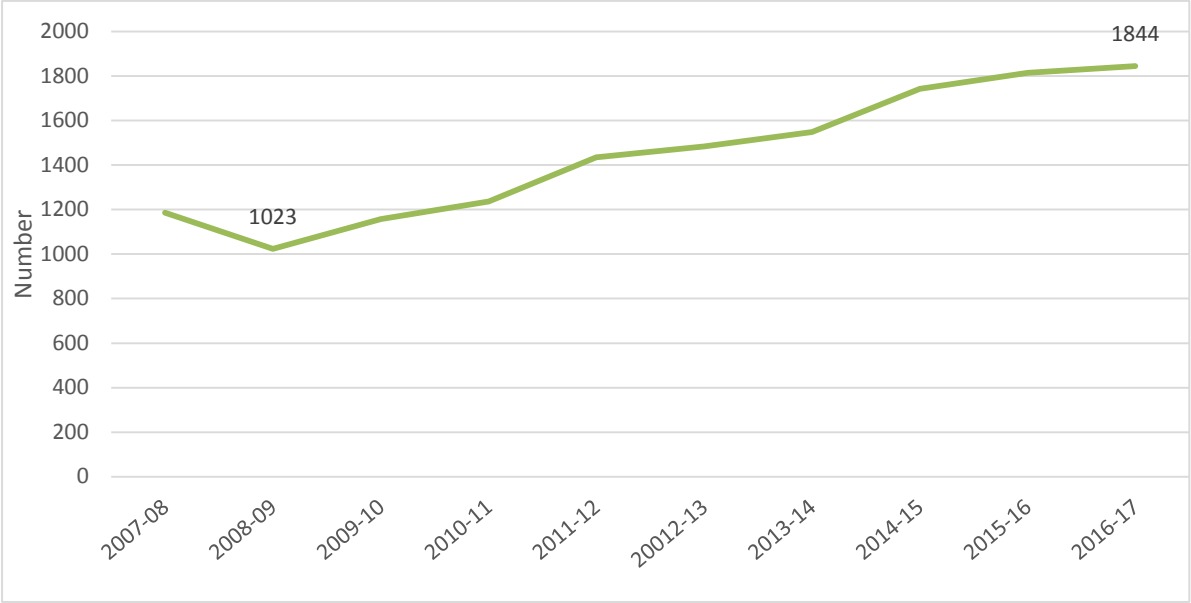
As noted above, a DMP can authorise treatment if a patient is incapable of consenting, and in some cases, if they are capable and refusing. The following section looks at the trends in T3 certificates over the last 10 years. There has been a significant increase in the number of T3s issued since the Act came in to force in October 2005. The numbers of T3s issued each year is shown in the following table and graph. There were 1844 T3s issued in the 2016/17 reporting year. The table also shows the number of certificates issued for each treatment. The number of DMPs available to undertake these visits has not increased by the same proportion so there is an increased reliance on existing DMPs, who often undertake these assessments outside of their own normal working hours, to do more visits. Information on the numbers of DMPs is provided later in this section.

Table 9.2 Certificate of the designated medical practitioner (T3) 2007/08 to 2016/17 (All age groups)

Treatment type	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
ECT	142	118	166	180	203	147	171	186	207	176
Medication to reduce sex drive	4	2	1	1	1	5	5	9	7	10
Artificial nutrition	25	16	22	26	38	49	55	77	98	99
Medication beyond 2 months	1015	887	968	1030	1193	1283	1317	1470	1503	1559
Total T3 certificates*	1186	1023	1157	1237	1435	1484	1548	1742	1815	1844

*T3 certificate may be for more than one treatment

Figure 9.2 Certificates of the designated medical practitioner (T3s) issued per year



Electroconvulsive Therapy (ECT)

Treatment with ECT can only be given if a patient is capable of consenting and consents, or is incapable and treatment is authorised by a DMP. ECT cannot be given under any circumstance to a patient who has the capacity to consent, but refuses to consent.

As well as assessing the patient's capacity to consent, the DMP must also consider whether the patient resists or objects to treatment with ECT. If the patient lacks capacity and is resisting or objecting, the DMP must also be satisfied that treatment is necessary to save the patient's life; prevent serious deterioration; and/or alleviate serious suffering. This is recorded on the T3 certificate.

The following table shows the number of T3 certificates issued for ECT each year, as well as the number of patients considered to be resisting or objecting. For those resisting or objecting, the percentage in which treatment was authorised to prevent serious deterioration and/or alleviate serious suffering or save life is shown.

In the last year, treatment was authorised to save life in a resisting or objecting patient on 14.4% of occasions. This figure has been fairly stable in the last 4 years, but had been 19-20% in previous years.

Table 9.3 Certificate of the designated medical practitioner for ECT 2007/08 to 2016/17

	2007-08	2008-09	2009-10	2010-11	2011-12	20012-13	2013-14	2014-15	2015-16	2016-17
Number of T3 Certificates issued for ECT	142	118	166	180	203	147	171	186	207	176
Percentage resisting or objection	52.8%	49.2%	45.8%	62.8%	64.0%	59.9%	70.2%	72.6%	66.7%	71.0%
Percentage of those resisting where treatment required to alleviate serious suffering, prevent serious deterioration or save life	98.7%	94.8%	100.0%	99.1%	99.2%	98.9%	99.2%	98.5%	99.3%	100.0%

Artificial Nutrition

As can be seen from table 9.4, there has been a significant increase in the number of certificates issued to authorise the use of artificial nutrition. There were 25 certificates in 2007/08 and 99 in 2016/17. The number of certificates issued for under 18 year olds and the percentage of the total is also shown. There has been an increase in the number of specialist eating disorder beds in Scotland during the last 10 years, and the clinical impression is that the Act is being used more in the treatment of eating disorders than it had been previously. We are interested in looking at this further.

Table 9.4 Certificate of the designated medical practitioner for artificial nutrition 2007/08 to 2016/17

Artificial Nutrition	2007-08	2008-09	2009-10	2010-11	2011-12	20012-13	2013-14	2014-15	2015-16	2016-17
Total T3	25	16	22	26	38	49	55	77	98	99
Under 18s	14	9	7	15	20	30	28	43	50	51
Under 18s %	56%	56%	32%	58%	53%	61%	51%	56%	51%	52%

Children and Young People

Young people under the age of 18 are considered a 'child' for Part 16 of the 2003 Act. An RMO must be a child specialist to complete a T2 Consent to Treatment for a patient who is under 18. Either the RMO or the DMP must be a child specialist for a T3 to be completed. The Commission aims to send a child specialist DMP to all patients under the age of 18 when a visit is requested.

Table 9.5 shows the number of T2s received for each form of treatment.

Table 9.5 T2 certificates for young people

Treatment	2007-08	2008-09	2009-10	2010-11	2011-12	20012-13	2013-14	2014-15	2015-16	2016-17
ECT									1	
Medication over 2 months	3	14	11	16	17	17	26	31	39	35
Artificial Nutrition							1	3		
Total	3	14	11	16	17	17	27	34	40	35

Table 9.6 shows the number of T3s received for each form of treatment. There has been a gradual increase in medication beyond two months, but as noted above, a more significant increase in authorisation for the use of artificial nutrition.

Table 9.6 Certificate of the designated medical practitioner for ECT 2007/08 to 2016/17 (Young people)

Treatment type	2007/08	2008/09	2009/10	2010/11	2011/12	20012/13	2013/14	2014/15	2015/16	2016/17
ECT	0	0	1	0	0	2	5	2	1	2
Artificial nutrition	14	9	7	15	20	30	28	43	50	51
Medication beyond 2 months	19	15	12	23	26	27	39	35	45	41
Total T3 certificates	33	24	20	38	46	59	72	80	96	94

*T3 certificate may be for more than one treatment

Neurosurgery for Mental Disorder (Sections 235 and 236)

The 2003 Act requires that all patients (including informal patients) who are to be considered for a procedure classified as neurosurgery in Scotland should first be assessed by a DMP and two other persons (not medical practitioners) arranged by the Commission. These three persons assess the individual's capacity to consent to neurosurgery and confirm this consent has been recorded in writing. In addition, the DMP also assesses that the treatment is in the person's best interests.

There has been no neurosurgery for mental disorder undertaken in Scotland in the last two years.

Patients from Scotland requiring these procedures are now treated at the National Hospital for Neurology and Neurosurgery in London, following detailed assessment by the Advanced Intervention Service in Dundee. Under the English Mental Health Act 1983, the Care Quality Commission (CQC) has a statutory role in assessing capacity to consent and assessing whether treatment is appropriate. This role is similar to the role previously undertaken by the Mental Welfare Commission under Sections 235 and 236.

Although we will no longer have a role in assessing patients prior to surgery, we continue to request progress reports following treatment of Scottish patients as we believe that this is an important monitoring role.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