mentalwelfare commission for scotland

dignity & rights ethical tre respect ca & equality

STATISTICAL MONITORING

Mental Health Act Monitoring 2014/15

SEPTEMBER 2015

Contents

1. What we do

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

We do this by:

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

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

We have a statutory responsibility to monitor the use of the Mental Health Act, here we publish a summary of its use in 2014/2015 and comment on any trends since the act was implemented in October 2005.

The number of new episodes of compulsory treatment rose again and is now at the highest level since the new act was introduced. There was an increase in the use of short term detention as the entry into compulsory treatment, this offers more safeguards and is the preferred route.

There was also an increase in the use of emergency detention which offers fewer safeguards, over the past 3 years this has risen 12%. There was a further fall in the proportion of emergency detentions with mental health officer consent and significant variability between different health boards.

The increase in the use of emergency detention was largely due to increased use in older people. There was also a significant increase in the number of new compulsory treatment orders for older people.

The completion of social circumstances reports remains poor, again with significant variability between different local authorities.

3. New episodes of civil compulsory treatment

Our interest in these figures

We are interested in how many people enter a spell of compulsory treatment each year. Short-term detention, rather than emergency detention, should be the usual route into compulsory treatment.

Table 3.1 New episodes of civil compulsory treatment initiated 2006-2015

Episode Sequence	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	14/15 *% rise*
EDC	2029	1908	1837	1785	1787	1760	1872	1883	1964	*4.3%*
Direct to STDC	2217	2152	2211	2201	2409	2417	2438	2531	2796	*10.5%*
Direct to CTO* [xx] (included interim orders)	133	132	95	83	108	94	103	116	[xx]91	*-19.5%*
Total episodes	**4379**	**4192**	**4143**	**4069**	**4304**	**4271**	**4415**	**4530**	**4851**	***7.1%***

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

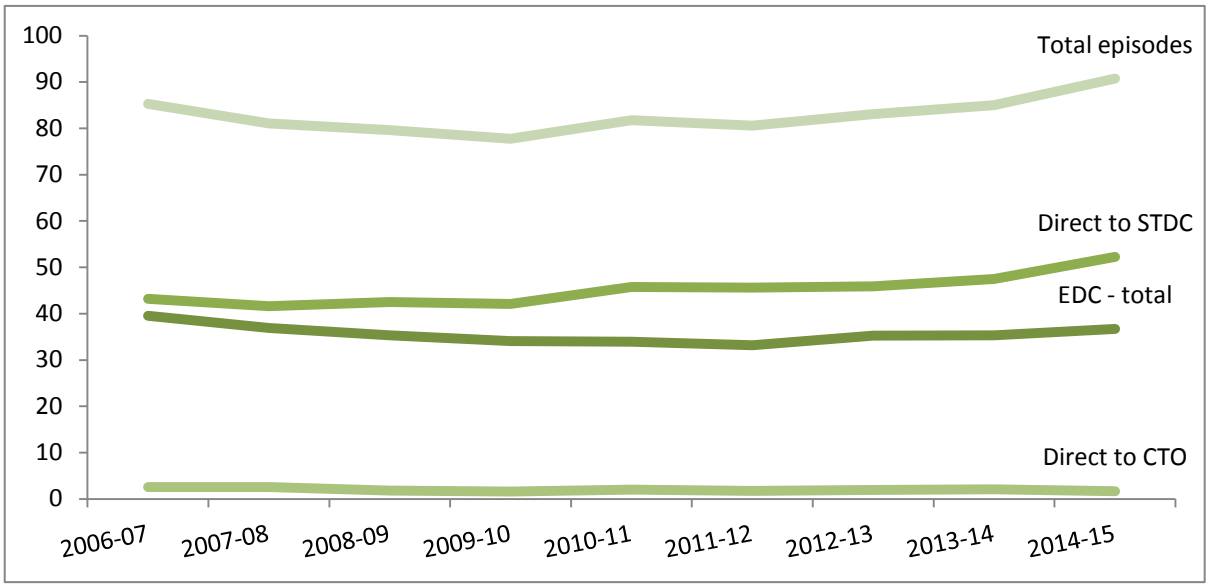
[xx] The 91 includes 6 cases direct to ICTO only, 16 to ICTO then to CTO and 69 direct to CTO

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.

What we found

We were notified of 4851 new episodes of compulsory treatment during the year. This was an increase of over 7% on previous years. It is the highest number of new compulsory episodes since the 2003 Act was implemented and is now at the same level as new compulsory episodes under the 1984 Act in 2001/02 (4849) having followed an upward trend since 2009/10. The reasons for this are unclear but could reflect greater awareness of human rights and unlawful deprivation of liberty.

Figure 3.1 New compulsory episodes initiated 2006/07 to 2014/15 (rate per 100,000 population) by episode type

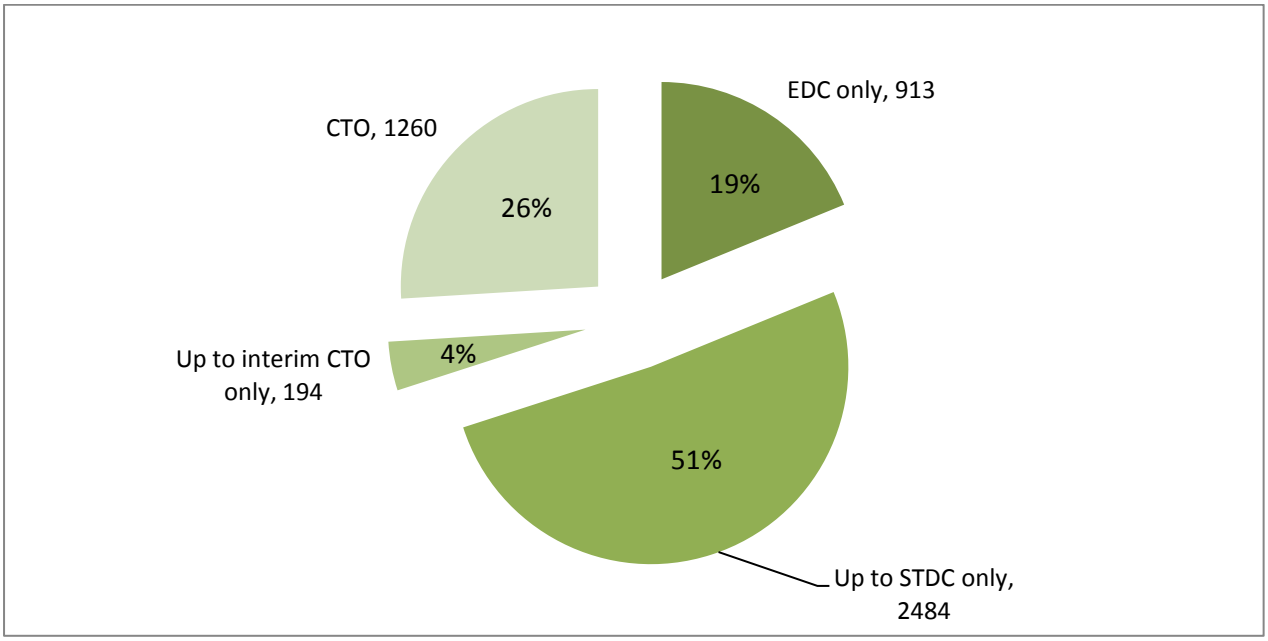


The use of EDCs rose 4.3%; this means that over the past 3 years there has been a 12% increase. The increase was largely due to increased use of emergency detention in older people.

There was 10.5% increase in the number of people put straight onto a STDC, to 2796: this now stands at the highest since the Act was introduced. This is the preferred route to compulsory treatment as it affords the patient more safeguards.

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

Figure 3.2 Progression of types of compulsory civil episodes 2014 to 2015

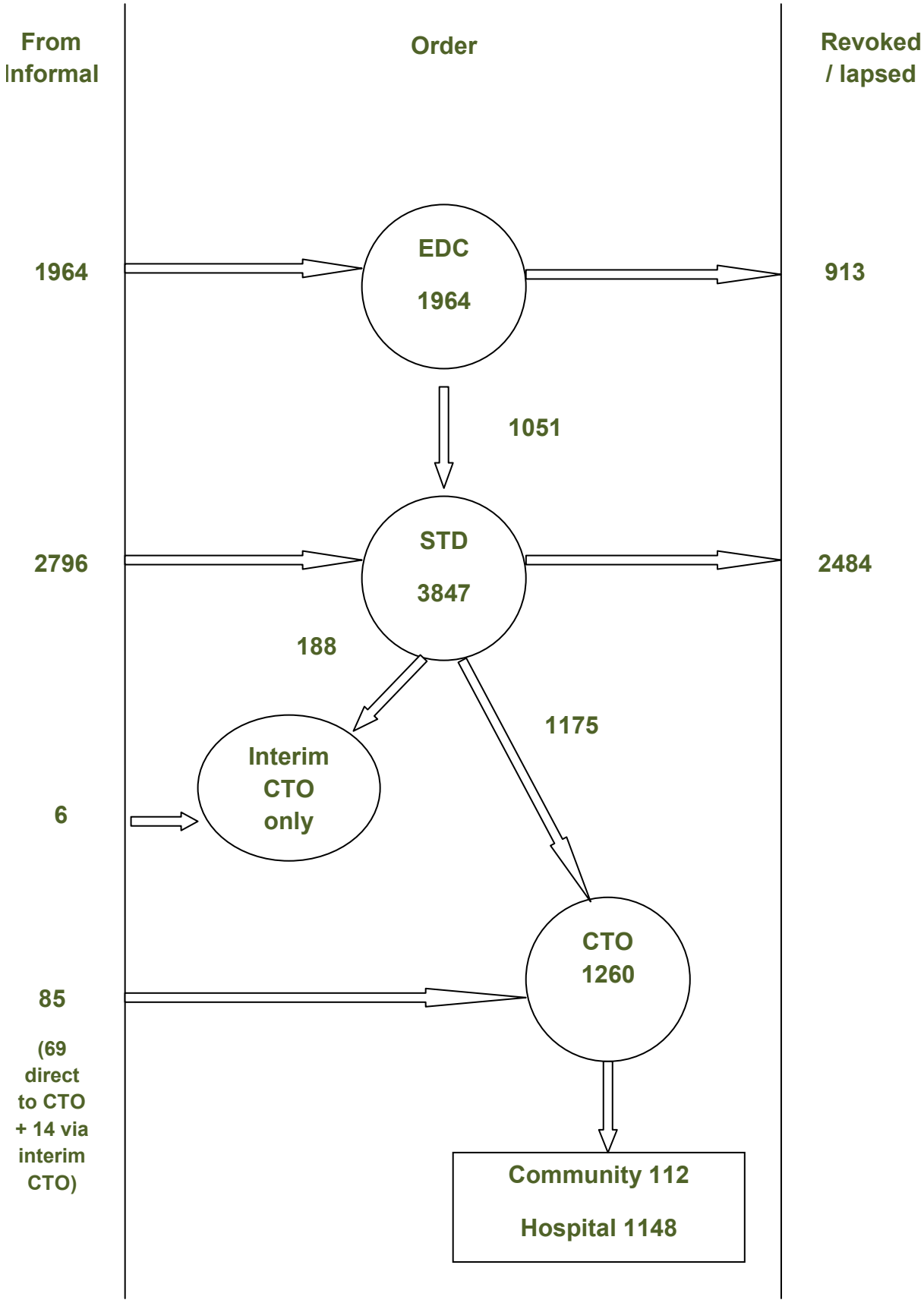


Findings of note from this chart are:

- Only 26% 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 70% of all episodes of compulsory treatment lasted for 28 days or less.

Of the 4851 people who became subject to the Act during 2013/14, 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 Figure 3.3 below.

Figure 3.3 Pattern of progression through civil compulsory orders 2014-15



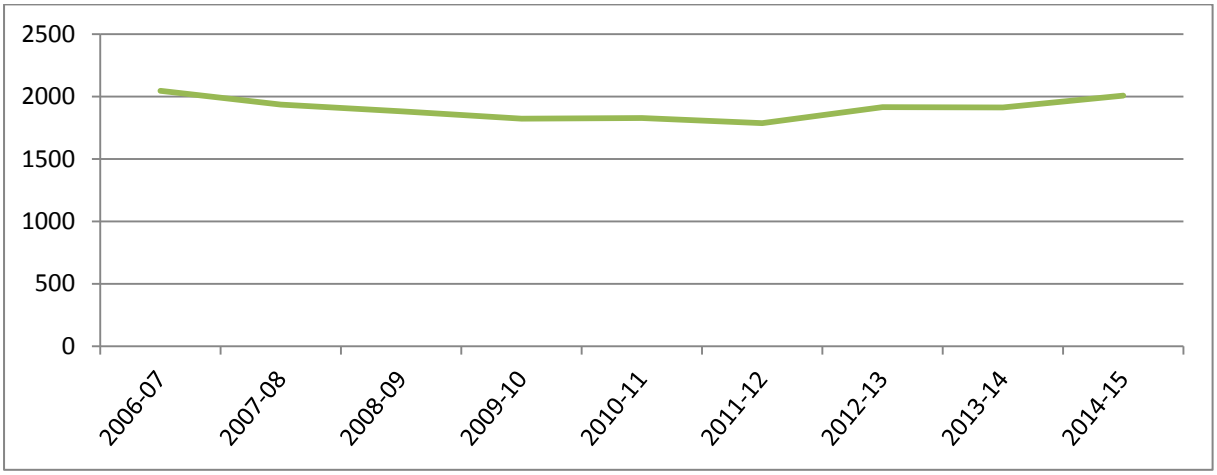
3.1 Emergency detentions

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

What we found

Figure 3.4 Emergency Detention Certificates 2006-2007 to 2014-2015



The total number of EDCs this year is 2006, an increase of 4.9% since last year's high at 1912, which had followed a gradual reduction since 2006/07 to a low of 1786 in 2011/12. There has been some reduction in numbers of EDCs in the youngest age group (0-15 year olds, from 23 last year to 17 this year. There has been a decrease of 5.7% in the 45-64 age group. In the 65-84 age group there has been a significant rise, from 317 last year to 378 in 2014/15, a 19.2% increase.

The use of EDCs is similar overall between women (51%) and men (49%) but there are higher percentages of women in the younger (16-17 years, 61%) and oldest (85+ years, 62%) age-groups.

The rate per 100,000 population was 39.8 (2006/07) in the first full year of the new Act; it dropped to a low of 33.7 (2011/12) and has since risen to this year's 37.5 (2014/15).

3.1.1 Mental Health Officer Consent

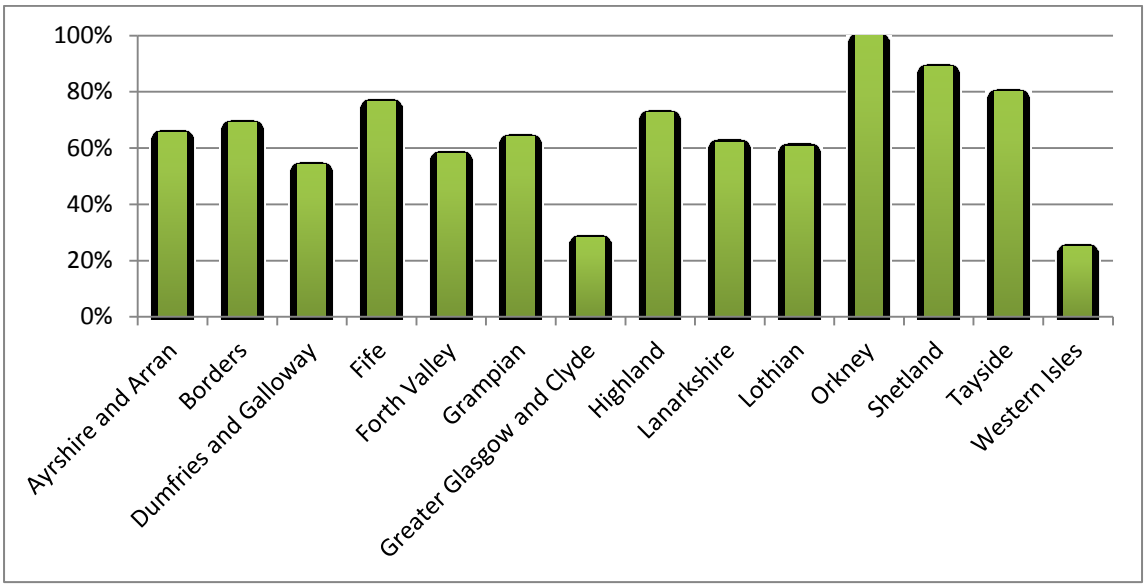
Our interest in this

We place value on 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, their rights and make arrangements to make admission easier and to safeguard the person's property and possessions. We would like to see consent in as many cases as possible.

What we found

Figure 3.5 Percentage of EDCs with MHO consent for all NHS Boards (2014-15)



Of the 2006 people made subject to an EDC in 2014/15; we found that 45% did not have the consent of an MHO compared to 42% last year and 37% in 2012/13.

It concerns us that in Greater Glasgow and Clyde, the area with the highest use of emergency detention in Scotland (53 per 100K population), the proportion of EDCs with consent is even lower this year (28%) than last year (37%). At present 72 % of people detained on an EDC in Greater Glasgow and Clyde do not have the safeguard of MHO consent.

Tayside shows improvement from last year with 80% now having MHO consent.

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

3.1.2 Other factors relevant to Emergency Detention

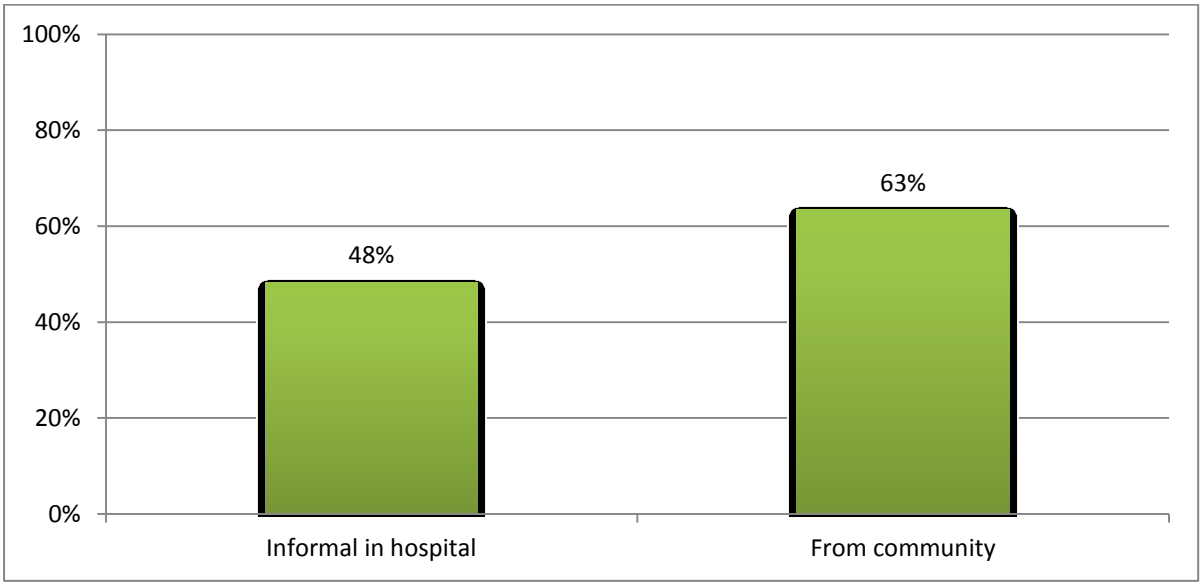
Pre-detention status

Our interest in this

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.

What we found

Figure 3.6 EDCs by pre-detention status and MHO consent to detention 2014-15 (%)



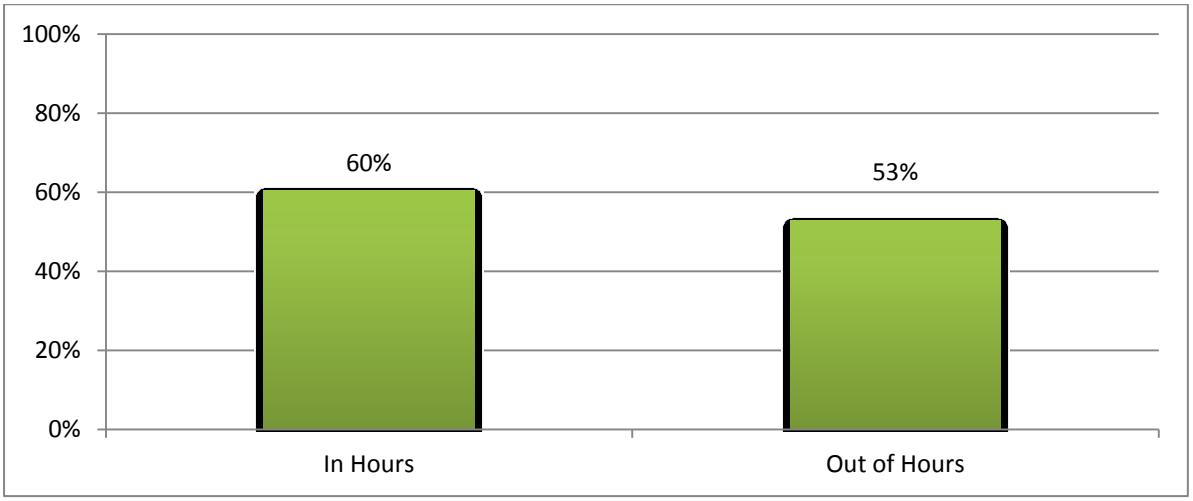
48% (523) of those in hospital received MHO consent for an EDC compared to 63% (586) of those detained from the community which is similar to last year.

3.1.3 Timing of Emergency Detention

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.

Figure 3.7 EDCs by time of granting of certificate and MHO consent to detention 2014-15 (%)



What we found

67% of EDCS happen outside office hours and 33 % within office hours and this is similar to last year.

Of those carried out within office hours, 60% will have MHO consent, same as last year; outside office hours 53% will have MHO consent, a decrease from 57% last year. It is important that local authorities have good out-of-hours arrangements to ensure that MHOs can attend wherever possible.

3.1.4 Duration of Emergency Detention

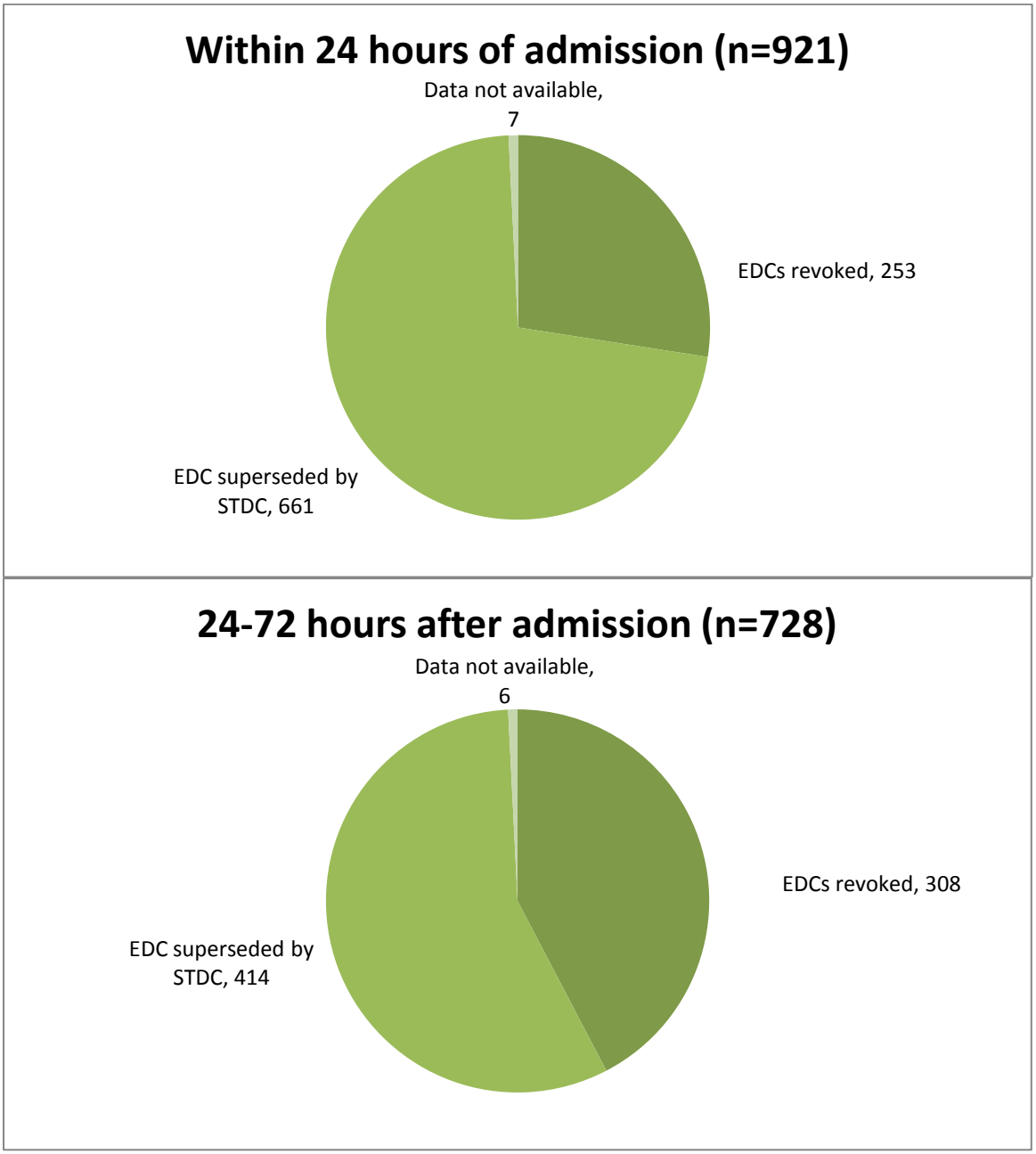
Our interest in this

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. 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.

What we found

This year there was an 8% rise in the number of people detained on an EDC who had the order either revoked or superseded by an STDC within the first 24 hours.

Figure 3.8 Duration of emergency detention certificates granted 2014-15



3.2 Short term detentions

3.2.1 STDCs by age and gender

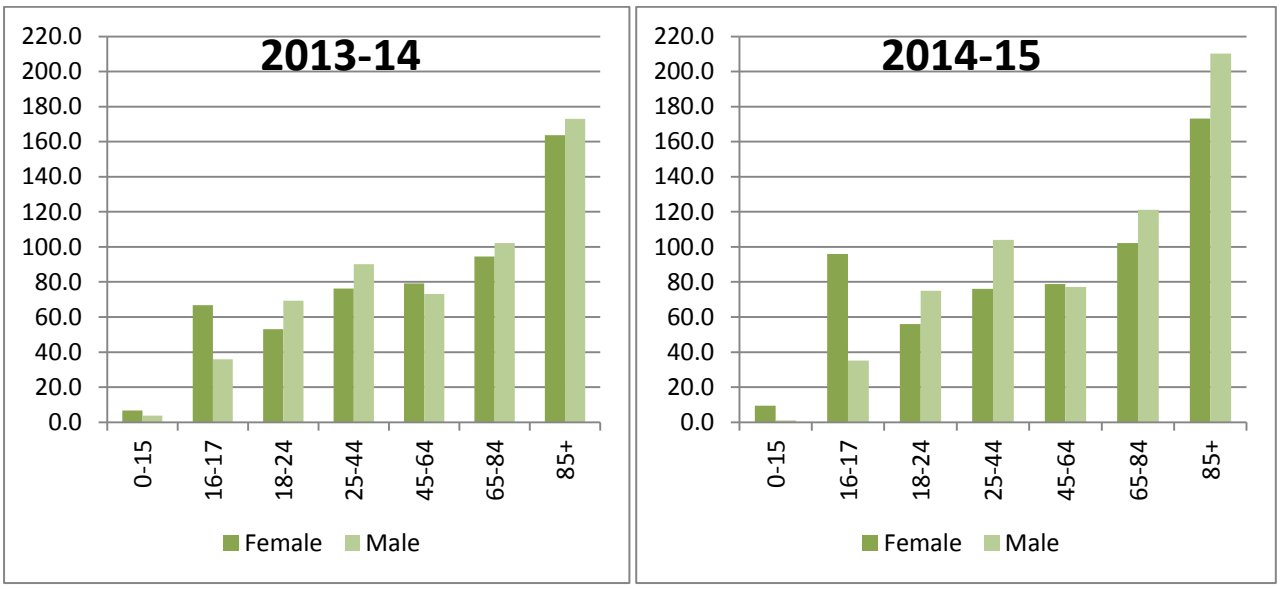
Our interest in this

A short-term detention certificate (STDC) 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.

What we found

3993 STDCs were granted in 2014/15, an overall 8.9% rise in the number on last year (3665).

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



There are increased numbers across most age groups, particularly in the 16-17 age group (25.4% rise) and older age groups (age 65-84, 18.4% rise; age 85+ 16.5% rise).

This year 49% of STDC granted were for women and 51% for men. The chart above illustrates variances by gender and age group in rates per 100K population.

Young people

The number of young women in the 0-15 age group has increased by 40% (12) to a total of 42; whilst there are only five young men in this age group this year. Six young people were admitted both for own safety and safety of others, the rest for their own safety only.

The 16-17 age group is 72% female and 28% male. This year the number of young women has increased by 43%, 17 to 57; the number of young men (22) is similar to last year. 22 were admitted for safety of self and others, 57 for own safety only.

When we look at the rate per 100K of population, there has been an increase in STDC granted for young women age 16-17 from a rate of 67 to 96 per 100K.

Older people

The 85+ age group is comprised of 133 (63%) women and 79 (37%) men. Rates of STDCs for this age group were again higher this year for both women (173 per 100K) and men (201 per 100K).

In the 65-84 age group rates of STDCs for this age group were higher this year for both women (102 per 100K) and men (121 per 100K) this year.

3.2.2 Diagnosis recorded

Our interest in this

We want to know the type of mental disorder(s) specified on STDC forms. The Act defines "mental disorder" as "mental illness, learning disability or personality disorder". A person may have more than one type of mental disorder. It is important to recognise the relative contributions of each category of mental disorder.

What we found

Table 3.2 Short-term detention certificates 2014-15: types & combinations of mental disorders recorded

Mental disorder	STD Certificates	
	No.	%
Mental Illness	3553	89%
Mental Illness + Learning Disability	123	3%
Mental Illness + Personality Disorder	150	4%
Mental Illness + Personality Disorder + Learning Disability	13	0%
Personality Disorder	72	2%
Personality Disorder + Learning Disability	9	0%
Learning Disability	37	1%
Not recorded	36	1%
Total	**3993**	**100%**

Mental illness accounts for the vast majority of people detained under STDC. Only 1% of STDC were for people with learning disability alone and 3% for people with learning disability and mental illness. Similarly only 2% were for people with a personality disorder alone.

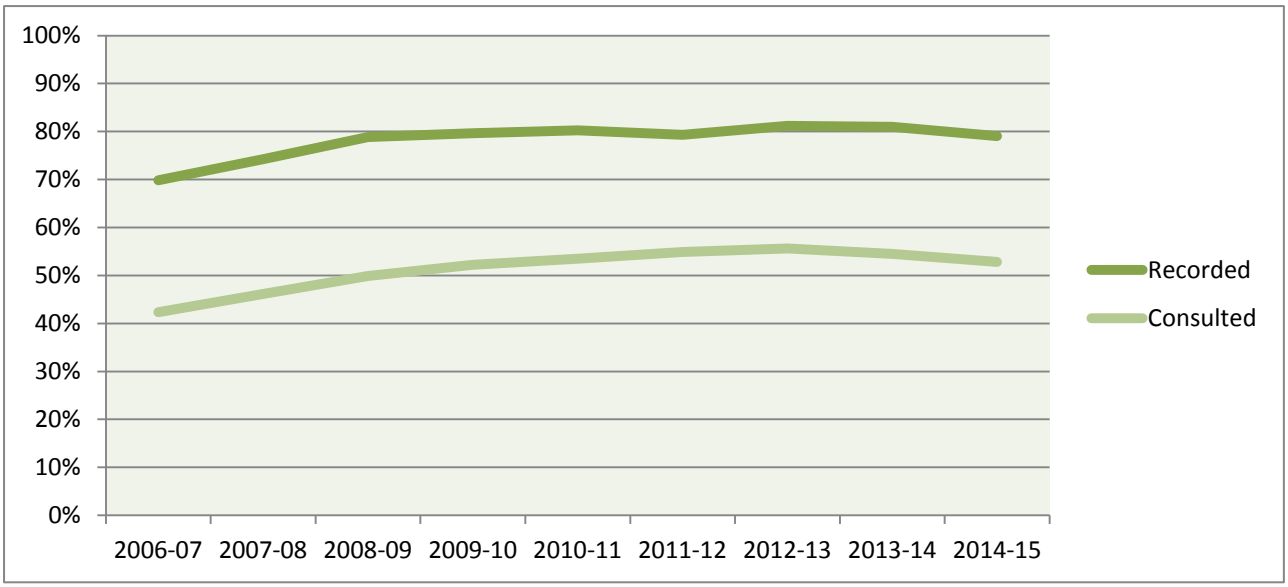
3.2.3 Named person consultation

Our interest in this

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.

What we found

Figure 3.10 Short-term detention certificates 2006-2015: Percentage where named person has been recorded and/or consulted.



This year, there has been a slight decrease in the percentage of STDCs where the named person was consulted, from 54% to 53% since last year.

The proportion of STDCs where the named person is recorded has also decreased from 81% to 79% this year.

3.3 Compulsory treatment orders

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.

Table 3.3 Compulsory treatment orders granted by age and gender 2014-15

Compulsory treatment orders*	Female	Male	Total	Female	Male	Total
	No.	No.	No.	%	%	%
Under 16 yrs	25	5	30	83	17	100
16-17 yrs	22	11	33	67	33	100
18-24 yrs	26	58	84	31	69	100
25-44 yrs	134	210	344	39	61	100
45-64 yrs	166	182	348	48	52	100
65-84 yrs	165	183	348	47	53	100
85+ yrs	38	34	72	53	47	100
Total	**576**	**683**	**1259**	**46**	**54**	**100**

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

What we found

- The total number of new CTOs (1259) is 7% higher than last year.
- As in previous years, the use of CTOs is higher for men.
- The number of CTOs for young people (under 18) rose again this year. It remains much higher for girls.
- The number of new CTOs for people age 65 and over rose again significantly this year from 348 to 420, a 21% increase.

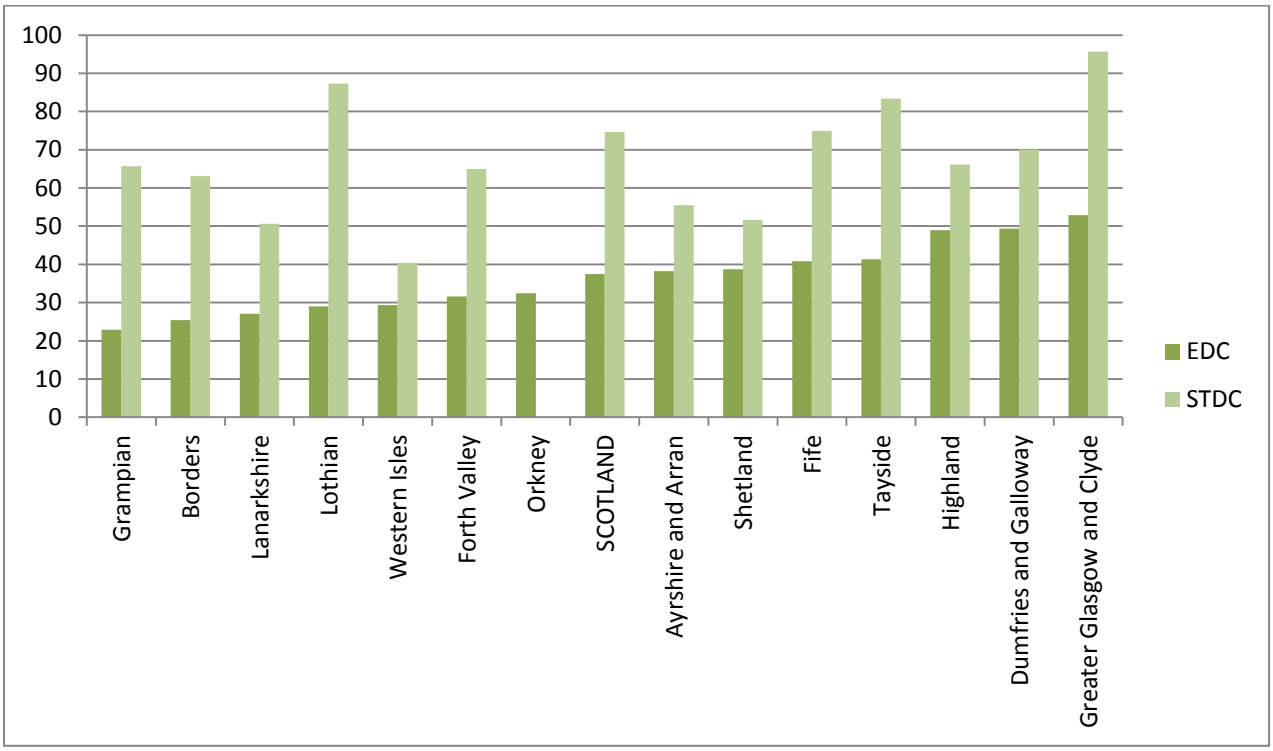
3.4 Geographical variations

Our interest in this

Each year, we look at how orders are used in different NHS Board areas. We usually 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 have found 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.

What we found

Figure 3.11 Emergency and short-term detention by NHS Board 2014-15 - rate per 100k population



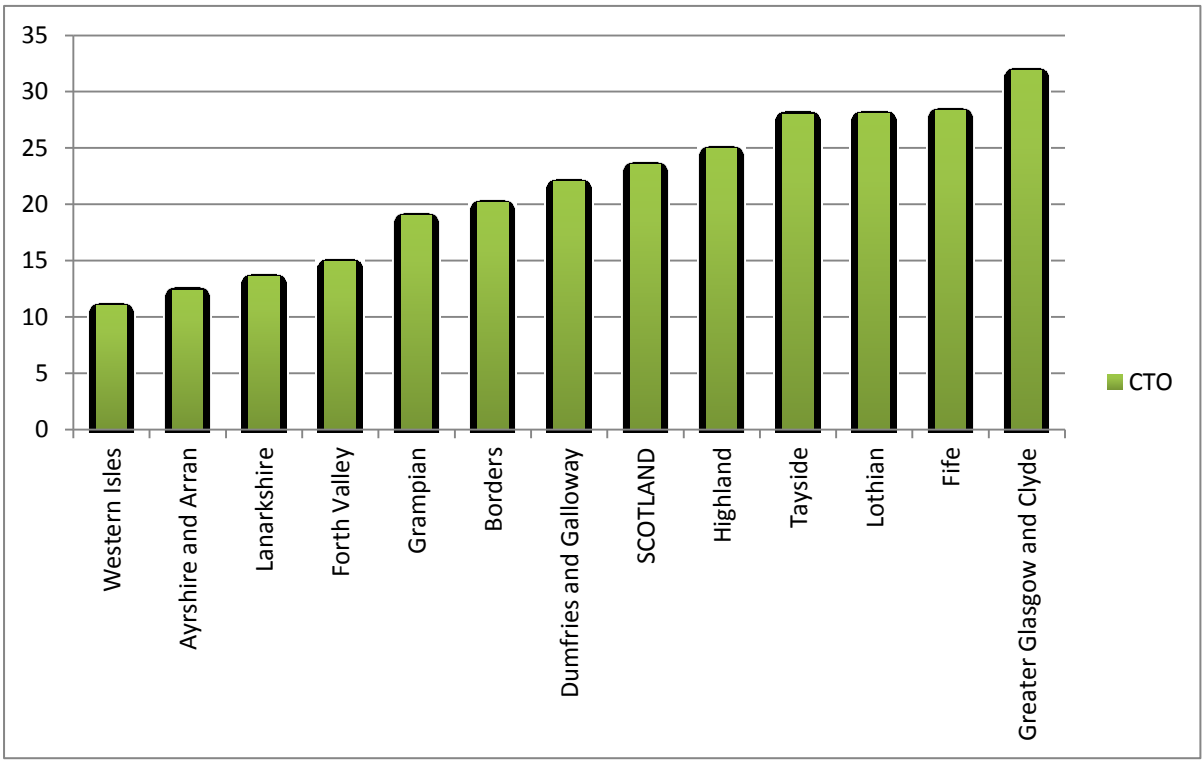
Emergency detention:

- Glasgow and Clyde, Dumfries and Galloway and Highland again 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 again 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:

- Greater Glasgow and Clyde and Lothian have the highest use of short-term detention, the use in both boards has increased this year (14%, 9%).
- Twelve mainland boards showed an increase in the rate per 100K (full population), the largest increase being in Dumfries and Galloway (29%) and Tayside (18%)
- Of mainland boards, Lanarkshire and Ayrshire and Arran have the lowest use of short-term detention.

Figure 3.12 Compulsory Treatment Orders by NHS Board 2014-15 - rate per 100k population



- Greater Glasgow and Clyde, Fife, Lothian, and Tayside have the highest rate of new CTOs this year. Ayrshire and Arran has the lowest rate of new CTOs, half the Scottish average.

3.5 Variations between local authorities

Our interest in this

We are interested in differences between local authority areas. We do not examine variations in emergency detention. 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.

What we found

- Glasgow City, Edinburgh City and Dundee City have by far the highest rates of short-term detention. People with severe and enduring mental illness tend to move towards inner city areas so are likely to be a factor in this.
- CTO rates are highest in Inverclyde and West Dunbartonshire.

Table 3.4 Short-term detentions and compulsory treatment orders by local authority 2014-15 – number and rate per 100k population

Local Authority	Short Term Detentions		Compulsory Treatment Orders	
	No.	Rate per 100K	*No.	Rate per 100K
Aberdeen City	173	76	58	25
Aberdeenshire	124	48	37	14
Angus	56	48	22	19
Argyll & Bute	67	76	17	19
Clackmannanshire	26	51	6	12
Dumfries & Galloway	106	71	35	23
Dundee City	155	105	46	31
East Ayrshire	79	65	19	16
East Dunbartonshire	47	44	21	20
East Lothian	61	60	23	23
East Renfrewshire	40	43	19	21
Edinburgh City	527	107	146	30
Eilean Siar (Western Isles)	10	37	5	18
Falkirk	111	70	24	15
Fife	275	75	107	29
Glasgow City	699	117	185	31
Highland	162	69	69	30
Inverclyde	61	76	33	41
Midlothian	50	58	18	21
Moray	60	63	15	16
North Ayrshire	74	54	16	12
North Lanarkshire	208	62	63	19
Orkney Islands	5	23	2	9
Perth & Kinross	138	93	49	33
Renfrewshire	120	69	39	22
Scottish Borders	74	65	28	25
Shetland Islands	14	60	1	4
South Ayrshire	51	45	14	12
South Lanarkshire	177	56	48	15
Stirling	55	60	18	20
West Dunbartonshire	58	65	34	38
West Lothian	130	73	42	24
Total	**3993**	**75**	**1259**	**24**

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

3.6 Nurse's power to detain

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.

What we found

The use of the nurse's power to detain has risen by 5% since last year to 186 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, 37 different sites this year compared to 34 last year.

This year again women accounted for 63% of the times it was used.

The total rate has risen this year (3.5 per 100K) and increased for both women (4.3 per 100K) and men (2.6 per 100K).

Table 3.5 Use of Nurse's Power to Detain

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

We are not clear about the reasons why the rate of use of this power is higher for women (4.3 per 100K) than men (2.6 per 100K). The majority of women and men detained are aged between 25-64 years. There were 12 detentions for under 18 year olds and 34 for people aged 65+.

4. Total number of Mental Health Act orders in existence

4.1 All orders

Our interest in this

For some orders looking at the total number in existence on a given day can be more meaningful than looking at new orders.

What we found

The total numbers of orders in existence in Scotland varied little throughout the year (Table 4.1).

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

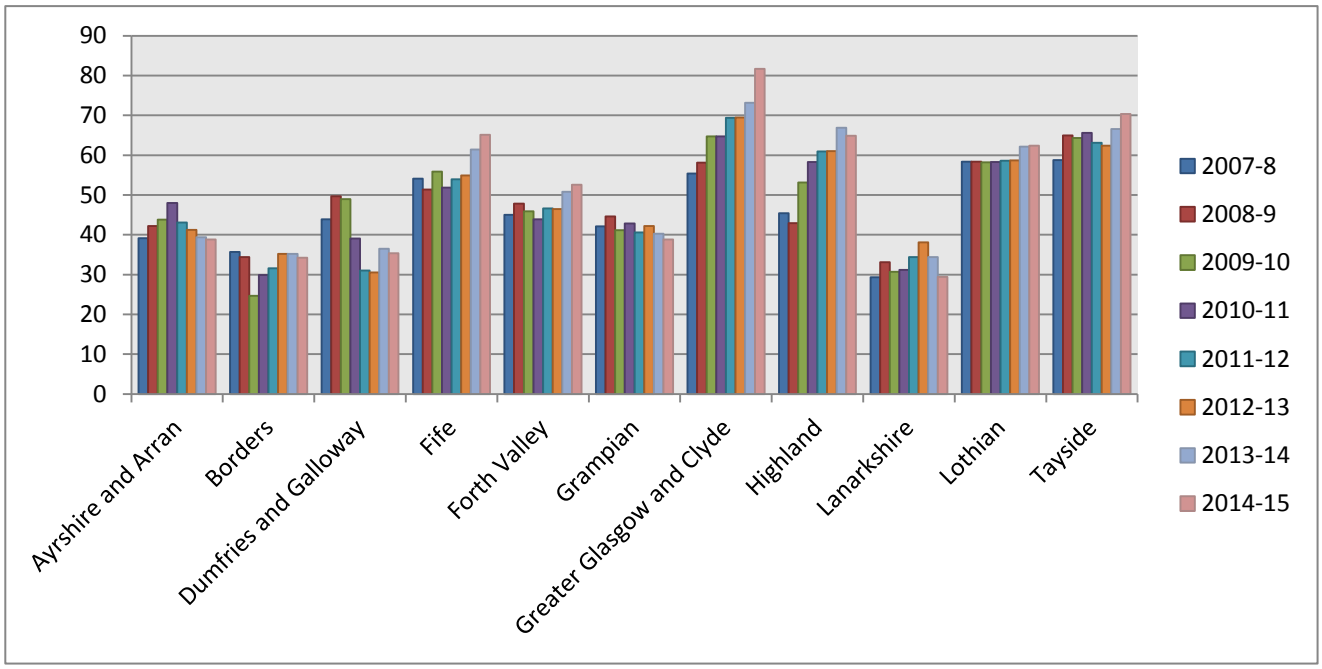
- Urban versus rural populations
- Culture and attitudes of practitioners
- Availability of early intervention, treatment and support
- Use of alcohol and drugs

We found that:

- Greater Glasgow and Clyde continues to have the highest prevalence of compulsory treatment. Tayside and Lothian are also high, reflecting significant numbers of deprived inner city areas where the number of people with major mental illness is likely to be highest.
- However, Highland also has a relatively high use of compulsory treatment.
- 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. Last year we saw a slight rise in the overall use of compulsory treatment, maintained at a similar level this year, but the prevalence is still lower than it was 7 years ago.
- Lanarkshire and Borders also have a low prevalence of compulsory treatment.

We still find some of this variation hard to explain.

Figure 4.1 Eight year trends in prevalence of all compulsory orders per 100,000 population by NHS board (2007- 08 to 2014-15)*



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

Table 4.1 Number of extant compulsory orders by type at quarterly census dates 2014-15

Order	2014/15			
	Apr-14	Jul-14	Oct-14	Jan-15
Emergency detention	10	15	13	12
Short-term detention	228	287	257	235
Interim compulsory treatment order	38	43	50	35
Interim compulsory treatment order - community		2	3	2
Compulsory treatment order	2212	2212	2257	2274
Hospital-based	1284	1294	1371	1364
Community-based	928	918	886	910
Assessment order	8	5	8	11
Treatment order	12	18	10	15
Interim compulsion order	7	7	6	11
Compulsion order S57 A (2) -	124	127	124	119
Compulsion order S57 A (2) - community	75	76	80	76
Compulsion order S57(2)(a)	28	26	34	28
Compulsion order S57(2)(a) - community	20	21	19	17
Compulsion order S57(2)(b) - CORO	65	64	65	66
Compulsion order with restriction order S59	199	204	202	200
Transfer for treatment direction	82	82	79	81
Hospital direction	7	6	6	7
Remand in custody or on bail for enquiry into mental condition				
Probation order requiring treatment (s230)				
Temporary compulsion order	1	2	3	2
S200 Committal				
Indeterminate status*	11	7	6	10
Total**	**3127**	**3204**	**3222**	**3201**

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

** A small number of people may have more than one order extant on the same day. (e.g. a MHA and a CPSA order).

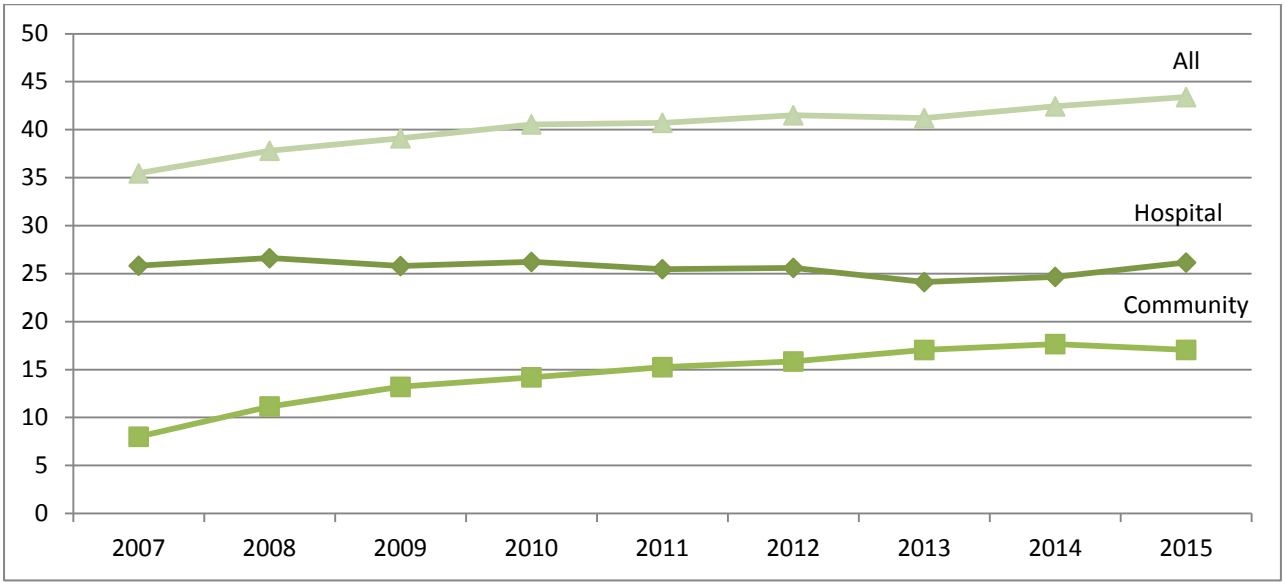
4.2 Compulsory treatment orders

Our interest in these figures

We also looked at the trend in the prevalence of CTOs (hospital and community) since the act was implemented. It helps us to see how long-term compulsory treatment is used over time.

What we found

Figure 4.2 Point prevalence of compulsory treatment orders (CTOs) 2007-2015* (rate per 100,000 population)



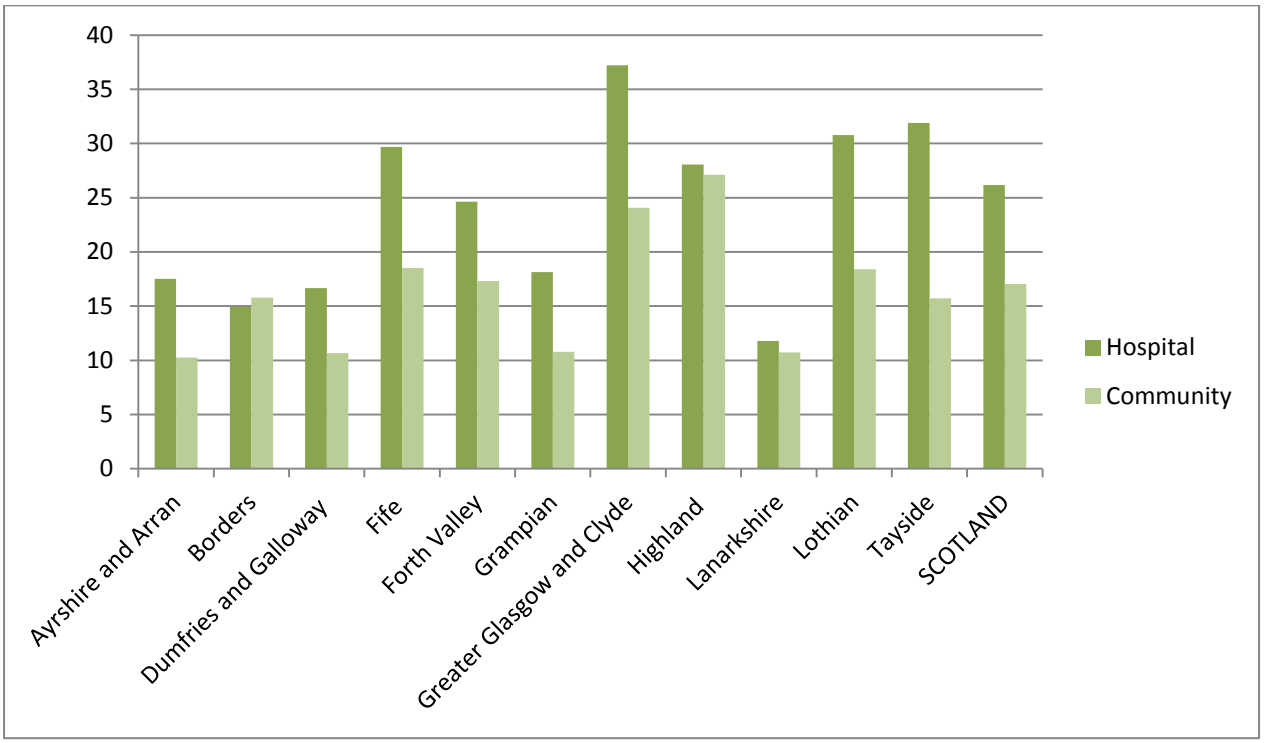
*All data has been refreshed back to January 2007

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

Community orders now account for 39% of all CTOs. In January 2006 they accounted for just 4% and by January 2007, 23%: This shows the extent to which the balance of care has shifted to the community for people subject to compulsion.

- The use of hospital-based CTOs is highest in Greater Glasgow and Clyde, followed by Tayside, Lothian and Fife. 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.
- Borders is the only mainland board which makes more use of community CTOs than hospital CTOs.

Figure 4.3 All existing hospital vs community CTOs per 100,000 population by mainland NHS Board Jan 2015



5. Compulsory readmissions from Community CTOs

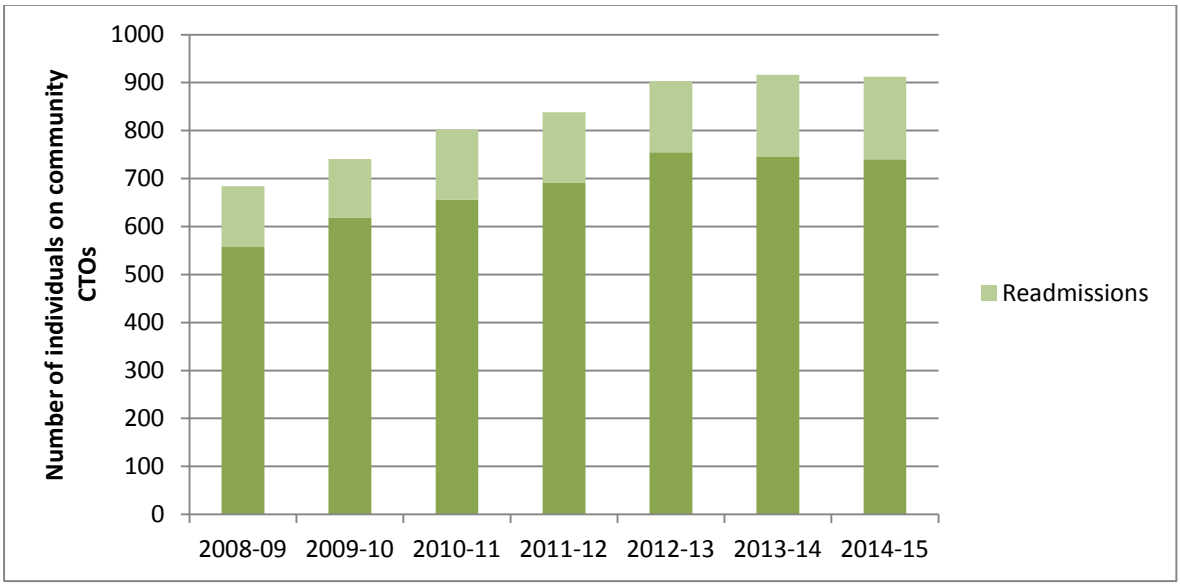
Our interest in this

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.

What we found

Figure 5.1 Admissions and readmissions from CCTOs (individuals) 2008-15



*The table and chart refer to individuals rather than episodes; all data recalculated for 2014-15.

Fewer than 20% of all individuals on community CTOs had at least one compulsory readmission to hospital each year; 172 people in 2014/15. It is encouraging that over 80% of people on community CTOs do not require compulsory hospital admission.

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

6. Advance statement overrides

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

Table 6.1 Notifications of treatment that is in conflict with an advance statement by year (2009/10 to 2014/15)

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	No.	No.	No.	No.	No.	No.
Number of notifications	52	33	29	25	36	55
Actual overrides	29	18	19	18	31	47
Refusal of depot injection	16	9	11	5	20	20
Refusal of any medication	5	3	2	6	0	5
Refusal of ECT	1	2	1	1	0	3
Refusal of or Request for one specific medication				4	6	10

We received notification of an advance statement override on 55 occasions. In eight 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 nine occasions. In six of these cases we asked for more information, and in three cases we gave advice. We also contacted Designated Medical Practitioners on two occasions to ask for more information.

7. Compulsory treatment under criminal proceedings

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, 222 individuals were subject to CPSA order, with the total number of orders amounting to 398. This total is very similar to 2013/14, when there were 404 CPSA orders.

7.1 Assessment and Treatment Orders

The key purpose of both assessment and treatment orders is to allow assessment of a person prior to trial, or after conviction before sentencing. It allows courts to remand a person to hospital instead of custody, where it appears that the person is suffering from a mental disorder. Both orders allow for the transfer of a person remanded in custody, and awaiting court appearance to be admitted to hospital for assessment. An assessment order can last up to 28 days and be extended on one occasion by a further 7 days. An assessment order may be followed by a Treatment Order.

Table 7.1 Number of Assessment and Treatment Orders

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

The number of Assessment orders has remained steady this year (132) after the 2012/13 rise to 158.

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 (106) has remained at a lower level similar to last year (96). Our information management system records each treatment Order received as a distinct order, so an individual may be recorded as having 2 or 3 consecutive treatment orders and then an interim compulsion order for example. The number of individuals who have been subject to Treatment Orders in 2014/2015 is 86.

7.2 Unfitness for trial and acquittal by reason of mental disorder

If a person's mental disorder is such that they cannot participate in the court process, the court may find the person unfit for trial. A temporary compulsion order (Section 54(4)) allows for a person, found unfit for trial, to be detained in hospital prior to an examination of fact.

Unfitness for Trial

Table 7.2 Number of Temporary Compulsion Orders

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

This year there has been some rise in the use of the Temporary Compulsion Order (20 orders granted). However, the number of Temporary Compulsion Orders granted in 2013/14 was unusually low (7).

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

Where a person has been acquitted on account of insanity, or has been found insane in bar of trial, then there are a number of disposals available to the court.

Table 7.3 Acquitted by reason of mental disorder and unfitness for trial: disposals

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

As can be seen, the majority of outcomes involved inpatient treatment. It is likely that his reflects the serious nature of the patient's mental condition. No individual was sentenced to a community based compulsion order.

7.3 Post Conviction Predisposal

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

Table 7.4 Post- Conviction, Pre- Disposal

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

During 2014/15 we carried out a retrospective analysis of the outcome of the 26 individuals made subject to an interim compulsion order in 2012/2013. This was not possible with orders made in 2013/2014 due to the time-frame to conclude an in-patient evaluation. Of those 26 individuals made subject to an Interim Compulsion Order, 10 had a final mental health disposal by compulsion order and 15 by a compulsion order and restriction order; in one case the Interim Compulsion Order was revoked by the court. Section 200 is little used due to the more flexible use of assessment and treatment orders post conviction.

7.4 Final mental health disposals by the court.

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

Mental Health Disposals

Table 7.5 Number of mental health disposals

Order Type	2010/11	2011/12	2012/13	2013/14	2014/15
S57A(2) Compulsion Order	52	45	58	53	42
S59 CORO*	3	11	9	10	7
Hospital Direction	1	1	1	2	3
Probation Order S230				0	0
Guardianship Order S58	1	1	1	1	2

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

There is no discernible trend in the number of compulsion orders or restriction orders being made.

Transfer for treatment directions

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

Table 7.6 Number of Transfer for Treatment Directions

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

While there is little evidence of any significant change over time with regard to the number of transfers from prison, the number in 2014/15 (36) was lower than in the previous three years.

8. Place of safety orders

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.

What we found

The number of notifications received has maintained the level reached last year, an 11% rise since 2011/12. The proportion of incidents where the place of safety was a police station has further decreased in the same period from 106 (18%) to 46 (7%). We are pleased with this reduction.

Table 8.1 Place of safety orders notified to the Commission

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

Table 8.2 Was Place of Safety a Police Station?

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

9. Social circumstances reports

Our interest in this

We place importance on the helpful information that SCRs can provide to RMOs in relation to assessment, care planning and participation of family/carers. SCRs also aid RMOs and the Commission understand the broader social context of an individual.

What we found

The percentage of STDCs that triggered the completion of an SCR was similar to last year at 39% even though there was an increased number of STDCs.

The two largest local authorities, Glasgow and Edinburgh were once again amongst those who completed the lowest percentages of SCRs following an STDC, 17% and 26% respectively. There is substantial variation between adjacent local authorities, for example, Falkirk 46%, Stirling 25% and Clackmannanshire 27%. This may reflect more limited resources or lack of prioritization of this area of work.

In 18 local authority areas, such as East Lothian, East Renfrewshire, Perth and Kinross there was an increase in the percentage of SCRs completed rate (compared with last year's 13 authorities). 11 local authorities managed to produce a smaller proportion than last year (including Renfrewshire, West Dunbartonshire and West Lothian).

We continue to promote the completion of SCRs in line with our published guideline[1] because we believe they can add vital information and insights of which the clinical team and MWC might otherwise be unaware.

[1] 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

Table 9.1 Provision of Social Circumstances Reports following STDC - 2014-15

	Documents returned to MWC following STDC						STDCs in LA	
Local Authority*	None		"Serve no purpose" letter		SCR		Total	
	No.	%	No.	%	No.	%	No.	%
Aberdeen City	76	44	17	10	80	46	173	100
Aberdeenshire	41	33	10	8	73	59	124	100
Angus	24	43	2	4	30	54	56	100
Argyll and Bute	45	67		0	22	33	67	100
City of Edinburgh	330	63	62	12	135	26	527	100
Clackmannanshire	17	65	2	8	7	27	26	100
Dumfries and Galloway	41	39	11	10	54	51	106	100
Dundee City	47	30	30	19	78	50	155	100
East Ayrshire	25	32	8	10	46	58	79	100
East Dunbartonshire	25	53	1	2	21	45	47	100
East Lothian	27	44	3	5	31	51	61	100
East Renfrewshire	19	48	3	8	18	45	40	100
Eilean Siar	9	90		0	1	10	10	100
Falkirk	45	41	15	14	51	46	111	100
Fife	122	44	20	7	133	48	275	100
Glasgow City	536	77	46	7	117	17	699	100
Highland	67	41	16	10	80	49	162	100
Inverclyde	21	34	9	15	31	51	61	100
Midlothian	27	54	6	12	17	34	50	100
Moray	32	53	1	2	27	45	60	100
North Ayrshire	10	14	6	8	58	78	74	100
North Lanarkshire	89	43	16	8	103	50	208	100
Orkney		0		0	5	100	5	100
Perth and Kinross	24	17	17	12	97	70	138	100
Renfrewshire	90	75	8	7	22	18	120	100
Scottish Borders	50	68	3	4	21	28	74	100
Shetland	1	7	5	36	8	57	14	100
South Ayrshire	13	25	8	16	30	59	51	100
South Lanarkshire	80	45	33	19	63	36	177	100
Stirling	41	75		0	14	25	55	100
West Dunbartonshire	37	64	15	26	6	10	58	100
West Lothian	33	25	28	22	69	53	130	100
SCOTLAND	**2044**	**51**	**401**	**10**	**1548**	**39**	**3993**	**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.

10. Consent to treatment under Part 16 of the Act

Our interest in these figures

Part 16 of the 2003 Act makes provisions for additional safeguards in relation to medical treatment particularly, but not only, where this is given without the patient's consent. There are specific safeguards for certain forms of medical treatment including Electroconvulsive Therapy (ECT) and procedures classified as Neurosurgery for Mental Disorder (NMD).

Under the 2003 Act certain treatments can only be authorised by an independent doctor, known as a Designated Medical Practitioner (DMP).

What we found

Safeguarded treatments (Sections 237 and 240)

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

We received 802 T2 forms, 8 less than last year. The majority (779) were for medication, 16 for ECT and 5 for artificial nutrition.

Table 10.1 Certificate of the designated medical practitioner (T3) 2014-15

Treatment type	2013/14	2014/15
	No.	No.
ECT	171	186
Medication to reduce sex drive	5	9
Artificial nutrition	54	76
Medication beyond 2 months	1320	1473
Total T3 certificates*	**1546**	**1742**

*T3 certificate may be for more than one treatment

The number and types of treatments authorised by a Certificate of the DMP (Form T3) is shown in Table 9.1 above. There were 13% more T3 forms than last year. The majority of treatments authorised were for medication beyond two months, and there was an increase in these and also for ECT. The biggest increase, however, was in T3 forms for artificial nutrition. Of the patients receiving ECT, 135 objected to or were resisting the treatment, an increase from 2014/15. 17% of those who resisted or objected required treatment to save life, the remainder to alleviate serious suffering and/or prevent serious deterioration.

There were 26 DMP visits when T3s were not issued. On some occasions, the DMP visited to find that a valid T3 was already in place or that the patient was on no medication and a T3 was therefore not required. Other situations where a T3 was not issued include the

DMP not authorising ECT or nutrition by artificial means. On a further 5 visits, the DMP thought that the patient was capable of and willing to consent so completed a T2.

Children and Young People

We received 36 T2 forms for patients who were under 18 at the time of consenting to treatment. These were all for medication beyond two months apart from three for nutrition.

One of the RMOs completing the T2 was not a child specialist as required by Section 238 and this has been followed up with the RMO.

There were 80 T3 forms issued for patients aged under 18 for treatment without consent. Two forms were issued for ECT, both for the same patient. 37 T3 forms were for medication beyond two months and 41 for artificial nutrition which is a significant increase since last year. It is not entirely clear why this is, although one unit reported that they have seen an increase in eating disorder admissions, particularly at younger ages. We will continue to monitor this. In 8 cases the DMP was not a child specialist; however the RMO in these cases was a child specialist.

Neurosurgery for Mental Disorder (Sections 235 and 236)

The 2003 Act requires that all patients (including informal patients) who are to be considered for a procedure classified as neurosurgery in Scotland should first be assessed by a 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.
In 2014/15 no neurosurgery for mental disorder was carried out in Scotland.

For the foreseeable future these procedures will be undertaken at the National Hospital for Neurology and Neurosurgery in London. As the procedures will now take place in England, they are covered by English legislation. The Care Quality Commission (CQC) have a statutory role in assessing capacity to consent and assessing whether treatment is appropriate, similar to the role previously undertaken by the Mental Welfare Commission under Sections 235 and 236.

Referrals for neurosurgery for mental disorder will continue to come from the Advanced Intervention Service in Dundee following their detailed assessment of patients. Although we will no longer have a role in assessing patients prior to surgery, we will continue to request progress reports following treatment of Scottish patients as we believe that this is an important monitoring role. We have drawn up an information sharing agreement with the CQC to allow for collaborative assessment and follow up of these patients under our respective regulatory requirements.

11. APPENDIX OF TABLES

Additional tables supporting this report can be found below:
http://www.mwcscot.org.uk/media/240686/appendix_mha_monitoring_2014-15_tables.pdf


npm
national
preventive
mechanism

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

Mental Welfare Commission (09/15)