Annual monitoring report

mentalwelfare
commission for scotland

Key findings from our monitoring of the Mental Health Act

2011–12

Annual monitoring report - 2011-12
The Mental Health (Care and Treatment) (Scotland) Act 2003.

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Overview of mental health and incapacity legislation in Scotland

The Commission provides statistical reports on the use of mental health legislation and of some interventions under incapacity legislation. We also report to Scottish Ministers on the operation of the legislation and let them know of any problems we find. Here is a summary of what we have found this year.

Last year, the number of new episodes of treatment under the mental health act rose sharply. It has fallen slightly this year. Over 70% of all episodes last no more than 31 days.

We looked at all orders in existence on selected dates during the year. This gives a good picture of how long-term compulsory treatment is used. We found an increase in the number of long term orders, especially community orders. We think that responsible orders should review the need for orders more often. We also want to see more evidence of work to help people to recover to the point where they can take responsibility for their own treatment without the need for compulsion.

We looked at variations in the use of the act across Scotland. This year, 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. The differences among Boards were less when applying the NRAC formula. Greater Glasgow and Clyde, Lothian and Tayside have high rates of new orders. Borders and Dumfries and Galloway had lowest numbers. The use of long-term orders have fallen sharply in Dumfries and Galloway (mainly hospital orders) and risen sharply in Highland (mainly community orders).

We looked in detail at the care and treatment of people under 18. The number of young people treated under the act has been much higher over the last two years than previously. The rise was mainly in girls, usually because of eating disorders or suicide risk. We also looked at the treatment of young people in non-specialist wards (usually adult mental health wards). There has been a

fall in these admissions over the last two•years,•but•still•well•short•of•the•Government's•target•of•50%•reduction.•There•were•marked differences across NHS Boards. Lothian had very few admissions of young people to adult wards. This is probably due to investment in intensive home treatment for this age group. The numbers of admissions in Greater Glasgow and Clyde, Grampian and Lanarkshire remain high. We found three cases where young people were being given safeguarded treatments without a certificate granted by a child specialist. We acted quickly to correct this.

A surprising finding this year was the increase in some compulsory admissions via the courts. There was a sharp rise in the number of•"treatment•orders"•(hospital•orders•for•people•awaiting•trial•or•sentence•for•a•criminal•offence). If this is still high next year, we will look into this further.

We noted an increase in the number of certificates we received authorising safeguarded treatment (usually medication beyond the first two months). We also found a slight rise in the number of certificates for safeguarded treatments under incapacity legislation. These findings may be due to the work we have done to check compliance with the law on these treatments.

In addition to our general monitoring report, we have produced special reports this year on young people and on equality. We have also published a separate report on welfare and medical treatment under the Adults with Incapacity (Scotland) Act 2000.

New episodes of civil compulsory treatment

New episodes of civil compulsory treatment initiated 2006-2012

Episode Sequence	2006-7	2007-8	2008-9	2009-10	2010-11	2011-12	2011-2012 % of all episodes
Total EDC	2029	1908	1837	1785	1787	1760	41%

EDC to informal status	991	916	918	756	875	828	19%
EDC to short-term detention	1038	992	919	1029	912	932	22%
Direct to STDC	2217	2152	2211	2201	2409	2417	57%
Direct to CTO* (including interim orders)	133	132	95	83	108	94	2%
Total episodes	4379	4192	4143	4069	4304	4271	100%

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

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.

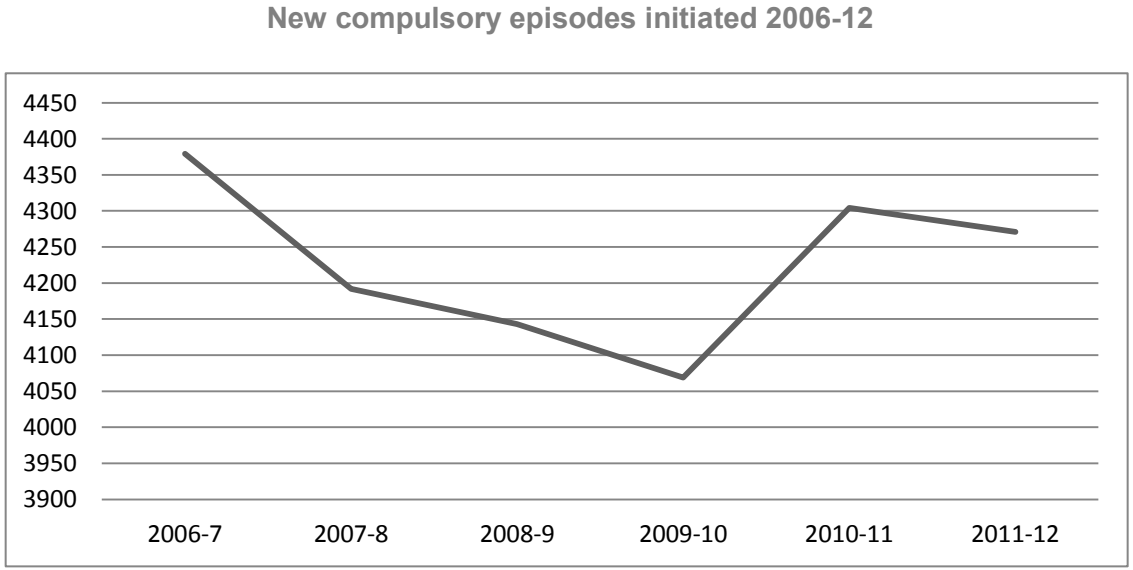
Our interest in these figures

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

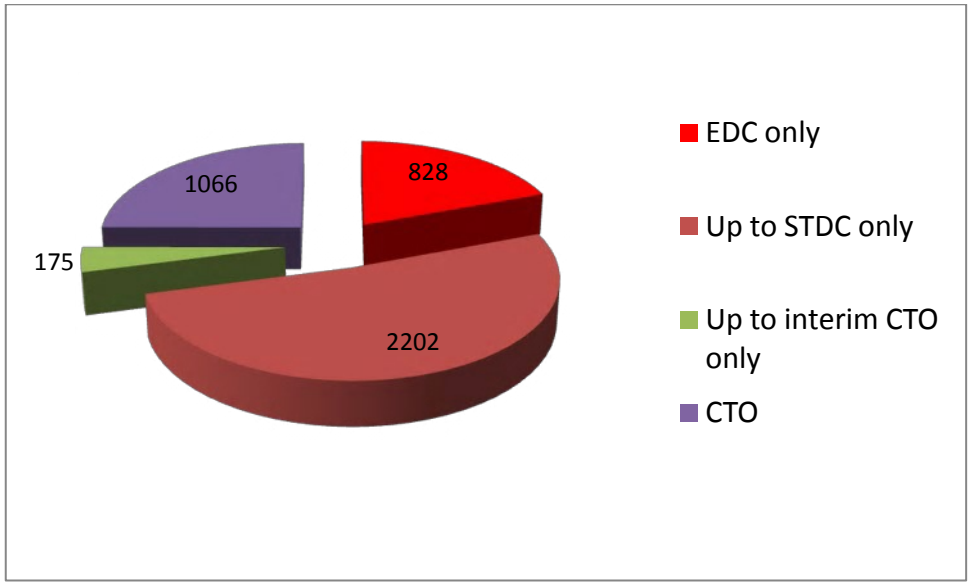
We were notified of 4271 episodes of compulsory treatment during the year. This was lower than last year but still higher than any previous year after 2006-7. See figure below.



The slight reduction in the number of new episodes was mostly due to a fall in the number of emergency detentions, especially brief episodes that did not progress to short-term detention. Given our concerns last year, this fall is reassuring. We have reported separately on crisis and intensive home treatment services. Better availability of these services across Scotland may reduce the need for emergency detention further.

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 2011 to 31 March 2012

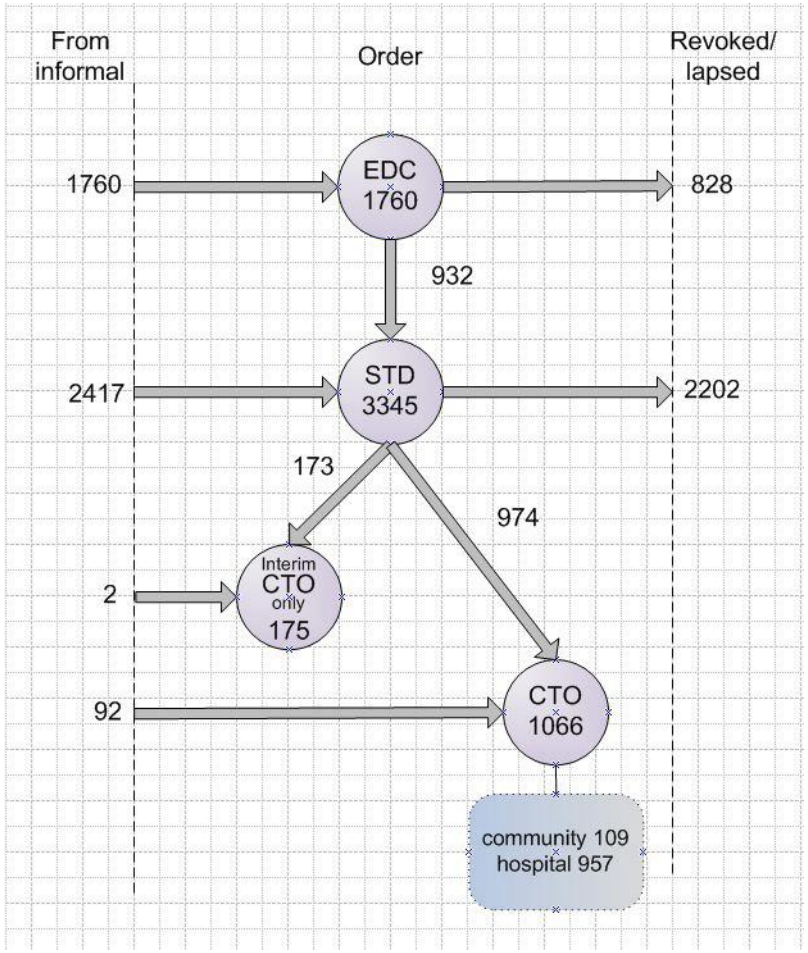


Findings of note from this chart are:

- Only 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 4271 people who became subject to the Act during 2011-12, 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 1 April 2011 to 31 March 2012



New Orders – Emergency detentions

Emergency detention by age and gender, 1 April 2011 to 31 March 2012

Age Range	Female	Male	Totals (%)
0-15	7	3	10
16-17	9	7	16
18-24	89	94	183
25-44	330	349	679
45-64	282	253	535
65-84	148	135	283
85+	53	27	80
Totals	**918 (51%)**	**868 (49%)**	**1786**

Our interest in this

An emergency detention certificate (EDC) can be issued by any registered medical practitioner. There should be consent from a mental health officer 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. Last year, we reported a rise in EDCs for young people under 18, especially girls.

What we found

The total number of EDCs was slightly fewer than last year. There were 56 fewer women detained on an EDC this year. The number of men detained rose by 16. Numbers can vary from year to year by chance, but we have found evidence to suggest that more women than men receive intensive home treatment. We have speculated that intensive home treatment has been responsible for an overall fall in the use of EDCs over the years. While there may be differences in the ways that men and women experience mental health crises, services must make sure that there is no inherent discrimination when decisions are made about admission versus home treatment. For more information, see our•report•about•intensive•home•treatment•"Intensive not Intrusive",•2012.

Age

- EDCs for people aged 65 and over rose by 11% this year. Despite a slight fall last year, we are seeing an overall increase in the use of EDCs in this age group. It is important that home treatment is available across all age groups.
- The sharp rise in EDCs for young people last year has not been sustained. In contrast, short-term detention and compulsory treatment orders have remained higher for young people than in previous years.

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. From the forms sent to us, we recorded that more than 50% were in hospital already on an informal basis, but our visits have shown that some of these notifications include people detained in A&E departments.

EDCs with and without MHO consent by NHS Board, 1 April 2011 to 31 March 2012

		Before detention		EDCs With MHO consent		EDCs Without MHO consent	
		In community	In hospital				
Health Board	Rate per 100,000 Population	%	%	No.	%	No.	%
Ayrshire & Arran	35	*23*	77	51	39	79	61
Borders	11	*50*	50	10	83	2	17
Dumfries & Galloway	43	*44*	56	40	63	24	37
Fife	32	*50*	50	89	77	26	23
Forth Valley	22	*58*	42	55	83	11	17
Grampian	14	*80*	20	56	70	24	30
Greater Glasgow & Clyde	49	*35*	65	258	44	329	56

Highland	42	*45*	55	78	60	51	40
Lanarkshire	34	*26*	74	125	64	69	36
Lothian	26	*59*	41	158	73	57	27
Orkney	30	*67*	33	6	100	0	0
Shetland	36	*38*	62	7	88	1	12
Tayside	44	*53*	47	146	81	33	19
Western Isles	4	*100*	0	1	100	0	0
Scotland	**34**	***43***	**57**	**1080**	**60**	**706**	**40**

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. In previous years, around half of EDCs were granted for people who were already in hospital.

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 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 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 Health 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

The proportion of EDCs with MHO consent remains very low in Ayrshire and Arran. We understand that the Ayrshire local authorities decided to withdraw from the west of Scotland out-of-hours service. They decided to set up their own out-of-hours service from 1st April 2012. We hope that this will result in a higher proportion of EDCs with MHO consent in future.

It also concerns us that the proportion is still low in Greater Glasgow and Clyde. This area has the highest use of emergency detention in Scotland and a relatively low proportion of EDCs with MHO consent; it fell from 52% in 2010-11 to 44% this year. Because of the size of this Board's area, it has resulted in a fall in the overall proportion of MHO consent in Scotland falling from 62% to 60%. Therefore, 40% of people detained on an EDC do not have the safeguard of MHO consent. This Board and its local authority partners should look into the reasons for this.

Also, the Scottish Government should consider revising the 2003 Act to shorten the time period during which a person can be detained without MHO consent.

EDCs by pre-detention status and MH0 consent to detention 1 April 2011 to 31 March 2012

	With MHO consent		Without MHO consent		Total	
	No.	%	No.	%	No	%
Informal in hospital	549	54	470	46	1019	100
From community	531	69	236	31	767	100

	1080	60	**706**	40	**1786**	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 for up to 72 hours without MHO consent.

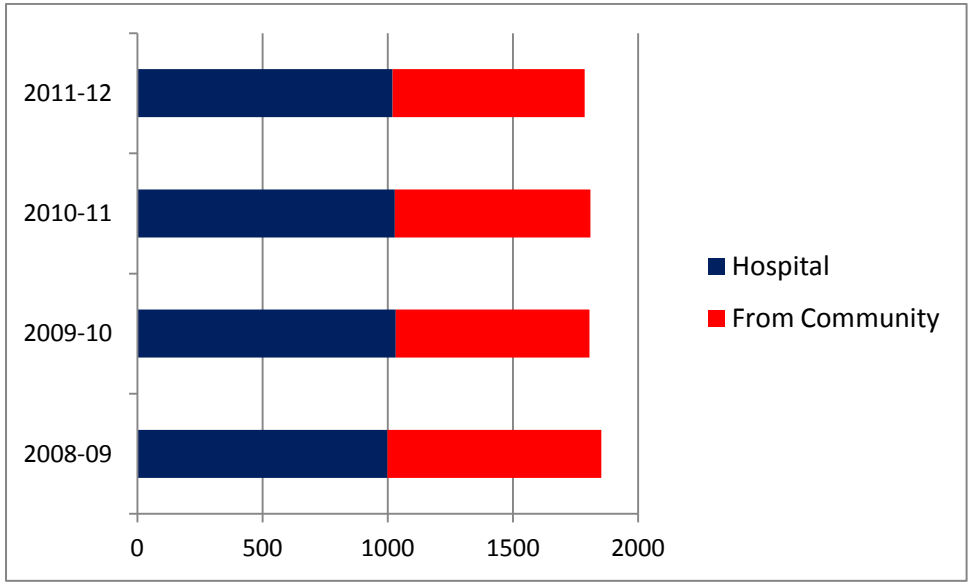
What we found

Again, people who were reported as being already in hospital were much less likely to have consent from an MHO when detained under EDC. This year, only 54% of these EDCs had MHO consent, compared with 56% last year and 61% the year before. We are increasingly concerned about this. It provides further argument for amendments to the Act to reduce the need for emergency detention and/or make the period of detention without MHO consent shorter. In our view, there is a pressing need to amend this part of the legislation.

We looked at the use of EDC for people in hospital versus people in the community over the last four years. We had seen a steady drop in the use of EDCs. Proportionately more of them were reportedly for people already in hospital. We have looked into these cases further and found that many of these people had not been informal in-patients. They were being seen for assessment, often in A&E departments. We are producing a special report on this. If this group of people was classified as having been admitted from the community under EDCs, it would look more like 41% of all EDCs were for individuals who were already hospital in-patients and 59 % were admitted from the community.

The underlying problem remains the difficulty in obtaining MHO consent for someone who is seen in a healthcare setting, appears to meet the criteria for compulsion, but refuses to stay.

Trend in the use of EDCs for people already in hospital and from the community 2008-12

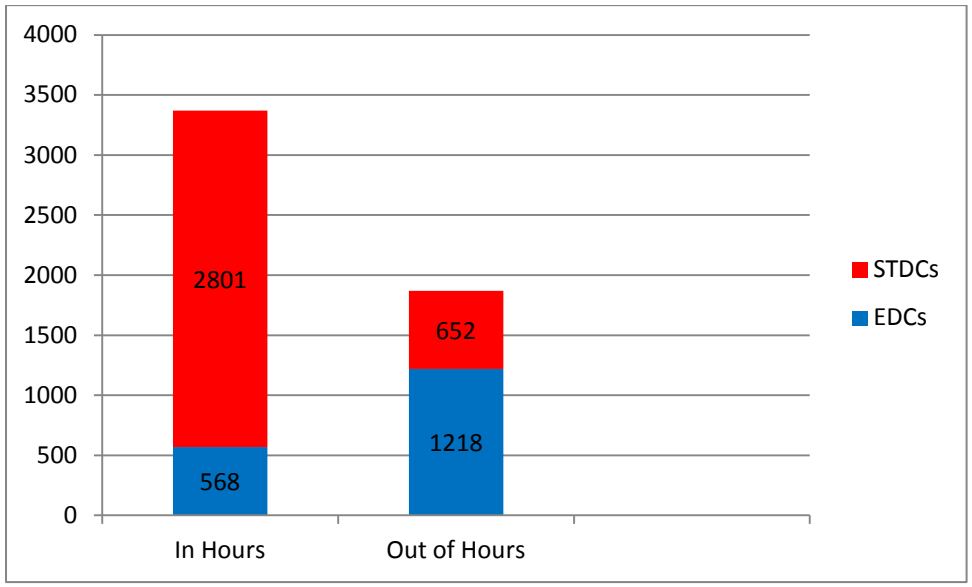


EDCs by time of granting of certificate and MHO consent to detention, 1 April 2011 to 31 March 2012

Time of granting of certificate	% of total no. of EDCs	Of these, % with consent	% without consent
Within office hours	32	66	34

Outside office hours	68	58	42

Granting of EDCs vs STDCs, in hours and out of hours 2011-12



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, 1 April 2011 to 31 March 2012

	Within 24 hours of admission		24-72 hours after admission		Total	
	No.	%	No.	%	No.	%
EDCs revoked	228	-	247	-	475	27
EDC superseded by STDC	505	-	419	-	924	52
Order expired at 72 hours	n/a	-	n/a	-	345	19
Sub-total	733	42	666	38	**1744**	-
Not available	26		34		**42**	2
Total	759	42	700	39	**1786**	100

Notes – these figures include people admitted while on community-based compulsory orders but exclude 42 people where we have been unable to determine the duration of the EDC.

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 approved medical practitioner (AMP) and a social work mental health officer (MHO). Emergency detention certificates (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

As with the previous year, 42% of people detained on an EDC had the order either revoked or superseded by an STDC within the first 24 hours. We still found that a substantial minority (19%) ran for the full 72 hours before expiring. We had hoped for more evidence that orders were being reviewed earlier. Our visits have shown that people detained on a Friday or Saturday are, in some Board areas, less likely to be reviewed by an AMP over the weekend.

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 short-term detention certificate means that he/she can initiate an application to the Tribunal to have the order revoked.

New orders – Short term detentions

Short-term detention certificates granted by age and gender, 1 April 2011 to 31 March 2012

Short-term detentions	Female	Male	Totals (%)
<16(includes only 12-15)	26	11	37 (1)

16-17	26	21	47 (1)
18-24	111	190	301(9)
25-44	553	632	1185 (34)
45-64	502	520	1022 (30)
65-84	392	326	718 (21)
85+	91	52	143 (4)
Totals (%)	**1701 (49 %)**	**1752 (51%)**	**3453 (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 approved medical practitioner (AMP) and consent from a mental health officer (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:

- An overall 7% rise in STDCs over the previous 3 years;
- An increase in previous years of the number of older people detained under STDC, although there was no increase in 2010-11;
- A sharp increase in STDCs for young women (under 18) in 2010-11.

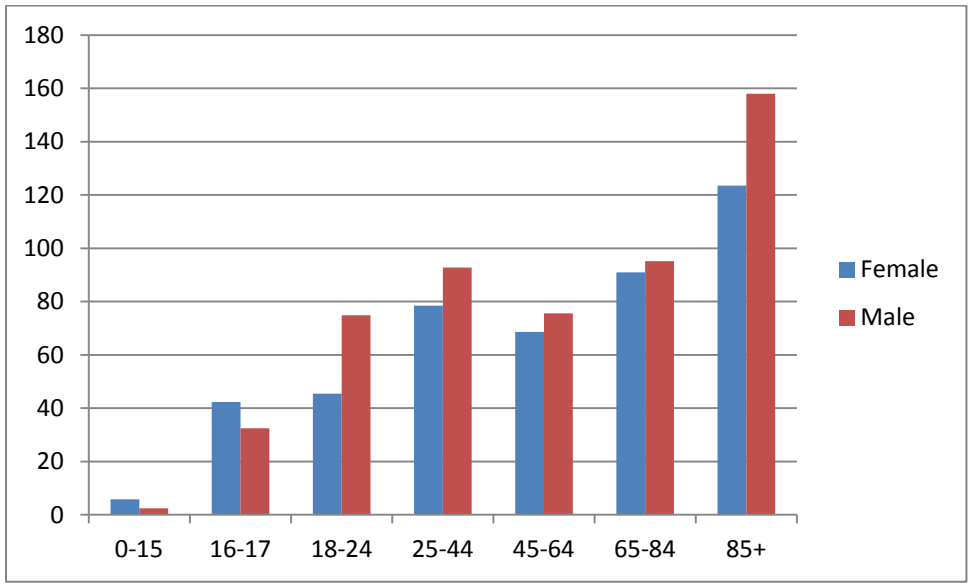
What we found

There has been little change in the number of SDTCs this year (8 fewer than last year). The number of STDCs for girls under 18 remains high, with a tendency towards more detentions of girls aged 12-15. We think that practitioners are likely to use detention

more readily for girls who harm themselves. They may be more concerned about suicide risk following recent concerns over suicides. Also, they may be more likely to detain girls who have eating disorders. We have advised that the 2003 Act should be used in preference to parental consent for young people who refuse or resist treatment for mental health problems, especially anorexia nervosa. See our special report on young people for more information on this.

We looked at the rates of STDCs based on age and gender in the figure below.

STDCs by age and gender per 100,000 population, 1 April 2011 to 31 March 2012



The main findings are:

- STDCs are more likely to be granted for men than for women in all age groups apart from the under 18s;
- The relative risk of detention for men is greatest in young adult life and in old age;
- The rates of detention for men and women rise until the 40s. Most major mental illnesses present during early adulthood. The rate then falls slightly and rises again in old age because of the onset of dementia.

In our report on intensive home treatment, we commented on apparent preferential use for women and a risk that older people were denied access to this service. If intensive home treatment prevents compulsory admission, the above figures serve to repeat these warnings.

Number and percentage of short-term detention certificates granted by type of mental disorder specified, 1 April 2011 - 31 March 2012

Type of mental disorder*	No	% of certificates
Mental illness	3339	97
Learning disability	149	4
Personality disorder	200	6
Not recorded	10	0
Total certificates	**3453**	**100%**

*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 account for the vast majority of people detained under STDCs. We found slight rises in the number of people with diagnoses of learning disability and personality disorder. There have been no overall significant trends in the last few years.

Types and combinations of mental disorders recorded in short-term detention certificates, 1 April 2011 to 31 March 2012

Mental disorder	No	% of certificates
Mental illness	3108	90
Mental illness + learning disability	98	3
Mental illness + personality disorder	122	4
Mental illness +personality disorder + learning disability	11	0
Personality disorder	64	2
Personality disorder + learning disability	3	0
Learning disability	37	1
Not recorded	10	0
Total	**3453**	**100%**

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 revised STDC forms allow us to determine more clearly the number of people receiving more than one diagnosis. There are people who have either (or both) personality disorder or learning disability but not a mental illness. Findings of interest were:

- The number and percentage of people with a diagnosis of learning disability alone rose from 21 (17% of all STDCs for people with learning disability) in 2010-11 to 37 (25%) in 2011-12.
- The number and percentage of people with a diagnosis of personality disorder alone rose from 47 (26% of all STDCs for people with personality disorder) in 2010-11 to 64 (32%) in 2011-12.

We do not have an explanation for these findings. It will be interesting to see if a trend develops here. Learning disability and personality disorder were included within the definition of mental disorder under the 2003 Act. If the other grounds for compulsion exist, we think it is important that people with these diagnoses receive the protection of the Act. We will be conducting a further census of the use of the Act for people with learning disability during 2012-13.

STDs granted where named person is recorded or consulted,
1 April 2010 to 31st March 2012

	Short-term detentions per year	
Named person	**2010-11**	**2011-12**

	No.	%	No.	%
Recorded	2778	80	2738	79
Consulted	1851	53	1895	55

Our interest in this

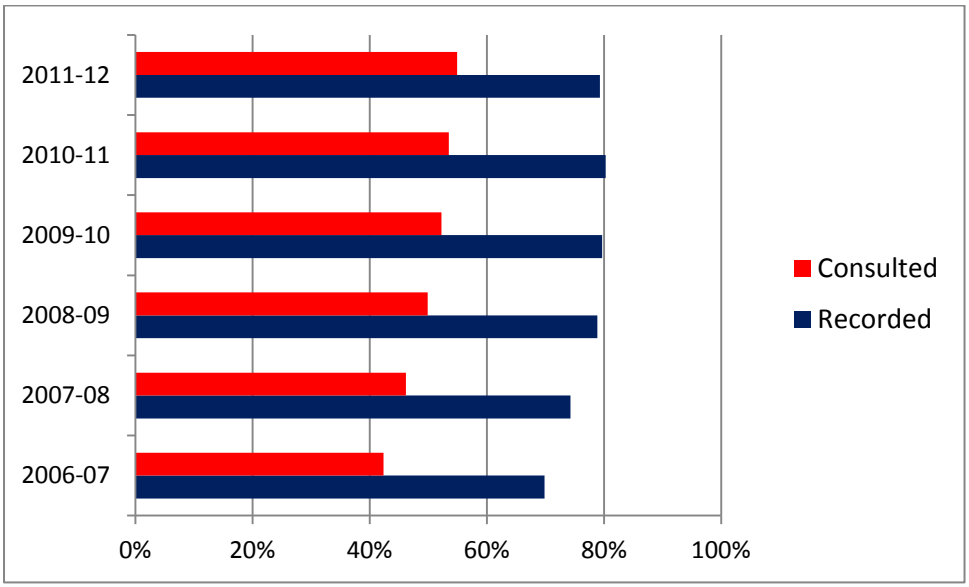
The concept of each person having a named person who would have an interest in the care and treatment of a person with mental disorder was an important aspect of the Act. The right to be consulted over the proposed granting of an STDC is an important part of the named person's role. It is the duty of 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 a slight further increase in the percentage of STDCs where the named person was consulted. Practitioners are making more efforts to consult the named person. We commend this and encourage them to increase their efforts further.

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.

Percentage of STDCs where named person has been recorded and/or consulted, 2006-2012.



Compulsory treatment orders granted by age and gender,
1 April 2011 to 31 March 2012

Compulsory treatment orders	Female	Male	Totals	%
Under 16 yrs	15	7	22	2
16-17 yrs	14	8	22	2
18-24 yrs	23	75	98	9
25-44 yrs	148	221	369	33
45-64 yrs	172	161	333	30
65-84 yrs	127	108	235	21
85+ yrs	28	12	40	4
Total	**527 (47%)**	**592 (53%)**	**1119**	**100%**

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

Our interest in this

Compulsory treatment orders are granted by the Mental Health Tribunal. They last for six months, can be extended by the responsible medical officer for a further six months and then extended annually. The Tribunal reviews them at least every two years. Therefore, they can restrict or deprive individuals of their liberty for long periods of time. We look at how these orders are used for people of different ages and genders to see if there are any trends. Over recent years, the number of new orders has come down. They are usually used more for men than women. Last year, we noted a rise in the use of CTOs for young people (under 18).

What we found

- The total number of new CTOs has risen by 5% this year. It appears to fluctuate year by year. There is no overall trend, but this is the highest number of new CTOs in any year since the 2003 Act was implemented. It is still lower than the number of long term orders granted in any of the last five years of the 1984 Act.
- The rise this year was 7% for men and 3% for women. This reverses last year's isolated finding that the use of CTOs for women was proportionately higher than previous years.
- The number of CTOs for young people (under 18), rose further this year, especially for girls under 16 (fifteen new orders this year compared with only four last year). The rise in the use of mental health legislation for girls over the last two years is striking and probably reflects greater use of legislation for girls with eating disorders or self-harm. Increased use of the Act for under-16s with eating disorders would be in line with our guidance. Mental health legislation gives the young person more rights and protection than relying on parental consent for children who cannot consent to their own treatment for an eating disorder. The youngest person was aged 12.
- We looked at the use of the Act for older people. The number of new CTOs for people aged 65 and over was about the same as last year.

New orders – Compulsory treatment order and geographical variations

No. and rate per 100k population of compulsory powers granted, by order type and NHS Board, including adjustment by NRAC formula*, 1st April 2011 to 31st March 2012

	Emergency Detention			Short Term Detention		
	EDCs	Rate per 100K	Rate per 100K (NRAC-adjusted)	STD (N)	Rate per 100K	Rate per 100K (NRAC-adjusted)
Ayrshire and Arran	130	35	34	193	53	50
Borders	12	11	11	53	47	49
Dumfries and Galloway (HB)	64	43	44	68	46	46
Fife (HB)	115	32	33	217	59	62
Forth Valley	66	22	23	149	51	51
Grampian	80	15	16	344	62	70
Greater Glasgow and Clyde	587	49	44	980	81	74
Highland (HB)	129	42	41	196	63	62
Lanarkshire	194	34	36	328	58	61
Lothian	215	26	26	608	73	75
Orkney (HB)	6	30	34	0	0	0
Shetland (HB)	8	36	44	6	27	33
State	0	0	0	0	0	0
Tayside	179	44	41	303	75	70

Western Isles	1	4	4	8	31	32
SCOTLAND	1786	34	34	3453	66	66

**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*

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:

- Greater Glasgow and Clyde has the highest rate of emergency detention;
  When the NRAC formula was used to adjust the data, Greater Glasgow and Clyde and Dumfries and Galloway had the highest rates of the mainland NHS Boards;
- Borders and Grampian had very low use of emergency detention (with and without the NRAC correction);
  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 again has the highest rate, but this falls to closer to the Scottish average when the NRAC formula is applied.
- With the NRAC formula, Lothian, Greater Glasgow and Clyde, Tayside and Grampian have relatively high rates. Dumfries and Galloway and Borders have the lowest rates.
- Using the NRAC formula, there is less variation among NHS Boards.

Looking at previous years' data, we found that the numbers of new orders in Dumfries and Galloway have fallen. There were 30% fewer EDCs and 38% fewer STDCs than in 2010-11. The total number of existing orders has also fallen. We speculate that this may have been due to the process to close the Crichton Royal Hospital, provide a new assessment unit and increase the range of community services.

Number and rate per 100k population of CTOs granted, 1 April 2011 to 31 March 2012

NHS Board	No. of CTOs	Rate per 100 k
Ayrshire and Arran	46	13
Borders	13	12
Dumfries and Galloway	17	11
Fife	87	24
Forth Valley	54	18
Grampian	101	18

Greater Glasgow & Clyde	345	29
Highland	82	26
Lanarkshire	81	14
Lothian	176	21
Not recorded	1	0
Orkney	1	5
Shetland	1	4
Tayside	111	28
The State Hospital	1	0
Western Isles	2	8
SCOTLAND	**1119**	**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 (see table 22) gives a better guide to regional variation.

What we found

- NHS Greater Glasgow and Clyde has the highest rate of new CTOs, followed by Tayside and Highland.
- As with EDCs and STDCs, the number and rate of CTOs in Dumfries and Galloway fell. Other than the Island areas, this area had the lowest rate of new CTOs per 100,000 population this year. Numbers in this area are small and we cannot read too much into this.

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.

No. and rate per 100k population of short-term detentions and compulsory treatment orders by local authority, 1st April 2011 to 31st March 2012

Local Authority	Short -Term Detentions	Rate per 100k	CTOs*	Rate per 100k
Aberdeen City	156	72	49	23
Aberdeenshire	124	50	45	18
Angus	42	38	19	17

Argyll and Bute	62	70	24	27
City of Edinburgh	406	84	106	22
Clackmannanshire	23	45	8	16
Dumfries and Galloway (LA)	66	45	18	12
Dundee City	142	98	52	36
East Ayrshire	49	41	14	12
East Dunbartonshire	58	55	20	19
East Lothian	54	55	20	21
East Renfrewshire	30	34	13	15
Eilean Siar	9	34	2	8
Falkirk	72	47	30	20
Fife (LA)	220	60	90	25
Glasgow City	655	110	197	33
Highland (LA)	144	65	63	28
Inverclyde	49	61	21	26
Midlothian	36	44	13	16
Moray	49	56	12	14

North Ayrshire	58	43	18	13
North Lanarkshire	180	55	53	16
not recorded	20	-	1	-
Orkney	1	5	0	0
Perth and Kinross	117	79	31	21
Renfrewshire	90	53	24	14
Scottish Borders	61	54	17	15
Shetland (LA)	7	31	3	13
South Ayrshire	62	56	13	12
South Lanarkshire	187	60	66	21
Stirling	58	65	20	22
West Dunbartonshire	55	61	27	30
West Lothian	100	58	30	17
WSSS**	11	0	0	0
SCOTLAND	**3543**	**66**	**1119**	**21**

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

**WSSS•is•a•West•of•Scotland•“out•of•hours”•service.

Our interest in these figures

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 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. Dundee City also has a high rate of STDC use
- CTO rates are highest in Dundee City, followed by Glasgow. West Dunbartonshire also has a high rate of CTOs this year; much higher than previous years. This may be a one-off finding but the local authority and NHS Greater Glasgow and Clyde might want to look at the reasons for this. A local mental health in-patient unit was closed recently in this area.
- Rural and more affluent areas have low use of mental health legislation. Highland council continues to have an unexpectedly high rate.

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 – nurses' power to detain

The use of nurses' power to detain by hospital and gender, 1 April 2011 to 31 March 2012.

Hospital	Female	Male	Totals
Aberdeen Royal Infirmary	0	1	1

Ailsa	0	1	1
Argyll and Bute	1	1	2
Arrol Park resource Centre	0	1	1
Blythswood House	1	1	2
Carseview Centre	5	2	7
Crichton Royal	9	2	11
Crosshouse	3	1	4
Dr. Grays	1	0	1
Dykebar	7	1	8
Gartnavel Royal	5	1	6
Hairmyres	0	1	1
Huntlyburn House	3	1	4
Midpark	2	3	5
Monklands	4	5	9
Murray Royal	0	2	2
New Craigs	5	4	9
Queen Margaret	3	5	8
Royal Alexandra	1	1	2
Royal Cornhill	1	0	1

Royal Edinburgh	25	18	43
St Johns	2	2	4
Stobhill	1	0	1
Stratheden	2	1	3
Surehaven	0	3	3
Udston	1	0	1
Whytemans Brae	1	1	2
Wishaw General	5	1	6
SCOTLAND	**88**	**60**	**148**

Our interest in this

Nurses have the power to detain people in hospital pending medical examination, in situations where that person, or others, may be at risk. This is often described as the•nurse's holding•power'.•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. We looked closely at the figures this year to see if this pattern continued or if there was any change.

What we found

Overall, use of the nurse's power to detain has risen since last year but is lower than the 2009-10 high of 162 reported uses. It shows a similar pattern to the 2008-9 figure of 145.

We continue to find significant variation in the use of this power between hospitals across the country. As in previous years the notifications received from the Royal Edinburgh Hospital indicate a higher use compared to similar urban services. This year this one hospital represents 29% of the uses of the power across Scotland. Last year we noted a comparatively high use at the Crichton•Royal•Hospital•but•this•year•the•Crichton's•use•is•similar•to•several•other•hospitals.

The use of the nurse's power to detain may be influenced by a number of factors such a local understanding of the power, variations in nursing practices and the availability of approved medical practitioners and mental health officers.

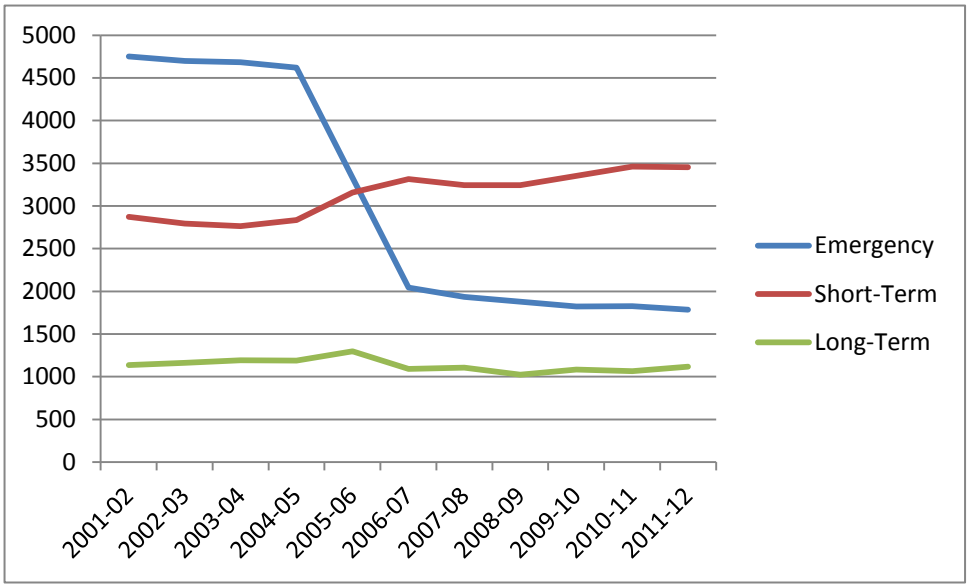
Since we started reporting on the use of this power, its use has been higher for women than for men. One explanation for this may be that nurses are more likely to restrain women. In 2009-10, although the power was still used more with women than with men, we noticed a marked increase in the number of men detained by nurses pending medical examination which contributed to a noticeable overall increase in the total number of people detained by nurses. However, last year (2010-11) the ratio of uses with women: men reverted back to the previously noted pattern of approximately 2:1, with women representing 66% of the total and men 34%. This year women represented 59.5% and men 40.5%

We looked at the figures carefully this year to see if there was any evidence for a trend towards more equitable use, but over the last four years there is no discernable pattern emerging. The total use of the power and the gender distribution in 2011 -12 is remarkably similar to that noted in 2008-9. For 2011-12 the respective rates were Women 3.3 per 100K ; Men 2.4 per 100K.

Managers should examine the use of this power in their areas and ensure nursing staff have a clear understanding of the appropriate use of their power to detain.

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 whether these trends continued.

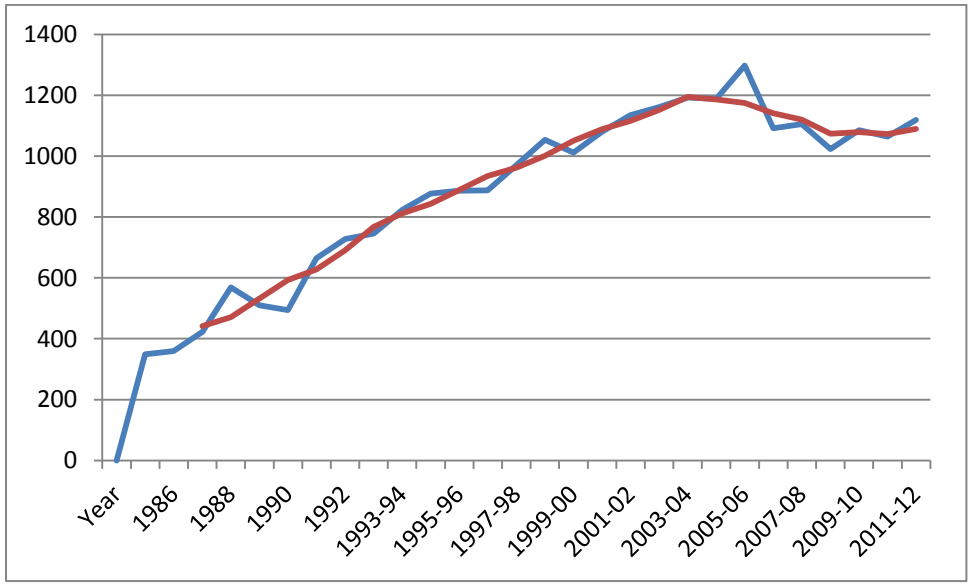
What we found

Main findings are:

- The use of emergency detention continues to fall. This is encouraging, but would be helped further by amendments to the Act. We have recommended changes to the use of the nurse's power to detain for short periods in order that both an approved medical practitioner and a mental health officer can examine someone who is being treated informally in hospital and wishes to leave.
- Short-term detention rates had begun to rise in the year prior to the introduction of the 2003 Act, and have continued to rise until reaching last year's high point which has been maintained this year. An unintended consequence of using short-term detention as the usual route into compulsion was that more people might be detained beyond an initial 72 hour period. We continue to remind psychiatrists to review these orders frequently, especially during the first few days.
- Following the introduction of the 2003 Act, rates of emergency detention (72 hours) have reduced, whilst rates of short-term detention (28 days) have slowly increased.
- The number of new long-term detention orders is high this year. It has risen by 5% since last year. This figure has fluctuated year by year, but is still generally lower than the peak use of long term orders under the 1984 Act.

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 a way of smoothing the graph. The figure below shows that the overall trend has reversed since the 2003 Act was introduced.

Trend in the granting of new long-term civil orders 1985-2012: 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.

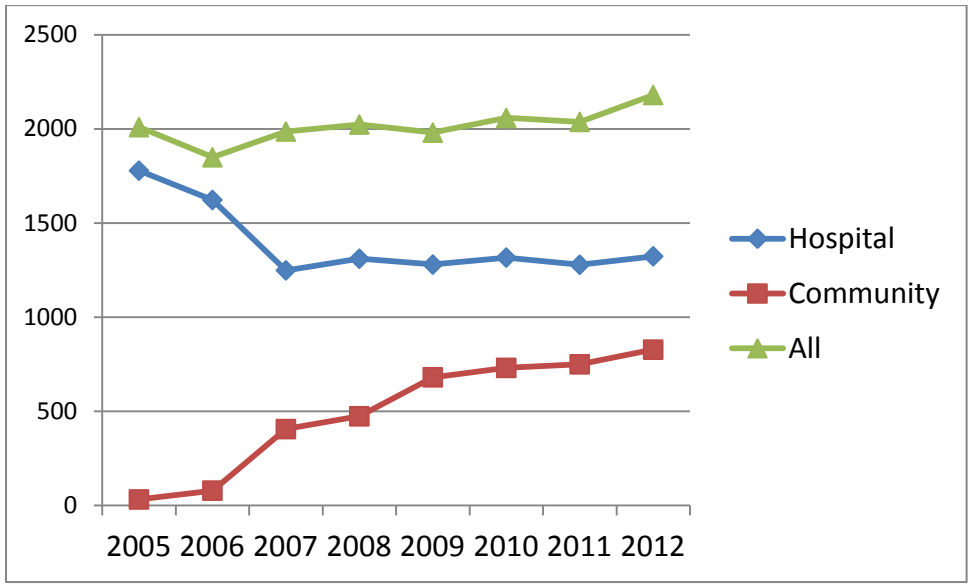
Number of people subject to compulsory powers by type at quarterly census dates, 2011-12

Order	April 2011	Jul 2011	Oct 2011	Jan 2012
Emergency detention	14	7	14	6
Short-term detention	225	247	228	207
Interim compulsory treatment order	46	47	41	29
Compulsory treatment order	**2087**	**2092**	**2166**	**2150**
Hospital-based	1292	1283	1340	1323
Community-based	795	809	826	827
Assessment order	17	9	13	11
Treatment order	10	19	13	11
Interim compulsion order	11	8	13	6
Compulsion order S57 A (2) (including community)	182	180	181	182
Compulsion order S57(2)(a)	29	29	32	31
Compulsion order with restriction order	237	239	239	244

Transfer for treatment direction	65	70	71	74
Hospital direction	5	5	5	5
Remand in custody or on bail for enquiry into mental condition	0	0	0	0
Probation order requiring treatment (s230)	0	0	0	0
Temporary compulsion order	0	0	0	0
Indeterminate status*	10	14	8	9

*In these cases, we have made improvements to the way forms are validated, resulting in a much higher rate of confidence in results hence a substantial reduction where status is indeterminate.

Point prevalence of compulsory treatment orders 2005-2012



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.

Our interest in these figures

Here we show all the orders that are in force on four dates throughout the year. This is known as "point-prevalence" data. 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.

What we found

We have seen slight rises in the number of CTOs in existence. There•is•a•6%•rise•on•last•year's•highest•figure•2040•to•this•year's highest figure 2166. The numbers of hospital and community CTOs have both risen. The small rise in new CTOs is not enough to explain this. The other explanation is that orders may still not be renewed often enough. We want to see more evidence that responsible•medical•officers•are•conducting•"from time•to•time"•reviews.

We have had some discussion with tribunal members and suggested that they examine the strategies to revoke orders when conducting reviews. We remind practitioners of the need to conduct regular reviews of the orders and work towards an end point, where the patient has recovered to the extent that compulsion is no longer required.

Number of people subject to compulsory powers on 5 January 2012, rate per 100,000, by NHS Board in rank order.

NHS Board	Rate per 100K population
Greater Glasgow & Clyde	65
Highland	65
Tayside	60
Lothian	55
Fife	51
Forth Valley	47
Grampian	42
Ayrshire and Arran	39
Lanarkshire	33

Borders	31
Dumfries and Galloway	26
Western Isles	9
Shetland	6
Scotland	**51**

These figures have been calculated including indeterminate orders.
Population used for calculation is over 16s by Health Board area.

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:

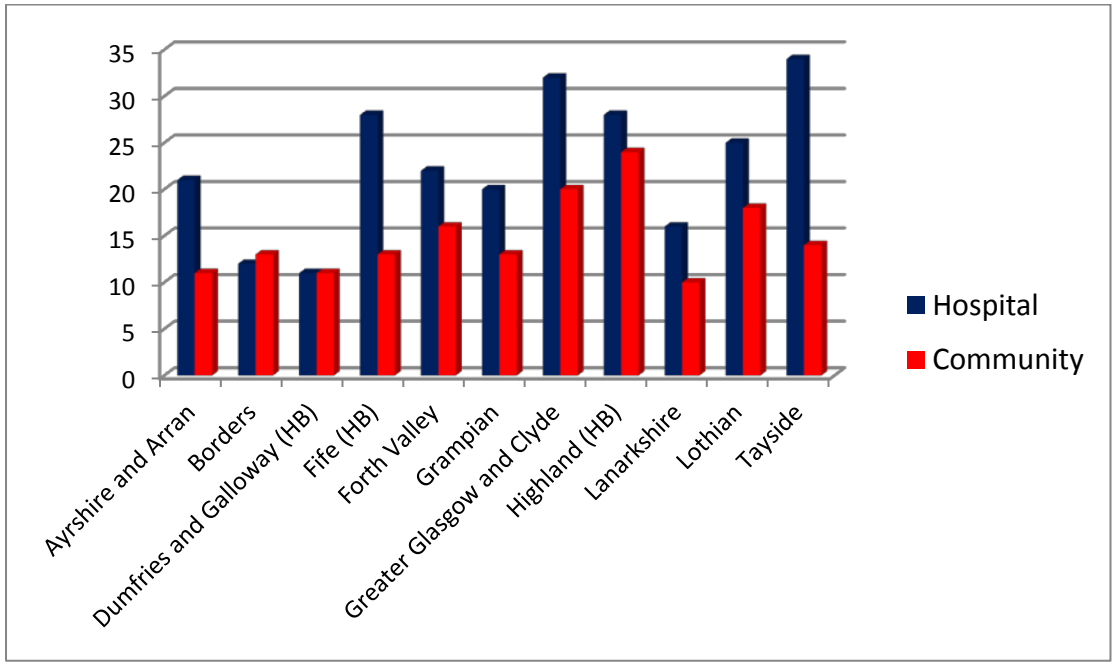
- Urban versus rural populations
- Culture and attitudes of practitioners
- Availability of early intervention, treatment and support
- Use of alcohol and drugs

What we found

- Greater Glasgow and Clyde has been joined by Highland as the areas of highest CTO use. Tayside also remains high. The rise in the number of compulsory orders in Highland is notable.
- As with new orders, the number of existing orders in Dumfries and Galloway has dropped markedly. This area saw the process to close Crichton Royal Hospital replace it with a new unit and more community services. This may have had an impact on the rate of compulsory treatment. The prevalence of hospital-based CTOs in this area has decreased markedly.

We decided this year to provide data on prevalence of CTOs, breaking this down into hospital and community orders.

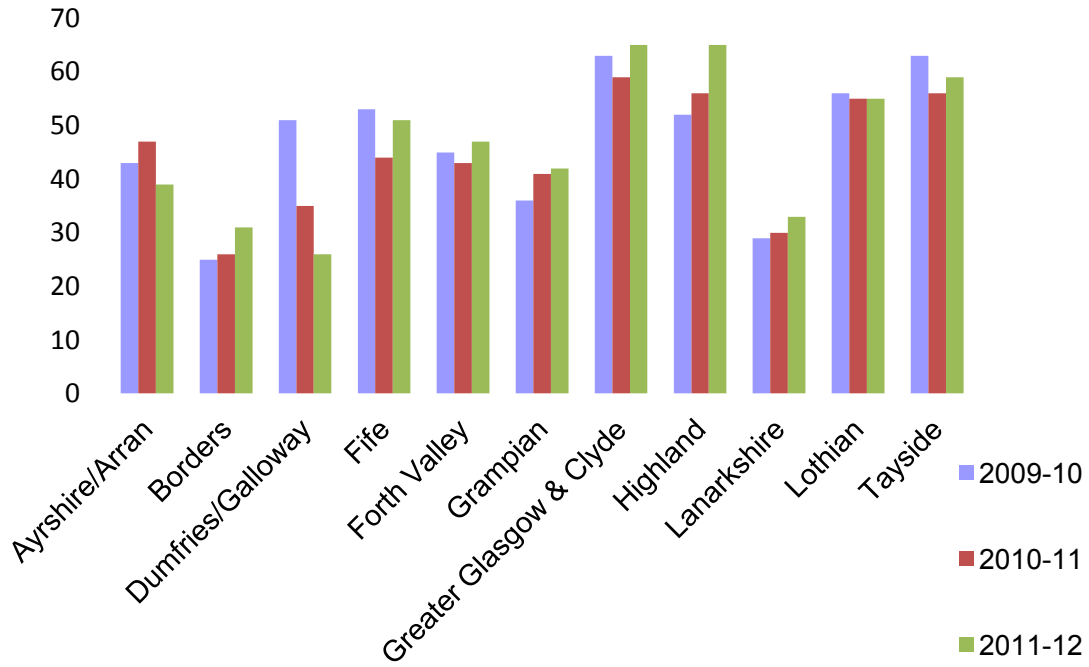
All existing hospital vs community CTOs per 100,000 population by NHS Board Jan 2012.



The important findings are:

- Tayside has a high use of hospital CTOs while their use of community CTOs is average. This NHS Board should examine its balance between hospital and community services. It may need to do more to shift the balance towards community services.
- Greater Glasgow and Clyde has high use of both hospital and community CTOs. There is a generally high rate of compulsory treatment in this area, perhaps because of areas of deprivation and high drug or alcohol use.
- Highland has a very high use of community CTOs. It may be difficult to review community orders in remote locations. We have discussed the use of video technology to conduct reviews. At present, the Act and codes of practice make no reference to its use. We are discussing this matter with the Tribunal and the Scottish Government. We have recommended changes in the law to permit interview by video for the purposes of the Act in some situations.

Trend in prevalence of compulsory treatment per 100,000 population by NHS Board 2009-10 to 2011-12



We looked at the point prevalence of compulsory treatment over the last three years and compared the mainland NHS Board areas. NHS Boards may find it helpful to examine the trends in the number of people subject to compulsion. While numbers can vary year by year, the overall trend can be informative.

The rise in the use of the Act in Highland is marked and has been a consistent trend over the last four years. This figure also demonstrates the sharp fall in Dumfries and Galloway.

Some of the variations and changes in the use of the Act may reflect the numbers of people detained in regional units. For example, the Ayr Clinic and the low secure learning disability forensic unit in Lynebank Hospital, Fife will have significant numbers of detained patients, enough to skew the numbers per head of population in a small NHS Board area.

We advise NHS Boards at the extremes of the range to examine the reasons for this. Areas of high use may need to examine better ways to engage and support people in care and treatment. Areas of low use may need to consider the possibility that they are not targeting people with serious mental illness. They may also be using coercion to engage people who are reluctant to accept treatment.

We will discuss the major variations with individual NHS Boards.

Advance statement overrides

Analysis of notifications of treatment that is in conflict with an advance statement, 1 April 2011 to 31 March 2012.

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

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. It is important to understand the circumstances where an advance statement is overridden so when we are notified of a potential override we make inquiries to ascertain whether or not it is a genuine override, and if so, what steps have been taken to discuss this with the person concerned.

What we found

Given the previously high number of erroneous notifications, the Commission has changed its process for reviewing Advance Statement overrides. Only those where there is a valid advance statement are recorded on our casework screens. We reviewed advance statement overrides on 29 occasions and in 10 cases found that no override had actually occurred. There were various reasons for this.•In•some•cases,•the•advance•statement•no•longer•reflected•the•individual's•wishes•and•they•were•intending•to withdraw the existing advance statement, write an amended one or had already withdrawn the advance statement referred to in the override. On two occasions the Commission took the view that the advance statement could not be reasonably complied with and on•one•there•were•significant•concerns•about•the•individual's•"capacity•to•properly•intend"

The number of actual overrides is little changed from last year. Of the 19 cases where an override took place, we contacted the RMO on two occasions to raise issues regarding the current T3 authorisation. In all other cases, the DMP had discussed the override fully with the patient and written to them or the matter had been fully discussed at the Tribunal with the patient present.

The Commission will be producing guidance on the completion and content of advance statements during the next year.

Compulsory treatment under criminal proceedings

Number of orders granted by order type, 2010/11 and 2011/12

No. of orders		
Order Type	**2011/12**	**2010/11**
Assessment Order	130	139
Hospital Direction	1	1
Interim Compulsion Order	18	17
S200 Commital	1	0
S57(2)(a) Compulsion Order	8	8
S57(2)(b) CORO*	4	0
S57A(2) Compulsion Order	45	52
S59 CORO*	11	3
Temporary Compulsion Order	12	13
Transfer for Treatment Direction	40	30
Treatment Order	101	61

Compulsion order with restriction order

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 Procedures (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.

Episodes of compulsion under criminal proceedings, by age and gender, 2011-12

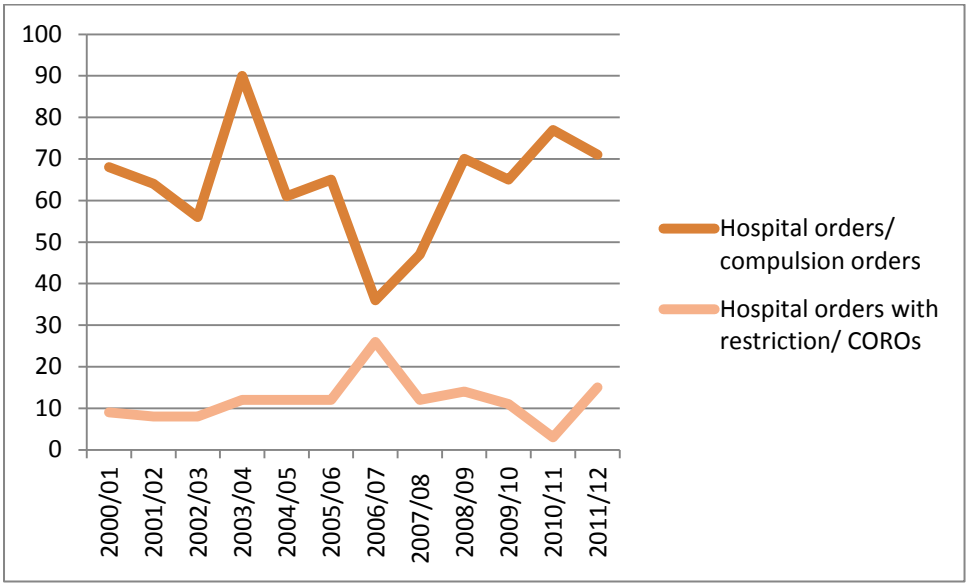
Age Range	Female	Male	Totals
Under 16	0	0	0
16-17	0	2	2
18-24	1	51	52
25-44	34	194	228
45-64	14	72	86
65-84	0	1	1
85+	0	2	2
Totals (%)	**49 (13%)**	**322 (87%)**	**371(100%)**

Trends in the use of CPSA orders are difficult to interpret on an annual basis. Whilst there have been increases in the number of Treatment orders and Section 59 COROs 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 coexistent mental disorder. The majority of orders granted are 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)].

The increase in the use of Treatment orders is interesting and we will need to see whether this trend continues in future years. Treatment Orders are imposed either at a post conviction, pre- sentence stage or pre-trial where an individual has been charged but the proceedings have not yet got 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. We may review the length of time spent on treatment orders as part of a specific monitoring exercise in the future.

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

Criminal proceeding trends in Scotland, 1994/95 to 2010/12



Place of safety orders

Place of safety orders notified to the Commission, 1 April 2011 to 31 March 2012.

	Was Place of Safety a Police Station?			
Police Force	No	Not recorded	Yes	Total
CENTRAL SCOTLAND	9	0	0	9
FIFE	130	6	4	140
GRAMPIAN	117	7	2	126
LOTHIAN AND BORDERS	36	7	94	137
NORTHERN	89	11	2	102
STRATHCLYDE	63	3	2	68
TAYSIDE	7	0	2	9
Totals	**451**	**34**	**106**	**591**

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

There has been a significant increase in notifications from 286 in 20010/11 to 591 this year (more than twice as many)

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 however 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.

Social circumstances reports

Provision of Social Circumstances Reports following short term detention by local authority 1 April 2011 – 31 March 2012*

Local Authority	Nothing received following STDC		"Serve no purpose" letter received following STDC		SCR received after STDC		Total Number of STDCs in LA area	
	No.	%	No.	%	No.	%	No.	%
Aberdeen City	81	52	3	2	72	46	156	100
Aberdeenshire	36	29	3	2	87	69	126	100
Angus	13	31	2	5	27	64	42	100
Argyll and Bute	34	55		0	28	45	62	100
City of Edinburgh	237	58	68	17	102	25	407	100
Clackmannanshire	10	43		0	13	57	23	100
Dumfries and	25	38	2	3	39	59	66	100
Dundee City	39	27	29	20	75	52	143	100
East Ayrshire	14	28	5	10	31	62	50	100
East Dunbartonshire	19	33	3	5	36	62	58	100
East Lothian	33	61	3	6	18	33	54	100
East Renfrewshire	12	40	3	10	15	50	30	100
Eilean Siar	6	67		0	3	33	9	100

Falkirk	26	36	9	13	37	51	72	100
Fife (LA)	72	33	20	9	128	58	220	100
Glasgow City	460	70	49	7	149	23	658	100
Highland (LA)	122	85		0	22	15	144	100
Inverclyde	32	65	3	6	14	29	49	100
Midlothian	17	47	4	11	15	42	36	100
Moray	32	65	2	4	15	31	49	100
North Ayrshire	2	3	6	10	51	86	59	100
North Lanarkshire	63	35	10	6	108	60	181	100
not recorded	8	40	1	5	11	55	20	100
Orkney		0		0	1	100	1	100
Perth and Kinross	13	11	28	23	82	67	123	100
Renfrewshire	47	52	11	12	32	36	90	100
Scottish Borders	43	70	5	8	13	21	61	100
Shetland (LA)	3	43	1	14	3	43	7	100
South Ayrshire	8	13	7	11	47	76	62	100
South Lanarkshire	64	33	54	28	77	39	195	100
Stirling	31	53	6	10	21	36	58	100
West Dunbartonshire	45	82		0	10	18	55	100
West Lothian	18	18	14	14	68	68	100	100
SCOTLAND	**1671**	48	**353**	10	**1454**	42	**3478**	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 STD. If you wish to discuss variations in more detail please contact us.

Twelve SCRs were completed by a service covering the West of Scotland (WSSS) and not a specific local authority. These are not included in this table.

For the past three years, a little over 40% of STDs resulted in an SCR being completed. When we do not receive an SCR we are often unable to identify exactly which local authority is responsible for failing to comply with this duty. From the information we have, we found that some local authorities comply more often than others. We received an SCR following an STD on less than 30% of occasions from six local authorities - Inverclyde, City of Edinburgh, Glasgow City, Scottish Borders, West Dunbartonshire, and Highland. Whereas 10 local authorities provided an SCR in over 60% of STDs - North Ayrshire, South Ayrshire, Aberdeenshire,

West Lothian, Perth and Kinross, Angus, East Ayrshire, East Dunbartonshire, and North Lanarkshire. These are similar to our findings in previous years.

What we cannot tell is in how many of the cases of non-provision of an SCR would have served little or no purpose, and in how many cases the duty to write an SCR is being ignored when it would have produced significant benefit. We have consistently argued that the role of the MHO within Scottish legislation is to bring and present a valuable perspective to the care and treatment of people with mental health problems and we will continue to promote the writing of SCRs as one important element of this.

The Commission is writing to those local authorities where non-compliance is highest to ask them to carry out an audit of the reasons why they are unable to provide SCRs and whether they are following the recommendations identified in our good practice guidance on their preparation published by us in 2009.

Consent to treatment under Part 16 of the Act

Certificate of the designated medical practitioner (T3), 1 April 2011 to 31 March 2012 Treatment type	No.
ECT	203
Medication to reduce sex drive	1
Artificial nutrition	40
Medication beyond 2 months	1188
Total T3 certificates	**1430**

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

1. 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 and this year we again assessed patients attending there from Scotland and England.

Four patients were seen for assessment during the reporting year. Of those seen, three patients had treatment resistant depression, and one had treatment resistant obsessive compulsive disorder. For one patient the treatment proposed was the procedure known as Deep Brain Stimulation (DBS). In all cases the treatment was considered to be in their best interests and form T1 certificate of consent to treatment was issued.

In 2011 the NHS National Services Division undertook a Review of the Advanced Interventions Service. We commented on the proposed project for the review, participated in the Expert Advisory Group and commented on the draft final report. This was submitted to the National Services Advisory Group and the final report is awaited.

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.

2. 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 804 T2 forms, a 15% increase on the previous year. The majority were for medication, 29 for ECT. There were none for artificial nutrition. The latter 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. The chief executive's advice note in November 2011 reminded RMOs that section 238 of the act requires form T2 to be sent to MWC within 7 days. The topic was also discussed at the Excellence in Practice Seminars on Consent to Treatment.

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. 129 of the patients receiving ECT objected to it or were resisting the treatment. About a fifth 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. In several cases following discussion with the RMO the medication plan was amended prior to approval. *For example, DMP Dr A was asked to approve a change to a treatment plan already authorised by T3 form which had been in place for some time. After speaking with the patient, the named person and the care team Dr A discussed his opinion with the RMO. He suggested they consider a behaviour management plan and recommended a pharmacy review of medication. He issued a T3 for a limited period of three months to allow the patient to receive appropriate medication while this was undertaken. After three months a modified treatment plan was approved and a further T3 certificate issued.*

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 the DMP did not consent. This year there were also

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.

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 2 cases 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 46 T3 forms for patients under 18 receiving treatment without consent. None were for ECT. 26 were for medication beyond two months and 20 for artificial nutrition. In all cases except one either the RMO or the DMP were child specialists. One patient under age 18 in an adult learning disability ward initially had a DMP who was not a child specialist. As soon as it was identified that the RMO was not a child specialist an appropriate DMP visit was arranged.

Designated Medical Practitioners

There were 83 DMPs on our register to provide second opinions on safeguarded treatments during the year. We held our annual DMP seminar in November 2011 when topics included legal aspects of consent, and updates on medication and on ECT. 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 are grateful to all our DMPs who undertake second opinion visits. Recruitment of DMPs has improved as a result of information placed on both MWC and Royal College of Psychiatrists in Scotland websites, but we still need to recruit additional psychiatrists due those retiring or giving up due to workload issues. It remains a challenge to recruit sufficient psychiatrists to visit Grampian and Highland regions. We have also been reviewing recruitment in the light of changing work patterns and considering the implications of revalidation requirements.