mentalwelfare commission for scotland

STATISTICAL MONITORING

Mental Health Act Monitoring 2015-16

SEPTEMBER 2016

Contents

1. What we do

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

We do this by:

- Checking if individual care and treatment are lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy and service development.

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

We have a statutory duty to monitor the use of the Mental Health Act (Care & Treatment) (Scotland) 2003.

This year, we saw a rise of just over 3% in new episodes of compulsory treatment. This is now at the highest level since the Mental Health Act was implemented in 2005, and above the level under the previous mental health act. The most marked rise was in the use of emergency detention certificates (EDCs) which rose by 10%, with an increase across all age groups except from the very young. There has been a 23% increase in the use of emergency detention since 2011/2012.

There was a 12% increase in the number of EDCs revoked or superseded by another order within the first 24 hours, which the Commission considers to be in line with good practice.

The rate of mental health officer (MHO) consent to emergency detention remains low at 44%, but has improved in certain health boards, e.g. Borders, Greater Glasgow and Clyde and Lanarkshire.

Seventy one percent of compulsory treatment episodes lasted for less than 28 days.

There was a significant reduction in the use of short-term detention certificates (STDCs) in the 85+ age group.

Eighty eight percent of short-term detentions were for people with a mental illness, 3% for people with both a mental illness and learning disability, and 1% for people with learning disability alone.

As we have seen in previous years, there was considerable geographical variation across health boards in the use of the Mental Health Act.

Notification of the use of place of safety orders increased by 21% and the use of police stations as a place of safety has declined (1%). This shows a significant improvement in practice over recent years.

There was an increase in the number of advance statement overrides notified, which may be as a result of more advance statements being made.

3. New episodes of civil compulsory treatment

What we found

We were notified of 5,008 new episodes of compulsory treatment during the year. This was an increase of 3.2% on the previous year. This is the highest number of new compulsory episodes since the 2003 Act was implemented, and is now above the level of new compulsory episodes under the 1984 Act in 2001/02 (4,849) having followed an upward trend since 2009/10.

Table 3.1 New episodes of civil compulsory treatment initiated 2006-2016

New episode starts with this order[y]	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**15/16 % rise**
EDC	2029	1908	1837	1785	1787	1760	1872	1883	1964	2159	9.9%
STDC	2217	2152	2211	2201	2409	2417	2438	2531	2796	2754	-1.5%
Compulsory Treatment Order (CTO)* [xx] **(included interim orders)**	133	132	95	83	108	94	103	116	91	[xx] 95	4.4%
Total episodes	**4379**	**4192**	**4143**	**4069**	**4304**	**4271**	**4415**	**4530**	**4851**	**5008**	**3.2%**

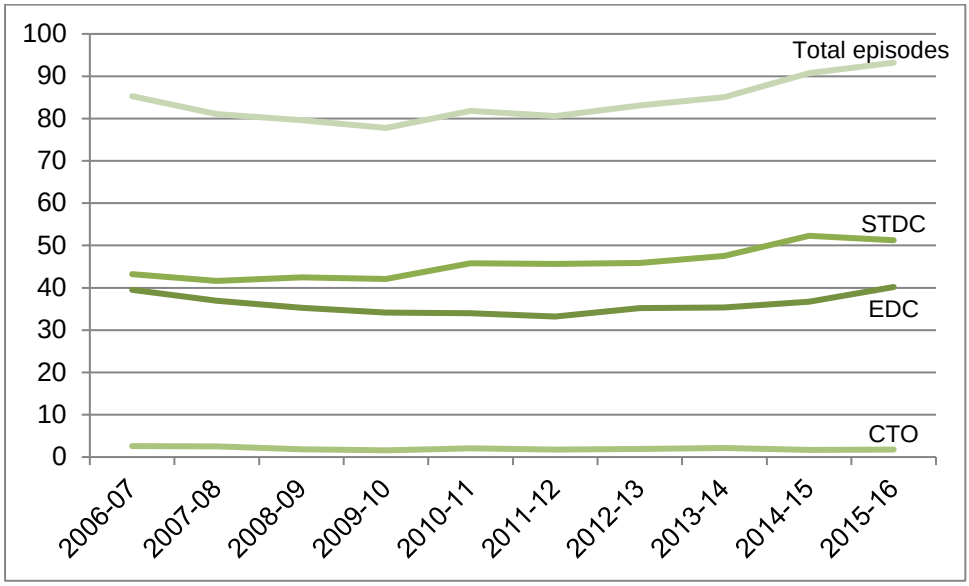
*Taken from our information on hospital admissions.

[xx]The 95 includes 4 cases direct to ICTO only, 17 to ICTO then to CTO and 74 direct to CTO

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

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

Figure 3.1 New compulsory episodes initiated 2006/07 to 2015/16 (rate per 100,000 population) by episode starting order

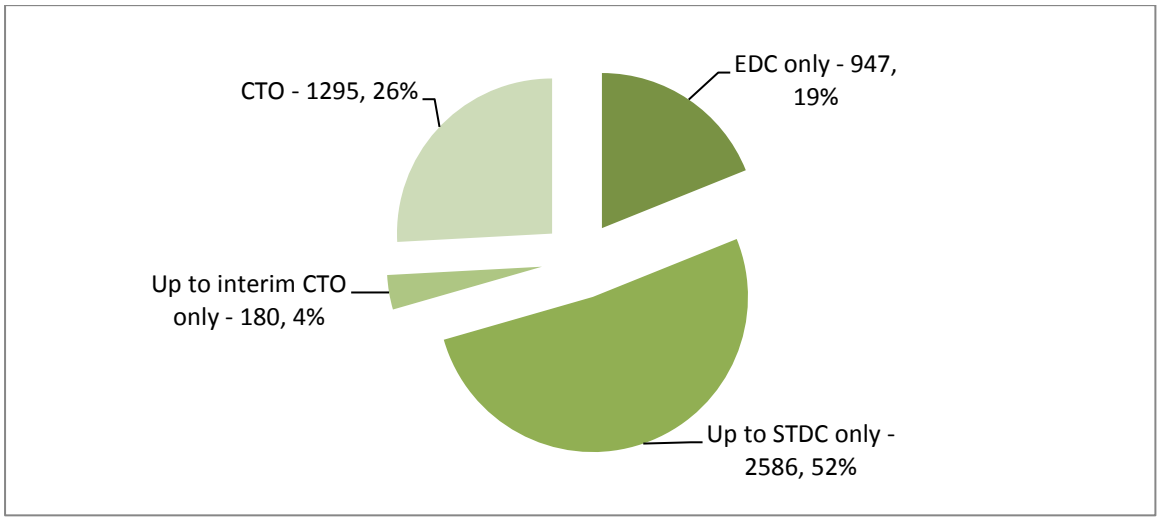


The use of EDCs has risen by 9.9% with an increase of 22.7% since 2011/2012. There was an increase across all age groups apart from the very young.

The number of people put straight onto a STDC has decreased slightly from a high of 2,796 in 2014/15 to 2,754 in 2015/16. This is the preferred route to compulsory treatment as it affords the patient more safeguards.

We looked at the progression of episodes of compulsory treatment that were initiated during the year (Figure 3.2).

Figure 3.2 Progression of types of compulsory civil episodes 2015 to 2016

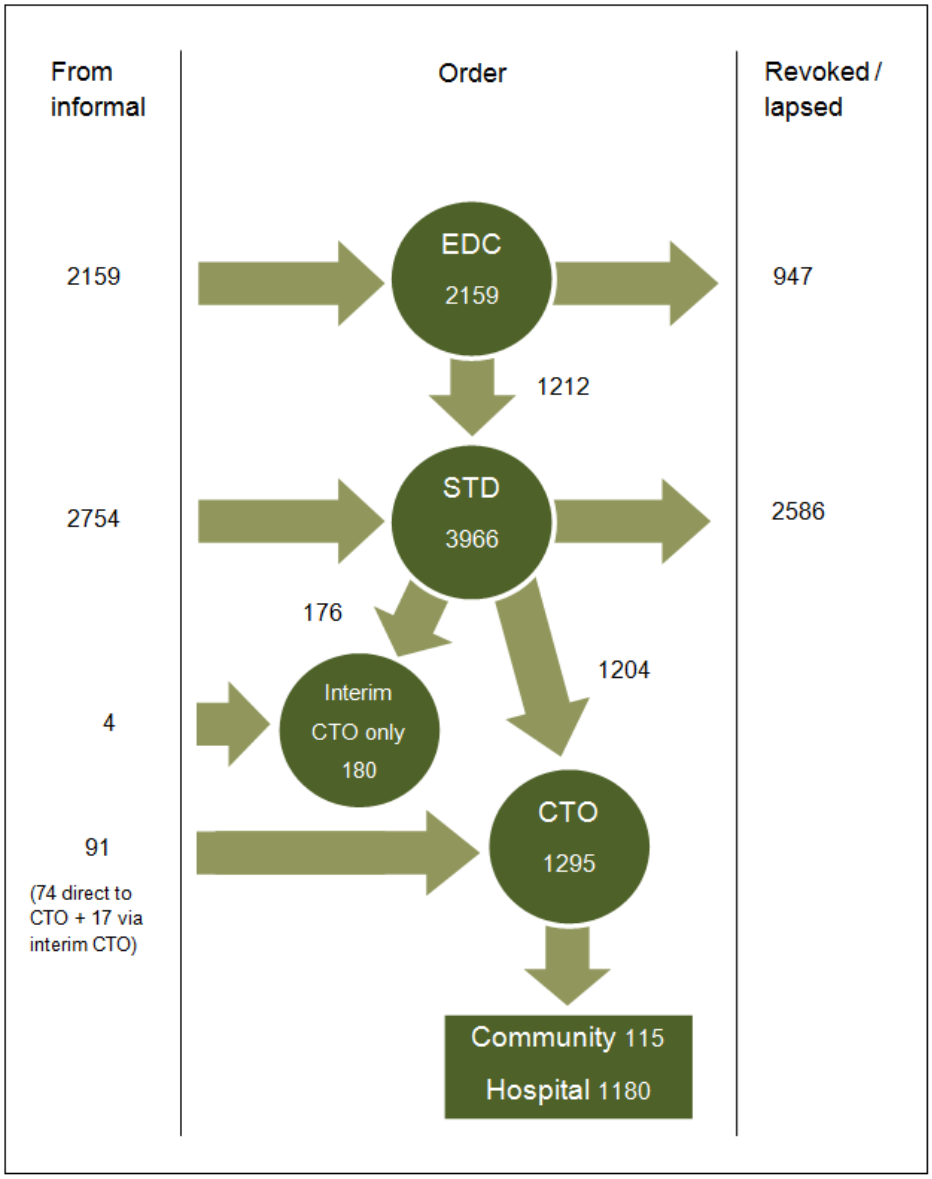


Findings of note from this chart are:

- Only 26% of all episodes of compulsory treatment result in the granting of a long-term CTO. In addition, 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 5,008 episodes under the Act which started during 2015/16, 71% 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 Figure 3.3 below.

Figure 3.3 Pattern of progression through civil compulsory orders 2015-16



3.1 Emergency detentions 2015-16

What we found

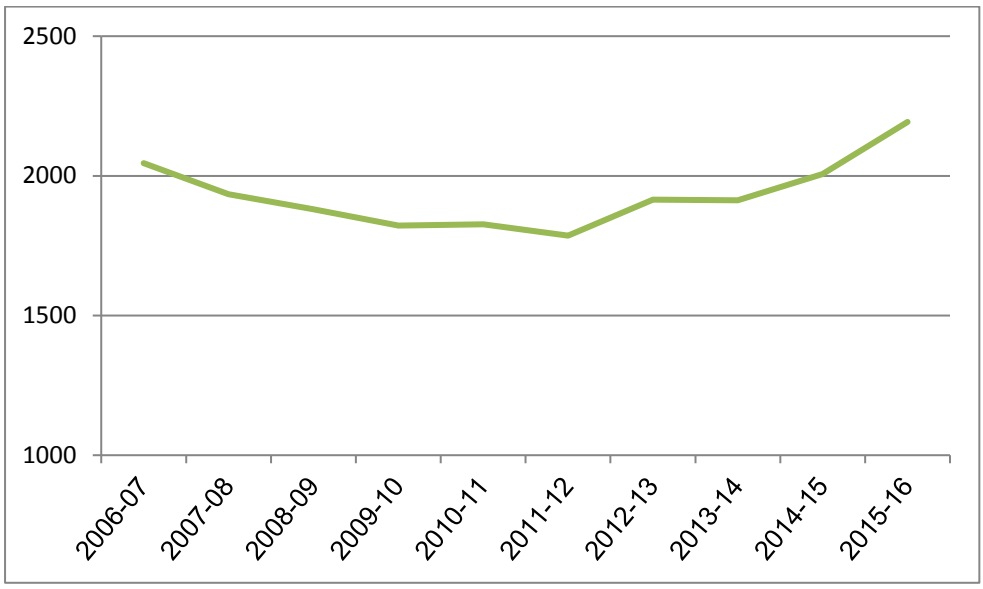
The total number of EDCs has further increased this year by 9.3%. The total at 2,193[1] has now risen above the 2006/07 figure of 2,045. There had been a gradual reduction since 2006/07 to a low of 1,786 in 2011/12; however, since then there has been a rise of 22.8% to this year's high of 2,193.

There has been further reduction in numbers of EDCs in the youngest age group (0-15 year olds), from 23 in 2013/14 to 17 last year and just eight this year. After last year's decrease, the 45-64 age group at 663 has returned to the 2013/14 level. In the 65-84 age group last year's significant rise has been maintained, from 317 in 2013/14 to 378 in 2014/15, and finally to 372 in 2015/16.

Overall, the use of EDCs is similar between women (49%) and men (51%); however, there are higher percentages of women in the oldest (85+ years, 64%) age group.

The rate per 100,000 population was 39.8 (2006/07) in the first full year of the new Act. It dropped to a low of 33.7 (2011/12) and has since continued to rise to this year's high at 40.8 (2015/16).

Figure 3.4 EDCs 2006-2007 to 2015-2016



[1] This includes EDCs for people already subject to community CTOs (34), more than the 2159 new episode EDCs noted in table 2.1 earlier.

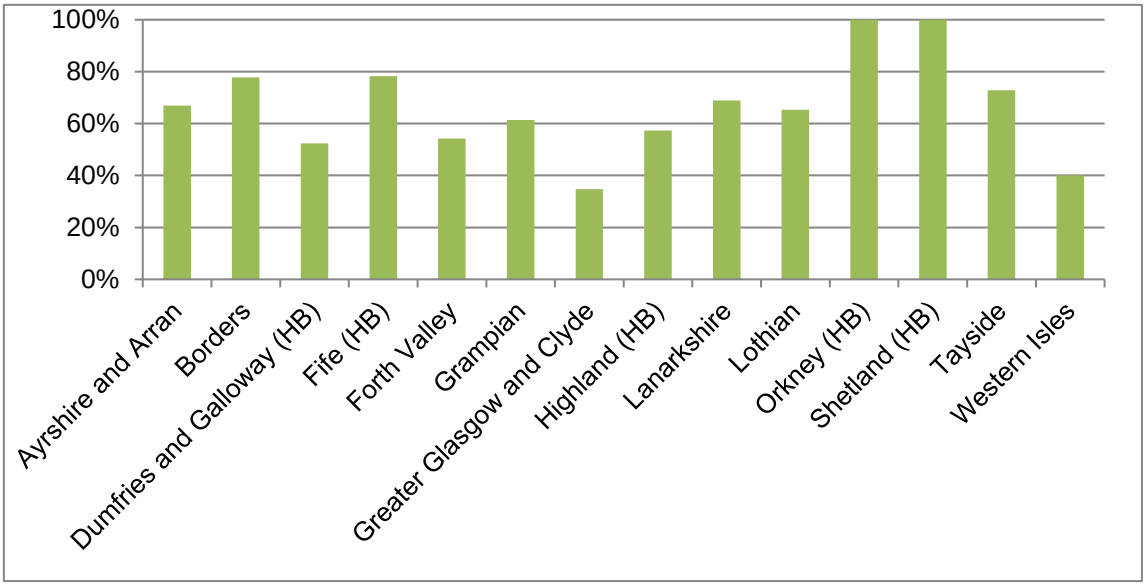
MHO Consent

What we found

Of the 2,193 people made subject to an EDC in 2015/16, we found that 44% did not have the consent of an MHO, similar to the 45% of the previous year.

This year, four health boards have made improvements in the percentage of consents: Borders from 69%-78%; Greater Glasgow and Clyde from 28% to 35%; Lanarkshire from 62% to 69%; Lothian from 61% to 65%.

Figure 3.5 Percentage of EDCs with MHO consent for all NHS Boards (2015-16)



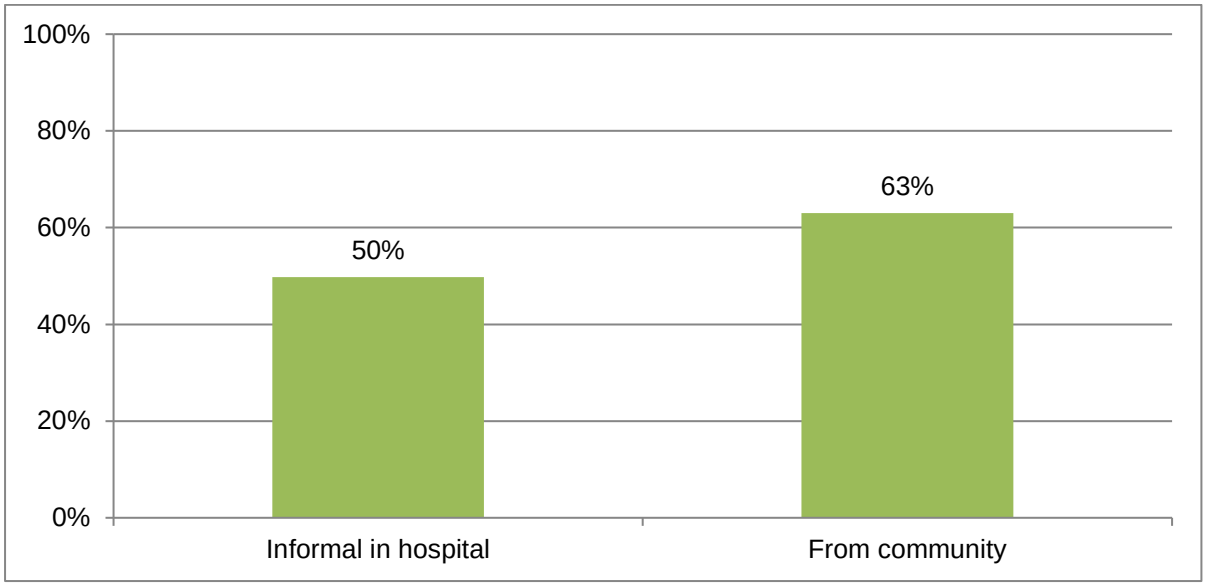
Other factors relevant to Emergency Detention

Pre-detention status

What we found

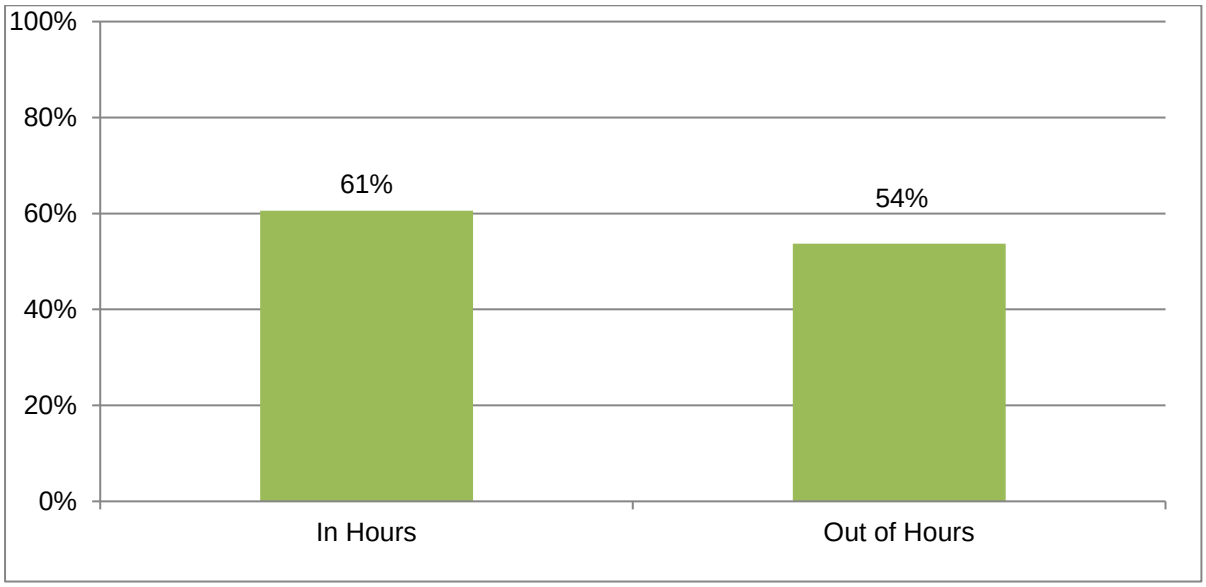
Fifty percent (599) of those in hospital received MHO consent for an EDC compared to 63% (624) of those detained from the community which is similar to last year.

Figure 3.6 EDCs by pre-detention status and MHO consent to detention 2015-16 (%)



Timing of Emergency Detention

Figure 3.7 EDCs by time of granting of certificate and MHO consent to detention 2015-16 (%)



What we found

Seventy percent of EDCs happen outside of office hours[2], and 30% within office hours. This is a higher percentage occurring outside of office hours than last year.

Of those carried out within office hours, 61% will have MHO consent, similar to last year (60%); outside office hours, 54% will have MHO consent, which is 3% less than in 2013/14. It is important that local authorities have good out-of-hours arrangements to ensure that MHOs can attend wherever possible.

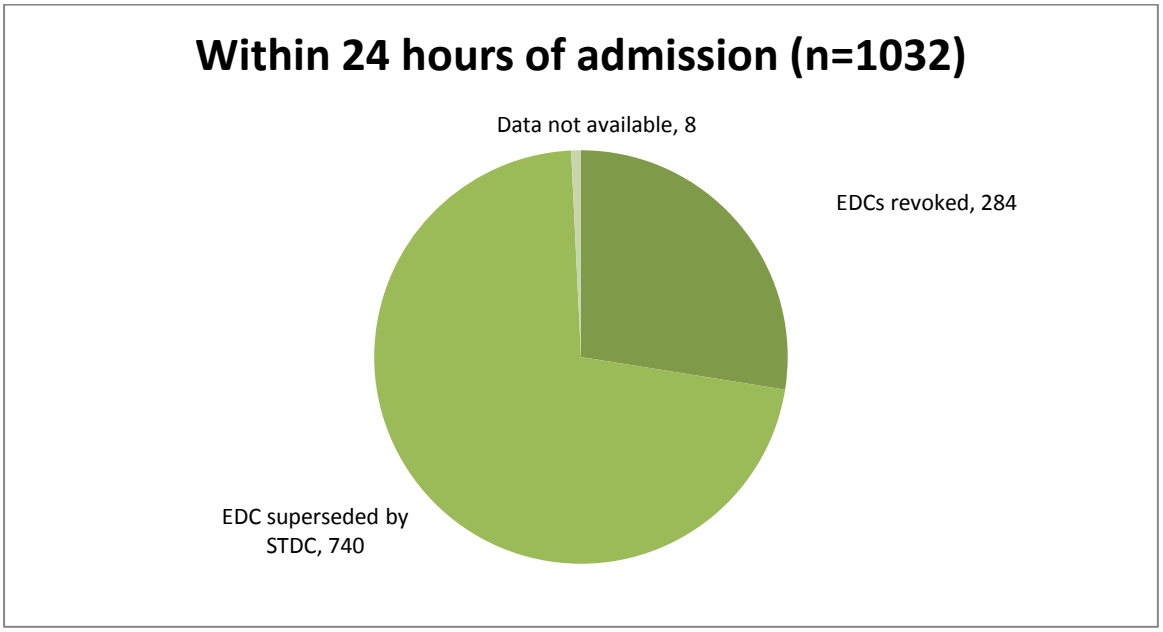
[2] For this exercise within office hours is defined as between 08:30 and 17:00 Monday to Friday. Weekends and the major standard statutory holidays are defined as out of hours. This approach allows continuity of monitoring over the years. We recognise that local authorities out of hours arrangements vary widely and over time. We take account of this in more specific ad-hoc monitoring exercises.

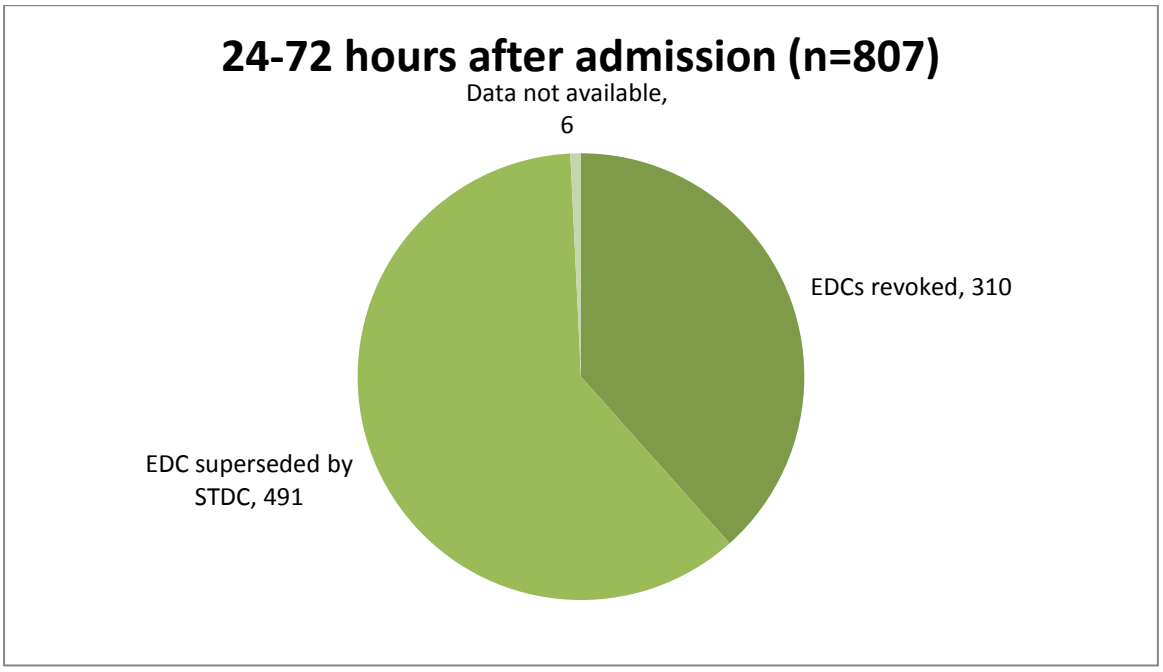
Duration of Emergency Detention

What we found

This year, there was a further 12% rise in the number of people detained on an EDC who had the order either revoked or superseded by an STDC within the first 24 hours.

Figure 3.8 Duration of EDCs granted 2015-16





3.2 Short-term detentions

STDCs by age and gender

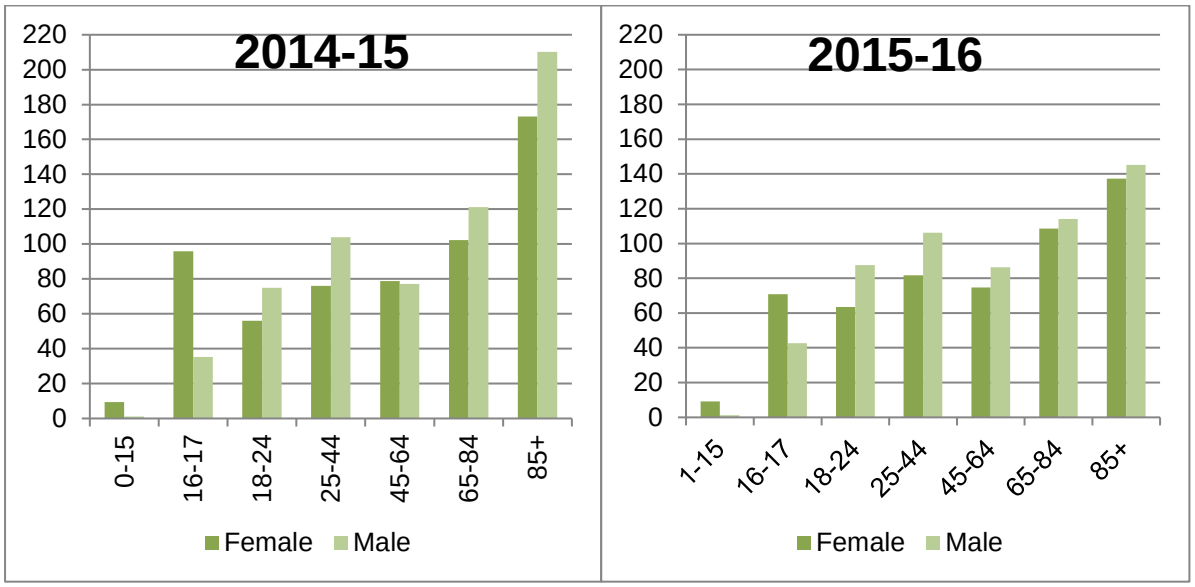
What we found

There were 4,098 STDCs granted in 2015/16, an overall 2.6% rise from last year's figure (3,993).

In 2015/16, the most significant change was a decrease of 23.6% in the 85+ age group (from 212 last year to 162).

Forty nine percent of STDCs granted were for women and 51% for men.

Figure 3.9 STDCs by age and gender rate per 100,000 populations



The chart above illustrates variances by gender and age group in rates per 100K population.

Young people

The number of young women in the 0-15 age group has remained at the higher level of 41 (after a 40% (12) increase last year to 42). On the other hand, there are only a small number (6) of young men in this age group again this year. Twelve young people were detained both for their own safety and safety of others, one for safety of others only, and the rest (34) for their own safety only.

The 16-17 age group is 61% (41) female and 39% (26) male. Twenty four were admitted for safety of self and others and 43 for own safety only.

Older people

The 85+ age group is comprised of 106 (65%) women and 56 (35%) men. Rates of STDCs for this age group have decreased since last year for both women and men.

In the 65-84 age group, rates of STDCs were slightly higher this year for women but lower for men.

Diagnosis recorded

Our interest in this

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

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

What we found

Table 3.2 2015-16: Types & combinations of mental disorders recorded

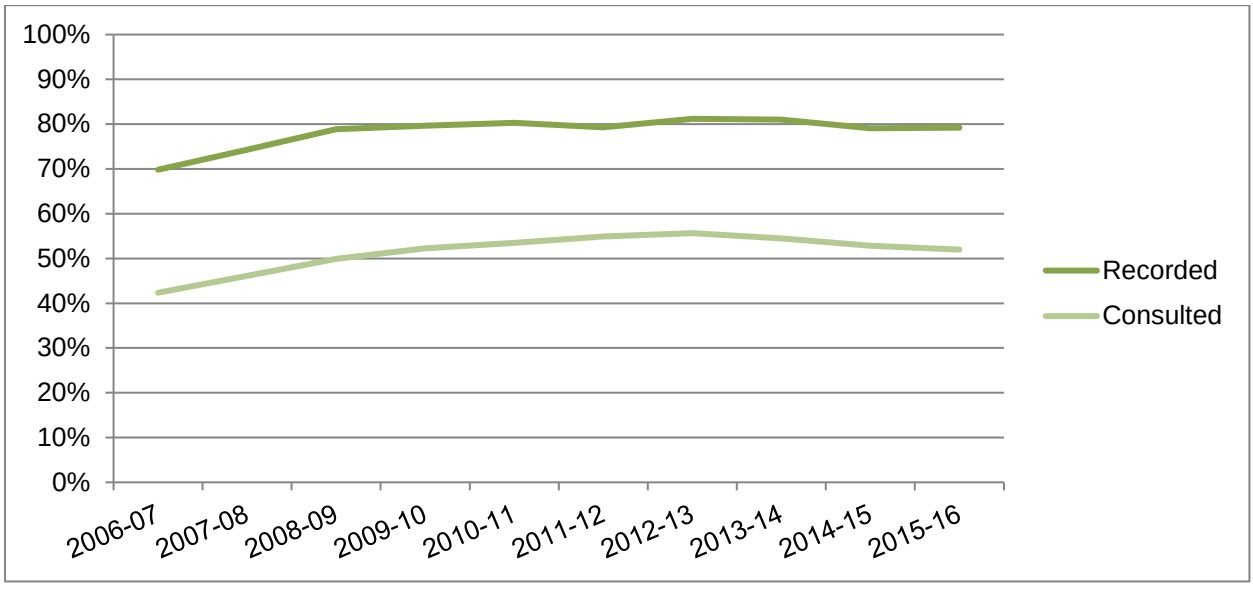
Mental disorder	STD Certificates	
	No.	%
Mental Illness	3621	88%
Mental Illness +Learning Disability	128	3%
Mental Illness + Personality Disorder	210	5%
Mental Illness + Personality Disorder + Learning Disability	13	0%
Personality Disorder	46	1%
Personality Disorder + Learning Disability	8	0%
Learning Disability	41	1%
Not recorded	31	1%
Total	**4098**	**100%**

Mental illness accounts for the vast majority of people detained under a STDC. Only 1% of STDCs were for people with learning disability alone, and 3% for people with learning disability and mental illness. Similarly, only 1% were for people with a personality disorder alone.

Named person consultation

What we found

Table 3.3 STDCs 2006-2016: Percentage where named person has been recorded and/or consulted



The slight downward trend in the percentage of STDCs where the named person was consulted has continued this year from 56% in 2012/13 to 52%.

The proportion of STDCs where the named person is recorded has remained at 79% this year.

3.3 Compulsory treatment orders (CTOs)

What we found

- The total number of new CTOs (1,366) is 8% higher than last year.
- As in previous years, the use of CTOs is higher for men.
- The number of CTOs for young people (under 18) decreased this year from 63 to 46. It remains much higher for girls (36).
- The number of new CTOs for people age 65-84 showed a 7% increase this year; there was a decrease in those aged 85+ (-8%).

Table 3.4 CTOs granted by age and gender 2015-16

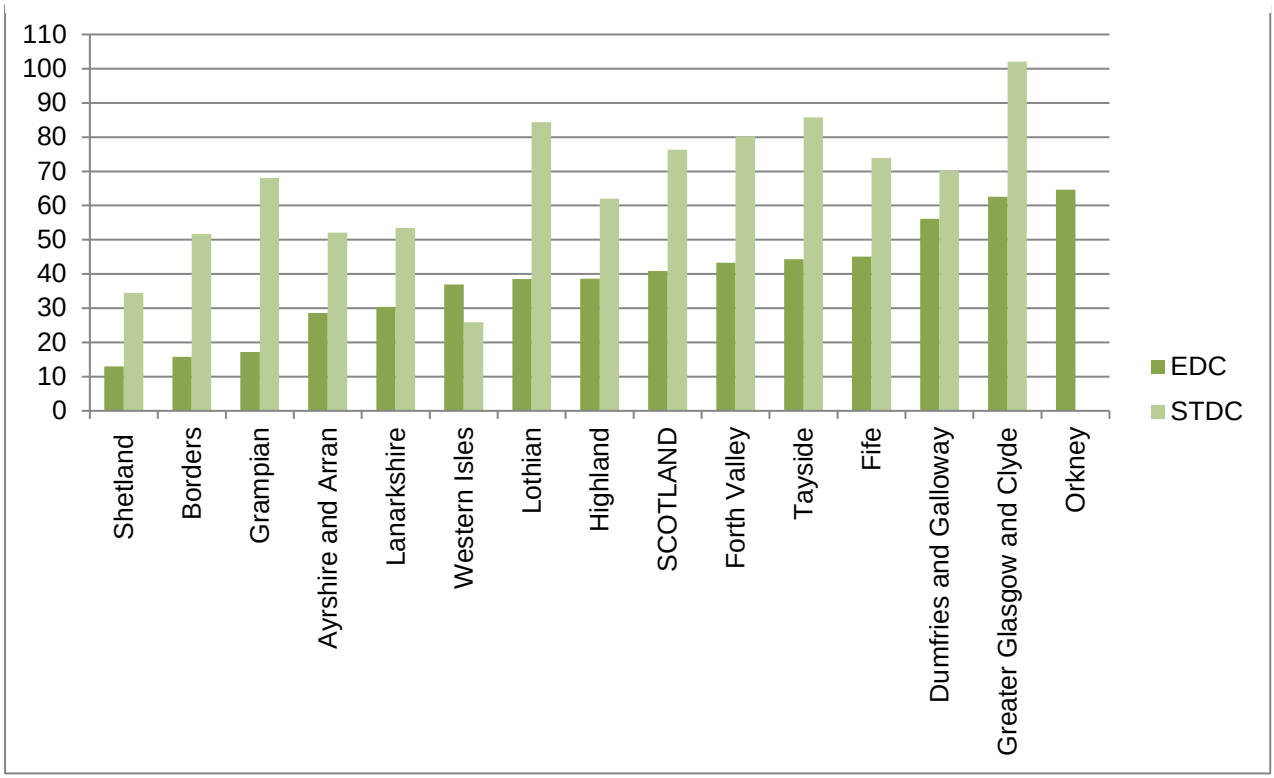
CTOs*	Female	Male	Total	Female	Male	Total
	No.	No.	No.	%	%	%
Under 16 yrs	16	2	18	89	11	100
16-17 yrs	20	8	28	71	29	100
18-24 yrs	46	58	104	44	56	100
25-44 yrs	160	232	392	41	59	100
45-64 yrs	187	198	385	49	51	100
65-84 yrs	188	185	373	50	50	100
85+ yrs	35	31	66	53	47	100
Total	**652**	**714**	**1366**	**48**	**52**	**100**

*These figures are supplied to the Commission by the Mental Health Tribunal Scotland.

3.4 Geographical variations

What we found

Figure 3.10 Emergency and short-term detention by NHS Board 2015-16 - rate per 100k population



Emergency detention:

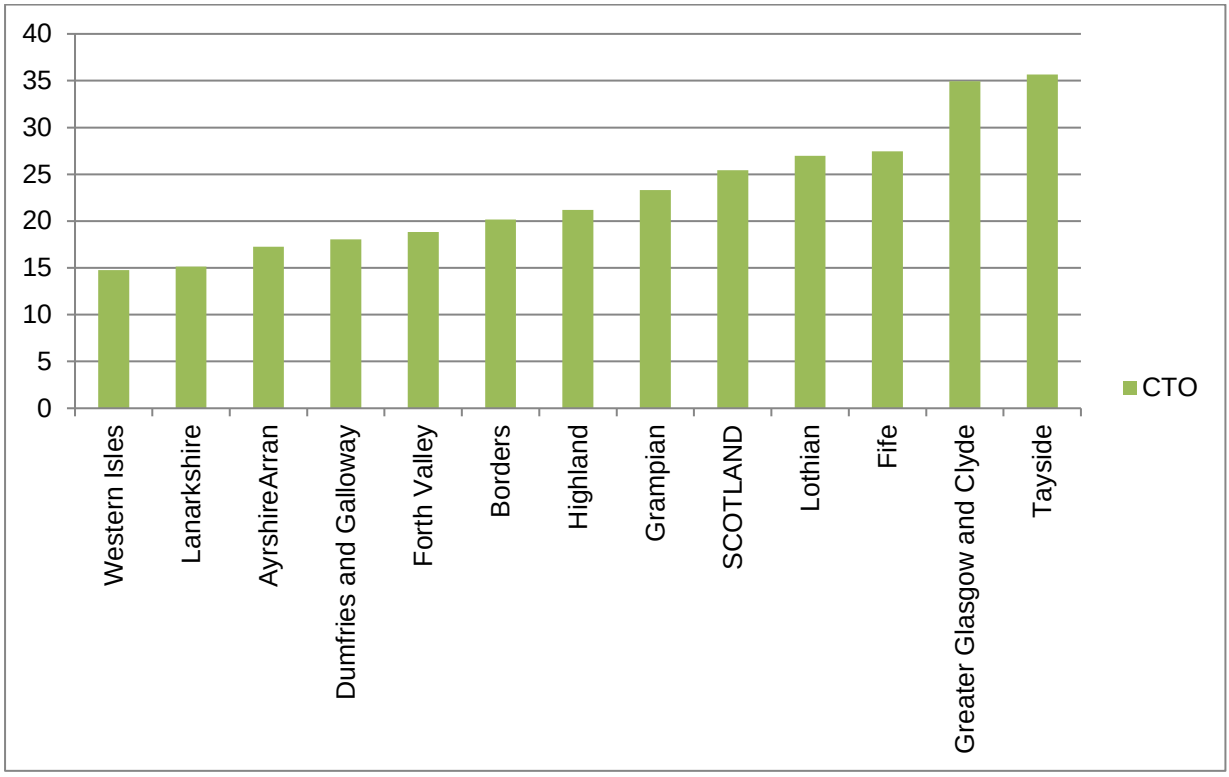
- Orkney, Glasgow and Clyde, Dumfries and Galloway have the highest use of emergency detention this year. Two of these areas have remote and rural communities, so this is understandable.
- However, Shetland and Borders had low EDC use and also have rural communities. There may be differences in service configuration and clinical practice that other rural boards could study.
- 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, Tayside, Lothian and Forth Valley have the highest use of short-term detention this year.

- Five mainland boards showed an increase in the rate per 100K (full population), the largest increase being in Forth Valley (24%) and Greater Glasgow and Clyde (7%)
- Of mainland boards, Ayrshire and Arran, Borders and Lanarkshire have the lowest use of short-term detention.

Figure 3.11 CTOs by NHS Board 2015-16 - rate per 100k population



- Tayside and Greater Glasgow and Clyde have the highest rate of new CTOs this year. Lanarkshire has the lowest rate of new CTOs.

3.5 Variations between local authorities

What we found

- Glasgow City, Inverclyde and Perth and Kinross have by far the highest rates of short-term detention.
- CTO rates are highest in Glasgow City and Perth and Kinross this year.

Table 3.5 STDCs and CTOs by local authority 2015-16 – number and rate per 100k population

Local Authority	STDCs		CTOs	
	No.	Rate per 100K	*No.	Rate per 100K
Aberdeen City	210	91	79	34
Aberdeenshire	119	45	40	15
Angus	55	47	38	33
Argyll and Bute	53	61	18	21
Clackmannanshire	51	99	11	21
Dumfries and Galloway	106	71	28	19
Dundee City	145	98	49	33
East Ayrshire	71	58	25	20
East Dunbartonshire	38	36	16	15
East Lothian	75	73	34	33
East Renfrewshire	36	39	16	17
City of Edinburgh	458	92	132	26
Eilean Siar	9	33	5	18
Falkirk	129	81	36	23
Fife	271	74	104	28
Glasgow City	744	123	236	39
Highland	158	67	57	24
Inverclyde	94	118	27	34
Midlothian	50	57	23	26
Moray	68	71	18	19
North Ayrshire	69	51	21	15
North Lanarkshire	207	61	53	16
Orkney	4	18	6	28
Perth and Kinross	159	106	57	38
Renfrewshire	115	66	41	23
Scottish Borders	58	51	24	21
Shetland	9	39	2	9
South Ayrshire	59	52	18	16
South Lanarkshire	200	63	76	24
Stirling	65	70	9	10
West Dunbartonshire	69	77	31	35
West Lothian	144	81	36	20
Scotland	**4098**	**76**	**1366**	**25**

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

3.6 Nurse's power to detain 2015-16

What we found

The use of the nurse's power to detain has decreased by 27 % this year from 186 in 2014-15 to 136 in 2015-16. This year, there has been a decrease in the overall number of hospitals where this power was used - 28 different sites compared to 37 last year.

The greatest reduction has been in NHS Lothian (Royal Edinburgh Hospital) and across Greater Glasgow and Clyde, accounting for almost 82% of the overall decrease.

This decrease in the use of the nurse's power to detain has coincided with a rise in the number of emergency detentions.

This year, women accounted for 60% of the times it was used.

The total rate has decreased sharply this year (2.5 per 100K) and decreased for both men (2.1 per 100K) and women, but most sharply for women (2.9 per 100K).

From spring 2017, the Mental Health Act 2015 will change the timings for nurse's power to detain. The Commission is planning on issuing updated good practice guidance to reflect these changes.

Table 3.6 Use of Nurse's Power to Detain

	Rate per 100K Population				
	2011-12	2012-13	2013-14	2014-15	2015-16
Women	3.3	3.6	4.1	4.3	2.9
Men	2.4	2.9	2.5	2.6	2.1
Total	**2.8**	**3.3**	**3.3**	**3.5**	**2.5**

The majority of women and men detained are aged between 25-64 years. There were eight detentions for under 18 year olds and 19 for people aged 65+.

4. Total number of Mental Health Act orders in existence

4.1 All orders

What we found

The total numbers of orders in existence in Scotland was at a higher rate than last year throughout the year (see Table 4.1). In 2014-15, the highest quarterly prevalence was 3,222 (October 2014). This year, the quarterly prevalence ranged from 3,248 (April 2015) to 3,332 (October 2016) to 3,312 (January 2016).

The total number of people who are subject to compulsory treatment in each board area on one date during the year is shown in Figure 4.1. This is shown per 100,000 people. This is a good guide to the overall use of compulsion in each NHS Board area. Factors which may affect use are:

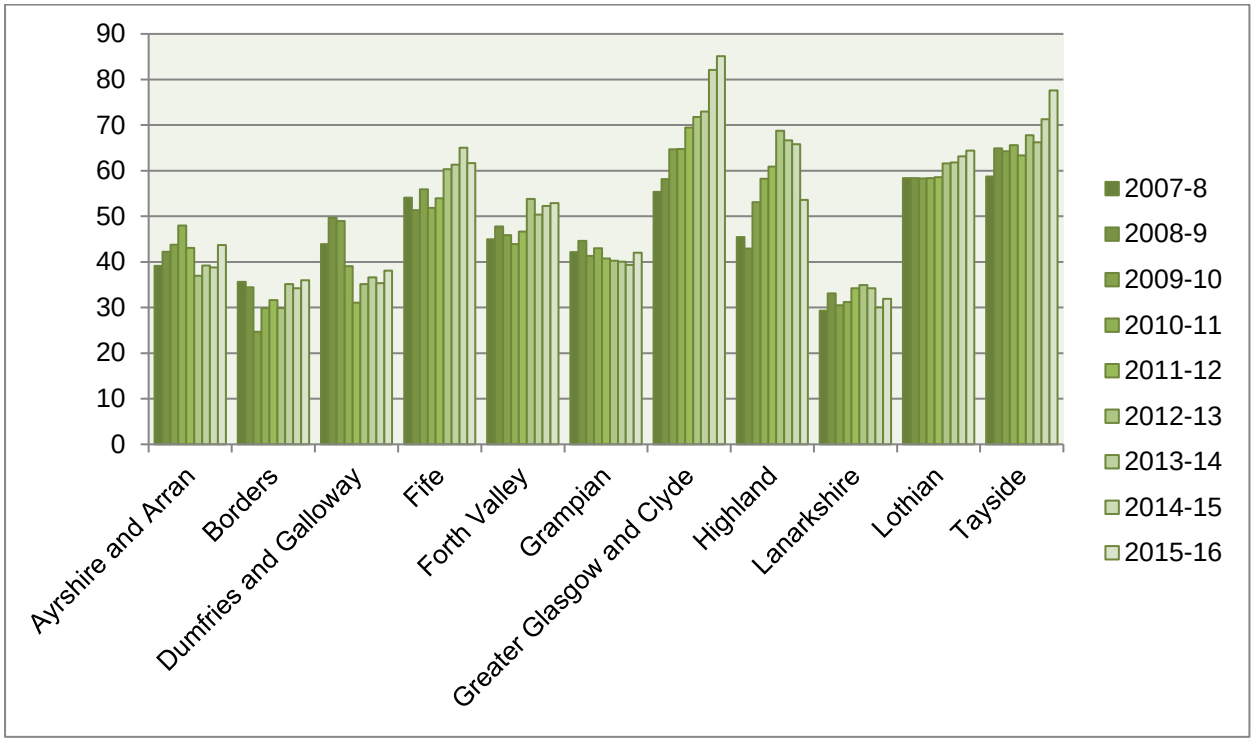
- Urban versus rural populations
- Culture and attitudes of practitioners
- Availability of early intervention, treatment and support
- Use of alcohol and drugs

We found that:

- Greater Glasgow and Clyde continues to have the highest prevalence of compulsory treatment. 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 also has a relatively high use of compulsory treatment.
- Borders, Dumfries and Galloway and Lanarkshire have a low prevalence of compulsory treatment.

We still find this variation hard to explain.

Figure 4.1 Nine year trends in prevalence of all compulsory orders per 100,000 population by NHS board (2007- 08 to 2015-16)*



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

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Table 4.1 Number of extant compulsory orders by type at quarterly census dates 2015-16

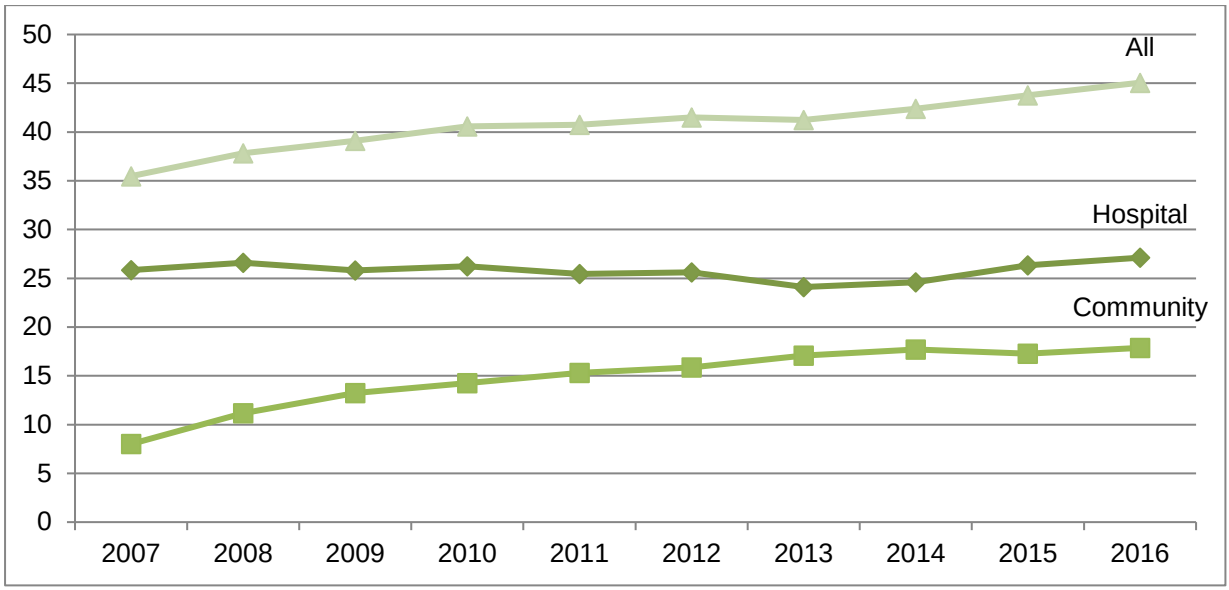
Order	2015/16			
	Apr-15	Jul-15	Oct-15	Jan-16
Emergency detention	6	8	8	15
Short-term detention	241	283	271	258
Interim compulsory treatment order	37	52	46	40
Interim compulsory treatment order - community	1	1		4
Compulsory treatment order	2319	2304	2363	2373
Hospital-based	1384	1375	1415	1417
Community-based	935	929	948	956
Assessment order	12	8	10	6
Treatment order	23	18	20	21
Interim compulsion order	5	5	6	7
Compulsion order S57 A (2)	123	128	127	110
Compulsion order S57 A (2) - community	75	70	69	70
Compulsion order S57(2)(a)	24	32	31	30
Compulsion order S57(2)(a) - community	19	17	20	20
Compulsion order S57(2)(b) - CORO	67	70	66	66
Compulsion order with restriction order S59	203	203	203	202
Transfer for treatment direction	82	79	78	78
Hospital direction	7	7	8	8
Remand in custody or on bail for enquiry into mental condition	0	0	0	0
Temporary compulsion order	1	1	3	0
S200 Committal	0	0	0	0
Indeterminate status*	3	8	3	4
Total**	**3248**	**3294**	**3332**	**3312**

*Indeterminate status – MWC internal data validation has greatly reduced numbers where status is not clear.
** A small number of people may have more than one order extant on the same day. (e.g. a MHA and a CPSA order).

4.2 Compulsory treatment orders

What we found

Figure 4.2 Point prevalence of CTOs 2007-2016* (rate per 100,000 population)



*All data has been refreshed back to January 2007

There was an increase in the prevalence of all CTOs again this year (3%). This continues the trend seen since 2007.

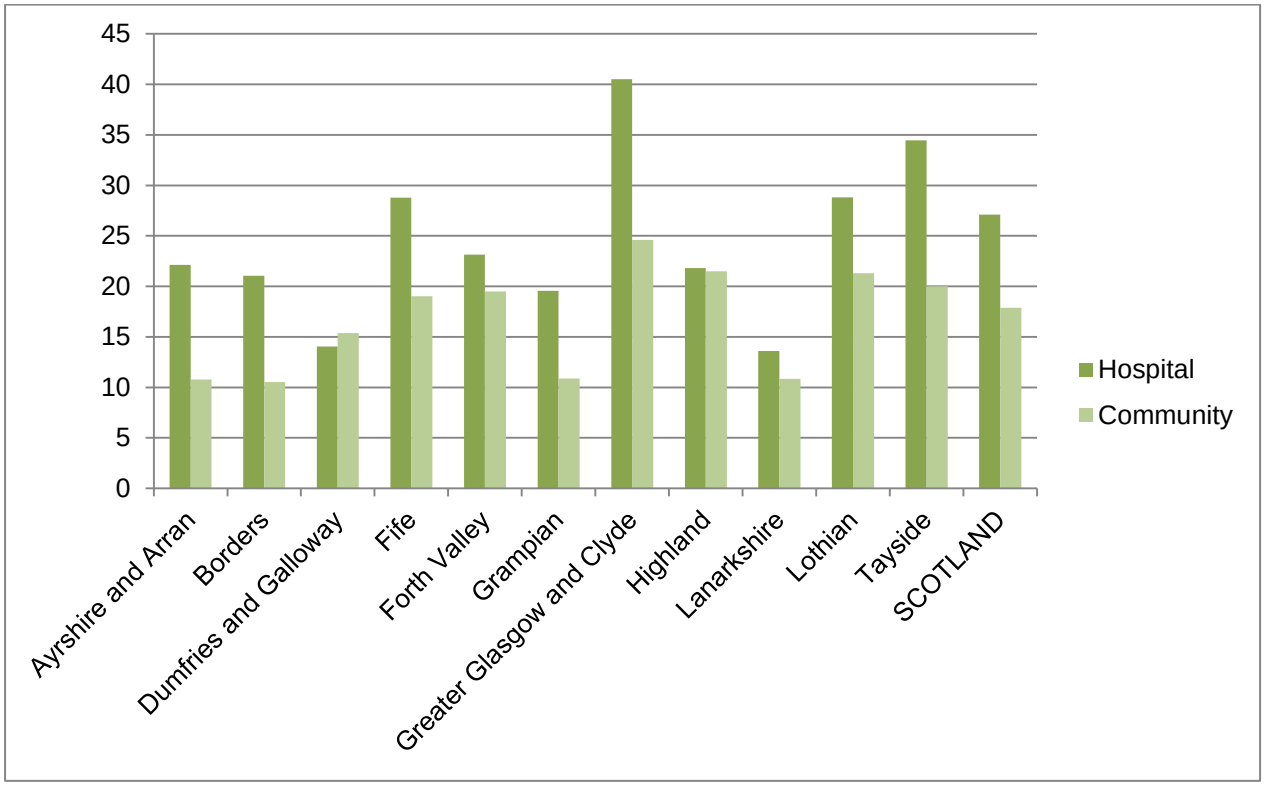
Community orders account for 40% of all CTOs. In January 2006, they accounted for just 4% and 23% by January 2007. This shows the extent to which the balance of care has shifted to the community for people subject to compulsion.

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

- Greater Glasgow and Clyde, Highland and Lothian have the highest use of community compulsory treatment in Scotland.

- Dumfries and Galloway is the only mainland board which makes more use of community CTOs than hospital CTOs. Previously, this was the case in Borders but the balance has changed this year.

Figure 4.3 All existing hospital vs community CTOs per 100,000 population by mainland NHS Board Jan 2016



5. Compulsory re-admissions from Community CTOs

What we found

Fewer than 20% of all individuals on community CTOs had at least one compulsory re-admission to hospital each year (186 people in 2015/16). It is encouraging that over 80% of people on community CTOs do not require compulsory hospital admission.

We still find a very low reported use of section 112. There were only 11 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.

Figure 5.1 Admissions and readmissions from CCTOs (individuals) 2008-16

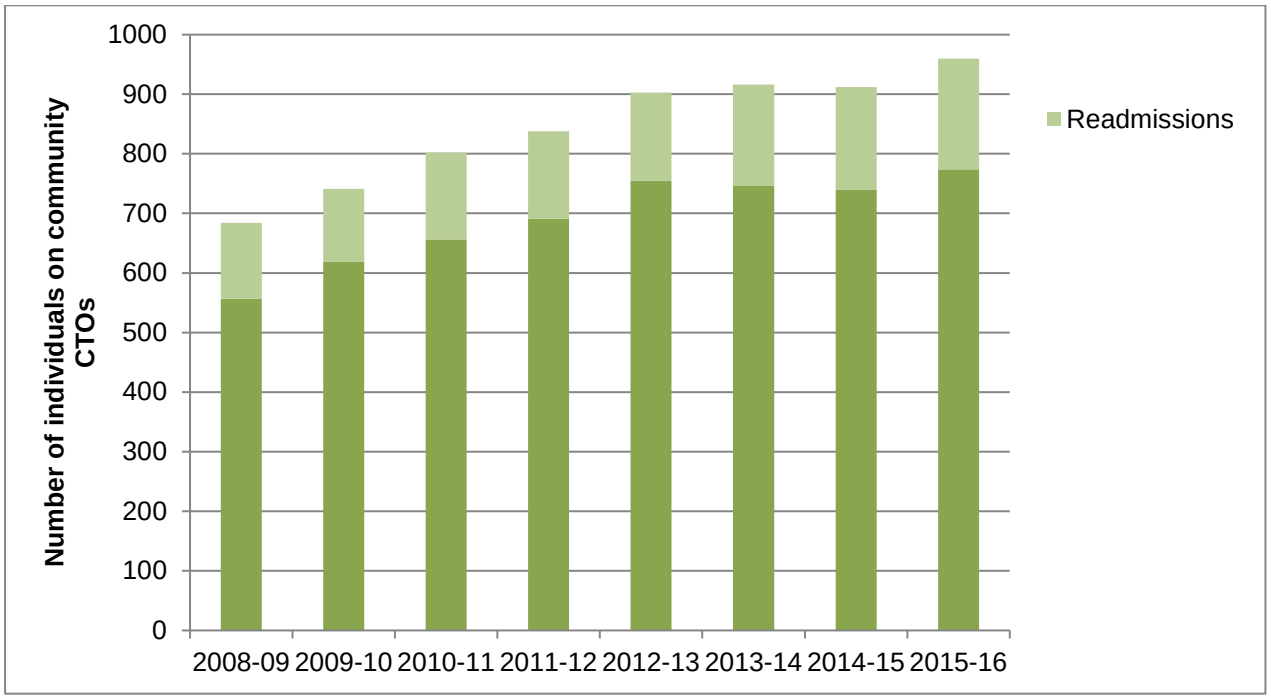


Table 5.1 Notifications of treatment that is in conflict with an advance statement by year 2009/10 to 2015/16

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

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

We received notification of an advance statement override on 66 occasions. The number of actual overrides has increased from the previous year. The most common override related to the prescription of depot medication.

As a result of our monitoring of advance statement overrides, we contacted designated medical practitioners (DMPs) on six occasions. In five of these cases, we wanted to check that the necessary notifications had been sent to patients and named persons, and in one case we required further information. We also contacted responsible medical officers on five occasions to give advice.

The Commission has produced guidance regarding advance statements and a section on our website has short films promoting their use. We hope that this will encourage people to make advance statements, contributing to the partnership between clinical teams and patients.

6. Compulsory treatment under criminal proceedings

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

What we found

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

6.1 Assessment and Treatment Orders

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

Table 6.1 Number of Assessment and Treatment Orders

Order Type	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Assessment Order	139	130	158	135	132	146
Treatment Order	61	101	143	96	106	114

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

6.2 Unfitness for trial and acquittal by reason of mental disorder

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

Unfitness for Trial

Table 6.2 Number of Temporary Compulsion Orders

Order Type	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Temporary Compulsion Order	13	12	17	7	20	19

The use of the Temporary Compulsion Order has been virtually the same as last year (19 orders granted), after unusually low use in 2013/14 (7).

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

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

Table 6.3 Acquitted by reason of mental disorder and unfitness for trial: disposals

Order Type	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
S57(2)(a) Compulsion Order	8	8	11	15	21	24
S57(2)(a) Compulsion Order - community	1	0	0	1	0	0
S57(2)(b) Compulsion Order with Restriction Order (CORO)	0	4	4	8	7	3
Guardianship S57(2)(c)	0	1	0	0	0	1
Supervision & Treatment Order S57(2)(d)	0	0	0	0	1	0

As can be seen, all but one of the outcomes involved inpatient treatment. It is likely that this reflects the serious nature of the patient's mental condition. No individual was sentenced to a community based compulsion order. Fewer COROs were granted this year (3) than in the last two years (7 and 8), but the rates in those years were higher than previous years.

6.3 Post Conviction Predisposal

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

Table 6.4 Post- Conviction, Pre- Disposal

Order Type	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Interim Compulsion Order	17	18	26	31	21	24
S200 Committal	0	1	2	1	0	0

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

6.4 Final mental health disposals by the court.

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

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

Mental Health Disposals

Table 6.5 Number of mental health disposals

Order Type	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
S57A (2) Compulsion Order	52	45	58	53	42	43
S57A (2) Compulsion Order - community	0	0	0	0	1	0
S59 CORO*	3	11	9	10	7	6
Hospital Direction	1	1	1	2	3	2
Guardianship Order S58	1	1	1	1	2	1
Community Payback Order with a mental health treatment requirement S227A(2)(f)	*see note below					

The number of hospital directions remains low, suggesting that the remand provisions, including the interim compulsion order, allow careful evaluation prior to final disposal.

The numbers of compulsion orders and COROs are very similar to last year.

Transfer for treatment directions

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

Table 6.6 Number of Transfer for Treatment Directions

Order Type	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transfer for Treatment Direction	30	40	45	45	36	35

7. Place of safety orders

What we found

The number of notifications received (795) has risen by 21% from last year (657) - this is a 35% rise since 2011/12. The proportion of incidents where the place of safety was a police station has again further decreased in the same period from 106 (18%) to 7 (1%). We are pleased with this reduction.

Table 7.1 Place of safety orders notified to the Commission

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Scotland	130	191	192	209	286	591	561	654	657	795

Table 7.2 Was Place of Safety a Police Station?

Was Place of Safety a Police Station?	2011/12		2012/13		2013/14		2014/15		2015/16	
	No.	%	No.	%	No.	%	No.	%	No.	%
No	451	76%	451	80%	581	89%	611	93%	788	99%
Not recorded	34	6%	9	2%	14	2%	0	0%	0	0%
Yes	106	18%	101	18%	59	9%	46	7%	7	1%
Grand Total	**591**	**100%**	**561**	**100%**	**654**	**100%**	**657**	**100%**	**795**	**100%**

8. Social circumstances reports (SCRs)

What we found

The percentage of STDCs that triggered the completion of an SCR was 40%. This, again, was similar to last year, even though there was an increased number of STDCs (4098).

Aberdeen City had an increased number of STDCs (from 173 to 210) and also an increased proportion of SCRs prepared (from 46% to 63%).

Edinburgh City had a drop in the number of STDCs (from 527 to 458) and a modest increase in those with a SCR prepared (from 26% to 31%).

The local authorities with the lowest percentage of SCR completion were Clackmannanshire, Inverclyde and Glasgow City.

Eighteen local authorities this year showed an increase in the percentage of SCRs completed rate.

We continue to promote the completion of SCRs in line with our published guideline[3] as we believe they can add vital information and insights of which the clinical team and MWC might otherwise be unaware.

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

Table 8.1 Provision of Social Circumstances Reports following STDC – 2015-16

	Documents returned to MWC following STDC						STDCs in LA	
Local Authority*	**None**		**"Serve no purpose" letter**		**SCR**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Aberdeen City	71	34	7	3	132	63	210	100
Aberdeenshire	31	26	9	8	79	66	119	100
Angus	18	33	4	7	33	60	55	100
Argyll and Bute	36	68	0	0	17	32	53	100
City of Edinburgh	274	60	42	9	142	31	458	100
Clackmannanshire	42	82	3	6	6	12	51	100
Dumfries and Galloway (LA)	32	30	7	7	67	63	106	100
Dundee City	48	33	31	21	66	46	145	100
East Ayrshire	21	30	10	14	40	56	71	100
East Dunbartonshire	16	42	4	11	18	47	38	100
East Lothian	39	52	5	7	31	41	75	100
East Renfrewshire	17	47	4	11	15	42	36	100
Eilean Siar	9	100	0	0	0	0	9	100
Falkirk	74	57	12	9	43	33	129	100
Fife (LA)	61	23	16	6	194	72	271	100
Glasgow City	584	78	57	8	103	14	744	100
Highland (LA)	66	42	13	8	79	50	158	100
Inverclyde	68	72	18	19	8	9	94	100
Midlothian	27	54	6	12	17	34	50	100
Moray	30	44	6	9	32	47	68	100
North Ayrshire	6	9	7	10	56	81	69	100
North Lanarkshire	111	54	15	7	81	39	207	100
Orkney (LA)	1	25		0	3	75	4	100
Perth and Kinross	50	31	19	12	90	57	159	100
Renfrewshire	70	61	12	10	33	29	115	100
Scottish Borders	32	55	4	7	22	38	58	100
Shetland (LA)	2	22	1	11	6	67	9	100
South Ayrshire	23	39	6	10	30	51	59	100
South Lanarkshire	75	38	50	25	75	38	200	100
Stirling	45	69	3	5	17	26	65	100
West Dunbartonshire	49	71	9	13	11	16	69	100
West Lothian	39	27	25	17	80	56	144	100
Grand Total	**2067**	**50**	**405**	**10**	**1626**	**40**	**4098**	**100**

9. Consent to treatment under Part 16 of the Act

Our interest in these figures

Part 16 of the 2003 Act makes provisions for additional safeguards in relation to medical treatment, 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 DMP.

What we found

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 776 T2 forms - 26 less than last year. The majority (765) were for medication; eight were for ECT, one for artificial nutrition and two for medication to reduce sex drive.

Table 9.1 Certificate of the designated medical practitioner (T3) 2015-16

Treatment type	2014/15	2015/16
	No.	No.
ECT	186	207 (11% ↑)
Medication to reduce sex drive	9	8
Artificial nutrition	76	97 (28%) ↑)
Medication beyond 2 months	1473	1503
Total T3 certificates*	**1742**	**1815**

*T3 certificate may be for more than one treatment

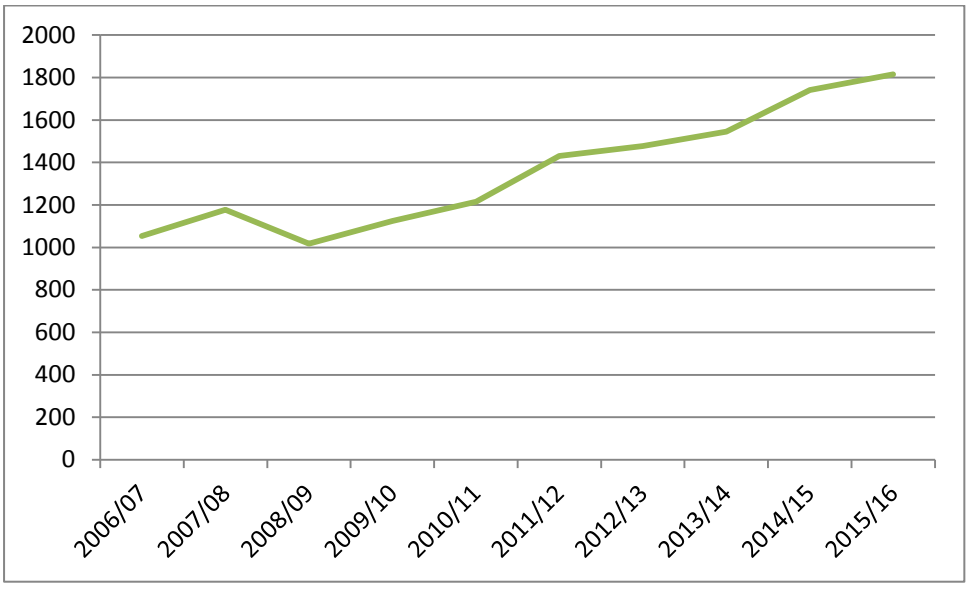
The number and types of treatments authorised by a certificate of the DMP (Form T3) is shown in Table 10.1 above. There were 4.2% more T3 forms issued than last year. The majority of treatments authorised were for medication beyond two months, and there was an increase in these, as well as for ECT. The biggest increase, however, was in T3 forms for artificial nutrition.

Of the patients receiving ECT, 138 objected to or were resisting the treatment, a similar number as 2014/15 (135). 14% (19) of those who resisted or objected required treatment to save life, the remainder to alleviate serious suffering and/or prevent serious deterioration.

There were 38 DMP visits when T3s were not issued. On some occasions, the DMP visited to find that a valid T3 was already in place or that the patient was on no medication and a T3 was therefore not required. Other situations where a T3 was not issued include the DMP not authorising ECT or nutrition by artificial means. This was due to an improvement in the patient's condition and ECT no longer being required, or the patient regaining capacity to consent.

There has been a significant increase in T3 certificates issued since the 2003 Act came into force in October 2005 (Figure 9.1). The table below shows the number of T3s issued per year, together with the percentage change from the previous year.

Figure 9.1 Number of T3s issued per year



Children and Young People

We received 40 T2 forms for patients who were under 18 at the time of consenting to treatment. These were all for medication beyond two months, apart from one for ECT. There were no T2 forms for artificial nutrition.

There were 96 T3 forms issued for patients aged under 18 for treatment without consent. This is a 20% increase since the previous year. 45 forms were for medication beyond two months and 50 for artificial nutrition which is 22% increase since last year. There was one was for ECT. On one occasion, a DMP who is not a child specialist carried out an assessment when the RMO was also not a child specialist either. This was noted when the T3 form was returned to the Commission and a child specialist DMP was then sent out. This patient was in a specialist learning disability unit. We have reviewed our processes to ensure that administration staff check the patient's age before checking whether the RMO is a child specialist. In 12 cases the DMP was not a child specialist; however, the RMO in these cases was a child specialist.

There were five times the number of T3s issued for under 18 year olds in 2015/16 than in 2006/07, with half of these being for artificial nutrition in the last two years.

Table 9.2 Type of T3 form issued for under 18 year olds

Year	Medication	Artificial Nutrition	ECT	Total T3
2006/07	19	0	0	19
2007/08	Unclear	Unclear	0	30
2008/09	15	9	0	24
2009/10	12	7	1	19
2010/11	23	15	0	38
2011/12	26	20	0	46
2012/13	27	29	2	58
2013/14	39	28	5	72
2014/15	37	41	2	80
2015/16	45	50	1	96

Of the Artificial Nutrition T3s, 53 of the 97 were individual certificates for individual patients. Seven patients had two T3s, six had three, and three had four T3s all for artificial nutrition in the reporting year.

Neurosurgery for Mental Disorder (Sections 235 and 236)

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

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

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

Although we will no longer have a role in assessing patients prior to surgery, we continue to request progress reports following treatment of Scottish patients as we believe that this is an important monitoring role.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Mental Welfare Commission (SEP 16)