mental welfare
commission for scotland

MHA monitoring report 2018-19

Annual statistical monitoring

23 October 2019

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

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

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

1: Overview of the use of the Mental Health (Care and Treatment)(Scotland) Act 2003: A Summary and Key Findings

The Mental Welfare Commission for Scotland has a statutory duty to monitor the use of the Mental Health (Care & Treatment) (Scotland) Act 2003 (the 2003 Act). We do this by collating and analysing data compiled from the relevant paperwork provided to us and by publishing monitoring reports with comment and analysis of trends in the use of the Act.

As part of a strategic review in 2017 we took the decision to publish the monitoring reports on the use of this Act and the Adults with Incapacity (Scotland) Act in alternate years, and intermittently publish some in-depth reports into specific areas of the Acts. In 2018 we published reports on the use of the Adults with Incapacity Act in Scotland, and some aspects of the Mental Health Act with comment and analysis (Place of Safety Monitoring Report, August 2018).

This report outlines data on the use of the 2003 Act during 2018/19. The report also includes a broader range of figures, and comparisons over the last ten years.

We are undertaking further work on some areas of activity such as advance statement overrides, named persons, nurses' power to detain, and patterns in the use of specific forms of detention back to 2005. We will publish our findings in these areas in the forthcoming year.

We have also linked with the NHS Information Services Division to explore ways in which the data we hold can be further used alongside other sources of mental health related data to help inform best care and treatment.

Summary and Key Findings *(explanation of terminology on page 7)*

1. **New Episodes of Compulsory Treatment:** In 2018/19 we were notified of 6,038 new episodes of compulsory treatment during the year. This is the highest number of episodes recorded since the 2003 Act was implemented.

2. **Emergency Detention Certificates:** Rates of emergency detention vary considerably across Scotland. For instance, for mainland health boards, the rates of detention on Emergency Detention Certificates (EDCs) vary from 19.7 per 100,000 population (Grampian) to 84.2 per 100,000 population (Greater Glasgow and Clyde, (GGC)).

3. **Young men age 16-17 have seen the greatest increase in rate of EDCs per 100,000 population in the past year and both men and women age 16-17 have shown the greatest increase in the rate of emergency detentions across the ten year period observed.**

4. Percentages of **EDCs granted with consent from mental health officers**, (MHOs) vary across health boards. Some mainland boards are achieving rates of 83% (Dumfries and Galloway) whereas the rate for GGC is 33%.

5. The number of **Short Term Detention Certificates** (STDCs) completed per year has increased by 39.9% (3,372 to 4,719) over the ten year period. The Scotland rate of detention on STDC is 86.8 per 100,000 population. Like EDCs, rates vary across Scotland. Some areas have seen sharp increases in recent years (Tayside) whereas other areas have seen a reduction (Grampian).

6. Similarly to EDCs there has been a rise in the numbers of young people subject to short term detention. **In women under the age of 25 there has been a 122.5% increase in STDCs since 2009/10,** rising from a total of 142 to 316.

7. With regards to category of diagnoses recorded on 4,719 STDCs, **most detentions are for mental illness alone (89%)** with 3% for personality disorder only, and 1% for learning disability only. The remainder are combinations of these.

8. With regards to **Compulsory Treatment Orders, there has been a 41% increase of orders over the last ten years**. GGC has had a higher rate (currently 39.4 per 100,000) than the Scotland rate (currently 28.2 per 100,000) for the last ten years. Tayside rates (currently 42.1 per 100,000) have increased above the national rate over the last six years. Ayrshire and Arran and Lanarkshire have recorded lower rates than the national rate for the last ten years.

9. The Commission is interested in how the Act is applied to different groups. With regards to ethnicity, **4% of Scotland's population is minority ethnic. From the ethnicity monitoring forms completed and returned 5.8% of people in Scotland subject to detention are ethnic minorities. However there is a gap in the completeness of data**. Over the past five years for 9% to 13% of forms returned, we have not found the matching ethnicity form and where the ethnicity form is present, ethnicity information has not been completed on 16% to18% of all forms.

10. In 2018/19, there have been **178 instances of nursing staff using the Nurses Holding Power that allows the detention of a hospital patient for up to three hours**. 65% (115) relate to female patients and 35% (63) relate to male patients. The inpatient census provides a snapshot of how mental health beds are occupied on a given day in 2018; and shows that 58% of mental health inpatients are male and 42% are female. The reasons for this sharp difference between genders are unclear.

11. For continuing (rather than new episodes of detention) over the past ten years the **total numbers of orders in existence in Scotland has risen steadily, increasing by 25.6% from 2,840 (January 2010) to 3,567 (January 2019)**. The rates of orders in existence vary across health boards with GGC and Tayside showing higher rates of orders and Lanarkshire and Borders lower rates.

12. Orders can be hospital based or community based. **The proportion of community orders relative to hospital orders has risen over a ten year period, from 37.6% January 2010 to 45.8% January 2019. The proportion reached a high of 48.3% at January 2018. This shows the extent to which the balance of care has shifted to the community for people subject to compulsion.**

13. 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 2018/19, 217 individuals were subject to a CPSA order, with the total number of orders amounting to 373 orders. These numbers are similar to those of 2009/10.

14. We published a detailed report into the use of Place of Safety in 2018 and one of the aims of this work was to encourage a reduction in the use of police stations as a place of safety. Following work by Police Scotland and others, **use of police stations as a place of safety has fallen to one of its lowest levels yet (3% of use of place of safety as compared to 18% in 2011/12)**.

15. **Over the ten year period, completion of Social Circumstances Reports in relation to STDCs has been on a downward trend from 44% to 37% across Scotland as a whole. There is significant local variation** with Edinburgh City, Glasgow City and West Dunbartonshire consistently completing the lowest percentage of SCRs following a STDC. (Average across ten years: Edinburgh City 23%, Glasgow City 17%, West Dunbartonshire 21%). At the same time a number of local authorities have seen a substantial increase in completion of SCRs from the starting year 2009/10 to the current year 2018/19, notably Highland (15%-61%).

16. We would take this opportunity to remind local authorities of their duties under legislation to designate MHOs for each patient's case (s.229) and to appoint sufficient MHOs for the purpose of discharging statutory functions (s.32) of the 2003 Act.

2: New episodes of civil compulsory treatment

In 2018/19 we were notified of 6,038 new episodes of compulsory treatment during the year. This was an increase of 6.7% on the previous year. This is the highest number of new compulsory episodes since the 2003 Act was implemented in 2005, having followed an upward trend since 2009/10 (with a dip in 2011/12). In the last ten years the rate has increased from 78.6 (2009/10) to 111.0 (2018/19) per 100,000 population.

Explanation of terminology

Emergency detention certificates (EDCs)

Emergency detention certificates (EDCs) are designed to be used only in crisis situations to detain a person who needs urgent care or treatment for mental ill health. They can be issued by any doctor, with the input of a mental health officer (MHO) and allow someone to be kept in hospital for up to 72 hours.

Short term detention certificates (STDCs)

The preferred route to compulsory treatment is through short term detention orders. They should only take place if recommended by a psychiatrist and a mental health officer. These certificates can detain an individual in hospital for up to 28 days.

Compulsory treatment orders (CTOs)

A mental health officer (MHO) can make an application for a CTO to the Mental Health Tribunal. The application must include two medical reports, an MHO report and a proposed care plan. The Tribunal decides whether a CTO is to be granted. The Tribunal is made up of three people - a lawyer, a psychiatrist, and another person with relevant skills and experience, e.g. a nurse, social worker, or someone with personal experience of serious mental illness.

The CTO can last up to six months. It can be extended for a further six months and then for periods of 12 months at a time.

Mental Health Officer (MHO)

A mental health officer (MHO) is a registered social worker who has completed specialist training and has an additional qualification in mental health.

Responsible Medical Officer (RMO)

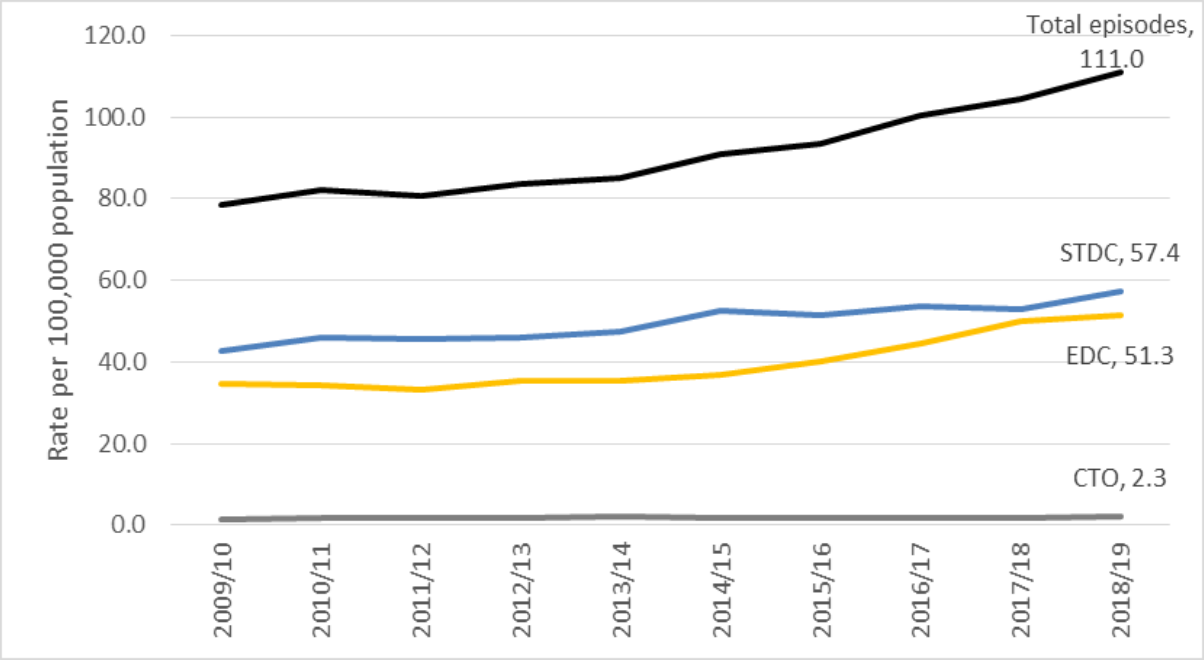
A responsible medical officer (RMO) is a psychiatrist who must have required qualifications and experience and be approved by a health board as having special experience in the diagnosis and treatment of mental disorder

Table 2.1: New episodes of civil compulsory treatment initiated 2009/10 to 2018/19

New episode starts with this order [y]	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16-17	17-18	18-19	18/19 % rise
EDC	1805	1805	1765	1878	1888	1969	2165	2411	2704	2792	3.3%
STDC	2231	2423	2421	2452	2531	2801	2755	2908	2864	3122	9.0%
Compulsory Treatment Order (CTO)[xx] (includes interim orders)	78	101	95	102	112	90	93	101	89	124	39.3%
Total episodes	**4114**	**4329**	**4281**	**4432**	**4531**	**4860**	**5013**	**5420**	**5657**	**6038**	**6.7%**

All data has been taken from the Commission information management system.
[xx] Includes a small number of cases direct to ICTO only (1 to 6), or initially to ICTO then onto CTO (12 to 24)
[y] This is the starting order in a new sequence of one or more orders.
NB: these are new episodes only. This does not include EDCs and STDCs for people already subject to community CTOs. The numbers of EDCs and STDCs reported elsewhere in our report are larger because they include these additional people.

Figure 2.1: New compulsory episodes initiated 2009/10 to 2018/19 (rate per 100,000 population) by episode starting order



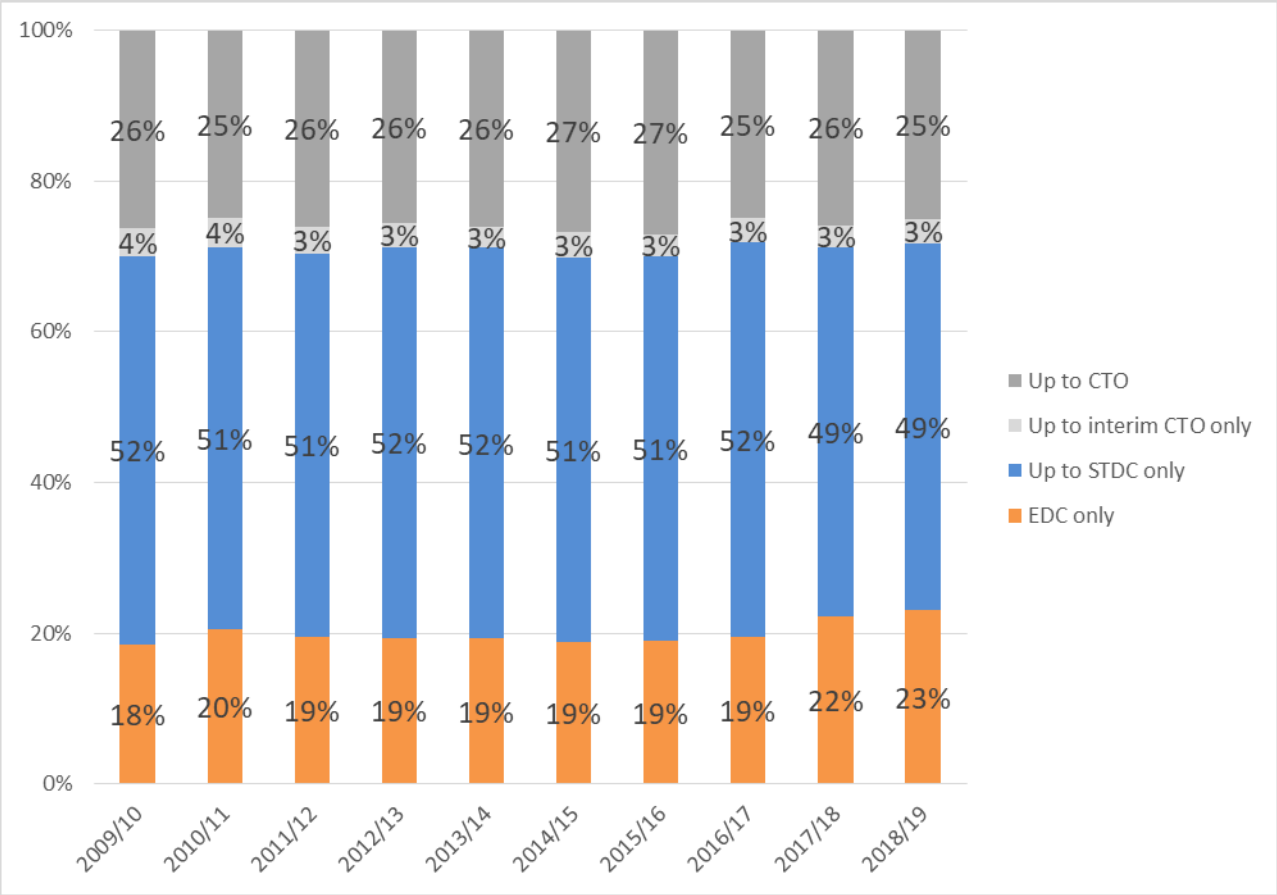
The number of new episodes starting with an EDC has risen by 3.3% this year, with an increase in numbers of 54.7% since 2009/10. In the ten year period the rate has increased from 34.5 to 51.3 per 100,000 population.

The number of people put straight onto a STDC has risen over the ten year period by 39.9%. The rate has increased from 42.6 to 57.4 per 100,000. This is the preferred route to compulsory treatment as it affords the patient more safeguards.

New episodes per year starting with a compulsory treatment order have varied from 78 (rate 1.5 per 100,000) in 2009/10, to the current figure of 124 per year (rate 2.3 per 100,000).

We looked at the progression of episodes of compulsory treatment that were initiated during the year.

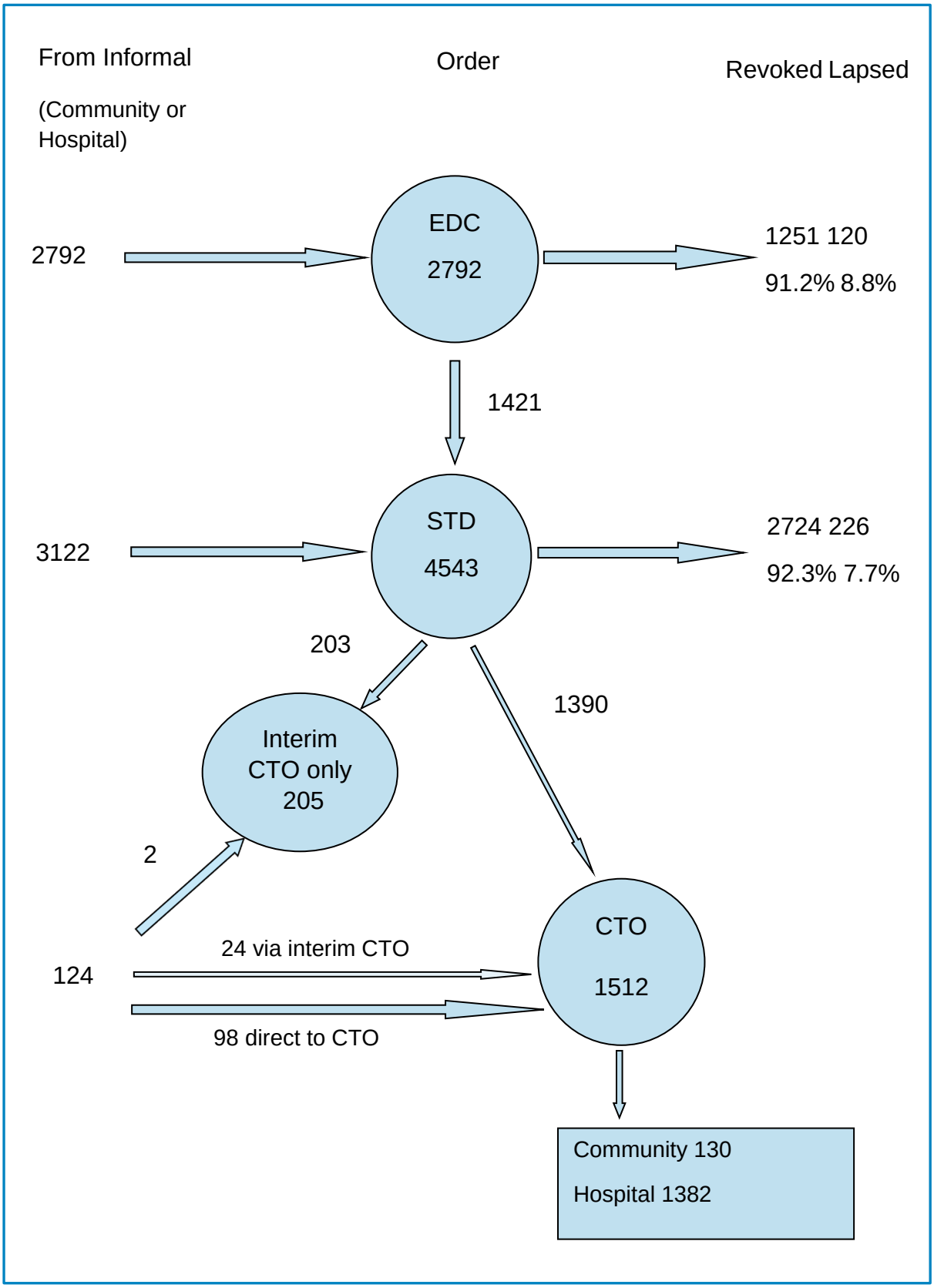
Figure 2.2: Progression of types of compulsory civil episodes 2009/10 to 2018/19



Findings of note from this chart are:

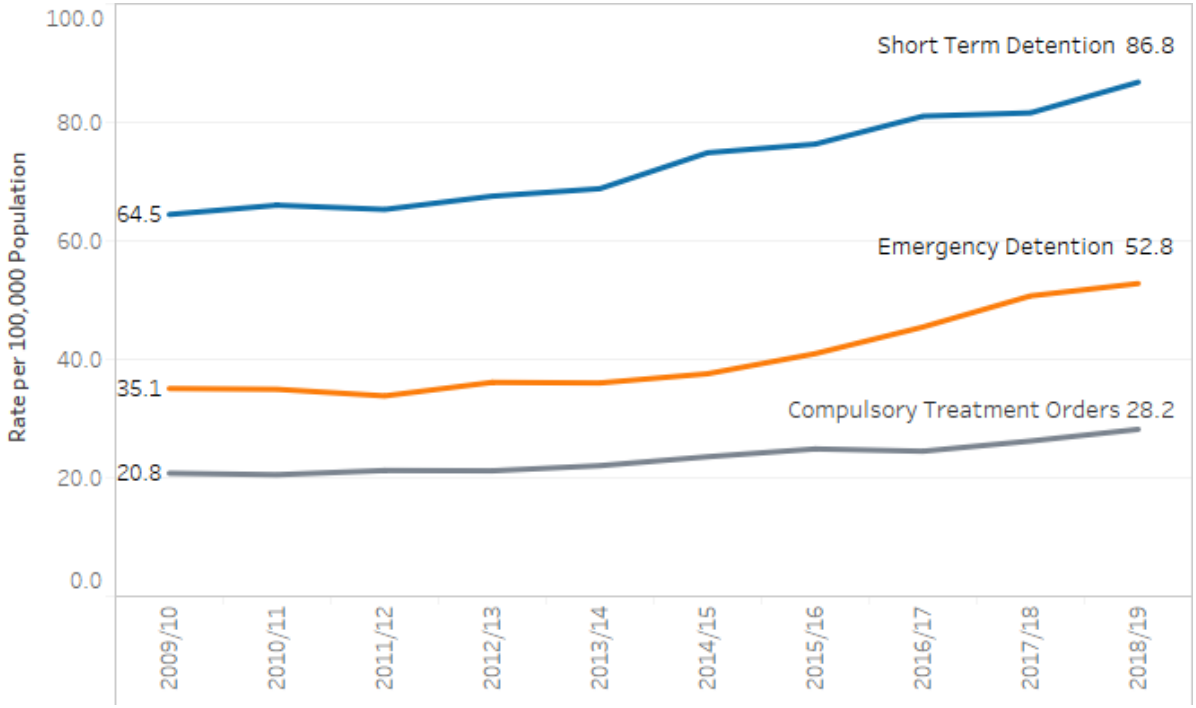
- Over the ten year period, around a quarter (25-27%) of all episodes of compulsory treatment resulted in the granting of a CTO. In addition, 3-4% of episodes progressed to an interim CTO without a final CTO being granted.
- The remaining 70-72% of all episodes of compulsory treatment lasted for 31 days or less. In 2018/19, 72% of all episodes lasted for 31 days or less.
- In 2018/19, 2792 new episodes started with an EDC and of those 1371 (49%) went no further with 1,251 (91.2%) being revoked within the three day time period and 120 (8.8%) lapsing after three days. Therefore 1,371 (23%) of all new episodes lasted three days or less, maintaining the increase seen in 2017/18 in comparison with previous years.
- In 2018/19 there was a total of 4,543 STDC episodes in the year (1,421 progressed from EDC to a STD; 3,122 started with a STDC). Of all new episodes in the year, 49% (2,950 of 6,038) ended at STDC when 2,724 were revoked and 226 allowed to lapse.

Figure 2.3: Diagrammatic representation of progression across orders 2018/19



3: New orders at Heath Board level

Figure 3.1: New orders across Scotland (rate per 100,000 population)



These are the total orders of each type which were initiated in the year and includes orders which were the first to be initiated, follow-on orders, and orders overlaid on existing CTOs. On the following pages we look at the different orders in more detail at health board level.

3.1: Emergency detention certificates (EDCs)

The number of EDCs initiated per year has increased by 56.5% (1,835 to 2,871) over the ten year period rising from 35.1 to 52.8 per 100,000 population.

The following charts show the NHS boards which are significantly above or below the national average.

Over the ten years, two health boards have been consistently above the Scotland rate. Greater Glasgow and Clyde has risen from 45.8 to 84.2 per 100,000, and has shown a steep rising trend since 2012/13. Dumfries and Galloway rose from 50.3 to a high of 76.2 (2016/17) and has fallen over the past two years to the current rate 67.9 per 100,000. Tayside has risen above the national rate in the past two years, (now 66.8).

Figure 3.1.1: EDCs Greater Glasgow & Clyde (95% confidence intervals[1])

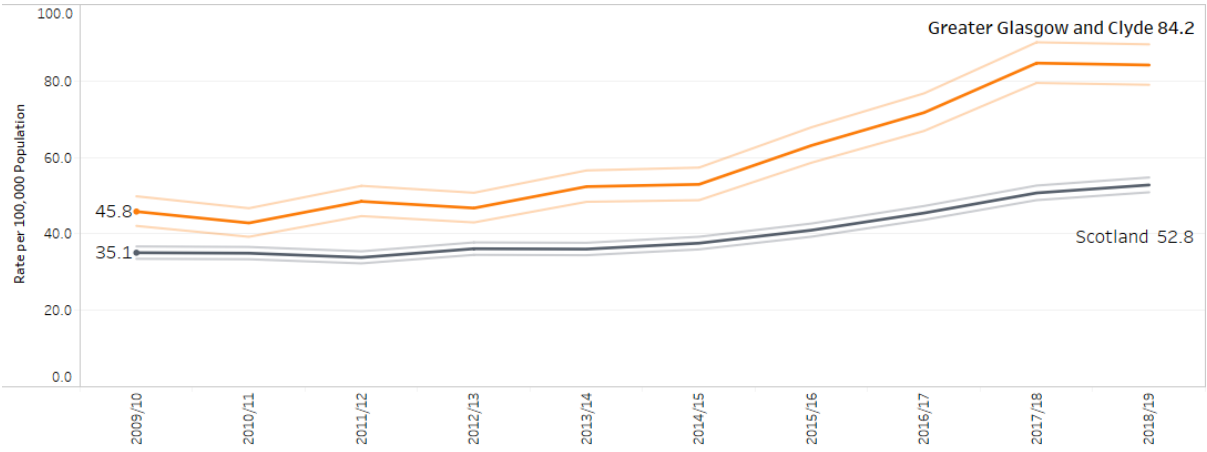


Figure 3.1.2: EDCs Dumfries & Galloway (95% confidence intervals)

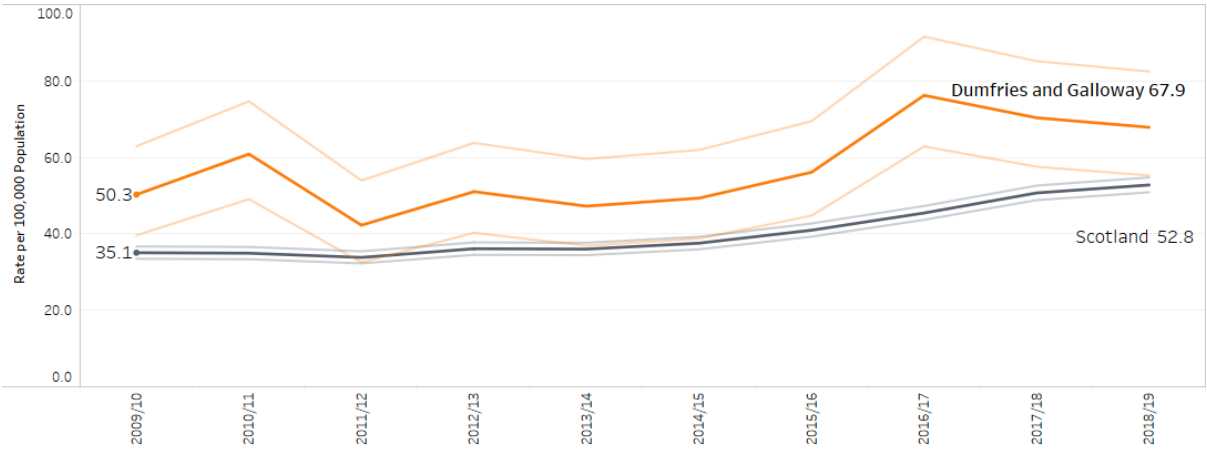
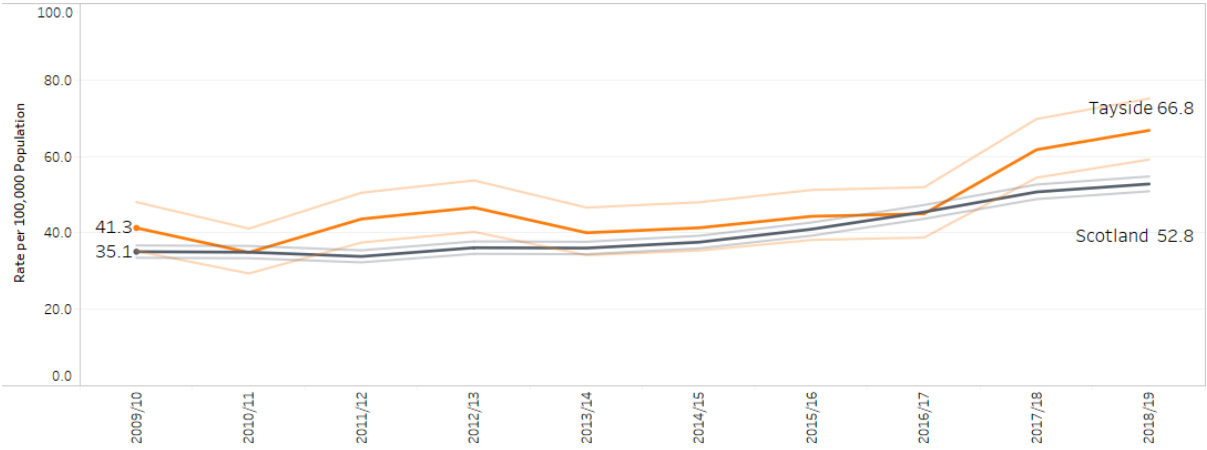


Figure 3.1.3: EDCs Tayside (95% confidence intervals)



[1] A confidence interval gives a measure of the precision of a value. It shows the range of values that encompass the population or 'true' value, estimated by a certain statistic, with a given probability. For example, if 95% confidence intervals are used, this means we can be sure that the true value lies within these intervals 95% of the time.

Five mainland health boards and one island board (Shetland) are currently below the national rate.

Figure 3.1.4: EDCs Grampian (95% confidence intervals)

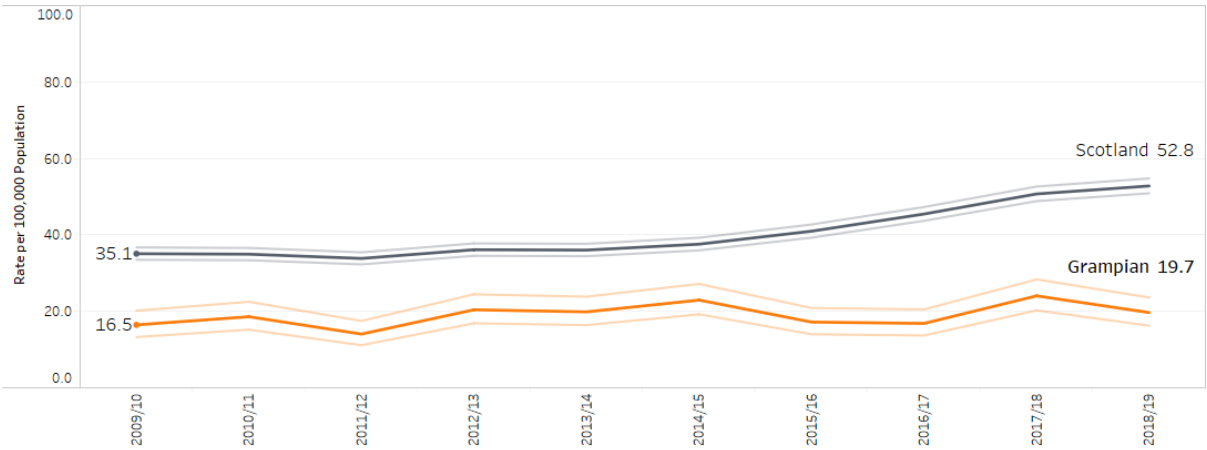
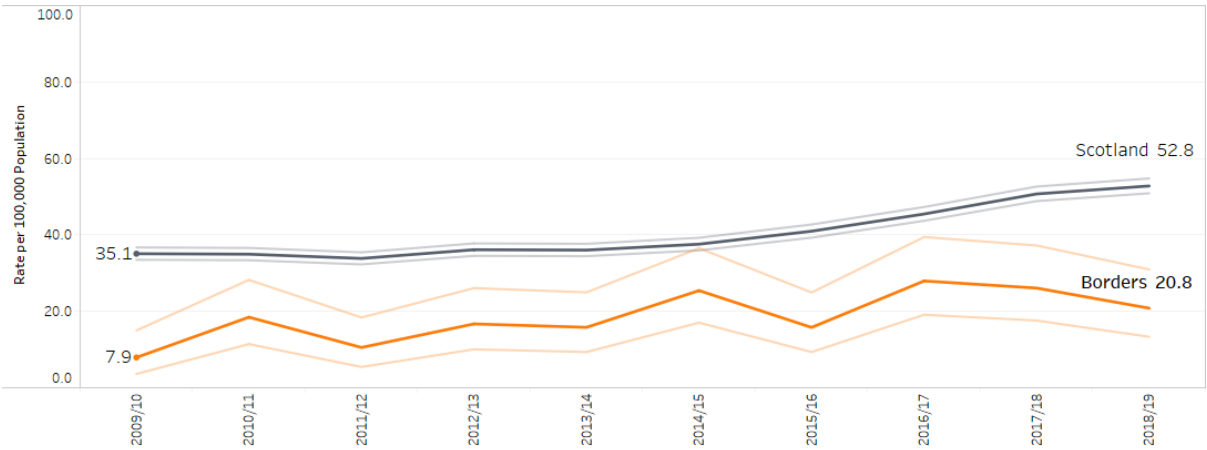


Figure 3.1.5: EDCs Borders (95% confidence intervals)



Grampian and Borders have been consistently below the Scotland rate; but whereas the Grampian rate has fluctuated little (16.5 to 19.7), Borders has risen (7.9 to 20.8 this year). Highland, Ayrshire and Arran, and Lanarkshire have each remained below the Scotland rate for the past three years.

Figure 3.1.6: EDCs Highland (95% confidence intervals)

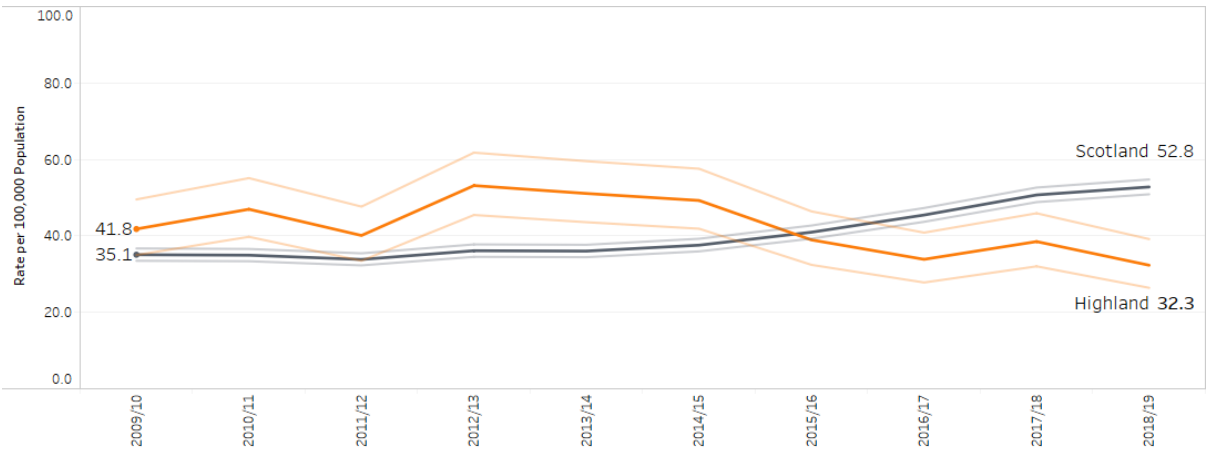


Figure 3.1.7: EDCs Ayrshire and Arran (95% confidence intervals)

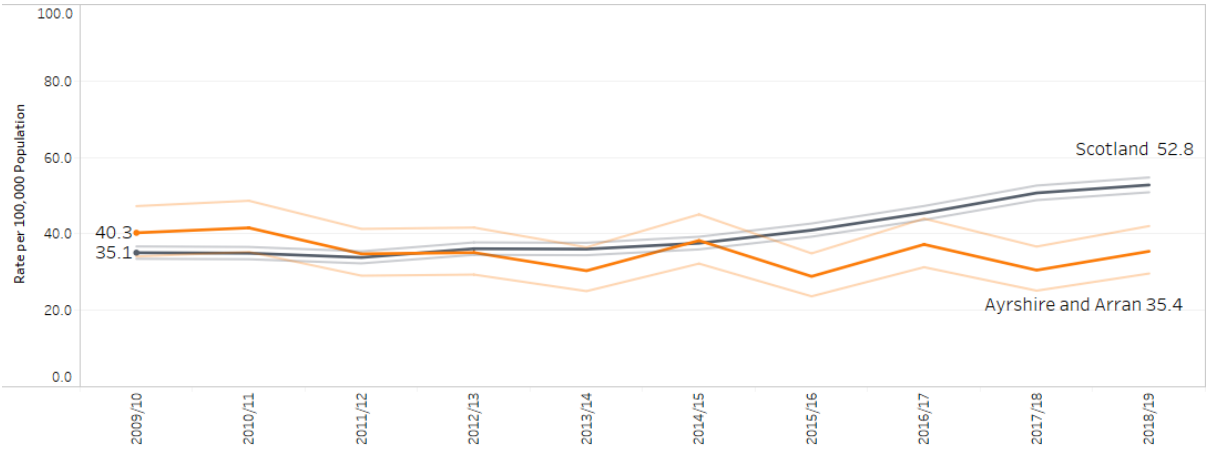
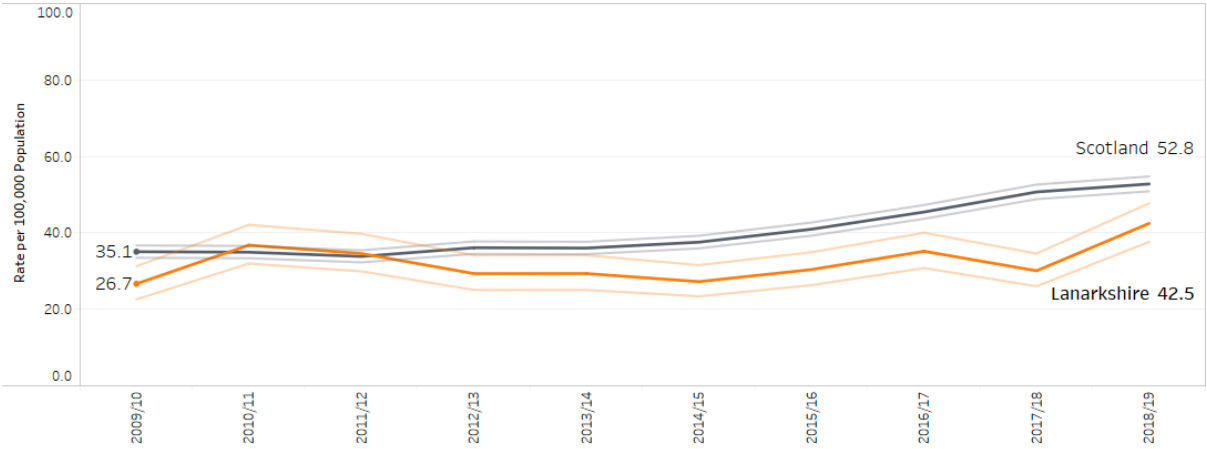
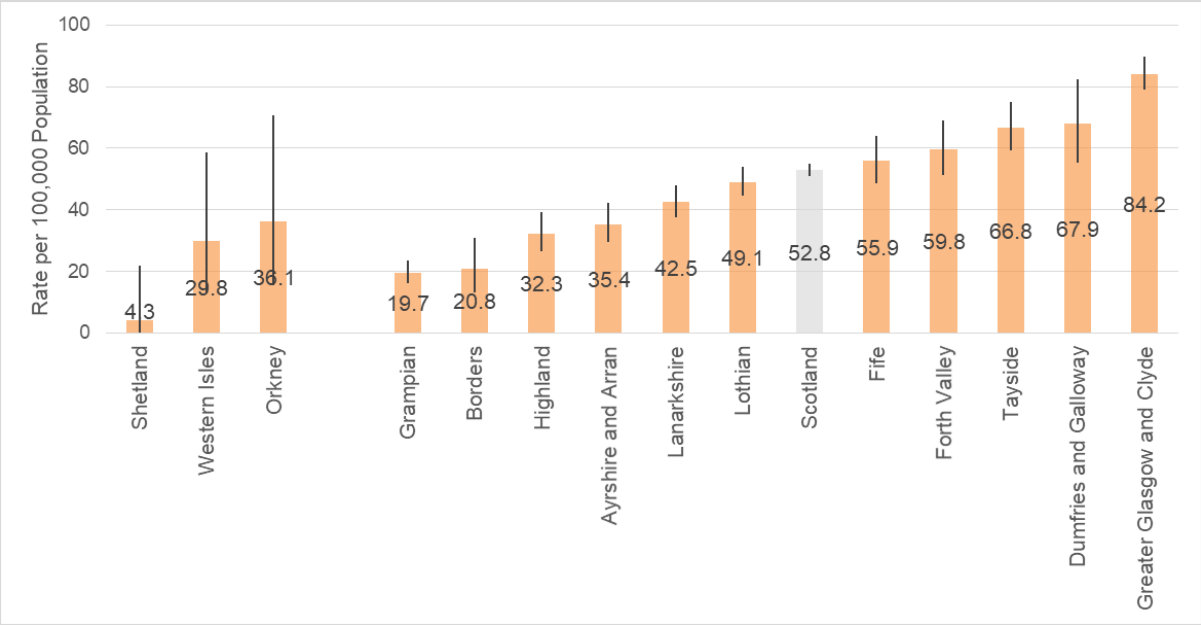


Figure 3.1.8: EDCs Lanarkshire (95% confidence intervals)



Emergency detention certificates by health board 2018/19

Figure 3.1.9: EDCs by health board 2018/19 (rate per 100,000 population with 95% confidence intervals)



In mainland boards the rate varies from 19.7 per 100,000 (Grampian) to 84.2 per 100,000 (Greater Glasgow and Clyde).

In 2018/19 four health boards were significantly above the Scotland rate (52.8; 95% CI: 50.9 to 54.8). Greater Glasgow & Clyde (84.2; 95% CI: 79.0 to 89.6), which has the largest population, Dumfries and Galloway with one of the smallest populations also remains high (67.9; 95% CI: 55.3 to 82.5). Tayside (66.8; 95% CI: 59.2 to 75.1).and Forth Valley (59.8; 95% CI: 51.4 to 69.1).

In 2018/19 five health boards were significantly below the Scotland rate: Ayrshire and Arran, Borders, Grampian, Highland, and Lanarkshire.

The three island boards have low numbers and small population sizes so confidence intervals are wide.

Emergency detention certificates by gender and age group

The number of emergency detention certificates completed per year has increased by 56.5% (1,835 to 2,871) over the ten year period.

The national rate has risen steadily from 35.1 to 52.8 per 100,000 people.

The national rate for women has risen from 35.9 to 52.0 and for men from 34.2 to 53.6 per 100,000 people.

The following charts illustrate variances by gender and age group in rates per 100,000 population.

Figure 3.1.10: EDCs – by Gender 2009/10 to 2018/19

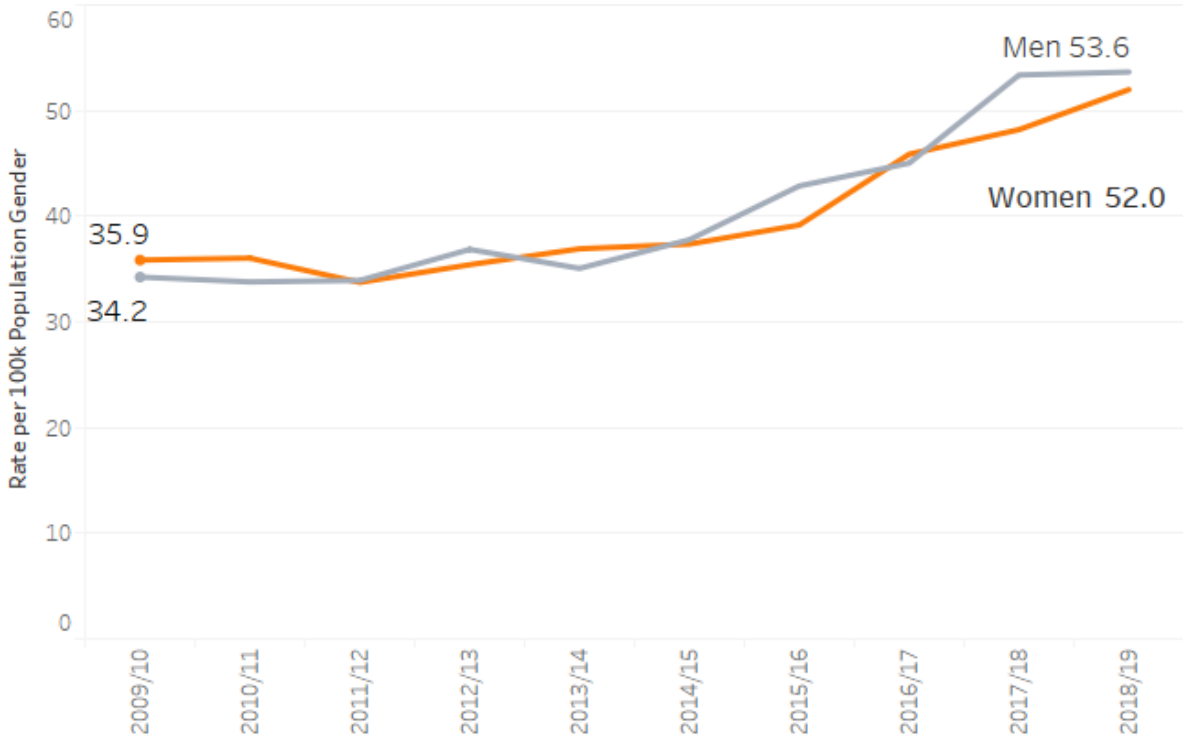


Figure 3.1.11: EDCs - Women by age group 2009/10 to 2018/19

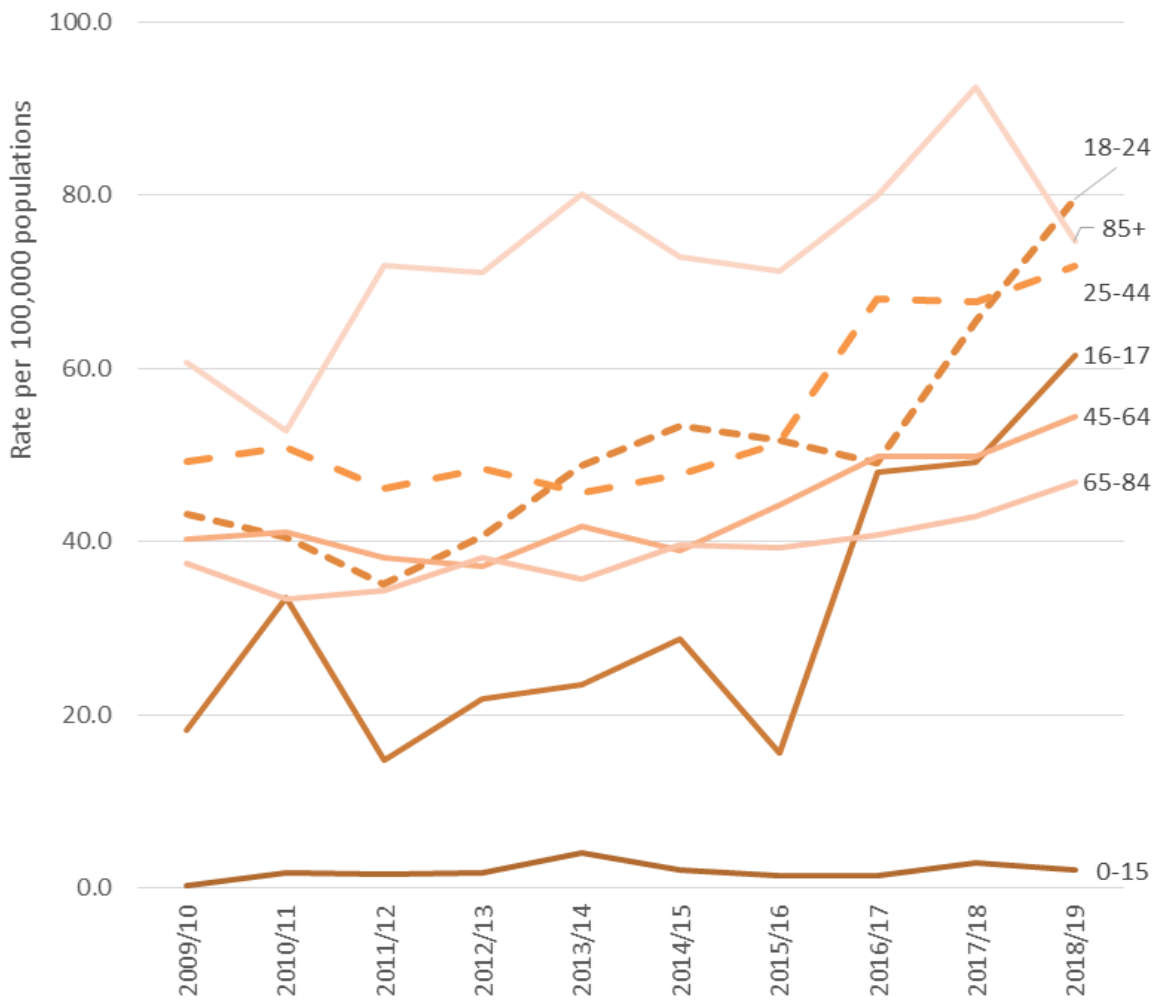


Table 3.1.1: EDCs - Women by age group 2009/10 to 2018/19 - counts

Women age group	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
0-15	1	8	7	8	18	9	6	6	13	9
16-17	12	21	9	13	14	17	9	27	27	33
18-24	105	101	89	103	122	132	128	120	156	185
0-24	**118**	**130**	**105**	**124**	**154**	**158**	**143**	**153**	**196**	**227**
25-44	355	365	329	344	322	336	362	481	481	513
45-64	291	301	284	277	313	294	337	383	385	422
25 to 64	**646**	**666**	**613**	**621**	**635**	**630**	**699**	**864**	**866**	**935**
65-84	161	144	150	171	163	184	185	194	206	228
85+	43	38	53	53	60	56	55	63	74	60
65-85+	**204**	**182**	**203**	**224**	**223**	**240**	**240**	**257**	**280**	**288**
Total	968	978	921	969	1012	1028	1082	1274	1342	1450

Figure 3.1.12: EDCs - Men by age group 2009/10 to 2018/19

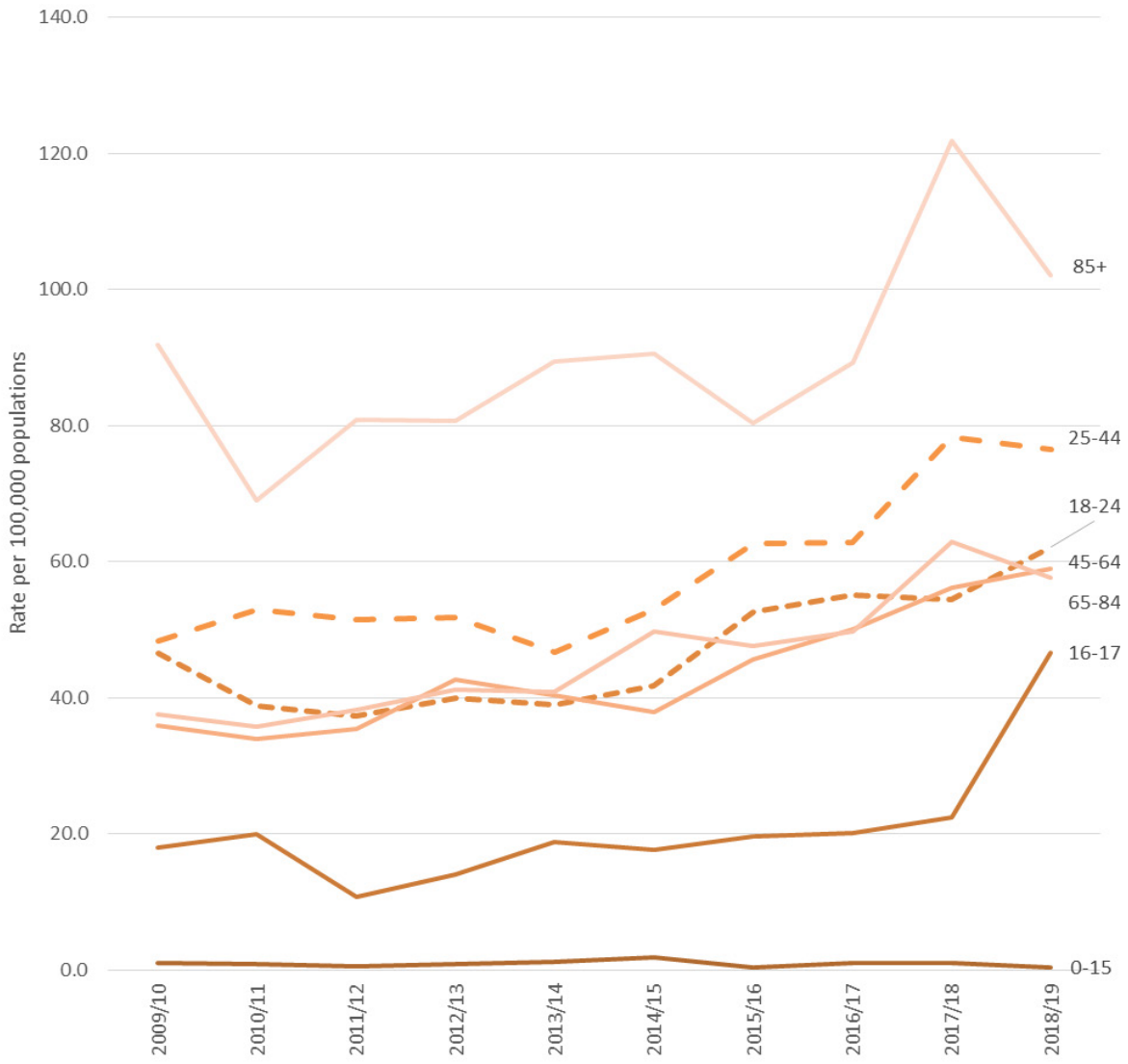


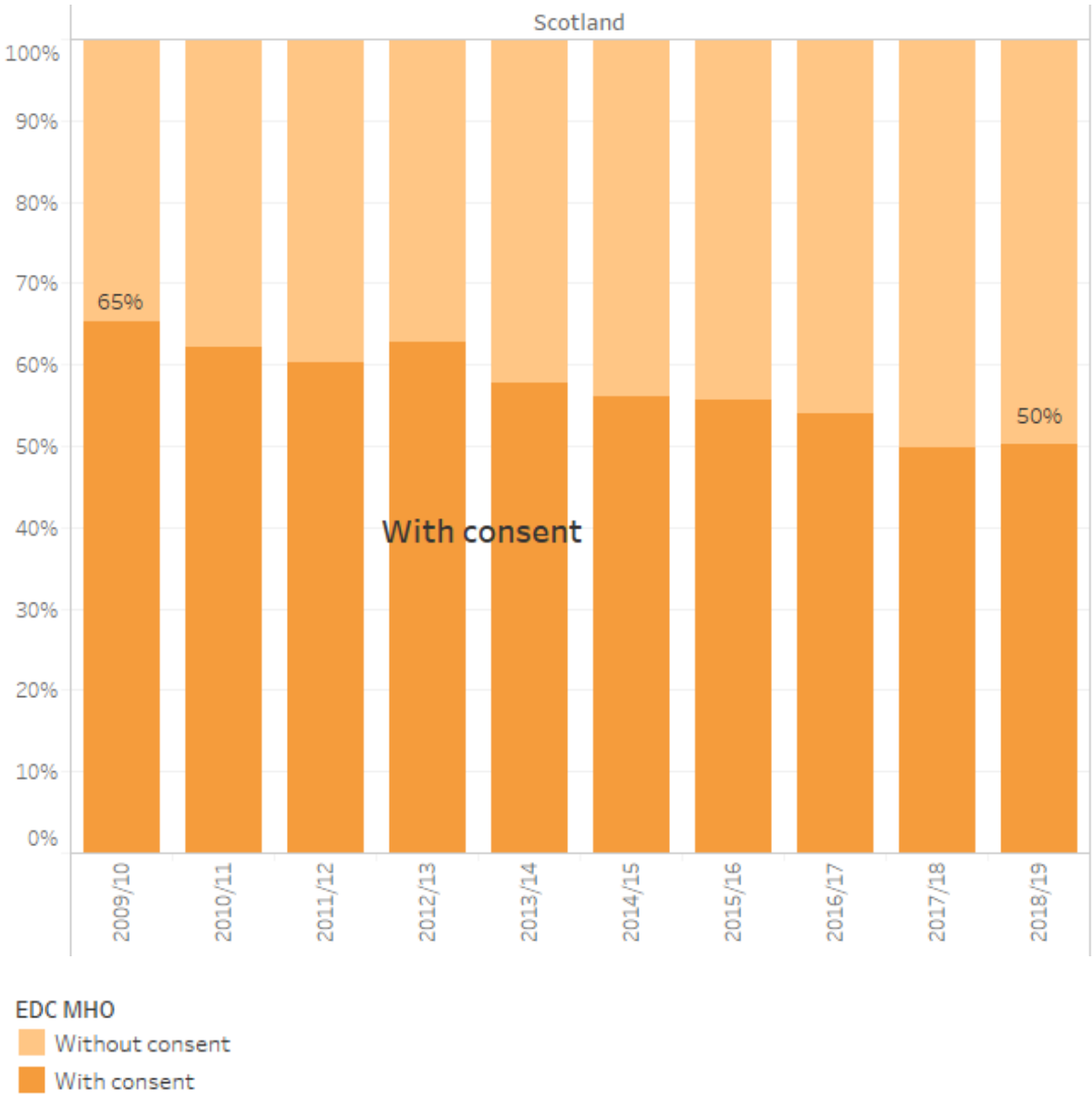
Table 3.1.2: EDCs - Men by age group 2009/10 to 2018/19 - counts

Men age group	**2009 / 10**	**2010/ 11**	**2011/ 12**	**2012/ 13**	**2013/ 14**	**2014/ 15**	**2015/ 16**	**2016/ 17**	**2017/ 18**	**2018/ 19**
0-15	5	4	3	4	6	9	2	5	5	2
16-17	12	13	7	9	12	11	12	12	13	26
18-24	113	96	94	101	98	104	131	136	132	149
0-24	**130**	**113**	**104**	**114**	**116**	**124**	**145**	**153**	**150**	**177**
25-44	333	363	353	352	316	357	425	430	541	531
45-64	248	239	253	304	288	272	329	363	409	429
25 to 64	**581**	**602**	**606**	**656**	**604**	**629**	**754**	**793**	**950**	**960**
65-84	128	124	135	152	155	194	189	201	258	240
85+	28	22	27	28	32	34	31	36	51	44
65-85+	**156**	**146**	**162**	**180**	**187**	**228**	**220**	**237**	**309**	**284**
Total	867	861	872	950	907	981	1119	1183	1409	1421

Young men age 16-17 have seen the greatest increase in rate of EDCs per 100,000 population in the past year and both men and women age 16-17 have shown the greatest increase in the rate of emergency detentions across the ten year period observed.

Mental health officer (MHO) Consent

Figure 3.1.13: Percentage of EDCs across Scotland with MHO consent



Over the ten year period, the percentage of EDCs across Scotland with MHO consent has fallen from a high of 65% in 2009/10 to the current percentage of 50% in 2018/19.

In 2018/19, of the 2,871 people across Scotland made subject to an EDC, we found that 50% did not have the consent of an MHO.

Greater Glasgow and Clyde, Forth Valley and Western Isles were below the national average for EDCs with MHO consent in 2018/19.

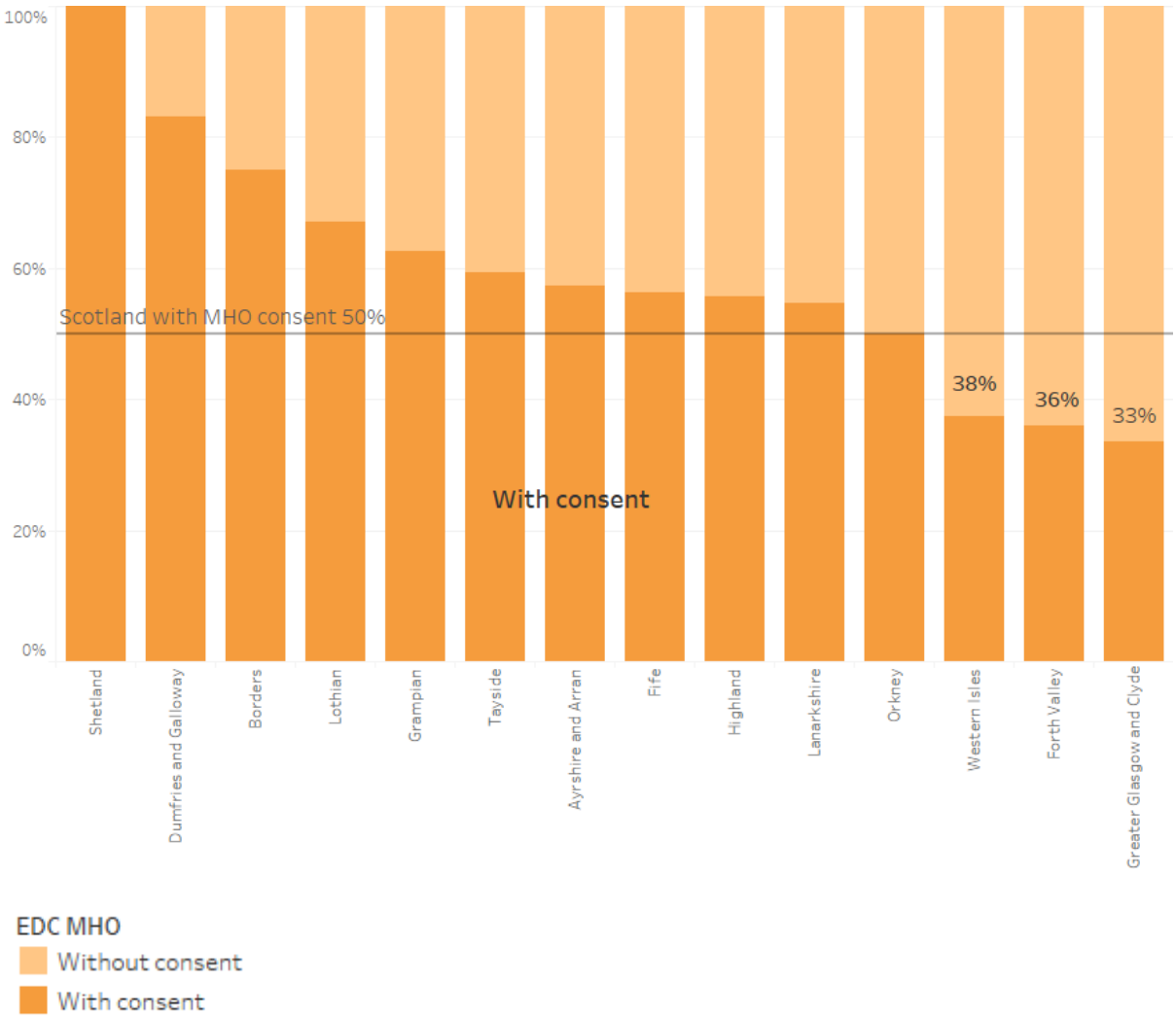
Forth Valley has continued to decrease, now at 36% with consent.

Greater Glasgow and Clyde has remained at 30-35% over the past five years.

Dumfries and Galloway has continued to improve over the past few years, now at 83% with consent.

In 2016 we published a report which examines Scotland's high levels of emergency mental health detention without the consent of mental health officers[2]. This continues to be an issue of concern to the Commission because this is an important safeguard in the process of detention of individuals. We hope that it will be taken into account in the implementation of the commitment in the Scottish Government Mental Health Strategy to consider how to alleviate pressures on MHOs. It also requires local action, particularly in areas where the level of consent is low. We will continue to raise this with NHS boards, local authorities and health and social care integration joint boards (IJBs).

Figure 3.1.14: Percentage of EDCs with MHO consent for all NHS boards 2018/19

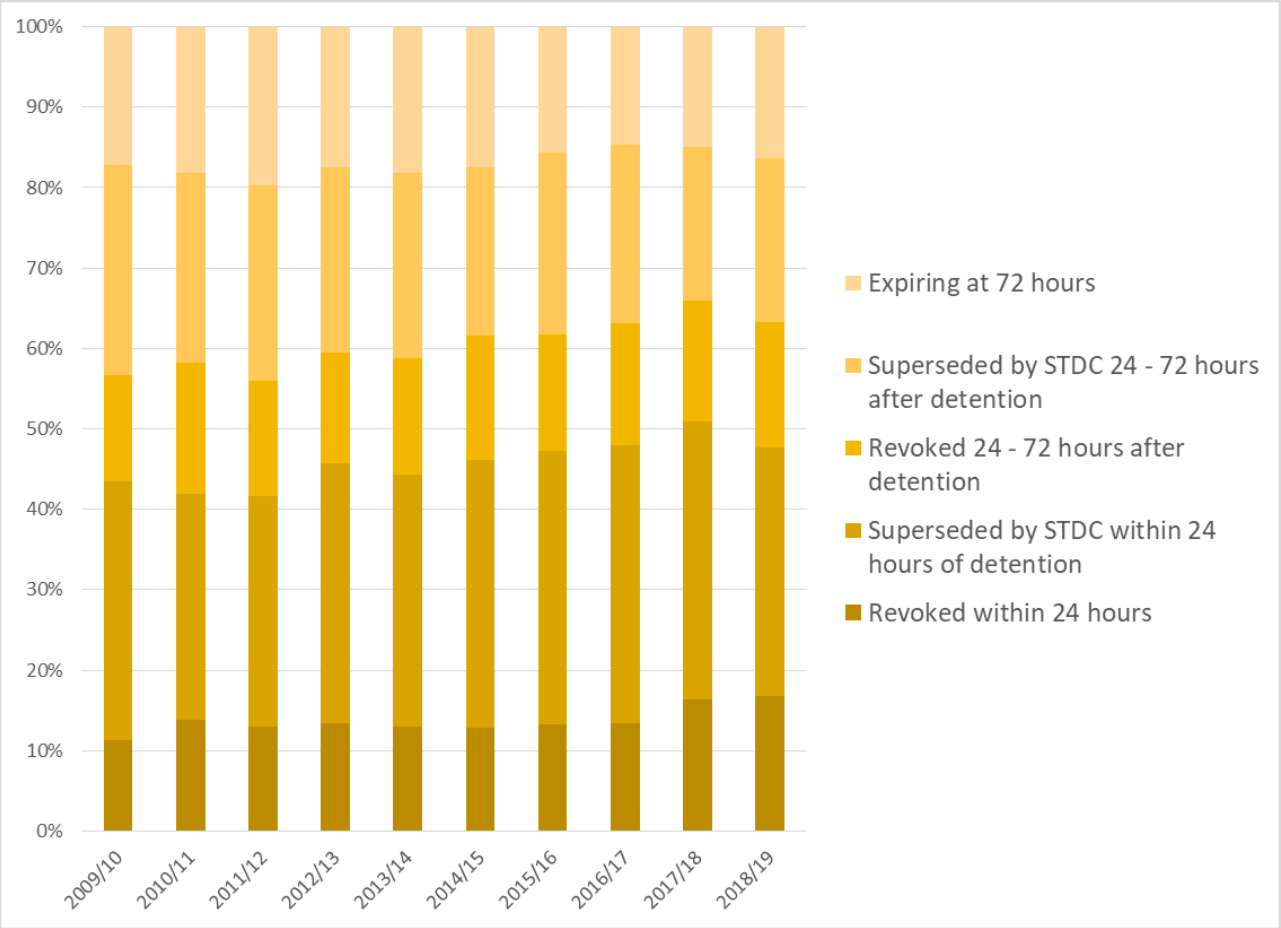


[2] Mental Welfare Commission for Scotland (June 2016) Emergency detention certificates without mental health officer consent: https://www.mwcscot.org.uk/node/889/

Duration of emergency detention

Over the ten year period, the percentage of individuals on an EDC who have had the order revoked or superseded by a short term detention order (STDC) within the first 24 hours has increased from 43.2% (792) to 47.0% (1,349), a fall from the high of 50.3% (1,383) in 2017/18. Early revocation of EDCs or superseding of EDCs with STDCs limits the time spent by individuals under detention without the safeguards offered by short term detention orders.

Figure 3.1.15: Duration of emergency detention 2009/10 to 2018/19

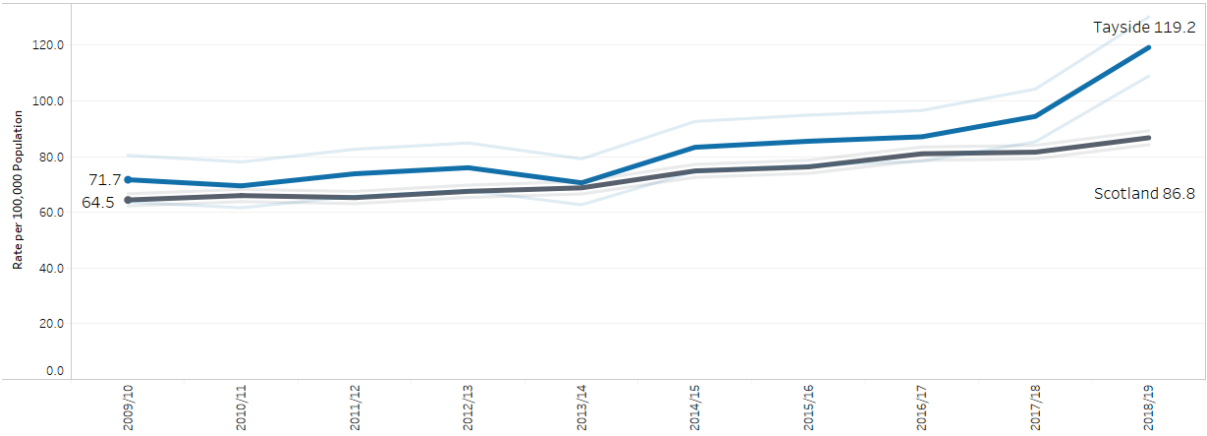


3.2: All short term detention certificates (STDCs) initiated across Scotland

The number of short term detention certificates completed per year has increased by 39.9% (3,372 to 4,719) over the ten year period.

The national rate has risen steadily from 64.5 to 86.8 per 100,000 population. The charts below show the rates over the past decade for some areas with particularly high or low rates or where there has been notable change.

Figure 3.2.1: STDCs in Tayside (95% confidence intervals)



Tayside has shown a sharp increase in rate over the past year, from 94.5 to 119.2.

Figure 3.2.2: STDCs in Greater Glasgow & Clyde (95% confidence intervals)

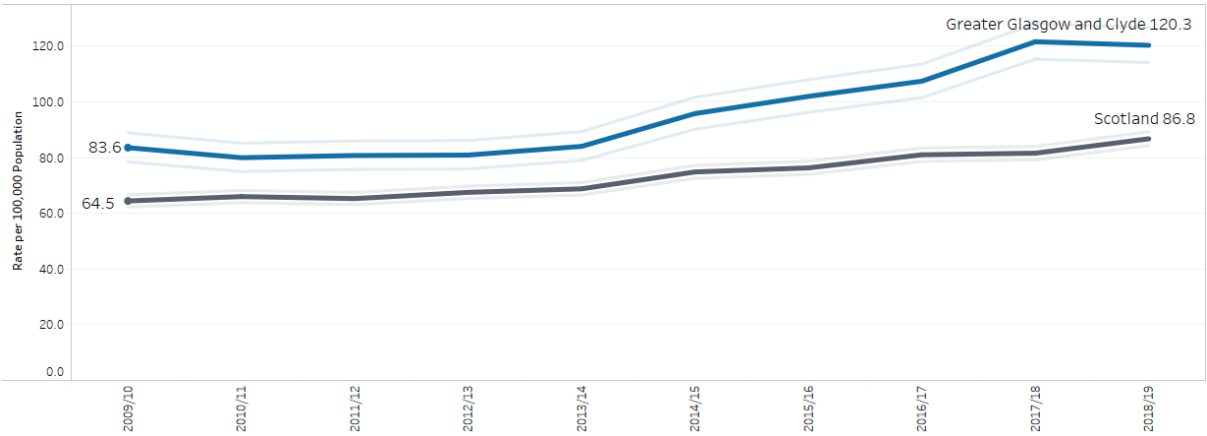
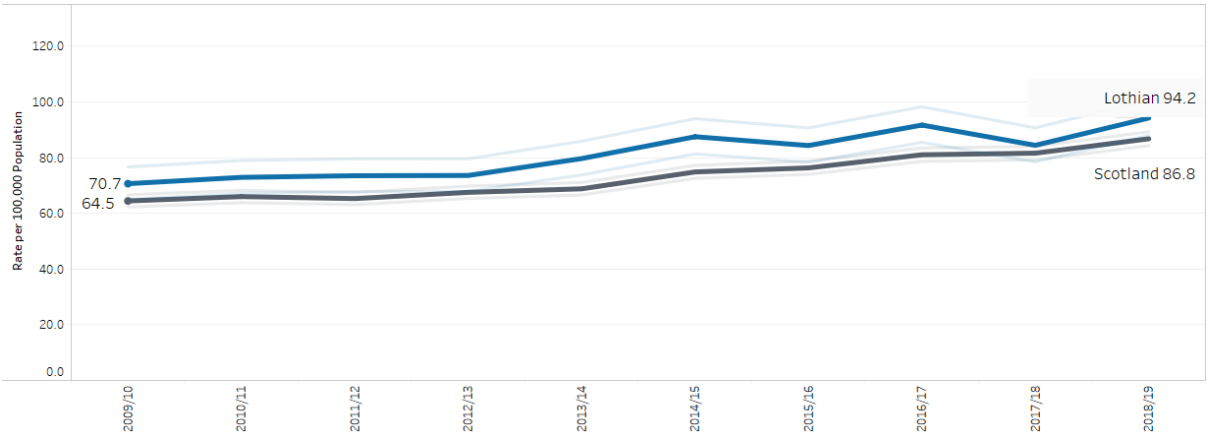


Figure 3.2.3: STDCs in Lothian (95% confidence intervals)



Greater Glasgow and Clyde has had consistently higher rates than Scotland, the rate increasing over the ten year period from (83.6 to 120.3), whilst Lothian has increased from 70.7 to 94.2 in the same period.

Figure 3.2.4: STDCs in Lanarkshire (95% confidence intervals)

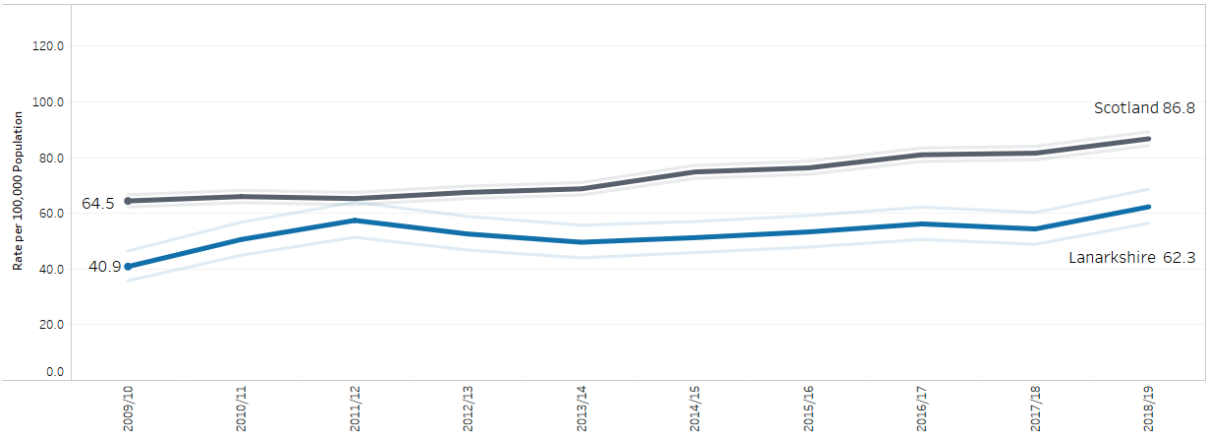


Figure 3.2.5: STDCs in Borders (95% confidence intervals)

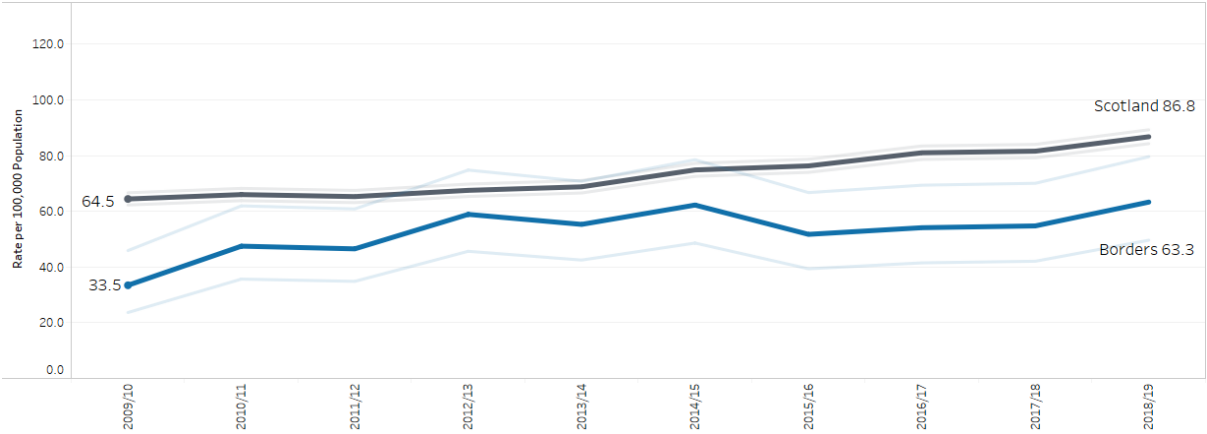
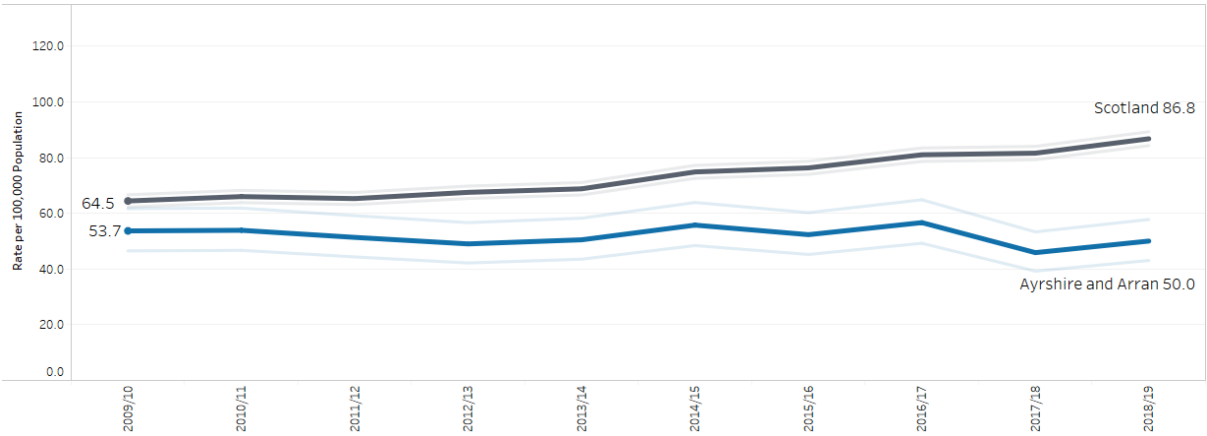


Figure 3.2.6: STDCs in Ayrshire & Arran (95% confidence intervals)



Two health boards have been lower than the national rate over the ten year period. Lanarkshire and Borders rates are rising, whilst Ayrshire & Arran rates are decreasing.

Figure 3.2.7: STDCs in Highland (95% confidence intervals)

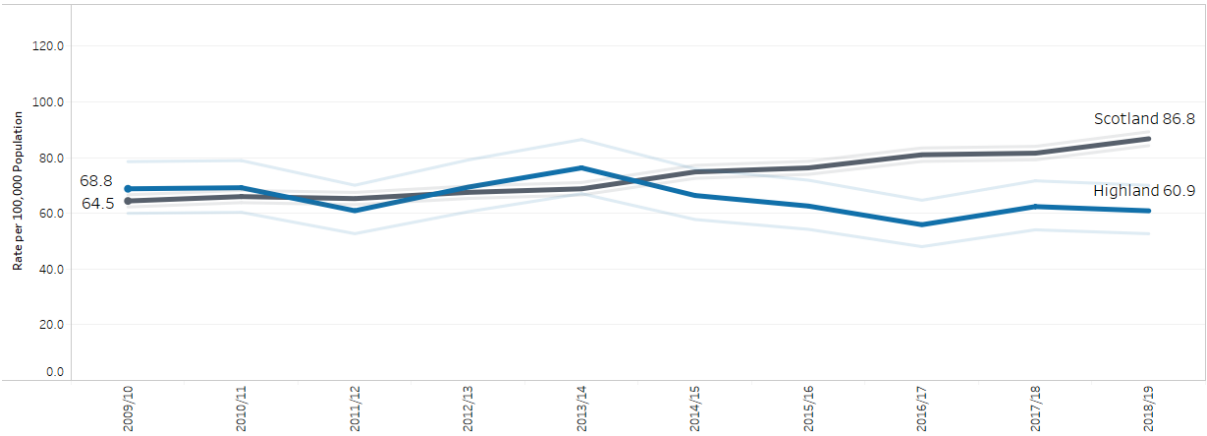
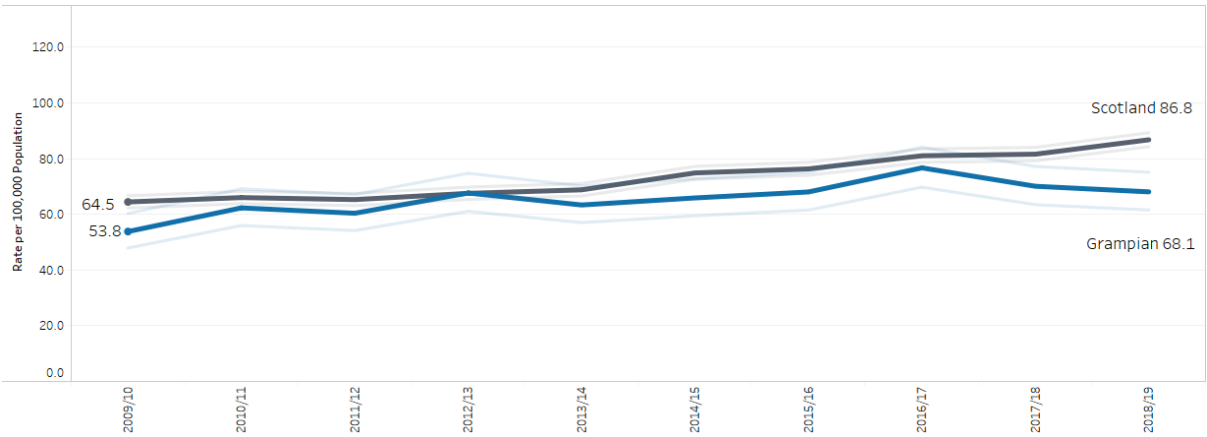


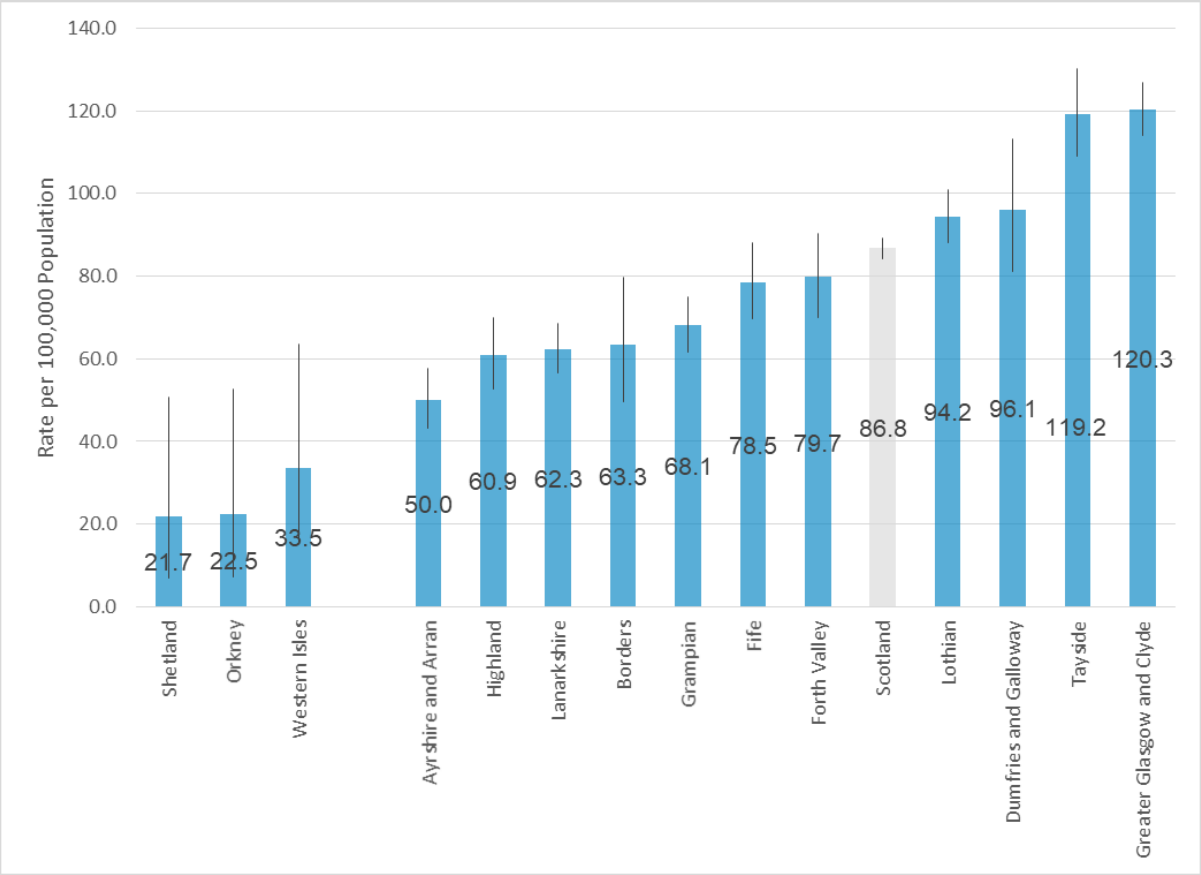
Figure 3.2.8: STDCs in Grampian (95% confidence intervals)



Highland has been significantly below the national rate for the past three years. This year Grampian has fallen significantly below the national average for the first time in the ten year period.

Short term detention certificates 2018/19

Figure 3.2.9: STDCs by health board 2018/19 (rate per 100,000 population with 95% confidence intervals)



In 2018/19 boards above the Scotland rate (86.8; 95% CI: 84.3 to 89.3) include Greater Glasgow & Clyde (120.3; 95% CI: 114.2 to 126.8), which has the largest population, and has the highest rate; and Tayside (119.2; 95 CI: 108.9 to 130.2) which is significantly above the national average for the first time in ten years. Lothian and Dumfries and Galloway are closer to the national average.

In 2018/19 five health boards are significantly below the Scotland rate (86.8; 95% CI 84.3 to 89.3): Ayrshire & Arran (50.0; CI: 43.1 to 57.8) and Highland (60.9; 95% CI: 52.7 to 70.1). Lanarkshire (62.3; 95% CI: 56.5 to 68.7) Borders (63.3; 95% CI 49.6 to 79.6). Grampian (68.1; 95% CI: 61.6 to 75.1) has fallen below for the first time this year.

The low counts (below ten) in the island boards make their numbers difficult to interpret.

STDCs by age and gender

The number of short term detention certificates completed per year has increased by 39.9% (3,372 to 4,719) over the ten year period.

The national rate has risen from 64.5 to 86.8 per 100,000 people.

The national rate for women has risen from 62.9 to 85.6, and for men from 66.2 to 88.0 per 100,000 people.

The following charts illustrate the variances by gender and age group in rates per 100,000 population.

Figure 3.2.10: STDCs – by gender 2009/10 to 2018/19

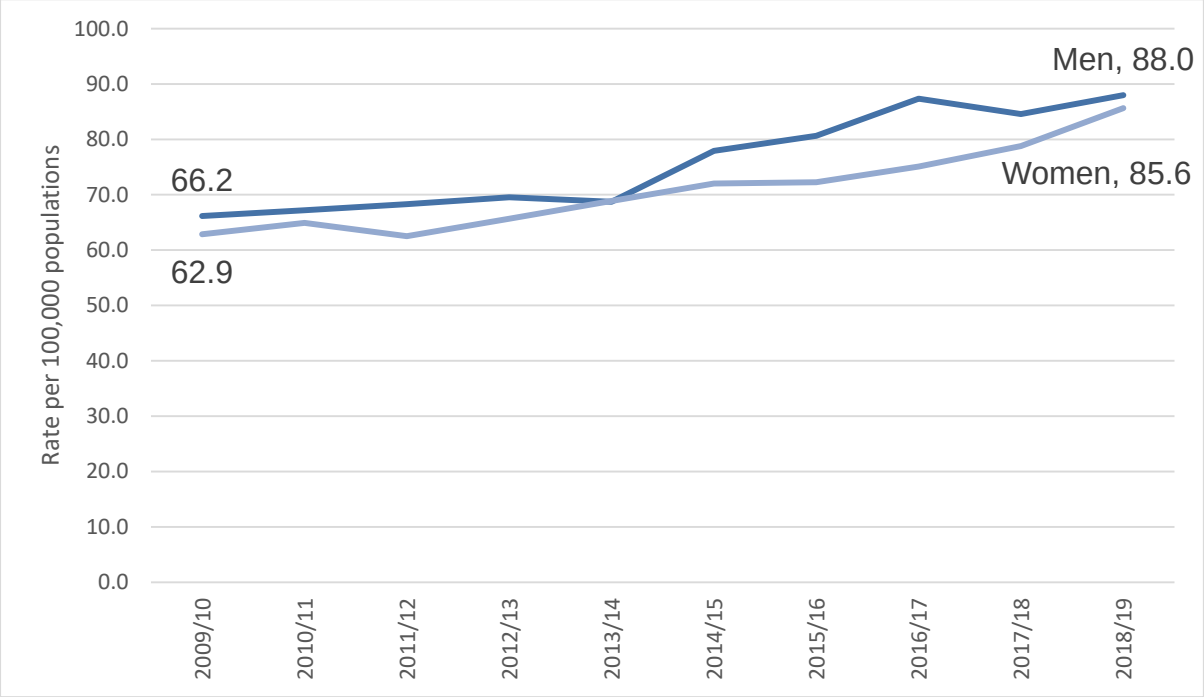


Figure 3.2.11: STDCs – Women by age group 2009/10 to 2018/19

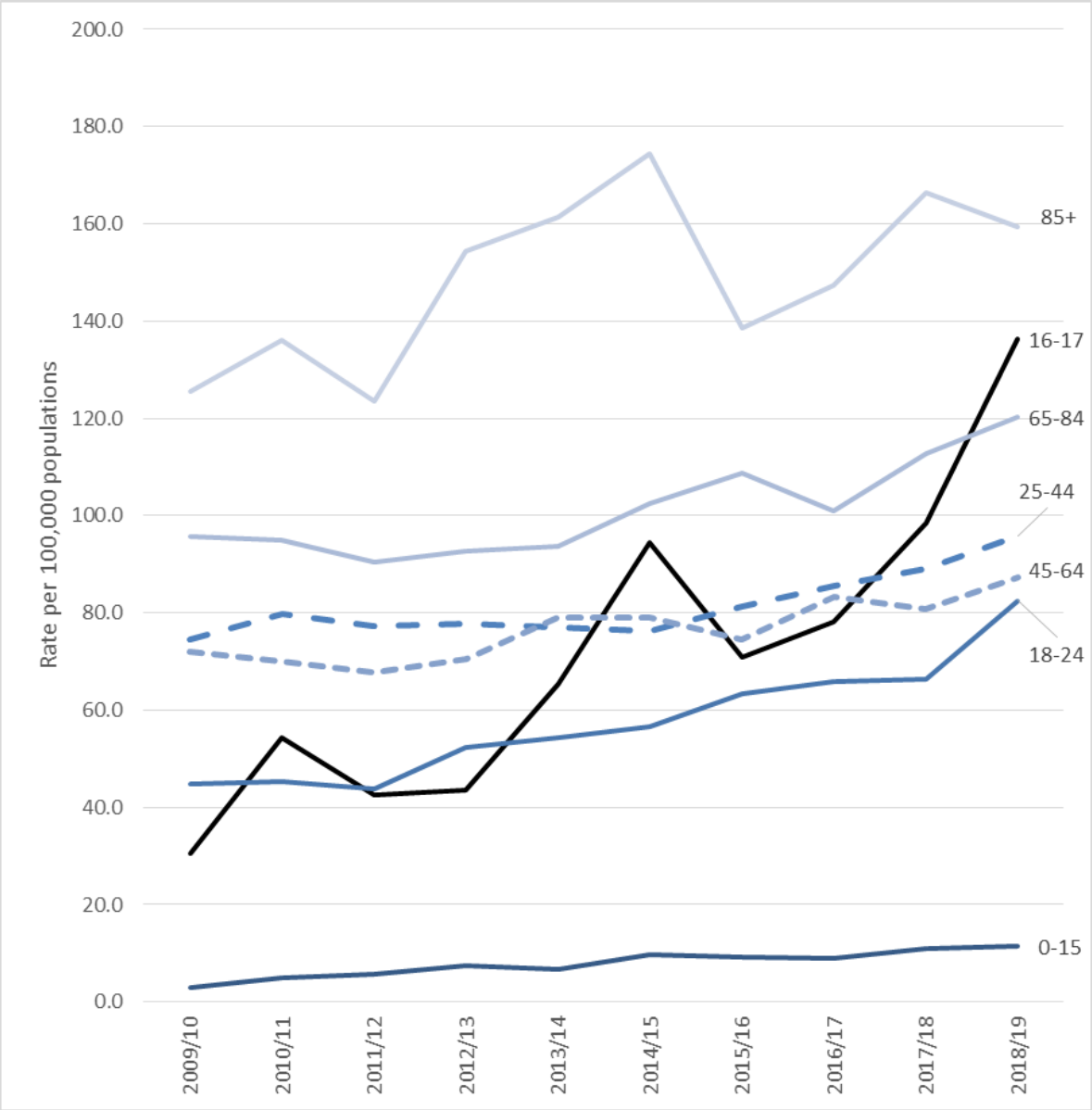


Table 3.2.1: STDCs – Women by age group 2009/10 to 2018/19 – Counts

Women Age group	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
0-15	13	22	26	33	30	43	41	40	49	51
16-17	20	34	26	26	39	56	41	44	54	73
18-24	109	113	111	132	136	140	157	161	158	192
0-24	**142**	**169**	**163**	**191**	**205**	**239**	**239**	**245**	**261**	**316**
25-44	537	572	553	551	542	535	572	605	633	685
45-64	519	513	505	525	592	597	567	639	625	676
25 to 64	**1056**	**1085**	**1058**	**1076**	**1134**	**1132**	**1139**	**1244**	**1258**	**1361**
65-84	410	410	394	415	428	476	511	480	542	584
85+	89	98	91	115	121	134	107	116	133	128
65-85+	**499**	**508**	**485**	**530**	**549**	**610**	**618**	**596**	**675**	**712**
Total	**1697**	**1762**	**1706**	**1797**	**1888**	**1981**	**1996**	**2085**	**2194**	**2389**

Figure 3.2.12 STDCs – Men by age group 2009/10 to 2018/19

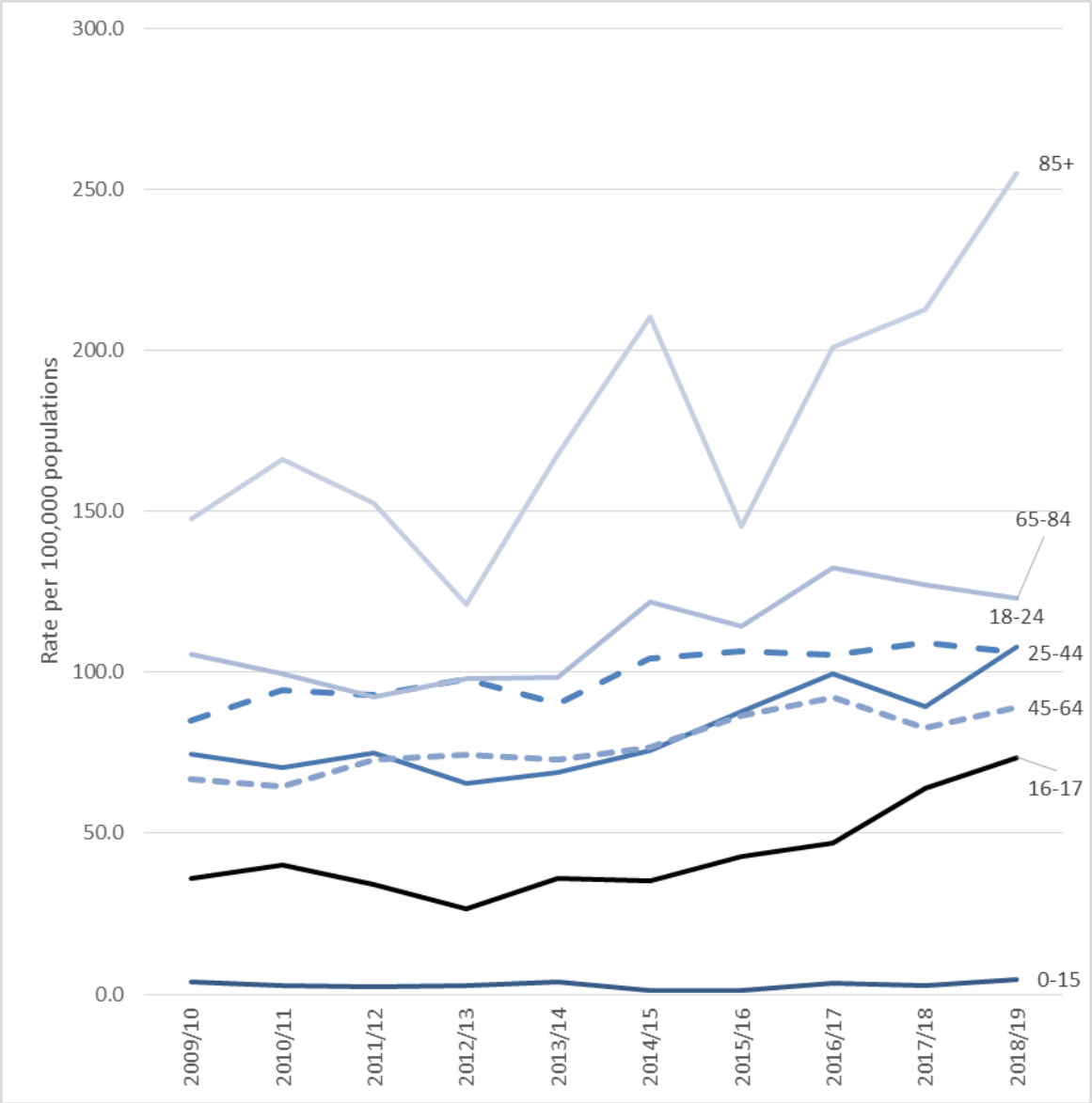


Table 3.2.2 STDCs – Men by age group 2009/10 to 2018/19 - Counts

Men Age group	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
0-15	17	13	11	13	18	5	6	16	13	22
16-17	24	26	22	17	23	22	26	28	37	41
18-24	181	174	189	165	173	189	219	245	217	258
0-24	**222**	**213**	**222**	**195**	**214**	**216**	**251**	**289**	**267**	**321**
25-44	586	647	636	664	610	705	722	722	754	738
45-64	462	454	520	530	520	549	622	667	601	649
25-64	**1048**	**1101**	**1156**	**1194**	**1130**	**1254**	**1344**	**1389**	**1355**	**1387**
65-84	360	345	326	361	374	474	454	536	522	512
85+	45	53	51	42	60	79	56	81	89	110
65-85+	**405**	**398**	**377**	**403**	**434**	**553**	**510**	**617**	**611**	**622**
Total	**1675**	**1712**	**1755**	**1792**	**1778**	**2023**	**2105**	**2295**	**2233**	**2330**

Young people

In women under the age of 25 there has been a 122.5% increase in STDCs since 2009/10, rising from a total of 142 to 316. In men under 25 there has been a 44.6% increase (from 222 to 321)

The rate for young women under 15 years has increased from 2.9 to 11.4 per 100,000 people over the ten year period. The increase in rate for young men under the age of 15 years has been less marked (3.6 to 4.7 per 100,000 people over the ten year period).

The rate for young women aged 16-17 years has increased from 30.4 to 136.3 per 100,000 people over the ten year period. For young men aged 16-17 years the rate has increased from (35.9 to 73.6 per 100,000 people over the ten year period).

Older people

In women of 65 and over there has been a 42.7% increase in STDCs since 2009/10, rising from a total of 499 to 712. In men of 65 and over there has been a 53.6% increase (from 405 to 622).

Diagnosis recorded

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

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

Table 3.2.3: Types and combinations of mental disorders recorded 2018/19

Mental disorder	**STD Certificates**	
	No.	**%**
Mental Illness	4194	89%
Mental Illness + Learning Disability	109	2%
Mental Illness + Personality Disorder	230	5%
Mental Illness + Personality Disorder + Learning Disability	9	0%
Personality Disorder	135	3%
Personality Disorder + Learning Disability	7	0%
Learning Disability	30	1%
Not recorded	5	0%
Total	**4719**	**100%**

Mental illness accounts for the vast majority of people detained under a STDC. In 2018/19 only one per cent of STDCs were for people with learning disability alone, and two per cent for people with learning disability and mental illness. Similarly, only three per cent were for people with a personality disorder alone.

The proportions have changed little over the past ten years.

For 2018/19 STDC diagnosis data, at initial inspection we found 49 (1%) cases to be 'blank' for the diagnosis category. Further inspection of forms found this was due to in-house processing errors (12) or clinician error (37).

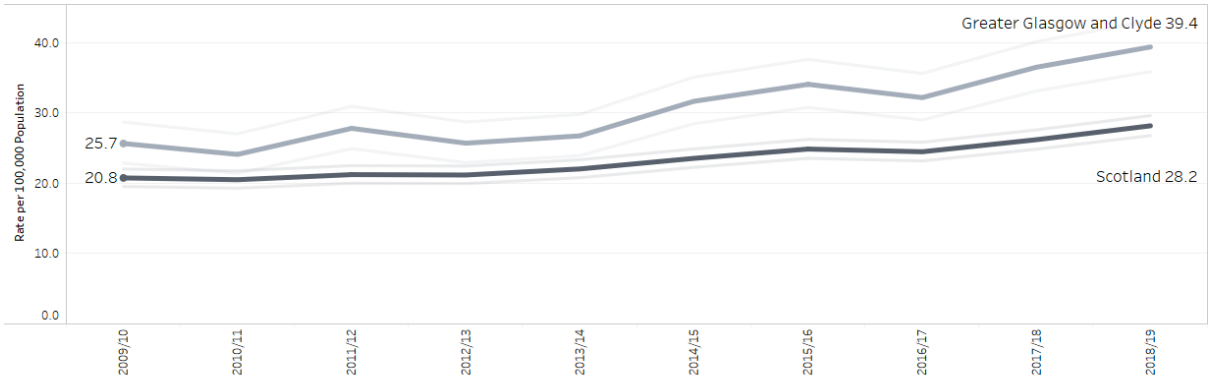
Where possible we used available data from the complete form to reassign the missing diagnosis categories; five cases remained unresolvable.

3.3: Compulsory treatment orders (CTOs)

The number of compulsory treatment orders completed per year has increased by 41.0% (1,087 to 1,533) over the ten year period.

The national rate for compulsory treatment orders has been rising steadily over the past ten years (from 20.8 to 28.2 per 100,000). The rate of increase is slower than for EDCs or STDCs.

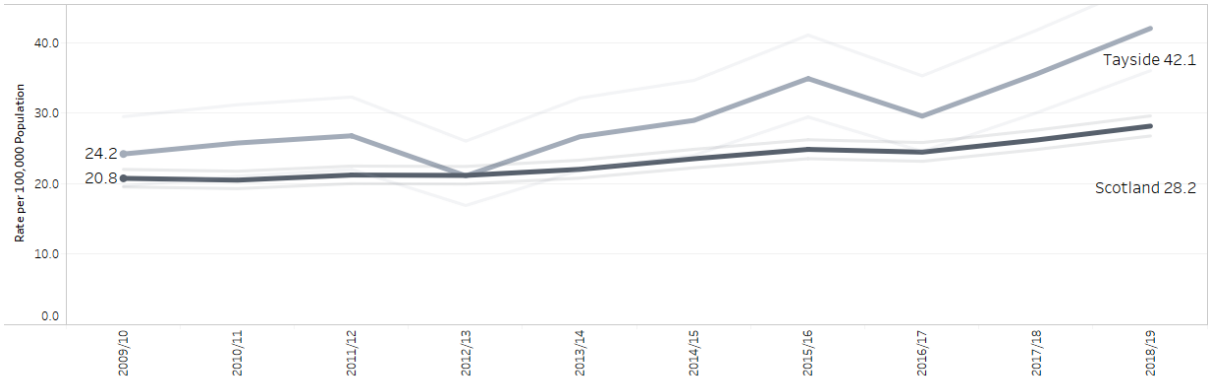
Figure 3.3.1: CTOs in Greater Glasgow & Clyde (95% confidence intervals)



Includes hospital and community CTOs (all interim orders are excluded)

The rate for Greater Glasgow and Clyde has been significantly above the national average for the past ten years (apart from a dip in 2010/11). Over the period it has risen from 25.7 to 39.4.

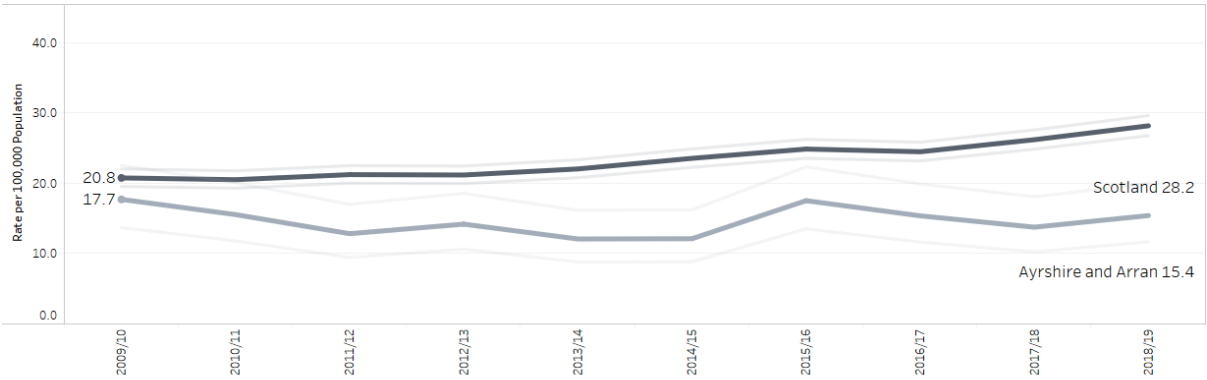
Figure 3.3.2: CTOs in Tayside (95% confidence intervals)



Includes hospital and community CTOs (all interim orders are excluded)

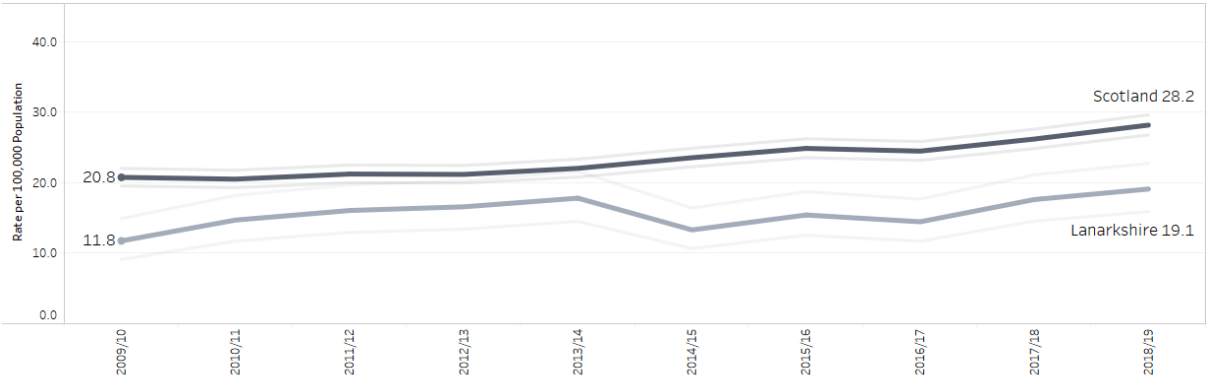
Tayside has been rising above the national average over the past six years.

Figure 3.3.3: CTOs in Ayrshire & Arran (95% confidence intervals)



Includes hospital and community CTOs (all interim orders are excluded)

Figure 3.3.4: CTOs in Lanarkshire (95% confidence intervals)



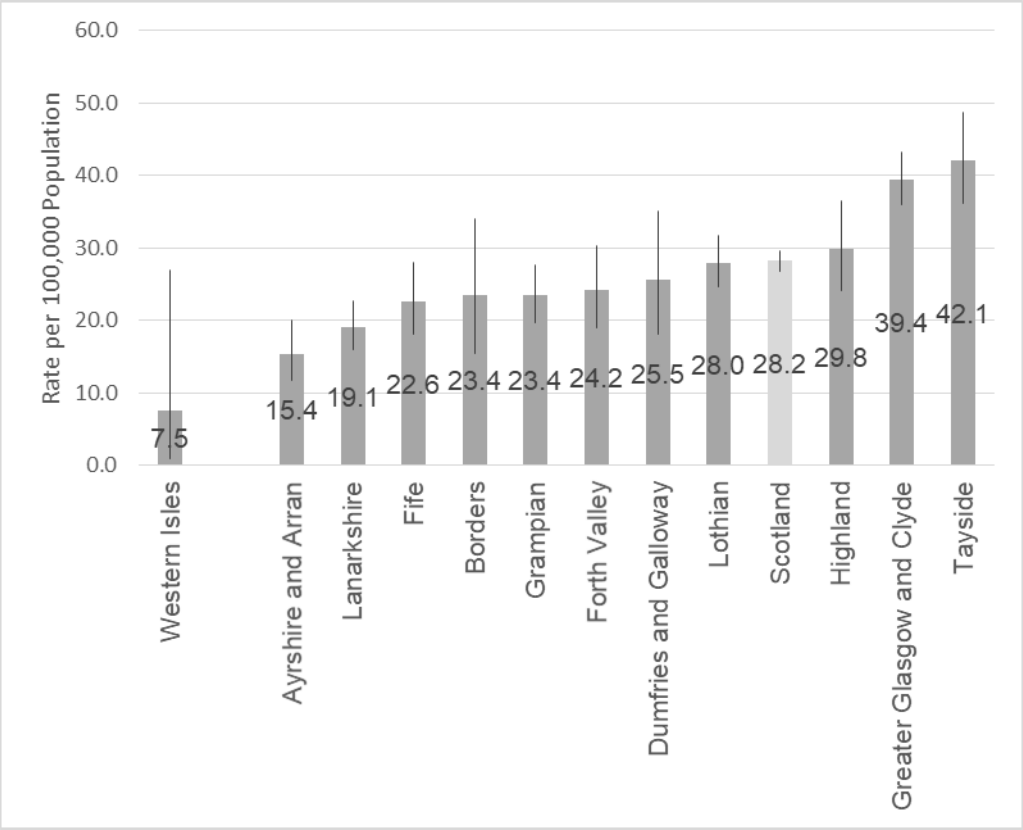
Includes hospital and community CTOs (all interim orders are excluded)

Ayrshire and Arran and Lanarkshire have had a lower CTO rate than Scotland over most of the ten years.

All other boards have not varied significantly from the national rate during the period.

Compulsory treatment orders 2018/19

Figure 3.3.5: CTOs by health board 2018/19 (rate per 100,000 population with 95% confidence intervals)



In 2018/19 two health boards were significantly above the Scotland rate (28.2; 95% CI: 26.8 to 29.6): Greater Glasgow & Clyde (39.4; 95% CI: 35.9 to 43.2) and Tayside (42.1; 95% CI: 36.1 to 48.8).

In 2018/19 two boards continued significantly below the Scotland rate (28.2; 95% CI 26.8 to 29.6): Lanarkshire (19.1; 95% CI 15.9 to 22.8) and Ayrshire & Arran (15.4; 95% CI: 11.7 to 20.0).

Orkney Health Board had no new CTOs in 2018/19.

3.4: Variations between local authorities

Glasgow City, Perth & Kinross, Dundee City have the highest rates of short term detention this year.

Perth & Kinross, West Dunbartonshire and Glasgow City have the highest rates for CTOs this year.

Table 3.4.1: STDCs and CTOs by local authority 2018/19– number and rate per 100k population

Local Authority	STDCs		CTOs	
	No.	Rate per 100K	*No.	Rate per 100K
Aberdeen City	209	91.8	70	30.8
Aberdeenshire	130	49.7	48	18.4
Angus	73	62.9	34	29.3
Argyll and Bute	60	69.6	24	27.8
City of Edinburgh	530	102.2	146	28.2
Clackmannanshire	59	114.8	18	35.0
Dumfries and Galloway	145	97.5	40	26.9
Dundee City	210	141.2	40	26.9
East Ayrshire	57	46.8	20	16.4
East Dunbartonshire	55	50.8	22	20.3
East Lothian	79	74.7	31	29.3
East Renfrewshire	63	66.2	26	27.3
Eilean Siar	9	33.5	2	7.5
Falkirk	125	78.0	44	27.4
Fife	292	78.5	88	23.7
Glasgow City	903	144.2	254	40.5
Highland	157	66.7	87	36.9
Inverclyde	93	119.0	30	38.4
Midlothian	65	71.2	20	21.9
Moray	58	60.7	20	20.9
North Ayrshire	66	48.8	25	18.5
North Lanarkshire	239	70.3	74	21.8
Orkney	5	22.5	0	0.0
Perth and Kinross	215	142.1	87	57.5
Renfrewshire	132	74.2	52	29.2
Scottish Borders	72	62.5	30	26.0
Shetland	6	26.1	7	30.4
South Ayrshire	65	57.8	18	16.0
South Lanarkshire	249	78.1	80	25.1
Stirling	69	73.1	17	18.0
West Dunbartonshire	66	74.0	37	41.5
West Lothian	163	89.5	42	23.1
Scotland	4719	86.8	1533	28.2

3.5: Equalities monitoring

Table 3.5.1: Missing ethnicity forms 2014 - 2019

	2014-2019	2018/19	
	Missing ethnicity forms (Range %)	**Total number of MHA forms**	**Missing ethnicity forms (%)**
CTO1	21% to 31%	1503	350 (23%)
DET1	8% to 10%	2963	248 (8%)
DET2	6% to 12%	4814	278 (6%)
NUR1	9% to 17%	181	17 (9%)
Total	9% to 13%	9461	893 (9%)

Over the past five years, for 9% to 13% of forms returned, we have not found the matching ethnicity form (i.e. the form which should have come in with the order). Over the five year period the different forms have varied in the proportion missing.

Table 3.5.2: Completion of ethnicity information where forms are present

	2014-2019	2018/19	
	Ethnicity information not completed (Range %)	**Total number of forms**	**Ethnicity information not completed (%)**
CTO1	14% to 16%	1153	187 (16%)
DET1	12% to 14%	2715	355 (13%)
DET2	18% to 22%	4536	1013 (22%)
NUR1	4% to 7%	164	7 (4%)
Total	16% to 18%	8568	1562 (18%)

Over the past five years, where the ethnicity form is present, ethnicity information has not been completed on 16% to18% of all forms. In 2018/19, DET2 forms for short term detention were the forms in which details of ethnicity was least often completed of the four forms monitored.

Table 3.5.3: Ethnicity as recorded in forms with a start date in 2018/19

Patient ethnicity	**Number**	**%**
White – Scottish	5713	83.6%
White – British	426	6.2%
White Polish	63	0.9%
White-Other	234	3.4%
Asian	185	2.7%
All other ethnic groups	215	3.1%
Total known	6836	100.0%
Information not provided or blank	2287	25.1%
Total number of forms	9123	
Blank	836	9.2%
Information not provided	1451	15.9%

For 25.1% of the ethnicity monitoring forms received, the form shows either “information is not provided” (15.9% of total i.e. this category has been positively recorded) or the options have been left blank (9.2% of total i.e. none of the options have been ticked).

This varies by form with the Nurses Power to Detain having 19.9% in the categories of information not provided or left blank and Short Term Detention forms having 26.9% in the categories of information not provided or blank.

The 2011 Census stated 4% of the population to be minority ethnic. The Scottish Government states 4% of the adult population are minority ethnic. https://scotland.shinyapps.io/sg-equality-evidence-finder/ (Source: Scottish Surveys Core Questions 2017, last updated: April 2019).

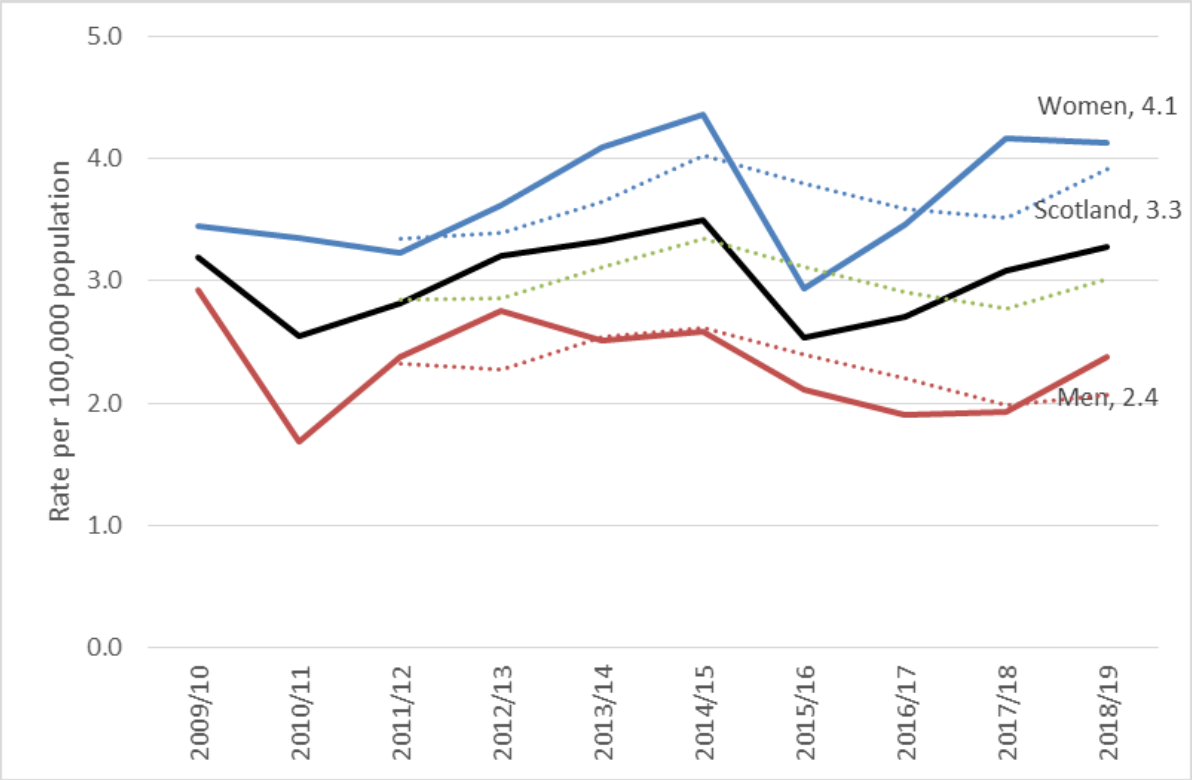
The above table shows ethnicity recorded by Census categories. Where ethnicity is known 5.8% of our forms are for minority ethnic populations (Asian 2.7%, all other ethnic groups 3.1%).

4: Nurse's power to detain

The Mental Health (Scotland) Act 2015 amends Section 299 of the 2003 Act; this means that a patient can be detained by the nurse for a period of up to three hours. The nurse exercising the power to detain must take all reasonable steps to inform an MHO of the detention.

In next year's monitoring report we will explore whether use of the nurse's holding power has changed following the 2015 Act amendment.

Figure 4.1: Nurse's power to detain by gender 2009/10 to 2018/19 - rate per 100,000 population, with three year moving average



Over the last ten years the number of times nurse's powers to detain were used across Scotland has varied between 134 and 187 (2014/15) per year.

The rate has risen in the past year to 3.3 per 100,000 population (178). The current rate for women at 4.1 continues higher than the rate for men at 2.4.

The 2018 Mental Health Inpatient Bed Census[3] recorded that 58% of inpatients were male and 42% female. The NUR1 returns to the Commission show a different gender ratio in the use of nurses power to detain, with 35% (63) of instances involving male patients and 65% (115) female patients.

	2018 Census		General Pop 2017	NUR1 2018	
Male	1993	58%	49%	63	35%
Female	1448	42%	51%	115	65%
All	3441	100%	100%	178	100%

[3] Scottish Government (2018) *Inpatient Census, 2018 Part 1: Mental Health & Learning Disability Inpatient Bed Census*

Table 4.1 Instances of use of nurse's powers to detain by Health Board.

Health Board	All
Ayrshire and Arran	9
Borders	~
Dumfries and Galloway	10
Fife	17
Forth Valley	7
Grampian	~
Greater Glasgow and Clyde	39
Highland	6
Lanarkshire	~
Lothian	53
Tayside	24
Western Isles	~
Scotland	178

~ Health Boards with five or fewer uses of Nurse's power to detain

This year we undertook a short exercise to review the 178 NUR1 forms we received.

On reviewing the forms, we found that over half (55%, 98) gave reasonable detail about the patient's presenting difficulties or symptoms and the risks associated with the need for the nurse to detain the patient. However around a third (35%, 63) recorded only brief paragraphs with minimal detail.

10% (17) of forms were detailed and covered the areas that we would expect to be considered. These included:

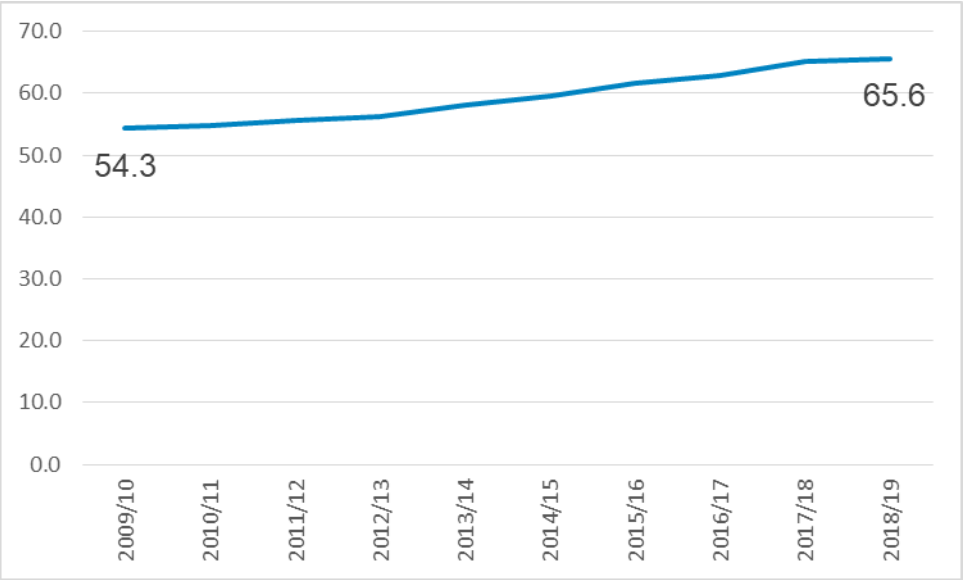
- Details about the specific mental health symptoms that are present at the time;
- Details about the patient's behaviours at the time;
- Details about the risks that have been/are present;
- Details about the risks should patient leave the clinical area;
- Details about why the nurse considers the need for medical assessment;
- Details of any interventions/practice that are required to manage the patient prior to medical assessment.

5: Total number of Mental Health Act orders in existence

5.1: All orders

Over the past ten years the total numbers of orders in existence in Scotland has risen steadily, increasing by 25.6% from 2,840 (January 2010) to 3,567 (January 2019). The national prevalence rate of all compulsory orders has risen by 20.8% from 54.3 to 65.6 per 100,000 population.

Figure 5.1.1: Total number of Mental Health Act orders in existence (Scotland rate per 100,000 population)



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 5.1.2. 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:

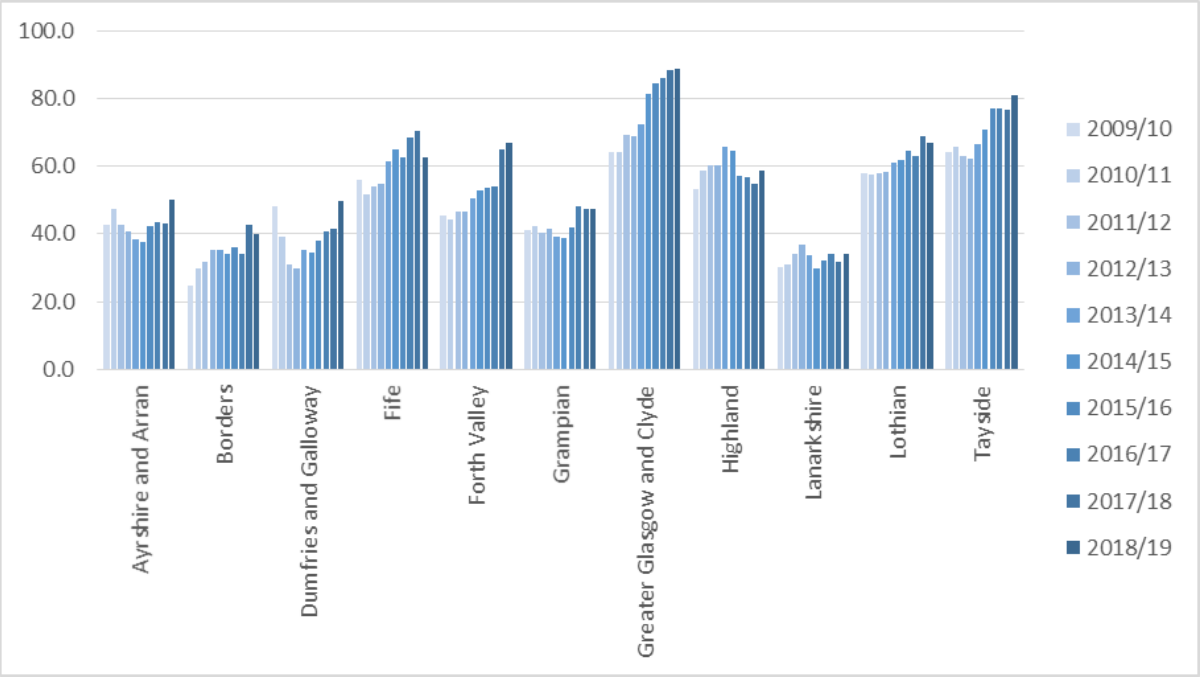
- Greater Glasgow and Clyde and Tayside have the highest prevalence of compulsory treatment which has continued to rise over the ten year period (GGC 64.0 to 88.8; Tayside 64.0 to 81.0).
- Borders (39.9) and Lanarkshire (34.3) have the lowest prevalence of compulsory treatment.

In our previous published report[4] we recommended that "the Scottish Government explores how to better understand the significant variations in the use of compulsory treatment through data linkage with other information sources." Since publishing this recommendation initial

[4] Mental Welfare Commission for Scotland (2017) Mental Health Act monitoring report 2016-17.

progress has been made - with the inclusion of Mental Health Act Activity among the suite of Quality Improvement indicators for mental health, and a commitment from ISD to scope out further potential in this area.

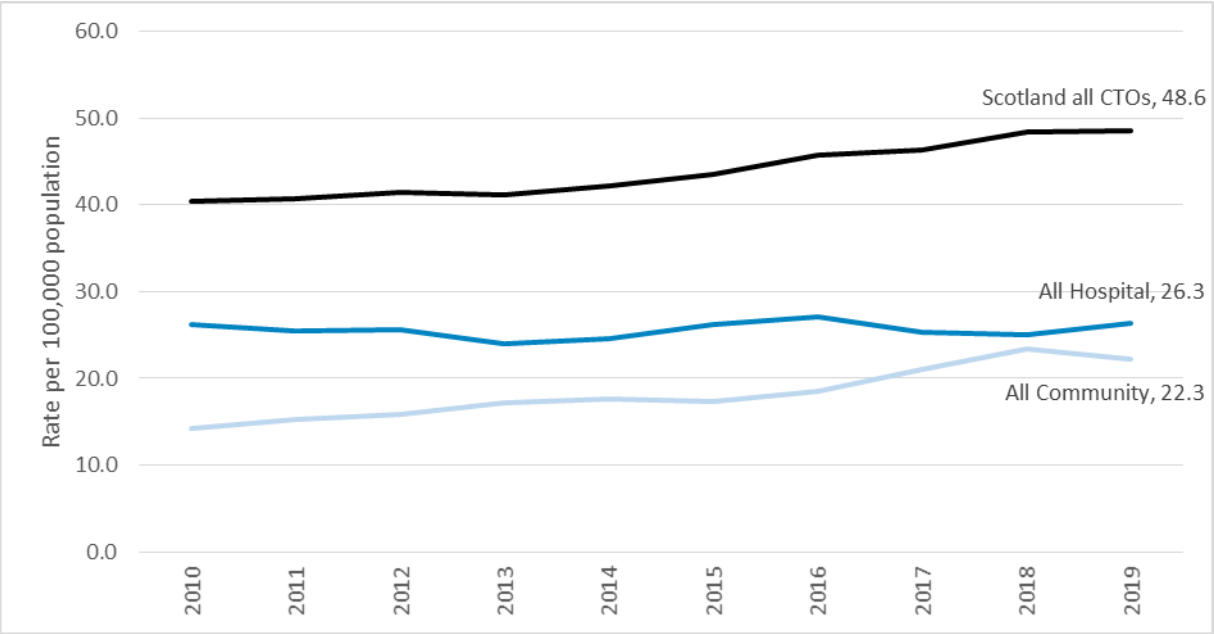
Figure 5.1.2: Ten year trends in prevalence of all compulsory orders per 100,000 population by NHS board (2009/10 to 2018/19)*



*All prevalence data has been refreshed this year. Prevalence is taken at first week of January each year.

5.2: Compulsory treatment orders

Figure 5.2.1: Point prevalence of CTOs 2010-19* (rate per 100,000 population)



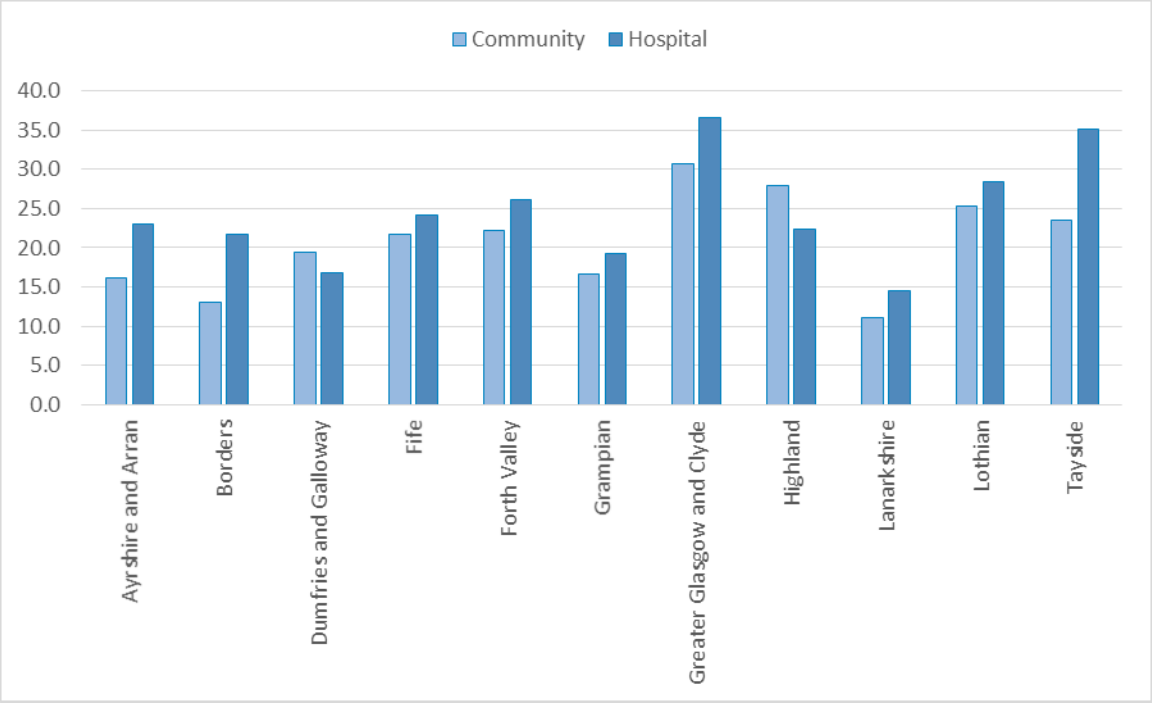
*All data has been refreshed back to January 2010

Over the ten year period the point prevalence of all CTOs has increased by 20.1% from 40.5 (per 100,000) at January 2010 to 48.6 (per 100,000) at January 2019. This continues the upward trend. Most of the increase is due to the 56.4 rise in point prevalence of community based orders from 14.2 to 22.3 (per 100,000) while that of hospital based CTOs has been static at 26.2 to 26.3 (per 100,000).

The proportion of community orders relative to hospital orders has risen over the period, from 37.6% January 2010 to 45.8% January 2019. The proportion reached a high of 48.3% at January 2018. 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 (36.6), followed by Tayside (35.1) and Lothian (28.4). Lanarkshire (14.6) has the lowest prevalence of hospital CTOs compared with other mainland NHS boards.
- Greater Glasgow and Clyde (30.6), and Highland (28.0) have the highest use of community compulsory treatment in Scotland.
- Dumfries and Galloway and Highland are currently the only mainland boards which make more use of community CTOs than hospital CTOs.

Figure 5.2.2: All existing hospital vs community CTOs per 100,000 population by NHS board Jan 2019



5.3: Advance Statements

An advance statement is a written statement, created when a person is well that sets out how they would prefer to be treated (or not treated) if they were to become ill in the future. It has to be signed, witnessed and dated. The Tribunal and any medical practitioner treating a person must have regard to their advance statement. If the wishes set out in an advance statement have not been followed a written record (an Advance Statement Override) giving the reasons must be sent to the Mental Welfare Commission.

In 2018/19 under section 276A of the Act, Hospital Managers returned 271 forms for 253 people. Any form with the hospital managers' signature date in 2018/19 was included (at the bottom of the Advance Statement ADV 1 form). For some forms the date the advance statement commenced (Date of advance statement) would have been in earlier years.

Individual has an advance statement	251
Individual had both an advance statement and a withdrawn advance statement	19
Individual withdrew advance statement	1
Total	271

Table 5.3.1: Advance Statements by Health Board

Health board	Number
Ayrshire and Arran	1
Borders	0
Dumfries and Galloway	8
Fife	5
Forth Valley	4
Grampian	13
Greater Glasgow and Clyde	128
Highland	2
Lanarkshire	10
Lothian	26
Shetland	0
State hospital	4
Tayside	26
Private hospitals	24
Total	271

The Commission intends to publish data for Advance Statement Overrides for 2017/18 and 2018/19 once these have been fully collated.

6: Compulsory treatment under criminal proceedings

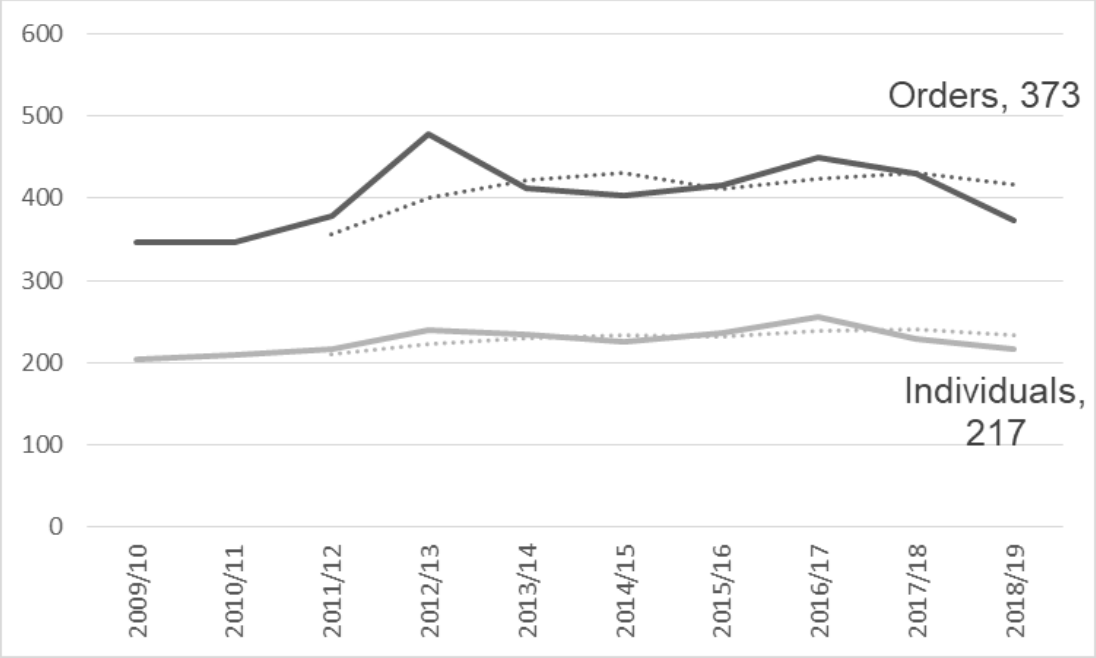
People with a mental disorder who are accused or convicted of a criminal offence may be dealt with by being placed on an order under the Criminal Procedure (Scotland) Act 1995 (CPSA), which requires them to be treated in hospital or, occasionally, in the community. In some cases, additional restrictions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

In 2018/19, 217 individuals were subject to a CPSA order, with the total number of orders amounting to 373 orders. These numbers are similar to those of 2009/10 but in the more recent intervening years the number of orders imposed increased relative to the number of individuals. This might reflect a changing threshold by services to report hospital based incidents of violence by patients to police followed by charges being brought.

Table 6.1: Total number of CPSA orders and individuals per year

Order Type	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Orders	347	346	378	478	412	404	416	449	430	373
Individuals	204	210	217	239	235	226	236	255	229	217

Figure 6.1: Total number of CPSA orders and individuals per year (with three year moving average)



6.1: Assessment and Treatment Orders

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

Table 6.1.1: Number of Assessment and Treatment Orders

Order Type	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Assessment Order	131	142	130	158	131	133	141	129	131	122
Treatment Order	78	64	103	142	98	106	113	109	115	96

Our information management system records each treatment order received as a distinct order. For example, an individual may be recorded as having two or three consecutive treatment orders and then an interim compulsion order. The number of individuals who have been subject to treatment orders in 2017/18 is 87 (115 orders) and in 2018/19 is 80 (96 orders).

6.2: Unfitness for trial and acquittal by reason of mental disorder

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

Unfitness for trial

Table 6.2.1: Number of Temporary Compulsion Orders

Order Type	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Temporary Compulsion Order	10	14	12	17	7	20	18	20	20	13

This year the use of the Temporary Compulsion Order (13) has returned to a similar level to years 2009-2012.

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

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

Table 6.2.2: Acquitted by reason of mental disorder and unfitness for trial: disposals

Order Type	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
S57(2)(a) Compulsion Order	13	10	7	12	15	21	26	28	50	33
S57(2)(a) Compulsion Order - community	0	1	0	0	1	0	0	0	0	0
S57(2)(b) Compulsion Order with Restriction Order (CORO)	1	2	5	4	9	5	3	5	4	6
Guardianship S57(2)(c)*	0	0	1	0	0	0	0	0	0	0
Supervision & Treatment Order S57(2)(d)*	0	0	0	1	0	3	0	3	1	1

*Data refreshed for 2017/18 and 2018/19. Data from 2016/17 report for previous years.

As can be seen, other than one Supervision and Treatment Order all of the outcomes for 2018/19 involved inpatient treatment. It is likely that this reflects the serious nature of the patients' mental condition. No individual was sentenced to a community based compulsion order.

6.3: Post-conviction predisposal

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

Table 6.3.1: Post-Conviction, Pre-Disposal

Order Type	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Interim Compulsion Order	17	22	19	26	32	21	23	26	23	15
S200 Committal	0	0	1	2	1	0	0	0	0	0

At 15 the number of interim compulsion orders recorded in 2018/19 is the lowest in the ten year period. Section 200 is seldom used due to the more flexible use of assessment and treatment orders post-conviction.

6.4: Final mental health disposals by the court

There are three hospital disposals available, namely a compulsion order, compulsion order with restriction order (CORO) and hospital direction. A CORO 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 where the person's offence is not related to mental disorder but, once they recover, to be transferred to prison to complete their sentence.

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

Mental Health Disposals

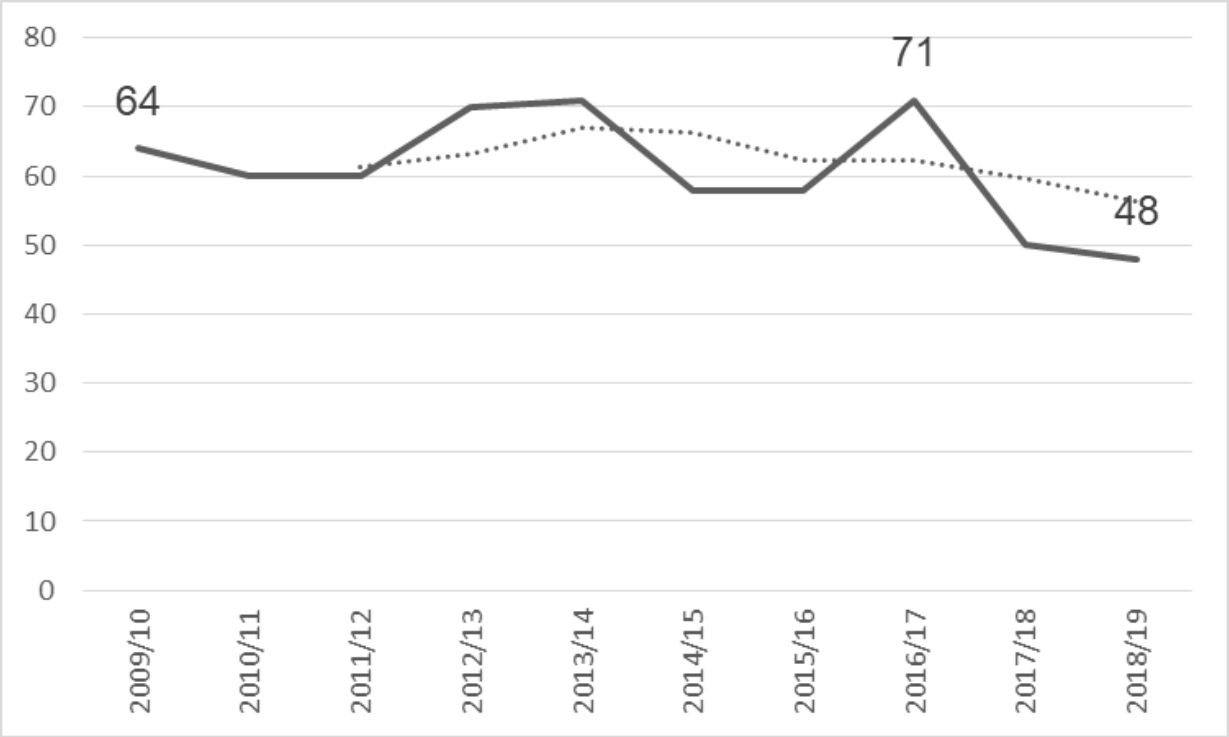
Table 6.4.1: Number of mental health disposals

Order Type	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
S57A (2) Compulsion Order	53	50	46	60	57	44	45	60	42	39
S57A (2) Compulsion Order - community	1	3	0	1	1	1	0	1	1	0
S59 CORO	9	5	12	7	10	8	9	10	4	7
Hospital Direction	0	1	1	1	2	3	2	0	2	2
Guardianship Order S58* [z]	1	1	(1)	1	1	2	1(1)	0	1	0
All mental health disposals	64	60	60	70	71	58	58	71	50	48

* Data refreshed for 2017/18 and 2018/19. Data from 2016/17 report for previous years.
[z] Figures in brackets represent renewals in that year

The number of hospital directions remains low, suggesting that the remand provisions, including the interim compulsion order, allow careful evaluation prior to final disposal. The numbers of compulsion orders and COROs have remained low in 2018/19 relative to previous years.

Figure 6.4.1: All CPSA mental health disposals (with three year moving average)



Transfer for treatment directions

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

Table 6.4.2: Number of transfer for treatment directions

Order Type	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Transfer for Treatment Direction	33	31	42	46	47	37	36	58	36	39

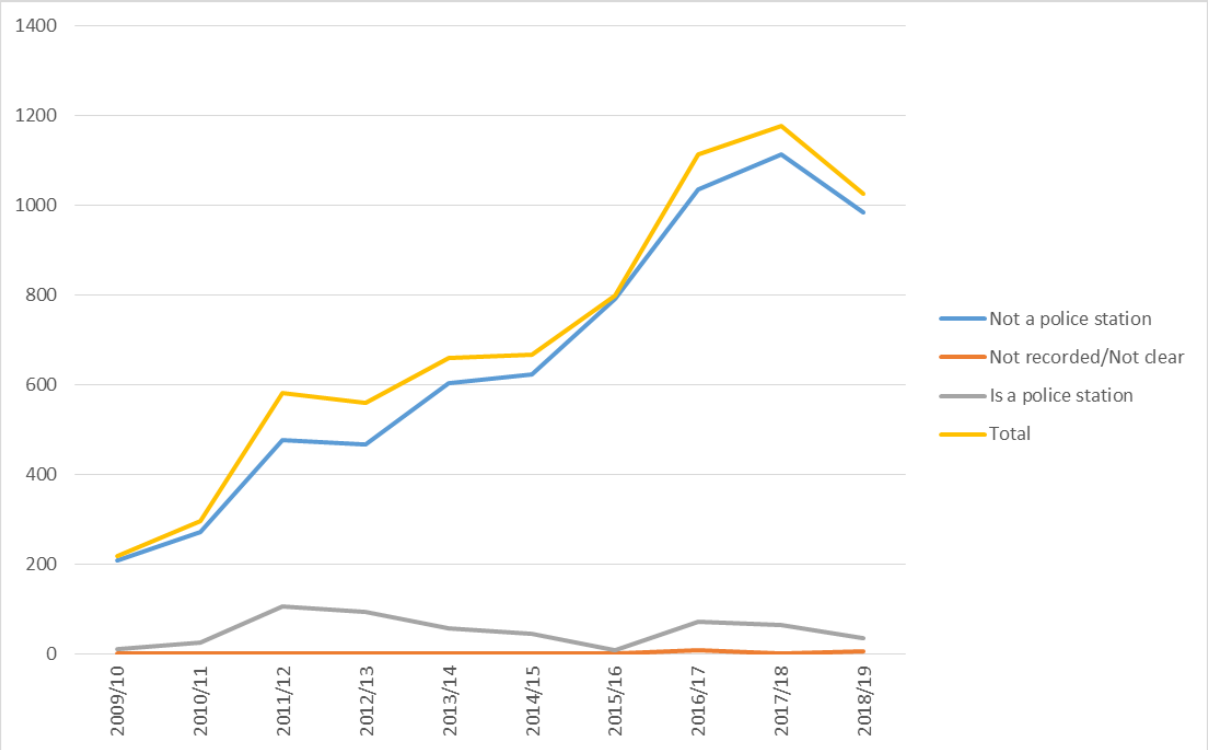
7: Place of Safety orders

Table 7.1: Place of Safety notifications 2009-19, by location (NHS or Police Station) (% in brackets)

Location	2009 /10	2010 /11	2011/ 12	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19
NHS	207	272	476	466	604	624	791	1036	1115	984
Not recorded/ Not clear	0	0	0	0	0	0	0	7	0	6
Police station	10 (5%)	25 (8%)	106 (18%)	94 (17%)	56 (8%)	44 (7%)	8 (1%)	71 (6%)	63 (5%)	35 (3%)
Total	217	297	582	560	660	668	799	1114	1178	1025

*All data refreshed in 2018/19.

Figure 7.1: Place of safety notifications 2009-19, by location (NHS or Police Station)



Total numbers of POS had been rising steadily but has dropped in the last year.

The number of orders in which the identified place of safety was a police station was at its highest in 2011/12 at 106 (18%). This percentage has dropped to 3% (35).

A very small number (11 over ten years) were incidents picked up by the British Transport Police.

We published a detailed monitoring report regarding place of safety orders in 2018[5]. In response to this Police Scotland have worked on improving data collection (with a pilot using hand held devices underway uploading information to a centralised hub) and have given renewed focus to engaging with mental health services to identify appropriate pathways of care for people who present to police in crisis. Reducing the use of POS where possible and using police stations only as a last resort have been key outcomes for this work.

The Commission continues to monitor this activity and its relevance to the content of local psychiatric emergency plans.

Table 7.2: Number of POS notifications by Local Authority 2018/19

Local Authority	POS at NHS site	Not clear	Taken into custody	PO	Total
Aberdeen City	122	1			123
Aberdeenshire	30				30
Angus	9			6	15
Argyll & Bute	19			1	20
Argyll and Bute	1				1
City of Edinburgh	20				20
Clackmannanshire	4				4
Dumfries & Galloway	20		1		21
Dundee City	15		1	11	27
East Ayrshire	9				9
East Dunbartonshire	6				6
East Lothian	8				8
East Renfrewshire	1				1
Edinburgh City of	41		1		42
Falkirk	12			1	13
Fife	112		1		113
Fife	5			1	6
Glasgow City	50				50
Highland	100			1	101
Highland	31			1	32
Inverclyde	2				2
Midlothian	2				2
Moray	12				12
North Ayrshire	7				7
North Lanarkshire	18				18
Orkney Islands	1				1
Perth & Kinross	4			1	5
Perth and Kinross	1			2	3
Renfrewshire	16			1	17
Scottish Borders	12			*(1)	13
South Ayrshire	7				7
South Lanarkshire	26				26
Stirling	8			2	10
West Dunbartonshire	9			1	10
West Lothian	13				13
Not clear	231		1	5	237
Total	984	1	5	*35	1025

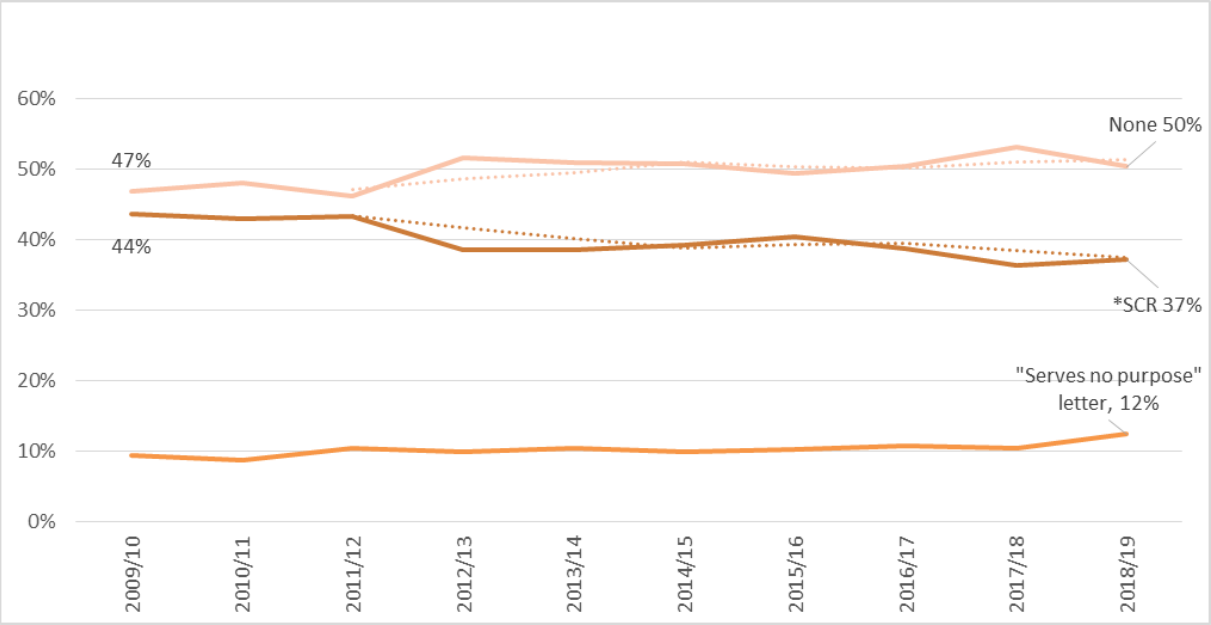
*Includes one British Transport Police – Scottish Borders

[5] Mental Welfare Commission for Scotland (2018) *Place of Safety Monitoring report 2018.* https://www.mwcscot.org.uk/sites/default/files/2019-06/Place%20of%20safety%20report%202018_0.pdf

8: Social circumstances reports (SCRs)

Figure 8.1: Percentage of SCRs completed across Scotland for STDCs* (with three year moving average)

A Social Circumstances Report is a document prepared by a Mental Health Officer within 21 days of a person being detained under a STDC that provides an account of the circumstances of the person who is detained under a STDC. Other detention events also can require the preparation of an SCR; the most common detention requiring this is a STDC. These reports provide information about the interaction between a person's mental disorder and their personal and social circumstances, the MHO's views on the use of compulsory powers, the alternatives that might be available to compulsory treatment and other relevant factors that might help an RMO and treatment team in delivering care and treatment to the individual and the Commission in discharging its duties under the Act.



*2018/19: 1754 SCRs completed for total 4719 STDCs.

Over the ten year period, completion of SCRs in relation to STDCs continues a downward trend from 44% to 37% across Scotland as a whole.

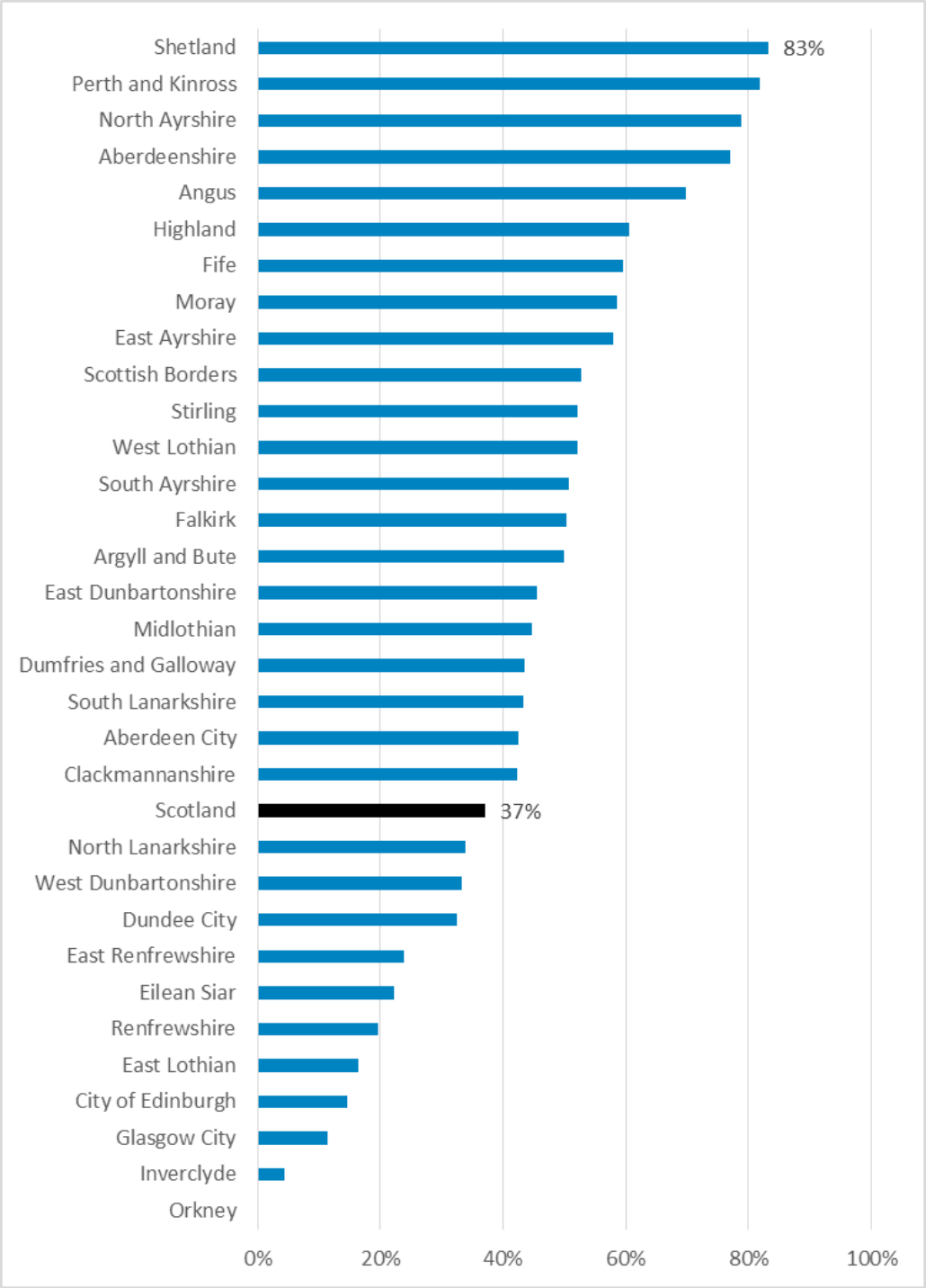
However, this is in the context of an additional 1,347 STDCs per year by 2018/19, generating an additional 282 SCRs and 270 'serves no purpose' notifications per year.

There is a significant variation in the completion of SCRs across Scotland, with Edinburgh City, Glasgow City and West Dunbartonshire consistently completing the lowest percentage of SCRs following a STDC. (Average across ten years: Edinburgh City 23%, Glasgow City 17%, West Dunbartonshire 21%).

A number of local authorities have seen a substantial increase in completion of SCRs from the starting year 2009/10 to the current year 2018/19, notably Highland (15%–61%).

East Renfrewshire has a reduced completion of SCRs over the ten year period from 61% to 24%. Inverclyde has seen substantial reduction in completion of SCRs in recent years from 51% in 2014/15 to 4-10% over the past four years. East Lothian has shown a sharp drop from 37% in 2017/18 to 16% this year.

Figure 8.2: SCRs completed following STDC 2018/19 (%)



The percentage of STDCs that triggered the completion of an SCR in 2018/19 was 37%. There was very wide variation across local authorities in the percentage completion of SCRs following an STDC.

Table 8.1: Provision of SCRs following STDC – 2018/19

Local Authority	Documents returned to MWC following STDC						STDCs in LA	
	None		"Serve no purpose" letter		SCR		Total	
	No.	%	No.	%	No.	%	No.	%
Aberdeen City	105	50%	15	7%	89	43%	209	100%
Aberdeenshire	15	12%	15	12%	100	77%	130	100%
Angus	20	27%	2	3%	51	70%	73	100%
Argyll and Bute	26	43%	4	7%	30	50%	60	100%
City of Edinburgh	406	77%	47	9%	77	15%	530	100%
Clackmannanshire	21	36%	13	22%	25	42%	59	100%
Dumfries and Galloway	72	50%	10	7%	63	43%	145	100%
Dundee City	104	50%	38	18%	68	32%	210	100%
East Ayrshire	17	30%	7	12%	33	58%	57	100%
East Dunbartonshire	28	51%	2	4%	25	45%	55	100%
East Lothian	64	81%	2	3%	13	16%	79	100%
East Renfrewshire	43	68%	5	8%	15	24%	63	100%
Eilean Siar	2	22%	5	56%	2	22%	9	100%
Falkirk	50	40%	12	10%	63	50%	125	100%
Fife	83	28%	35	12%	174	60%	292	100%
Glasgow City	640	71%	161	18%	102	11%	903	100%
Highland	18	11%	44	28%	95	61%	157	100%
Inverclyde	89	96%		0%	4	4%	93	100%
Midlothian	29	45%	7	11%	29	45%	65	100%
Moray	21	36%	3	5%	34	59%	58	100%
North Ayrshire	10	15%	4	6%	52	79%	66	100%
North Lanarkshire	139	58%	19	8%	81	34%	239	100%
Orkney	5	100%		0%		0%	5	100%
Perth and Kinross	12	6%	27	13%	176	82%	215	100%
Renfrewshire	80	61%	26	20%	26	20%	132	100%
Scottish Borders	27	38%	7	10%	38	53%	72	100%
Shetland		0%	1	17%	5	83%	6	100%
South Ayrshire	22	34%	10	15%	33	51%	65	100%
South Lanarkshire	101	41%	40	16%	108	43%	249	100%
Stirling	29	42%	4	6%	36	52%	69	100%
West Dunbartonshire	36	55%	8	12%	22	33%	66	100%
West Lothian	64	39%	14	9%	85	52%	163	100%
Scotland	2378	50%	587	12%	1754	37%	4719	100%

The Commission published a Good Practice Guide in relation to Social Circumstances reports in April 2009 and a recent review of this would suggest that the information remains relevant today.

The 2003 Act extended the duties and responsibilities of mental health officers, one of which required the MHO to produce a SCR under section 231 of the Act. An MHO is regarded as having the expertise in analysing the interaction between the health and social circumstances of the person who has been detained, together with the knowledge of alternative care and support options which may be available in the community.

With the implementation of Self Directed Supports, these options have increased further and could offer a real alternative to lengthier detention in hospital.

The absence of this level of analysis by the MHO is significant and could impact on outcomes for the adult at a crucial time in their lives.

There is an awareness that there may be a duplication in information provided within the SCR and an application for ongoing detention under a Compulsory Treatment Order but the purposes and timing of these reports are distinct. The SCR should be completed within 21 days of the relevant event which has prompted it as a tool to assist in the planning for ongoing care. Retrospective completion of this report post a decision about further detention defeats the purpose for which it was intended and non-completion, unless it serves no purpose, represents a missed opportunity for the consideration of alternatives to detention.

It is worth noting, however, that the Good Practice Guidance referred to above was written at a time where demands on MHO services were significantly less than they are today and while the provision of SCR's remain as relevant, MHO capacity to provide them continues to reduce year on year as competing demands rise. We would take this opportunity to remind local authorities of their duties under legislation to designate MHO's for each patient's case (s.229) and to appoint sufficient MHO's for the purpose of discharging statutory functions (s.32 MH(C&T)(S) Act 2003.

9: Consent to treatment under Part 16 of the Act

Our interest in these figures

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

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. Transcranial Magnetic Stimulation (TMS) and Vagus Nerve Stimulation (VNS) are also treatment options available for severe depression and are subject to safeguards under section 237(3)(b). However these (TMS, VNS are not commonly used treatments and the Commission has not received requests to approve these treatments for patients subject to these safeguards in the period of this monitoring report.

If a patient is considered to be capable of consenting, and does so in writing, the responsible medical officer (RMO) completes a Form T2 'Certificate of Consent to Treatment.'

If a patient is incapable of consenting, treatment may be authorised by a DMP on Form T3 'Certificate of the Designated Medical Practitioner.' Section 240 treatment (medicine for the purpose of reducing sex drive, medicine given beyond two months, and artificial nutrition) can also be authorised by a DMP if a patient is capable but refusing consent, if the DMP certifies that the treatment is in the patient's best interest.

The following tables show the trends over the last ten years in T2 and then T3 forms for the various treatments.

Certificate of Consent to Treatment (Form T2)

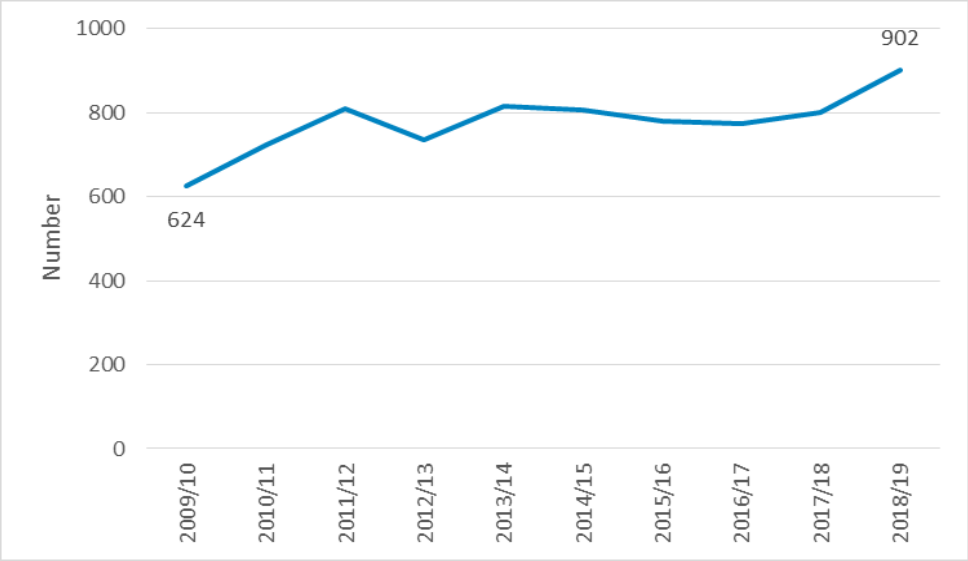
The majority of T2 forms relate to treatment with medication given beyond two months from the point of any detention under the Act. This therefore includes treatment that might have started on an EDC and continued if the person was then detained on a STDC. T2 forms are rarely used in relation to medicine to reduce sex drive or artificial nutrition. It is more common for these to be given with DMP authorisation, or under the Adults with Incapacity (Scotland) Act 2000 in the case of medicine to reduce sex drive. The figures had been fairly stable for eight years. This year we note a rise in the number of T2 certificates. This may reflect an increasing number of people detained under the Act.

Table 9.1: Certificate of Consent to Treatment (T2) 2009/10 to 2018/19

Treatment type	2009/10	2010/11	2011/12	20012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
ECT	15	15	26	17	14	16	8	21	23	30
Medication to reduce sex drive	0	0	0	1*	0	2*	0	1	1	2
Artificial nutrition	1	1	0	2	2	5	1	0	3	8
Medication beyond 2 months	608	707	783	717	798	785	769	751	773	862
Total T2 certificates*	624	723	809	736	814	807	778	773	800	902

*One T2 certificate had medication to reduce sex drive as well as medication beyond two months

Figure 9.1: Certificate of Consent to Treatment (T2) 2009/10 to 2018/19



Certificate of the designated medical practitioner (Form T3)

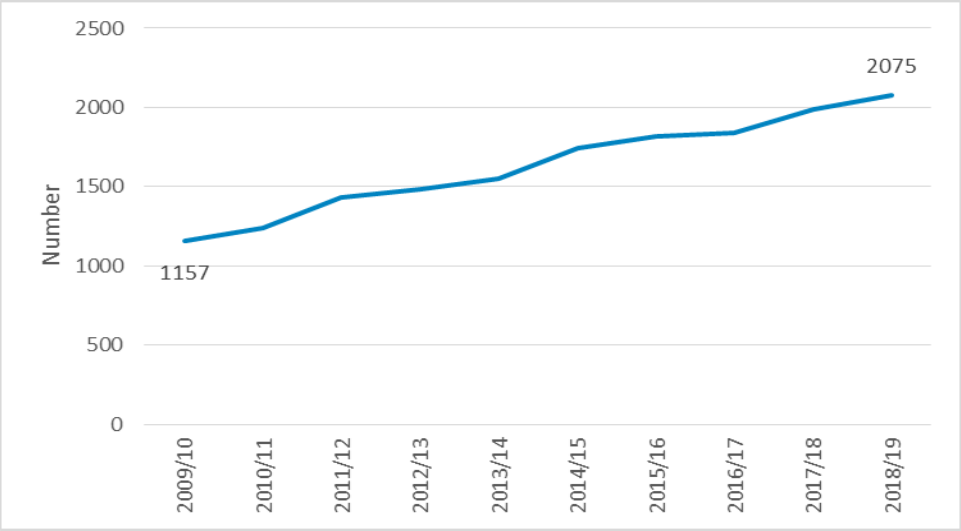
As noted above, a DMP can authorise treatment if a patient is incapable of consenting, and in some cases, if they are capable and refusing. The following section looks at the trends in T3 certificates over the last ten years. There has been a significant increase in the number of T3s issued since the Act came in to force in October 2005. The numbers of T3s issued each year is shown in the following table and graph. There were 2075 T3s issued in the 2018/19 reporting year. The table also shows the number of certificates issued for each treatment. The number of DMPs available to undertake these visits has not increased by the same proportion so there is an increasing reliance on existing DMPs, who often undertake these assessments outside of their own normal working hours,. Further information on the DMPs is provided later in this section.

Table 9.2: Certificate of the designated medical practitioner (T3) 2009/10 to 2018/19 (All age groups)

Treatment type	2009/10	2010/11	2011/12	20012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
ECT	166	180	203	147	171	186	207	176	224	222
Medication to reduce sex drive	1	1	1	5	5	9	7	10	10	12
Artificial nutrition	22	26	38	49	55	77	98	99	116	137
Medication beyond 2 months	968	1030	1193	1283	1317	1470	1503	1559	1642	1704
Total T3 certificates*	1157	1237	1435	1484	1548	1742	1815	1844	1992	2075

*T3 certificate may be for more than one treatment

Figure 9.2: Certificates of the designated medical practitioner (T3s) issued per year



Electroconvulsive Therapy (ECT)

Treatment with ECT can only be given if a patient is capable of consenting and consents, or is incapable and treatment is authorised by a DMP. ECT cannot be given under any circumstance to a patient who has the capacity to consent, but refuses to consent.

As well as assessing the patient's capacity to consent, the DMP must also consider whether the patient resists or objects to treatment with ECT. If the patient lacks capacity and is resisting or objecting, the DMP must also be satisfied that treatment is necessary to save the patient's life; prevent serious deterioration; and/or alleviate serious suffering. If the patient lacks capacity and is not resisting then the DMP must be satisfied that the ECT treatment will alleviate serious suffering and/or prevent serious deterioration. This is recorded on the T3 certificate.

The following table shows the number of T3 certificates issued for ECT each year, as well as the number of patients considered to be resisting or objecting. For those resisting or objecting, the percentage in which treatment was authorised to prevent serious deterioration and/or alleviate serious suffering or save life is shown.

In the last year, treatment was authorised to save life in a resisting or objecting patient on 14.4% of occasions. This figure has been fairly stable in the last four years, but had been 19-20% in previous years.

Table 9.3: Certificate of the designated medical practitioner for ECT 2009/10 to 2018/19

	2009/10	2010/11	2011/12	20012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Number of T3 Certificates issued for ECT	166	180	203	147	171	186	207	176	224	222
Percentage resisting or objection	45.8%	62.8%	64.0%	59.9%	70.2%	72.6%	66.7%	71.0%	72.3%	63.8%
Percentage of those resisting where treatment required to alleviate serious suffering, prevent serious deterioration or save life	100.0%	99.1%	99.2%	98.9%	99.2%	98.5%	99.3%	100.0%	100.0%	98.6%

This year (2018/19) 46 different DMPs (the Commission maintains the register of DMPs) issued the 222 certificates for ECT. The Commission does not currently report on how many authorisations for ECT are refused or restricted following visits by DMPs. The Commission aims to report on this in future monitoring reports. We aim to explore the Appendix A reports that DMPs submit to the Commission following visits and the accompanying letters to RMOs (senior doctors that lead a patient's clinical care) to gain a better understanding of this safeguard as it relates to ECT authorisations, modifications and refusal of authorisations.

Artificial Nutrition

As can be seen from table 9.4, there has been a significant increase in the number of certificates issued to authorise the use of artificial nutrition. There were 22 certificates in 2009/10 and 137 in 2018/19. The number of certificates issued for under 18 year olds and the percentage of the total is also shown. The Commission is currently undertaking a focussed visit on Eating Disorders services in Scotland.

Table 9.4: Certificate of the designated medical practitioner for artificial nutrition 2009/10 to 2018/19

Artificial Nutrition	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total T3	22	26	38	49	55	77	98	99	116	137
Under 18s	7	15	20	30	28	43	50	51	63	65
Under 18s %	32%	58%	53%	61%	51%	56%	51%	52%	54%	45%

Children and Young People

Young people under the age of 18 are considered a 'child' for Part 16 of the 2003 Act. An RMO must be a child specialist to complete a T2 Consent to Treatment for a patient who is under 18. Either the RMO or the DMP must be a child specialist for a T3 to be completed. The Commission aims to send a child specialist DMP to all patients under the age of 18 when a visit is requested.

Table 9.5 shows the number of T2s received for each form of treatment.

Table 9.5: T2 certificates for young people

Treatment	2009/10	2010/11	2011/12	20012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
ECT							1			
Medication over 2 months	11	16	17	17	26	31	39	35	36	36
Artificial Nutrition					1	3			1	
Total	11	16	17	17	27	34	40	35	37	36

Table 9.6 shows the number of T3s received for each form of treatment. There has been a gradual increase in medication beyond two months, but as noted above, a more significant increase in authorisation for the use of artificial nutrition. This may reflect the growing recognition, identification and treatment of young people with eating disorders.

It is important to note that the T3 certificates may be for more than one treatment and also that a single individual may have had more than one T3 issued. The 65 artificial nutrition T3s issued in 2018/19 relate to 30 individuals, the five ECT T3s issued relate to three individuals.

Table 9.6: Certificate of the designated medical practitioner (T3) 2009/10 to 2018/19 (young people)

Treatment type	2009/10	2010/11	2011/12	20012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
ECT	1	0	0	2	5	2	1	2	6	5
Artificial nutrition	7	15	20	30	28	43	50	51	63	65
Medication beyond 2 months	12	23	26	27	39	35	45	41	44	61
Total T3 certificates	20	38	46	59	72	80	96	94	113	131

*T3 certificate may be for more than one treatment

Neurosurgery for Mental Disorder (Sections 235 and 236)

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

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

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

The CQC report that across the UK they had two requests for neurosurgery for mental disorders for patients submitted to the CQC panel in their last reported monitoring year (2017/18) however neither of these requests were progressed. (Monitoring the Mental Health Act in 2017-18, CQC, page 21) Although we will no longer have a role in assessing patients prior to surgery, we continue to request progress reports following treatment of Scottish patients as we believe that this is remains an important monitoring role.

T4 certificates

T4 certificates are issued to record treatment that is provided to a patient detained under the Act that is provided under section 243 (Emergency Treatment) that is necessary to save the patient's life; prevent serious deterioration in the patient's condition; alleviate serious suffering on the part of the patient; and prevent the patient from behaving violently; or being a danger to the patient or others.

In 2018/19 the Commission received 376 T4 certificates. These show treatments that were not part of a treatment plan for emergencies agreed with a patient and recorded on a T2, recorded by a DMP on a T3 or that were provided on an EDC. 244 of these were for women (65%).

Table 9.7: T4s 2018/19 by age range

Age group	Number
0-15	27
16-17	24
18-24	49
25-44	109
45-64	101
65-84	61
85+	5
Total	376

Table 9.8: T4s by health board

Health Board	Number
Ayrshire and Arran	37
Borders	7
Dumfries and Galloway	22
Fife	31
Forth Valley	7
Grampian	28
Greater Glasgow and Clyde	96
Highland	10
Lanarkshire	13
Lothian	54
State	3
Tayside	68
Total	376

The Commission does not have a record to the ethnicity of patients who receive treatment on a T4.

Regulated Treatments under Section 48 of the AWI Act

Certain treatments for patients who lack capacity to consent require approval from a Commission appointed doctor (DMPs generally undertake this role). These treatments include drug treatment to reduce sex drive, ECT, treatment likely to lead to sterilisation, abortion. The following table shows the number of section 48 treatment authorisation visits undertaken by Commission appointed doctors. (Note the 'others' are medications that there were disputes over between the treating clinician and a proxy for the person who lacked capacity necessitating authorisation by a second opinion doctor)

Table 9.9: Treatments authorised under Section 48

Treatment	Number
Drug treatment to reduce sex drive	20
Electro-convulsive Therapy (ECT)	27
Others	2
Treatment likely to lead to sterilisation	1
Total	50

DMPs

DMPs are experienced, senior psychiatrists, with at least three years of experience at consultant level in Scotland. The register of DMPs is maintained by the Mental Welfare Commission and the Commission organises the induction and provides training and an annual seminar for DMPs, however the DMPs are independent practitioners using their knowledge and experience to reach their own conclusions. We currently have 83 DMPs on the register.

10: Appendix – Methodology

In this report we present crude counts and crude rates per 100,000 relevant population.

Population estimates are provided by Information Services Division based on National Records Scotland Population Estimates Time series data (updated 25 April 2019).

For years 2014 to 2018 we use:

Mid-year population estimates: Scotland and its NHS Board areas by single year of age and sex: 1981 to 2018

https://www.nrscotland.gov.uk/files//statistics/population-estimates/time-series/mid-18/mid-year-pop-est-18-time-series-4.xlsx

For years 2009 to 2013 we use:

Mid-year population estimates: Scotland and its pre-April 2014 NHS Board areas by single year of age and sex: 1981 to 2013

https://www.nrscotland.gov.uk/files//statistics/time-series/population/hbe8113-pre-14-nhs-board-areas-revised.xlsx

We publish detention activity for the Health Board areas in which this activity took place, which for a small number of cases may not be the Health Board wherein the individual to which the data relates actually resides.

Our intention is to include adjusted data and possibly some data-linkage work in future monitoring reports.

11: Appendix – Tables of counts

Table 11.1: Emergency detention certificates – Number

Health Board – Number	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Ayrshire and Arran	150	155	130	131	113	142	107	138	113	131
Borders	9	21	12	19	18	29	18	32	30	24
Dumfries and Galloway	76	92	64	77	71	74	84	114	105	101
Fife	146	105	115	134	122	150	167	162	181	208
Forth Valley	102	99	66	98	92	95	130	146	179	183
Grampian	92	105	80	117	115	134	101	99	141	115
Greater Glasgow and Clyde	550	517	589	569	638	605	726	833	990	989
Highland	133	150	129	170	164	158	125	109	124	104
Lanarkshire	152	210	198	168	168	178	199	231	198	280
Lothian	252	241	216	216	238	249	333	390	400	441
Orkney	2	1	6	7	4	7	14	5	15	8
Shetland	1		8	8	7	9	3	7	8	1
Tayside	167	142	179	192	165	171	184	187	257	278
Western Isles	3	1	1	13	4	8	10	4	10	8
Scotland	1835	1839	1793	1919	1919	2009	2201	2457	2751	2871

Table 11.2: Emergency detention certificates – Rate

Health Board	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Ayrshire and Arran	40.3	41.6	34.8	35.1	30.4	38.3	28.9	37.2	30.5	35.4
Borders	7.9	18.5	10.5	16.7	15.8	25.4	15.8	27.9	26.1	20.8
Dumfries and Galloway	50.3	60.9	42.3	51.0	47.2	49.3	56.1	76.2	70.4	67.9
Fife	40.4	29.0	31.5	36.6	33.3	40.8	45.4	43.7	48.7	55.9
Forth Valley	34.7	33.4	22.1	32.8	30.7	31.6	43.0	48.0	58.6	59.8
Grampian	16.5	18.6	14.0	20.4	19.9	22.9	17.2	16.8	24.0	19.7
Greater Glasgow and Clyde	45.8	42.9	48.5	46.8	52.4	52.9	63.1	71.7	84.7	84.2
Highland	41.8	47.0	40.1	53.2	51.1	49.3	38.9	33.9	38.5	32.3
Lanarkshire	26.7	36.8	34.6	29.3	29.4	27.2	30.4	35.2	30.1	42.5
Lothian	30.9	29.2	25.8	25.6	28.0	29.0	38.4	44.3	45.0	49.1
Orkney	9.6	4.7	28.0	32.5	18.6	32.4	64.6	22.9	68.2	36.1
Shetland	4.4	0.0	34.4	34.5	30.2	38.8	12.9	30.2	34.7	4.3
Tayside	41.3	34.9	43.6	46.6	40.0	41.3	44.3	45.0	61.8	66.8
Western Isles	10.9	3.6	3.6	47.2	14.6	29.4	36.9	14.9	37.1	29.8
Scotland	35.1	34.9	33.8	36.1	36.0	37.6	41.0	45.5	50.7	52.8

Table 11.3: Short Term detention certificates – Count

Health Board	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Ayrshire and Arran	200	201	192	183	188	207	194	210	170	185
Borders	38	54	53	67	63	71	59	62	63	73
Dumfries and Galloway	102	110	68	90	82	105	105	134	97	143
Fife	257	215	217	235	255	276	272	282	266	292
Forth Valley	145	167	149	163	175	195	244	257	270	244
Grampian	301	352	344	388	367	385	400	451	411	398
Greater Glasgow and Clyde	1003	965	981	985	1024	1095	1173	1248	1422	1414
Highland	219	221	196	222	245	213	201	180	201	196
Lanarkshire	233	289	329	301	284	335	349	369	358	411
Lothian	577	602	615	621	677	751	732	807	751	846
Orkney				3	1		1	1	5	5
State	1	5		3	2	3	1	1	1	2
Shetland	1	7	6	8	7	12	8	7	9	5
Tayside	290	283	303	313	291	345	355	362	393	496
Western Isles	5	3	8	7	5	11	7	9	10	9
Scotland	3372	3474	3461	3589	3666	4004	4101	4380	4427	4719

Table 11.4: Short Term detention certificates – Rate

Health Board	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Ayrshire and Arran	53.7	53.9	51.4	49.0	50.5	55.8	52.3	56.7	45.9	50.0
Borders	33.5	47.5	46.5	58.9	55.3	62.3	51.7	54.1	54.8	63.3
Dumfries and Galloway	67.5	72.8	44.9	59.7	54.6	70.0	70.2	89.6	65.0	96.1
Fife	71.1	59.3	59.4	64.2	69.5	75.2	73.9	76.1	71.6	78.5
Forth Valley	49.3	56.4	50.0	54.5	58.4	64.9	80.6	84.4	88.4	79.7
Grampian	53.8	62.3	60.4	67.7	63.4	65.9	68.0	76.7	70.1	68.1
Greater Glasgow and Clyde	83.6	80.0	80.8	80.9	84.1	95.8	102.0	107.5	121.6	120.3
Highland	68.8	69.2	60.9	69.4	76.3	66.4	62.6	55.9	62.4	60.9
Lanarkshire	40.9	50.6	57.5	52.6	49.6	51.3	53.3	56.2	54.4	62.3
Lothian	70.7	72.9	73.5	73.6	79.7	87.5	84.4	91.7	84.4	94.2
Orkney	0.0	0.0	0.0	13.9	4.6	0.0	4.6	4.6	22.7	22.5
Shetland	4.4	30.4	25.8	34.5	30.2	51.7	34.5	30.2	39.0	21.7
State										
Tayside	71.7	69.5	73.9	76.0	70.6	83.4	85.5	87.1	94.5	119.2
Western Isles	18.2	10.9	28.9	25.4	18.2	40.4	25.9	33.5	37.1	33.5
Scotland	64.5	66.0	65.3	67.5	68.8	74.9	76.3	81.0	81.6	86.8

Table 11.5: Compulsory Treatment Orders – Count

Health Board	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Ayrshire and Arran	66	58	48	53	45	45	65	57	51	57
Borders	10	10	13	28	17	24	19	21	25	27
Dumfries and Galloway	33	25	18	24	29	31	28	39	30	38
Fife	96	90	90	74	86	102	98	94	84	84
Forth Valley	38	47	52	57	48	48	54	67	87	74
Grampian	97	109	106	116	108	117	137	163	128	137
Greater Glasgow and Clyde	308	291	338	313	326	362	392	374	427	463
Highland	84	77	82	86	82	75	65	69	73	96
Lanarkshire	67	84	92	95	102	87	101	95	116	126
Lothian	184	180	175	188	219	243	229	214	245	251
Orkney								1	1	
Shetland	2	3		4	2	2	1	4	3	3
Tayside	98	105	110	87	110	120	145	123	148	175
Western Isles	4	1	2	1	1	4	3	3	4	2
Scotland	1087	1080	1126	1126	1175	1260	1337	1324	1422	1533

Table 11.6: Compulsory Treatment Orders – Rate

Health Board	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Ayrshire and Arran	17.7	15.6	12.8	14.2	12.1	12.1	17.5	15.4	13.8	15.4
Borders	8.8	8.8	11.4	24.6	14.9	21.0	16.7	18.3	21.7	23.4
Dumfries and Galloway	21.8	16.5	11.9	15.9	19.3	20.7	18.7	26.1	20.1	25.5
Fife	26.6	24.8	24.6	20.2	23.4	27.8	26.6	25.4	22.6	22.6
Forth Valley	12.9	15.9	17.4	19.1	16.0	16.0	17.8	22.0	28.5	24.2
Grampian	17.3	19.3	18.6	20.2	18.6	20.0	23.3	27.7	21.8	23.4
Greater Glasgow and Clyde	25.7	24.1	27.8	25.7	26.8	31.7	34.1	32.2	36.5	39.4
Highland	26.4	24.1	25.5	26.9	25.5	23.4	20.2	21.4	22.7	29.8
Lanarkshire	11.8	14.7	16.1	16.6	17.8	13.3	15.4	14.5	17.6	19.1
Lothian	22.5	21.8	20.9	22.3	25.8	28.3	26.4	24.3	27.5	28.0
Orkney	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.6	4.5	0.0
Shetland	8.8	13.0	0.0	17.2	8.6	8.6	4.3	17.2	13.0	13.0
Tayside	24.2	25.8	26.8	21.1	26.7	29.0	34.9	29.6	35.6	42.1
Western Isles	14.6	3.6	7.2	3.6	3.6	14.7	11.1	11.2	14.8	7.5
Scotland	20.8	20.5	21.2	21.2	22.1	23.6	24.9	24.5	26.2	28.2

Ethnicity Monitoring

Table 11.7: Ethnicity recording on forms for emergency detention, short term detention, compulsory treatment orders and powers to detain

	2014 – 2015			2015 - 2016			2016 - 2017			2017 - 2018			2018 - 2019		
	Form	No form	Total	Form	No form	Total	Form	No form	Total	Form	No form	Total	Form	No form	Total
CTO1	1210	328	1538	1146	367	1513	936	427	1363	1113	312	1425	1153	350	1503
DET1	2321	249	2570	2359	239	2598	2776	324	3100	3486	296	3782	2715	248	2963
DET2	4663	486	5149	4254	555	4809	5292	631	5923	5864	435	6299	4536	278	4814
NUR1	227	22	249	141	20	161	136	20	156	142	30	172	164	17	181
Total	8421	1085	9506	7900	1181	9081	9140	1402	10542	10605	1073	11678	8568	893	9461

Table 11.8: Ethnicity recording – numbers completed and not completed on received forms

	2014 – 2015			2015 - 2016			2016 - 2017			2017 - 2018			2018 - 2019		
	Completed	Not Completed	Total	Completed	Not Completed	Total	Completed	Not Completed	Total	Completed	Not Completed	Total	Completed	Not Completed	Total
CTO1	1034	176	1210	974	172	1146	804	132	936	935	178	1113	966	187	1153
DET1	1996	325	2321	2060	299	2359	2421	355	2776	3075	411	3486	2360	355	2715
DET2	3626	1037	4663	3439	815	4254	4319	973	5292	4755	1109	5864	3523	1013	4536
NUR1	212	15	227	132	9	141	128	8	136	133	9	142	157	7	164
Total	6868	1553	8421	6605	1295	7900	7672	1468	9140	8898	1707	10605	7006	1562	8568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