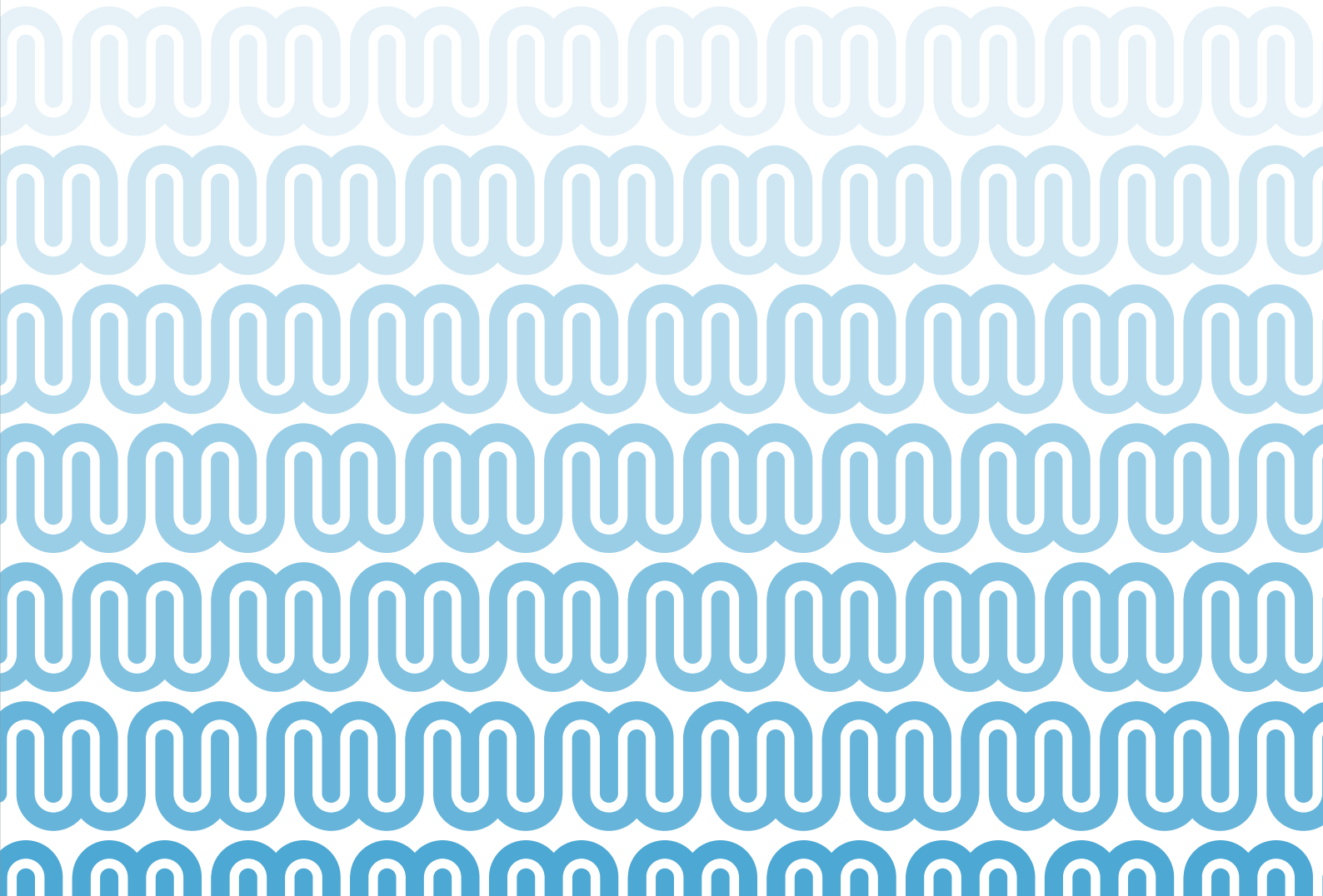
mental welfare commission for scotland

Characteristics of young people detained under the Mental Health Act in Scotland 2015-19

Statistical Monitoring

15 October 2020



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

Executive summary

Mental illness in young people can be short term, or can continue into adulthood. It can disrupt education, the development of friendships and the transition into adulthood, significantly affecting both the young person and their family or carers. Getting the right help early can make a major difference.

Over the past few years reported declines in mental health among children and young people has been described as a key public health challenge in the Scotland and globally.[1]

In the Commission's *Mental Health Act Monitoring Report 2018–19* we reported on the increasing number of detentions under the Mental Health (Care and Treatment)(Scotland) Act 2003 (the Mental Health Act) in the age groups 16–17 and 18–25 years for emergency and short-term detentions. These trends raise questions not only about the state of mental health and emotional wellbeing in children and young people, but also the accessibility and responsiveness of children's services. The Scottish Government states in the *Mental Health Strategy 2017-2027* that "work on treatment pathways and development of Child and Adolescent Mental Health Services (CAMHS) intensive treatment services out with an inpatient setting are essential" and proposes a number of initiatives to enhance available mental health support across all children's services.[2]

In this report, we expand on data presented in the *Mental Health Act Monitoring Report*, to explore the context around detentions and presentations of young people detained under the Mental Health Act. The rate of detention for the age group 16–17 years has increased over time and we undertook a detailed analysis of characteristics and presentations of detained patients, which might be a helpful contribution in considering who might be supported by intensive treatment services. Presentations included the reason for the detention as well as any other underlying mental health conditions included on the detention form. We reviewed 608 detention forms relating to 402 individuals aged 16–17 years who were detained during the last five years (2014-15 to 2018-19). This included 187 emergency detention certificates (EDCs) and 421 short-term detention certificates (STDCs). Key findings are:

- Over the five-year period, 60% of detained patients displayed self-harming behaviours (suicidality[3] or deliberate self-harm). This was higher in those detained on EDCs compared to STDCs (74% and 53%, respectively).
- There has been a rise in the proportion of detentions in which self-harming behaviour is reported over the last five years.
- Breaking this finding down by gender, there has been an increase in detentions in which self-harming behaviour was reported in girls whilst detentions reporting self-harming in boys decreased. Self-harming behaviour was higher than the overall average for individuals detained with a trauma-related history/presentation; anxiety,

[1] V. Patel et al., Mental health of young people: a global public-health challenge, Lancet, vol. 369, pp. 1202-13, 2007; T. Potrebny, N. Wiium and M. M-I. Lundegård, Temporal trends in adolescents' self- reported psychosomatic health complaints from 1980-2016: A systematic review and meta-analysis, PLoS ONE, vol. 12(11): pp. e0188374, 2017; J. Pitchforth et al., Mental health and well-being trends among children and young people in the UK, 1995–2014: analysis of repeated cross sectional national health surveys, Psychological Medicine, vol. 49: pp. 1275–1285, 2019; Scottish Government Social Research, Exploring the reported worsening of mental wellbeing among adolescent girls in Scotland. Research Findings No 143/2019.

[2] Scottish Government, *Mental Health Strategy 2017–2027.*

[3] Suicidality is suicidal ideation, plans or actions

stress-related and somatoform disorders; personality disorder; mood disorders/difficulties; and neurodevelopmental conditions.
- A higher proportion of patients detained under an EDC and STDC were girls (60% and 64%, respectively).
- Most (81%) of the Emergency Detentions occurred during out-of-hours (weekends and 5pm-9am on weekdays). 38% of STDCs occurred out-of- hours.
- A significant proportion of forms are missing recording of ethnicity.
- Postcode data is largely missing from forms.
- Only 51% of emergency detentions had consent of a Mental Health Officer (MHO) recorded.
- Most detentions related to concerns about the patient's own safety, though boys more often presented as a risk to themselves and to other people compared to girls.
- Psychotic symptoms/disorder was the most common presentation in all detentions (40%), with a higher proportion among boys than girls (54% and 32%, respectively). Psychotic symptoms were more commonly recorded in STDCs than in EDCs (44% and 33%, respectively).
- Mood disorder/difficulties was described in 35% of patients, with an equal distribution in boys and girls (35% and 35%, respectively).
- Substance use (confirmed or suspected) was indicated in seven percent of detentions, higher among boys than girls (12% and 4%, respectively).

This is the first report to describe in detail the characteristics and presentations of young people (16–17 years) detained under the Mental Health Act. There is a higher proportion of self-harming behaviours recorded in detention forms in more recent years. The high proportion of emergency detentions during out-of-hours may need further exploring as well as the gender differences. Further work is needed to better understand the increasing rate of detentions among young people over time, the reasons for detentions, and how these elements fit within the wider context of mental health problems, outcomes, treatment and service provision. Whilst this is a descriptive statistical report on the use of the Mental Health Act in this age group, the findings suggest areas where improvement may be needed.

Recommendations

- Further work is needed around exploring the proportion of detention as part of overall mental health admissions, differences in individual characteristics and variation between geographical areas. The Commission will continue to develop collaboration with relevant organisations to expand on our detention data to provide further insights where possible.
- There is need for work to explore clinicians' views on the rising rate of detentions and how attitudes towards detaining young people may have changed over time in line with developments within policy or clinical guidelines. This may form part of the considerations for the Scottish Mental Health Law Review. The Commission will present this data set in evidence to the Review.
- Child and Adolescent Mental Health Services Lead Clinician Group, Services and professionals to reflect on the rising rates of self-harming which are reported in considerations around detention. Particular attention should be paid to young people with a history or current presentation of trauma, and those with emerging personality disorder, given the high levels of self harm in these two specific groups,

to ensure that mental health services have the right services available at the right time for them.

- The Commission will continue to work with health boards to improve recording of ethnicity and postcodes to allow for analyses of differences relating to inequalities.
- The Commission will use the findings of the report to inform future Mental Health Act monitoring reports and focus on areas of importance for younger age groups.
- The Commission notes the lack of MHO (a mental health officer, specialist social worker trained in mental health issues) consent in about half of all emergency detentions. The safeguard of an independent MHO consenting to the detention is an important one and the fact that this does not seem to be reliably used to protect the interests of young people is concerning. The Commission has raised this issue and the reasons behind this before, particularly for this vulnerable group of young people. The Commission will raise concern about the safeguard with the Scottish Mental Health Law Review to consider the way forward for this safeguard.

Composite case examples of detained young people[4]

Short-term detention of young woman with severe dehydration

***Atypical Anorexia Nervosa,* significant physical compromise**

A 17-year-old young woman was awaiting discharge from CAMHS day services, where she had been for several months, following an overdose. The impending discharge was believed to have affected her mood. The patient had an underlying diagnosis of Atypical Anorexia Nervosa and had a previous history of requiring detention to enable the provision of treatment. The patient now needed urgent care due to severe dehydration after restricting food and fluid intake for several days. The patient had initially agreed to nutrition through artificial means, but subsequently withdrew consent to treatment and transfer to hospital. The patient required urgent medical treatment to prevent kidney failure, and was placed on a STDC.

Emergency detention of young man with manic episode

Bipolar disorder, manic episode, psychosis

A 17-year-old boy with an established diagnosis of bipolar disorder was presenting to emergency services in an extremely agitated state with pressure of speech and disordered thought processes. Symptoms were in keeping with a manic episode. The patient was making threats against the police and to self-harm. His behaviour suggested that he had not been compliant with his medication, though the patient disputed this. The patient was in need of detention for his own safety and that of others, in view of his behaviour. The patient was acutely psychotic and required emergency detention. Any delay to detain the patient would result in unacceptable risk to the patient and to others.

Short-term detention of a young person with paracetamol overdose

Developing Personality disorder, suicidal ideation, overdose

A 16-year-old young person who was care experienced and placed in residential care by their local authority presented to A&E with difficulties suggestive of a diagnosis of emotionally unstable personality disorder. They had a history of self-harming and had taken an overdose of paracetamol requiring medical attention due to the risk of liver failure. The young person stated they had taken an overdose of paracetamol to enable themselves to jump off a bridge and they had expressed a strong desire to die. They were refusing medical treatment for the overdose and therefore needed to be detained to provide authority for the medical treatment and assessment of their mental health difficulties.

[4] We here present three composite cases of male and female gender as well as a gender neutral case. We do this to draw attention to the fact that detention forms do not contain an option other than male and female gender, which is something the Commission will look further into with our stakeholders.

Introduction

General background - mental health and young people

Increasing mental ill health in young people is a significant public health issue globally.[5] However, it is not yet clear what is driving this apparent increase in different countries and whether this reflects an increase in recognition, is the result of a worsening of mental health, or a combination of these and other factors. In Scotland, self-reported mental health problems in 16-year-olds rose from 3.1% in 2003 to 9.7% in 2014.[6] More recently, various Scottish surveys have indicated increasing problems, particularly in girls, in emotional and behavioural problems, mental wellbeing, and psychological complaints.[7] A 2017 NHS survey of a large sample of young people in England showed that one in eight of 5–19-year-olds had at least one mental disorder. There was a slight increase in prevalence on mental disorders in 5–17-year-olds (there were no comparative data for older adolescents), from 9.7% in 1999 to 11.2% in 2017.[8] This same survey found a small but statistically significant rise in diagnosable emotional disorders, such as depression and anxiety, particularly in girls.

Demand on mental health services has increased over a similar time frame. In Scotland, referrals to Child and Adolescent Mental Health Services (CAMHS) increased by 20% overall between 2015 and 2018[9]. A similar picture has been seen in England with concerns expressed that increasing CAMHS capacity was not keeping up with increasing demand for services.[10]

Recent studies have explored whether factors such as increased social media use, reliance on technology, poor sleep, social pressures, and body image may be playing a role in the increased mental health difficulties in young people.[11] At the same time, research from the UK has suggested that risk factors reported historically, such as alcohol and drug use, do not appear to have persisted as risk factors in more recent years.[12]

An area of particular concern relates to the rates of self-harm in children and young people, however this is an area that remains incompletely understood. A number of studies in recent years have shown that rates of self-injurious behaviour or self-harm in young people have been

---

[5] V. Patel et al., *Mental health of young people: a global public-health challenge,* Lancet, vol. 369, pp. 1202-13, 2007.
[6] J. Pitchforth et al., *Mental health and well-being trends among children and young people in the UK, 1995–2014: analysis of repeated cross sectional national health surveys,* Psychological Medicine, vol. 49: pp. 1275–1285, 2019.
[7] Scottish Government Social Research, *Exploring the reported worsening of mental wellbeing among adolescent girls in Scotland.* Research Findings No 143/2019.
[8] NHS Digital, *Mental Health of Children and Young People in England*, 2017 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017
[9] Scottish Government , *A qualitative and quantitative audit of rejected referrals to CAMHS*, 2018 https://www.gov.scot/publications/rejected-referrals-child-adolescent-mental-health-services-camhs-qualitative-quantitative/
[10] Education Policy Institute, *Access to children and young people's mental health services*, 2018 https://epi.org.uk/publications-and-research/access-to-camhs-2018/; NHS Digital, *Mental Health of Children and Young people in England*, 2018 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017; Children's Commissioner, *Children's Mental Health Briefing,* 2018 https://www.childrenscommissioner.gov.uk/report/childrens-mental-health-briefing/
[11] Scottish Government Social Research, *Exploring the reported worsening of mental wellbeing*
[12] P. Patalay and S. H. Gage, *Changes in millennial adolescent mental health and health-related behaviours over 10 years: a population cohort comparison study,* International Journal of Epidemiology, vol. 48(5): pp. 1650–1664, 2019.

increasing in the UK. However it is less clear whether this reflects an actual increase in self harm or changes in self harm's detection and recognition.[13] Self-harm or self-injurious behaviour describes a range of behaviours in which somebody intentionally damages themselves or injures their body. Self-harm may be associated with suicidal ideation or intent, or may be a way in which an individual tries to manage or cope with emotional distress. Sometimes it may represent a mixture of these elements. The relationship between self harm and suicide is complex. Many people who die through suicide have a history of self harm, however most people who self harm do not go on to take their own lives.[14] On account of self harm being a behaviour rather than a diagnosis one of the challenges in the research looking at self harm in young people is the differing ways in which self harm can be defined and measured. Researchers in the US often distinguish between self harm with or without suicidal intent in their studies whilst those in Europe and many other countries consider self harm as a broad category and include suicide attempts, non-suicidal self-injurious behaviour and self-harm with ambiguous intent together.[15] The adoption of this latter approach partly reflects the difficulties inherent when determining intent, the changing nature of self harm methods in young people and the increased risk of later suicide attempts and completed suicide in young people regardless of intent.[16]

Self harm often begins in early adolescence and peaks in mid adolescence although a small number of young people continue the behaviour into adulthood.[17] Most self harm in the UK occurs within the community and many young people who self harm never present to services.[18] Apart from its immediate impact on the young person, studies show that deliberate self harm remains important risk factor for completed suicide. Although the numbers are small, suicide is a leading cause of death in young people in the UK and accounts for 14% of deaths in 10–19-year-olds.[19] Death by suicide remains the second highest cause of death globally in 15–24 year olds. Rates across the UK differ and recent figures have shown a recent increase in deaths among young women under the age of 25 years in Scotland.[20] Suicide and self-harm can be related to a number of factors other than mental ill health,[21] however ensuring that young people have timely access to help for mental health difficulties and illness when they are present is important. Over half of the young people who die by suicide have a

[13] D. Cottrell, How to reduce self harm in young people? Challenges for future research, ACAMHS lecture to launch Journal of Child Psychology and Psychiatry Special Issue 2019 Suicide and Self-harm: Pathways for minimizing suicide and premature deaths and maximizing health and wellbeing.
[14] K. Hawton et al., *Repetition of self-harm and suicide following self-harm in children and adolescents: Findings from the Multicentre Study of Self-Harm in England,* Journal of Child Psychology and Psychiatry, vol. 53: pp.1212–1219, 2012.
[15] J. R. Asarnow and L. Mehlum, *Practitioner Review: Treatment for suicidal and self-harming adolescents-advances in suicide prevention care,* Journal of Child Psychology and Psychiatry, vol. 60(10): pp. 1046–1054, 2019.
[16] K. Hawton et al., *Repetition of self-harm and suicide following self-harm*; J. D. Ribeiro et al., *Self-injurious thoughts and behaviours as risk factors for future suicide ideation, attempts, and death: A meta-analysis of longitudinal studies*, Psychological Medicine, vol. 46: pp. 225–236, 2016.
[17]P. Moran et al. *The Natural History of self-harm from adolescence to young adulthood: a population based cohort study*, The Lancet, vol. 379(9812): pp. 236-243, 2012.
[18] K. Hawton et al., *Adolescents who self harm: a comparison of those who go to hospital and those who do not,* Child and Adolescent Mental Health, vol. 14: pp. 24–30, 2009; H. Meltzer et al., *Non-fatal suicidal behaviour among adults aged 16 to 74.* London: Stationery Office, 2002.
[19] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), *Suicide by children and young people*, 2017. https://www.hqip.org.uk/wp-content/uploads/2018/02/8iQSvI.pdf
[20] Office for National Statistics (ONS), *Suicides in the UK: 2018 registrations*, 2019 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations
[21] NCISH, *Suicide by children and young people*.

history of self-harm[22] and studies from England have shown a 68% increase in reports of self-harm among girls aged 13–16 years since 2011.[23] Other studies have shown increasing trends in rates of admission of young people and young adults aged 10–24 years relating to self-harm in England between 2011 and 2018.[24] How much this reflects factors such as improving recognition of self-harm as opposed to increasing rates remains unclear.

A 2007 academic paper in the *Lancet* journal addressing the global issue of mental health in children and young people highlighted that growing concerns about declines in mental health for this age group is exacerbated by lack of health professionals and services with specialised knowledge in addressing mental health problems in the young.[25] Increased funding for Child and Adolescent and Mental Health Services in the UK, along with more research into underlying causes for mental health problems, have been acknowledged as important factors to achieve goals set out in mental health policy documents.[26]

In Scotland, supporting the mental health and wellbeing of children and young people is an important part of the *Mental Health Strategy 2017–2027*, which sets out particular actions to address mental health problems and promote mental wellbeing.[27] Furthermore, the Scottish suicide prevention strategy sets out the need for wider mental health support for children and young people, including training school staff and teachers.[28]

Improving access to specialist mental health services remains a key focus in trying to support children and young people with significant mental health problems. In Scotland, the *Mental Health Quality Indicators* have set a target for 90% of children and young people to start treatment within 18 weeks of referral to CAMHS.[29] In the quarter ending December 2019, 66% were seen within the 18-week target, a decrease from 73% the previous year. Approximately half of all patients started treatment within 13 weeks and overall 14% did not attend their first CAMHS appointment.[30]

International studies - the use of detention

Although most children and young people who require care for mental health conditions will receive this in the community, for some young people inpatient care may be necessary during times of crisis, to receive specialist treatment, or for observation to help clarify the nature of

[22] *Ibid.*
[23] C. Morgan et al., *Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care*, BMJ, vol. 359(j4351), 2017.
[24] Nuffield Trust, *Hospital admissions as a result of self-harm in children and young people*, 2019. https://www.nuffieldtrust.org.uk/resource/hospital-admissions-as-a-result-of-self-harm-in-children-and-young-people
[25] Patel et al., *Mental health of young people.*
[26] D. Gunnell, J. Kidger and H. Elvidge, *Adolescent mental health in crisis – we need to understand the causes to inform prevention.* BMJ, vol. 361: pp. k2608, 2018.
[27] Scottish Government, *Mental Health Strategy 2017–2027.*
[28] Scottish Government, *Every Life Matters – Scotland's Suicide Prevention Action Plan.* 2018
[29] Scottish Government, *Mental health quality indicators: background and secondary definitions.* *https://www.gov.scot/publications/mental-health-quality-indicators-background-secondary-definitions/pages/1/*
[30] Public Health Scotland, *Child and Adolescent Mental Health Services in Scotland: Waiting Times Quarter ending 31 December* 2019, 2020. https://beta.isdscotland.org/media/3996/2020-03-03-camhs-waitingtimes-report.pdf

the problems or other reasons. For some young people inpatient care may be required due to concerns about the risk of self-harm or suicide.

The majority of hospital admissions are voluntary. However, in some cases voluntary hospitalisation of a patient is not possible as patients may not consent or have the capacity to consent to an informal admission. The Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) outlines provisions for involuntary hospitalisations, or detention, to provide care and treatment including hospitalisation to patients unable to consent.[31] The criteria which have to be applied in order for an individual to be detained and the organisation of services in which detention takes place varies from country to country. The World Health Organization (WHO) recommends that mental health legislation should specifically discourage involuntary admission of minors.[32] When children and young people are detained their opinions and wishes should be taken into consideration and assessed in relation to their age and maturity.[33] The UN Committee on the Convention of the Rights of the Child (UNCRC) last visited the UK in 2016 and raised concerns about the increase in the number of children with mental health needs and the shortage of adequate child-specific mental health support. The Committee also raised concerns about the distance that children sometimes needed to travel to access mental health support.[34]

The research literature on the factors associated with the use of involuntary hospitalisation in children and young people is scarce and legislation around detention of children and young people varies between jurisdictions. Studies from Finland have indicated that between one fifth and one third of psychiatric inpatient admissions of minors are involuntary.[35] A longitudinal study in Finland also indicated that the rate of detentions increased more than threefold between 1996 and 2000.[36] In contrast, a study of involuntary admissions to three child and adolescent psychiatric hospitals in Germany found a decline in involuntary admissions from 22% to 16% over a six-year period.[37] Data from England, based on all admitted patients on a given day in 1999, found that 19% were formally admitted, either under the Mental Health Act (78%) or the Children Act (22%).[38] The literature, albeit limited and dated, therefore suggests that the proportion of psychiatric inpatient admissions that are detentions are a substantial minority.

Factors associated with involuntary hospitalisation

In Scotland, prior to the use of the Mental Health Act, the doctor in attendance has to be satisfied that the criteria for detention are met. Consultation with and the consent of a of a mental health officer (MHO) who has interviewed the person is required prior to the use of a

[31] Mental Health (Care and Treatment) (Scotland) Act 2003
[32] World Health Organization, *WHO resource book on mental health, human rights and legislation*, 2005
[33] *ibid*
[34] G. Rosa, *Using children's rigths in mental health policy and practice,* Children's Rights Alliance for England, 2018 http://www.crae.org.uk/media/125976/mentalhealth-briefing-final-digital-version-.pdf
[35] H. T. Ellila et al., *The involuntary treatment of adolescent psychiatric inpatients – A nation-wide survey from Finland,* Journal of Adolescence, vol. 31: pp. 407–419, 2008; R. Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors – A register study,* Social Psychiatry and Psychiatric Epidemiology, vol. 39: pp. 53–59, 2004; J. Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent psychiatry: a German sample,* European Child & Adolescent Psychiatry, vol. 23, pp. 151–161, 2014.
[36] R. Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors*
[37] J. Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent psychiatry*
[38] A. Maers et al., *Characteristics of the Detained and Informal Child and Adolescent Psychiatric In-Patient Populations,* Child and Adolescent Mental Health, vol. 8(3), pp. 131–134, 2003.

short-term detention certificate (STDC), which can last for up to 28 days. An MHO should be consulted prior to detaining a person on an emergency detention certificate (EDC), under which a patient can be detained for up to 72 hours.

In order to meet criteria for either an EDC or an STDC the doctor has to decide that the individual is likely to have a mental disorder, that their ability to make decisions about their mental health treatment is significantly impaired, and that they are at significant risk to themselves or towards others as a result of their mental health difficulties. Finally, it has to be shown that compulsory admission to hospital is necessary and that there is no alternative to an involuntary admission. Rates in the use of detention within a population may change over time due to differences in a number of factors including characteristics of the mental health legislation in use, mental health difficulties of the population (in either prevalence or characteristics), changes in practice and/or culture of mental health services, or changes in the design of services and the availability of alternatives to admission.[39]

International comparisons

The variation in detention between regions within the same country extends beyond different levels of prevalence of mental disorder. Studies from Norway and Finland have shown that the great variation in proportion of admissions that were detentions did not align with prevalence of mental disorders.[40] In Finland, increases in the rate of detention and child welfare placements were positively correlated and suggests that wider systemic factors that impact on children and young people's mental wellbeing may also impact on rate of detentions.[41] Another study from Finland compared one district with above-average and one with below-average detention rates. There was no difference in number of psychiatric beds for adolescents, but the area with higher detention rates had a larger adolescent psychiatry budget, more staff in outpatient services, more private and public child welfare services, and less outpatient visits. The study also showed that the above-average detention region fared worse on a number of socio-economic factors and the authors suggested that in order to address detention rates, attention to well-being and welfare of families may be needed.[42]

Studies have also assessed the association between demographic factors, diagnosis and safety aspects with the likelihood of being detained. Involuntary hospitalisation is higher in adolescents than children.[43] Gender differences are not consistent; studies have indicated a higher proportion of detentions of girls,[44] higher proportion boys,[45] or no difference between

[39] L.S. Rains et al., Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study, Lancet Psychiatry, vol. 6(5): pp. 403–417, 2019.
[40] K. Hanssen-Bauer et al., *Admissions to acute adolescent psychiatric units: a prospective study of clinical severity and outcome*, International Journal of Mental Health Systems, vol. 5(1), 2011; U. Siponen, et al., *Increase in involuntary psychiatric treatment and child welfare placements in Finland 1996–2003 – a nationwide register study,* Social Psychiatry & Psychiatric Epidemiology, vol. 42: pp. 146–152, 2007.
[41] U. Siponen, et al., *Increase in involuntary psychiatric treatment and child welfare placements*
[42] U. Siponen et al., *A comparison of two hospital districts with low and high figures in the compulsory care of minors: an ecological study,* Social Psychiatry & Psychiatric Epidemiology, 46: 661–667, 2011.
[43] Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent psychiatry*; J. Persi B. M. Bird and C. DeRoche, *A Comparison of Voluntary and Involuntary Child and Adolescent Inpatient Psychiatry Admissions*, Residential Treatment for Children & Youth, vol. 33(1): pp. 69–83, 2016; Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors.*
[44] Siponen et al., *Increase in involuntary psychiatric treatment and child welfare placements.*
[45] Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent psychiatry*; Maers et al., *Characteristics of the Detained and Informal.*

genders.[46] Gender differences has however been evident when comparing diagnoses, with substance use and conduct disorders more likely diagnoses in detained boys and mood disorders or neurotic, stress-related or somatoform disorders in detained girls.[47] Importantly, more severe disorders increase the likelihood of a detention[48] and detained young patients have been found to be more likely to have schizophrenia,[49] substance use disorder,[50] psychotic disorder,[51] and present with suicidal ideation or having carried out suicidal acts.[52]

Authors

Lisa Schölin PhD, Researcher

Dr Helen Dawson, Medical Officer

Dr Moira Connolly, Executive Project Advisor

Dr Arun Chopra, Medical Director

[46] Persi, Bird and DeRoche, *A Comparison of Voluntary and Involuntary*; R. Kaltiala-Heino, *Involuntary commitment and detainment in adolescent psychiatric inpatient care,* Social Psychiatry and Psychiatric Epidemiology, vol. 45: pp. 785–793, 2010; Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors.*
[47] Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors.*
[48] Persi, Bird and DeRoche, *A Comparison of Voluntary and Involuntary.*
[49] Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors*; Maers et al., *Characteristics of the Detained and* Informal; Kaltiala-Heino, *Involuntary commitment and detainment*.
[50] Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors;* Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent* psychiatry; Ellila et al., *The involuntary treatment.*
[51] Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent* psychiatry; Kaltiala-Heino, *Involuntary commitment and detainment*.
[52] Kaltiala-Heino, *Involuntary commitment and detainment*; Persi, Bird and DeRoche, *A Comparison of Voluntary and Involuntary;* Ellila et al., *The involuntary treatment.*

This report – Scotland's data

In the Commission's *Mental Health Act Monitoring Report 2018-19*[53] we reported on the increase in rates of EDCs and STDCs of young people in the age groups 16–17 and 18–25 years. Increases have been particularly stark in the age group 16–17 years, for whom the number of EDCs and STDCs increased between 2009-10 and 2018-19, from 24 to 59 and from 44 to 114, respectively. This report therefore aims to explore characteristics of these detentions in more detail.

This report is the first time that the Commission has published data on detentions for any group at this level of detail. The aim is to provide a starting point for services to better understand the increased number of young people needing involuntary hospitalisation for mental health disorders in the light of research evidence, that might help with service design and meeting the needs of the young people.

When an individual is detained under an EDC or STDC, a detention form is completed and sent to the Commission and this data is entered into a database to enable monitoring of the use of the legislative powers within the Mental Health Act (a statutory function of the Commission under the Mental Health Act). An initial scoping exercise was undertaken to define a sample for the current report. Due to the large number of detentions for young people aged 16–17 years, we limited our analysis to the last five reporting years.

The dataset therefore includes all detentions under an EDC and STDC from 1 April 2014 (2014-15) to 31 March 2019 (2018-19), for which the latter is the latest year complete data on detentions is available. We extracted information for all detentions during this time period to describe the characteristics of these detentions, but for the analysis of demographic characteristics we included information from each unique individual only once.

For our reporting, we follow Public Health Scotland standards on data disclosure,[54] as data relating to mental health and vulnerable populations is considered sensitive. Measures to prevent identifications should be taken and we therefore supress numbers of less than five where needed and secondary suppression has been done where only supressing one cell would allow for deriving the number through subtraction.

Data quality

Two demographic characteristics where data is currently of poorer quality due to gaps in completion are ethnicity and postcode.

For ethnicity, each detention form should be accompanied by an ethnicity form, however in our last *Mental Health Act Monitoring Report* we indicated that 9% of all 2018-19 detention forms were not accompanied by an ethnicity form. Of the ethnicity forms we did receive, 18% had missing information. In the current report, we found that ethnicity recording forms were missing for 18% of STDCs and EDCs in young people. While we are working with services to

[53] Mental Welfare Commission for Scotland. *Mental Health Act Monitoring Report 2018–19.* https://www.mwcscot.org.uk/sites/default/files/2019-11/MHA-MonitoringReport2019.pdf
[54] Public Health Scotland, *Statistical Disclosure Control Protocol v.1,* 2020 https://www.publichealthscotland.scot/media/2628/public-health-scotland-statistical-disclosure-control-protocol.pdf

remind professionals and administrators of the need to improve the completion rate of ethnicity forms, it is important to acknowledge the level of missing data for ethnicity.

Similarly, our postcode data is incomplete for a substantial proportion of detention forms for postcode. Our presentation of quintiles of the Scottish Index of Multiple Deprivation (SIMD) therefore needs to be interpreted with caution as we are aware that the quality of this data currently is incomplete. As with ethnicity, there is ongoing work in the Commission to improve the quality and completion of this information.

Coding of presentations

The Commission does not routinely extract detailed data on diagnosis for each individual who gets detained.[55] The Commission research and monitoring team therefore undertook a retrospective analysis of information collected of the EDC and STDC forms. Each detention was coded in relation to the description given of the mental health difficulties of the patient. Individual coding of conditions, symptoms or disorders were recorded as they were written on the forms and the coding was discussed with medical members of the Commission throughout the process. We coded all information on the form, which included the presentation leading to the detention as well as other comments about existing diagnoses or co-morbid difficulties. It is important to highlight that the descriptions of presentations in this report do not represent necessarily the *reason* for the detention but also include associated conditions and difficulties included on the detention form. As a consequence more than one coding may be given for any one form depending on the information provided on the detention certificate.

The coding of presentations was undertaken by a researcher trained in public health. A subsample of forms were double coded by two psychiatrists which indicated relatively high agreement in information coded from the forms. Any discrepancies were discussed and the dataset was double checked against such discrepancies to identify any codes that may have been missed. We note that the amount of information on the forms varies. We looked at a random sample of 20 forms and counted the number of words given within each of the boxes outlined in detention forms for an EDC (Det1v7.0, six text boxes) and STDC (Det2v7.0, five text boxes).[56] The number of words on the EDC form ranged from 54 to 166 words (average=122) and on the STDC forms ranged from 84 to 413 words (average=232). The varying degree of detail in the forms therefore influenced the coding process, as some forms may have had more information about patient history.

Presentations

Following the coding of each form, the presentation codes were grouped into major categories so as to facilitate describing the mental health difficulties reported in the individuals who were detained. The categorisation was done with regard to both ICD 10 and DSM IV classification groupings (these are two internationally recognised classifications of illness and disease) and symptom clusters to reflect the fact that a formal diagnosis of the mental disorder is not required to support detention with an EDC or STDC, and that many young people's difficulties were, for good reason, described on the forms in terms of symptoms alone. Although not

[55] For more details about data we report on routinely, see our *Mental Health Act Monitoring Report*
[56] Scottish Government. *Mental Health law: forms,* 2019 https://www.gov.scot/publications/mental-health-law-forms/

following an international diagnostic scheme, this method resembled the clinical landscape and terms that were being used over the study period and also reflected the lack of a formal diagnosis in most of the young people who were detained at the time of detention. This lack of diagnosis is explained by an understandable reluctance to give a formal diagnosis to an individual at such a young age, when so many aspects of their presentation remain in development. A summary of presentations/symptoms coded on the forms and corresponding grouping is presented in Table 1.

Self-harming behaviour

As suicidality has been shown to be more prevalent in detained than informal patients, [57] we were particularly interested in looking at presentations where the patient displayed suicidal ideation or attempts, as well as deliberate self-harm and overdosing. We created a composite category for self-harming behaviour where any form of self-harm, or suicidal behaviour or ideation was involved. We used this measure to explore the proportion of patients with self-harming behaviours across type of detention, gender and presentation. We also explored suicidality specifically.

[57] Persi, Bird and DeRoche, *A Comparison of Voluntary and Involuntary*.

Table 1. Grouping of presentation of detained patients

Grouping	Description of presentation/symptoms
Anxiety, stress-related and somatoform[58] disorders	Anxiety Social anxiety disorder Obsessive Compulsive Disorder Adjustment Disorder Dissociative Disorder Pseudoseizures
Eating Disorder	Anorexia Nervosa Bulimia Nervosa Atypical eating disorder Unspecified eating disorder
Learning Disability	Learning Disability Intellectual Disability
Mood disorder/difficulties	Mania Hypomania Mixed affective state Depression Low mood Bipolar affective disorder Unspecified
Neurodevelopmental conditions	Autism Spectrum Disorder Asperger's Syndrome[59] ADHD FAS
Personality disorder	Personality Disorder Borderline Personality Disorder Emotionally Unstable Personality Disorder
Psychotic symptoms/disorder	Schizophrenia Schizoaffective disorder Hallucinations Paranoia Psychosis Thought disorder
Substance use	Patient under influence of alcohol and/or drugs Presentation thought to be substance-induced
Trauma-related history/presentation	Post-traumatic stress disorder Trauma
Other	Organic mental disorder Disorder of early childhood Emotional dysregulation Unspecified mental disorder Gender dysmorphia

[58] Somatoform disorders are those where the mental disorder manifests as physical symptoms which a general medical condition cannot fully explain.
[59] We coded the terms used on the detention forms but are aware that this term may not be preferred

Results

Demographics and related information of the sample

This dataset includes a total of 608 detentions (187 EDCs and 421 STDCs), comprising of 402 individuals (154 and 248, respectively) over the time period 2014–2019. Most young people appeared only once in the dataset over the selected time period (67%) while a quarter (24%) had two detention episodes and 9% had more than two episodes.

We explored demographic characteristics of all individuals who were detained during the time period (Table 2). A higher proportion of detained 16-17-year-olds were girls, particularly for short-term detentions. Most were detained in NHS Greater Glasgow and Clyde or NHS Lothian areas.

Table 2. Demographic and background characteristics of detained patients, n (%)

Characteristic	All individuals (N=402)	EDC (N=154)	STDC (N=248)
Gender			
Boys	153 (38)	65 (42)	88 (35)
Girls	249 (62)	89 (58)	160 (65)
Health board			
Ayrshire and Arran	15 (4)	6 (4)	9 (4)
Borders	*	*	*
Dumfries and Galloway	5 (1)	*	*
Fife	12 (3)	8 (5)	*
Forth Valley	22 (5)	14 (9)	8 (3)
Grampian	17 (4)	5 (3)	12 (5)
Greater Glasgow and Clyde	130 (32)	40 (26)	90 (36)
Highland	19 (5)	12 (8)	7 (3)
Lanarkshire	33 (8)	22 (14)	11 (4)
Lothian	91 (23)	25 (16)	66 (27)
Orkney	*	*	0
Shetland	*	*	*
Tayside	50 (12)	13 (8)	37 (15)
Ethnicity			
Not provided or missing[a] (n)	74	17	57
White Scottish	270 (82)	112 (82)	158 (83)
White Other	40 (12)	18 (13)	22 (12)
Black	6 (2)	*	*
Asian	7 (2)	*	*
Mixed	*	*	*
Other	*	*	*
SIMD quintile			
Not provided or missing[a] (n)	283	111	172
1 (most deprived)	34 (29)	16 (37)	18 (24)
2	19 (16)	10 (23)	9 (12)
3	21 (18)	*	15 (20)
4	27 (23)	8 (19)	19 (25)
5 (least deprived)	18 (15)	*	15 (20)

**Data suppressed due to n<5*

[a]Missing data were excluded from the total denominator for calculating proportions.

White other including: Polish, Other British, Other Irish, Gypsy/Traveller; Black including: Black African and Black Other; Asian including: Chinese, Indian, Pakistani

While our data on ethnicity and deprivation is incomplete, of those whose ethnicity data was available, 95% were white. Of the 119 (30%) for whom we had postcode data the highest proportion of detained patients was in the most deprived category. For emergency detentions 60% were in the two most deprived quintiles compared to 33% of short-term detentions. These differences should be interpreted with caution since this data is mostly incomplete.

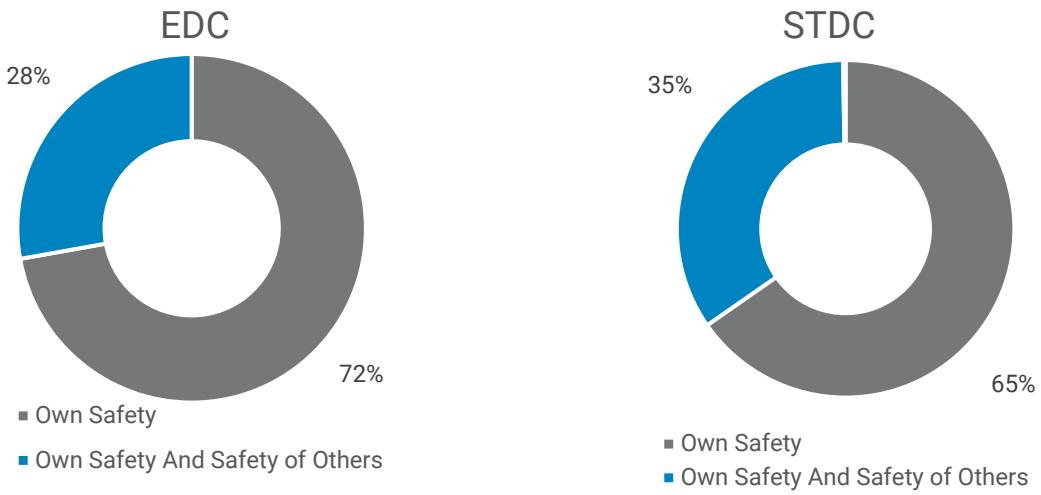
Among those detained under an EDC, only 51% had MHO consent, and 55% were detained following an initial informal admission whereas 45% had a pre-detention status of being in the community.

Time of detention and safety of patient

We analysed day of the week and time of the day the detention took place, which indicated that most of the EDCs were granted during the out-of-hours period (81%), compared to 38% of STDCs. Of the out-of-hour detentions, there was a higher proportion that were girls for both EDCs and STDCs (64% and 64%, respectively).

An important aspect of the reason for the detention is the perceived risk to the patient and/or other people. A higher proportion of EDCs were due to concerns about the patient's own safety compared to STDCs (Figure 1). Overall, a much higher proportion of detentions involving girls were due to safety to themselves alone (80%), compared to boys (47%). These differences were evident for both EDCs (83% and 55%, respectively) and STDCs (78% and 43%, respectively). No EDC and only one STDC detention was based on safety concerns of others alone.

Figure 1. Detention made based on safety aspect of patient or patient and others



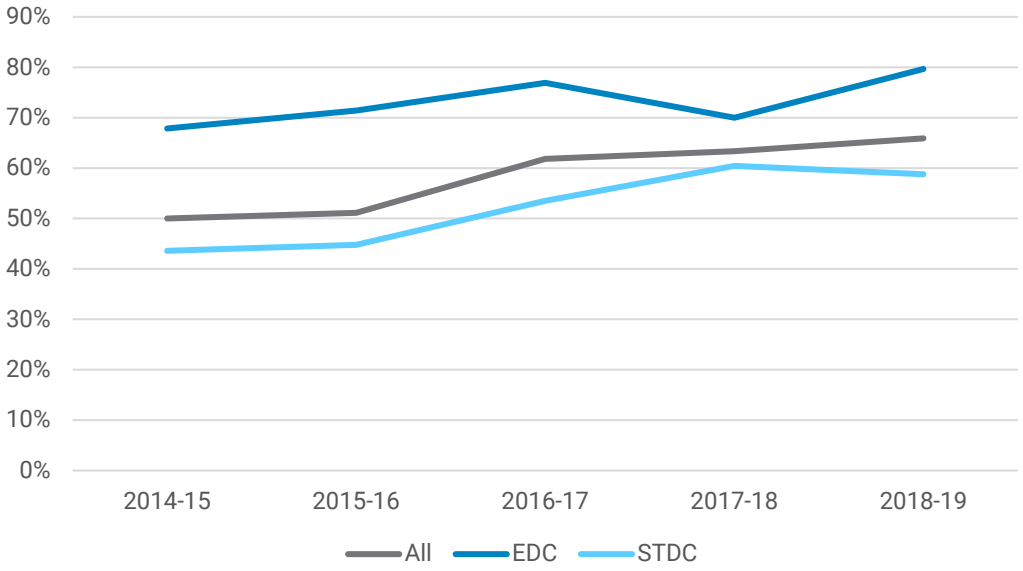
Self-harming behaviour

Previous research has indicated that suicidality is more prevalent among detained compared to informal patients.[60] We explored the presence of any self-harming behaviour noted on the

[60] Kaltiala-Heino, *Involuntary commitment and detainment;* Persi, Bird and DeRoche, *A Comparison of Voluntary and* Involuntary; Ellila et al., *The involuntary treatment.*

detention form (deliberate self-harm, overdoses and suicidality). Over time, there was an increase in detentions that reported self-harming behaviour (Figure 2).

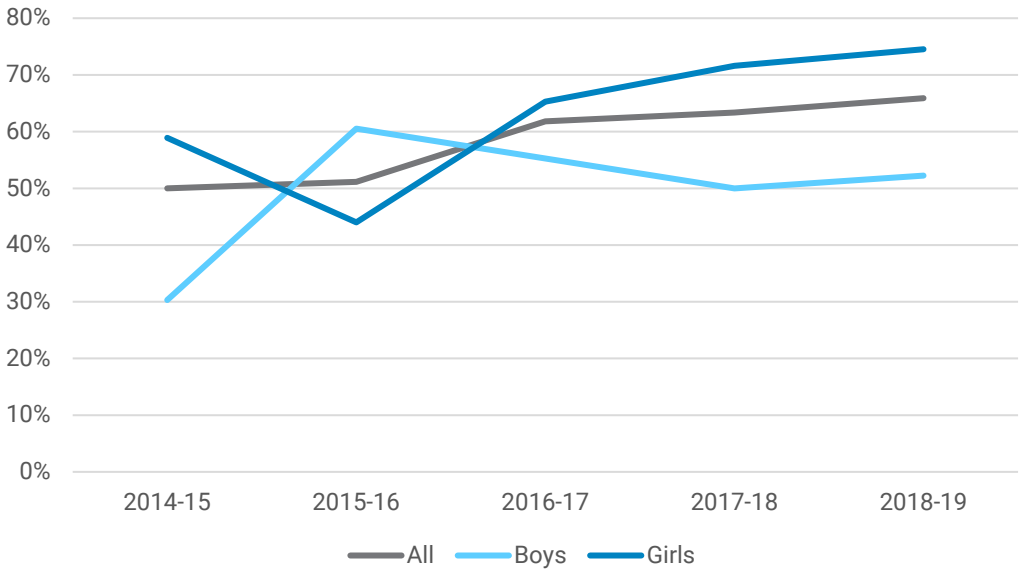
Figure 2. Proportion of detentions in Scotland with indicated self-harming, by order type



Over all five years, 60% of all detentions described self-harming on the detention forms. As shown in Figure 2, the proportion increased from 50% in 2015-16 to 66% in 2018-19. The increase was marked for both EDCs and STDCs, with much higher proportion of emergency detentions describing self-harming (80% compared to 59% in 2018-19).

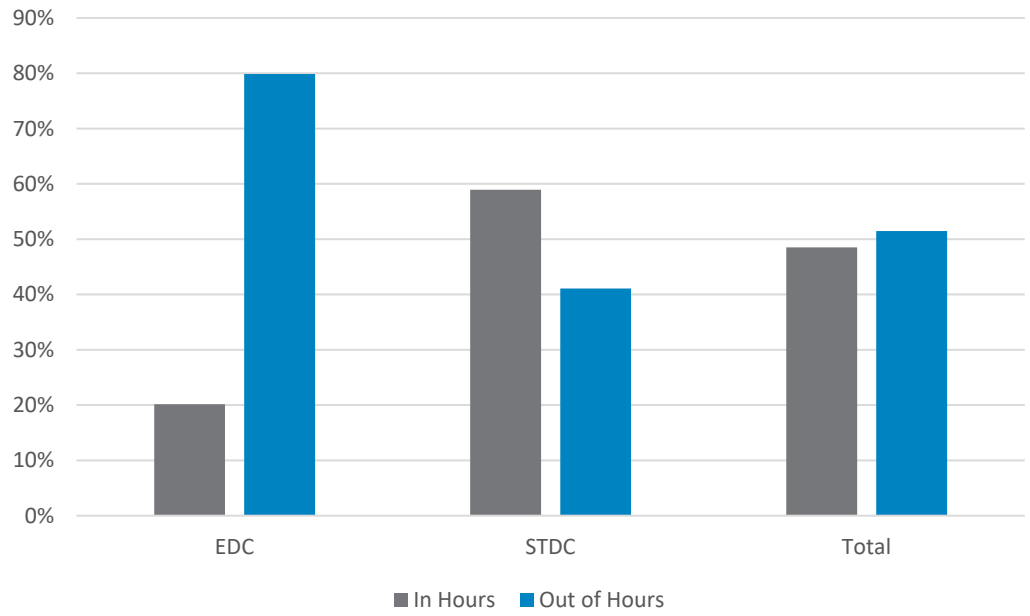
Importantly, there is a gender difference in the proportion of detentions with self-harming; an increase in self-harming behaviour in detained girls has been evident since 2015-16, while the proportion in boys has decreased in the same time period (Figure 3).

Figure 3. Proportion of detentions in Scotland with indicated self-harming, by gender



We were also interested in the time of the day in which the detention took place in relation to self-harming. For EDCs, 80% of detentions which included self-harming behaviour were done during out-of-hours, compared to 41% of STDCs (see figure 4). Overall, 51% of self-harming patients were detained during out-of-hours (5pm to 9am on weekdays and weekends).

Figure 4. Time of detention in Scotland of self-harming patients



There were differences in girls and boys in relation to time of detention among those who were self-harming; a higher proportion of girls detained under an EDC were out-of-hours compared to boys (86% and 69%, respectively) as were the case for STDCs (43% and 35%, respectively) (data not shown).

Presentations

One factor identified as a predictor for detention under mental health legislation among young people is substance abuse.[61] We recorded all instances where substance use was reported as being part of the presentation (e.g. as patient was described as being under the influence of alcohol or drugs) or likely to be part of the presentation (e.g. suspected drug-induced psychosis). Seven percent of all detentions featured substance use, which was higher among boys than girls (12% and 4%, respectively) (see Figure 5 and Table 3).

[61] Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minor;* Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent psychiatry*; Ellila et al., *The involuntary treatment.*

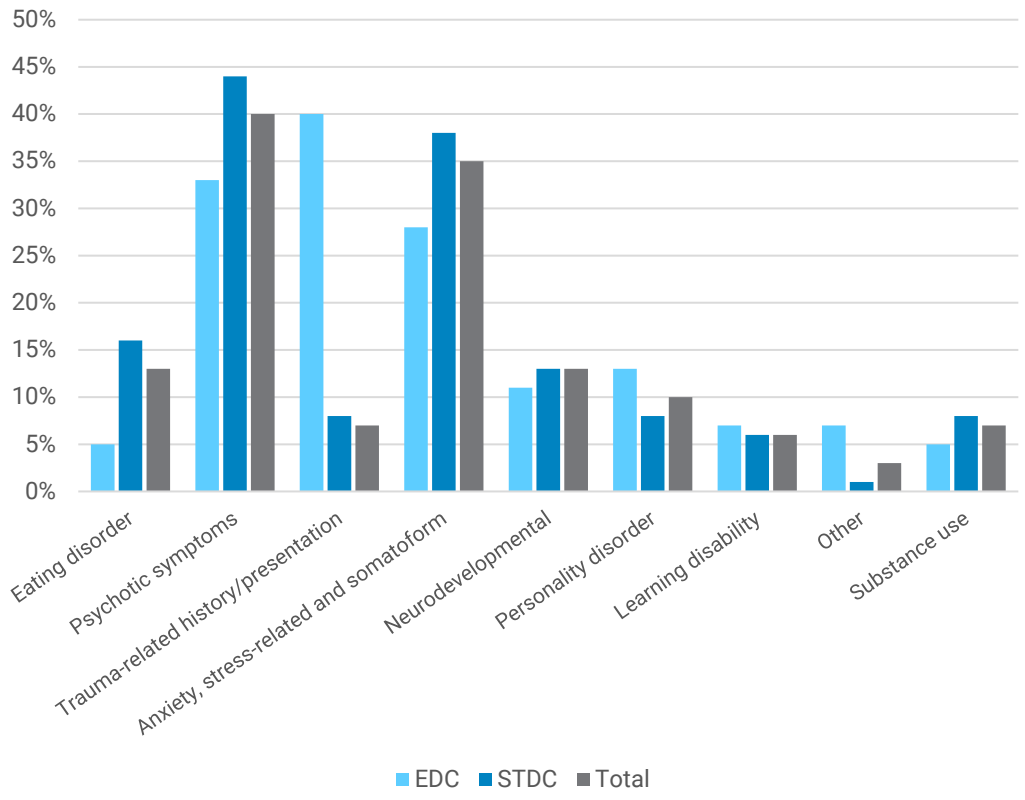
Table 3. Presentations of detained patients in Scotland by gender

Presentation	Total (N=608)	Girls (N=382)	Boys (N=226)
Anxiety, stress-related and somatoform disorders	41 (7)	32 (8)	9 (4)
Eating Disorder	78 (13)	74 (19)	*
Learning Disability	38 (6)	24 (6)	14 (6)
Mood disorder/difficulties	214 (35)	135 (35)	79 (35)
Neurodevelopmental conditions	76 (13)	46 (12)	30 (13)
Personality Disorder	58 (10)	44 (12)	14 (6)
Psychotic symptoms/disorder	245 (40)	122 (32)	123 (54)
Substance use	44 (7)	17 (4)	27 (12)
Trauma related	60 (10)	48 (13)	12 (5)
Other	19 (3)	14 (4)	*

**Suppressed as n<5; Categories are not mutually exclusive as patients may have displayed several presentations and had underlying mental health conditions that were recorded*

Figure 5 shows the proportion of patients with each presentation detained under an EDC and STDC (see also Table 3). For neurodevelopmental, personality disorder, learning disability and substance use the proportions were relatively similar for the different types of detentions. On the other hand, the proportion of presentations in STDCs were higher than EDCs for eating disorders (16% and 5%, respectively), psychotic symptoms (44% and 33%, respectively), and anxiety, stress-related and somatoform disorders (35% and 28%, respectively). In contrast, a much higher proportion of patients detained under an EDC had a presentation that included trauma-related history/presentation (40% and 8%, respectively).

Figure 5. Presentations by order type in Scotland

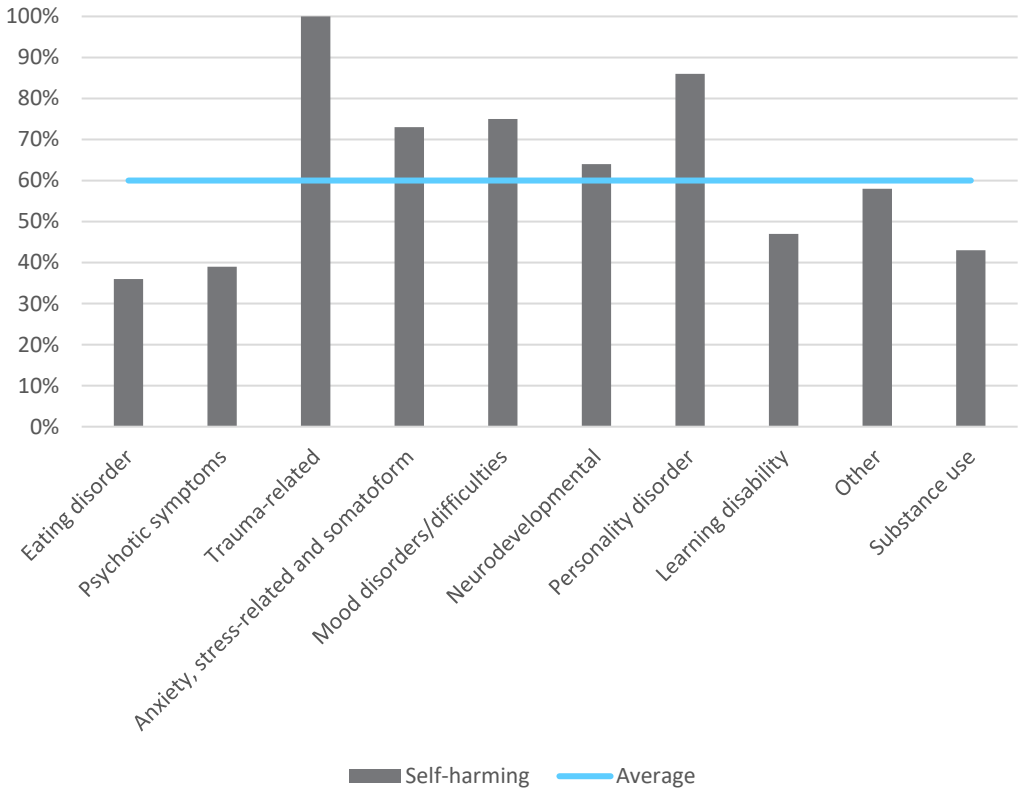


Self-harming and presentations

Given the importance self-harming behaviours have on detentions, as evident in the increasing proportion with self-harming behaviours, in particular reported suicidality, we explored how the proportion of patients with self-harming behaviours varied by presentation.

Figure 6 shows that some presentations had higher proportion of patients with self-harming behaviour compared to the overall proportion. These were trauma-related history/presentation (100%), personality disorder (86%), mood disorder/difficulties (75%), anxiety, stress-related and somatoform disorders (73%) and developmental conditions (64%). Despite the remaining presentations having lower than average proportions of patients with self-harming behaviours, more than one third of patients were displaying self-harming behaviour in these groups of presentations.

Figure 6. Proportion of self-harming behaviours within each presentation



Discussion

This is the first report to explore in depth the characteristics of young people detained under the Mental Health Act in Scotland. While these findings cannot answer the question of why we have seen continuous increases in detention rates over time, they indicate that the patients who are detained display high levels of distress and present with significant difficulties. The prevalence of psychotic symptoms in this group and the level of self harm and suicidality supports this assumption. Most emergency detentions occur out-of-hours – much higher than has been reported in previous studies.[62] This raises questions about what influencing factors are at work, as well as the availability of crisis services for young people out of hours, and the options available other than hospital admission for young people presenting in significant distress.

A recent UK study reflected how suicidality might emerge quite suddenly in this age group and recommended the development of widely available crisis services for young people.[63] In the absence of any child intensive treatment services, admission may be the only way to ensure safety and this may be voluntary or under detention.

Another inferred factor, given the rise in detention rates over the last five years for this age group, is that it appears to indicate a greater recording of self-harming. The prominence of these factors in trauma-related presentations and personality disorder raises the question of whether wider children's services are presently configured to meet the needs of young people with these difficulties. Addressing these issues requires wider involvement of children's services rather than mental health services alone and the importance of collaborative working between acute hospitals, mental health services and the local authority when responding to the needs of a young person's self harm has been highlighted in the UK Royal College of Psychiatrist's 2014 report on self harm in young people.[64]

Until relatively recently the evidence base around self harm in young people has not been strong but slowly over the past decade the evidence base has begun to develop, not just in relation to beneficial mental health interventions for young people who self harm but also in relation to prediction and prevention of self-harm.[65] A study in England has shown that the interaction between parents and young person and the young person's *experience of their school culture* and their *neighbourhood* are associated with reduced likelihood of self-harming behaviours during adolescence[66] and 'school connectedness'[67] has been found to reduce a range of adverse outcomes including self-harm and suicide in young people but also

[62] Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent psychiatry*.
[63] C. Rodway et al., *Suicide in children and young people*
[64] Royal College of Psychiatrists. *Managing Self harm in young people,* CR 192, 2014. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr192.pdf?sfvrsn=abcf1f71_2
[65] J. R. Asarnow and L. Mehlum, *Practitioner Review: Treatment for suicidal and self-harming adolescents.*
[66] E. Klemera, et al., ; *Self Harm in Adolescence: Protective Health Assets in the Family, School and Community,* International Journal of Public Health, vol. 62(6): pp. 631–638, 2017.
[67] M. E. Marraccini and Z. M. Brier, *School Connectedness and Suicidal Thoughts and Behaviours: A Systematic Meta-Analysis*, School Psychology Quarterly, vol 32(1): pp. 5–21, 2017.

substance abuse, absenteeism, violence, poor educational outcomes and early sexual initiation. [68]

The Scottish Government is currently attempting to strengthen the support available to young people in the community and schools[69] as part of its approach to supporting mental health and suicide prevention in young people.[70] A key deliverable of the recently constituted Children and Young People's Mental Health and Wellbeing Programme Board is also to enhance the crisis support available to children and young people and existing community supports and develop innovative new approaches for emotional and mental distress.[71] The pilot of Distress Brief Intervention has recently been extended to cover 16–17-year-olds in the pilot sites for this programme and that the programme is now available across Scotland.[72]

The role of gender in mental health problems and inpatient care

In Scotland, reports about declining mental health in girls have been addressed in research by SG Social Research.[73] In the data of detained young people we saw a higher proportion of girls and some differences in presentations when comparing girls and boys.

Previous international research has shown that detentions by gender may differ, with reports of higher proportion of girls detained,[74] of boys,[75] or no gender significant difference.[76] The inconsistency in the literature regarding detention rates by gender for young people is in contrast to findings from a systematic review including adult populations, where being male was associated with an increased odds of being detained (along with socioeconomic factors and psychiatric diagnosis).[77] We however found a higher proportion of girls in this group of detained young people.

Gender differences are also apparent in diagnoses of detained patients, for example an Irish study involving involuntary patients found a higher proportion of schizophrenia in male patients while female patients to greater extent had an affective disorder.[78] Such differences also appear to be evident in children and young people, with suggestions such as that

---

[68] Centres for Disease Control and Prevention. *School Connectedness: Strategies for Increasing Protective Factors Among Youth.* Atlanta, GA: U.S. Department of Health and Human Services, 2009. https://www.cdc.gov/healthyyouth/protective/pdf/connectedness.pdf

[69] Scottish Government, *Improving mental health services for young people, 2020* https://www.gov.scot/news/improving-mental-health-services-for-young-people/#:~:text=The%20Scottish%20Government%2C%20in%20partnership,across%20the%20whole%20of%20Scotland

[70] Scottish Government, *Every Life Matters – Scotland's Suicide Prevention Action Plan.* 2018; Scottish Government, *Children and Young People's Mental Health and Wellbeing Programme Board,* N.D. https://www.gov.scot/groups/children-and-young-peoples-mental-health-and-wellbeing-programme-board/

[71] Scottish Government, *Children and Young People's Mental Health and Wellbeing Programme Board*

[72] Scottish Government, *New mental health support,* 2020 https://www.gov.scot/news/new-mental-health-support/ [Accessed 29 July 2020]

[73] Scottish Government Social Research, *Exploring the reported worsening of mental wellbeing*

[74] Siponen et al., *Increase in involuntary psychiatric treatment and child welfare placements.*

[75] Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent psychiatry*; Maers et al., *Characteristics of the Detained and* Informal.

[76] Persi, Bird and DeRoche, *A Comparison of Voluntary and Involuntary;* Kaltiala-Heino, *Involuntary commitment and detainment*; Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors.*

[77] S. Walker et al., *Clinical and social factors associated with increased risk for involuntary psychiatric hospitalisation: a systematic review, meta-analysis, and narrative synthesis,* Lancet Psychiatry, vol. 6(12): pp. 1039-53, 2019.

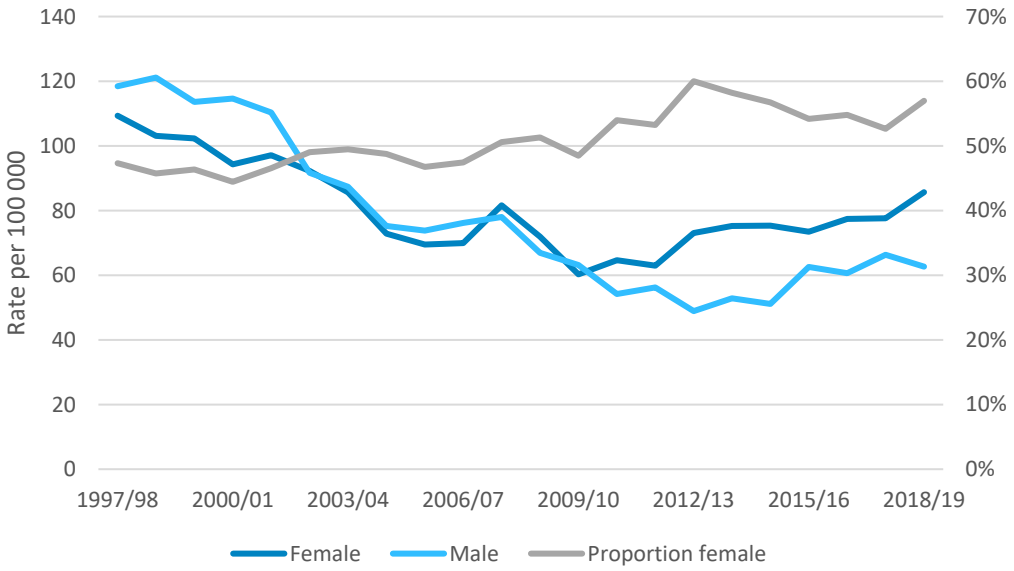
[78] A. Feeney et al., *Gender, diagnosis and involuntary psychiatry admission in Ireland: A report from the Dublin Involuntary Admission Study (DIAS),* International Journal of Law and Psychiatry, vol. 66: pp. 101472, 2019.

threshold for detention when the patient is aggressive might be perceived differently in boys and girls and influence considerations of detention.[79] Further work is needed to explore the role of gender in the likelihood of detention, especially comparing different age groups and diagnosis, which to date has not been done with Scottish detention data.

Representation of gender needs to be seen within the context of increasing demands on psychiatric care in general. Evidence from Finland showed that the proportion of girls in adolescent inpatient psychiatric wards significantly increased from 57% in 2000 to 70% in 2011.[80]

Data from Public Health Scotland shows that the overall rate of patients who received inpatient mental health care decreased until around 2009-10, after which rates have increased again. In addition, the proportion of female patients in inpatient mental health care has increased; in 2018-19 the proportion female was 57% (Figure 7).[81]

Figure 7. Patient rate for inpatient mental health care (SMR01 and SMR04)[82] among 0–17-year-olds (left axis) and proportion female patients (right axis)



Source: Public Health Scotland, *Mental Health Inpatient Activity*[83]

Presentations and self-harming behaviour

We identify some similarities in the Scottish data with published studies on this topic, but note that comparisons need to be made with caution due to differences in the way we have grouped presentations or symptoms compared to other work. Our findings that 40% of young people were reported to have psychotic symptoms is similar to a Finnish study indicating 56% of

[79] Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors.*
[80] K. Kronström et al., *Changes in the clinical features of child and adolescent psychiatric inpatients: a nationwide time-trend study from Finland*, Nordic Journal of Psychiatry, vol. 70(6): pp. 436–441, 2016.
[81] Public Health Scotland, *Mental Health Inpatient Activity*. https://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2019-09-10/mental-health-inpatient-activity/data-summary/ [accessed 6 May 2020].
[82] SMR01 relates to care in in the General/Acute specialties and SMR04 relates to Mental Health Inpatient and Day Cases
[83] Public Health Scotland, *Mental Health Inpatient Activity*.

detained patients (13–17 years) had psychotic symptoms, [84] while higher than in a German study where only 6.8% of young people (<17 years) displayed psychotic symptoms.[85] Substance use was confirmed or suspected in 7% of young people in the current study, similar to evidence from Finland (8%) and Germany (5%).[86] Further work to compare how presentations in Scotland compare to other jurisdictions would provide further insights into characteristics of young people who require an involuntary admission. Such comparisons should take into consideration the differences in legal provisions for detentions.

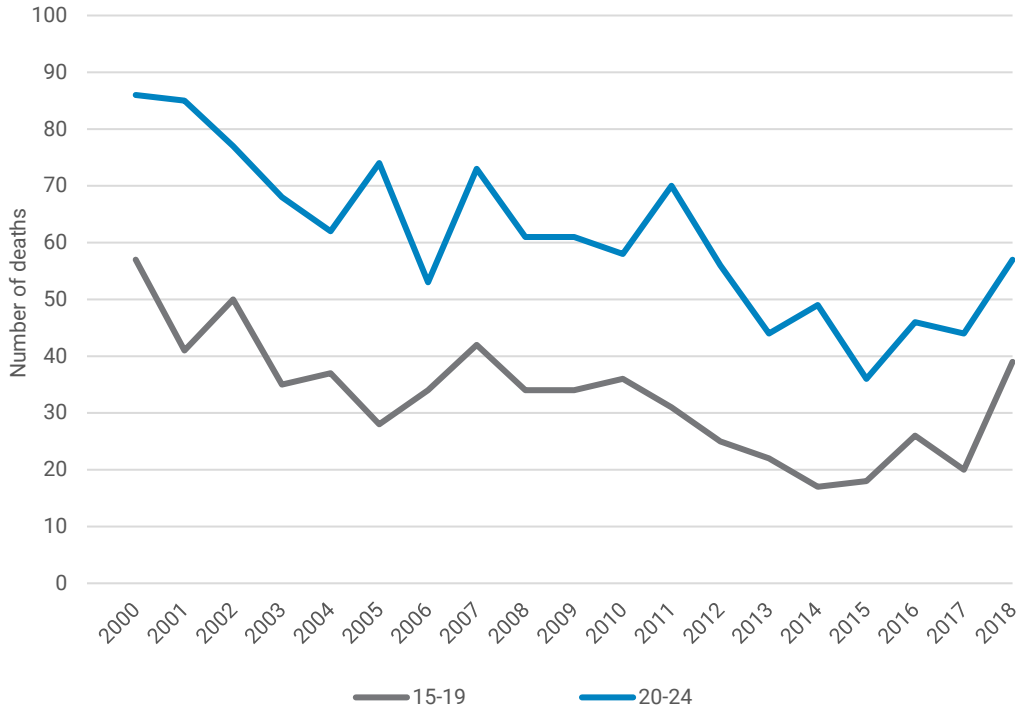
Our findings show important increases in self-harming behaviour in the same time frame in which we note an increases in the rate of detention in this age group. Suicidality, in particular has previously been estimated, in a Canadian study to range from 73% to 89% in detained young people.[87] In this report related to Scotland, we coded notes in the detention forms but there may be lack of details in some forms where the patient may have been suicidal but it was not made explicit. We specifically coded instances where the clinician had explicitly reported suicidal ideation, plans or attempts as well as instances of deliberate self-harm. As mentioned earlier it can often be difficult to distinguish self-harm with or without suicidal intent however as we created a composite category for all self-harming we captured all instances which included either explicit suicidality or self-harm.

The high proportion of self-harming in our sample may be indicative of wider problems. Evidence from Finland has shown increasing trend in suicidal acts in adolescent girls, despite no change overall in prevalence of suicidal threats or acts among young people in inpatient psychiatric care.[88]

Data from National Records Scotland show that the absolute number of deaths by suicide in the age groups 15–19 and 20–24 years has increased since 2015, after a longer declining trend (Figure 8). Our findings of increasing self-harming behaviours in detained young people may therefore form part of a wider issue of mental ill health in young people leading to increasing number of suicides. The high proportion of detained young people in Scotland displaying self-harming behaviours emphasises the importance of intervening in psychiatric emergencies.

[84] Kaltiala-Heino, *Involuntary commitment and detainment*.
[85] Kaltiala-Henio, *Increase in involuntary psychiatric admissions of minors.*
[86] Kaltiala-Heino, *Involuntary commitment and detainment*; Jendreyschak et al., *Voluntary versus involuntary hospital admission in child and adolescent* psychiatry.
[87] Kaltiala-Heino, *Involuntary commitment and detainment*; Persi, Bird and DeRoche, *A Comparison of Voluntary and Involuntary.*
[88] K. Kronström et al., *Suicidality among child and adolescent psychiatric inpatients: time trend study comparing 2000 and 2011,* European Child & Adolescent Psychiatry, vol. 28: pp. 1223–1230, 2019.

Figure 8. Deaths in Scotland with underlying cause of 'intentional self-harm' or 'event of undetermined intent', 15–24 years[89]



Source: National Records of Scotland: *Probable Suicides*[90]

Impact of detentions and variations in detention practice

A key question in relation to detentions is how they fit within a patient's previous and future experience of mental health care. A systematic review of adults detained under mental health legislation indicated that previous involuntary hospitalisation, along with characteristics such bipolar disorder, increased the odds of another detention.[91] In this sample, we could identify a number of patients who had more than one detention during the five-year study period.

Synthesis of qualitative research, which did not include children and young people, suggests that detention can be distressing for patients and lead to feelings of disempowerment from coercive treatment. Some studies have found that patients worry that a detention will increase the risk of another detention in the future.[92] If an index detention is a predictor for subsequent detentions, strategies to ensure that support services for individuals who have been detained are in place could be crucial. The extent to which young people are detained multiple times should therefore be explored further as well as gaps in provision for children and young people, particularly the lack of specialist advocacy support for young people admitted in adult

[89] Using new coding rule data from 2011 onwards
[90] National Records of Scotland, *Probable Suicides: Deaths which are the Result of Intentional Self-harm or Events of Undetermined Intent* (Data table 3) Available at: https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/suicides
[91] Walker et al., *Clinical and social factors.*
[92] S. F. Akther et al., *Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis.* BJPsych Open, vol. 5(e37): pp. 1–10, 2019.

settings which we have previously highlighted.[93] Those who have experienced an episode of detention or indeed an informal admission might also wish to be supported in writing an advance statement.

In understanding the impact a detention may have, clinicians' use of detention and their views on detaining young people may be contributing factors. Regional differences in detention in Finland has been suggested to stem from factors beyond individual characteristics of patients.[94] A qualitative study of Finnish psychiatrists' views on the criteria for detaining a minor (<16 years) under Finnish mental health legislation, indicated that psychiatrists supported the detention criteria for young people which are different and broader to the criteria used for adults. Reasons included that they felt a detention could protect developmental disruption by intervening and preventing future mental health problems; that minors due to their age are less competent in evaluating the consequences of receiving or abstaining from treatment; the inability to provide a descriptive diagnosis based on minors' level of development that may prevent expression of symptoms to accurately provide a diagnosis; and that medical rights need to be prioritised over right to self-determination.[95] Although this study explored the views on the use of detention in the under 16 population in whom capacity in relation to fully autonomous decision making is not regarded as necessarily being present, attitudes towards detention of 16–17–year-olds in Scotland could be useful to explore factors relating to received practice and culture towards those young people. This may be for the current review of Scottish Mental Health Law to consider. Underlying reasons for the increases in detention that we have observed in Scotland have not been explored from practitioners' perspective in terms of changes that may be seen within services. The way in which clinicians approach the decision of detaining a young person could be an important factor in the increasing rate of detention, which we have continued to report on.[96]

Limitations

This report has provided an analysis of routinely collected data, which has a high level of accuracy and is of good quality. This does not, however, mean the work is without limitations. Firstly, we did not report on clinical diagnoses – the analysis was limited to interpretation of notes made on the detention forms and coding was done broadly and informed by ICD-10/DSM-IV categories and grouping of symptoms. This is substantially different to studies that have analysed clinicians' diagnosis as per ICD codes. As noted, our EDC data does not include an ICD-10 code and the sample of STDC records had a substantial proportion of missing data. The results therefore need to be interpreted with the caveat of not being a determined diagnosis, or necessarily the reason for detention, and comparisons with other studies need to be done carefully.

Secondly, the coding of the data was limited to the level of detail within each form, which varied greatly. Our analysis, therefore, is reliant on the level of detail within these forms and needs to be acknowledged as a limitation in that the same level of detail, for example whether or not the reason for the detention was made clear, was not uniform. Furthermore, EDCs are

[93] Mental Welfare Commission, *The Right to Advocacy A review of how local authorities and NHS Boards are discharging their responsibilities under the Mental Health (Care and Treatment) (Scotland) Act 2003*. 2018 https://www.mwcscot.org.uk/sites/default/files/2019-06/the_right_to_advocacy_march_2018.pdf
[94] Siponen, et al., *Increase in involuntary psychiatric treatment.*
[95] S. Turunen, M. Välmäki and R. Kaltiala-Heino, *Psychiatrists' views of compulsory psychiatric care of minors*, International Journal of Law and Psychiatry, vol. 33: pp. 35–42, 2010.
[96] Mental Welfare Commission, *Mental Health Act Monitoring Report.*

completed by medical practitioners from different specialties and who may have limited experience with young people and how mental health disorders present in this age group.

While our data suggests most detained patients are white, we currently have substantial missing data for ethnicity. There are also gaps in postcode data whereby the SIMD distribution should be interpreted with caution. Going forward, exploring trends and characteristics of detentions by ethnicity and deprivation are important to the overall strategy of reducing inequalities.

This is particularly important as research has shown that ethnic minority groups have an increased likelihood of being detained compared to white ethnic groups.[97]

Finally, there might be more fine-grained details of detentions worth exploring, such as the mention of violence or aggression. Such additional factors in the presentation may be important in order to understand differences in detention of girls and boys. There may be different thresholds for detaining girls who act violently compared to boys, which has been found elsewhere.[98]

Recommendations

- Further work is needed around exploring the proportion of detention as part of overall mental health admissions, differences in individual characteristics and variation between geographical areas. The Commission will continue to develop collaboration with relevant organisations to expand on our detention data to provide further insights where possible.
- There is need for work to explore clinicians' views on the rising rate of detentions and how attitudes towards detaining young people may have changed over time in line with developments within policy or clinical guidelines. This may form part of the considerations for the Scottish Mental Health Law Review. The Commission will present this data set in evidence to the Review.
- Child and Adolescent Mental Health Services Lead Clinician Group, Services and professionals to reflect on the rising rates of self-harming which are reported in considerations around detention. Particular attention should be paid to young people with a history or current presentation of trauma, and those with emerging personality disorder, given the high levels of self harm in these two specific groups, to ensure that mental health services have the right services available at the right time for them.
- The Commission will continue to work with health boards to improve recording of ethnicity and postcodes to allow for analyses of differences relating to inequalities.
- The Commission will use the findings of the report to inform future Mental Health Act monitoring reports and focus on areas of importance for younger age groups.
- The Commission notes the lack of MHO (a mental health officer, specialist social worker trained in mental health issues) consent in about half of all emergency detentions. The safeguard of an independent MHO consenting to the detention is an important one and the fact that this does not seem to be reliably used to protect the interests of young people is concerning. The Commission has raised this issue

[97] P. Barnett, *Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data*. Lancet Psychiatry, 6: 305-317, 2019.
[98] Kaltiala-Heino, *Involuntary commitment and detainment*.

and the reasons behind this before, particularly for this vulnerable group of young people. The Commission will raise concern about the safeguard with the Scottish Mental Health Law Review to consider the way forward for this safeguard.

Each form we've analysed to provide this picture of the use of the Mental Health Act for 16–17-year-olds in Scotland represents a time of real difficulty for that young person and those important to them. We hope that this 'big picture' analysis by the Commission shows how we are using the recording of those situations to provide a sense of where services are currently at, in the hope that it helps to create change that might make a difference for other young people and those important to them.

Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk
Mental Welfare Commission 2020