mentalwelfare commission for scotland

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STATISTICAL MONITORING

Mental Health Act monitoring 2013/2014

Contents

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

We receive notifications of most interventions under the 2003 Act. We use these to report on how the Act is used. We also continue to report geographical variations in the use of the Act. Some of the variation we see is difficult to explain and we plan to look into this further. This year, we were pleased to see a fall in the use of police stations as a place of safety and to see an increase in people going straight onto a short-term detention, which offers more safeguards. However, we are concerned about low rates of mental health officer consent to emergency detention, low completion of social circumstance reports and the admission of children to non-specialist wards.

We found a 3% rise in all new episodes of compulsory treatment. The number of new episodes of compulsory treatment is the highest since the 2003 Act was implemented. Last years' increase in the use emergency detention was not repeated but neither was it reversed, thus the downward trend seen from 2005 until last year has not resumed. Dumfries and Galloway, Greater Glasgow and Clyde and Highland had the highest use of emergency detention. There was a rise in the use of emergency detention for the very young and the very old.

We expect that short-term detention should be used as the main gateway to compulsory treatment. This involves assessment by an experienced psychiatrist and social worker before the individual is deprived of liberty and given treatment without consent, and right of appeal. The increase in the number of people entering compulsory treatment via short term detention has continued this year, reaching its highest level since implementation of the 2003 Act.

If emergency detention is used, a mental health officer (MHO) must consent unless this is impracticable. Across Scotland there was a 5% fall in MHO consent and in Dumfries and Galloway and Greater Glasgow and Clyde the majority of emergency detentions did not have the important safeguard of MHO consent. These NHS Boards and their local authority partners must examine out-of-hours MHO services as a matter of urgency as most emergency detentions happen outside office hours.

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

The Scottish Government's previous mental health strategy included a commitment to reduce admissions of children to non-specialist wards. Most NHS Boards have

struggled to achieve this. This year, the number of admissions reported to us rose to 202. Nearly two thirds were in four NHS Boards: Greater Glasgow and Clyde, Forth Valley, Highland and in particular, Lanarkshire which had 43 admissions to non-specialist wards. However, we are pleased that Lanarkshire had reduced the number of admissions from last year. In contrast, Borders, Fife and Lothian had very few admissions to adult wards.

Admission to adult wards is least likely in areas where intensive home treatment is available.

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

Please see our separate report - Young Person monitoring 2013/ 2014 - for more information.

Other main findings were:

- Short-term detention rates were highest in inner city areas.
- Detention by nurses has risen but we still think this is not reported as often as it should be.
- There was a significant reduction in the use of police stations as a place of safety.
- The total numbers of compulsory treatment orders (CTOs) in existence rose slightly. It is striking that 41% are now community based orders; there has been a huge shift to community compulsory treatment without a major rise in the total use of long-term orders.
- Greater Glasgow and Clyde has the highest numbers of people on long-term orders of all types. Highland has a very high use of community orders.
- This year, 229 individuals were subject to new mental health orders under criminal procedure legislation. This compares to 236 individuals the previous year. The number of people who continue on these orders in the longer term remains stable.
- We have examined difference in the use of the Act depending on age, gender and ethnicity.

2. New episodes of civil compulsory treatment

Table 2.1 New episodes of civil compulsory treatment initiated 2006-2014

Episode Sequence	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	13/14 *% rise*
	No.	No.	No.	No.	No.	No.	No.	No.	
EDC - total	2029	1908	1837	1785	1787	1760	1872	1883	*0.6%*
EDC - to informal	991	916	918	756	875	828	857	866	*1.1%*
EDC - to STDC	1038	992	919	1029	912	932	1015	1017	*0.2%*
Direct to STDC	2217	2152	2211	2201	2409	2417	2438	2531	*3.8%*
Direct to CTO* xx (included interim orders)	133	132	95	83	108	94	103	**116	*9.7%*
Total episodes	4379	4192	4143	4069	4304	4271	4415	4530	*2.6%*

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

** The 116 includes 3 cases direct to ICTO only, 14 to ICTO then to CTO and 99 direct to CTO
xx This includes 14 cases direct to interim CTO subsequently becoming CTOs
NB: these are new episodes only. This does not include EDCs and STDCs for people already subject to community CTOs. The numbers of EDCs and STDCs reported elsewhere in our report are larger because they do include these additional people.

Our interest in these figures

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

We have looked at these trends from the first full year after the implementation of the 2003 Act. The number of new compulsory episodes had been falling since the Act was implemented until 2010/2011, when it rose sharply. We expressed particular concern about the rise in brief periods of emergency detention.

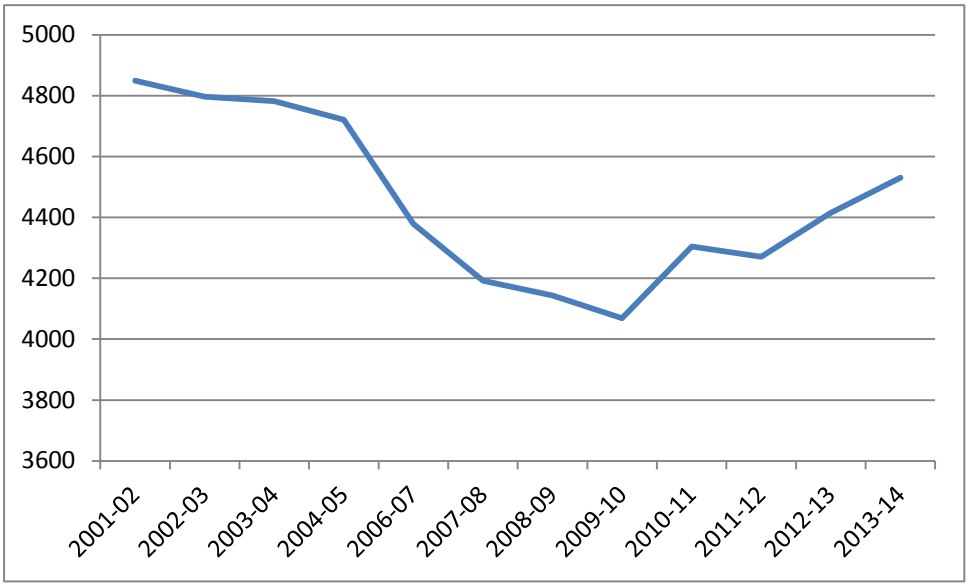
What we found

We were notified of 4530 episodes of compulsory treatment during the year. This was an increase of almost 3% on previous years. It is the highest number of new compulsory episodes since the 2003 Act was implemented. It is still lower than the number of new compulsory episodes under the previous 1984 Act. Overall, there has been an upward trend since 2009-10. The reasons for this are unclear but could reflect greater awareness of people's rights and the potential for de facto detention[1].

[1] De facto detention is where a patient feels under pressure to agree to admission to hospital or to remain in hospital, often because they feel threatened by the possibility of detention and are therefore not giving valid consent to their stay in hospital.

"Where an informal patient wishes to leave hospital against medical advice, he/she should not be placed in the position of feeling he/she must agree to stay in hospital purely because of the possibility of being

Figure 2.1 New compulsory episodes initiated 2001-14



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

All types of episodes of compulsory treatment rose during 2013/2014. There was a much smaller rise in emergency detentions than in 2012/2013. There was an increase in the number of people put straight onto a STDC, to 2531; this now stands at the highest since the Act was introduced. As this is the preferred route to compulsory treatment we are pleased to see this.

We looked at the types of episodes of compulsory treatment that were initiated during the year (Figure 2.2).

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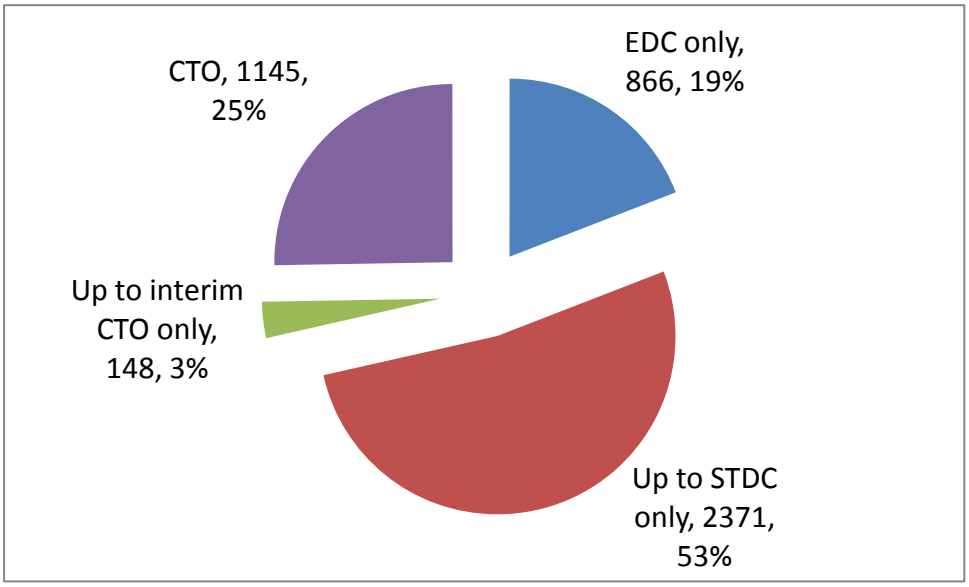
detained under the Act. Such 'de facto detention' places restrictions on an informal patient without according him/her the protection of the rights he/she would be accorded were he/she to be formally detained; and it is important to remember that the patient's perception of whether or not he/she is likely to be detained if he/she does not comply with the medical practitioner's wishes is an important factor in deciding whether or not the patient is subject to 'de facto detention'.

Mental Health (Care and Treatment) Act 2003: Code of practice, Volume 2, Chapter 7, paragraph 18

Figure 2.2 Types of compulsory civil episode 1 April 2013 to 31 March 2014

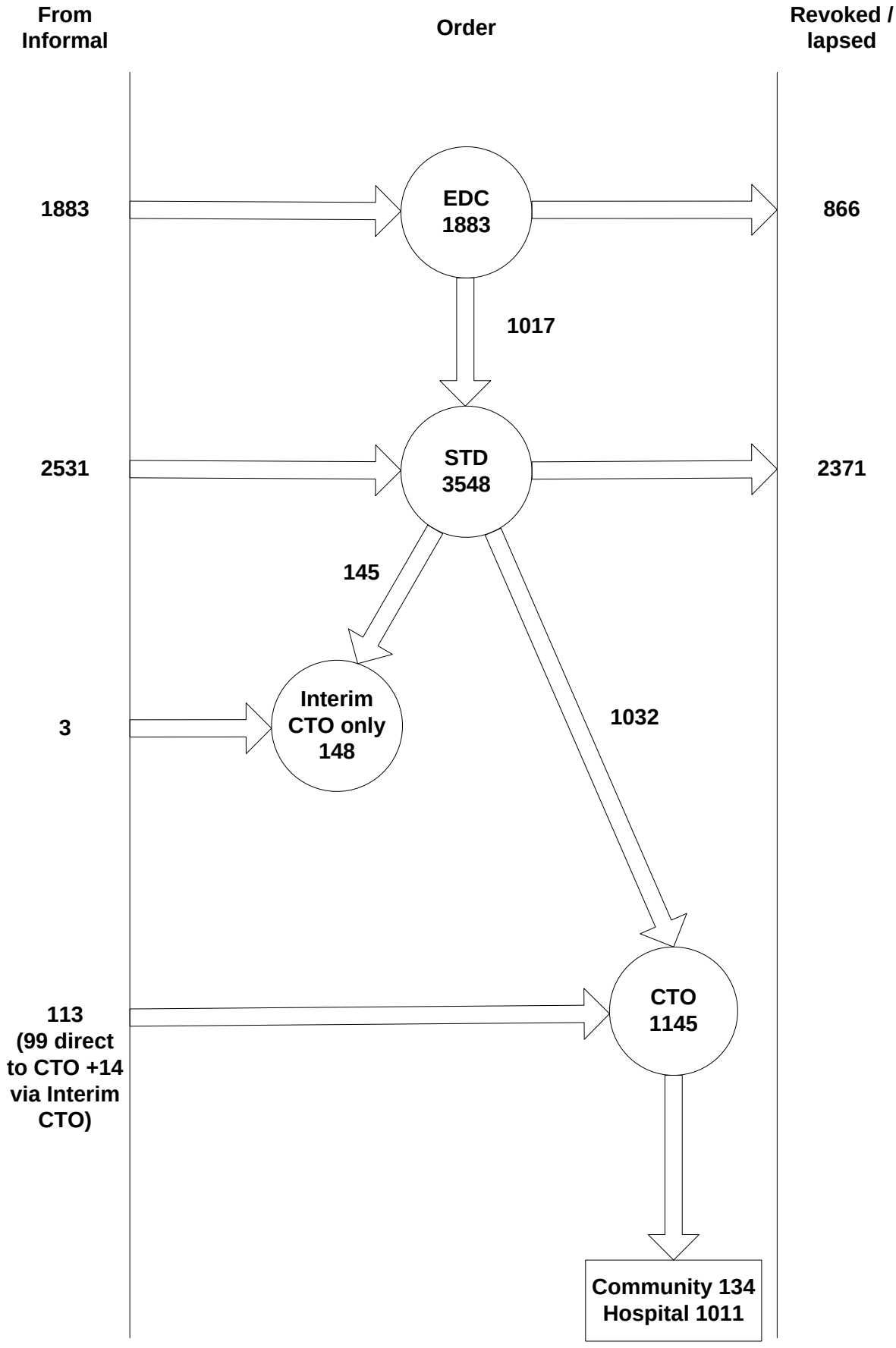


Findings of note from this chart are:

- Only 25% of all episodes of compulsory treatment result in the granting of a long-term compulsory treatment order. A further 3% of episodes progress to an interim CTO without a final CTO being granted.
- The remaining 72% of all episodes of compulsory treatment lasted for 28 days or less.

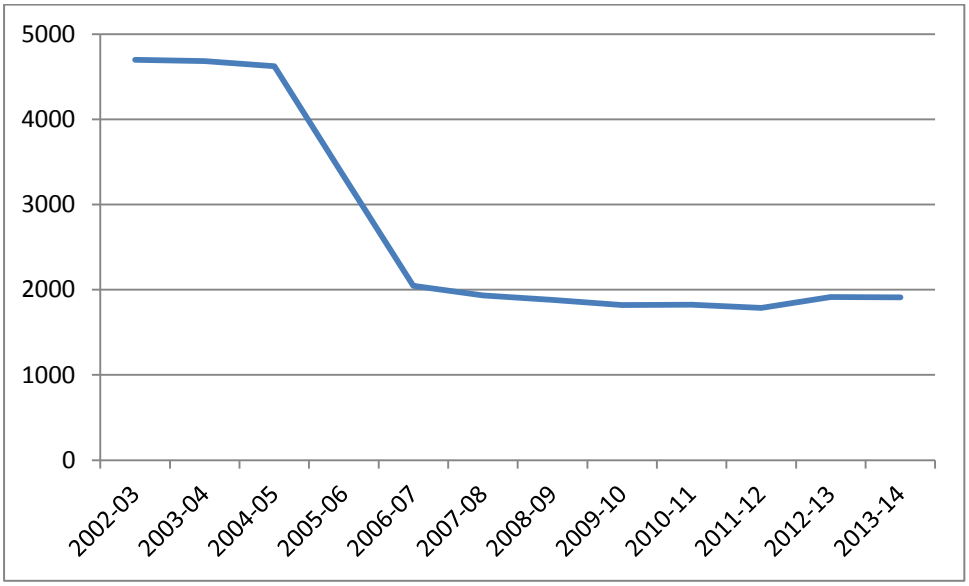
Of the 4530 people who became subject to the Act during 2013-2014, over 70% were given compulsory treatment for relatively short periods of time. This is similar to findings from previous years. The pattern of progression through the civil powers of the Act is shown in the figure below.

Figure 2.3 Pattern of progression through civil compulsory orders 2013-14



2.1 Emergency detentions

Figure 2.4 Emergency Detention Certificates 2002 to 2014



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. EDCs should only be used if it is not possible to secure assessments by both an approved medical practitioner and a mental health officer. It is likely to be used in crisis situations.

Last year we reported a rise of 7% on the overall number of EDCs, the first rise since 06/07 .We were concerned about this upward trend as EDCs should only be used if it is not possible to secure assessments by both an approved medical practitioner and a mental health officer.

What we found

The total number of EDCs this year is 1912, maintaining the increase seen last year (1915) which had followed a gradual reduction since 2006-07 to a low of 1786 in 2011-12.

Table 2.2 Emergency detention by age and gender 2013-14

Age Range	Women	Men	Total	Women	Men	Total
	No.	No.	No.	%	%	%
0-15	18	5	23	78	22	100
16-17	14	12	26	54	46	100
18-24	121	99	220	55	45	100
25-44	319	315	634	50	50	100
45-64	310	290	600	52	48	100
65-84	162	155	317	51	49	100
85+	60	32	92	65	35	100
Total	1004	908	1912	53	47	100

There has been a marked increase in numbers of EDCs in the oldest and youngest age groups (0-15 year olds, 11 cases (92%), 85+, 11 cases (14%). We reported an increase last year, in the 65-84 age-group but advised caution given the small numbers involved; the trend appears to continue this year.

The total EDCs are divided across women (53%) and men (47%) but there are higher percentages of women in the youngest (0-15 years, 78%) and oldest (65+ years, 65%) age-groups.

Young people

In the 0-15 age range the gender split is striking; last year 8 women were detained rising to 18 this year (a 125% increase) whereas the number of males detained has remained relatively stable, 4 in 2012-135 and 5 this year.).

We wanted to look further at the reasons for this so we looked at each of the individual EDC forms we received.

In the 0-15 age group, of the 23 forms we received the majority related to suicidality; six were as a direct result of an overdose with ongoing suicidal thinking and 13 were because of suicidal thinking and planning. Of the 23 detentions, 18 of the cases were outside of office hours.

Almost one in three cases (30%) were from one Health Board area.

In the 16-17 age group, of the 26 forms we received, 14 young people were detained due to ongoing suicidal ideation following high incidences of self harm or suicide attempts. Of the 26 detentions, 17 of the cases were outside of office hours. There appeared to be an even spread of cases across Health Board areas.

We found no reason to conclude that any of the cases we looked at were inappropriate admissions and detentions. In the younger age groups, the predominant reason for emergency detention is risk of suicide. Whether this represents an increase in the number of young people who present or a lowered risk threshold by individual practitioners is difficult to say.

Older people

There has been a 13.6% increase in the number of people aged over 85 who were detained in an emergency, the gender spilt is largely unchanged with women representing 65% of those detained.

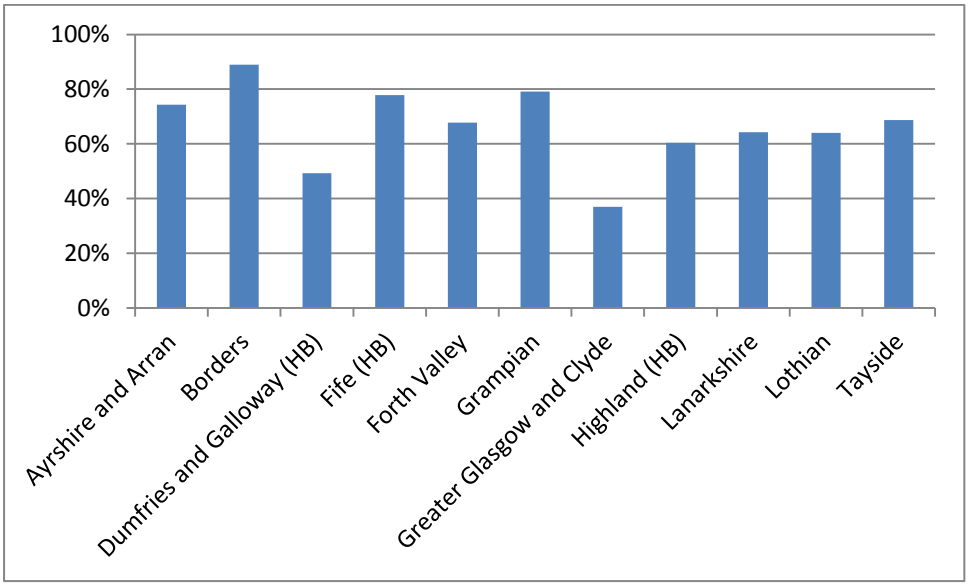
There will of course be times when an emergency certificate is appropriate but we would be concerned about a continued rise of emergency detention certificates in this population. It is likely that those over 85 will have complex physical and social care needs. EDCs do not necessitate the assessment of a mental health officer and this is an important safeguard for highly vulnerable older people.

We looked closely at the hospitals involved to see where the majority of the detentions were happening and these tended to be psychiatric hospitals rather than general hospitals. We would expect that in these hospitals and community teams it would be routine practice to secure assessment for a short term certificate by an approved medical practitioner and a mental health officer. We are taking a keen interest in this and will be carrying out some further scrutiny of detentions in the over 85 population over the next year.

Table 2.3 EDCs with and without MHO consent by NHS Board 2013-14

Health Board	Rate per 100K Population	Before detention		MHO consent			
		Community	Hospital	With		Without	
		%	%	No.	%	No.	%
Ayrshire & Arran	30	39	61	84	74	29	26
Borders	16	78	22	16	89	2	11
Dumfries & Galloway	47	54	46	35	49	36	51
Fife	33	52	48	95	78	27	22
Forth Valley	30	58	42	61	68	29	32
Grampian	20	77	23	91	79	24	21
Greater Glasgow & Clyde	52	40	60	236	37	401	63
Highland	51	54	46	99	60	65	40
Lanarkshire	29	37	63	108	64	60	36
Lothian	28	50	50	151	64	85	36
Orkney	19	100	0	4	100		0
Shetland	30	71	29	6	86	1	14
Tayside	40	60	40	112	69	51	31
Western Isles	15	75	25	4	100		0
Scotland	36	49	51	1102	58	810	42

Figure 2.5 Percentage of EDCs with MHO consent for all mainland NHS Boards (2013-14)



Our interest in this

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

We place great importance in the role of the mental health officer 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.

What we found

A total of 1912 people were made subject to an EDC in 2013-14; we found that 42% did not have the consent of an MHO compared to 37% last year and 40% in 2011-12.

Whilst the annual total of EDCs has remained much the same this year, the percentage of EDCs without MHO consent pre-detention has increased by five percentage points to 42% from 37% in 2012-13.

There is wide variation across the country in relation to MHO consent. The island boards, Western Isles and Orkney, ensured 100% of all EDCs had MHO consent. Dumfries and Galloway, Forth Valley, Greater Glasgow and Clyde, and Lothian, and Tayside showed a decrease in percentages with consent. It concerns us that in Greater Glasgow and Clyde, the area with the highest use of emergency detention in Scotland, the proportion of EDCs with consent is still low (37%). At present 63 % of people detained on an EDC in Greater Glasgow and Clyde do not have the safeguard of MHO consent.

Whilst GGC actual numbers with consent have stayed much the same (234 last year to 236 this year) the number and percentage without consent has increased from 332 (59%) last year to 401 (63%) this year (an increase of 69 individuals without consent). We have commented on this in previous reports and raised this with NHS Greater Glasgow and Clyde.

We will discuss these rates of non consent further with individual Health Boards and Local Authorities at our annual meetings. In the meantime, Local Authorities should

review the responsiveness of their MHO teams for people who require detention in an emergency.

We have also raised this issue with the Care Inspectorate and are in discussions with them about looking at how the rates of non consent can be reduced and will report on this further during the year.

Table 2.4 EDCs by pre-detention status and MHO consent to detention 2013-14

Pre-detention status*	MHO Consent					
	With		Without		Total	
	No.	%	No.	%	No	%
Informal in hospital	517	53	464	47	981	100
From community	585	63	346	37	931	100
Total	1102	58	810	42	1912	100

*This year we have improved the way we extract pre-detention status from forms received at the Commission to improve accuracy

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.

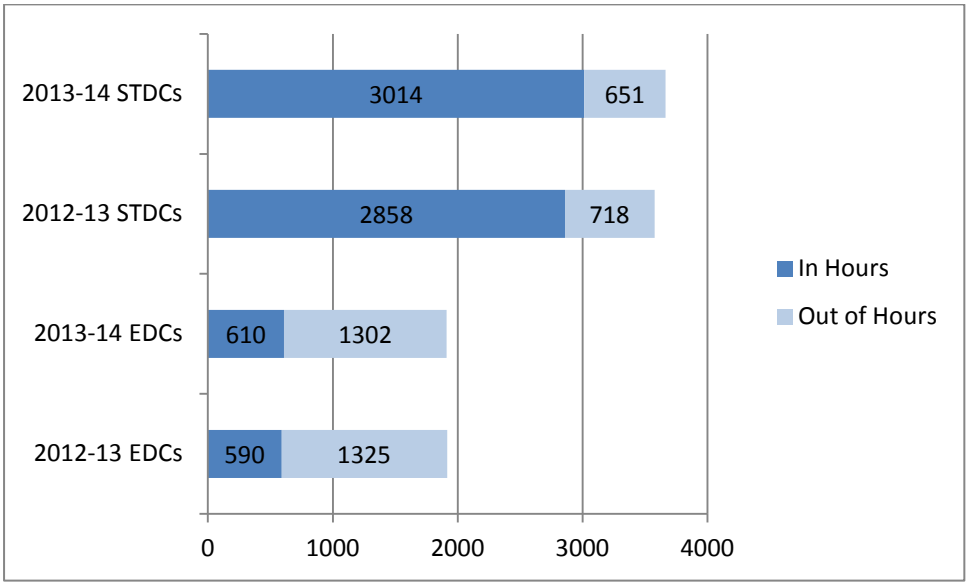
What we found

In previous years people who were reported as being already in hospital were less likely to have consent from an MHO when detained under EDC. This remains the same in 2013-14 with 53% of those in hospital receiving MHO consent compared to 63% of those receiving MHO consent when detained from the community. Across the total this is a 5% decrease on last year.

Table 2.5 EDCs by time of granting of certificate and MHO consent to detention 2013-14

Time of granting certificate	EDCs		MHO consent				
			With		Without		Total
	No.	%	No.	%	No.	%	%
Within office hours	610	32	366	60	244	40	100
Outside office hours	1302	68	736	57	566	43	100
Total	1912	100	1102	58	810	42	100

Figure 2.6 Granting of EDCs vs. STDCs, in hours and out of hours 2012-13 and 2013-14



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

68 % of EDCS happen outside office hours and 32 % within office hours and this is similar to last year.

Of those carried out within office hours, 60% will have MHO consent, a decrease of 8% this year; outside office hours 57% will have MHO consent. It is important that local authorities have good out-of-hours arrangements to ensure that MHOs can attend wherever possible.

Table 2.6 Duration of emergency detention certificates granted 2013-14

	Within 24 hours of admission		24-72 hours after admission		Total	
	No.		No.		No.	%
EDCs revoked	248		276		524	27
EDC superseded by STDC	596		432		1027	54
Order expired at 72 hours	n/a		n/a		342	18
Not available	*10		*9		*19	1
Total	853		717		1912	100

*For 19 people we were unable to determine the duration of the EDC; the dispersal across length of time has been estimated this is fewer than the 44 last year.

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. 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

Last year there was a 17% 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 and we believe this to be good practice. This year though there was a 2% decrease .Last year we were unable to determine the length of the EDC in 44 cases but this has reduced to 19 this year so this decrease may be explained by more accurate data but we will keep this under review.

The main findings are:

- The total number of EDCs remains at about the same level this year, 1912 there has been a marked increase in numbers of EDCs in the oldest (85+ years) and youngest age groups (0-15years).
- There has been a 5% reduction in the number of EDCs granted that had the consent of an MHO.

2.2 Short term detentions

Table 2.7 Short-term detention certificates granted by age and gender 2013-14

Age Range	Women	Men	Total	Women	Men	Total
	No.	No.	No.	%	%	%
0-15	30	18	48	2	1	1
16-17	40	23	63	2	1	2
18-24	134	175	309	7	10	8
25-44	541	611	1152	29	34	31
45-64	590	521	1111	31	29	30
65-84	424	376	800	23	21	22
85+	122	60	182	6	3	5
Total	1881	1784	3665	100	100	100

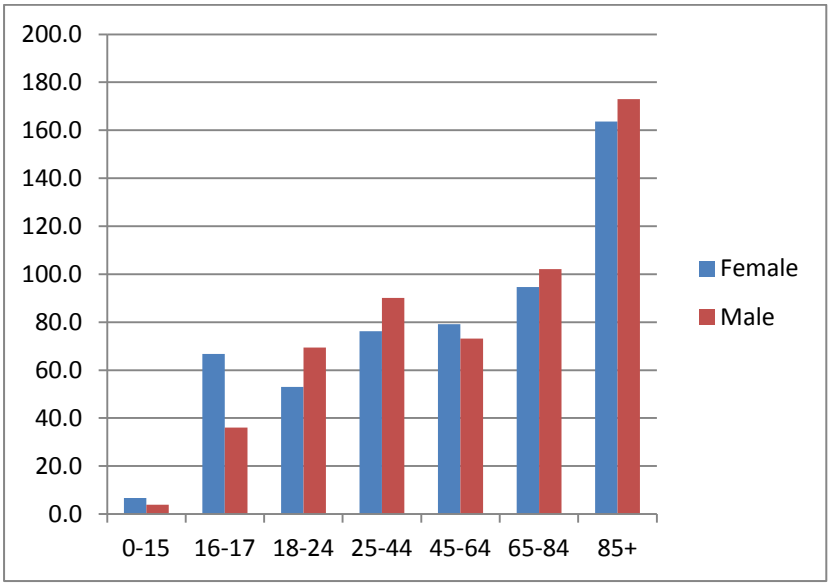
Our interest in this

Short-term detention certificates (STDCs) should be the usual start for an episode of compulsory treatment. An STDC involves examination by an AMP and consent from a MHO. It can last for up to 28 days. We look at how this power is used for people of different ages and genders to see if there is evidence of unequal treatment. We also compare this data with previous years to see if there are any trends. Last year, we commented on a 3.6% rise in the overall numbers of STDCs, the highest single rise since 2006-07, and also a 31% increase in the number of girls aged under 16 where STDCS were granted.

What we found

3665 STDCs were granted in 2013/14, an overall 2.5% rise in the number on last year.

Figure 2.7 STDCs by age and gender per 100,000 populations 2013-14



There are increased numbers across all the age groups but particularly in the 16-17 age range (47% rise) and age 85+ (17% rise), a similar pattern to EDCs.

Overall, more STDCs granted are for women (51%) than for men (49%). The chart above illustrates variances by gender and age group in rates per 100K population are detailed below.

Young people

The 16-17 age group is 63% female to 37% male. The number of detentions for males has risen by 35% and for females by 54%.

When we look at the rate per 10000 of population, there has been a jump in STDCs granted for girls age 16-17 from a rate of 43 to 67 per 100K.

Older people

The 85+ age group is comprised of 122, 67% women and 60, 33% men . Rates of STDCs for this age group were higher for both women (164 per 100K) and men (173 per 100K) this year. .

For both of these age ranges, the very young and very old, we have seen a consistent rise over the past 2 years in numbers of EDCs and STDCs. We are looking more closely at the reasons for this and will have further information next year.

One possible reason, though only speculative, is that we are seeing an increasing awareness of the rights of the individual and in previous years some young people

may have been “detained” and receiving treatment relying on parental consent and /or common law rather than under the Act.

The main findings are:

- Another year on rise in the number of STDCs granted
- A continued sharp rise in the number of STDCs granted in the youngest and oldest age groups.

Table 2.8 Short-term detention certificates 2013-14: types & combinations of mental disorders recorded

Mental disorder	STD Certificates	
	No.	%
Mental illness	3220	88
Mental illness + learning disability	125	3
Mental illness + personality disorder	169	5
Mental illness +personality disorder + learning disability	16	0
Personality disorder	87	2
Personality disorder + learning disability	5	0
Learning disability	32	1
Not recorded	11	0
Total	3665	100*

*Some percentages rounded down

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

What we found

The percentage of short term detention certificates where personality disorder was identified as the type of mental disorder has increased from 6% to 8% this year (a 28% increase in number of STDCs from 217 to 277). Mental illness continues to account for the vast majority of people detained under STDCs.

- There has been a rise in the number of individuals with a combination of mental illness, personality disorder and learning disability recorded. The numbers as an overall percentage of all STDCs are small but rose from 4 individuals to 16.

- The number of people where personality disorder alone was recorded rose from 50 to 87 and this represents a 74% increase in this category.
- In all other categories there was little percentage change

We carried out a census of the use of the Act for people with learning disability as at September 2012. This provides further information specific to people with a learning disability. It found the number of individuals with learning disability subject to compulsion continues to increase. There was a 4% overall rise since the last census in 2010. The full report can be found on our website[2] .

Table 2.9 Short-term detention certificates 2010-2014: by year and where named person is recorded or consulted

Named person	Short-term detentions per year							
	2010-11		2011-12		2012-13		2013-14	
	No.	%	No.	%	No.	%	No.	%
Recorded	2778	80	2738	79	2903	81	2968	81
Consulted	1851	53	1895	55	1990	56	1997	54

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

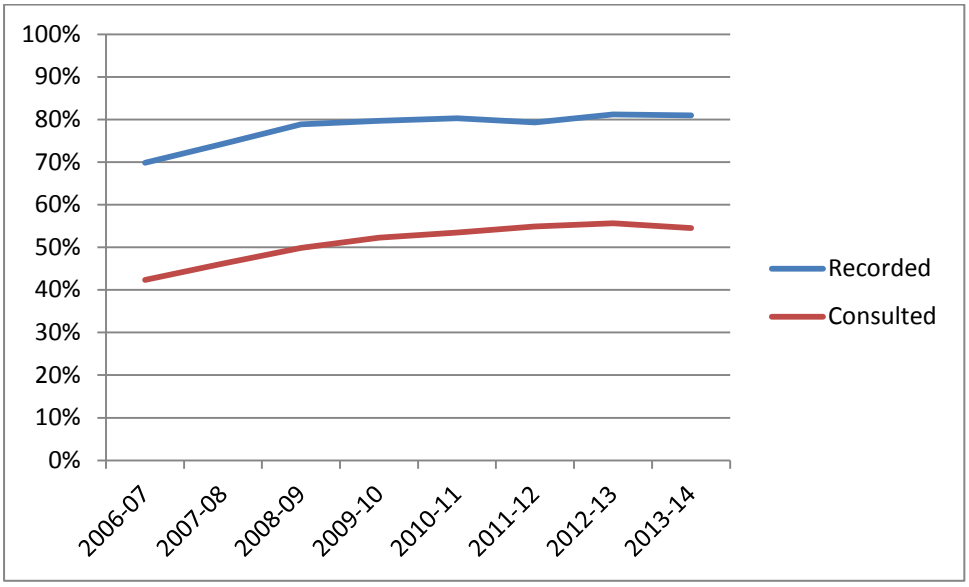
This year, there has been a slight decrease in the percentage of STDCs where the named person was consulted, a 2% decrease since last year.

The proportion of STDCs where the named person is recorded has remained the same at 81%.

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

[2] The Mental Welfare Commission for Scotland (2013) *Learning Disability Census 2012* http://www.mwcscot.org.uk/media/139675/ld_census_2012.pdf

Figure 2.8 Short-term detention certificates 2006-2014: Percentage where named person has been recorded and/or consulted.



2.3 Compulsory treatment orders

Table 2.10 Compulsory treatment orders granted by age and gender 2013-14

Compulsory treatment orders*	Female	Male	Total	
	No.	No.	No.	%
Under 16 yrs	12	5	17	1
16-17 yrs	16	7	23	2
18-24 yrs	35	64	99	8
25-44 yrs	154	189	343	29
45-64 yrs	179	164	343	29
65-84 yrs	149	146	295	25
85+ yrs	34	19	53	5
Total	579	594	1173	100%
%	49%	*51%*		

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

What we found

- The total number of new CTOs (1173) is higher than last year.
- As in previous years, the use of CTOs is slightly higher for men although the gender gap has narrowed considerably over the past 3 years.
- The number of CTOs for young people (under 18) rose this year. It remains much higher for girls. We had previously found a higher use of CTOs for young people (almost all girls) with eating disorders.
- We looked at the use of the Act for older people. The number of new CTOs for people age 65 and over rose significantly this year from 272 to 348, a 28% increase. We will look into this further over the coming year**.**

2.4 Geographical variations

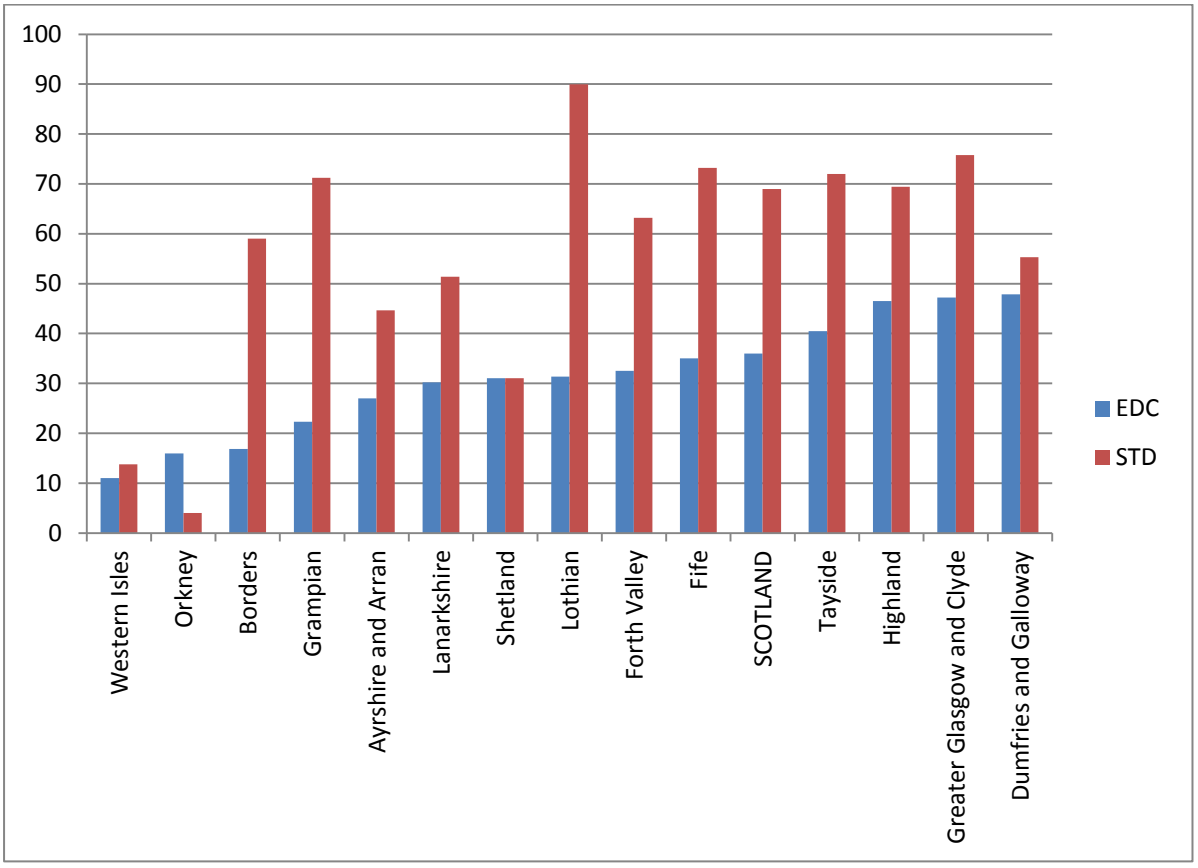
Table 2.11 Compulsory powers granted, by order type and NHS Board 2013-14 - number, rate per 100k population and NRAC formula adjustment

NHS Board	Emergency Detention			Short Term Detention		
	No.	Rate per 100K	NRAC-adjusted	No.	Rate per 100K	NRAC-adjusted
Ayrshire and Arran	113	30	27	187	50	45
Borders	18	16	17	63	55	59
Dumfries and Galloway	71	47	48	82	54	55
Fife	122	33	35	255	70	73
Forth Valley	90	30	33	175	59	63
Grampian	115	20	22	367	64	71
Greater Glasgow and Clyde	637	52	47	1023	84	76
Highland	164	51	46	245	77	69
Lanarkshire	168	29	30	286	50	51
Lothian	236	28	31	677	80	90
Orkney	4	19	16	1	5	4
Shetland	7	30	31	7	30	31
State				2		
Tayside	163	40	40	290	70	72
Western Isles	4	15	11	5	18	14
SCOTLAND	1912	36	36	3665	69	69

*****We looked into this further by applying the NHS Scotland Resource Allocation Committee (NRAC) Formula[3] when making comparisons among NHS Boards. NRAC adjusts the population of each NHS Board area based on features such as age, sex, morbidity and life circumstances and geography

[3] We will be reviewing the use of the NRAC formula in this context with ISD in the coming year.

Figure 2.9 Emergency and short-term detention by NHS Board 2013-14 - rate per 100k population with NRAC formula adjustment



Our interest in this

Most people who are detained under the Act are held for up to 72 hours (emergency detention) or 28 days (short-term detention). Each year, we look at how these orders are used in different NHS Board areas. We always find large variations and causes are not easy to explain. Because people with severe and enduring mental illness tend to live in inner city areas, we usually find detention rates higher in these areas. Emergency detention can be high in rural areas because it is less easy to get an approved medical practitioner and a mental health officer for short-term detention. This does not explain all the variation 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. The main findings are:

Emergency detention:

- Dumfries and Galloway, Greater Glasgow and Clyde and Highland have the highest use of emergency detention this year. Two of these areas have remote and rural communities, so this is understandable to some extent.
- However, Borders had low use of emergency detention and also has mainly rural communities. There may be differences in service configuration and clinical practice that other rural Boards could study.
- 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:

- Lothian has the highest use of short-term detention, the use has increased by over 20% this year.
- Of mainland boards, Ayrshire and Arran has the lowest use of short-term detention.

Table 2.12 Compulsory Treatment Orders granted 2013-14 - number and rate per 100k population

NHS Board	CTOs granted		
	*No.	Rate per 100K	NRAC adjusted
Ayrshire and Arran	48	13	11
Borders	17	15	16
Dumfries and Galloway	29	19	20
Fife	85	23	24
Forth Valley	48	16	17
Grampian	107	19	21
Greater Glasgow & Clyde	328	27	24
Highland	82	26	23
Lanarkshire	98	17	18
Lothian	218	26	29
Orkney	0	0	0
Shetland	1	4	4
Tayside	108	26	
The State Hospital	2		27
Western Isles	2	7	6
SCOTLAND	1173	22	22

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

Our interest in this

Compulsory treatment orders (CTOs) are used to authorise long-term compulsory treatment. Each year, we look at how these orders are used in different NHS Board areas. We always find large variations and causes are not easy to explain. Because people with severe and enduring mental illness tend to live in inner city areas, we usually find rates higher in these areas. This does not explain the variations that we see. We are concerned that areas with high use may be intervening excessively where there may be alternatives to depriving people of their liberty. Low use could mean that people are not being adequately treated or protected. There is also a risk that excessive persuasion is used to treat people in hospital. This could amount to unlawful deprivation of liberty.

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

What we found

- Lothian, Greater Glasgow and Clyde and Fife have the highest rate of new CTO's this year. Ayrshire and Arran has the lowest rate of new CTOs, half the Scottish average.
- The rise seen last year in new CTOs in Borders was reversed this year with the rate falling from 26 to 16. This is consistent with the generally low use of mental health legislation in this board.

NHS Boards should look at this data and our data on prevalence rates (Table 3.1) in order to compare their figures with the national average.

Table 2.13 Short-term detentions and compulsory treatment orders by local authority 2013-14 – number and rate per 100k population

Local Authority	Short Term Detentions		Compulsory Treatment Orders	
	No.	Rate per 100K	*No.	Rate per 100K
Aberdeen City	180	80	56	25
Aberdeenshire	121	47	36	14
Angus	47	40	23	20
Argyll & Bute	66	76	15	17
Edinburgh City	470	97	126	26
Clackmannanshire	21	41	5	10
Dumfries & Galloway	82	54	30	20
Dundee City	125	85	40	27
East Ayrshire	59	48	13	11
East Dunbartonshire	60	57	16	15
East Lothian	48	48	20	20
East Renfrewshire	34	37	16	18
Eilean Siar (Western Isles)	5	18	4	15
Falkirk	100	64	29	18
Fife	266	73	88	24
Glasgow City	656	110	186	31
Highland	177	76	69	30
Inverclyde	75	93	29	36
Midlothian	33	39	20	24
Moray	52	56	23	25
North Ayrshire	73	53	17	12
North Lanarkshire	165	49	61	18
Orkney Islands	5	23	1	5
Perth & Kinross	120	81	38	26
Renfrewshire	97	56	36	21
Scottish Borders	63	55	19	17
Shetland Islands	12	52	2	9
South Ayrshire	57	50	12	11
South Lanarkshire	155	49	63	20
Stirling	55	60	15	16
West Dunbartonshire	54	60	23	25
West Lothian	131	74	42	24
ESWS**				
WSSS**	1			
Total	3665	69	1173	22

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

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

Our interest in these figures

Table 2.13 shows 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 and Edinburgh City have the highest rates of short-term detention. The high rate in the related NHS boards appears to be due to the high rates in these council areas, they are urban areas so this is probably understandable.
- CTO rates are highest in Inverclyde, Glasgow City and Highland.

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.

2.5 Nurse's power to detain

Table 2.14 The use of nurse's power to detain by hospital and gender 2013-14

Hospital	Women	Men	Total
	No.	No.	No.
Aberdeen Royal Infirmary	1		1
Ailsa	1		1
Airbles Road	1		1
Arrol Park Resource Centre		1	1
Blythswood House	1	1	2
Borders NHS	3		3
Carseview Centre	6	5	11
Crosshouse	2	5	7
Dr. Grays	1	1	2
Dykebar	8		8
Forth Valley Royal		2	2
Gartnavel Royal	5	4	9
Hairmyres	4		4
Huntercombe	5		5
Inverclyde Royal		1	1
Leverndale	3		3
Mackinnon House	1	2	3
Midpark	3	7	10
Monklands	3	1	4
Murray Royal	4	1	5
New Craigs	2	3	5
Queen Margaret	2	1	3
Royal Alexandra		1	1
Royal Cornhill	4	1	5
Royal Edinburgh	26	19	45
Royal Infirmary Edinburgh	1		1
Skye house		2	2
St Johns	8	2	10
Stobhill	1		1
Stratheden	8	2	10
The Orchards		1	1
Western Isles	1		1
Whyteman's Brae	7	1	8
Wishaw General		1	1
Total	112	65	177
%	63%	37%	100%

Our interest in this

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

What we found

The use of the nurse's power to detain has risen by 3.5% since last year to 177 and this is the highest annual use of the power to date. This year we have seen a small rise in the overall number of hospitals where this power was used, 34 different sites this year compared to 31 last year.

This year women accounted for 63% of the times it was used compared to 57% last year. This continues to be a lower percentage than for 2010-11 when women represented 66%.

We are not clear about the reasons why women remain twice as likely as men to be detained under this section, particularly as emergency detention under section 36 shows a more even gender distribution. On closer inspection, the majority of women detained under this power, 45%, were in the 25 to 44 age group and 26% were in the 45 to 64 age group, similar to the age distribution for men.

The total rate, has stayed the same this year (3.3 per 100K) but has increased again for women (4.1 per 100K) and returned to the 2011-12 rate for men (2.5 per 100K).

Table 2.15 Use of Nurse's Power to Detain

	Rate per 100K Population		
	2011-12	2012-13	2013-14
Women	3.3	3.6	4.1
Men	2.4	2.9	2.5
Total	2.8	3.3	3.3

We believe there has been significant under reporting to the Commission of the use of the nurse's power to detain for many years and in general a lack of understanding of where and when it should be used .Because of this we produced good practice guidance on this subject and this was published on our website in January 2014 and in addition we printed 500 copies of the guidance and an easy read flow chart to be distributed to wards throughout the country.(insert web link to guidance).

We note that the Royal Edinburgh Hospital has a significantly higher use of the nurse's power to detain and this has been the case for several years now. We do

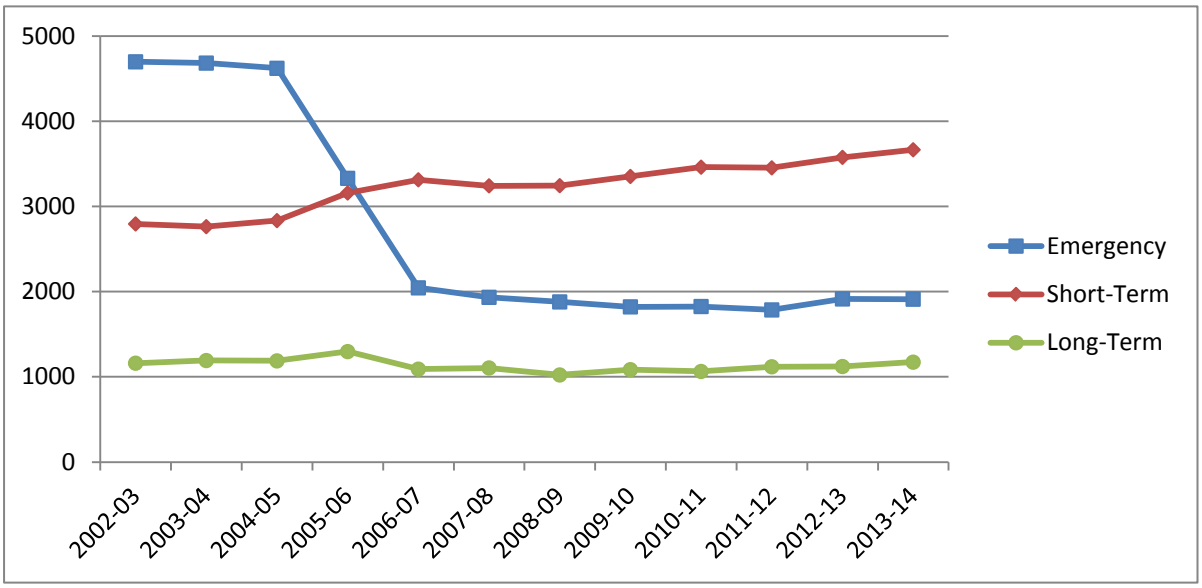
though believe that it is being used appropriately within the hospital but will keep this under review.

We will be very interested to look closely at the figures next year to see if there has been a rise in its use in other hospitals following publication of the guidance.

We also carried out a limited analysis of randomly selected NUR1 forms (100) for closer scrutiny .We found in general that nursing staff had given thoughtful consideration to the need to use the power to detain. On all occasions a doctor attended within the specified time scales. At the end of the period of detention, 74% of those went on to be further detained (40% under an emergency detention certificate and 34% under a short term certificate), 23% remained in hospital on an informal basis and 3 % were discharged from hospital.

2.6 Trends in the use of civil compulsory treatment

Figure 2.10 Trend in civil orders granted (2002-2014)



Our interest in these figures

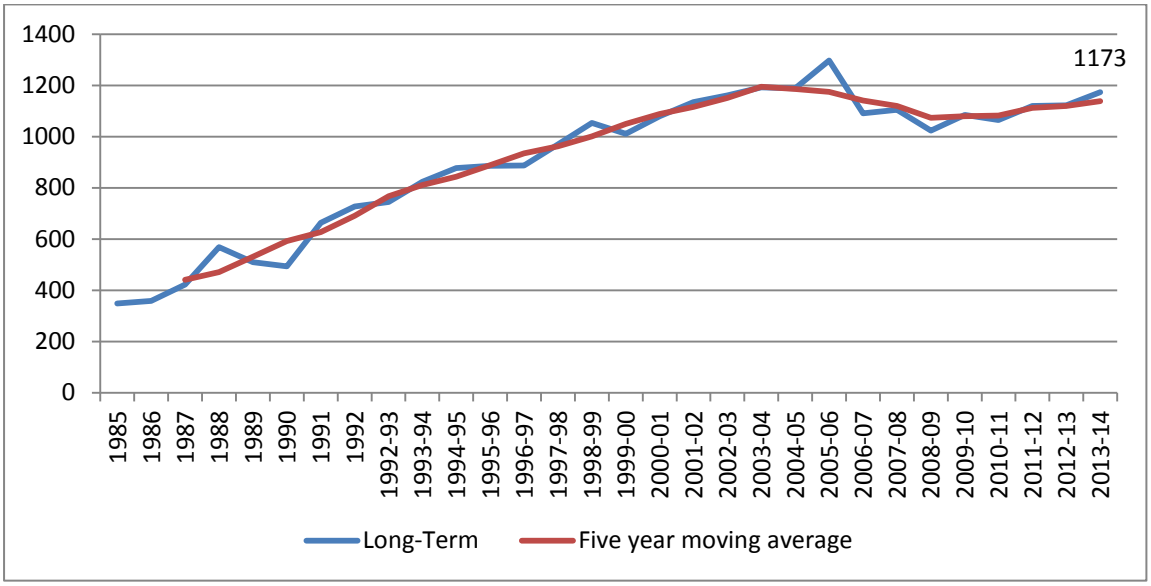
We look at how the main civil compulsory orders in Scotland have been used over time. Over the years, we have found an increasing use of long-term compulsory treatment. This was similar to other western European countries. This trend has not continued under the 2003 Act (introduced from October 2005). We were concerned last year by an increase in the use of emergency detention.

What we found

Main findings are:

- The use of emergency detention has risen only slightly this year however, this means that the downward trend seen until last year has not been resumed. Higher use of emergency detention may be an indicator that some services, for example in rural areas, have difficulty accessing AMPs in a crisis situation.
- Short-term detention has also increased and is now almost 30% higher than it was under the previous 1984 Act. This is the commonest type of compulsory order. Higher use can have a number of causes, including lack of alternatives to compulsory hospital treatment and lack of earlier intervention. It could also reflect better observance of the 2003 Act.
- The number of new long-term orders has changed little over the last ten years.
- We looked at the granting of all new long-term civil orders since 1985. We applied a “five year moving average” to see the overall trend. This is a way of smoothing the graph. The figure below shows that the previous upward trend reversed since the 2003 Act was introduced and has been relatively stable over the last few years.

Figure 2.11 Trend in the granting of new long-term civil orders 1985-2014: five year moving average



3. 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 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.

3.1 All orders

Table 3.1 Number of people subject to compulsory powers by type at quarterly census dates 2013-14

Order	2013-14			
	Apr-13	Jul-13	Oct-13	Jan-14
Emergency detention	10	11	7	6
Short-term detention	219	249	243	260
Interim compulsory treatment order	39	33	24	38
Interim compulsory treatment order - community			2	2
Compulsory treatment order	2171	2195	2207	2180
Hospital-based	1254	1259	1294	1264
Community-based	917	936	913	916
Assessment order	3	12	7	4
Treatment order	14	9	14	15
Interim compulsion order	9	13	8	8
Compulsion order S57 A (2) -	126	125	129	132
Compulsion order S57 A (2) - community	65	68	66	63
Compulsion order S57(2)(a)	25	28	29	34
Compulsion order S57(2)(a) - community	14	13	14	14
Compulsion order S57(2)(b) - CORO	61	59	62	64
Compulsion order with restriction order S59	194	195	197	196
Transfer for treatment direction	68	73	77	76
Hospital direction	5	5	5	5
Remand in custody or on bail for enquiry into mental condition				
Probation order requiring treatment (s230)				
Temporary compulsion order	2	1		
S200 Committal	1	1		
Indeterminate status*	20	19	19	17
Total	3046	3109	3110	3114

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

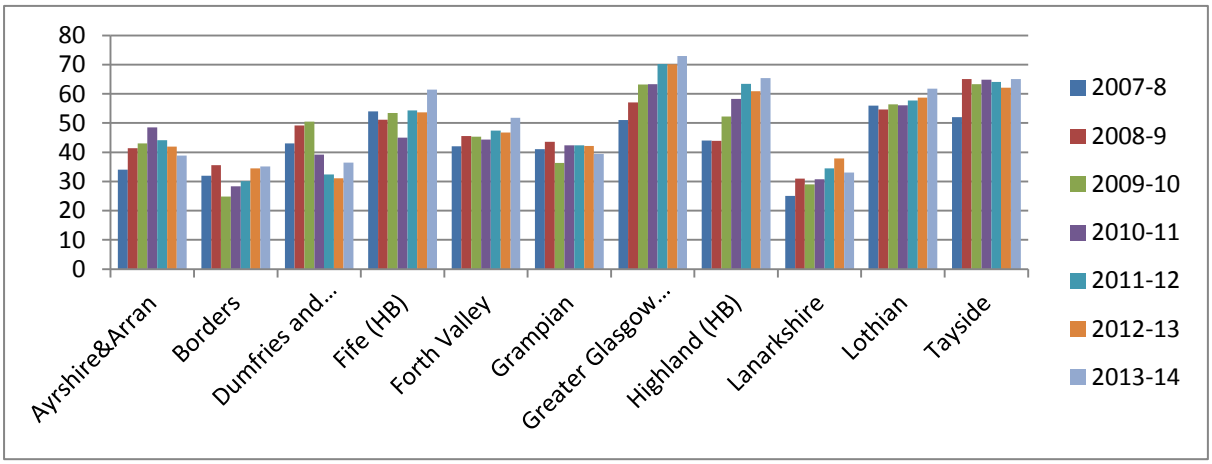
The total numbers of orders in existence varied little throughout the year.

Table 3.2 People subject to compulsory powers on 1 January 2014 rate per 100,000, by NHS Board in rank order.

NHS Board	Rate per 100K population*
Greater Glasgow & Clyde	73
Tayside	65
Highland	65
Lothian	62
Fife	61
Forth Valley	52
Grampian	39
Ayrshire and Arran	39
Dumfries and Galloway	36
Borders	35
Lanarkshire	33
Western Isles	15
Shetland	9
Scotland	59

*These figures have been calculated based on all orders, including indeterminate orders. Base population is MYE 2012 by full population by Health Board area.

Figure 3.1 Six year trends in prevalence of all compulsory orders per 100,000 population by NHS board (2007- 08 to 2012-14)



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. 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 may affect use are:

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

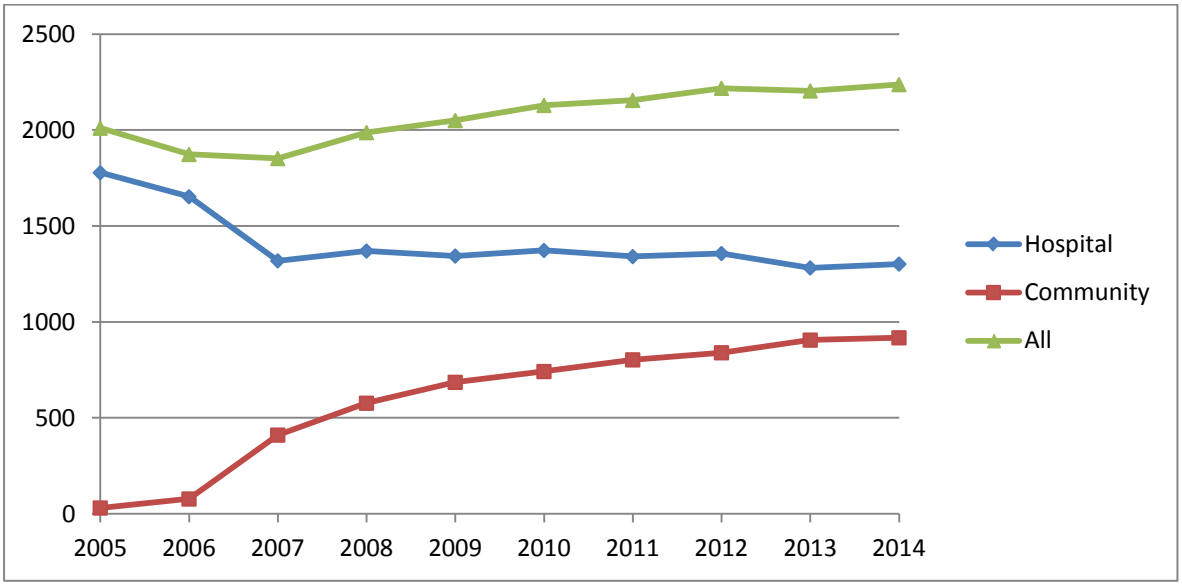
What we found

- 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.
- However, Highland also has a relatively high use of compulsory treatment. This is because of greater use of community compulsion.
- Dumfries and Galloway continues to interest us. In the process of closure of the Crichton Royal Hospital, we saw major reductions in new and long-term orders. This year we saw a slight rise in the overall use of compulsory treatment but the prevalence is still lower than it was 6 years ago.
- Lanarkshire and Borders also have low prevalence of compulsory treatment.

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

3.2 Compulsory treatment orders

Figure 3.2 Point prevalence of compulsory treatment orders (CTOs) 2005-2014



Notes:
All data has been refreshed back to Dec 2005. 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. Indeterminates are included in the total number of compulsory treatment orders; indeterminates at Jan 2014=17 only.
The above chart includes interim orders, at Jan 2014 interim compulsory treatment orders (hospital)= 38, (community)=2.

Our interest in these figures

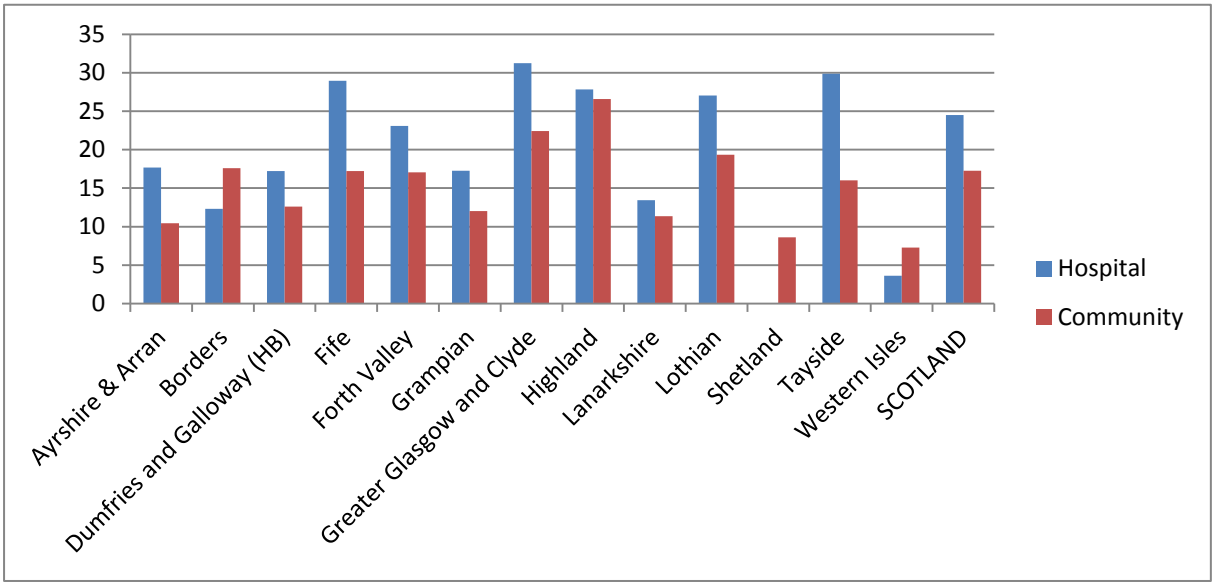
We also looked at the trend in the prevalence of CTOs (hospital and community) since the act was implemented. We think this is very important information, especially for long-term orders. It helps us to see how long-term compulsory treatment is used over time. We wanted to look at how much long-term treatment was in hospital and how much was in the community. We thought the numbers of people on community based orders under the 2003 Act would rise, at least for a while, when the Act was introduced in 2005. We thought that this might correspond with a fall in the number of people detained in hospital under long-term orders. Our most recent data, published in our “Lives less restricted” report, suggested that the number of community CTOs continued to rise. This meant that the total number of CTOs rose. We recommended more frequent reviews of community CTOs and that there should be a “revocation strategy” for all people on these orders. This year, we will be visiting a sample of people who have been on community CTOs for over 2 years

What we found

There was a slight increase in the prevalence of all CTOs this year. This continues the rising trend seen until last year.

Of greatest note is the narrowing of the gap between hospital and community CTOs. Community orders now account for 41% of all CTOs and since 2005 the percentage of CTOs which are hospital based has fallen by 27%: this is a remarkable finding and shows the extent to which the balance of care has shifted to the community for people subject to compulsion.

Figure 3.3 All existing hospital vs community CTOs per 100,000 population by NHS Board Jan 2014



Our interest in these figures

We look at the balance between all existing hospital and community CTOs in each NHS Board area.

What we found

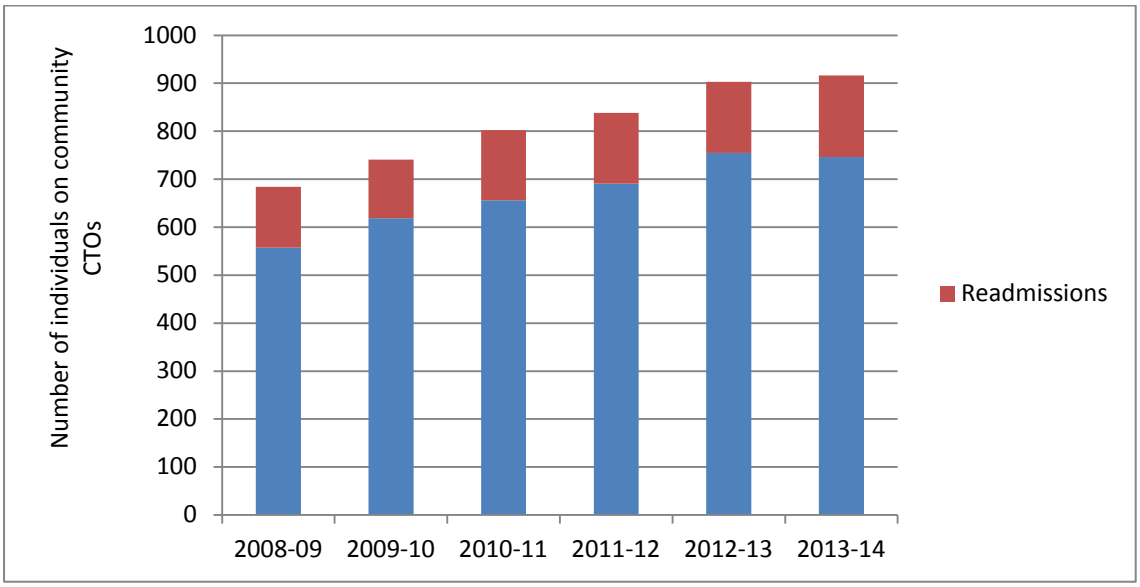
- The use of hospital-based CTOs is highest in Greater Glasgow and Clyde, closely followed by Tayside and Fife. Borders and Lanarkshire have the lowest prevalence of hospital CTOs compared with other mainland NHS Boards.
- Highland has by far the highest use of community compulsory treatment in Scotland, followed by Greater Glasgow and Clyde. Of mainland boards Ayrshire and Arran has the lowest use of community compulsory treatment.
- Borders is the only mainland board which makes more use of community CTOs than hospital CTOs.

4. Compulsory readmissions from Community CTOs

Table 4.1 Individuals readmitted from community CTOs 2008-14

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
All CCTOs*	684	741	802	838	903	916
Readmissions	127	122	146	147	148	170
%	19%	16%	18%	18%	16%	19%

Figure 4.1 Admissions and readmissions from CCTOs (individuals) 2008-14



*The table and chart refer to individuals rather than episodes; all data recalculated for 2013-14.

Out interest in this

Sometimes, individuals are readmitted to hospital while on a community CTO. This may be due to non-compliance with the order (section 113/114 is used for this) or because they become unwell and meet the criteria for EDC or STDC. Others may be admitted to hospital with their agreement. There is no requirement to report this to us.

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

What we found

For the last four years, fewer than 20% of all individuals on community CTOs had at least one compulsory readmission to hospital each year. 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 section112. There were only eight 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.

5. Advance statement overrides

Table 5.1 Notifications of treatment that is in conflict with an advance statement by year; 2009-10 to 2013-14

	2009-10	2010-11	2011-12	2012-13	2013-14
	No.	No.	No.	No.	No.
Number of notifications	52	33	29	25	36
Actual overrides	29	18	19	18	31
Refusal of depot injection	16	9	11	5	20
Refusal of any medication	5	3	2	6	0
Refusal of ECT	1	2	1	1	0
Refusal of or Request for one specific medication				4	6

Why we are interested

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 36 occasions. In five of these cases we considered that no override had actually occurred within the terms of the Act. 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 Responsible Medical Officers on four occasions. We also contacted Designated Medical Practitioners on four occasions. The purpose of these enquiries was most commonly to clarify that the necessary notification had been given to the patient and named person.

The Commission has produced guidance regarding Advance Statements. We hope that this guidance will encourage people to make advance statements, contributing to the partnership between clinical teams and patients.

6. Compulsory treatment under criminal proceedings

Table 6.1 Number of orders granted by order type: 2010-2014

Order Type	2010-11	2011-12	2012-13	2013-14
	No.	No.	No.	No.
Assessment Order	139	130	158	135
Hospital Direction	1	1	1	2
Interim Compulsion Order	17	18	26	31
S200 Committal	0	1	2	1
S57(2)(a) Compulsion Order	8	8	11	15
S57(2)(a) Compulsion Order-community	1			1
S57(2)(b) CORO*	0	4	4	8
S57A(2) Compulsion Order	52	45	58	53
S57A(2) Compulsion Order-community	1			
S59 CORO*	3	11	9	10
Temporary Compulsion Order	13	12	17	7
Transfer for Treatment Direction	30	40	45	45
Treatment Order	61	101	143	96
Total	326	371	474	404

*Compulsion order with restriction order

Table 6.2 Episodes of compulsion under criminal proceedings, by age and gender, 2011-14

Age Range	2011-12			2012-13			2013-14		
	Women	Men	Total	Women	Men	Total	Women	Men	Total
	No.	No.	No.	No.	No.	No.	No.	No.	No.
Under 16									
16-17			2	1	4	5	1	3	4
18-24	1	51	52		77	77	5	60	65
25-44	34	194	228	51	233	284	35	192	227
45-64	14	72	86	22	75	97	20	76	96
65-84		1	1		11	11		12	12
85+		2	2						
Total	49	322	371	74	400	474	61	343	404
%	*13%*	*87%*	*100%*	*16%*	*84%*	*100%*	*15%*	*85%*	*100%*

Our interest in this

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

What we found.

This year, 229 individuals were subject to CPSA orders, with a total number of orders amounting to 404. The significant increase in the total number of CPSA orders remarked upon last year (from 371 in 2010-11 to 474 in 2012-13) was primarily due to increase in the number of Treatment orders.

In 2011-12 we noted an apparent increase in the use of Treatment orders which continued into 2012-13. This year the number of Treatment orders has decreased to 96. 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. Because of the way in which these orders are counted by our system, each time an order is granted, a new episode is started so an individual may have 2 or 3 consecutive treatment orders and then an interim compulsion order for example. The number of individuals who have been subject to CPSA orders in 2013-2014 is 229, so clearly a number have had multiple episodes. A group has been set up to review our recording of Treatment orders on the Commission database.

The number of Assessment orders after an increase last year to158 has reduced this year to 135. As with treatment orders these are granted pre-conviction and may be followed by a Treatment order.

Only a minority of Treatment orders are assessed in high or medium secure hospitals. The majority of hospitals named in both Assessment and Treatment orders are low secure hospitals or IPCUs.

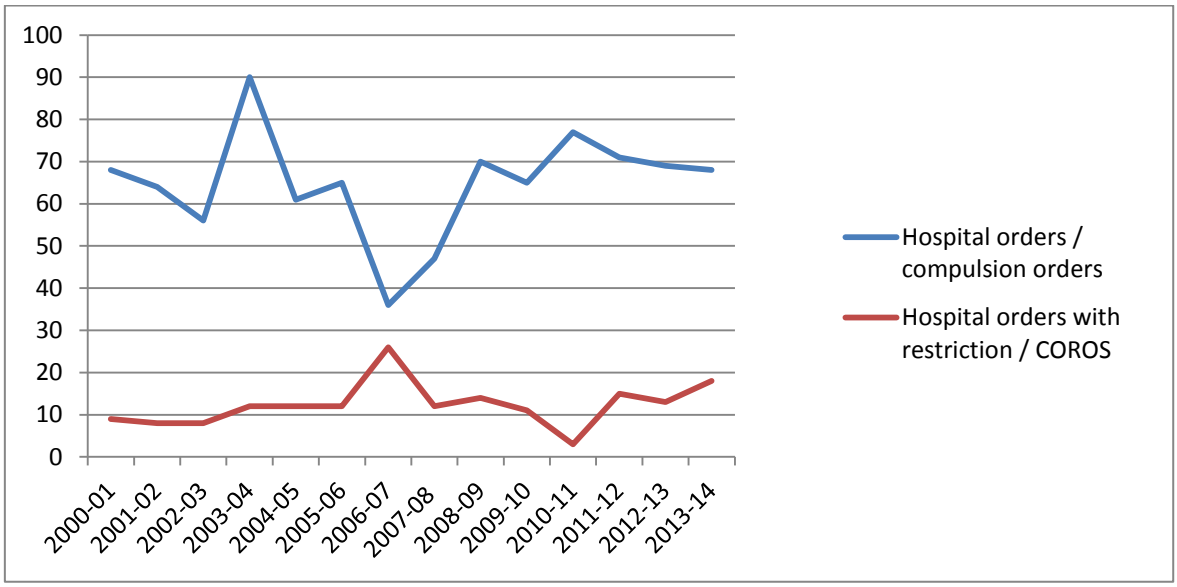
The numbers of ICOs, COROs, Transfer for Treatment Directions and Assessment orders show no discernible trend. While there is variation in the number of Restriction orders made each year, the total number of restricted patients remains stable, albeit there has been a small increase in the past three years.

Section 200 is now little used. This is likely to be due to the fact that both the Assessment and Treatment order can be used flexibly post-conviction and pre-sentence.

The Hospital Direction and Community-based COs are little used and there has been no change over time.

There are a small number of young people who are admitted to the adult estate. There was an increase from about one a year to five in 2012-2013. This is explored in the Young Person's monitoring report 2012-13[4].

Figure 6.1 Criminal proceeding trends in Scotland 2000-2014



There is significant variation in the two mental health disposals over time. It is not clear what caused the decrease in Compulsion orders and increase in COROs in 2006-07.

[4] The Mental Welfare Commission for Scotland (07/03/2014) *Young Person monitoring 2012/13* http://www.mwcscot.org.uk/media/175357/yp_provision_monitoring_report_2012-13_final.pdf

7. Place of safety orders

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
Scotland	130	191	192	209	286	591	561	654

Table 7.2 Was Place of Safety a Police Station?

Was Place of Safety a Police Station?	2011-12		2012-13		2013-14	
	No.	%	No.	%	No.	%
No	451	76%	451	80%	581	89%
Not recorded	34	6%	9	2%	14	2%
Yes	106	18%	101	18%	59	9%
Grand Total	591	100%	561	100%	654	100%

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 up to 24 hours; the 24 hours begins when the police officer removes the individual from a public place. Designated places of safety are normally a hospital and should not be a police station.

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

What we found

The number of notifications received has risen by 11% since 2011-12. The proportion of incidents where the place of safety was a police station has decreased in the same period from 106 (18%) to 59 (9%). We are pleased with this reduction.

Police Scotland was formally established 1st April 2013. In the coming year we will continue to work with Police Scotland to further improve practice in the recording and notification of incidents where people are removed to a place of safety.

In previous years we reported by the seven individual police force areas. Due to system changes we are reporting at national Scotland level only this year.

8. Social circumstances reports

Table 8.1 Provision of Social Circumstances Reports following STDC - 2013-14

	Documents returned to MWC following STDC						STDCs in LA	
Local Authority*	None		"Serve no purpose" letter		SCR		Total	
	No.	%	No.	%	No.	%	No.	%
Aberdeen City	97	54	9	5	74	41	180	100
Aberdeenshire	44	36	9	7	68	56	121	100
Angus	10	21	1	2	36	77	47	100
Argyll and Bute	39	59	1	2	26	39	66	100
City of Edinburgh	279	59	68	14	123	26	470	100
Clackmannanshire	17	81		0	4	19	21	100
Dumfries and Galloway	39	48	5	6	38	46	82	100
Dundee City	48	38	25	20	52	42	125	100
East Ayrshire	19	32	6	10	34	58	59	100
East Dunbartonshire	26	43	8	13	26	43	60	100
East Lothian	32	67	3	6	13	27	48	100
East Renfrewshire	20	59	4	12	10	29	34	100
Eilean Siar	5	100		0		0	5	100
Falkirk	46	46	12	12	42	42	100	100
Fife	124	47	19	7	123	46	266	100
Glasgow City	526	80	41	6	89	14	656	100
Highland	63	36	27	15	87	49	177	100
Inverclyde	30	40	12	16	33	44	75	100
Midlothian	17	52	5	15	11	33	33	100
Moray	24	46	3	6	25	48	52	100
North Ayrshire	5	7	9	12	59	81	73	100
North Lanarkshire	71	43	8	5	86	52	165	100
Orkney		0		0	5	100	5	100
Perth and Kinross	34	28	18	15	68	57	120	100
Renfrewshire	56	58	12	12	29	30	97	100
Scottish Borders	47	75	1	2	15	24	63	100
Shetland	4	33	1	8	7	58	12	100
South Ayrshire	8	14	11	19	38	67	57	100
South Lanarkshire	65	42	37	24	53	34	155	100
Stirling	40	73		0	15	27	55	100
West Dunbartonshire	26	48	14	26	14	26	54	100
West Lothian	34	26	12	9	85	65	131	100
SCOTLAND	1896	52	381	10	1388	38	3665	**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.

Overall for 2013-14 there was a 2.6% increase in STDCs this year. The percentage of STDCs that triggered the completion of an SCR was almost unchanged at 38%.

The two largest local authorities, Glasgow and Edinburgh were once again amongst those who completed the lowest percentages of SCRs following an STDC, 14% and 26% respectively. There is substantial variation between adjacent local authorities, for example, Falkirk 42%, Stirling 27% and Clackmannanshire 19%. This may reflect more limited resources or lack of prioritization of this area of work.

In 13 local authority areas, such as City of Edinburgh, Highland, Argyll and Bute, and Aberdeen City there was an increase in their SCR completion rate. 14 local authorities managed to produce fewer than last year.

We continue to promote the completion of SCRs in line with our published guideline[5] because we believe they can add vital information and insights of which the clinical team and MWC might otherwise be unaware.

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

9. Consent to treatment under Part 16 of the Act

Table 9.1 Certificate of the designated medical practitioner (T3) 2013-14

Treatment type	No.
ECT	171
Medication to reduce sex drive	5
Artificial nutrition	54
Medication beyond 2 months	1320
Total T3 certificates*	1546

*T3 certificate may be for more than one treatment

Our interest in these figures

The 2003 Act is designed to provide safeguards for patients in general. Part 16 makes provisions for additional safeguards in relation to medical treatment particularly, but not only, where this is given without the patient's consent. There are specific safeguards for certain forms of medical treatment including Electroconvulsive Therapy (ECT) and procedures classified as Neurosurgery for Mental Disorder (NMD). Under the 2003 Act certain treatments can only be authorised by an independent doctor, known as a Designated Medical Practitioner (DMP).

What we found

Neurosurgery for Mental Disorder (Sections 235 and 236)

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

As in previous years all patients attended the Advanced Interventions Service in Dundee. Six assessments were undertaken for five patients during the reporting year, two of whom were from Scotland and three from England. All were informal patients. Three of the patients had severe intractable depressive illness and two severe disabling symptoms of obsessive compulsive disorder (OCD). Some of the

clinical situations were very complex with more than one centre involved particularly for follow up therapy. Two assessments were for the procedure known as Deep Brain Stimulation (DBS).

The result of five of the assessments was that the proposed treatment was considered to be in the person's best interests and form T1 certificate of consent to treatment was issued. Following one assessment the outcome was that "the procedure was not approved at this time". This was with the agreement of all those involved, including the patient and the local RMO. In this case the patient's health was slightly improved by the time of assessment.

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

Other safeguarded treatments (Sections 237 and 240)

Treatments covered by sections 237 and 240 include ECT, any medicine for the purpose of reducing sex drive, medicine given beyond two months and artificial nutrition. Consent to treatment given with a patient's agreement is recorded on Form T2 usually by the RMO and by the patient's consent in writing. Treatment without consent is authorised by a DMP on Form T3.

We received 810 T2 forms: 11% more than the previous year but very similar to 2011/12. The majority (794) were for medication, 14 for ECT and 2 for artificial nutrition. The number for artificial nutrition may be under-reported due to the wording of the MHA, section 240 (3), and we have recommended that this be changed in the revision of the Act. Section 238 of the Act requires form T2 to be sent to the Commission within 7 days. A number of RMOs are failing to complete the form correctly and are reminded of the importance of shading all the correct boxes. All T2 forms should be accompanied by the patient's signed consent and RMOs are contacted if this has been omitted. Omissions are usually for administrative reasons as there is no statutory form for this part of the process. We have an example of good practice (blank proforma for consent) which can be provided to RMOs if needed. We have been contacting RMOs about incomplete forms, and we think that this aspect of RMO's work needs to be particularly addressed in AMP refresher training.

The number and types of treatments authorised by a Certificate of the DMP (Form T3) is shown in table 38 above. There were 5% more T3 forms than last year. The majority of treatments authorised were medication beyond two months. There were more certificates for ECT than the previous year. Of the patients receiving ECT 120 objected to or were resisting the treatment, an increase from 2013/14. 19% of those

who resisted or objected required treatment to save life, the remainder to alleviate serious suffering and/or prevent serious deterioration.

As in previous years there were several assessments by DMPs who agreed that a course of ECT was in the person's best interests but in their opinion the situation did not meet the necessity test for being given when the person objects or resists. Therefore the DMP did not give consent on those occasions. Some treatment plans for medication were approved after the RMO and DMP discussed an amendment, for example to dose range, physical monitoring requirements or for a shorter duration so that there was a further DMP review after a trial period on a new medication.

Children and Young People

We received 27 T2 forms for patients who were under 18 at the time of consenting to treatment all of which were for medication beyond two months other than one for nutrition. All the RMOs completing the forms were child specialists as is required by the Act.

There were 72 T3 forms issued for patients age under 18 for treatment without consent. Five forms were issued for ECT and the treatment was considered necessary to save life for the two patients involved. Early review was advised resulting in further DMP visits for both patients. This reflects good practice. One patient went on to receive ECT, the other did not proceed to treatment following improvement in their health. 39 T3 forms were for medication beyond two months and 28 for artificial nutrition. In all cases the RMO or the DMP were child specialists except one patient age 16 with a learning disability being cared for in an adult ward. A further DMP opinion was arranged as soon as this was identified. A number of patients had several forms mostly as a result of further DMP review prior to the RMO making changes to medication. This also reflects good practice in the treatment of young people.

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk