mentalwelfare commission for scotland

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CORPORATE REPORT

Mental Health Act monitoring 2012/13

Contents

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

We receive notifications of most interventions under the 2003 Act. We use these to report on how the Act is used. We also continue to report geographical variations in the use of the Act. This year, we have three major concerns: emergency detention, social circumstance reports and admission of children to adult wards.

This year, we found a 3% rise in all new episodes of compulsory treatment. We were concerned that the number of emergency detention certificates (EDCs) rose by 7%. We expect that short-term detention should be used. This involves assessment by an experienced psychiatrist and social worker before the individual is deprived of liberty and given treatment without consent. Highland and Dumfries and Galloway had the highest rates of emergency detention. Also, we found a high number of older people admitted from the community via an EDC. We are looking into the reasons for this.

If emergency detention is used, a mental health officer (MHO) must consent unless this is impracticable. This year, we found that the proportion of EDCs with MHO consent was much higher in Ayrshire than in previous years. Most EDCs are granted outside “office hours”. The Ayrshire councils withdrew from the West of Scotland standby service and set up their own out-of-hours MHO service. In contrast, most EDCs granted in Greater Glasgow and Clyde did not have MHO consent. This NHS Board and its local authority partners must examine out-of-hours MHO services as a matter of urgency.

We remain concerned that MHOs are not providing social circumstance reports (SCRs). We find these reports extremely valuable when we are asked to look into an individual’s care and treatment. There are many events that should trigger an SCR, too many, in our view. However, it is unacceptable for there to be no SCR at all for individuals detained under short-term certificates or criminal procedure orders. We are concerned that the lack of provision of SCRs shows that MHO services are struggling to cope with the duties imposed by mental health, incapacity and adult protection legislation.

The Scottish Government’s previous mental health strategy included a commitment to reduce admissions of children to adult wards. Most NHS Boards have failed to achieve this. This year, the number of admissions reported to us rose to 177. Nearly three-quarters were in four NHS Boards: Greater Glasgow and Clyde, Forth Valley, Grampian and, in particular, Lanarkshire where there was a large increase. In contrast, Lothian and Fife had very few admissions to adult wards.

The largest increase in admission to adult wards was for girls. Many of these were in response to actual or threatened self-harm. This is a challenge for the implementation of the Government’s latest mental health strategy. Admission to adult wards is least likely in areas where intensive home treatment is available.

We also found a rise in the treatment of girls under compulsory powers, especially short-term detention and safeguarded treatment with artificial nutrition. We had raised concerns that parents had been asked to give consent where girls under 16 were treated for eating disorders. The Act gives greater safeguards and we think it is probably good that it is being used more.

Other main findings were:

- Short-term detention was highest in inner city areas.
- Detention by nurses has risen but we still think this is not reported as often as it should be.
- The total numbers of compulsory treatment orders (CTOs) in existence fell slightly. Looking back to when the Act came into force, CTOs have risen by only 7% but over 40% are now community orders. This is a huge shift to community compulsory treatment without a major rise in the total use of long-term orders.
- Greater Glasgow and Clyde has the highest numbers of people on long-term orders of all types. Highland has a very high use of community orders. Dumfries and Galloway still has comparatively few people on long-term orders.
- This year, 236 individuals were subject to new mental health orders under criminal procedure legislation. This compares to 212 individuals the previous year. The number of people who continue on these orders in the longer term remains stable.
- We have examined difference in the use of the Act depending on age, gender and ethnicity. We have published a separate equality report summarising our main findings and providing some further analysis.

New episodes of civil compulsory treatment initiated 2006-2013

Episode Sequence	06/07	07/08	08/09	09/10	10/11	11/12	12/13	12/13 *% rise*
	No.	No.	No.	No.	No.	No.	No.	
EDC - total	2029	1908	1837	1785	1787	1760	1872	*5.7%*
EDC - to informal	991	916	918	756	875	828	857	*3.5%*
EDC - to STDC	1038	992	919	1029	912	932	1015	*8.9%*
Direct to STDC	2217	2152	2211	2201	2409	2417	2438	*0.9%*
Direct to CTO* [xx] **(included interim orders)**	133	132	95	83	108	94	103	*9.6%*
Total episodes	4379	4192	4143	4069	4304	4271	4415	*3.4%*

*Taken from our information on hospital admissions. This may differ slightly from Tribunal figures.

xx This includes 22 cases direct to interim CTO subsequently becoming CTOs

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 do include these additional people.

Our interest in these figures

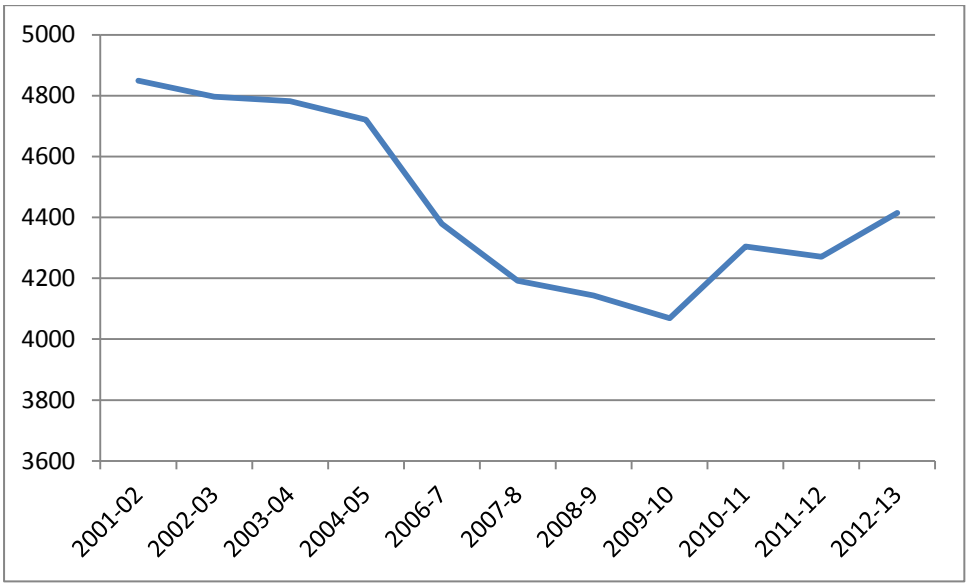
This table shows how people enter a spell of compulsory treatment. We want to see how episodes start and what happens to people after they are first detained. Short-term detention, rather than emergency detention, should be the usual route into compulsory treatment. We want to find out whether this is what happens.

We have looked at these trends from the first full year after the implementation of the 2003 Act. The number of new compulsory episodes had been falling since the Act was implemented until last year, when it rose sharply. We expressed particular concern about the rise in brief periods of emergency detention. Overall, the use of EDC was falling.

What we found

We were notified of 4415 episodes of compulsory treatment during the year. This was an increase of just over 3% on previous years. It is the highest number of new compulsory episodes since the 2003 Act was implemented. It is still lower than the number of new compulsory episodes under the previous 1984 Act. Overall, there has been an upward trend since 2009-10. It may be relevant that this coincides with the economic recession.

Figure: New compulsory episodes initiated 2001-13

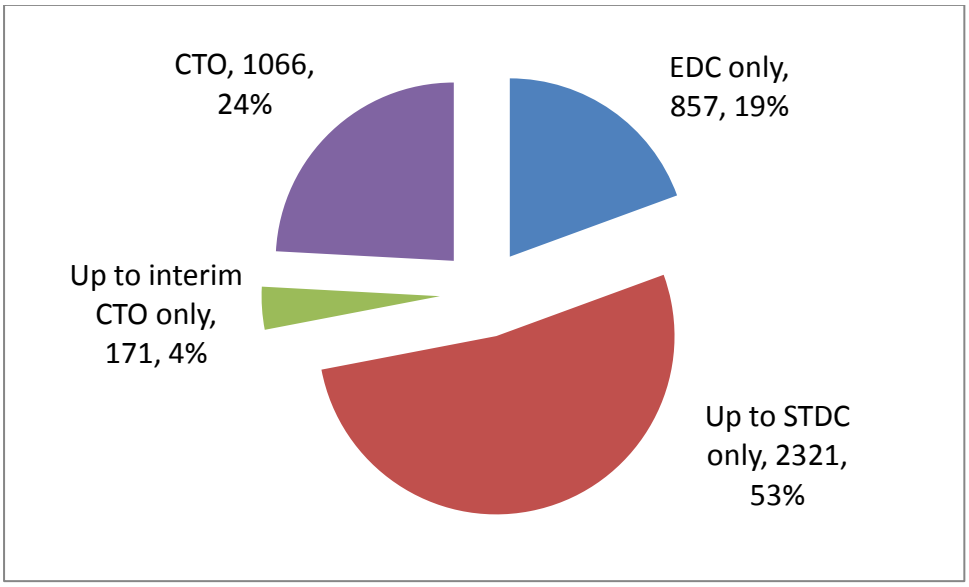


Note – this graph omits 2005-6 because of the changeover from the 1984 Act to the 2003 Act mid-way through the year.

All types of episodes of compulsory treatment rose during 2012-13. The greatest contribution to this rise was the number of emergency detention certificates (EDCs). This was surprising given the reduction in the number of EDCs granted in previous years. This may reflect an increasing pressure on psychiatric emergency services and/or a reduction in the capacity of services to cope with the demand.

We looked at the types of episodes of compulsory treatment that were initiated during the year. This is shown in the figure below

Types of compulsory civil episode 1 April 2012 to 31 March 2013

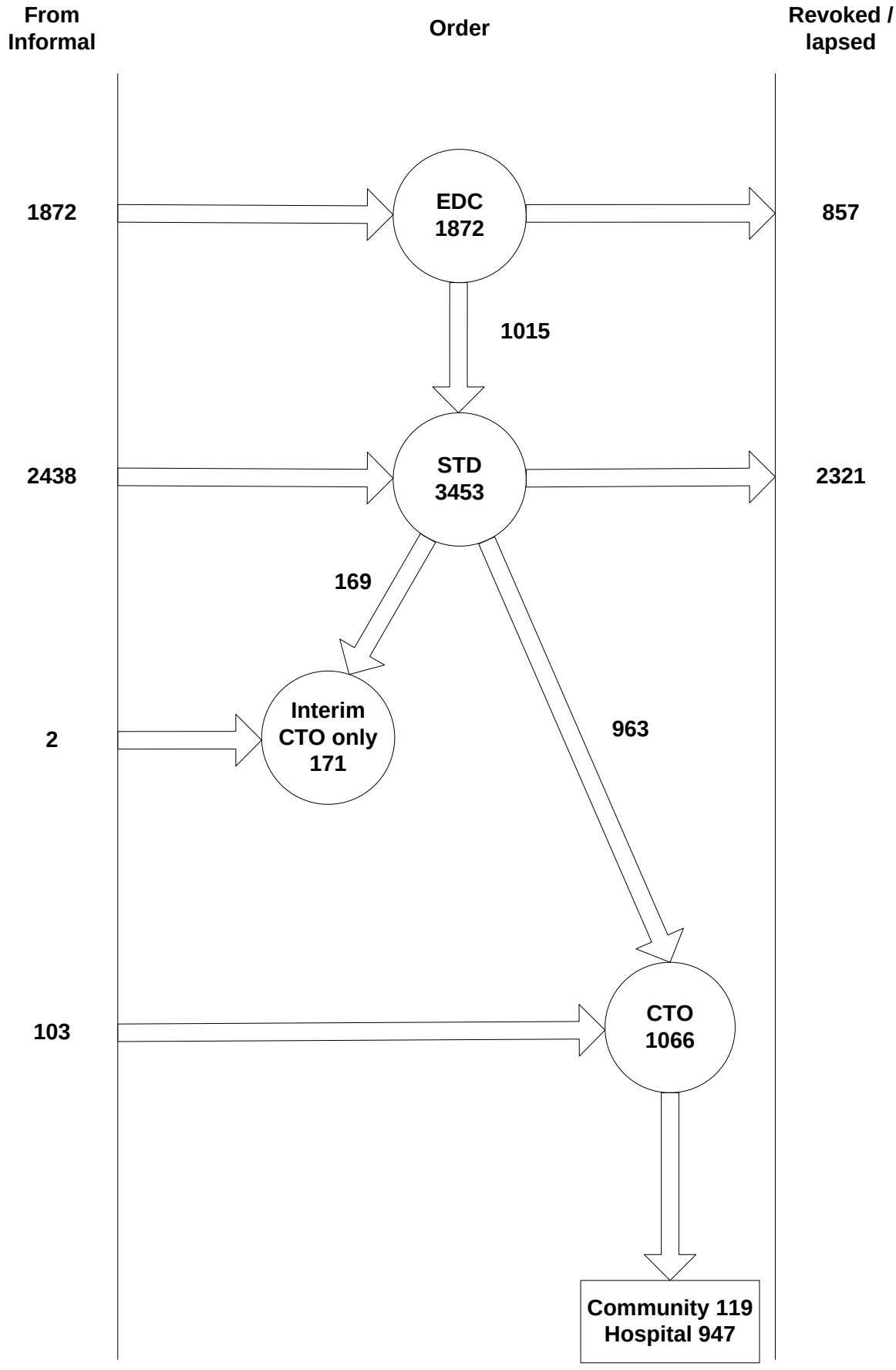


Findings of note from this chart are:

- Fewer than 25% of all episodes of compulsory treatment result in the granting of a long-term compulsory treatment order. A further 4% of episodes progress to an interim CTO without a final CTO being granted.
- The remaining 71% of all episodes of compulsory treatment lasted for 28 days or less.

Of the 4415 people who became subject to the Act during 2012-13, over 70% were given compulsory treatment for relatively short periods of time. This is similar to findings from previous years. The pattern of progression through the civil powers of the Act is shown in the figure below

Pattern of progression through civil compulsory orders 2012- 2013



New orders – Emergency detentions

Emergency detention by age and gender 2012-13

Age Range	Women	Men	Total	Women	Men	Total
	No.	No.	No.	%	%	%
0-15	8	4	12	67	33	100
16-17	13	9	22	59	41	100
18-24	102	101	203	50	50	100
25-44	343	351	694	49	51	100
45-64	277	303	580	48	52	100
65-84	171	152	323	53	47	100
85+	53	28	81	65	35	100
Total	967	948	1915	50	50	100

Our interest in this

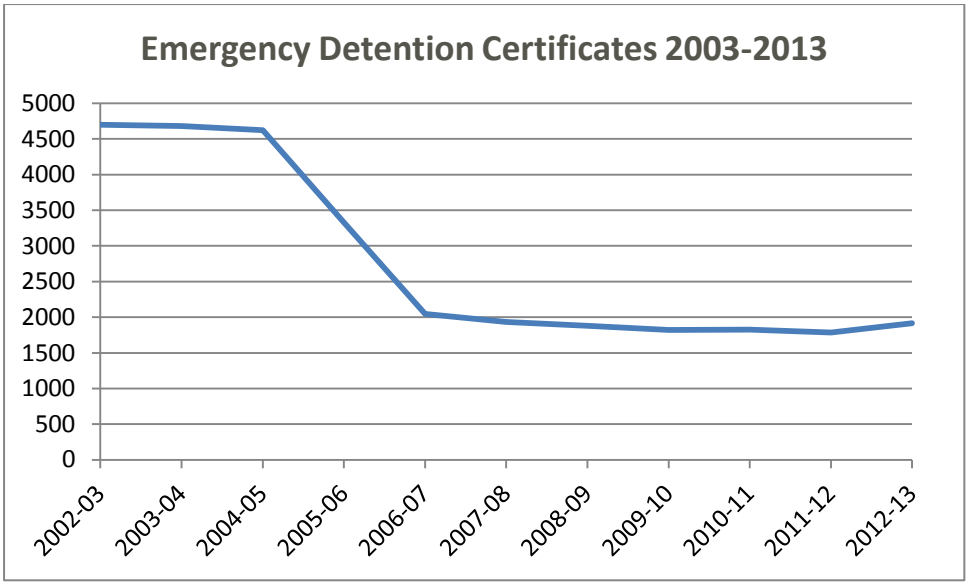
An EDC can be issued by any registered medical practitioner. There should be consent from a MHO if possible. We collect information on the age and gender of people detained in this way. We look for differences in the way EDCs are used for men and for women and any trends in the use of this power for different age groups. EDCs should only be used if it is not possible to secure assessments by both an approved medical practitioner and a mental health officer. It is likely to be used in crisis situations.

Last year we reported on a slight reduction in the overall number of EDC's, particularly for women.

What we found

The total number of EDCs is higher this year, a rise of 7%. We have reported in the last few years about the gradual reduction in EDC's and this is the first rise since 2006-07.

This is concerning as there is no right of appeal under an EDC and the preferred route into hospital should be an STDC as this affords the patient greater safeguards under the Act. We compared the use of EDCs across NHS Boards. This is shown in our section on geographical variations starting on page 23.



Age and gender

There has been an increase in numbers of EDCs in the two youngest age groups (16-17 year olds, 6 cases (37.5%); 0-15 year olds, 2 cases (20%)); however, changes in such small numbers are to be viewed with caution. A definite increase can be seen in the 65-84 age group, up 14% (40 cases) from the previous year.

The rise in the number of young people detained under an EDC corresponds with a continued overall rise for younger people across STDCs.

Although there are higher numbers of women than men in the two youngest and the oldest age groups, the percentage spread across age groups for men and women is broadly similar. This year there is an even 50:50 gender split of overall numbers of EDCs. The gender split within individual age groups is largely unchanged from last year. Within the 45-64 age group, this year men account for 52% compared to just under 48% last year.

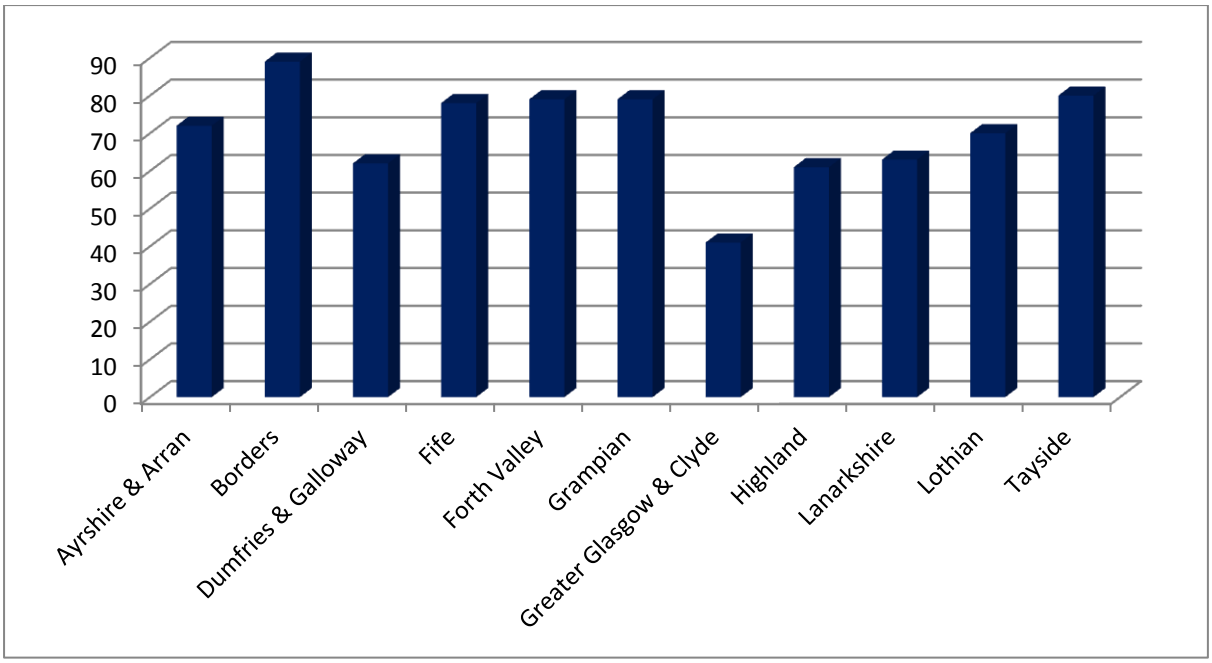
We reported last year on evidence to suggest that more women than men receive intensive home treatment. We speculated that intensive home treatment has been responsible for an overall fall in the use of EDCs over the years. (For more information, see our report about intensive home treatment "Intensive not Intrusive", 2012[1].)

[1] Intensive, not Intrusive: Our visits and telephone interviews with individuals and carers who have http://www.mwcscot.org.uk/media/124340/intensive_home_treatment_visit_report_2012.pdf

EDCs with and without MHO consent by NHS Board 2012-13

		Before detention		MHO consent			
		Community	Hospital	With		Without	
Health Board	Rate per 100K Population	%	%	No.	%	No.	%
Ayrshire & Arran	35	36	64	93	72	37	28
Borders	17	26	74	17	89	2	11
Dumfries & Galloway	52	47	53	48	62	29	38
Fife	36	40	60	105	78	29	22
Forth Valley	33	43	57	78	79	21	21
Grampian	21	72	28	92	79	25	21
Greater Glasgow & Clyde	47	35	65	234	41	332	59
Highland	54	50	50	103	61	66	39
Lanarkshire	30	29	71	105	63	62	37
Lothian	25	53	47	151	70	65	30
Orkney	35	57	43	7	100		0
Shetland	36	63	38	7	88	1	13
Tayside	47	45	55	153	80	39	20
Western Isles	54	50	50	6	43	8	57
Scotland	**35**	**43**	**57**	**1199**	**63**	**716**	**37**

Figure: proportion of EDCs with MHO consent for all mainland NHS Boards



Our interest in this

Emergency detention should only be used where granting a short-term detention certificate would involve too much of a delay. We look at the extent to which emergency detention is used to detain people already in hospital or to admit them from the community. We hear of anxiety from some people that, although they agree to be in hospital, they may be detained if they want to leave. We want to find out how often this happens.

We place great importance in the role of the mental health officer (MHO) in the decision to detain a person. The MHO provides the important safeguard of looking independently at the proposal to detain the person and can help to look at alternative ways to support the person without needing to use compulsory admission. Where the person needs to be admitted, the MHO can help to explain the process and make arrangements to make admission easier and to safeguard the person's property and possessions. The Act requires either consent from an MHO or an explanation of why this was not possible. We would like to see consent in as many cases as possible. We look to see whether there is more likely to be MHO consent in some NHS Board areas than others.

In recent years, NHS Ayrshire and Arran and NHS Greater Glasgow and Clyde have had lower rates of MHO consent than any other NHS Board.

What we found

A total of 1915 people were made subject to an EDC in 2012-13; we found that a similar proportion this year (37%) did not have the consent of an MHO compared to the previous year 2011-12 (40%).

It still concerns us that in Greater Glasgow and Clyde, the area with the highest use of emergency detention in Scotland, the proportion of EDCs with consent is still relatively low (41%). At present 59% of people detained on an EDC in Greater Glasgow and Clyde do not have the safeguard of MHO consent. This Board and its local authority partners should continue to work to address the reasons for this.

We are pleased to note that the proportion of EDCs with MHO consent in Ayrshire and Arran has risen substantially, from only 39% last year to 72% this year and this is probably due to setting up their own out-of-hours service from 1st April 2012.

In our report, *Emergency detention, a report into the emergency detention of people who are already in hospital, 2012*[2], we recommended that the Scottish Government should consider shortening the period of emergency detention to 24 hours in cases where there is no MHO consent.

EDCs by pre-detention status and MHO consent to detention 2012-13

	MHO Consent					
	With		Without		Total	
	No.	%	No.	%	No	%
Informal in hospital	634	58	464	42	1098	100
From community	565	69	252	31	817	100
Total	1199	63	716	37	1915	100

Our interest in this

Consent for emergency detentions is very important. We usually find that detention of a person already in hospital is less likely to involve MHO consent. This is probably because the person is stating an immediate wish to leave and the medical practitioner has conducted an examination, decided that the person should be detained but cannot wait for the MHO. We have concerns that people can be detained in this way for up to 72 hours without MHO consent.

What we found

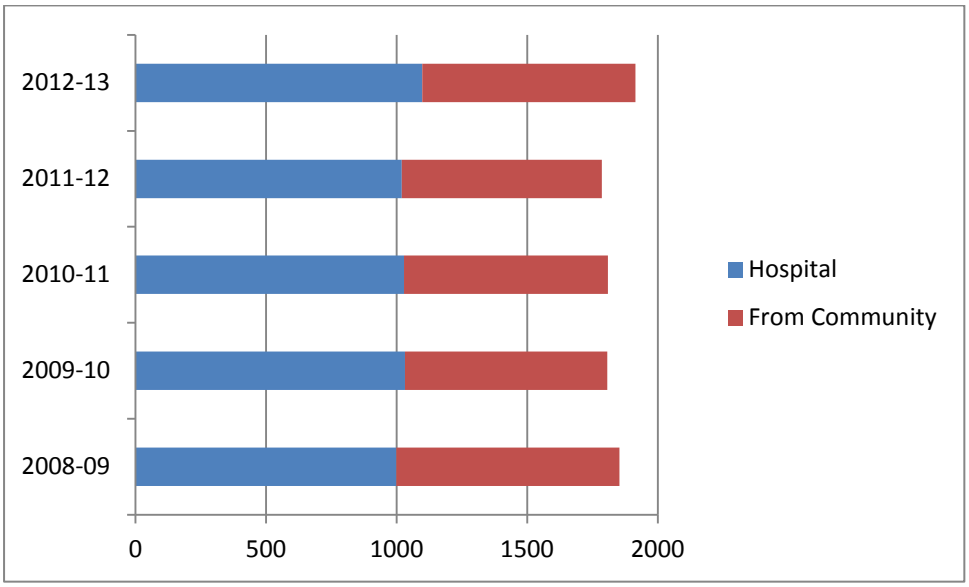
In previous years people who were reported as being already in hospital were less likely to have consent from an MHO when detained under EDC. This remains the same in 2012-13 with 58% of those in hospital receiving MHO consent compared to 69% of those receiving EDC from the community. However, a larger percentage of those in hospital (58%) received MHO consent than last year (54%).

[2] Emergency Detention: A report into the emergency detention of people who are already in hospital (2012)
http://www.mwcscot.org.uk/media/98818/edc_report.pdf

We looked at the use of EDC for people in hospital versus people in the community over the last few years.

In this and previous years, just over half of EDCs were granted for people who were already in hospital. This varies widely across NHS Boards e.g. in Borders 26% of people on an EDC were in the community prior to the detention, whereas the percentage in Grampian was 72%. We are informed that on-call approved medical practitioners (AMPs) attend hospitals in Grampian in order to assess individuals who wish to leave. In some other NHS Boards, this task is performed by junior on-call doctors who are not AMPs.

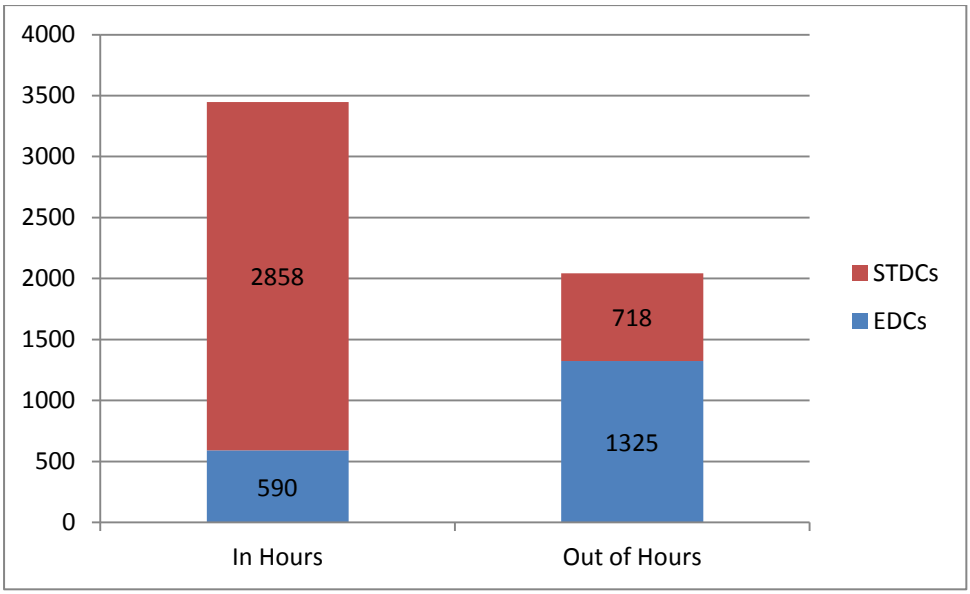
Trend in use of EDCs 2008-13: individuals already in hospital and from the community



EDCs by time of granting of certificate and MHO consent to detention 2012-13

Time of granting certificate	EDCs		MHO consent				
			With		Without		Tot
	No.	%	No.	%	No.	%	%
Within office hours	590	31	403	68	187	32	100
Outside office hours	1325	69	796	60	529	40	100
Total	1915	100	1199	63	716	37	100

Granting of EDCs vs. STDCs, in hours and out of hours 2012-13



Our interest in this

While short-term detention should be the usual route into compulsory treatment, emergency detention is still used, mostly outside office hours. We think it is important that there is consent from an MHO wherever possible. We want to find out if MHO consent is available outside office hours.

What we found

- Most EDCs have MHO consent
- Most EDCs are granted outside office hours.
- EDCs granted outside office hours are less likely to have MHO consent

It is important that local authorities have good out-of hours arrangements to ensure that MHOs can attend wherever possible.

Duration of emergency detention certificates granted 2012-13

	Within 24 hours of admission		24-72 hours after admission		Total	
	No.	%	No.	%	No.	%
EDCs revoked	252		257		509	27
EDC superseded by STDC	608		415		1023	55
Order expired at 72 hours	n/a		n/a		339	18
Not available	*25		*19		*44	2
Total	885	46	691	36	1915	100

- ***For 44 people we were unable to determine the duration of the EDC; the dispersal across length of time has been estimated**

Our interest in this

Short-term detention should be the usual route for admission to hospital under the Act. This involves mental health specialists – an AMP and a MHO. EDCs can be granted for up to 72 hours, an AMP or MHO is not necessarily involved and there is no right of appeal. The Act says that hospital managers should arrange for an AMP to examine the person as soon as possible after admission. We think this should happen within 24 hours. Usually, this should result in a decision to revoke the certificate or to detain the person under a short-term detention certificate. There are few situations where the certificate should run for the full 72 hours and then expire. We look at all EDCs and measure the time until they are either superseded or revoked to make sure that there is evidence of early expert assessment. If the person is admitted over a weekend, it might be acceptable for the AMP to assess but not make a decision and wait for the team that knows the person best to assess the person on the Monday. This should only happen occasionally.

What we found

There has been a 17% rise of people detained on an EDC who had the order either revoked or superseded by an STDC within the first 24 hours and this is positive to note.

We remind NHS Boards that they must arrange an examination by an AMP “as soon as practicable” after an individual is detained on an EDC. There is no right of appeal against an EDC. If detention is not necessary, it should be revoked. If it is necessary, detaining the person on a STDC means that he/she can initiate an application to the Tribunal to have the order revoked.

We reported on an analysis of EDCs revoked by AMPs in 2013[3]. In this report we highlighted the importance of individuals being reviewed by AMPs as soon as practicable. It is good practice to achieve this within 24hours.

New orders – Short term detentions

Short-term detention certificates granted by age and gender 2012-13

Age Range	Women	Men	Total	Women	Men	Total
	No.	No.	No.	%	%	%
0-15	34	12	46	74	26	100
16-17	26	17	43	60	40	100
18-24	130	165	295	44	56	100
25-44	550	663	1213	45	55	100
45-64	522	529	1051	50	50	100
65-84	413	359	772	53	47	100
85+	113	43	156	72	28	100
Total	**1788**	**1788**	**3576**	**50**	**50**	**100**

Our interest in this

Short-term detention certificates (STDCs) should be the usual start for an episode of compulsory treatment. An STDC involves examination by an AMP and consent from a MHO. It can last for up to 28 days. We look at how this power is used for people of different ages and genders to see if there is evidence of unequal treatment. We also compare this data with previous years to see if there are any trends. Last year, we commented on:

- Little change in the overall number of STDCs
- The number of STDCs relating to young women (under 18) remained high particularly in those aged 12 to 15
- STDCs were more likely to be granted for men than women across all age groups except for under 18s

[3] Emergency detention certificates revoked by approved medical practitioners (2013) http://www.mwcscot.org.uk/media/127052/emergency_detention_certificates_revoked_by_approved_medical_practitioners.pdf

What we found

There has been a 3.6% rise in the overall number of STDCs granted last year, the highest single rise since 2006-07.

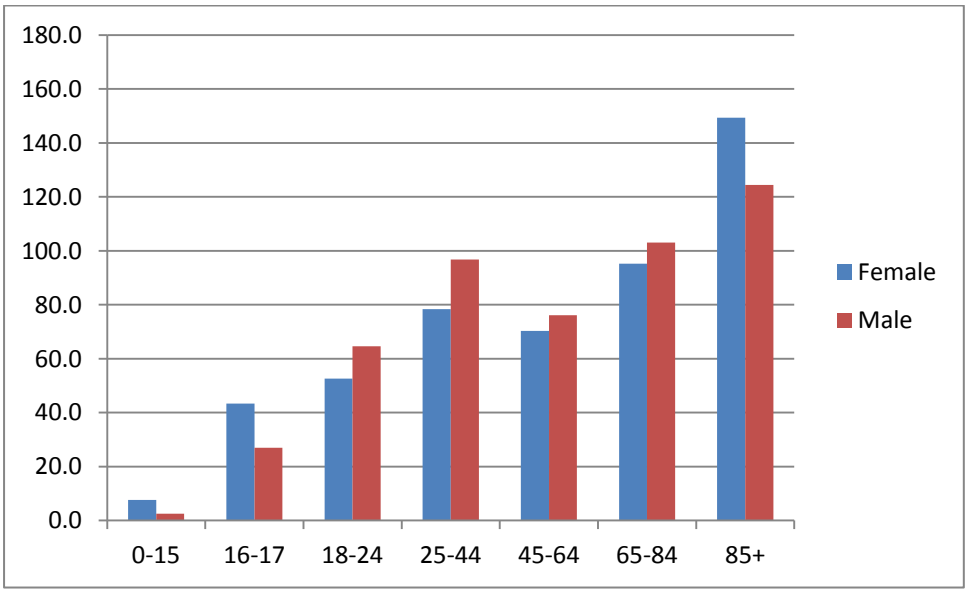
The number of STDCs for girls aged 16-17 has remained relatively stable since last year's rise but there has been another increase in the number of girls aged under 16 where STDCs have been granted, a 31% increase on last year (8 cases).

We said last year that we think that practitioners are likely to use detention more readily for girls who harm themselves, where there are concerns about suicide risk and for girls who have eating disorders (rather than rely on parental consent).

Overall there are an equal number of STDCs granted for men and women but there are significant variances in rate per 100K population across the different age groups; particularly higher rates for women at the very young (under 18) and older (over 85) age groups and higher rates for men particularly in the 18-44 age range.

The finding of a higher rate of detention of women aged 85+ compared with men in that age group is the opposite of last year's analysis. We have more to say on our findings on the use of the Act for older people in our equality report.

STDCs by age and gender per 100,000 population 2012-13



The main findings are:

- a 3.6% rise in the overall number of STDCs granted last year
- another increase in the number of girls aged under 16 under where STDCs have been granted

Short-term detention certificates granted 2012-13: by type of mental disorder

Type of mental disorder	Short-Term Detention Certificates	
	*No.	%
Mental illness	3477	97
Learning disability	167	5
Personality disorder	217	6
Not recorded	11	0
Total certificates	**3576**	

*More than one diagnosis may be specified – each diagnosis is included separately in the table. In many cases, people are diagnosed with more than one mental disorder.

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. Generally, most people are detained because of mental illness.

What we found

People with mental illness continue to account for the vast majority of people detained under STDCs. The numbers are relatively unchanged from last year; there have been no overall significant trends in the last few years.

Short-term detention certificates 2012-13: types & combinations of mental disorders recorded

Mental disorder	STDC Certificates	
	No.	%
Mental illness	3188	89
Mental illness + learning disability	125	3
Mental illness + personality disorder	160	4
Mental illness +personality disorder + learning disability	4	0
Personality disorder	50	1
Personality disorder + learning disability	3	0
Learning disability	35	1
Not recorded	11	0
Total	3576	100*

***Some percentages rounded down**

Our interest in this

People frequently present with more than one diagnosis. It is important to recognise the relative contributions of each category of mental disorder.

What we found

- The percentage of those identified with a mental illness and learning disability rose by 28%
- The percentage of those identified with a mental illness and personality disorder rose by 31%
- The number of people with a diagnosis of personality disorder alone fell from 64 last year to 50 this year, a 22% decrease from last year but falling back in line with the numbers reported in 2010-11.

  We have carried out a census of the use of the Act for people with learning disability during 2012-13. This will be published shortly and will provide further information specific to people with a learning disability.

Short-term detention certificates 2010-2013: by year and where named person is recorded or consulted

	Short-term detentions per year					
Named person	2010-11		2011-12		2012-13	
	No.	%	No.	%	No.	%
Recorded	2778	80	2738	79	2903	81
Consulted	1851	53	1895	55	1990	56

Our interest in this

The concept of each person having a named person who would have an interest in the care and treatment of a person with mental disorder was an important aspect of the Act. The right to be consulted over the proposed granting of an STDC is an important part of the named person's role. It is the duty of the MHO to identify the named person and the AMP must consult the named person unless it is impracticable to do so. We had found a steady increase since the Act was implemented in the percentage of STDCs where the named person had been consulted.

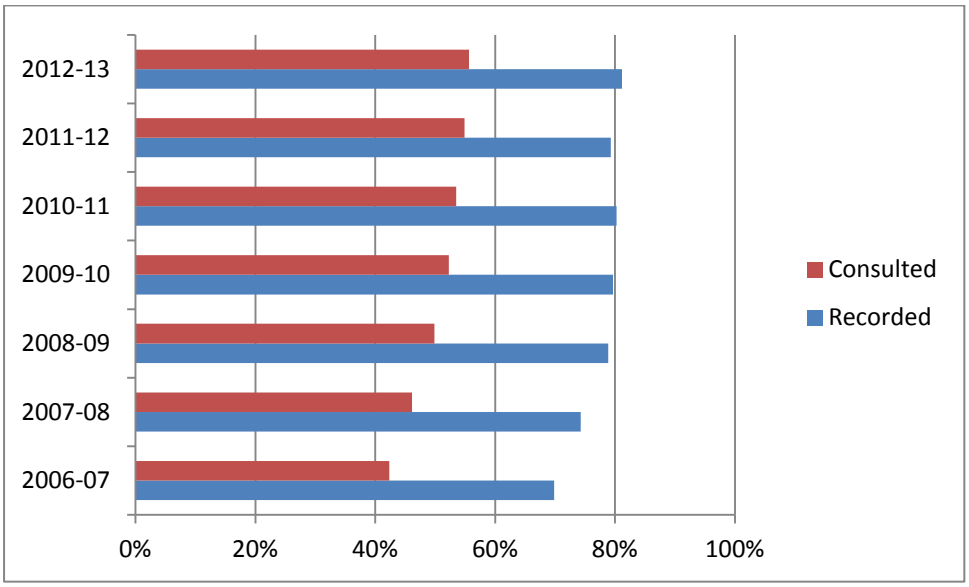
What we found

This year, there has been another slight increase in the percentage of STDCs where the named person was consulted, a 3% increase since 2010-2011.

The figure below shows the increase in recording and consulting named persons before STDCs are granted since the 2003 Act was implemented. The proportion of STDCs where the named person is recorded seems to be levelling out at 80%. There is a steady increase in the proportion where the named person has been consulted.

The Commission has been carrying out research into the role of named persons and interviewing named persons about their experience and understanding of their role and will report on this later this year.

Short-term detention certificates 2006-2013: Percentage where named person has been recorded and/or consulted.



New orders – Compulsory treatment orders

Compulsory treatment orders granted by age and gender 2012-13

Compulsory treatment orders	Female	Male	Total	
	No.	No.	No.	%
Under 16 yrs	13	1	14	1
16-17 yrs	12	8	20	2
18-24 yrs	32	53	85	8
25-44 yrs	160	219	379	34
45-64 yrs	163	179	342	31
65-84 yrs	129	104	233	21
85+ yrs	24	15	39	4
Total	533	579	1112	100%
%	*48%*	*52%*		

These figures are supplied to the Commission by the Mental Health Tribunal Scotland. Total CTOs in period=1122 (age data not available for 10 in table above total =1112).

Our interest in this

Compulsory treatment orders are granted by the Mental Health Tribunal. They last for up to six months, can be extended by the responsible medical officer for a further six months and then extended annually. Therefore, they can restrict or deprive individuals of their liberty for long periods of time. The Tribunal reviews them at least every two years. We look at how these orders are used for people of different ages and genders to see if there are any trends. In recent years, we found a higher use of CTOs for men and a rise in the number of CTOs for individuals under the age of 18

What we found

- The total number of new CTOs (1122) is similar to last year and, overall, had changed little since the 2003 Act was implemented.
- As in previous years, the use of CTOs is higher for men although the gender gap is narrower this year
- The number of CTOs for young people (under 18) fell this year, having risen in the previous two years. It remains much higher for girls. We had previously found a higher use of CTOs for young people (almost all girls) with eating disorders. We thought this was appropriate.
- We looked at the use of the Act for older people. The number of new CTOs for people aged 65 and over has changed little over the last three years.

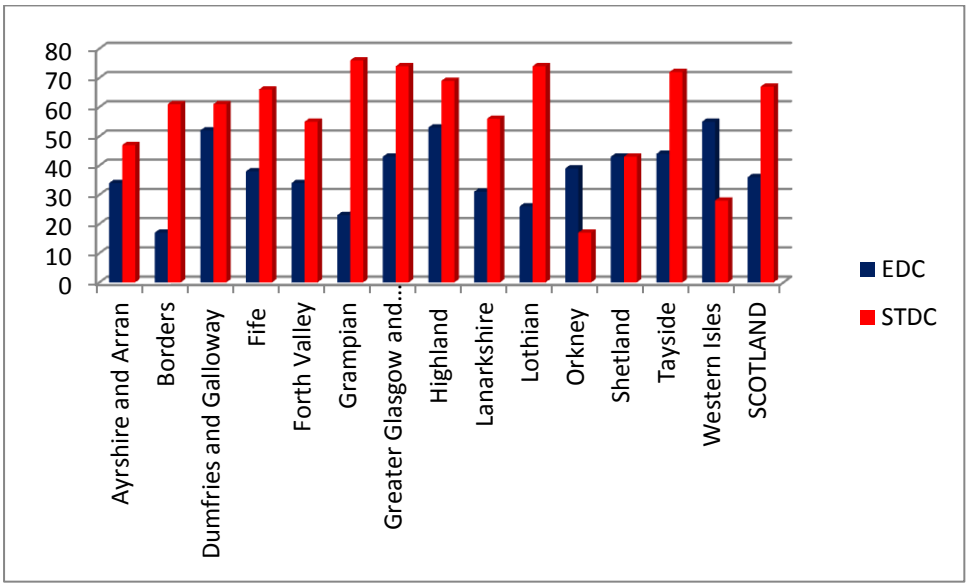
New orders – Geographical variations

Compulsory powers granted, by order type and NHS Board 2012-13 - number, rate per 100k population and NRAC formula adjustment

NHS Board	Emergency Detention			Short Term Detention		
	No.	Rate per 100K	NRAC-adjusted	No.	Rate per 100K	NRAC-adjusted
Ayrshire and Arran	130	35	34	183	50	47
Borders	19	17	17	67	59	61
Dumfries and Galloway	77	52	52	90	61	61
Fife	134	36	38	235	64	66
Forth Valley	99	33	34	163	55	55
Grampian	117	21	23	386	70	76
Greater Glasgow and Clyde	566	47	43	981	81	74
Highland	169	54	53	221	71	69
Lanarkshire	167	30	31	299	53	56
Lothian	216	25	26	618	73	74
Orkney	7	35	39	3	15	17
Shetland	8	36	43	8	36	43
State				3		
Tayside	192	47	44	312	77	72
Western Isles	14	54	55	7	27	28
SCOTLAND	1915	36	36	3576	68	67

**We looked into this further by applying the NHS Scotland Resource Allocation Committee (NRAC) Formula when making comparisons among NHS Boards. NRAC adjusts the population of each NHS Board area based on features such as age, sex, geography and lifestyle factors*

Figure: Emergency and short-term detention by NHS Board 2012-13 - rate per 100k population with NRAC formula adjustment



Our interest in this

Most people who are detained under the Act are held for up to 72 hours (emergency detention) or 28 days (short-term detention). Each year, we look at how these orders are used in different NHS Board areas. We always find large variations and causes are not easy to explain. Because people with severe and enduring mental illness tend to live in inner city areas, we usually find detention rates higher in these areas. Emergency detention can be high in rural areas because it is less easy to get an approved medical practitioner and a mental health officer for short-term detention. This does not explain the variations that we see. We are concerned that areas with high use may be intervening excessively where there may be alternatives to depriving people of their liberty. Low use could mean that people are not being treated or protected adequately. It could also mean that people are being persuaded to be in hospital when they want to leave. This can mean they are to all intents "detained" but without the safeguards of the Act.

What we found

We looked at this year's figures and compared them with previous years. Main findings are:

Emergency detention:

- Highland has the highest use of emergency detention this year. The number of EDCs in this area rose 27% compared with last year's data. Dumfries and Galloway also has a high use of EDCs. These areas have remote and rural communities, so this is understandable to some extent. However, the rise in Highland is striking and the NHS Board may need to look into the reasons for this.

- However, Borders had low use of emergency detention and also has mainly rural communities. There may be differences in service configuration and clinical practice that other rural Boards could study. Grampian has a low use of emergency detention but the number has risen by almost 50% this year.
- Areas with relatively low EDC use are likely to be ensuring good availability of approved medical practitioners to conduct urgent assessments. Areas with high use may need to do more in this regard.

Short term detention:

- Greater Glasgow and Clyde has the highest use of short-term detention. However, when the NRAC formula is applied, it is overtaken by Grampian. Numbers of short-term detention certificates have risen in this area by 12%.

The numbers of emergency and short-term detentions in Dumfries and Galloway had fallen in 2011-12 but rose again in 2012-13 towards previous levels. The Board may need to look into this. We had thought that investment in community services related to the closure of the Crichton Royal Hospital may have explained the substantial fall. If so, this has not been sustained.

Compulsory Treatment Orders granted 2012-13 - number and rate per 100k population

NHS Board	CTOs granted		
	*No.	Rate per 100K	NRAC adjusted
Ayrshire and Arran	56	15	15
Borders	29	26	26
Dumfries and Galloway	22	15	15
Fife	77	21	22
Forth Valley	59	20	20
Grampian	105	19	21
Greater Glasgow & Clyde	322	27	24
Highland	94	30	29
Lanarkshire	84	15	16
Lothian	183	22	22
Orkney	0	0	0
Shetland	2	9	11
Tayside	85	21	19
The State Hospital	3		
Western Isles	1	4	4
SCOTLAND	1122	21	21

*CTO numbers provided by - Mental Health Tribunal Scotland. (MHTS)

Our interest in this

Compulsory treatment orders (CTOs) are used to authorise long-term compulsory treatment. Each year, we look at how these orders are used in different NHS Board areas. We always find large variations and causes are not easy to explain. Because people with severe and enduring mental illness tend to live in inner city areas, we usually find rates higher in these areas. This does not explain the variations that we see. We are concerned that areas with high use may be intervening excessively

where there may be alternatives to depriving people of their liberty. Low use could mean that people are not being adequately treated or protected. There is also a risk that excessive persuasion is used to treat people in hospital. This could amount to unlawful deprivation of liberty.

Some of the variation among NHS Boards is explained by the presence of specialist facilities, e.g. secure units. Also, for long term orders, examining prevalence data gives a better guide to regional variation.

What we found

- Highland has the highest rate of new CTOs this year. The numbers of all types of compulsory orders have risen this year. This continues a general trend in increasing use of compulsory powers in this area. We will discuss the reasons for this with the NHS Board.
- There is a striking rise in the number of new CTOs in NHS Borders (from 13 in 2011-12 to 29 in 2012-13). This is an isolated finding this year and variations, especially in low numbers, can occur from year to year. This Board had a general low use of mental health legislation, so this is a surprising finding.

NHS Boards should look at this data and our data on prevalence rates (table 22) in order to compare their figures with the national average.

Short-term detentions and compulsory treatment orders by local authority 2012-13 – number and rate per 100k population

Local Authority	Short Term Detentions		Compulsory Treatment Orders	
	No.	Rate per 100K	No.	Rate per 100K
Aberdeen City	186	84	65	29
Aberdeenshire	124	50	25	10
Angus	44	40	21	19
Argyll & Bute	62	69	23	26
Edinburgh City	421	85	101	20
Clackmannanshire	26	51	7	14
Dumfries & Galloway	87	59	25	17
Dundee City	144	99	34	23
East Ayrshire	72	60	19	16
East Dunbartonshire	60	57	17	16
East Lothian	46	47	20	20
East Renfrewshire	31	35	11	12
Eilean Siar (Western Isles)	8	31	2	8
Falkirk	93	60	31	20
Fife	239	65	79	22
Glasgow City	604	101	164	27
Highland	174	78	75	34
Inverclyde	45	57	16	20
Midlothian	33	40	19	23
Moray	72	83	15	17
North Ayrshire	59	44	24	18

North Lanarkshire	174	53	54	17
Orkney Islands	3	15	4	20
Perth & Kinross	129	86	33	22
Renfrewshire	104	61	45	26
Scottish Borders	69	61	31	27
Shetland Islands	10	44	5	22
South Ayrshire	59	53	11	10
South Lanarkshire	171	55	62	20
Stirling	47	52	19	21
West Dunbartonshire	64	71	29	32
West Lothian	112	65	36	21
ESWS**	1			
WSSS**	3			
Total	3576	68	1122	21

*CTO numbers provided in this table are figures are from the MHTS.

**ESWS is East of Scotland & WSSS is a West of Scotland “out of hours” service.

Our interest in these figures

The tables above show the variation in civil compulsory orders by NHS Board area. We also want to look for differences across local authority areas. There are differences and overlaps in boundaries, especially in Glasgow and Lanarkshire. We do not examine figures for emergency detention because so many orders are outside office hours and the MHO may be from a different local authority as part of a regional standby service. For short-term detention and compulsory treatment orders, we usually find that inner city local authorities have highest rates. Some of this data may be skewed by “out-of area” placements (see our comments on NHS Board rates).

What we found

- Glasgow City has a very high rate of short-term detention. The high rate in NHS Greater Glasgow and Clyde appears to be due to the high number of

STDCs in the Glasgow City area. The higher rate of STDC use in Grampian appears to be mainly in Moray and Aberdeen City.

- CTO rates are highest in Highland Council. Argyll and Bute has a comparatively lower rate. The Highland Partnership may need to examine this. West Dunbartonshire again had a high rate of CTOs this year. We commented on this last year and the increase is sustained. A local mental health in-patient unit was closed recently in this area. It is possible that admission to a hospital at a greater distance (Gartnavel Royal) is less acceptable for some individuals and that there is therefore a greater use of detention. NHS Greater Glasgow and Clyde may need to look into this.

People with severe and enduring mental illness tend to move towards inner city areas. Variation of rates in rural areas may reflect the challenges in providing community services to a scattered population.

New orders – nurse's power to detain
The use of nurse's power to detain by hospital and gender 2012-13

Hospital	Women	Men	Total
	No.	No.	No.
Aberdeen Royal Infirmary	1		1
Ailsa	1	1	2
Argyll and Bute	1		1
Borders NHS	3	2	5
Carseview Centre	3	6	9
Crosshouse	3		3
Dr. Grays	2	1	3
Dykebar	4	3	7
Forth Valley Royal	2	1	3
Gartnavel Royal	6	5	11
Hairmyres	1		1
Huntercombe		1	1
Kirklands		1	1
Leverndale	1	3	4
Lochview	1		1
Midpark	4	10	14
Monklands	2	3	5
Murray Royal	1	3	4
New Craigs	6	1	7
Queen Margaret	11	2	13
Royal Alexandra		1	1

Royal Cornhill	2	1	3
Royal Dundee Liff	3	1	4
Royal Edinburgh	20	21	41
Southern General	1		1
St Johns	1		1
Stobhill		1	1
Stratheden	4		4
Town and County (Nairn	1		1
Whytemans Brae	10	2	12
Wishaw General	3	3	6
Total	**98**	**73**	**171**

Our interest in this

Under section 299, nurses of the prescribed class have the power to detain people in hospital pending medical examination, in situations where that person, or others, may be at risk. Since the introduction of the 2003 Act we have commented annually on the marked variation in the use of this power across Scotland and the significant difference in the way the power is used with men and women.

What we found

The use of the nurse's power to detain has risen by 16% since last year to 171 and this is the highest annual use of the power to date, 5.6% higher than the last high of 162 in 2009-10. This year women accounted for 57% of the times it was used compared to 59.5% last year. This continues to be a lower percentage than for 2010-11 when women represented 66% of the total and men 34%; a ratio of approximately 2:1.

The total rate, and rates for women and men per 100K population, have risen since last year.

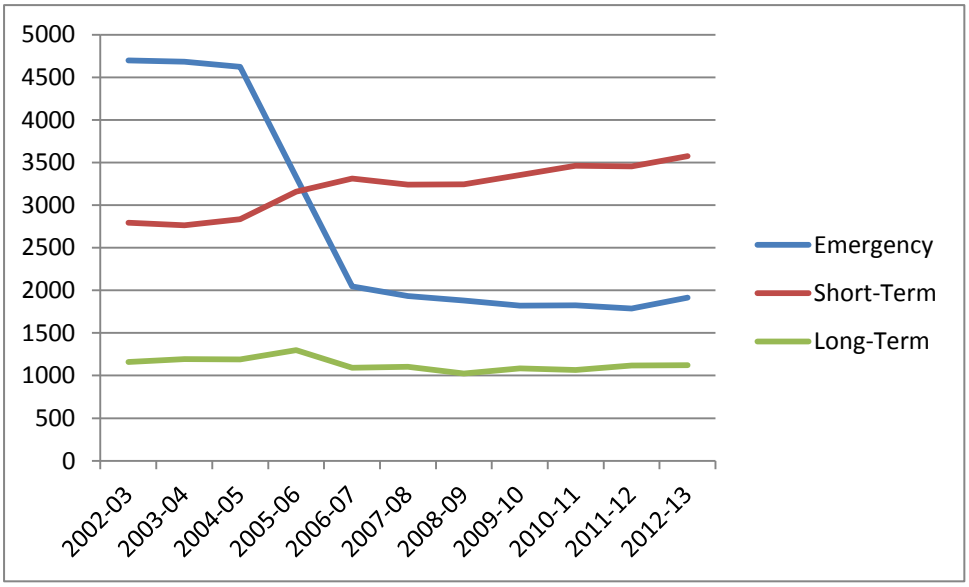
Use of Nurse's Power to Detain		
	Rate per 100K Population	
	2011-12	2012-13
Women	3.3	3.6
Men	2.4	2.9
Total	2.8	3.3

We believe that there continues to be significant under reporting to the Commission of the use of the nurse's power to detain and in general a lack of understanding of where and when it should be used.

We will be publishing good practice guidance on this subject later this year and would hope to see an incremental rise in its use thereafter. We will be providing statistical information to help with a research project looking at the varied reasons behind the variance in its use across the country and nurses understanding and use of Section 299.

Trends in the use of civil compulsory treatment

10 year trend in civil orders granted



Our interest in these figures

We look at how the main civil compulsory orders in Scotland have been used over time. Over the years, we have found an increasing use of long-term compulsory treatment. This was similar to other western European countries. This trend has not continued under the 2003 Act (introduced from October 2005). Emergency detention has been falling, accompanied by an initial rise in short-term detention. We wanted to see if these trends continued.

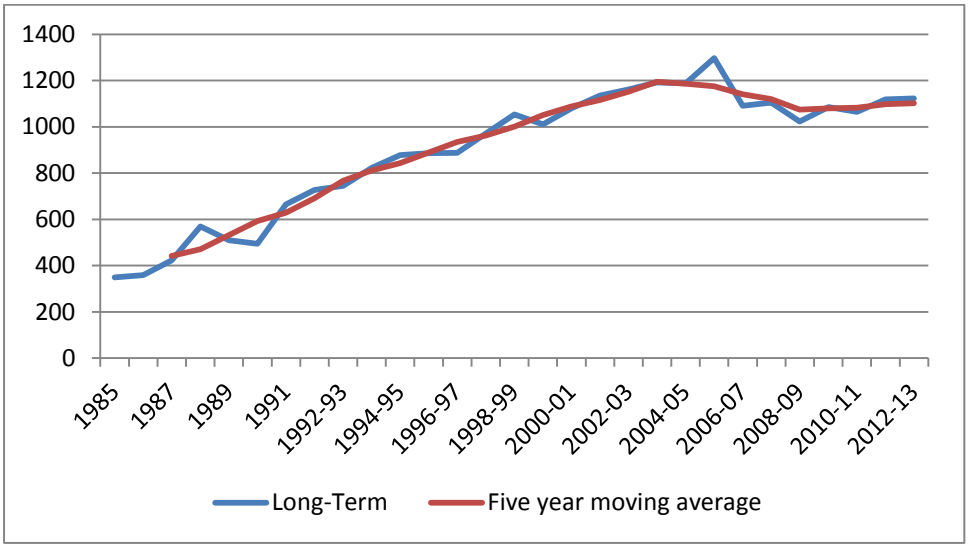
What we found

Our main findings are:

- The use of emergency detention has risen for the first time since the 2003 Act was introduced. This is against a previous downward trend and is a matter of concern. Higher use of emergency detention may be an indicator that individuals are more likely to experience mental health crises and/or less able to access community supports.
- Short-term detention has also increased and is now almost 30% higher than it was under the previous 1984 Act. This is the most common type of compulsory order. Higher use can have a number of causes, including poorer mental health in general, lack of alternatives to compulsory hospital treatment and lack of earlier intervention.
- The number of new long-term orders has changed little over the last ten years. Prevalence data is a better indicator of trends in long-term compulsory treatment.

We looked at the granting of all new long-term civil orders since 1985. We applied a “five year moving average” to see the overall trend. This is a way of smoothing the graph. The figure below shows that the previous upward trend reversed since the 2003 Act was introduced and has been relatively stable over the last few years.

Trend in the granting of new long-term civil orders 1985-2013: five year moving average



Total number of Mental Health Act orders in existence

This section of our report deals with the "prevalence" of orders under the Mental Health (Care & Treatment) (Scotland) Act 2003. For long term orders, this can be more meaningful than looking at new orders. We have worked hard over the last year to improve our knowledge of all long-term orders and have revised previous years' data to give an accurate picture of how the new Act has been used since its introduction.

All orders

Number of people subject to compulsory powers by type at quarterly census dates 2012-13

Order	2012 - 13			
	Apr-12	Jul-12	Oct-12	Jan-13
Emergency detention	11	12	15	7
Short-term detention	233	246	223	233
Interim compulsory treatment order	37	41	46	27
Interim compulsory treatment order - community	2	2	2	4
Compulsory treatment order	2160	2152	2117	2137
Hospital-based	1299	1289	1244	1255
Community-based	861	863	873	882
Assessment order	9	11	7	11
Treatment order	12	20	21	24
Interim compulsion order	4	4	2	12
Compulsion order S57 A (2) -	118	118	124	114
Compulsion order S57 A (2) - community	64	64	59	61
Compulsion order S57(2)(a)	17	16	17	19
Compulsion order S57(2)(a) - community	11	11	11	10
Compulsion order S57(2)(b) - CORO	61	62	63	63

Compulsion order with restriction order S59	189	190	193	191
Transfer for treatment direction	72	70	70	73
Hospital direction	5	5	5	5
Remand in custody or on bail for enquiry into mental condition				
Probation order requiring treatment (s230)				
Temporary compulsion order	1	3	1	1
S200 Committal				1
Indeterminate status*	8	13	13	10

*Indeterminate status – MWC internal data validation has greatly reduced numbers where status is not clear.

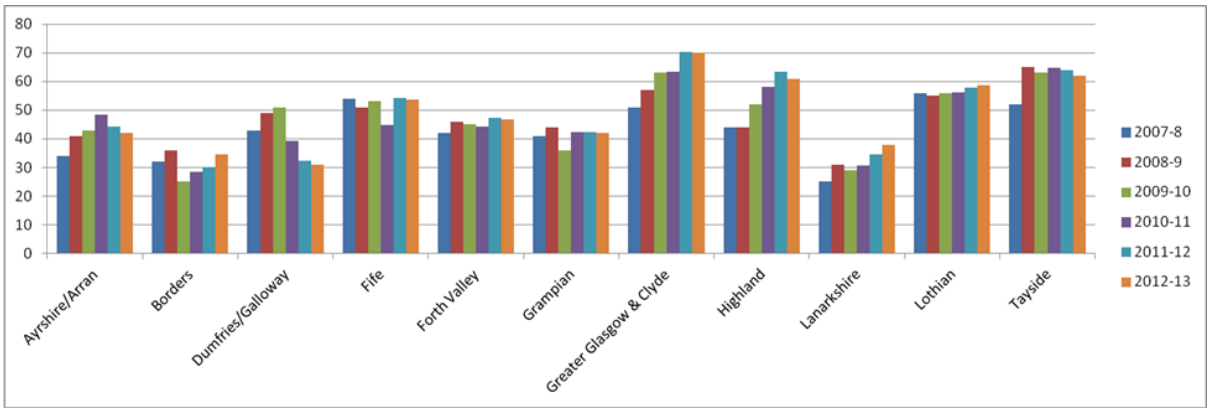
The total numbers of orders in existence varied little throughout the year. We comment in more detail on CTOs below. For all orders, we looked at variations and trends among NHS Boards.

People subject to compulsory powers on 2 January 2013 rate per 100,000, by NHS Board in rank order.

NHS Board	Rate per 100K population
Greater Glasgow & Clyde	70
Tayside	62
Highland	61
Lothian	59
Fife	54
Forth Valley	47
Grampian	42
Ayrshire and Arran	42
Lanarkshire	38
Borders	31
Dumfries and Galloway	26
Western Isles	15
Shetland	13
Scotland	57

These figures have been calculated based on all orders, including indeterminate orders.
Base population is MYE 2011 by full population by Health Board area.

Six year trends in prevalence of all compulsory orders per 100,000 population by NHS board



Our interest in these figures

We comment on the number of new orders in different NHS Board areas in other parts of this report. This table shows the total number of people in each area who are subject to compulsory treatment on one date during the year. This is shown per 100,000 people. In our experience, this is a good guide to the overall use of compulsion in each NHS Board area. We look to see which are the highest and lowest areas and try to explain the differences. Factors which appear to affect use are:

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

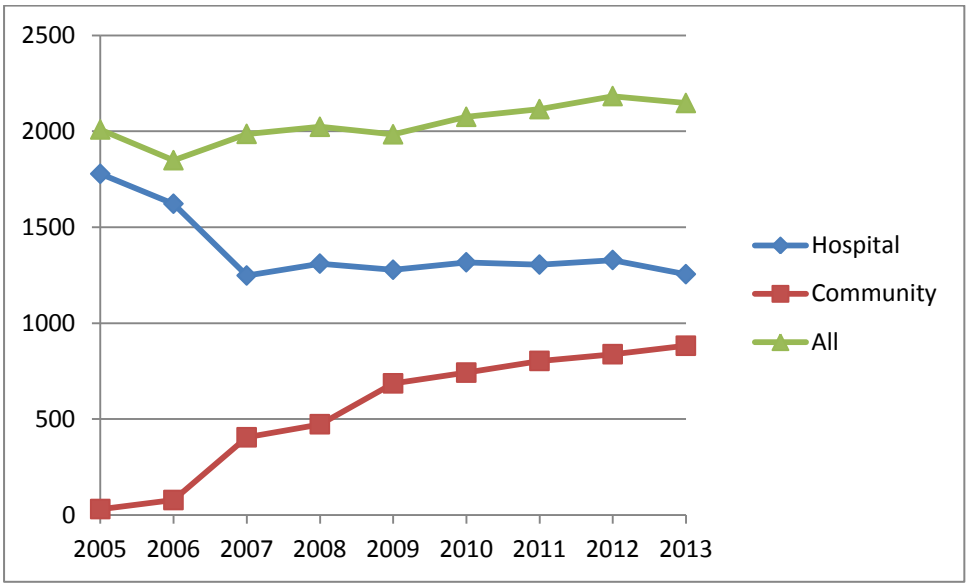
What we found

- NHS Greater Glasgow and Clyde continues to have the highest prevalence of compulsory treatment. Tayside and Lothian 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.
- Highland continues to have a relatively high use of compulsory treatment. This is because of greater use of community compulsion (see below).
- Dumfries and Galloway continues to interest us. In the process of closure of the Crichton Royal Hospital, we saw major reductions in new and long-term orders. This year, new orders have risen but the prevalence of long-term orders continues to fall.
- Lanarkshire and Borders also have low prevalence of compulsory treatment, but we have seen rises in both areas over the last three years.

We still find some of these variations hard to explain. NHS Boards and their partners should compare their data with other areas when examining service provision and practice.

Compulsory treatment orders

Point prevalence of compulsory treatment orders (CTOs) 2005-2013



Note: in 2008, we implemented new systems for orders where the measures granted were unclear. Until then, we knew of around 200 orders where our system was not able to identify what measures were granted. Data has been refreshed from 2009 onwards, indeterminates at Jan 2013=10 only.

Our interest in these figures

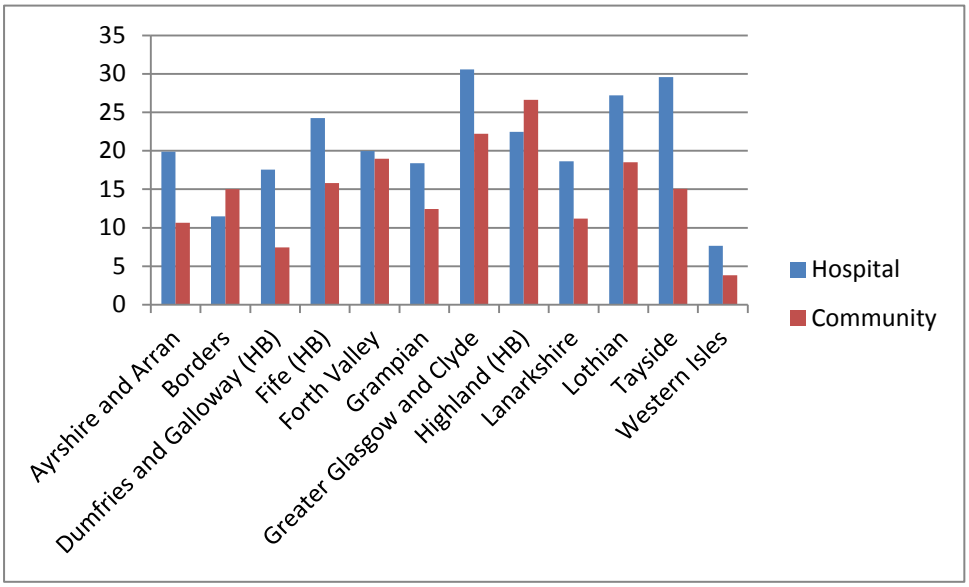
We also looked at the trend in the prevalence of CTOs (hospital and community) since the act was implemented. We think this is very important information, especially for long-term orders. It helps us to see how long-term compulsory treatment is used over time. We wanted to look at how much long-term treatment was in hospital and how much was in the community. We thought the numbers of people on community based orders under the 2003 Act would rise, at least for a while, when the Act was introduced in 2005. We thought that this might correspond with a fall in the number of people detained in hospital under long-term orders. Our most recent data, published in our “Lives less restricted” report, suggested that the number of community CTOs continued to rise. This meant that the total number of CTOs rose. We recommended more frequent reviews of community CTOs and that there should be a “revocation strategy” for all people on these orders. We also recommended to Tribunal members that they should be looking for a revocations strategy when conducting reviews of long-term orders.

What we found

There was a slight reduction in the prevalence of all CTOs this year. This is against the previous rising trend. Hospital-based CTOs fell, accompanied by a smaller rise in community orders. Figures can vary year by year, but it may be that practitioners and Tribunal members have taken note of our concerns.

Of greatest note is the narrowing of the gap between hospital and community CTOs. Community orders now account for 41% of all CTOs, despite a rise of only 7% in all CTOs since the 2003 Act was implemented. This is a remarkable finding and shows the extent to which the balance of care has shifted to the community for people subject to compulsion.

All existing hospital vs community CTOs per 100,000 population by NHS Board Jan 2013.



Our interest in these figures

We look at the balance between all existing hospital and community CTOs in each NHS Board area. This may reflect the balance between community and hospital-based care for people with serious mental illness.

What we found

- The use of hospital-based CTOs is highest in Greater Glasgow and Clyde, closely followed by Tayside. Borders has the lowest prevalence of hospital CTOs compared with other mainland NHS Boards.
- Highland has by far the highest use of community compulsory treatment in Scotland, followed by Greater Glasgow and Clyde. Dumfries and Galloway has a very low use of community compulsory treatment. However, it has an increased rate of new compulsory episodes. This NHS Board may need to

consider whether more use of community compulsory treatment might reduce the number of emergency and short-term detention certificates.

- Borders and Highland make more use of community CTOs than hospital CTOs.

Compulsory readmissions from Community CTOs

Figure: all individuals readmitted from community CTOs 2008-13

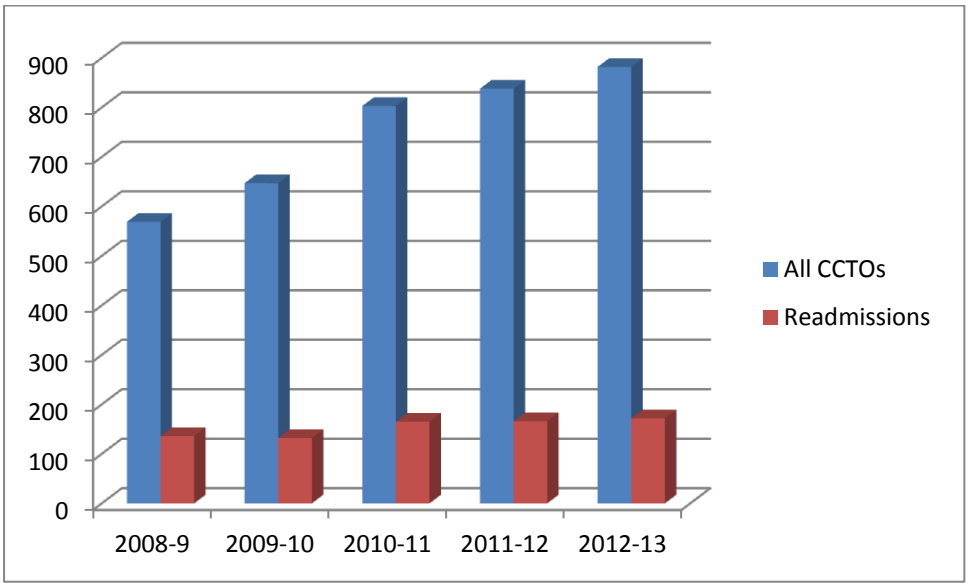
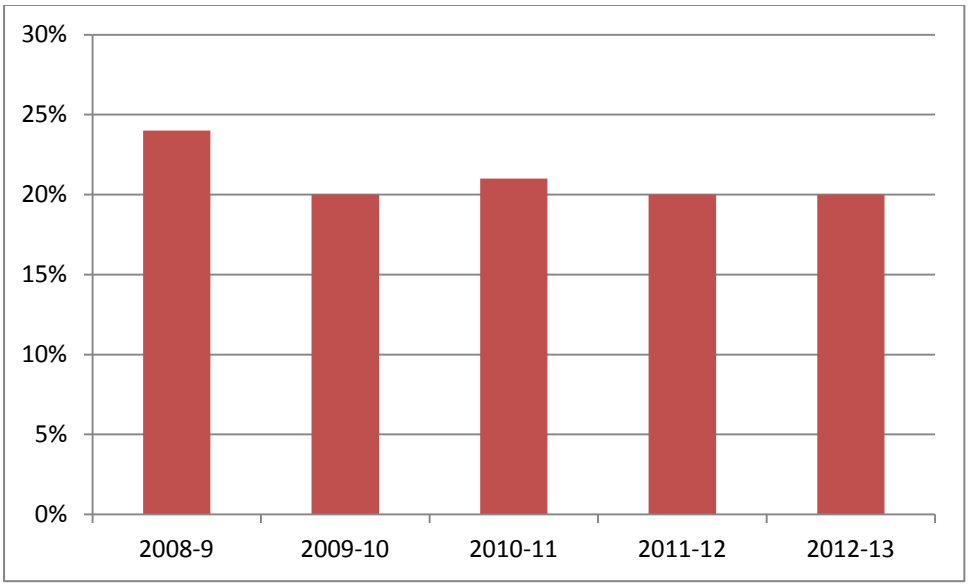


Figure: readmissions as a percentage of all community CTOs 2008-13



Out interest in this

Sometimes, individuals are readmitted to hospital while on a community CTO. This may be due to non-compliance with the order (section 113/114 is used for this) or because they become unwell and meet the criteria for EDC or STDC. Others may be

admitted to hospital with their agreement. There is no requirement to report this to us.

An individual who does not comply with medical treatment may be taken to hospital or another place of treatment for up to six hours. This is covered by section 112. We have had very few of these reported to us in the past.

What we found

For the last four years, around 20% of all individuals on community CTOs had at least one compulsory readmission to hospital each year. The percentage had been higher before 2009-10. It is encouraging that 80% of people on community CTOs do not require compulsory hospital admission.

We still find a very low reported use of section112. There were only seven notifications of the use of this power. For individuals who do not comply with medical treatment, it is a less restrictive intervention than admission to hospital under section 113. However, it may be that responsible medical officers are using this power more often and reporting it under section 113 in error.

Advance statement overrides

Notifications of treatment that is in conflict with an advance statement by year; 2009-10 to 2012-13

	2009-10	2010-11	2011-12	2012-13
Number of notifications	**52**	**33**	**29**	**25**
Actual overrides	**29**	**18**	**19**	**18**
Refusal of depot injection	16	9	11	**5**
Refusal of any medication	5	3	2	**6**
Refusal of ECT	1	2	1	**1**
Refusal of or Request for one specific medication				**4**

Why we are interested

Advance statements are one of the ways of increasing patient participation in their care and treatment. Whilst we do not know how many advance statement have been made, we must be informed when one is overridden. When an advance statement is overridden we expect the person authorising it to have fully discussed it with the patient. The patient and the named person must also be notified in writing.

What we found

Given the previously high number of erroneous notifications, we changed our process for reviewing Advance Statement overrides. Only those where there appears to be a valid advance statement are recorded on our casework screens. We received notification of an advance statement override on 25 occasions. In seven of these cases, we considered that no override had actually occurred within the terms of the Act. There were various reasons for this. In one case we determined that the statement was not valid as it had not been witnessed by an appropriate person, in another, our system continued to note an override from some years previously and there were duplicate notifications. In addition there were five where the override was solely due to the imposition of a CTO. We did not think the Act intended for the advance statement to be used to refuse in advance the imposition of a CTO.

The number of actual overrides is, therefore, little changed from last year. We required to contact the RMO for further information on only one occasion.

The Commission has produced guidance regarding Advance Statements. We hope that this will encourage people to make advance statements that are clear and that they contribute to the partnership between the clinical team and the patient.

Compulsory treatment under criminal proceedings
Number of orders granted by order type: 2010 - 2013

Order Type	2010-11	2011-12	2012-13
	No.	No.	No.
Assessment Order	139	130	158
Hospital Direction	1	1	1
Interim Compulsion Order	17	18	26
S200 Committal	0	1	2
S57(2)(a) Compulsion Order	8	8	11
S57(2)(b) CORO*	0	4	4
S57A(2) Compulsion Order	52	45	58
S59 CORO*	3	11	9
Temporary Compulsion Order	13	12	17
Transfer for Treatment Direction	30	40	45
Treatment Order	61	101	143

- Compulsion order with restriction order

Episodes of compulsion under criminal proceedings, by age and gender, 2011-13

	2011-12			2012-13		
Age Range	**Women**	**Men**	**Total**	**Women**	**Men**	**Total**
	No.	No.	No.	No.	No.	No.
Under 16						
16-17			2	1	4	5
18-24	1	51	52		77	77
25-44	34	194	228	51	233	284
45-64	14	72	86	22	75	97
65-84		1	1		11	11
85+		2	2			
Total	**49**	**322**	**371**	**74**	**400**	**474**
%	*13%*	*87%*	*100%*	*16%*	*84%*	*100%*

Our interest in this

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 or Compulsion Order and Restriction Order.

What we found

Trends in the use of CPSA orders are difficult to interpret on an annual basis. Whilst there have been apparently large increases in the number of assessment orders, treatment orders and interim compulsion orders granted, some of this will be due to the length of time taken for court processes and not necessarily an increase in serious offending behaviour by people with mental disorder. In addition, the way in which these orders are recorded on the Commission's database leads to some individuals having multiple orders noted as part of one continuous episode. Several

of these orders were for the same individual. We will be reviewing the way in which we record orders in the future. The figures we quote are for order incidence, i.e. the number of orders granted in the period.

This year, 236 individuals were subject to CPSA orders, the total number of orders amounting to 474, this compares to 212 individuals the previous year, with a total number of orders at 371. The number of individuals made subject to a “final disposal” order during 2012/13 was 83 or 35% of all individuals subject to CPSA orders. In 2011/12 this number was 69 or 33%. Thirty eight women were subject to CPSA orders in 2012/13 compared with 35 in 2011/12

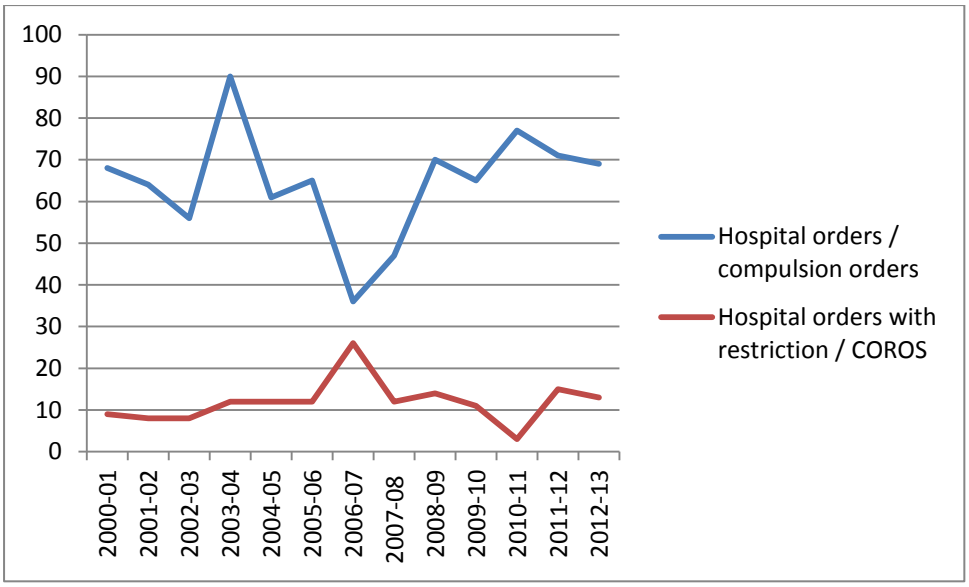
The majority of orders granted are, as before, for men in the 25-44 age group. The number of acquittals due to an “insanity” verdict remain low [57(2)(a) and (57)(2)(b)].

Last year we noted an increase in the use of Treatment orders which has continued this year. Treatment Orders are imposed either at a post conviction, pre- sentence stage or pre-trial where an individual has been charged but the proceedings are not yet underway or no decision about whether to proceed has been taken. Unlike Assessment orders which last for 28 days with an extension of 7 days permitted on one occasion only, treatment orders are dealt with as part of the remand procedures and although there are time limits these can be extended by the court. Because of the way in which these orders are counted by our system, each time an order is granted, a new episode is started so an individual may have 2 or 3 consecutive treatment orders and then an interim compulsion order for example. The number of individuals who have been subject to CPSA orders in 2012-2013 is 236, so clearly a number have had multiple episodes. We may review the length of time spent on treatment orders as part of a specific monitoring exercise in the future.

The number of assessment orders has also increased. As with treatment orders these are granted pre-conviction but are limited and may be followed by a Treatment order. Fifty two individuals were on an assessment order alone.

We will continue to monitor aspects of CPSA legislation as they apply to people with mental disorder.

Criminal proceeding trends in Scotland 2000-2013



Place of safety orders

Place of safety orders notified to the Commission 2012-2013

	Was Place of Safety a Police Station?			
Police Force	**No**	**Not recorded**	**Yes**	**Total**
Central Scotland	7		1	8
Fife	120	3	3	126
Grampian	160	1	5	166
Lothian and Borders	48	2	84	134
Northern	75	2		77
Strathclyde	38	1	3	42
Tayside	3		5	8
Total	451	9	101	561

Our interest in this

Section 297 provides authority for a police constable to remove a person from a public place where they reasonably suspect that the person has a mental disorder and is in immediate need of care or treatment. The order allows the person to be detained in the place of safety for 24 hours. Designated places of safety are normally a hospital and should not be a police station.

The Act places a duty on police officers to report to the Commission on any occasion that they convey people to a place of safety under section 297. We are aware that compliance with this part of the Act is variable.

What we found

The number of notifications is similar to last year

We have been in discussion with the Association of Chief Police Officers in Scotland about improving the recording and notification of incidents where people are removed to a place of safety. This appears to have resulted in improved understanding and a higher rate of notification although there are still circumstances where the forms have been used erroneously; for example, to record the transfer to hospital of a patient made subject to an emergency detention certificate in the community. We have identified practical difficulties in ensuring that notifications are made timeously and appropriately and are continuing to explore ways of minimising the impact of these difficulties. There are some fundamental problems which relate to the transfer of data in appropriate formats which we have not yet been able to address.

Until we are confident that we are receiving notifications about the majority of occasions when section 297 is used we will be unable to form any reasonable judgements about its use.

Provision of Social Circumstances Reports following short term detention by local authority 2012-13

	Documents returned to MWC following STDC						STDCs in LA	
Local Authority*	None		"Serve no purpose" letter		SCR		Total	
	No.	%	No.	%	No.	%	No.	%
Aberdeen City	114	61	9	5	63	34	186	100
Aberdeenshire	48	39	7	6	69	56	124	100
Angus	14	32	2	5	28	64	44	100

Argyll and Bute	44	71	2	3	16	26	62	100
City of Edinburgh	282	67	49	12	90	21	421	100
Clackmannanshire	18	69	1	4	7	27	26	100
Dumfries and Galloway	37	43	5	6	45	52	87	100
Dundee City	48	33	37	26	59	41	144	100
East Ayrshire	25	35	7	10	40	56	72	100
East Dunbartonshire	19	32	7	12	34	57	60	100
East Lothian	29	63	4	9	13	28	46	100
East Renfrewshire	17	55	1	3	13	42	31	100
Eilean Siar	8	100	0	0	0	0	8	100
Falkirk	36	39	16	17	41	44	93	100
Fife	101	42	21	9	117	49	239	100
Glasgow City	482	80	33	5	89	15	604	100
Highland	105	60	8	5	61	35	174	100
Inverclyde	26	58	6	13	13	29	45	100
Midlothian	20	61	5	15	8	24	33	100
Moray	40	56	0	0	32	44	72	100
North Ayrshire	2	3	9	15	48	81	59	100
North Lanarkshire	62	36	11	6	101	58	174	100
Orkney	0	0	0	0	3	100	3	100
Perth and Kinross	30	23	25	19	74	57	129	100
Renfrewshire	52	50	7	7	45	43	104	100
Scottish Borders	52	75	5	7	12	17	69	100
Shetland	1	10		0	9	90	10	100

South Ayrshire	14	24	4	7	41	69	59	100
South Lanarkshire	78	46	32	19	61	36	171	100
Stirling	17	36	6	13	24	51	47	100
West Dunbartonshire	47	73	9	14	8	13	64	100
West Lothian	33	29	13	12	66	59	112	100
SCOTLAND	**1901**	**53**	**341**	**10**	**1330**	**37**	**3572**	**100**

*It is difficult to attach a mental health act event to a local authority in some areas and difficult to link every SCR to a STDC. If you wish to discuss variations in more detail please contact us.

The percentage of STDCs that triggered the completion of an SCR fell this year by 5 percentage points from 42% to 37%. The two largest local authorities, Glasgow and Edinburgh, who together account for more than a third of all such triggering events, were amongst those who completed the lowest percentages of SCRs following an STDC, 15% and 21% respectively.

In some areas, such as Highland, Renfrewshire and Moray there was an increase in their SCR completion rate.

The Scottish Social Services Council recently reported[4] an increase in the number of practising MHOs between March and December 2012. The whole time equivalent number increased by 1.2%. However, they also record that the number of MHOs in specialist mental health teams had decreased over the same period by 6.6%. Having multiple MHOs involved during an episode from initial assessment and admission, to follow up care after discharge, may reduce the likelihood of an SCR being completed. Local authorities should ensure that MHOs are deployed in a way that maximises the effectiveness of their role under the Act.

We are conscious that MHOs also have increased demands from Adult Support and Protection Act and Adults with Incapacity Act work, but managers do not appear to be aware of what factors MHOs are using to prioritise whether to write SCRs or not following a relevant event.

For instance, many Criminal Procedure Act (CPSA) relevant events did not attract an SCR. We found in a recent report on this area of our work[5] that only about half of the individuals seen appeared ever to have had an SCR completed in respect of the imposition of a CPSA order. As all the orders are regarded as relevant events, this is concerning. In very few cases was there any indication that the MHO had

[4] Scottish Social Services Council (2013) *2012 Mental Health Officers' Report* http://www.sssc.uk.com/News/2012-mental-health-officers-report.html
[5] Mental Welfare Commission for Scotland (2013) *Early revocations of compulsion orders* (http://www.mwcscot.org.uk/media/128410/co_revocations_.pdf

determined under Section 231(2) that the production of an SCR “would serve little, or no, practical purpose”. Even for service users with extensive CPSA histories there was a dearth of SCRs available and our report highlights how if more information had been shared about the individual this could have improved the outcome for them.

Furthermore, in our March 2013 report "When parents are detained"[6] we found that mental health teams should always consider the specific needs of patients who are parents and whether they need support to maintain good relationships with their children. SCRs are a key tool in these circumstances and we recommended in the report that where the service user has a child under eighteen, the use of compulsory measures should always prompt consideration of an SCR at the beginning of each new episode. We found that the use of these reports was inconsistent. Involving MHOs at an early stage offers an opportunity to assess the support needs of children and parents.

We promote the completion of SCRs in line with our published guideline[74] because we believe they can add vital information and insights of which the clinical team and MWC might otherwise be unaware. For instance, we would like to see that the impact of recent changes to the benefits system on a service user, where they exist, be included in the SCR. Our practitioners routinely read SCRs and – if an MHO directs us in a covering letter – we will read them as soon as we receive them. We will continue to ask those local authorities where little priority is given to this important function to consider how they are meeting their statutory duties.

[6] Mental Welfare Commission for Scotland (2012) When parents are detained http://www.mwcscot.org.uk/about-us/latest-news/when-parents-are-detained-our-latest-report

[7] Mental Welfare Commission for Scotland (2009) *Good practice guidance on the preparation of Social Circumstances Reports for mental health officers and managers* http://www.mwcscot.org.uk/media/51846/Social_Circumstances_Reports.pdf

Consent to treatment under Part 16 of the Act
Certificate of the designated medical practitioner (T3) 2012-13

Treatment type	No.
ECT	147
Medication to reduce sex drive	6
Artificial nutrition	49
Medication beyond 2 months	1281
Total T3 certificates	**1477**

Note: T3 certificate may be for more than one treatment

Our interest in these figures

The 2003 Act is designed to provide safeguards for patients in general. Part 16 makes provisions for additional safeguards in relation to medical treatment 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).

What we found

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 should first be assessed by a Designated Medical Practitioner (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. All three practitioners sign Form T1 if the treatment is approved. We seek progress reports on all patients having neurosurgical procedures at 12 months and again at 24 months from the team providing ongoing care for the person. In some cases we seek reports on subsequent progress as well.

In Scotland the Advanced Interventions Service in Dundee remains the only centre offering neurosurgical procedures. Four patients were seen for assessment during the reporting year all of whom were from Scotland. All of the patients had severe

intractable depressive illness. For one patient the proposed treatment was the procedure known as Deep Brain Stimulation (DBS). In all four cases the treatment was considered to be in their best interests and form T1 certificate of consent to treatment was issued.

We also considered progress reports on a number of patients who had proceeded to neurosurgery previously. Training sessions were arranged for existing and new members of the group who undertake these visits.

Other 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. Consent to treatment given with a patient's agreement is recorded on Form T2 usually by the RMO and by the patient's consent in writing. Treatment without consent is authorised by a DMP on Form T3.

We received 732 T2 forms 9% fewer than the previous year. The majority were for medication, 16 for ECT and 2 for artificial nutrition. The number for artificial nutrition may be under-reported due to the wording of the MHA, section 240 (3), and we have recommended that this be changed in the revision of the act. Section 238 of the act requires form T2 to be sent to MWC within 7 days.

The number and types of treatments authorised by a Certificate of the DMP (Form T3) is shown in table 38 above. The majority of treatments authorised were medication beyond two months. There were fewer certificates for ECT than the previous year. Data for a similar time period obtained from the Scottish ECT Accreditation Network (SEAN) shows a small reduction in the number of people receiving ECT and a slight rise in the proportion of people who give informed consent. Of the patients receiving ECT 88 objected to or were resisting the treatment, a fall from 2011-12. About 15% of those who resisted or objected required treatment to save life, the remainder to alleviate serious suffering and/or prevent serious deterioration.

The role of the DMP includes consideration both of the appropriateness of the treatment plan, and the requirements of the MHA. Sometimes the DMP does not initially approve the treatment plan but recommends that a further visit is arranged after more assessments have been completed by the RMO and clinical team.

Examples of the DMP as a safeguard

DMP Dr B was concerned that an elderly patient was on a lot of medication. He approved the treatment plan but for only six months initially and recommended a pharmacy review. This was undertaken and the next DMP, who was a particular specialist in this area, agreed that due to the nature and severity of the patient's problem the treatment was in his best interests and a form T3 was appropriate.

DMP Dr C met a young person in a specialist unit and did not wish to approve the treatment plan until there was more clarity about the diagnosis. Following further assessment by the CAMHS team and another visit the DMP agreed with the clinical team's diagnosis of a psychotic illness, that treatment was in the young person's best interests and approved the treatment plan.

As in previous years in the case of ECT sometimes the DMP who attended agreed that it was in the person's best interests but the situation did not meet the necessity test for being given when the person objects or resists, and therefore the DMP did not consent. This year, there were again examples of RMOs seeking a non-statutory "second opinion" outside of the requirements for the MHA, for example within the first two months for medication. In these situations RMOs were advised to seek a local second opinion and that having a DMP provided no additional authority to any opinion. We wondered if this was a reflection of more consultants working in isolation from colleagues or the need for mentoring for those new to the RMO role.

Children and Young People

We received 17 T2 forms for patients who were under 18 at the time of consenting to treatment all of which were for medication beyond two months. In 1 case the RMO completing the form was not a child specialist and the need to remedy this was brought to the attention of the RMO and clinical team.

There were 58 T3 forms for patients under 18 receiving treatment without consent. Two were for ECT for the same patient. The DMP had specified review after a smaller number of treatments than would be the case for an adult, reflecting good practice. 27 were for medication beyond two months and 29 for artificial nutrition. In all cases the RMO or the DMP were child specialists. A number of patients had several forms. Many of these were for either review or restarting of artificial nutrition after a specified period or a trial period without feeding. This reflects good practice and the seriousness of an eating disorder for young people at a crucial phase in their growth and physical development.

Designated Medical Practitioners

There were 96 DMPs on our register to provide second opinions on safeguarded treatments during the year. This number reflects the turnover from resignations and

new DMPs who joined the register. We held our annual DMP seminar in November 2012. The topics included capacity and the law, pharmacology updates and audit of assessments after which T3 forms were not issued. Several induction sessions for new DMPs were held during the reporting year, and were also attended as a refresher training sessions by some current DMPs. We remain grateful to all our DMPs who undertake second opinion visits, particularly as Consultants report that their time is increasingly under pressure. A number of retired colleagues help with this work by being able to respond to requests at short notice. Recruitment of new DMPs has improved as a result of information placed on both MWC and Royal College of Psychiatrists in Scotland websites. As in previous years it remains a challenge to maintain sufficient psychiatrists to visit Grampian and Highland regions. At present we are uncertain if there will be an impact from revalidation on the recruitment of DMPs, particularly experienced psychiatrists at the end of their careers.

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