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STATISTICAL MONITORING

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Report to Scottish Government by the Mental Welfare Commission for Scotland - Emergency Detention Certificates without Mental Health Officer consent (Audit 1 July 2015-31 December 2015)

Introduction

Following the presentation of the Mental Welfare Commission's (the Commission) annual Mental Health Act monitoring report[1] to the Scottish Government, Shona Robison (Cabinet Secretary for Health, Wellbeing and Sport) was asked by Dr Richard Simpson (Mid Scotland and Fife) about the low level of involvement of mental health officers (MHOs) in the granting of Emergency Detention Certificates (EDCs) across Scotland, particularly in Greater Glasgow and Clyde (GGC).

Mental health officer (MHO) consent is regarded as an important safeguard when someone is being detained in hospital. There were concerns as to whether medical practitioners were consulting MHOs, where possible, and whether there were sufficient MHOs in place to meet the statutory duties of the local authorities. The Cabinet Secretary asked the Commission to undertake analysis of the reasons for low MHO consent for EDCs and asked "the Scottish Government's chief social work advisor to investigate issues to do with the shortfall in MHOs in local authorities with the chief social work officers". The Commission and the chief social work advisor were asked to report back to the Scottish Government by the end of April 2016.

Mental Health Officer Consent

An emergency detention certificate (EDC) can be issued by any registered medical practitioner and authorises detention in hospital for up to 72 hours. The Mental Health (Care and Treatment) (Scotland) Act 2003[2] (the Act) is clear that there should be consent from a MHO wherever practicable (s36 (3) and (6)). A short term detention certificate (STDC) is regarded as the preferred 'gateway' order when someone requires detention in hospital, as it requires assessment by an approved medical practitioner (AMP) (a psychiatrist with specific training and registered with the health board) and an MHO (a social worker with specific training and approved by the local authority). EDCs should only be used if it is not possible to secure assessments by both an AMP and a MHO. They are likely to be used in crisis situations.

The Commission places value on the role of the MHO in the decision to detain a person. The MHO provides the important safeguard of looking critically 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

[1] http://www.mwcscot.org.uk/media/240677/mha_monitoring_report_2014-15.pdf
[2] http://www.legislation.gov.uk/asp/2003/13/contents

explain the process, their rights, including access to advocacy, and make arrangements to make admission easier and to safeguard the person's property and possessions. We like to see consent in as many cases as possible, in line with the requirements of the Act, though recognise that the nature of the situation does not always allow this.

Table 1 EDCs with consent by health board in last five years (percentage)

Health Board*	2010-2011	2011-12	2012-13	2013-14	2014-15
	%	%	%	%	%
Ayrshire and Arran	37%	39%	72%	74%	65%
Borders	71%	83%	89%	89%	69%
Dumfries and Galloway	58%	63%	62%	49%	55%
Fife	85%	77%	78%	78%	77%
Forth Valley	73%	83%	80%	67%	58%
Grampian	66%	70%	79%	79%	64%
Greater Glasgow and Clyde	52%	44%	41%	37%	30%
Highland	68%	60%	61%	61%	74%
Lanarkshire	60%	64%	63%	64%	62%
Lothian	72%	74%	70%	64%	62%
Orkney	100%	100%	100%	100%	100%
Shetland	-	88%	88%	86%	89%
Tayside	84%	81%	80%	69%	80%
Western Isles	0%	100%	43%	100%	25%
Scotland	62%	60%	63%	58%	56%

- All data rerun February 2016. Numbers and percentages may vary slightly from previously published annual monitoring reports due to inclusion of late returns and ongoing data quality exercises.

Table 2 2014-15 EDCs without and with consent by health board (number & percentage)

Health Board*	Without consent	With consent	Total	Without consent	With consent	Total
	n	n	n	%	%	%
Ayrshire and Arran	49	93	142	35%	65%	100%
Borders	9	20	29	31%	69%	100%
Dumfries and Galloway	33	41	74	45%	55%	100%
Fife	35	115	150	23%	77%	100%
Forth Valley	40	55	95	42%	58%	100%
Grampian	48	86	134	36%	64%	100%
Greater Glasgow and Clyde	427	179	606	70%	30%	100%
Highland	41	116	157	26%	74%	100%
Lanarkshire	67	111	178	38%	62%	100%
Lothian	95	154	249	38%	62%	100%
Orkney	0	7	7	0%	100%	100%
Shetland	1	8	9	11%	89%	100%
Tayside	34	137	171	20%	80%	100%
Western Isles	6	2	8	75%	25%	100%
Scotland	885	1124	2009	44%	56%	100%

- All data rerun February 2016.

Nationally the percentage of EDCs with consent has shown a downward trend over the past five years. Notably, apart from 2013-14, Tayside has maintained a level of 80% or more with consent. Ayrshire and Arran have increased the percentage of EDCs with consent significantly over the last five years. The MHO out of hours arrangements have changed during this period in this area.

In 2014-15 just over half (56%) of EDCs in Scotland had consent. We have commented in previous annual monitoring reports on the variation in percentages of EDCs with consent across health boards. In 2014-15, of mainland boards, the lowest percentages with consent were: GGC, 30%; Dumfries and Galloway, 55%; Forth Valley, 58%. The mainland boards with the highest percentages of consent were: Tayside, 80%; Fife, 77%; Highland, 74%.

MHO consent by in and out of hours

Table 3 2014-15 Scotland MHO consent in hours and out of hours (number & percentage)

Hours	Without consent		With consent		Total	
	n	%	n	%	n	%
In Hours	246	38%	394	62%	640	100%
Out of Hours	639	47%	730	53%	1369	100%
Scotland	885	44%	1124	56%	2009	100%

- All data rerun February 2016.

68% (1369) of EDCS happen outside office hours and 32% (640) within office hours.

Of those carried out within office hours, 62% will have MHO consent; outside office hours 53% will have MHO consent. It is important that local authorities have good out-of-hours arrangements to ensure that MHOs can attend wherever possible.

EDC Project 2016

In February-March 2016 the Commission examined all EDCs without consent across Scotland for the six month period 1st July 2015 - 31st December 2015. The data was analysed by health board. We explored;

- Range of reasons for non-attendance of MHO
- Differences in and out of hours
- Patient's status prior to EDC-community or hospital
- Individual hospitals (GGC only)
- Type of medical staff doing assessment
- How soon the EDC was reviewed
- Whether the EDC was revoked or went to a STDC

MHO consent six months 1st July 2015 to 31st December 2015

Table 4 All EDCs with and without consent by health board, 1st July to 31st December 2015

Health Board	Without MHO consent		With MHO consent		Total	
	n	%	n	%	n	%
Ayrshire and Arran	14	29%	35	71%	49	100%
Borders	2	14%	12	86%	14	100%
Dumfries and Galloway	20	54%	17	46%	37	100%
Fife	21	28%	55	72%	76	100%
Forth Valley	28	42%	38	58%	66	100%
Grampian	16	33%	33	67%	49	100%
Greater Glasgow and Clyde	248	66%	126	34%	374	100%
Highland	27	39%	43	61%	70	100%
Lanarkshire	29	29%	71	71%	100	100%
Lothian	62	35%	113	65%	175	100%
Orkney			6	100%	6	100%
Shetland			1	100%	1	100%
Tayside	28	31%	61	69%	89	100%
Western Isles	2	67%	1	33%	3	100%
Scotland	497	45%	612	55%	1109	100%

Across mainland Scotland the proportion of EDCs without MHO consent ranged from 14% (Borders) to 66% (GGC), the national figure being 45%.

50% of the non-consents in Scotland for this period are in the GGC area.

Table 5 All EDCs in and out of hours - by health board, 1st July to 31st December 2015

Health Board	In hours		Out of hours		Total	
	n	%	n	%	n	%
Ayrshire and Arran	12	24%	37	76%	49	100%
Borders	1	7%	13	93%	14	100%
Dumfries and Galloway (HB)	17	46%	20	54%	37	100%
Fife (HB)	29	38%	47	62%	76	100%
Forth Valley	10	15%	56	85%	66	100%
Grampian	21	43%	28	57%	49	100%
Greater Glasgow and Clyde	105	28%	269	72%	374	100%
Highland (HB)	31	44%	39	56%	70	100%
Lanarkshire	21	21%	79	79%	100	100%
Lothian	57	33%	118	67%	175	100%
Orkney (HB)	3	50%	3	50%	6	100%
Shetland (HB)	1	100%		0%	1	100%
Tayside	22	25%	67	75%	89	100%
Western Isles	2	67%	1	33%	3	100%
Scotland	**332**	**30%**	**777**	**70%**	**1109**	**100%**

There is considerable variation between health boards in the percentage of EDCs in hours. Where the percentage of EDCs is low in hours it may be that more STDCs are being used as the 'gateway order' to detention.

Table 6 In hours - EDCs with and without consent by health board, 1st July to 31st December 2015

Health Board	Without MHO consent		With MHO consent		Total	
	n	%	n	%	n	%
Ayrshire and Arran	5	42%	7	58%	12	100%
Borders		0%	1	100%	1	100%
Dumfries and Galloway (HB)	5	29%	12	71%	17	100%
Fife (HB)	9	31%	20	69%	29	100%
Forth Valley	6	60%	4	40%	10	100%
Grampian	4	19%	17	81%	21	100%
Greater Glasgow and Clyde	48	46%	57	54%	105	100%
Highland (HB)	8	26%	23	74%	31	100%
Lanarkshire	8	38%	13	62%	21	100%
Lothian	26	46%	31	54%	57	100%
Orkney (HB)	0	0%	3	100%	3	100%
Shetland (HB)	0	0%	1	100%	1	100%
Tayside	5	23%	17	77%	22	100%
Western Isles	2	100%		0%	2	100%
Scotland	**126**	**38%**	**206**	**62%**	**332**	**100%**

In hours Lothian (46%) and GGC (46%) (also Forth Valley (60%) but low numbers), have the highest percentage of EDCs without MHO consent. The national average is 38%.

Table 7 Out of hours - EDCs with and without consent by health board, 1st July to 31st December 2015

Health Board	Without MHO consent		With MHO consent		Total	
	n	%	n	%	n	%
Ayrshire and Arran	9	24%	28	76%	37	100%
Borders	2	15%	11	85%	13	100%
Dumfries and Galloway (HB)	15	75%	5	25%	20	100%
Fife (HB)	12	26%	35	74%	47	100%
Forth Valley	22	39%	34	61%	56	100%
Grampian	12	43%	16	57%	28	100%
Greater Glasgow and Clyde	200	74%	69	26%	269	100%
Highland (HB)	19	49%	20	51%	39	100%
Lanarkshire	21	27%	58	73%	79	100%
Lothian	36	31%	82	69%	118	100%
Orkney (HB)	0	0%	3	100%	3	100%
Tayside	23	34%	44	66%	67	100%
Western Isles	0	0%	1	100%	1	100%
Scotland	**371**	**48%**	**406**	**52%**	**777**	**100%**

Out of hours Dumfries and Galloway (75%) and GGC (74%) have the highest percentage of EDCs without MHO consent. We are in discussion with Glasgow Health and Social Care Partnership (GHSCP) and will discuss these figures with the Dumfries and Galloway partnership.

Reasons Given for Lack of MHO consent

Table 8: Attempt at MHO contact by Health Board, incorporating inferred cases(1) 1st July to 31st December 2015

Health Board	Service contacted(2)		Unsuccessful attempt		No attempt(3)		Unclear		Total	
	n	%	n	%	n	%	n	%	n	%
Ayrshire and Arran	5	36%	1	7%	7	50%	1	7%	14	100%
Borders	0	0%	1	50%	1	50%	0	0%	2	100%
Dumfries and Galloway	8	40%	3	15%	8	40%	1	5%	20	100%
Fife	12	57%	3	14%	6	29%	0	0%	21	100%
Forth Valley	12	43%	3	11%	13	40%	0	0%	28	100%
Grampian	9	56%	4	25%	2	13%	1	6%	16	100%
Greater Glasgow and Clyde	116	47%	40	16%	82	33%	8	3%	246	100%
Highland	16	62%	4	15%	5	19%	1	4%	26	100%
Lanarkshire	15	52%	5	17%	8	28%	1	3%	29	100%
Lothian	20	33%	7	11%	34	56%	0	0%	61	100%
Tayside	13	46%	10	36%	4	11%	1	4%	28	100%
Western Isles	1	50%	0	0%	0	0%	1	5%	2	100%
Scotland	**227**	**46%**	**81**	**16%**	**170**	**34%**	**15**	**3%**	**493**	**100%**

Source: EDCs submitted to the Commission, July to December 2015, with no MHO consent. Total=493 on data cleaning 4 cases removed (GGC=2, Highland=1, Lothian=1)
On initial examination of records a total of 162 records showed unclear reasons for lack of MHO consent; from these a total of 147 reasons were inferred – inferred no attempt 127 and inferred attempt 20.
1 The table includes 147 cases where the attempt at contact has been inferred from the information provided on the EDC
2 Includes 20 inferred cases
3 Includes 127 inferred cases

Service contacted – means that service was contacted PRIOR to the EDC being granted.

No attempt – includes cases where the service was contacted AFTER the EDC was granted.

Other than in the Lothian and GGC areas, the numbers are too small to draw any conclusions. We are in discussion with GHSCP and will ask NHS Lothian about the number of cases where no attempt was made to contact the MHO service.

Table 9: Scotland: Attempts to contact MHO / outcome of contact

	n	**%**
1 service contacted	**227**	**46%**
situation urgent	55	11%
situation urgent - absconded	5	1%
discussed and EDC agreed	21	4%
situation urgent - would take too long to get there	26	5%
not available - on other call out	12	2%
not available - other reason	72	15%
not practical to attend	5	1%
on way but not in time to assess	13	3%
other	5	1%
other - no MHO on duty	11	2%
unclear	2	0%
2 unsuccessful attempt	**81**	**16%**
no answer from MHO service	41	8%
awaiting callback	30	6%
other	2	0%
unclear	8	2%
3 no attempt	**170**	**34%**
no attempt to contact and no reason given	3	1%
situation urgent	141	29%
situation urgent - absconded	16	3%
other	4	1%
unclear	6	1%
4 unclear	**15**	**3%**
situation urgent	1	0%
not available - other reason	2	0%
other	1	0%
other - no MHO on duty	1	0%
unclear	10	2%
All cases	**493**	**100%**

Source: EDCs submitted to the Commission, July to December 2015, with no MHO consent
Note: The table includes 147 cases where the attempt at contact / outcome was inferred

Revocation, Review and STDC 1st July 2015 to 31 December 2015

Table 10: Time to revocation or review by health board (number)

Health board	Hours to revocation or review for STDC							
	<=24		>24 to 48		> 48 to 72		At 72	Total
	REV	STDC	REV	STDC	REV	STDC	EXPIRED	Total
	n	n	n	n	n	n	n	n
Ayrshire and Arran	1	7		2	1	1	2	14
Borders			1		1			2
Dumfries and Galloway	1	4	3	4	3	3	2	20
Fife	4	4	2	5	4		2	21
Forth Valley	3	12	3	5	1	1	3	28
Grampian	1	8	1			1	5	16
Greater Glasgow and Clyde	40	89	24	37	8	10	31	239
Highland	4	10	3	4		1	4	26
Lanarkshire	9	3	2	6		4	5	29
Lothian	9	17	8	10	3	1	12	60
Tayside	5	10	2	6	2		2	27
Western Isles							2	2
Grand Total	**77**	**164**	**49**	**79**	**23**	**22**	**70**	**484**

*9 cases excluded where revoked EDC were for people on longer term orders.

Table 11: Time to revocation or review by health board (percentage)

Health board	Hours to revocation or review for STDC							
	<=24		>24 to 48		> 48 to 72		At 72	Total
	REV	STDC	REV	STDC	REV	STDC	EXPIRED	Total
	%	%	%	%	%	%	%	%
Ayrshire and Arran	7%	50%	0%	14%	7%	7%	14%	100%
Borders	0%	0%	50%	0%	50%	0%	0%	100%
Dumfries and Galloway	5%	20%	15%	20%	15%	15%	10%	100%
Fife	19%	19%	10%	24%	19%	0%	10%	100%
Forth Valley	11%	43%	11%	18%	4%	4%	11%	100%
Grampian	6%	50%	6%	0%	0%	6%	31%	100%
Greater Glasgow and Clyde	17%	37%	10%	15%	3%	4%	13%	100%
Highland	15%	38%	12%	15%	0%	4%	15%	100%
Lanarkshire	31%	10%	7%	21%	0%	14%	17%	100%
Lothian	15%	28%	13%	17%	5%	2%	20%	100%
Tayside	19%	37%	7%	22%	7%	0%	7%	100%
Western Isles	0%	0%	0%	0%	0%	0%	100%	100%
Grand Total	**16%**	**34%**	**10%**	**16%**	**5%**	**5%**	**14%**	**100%**

*9 cases excluded where revoked EDC were for people on longer term orders.

The audit looked at the length of time before the EDC was reviewed and revoked; or was reviewed and a STDC was put in place; or expired after 72 hours. 50% of people were reviewed by an AMP and either had the EDC revoked or were detained on a STDC (which also requires MHO consent) within 24 hours of the EDC. This rose to 76% within 48 hours of the EDC. Only 14% of EDCs expired after the 72 hour period and may not have been reviewed by an AMP.

Greater Glasgow and Clyde and their social care partners

We met with GGC and their social care partners for our annual meeting in December 2015 and discussed with them the continuing rise in EDCs without MHO consent. We agreed at that point that they would do further work on this and we would meet again on 24 March 2016. In the interim, the GHSCP had carried out an audit of 52 cases with and without consent in South Glasgow over a 3 month period. The Commission had carried out an audit of all EDCs across Scotland for the period 1st July 2015 to 31st December 2015.

Numbers with and without MHO consent

In the six month period of the Commission's audit there were 1109 EDCs in Scotland. 45% (497) did not have MHO consent.

A third of all the EDCs (374) in Scotland were in the GGC area. The national figures are therefore influenced by the numbers of EDCs in GGC. If excluded, 34% (249) of EDCs in the rest of Scotland did not have MHO consent.

In GGC 66% (248) did not have MHO consent. This is an improvement, to date, from the 2014-15 annual monitoring figures of 72%.

Reasons for no MHO consent

Table 12: Greater Glasgow and Clyde: Attempts to contact MHO / outcome of contact

	n	%
service contacted	**116**	**47%**
situation urgent	40	16%
situation urgent - absconded	2	1%
situation urgent - would take too long to get there	12	5%
discussed and EDC agreed	10	4%
not available - on other call out	8	3%
not available - other reason	29	12%
not practical to attend	4	2%
on way but not in time to assess	2	1%
other	3	1%
other - no MHO on duty	4	2%
unclear	2	1%
unsuccessful attempt	**40**	**16%**
no answer from MHO service	25	10%
awaiting callback	11	4%
other	1	0%
unclear	3	1%
no attempt	**82**	**33%**
situation urgent	68	28%
situation urgent - absconded	7	3%

no attempt to contact and no reason given	2	1%
other	1	0%
unclear	4	2%
unclear	**8**	**3%**
situation urgent	1	0%
not available - other reason	1	0%
unclear	6	2%
All cases	**246**	**100%**

Source: EDCs submitted to the Commission, July to December 2015, with no MHO consent
Note: The table includes 76 cases where the attempt at contact / outcome was inferred

In our six month audit we compared the reasons for lack of MHO consent in the GGC area with other health boards across Scotland. The pattern of reasons for non- consent in GGC was similar to the national picture. The reasons given for lack of MHO consent were multi factorial. Table 12 indicates:

21% of cases where the service was contacted were too urgent to wait for an MHO.

31% of cases where there was no attempt to contact the service were felt by the doctor to be too urgent to wait for an MHO. It is not possible to tell from the data available on these cases the potential for alerting the service earlier of the likely need for an EDC. This would increase the chances of an MHO attending, or the coordination of a joint assessment between the responsible medical officer (RMO) and MHO with nurses' power to detain (s299) being used until both the doctor and MHO could be there. (Nurses power to detain lasts for up to two hours from the start of Section 299 detention (s299) period to allow for medical assessment. If the doctor arrives between one and two hours of the started detention, the time can be extended for up to one hour from his/her arrival to allow for medical assessment. From April 2017, the time limit will be three hours in all cases. During the debate in Parliament, Ministers said that one reason for this extension was to make it easier for MHOs to attend.)

15% of doctors reported that there was no answer or they were waiting for a call back from the MHO service. There are dedicated telephone numbers specifically for professionals to access the MHO service in each locality and out of hours, which we understand are constantly manned. We were told the out of hours number is circulated regularly and listed in the Psychiatric Emergency Plan (PEP), though, it may be that the key personnel are still not sufficiently aware of these direct numbers. In addition, we were informed that the out of hours service has been supplemented by nine sessional MHOs.

Time of detention- in and out of hours

Across Scotland, in the six months 1 July to 31 December 2015, 38% (126 of 332) of EDCs in hours and 48% (371 of 777) out of hours did not have MHO consent.

In GGC 46% (48 of 105) of EDCs in hours and 74% (200 of 269) out of hours did not have MHO consent. In hours each local authority has its own MHO rota. The out of hours service covers the six local authorities in the health board area, as well as taking calls for Dumfries and Galloway.

Reasons for no MHO consent in and out of hours

Table 13: Greater Glasgow and Clyde: Attempts to contact MHO / outcome of contact in hours and out of hours

	In hours		Out of hours		All cases	
	n	%	n	%	n	%
service contacted	11	23%	105	53%	116	47%
unsuccessful attempt	8	17%	32	16%	40	16%
no attempt	24	51%	58	29%	82	33%
unclear	4	9%	4	2%	8	3%
All cases	47	100%	199	100%	246	100%

Source: EDCs submitted to the Commission, July to December 2015, with no MHO consent.
The table includes 76 cases where the attempt at contact / outcome was inferred.

The reasons for lack of MHO varied in and out of hours. In hours, the main reason was that no attempt was made to contact the service in 51% of cases.

Out of hours, the service was contacted in 53%, of cases but in 29% of cases could not respond due to the urgency of the situation. In 18% of cases, an MHO was not available, and in 7% of cases other reasons were given.

Location prior to detention – community or hospital

There was no difference in the reasons for lack of consent when we looked at whether people were in the community or in hospital on an informal basis prior to detention.

Type of medical practitioner doing the assessment

There was no significant pattern when we looked at whether the medical practitioner was a GP or hospital doctor.

Detention in and out of hours by hospital

Table 14 Consent In and Out of Hours by Hospital 1 July 2015-31 December 2015

Hospital	In hours				Out of hours			
	MHO consent		Total	% without consent[1]	MHO consent		Total	% without consent[1]
	No	Yes			No	Yes		
	n	n	n	%	n	n	n	%
Blytheswood Hs	1		1					
Drumchapel		1	1					
Dykebar	2	1	3		8	2	10	80%
Gartnavel General					1		1	
Gartnavel Royal	10	8	18	56%	42	4	46	91%
Glasgow Royal Infirmary	1	1	2		16	7	23	70%
Golden Jubilee					1		1	
Graham Anderson Hs						1	1	
Inverclyde Royal	2	8	10	20%	19	3	22	86%
Leverndale	6	6	12	50%	39	17	56	70%
Mackinnon Hs	8	7	15	53%	27	9	36	75%
Parkhead	2	8	10	20%	10	1	11	91%
Priory		2	2		2		2	
Queen Elizabeth	9	6	16	60%	17	13	30	58%
Royal Alexandria	4	7	11	36%	14	8	22	64%
Stobhill	1	1	2		3	1	4	
Vale of Leven	1	1	2		1	3	4	
All hospitals	48	57	105	46%	200	69	269	74%

1. Percentage shown for hospitals with more than 10 EDCs only

In hours, the higher numbers of EDCs and higher percentages of EDCs without MHO consent are at Gartnavel Royal Hospital (GRH) 56%, Queen Elizabeth University Hospital (QEUH) 60% and Mackinnon House 53%.

Out of hours, the higher numbers of EDCs, and higher percentages of EDCs without MHO consent are at Leverndale 70%, GRH 91%, Mackinnon House 75% and QEUH 58%. Two other hospitals also seem to have a high proportion of non consents out of hours but the actual number of EDCs at these hospitals is smaller: Parkhead (91%) and Inverclyde Royal Hospital (IRH) (86%).

This highlights the variation between hospitals in and out of hours with GRH being the most notable for lack of MHO consent out of hours.

Reasons for lack of consent by hospital

Table 15: GGC HB: Outcome of MHO contact by hospital (hospitals with at least 10 cases)

Hospital	service contacted		unsuccessful attempt		no attempt		unclear		All cases	
	n	%	n	%	n	%	n	%	n	%
Dykebar	4	40%	0	0%	6	60%	0	0%	10	100%
Gartnavel Royal	23	45%	10	20%	17	33%	1	2%	51	100%
Inverclyde Royal	14	67%	2	10%	5	24%	0	0%	21	100%
Leverndale	15	33%	8	18%	20	44%	2	4%	45	100%
Mackinnon House	16	46%	4	11%	14	40%	1	3%	35	100%
Parkhead	5	42%	3	25%	4	33%	0	0%	12	100%
Glasgow Royal	7	44%	5	31%	2	13%	2	13%	16	100%
Queen Elizabeth University	15	56%	2	7%	9	33%	1	4%	27	100%
Royal Alexandra	11	61%	3	17%	3	17%	1	6%	18	100%
All psychiatric hospitals	***77***	***44%***	***27***	***16%***	***66***	***38%***	***4***	***2%***	***174***	***100%***
All general hospitals	***33***	***54%***	***10***	***16%***	***14***	***23%***	***4***	***7%***	***61***	***100%***
All hospitals	110	47%	37	16%	80	34%	8	3%	235	100%

Source: EDCs s submitted to the Commission, July to December 2015, with no MHO consent

The figures show that;

- Where the service was contacted, there was less likely to be a response if the person was in IRH, the RAH or the QEUH. This may be related to distance in the case of the first two hospitals.
- Where there was an attempt to contact the MHO but it was unsuccessful, this was more likely to happen if the person was in Glasgow Royal Infirmary (GRI), Parkhead or GRH.
- There was less likelihood of a medical practitioner contacting the MHO service if the person was in Dykebar, Leverndale or Mackinnon House.

Improvement plan from Health and Social Care Partnerships (HSCPs) in Greater Glasgow and Clyde area

The data does not point to any one factor being significant in the low rate of MHO consent but indicates the need to interrogate the information on a number of fronts. The HSCPs have agreed a 22 point improvement plan. This includes;

- Encouraging clinical staff to think ahead, anticipate events and plan interventions, including the use of nurses, power to detain for up to three hours, and amending the protocol so the MHO is phoned at the same time as the medical practitioner;
- Reviewing communications, including confirming that all doctors have the correct phone numbers to directly access MHOs;

- Emphasising to medical practitioners the importance of contacting an MHO even in urgent cases after the EDC is completed. This will ensure that the detention can be reviewed by an AMP and an MHO as soon as possible;
- Examining the reasons for the variation in rates of MHO consent across hospitals, particularly in GRH in order to improve consistency. The Commission will provide the HSCPs with an anonymised EDC data set for the period 1 July to 31 December 2015 to enable further investigation;
- Impressing on the clinical directors the importance of ensuring junior doctors are applying the protocols and procedures relating to EDCs;
- Designing a multi-disciplinary training programme;
- The HSCPs and Out of Hours Services recording EDCs with and without consent and reporting to The Adult Services Core Leadership Group (ASCLG), who will consider future governance arrangements. Each HSCP will identify an individual to lead on the plan and report to this group;
- Undertaking a single audit process every six months;
- Reviewing and promoting the PEP including consideration of MHO response times;
- Preparing a workforce plan for MHOs.

In addition, there was discussion of the need to improve the consistency and the quality of the information when completing the EDC forms. The Commission will provide examples of good and poor examples of the reasons given for lack of MHO consent.

Summary

1. In 2014-2015 there were 2009 emergency detention certificates (EDCs) in Scotland, 606 of these were in the Greater Glasgow and Clyde area (GGC). There was considerable variation across mainland health boards in the percentage of EDCs without mental health officer (MHO) consent, ranging from 20% in Tayside to 70% in GGC.

2. The Mental Welfare Commission (the Commission), at the request of the Scottish Government, audited EDCs without MHO consent, for a six month period from 1 July 2015 to 31 December 2015, and looked at: the reasons for lack of consent; any differences in and out of hours; when the EDC was reviewed; and a number of other factors.

3. There were 1109 EDCs in this six month period, of which 374 were in GGC. The percentage without MHO consent ranged from 14% in Borders to 66% in GGC.

4. There were differences in and out of hours in the percentage without MHO consent. In hours Forth Valley (60%), Lothian (46%) and GGC (46%) had the highest percentage of EDCs without MHO consent. The national average was 38%. Out of hours Dumfries and Galloway (75%) and GGC (74%) had the highest percentage of EDCs without MHO consent. The national average was 48%. We are in discussion with Glasgow Health and Social Care Partnership (GHSCP) and will also discuss these figures with the Dumfries and Galloway Health and Social Care Partnership.

5. The reasons for lack of MHO consent were coded and these were then grouped under three broad headings –whether the MHO service was contacted, whether there was an attempt to contact the service but it was unsuccessful or whether no attempt was made to contact the service.

6. There was no single reason for lack of consent in any of the health boards and most had the same pattern of reasons for lack of consent.

7. The audit looked at the length of time before the EDC was reviewed and revoked; or was reviewed and a short term detention certificate (STDC) was put in place; or expired after 72 hours. 50% of people were reviewed by an approved medical practitioner (AMP) and either had the EDC revoked or were detained on a STDC (which requires MHO consent) within 24 hours of the EDC. This rose to 76% within 48 hours of the EDC. Only 14% of EDCs expired after the 72 hour period and may not have been reviewed by an AMP.

Greater Glasgow and Clyde Health and Social Care Partnerships (GHSCP)

8. We looked in more detail at the lack of MHO consent in the GGC area. We met with GHSCP to discuss the issues and possible remedies to the situation.

9. There was no single reason for lack of consent in any of the health boards and GGC had the same pattern of reasons for lack of consent as the majority of boards. The main differences in GGC are the volume of EDCs and the larger percentage without consent.

10. The reasons for lack of MHO consent varied in and out of hours. In hours, the main reason was that no attempt was made to contact the service in 51% of cases. Out of hours the service was contacted in 53% of cases but in 29% of cases could not respond due to the urgency of the situation. In 18% of cases an MHO was not available, and in 7% of cases other reasons were given.

11. There is considerable variation between hospitals in and out of hours; Gartnavel Royal Hospital (GRH) was the most notable for lack of MHO consent out of hours (91%). There was also variation in the reasons given for lack of MHO consent in different hospitals which needs further investigation by GGC.

12. The length of time before the EDC was reviewed and revoked, reviewed and a STDC was put in place, or expired after 72 hours, was no different in GGC than in other boards in Scotland.

13. Discussion between the Commission and GHSCP about the findings of the audit, together with an internal GHSCP audit of cases in South Glasgow, has led to a number of action points that GHSCP and the other five HSCPs will take forward. These include: work with clinical staff on anticipating events and amending protocols as to when the MHO is phoned and how nurses' power to detain may be used; reviewing communications to ensure medical staff have the correct phone number; reviewing the PEP; designing a multi-disciplinary training programme; ensuring all junior doctors across various clinical settings are applying the protocols and procedures; reporting EDCs with and without to the Adult Services Core Leadership Group (ASCLG) to consider future governance arrangements; further investigating the variation between hospitals; and preparing a workforce plan for MHO.

14. There will be continuing dialogue between the Commission and GHSCPs on the progress of these issues.

Recommendations

1. The Scottish Government should encourage health and social care partnerships with lower rates of MHO consent to develop action plans over the next 12 months to improve rates of consent. The Commission will continue to report on rates of MHO consent in its annual monitoring reports, and to discuss rates at end of year meetings with health and social care partnerships.

2. As part of the preparation for the implementation of the Mental Health (Scotland) Act 2015[3], the Scottish Government should review the Code of Practice to ensure it gives sufficiently clear guidance on the expectations on doctors and MHOs in relation to emergency detention. Guidance should also be produced in relation to the extension of the nurses' holding power (s20) to maximise the opportunity for an MHO to attend during the extended period.

3. Local authorities should ensure they are meeting the standards set out in National Standards for MHO Services[4], particularly Standard 2 relating to referral, assessment and admission procedures and Standard 4 relating to inter/intra agency collaboration and cooperation.

4. Health boards should review induction/training/guidance on EDC procedures for junior doctors.

5. Health boards should remind all medical practitioners of the expectations of MHO consent other than in exceptional circumstances as set out in the Code of Practice (Volume 2 Chapter 7, paras 33 to 37)[5].

6. Health boards should encourage clinical staff to anticipate events and plan interventions, including the use of nurses' power to detain and early contact with the MHO service.

7. There should be discussion between the Care Inspectorate and the Commission on collaborating on a review of MHO services within the next two to three years. This should be informed by this current EDC monitoring exercise, as well as the work of the Chief Social Work Inspector (CSWI).

8. The Commission will review the EDC form (DET 1) with a view to providing clearer guidance to doctors on the form and reducing the opportunities for error.

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[3] http://www.legislation.gov.uk/asp/2015/9/contents
[4] http://www.gov.scot/Publications/2005/05/1393048/30499
[5] http://www.gov.scot/resource/doc/57346/0017054.pdf

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