Agenda Item	6
Report No	HCW-03-26

The Highland Council

Committee: **Health, Social Care and Wellbeing Committee**

Date: **04 February 2026**

Report Title: **Highland Mental Health Officer (MHO) Service: Future Planning Report**

Report By: **Assistant Chief Executive - People**

1. Purpose/Executive Summary

1.1 The statutory roles of the MHO are predominantly defined within two key pieces of legislation. Daily duties include the consideration and application of compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003, and new and renewal Welfare Guardianship considerations under the Adults with Incapacity (Scotland) Act 2000.

1.2 The MHO role is enshrined in law and specific duties focus on the critically important time where individuals are assessed in relation to apparent capacity-related needs, and/or mental health care and treatment needs that may require compulsory measures. The use of powers under either piece of legislation should last for the shortest possible length of time, and the scrutiny of MHO decision-making is provided by the Mental Welfare Commission, the Office of the Public Guardian, the Scottish Courts and, by extension, the Mental Health Tribunal for Scotland. This report aims to provide an overview of service performance, pressures, and future planning considerations. To set local performance information in better context, reference will be made to national statistics provided by the Mental Welfare Commission.

2. Recommendations

2.1 Members are asked to:

i. **Note** the contents of this report,
ii. **Comment** on the analysis of local and national workforce planning indicators in relation to the capacity and performance of the service.

3. Implications

3.1 **Resource -** Please refer to Section 6.4 of this report.

3.2 **Legal -** The functions of the MHO role are enshrined in law. Further context is provided in Section 4 of this report and throughout Section 5. It is important to note that many of the timescales provided detailed in legislation relate to the interface of the team's work with Scottish Courts and, by extension, the Mental Health Tribunal for Scotland.

3.3 **Risk -** There are some risks arising from the workforce challenges experienced by the team, which have previously been raised with the Committee. The following risks are highlighted:

- Potential risk to the efficacy of MHO safeguarding if resource implications continue to influence the medical application of compulsory measures.
- Noted resource implications associated with the rising use of short-term compulsory measures and interventions.

3.4 **Health and Safety (risks arising from changes to plant, equipment, process, or people) -** Please refer to the risk section above.

3.5 **Gaelic -** No apparent or direct implications.

4. Impacts

4.1 In Highland, all policies, strategies or service changes are subject to an integrated screening for impact for Equalities, Poverty and Human Rights, Children's Rights and Wellbeing, Climate Change, Islands and Mainland Rural Communities, and Data Protection. Where identified as required, a full impact assessment will be undertaken.

4.2 Considering impacts is a core part of the decision-making process and needs to inform the decision-making process. When taking any decision, Members must give due regard to the findings of any assessment.

4.3 This is a monitoring report and therefore an impact assessment is not required.

5. Background and Context

5.1 There is an established structure to manage and support the delivery of Highland Mental Health Officer Service. This service must meet the Highland Council's statutory duty to appoint MHOs under Section 32 (1) of the Mental Health (Care and Treatment) (Scotland) Act 2003. The Chief Social Work Officer of the Local Authority, or their delegate, is required to appoint a sufficient number of MHOs to discharge functions under:

- The Mental Health (Care and Treatment) (Scotland) Act 2003 (The 2003 Act)
- The Mental Health (Scotland) Act 2015 (The 2015 Act)
- The Adults with Incapacity (Scotland) Act 2000 (The 2000 Act)
- The Criminal Procedure (Scotland) Act 1995 (The 1995 Act)

5.2 MHOs are experienced and qualified social workers with an additional Postgraduate Certificate award. The role requires an enhanced understanding of mental health legislation and the underpinning principles to apply such in everyday practice. The MHO is regularly required to make decisions that balance individual rights, needs, and risk, alongside community safety considerations, retaining full agency for their recommendations. Their recommendations are scrutinised by the Mental Health Tribunal for Scotland and the Scottish Court, in addition to other regulatory bodies, such as the Mental Welfare Commission (MWC) and the Office of the Public Guardian (OPG). For this reason, it is essential to strike a defensible balance between risk management and the promotion of self-determination in accordance with an individual's personal rights and liberties. The autonomous role of the MHO is

independent from health and social care services and is a fundamental safeguard for individuals requiring this service.

5.3 The Mental Health Act MHO Team and The Adults with Incapacity MHO Team are 2 of the 3 MHO teams within the service, which is supported by 3 WTE Practice Lead MHOs and 20 WTE substantive MHOs. MHOs in this team have a combination workload comprised of 2003 Act and 2000 Act duties, which will be the focal point of this report.

6. Key Findings and Local Performance

6.1 <u>The 2003 Act: Increased use of Emergency and Short-Term Compulsory Measures</u>

6.1.1 Local statistics indicate significant increases in the use of both Emergency Detention Certificates (EDCs) and Short-Term Detention Certificates (STDCs) **Appendix 1**. The number of STDCs have increased by 46% and the number of EDCs by 170% over the past 10 years. This increased volume of work is being managed with one additional WTE main-grade MHO in the same period. Recent trends include the notable EDC increase since 2020, and a more drastic increase between 2023 and 2024. Whilst data is incomplete for this financial year, early indications suggest the upward trend continues. Recent STDC statistics show numbers have increased and remained high since 2021, whilst there was an insignificant reduction between 2023-24. Like EDCs, incomplete statistics for this financial year strongly suggest an upward trend.

6.1.2 The completion of both EDCs and STDCs are classed in law as ‘relevant events’, meaning a Social Circumstances Report (SCR) must be produced by the MHO (see 6.2 for more information). The initial assessment, ongoing involvement throughout compulsion, and the production of a detailed SCR, has a significant impact on workforce capacity. Without an increase to the MHO establishment, increased workload pressures will become unsustainable in the medium-to-long-term.

6.1.3 The MWC Mental Health Act Monitoring Report **Appendix 2**, references a national increase in 2003 Act compulsory measures. It is the writer’s view that the nationwide 3.3% increase in the use of 2003 Act compulsory measures **Appendix 2** does not necessarily provide a full picture. During the MWC 2024-2025 review period, the availability of psychiatric inpatient beds in Highland, and numerous other health board areas has remained extremely limited. Like all psychiatric hospitals nationally, there are issues in terms of bed availability – and it may be that such issues have an influence on medical decision-making in this regard. This perspective is based on health-based resource forecasts, which are not set to improve in the short or medium-term. Furthermore, considerations made during local MHO/RMO Forum, and National MHO forums organised by the Scottish Association of Social Work (SASW) and Social Work Scotland (SWS) have noted the influence resources on decision-making.

6.2 The 2003 Act: MHO Consent to Emergency Detention Certificates (EDCs)

6.2.1 Prior to the imposition of an EDC, best practice should involve MHO assessment and garnering of their autonomous consent to the order. If seeking an MHO opinion would cause an undesirable delay in an emergency, advice and guidance can be sought from an MHO, often via telephone. This is available 24 hours a day in Highland as all social workers within the Emergency Social Work Service are qualified MHOs. It is

not always possible to attend these assessments in person due to geographical implications, or the travel time being outwith the urgent/necessary timeframe. Medical practitioners do not always inform of EDC imposition until after the fact. There is a desire to better understand what is happening with EDC consent in the Highland Local Authority area as the MWC only gathers stats in relation to health board area.

6.2.2 The availability of MHO consent to EDCs in the Highland Health Board area is 59.4% **Appendix 2**. However, the MWC report this statistic by Health Board area, and not by Local Authority area, and it is important to note Argyll & Bute is included in this statistic as part of NHS Highland. As such, this statistic should be viewed as a general indicator of Highland MHO Service performance in this regard. The national average of EDCs with MHO consent is just 38.6%. This national statistic has been in decline over the past 10 years and is indicative of national resource pressures on MHO services.

6.3 The 2003 Act: Completion of Social Circumstances Reports (SCRs)

6.3.1 An MHO is required to produce an SCR under Section 231 of the 2003 Act following a 'relevant event' when specific compulsory measures are applied. The SCR provides a detailed social background and analyses the interaction between an individual's health and social circumstances, providing information about alternative care and support options that may be available. The value of this considered social-model perspective cannot be overstated. The SCR is prepared for the Responsible Medical Officer (RMO – Ordinarily the Consultant Psychiatrist) and the MWC. In situations where a full SCR report is not required, the MHO must submit a form to the MWC to explain why.

6.3.2 MWC data in relation to SCRs **Appendix 2** fails to illustrate a clear picture of what is happening within the Highland Local Authority area as this information is captured by Health Board area. However, local data has been gathered since 2023 **Appendix 1**, and it is positive to note that, since then, the SCR return rate is 86%. Of this percentage, 76% were sent alongside a full report. Return rates have remained consistent over the past 3 years despite the increased number of short-term orders.

6.3.3 The Highland MHO Service SCR completion rate is well-above the national average of 53% completion **Appendix 2** noted in 2024-2025 statistics. This is an example of the work-rate and attention afforded to this statutory requirement locally.

6.4 The 2000 Act: Safeguarding Reports

6.4.1 With significant developments in English and Welsh Adults with Incapacity law, the safeguards afforded by equivalent Scottish law have come under increased scrutiny. Case law challenges regarding the effectiveness of safeguards during the Welfare Guardianship application process have resulted in an increased request for Safeguarding Reports to be completed, in addition to the MHO's Welfare Guardianship Application. Whilst extra consideration and scrutiny relating to a vulnerable person's past and present wishes is welcomed, the cost of preparing this report is charged to the Highland Council's MHO Service, unless otherwise stipulated by the presiding Sheriff.

6.4.2 The Chief Social Work Officer, the Highland Council Legal Department, and the Highland MHO Service have been working collaboratively to mitigate the financial impact on the service and £100,000 of funding has been secured over a three-year

period to mitigate the cost of such report requests. Additional funding appears to be adequate at present and will continue to be monitored. It should be noted that legislative reform may eliminate this financial pressure, but such reforms remain in the very early stages.

6.5 The 2000 Act: Welfare Guardianship Orders and Renewal Applications

6.5.1 The number of new Welfare Guardianship Orders (WGOs) granted over the past 10 years has remained relatively consistent **Appendix 1**. Unfortunately, there is currently no reliable way to gather local data on the number of WGO renewals. This is something the service will seek to address when recruitment to the vacant 0.5 WTE Information, Research and Quality Assurance Officer role is completed (expected January 2026). With changes in practice guidance, it is apparent the volume of WGO renewals will have increased in the past 10 years. For example, the typical length of a WGO is now typically 1, 3 or 5 years with reviews being required prior to expiry. It was historically common practice for WGOs to be imposed for an 'indefinite' period, which nullified the appropriate need for review and reconsideration of the powers granted.

6.5.3 The findings regarding the length of WGOs support the increase in renewals **Appendix 3**. 89.1% of orders granted nationally were for a period of five years or less in the 2023-24 period. In the same period, 9.9% of granted orders were for six years or longer, and 1.0% were indefinite orders. It is important to note the national number of Guardianship Orders has risen from 9,333 in 2015 to 20,152 as of 31st March 2025. Given the appropriate trend towards shorter-term orders and more regular review of granted powers, it is safe to say the demands on the service are increasing. The Highland MHO Service will endeavour to make better sense of the volume of local WGO renewals.

6.6 The MHO Workforce: Potential Resource Implications

6.6.1 The MHO Service has overcome several challenges due to flexible and standard retirement in the past year, in addition to managing the significant rise in the volume of statutory orders across the board. This has resulted in increased workload pressures, which are unsustainable in the medium-to-long-term. Despite workload pressures, it is pleasing to report that the Highland MHO Service has maintained an above-average standard when benchmarked against national averages. The Committee are likely aware of general workforce challenges within Health and Social Care services, which are applicable to the Highland MHO Service as a unique branch of social work practice.

6.6.2 A key success in relation to workforce planning has been the successful implementation of the Trainee Mental Health Officer Scheme in 2022, which was developed in partnership with Robert Gordon University, Aberdeen. The Trainee MHO Scheme attracted national recognition, winning the 2023 SASW Practice Improvement Award in recognising the forward-thinking approach to recruitment and retention challenges. This has been reported to the Committee previously as a "good news" story. 8 Trainee MHOs have qualified and remained within the service since the scheme became operational in 2022. A further 2 Trainee MHOs commenced employment in August 2025 and are on-track to qualify in August 2026. Trainees require significant support from mentors and practice assessors within the existing workforce for the duration of the study period, which runs from September 2025 to August 2026. Although developing Trainee MHOs places a short-term demand on the

current staff group, there are simply not enough pre-existing social workers with the MHO qualification in Highland. It is hoped the service will be able to continue recruiting in this way when the scheme is reviewed later this year. It is due to expire at the end of 2026.

6.6.3 An enhancement, which recognises MHO status (and the need for an additional qualification) was implemented in 2022 to attract experienced social workers into the profession, and to account for the need for that qualification to practice as an MHO. However, there is a need for the rate of pay to remain competitive with other local social work employers. The apparent difficulties surrounding recruitment and retention of social workers and MHOs is a national issue, which is a constant theme reflected in the Scottish Government's mental health strategy.

Designation: Chief Officer, Health and Social Care

Date: 16 January 2026

Author: Euan Williamson, Principal Mental Health Officer

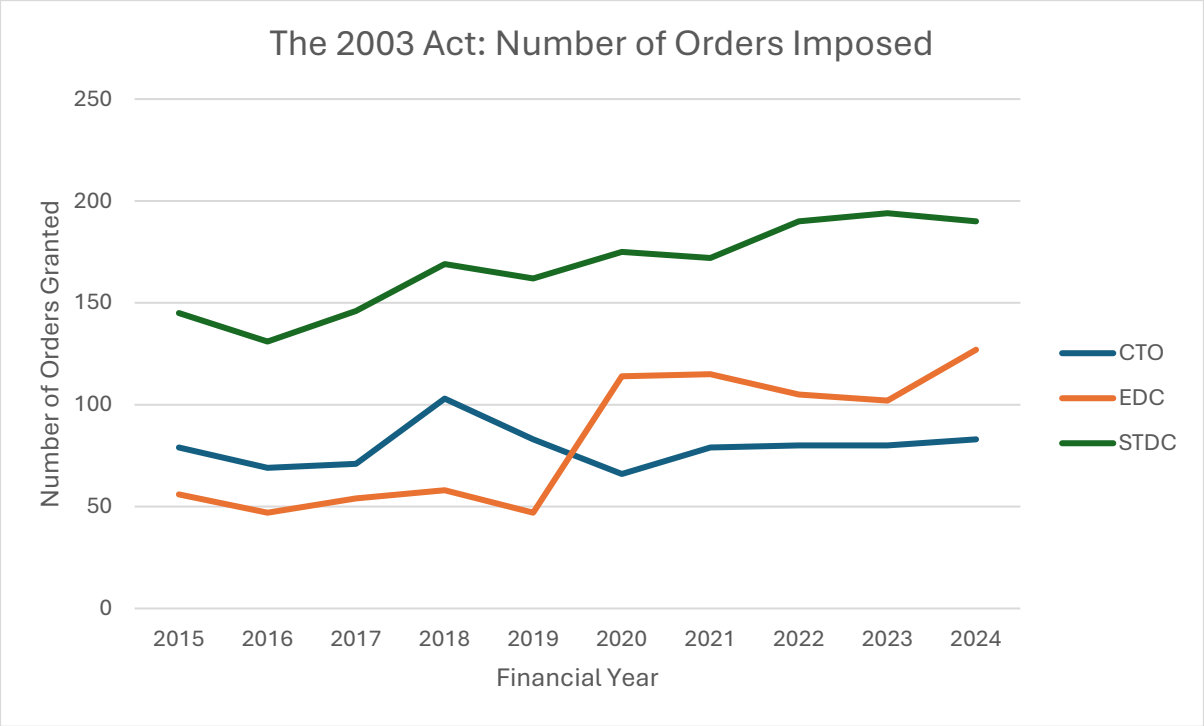
Background Papers: N/A

Appendices:

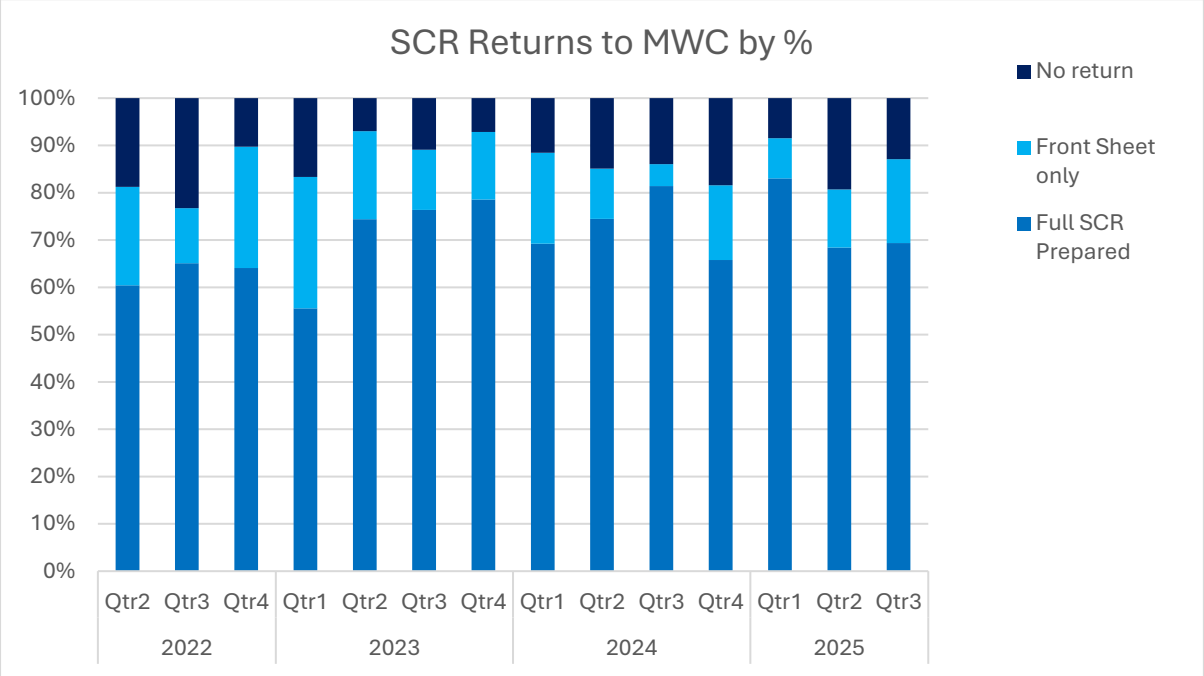
Appendix 1 – The Highland MHO Service: Local Data
Appendix 2 – MWC: Mental Health Act Monitoring Report, 2024-2025
Appendix 3 – MWC: Adults with Incapacity Monitoring Report, 2024-2025

Appendix 1 - Highland MHO Service: Local Data

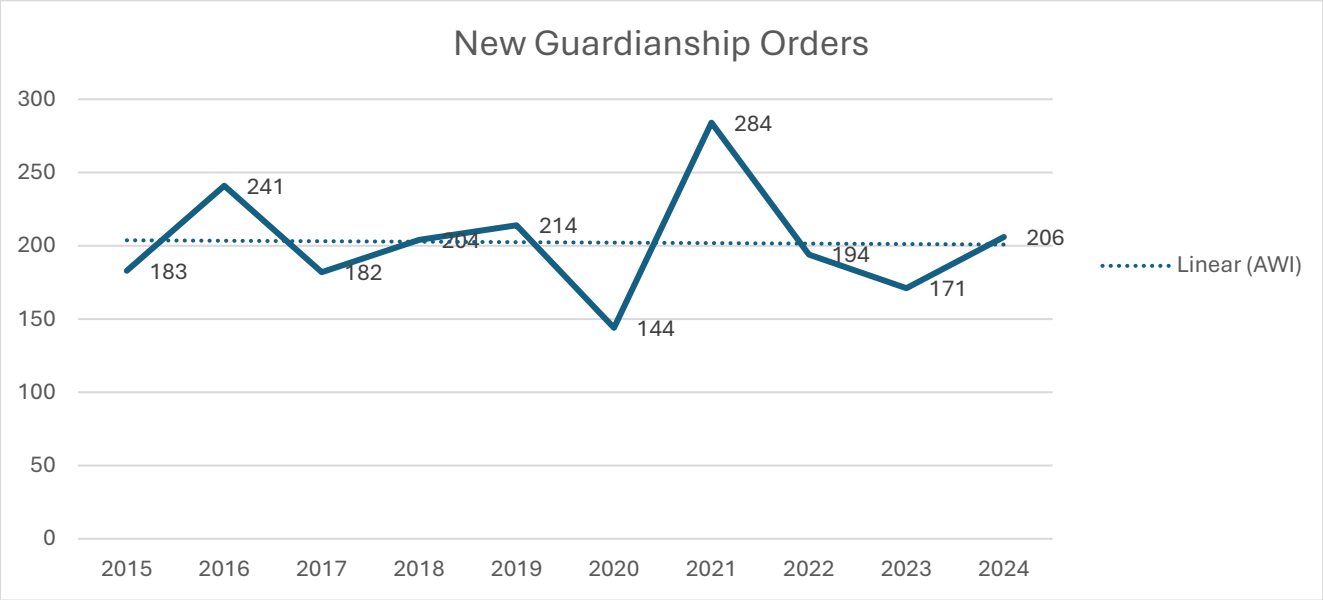
6.1 - The 2003 Act: Increased use of Emergency and Short-Term Compulsory Measures



6.3 - The 2003 Act: Completion of Social Circumstances Reports (SCRs)



6.5 - The 2000 Act: Welfare Guardianship Orders and Renewal Applications



mental welfare commission for scotland

Mental Health Act Monitoring Report 2024-25

Statistical monitoring

November 2025

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.

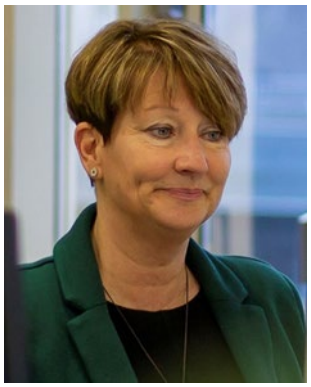
- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

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

Contents

Foreword – Julie Paterson, chief executive



When people become very unwell with mental ill health, some aspects of their care and treatment may need to be delivered against their will, to ensure their safety and wellbeing. All such, use of compulsion must be done using the Mental Health Act, should last for the shortest possible length of time, and must be reported to the Mental Welfare Commission.

The Commission has a statutory duty to monitor how Scotland's principle-based mental health law is used. We do this by publishing a transparent annual statistical report.

This year's report shows that a total of 7,449 detention episodes began in 2024-25, which was 3.3% more than in 2023-24 and slightly lower than the average year-on-year increase in the previous years of 4.7%.

We hope that the details provided in this report are helpful to organisations that are involved in the planning and delivery of services across Scotland and allow for more local scrutiny of trends and more local understanding.

The Commission also recognises that while this report summarises statistical information at a population level, every incident relates to an individual person and represents a time of difficulty for them, their carers, and those that matter to them.

November 2025

Summary and key findings

1. For some people with mental health difficulties, some aspects of their care and treatment might need to be delivered against their expressed wishes at that time. This is done as set out in the Mental Health (Care and Treatment)(Scotland) Act 2003 (the Mental Health Act)[1] which includes legal safeguards that ensure the person is cared for appropriately and for the shortest time possible.
2. The Mental Welfare Commission (the Commission) has a duty under section 5 of the Mental Health Act to monitor and promote best practice in the use of the Act. This report is published as part of this duty and outlines data primarily on the use of the Mental Health Act during 2024-25. We also make reference to the Criminal Procedure (Scotland) Act 1995[2] (the Criminal Procedure Act).

Detentions under the Mental Health Act

1. A total of 7,449 detention episodes began in 2024-25, which was 3.3% more episodes than the updated figure in 2023-24 of 7,211 and slightly lower than the average year-on-year increase in the previous years of 4.7%. Out of all episodes, 51.3% began with an emergency detention certificate (EDC), 47.4% with a short-term detention certificate (STDC), and 1.4% with a compulsory treatment order (CTO) or an interim compulsory treatment order (iCTO).
2. The rate of new detention orders increased very slightly for all types of order compared with 2024-25. The rate of detention for EDCs increased from 66.8 per 100,000 to 69.8 per 100,000 in 2024-25. The rate of STDCs increased only very slightly from 103.1 per 100,000 to 104.6 per 100,000 in 2024-25. The rate for CTOs increased from 33.4 per 100,000 in 2023-24 to 35.7 per 100,000 in 2024-25.
3. We continue to monitor detentions by the level of deprivation according to the Scottish Index of Multiple Deprivation (SIMD) based on the home address of the person being detained. There was a clear gradient of new detention orders in 2024-25 with a higher proportion of detentions of individuals from the most deprived parts of Scotland. The proportion of detentions from SIMD category 1 (most deprived) was 30.3%.
4. Consent of a mental health officer (MHO) is an important safeguard. For detention under an EDC, MHO consent has been falling over the years. We are still concerned at the low rate of 38.6%, however we note that there has been a slight increase in the number of MHO consents compared with the 2023-24 low of 35.7%. In mainland health boards this ranged from 27.0% in Greater Glasgow and Clyde to 81.4% in Dumfries and Galloway.
5. Social circumstances reports (SCRs) are a critical safeguard which address the interaction of a person's mental health *and* their social circumstances. For

53.0% of STDCs in 2024-25 the Commission received notification that an SCR had been prepared or that an SCR would serve no purpose (and therefore had not been prepared). In 47.0% of cases, we received no notification compared with 50.9% in 2023-24.

6. There were 187 detentions under section 299 (nurse's power to detain pending a medical examination) in 2024-25, which is a 10.1% decrease compared with 2023-24 revised figures.
7. There were 1,231 section 297 (place of safety) orders in 2024-25, which was a 3.8% decrease compared with the year before.
8. As well as the incidence of new episodes and orders, we count the number of individuals who were subject to an order on the first Wednesday in January each year (known as extant orders). In 2025, there were 4,216 extant orders which was similar compared with the same day in 2024. Of extant CTOs, 33.3% were community-based.
9. The Commission was notified of 138 deaths that occurred when someone was subject to an order under the Mental Health Act and nine deaths when someone was subject to the Criminal Procedure Act, equating to 1.1% of all orders in 2024-25. The percentage of deaths as a proportion of total orders remains consistent over time, ranging from 1.1% to 1.3%.

Detentions under the Criminal Procedure Act

10. There were 315 orders under the Criminal Procedure Act in 2024-25, this is the lowest figure we have recorded in the last 10 years. The average number of orders over the last 10 years was 384.
11. There was a total of 1,015 T2[1] certificates issued during 2024-25, compared with an average of 856 during the years 2015-16 to 2023-24. Most T2 certificates (96.5%) were issued for medication over two months while 2.5% were issued for electroconvulsive treatment (ECT). There were less than five T2s for artificial nutrition in 2024-25. Of the T2s, 5.0% were for young people (<18 years).
12. There were 2,845 T3 certificates issued in 2024-25, which was an 8.3% increase on the 2023-24 figure. Most T3s were for medication over two months (85.8%), while 7.9% were for ECT, 5.9% for artificial nutrition, and 0.4% for medication to reduce sex drive. This is broadly similar to previous years. Of the T3s, 4.7% were for people <18 years.
13. We were notified of 620 T4 certificates issued in 2024-25; a 12.1% increase on the number of T4s in 2023-24. Of the T4s, 19.5% were for people <18 years, which is an increase in the proportion from 12.8% in 2023-24.
14. Health boards are required to notify us each time someone registers, or withdraws, an advance statement containing a written statement of a

[1] Please see Box 3 on page 57 that provides details of the different treatment authorisation certificates.

person’s wishes regarding treatment if they become unwell in the future. In 2024-25, registrations had increased by 175 compared with last year’s register.

Introduction

The Mental Welfare Commission for Scotland has a statutory duty to monitor the use of the Mental Health Act. We do this by:

- collating and analysing data compiled from the relevant paperwork sent to us and,
- by publishing monitoring reports with comment and analysis of trends in the use of the Act.

This monitoring report is a statistical report based on detentions and the wider use of compulsion. We know that a detention occurs when someone is compelled to receive assessment and/or treatment in relation to their mental health. However, we fully recognise that each of the instances that make up this report, relates to a time of difficulty for the person and for those important to them.

Methods

In this report we present a number of different measures of compulsory care under the Mental Health Act[1] and also some in relation to the Criminal Procedure Act[2]; we report counts and rates of episodes, orders, or other indicators related to detentions or treatment. We also calculate percentages where relevant. Unless specified, the figures reported relate to the most recent reporting year (1 April 2024 to 31 March 2025). In the following sections we give an overview of how we report on this information and areas we have changed to improve the quality of the data we report on.

The Commission's data

The datasets we report here are based on notifications we receive from health boards when someone is made subject to the Mental Health Act or the Criminal Procedure Act. We also report on authorisations which are sent to us for safeguarded treatments under section 16 of the Mental Health Act. Our data is dynamic; that is, the number of detentions, or other indicators, might change retrospectively. This could be because some paperwork may not have reached us at the time we produce the monitoring reports. Updates sometimes happen and this means that figures in this report and previous reports may differ. In addition, this year we have been cleansing our database in anticipation of a data migration to a new system so there are very slight changes in historical data. The latest publication should always be referred to for the most accurate figures.

Scottish Index of Multiple Deprivation (SIMD)

We report level of deprivation according to SIMD categories in this monitoring report using the 2020v2 postcode look up file[4]. We report the level of completeness for this information as sometimes an individual may be of no fixed abode or is receiving long-term care in hospital and does not have a home address. Overall valid postcode data was available for 93.2% of detentions in 2024-25.

Mid-year population estimates and age standardisation

The most recent Scottish mid-year population estimates available are for 2024 and include revised estimates for 2023. The revised 2023 estimates have been used to revise the 2023-24 data and the 2024 estimates are applied to the 2024-25 data[5].

We continue to use Age Standardised Rates where possible using the European Standard Population 2013[6]. Age Standardised Rates take both population size and age structure into consideration to allow a like-for-like comparison between areas.

Compulsory treatment under the Mental Health Act

Box 1. Explanation of terminology

Emergency detention certificates (EDCs): EDCs are designed to be used only in crisis situations to detain a person who requires urgent care or treatment for mental ill health. An EDC can be issued by any doctor, with the consent of an MHO unless impracticable, which allows 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 an MHO. An STDC can detain an individual in hospital for up to 28 days.

Compulsory treatment orders (CTOs): An 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 panel decides the outcome of the application. The tribunal panel is made up of three people: a lawyer, a psychiatrist, and a general member. A general member may be a person with relevant skills and experience, for example a person with a mental health condition and with experience of using services, a carer, nurse, social worker, psychologist, or occupational therapist. The CTO can last for up to six months. It can be extended for a further six months and subsequently for periods of 12 months at a time.

New episodes of compulsory treatment

An 'episode' is a period where an individual is subject to the Mental Health Act. For example, an individual may be detained under an EDC then they might be detained under an STDC. Once the individual is well enough the doctor may end the STDC and the individual is therefore no longer detained. This would constitute an episode.

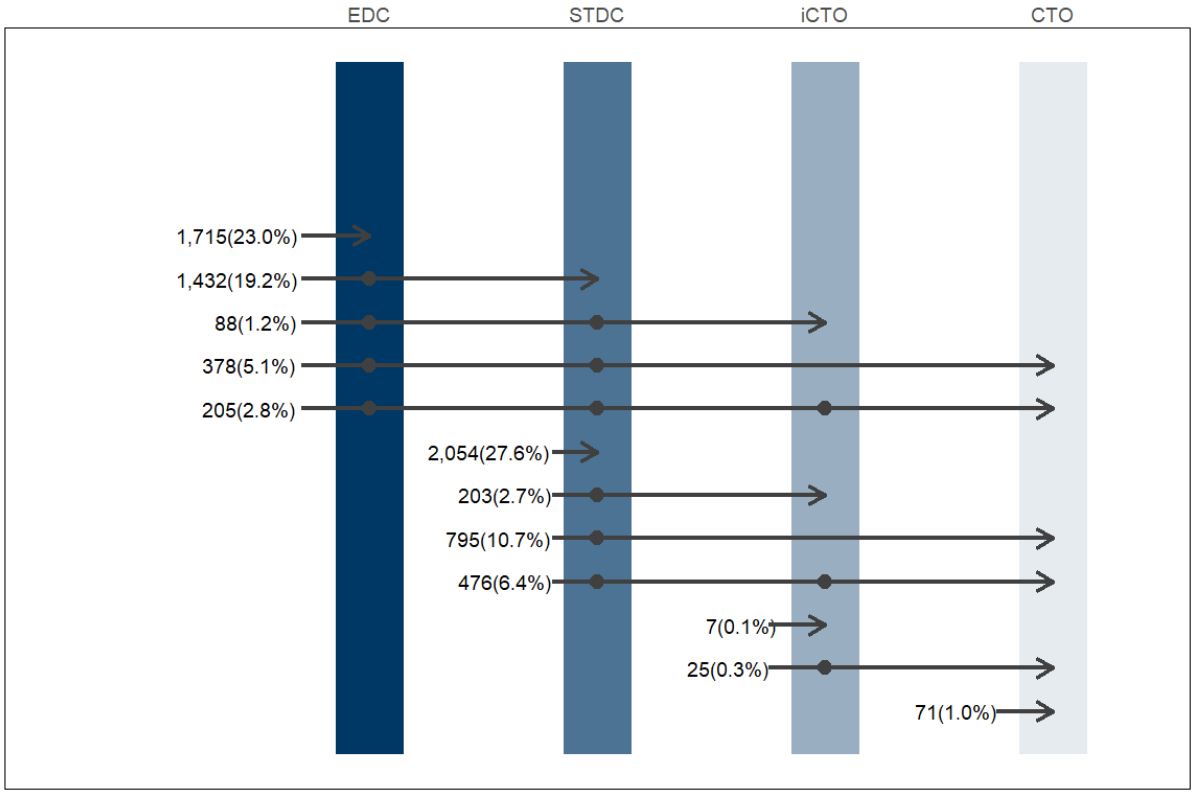
A total of 7,449 detention episodes began in 2024-25. The average year-on-year change of new episodes in 2015-16 to 2023-24 was 4.7% (ranging from -2.0% to 10.9%) (Appendix table A1.1[2]). The year-on-year increase between this year and 2023-24 was 3.3%, slightly lower than the previous average.

Figure 1 shows the structures of all episodes in 2024-25. We can see that an episode can consist only of an emergency detention, of emergency and short-term detention, only short-term detention and so on.

[2] All tables or figures marked with an A refer to a table or figure in the Appendices

51.3% of all episodes began with an EDC, 47.4% with a STDC, and 1.4% with a CTO or an interim compulsory treatment order (iCTO).

Figure 1. Order progression among all episodes in 2024-25



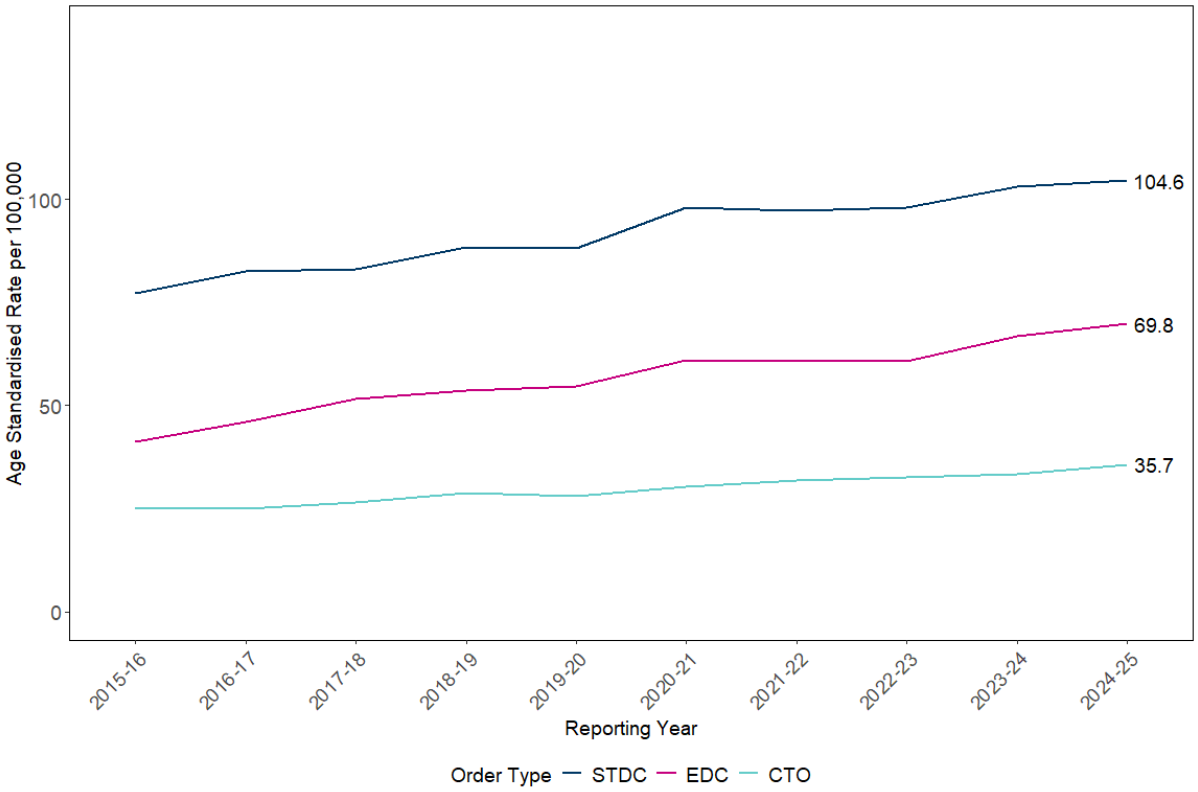
In 2024-25, 46.8% of all episodes progressed as far as an STDC, 26.2% progressed to a CTO, 4.0% as an iCTO and 23.0% ended as an EDC (Appendix figure A2.1). This was similar to the average in the previous years.

New Mental Health Act orders

An order is an instance where an individual becomes subject to the Mental Health Act, for example, an EDC, an STDC, or a CTO. When we count orders, we count each of these instances regardless of where the order lies within an episode of compulsion, for example, in the situation where a person may be subject to a suspended hospital-based CTO but is initially admitted under an EDC.

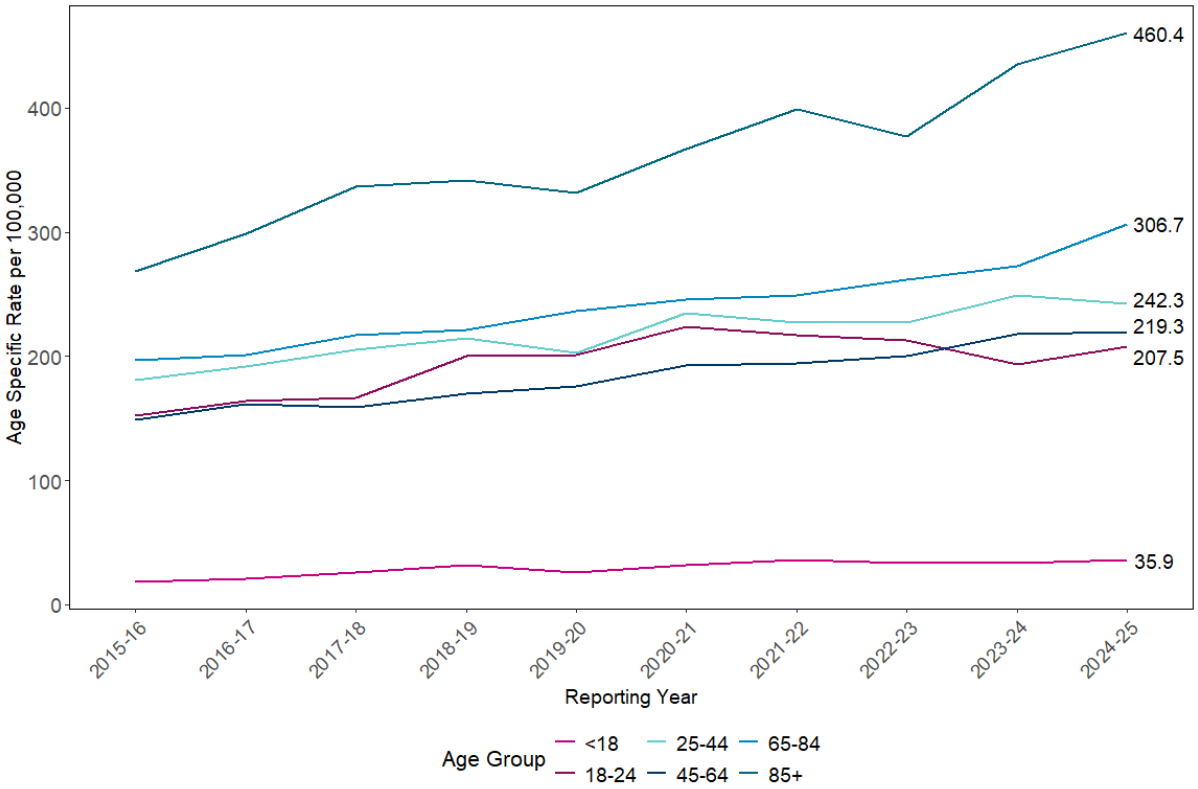
Figure 2 shows the rates per 100,000 for each type of order. The rate of new orders increased very slightly for all types of order compared with 2023-24. The rate of detention for EDCs increased from 66.8 per 100,000 to 69.8 per 100,000 in 2024-25. The rate of STDCs increased only very slightly from 103.1 per 100,000 to 104.6 per 100,000 in 2024-25. The rate for CTOs increased from 33.4 per 100,000 in 2023-24 to 35.7 per 100,000 in 2024-25. The numbers of orders are presented in Appendix tables A1.2-A1.4.

Figure 2. Age Standardised Rate[3] of new orders by year



[3] Age standardising data: What does this mean and why does it matter? | National Statistical

Figure 3. Age specific rate of new orders by year



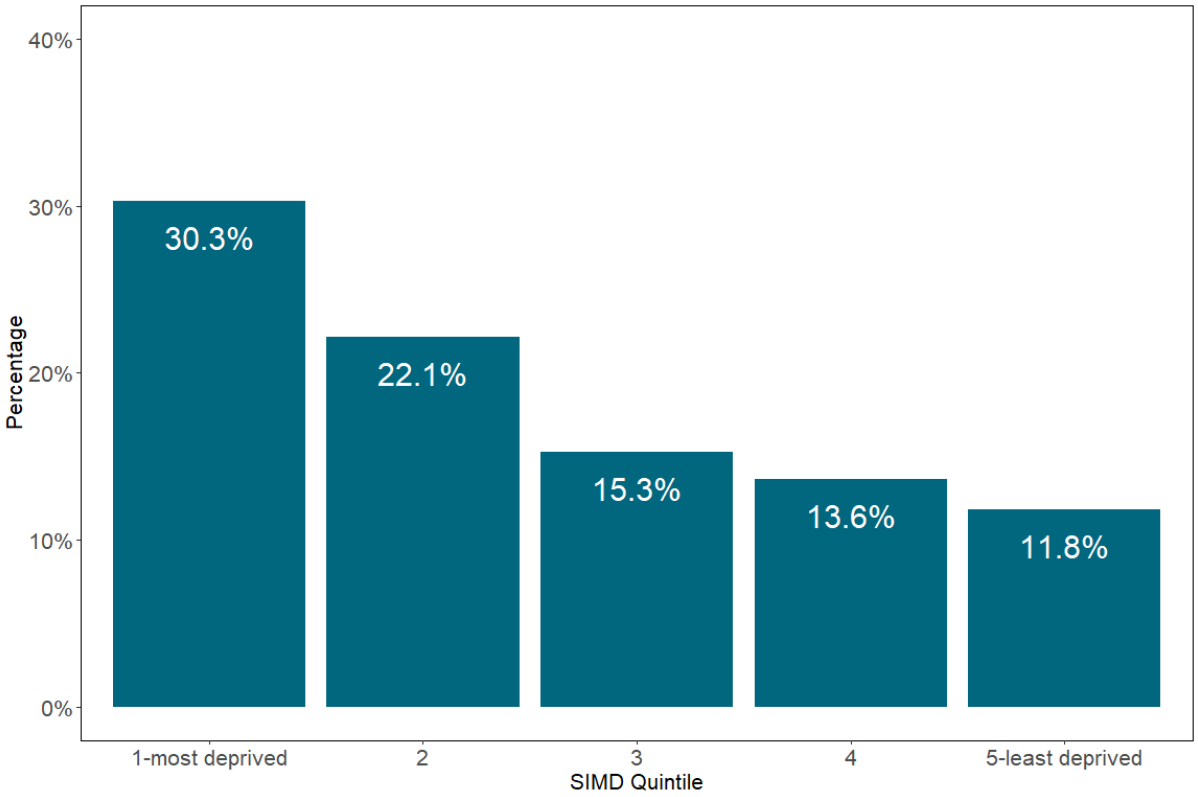
Looking at age specific rates, we can see the highest rates are in the over 85 age group, with the lowest rates in people under the age of 18 years. Over the last 10 years there has been more variability in the 18-24, 25-44 and 45-64 age groups. Overall, the trend appears to be increasing rates across all age groups.

Deprivation

We report on the breakdown by SIMD category. This is an important indicator within a wider approach to public mental health. It looks at how detentions may be disproportionally affecting people from different areas of deprivation.

We were able to match 93.2% of orders with SIMD by using a valid home postcode. Figure 4 shows a clear gradient in the level of deprivation for new orders under the Mental Health Act, with 30.3% of detentions of people from the 20% most deprived areas of Scotland. A breakdown of SIMD by each order type can be found in Appendix figures A2.2-A2.4.

Figure 4. New orders in 2024-25 by level of deprivation



Ethnicity

We had ethnicity information for 82.5% of new orders in 2024-25. Figures showing the ethnicity breakdown over the last 10 years can be found in Appendix figure A2.5.

In the following sections we give information on each order type for 2024-25.

Emergency detention certificates (EDCs)

Unlike in the Mental Health (Scotland) Act 1984, there is an expectation that emergency orders will be used 'sparingly' in the current Mental Health Act[1]. Clear reasons need to be recorded as to the necessity for granting an EDC rather than the preferred route of a STDC. An STDC provides the person with more safeguards and we would expect local areas to explore why EDCs are being used rather than STDCs.

The overall rate of EDCs in 2024-25 was 69.8 per 100,000 (67.6 - 72.1[4]), slightly higher than the previous year's revised rate of 66.8 per 100,000 (64.6 - 69.0) (Figure 2). The number of orders is shown in Appendix table A1.2.

The rate of EDCs varies by gender. In 2024-25 the rate of EDCs for females was 63.8 per 100,000 (60.9 - 66.7) and 76.6 per 100,000 for males (73.3 - 80.1).

[4] 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.

The rate of EDCs in Scottish mainland health boards varied from 16.2 per 100,000 in Grampian to 121.4 in Greater Glasgow and Clyde. As in 2023-24, Greater Glasgow and Clyde continues to have the highest rate of EDCs and appears to be an outlier compared with other health boards. The numbers of EDCs by health board are shown in Appendix table A1.2 and rates are shown in Appendix figure A2.6.

This year, we have again used postcodes to complete local authority information for EDCs. We were able to find local authority areas for 96.6% of EDCs. The remaining 3.4% was made up of people with no fixed abode, had a hospital or prison address, did not have a Scottish postcode, or where the postcode could not be found. The rate of EDCs in Scottish local authorities varied from 15.3 per 100,000 in Aberdeen City to 127.3 per 100,00 in Glasgow City (see Appendix figure A2.7).

MHO consent

In line with previous years, MHO consent continues to be lower than we would expect to see, although there is a slightly higher percentage of EDCs with MHO consent in 2024-25 than in the preceding two years. However, we continue to draw attention to the low percentage as this is an important safeguard. This year the proportion of EDCs with MHO consent is 38.6%.

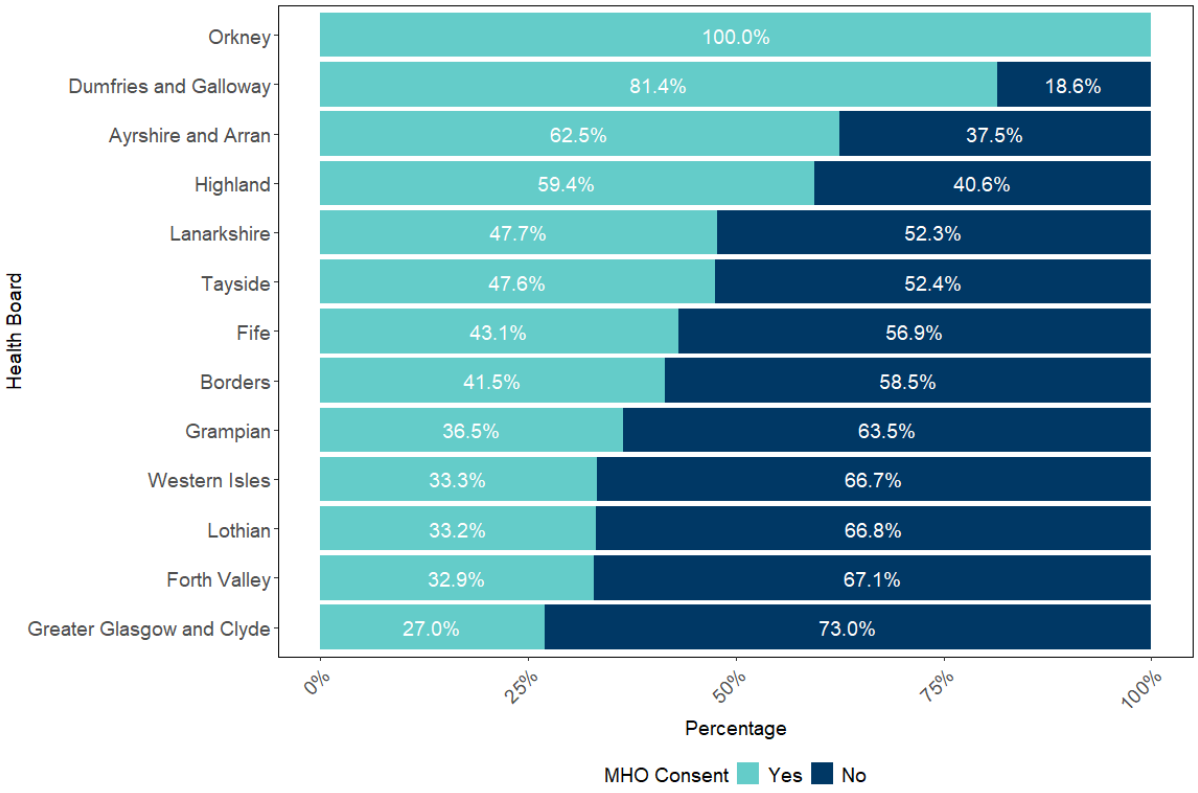
If an MHO is not consulted as part of the assessment for an EDC, the medical practitioner must explain the reasons for this. The medical practitioner must also explain the reasons for granting the certificate and why alternatives to detention were considered inappropriate. We expect there to be audits undertaken of the reasons for the failure to include MHO consent in EDCs and we seek feedback at end of year meetings from health and social care partnerships, supported by respective health boards and local authorities, to explain this pattern.

We remain concerned about the low levels of MHO consent and will be undertaking further analysis of the circumstances leading to decisions taken which state that it was impractical to consult an MHO. We will report on this detail in 2026.

We found that across all age groups, most people with EDCs did not receive MHO consent. It is particularly concerning that for the under 25 age group (n=416), in 68.0% of cases (n=283), MHO consent was not provided as part of the EDC assessment and subsequent detention.

When we look at the breakdown by health board in 2024-25, we continue to see great variation in MHO consent to EDCs. Orkney again has 100% MHO consent. On the mainland, there is much variation in MHO consent to EDCs ranging from 27.0% (Greater Glasgow and Clyde) to 81.4% (Dumfries and Galloway) (Figure 5). (We acknowledge the differentials in population sizes).

Figure 5. MHO consent for EDCs in 2024-25, by health board



Greater Glasgow and Clyde have the highest rate of EDCs (121.4 per 100,000) but the lowest proportion of MHO consent (27.0%). We also note that three of the local authorities in the Greater Glasgow and Clyde area have hours on MHO work per 10,000 below the Scottish average and three above[7]. We will be investigating whether this has any impact in the further analysis report due 2026.

Of those detained under an EDC, 29.5% were not in a hospital at the time of the detention whereas 70.5% were in a named hospital. This is something we will also look into in more depth in our further analysis.

Similar to previous years just over half (55.6%) of EDCs were superseded by a STDC, most commonly within 24 hours.

Short-term detention certificates (STDCs)

The overall rate of STDCs in 2024-25 was 104.6 per 100,000 (101.9 - 107.3), similar to the revised rate of 103.1 per 100,000 in 2023-24 (Figure 2). The number of STDCs are shown in Appendix table A1.3.

The rate of STDCs varies by gender. In 2024-25 the overall rate of STDCs for females was 94.2 per 100,000 (90.7 - 97.8) and 115.6 per 100,000 for males (111.6 - 119.8).

In the mainland health boards, the rate of STDCs varied from 50.5 per 100,000 in Borders (38.0 - 65.6) to 146.4 per 100,000 in Greater Glasgow and Clyde (139.6 - 153.5). The rates for health boards are shown in Appendix figure A2.8.

The rate of STDCs in mainland local authorities ranged from 49.5 per 100,000 in Aberdeenshire (41.1 - 59.0) to 176.1 in Glasgow City (165.3 - 187.4). The number and rate of STDCs by local authority is shown in Appendix tables A1.4 and A1.5 and Appendix figure A2.9.

The data shows that Glasgow City continues to have the highest rates for both EDCs and STDCs.

Diagnostic categories
All but 56 STDCs had broader level categories of mental disorder recorded. The vast majority of STDCs were for the category mental illness (91.4%). For 4.2% the categories were mental illness and personality disorder, 1.7% had personality disorder, and 1.7% had mental illness and learning disability. Learning disability alone was recorded in 0.5% of STDCs. Only 0.2% had a diagnosis of mental illness, learning disability and personality disorder and only 0.2% had a diagnosis of learning disability and personality disorder (see Appendix figure A2.10).

The non-statutory forms used to record diagnostic categories have been updated on the Scottish Government website to replace the World Health Organisation's International Classification of Disease-10 (ICD-10) with ICD-11 codes.

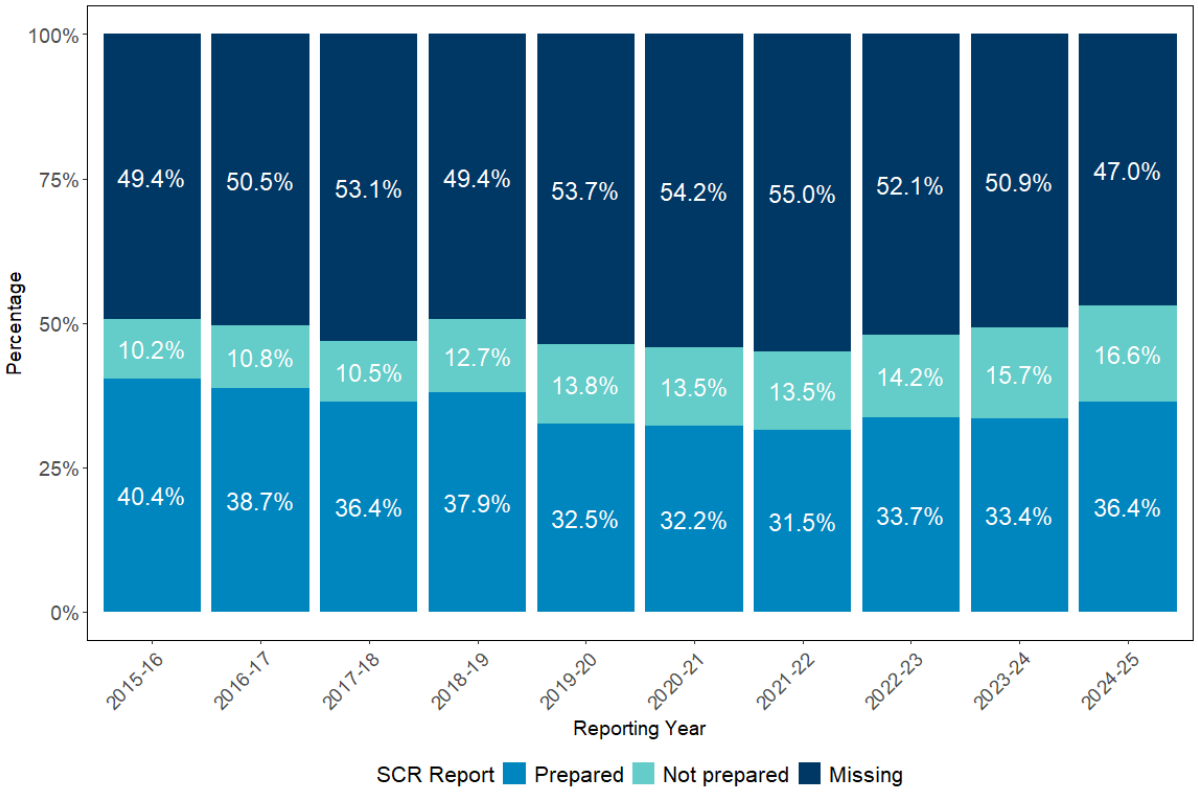
Social circumstances reports (SCRs)
Looking at a person's social circumstances is very important for mental health services to fulfil their duty to respect people's social, economic and cultural rights.

An MHO must prepare an SCR within 21 days of a person being made subject to a STDC. In cases where the MHO considers such a report would serve little or no, practical purpose, the MHO must send a statement of those reasons to the Commission. For 53.0% of STDCs in 2024-25 the Commission received notification that an SCR had been prepared or that an SCR would serve no purpose (16.6% did not have a social circumstances report prepared as it was deemed that it 'serves no purpose' while 36.4% of all STDCs had one prepared). In 47.0% of cases we received no notification (termed "missing" in the discussions below). This is a similar percentage to the revised figure from last year (Figure 6).

Although this is the highest proportion of prepared reports since 2019-20 and the lowest proportion of missing reports since 2015-16, completion rates of SCRs remain a significant concern.

The Commission continues to retain a focus on SCRs and started auditing SCRs again in 2024. We continue to raise concerns at end of year meetings where provision remains low and seek assurance where significant numbers relate to reports deemed to serve little or no practical purpose.

Figure 6. Proportion of STDCs with an SCR prepared, by year



The proportion of completed SCRs varied from 11.2% in Glasgow City (where there is the highest rate of STDCs) to 71.4% in Shetland (Appendix figure A2.11). Proportion of STDCs missing an SCR all together ranged from 0.0% in Shetland to 76.0% in City of Edinburgh. SCRs that were returned but indicated as not completed as they 'serve little or no practical purpose' ranged from none in Orkney to 31.9% in Midlothian.

Compulsory treatment orders (CTOs)

The overall rate of CTOs in 2024-25 was 35.7 per 100,000 (34.2 - 37.3), just slightly higher than the 2023-24 revised rate of 33.4 per 100,000 (31.9 - 35.0) (Figure 2). The numbers of CTOs are shown in Appendix table A1.6.

The rate of CTOs varies by gender. In 2024-25 the overall rate of CTOs for females was 30.7 per 100,000 (28.7 - 32.7) and 41.3 per 100,000 for males (38.9 - 43.8).

In the mainland health boards, the rate of CTOs varied from 17.3 per 100,000 in Borders (95% CI: 10.3-27.2) to 47.0 in Greater Glasgow and Clyde (95%CI: 43.2-51.1). The rates across all health boards are shown in Appendix figure A2.12.

We also looked at the rate of CTOs by local authority. The mainland rates ranged from 17.9 per 100,000 in Aberdeenshire (13.0 - 23.9) to 55.5 per 100,000 in City of Edinburgh (49.1 - 62.5). The number and rate of CTOs is shown in Appendix table A1.7 and A1.8 and Appendix figure A2.13.

Diagnostic categories
We had categories recorded for all but three CTOs in 2024-25. The vast majority of CTOs were for mental illness (96.4%). For 1.5% the diagnostic categories were mental illness and personality disorder, and 0.9% had mental illness and learning disability. Learning disability alone made up 0.6% of the CTO recorded categories. Personality disorder alone made up 0.5% of recorded categories.

Nurses' power to detain pending medical examination
The Mental Health (Care and Treatment)(Scotland) Act 2015[9] amended section 299 of the Mental Health Act and grants nurses, of the prescribed class, the power to detain someone in hospital for up to three hours; the purpose of which is to enable arrangements to allow for a medical examination of the person to be carried out[10].

In 2024-25, there were a total of 187 detentions under section 299, relating to 176 people, slightly lower than the revised figure of 208 in 2023-24 relating to 185 individuals. (Appendix table A1.9). The overall rate of nurses' power to detain in 2024-25 was 3.3 per 100,000 (2.9 - 3.9), which was a slight decrease on the previous year's revised rate of 3.8 (3.3 - 4.4) (Appendix table A1.10).

The rate of nurses' power to detain varies by gender. In 2024-25 the overall rate for females was 3.9 per 100,000 (3.2 - 4.7) and 2.6 for males (2.1 - 3.3), Appendix figure A2.14 shows these rates over the last 10 years.

There are also differences by age as well as gender, rates are higher for females under 18 years to 44 years and in the 65-84 category. There is very little difference in gender for the 45-64 age category. Males have higher rates in the 85+ category however, these rates should be interpreted with caution given the small numbers involved.

Place of safety orders
According to section 297 of the Mental Health Act, a police constable can remove an individual from a public place and take them to a place of safety if they think the person has a mental health condition and is in need of immediate care and treatment. A place of safety can be, for example, a hospital but if no place of safety is immediately available then the law allows the police constable to take the individual to a police station.

The Commission expects the place of safety to be a health care facility. While the percentage of people taken to a police station has slightly increased (2.4% compared with 1.8% in 2023-24), it is still a small percentage (see Appendix figure A2.15).

In last year's report, we noted the rising amount of missing data and committed to working collaboratively with Police Scotland to resolve this. Since then, we have undertaken a more in-depth review of the data provided by Police Scotland and have been able to reduce the missingness by reviewing the addresses of the facility where

people have been taken to as a place of safety. Currently, the Commission and Police Scotland are working together to strengthen technology solutions, which will seek to address the missingness of outcome in the dataset.

There were 1,231 section 297 (place of safety) orders in 2024-25, which was a 3.8% decrease compared with 2023-24 (Appendix table A1.11). These forms related to 955 individuals. There were some individuals with multiple detentions under section 297. In particular, we note that seven individuals had been detained under section 297 five times or more.

The proportion of orders where the individual was taken to a police station as a place of safety has differed over the years with a high of 5.3% in 2016-17 and 2017-18 and a low of 1.6% in 2015-16. This year, the figure was 2.4%, 97.3% of people were taken to a health care facility (see Appendix figure A2.15).

The gender split of individuals detained under section 297 was 50.9% male. The highest proportion of place of safety orders were for individuals aged 25-44 years. The gender split was higher for females than males in the <25s age group, and higher among males aged over 45 years.

The number of place of safety orders varies by local authority. Table 1 shows both the number of orders in 2024-25 as well as the number of people detained under section 297.

The Commission participates in the Scottish Government's multi-agency work on psychiatric emergency plans (PEPs), which is reviewing how local health boards, Police Scotland, and other partners respond to people in acute mental-health crisis. The aim is to strengthen consistency of practice, ensure that police custody is used only as a last resort, and promote clear local escalation and care-planning arrangements. Insights from this national work will inform the Commission's future monitoring of section 297 use and our engagement with health boards and partnerships on crisis-response pathways.

Table 1. Number of place of safety orders by local authority in 2024-25

Local authority	Number of orders	Number of people
Aberdeen City*[5]	419	292
Angus	*	*
Argyll and Bute	26	22
City of Edinburgh	96	82
Clackmannanshire	0	0
Dumfries and Galloway	22	18
Dundee City	13	11
East Ayrshire	6	*
East Dunbartonshire	*	*
East Lothian	11	10
East Renfrewshire	*	*
Eilean Siar	*	*
Falkirk	46	35
Fife	89	70
Glasgow City	74	65
Highland	119	86
Inverclyde	8	6
Midlothian	6	*
Moray	71	52
North Ayrshire	18	15
North Lanarkshire	6	6
Orkney	7	7
Perth and Kinross	18	15
Renfrewshire	11	9
Scottish Borders	18	17
Shetland	6	6
South Ayrshire	*	*
South Lanarkshire	9	9
Stirling	0	0
West Dunbartonshire	34	28
West Lothian	39	31
Total	**1,231**	**955**

**n≤5*

Extant orders

We count the number of people who are subject to an active Mental Health Act or Criminal Procedure Act order on a particular day - the first Wednesday of January based on available data. We call this ‘extant orders’.

On Wednesday 1 January 2025 there were 4,216 extant orders. This was a similar figure to the same day in 2024 (Appendix table A1.12). The rate on 1 January 2025 was 76.1 per 100,000 (73.8 - 78.4).

Of the orders in place on 1 January 2025, 65.0% related to males and most people on orders were aged 25-44 years or 45-64 years.

[5] It should be noted that since 2019 Aberdeenshire and Aberdeen City POS data are reported together.

The rate of orders in existence in mainland health boards varied from 39.5 per 100,000 (34.9 - 44.5) in Lanarkshire to 103.9 (98.2-109.9) in Greater Glasgow and Clyde (Appendix tables A1.12 and A1.13 and Appendix figure A2.16).

When we look at the orders in existence on a given day, this time on 1 January 2025, the majority of orders were CTOs (73.6%). A breakdown of the orders individuals were subject to are shown in Appendix figure A2.17.

Compulsory treatment under criminal proceedings

People with a mental illness, learning disability or related condition who are accused or convicted of a criminal offence may be placed on an order under the Criminal Procedure Act[2]. The Criminal Procedure Act requires an individual to be treated in hospital or, occasionally, in the community. Sometimes the order includes additional restrictions for the individual. Any easing of security status or suspension of the order has to be approved by Scottish ministers. An overview of Criminal Procedure Act orders is provided in Box 2. An individual may be subject to a number of orders before a final disposal of the case.

Box 2. Overview of Criminal Procedure Act orders

Assessment and treatment orders

An assessment order allows for an individual to be assessed for a mental illness or related condition. This means that the court can remand the individual in hospital instead of in custody if it appears that they have a mental illness. An assessment order can last up to 28 days but can be extended for up to seven days.

A treatment order allows for individuals to be remanded to hospital for treatment while waiting for trial, in cases where the court believes the individual may have a mental illness. Two doctors, one of which needs to be a psychiatrist, has to examine the individual and be in agreement about the need for treatment in hospital for the order to be granted. The treatment order lasts until the court has made a decision for either acquittal or conviction.

Unfitness for trial and acquittal due to mental disorder

Temporary compulsion order: If an individual's mental illness means that they cannot participate in the court process, the court might find them unfit for trial. A temporary compulsion order allows for an individual who is found unfit for trial to be detained in hospital prior to an examination of facts.

Post-conviction predisposal

This includes interim compulsion order or a section 200 committal. An interim compulsion order allows for a period of inpatient assessment before a final disposal is made for a mentally ill offender convicted of a serious offence. This order is recommended in cases where a restriction order is considered and can last up to 12 months to allow for comprehensive inpatient assessment.

Mental health disposals

A disposal refers to a sentence that the courts may use when sentencing an offender with a mental illness, learning disability, neurodevelopmental disorder and related conditions. There are three types of disposals that can be given as a final disposal from the court. These are compulsion order, compulsion order with restriction order (CORO), and hospital direction. In addition to these three orders, an individual can be given a community compulsion order, guardianship order, or a community payback order with a mental health treatment requirement.

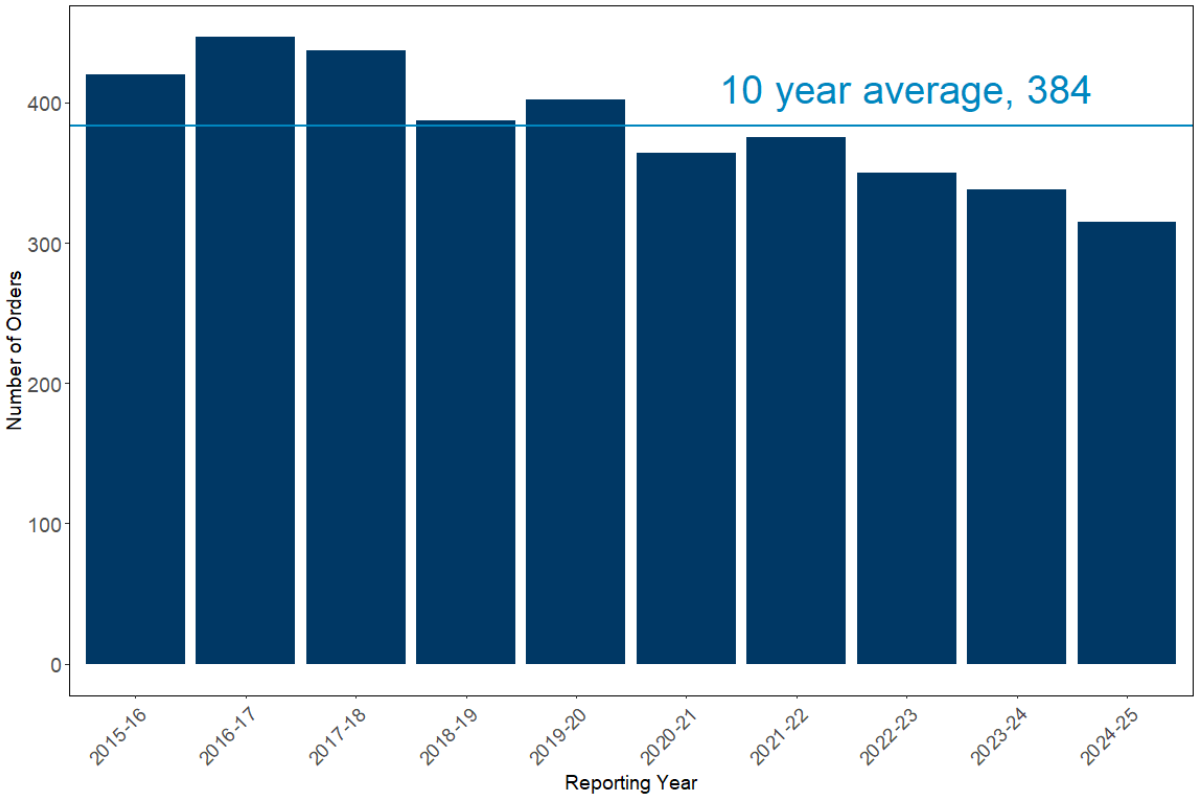
Transfer for treatment

A transfer for treatment direction allows for transferring a prisoner from prison to hospital to provide treatment for a mental illness or related condition.

Total number of Criminal Procedure Act orders

There was a total of 315 orders under the Criminal Procedure Act in 2024-25, a decrease of 7.3% on last year's revised figure and the lowest figure in the last 10 years. The average number of orders was 384 in the previous 10 years (Figure 7). The 315 orders related to 196 individuals (Appendix table A1.15).

Figure 7. Number of Criminal Procedure Act orders by year



Individuals detained under the Criminal Procedure Act in 2024-25 were primarily male (80.6%). Most were aged 25-44 years (63.8%) with the average age of 37 years 5 months.

Assessment and treatment orders

In 2024-25 there were 87 assessment orders and 87 treatment orders, relating to 86 and 74 individuals, respectively. The number of assessment and treatment orders by year with the average for the last 10 years. There were fewer assessment orders compared with the 10-year average (average=122) and fewer treatment orders (average=105).

Unfitness for trial and acquittal by reason of mental disorder

If a person's mental health condition 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.

There was a total of six individuals, who in 2024-25 were deemed unfit for trial, see Appendix table A1.16.

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 12 months to allow for a comprehensive inpatient assessment.

A total of 22 interim compulsion orders were recorded in 2024-25, higher than the 11 interim compulsion orders in 2023-24. There were less than five individuals subject to section 200[6] in 2024-25.

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. There are also community options; compulsion order, guardianship order and a community payback order with a mental health treatment requirement.

There was a total of 61 mental health disposals in 2024-25, given as a final disposal by the court (Appendix table A1.16). This compares to 54 mental health disposals in 2023-24.

Transfer for treatment
This provision allows for the transfer of a sentenced prisoner from prison to hospital for the treatment of a mental illness or related condition.

There was a total of 32 transfer for treatment directions in 2024-25, slightly higher than the revised figure of 28 in 2023-24 but lower than the average of previous years. (Appendix table A1.16).

Consent to treatment

There are specific safeguards for specific forms of medical treatment including ECT and procedures classified as neurosurgery for mental disorder. Under the Mental Health Act, certain treatment can only be authorised by an independent doctor; a designated medical practitioner (DMP).

The Commission appoints DMPs and for the reporting period 2024-25 we had 112 DMPs. DMPs are experienced, senior psychiatrists in Scotland. The register of DMPs is maintained by the Mental Welfare Commission. The Commission organises DMP induction and provides training for DMPs, such as the annual DMP seminar.

[6] Section 200 is a procedure for Scottish Government to vary conditions on a conditional discharge Mental Health (Care and Treatment) Scotland Act 2003 (legislation.gov.uk)

However, DMPs are independent practitioners who use their knowledge and experience to reach their own conclusions.

Consent to treatment under part 16 of the Mental Health Act

Part 16 of the Mental Health Act provides safeguards for individuals subject to the Mental Health Act where treatment may be given with or without the individual's consent.

Sections 237 and 240 include ECT, any medication for the purpose of reducing sex drive, medication 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 273(1)(b). TMS and VNS are not commonly used treatments. The various certificate authorising treatments under part 16 are listed in Box 3.

Box 3. Types of treatment certificates

T1 certificate

A T1 certificate is a statutory form ensuring necessary treatment safeguards for neurosurgical treatments for mental disorder. Such treatments are not available in Scotland.

T2 certificate

A T2A certificates covers treatment under section 237(3) of the Act, including: ECT, VNS and TMS, for where the patient's RMO, or a DMP, certifies that the patient is capable to consenting to treatment and is not refusing consent.

A T2B certificate covers treatment under section 240(3) of the Mental Health Act: (a) any medicine (other than the surgical implantation of hormones) given for the purpose of reducing sex drive; and (b) any other medicine given beyond a period of 2 months since the start of compulsory treatment where the patient's RMO, or a DMP, certifies that the patient is capable of consenting to treatment and is not refusing consent.

A T2C certificate covers provision of nutrition by artificial means where the patient's RMO, or a DMP, certifies that the patient is capable of consenting to treatment and is not refusing consent.

Box 3. Types of treatment certificates continued

T3 certificates

A T3A certificate covers treatment under section 237(3) of the Mental Health Act: ECT, VNS and TMS, where a DMP is required to provide a certificate for medical treatment where a patient is incapable of consenting.

A T3B certificate covers treatment under section 240(3) of the Mental Health Act in relation to the following treatment(s): (a) any medicine (other than the surgical implantation of hormones) given for the purpose of reducing sex drive; (b) any other medicine given beyond a period of 2 months since the start of compulsory treatment; and (c) provision, without consent of the patient and by artificial means, of nutrition to the patient where a DMP is required to provide a certificate for medical treatment(s) where a patient is refusing consent or incapable of consenting.

T4 certificate

A T4 certificate is issued to record treatment under section 243 of the Mental Health Act in relation to emergency treatment necessary to save a patient's life, prevent serious deterioration of the patient's condition, alleviate serious suffering, prevent the patient from behaving violently, or prevent the patient from being a risk to other people.

T1 certificate treatments

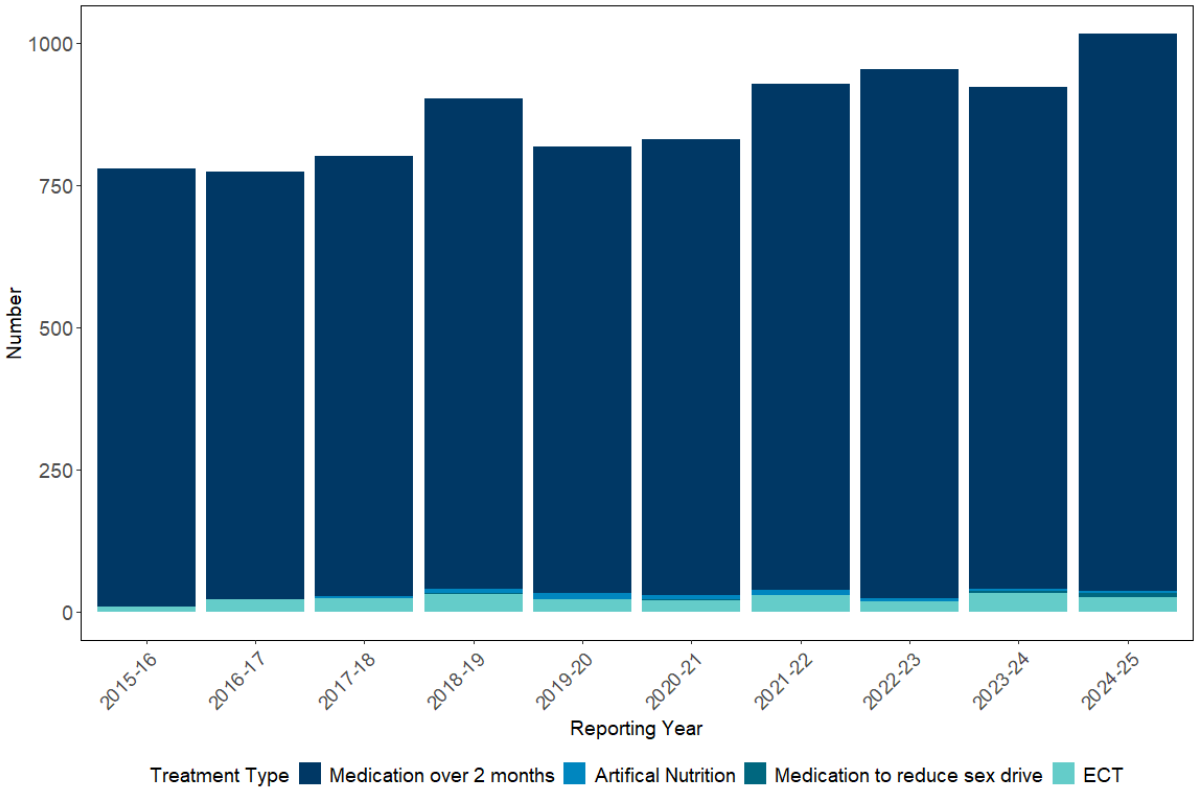
The Commission has received no T1 certificates. Neurosurgery is not undertaken in Scotland. Section 57 of the Mental Health Act for England and Wales (1983) allows for this treatment which is reviewed by the Care Quality Commission in England.

T2 certificate treatments

In 2024-25, we conducted a review of the T2 and T3 certificates for the past three years and have amended the data to reflect our findings. We will be working with DMPs to ensure the correct completion of paperwork in the future.

There was a total of 1,015 T2 certificates issued during 2024-25, 10.1% higher than in 2023-24 (Figure 8). The average for the years 2015-16 to 2023-24 was 856 T2 certificates per year.

Figure 8. Number of T2 certificates by year



Most T2 certificates (96.5% n=979) were issued for medication over two months while 2.5% (n=25) were issued for ECT. There were less than five T2s for artificial nutrition. The breakdown of certificates by type of treatment is provided in Appendix table A1.17.

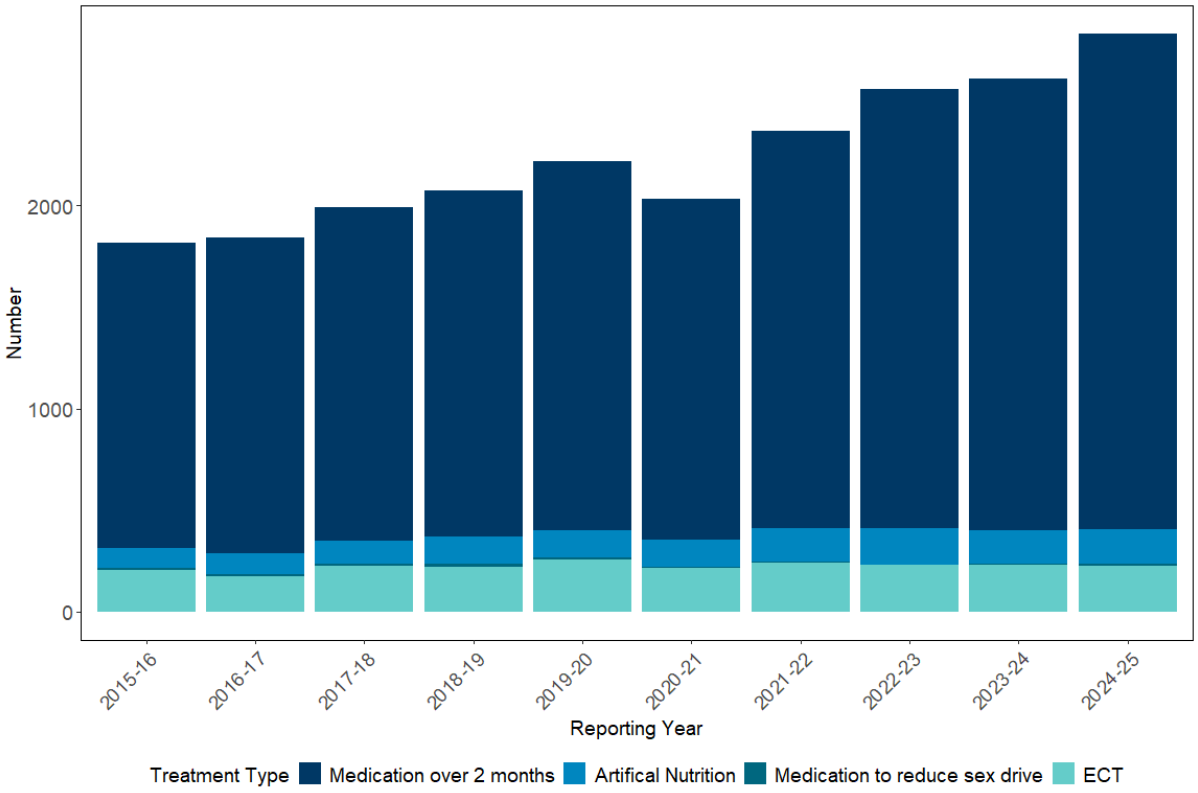
Of the T2s we received in 2024-25, 5.0% were for young people under the age of 18 years and 9.1% were for people aged 18-24. 46.2% of T2s were for people aged 25-44, 32.4% were for those aged 45-64 and 7.2% were for people aged over 65 years.

There were differences in gender for the various treatments under T2 certificates in 2024-25; for ECT most were female (68.0%) and medication over two months had a higher proportion of males (56.1%). All T2s for artificial nutrition were for females in 2024-25.

T3 certificate treatments

There was a total of 2,845 T3 certificates issued in 2024-25, which was an 8.3% increase on the 2023-24 figure (Figure 9). Most T3s were for medication over two months (85.8%), while 7.9% were for ECT, 5.9% for artificial nutrition, and 0.4% for medication to reduce sex drive. This is similar to previous years (Appendix table A1.18).

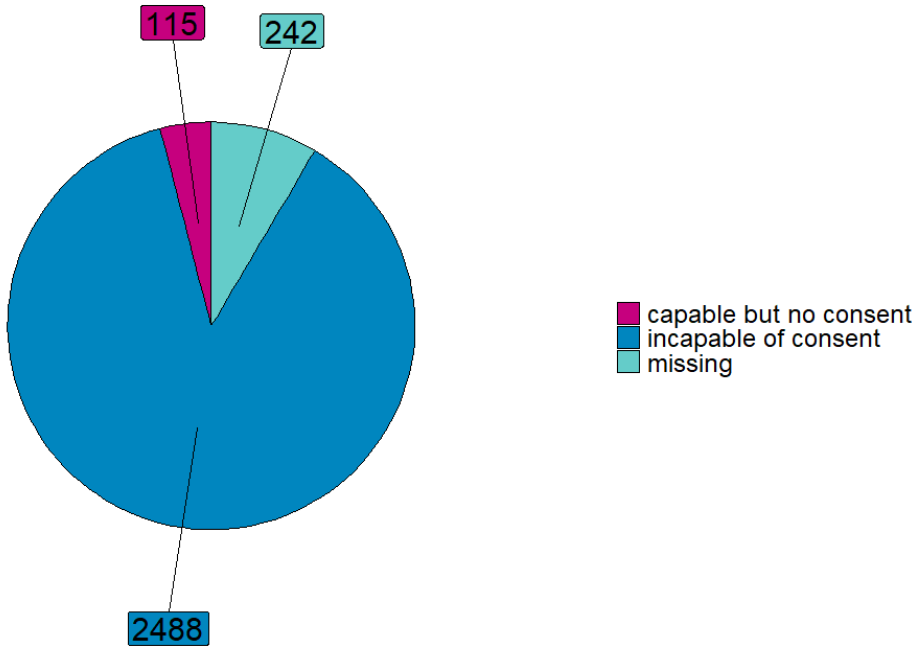
Figure 9. Number of T3 certificates by year



Of the T3s we received in 2024-25, 4.7% were for young people under the age of 18 years, similar to the 4.5% seen in 2023-24. There were differences in gender for the various treatments under T3 certificates in 2024-25; for ECT a higher proportion were female (64.3%) while medication over two months had a higher proportion of males (61.7%). T3s for artificial nutrition were predominantly issued for females (81.0%).

We noted recommendation (9.8) made in the Scottish Mental Health Law Review. It states that where a person is able to make an autonomous decision about a specific treatment and refuses, that treatment should not be given. To explore this further, we looked at the use of T3s when a person was deemed to be capable of consent (Figure 10). We wanted to see how often treatment was given under the Mental Health Act when a person capable of consent, refused medication two months after treatment began. We found that medication was authorised in 115 instances where the person was deemed capable of consent but did not consent (4.0%); this compares to 84 instances (3.2%) in 2023-24.

Figure 10. T3 certificate consent to treatment in 2024-25

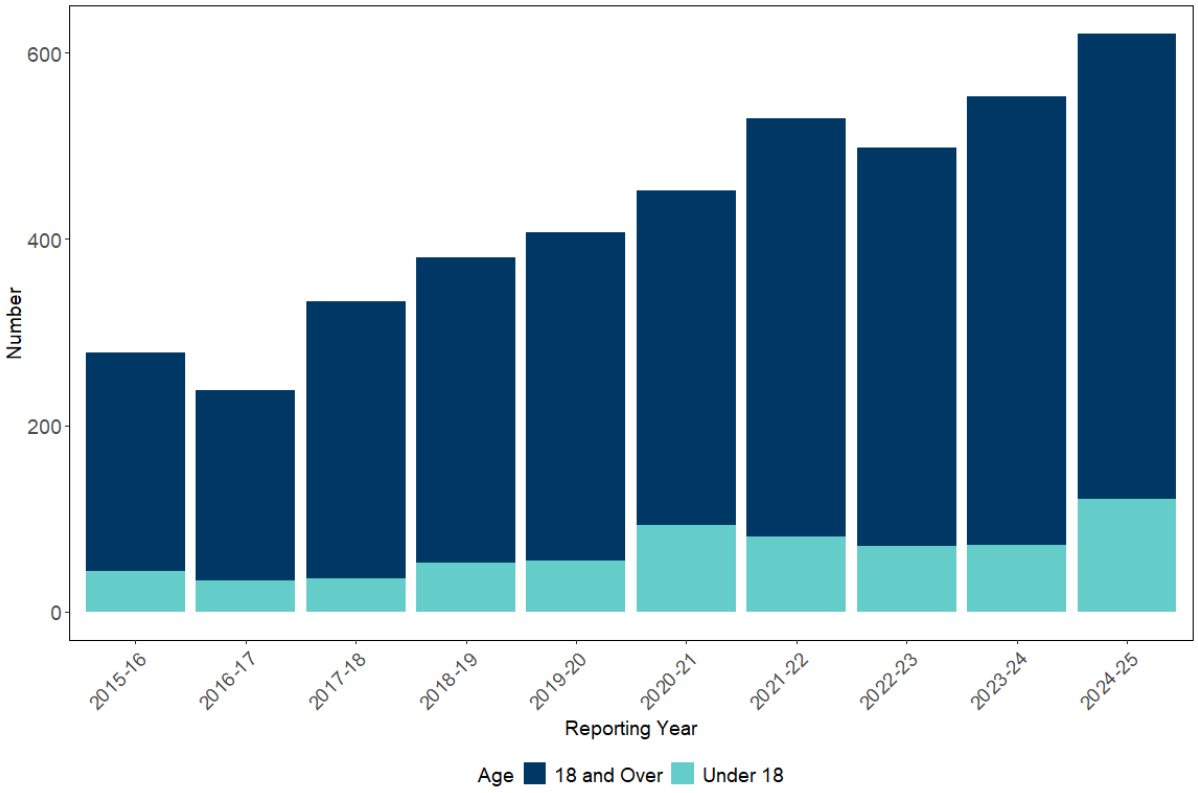


T4 certificate treatments

There were 620 T4 certificates notified to the Commission in 2024-25, which was a 12.1% increase on the number of T4s in 2023-24 (Figure 11). Of the T4s issued in 2024-25, 19.5% were for individuals aged under 18 years which is an increase in the proportion from 12.8% in 2023-24 (Appendix table A1.19). During 2024-25 we have raised the issue of having the correct authority to treat in place and this could be one factor in the increase. We are conducting a more in-depth analysis of the data to better understand the cause of the increase and will be working with services to better understand the circumstances in which the T4s were used.

Overall, 57.7% of all T4s were for females but the gender split for under 18 years was 88.4% female, compared with 50.3% female in the over 18 category. An overview of number of T4 certificates by health board is provided in Appendix table A1.20.

Figure 11. Number of T4s by year



Advance statements

Advance statements are written statements made by a person when they are well, setting out the care and treatment they would prefer or would dislike should they become mentally unwell in the future. The Tribunal and any medical practitioner treating a person must take their advance statement into account. If the wishes set out in an advance statement have not been followed, a written record (an advance statement override) stating the reasons must be sent to the Commission. Our last report on advance statement overrides was published in February 2021[11].

The advance statement register has been in operation since 2017. Since 2017, each time someone either writes a statement or withdraws a statement, health boards should notify the Commission about this via an ADV1 form. The register does not include advance statements made before it became operational in 2017.

Over time, our work with the register has developed. We look at the first ever ADV1 form we receive relating to an advance statement for a person (creation or withdrawal) and consider this their first engagement with the register.

For the first two years we had complete data (2018-19 and 2019-20), there were 244 and 258 individuals where we noted a first engagement with the register (Appendix figure A2.18). In 2020-21, this dropped to 79; this may indicate a significant impact of the Covid pandemic on services' abilities to engage with individuals on matters to do with advance care planning. In 2021-22, the figure increased to 117 and to 162 in

2022-23, there was a slight drop in 2023-24 to 153. However, in 2024-25, there was an increase in the number of people engaging with the advance statement register (175). We recognise that some people will choose not to have an advance statement. In such circumstances, we ask that services record that the right to an advance statement was discussed and offered.

We have learned that there has been misinterpretation that advance statements cannot be completed whilst a person is in hospital or cannot be completed by children and young people. We therefore direct services to our good practice guide on this subject[7].

Characteristics
The individuals on the register have an average age of 48 years 8 months and 55.8% are male. The age distribution for males and females indicates that more young females (<25 years) and older females (over 65 years) have engaged with the advance statement process.

We had valid postcodes to match SIMD for 93.1% of all individuals (based on their first engagement) on the register. The 94 invalid postcodes were because the person's home address was listed as elsewhere in the UK or non-UK, was a hospital, they were of no fixed abode, or no address were entered on the form. The distribution of postcodes is starting to reflect the distributions of detentions. However, to truly reflect the detention distribution, more work is required to engage those in the most deprived areas of Scotland.

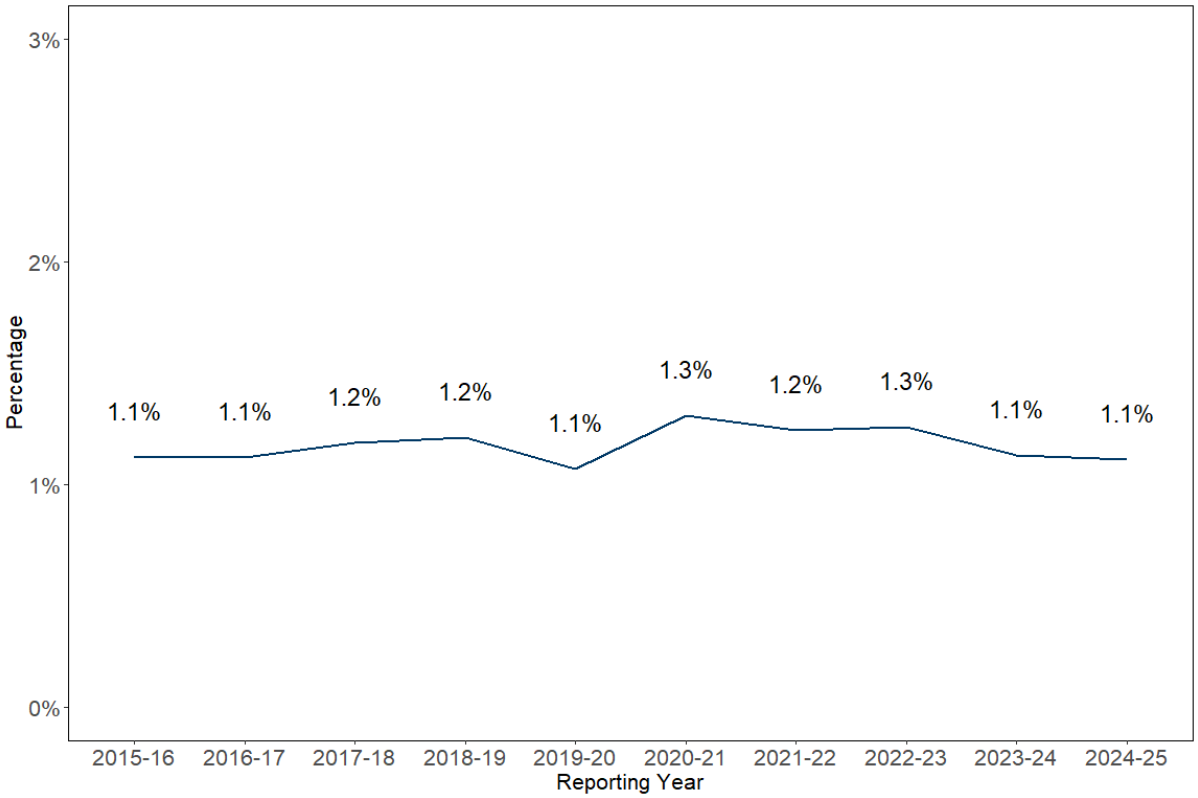
Deaths in detention

This year, we have again included deaths in detention as part of our monitoring report. The Commission is notified by local services of the death of a person who was subject to the Mental Health Act or Criminal Procedure Act at the time of their death.

The percentage of deaths as a proportion of total orders remains consistent over time, ranging from 1.1% to 1.3%. In 2024-25, there were 138 deaths reported to the Commission of people whose death occurred while detained under the Mental Health Act and another nine while subject to the Criminal Procedure Act, totalling 147 deaths and accounting for 1.1% of the total orders (Figure 12), similar to the 2023-24 revised figure of 144 (1.1%).

[7] https://www.mwcscot.org.uk/sites/default/files/2024-09/AdvanceStatements-2024.pdf

Figure 12. Deaths in detention as a percentage of total orders by year



The average age of male deaths was 67.6 years and 69.1 years for females. This is lower than the average life expectancy in Scotland that was 76.8 years for males and 80.8 years for females in 2021-2023[12]. Fewer female deaths occurred in the 25-44 and 45-65 age groups, there were more female than male deaths in the 65+ year age group.

Concluding remarks

This report outlines data during 2024-25 relating to critically important times in people's lives, where they have been assessed as needing to be treated against their will, using compulsory measures under Scotland's Mental Health and Criminal Procedure Acts.

The Commission continues to await the agreement and implementation of the recommendations made by the Scottish Mental Health Law Review in 2022. We stand ready to extend our monitoring role as recommended, particularly in relation to coercive practices and investigation of deaths in detention and homicides.

We will continue to play our part, with vigilance, in areas that require improvement, to protect and promote the rights of those with mental illness, personality disorder, learning disability, dementia and related conditions. Notably from our 2024-25 statistical report, this includes, the rate of EDCs compared with STDCs, MHO consent and EDCs, the take up of advance statements and the provision of SCRs.

We remain committed to working in partnership with those who use services, their families and carers, and all other stakeholders to ensure transparent reporting on the use of mental health legislation across Scotland. We will ensure our current laws and practice keep pace with human rights expectations and identify where our monitoring highlights that this is not the case.

Glossary

Designated medical practitioner (DMP)

DMPs are experienced psychiatrists who have received special training from the Mental Welfare Commission. DMP duties are set out in law and are an important safeguard. Their role is to independently decide whether the treatment the doctor has planned is in line with the law and the best interests of the person. A DMP can only give an opinion on the specific medical treatment. A DMP cannot give a second opinion on diagnosis or general treatment.

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.

MHO consent

To grant an EDC or STDC following a medical examination of a patient, the practitioner should seek the consent of an MHO. An EDC can be issued without MHO consent, in circumstances where waiting for the assessment would be considered impracticable and result in undesirable delay. An STDC cannot be issued without MHO consent.

Mental Health Tribunal for Scotland (MHTS)

The MHTS considers and determines applications for CTOs under the Mental Health Act and operates in an appellate role to consider appeals against compulsory measures made under the Mental Health Act.

Responsible medical officer (RMO)

An 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.

Appendix 1 – Data tables

Table A1.1. New episodes of civil compulsory treatment by starting order, n (%)

Starting order[a]	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
EDC	2168 (43.2%)	2412 (44.5%)	2706 (47.9%)	2812 (46.4%)	2868 (47.3%)	3219 (47.9%)	3188 (48.3%)	3240 (48.1%)	3602 (50.0%)	3818 (51.3%)
STDC	2753 (54.9%)	2905 (53.6%)	2859 (50.6%)	3131 (51.6%)	3082 (50.8%)	3371 (50.1%)	3256 (49.3%)	3413 (50.7%)	3493 (48.4%)	3528 (47.4%)
CTO	93 (1.9%)	99 (1.8%)	87 (1.5%)	120 (2.0%)	113 (1.9%)	136 (2.0%)	157 (2.4%)	83 (1.2%)	116 (1.6%)	103 (1.4%)
Total	**5,014**	**5,416**	**5,652**	**6,063**	**6,063**	**6,726**	**6,601**	**6,736**	**7,211**	**7,449**

[a]The starting order relates to the first order in a sequence of one or more orders

Table A1.2. Number of EDCs by health board and year

Health board	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Ayrshire and Arran	108	138	113	131	161	161	184	224	228	293
Borders	18	32	30	24	34	49	48	40	51	82
Dumfries and Galloway	84	114	105	103	148	117	112	101	113	113
Fife	168	163	181	207	203	223	193	241	290	260
Forth Valley	130	146	179	185	159	165	187	151	160	164
Grampian	101	99	141	117	135	171	171	170	126	96
Greater Glasgow and Clyde	726	833	989	994	1030	1141	1248	1246	1356	1480
Highland	125	109	123	104	96	96	110	83	75	106
Lanarkshire	199	230	198	280	254	323	313	336	353	396
Lothian	334	390	402	440	450	536	432	467	678	626
Orkney	14	*	16	8	*	*	11	7	*	*
Shetland	*	7	8	*	*	*	*	0	0	0
Tayside	184	187	256	278	256	277	247	227	238	267
Western Isles	*	*	10	*	6	7	*	6	*	*
Total	**2,204**	**2,457**	**2,752**	**2,887**	**2,941**	**3,284**	**3,268**	**3,312**	**3,683**	**3,905**

*n≤5 and secondary suppression to maintain confidentiality

Table A1.3. Number of STDCs by health board and year

Health board	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Ayrshire and Arran	194	212	170	184	169	249	281	287	349	377
Borders	59	62	62	75	74	85	78	63	63	60
Dumfries and Galloway	105	134	98	142	138	140	123	133	172	144
Fife	272	282	266	287	264	340	337	366	336	366
Forth Valley	244	259	271	244	242	320	358	325	317	329
Grampian	399	452	411	397	483	502	447	512	529	453
Greater Glasgow and Clyde	1173	1252	1422	1415	1502	1635	1637	1631	1708	1756
Highland	200	180	199	200	189	180	184	200	203	203
Lanarkshire	349	369	358	411	410	392	390	431	410	526
Lothian	733	806	756	847	839	938	889	962	1085	1108
Orkney	*	*	*	*	*	*	0	6	*	*
Shetland	8	7	9	*	11	14	21	10	13	6
State Hospital	*	*	*	*	*	*	*	*	*	*
Tayside	357	362	393	496	413	456	489	425	501	500
Western Isles	7	9	10	9	13	15	13	7	11	7
Total	**4,102**	**4,388**	**4,432**	**4,738**	**4,770**	**5,296**	**5,266**	**5,371**	**5,719**	**5,855**

*n≤5 and secondary suppression to maintain confidentiality

Table A1.4. Number of STDCs by local authority and year

Local authority	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Aberdeen City	210	259	210	209	262	282	243	274	256	250
Aberdeenshire	119	129	139	130	143	157	157	167	186	128
Angus	55	52	47	74	52	81	91	64	103	103
Argyll and Bute	53	46	82	60	51	50	72	57	58	66
City of Edinburgh	458	562	525	531	558	587	550	620	727	710
Clackmannanshire	51	47	44	59	39	64	70	53	53	62
Dumfries and Galloway (LA)	106	139	99	144	139	141	124	132	171	142
Dundee City	146	165	181	213	199	185	202	200	218	212
East Ayrshire	72	84	64	57	57	85	76	119	130	135
East Dunbartonshire	38	56	56	55	64	64	58	93	86	96
East Lothian	75	63	51	79	60	80	64	77	91	94
East Renfrewshire	36	57	55	63	76	65	67	64	54	86
Eilean Siar	*	9	11	9	13	*	14	6	11	7
Falkirk	129	155	155	126	112	132	171	151	152	167
Fife (LA)	271	284	266	291	275	344	337	369	340	372
Glasgow City	744	768	903	908	967	1080	1090	1052	1148	1075
Highland (LA)	159	152	148	162	155	164	146	172	176	165
Inverclyde	94	79	74	94	102	64	73	67	61	105
Midlothian	50	50	40	65	64	66	63	61	64	70
Moray	67	65	62	59	78	60	51	72	81	68
North Ayrshire	69	83	62	65	55	93	113	89	122	141
North Lanarkshire	206	221	206	238	239	247	242	243	245	336
Orkney (LA)	*	*	*	*	*	*	0	7	6	8
Perth and Kinross	159	146	174	215	167	194	196	160	178	169
Renfrewshire	115	119	145	133	148	183	149	160	139	167
Scottish Borders	58	65	62	74	79	88	80	65	64	61
Shetland (LA)	*	*	*	*	*	19	21	12	14	6
South Ayrshire	59	56	45	65	59	57	82	91	110	101
South Lanarkshire	200	209	227	250	234	224	241	270	267	297
Stirling	66	62	71	69	96	130	131	127	115	111
West Dunbartonshire	69	70	75	67	62	83	87	76	89	74
West Lothian	144	125	140	163	151	208	204	192	203	225
Total	**4,102**	**4,388**	**4,432**	**4,738**	**4,770**	**5,296**	**5,266**	**5,371**	**5,719**	**5,855**

*n≤5 and secondary suppression to maintain confidentiality

Table A1.5. Age Standardised Rate of STDCs by 100,000 population by local authority and year

Local authority	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Aberdeen City	89.4	113.7	92.5	94.4	117.9	124.1	110.5	123.1	113.2	106.6
Aberdeenshire	47.5	51.4	53.8	51.5	55.9	62.4	61.5	63.8	72.0	49.5
Angus	46.9	43.6	40.4	64.5	44.3	71.7	79.2	54.0	88.6	88.6
Argyll and Bute	59.0	52.3	91.0	71.5	62.9	55.9	83.9	63.6	68.9	80.0
City of Edinburgh	95.9	119.1	107.5	108.9	112.0	118.1	111.1	122.0	142.6	138.1
Clackmannanshire	104.0	93.6	87.1	116.1	79.7	128.7	143.9	103.4	106.3	121.5
Dumfries and Galloway	67.8	93.2	66.2	95.3	93.9	94.2	90.8	85.9	108.3	96.7
Dundee City	100.3	113.6	126.5	146.0	136.2	129.7	138.8	136.1	145.0	145.9
East Ayrshire	59.6	70.3	54.1	48.7	47.1	71.1	63.3	101.3	107.1	109.7
East Dunbartonshire	38.0	52.9	54.0	51.6	56.7	57.7	50.3	83.1	75.7	89.8
East Lothian	72.4	60.5	48.1	74.0	55.6	73.5	57.6	68.3	79.0	80.8
East Renfrewshire	40.5	61.4	60.4	70.9	84.6	68.6	68.9	68.6	57.0	86.6
Eilean Siar[a]	NA	NA	39.6	NA	51.6	54.0	50.9	NA	45.8	NA
Falkirk	83.5	100.0	100.5	80.4	70.9	83.4	109.5	95.0	95.5	103.7
Fife	74.3	77.9	72.9	80.0	74.2	93.3	92.1	98.8	89.7	98.6
Glasgow City	130.0	132.8	154.7	156.2	168.6	185.4	186.6	177.3	189.9	176.1
Highland	70.1	66.3	62.9	69.3	65.9	69.6	60.4	72.9	75.3	68.5
Inverclyde	116.4	95.5	90.7	115.7	126.1	79.4	96.8	88.0	76.2	133.0
Midlothian	57.5	59.2	46.8	73.2	72.6	73.6	67.6	67.3	66.9	72.3
Moray	70.1	69.1	66.7	62.5	83.2	62.8	54.3	73.9	82.6	67.4
North Ayrshire	53.0	62.2	46.7	49.8	41.1	69.2	88.9	65.5	86.4	103.2
North Lanarkshire	64.5	68.1	63.5	72.8	73.8	73.8	71.9	73.3	72.4	98.5
Orkney[a]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Perth and Kinross	104.3	95.6	112.5	141.6	111.5	127.4	127.7	104.6	113.5	109.4
Renfrewshire	66.1	68.0	80.6	73.7	82.1	101.4	81.8	86.5	75.4	89.1
Scottish Borders	51.8	57.1	52.2	63.0	65.9	78.3	69.4	57.4	58.2	51.7
Shetland[a]	NA	NA	44.9	0.0	50.8	87.0	93.2	57.0	62.6	NA
South Ayrshire	53.6	52.6	40.3	60.5	57.0	51.6	73.2	77.2	93.4	86.8
South Lanarkshire	63.8	66.3	71.9	78.2	71.4	68.9	74.5	82.9	80.1	87.8
Stirling	71.8	69.9	78.7	76.8	104.0	142.0	140.5	139.7	117.1	114.9
West Dunbartonshire	76.8	80.7	85.7	76.5	70.1	96.6	100.0	83.2	101.8	83.0
West Lothian	83.9	72.8	81.8	94.7	86.3	121.7	116.1	107.8	114.6	125.9

[a] It is not possible to calculate Age Standardised Rates where n<10 (NA).

Table A1.6. Number of CTOs by local authority and year

Local authority	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Aberdeen City	77	97	72	71	80	71	76	76	84	96
Aberdeenshire	39	44	32	48	41	27	38	38	65	46
Angus	38	26	30	34	35	40	39	34	44	46
Argyll and Bute	15	14	24	24	22	21	20	19	26	27
City of Edinburgh	132	130	156	150	151	217	188	207	241	283
Clackmannanshire	11	15	17	18	12	21	13	19	21	26
Dumfries and Galloway (LA)	28	41	30	40	40	60	59	65	55	49
Dundee City	50	40	48	40	43	50	48	59	63	55
East Ayrshire	24	11	21	20	17	25	30	28	28	33
East Dunbartonshire	15	24	21	23	24	20	30	38	28	38
East Lothian	33	26	18	31	24	31	42	28	50	39
East Renfrewshire	15	16	18	26	30	33	28	21	31	33
Eilean Siar	*	*	*	*	*	6	*	*	*	*
Falkirk	34	41	48	44	44	43	57	66	67	69
Fife (LA)	102	92	89	89	110	131	121	129	114	127
Glasgow City	222	175	213	256	292	275	310	320	314	309
Highland (LA)	57	66	61	89	68	57	77	76	76	72
Inverclyde	28	27	30	30	44	30	25	28	23	32
Midlothian	22	18	20	20	25	21	38	28	22	23
Moray	18	15	18	20	16	13	13	17	22	31
North Ayrshire	22	21	18	25	20	36	39	38	38	53
North Lanarkshire	52	57	67	75	65	80	80	74	64	98
Orkney (LA)	*	8	*	0	0	*	*	*	*	*
Perth and Kinross	56	62	62	87	59	64	53	44	55	60
Renfrewshire	40	52	60	54	59	57	58	54	57	68
Scottish Borders	24	26	28	30	22	29	24	16	20	21
Shetland (LA)	*	*	*	*	*	*	*	7	6	*
South Ayrshire	18	26	17	19	11	14	15	40	35	42
South Lanarkshire	80	62	87	80	63	64	74	92	92	100
Stirling	9	13	25	17	21	23	27	47	39	33
West Dunbartonshire	31	38	38	37	32	42	41	38	31	22
West Lothian	35	37	41	43	44	43	63	46	51	63
Total	**1,338**	**1,327**	**1,425**	**1,549**	**1,522**	**1,650**	**1,738**	**1,800**	**1,871**	**2,013**

*n≤5 and secondary suppression to maintain confidentiality

Table A1.7. Number of CTOs by health board and year

Health board	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Ayrshire and Arran	65	57	51	58	46	74	81	102	95	121
Borders	19	21	25	27	20	23	21	12	18	20
Dumfries and Galloway	28	39	30	38	40	62	59	64	53	48
Fife	98	95	84	85	102	128	120	121	108	123
Forth Valley	54	67	87	74	76	87	98	129	123	127
Grampian	137	164	128	138	139	112	129	137	179	182
Greater Glasgow and Clyde	392	374	427	468	508	496	536	545	534	564
Highland	65	69	73	97	79	62	81	78	86	84
Lanarkshire	101	95	116	127	108	114	124	134	130	162
Lothian	229	214	246	255	252	317	333	324	370	411
Orkney	0	*	*	0	0	0	0	0	0	0
Shetland	0	0	0	0	0	*	*	0	0	0
State	*	*	*	*	*	7	*	*	*	*
Tayside	146	124	149	177	142	161	148	150	168	164
Western Isles	*	*	*	*	*	*	*	*	*	*
Total	**1,338**	**1,327**	**1,425**	**1,549**	**1,522**	**1,650**	**1,738**	**1,800**	**1,871**	**2,013**

*n≤5 and secondary suppression to maintain confidentiality

Table A1.8. Age Standardised Rate of CTOs by 100,000 population by local authority and year

Local authority	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Aberdeen City	33.4	43.0	31.9	32.5	36.8	31.3	35.3	33.0	37.3	40.4
Aberdeenshire	15.7	17.8	12.1	19.0	16.0	10.8	14.8	14.7	25.3	17.9
Angus	31.4	22.8	25.9	29.5	30.2	35.0	33.0	26.7	34.9	39.2
Argyll and Bute	16.2	14.4	25.8	26.6	25.5	22.0	22.8	20.4	28.7	31.8
City of Edinburgh	27.7	27.3	31.8	30.6	30.9	44.3	39.5	41.9	48.9	55.5
Clackmannanshire	22.4	29.4	34.2	35.3	22.6	41.2	26.0	36.0	42.1	50.6
Dumfries and Galloway	18.0	27.4	18.8	24.4	25.9	38.4	41.3	42.9	35.7	32.2
Dundee City	34.2	26.7	33.4	28.0	29.5	35.4	32.3	41.2	42.6	37.4
East Ayrshire	20.2	9.2	17.5	17.7	13.7	21.5	24.0	24.0	23.1	27.2
East Dunbartonshire	13.5	22.0	20.7	21.5	22.3	18.5	25.9	34.9	23.5	36.5
East Lothian	31.9	25.2	16.6	29.2	22.4	27.7	36.8	24.3	41.8	32.9
East Renfrewshire	16.8	16.9	19.6	29.6	33.0	34.9	27.9	22.5	32.0	34.7
Eilean Siar[a]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Falkirk	22.6	26.8	30.7	28.0	27.9	27.8	35.9	41.1	41.8	42.6
Fife	27.7	25.2	24.3	24.3	29.6	35.2	31.8	33.8	29.8	33.0
Glasgow City	40.9	31.2	38.3	44.9	51.0	48.1	56.1	55.1	53.0	51.4
Highland	24.4	28.8	26.7	37.9	27.9	24.5	32.0	31.6	30.5	28.9
Inverclyde	33.7	33.2	37.7	37.8	51.5	36.5	30.2	36.4	29.0	39.1
Midlothian	25.3	20.2	23.2	22.1	28.7	23.6	40.3	29.9	22.7	23.6
Moray	18.8	16.0	19.0	21.8	16.4	12.7	14.4	17.2	22.2	31.4
North Ayrshire	17.8	16.1	13.2	19.4	14.3	27.4	28.6	28.2	26.2	37.2
North Lanarkshire	16.1	17.2	20.6	22.6	19.6	24.2	23.4	22.5	18.5	28.6
Orkney[a]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Perth and Kinross	37.0	41.0	40.6	56.4	38.7	40.9	31.7	29.3	34.7	35.4
Renfrewshire	23.0	29.6	33.6	30.2	32.6	31.6	32.1	29.0	30.2	35.9
Scottish Borders	21.2	23.3	24.5	24.9	18.0	25.8	18.0	14.2	18.3	18.5
Shetland[a]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
South Ayrshire	16.2	24.4	16.3	17.9	11.1	15.0	11.8	35.3	32.0	34.0
South Lanarkshire	26.0	19.8	27.2	25.2	19.0	19.3	23.1	27.8	27.4	29.3
Stirling	NA	14.3	27.8	18.4	21.3	26.6	28.1	48.7	39.9	33.2
West Dunbartonshire	35.9	43.3	43.1	42.2	35.5	48.0	46.3	42.9	36.7	25.1
West Lothian	21.5	21.7	24.2	26.6	25.7	25.2	36.2	26.0	29.0	34.8

[a] It is not possible to calculate Age Standardised Rates where n<10 (NA).

Table A1.9. Number of detentions under nurses' power to detain by year and gender

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Female	81	96	116	119	119	103	109	84	123	113
Male	55	50	51	63	63	52	61	59	85	71

Note: There are n≤5 people in certain years where gender is unknown or not specified

Table A1.10. Rate of detentions under nurses' power to detain by year and gender

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Scotland rate	2.5 (2.1-3.0)	2.7 (2.3-3.2)	3.1 (2.6-3.6)	3.4 (2.9-3.9)	3.4 (2.9-3.9)	2.9 (2.4-3.3)	3.2 (2.7-3.7)	2.6 (2.2-3.1)	3.8 (3.3-4.4)	3.3 (2.9-3.9)
Female rate	2.9 (2.3-3.6)	3.4 (2.8-4.2)	4.1 (3.4-5.0)	4.3 (3.6-5.2)	4.3 (3.6-5.2)	3.7 (3.0-4.5)	4.0 (3.3-4.8)	3.0 (2.4-3.7)	4.4 (3.7-5.3)	3.9 (3.2-4.7)
Male rate	2.1 (1.6-2.8)	2.0 (1.4-2.6)	1.9 (1.4-2.5)	2.4 (1.8-3.1)	2.5 (1.9-3.2)	2.0 (1.5-2.6)	2.4 (1.8-3.0)	2.2 (1.7-2.9)	3.2 (2.6-4.0)	2.6 (2.0-3.3)

Note: There are n≤5 people in certain years where gender is unknown or not specified

Table A1.11. Number of place of safety orders by year

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Number of orders	831	1,140	1,181	1,115	1,134	1,141	1,254	1,331	1,279	1,231

Table A1.12. Point prevalence orders by year and health board

Health board	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Ayrshire and Arran	159	165	163	187	179	181	202	219	222	234
Borders	41	39	49	46	46	55	33	35	43	46
Dumfries and Galloway	57	61	60	75	73	92	94	99	105	106
Fife	232	256	262	242	249	268	277	275	265	267
Forth Valley	162	163	197	204	210	223	227	247	236	262
Grampian	249	283	279	285	289	279	307	309	333	347
Greater Glasgow and Clyde	986	1011	1047	1073	1135	1196	1248	1304	1276	1256
Highland	185	182	179	206	209	180	195	184	197	185
Lanarkshire	219	233	211	244	229	238	272	289	276	270
Lothian	566	562	631	624	638	688	728	731	743	760
Tayside	319	320	321	337	319	357	348	357	381	366

Table A1.13. Age Standardised Rate of point prevalence orders by year and health board

Health board	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Ayrshire and Arran	44.2	45.8	45.7	53.5	50.8	52.0	57.6	63.7	63.7	66.4
Borders	37.4	35.4	44.3	39.5	40.4	48.3	27.2	30.1	38.9	41.7
Dumfries and Galloway	38.3	41.4	42.2	51.6	53.8	66.1	70.7	74.8	76.6	78.1
Fife	64.2	71.1	72.9	67.8	68.8	74.0	76.2	75.6	72.8	73.0
Forth Valley	54.3	54.7	65.8	68.1	70.0	74.6	75.9	81.5	77.9	86.1
Grampian	42.1	48.1	47.7	49.0	50.0	48.4	53.4	53.2	56.6	58.8
Greater Glasgow and Clyde	86.7	88.6	91.0	92.5	96.8	102.5	107.8	110.7	106.9	103.9
Highland	58.6	57.7	56.4	65.8	66.8	57.1	61.3	58.5	62.0	58.3
Lanarkshire	33.5	35.4	32.4	36.7	34.3	35.9	40.7	43.1	41.0	39.5
Lothian	66.3	64.9	72.0	71.1	72.1	77.7	82.0	81.9	82.4	82.6
Tayside	79.5	80.2	80.1	83.0	79.0	87.7	85.8	87.9	93.3	90.3

Island rates cannot be calculated due to n<10.

Table A1.14. Age Standardised Rate of point prevalence CTOs by health board and CTO type

Health board	Community rate (95%CI)	Hospital rate (95% CI)
Ayrshire and Arran	18.6 (14.2 - 23.9)	26.9 (21.7 - 32.9)
Borders	23.3 (14.8 - 34.7)	12.2 (6.3 - 21.1)
Dumfries and Galloway	36.5 (26.4 - 49.0)	28.2 (19.8 - 38.9)
Fife	26.5 (21.4 - 32.4)	26.9 (21.9 - 32.8)
Forth Valley	36.8 (30.2 - 44.4)	33.6 (27.4 - 40.8)
Grampian	15.0 (12.0 - 18.5)	26.2 (22.3 - 30.7)
Greater Glasgow and Clyde	36.6 (33.2 - 40.2)	43.9 (40.2 - 47.8)
Highland	28.2 (22.5 - 34.9)	18.4 (14.0 - 23.8)
Lanarkshire	12.3 (9.8 - 15.3)	15.8 (12.9 - 19.0)
Lothian	27.9 (24.5 - 31.5)	35.8 (32.0 - 39.9)
Tayside	26.2 (21.3 - 31.8)	37.6 (31.9 - 44.0)

Island rates cannot be calculated due to n<10.

Table A1.15. Number of orders under Criminal Procedure Act and number of individuals with an order by year

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Orders	420	447	437	387	402	364	375	350	338	315
Individuals	234	252	227	220	221	215	221	202	216	196

Table A1.16. Number of Criminal Procedure Act orders by order type and year

Category	Order	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Treatment and assessment	Treatment Order	113	109	121	100	100	105	106	110	97	87
	Assessment Order	145	130	133	122	141	106	132	112	109	87
Unfitness for trial	Temporary Compulsion Order	18	20	20	16	11	12	18	11	*	6
Acquittal due to mental disorder	S57(2)(a) Compulsion Order	26	28	50	33	22	27	22	22	26	15
	S57(2)(a) Compulsion Order - Community	0	0	0	0	0	0	*	0	0	*
	S57(2)(b) CORO	*	*	*	*	*	*	*	*	*	*
Post-conviction pre-disposals	Interim Compulsion Order	23	26	23	15	24	13	14	19	11	22
	S200 Commital	0	0	0	0	*	0	0	0	0	*
Mental health disposals	Hospital Direction	*	0	*	*	0	0	*	0	*	*
	S57A(2) Compulsion Order	45	60	43	46	52	45	39	41	44	52
	S57A(2) Compulsion Order - Community	0	*	*	0	0	*	*	0	0	*
	S59 CORO	9	10	*	8	8	6	*	*	10	6
Transfer for treatment	Transfer for Treatment Direction	36	58	36	40	38	44	33	23	28	32
Total		**420**	**447**	**437**	**387**	**402**	**364**	**375**	**350**	**338**	**315**

*n≤5 and secondary suppression to maintain confidentiality

Table A1.17. Number of T2s by treatment type and year

Treatment	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
ECT	8	21	23	30	21	20	29	18	32	25
Medication to reduce sex drive	*	*	*	*	*	*	0	0	*	*
Artificial nutrition	*	*	*	*	*	*	9	6	*	*
Medication beyond two months	769	751	773	862	785	801	890	930	882	979

*n≤5

Table A1.18. Number of T3s by treatment type and year

Treatment	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
ECT	207	176	224	222	255	214	240	230	229	224
Medication to reduce sex drive	7	10	10	12	11	7	8	*	9	12
Artificial nutrition	98	99	116	137	132	135	164	177	161	168
Medication beyond two months	1503	1559	1642	1704	1823	1675	1954	2164	2227	2441

*n≤5

Table A1.19. Number of T4s by age and year

Age	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2014-25
Under 18	44	33	36	52	55	93	81	70	71	121
18 and older	234	205	297	328	352	359	449	428	482	499
Total	**278**	**238**	**333**	**380**	**407**	**452**	**530**	**498**	**553**	**620**

Table A1.20. Number of T4s by health board and year

Health board	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Ayrshire and Arran	34	22	34	38	17	12	25	12	26	41
Borders	0	*	*	*	*	10	7	12	*	6
Dumfries and Galloway	9	6	9	22	13	20	19	*	21	38
Fife	19	15	11	32	32	34	40	37	31	47
Forth Valley	9	*	*	*	15	9	*	27	20	27
Grampian	16	21	27	28	36	39	39	47	67	55
Greater Glasgow and Clyde	56	37	68	97	120	106	137	154	135	151
Highland	*	*	10	10	*	*	18	27	12	15
Lanarkshire	7	15	14	13	19	13	30	17	16	11
Lothian	58	58	71	54	70	81	96	87	90	125
State	*	6	*	*	9	*	*	*	*	*
Tayside	60	47	78	69	66	117	106	72	127	98
Western Isles	*	0	0	0	0	0	0	0	0	0
Shetland	*	*	0	0	0	0	0	0	0	0
Orkney	0	0	0	0	0	0	0	0	0	*
Total	**278**	**238**	**333**	**380**	**407**	**452**	**530**	**498**	**553**	**620**

*n≤5 and secondary suppression to maintain confidentiality

Appendix 2 – Figures

Figure A2.1. Longest period of permitted detention an episode of detention progressed to by year

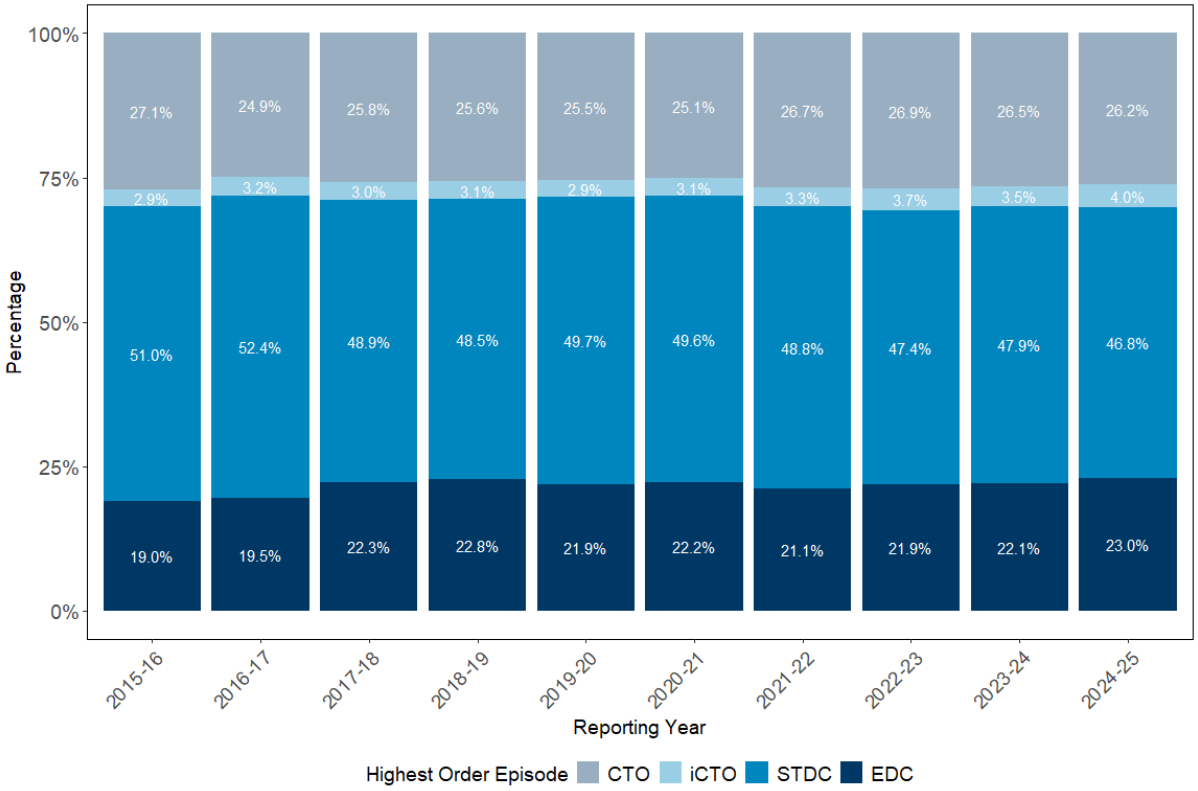


Figure A2.2. EDCs in 2024-25 by level of deprivation (based on 97.1% of EDCs with eligible postcodes)

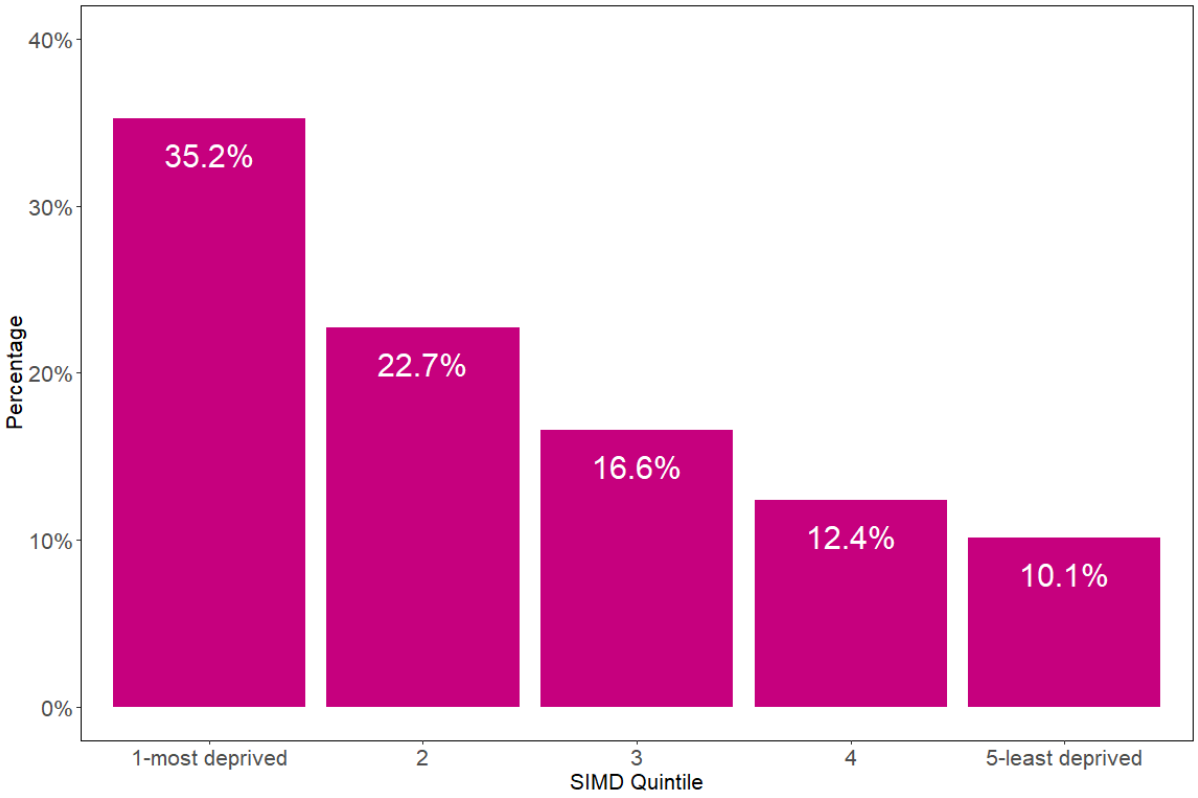


Figure A2.3. STDCs in 2024-25 by level of deprivation (based on 96.4% of STDCs with eligible postcodes)

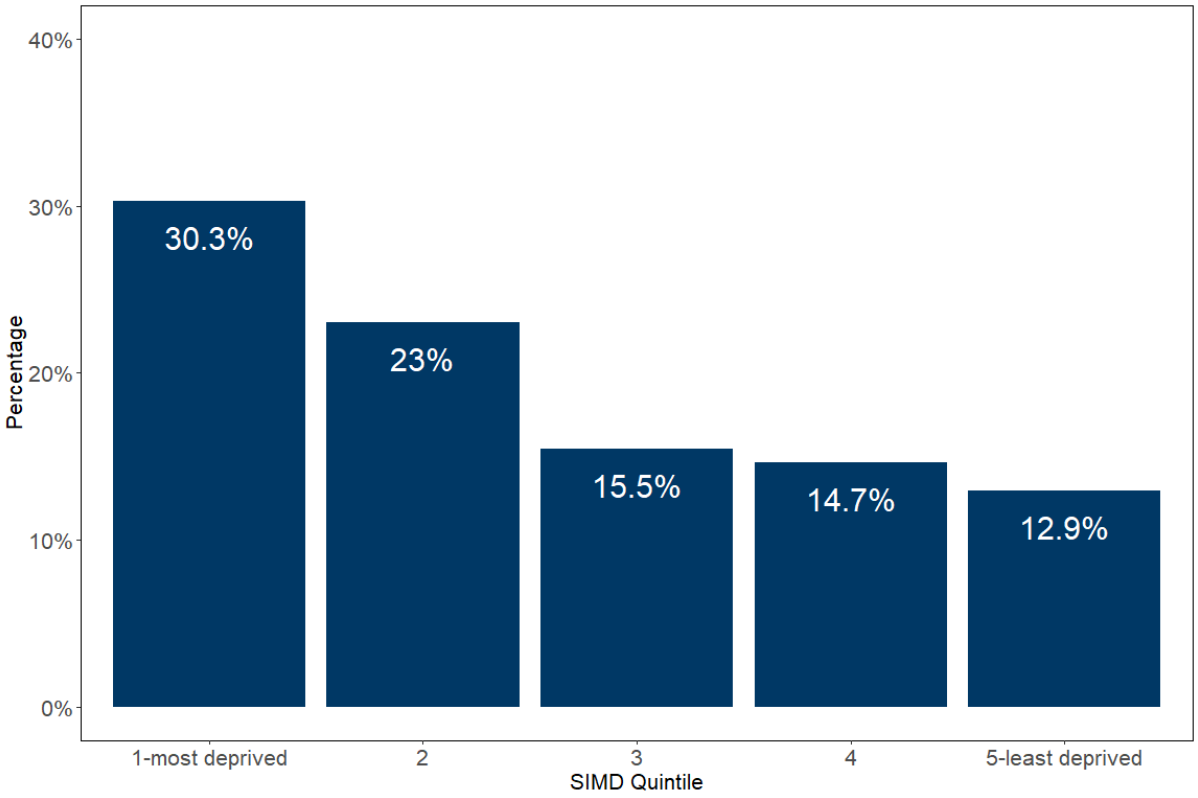


Figure A2.4. CTOs in 2024-25 by level of deprivation (based on 90.3% of CTOs with eligible postcodes)

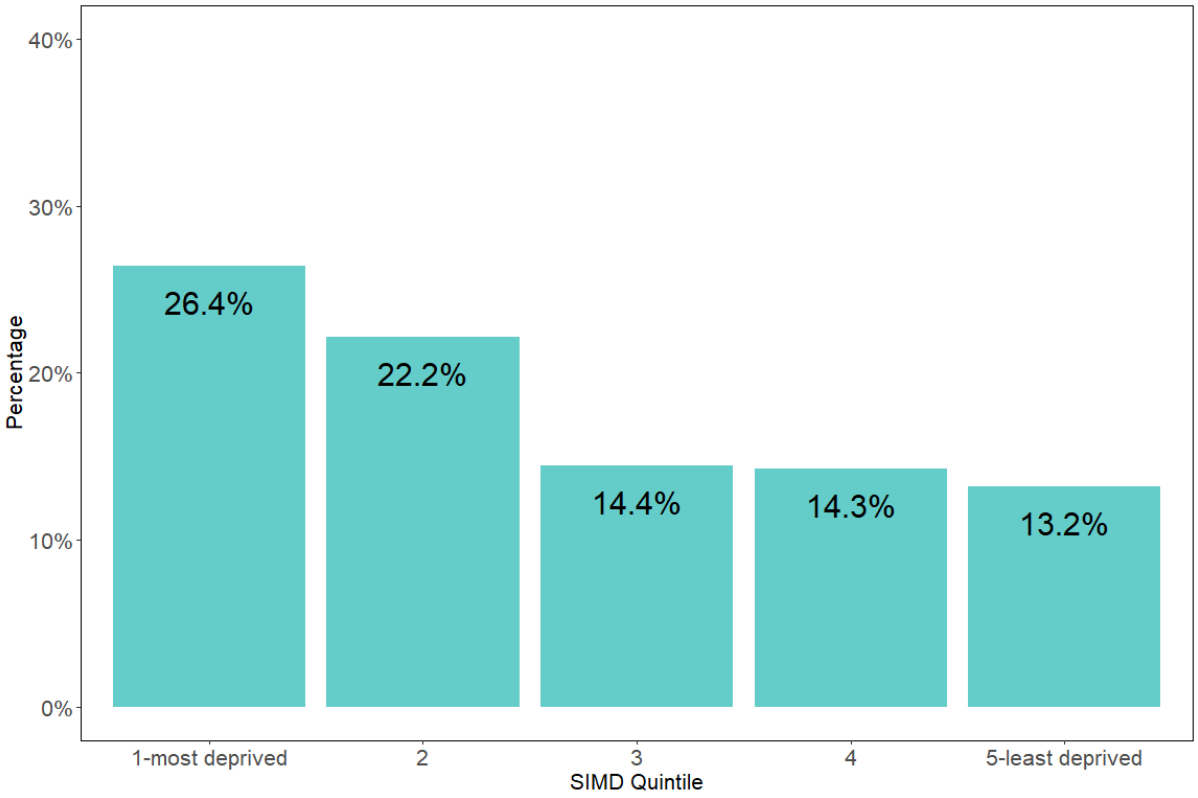


Figure A2.5. New orders by ethnicity by year (percentages)

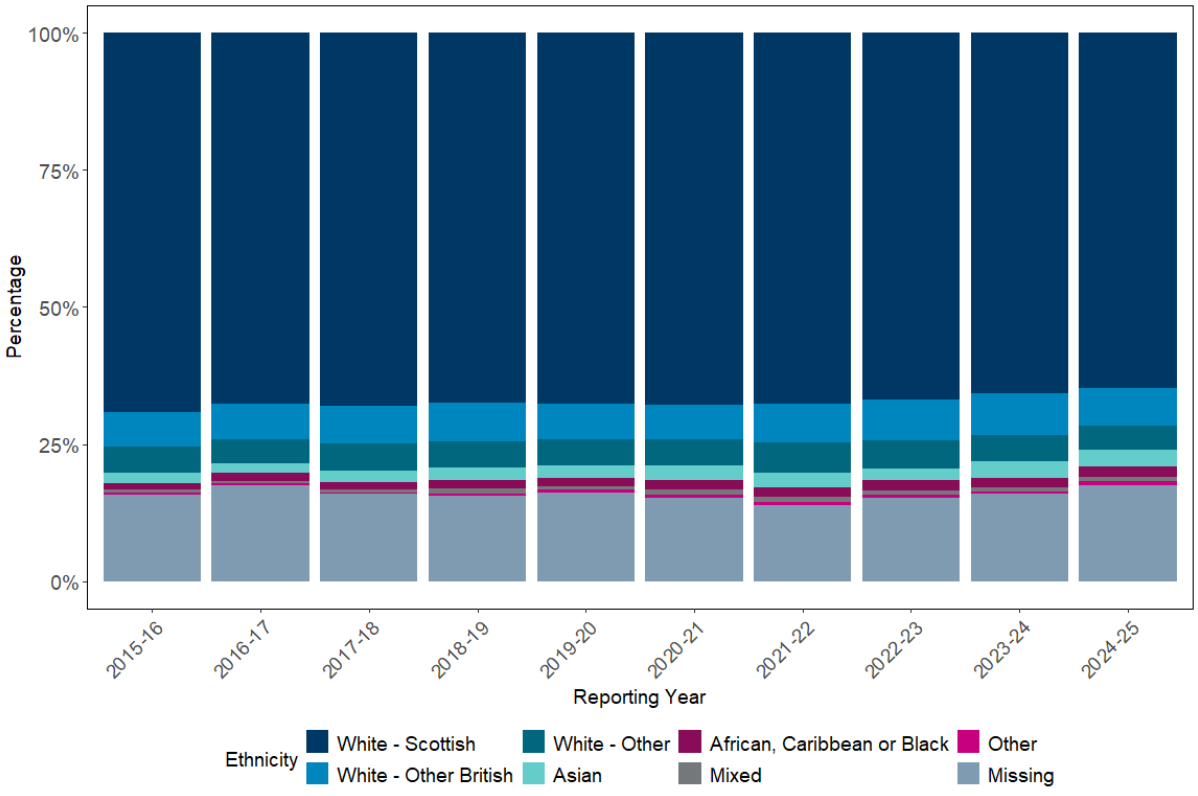


Figure A2.6. Age Standardised Rate of EDCs per 100,000 in 2024-25, by health board

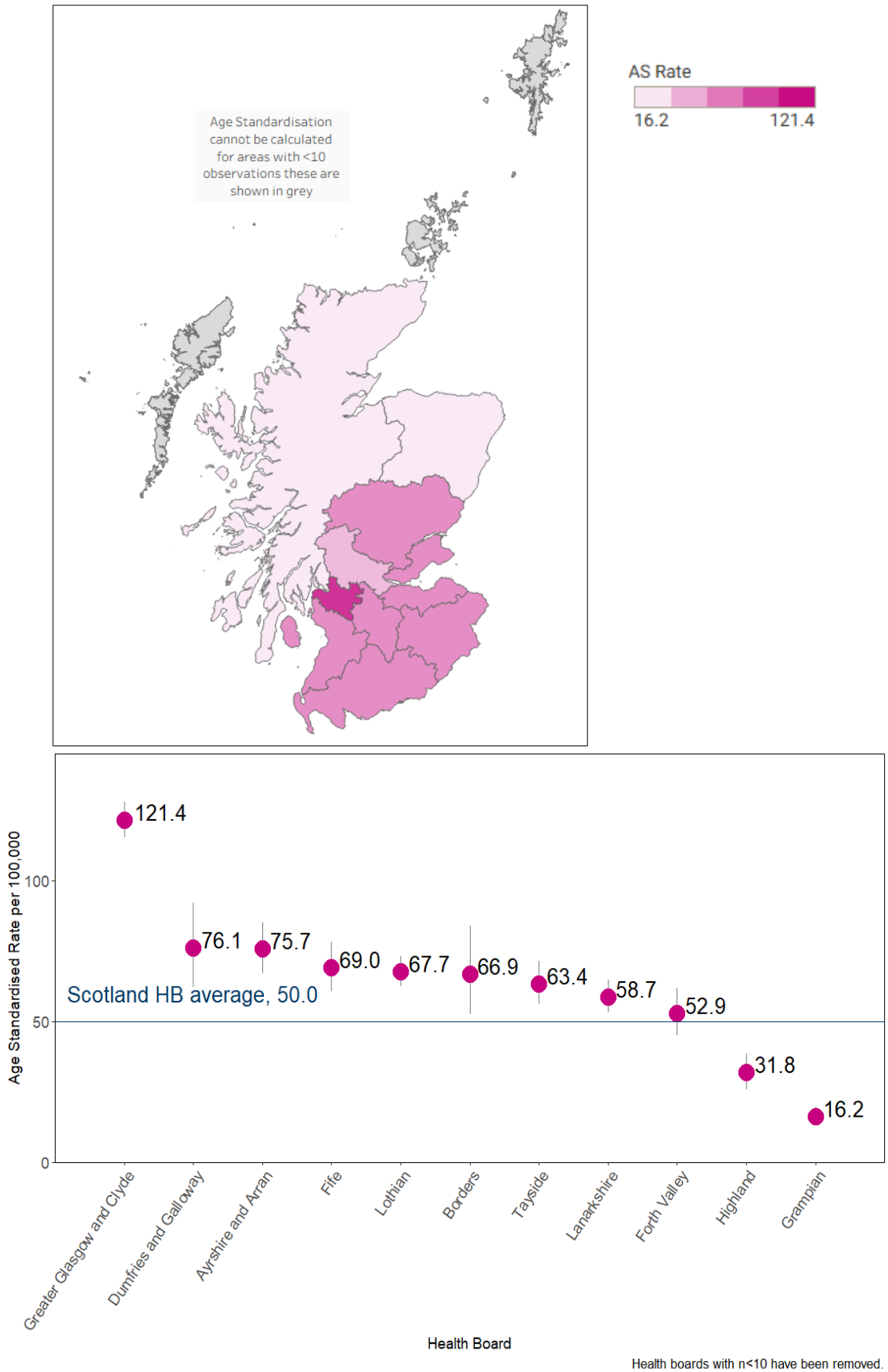


Figure A2.7. Age Standardised Rate of EDCs per 100,000 in 2024-25, by local authority

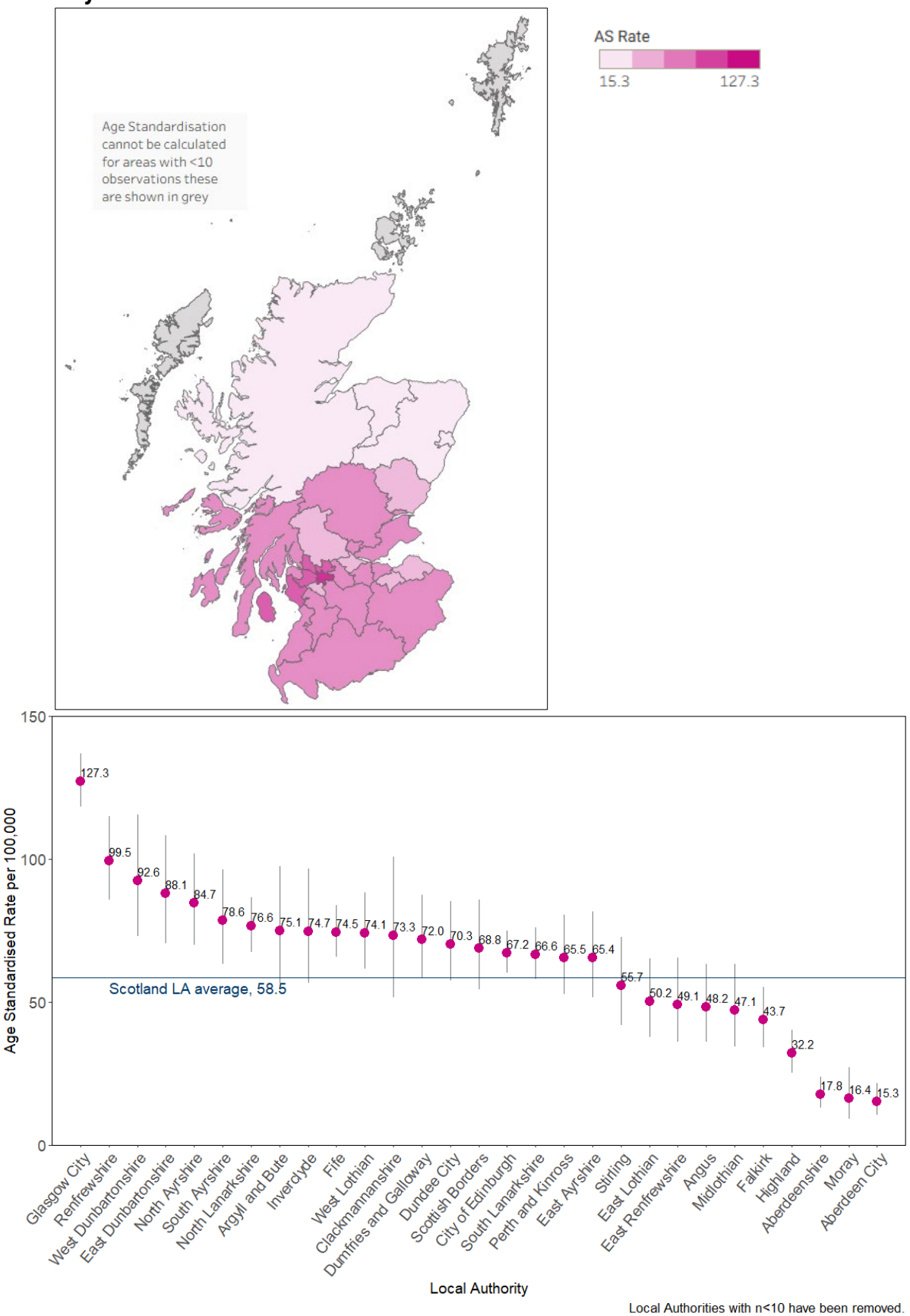
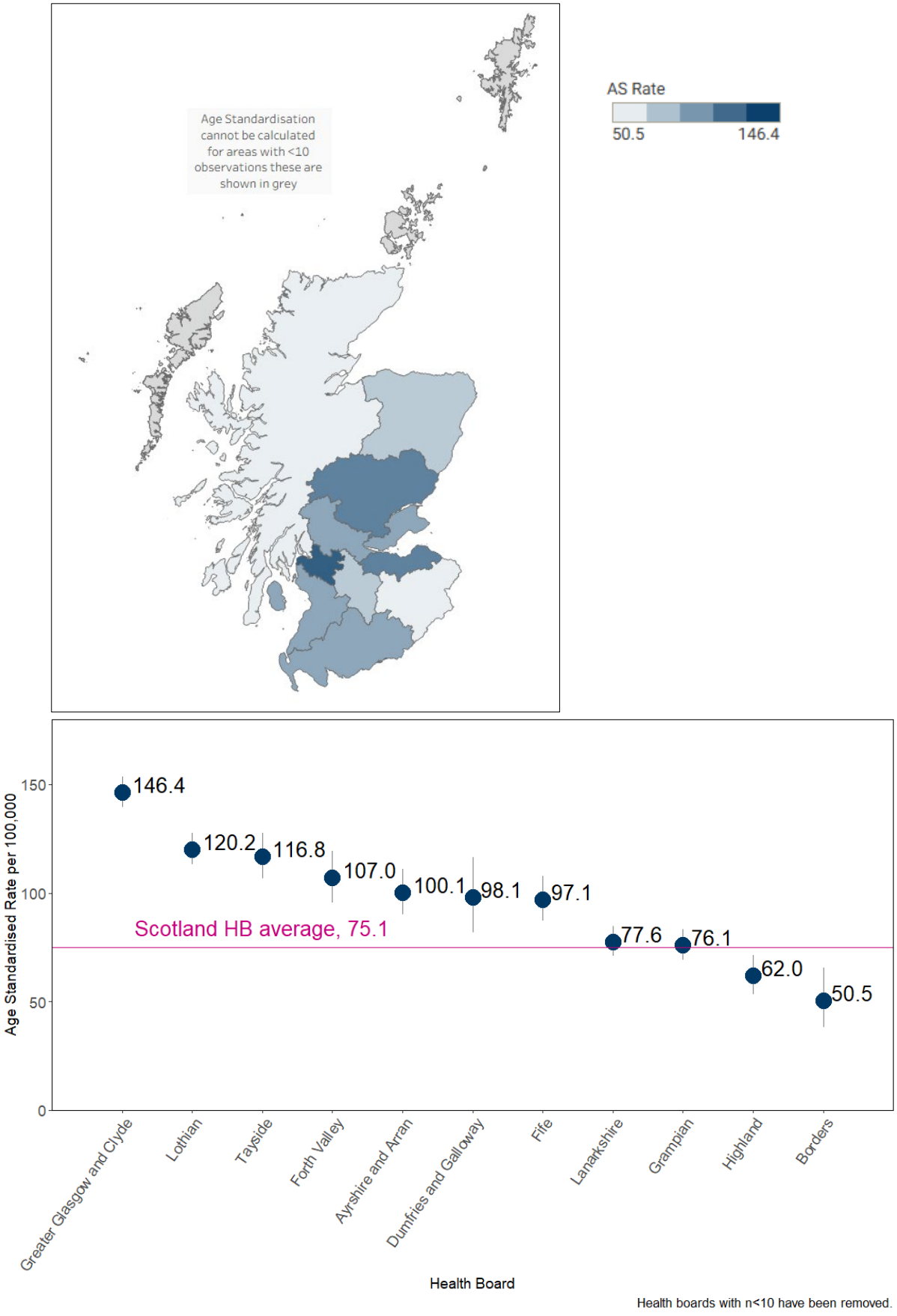
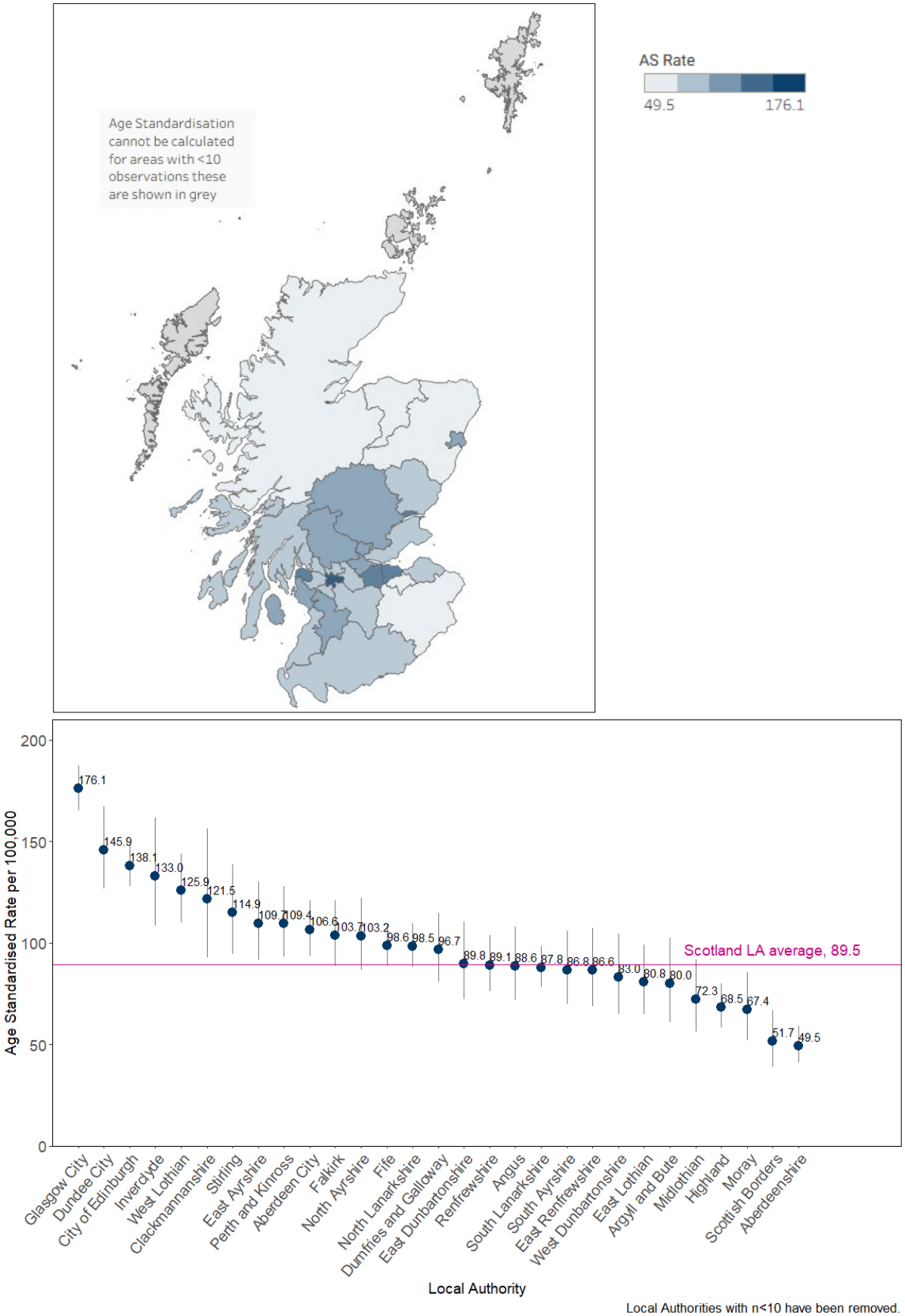


Figure A2.8. Age Standardised Rate of STDCs per 100,000 in 2024-25, by health board



Health boards with n<10 have been removed.

Figure A2.9. Age Standardised Rate of STDCs per 100,000 in 2024-25, by local authority



Local Authorities with n<10 have been removed.

Figure A2.10. Diagnostic categories recorded on detentions under a STDC in 2024-25

Figure A2.11. Social circumstances reports completed in 2024-25, by local authority

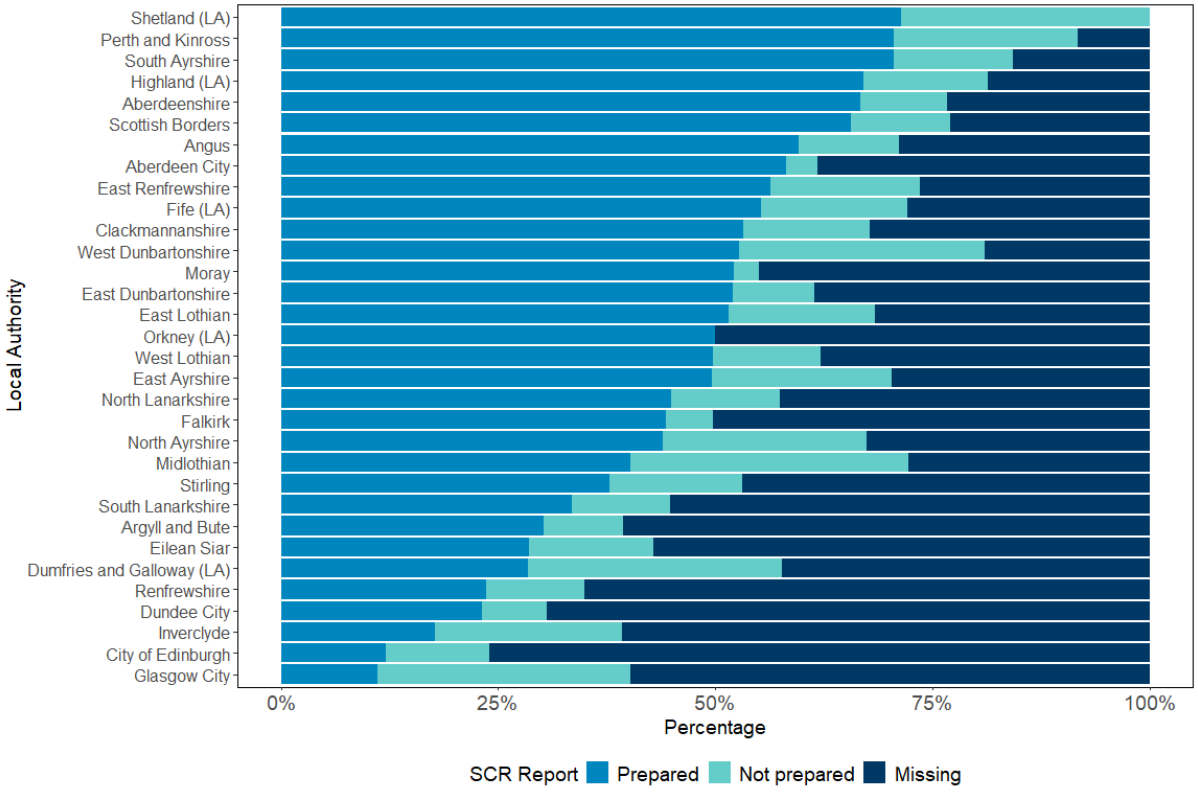
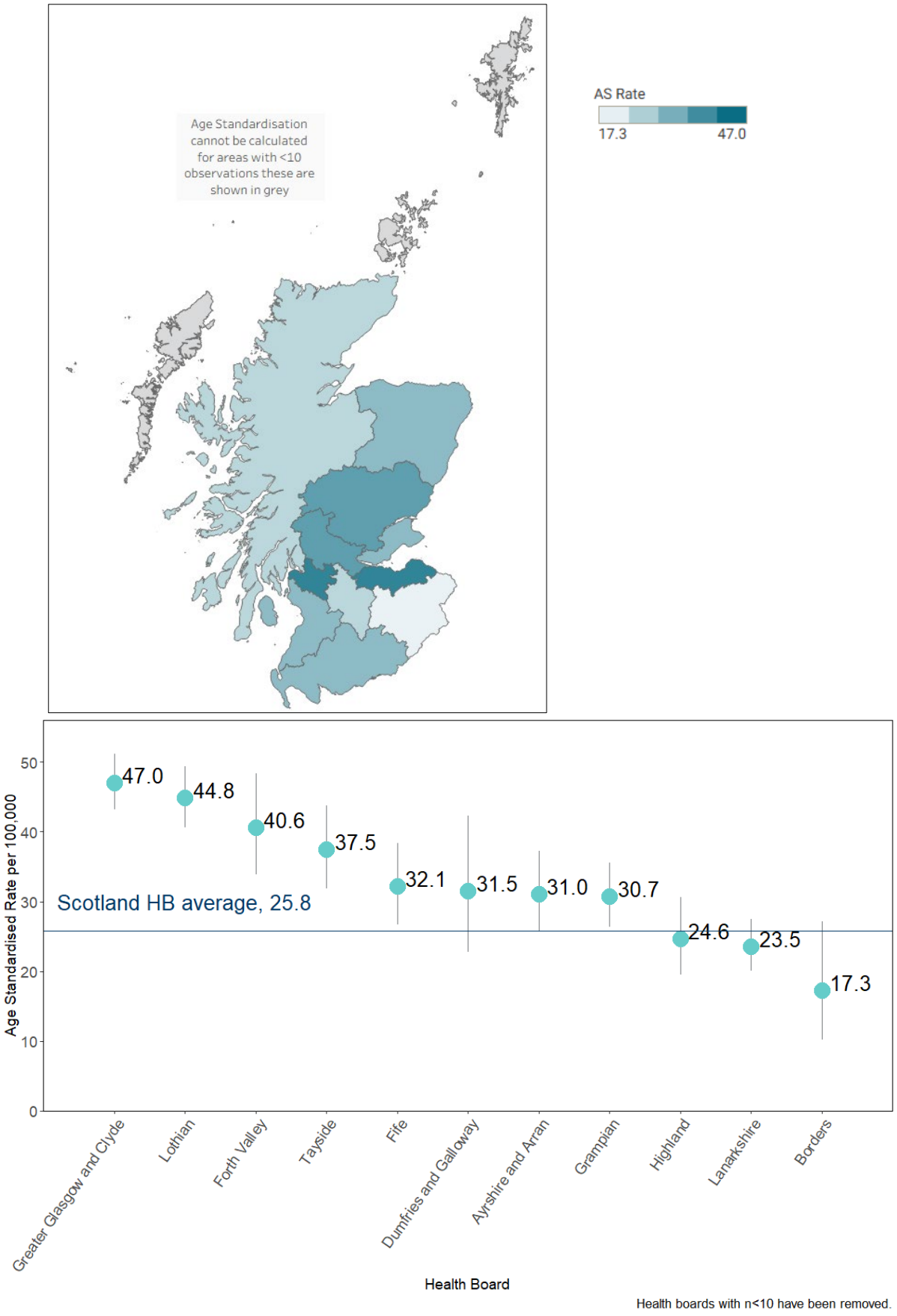
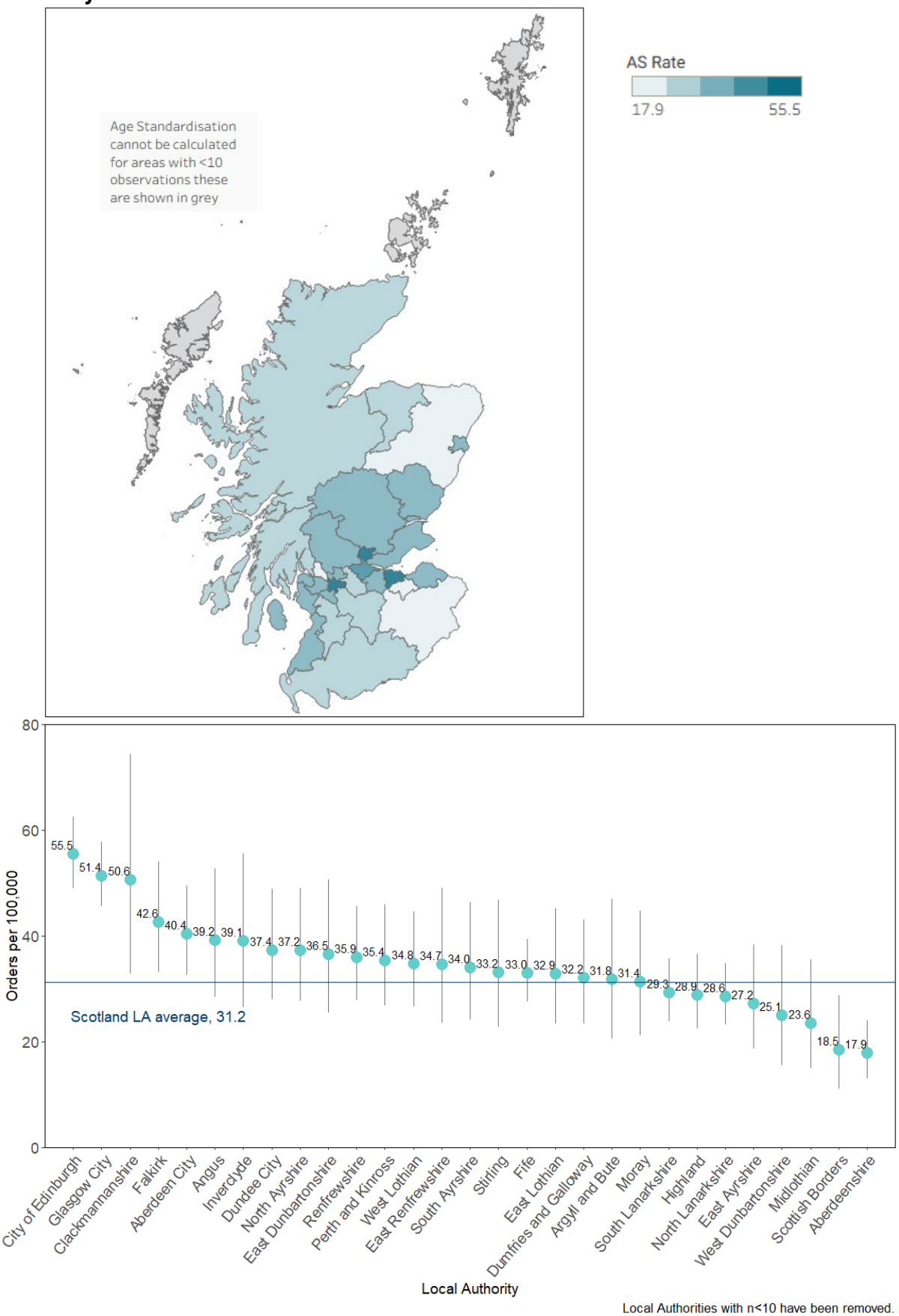


Figure A2.12. Age Standardised Rate of CTOs per 100,000 in 2024-25, by health board



Health boards with n<10 have been removed.

Figure A2.13. Age Standardised Rate of CTOs per 100,000 in 2024-25, by local authority



Local Authorities with n<10 have been removed.

Figure A2.14. Age Standardised Rate of use of nurse's power to detain by gender with 95% CI by year

Figure A2.15. Detentions under Section 297 orders by the place individual was taken to by year

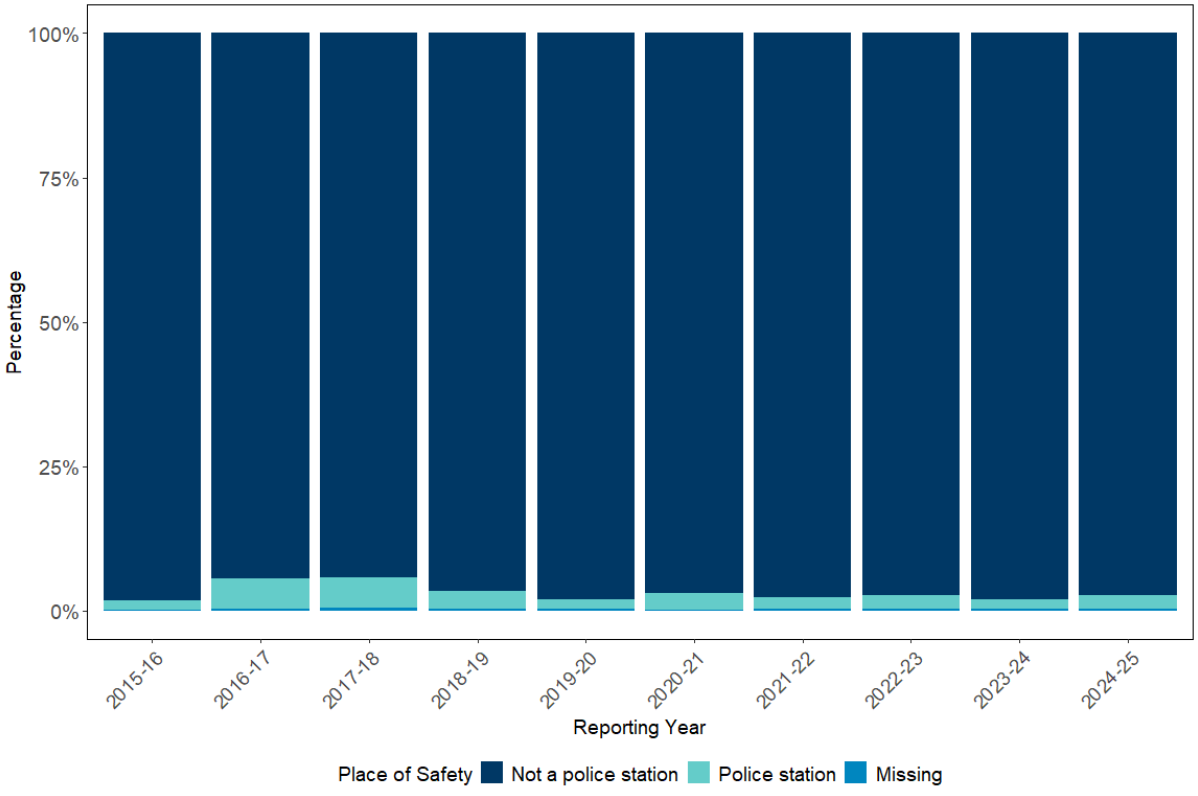
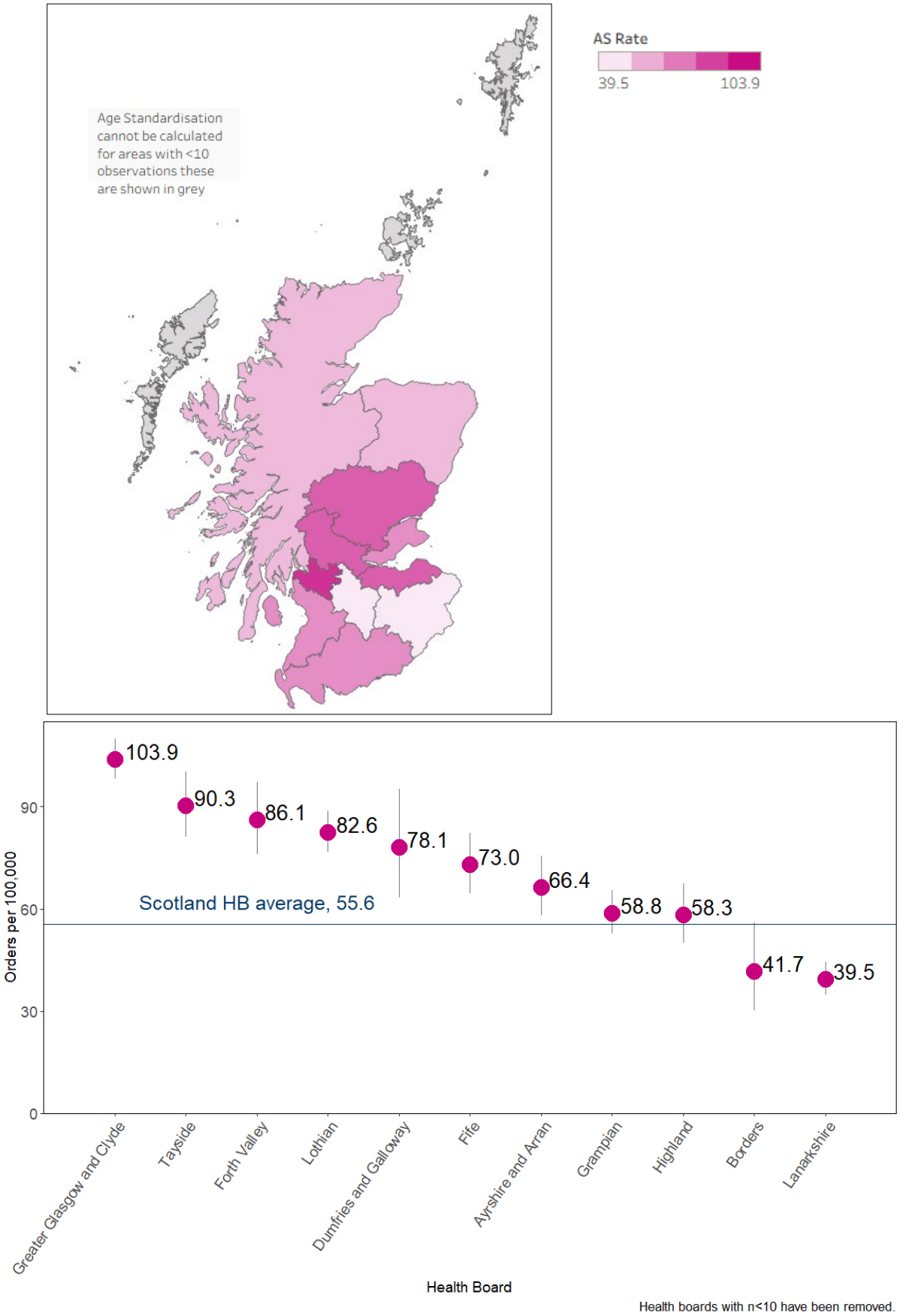


Figure A2.16. Age Standardised Rate of extant orders per 100,000 on 1 January 2025, by health board



Health boards with n<10 have been removed.

Figure A2.17. Type of order individuals were subject to on 1 January 2025

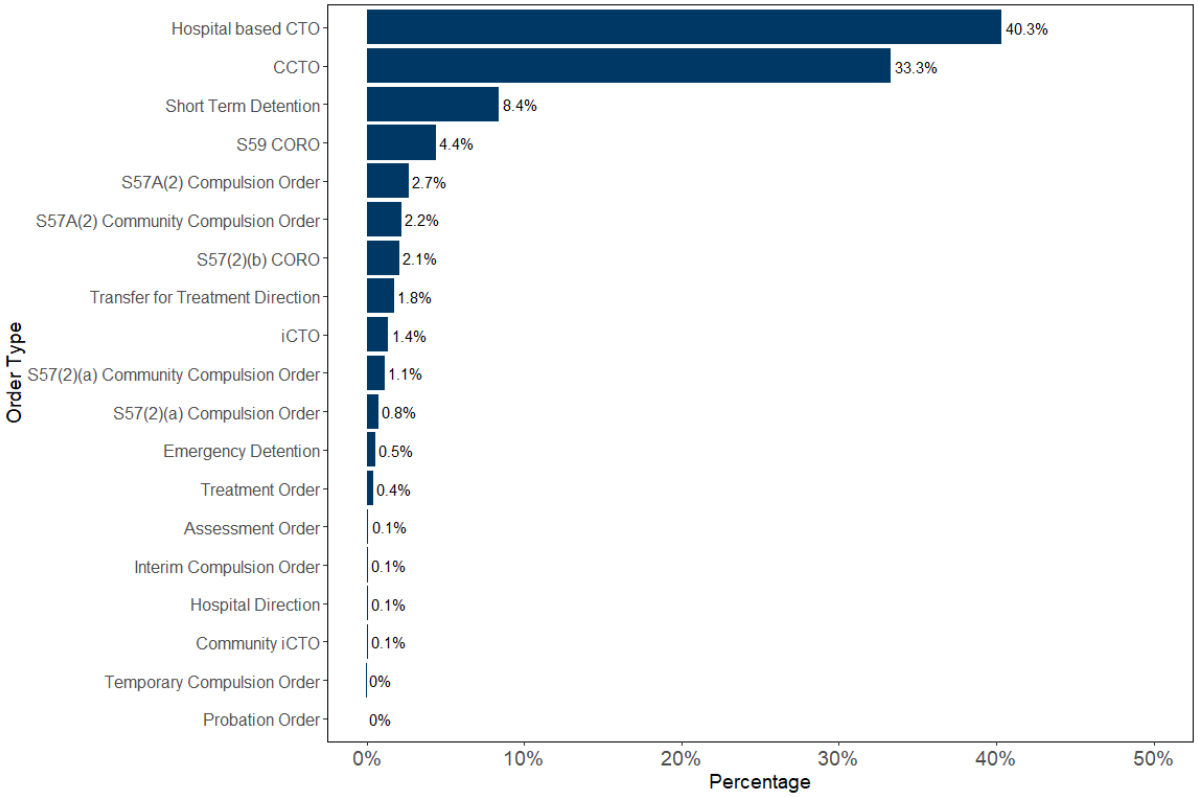
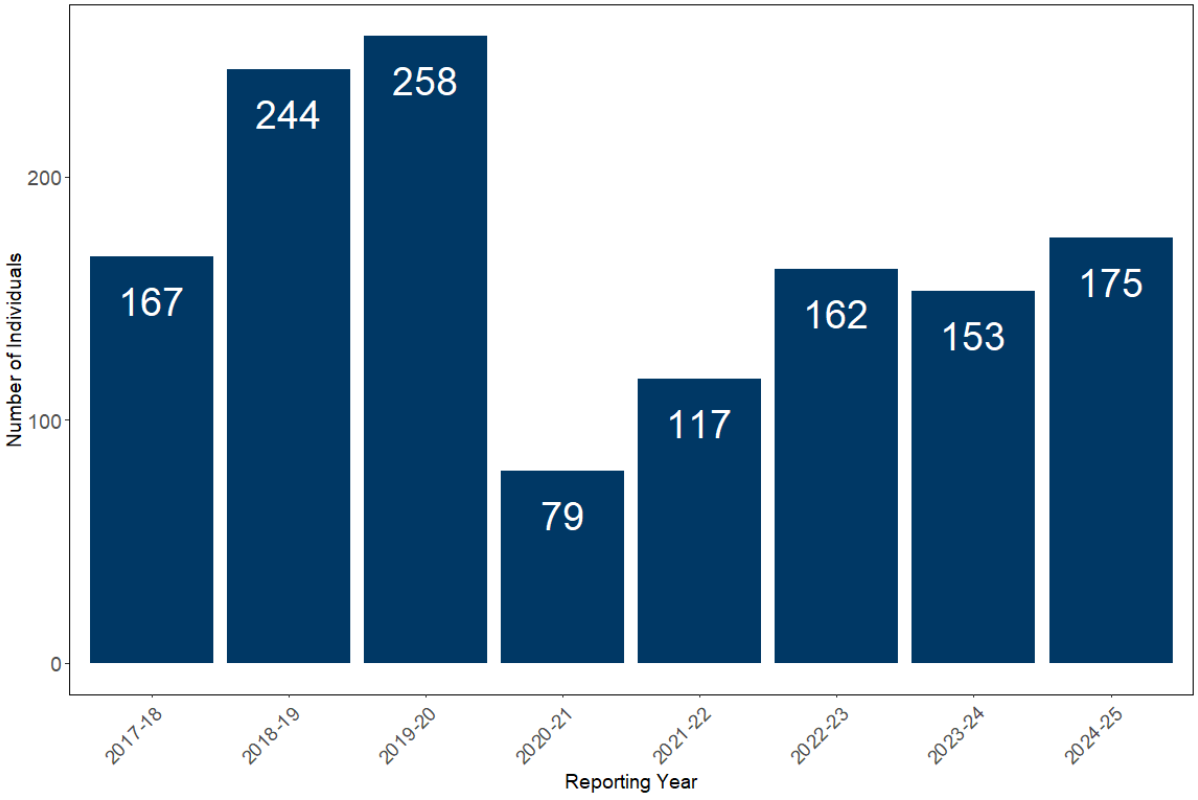


Figure A2.18. Number of individuals with a first engagement with the advance statement register by year



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Mental Welfare Commission 2025

mental welfare commission for scotland

Adults With Incapacity Act monitoring report 2024-25

Appendix 3

Statistical monitoring

October 2025

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

Initial Key findings

Part one: statistical monitoring 2024-25

- There was a total of 20,152 individuals subject to a guardianship order in Scotland on 31 March 2025 compared to 19,078 in 2024, representing a 5.6% increase.
- A total of 4,300 guardianship orders were granted in 2024-25, 4.1% more than in 2023-24 (based on revised 2023-24 figure n=4,131).
- 85.9% of guardianship orders granted in 2024-25 were new orders while 14.1% were renewals of existing guardianship orders, this is similar to previous years' figures.
- Private guardianship orders accounted for 70.5% of all guardianships granted, similar to previous years.
- The most common category of primary diagnosis was learning disability with 49.4%, similar to last year. Dementia was the second largest category of primary diagnosis with 32.3%.
- 89.1% of the granted orders were for a period of five years or less (compared to 84.0% last year). 9.9% were for six years or longer, fewer than last year's revised figure of 14.2%. 1.0% were indefinite orders, lower than last year's revised figure of 1.8%.
- There have been 24 recalls of orders by the relevant local authority and four recalls by the Sheriff Courts in the last 10 years.
- In 2024-25, there were 40 requests for a section 48 visit by a doctor appointed by the Commission, resulting in 36 designated medical practitioner (DMP) visits and 20 certificates. The majority were for electro-convulsive therapy (ECT).
- There were fewer than five requests for an independent second opinion doctor visit under section 50 of the Act.

Part two: guardianship visits 2024-25

- In 2024-25 we visited 351 adults subject to welfare guardianship orders. There were 15 cancelled visits e.g. person was unwell on the day, was attending an appointment etc.
- 96.6% of our visits were undertaken 'in person'.
- 87.2% were routine visits and 9.7% were due to concerns that had been raised.
- In 50.0% (n=175) of our visits, we provided advice and undertook further actions in 34.8% (n=122).
- Of the 184 individuals who we visited who were on a private guardianship order, 67.9% had a local authority supervising officer allocated at the time we visited.

Introduction

What are welfare powers of attorney and guardianship orders?

The Adults with Incapacity (Scotland) Act 2000 (AWI Act)[1] introduced a system for safeguarding the welfare and managing the property and finances of people who lack capacity to act, or to make some or all decisions for themselves due to a mental illness, learning disability, dementia or related conditions. This system allows other people, called guardians or attorneys, to make decisions on behalf of those who lack capacity, subject to safeguards.

When a person has capacity, they can grant a power of attorney (POA) to someone to act on their behalf. Whilst a person with capacity can allow someone to manage their finances via a power of attorney, welfare powers of attorney can only be used if the person does not have the capacity to make the specific decisions themselves. Sometimes the person's solicitor will write a specific clause in the power of attorney document ensuring that this will be determined by a medical practitioner. Other documents may not have such clarity and are left to be determined by the proxy decision maker (attorney). The Commission would suggest the former is the better option, as an independent person determines the level of incapacity.

When a person no longer has capacity, and has no pre-existing POA, an application may be made to the court. The sheriff may appoint a welfare guardian as proxy decision maker. The welfare guardian is then involved in making key decisions concerning the person's personal and medical care. Decisions by attorneys or guardians should always be in line with the principles of the AWI Act (see Box 1).

The majority of guardians are private individuals, usually a relative, carer or a friend. These are known as private guardians. The court can also appoint the Chief Social Work Officer (CSWO) of a local authority to be the person's welfare guardian, especially if private individuals do not wish to or are not able to take on the role as guardian. This is known as a local authority guardianship order.

Under the AWI Act, local authorities have a duty to make an application for welfare guardianship orders where it is required and where no one else is applying. Local authorities also have a duty under the AWI Act to support and supervise all welfare guardians, and to visit the person and their guardian at regular intervals. In addition, local authorities can investigate issues relating to the welfare of an adult where a proxy decision maker (guardian or attorney) exists and there are welfare concerns (under section 10(1) of the AWI Act)[1].

Box 1. Principles of the AWI Act

Principle 1 – Benefit
Any action or decision taken must benefit the person and only be taken when that benefit cannot reasonably be achieved without it.

Principle 2 – Least-restrictive option
Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.

Principle 3 – Take account of the wishes of the person
In deciding if an action or decision is to be made, and what that should be, account must be taken of the present and past wishes and feelings of the person as far as these may be understood. Some adults will be able to express their wishes and feelings clearly, although they would not be capable of taking the action or decision which you are considering. For example, they may continue to have opinions about a particular item of household expenditure, without being able to carry out the transaction personally. The person must be offered help to communicate their views. This might mean using memory aids, pictures, non-verbal communication, advice from a speech and language therapist, or support from an independent advocate.

Principle 4 – Consultation with relevant others
Take account of the views of others with an interest in the person's welfare. The AWI Act lists those who should be consulted whenever practicable and reasonable. It includes the person's primary carer, nearest relative, named person, attorney, or guardian, if there is one.

Principle 5 – Encourage the person to use existing skills and develop new skills
Encouraging and allowing the adult to make their own decisions and manage their own affairs and, as much as possible, to develop the skills needed to do so.

The role of the Mental Welfare Commission

The Mental Welfare Commission for Scotland ('the Commission') is part of the framework of legal safeguards in place to protect the rights of people subject to welfare guardianship orders, intervention orders and powers of attorney (POA). We monitor the use of the welfare provisions of the AWI Act. We also monitor the use of Part 5 of the AWI Act relating to consent to medical treatment and research.

The Commission receives a copy of every application for a welfare guardianship order, including the powers sought, medical and mental health officer (MHO) assessments, and a copy of the order granted by the sheriff. We collate and analyse data compiled from the relevant paperwork provided to us and publish monitoring reports, such as this one, with comment and analysis of trends in the use of the Act; the statistical monitoring is covered in Part 1 of this report.

One of the best ways to check that people are getting the care and treatment they need is to meet with them and ask them what they (and important people to them) think. We therefore visit people who are subject to guardianship orders in whatever setting they live and provide advice and good practice guidance on the operation of the AWI Act as part of our casework function. Our visits may lead to further inquiries or investigations, where indicated, to protect and promote the rights of the person.

This report

This report relates to the period 1 April 2024 - 31 March 2025. The first part of this report looks at the data and trends of existing and new guardianship orders in Scotland. Monitoring these trends helps to inform policy and practice. The second part of this report provides information about the work that the Commission undertakes when it visits people subject to guardianship orders.

Our data

When an application is made to a sheriff and a guardianship order is granted, the Commission is sent a record which is stored on our database. This year's report concerns all granted guardianship orders from 1 April 2024 - 31 March 2025 and where appropriate, trends from 2015-16 onwards are presented. We report using the most up to date information from our database therefore, percentages from previous years may differ slightly as more information has been added since the last reporting period. We also report on extant or existing guardianship orders, which includes all individuals in Scotland who were subject to a guardianship order on 31 March 2025. We are particularly interested in understanding the context and characteristics of the guardianship orders and our analyses therefore focus on a) demographic characteristics (age, gender, diagnosis), b) guardianship status (new or renewed order), c) guardian type (private or local authority), and d) length of guardianship order. At this point in time, we are not able to report on ethnicity as this information is not gathered in current applications to court.

We follow Public Health Scotland standards on data disclosure, as data relating to mental health and vulnerable populations is considered sensitive[2]. Measures to prevent identification are therefore taken and we supress numbers of less than five where needed and employ secondary suppression if some figures can be calculated from totals.

All percentages throughout the report have been rounded and in places the total may therefore not add up to 100%. Rate per 100,000 population were calculated using mid-2024 population statistics from National Records Scotland for the population aged ≥16 years[3]. Data from last year (2023-24) have been updated using the revised mid-2023 population estimates so will differ from previously published figures.

Part 1: Adults with Incapacity Act statistical monitoring

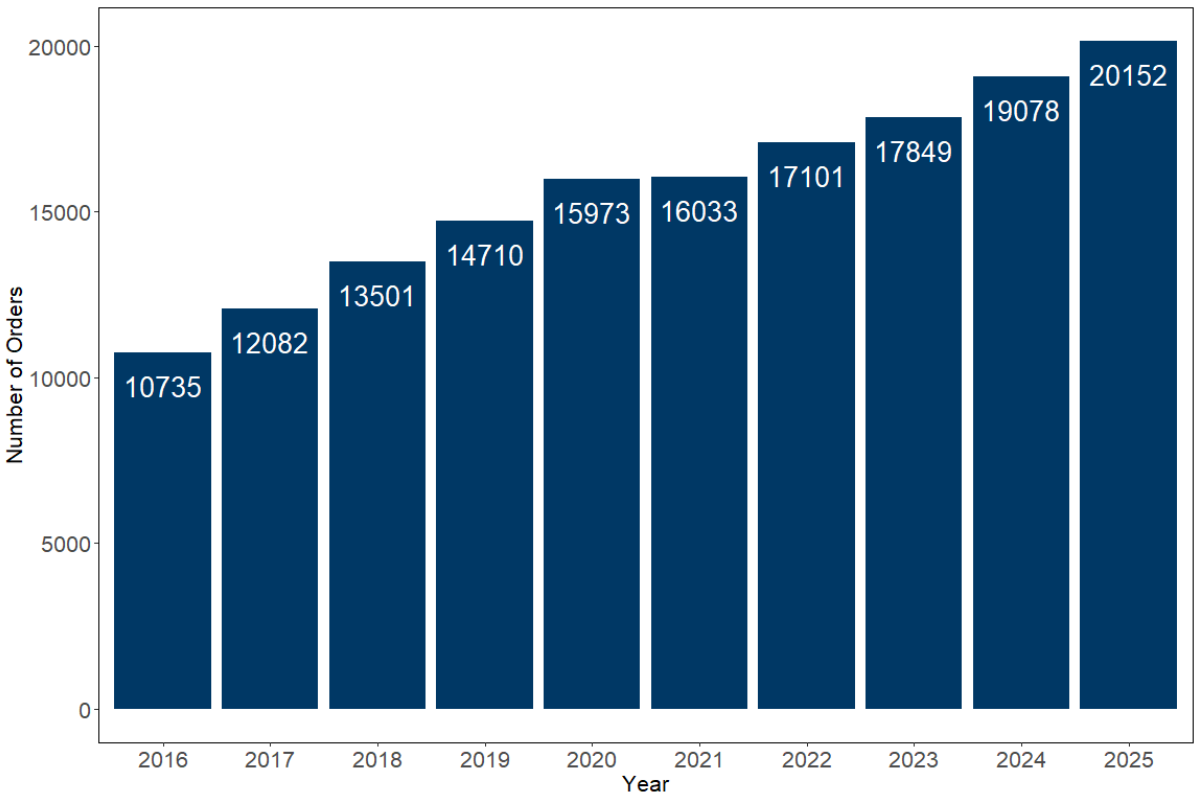
Extant guardianships

We count the number of people who are subject to a welfare guardianship order on a particular day, 31 March. We call this 'extant or existing' orders.

There was a total of 20,152 individuals subject to a guardianship order in Scotland on 31 March 2025 compared to 19,078 in 2024, a 5.6% increase (Figure 1). While the increase is similar to previous years, the number of existing guardianship orders has more than doubled in the last 10 years (2016, n=10,735). As with last year, Glasgow City have the highest number of extant or existing orders (13.4%; n=2,694) followed by Fife (7.5%; n=1,519).

A breakdown of characteristics of extant (or existing) guardianship orders is provided in Appendix Table A1, which shows that 44.2% (n=8,900) of all people on a guardianship order were 65 years or older (a similar proportion to the 44.7% reported last year (n=8,526)) and 23.3% (n=4,695) were on an indefinite order (compared to 25% last year). The most common primary diagnostic categories were learning disability (52.0%) and dementia (33.8%), both similar to the proportion reported last year (51.5% and 35.0% respectively). 76.9% of people were subject to a private guardianship order, similar to last year's figure of 77.3%.

Figure 1. Number of guardianship orders in Scotland on 31 March by year

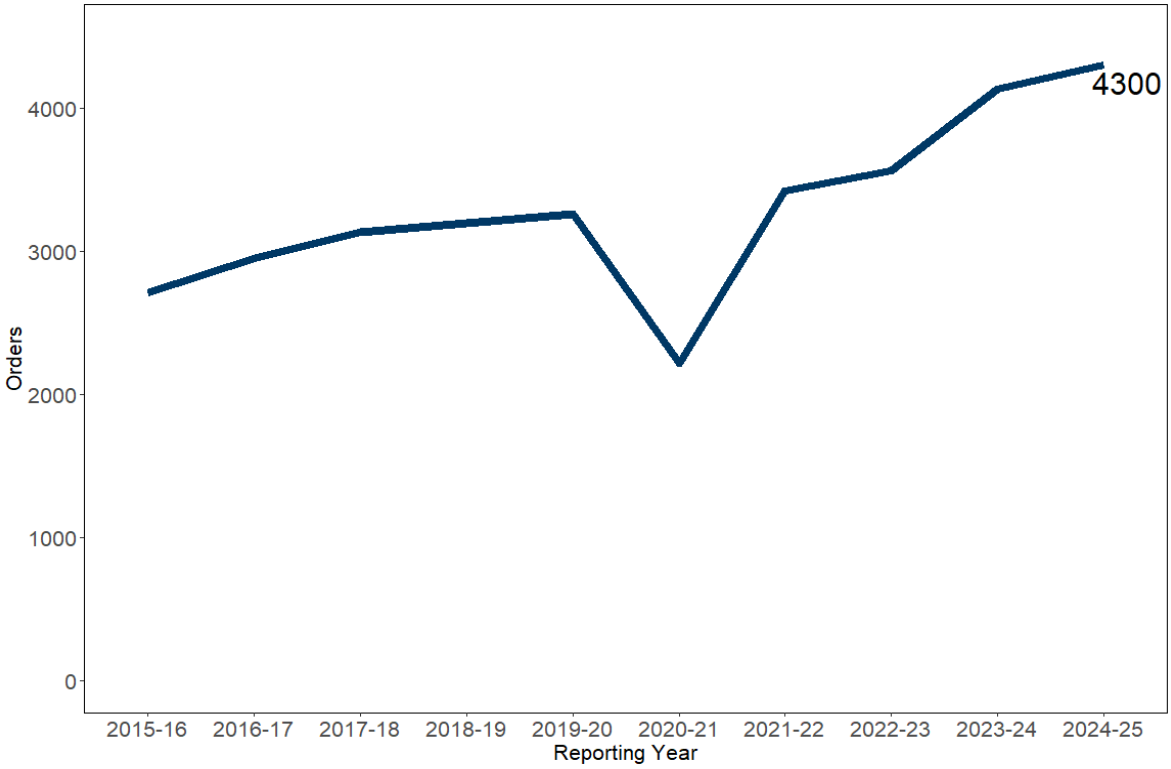


Whilst the AWI Act recognises that there might be circumstances in which an adult no longer requires a guardian, for example if they recover sufficient capacity, our data shows that there have only been 24 recalls of orders by the relevant local authority and less than five recalls by the Sheriff Courts in the last 10 years (please see our good practice guide in relation to recalls)[1].

Granted guardianship orders

A total of 4,300 guardianship orders were granted in 2024-25 (both new orders and renewals), 4.1% more than in 2023-24 (based on revised 2023-24 figure n=4,131). This is a far lower increase than the previous year of 16.0% based on the revised figures.

Figure 2. Total number of new and renewed guardianship orders granted by year



For guardianship orders granted in 2024-25, 53.7% were for males and 46.2% were for females (gender was not stated or unknown in <0.1% of orders). Most guardianship orders were for individuals with a primary diagnosis category of learning disability with 49.4%, similar to last year. Dementia was the second largest category of primary diagnosis with 32.3%. We were missing a primary diagnosis for 51 people (1.2%) (see Table 1 and Appendix Table A2).

In terms of duration, 89.1% of the granted orders were for a period of five years or less (compared to the revised figure of 84.0% last year). 39.1% of orders granted this year were for 0-3 years, slightly higher than the revised figure for last year of 32.6%.

[1] https://www.mwcscot.org.uk/sites/default/files/2024-09/RecallOfGuardianshipGoodPracticeGuide-2024.pdf

9.9% were for longer than five years, lower than last year's revised figure of 14.2%. 1.0% were indefinite orders (down from 1.8% in 2023-24).

Private guardianship orders accounted for 70.5% of all guardianship orders granted, compared to the revised figure of 73.2% last year. (Appendix Table A3 shows details for local authorities). Those subject to guardianship orders tended to be older; 59.5% were 45 years or older (Table 1). The age of those granted a guardianship order in 2024-25 was similar to the previous year.

Table 1. Characteristics of granted guardianship orders 2024-25

Category	Grouping	n (%)
Gender	Male	2,311 (53.7%)
	Female	1,987 (46.2%)
Age	16-24	1,005 (23.4%)
	25-44	736 (17.1%)
	45-64	742 (17.3%)
	65+	1,817 (42.3%)
Guardian type	Local authority	1,268 (29.5%)
	Private	3,032 (70.5%)
Length of order	0 - 3	1,683 (39.1%)
	4 - 5	2,150 (50.0%)
	> 5	426 (9.9%)
	Indefinite	41 (1.0%)
Diagnostic group	Learning Disability	2,124 (49.4%)
	Dementia/Alzheimer's Disease	1,387 (32.3%)
	Acquired Brain Injury	278 (6.5%)
	Alcohol Related Brain Damage	184 (4.3%)
	Mental Illness	202 (4.7%)
	Other	67 (1.6%)
	Inability to communicate	7 (0.2%)

Those with 'unknown' or 'not stated' gender or diagnosis have been omitted from this table

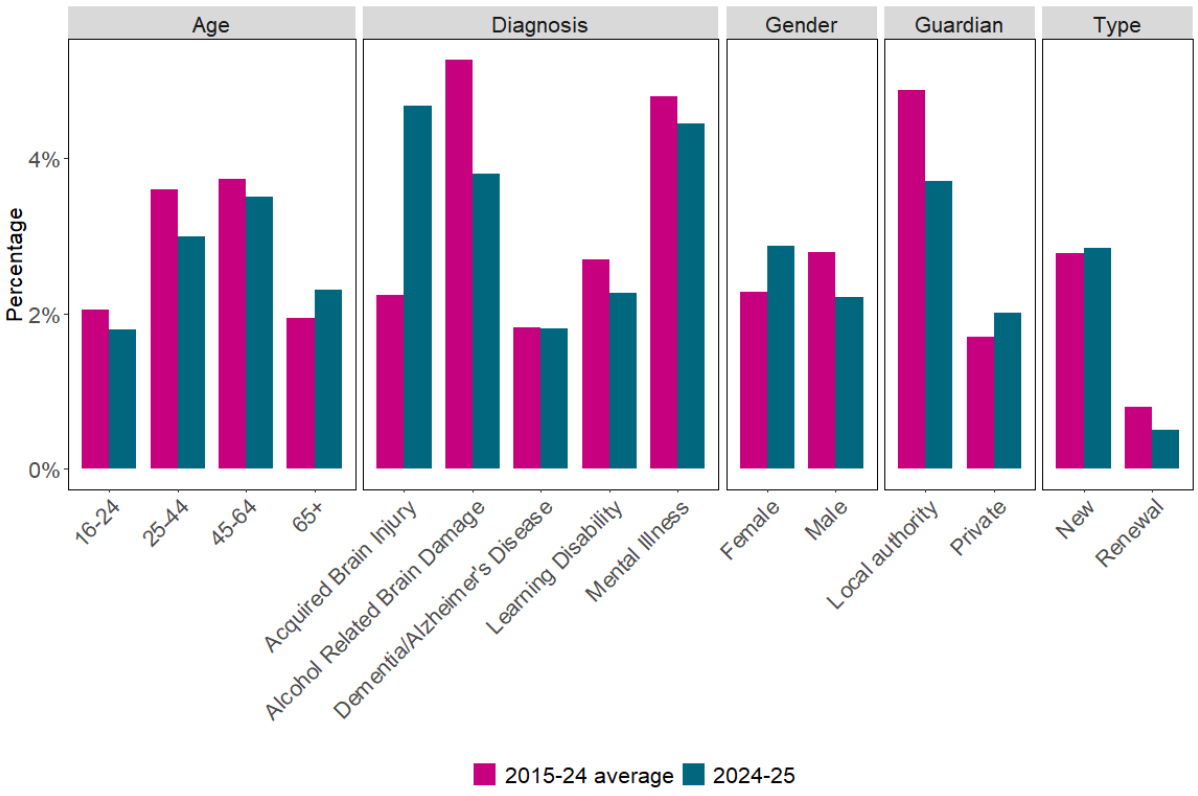
Time between application and granting of the order

The Commission is notified of the application for guardianship and also the date the order is granted.

Most (91.1%) orders were granted within two months or less of the application being made to court, 5.2% were within 3-4 months, 1.2% within 5-6 months and 2.5% took more than six months from application to granting this year.

When looking at orders that took more than six months to granting, we could see some differences. Figure 3 shows that the proportion waiting more than six months to granting was higher than average for those with an acquired brain injury (ABI) but similar for dementia and lower than average for learning disability, alcohol related brain damage (ARBD) and mental illness. For orders that took more than six months to granting, less than five had a diagnosis of inability to communicate due to physical illness, less than five had a diagnosis of 'other' and less than five had an unrecorded diagnosis.

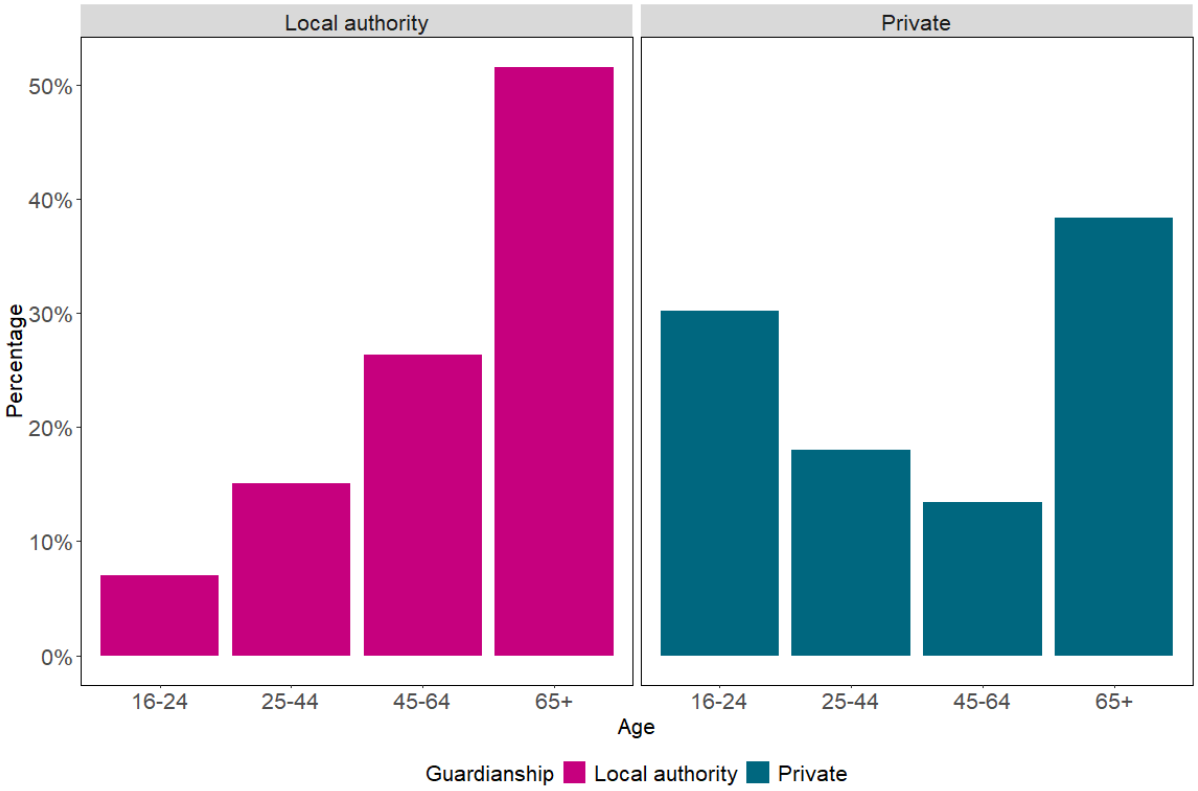
Figure 3. Proportion of orders granted after more than six months in 2024-25 compared to average for 2015-16 to 2023-24 by Age, Primary Diagnosis, Gender, Guardian and Guardian Type



Age

There are some differences in age of the individual depending on guardianship status. Local authority guardianship orders relate more often to people over the age of 65 years (51.6% n=654) with only 7.0% (n=89) of orders in the youngest age group (Figure 4). For private guardianships, orders granted in 2024-25 were also mostly in place for the over 65 years group (38.4%, n=1,163) however the second biggest category was the youngest age group, 16–24 years (30.2% n=912) (see Appendix Table A4).

Figure 4. Percentage of guardianships (local authority vs private) in 2024-25 by age group



Primary category of diagnosis

The number of granted orders increased in all categories of primary diagnoses except for those with dementia or Alzheimer's Disease, where there was a very slight decrease in numbers compared to 2023-24 (Figure 5). In 2024-25, there were n=51 where no diagnosis was recorded.

Figure 6 shows that in 2024-25 there was an above average increase in the relative year on year change for previous years for mental illness and ABI. For learning disability and ARBD there was a below average relative increase and for dementia or Alzheimer's Disease we saw a relative decrease. Other details relating to category of diagnosis can be found in Appendix Table A5.

Figure 5. The number of granted guardianship orders by primary diagnosis and year

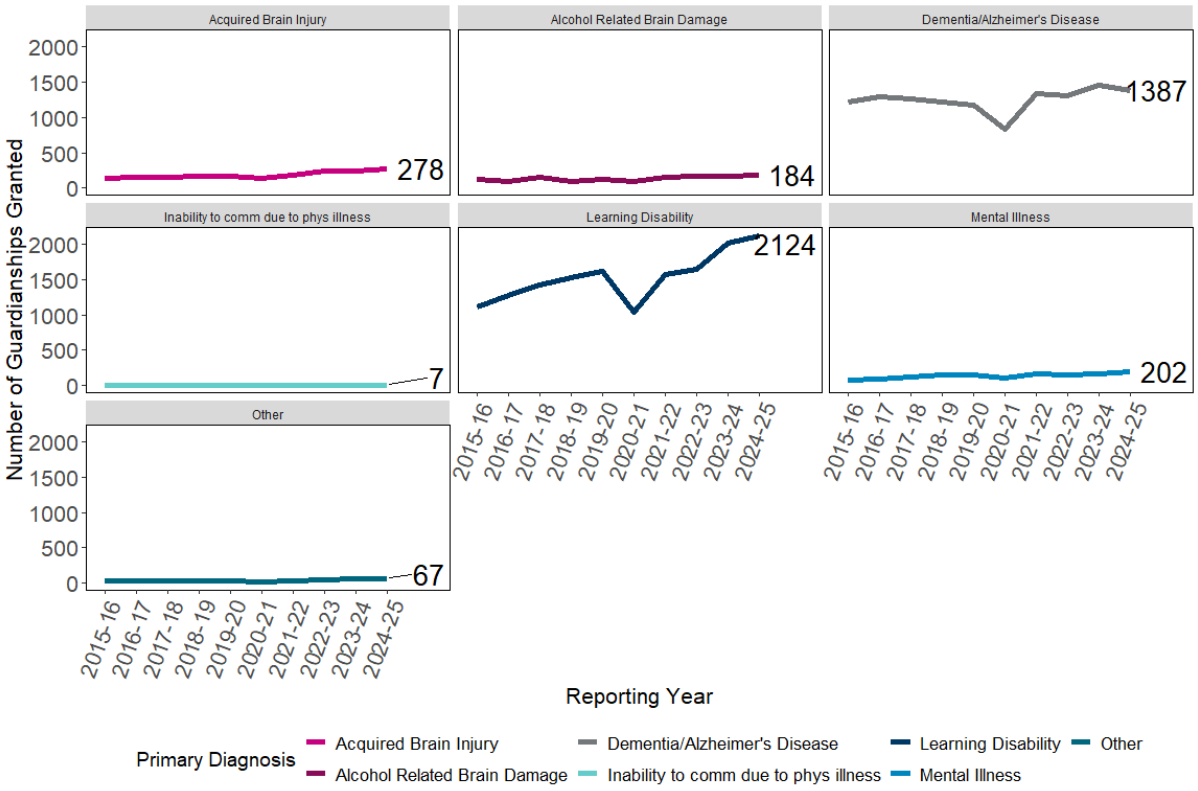
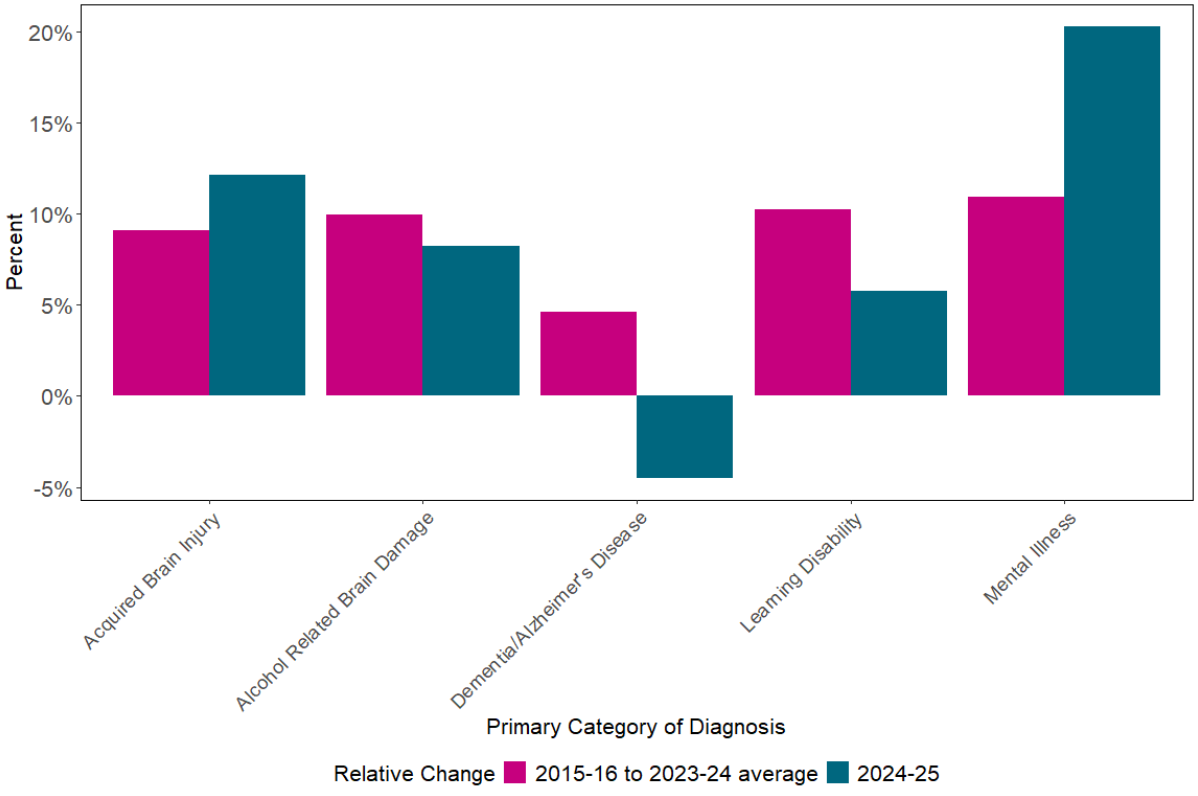


Figure 6. Relative change in number of granted orders by primary diagnosis



Guardian type

The type of guardianship order varies by category of diagnosis (Table 2); alcohol related brain damage and mental illness continue to have a higher proportion of local authority guardianship orders compared to private guardianship orders.

Table 2. Private and local authority guardianship orders by primary diagnosis 2024-25

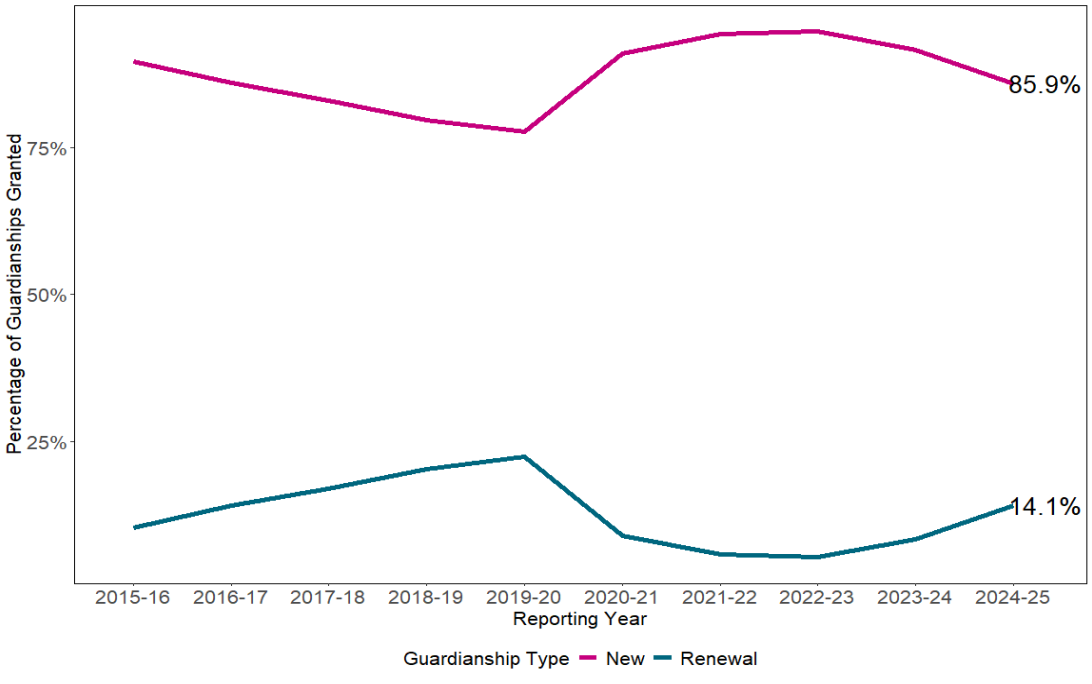
Category of diagnosis	Local authority	Private
Acquired brain injury	70 (25.2%)	208 (74.8%)
Alcohol related brain damage	117 (63.6%)	67 (36.4%)
Dementia/Alzheimer's disease	448 (32.3%)	939 (67.7%)
Inability to comm due to physical illness	0 (0.0%)	7 (100.0%)
Learning disability	446 (21.0%)	1678 (79.0%)
Mental illness	146 (72.3%)	56 (27.7%)
Other	24 (35.8%)	43 (64.2%)
Unknown	17 (33.3%)	34 (66.7%)

Guardianship renewals

The majority (85.9% n= 3,694) of guardianship orders granted in 2024-25 were new orders while 14.1% (n=606) were renewals of existing guardianship orders (Figure 7), a higher percentage than last year (revised figure of 8.4%).

From 2019-20 to 2022-23 there was an increasing trend in new orders and a corresponding decline in renewed orders. However, this appears to have started to reverse, similar to the trend seen before 2019-20, where year-on-year we saw a growing proportion of renewals and a corresponding decrease in new orders granted in previous years (Figure 7).

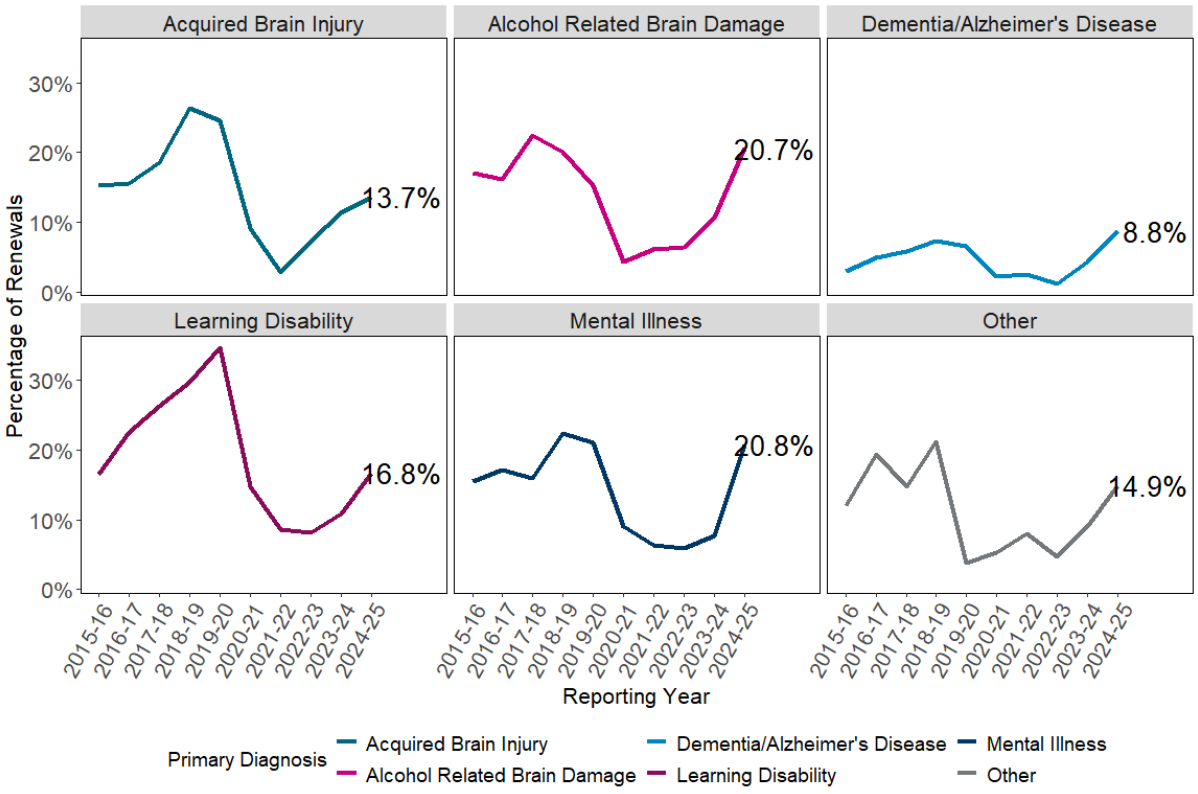
Figure 7. Proportion of new and renewed orders, by year



In 2024-25 there were a total of 606 renewals, compared with a revised figure of 345 renewals in 2023-24. Of the 606 renewals in 2024-25, 58.7% (n=356) were in relation to people with a learning disability, 20.1% (n=122) for people with dementia/Alzheimer's Disease and 6.9% (n=42) were in relation to people with mental illness (Appendix Table A6). The percentage of renewed orders by age, gender and year can be found in Appendix Table A7.

Figure 8 shows the percentage of orders granted as renewals (compared to new orders) by diagnostic category over a 10-year period, the percentage of orders granted as renewals has increased slightly in all categories. There were no renewals where diagnosis was unknown and there were no renewals where primary diagnosis was inability to communicate due to physical illness.

Figure 8. Percentage of orders granted as renewals by primary diagnosis and year



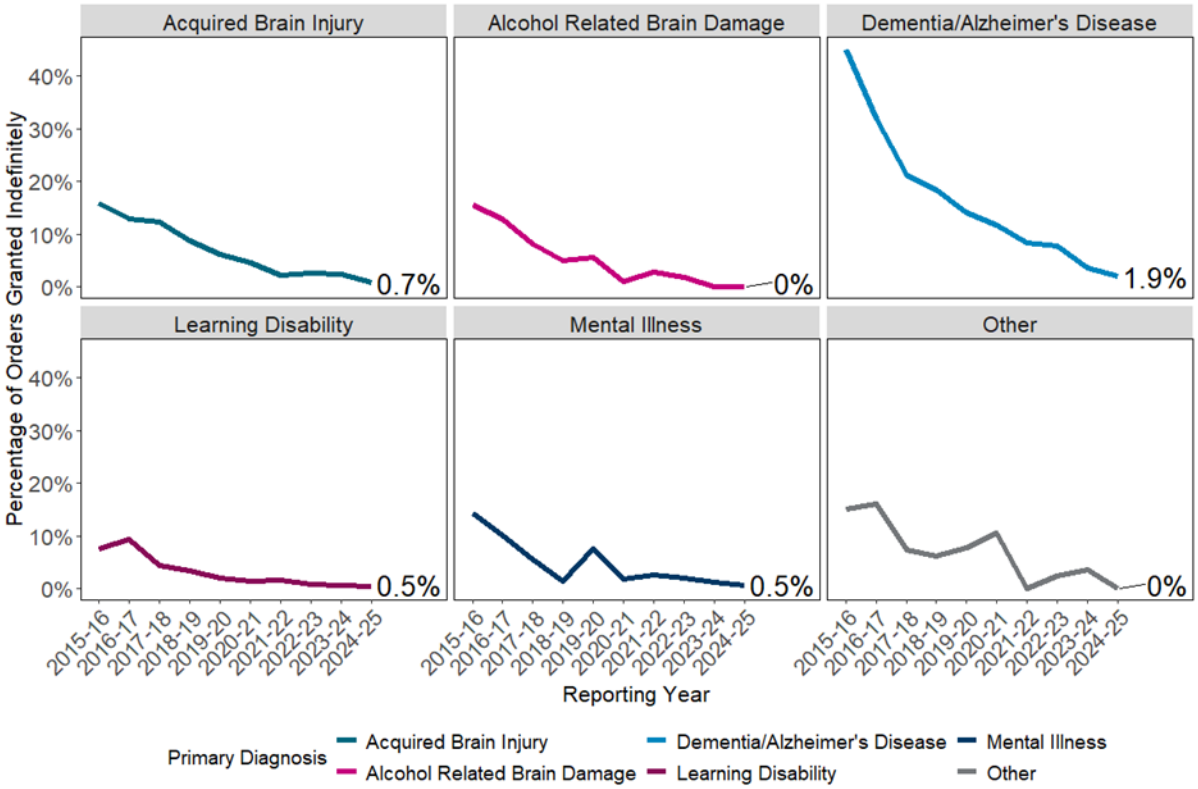
Indefinite guardianship orders

The Commission once again reiterates that an indefinite order may be appropriate in some specific individual cases, for example, an elderly person with an advanced dementia. In other circumstances, we do not believe that indefinite orders are good practice or consistent with the principles of the AWI Act. Indefinite orders potentially breach Article 5 of the European Convention on Human Rights (ECHR)[4], where indefinite guardianship orders are used to authorise deprivation of liberty. European case law makes clear that there is a need for regular review of any restriction of liberty.

The Commission therefore welcomes the continued progress in addressing the issue of the length of time for which guardianship orders are granted. Overall, the proportion of indefinite guardianship orders has declined to its lowest level in the last 10 years, from 25.5% in 2015-16 to 1.0% in 2024-25. In the 25-44 age group there was a very slight increase in indefinite orders from 0.4% in 2023-24 to 0.7% in 2024-25 however this is small and there is an overall decrease over the 10-year period. All other age groups saw a decline in indefinite guardianship orders across all age groups over time (Appendix Table A8), most starkly seen in the over 65 years group, from 43.5% in 2015-16 to 1.8% in 2024-25. The declining use of indefinite orders may be a factor in the increasing use of renewals of guardianship.

The decline in the use of indefinite orders over the last 10 years across all primary diagnosis categories is shown in Figure 9. The starkest decline in the use of indefinite orders is seen in the dementia category, dropping from 45.0% to 1.9% of guardianships, its lowest figure in the last 10 years. Once again, we welcome this decline as the need for regular review of restriction is not diagnosis dependent.

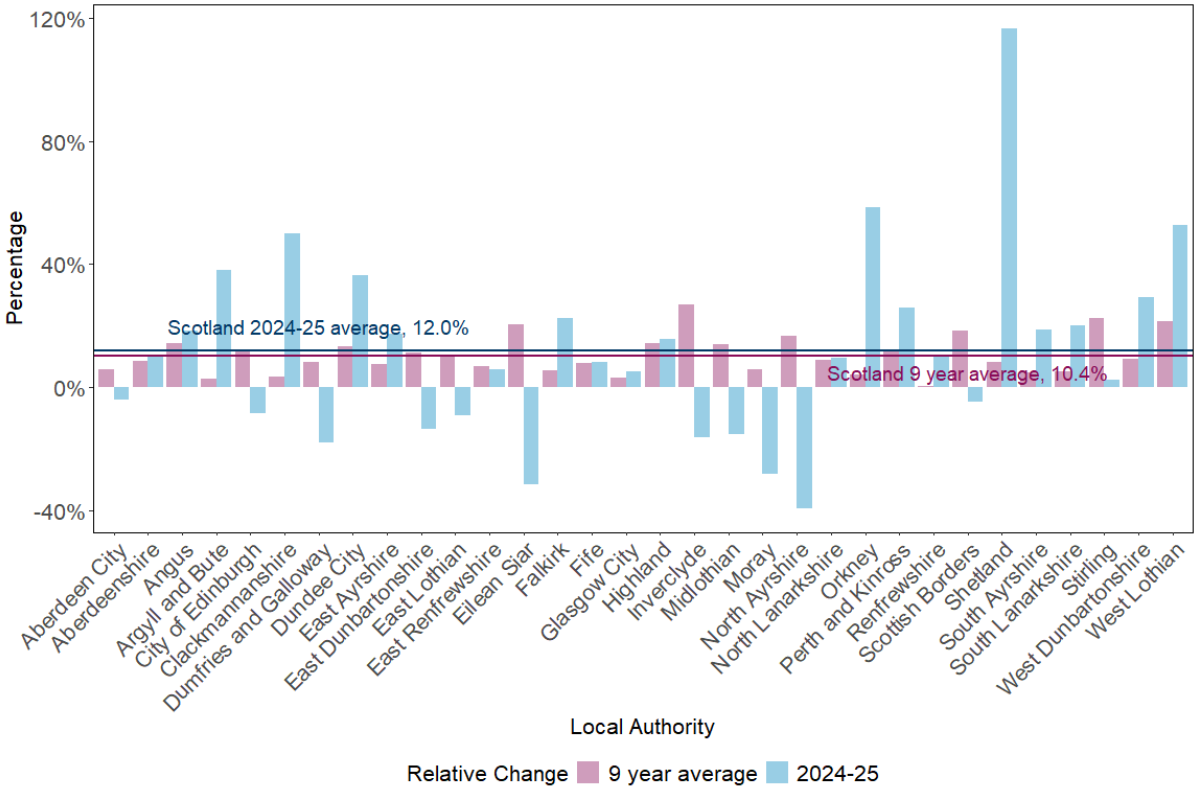
Figure 9. Percentage of orders granted indefinitely, by primary diagnosis and year



Geographical variation in number of granted guardianships

The number of guardianship orders granted in 2024-25 for each of the local authorities in Scotland are presented in Appendix Table A9. Figure 10 shows the average year-on-year change between 2015-16 and 2023-24 and then the change in 2024-25. The change over the more recent year was slightly higher than in the previous years, 12.0% compared to the 10.4% average.

Figure 10. Average year-on-year change (2015-16 to 2023-24) in number of granted guardianships and change between 2023-24 and 2024-25 by local authority

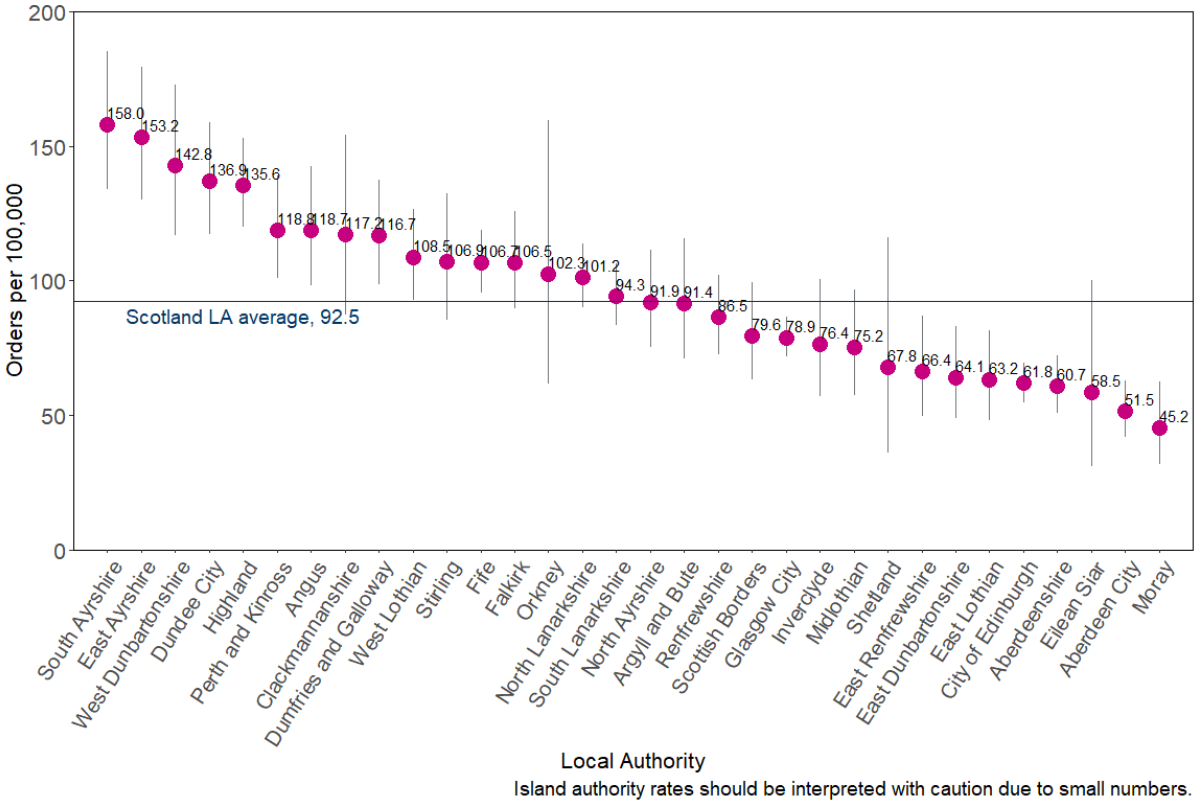


The overall rate of granted guardianship orders in 2024-25 was 92.5 per 100,000 population in Scotland[2]. The rate varies between local authorities (Appendix Table A10), with the highest rates in South Ayrshire (158.0 per 100,000), East Ayrshire (153.2 per 100,000) followed by West Dunbartonshire (142.8 per 100,000). Note: this is a crude rate and does not take into account the age structure of the local authority area.

Figures 11a and 11b provide an 'at a glance view' of guardianship rates across Scotland and where the rate is higher or lower in different local authority areas according to the national rate.

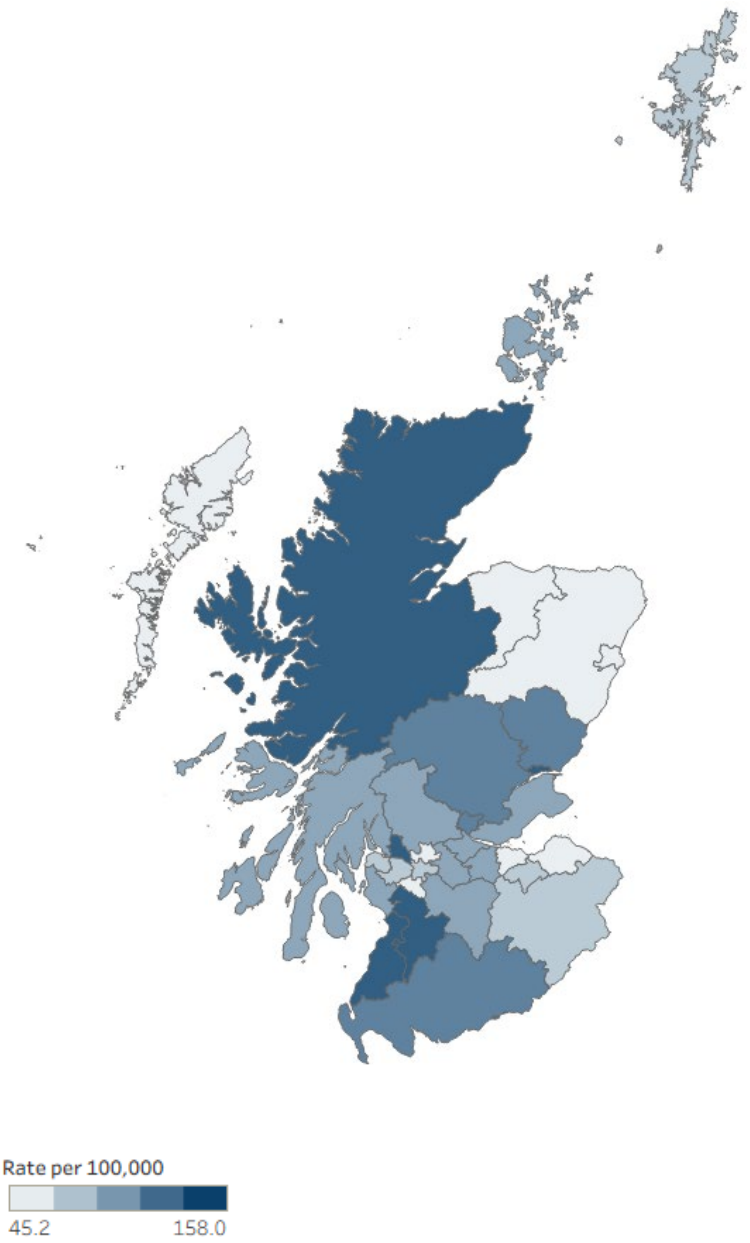
[2] The rate is calculated by taking the overall number of guardianships granted in Scotland divided by the over 16 population in Scotland and multiplied by 100,000

Figure 11a. Rate of granted guardianship orders (new and renewed) in 2024-25 per 100 000 population (≥16 years) with 95% confidence intervals[3] by local authority



[3] 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.

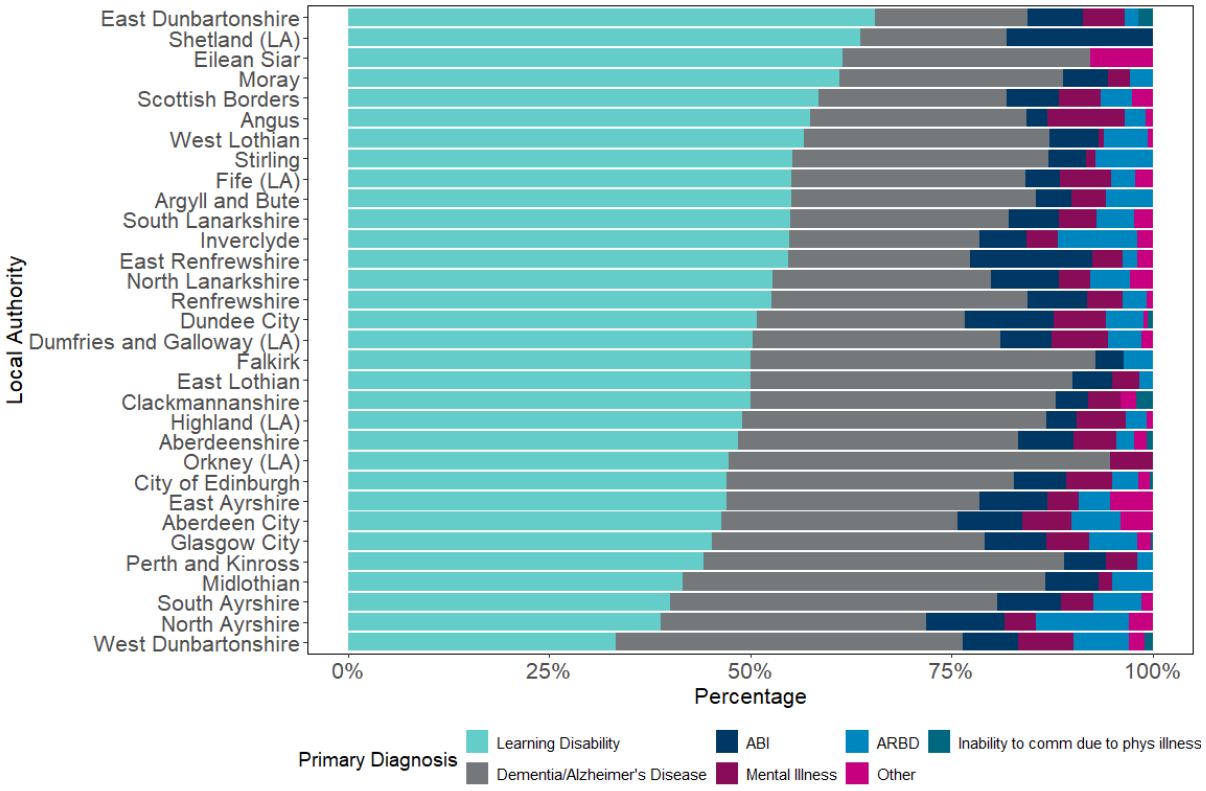
Figure 11b. Map of Rate of granted guardianship orders (new and renewed) in 2024-25 per 100,000 population (≥16 years) by Local Authority



Local Authority	Crude Rates
South Ayrshire	158.0
East Ayrshire	153.2
West Dunbartonshire	142.8
Dundee City	136.9
Highland	135.6
Perth and Kinross	118.8
Angus	118.7
Clackmannanshire	117.2
Dumfries and Galloway	116.7
West Lothian	108.5
Stirling	106.9
Fife	106.7
Falkirk	106.5
Orkney	102.3
North Lanarkshire	101.2
South Lanarkshire	94.3
Scotland	**92.5**
North Ayrshire	91.9
Argyll and Bute	91.4
Renfrewshire	86.5
Scottish Borders	79.6
Glasgow City	78.9
Inverclyde	76.4
Midlothian	75.2
Shetland	67.8
East Renfrewshire	66.4
East Dunbartonshire	64.1
East Lothian	63.2
City of Edinburgh	61.8
Aberdeenshire	60.7
Eilean Siar	58.5
Aberdeen City	51.5
Moray	45.2

Figure 12 shows the guardianship orders by primary diagnosis category granted in each local authority area in 2024-25. Further information by local authority areas can be found in Appendix Tables A11, A12 and A13.

Figure 12. Guardianships by primary diagnosis category as a percentage of the total guardianships granted in each local authority area in 2024-25



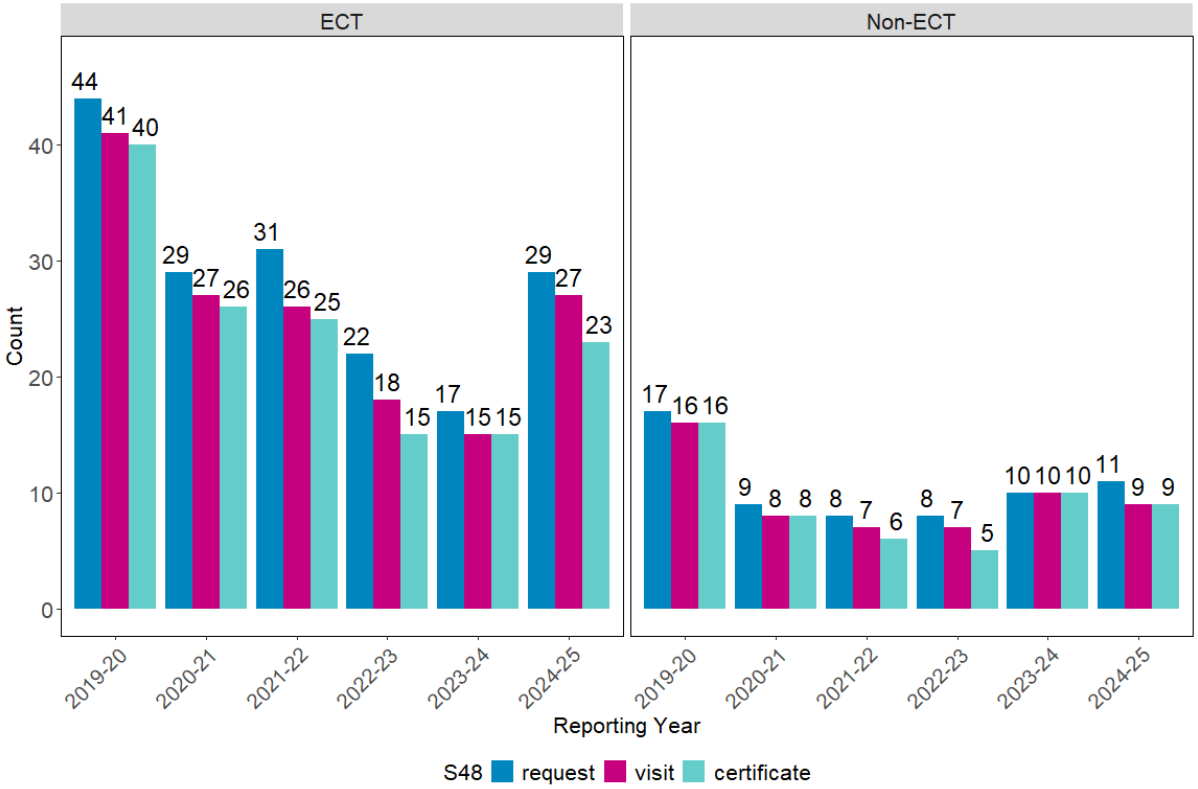
Medical treatment

The Commission has a responsibility under the AWI Act to provide independent medical opinions for treatments that are not covered by the general authority to treat (section 47).

These specific treatments are regulated under section 48, for example, electro-convulsive treatment (ECT)[5]. In addition, where there is a welfare proxy with the power to consent to medical treatment, and there is disagreement in the treatment between the proxy decision maker and the treating doctor, the doctor can request that the Commission nominate and arrange an independent medical opinion by an appropriate specialist to resolve the dispute. These provisions are in section 50 [1]. In 2024-25 there were fewer than 5 requests for an independent second opinion doctor visit under section 50, this figure is similar to previous years.

In 2024-25 there were 40 requests for a section 48 visit for which 36 visits took place. This is higher than the figures in 2023-24 (Figure 13). The increase was mostly seen in requests for ECT while non-ECT requests are similar to last year.

Figure 13. Number of section 48 requests, visits and certificates issued by year



For both requests and visits this year, the majority were for electro-convulsive therapy (ECT), with the remaining for drug treatment to reduce sex drive (Table 3).

Table 3. section 48 requests and certificates issued for treatment

Treatment	Requests	Visits [a]	Certificates [b]
Medication to reduce sex drive	11	9	9
ECT	29	27	23
Total	**40**	**36**	**32**

[a] Where a section 48 visit does not go ahead after a request, this may be for one of a number of reasons e.g. the person's circumstances change or there is clinical improvement and the treatment is no longer necessary, or they require treatment under the Mental Health Act.

[b] In cases where an independent section 48 doctor visited and did not issue a section 48 certificate this may be due a clinical improvement such that they no longer considered that the proposed treatment was necessary.

Part 2: Guardianship visits

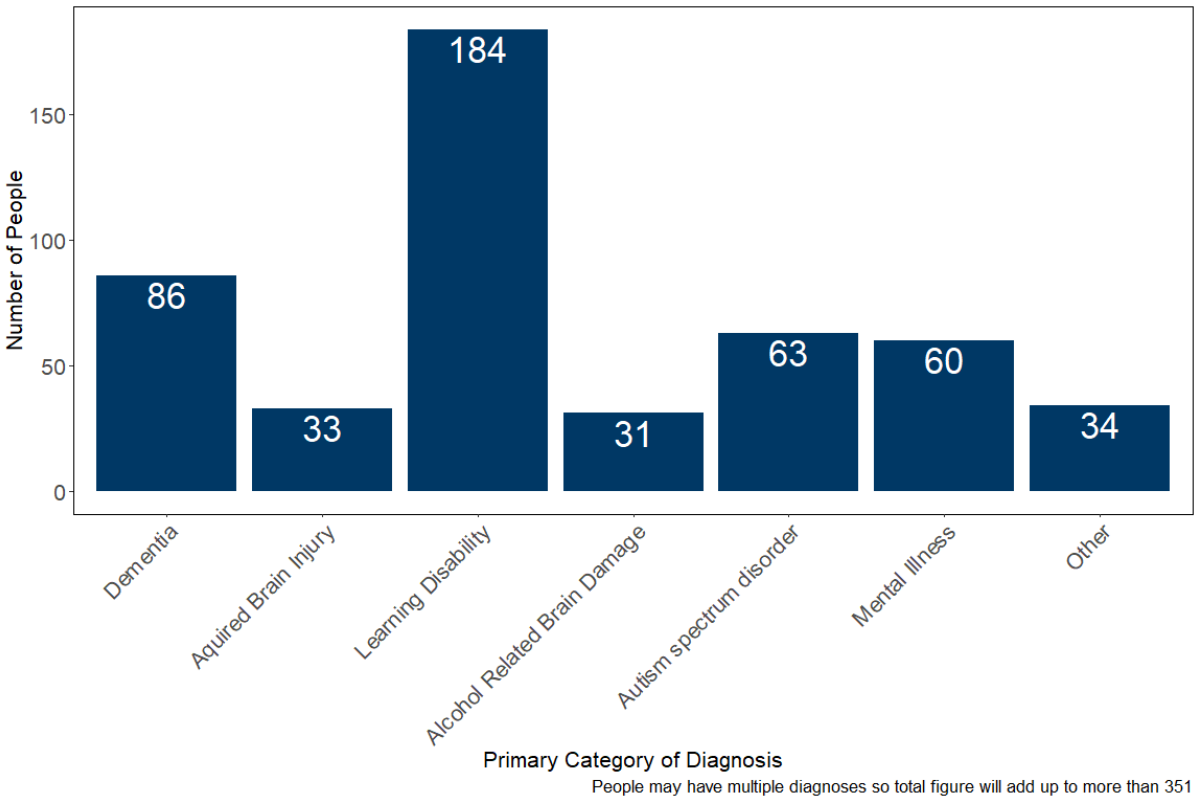
Our visits

During 2024-25 we visited 351 individuals on a guardianship order, 7.3% more than in 2023-24. There were an additional 15 visits that our staff attended but were cancelled on the day, due to the person being unwell, attending another appointment etc. 96.6% of visits were in person, most were routine visits (87.2%, n=306), while 9.7% (n=34) were due to concerns that had been raised.

This year we visited a slightly higher proportion of people with private guardianship orders (52.4%, n= 184) than local authority guardianship orders (39.9%, n=140).

Out of the 351 individuals we visited, 16.5% (n=58) lived with their guardian, while 76.6% (n=269) did not (6.8%, n=24 this information was not recorded). Figure 14 below details the diagnostic groups of the people we visited.

Figure 14. People we visited who were subject guardianship orders in 2024-25 by category of diagnoses



We asked the individuals and their guardians about how they felt the guardianship order was working. For some people we visited we were unable to gather their individual views due to the type and stage of their illness.

The range of views that Commission staff did hear and reported on included:

"She appears to be much happier in her new accommodation with the current care and support. She feels a sense of freedom and although there are restrictive powers in place, it does not appear that these are having to be exercised on a daily basis. There was clear evidence that…has more opportunity to socialise and go out and about in the community, which is important to her."

"This was a positive visit…he took pride in showing me his bedroom and there was good evidence of access to the community and activities for him, via his family. There has been a risk of harm, but the guardian and family members have worked with him to encourage him to think through the risks of any given situation. When this has not been successful, the powers in the guardianship order have been required to ensure his safety".

For others, the views gathered from the individual or the guardian identified that further actions may be required:

"His father and sister are joint welfare and financial guardians. His father was not clear who the supervising officer was or whether a review would be taking place. The guardian had a good understanding of the Adults with Incapacity Act, has participated in many committees, charities and support groups (including parent support groups) for the residents of the supported accommodation that his son stays in. He told me that he wasn't keen on the changes to the support staff and felt that he had to "educate" the team as they were not provided with the training in AWI. He did say that he feels that his son is happy and content and that was important to the family".

"His sister had been concerned about some environmental issues that needed to be attended to. She feels that the guardianship order has enabled her to take this forward on behalf of her brother to ensure he lives in a comfortable and homely environment".

Overall, for the majority of our visits, we heard that the guardianship order and use of associated powers, when required, impacted positively on outcomes.

Accommodation and living circumstances

46.4% (n=163) of our visits were to a registered care home, 21.1% (n=74) were to people living in supported tenancies, 22.2% (n=78) took place in the family home, and 4.6% (n=16) were hospital-based visits, the remaining people were in other types of settings, or we weren't able to establish living circumstances.

We undertook 351 visits and provided advice/took action in relation to 283 of these visits. Of the 283 occasions, 5% (n=15) related to accommodation and/or the person's individual living circumstances.

Mr A

We visited Mr A and found a gap in powers detailed in the guardianship order which was not due for renewal for another four years.

We noted that no tenancy agreement was in place for Mr A who was living in a property owned by a relative. There were also questions about benefit entitlement.

We followed up with the allocated social work officer and the welfare guardian and discussed Mr A's rights, including to advocacy support, to ensure Mr A's views were captured regarding his current accommodation and any future move he may wish. We also asked that the guardianship powers in place be revisited with legal advice to determine whether an early review was indicated. The Commission has developed guidance for individuals and guardians in relation to tenancies.

Mr B

During a guardianship visit to Mr B, we heard that both Mr B and his brother (his welfare guardian) were unhappy with Mr B's living arrangements in a care home. Both advised that either shared accommodation, ideally with one or two people, or an assisted living tenancy would provide a more homely environment, like the one Mr B had shared with his parents.

While no longer living with his parents, Mr B still enjoyed a busy lifestyle with them although some of the clubs he used to attend had not reopened since the pandemic.

Mr B's multidisciplinary team assessed that Mr B required care over a 24-hour period, seven days per week. Mr B is, however, currently working on his independent living skills and learning how to safely manage so that in future he may not require this level of support. Feedback from the keyworker and Mr B's social worker is that finding a placement that meets his needs has been a challenge.

The Commission welcomes the action being taken to source an alternative placement for Mr B and we will keep in touch with the social worker involved to see how this is progressing.

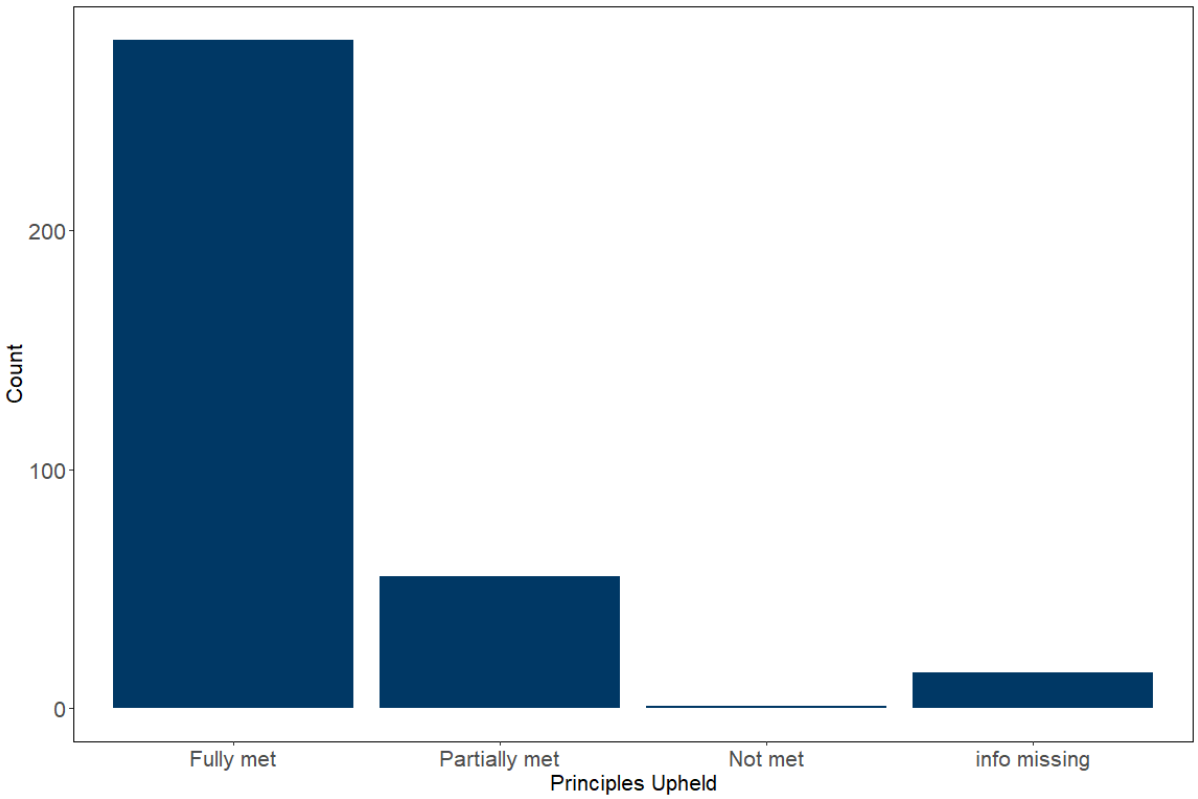
Mr C

The Commission's visit to Mr C highlighted concerns about aspects of his living circumstances that included the lack of personalisation in his bedroom. It appeared that Mr C had had to share his bedroom space with another member of the family. The bedroom had items that did not belong to Mr C and the room was not personalised to his individual preferences and interests. We also noted that the bathroom that Mr C used did not have the facility to be locked and needed cleaning and repair; we considered that the issues with the bedroom and bathroom were likely to have an impact on Mr C's privacy and dignity.

We advised the welfare guardian to address the repair issue with the bathroom and requested that steps be taken to provide a space for Mr C where his individual needs could be better met. We recommended to the local authority that a supportive review be completed with the welfare guardian and a copy shared with the guardian and the Commission. We look forward to receiving this in due course.

For each visit undertaken, we evaluated the individual's situation in relation to the overall principles of the AWI Act (see box 1). We found that 79.8% (n=280) guardianship orders fully met the five principles similar to the proportion last year (80.1%) (see figure 15), 15.7% (n=55) partially met the principles, the principles were not met in one visit (we remain involved and are continuing to follow up) and we were unable to ascertain this in 4.3% (n=15) of the visits we made.

Figure 15. Principles upheld



Person-centred care plans

During a guardianship visit we review any available care plans. We expect care plans to describe the care, treatment, and support available and to reflect the person's hopes and aspirations as a unique individual. Care plans should be person-centred and inclusive. Of the 295 care plans we reviewed, 75.5% (n=265) were person-centred, slightly lower than the 80.4% seen last year.

Advice was given about the quality and detail of care plans on 6% (n=16) of our visits, with specific action required in a further 4% (n=12) of these.

Mrs D

During a visit to Mrs D, it was evident that she required 24-hour care in a care home setting to meet her assessed care and support needs. The Commission were not satisfied with aspects of the care plans and the care being provided in the setting where she lived, however. As part of a series of follow up actions, the Commission contacted the Care Inspectorate (CI) in relation to concerns; this led to a follow up visit from the CI who found that practice did not always meet health and social care standards and that further work was needed to ensure that personal plans accurately reflected care needs and preferences. The CI's findings went on to state that management must have a better overview of staff practice, incidents and accidents and quality assurance.

The Commission has continued to remain involved and has completed a subsequent follow up visit to Mrs D.

Ms E

Ms E has been known to psychiatric and social work services for a number of years. She has a complex history that had had a significant impact on her life where she, her family and her neighbourhood could be at risk due to her extreme behaviours. The guardianship order was assessed as necessary to ensure that Ms E's overall health and wellbeing were monitored and risks were managed appropriately. The Commission's review of the evidence about the care and support provided did not provide assurance of monitoring or specific health screening. Additional feedback on improvements also related to quality of care planning and risk assessment.

Meaningful activity

We found an individualised programme of meaningful activity in place for 77.2% (n=271) of the people we visited, similar to the figure in 2023-24. For 13.7% (n=48) we found that this was not the case. For the remaining individuals (9.1%, n=32), there was limited information provided about their day-to-day routine.

Ms F

We heard that Ms F required support 24 hours a day, seven days a week. The guardian told us that while she accepted that her daughter would never "recover", she had made "great strides" in terms of having opportunities to engage in activities that had purpose. Ms F, who was unable to communicate verbally, had a range of professionals supporting her rehabilitation and her family ensured she maintained connections with her community.

Ms G

In contrast, Ms G, told us that she was "bored" and "fed up of being stuck indoors". Principle 5 of the AWI Act focuses on encouraging the adult to exercise their existing skills and to develop new skills. There was little evidence of pro-social activities, with the only activities Ms G regularly engaged in being some online chats, watching Netflix, reading or vaping. Following on from our visit, where the action recommended by the Commission was that there should be supervision of the guardian and a review of social activities by the guardian and the health and social care partnership (HSCP), the allocated social work officer met with Ms G and her guardian, and there were plans to engage support workers and a possible respite placement to build Ms G's activities around her personal care, cooking and community activities.

Guardian supervision and contact

Under the AWI Act, four public bodies are involved in the regulation and supervision of those authorised to make decisions on behalf of a person with incapacity:

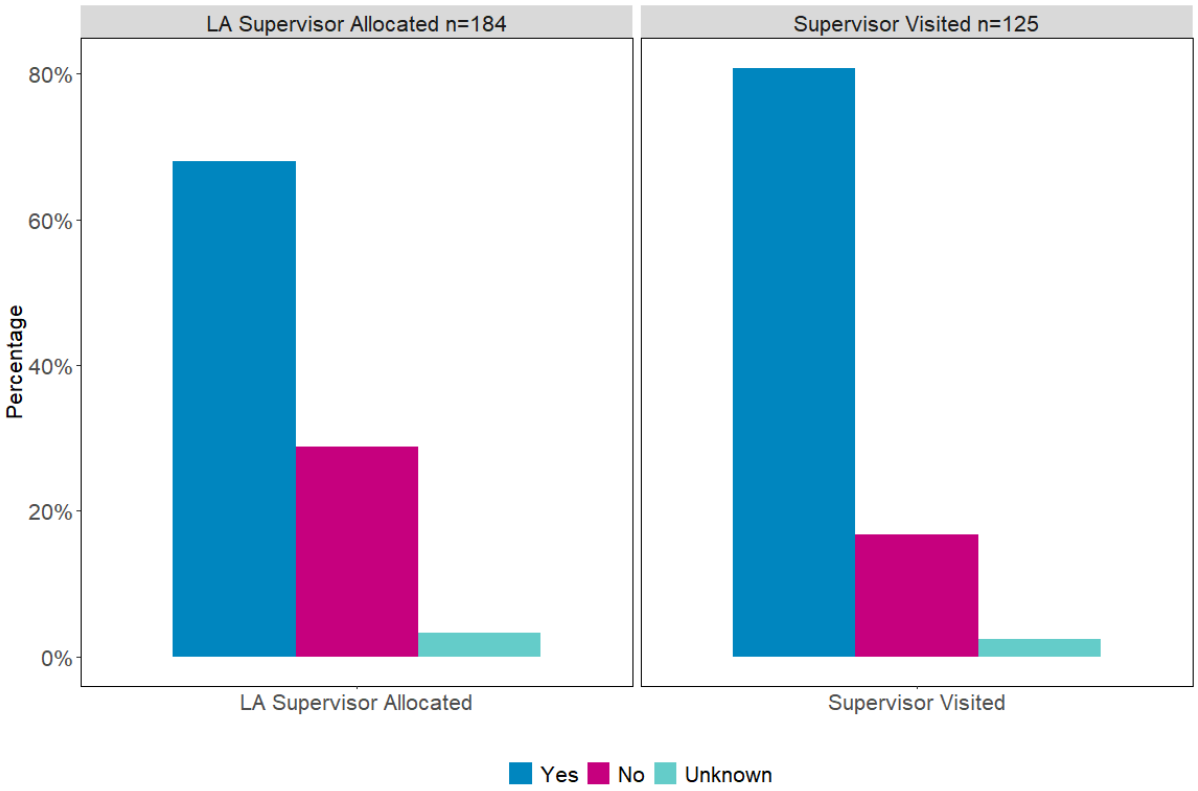
- the Office of the Public Guardian (Scotland),
- the Commission,
- the courts, and
- local authorities.

According to the AWI Act, local authorities must fulfil certain duties in relation to people who are on welfare guardianship orders:

"A local authority shall have the following general functions under this Act to supervise a guardian appointed with functions relating to the personal welfare of an adult in the exercise of those functions" [1].

We expect all individuals we visit on a private guardianship order to have a local authority supervising officer allocated. Of the 184 individuals we visited who were on a private guardianship order, 67.9% (n=125) had a local authority supervising officer allocated, 28.8% (n=53) did not and we were missing this information for 3.3% (n=6). In chart 16, for the 125 people under private guardianship where an officer was allocated, 80.8% (n=101) of individuals had received a visit in the past six months, 16.8% (n=21) had not. There was no information for the remaining people.

Figure 16. Allocation and supervision of guardianship order



The interpretation of supervision comes via codes of practice or statutory instruments which explain how powers should be used. Support and supervision requirements of private welfare guardians changed in 2014; this allows local authorities to consider reducing or ceasing visits where all parties are in agreement[6]. There is scope for local authorities to cease or vary private guardian statutory supervisory requirements (on a case-by-case basis) under the Adults with Incapacity (Supervision of Welfare Guardians etc. by Local Authorities) (Scotland) Amendment Regulations 2014, which applies only in situations where the local authority has no concerns about the operation of the private welfare guardianship order. The Commission must be formally notified of any cease or vary agreements. We have produced an advice note in relation to the cease and vary arrangements that is available on our website[4].

During our visits we seek to gather information regarding how often the appointed guardian has visited the person and we follow up on an individual basis where indicated. In 2024-25 we continued to advise and require follow up action on the need to ensure that there was an allocated supervising officer and that a timely review of the guardianship order was carried out.

We have again written to local authorities to request an updated record of the names and contact details of the delegated officer who is acting as guardian on behalf of

[4] https://www.mwcscot.org.uk/sites/default/files/2025-07/Cease-and-Vary_AdviceNote_2025.pdf

the chief social work officer (CSWO) or supervising a private guardian. We have received responses from all local authorities.

Through continuing our proactive approach, we aim to ensure there are no gaps in allocation of these key roles to ensure responsibilities and duties of the welfare guardian/supervisor are being fulfilled as per the court order granted.

Rights and restrictions

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is a comprehensive convention of human rights for people with disabilities. The Convention "adopts a broad categorisation of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms"[7].

During our visits, we look for examples of the principles of the AWI Act and of rights in line with the UNCRPD to demonstrate the adult is supported to exercise their rights, wherever possible, in relation to all aspects of their lives. This might include elements of supported decision making to allow them to participate and make the decisions they are able to make for themselves.

Mr H

The Commission's visit to Mr H found that the restrictive powers that were in place when the guardianship order was granted in 2017 remained relevant and provided the required legal authority to support him in the best way possible; there were no powers in place that were not being exercised as part of his support.

The environment Mr H was living in was specifically designed for individuals with complex needs associated with a learning disability (LD) and/or autistic spectrum disorder (ASD), with staff knowledgeable and trained in the use of positive behaviour support (PBS).

While it was clear that the order supported Mr H living in the community, in his own home with his own staff team, he required intensive support to manage his levels of anxiety. This was managed with a combination of medication, a restrictive reduction plan, crisis intervention and proactive strategies. There were practice logs kept when restrictions were applied, explaining how the restrictions were authorised and reviewed, although the visit identified that more detail was required and needed to be linked to the powers set out in the order. Although the welfare guardian had provided signed consent in relation to the use of physical restraint, the document required updating.

Advice from the Commission included a review of the restrictive practice logs and care plans to ensure they included more detailed information and for the service to link in with the nearest NHS learning disability team.

Medication and section 47 certificates

The *Code of Practice* [8] and Commission guidance [9] are clear in relation to the use of section 47 certificates. Where an individual does not have the capacity to consent to the treatment they require, a doctor should formally assess their capacity and, on finding someone incapable of consenting, complete a certificate. Where this treatment is complex, they should complete a treatment plan. If a certificate is not done, then the treatment given is unlawful.

If there is a proxy decision maker, namely a welfare guardian or someone acting as a welfare power of attorney (POA), then the medical practitioner should also discuss the treatment with them. There is a clear space on the certificate for the doctor to put the name of the proxy decision maker. Care staff should assist the doctor in identifying the proxy decision maker from records and their knowledge of the adult.

Most individuals we met (82.9%, n=291) had medical powers granted within the guardianship order, 10.3% (n=36) did not and we did not have information for 6.8% (n=24). A section 47 certificate was required for 74.4% of those individuals (n=261) (17.9% (n=63) did not require one and we did not have information on 7.7% (n=27). Of those who required a section 47 certificate (n=261), the majority (83.9%, n=219) had one in place. However, 13.4% (n=35) of the people we met with did not have authority in place to provide treatment and that is a concern, we had no information on a further 2.7% of people (n=7).

Where we consider that a section 47 should be in place, we can either advise that this be progressed on the day of our visits, or we can ask that action be taken to ensure that the authorisation is given for the certificate, which should then be put in place along with the treatment plan identifying which treatments the adult does not have capacity to make decisions about.

For the 219 individuals for whom a section 47 certificate was required and in place, 97.3% were appropriate (n=213), 73.5% (n=161) had a treatment plan, higher than the 59.9% last year. However, 24.2% (n=53) did not have one in place and we were missing information for 2.3%, n=5). In 67.1% (n=147) of cases the guardian was consulted about the section 47 certificate, higher than the 58.5% seen last year. In 8.7% of cases (n=19) the guardian was not consulted, in 18.7% (n=41) it was not clear whether consultation with the guardian had taken place, and we were missing information in 5.5% of cases (n=12).

Mr J

A Commission visit to Mr J in a care home highlighted that the section 47 certificate in place related to his care and treatment in a previous setting (hospital). There was no record of a consultation with the guardian/proxy decision maker, no treatment plan and the interventions noted in the certificate were not documented in any care record. There was also a do not attempt cardiopulmonary resuscitation (DNACPR) form, and again a lack of information about whether consultation with the guardian/proxy decision maker had taken place. There was also no review date.

After the visit, the Commission visitor contacted the delegated guardian to update them of the outcome of the visit and to take forward the actions relating to their delegated powers.

Do not attempt cardiopulmonary resuscitation (DNACPR)

If an individual lacks capacity to make some or all decisions, the principles of the AWI Act apply. In those circumstances where applicable, intervention with cardiopulmonary resuscitation (CPR) should be considered if it is likely to be of overall benefit for the individual. If the clinical opinion is that there would be no benefit, then a do not attempt CPR (DNACPR) decision is appropriate. The past and current views of the individual, if known, must be considered and there is a duty to consult relevant others and ask if there is any valid advance directive which should be assessed to see if it is applicable. Proxy decision-makers, i.e. welfare attorney/welfare guardian must be involved in the process as they would have the same power to consent or refuse consent to a medical intervention as a capable individual would [10].

Of the people we visited, a DNACPR was in place for 24.2% of people we visited (n=85) and 63.25% of people did not have this (n=222). In 12.5% cases information about whether a DNACPR had been put in place was missing or not recorded (n=44). These figures are similar to last year. Where we found a DNACPR in place, the welfare guardian was consulted in 70.6% of cases (n=60), lower than the 77.8% last year, and not consulted in 23.5% (n=20). It was unclear whether the guardian was consulted for 5.9% (n=5).

Finances

The AWI Act provides arrangements for making decisions and taking actions to safeguard the personal welfare, property, and financial affairs of adults whose capacity to do so is impaired. Part 6 allows for an application to be made to the court for:

- An intervention order authorising a person to take action, or make a decision, on which the adult is incapable.
- An order appointing a person or office holder as guardian in relation to the adult's property, financial affairs, and personal welfare.
- An order appointing a person or office holder in relation to a child who will become an adult within three months, but such an order will not have effect until the person's 16th birthday.[1]

Practical guidance around financial guardianship is outlined in our guidance *Money Matters* [11]. We reviewed the management of an individual's finances on all our visits during 2024-25. A financial guardian (48.2% n=169) or Department for Work and Pensions (DWP) appointee (39.0% n=137) were responsible for finances for most people. In a few cases it was the adult themselves with or without support (2.8%, n=10). Financial authority Part3 and Part4 (4.3%, n=15) were also stated. There were very few cases where a financial power of attorney handled the finances. The majority of individuals were assessed as having sufficient access to funds (85.5%, n=300).

Following on from some of the visits where advice was given, or action was required in relation to an individual's finances, we found that while there were some examples of finances being used to support care and treatment, there were others where we were concerned, and escalated these accordingly.

Mr K

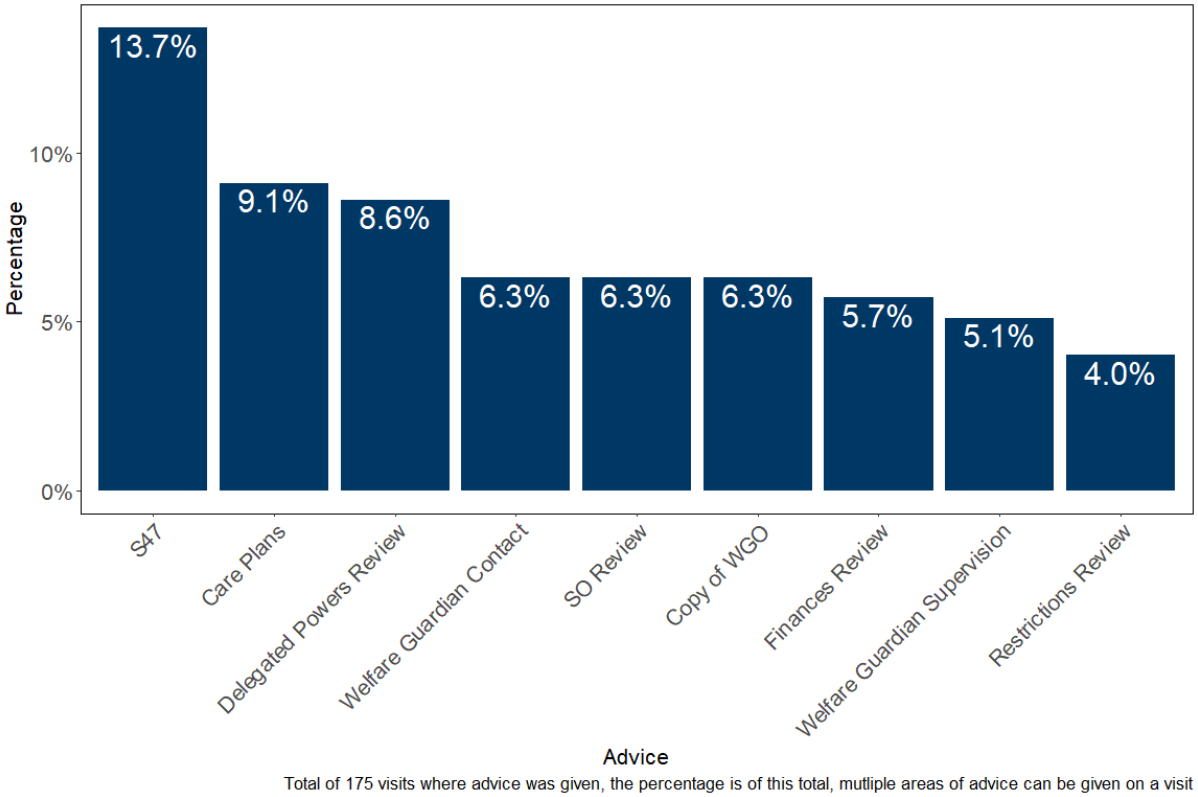
The visit to Mr K raised significant concerns. We were provided with evidence of neglect, poor housing circumstances and reports from the care providers that Mr K's presentation at the day centre had already raised some questions as to whether the guardian was adhering to the principles of the AWI Act. There was evidence of financial harm and a question about the spending on items to the value of £9000; the local HSCP were in the process of investigating the concerns. The Commission has requested immediate supervision of the guardian, investigation into the aspects of neglect, support for the housing association to address the poor living conditions and we remain in contact with the local authority and the day centre team regarding Mr K.

Specific advice given by the Commission[5]

Either at the time of a guardianship visit, or after we have completed one, the Commission may follow up with any questions we have in relation to our findings. We also monitor this activity as part of our own internal governance, and in the past, this has led to further work being identified such as our good practice guidance, or a themed visit.

Of the 351 visits we completed during 2024-25, advice on more than one area was given in 50.0% (n=175) of those visits. The most frequent topics for advice are shown in Figure 17.

Figure 17. Most frequent areas of advice given



Other topics included:

Advice on the use of the Commission's good practice guides, review of activities, advice with risk assessment, input needed from a specialist team, review of self-directed support, assessment of needs, copies of guardianship powers, review of discharge plans and further information required for the Commission.

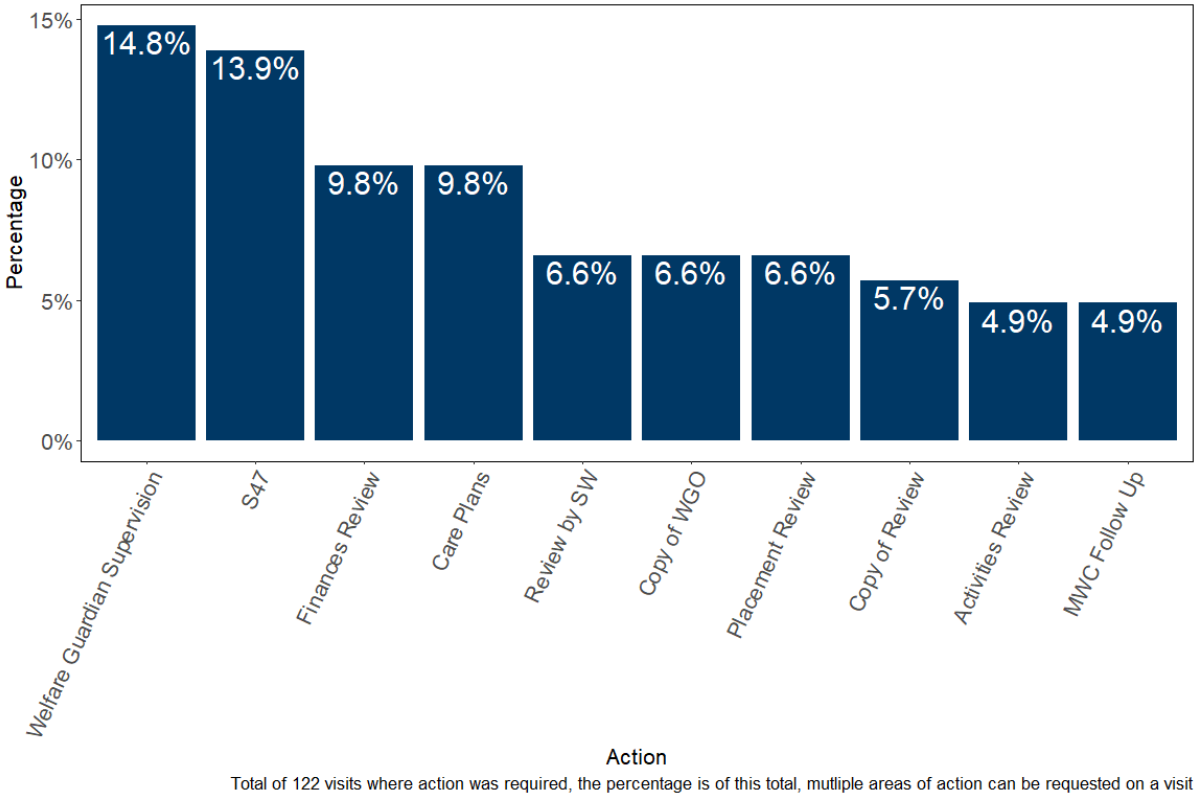
[5] The Commission provides a telephone advice line daily, Monday to Friday, and during 2024-25, 680 calls were received specifically seeking advice in relation to the AWI Act, a 16.6% decrease on the 815 calls received in 2023-24.

Action required

At times, following on from a visit and where specific advice has been given, the Commission will set out some actions to be progressed as a matter of urgency. These actions may be directed at the care provider who has delegated powers, or to the supervising officer of the guardianship order, or to other professionals involved in the person's care.

In 34.8% (n=122) of the visits where specific advice was given, we also required further action to be taken. The most frequent areas where action was required are shown in Figure 18.

Figure 18. Most frequent actions required



Total of 122 visits where action was required, the percentage is of this total, mutliple areas of action can be requested on a visit

Other topics included:

Action related to the risk assessment, review by healthcare/GP, training in AWI Act, updating the DNACPR, review of medication, assessment for carers, reviews of the package of care or the environment.

Summary

This report relates to the year 2024-25 and presents monitoring of the AWI Act and our active assessments of the implementation of the AWI Act through visiting adults and guardians.

Part one of this report provides statistical analysis and relates to critically important times in people's lives when they are unable to make some or all welfare decisions themselves and required intervention under the AWI Act to protect and promote their rights.

This year we report that there was a total of 20,152 individuals subject to a guardianship order in 2025 compared to 19,078 people in 2024. A total of 4,300 guardianship orders were granted in 2024-25, 4.1% more than in 2023-24 (based on revised 2023-24 figure n=4,131) and a far lower % than the previous year.

Our visiting programme to people subject to guardianship orders and our discussions with those undertaking key roles as care providers, guardians or supervisors of guardians highlighted recurrent themes.

We continue to find that there are issues with section 47 certificates. The Scottish Mental Health Law Review (SMHLR)[6] proposed in Chapter 13 that the Commission could oversee arrangements for a proportionate process of audit of section 47 certificates. Having secured additional resource, we are now planning to do some focused audit work in relation to section 47 certificate monitoring in 2025 and 2026 to try to understand and address this recurrent theme.

Knowledge of the AWI Act continues to be an area highlighted throughout our work but is growing thanks to the Commission's collaboration with NHS Education Scotland. The podcast 'There is no such thing as an AWI' continues to prove popular with over 3200 downloads of the 5 episodes so far and 'Crossing the Acts' is a new resource to meet learning needs identified in relation to how the three pieces of safeguarding legislation interact (relating to mental health, incapacity and adult support and protection).

At the time of writing there is once again focus on AWI Act reform with the first Ministerial Oversight Group taking place in September 2025. Our AWI Act is over two decades old and needs to take account of recommendations made in the SMHLR. We therefore welcome the Scottish Government's stated commitment to now shift towards shaping actions/implementing solutions rather than continuing to consult and talk about the need for reform.

We look forward to working with Scottish Government and stakeholders on the work progressing ensuring that adults remain at the centre of implementation of reform.

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6 (https://webarchive.nrscotland.gov.uk/20230327160310/https://cms.mentalhealthlawreview.scot/wp-content/uploads/2022/09/SMHLR-FINAL-Report-.pdf)

Appendix A - Glossary

ABI	Acquired Brain Injury
ARBD	Alcohol-related brain damage
AWI Act	Adults with Incapacity (Scotland) Act 2000
CI	Confidence interval
CSWO	Chief social work officer
ECT	Electro-convulsive therapy
ECHR	European Convention of Human Rights
Inability to communicate	Inability to communicate due to physical impairment, for example, Huntington's Disease
Mental Health Act	Mental Health (Care and Treatment) (Scotland) Act 2003
MHO	Mental health officer
s47	Certificate issued by a doctor where the adult cannot consent to the treatment being given
s48	Exceptions to authority to treat
s50	Medical treatment where guardian etc. has been appointed
POA	Power of Attorney
UNCRPD	UN Convention of the Rights of People with Disability

Appendix B – Data tables

Table A1. Extant guardianships in Scotland as of 31 March 2025

Category	Grouping	n (%)
Guardian	LA	4,662 (23.1%)
	Private	15,490 (76.9%)
Local authority [a]	Aberdeen City	745 (3.7%)
	Aberdeenshire	843 (4.2%)
	Angus	448 (2.2%)
	Argyll and Bute	248 (1.2%)
	City of Edinburgh	1,162 (5.8%)
	Clackmannanshire	224 (1.1%)
	Dumfries and Galloway (LA)	641 (3.2%)
	Dundee City	796 (3.9%)
	East Ayrshire	548 (2.7%)
	East Dunbartonshire	293 (1.5%)
	East Lothian	257 (1.3%)
	East Renfrewshire	290 (1.4%)
	Eilean Siar	109 (0.5%)
	Falkirk	555 (2.8%)
	Fife	1,519 (7.5%)
	Glasgow City	2,694 (13.4%)
	Highland	1281 (6.4%)
	Inverclyde	192 (1.0%)
	Midlothian	265 (1.3%)
	Moray	330 (1.6%)
	North Ayrshire	561 (2.8%)
	North Lanarkshire	1,032 (5.1%)
	Orkney	77 (0.4%)
	Perth and Kinross	794 (3.9%)
	Renfrewshire	762 (3.8%)
	Scottish Borders	369 (1.8%)
	Shetland	57 (0.3%)
	South Ayrshire	514 (2.6%)
	South Lanarkshire	1,153 (5.7%)
	Stirling	394 (2.0%)
	West Dunbartonshire	380 (1.9%)
	West Lothian	510 (2.5%)
Age (years)	16–24	3,095 (15.4%)
	25–44	4,691 (23.3%)
	45–64	3,466 (17.2%)
	65+	8,900 (44.2%)
Gender	Male	10,392 (51.6%)
	Female	9,752 (48.4%)
	Unknown or not stated [a]	6 (0.1%%)
Length	0–3 years	3,666 (18.2%)
	4–5 years	7,621 (37.8%)
	>5 years	4,170 (20.7%)
	Indefinite	4,695 (23.3%)
Diagnostic categories [a]	Acquired Brain Injury	1,078 (5.3%)
	Alcohol Related Brain Damage	703 (3.5%)
	Dementia	6,816 (33.8%)
	Inability to communicate	32 (0.2%)
	Learning disability	10,469 (52.0%)
	Mental illness	746 (3.7%)
	Other	230 (1.1%)
Total		**20,152**

[a] no information about LA (n=109, 0.5%) or diagnosis (n=78, 0.4%) available in the record

Table A2. The number and percentage of each category of diagnosis of granted guardianships by year

Category of Diagnosis [a]	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Acquired brain injury	138 (5.1%)	154 (5.2%)	146 (4.7%)	171 (5.4%)	163 (5.0%)	131 (5.9%)	179 (5.2%)	235 (6.6%)	248 (6.0%)	278 (6.5%)
Alcohol related brain damage	117 (4.3%)	93 (3.2%)	147 (4.7%)	100 (3.1%)	124 (3.8%)	92 (4.1%)	148 (4.3%)	171 (4.8%)	170 (4.1%)	184 (4.3%)
Dementia/Alzheimer's disease	1,222 (45.1%)	1,292 (43.8%)	1,264 (40.4%)	1,210 (37.9%)	1,177 (36.1%)	831 (37.5%)	1,334 (39.0%)	1,308 (36.7%)	1,452 (35.1%)	1,387 (32.3%)
Learning disability	1,115 (41.1%)	1,278 (43.4%)	1,417 (45.3%)	1,531 (47.9%)	1,619 (49.6%)	1032 (46.5%)	1,566 (45.8%)	1,642 (46.1%)	2,008 (48.6%)	2,124 (49.4%)
Mental illness	84 (3.1%)	99 (3.4%)	125 (4.0%)	147 (4.6%)	147 (4.5%)	110 (5.0%)	159 (4.6%)	152 (4.3%)	168 (4.1%)	202 (4.7%)
Other	33 (1.2%)	31 (1.1%)	27 (0.9%)	33 (1.0%)	26 (0.8%)	19 (0.9%)	25 (0.7%)	43 (1.2%)	55 (1.3%)	67 (1.6%)

[a] Those with inability to communicate due to physical illness and 'unknown' diagnosis have been omitted to maintain confidentiality

Table A3. Number of local authority (LA) and private (P) guardianships, by local authority and year

	2015-16		2016-17		2017-18		2018-19		2019-20		2020-21		2021-22		2022-23		2023-24		2024-25	
	LA	**P**	**LA**	**P**	**LA**	**P**	**LA**	**P**	**LA**	**P**	**LA**	**P**	**LA**	**P**	**LA**	**P**	**LA**	**P**	**LA**	**P**
Aberdeen City	26	52	29	56	17	61	30	65	24	55	26	39	43	59	42	67	33	71	38	62
Aberdeenshire	22	59	20	78	23	86	29	67	30	75	26	37	34	69	47	60	43	77	34	98
Angus	13	35	26	29	26	45	26	32	25	42	26	20	40	51	32	57	41	56	49	66
Argyll and Bute	16	26	8	29	9	30	*	38	17	26	10	31	13	31	21	33	11	39	22	47
City of Edinburgh	49	95	58	129	46	122	70	134	81	140	56	113	88	153	101	159	107	200	105	176
Clackmannanshire	*	28	*	31	6	24	6	22	6	17	*	16	*	28	8	33	15	19	14	37
Dumfries and Galloway	47	72	33	85	27	87	45	102	30	99	26	60	33	107	43	108	44	133	49	96
Dundee City	21	49	32	75	25	58	29	70	39	57	16	37	28	59	37	70	50	76	82	90
East Ayrshire	23	78	24	64	35	64	25	59	36	61	22	34	44	44	30	67	35	97	39	116
East Dunbartonshire	*	37	6	30	*	45	8	36	8	47	*	27	6	35	6	38	9	58	10	48
East Lothian	17	30	8	26	11	41	16	32	17	36	6	27	12	47	18	50	21	45	16	44
East Renfrewshire	7	30	*	26	7	38	*	30	*	26	6	36	10	36	*	38	6	44	13	40
Eilean Siar	*	11	*	24	*	13	*	16	*	14	*	*	*	11	*	6	*	15	*	13
Falkirk	27	65	25	54	32	67	24	67	31	79	28	46	31	73	20	88	30	86	36	106
Fife	70	145	59	145	102	161	63	166	54	150	43	90	58	137	81	158	66	244	95	240
Glasgow City	54	324	43	326	55	388	55	396	62	447	31	295	73	363	55	350	75	339	77	358
Highland	46	101	87	115	66	99	67	121	67	131	43	73	83	183	81	148	83	152	110	162
Inverclyde	9	11	12	26	8	23	9	21	10	14	8	12	14	39	9	37	16	45	11	40
Midlothian	12	20	10	23	15	38	17	37	14	25	12	21	17	31	23	36	30	42	31	30
Moray	11	33	12	43	12	27	7	38	10	22	*	22	10	34	16	30	10	40	10	26
North Ayrshire	8	58	18	69	11	70	28	61	28	61	17	53	27	86	25	77	50	121	38	66
North Lanarkshire	41	147	30	153	60	177	58	193	51	178	32	90	56	143	68	161	64	199	67	221
Orkney	*	13	*	*	*	*	*	*	6	10	9	17	6	11	6	6	8	*	7	12
Perth and Kinross	16	48	27	51	39	61	25	63	34	76	38	49	50	95	32	90	36	87	52	103
Renfrewshire	36	105	25	90	25	85	20	109	26	83	27	59	22	79	37	103	17	107	20	117
Scottish Borders	12	28	13	29	10	48	15	37	13	32	10	21	10	58	14	36	17	66	24	55
Shetland	*	*	*	*	*	*	*	*	*	6	*	*	*	10	7	6	*	*	*	11
South Ayrshire	22	76	16	74	26	90	25	90	19	81	18	62	27	81	37	76	41	86	63	88
South Lanarkshire	38	136	46	181	55	155	36	171	47	192	34	116	42	150	47	165	49	169	70	192
Stirling	6	28	11	53	19	31	16	42	24	40	9	21	15	48	16	49	22	61	19	66
West Dunbartonshire	11	46	9	37	8	24	*	34	9	25	7	20	9	33	13	44	13	69	31	75
West Lothian	7	34	18	63	16	59	15	48	20	69	17	45	23	102	29	91	22	86	34	131

* n<=5 or secondary suppression to maintain confidentiality. Those with 'unknown' LA have been omitted from this table.

Table A4. Total granted guardianships orders 2024-25 by guardian status, n (%)

Characteristic	Total	Local authority	Private
Gender			
Female	1,987 (42.6%)	585 (46.1%)	1,402 (46.2%)
Male	2,311 (53.7%)	682 (53.8%)	1,629 (53.7%)
Age			
16-24	1,005 (23.4%)	89 (7.0%)	916 (30.2%)
25-44	736 (17.1%)	191 (15.1%)	545 (18.0%)
45-64	742 (17.3%)	334 (26.3%)	408 (13.5%)
65+	1,817 (42.3%)	654 (51.6%)	1,163 (38.4%)
Diagnostic categories [a]			
Acquired brain injury	278 (6.5%)	70 (5.5%)	208 (6.9%)
Alcohol related brain damage	184 (4.3%)	117 (9.2%)	67 (2.2%)
Dementia/Alzheimer's disease	1,387 (32.3%)	448 (35.3%)	939 (31.0%)
Inability to communicate	7 (0.2%)	0 (0.0%)	7 (0.2%)
Learning disability	2,124 (49.4%)	446 (35.2%)	1,678 (55.3%)
Mental illness	202 (4.7%)	146 (11.5%)	56 (1.8%)
Other	67 (1.6%)	24 (1.9%)	43 (1.4%)
Length			
0 – 3 years	1,683 (39.1%)	780 (61.5%)	903 (29.8%)
4 – 5 years	2,150 (50.0%)	457 (36.0%)	1,693 (55.8%)
> 5 years	426 (9.9%)	29 (2.3%)	397 (13.1%)
Indefinite	41 (1.0%)	*	*
Guardianship status			
New	3694 (85.9%)	1,018 (80.3%)	2,676 (88.3%)
Renewal	606 (14.1%)	250 (19.7%)	356 (11.7%)

* n<5 or secondary suppression to maintain confidentiality

Those with 'unknown' or 'not stated' gender or diagnosis have been omitted from this table

Table A5. Granted guardianships 2024-25 by diagnostic category, n (%)

Characteristic	Total	ABI (n=278)	ARBD (n=184)	Dementia (n=1,387)	Learning Disability (n=2,124)	Mental Illness (n=202)	Other (n=67)
Gender							
Female	1,987 (42.6%)	111 (39.9%)	64 (34.8%)	860 (62.0%)	805 (37.9%)	85 (42.1%)	35 (52.2%)
Male	2,311 (53.7%)	167 (60.1%)	120 (65.2%)	527 (38.0%)	1317 (62.0%)	117 (57.9%)	32 (47.8%)
Age							
16-24	1,005 (23.4%)	11 (4.0%)	0 (0.0%)	*	957 (45.1%)	*	13 (19.4%)
25-44	736 (17.1%)	38 (13.7%)	6 (3.3%)	*	635 (29.9%)	*	8 (11.9%)
45-64	742 (17.3%)	87 (31.3%)	83 (45.1%)	82 (5.9%)	386 (18.2%)	88 (43.6%)	11 (16.4%)
65+	1,817 (42.3%)	142 (51.1%)	95 (51.6%)	1294 (93.3%)	146 (6.9%)	75 (37.1%)	35 (52.2%)
Length of guardianship							
0 - 3	1,683 (39.1%)	118 (42.4%)	105 (57.1%)	595 (42.9%)	705 (33.2%)	110 (54.5%)	26 (38.8%)
4 - 5	2,150 (50.0%)	134 (48.2%)	71 (38.6%)	691 (49.8%)	1102 (51.9%)	86 (42.6%)	36 (53.7%)
> 5	426 (9.9%)	*	8 (4.3%)	74 (5.3%)	307 (14.5%)	*	5 (7.5%)
Indefinite	41 (1.0%)	*	0 (0.0%)	27 (1.9%)	10 (0.5%)	*	0 (0.0%)
Guardian							
LA	1,268 (29.5%)	70 (25.2%)	117 (63.6%)	448 (32.3%)	446 (21.0%)	146 (72.3%)	24 (35.8%)
Private	3,032 (70.5%)	208 (74.8%)	67 (36.4%)	939 (67.7%)	1678 (79.0%)	56 (27.7%)	43 (64.2%)
Guardianship status							
New	3,694 (85.9%)	240 (86.3%)	146 (79.3%)	1265 (91.2%)	1768 (83.2%)	160 (79.2%)	57 (85.1%)
Renewed	606 (14.1%)	38 (13.7%)	38 (20.7%)	122 (8.8%)	356 (16.8%)	42 (20.8%)	10 (14.9%)

* n<5 or secondary suppression to maintain confidentiality

Those with 'unknown' or 'not stated' gender or diagnosis have been omitted from this table. The numbers for inability to communicate were small and could have led to identification therefore neither are not included in this table.

Table A6. Granted guardianships 2024-25 by guardianship status, n (%)

Characteristic	Total	New guardianship	Renewal
Gender			
Female	1987 (42.6%)	1729 (46.8%)	258 (42.6%)
Male	2311 (53.7%)	1963 (53.1%)	348 (57.4%)
Age			
16-24	1005 (23.4%)	854 (23.1%)	151 (24.9%)
25-44	736 (17.1%)	590 (16.0%)	146 (24.1%)
45-64	742 (17.3%)	608 (16.5%)	134 (22.1%)
65+	1817 (42.3%)	1642 (44.5%)	175 (28.9%)
Diagnostic categories [a]			
Acquired Brain Injury	278 (6.5%)	240 (6.5%)	38 (6.3%)
Alcohol Related Brain Damage	184 (4.3%)	146 (4.0%)	38 (6.3%)
Dementia/Alzheimer's Disease	1387 (32.3%)	1265 (34.2%)	122 (20.1%)
Inability to comm due to physical illness	7 (0.2%)	7 (0.2%)	0 (0.0%)
Learning Disability	2124 (49.4%)	1768 (47.9%)	356 (58.7%)
Mental Illness	202 (4.7%)	160 (4.3%)	42 (6.9%)
Other	67 (1.6%)	57 (1.5%)	10 (1.7%)
Length			
0-3	1683 (39.1%)	1560 (42.2%)	123 (20.3%)
4-5	2150 (50.0%)	1757 (47.6%)	393 (64.9%)
>5	426 (9.9%)	338 (9.1%)	88 (14.5%)
indefinite	41 (1.0%)	*	*
Guardian			
LA	1268 (29.5%)	1018 (27.6%)	250 (41.3%)
Private	3032 (70.5%)	2676 (72.4%)	356 (58.7%)

* n<5 or secondary suppression to maintain confidentiality

[a] Those with 'unknown' diagnosis have been omitted n=51.

Table A7. Percentage of renewed orders by age, gender and year

	16-24 years		25-44 years		45-64 years		65+ years	
	Female	Male	Female	Male	Female	Male	Female	Male
2015-16	14.2%	15.1%	16.7%	19.8%	17.3%	17.0%	3.7%	4.8%
2016-17	22.9%	19.1%	32.4%	24.5%	16.5%	20.0%	5.7%	5.5%
2017-18	18.6%	24.9%	38.3%	31.3%	19.8%	25.1%	6.5%	6.5%
2018-19	25.4%	25.7%	36.5%	36.5%	29.1%	26.0%	8.8%	9.1%
2019-20	32.9%	28.4%	34.3%	43.7%	33.8%	29.7%	8.1%	7.7%
2020-21	14.0%	10.5%	16.4%	19.3%	11.4%	14.4%	2.0%	4.0%
2021-22	6.8%	5.8%	14.2%	11.3%	9.5%	7.3%	2.4%	2.3%
2022-23	8.2%	6.2%	11.2%	10.2%	7.3%	5.8%	1.9%	2.3%
2023-24	11.0%	7.1%	17.9%	15.1%	9.7%	8.4%	5.4%	4.6%
2024-25	16.1%	14.5%	19.0%	20.5%	16.8%	18.9%	9.2%	10.3%

Table A8. Length of guardianships (years) by age group

	16-24 years				25-44 years				45-64 years				65+ years			
Year	0 - 3	4 - 5	> 5	Indef	0 - 3	4 - 5	> 5	Indef	0 - 3	4 - 5	> 5	Indef	0 - 3	4 - 5	> 5	Indef
2015-16	30.1%	46.5%	17.6%	5.8%	34.8%	38.7%	20.1%	6.4%	31.0%	42.6%	15.8%	10.5%	19.7%	24.3%	12.5%	43.5%
2016-17	24.2%	52.0%	14.8%	9.0%	21.0%	52.4%	19.0%	7.6%	31.5%	41.6%	16.8%	10.2%	19.2%	29.1%	20.7%	31.0%
2017-18	25.3%	49.0%	22.7%	3.0%	23.5%	47.5%	25.5%	3.5%	32.7%	44.6%	17.0%	5.6%	21.0%	38.2%	19.7%	21.1%
2018-19	25.8%	53.6%	18.9%	1.6%	25.6%	48.7%	22.9%	2.8%	32.9%	48.2%	14.8%	4.0%	23.1%	41.9%	16.9%	18.1%
2019-20	26.6%	50.6%	21.5%	1.3%	27.8%	47.3%	23.7%	1.2%	28.3%	45.9%	22.0%	3.8%	24.9%	45.5%	16.2%	13.4%
2020-21	32.5%	48.9%	17.7%	0.8%	24.9%	44.1%	29.0%	2.1%	34.5%	48.7%	14.7%	2.2%	29.4%	46.1%	14.1%	10.4%
2021-22	31.5%	51.4%	16.0%	1.1%	30.6%	47.2%	21.6%	0.6%	37.1%	46.8%	13.9%	2.2%	30.7%	47.4%	14.1%	7.9%
2022-23	36.6%	49.8%	13.2%	0.4%	25.0%	51.8%	22.4%	0.7%	35.4%	48.4%	14.5%	1.8%	31.9%	48.2%	13.1%	6.8%
2023-24	36.6%	49.8%	13.2%	0.4%	25.6%	49.3%	24.7%	0.4%	32.8%	52.5%	13.4%	1.3%	34.8%	52.0%	9.9%	3.3%
2024-25	39.7%	49.8%	10.3%	0.2%	26.0%	54.5%	18.9%	0.7%	42.6%	46.0%	11.2%	0.3%	42.8%	50.0%	5.5%	1.8%

Indef: Indefinite order

Table A9. Number of guardianships granted, by local authority and year

Local authority	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Aberdeen City	78	85	78	95	79	65	102	109	104	100
Aberdeenshire	81	98	109	96	105	63	103	107	120	132
Angus	48	55	71	58	67	46	91	89	97	115
Argyll and Bute	42	37	39	41	43	41	44	54	50	69
City of Edinburgh	144	187	168	204	221	169	241	260	307	281
Clackmannanshire	33	36	30	28	23	19	30	41	34	51
Dumfries and Galloway	119	118	114	147	129	86	140	151	177	145
Dundee City	70	107	83	99	96	53	87	107	126	172
East Ayrshire	101	88	99	84	97	56	88	97	132	155
East Dunbartonshire	40	36	50	44	55	31	41	44	67	58
East Lothian	47	34	52	48	53	33	59	68	66	60
East Renfrewshire	37	29	45	35	30	42	46	43	50	53
Eilean Siar	16	29	16	19	14	7	13	8	19	13
Falkirk	92	79	99	91	110	74	104	108	116	142
Fife	215	204	263	229	204	133	195	239	310	335
Glasgow City	378	369	443	451	509	326	436	405	414	435
Highland	147	202	165	188	198	116	266	229	235	272
Inverclyde	20	38	31	30	24	20	53	46	61	51
Midlothian	32	33	53	54	39	33	48	59	72	61
Moray	44	55	39	45	32	26	44	46	50	36
North Ayrshire	66	87	81	89	89	70	113	102	171	104
North Lanarkshire	188	183	237	251	229	122	199	229	263	288
Orkney	18	8	8	9	16	26	17	12	12	19
Perth and Kinross	64	78	100	88	110	87	145	122	123	155
Renfrewshire	141	115	110	129	109	86	101	140	124	137
Scottish Borders	40	42	58	52	45	31	68	50	83	79
Shetland	6	8	7	7	8	6	12	13	6	13
South Ayrshire	98	90	116	115	100	80	108	113	127	151
South Lanarkshire	174	227	210	207	239	150	192	212	218	262
Stirling	34	64	50	58	64	30	63	65	83	85
West Dunbartonshire	57	46	32	39	34	27	42	57	82	106
West Lothian	41	81	75	63	89	62	125	120	108	165
Scotland	**2,711**	**2,948**	**3,131**	**3,193**	**3,261**	**2,218**	**3,421**	**3,562**	**4,131**	**4,300**

Those with 'unknown' LA have been omitted from this table.

Table A10. Rate of granted guardianships with mid-year population estimates (≥16 years) by local authority

Local authority	Crude rate	Orders	Population
Aberdeen City	51.5	100	194,067
Aberdeenshire	60.7	132	217,500
Angus	118.7	115	96,901
Argyll and Bute	91.4	69	75,511
City of Edinburgh	61.8	281	454,400
Clackmannanshire	117.2	51	43,499
Dumfries and Galloway	116.7	145	124,243
Dundee City	136.9	172	125,683
East Ayrshire	153.2	155	101,196
East Dunbartonshire	64.1	58	90,453
East Lothian	63.2	60	94,955
East Renfrewshire	66.4	53	79,848
Eilean Siar	58.5	13	22,222
Falkirk	106.5	142	133,315
Fife	106.7	335	313,927
Glasgow City	78.9	435	551,455
Highland	135.6	272	200,550
Inverclyde	76.4	51	66,725
Midlothian	75.2	61	81,149
Moray	45.2	36	79,648
North Ayrshire	91.9	104	113,113
North Lanarkshire	101.2	288	284,593
Orkney	102.3	19	18,578
Perth and Kinross	118.8	155	130,449
Renfrewshire	86.5	137	158,468
Scottish Borders	79.6	79	99,253
Shetland	67.8	13	19,177
South Ayrshire	158.0	151	95,555
South Lanarkshire	94.3	262	277,832
Stirling	106.9	85	79,513
West Dunbartonshire	142.8	106	74,225
West Lothian	108.5	165	152,064
Scotland	**92.5**	**4,300**	**4,650,067**

Those with 'unknown' LA have been omitted from this table.

Table A11. Number of new and renewed granted guardianships, by local authority and year

	2015-16		2016-17		2017-18		2018-19		2019-20		2020-21		2021-22		2022-23		2023-24		2024-25	
Local authority	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**
Aberdeen City	74	*	79	6	74	*	81	14	65	14	63	*	92	10	105	*	97	7	85	15
Aberdeenshire	71	10	77	21	90	19	81	15	88	17	57	6	101	*	103	*	113	7	120	12
Angus	42	6	42	13	66	5	43	15	46	21	42	*	90	*	88	*	85	12	83	32
Argyll and Bute	39	*	31	6	36	*	34	7	35	8	35	6	43	*	44	10	44	6	55	14
City of Edinburgh	131	13	170	17	148	20	172	32	177	44	152	17	234	7	253	7	282	25	218	63
Clackmannanshire	30	*	33	*	26	*	24	*	19	*	14	5	27	*	37	*	31	*	43	8
Dumfries and Galloway	103	16	101	17	87	27	93	54	97	32	79	7	132	8	142	9	165	12	128	17
Dundee City	67	*	100	7	70	13	93	6	83	13	47	6	85	*	106	*	122	*	150	22
East Ayrshire	87	14	69	19	77	22	65	19	67	30	50	6	83	5	91	6	125	7	139	16
East Dunbartonshire	38	*	32	*	34	16	33	11	47	8	28	*	36	5	38	6	63	*	51	7
East Lothian	36	11	26	8	36	16	37	11	39	14	31	*	58	*	67	*	59	7	48	12
East Renfrewshire	32	5	26	*	39	6	32	*	23	7	38	*	44	*	41	*	48	*	46	7
Eilean Siar	16	*	29	*	12	*	17	*	14	*	7	*	13	*	8	*	19	*	13	*
Falkirk	80	12	66	13	85	14	82	9	80	30	68	6	102	*	105	*	105	11	120	22
Fife	201	14	178	26	232	31	177	52	169	35	121	12	190	5	231	8	287	23	289	46
Glasgow City	342	36	315	54	366	77	356	95	402	107	302	24	414	22	390	15	388	26	405	30
Highland	133	14	175	27	137	28	155	33	153	45	108	8	260	6	225	*	216	19	222	50
Inverclyde	15	5	31	7	23	8	24	6	18	6	19	*	51	*	45	*	59	*	41	10
Midlothian	24	8	26	7	45	8	42	12	30	9	32	*	47	*	58	*	66	6	50	11
Moray	41	*	53	*	34	5	39	6	30	*	26	*	43	*	46	*	46	*	33	*
North Ayrshire	61	5	72	15	66	15	77	12	64	25	61	9	98	15	89	13	153	18	90	14
North Lanarkshire	156	32	151	32	178	59	178	73	153	76	115	7	195	*	226	*	245	18	254	34
Orkney	12	6	6	*	7	*	5	*	14	*	24	*	16	*	11	*	11	*	16	*
Perth and Kinross	61	*	67	11	85	15	78	10	91	19	81	6	137	8	114	8	104	19	133	22
Renfrewshire	135	6	97	18	88	22	104	25	85	24	75	11	98	*	138	*	118	6	129	8
Scottish Borders	35	5	37	5	51	7	43	9	37	8	25	6	68	*	49	*	77	6	76	*
Shetland	6	*	8	*	7	*	7	*	6	*	6	*	11	*	10	*	5	*	11	*
South Ayrshire	87	11	73	17	95	21	89	26	72	28	68	12	86	22	95	18	99	28	118	33
South Lanarkshire	157	17	202	25	171	39	160	47	183	56	139	11	165	27	197	15	198	20	237	25
Stirling	29	5	61	*	45	5	45	13	48	16	27	*	56	7	53	12	70	13	67	18
West Dunbartonshire	55	*	43	*	29	*	35	*	33	*	26	*	41	*	51	6	76	6	99	7
West Lothian	35	6	59	22	61	14	44	19	63	26	52	10	104	21	102	18	95	13	125	40
Scotland	**2,431**	**280**	**2,535**	**413**	**2,600**	**531**	**2,545**	**648**	**2,532**	**729**	**2,020**	**198**	**3,225**	**196**	**3,374**	**188**	**3,786**	**345**	**3,694**	**606**

* n<5 or secondary suppression to maintain confidentiality; N: new guardianship; R: renewal

Table A12. Relative change to last year by age and local authority

	Age Group			
Local authority	**16-24**	**25-44**	**45-64**	**65+**
Aberdeen City	-11%	-42%	-12%	32%
Aberdeenshire	12%	6%	33%	4%
Angus	26%	0%	43%	8%
Argyll and Bute	17%	200%	167%	0%
City of Edinburgh	-23%	4%	-14%	-4%
Clackmannanshire	-20%	83%	33%	100%
Dumfries and Galloway	-48%	-24%	15%	-13%
Dundee City	72%	21%	48%	23%
East Ayrshire	46%	38%	-34%	27%
East Dunbartonshire	8%	6%	-36%	-25%
East Lothian	-14%	-7%	-27%	0%
East Renfrewshire	-14%	29%	60%	6%
Eilean Siar	-14%	-33%	0%	-50%
Falkirk	30%	67%	33%	6%
Fife	11%	16%	30%	-5%
Glasgow City	22%	-16%	4%	6%
Highland	68%	5%	-10%	11%
Inverclyde	-19%	140%	-50%	-29%
Midlothian	-7%	33%	-55%	-3%
Moray	-53%	100%	-30%	-33%
North Ayrshire	-55%	-57%	-4%	-36%
North Lanarkshire	-3%	22%	-3%	19%
Orkney	100%	0%	67%	60%
Perth and Kinross	42%	-23%	29%	36%
Renfrewshire	-3%	41%	47%	0%
Scottish Borders	-7%	23%	14%	-24%
Shetland	150%	100%	0%	200%
South Ayrshire	-13%	-8%	33%	38%
South Lanarkshire	17%	30%	11%	22%
Stirling	29%	0%	-50%	16%
West Dunbartonshire	-50%	8%	186%	76%
West Lothian	71%	178%	21%	27%

Table A13. Relative change to 2024-25 by diagnostic categories and local authority

Local authority	Dementia	Learning disability	Mental illness	ABI	ARBD	Other
Aberdeen City	38%	-30%	50%	33%	20%	100%
Aberdeenshire	-8%	19%	17%	13%	200%	100%
Angus	11%	47%	-8%	-50%	-40%	0%
Argyll and Bute	5%	73%	50%	0%	100%	-100%
City of Edinburgh	-9%	-11%	14%	20%	-44%	0%
Clackmannanshire	90%	9%		100%	0%	
Dumfries and Galloway	-15%	-30%	100%	13%	0%	-33%
Dundee City	16%	38%	175%	46%	33%	-50%
East Ayrshire	12%	6%	200%	30%	-14%	300%
East Dunbartonshire	-56%	15%	0%	100%	-50%	-100%
East Lothian	9%	-21%	100%	50%	-67%	0%
East Renfrewshire	-25%	0%		167%		-50%
Eilean Siar	-43%	-27%	-100%	0%	0%	
Falkirk	13%	56%	-100%	-44%	-29%	0%
Fife	-10%	12%	62%	-18%	11%	600%
Glasgow City	-5%	7%	53%	0%	37%	-36%
Highland	-2%	27%	60%	-38%	250%	-33%
Inverclyde	-40%	12%	-50%	-40%	-17%	
Midlothian	13%	-24%	-67%	-33%	-50%	0%
Moray	-47%	-19%	0%	100%	-50%	0%
North Ayrshire	-51%	-49%	-20%	25%	71%	0%
North Lanarkshire	13%	3%	-27%	20%	27%	167%
Orkney	80%	50%	0%	0%	0%	0%
Perth and Kinross	44%	24%	-33%	-11%	200%	-100%
Renfrewshire	-14%	31%	50%	67%	-50%	-50%
Scottish Borders	-10%	-8%	33%	67%	-50%	100%
Shetland		75%	-100%		-100%	0%
South Ayrshire	53%	-3%	20%	9%	80%	-33%
South Lanarkshire	-5%	30%	50%	7%	33%	100%
Stirling	-10%	9%	-75%	33%	100%	0%
West Dunbartonshire	76%	-28%	600%	133%	133%	-33%
West Lothian	56%	63%	-80%	150%	0%	0%

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