The Highland Council

Agenda Item	**5**
Report No	**HSW-02-24**

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

Date: **14 February 2024**

Report Title: **Mental Welfare Commission (MWC) Mental Health Act Monitoring Report, 2022-23: Highland Mental Health Officer (MHO) Service Response**

Report By: **Executive Chief Officer Health and Social Care**

1. Purpose/Executive Summary

1.1 In October 2023, the Mental Welfare Commission (MWC) produced their annual Mental Health Act Monitoring Report, 2022-23. This provided an opportunity for the Service in Highland to consider performance and benchmark on a wider basis and in relation to other authorities. This report will compare and analyse the performance of the Mental Health Officer (MHO) Team in Highland in relation to the national picture described in the report by the MWC.

1.2 The Mental Welfare Commission is a national body with a statutory duty to monitor how Mental Health Act legislation is used. Their remit extends to the critically important times where individuals are assessed as requiring mental health care and treatment against their will. The use of compulsion, under the auspices of mental health legislation, should last for the shortest possible length of time, and must be reported to the MWC. This report will highlight key observations from the MWC report and provide a more detailed local context to the findings of this report so the statistics can be better understood. Whilst the Highland MHO Service is comprised of three distinct service areas (Adults with Incapacity, Forensic Mental Health, and Mental Health Act), the MWC Report predominantly focuses on the remit of the Mental Health Act MHO Team and is dealt with in Section 4 of this report for more detail. The report by the MWC is attached as **Appendix 1** to this report.

1.3 The MWC report highlights national concerns in relation to the following subjects, which are individually addressed in the 'Key Findings' section of this report:

- A national increase in the rate of detention by 1.7%.
- A persistently low level of MHO consent when Emergency Detention Certificates (EDCs) are granted. In terms of the legislation MHO consent must be sought unless the circumstances are exceptional.
- A lack of completed Social Circumstances Reports (SCRs). MHOs have a statutory duty to produce SCRs within 21 days of a 'relevant event' / detention.
- The capacity of the MHO workforce and the safeguards of the role not being realised in practice.

- Mental Health Act detentions are much more common in areas with higher social deprivation. The need to understand this trend is highlighted with a view to implementing successful preventative practice.

2. Recommendations

2.1 Members are asked to:

i. Note the contents of this report.
ii. Comment on the analysis of local performance in the context of national indicators.

3. Implications

3.1 Resource
Please refer to Section 5.4 of this report.

3.2 Legal
The functions of the MHO role are enshrined in legislation. The legislative context is provided in Section 4 of this report and throughout Section 5. It is important to note that many of the timescales provided for by the legislation are in relation to the interface of the team's work with Court and Tribunal processes.

3.3 Community (Equality, Poverty, Rural and Island)
There are no direct implications although the Committee ought to note the role of the MHO service has general implications for community safety, which are reflected throughout the report.

3.4 Climate Change / Carbon Clever
No such implications.

3.5 Risk
There are some risks arising from the workforce challenges experienced by the team which have been raised generally to the Committee on previous occasions. The following ought to be highlighted:

- Potential risk to the safeguarding MHO role if resource implications directly influence the medical application of compulsion.
- Noted resource implications associated with the rise in use compulsory measures.

3.6 Health and Safety (risks arising from changes to plant, equipment, process, or people) There are no direct implications.

3.7 Gaelic
No such implications.

4. Background and Context

4.1 There is an established structure to manage and support the delivery of the Highland Mental Health Officer Service. This service meets the Highland Council's statutory duty to appoint MHOs under Section 32 (1) of the 2003 Act. The Chief Social Work

Officer of the Local Authority, or their delegate, is required to appoint sufficient 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 (as amended by the 2003 Act) - The 1995 Act

4.2 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. The MHO retains full agency for their recommendations and are scrutinised by the Mental Health Tribunal and the Court. 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 the health and social care services, and is a fundamental safeguard enshrined in law, for individuals receiving a service.

4.3 The Mental Health Act MHO Team in Highland is one of 3 teams within the service led by a Practice Lead and supported by approximately 15 Whole Time Equivalent (WTE) MHOs. MHOs in this team have a combination workload comprised of Mental Health Act and Adults with Incapacity Act duties. The 2003 Act involves MHO consideration of compulsory detention under the 2003 Act for the purpose of providing mental health care and treatment to individuals who meet the criteria for such intervention. Specific tasks include providing or withholding consent to compulsory detention and making applications to the Mental Health Tribunal. A substantial part of work under the 2003 Act is unplanned, giving rise to the need to conduct urgent assessments in respect of emergency detention. As part of this, the MHO may be required to apply to Sheriff Court for warrants to enact emergency protective measures and must often execute these warrants. Compulsory Treatment in hospital or in the community can be ordered under the 2003 Act. A daily MHO duty rota operates pan-Highland, and the duty MHO participates in the daily multi-agency 'huddle'. In addition, MHOs in this team manage a caseload of both inpatients and outpatients subject to compulsory mental health care and treatment. It should be noted too, given the nature of this work, that all social workers employed in the Emergency Social Work team, which operates out of "normal" business hours, also have an MHO qualification.

5. Key Findings and Local Performance

5.1 <u>Increased Use of Compulsion</u>

5.1.1 The report references an increased recourse to compulsory measures. It is the writer's view that the nationwide 1.7% increase in the use of compulsion does not necessarily provide the full picture. During the 2022-23 review period, the availability of psychiatric inpatient beds in Highland (and numerous other health board areas) has been very limited. Like all hospitals there are issues in terms of bed availability – in part as a result of staffing – and it may be that such issues have an influence on decision-making in this regard. This perspective is based on the health-based resource forecast, which is not set to improve in the short or medium-term.

5.2 MHO Consent to Emergency Detention Certificates (EDCs)

5.2.1 An EDC allows an individual to be held in hospital for up to 72 hours while their mental state is assessed. It can only be imposed when recommended by a doctor. MHO consent to this order should be sought unless impracticable due to the urgency of the situation. There is an expectation that EDCs are used 'sparingly' and that clear reasons are recorded as to the necessity for granting an EDC, rather than the preferred route of a Short Term Detention Certificate (STDC). The STDC is favoured as it provides the individual with more safeguards, including the right to appeal. Despite an increase in the overall number of EDCs and STDCs granted in Highland this year, there is a healthier proportion of STDCs compared to EDCs, in-keeping with best practice guidance.

5.2.2 The availability of MHO consent to EDCs in the Highland Health Board area is 49.4% (Page 19, MWC Monitoring Report). The MWC report this statistic by Health Board area, and not by Local Authority area. Accordingly, it is important to note the Argyll & Bute area is included in this statistic as part of NHS Highland and as such this statistic should be viewed as a general indicator of the Highland MHO Service performance in this regard. The statistic is a noted improvement by comparison to the 36.6% national average of cases where MHO consent is available (Page 17, MWC Monitoring Report). Over the past 10 years of MWC reporting, the availability of MHO consent has been in steady decline and is indicative of national resource pressures on MHO services.

5.2.3 Considering the challenging rural geography in Highland and the "urgent" nature of the need for such MHO consent it is the view of the writer that it is positive the percentage reported by the MWC is in significant excess of the national average. The Highland MHO duty service and the Emergency Social Work Service covers the entirety of Highland and, whilst 100% of the service are qualified MHOs, an in-person response cannot always be provided to more rural areas of Lochaber, Skye, Caithness, and Sutherland. Some EDCs marked without consent may include instances where the doctor has not sought this. In other cases, consultation by telephone may have been provided by the MHO. However, a visual assessment of the individual is required before MHO consent can be provided. A 24-hour MHO service (using the emergency team) is available aside from the aforementioned caveat.

5.2.4 There are plans to gather local data around MHO consent and EDCs. Specifically, it is hoped to provide numbers relating to formal consent, consultation without consent, and the number of EDCs granted without the doctor seeking MHO consent. Such future recording is also intended to show cases where notwithstanding that there has not been formal consent that there has been significant discussion about a particular case.

5.3 Completion of Social Circumstances Reports (SCRs)

5.3.1 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 SCR is prepared for the Responsible

Medical Officer (RMO) 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.

5.3.2 It is only possible to provide estimate completion percentages for SCR forms based on the information provided on Page 28 of the MWC Monitoring Report. It is positive to note that Highland Local Authority statistics reflect approximately 80% of SCRs forms were completed. Of this percentage, approximately 60% of completed forms were sent alongside a full report, and approximately 20% of completed forms provided clear reasons why a report was not required. Only approximately 20% of SCR forms were missing.

5.3.3 This statistic is well above the national average and is an example of the high work rate and quality of information-sharing with medical colleagues, and the MWC, within Highland.

5.4 MHO Workforce and Capacity

5.4.1 The MHO Service has overcome several challenges due to flexible and standard retirement. The Committee are aware of the workforce challenges within the Health and Social Care services and those challenges are reflected in the MHO team. In the coming year, an increased number of staff are eligible to retire. The MHO workforce is a conscientious group whose commitment is above question. However, it must be recognised that the relatively small service is currently running with 2.25 Whole Time Equivalent (WTE) vacancies due to staff sickness and unfilled vacancies. The rise in statutory detentions has resulted in increased workload pressures, which are unsustainable in the longer-term.

5.4.2 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 in order to be able 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 this MWC report, and in the Scottish Government's mental health strategy.

5.4.3 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 Award in recognition of the forward-thinking approach to recruitment and retention challenges and has been reported to the Committee previously as a "good news" story. The service has successfully recruited seven Trainee MHOs since becoming operative in Summer 2022. Two Trainee MHOs commenced employment in July 2023 and are on-track to qualify in 2024. They require significant support from mentors and practice assessors within the existing workforce for the duration of the study period, which will run from September 2023 to August 2024. Although developing Trainee MHOs places a short-term demand on the current staff group, there simply are not enough pre-existing social workers with the MHO qualification in Highland. It is hoped the service will be able to advertise at least 2 Trainee MHO posts in 2024, and a financial costing is currently being drawn up with regard this.

5.5 Social Deprivation and the Use of Compulsion

5.5.1 It is fair to say that the strong correlation between social deprivation and the increased use of compulsory measures could be better understood. The evidence base supports the view that that a person's mental health is more likely to deteriorate if exposed to a multitude of unfavourable social conditions including, for example, housing, finance, poverty, employment, geographical deprivation.

5.5.2 In 2023, the service recruited a part-time Information and Quality Assurance Officer, which is a full-time administrative role shared with the Justice Service. There are plans to develop robust process for gathering and analysing local data, and there is an expectation that the service will gain a lot of helpful insight by this process. In time, it may be possible to gain further insight in relation to social deprivation by analysing local statistics against the Scottish Index of Multiple Deprivation (SIMD), which is a quoted source within the MWC's Monitoring Report (Page 25).

5.6 Other Considerations – Place of Safety Orders

5.6.1 Section 297 of the 2003 Act provides that a police constable can remove an individual from a public place and take them to a place of safety if they reasonably suspect that the individual has a mental health condition requiring immediate care and treatment. A place of safety can be, for example, a psychiatric hospital but if no place of safety is immediately available, the law allows the police constable to take the individual to a police station (Page 39, MWC Monitoring Report).

5.6.2 The use of Section 297 of the 2003 Act might seem disproportionately high in Highland (224 orders) compared to other densely populated areas. Within the same timeframe, Glasgow City only recorded 74 orders, and City of Edinburgh only recorded 94 orders (Page 41, MWC Monitoring Report). This seemingly inflated Highland statistic may be down to Section 297 orders being appropriately documented by Police Scotland and NHS colleagues in the area. Use of this power should not be considered as intrinsically negative, as it can often result in appropriate mental health intervention at an early stage, which can support and protect a person to live safely within our communities. It is appropriate for the service – and clinical colleagues – to reflect upon performance in this area and what the national benchmarking might suggest in terms of future learning.

Designation: Executive Chief Officer Health and Social Care

Date: 15 January 2024

Author: Euan Williamson, Interim Principal Mental Health Officer

Background Papers:

Appendices: Mental Welfare Commission (MWC) Mental Health Act Monitoring Report, 2022-23

mental welfare commission for scotland

Mental Health Act monitoring report 2022-23

Statistical monitoring

October 2023

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.

We have a statutory duty to monitor how the law is used. This year's report shows increase in the rate of detention by 1.7%. This is less than the usual increase in the rate of detention that we have seen over time of around 4-5% each year however this does mark the reversal of the trend that we saw last year when we noted a reduction in the rates of detention.

We remain concerned over the way emergency detentions are taking place and how safeguards that ensure multi-disciplinary involvement in decisions about the use of this are not being used. Consent of a mental health officer (MHO- a specialist social worker) is an important safeguard and should happen every time a person is detained using the Act. For emergency detentions, consent from an MHO has fallen below half for all such detentions for the last six years in succession and this year has fallen below 40%, with considerable variations in different parts of Scotland. This is not acceptable; people should receive this safeguard, where practicable, no matter where they live in the country.

Over the last two years we have demonstrated the link between areas of greater deprivation and higher rates of detention. We show this link again this year. We hope that by sharing this information, geographical variations and many other aspects of detention, we can support efforts from Government and services so that they provide the right levels of resource and support for vulnerable communities.

September 2023

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 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 2022-23. We also make reference to the Criminal Procedure (Scotland) Act 1995 [2] (the Criminal Procedure Act).
3. The Commission recognises that while this report summarises information at a population level, every incident relates to a person, and represents a time of difficulty for them, their carers and those that matter to them.

Detentions under the Mental Health (Care and Treatment) (Scotland) Act 2003

4. A total of 6,713 detention episodes began in 2022-23, which was 1.7% more than in 2021-22 and lower than the average year-on-year increase in the previous years of 4.9%. 50.8% of all episodes began with a short term detention certificate (STDC), 48.0% with an emergency detention certificate (EDC) and 1.2% with a compulsory treatment order (CTO) or an interim compulsory treatment order (iCTO).
5. The rate of detention orders for emergency detention certificates (EDCs) was similar to previous years but increased slightly for short-term detention certificates (STDCs), and compulsory treatment orders (CTOs). For all types of orders the rate of detention was higher among males than females, with the smallest difference for EDCs where the rate for females was 58.8 per 100,000 compared to 61.4 for males. Age-standardised rates of detention were highest in the oldest age group (85+ years), apart from EDCs where the highest rate for females was in the age group 18–24 years and CTOs where the rate for females in the 85+ group is similar to the 65-84 group.
6. The proportion of individuals from an ethnic minority group (Asian, African, Caribbean or Black, Other, or Mixed) in the general population is 4%. Of detention orders that took place in 2022-23, the proportion who were from these groups was 4.8% for EDCs, 5.9% for STDCs, and 7.0% for CTOs.
7. We continue to monitor detentions by the level of deprivation based on the home address of the person being detained according to the Scottish Index of Multiple Deprivation (SIMD). For all three order types there was a clear gradient with a higher proportion of detentions of individuals from the most deprived parts of Scotland. The proportion from SIMD category 1 (most deprived) was 38.2% for EDCs, 30.8% for STDCs, and 29.3% for CTOs.
8. Consent of a mental health officer (MHO) is an important safeguard. For detention under an EDC, MHO consent has been falling over the years and we are again concerned that MHO consent in 2022-23 was the lowest we have seen over the last 10 years at 36.6%. This ranged from 21.2% in Greater Glasgow and Clyde to 84.2% in Dumfries and Galloway and 100% in Orkney.

9. Social circumstances reports (SCRs) are a critical safeguard which address the interaction of a person's mental health and their social circumstances. For 46.9% of STDCs in 2022-23 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 53.1% of cases we received no notification. That proportion of no notifications has increased slightly over the last 10 years.
10. There were 143 detentions under section 299 (nurses' power to detain pending a medical examination) in 2022-23, which is 16.4% less than in 2021-22. The overall rate of nurse's power to detain in 2022-23 was 2.3 per 100,000, which was a slight decrease on the previous year's rate of 3.1. The rate of nurse's power to detain orders was higher among females (3.0 per 100,000) than males (2.2 per 100,000).
11. There were 1,345 section 297 (place of safety) orders in 2022-23, which was a 7.2% increase compared to the year before. These orders related to 948 individuals. A higher proportion of place of safety orders was for males (53.1%) with the highest proportion of individuals detained aged 25–44 years. Of the individuals taken to a place of safety, 2.9% were taken to a police station and 97.1% were taken to a hospital/health care facility. The proportion of place of safety orders where the individual was taken to a police station has decreased over the years, from as high as 9.1% in 2013-14. This reduction is welcomed.
12. The Commission was notified of 144 deaths (due to any cause) that occurred when someone was subject to an order under the Mental Health Act, equating to 1.2% of all orders in 2022-23. The percentage of deaths as a proportion of total orders remains consistent over time, ranging from 1.0% in 2013-14 to 1.3% in 2020-21.
13. 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 2023, there were 4,061 extant orders which was a 0.5% increase compared to the same day in 2022. The rate of extant orders was similar to the year before. Of the total number of orders in place on 4 January 2023, 64.6% of these related to individuals who were male and most were aged 25–44 years or 45–64 years. The majority of extant orders were CTOs (71.9%). Of extant CTOs, 33.4% were community-based. The rate of hospital-based orders was higher than community based orders in all areas except Borders, Dumfries and Galloway and Highland.

Detentions under the Criminal Procedure (Scotland) Act 1995

14. There were 333 orders under the Criminal Procedure Act in 2022-23. The average number of orders was 396 in the previous 10 years. The 333 orders related to 196 individuals. Individuals detained under the Criminal Procedure Act in 2022-23 were primarily male (86.2%). Most were aged 25-44 years (63.3%) with the average age of 39 years.

Treatment and Part 16 of the Mental Health Act

15. There was a total of 954 T2 certificates issued during 2022-23, compared to an average of 828 during the years 2013-14 to 2022-23. Most T2 certificates (97.3%) were issued for medication over two months while 1.9% were issued for ECT. This was similar to previous years. Of the T2s, 5.0% were for young people (<18 years).
16. There were 2,573 T3 certificates issued in 2022-23, which was an 8.7% increase on the 2022-23 figure but is in line with the increasing trend in previous years. Most T3s

received were for medication over two months (84.1%), while 8.9% were for ECT, 6.9% for artificial nutrition, and 0.1% for medication to reduce sex drive. This is broadly similar to previous years. Of the T3s, 4.2% were for people <18 years.

17. We were notified of 498 T4 certificates issued in 2022-23; a 6.0% decrease on the number of T4s in 2021-22 and follows an increasing trend since 2017-18. Of the T4s, 14.1% were for individuals <18 years. This is an 8.0% decrease compared to 2021-22, but is still higher than figures in the years prior to 2020-21.
18. Health boards are required to notify us each time someone registers, or withdraws, an advance statement containing a written statement of a person's wishes regarding treatment if they become unwell in the future. We monitor this register and provide this information to the Scottish Government as part of their Mental Health Quality Indicators [3]. In 2022-23, this had increased by 155. The individuals on the register as a whole have an average age of 50 years and 54.6% are male. In comparison to detentions, there is a more even percentage distribution of individuals making advance statements from the most and least deprived areas of Scotland.

Introduction

The Mental Welfare Commission for Scotland has a statutory duty to monitor the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('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 e.g., this year we are producing reports on the use of place of safety provisions in the Act and an updated survey of recorded matters.

This report outlines data during the whole of 2022-23. The data we present shows the increasing number of detentions in Scotland over the years with a slight rise this year of reporting, that follows a slight decrease last year (2021-22) that occurred following a sharper increase during the previous year (2020-21) that we consider may have been due to the Covid-19 pandemic. Previous years have tended to show a gradually increasing number of detentions over time.

The report is a statistical report based on detentions and the wider use of compulsion. However, we recognise that a detention occurs when someone is compelled to receive assessment and/or treatment in relation to their mental health and that each of the instances that make up the report here, 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 (Scotland) Act 1995 [2] ('the Criminal Procedure Act'); 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 2022 to 31 March 2023). In this section 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 when someone is made subject to the Mental Health Act or the Criminal Procedure Act. We also report on authorisations for safeguarded treatments under Section 16 of the Mental Health Act which are sent to us.

Our data is dynamic; that is, the number of detentions, or other indicators, might change retrospectively. This is 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. The latest publication should always be referred to for the most accurate figures.

Ethnicity

In each section of this report we state the proportion of detentions where ethnicity was recorded. It should be noted that the Mental Health Act is the main database that we match ethnicity information. This means that the level of completeness for the Criminal Procedure Act is much lower than for detentions under the Mental Health Act.

Scottish Index of Multiple Deprivation (SIMD)

We report level of deprivation according to SIMD categories in this monitoring report using the 2020 v2 postcode look up file [4]. In each section, 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 93.4% of detentions in 2022-23.

Mid-year population estimates

Scottish mid-year population estimates for 2022 were not available at the time of publication. The latest available Scottish mid-year population estimates are from 2021 [5] and these have been used for both 2021-22 and 2022-23 data. The 2022-23 information using population data will be revised in future reports once the data becomes available.

Compulsory treatment under the Mental Health Act

Box 1. Explanation of terminology

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

Compulsory treatment orders (CTOs): A mental health officer (MHO) can make an application for a CTO to the Mental Health Tribunal. The application must include two medical reports, an MHO report and a proposed care plan. The Tribunal decides the outcome of the application. The Tribunal 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, e.g. a person with a mental health condition and with experience of using services, a carer, a nurse, a social worker, a psychologist or occupational therapist. The CTO can last up to six months. It can be extended for a further six months and subsequently then for periods of 12 months at a time.

New episodes of compulsory treatment

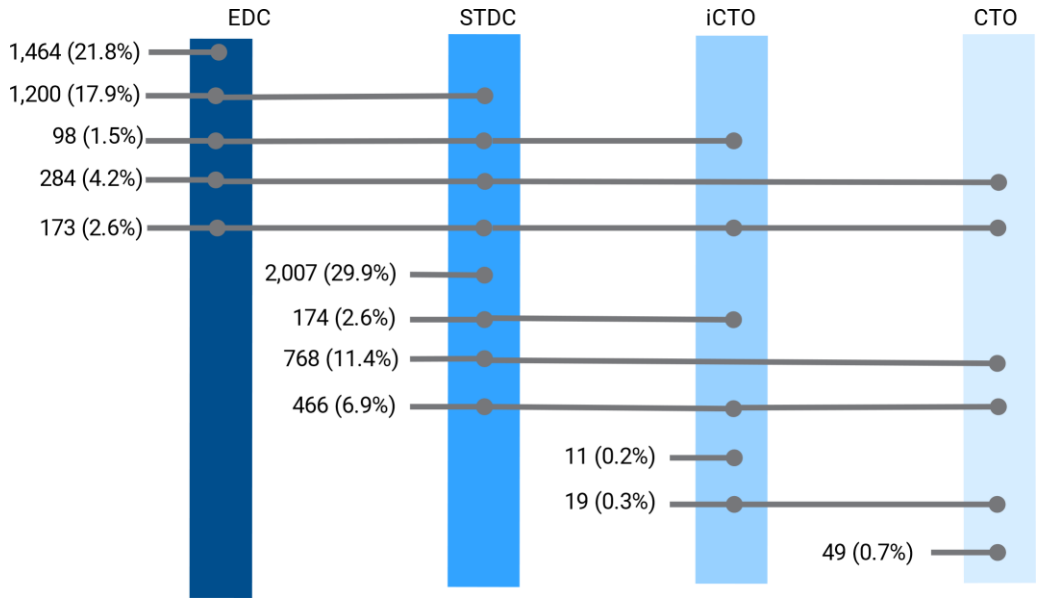
An 'episode' is a period where an individual is subject to the Mental Health Act. For example, an individual may be detained under an emergency detention certificate (EDC) then they might be detained under a short-term detention certificate (STDC). Once the individual is well enough the doctor may end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

In 2022-23, 6,713 episodes began, which was 1.7% more episodes than in 2021-22. The average year-on-year change of new episodes in 2013-14 to 2021-22 was 4.9% (ranging 0%–10.9%) (Appendix Table A1).

Figure 1 shows the structures of all episodes in 2022-23. 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.

50.9% of all episodes began with a STDC, 48.0% with an EDC, and 1.2% with a CTO or an iCTO (Appendix Table A1).

Figure 1. Order progression among all episodes in 2022-23



Of the 49 episodes which started as CTOs (Figure 1) 40.8% were community-based CTOs.

In 2022-23 almost half of all episodes progressed as far as an STDC, 26.2% progressed to a CTO, 4.2% as an iCTO (Figure 2) and 21.8% ended as an EDC. This was similar to the average in the previous years.

Figure 2. Longest period of permitted detention an episode of detention progressed to by year

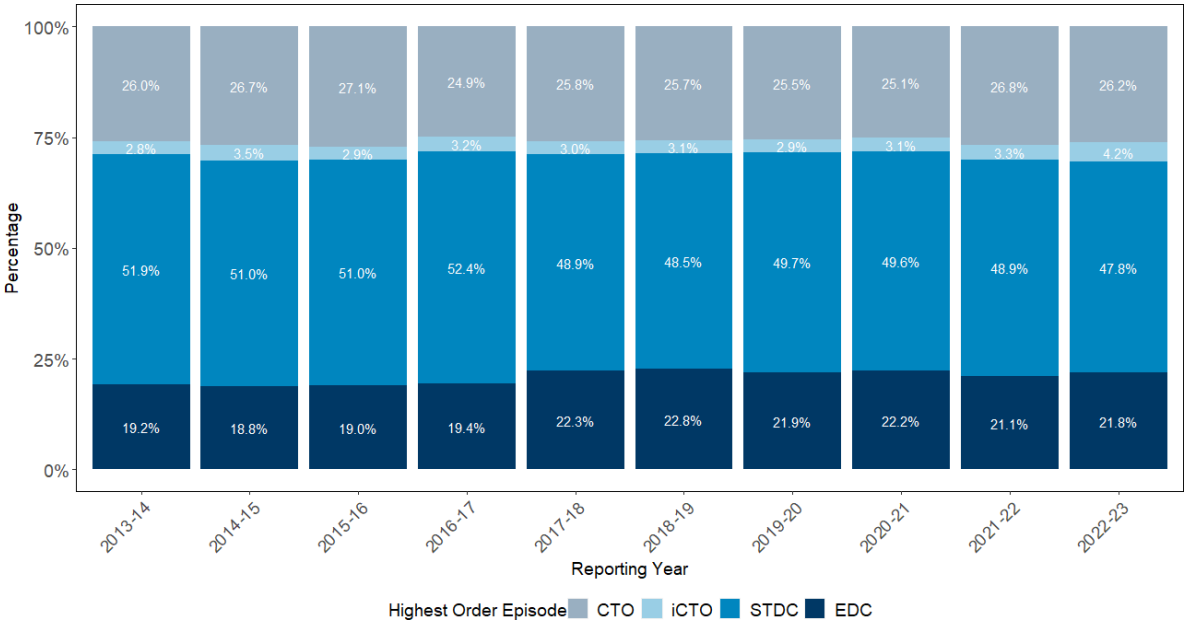
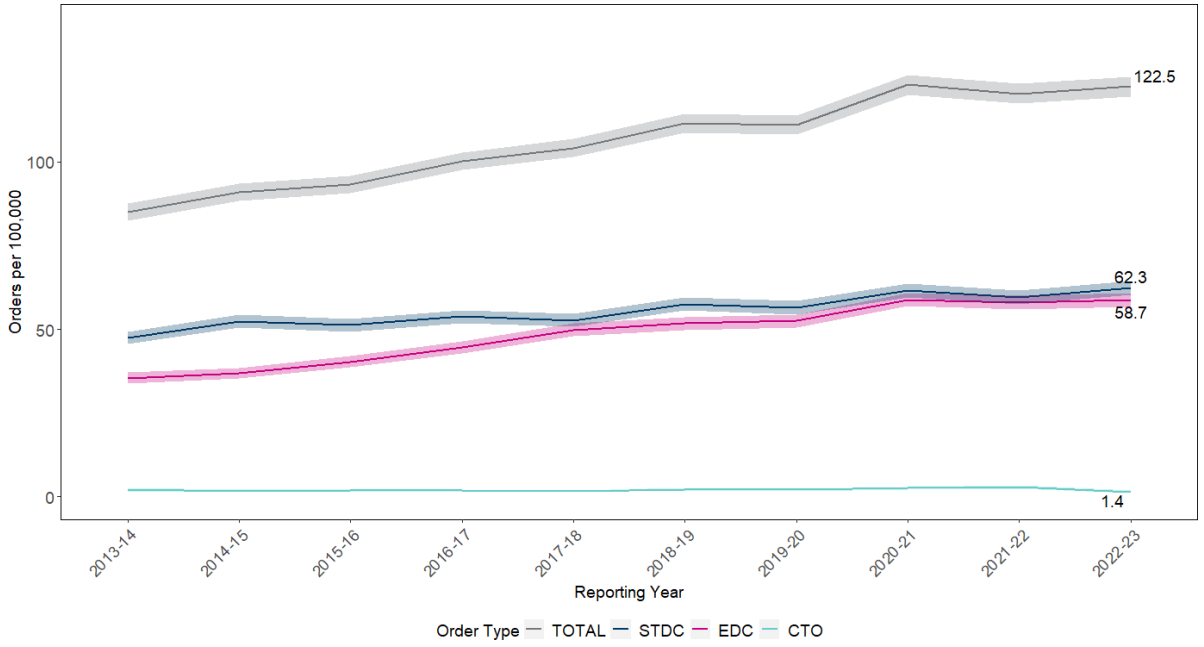


Figure 3 shows the change in rate of detention episodes over time with 95% confidence interval (CI)[1]. The rate of new episodes per 100,000 population was 122.5 (95% CI: 119.6–125.4). The rate of episodes by type of order (based on the starting order) was 58.7 (95% CI: 56.7–60.8) for EDC, 62.3 (95% CI: 60.2–64.4) for STDC and 1.4 (95% CI: 1.1-1.8) for CTO.

Figure 3. Rate of detention by year with 95% CI (shaded area)[2]



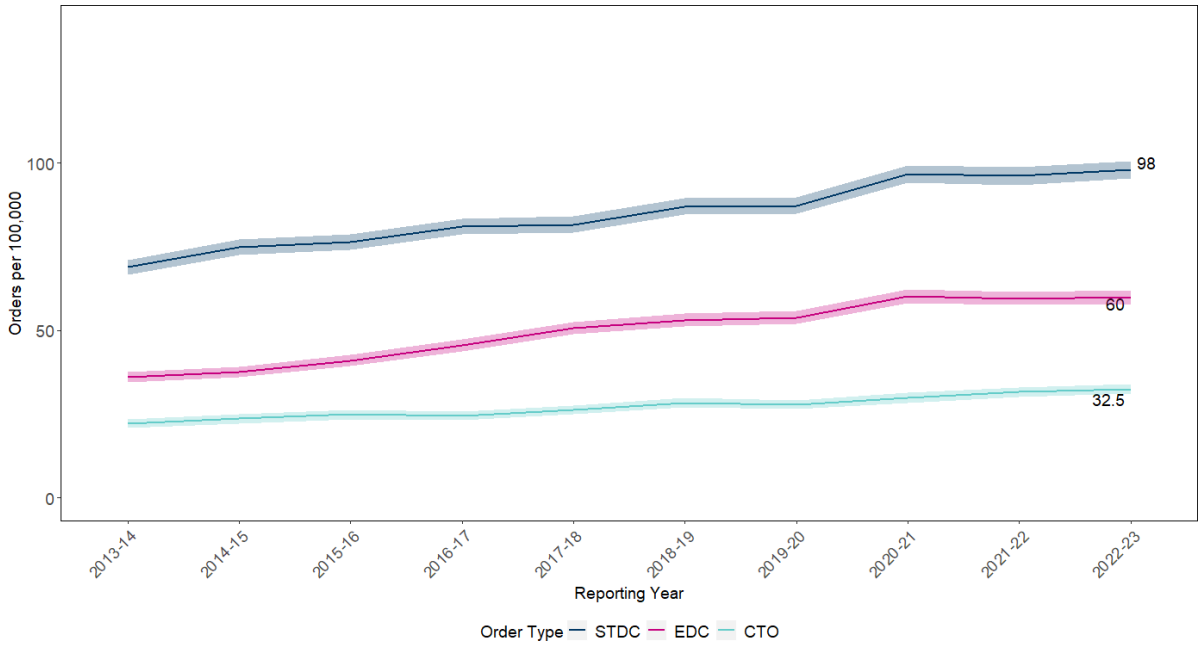
[1] A confidence interval gives a measure of the precision of a value. It shows the range of values that encompass the population or 'true' value, estimated by a certain statistic, with a given probability. For example, if 95% confidence intervals are used, this means we can be sure that the true value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

[2] Due to the scale of the x-axis, the CI for CTO is not visible on this graph.

New Mental Health Act orders

An order is an instance where an individual becomes subject to the Mental Health Act. For example, an EDC, a 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 e.g., in the situation where a person may be subject to a suspended hospital based CTO but is admitted under an EDC initially. The number of orders are presented in Appendix tables A2-A4. In the following sections we analyse standardised rates for each order type for 2022-23.

Figure 4. Rate of new orders with 95% CI (shaded area)



Emergency detention certificates (EDCs)

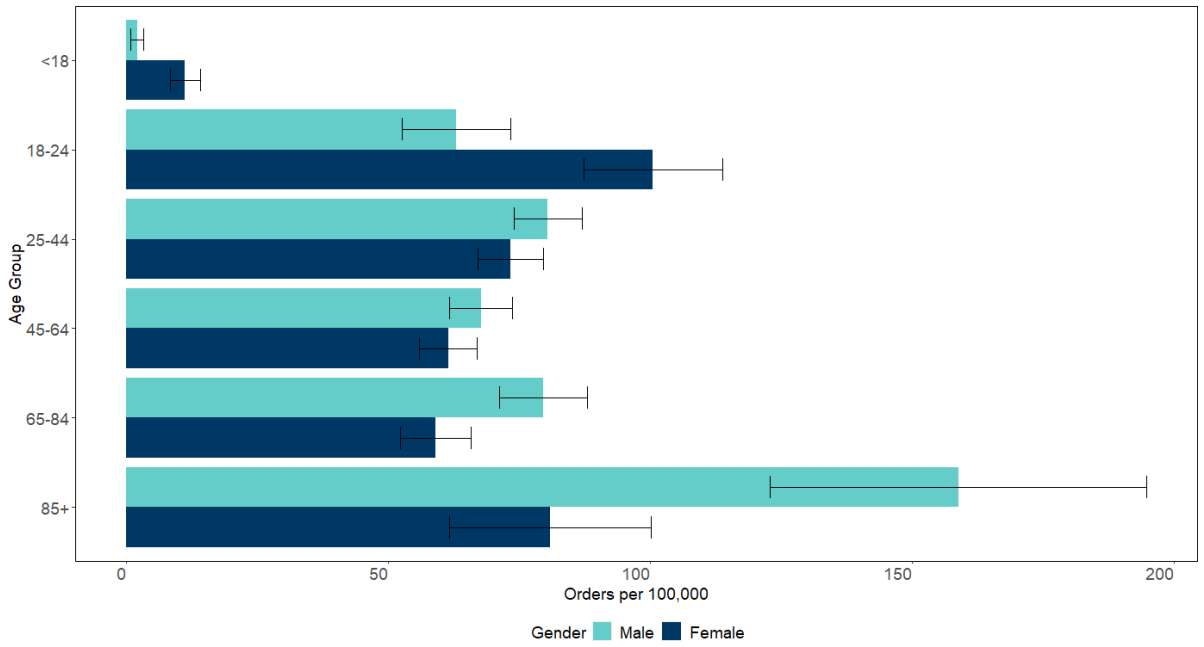
Unlike in the Mental Health (Scotland) Act 1984, there is an expectation that emergency orders will be used 'sparingly' in the current Mental Health Act [1]. Clear reasons need to be recorded as to the necessity for granting an EDC rather than the preferred route of a STDC which provides the person with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

The overall rate of EDCs in 2022-23 was 60.0 (95% CI: 58.0-62.1), very similar to the previous year's rate of 59.3 (95% CI: 57.2–61.3) (Figure 4). The number of orders is shown in Appendix Table A2.

The rate of EDCs vary slightly by gender. In 2022-23 the overall rate of EDCs was 58.8 (95% CI: 55.9–61.6) for females and 61.4 (95% CI: 58.4–64.3) for males.

Figure 5 shows the rate for each age group, indicating a higher rate for females than males in younger age groups but for those aged 25 years and older the opposite was true. The rate of EDCs was particularly high for males aged 85 years or older, which was 158.8 per 100,000 (95% CI: 122.8-194.7) higher compared to the rate last year of 131.2 per 100,000. However, it should be noted that the confidence interval is wide and the true estimate is therefore uncertain.

Figure 5. Age- and gender-standardised rate of EDCs in 2022-23 with 95% CI



The rate of EDCs in Scottish mainland health boards varied from 26.2 per 100,000 in Highland to 104.8 in Greater Glasgow and Clyde. Compared to our last monitoring report, rates decreased in six of 11 mainland boards; Borders, Dumfries & Galloway, Forth Valley, Highland, Lanarkshire and Tayside. The rate of EDCs increased compared to our last reported figures in Ayrshire & Arran, Fife and Lothian with Grampian and Greater Glasgow & Clyde remaining similar to last year. The rates across all health boards are shown in Figures 6a and 6b. The island boards have a small number of orders, which leads to unstable rates with very wide confidence intervals. The rates for these boards should therefore be interpreted with caution.

Figure 6a. Rate of EDCs per 100,000 in 2022-23 with 95% CI, by health board

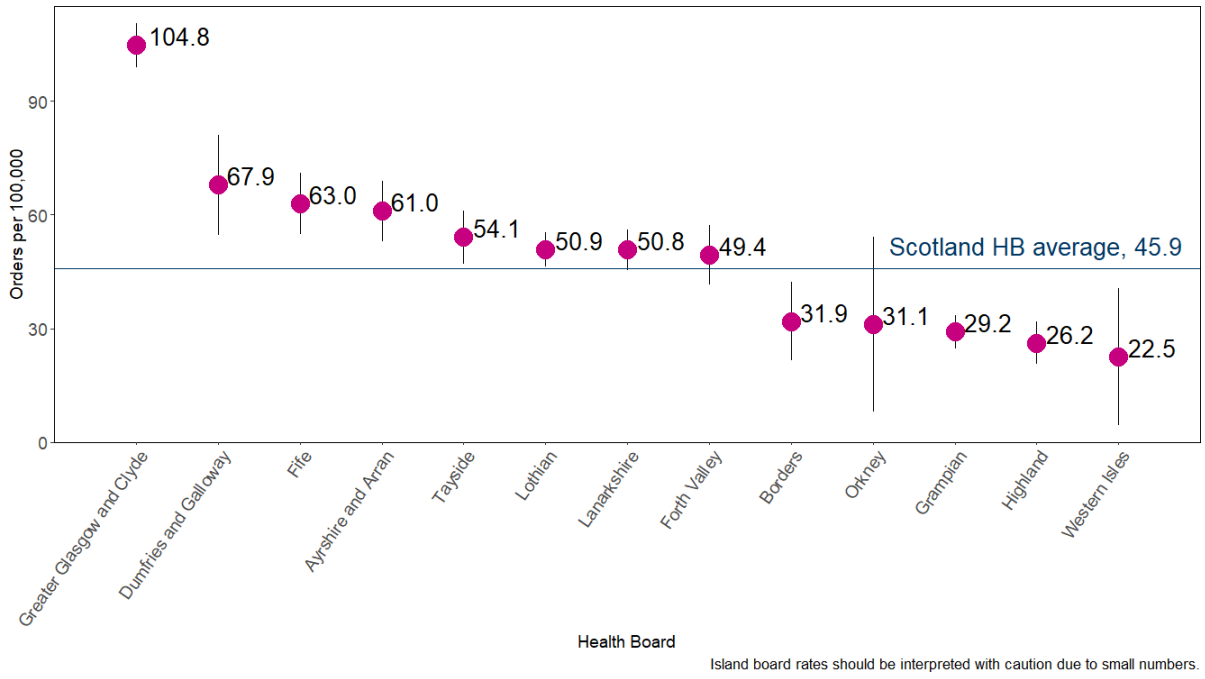
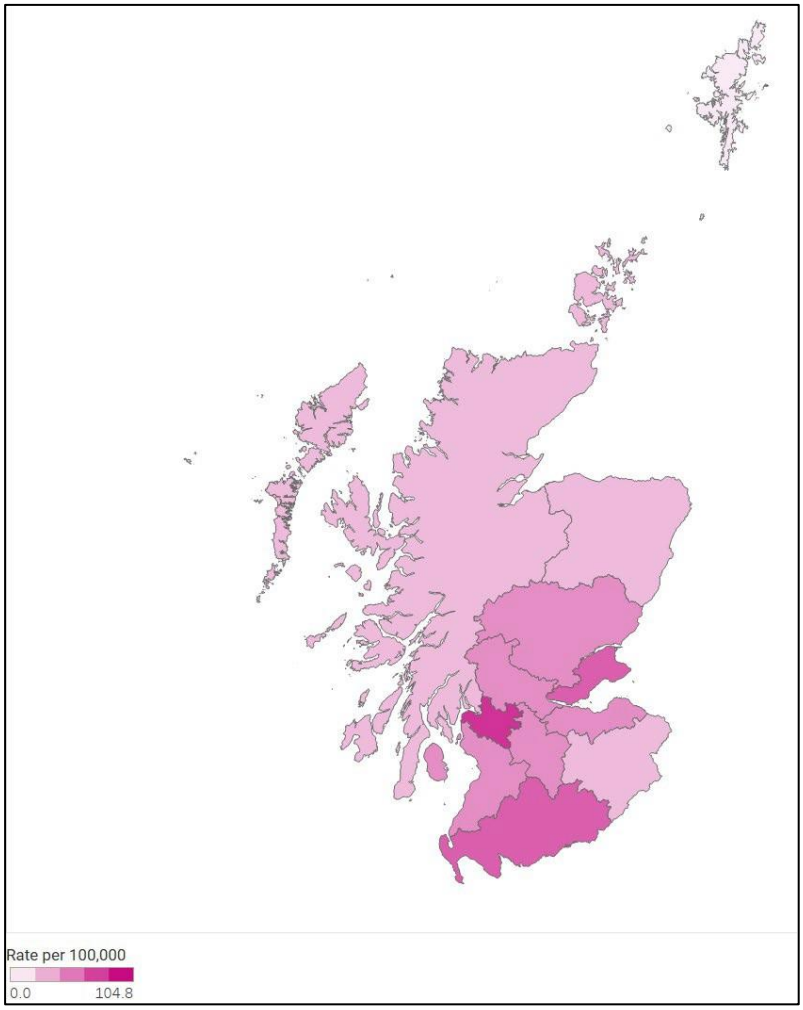


Figure 6b. Rate of EDCs per 100,000 in 2022-23, by health board



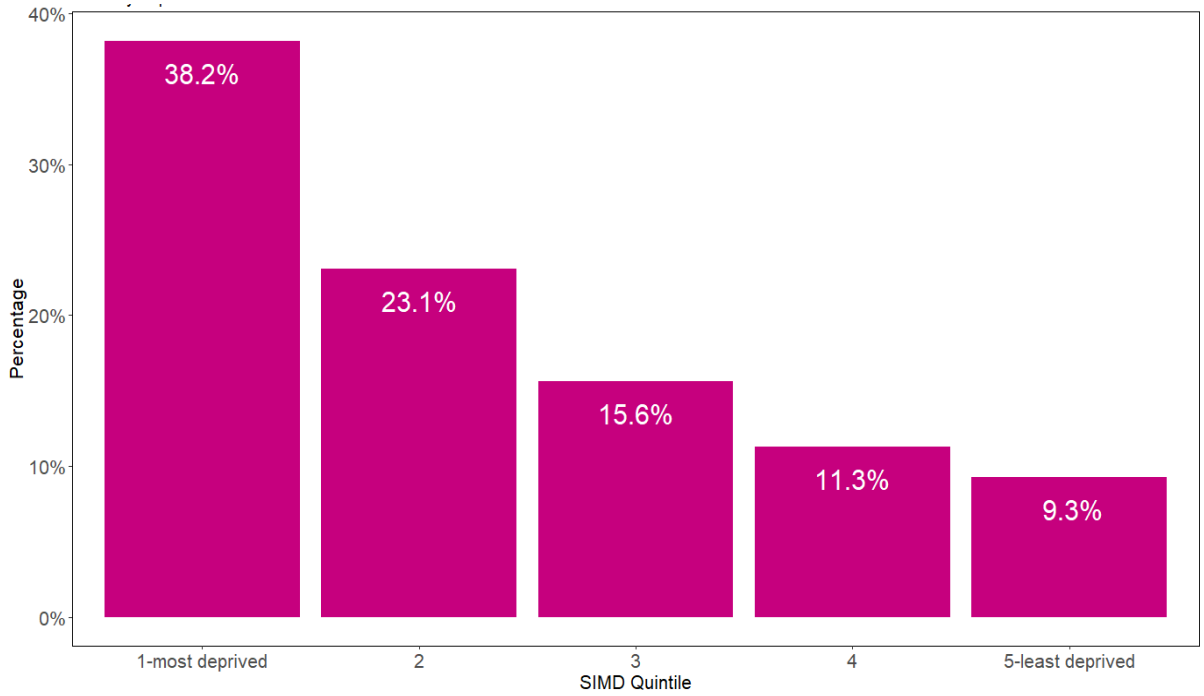
Health Board	Rate
Greater Glasgow and Clyde	104.8
Dumfries and Galloway	67.9
Fife	63.0
Ayrshire and Arran	61.0
Tayside	54.1
Lothian	50.9
Lanarkshire	50.8
Forth Valley	49.4
Scotland HB average	**45.9**
Borders	31.9
Orkney	31.1
Grampian	29.2
Highland	26.2
Western Isles	22.5
Shetland	0.(

Deprivation

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

We were able to match 97.5% of EDCs with SIMD by using a valid home postcode. Figure 7 shows a clear gradient in the level of deprivation for EDCs, with 38.2% of detentions of people from the 20% most deprived areas of Scotland.

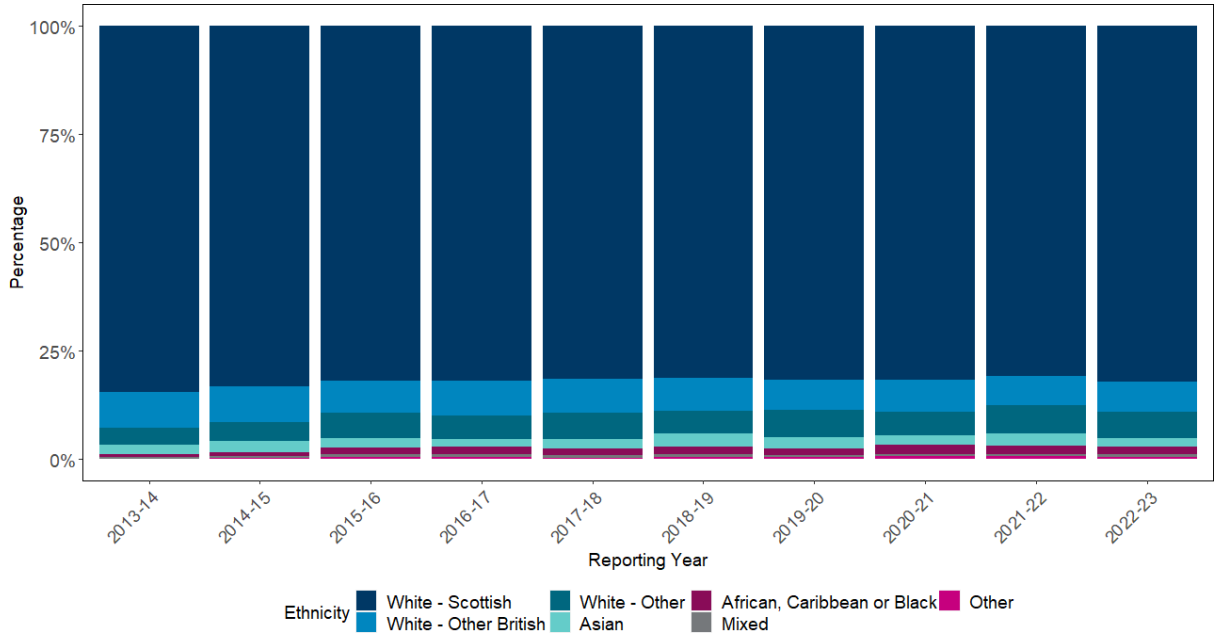
Figure 7. EDCs in 2022-23 by level of deprivation



Ethnicity

We had ethnicity information for 85.3% of EDCs in 2022-23. Figure 8 shows the breakdown of ethnicity categories of those detained under an EDC over the last 10 years, proportions remain broadly similar.

Figure 8. Ethnicity among EDCs by year



MHO consent

Mental health officers (MHOs) have a unique role in supporting and protecting people who are vulnerable because of a mental illness, learning disability or related condition. MHO duties include protecting individuals' health, safety, welfare, finances and property and the safeguarding of rights and freedom.

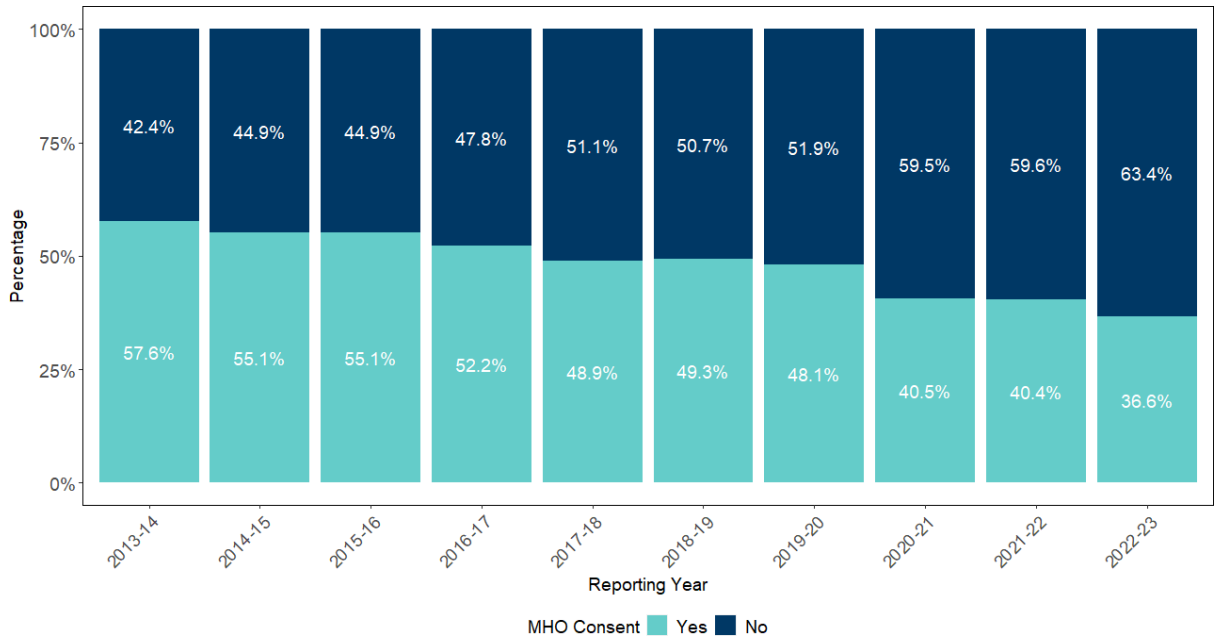
MHOs are involved in the assessment of individuals experiencing mental health difficulties who may need compulsory measures of care, treatment and in some cases, detention.

In line with previous years, MHO consent continues to be lower than we would expect to see.

Last year we drew attention to the continued decline in the percentage of this important safeguard. This year the proportion of EDCs with MHO consent has fallen further. Overall, 36.6% of EDCs had MHO consent in 2022-23 (Figure 9).

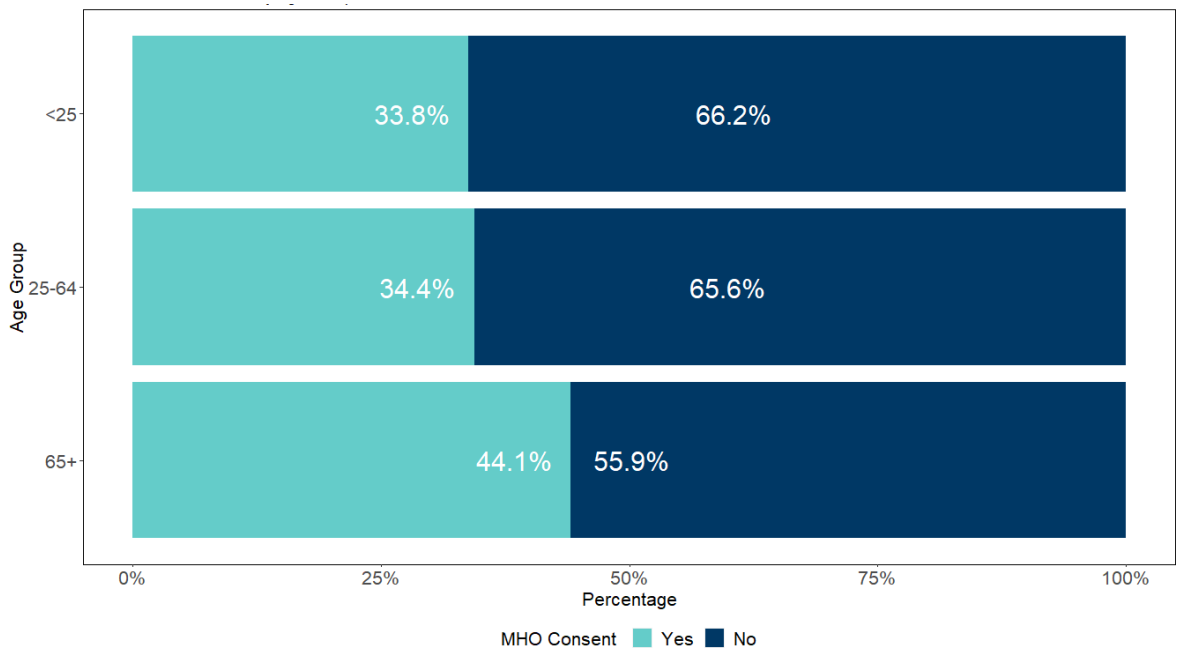
If an MHO is not consulted as part of the assessment for an EDC, the medical practitioner must explain the reasons for this. The medical practitioner must also explain the reasons for granting the certificate and why alternatives to detention were considered inappropriate. We expect there to be audits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

Figure 9. MHO consent for EDCs by year



We note the section (12.5.3) in the recently concluded Scottish Mental Health Law Review [6] that makes recommendations that section 36 of the Mental Health Act should be amended to make clear that detention under an EDC without MHO consent should only take place in exceptional circumstances. In the preceding paragraphs the review makes clear that there is a particular need to strengthen the safeguards under the Act as they apply to children. We therefore explored MHO consent by age. We found that across all age groups most people with EDCs did not receive MHO consent. In the light of the SMHLR comments on strengthening safeguards for young people, it is particularly concerning that for the under 25 age group (n=429), in 66.2% of cases, MHO consent was not provided as part of the EDC assessment and subsequent detention (Figure 10).

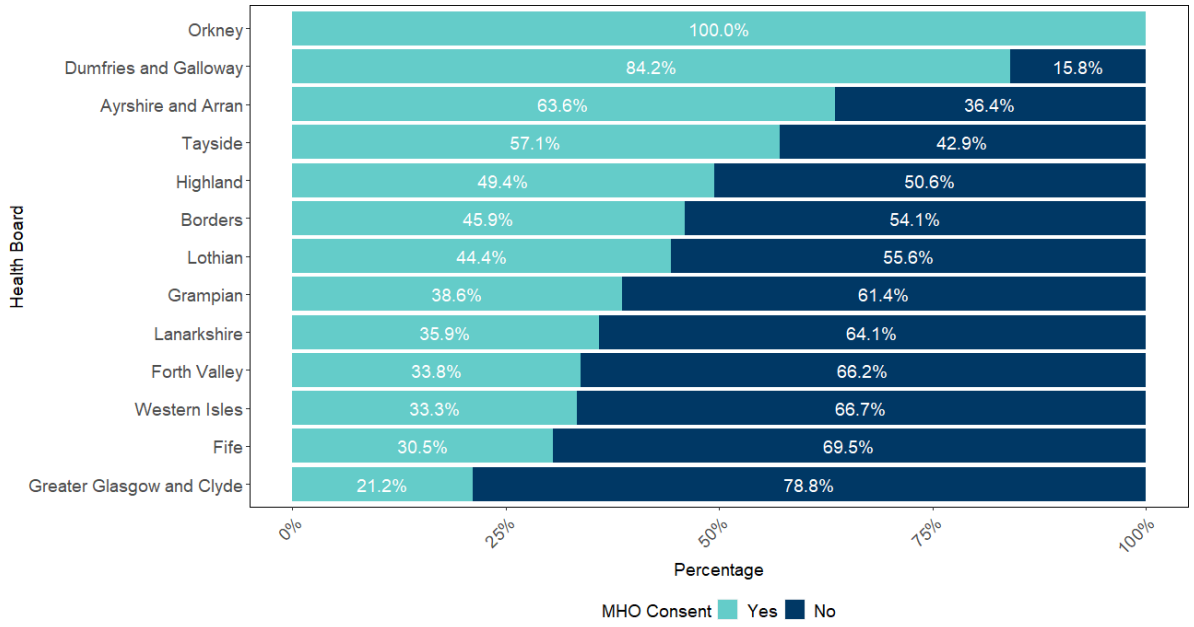
Figure 10. MHO Consent for EDC in 2022-23 by Age group



When we look at the breakdown by health board in 2022-23, we see great variation in MHO consent to EDCs. Orkney has the highest proportion of EDCs with 100% MHO consent. On the mainland, there is much variation in MHO consent to EDCs from as low as 21.2% (Greater Glasgow and Clyde) to 84.2% (Dumfries & Galloway) (Figure 11).

Of those detained under an EDC, 31.5% were not in a hospital at the time of the detention whereas 68.5% were in a named hospital, informally. The percentage of detentions that happened when the person was not in hospital was 0.7% higher than in the previous year, but 9.2% lower compared to the average for the years 2013-14 to 2021-22 when 40.7% of EDCs were for people not in hospital at the time of detention.

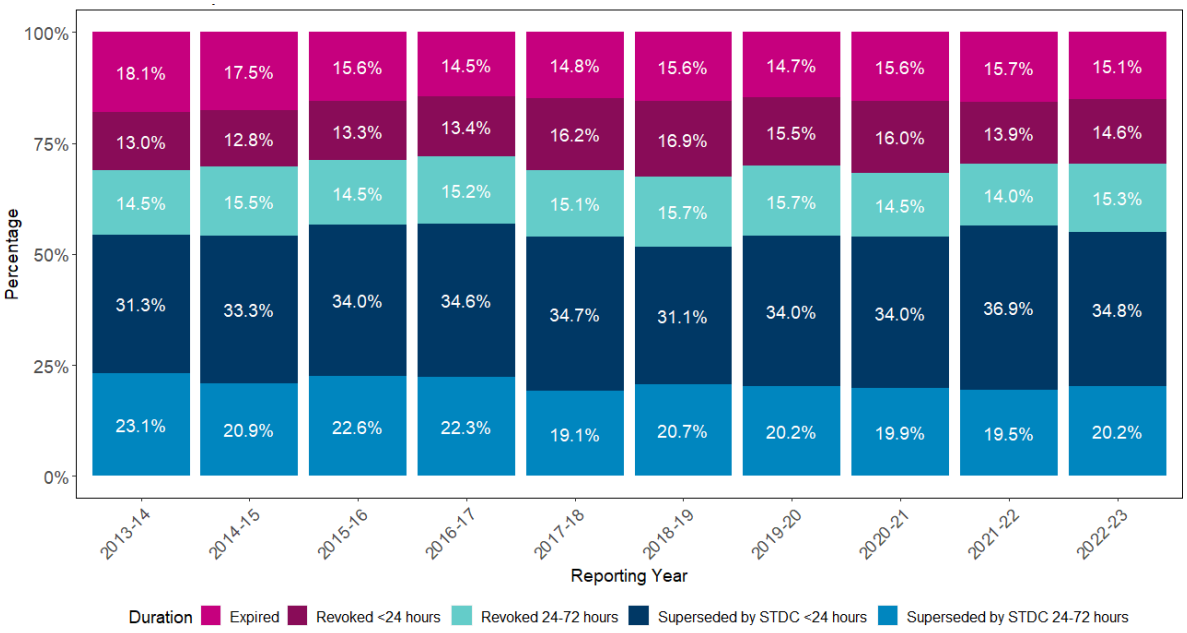
Figure 11. MHO consent for EDCs in 2022-23, by health board



Duration of emergency detentions

Similar to previous years just over half (55.0%) of EDCs were superseded by a STDC, most commonly within 24 hours. Over time there has been a shift towards more EDCs progressing to a STDC within 24 hours and fewer expiring at the end of the 72-hour-period. Over recent years there has been a slight shift in more revocations within 24 hours, while in 2022-23, this increased to 14.6%, it is still lower than the figures seen in 2017-18 to 2021-22 (Figure 12).

Figure 12. EDC conclusion by year



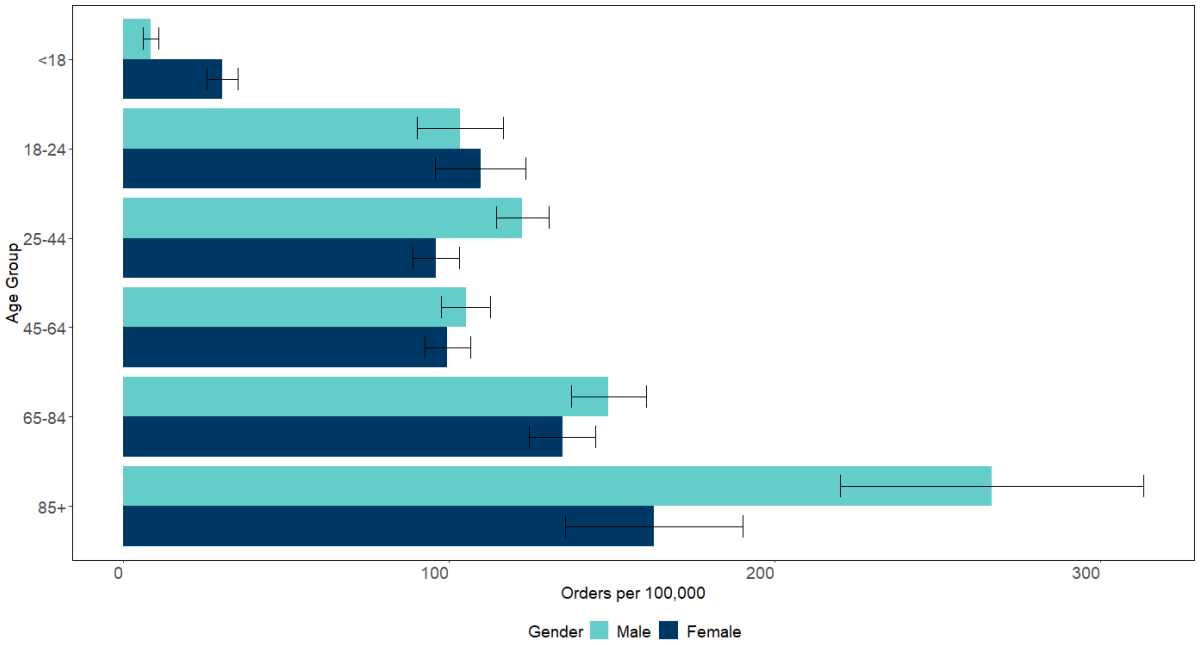
Short-term detention certificates

The overall rate of STDCs in 2022-23 was 98.0 (95% CI: 95.4-100.7), which is a slight increase on the 2021-22 figures of 95.5 (95% CI: 93.0–98.1) (Figure 4). The number of STDCs are shown in Appendix Table A3.

The rate of STDCs varies by gender. In 2022-23 the overall rate of STDCs was 95.4 (95% CI: 91.8–99.0) for females and 100.8 (95% CI: 97.0-104.6) for males.

Figure 13 shows the rate for each age group, showing that the rate of STDCs was higher among females than males under the age of 25 but higher among males than females over the age of 25. The rate for males over the age of 85 years was higher than other groups. However, just like with EDCs, the confidence intervals were very wide and the rate should therefore be interpreted with caution.

Figure 13. Age- and gender-standardised rate of STDCs in 2022-23 with 95% CI



In the mainland health boards the rate of STDCs varied from 56.0 (95% CI: 42.4–69.6) per 100,000 in Borders to 137.7 (95% CI: 131.0–144.4) in Greater Glasgow and Clyde. Compared to our last monitoring report, rates decreased in three of the 11 mainland health boards: Borders, Forth Valley and Tayside. The rate of STDCs increased compared to our last reported rates in Ayrshire & Arran, Dumfries & Galloway, Fife, Grampian, Highland, Lanarkshire and Lothian. Rates for Greater Glasgow and Clyde remained the same. The rates across all health boards are shown in Figure 14a & 14b. The island boards have small numbers of orders, which leads to unstable rates with very wide confidence intervals. The rates for these boards should therefore be interpreted with caution.

Figure 14a. Rate of STDCs per 100,000 in 2022-23, by health board with 95% CI

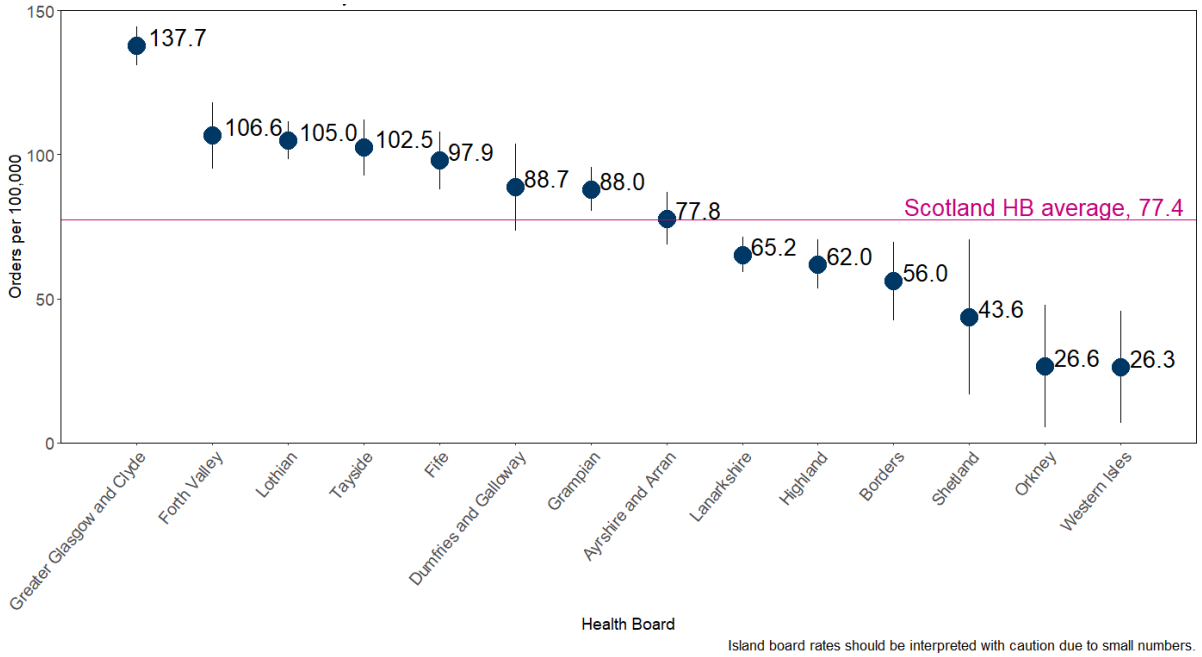
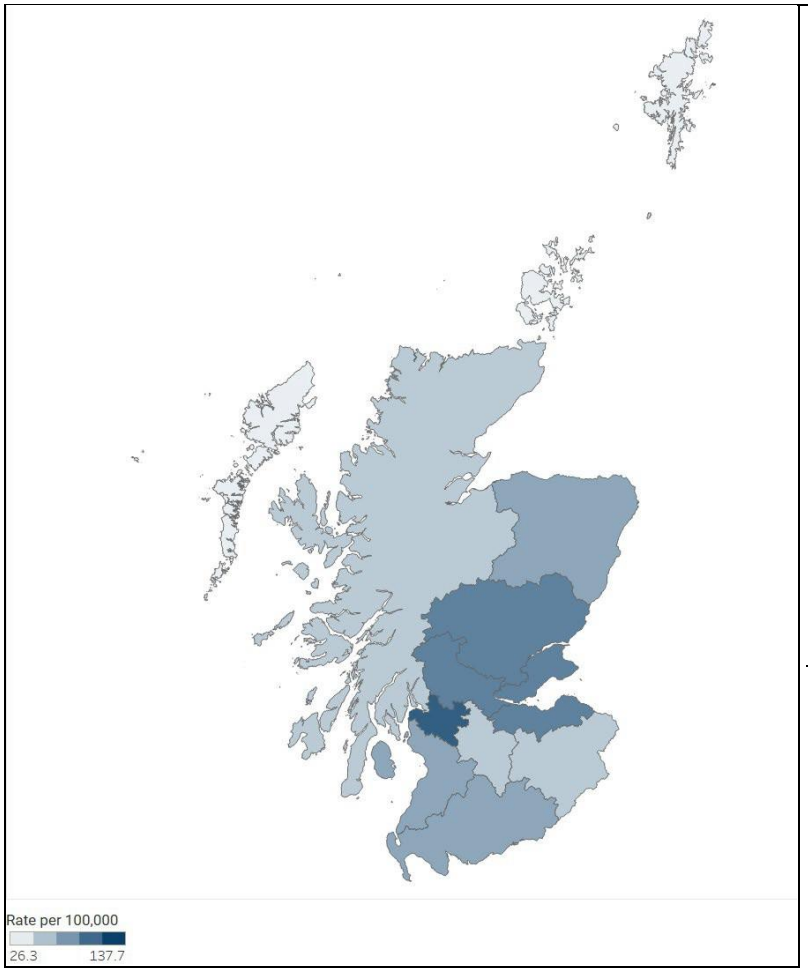


Figure 14b. Rate of STDCs per 100,000 in 2022-23, by health board



Health board	Rate
Greater Glasgow and Clyde	137.7
Forth Valley	106.6
Lothian	105.0
Tayside	102.5
Fife	97.9
Dumfries and Galloway	88.7
Grampian	88.0
Ayrshire and Arran	77.8
Scotland HB average	**77.4**
Lanarkshire	65.2
Highland	62.0
Borders	56.0
Shetland	43.6
Orkney	26.6
Western Isles	26.3

The rate of STDCs in mainland local authorities ranged from 55.1 per 100,000 (95% CI: 41.6–68.6) in Angus to 166.4 (95% CI: 156.4–176.5) in Glasgow City (Figure 15a & 15b). The number and rate of STDCs by local authority is shown in Appendix Table A4 and A5.

Figure 15a. Rate of STDCs per 100,000 in 2022-23, by local authority

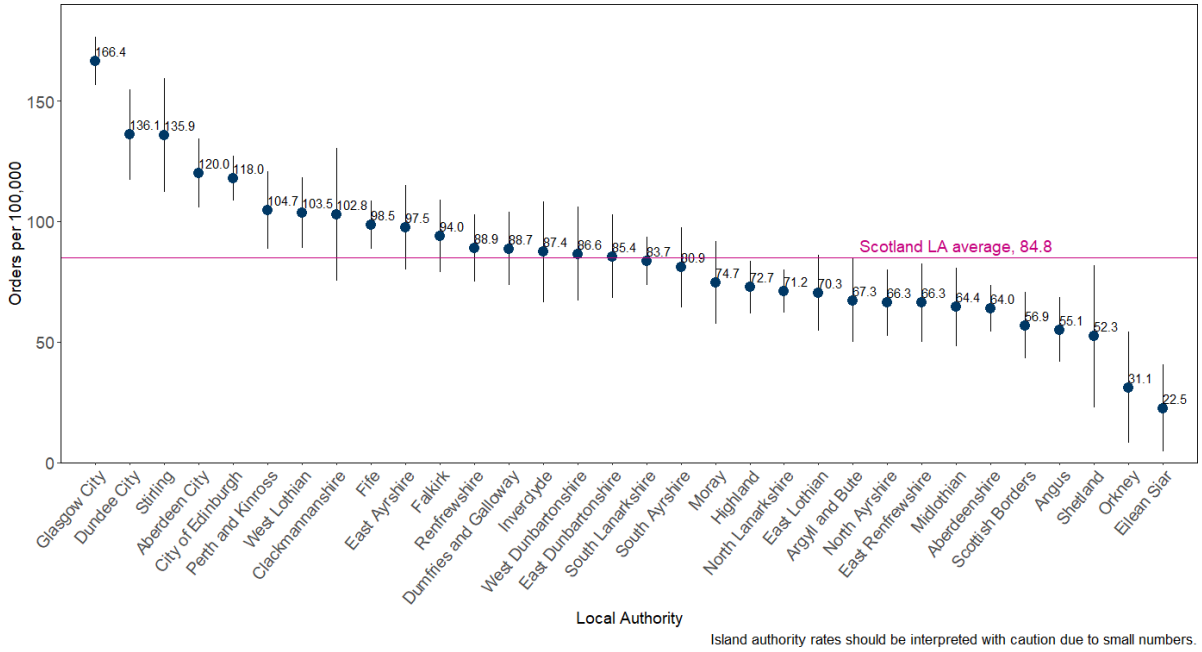
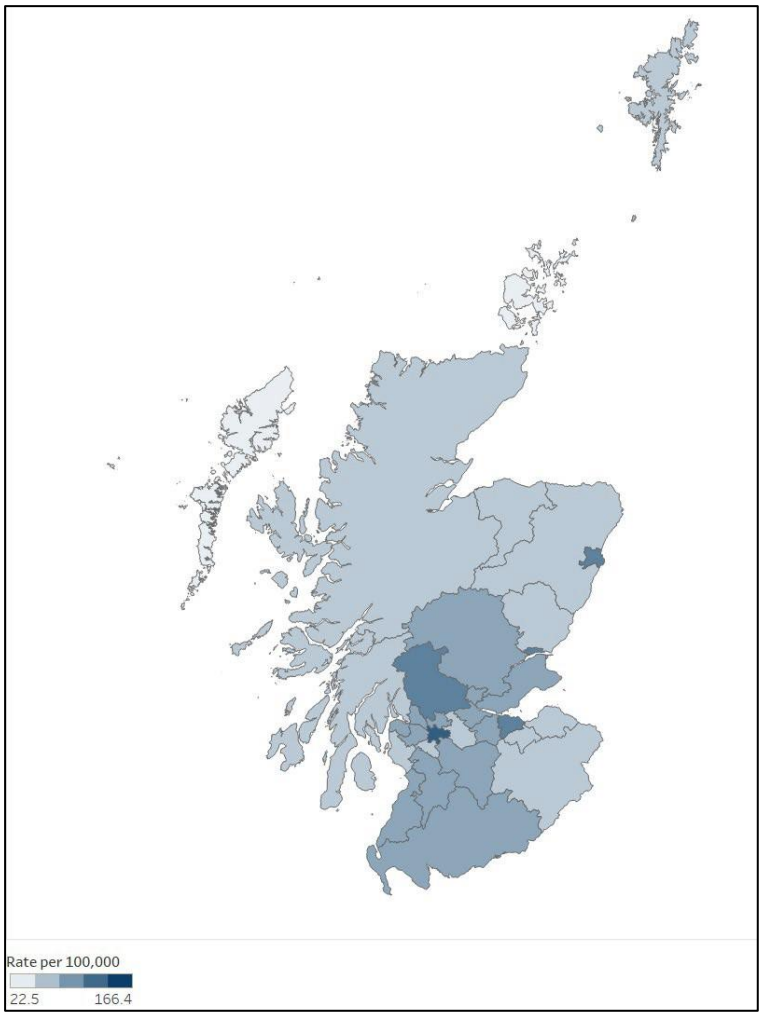


Figure 15b. Rate of STDCs per 100,000 in 2022-23, by local authority

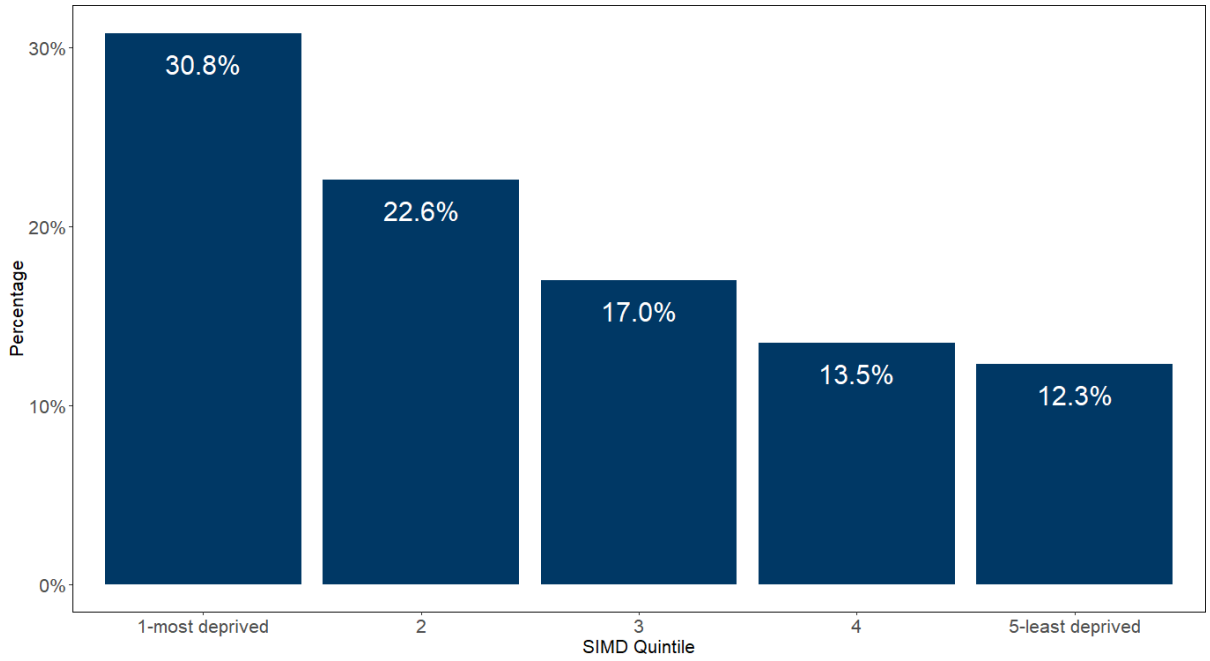


Local Authority	Rate
Glasgow City	166.4
Dundee City	136.1
Stirling	135.9
Aberdeen City	120.0
West Lothian	120.0
City of Edinburgh	118.0
Perth and Kinross	104.7
Clackmannanshire	102.8
Fife	98.5
East Ayrshire	97.5
Falkirk	94.0
Renfrewshire	88.9
Dumfries and Galloway	88.7
Inverclyde	87.4
West Dunbartonshire	86.6
East Dunbartonshire	85.4
Scotland LA average	**84.8**
South Lanarkshire	83.7
South Ayrshire	80.9
Moray	74.7
Highland	72.7
North Lanarkshire	71.2
East Lothian	70.3
Argyll and Bute	67.3
East Renfrewshire	66.3
North Ayrshire	66.3
Midlothian	64.4
Aberdeenshire	64.0
Scottish Borders	56.9
Angus	55.1
Shetland Islands	52.3
Orkney Islands	31.1
Na h-Eileanan an Iar	22.5

Deprivation

We were able to match 96.1% of STDCs with SIMD by using a valid home postcode. Figure 16 shows a clear gradient in level of deprivation for STDCs, with 30.8% of detentions of people from the 20% most deprived areas of Scotland.

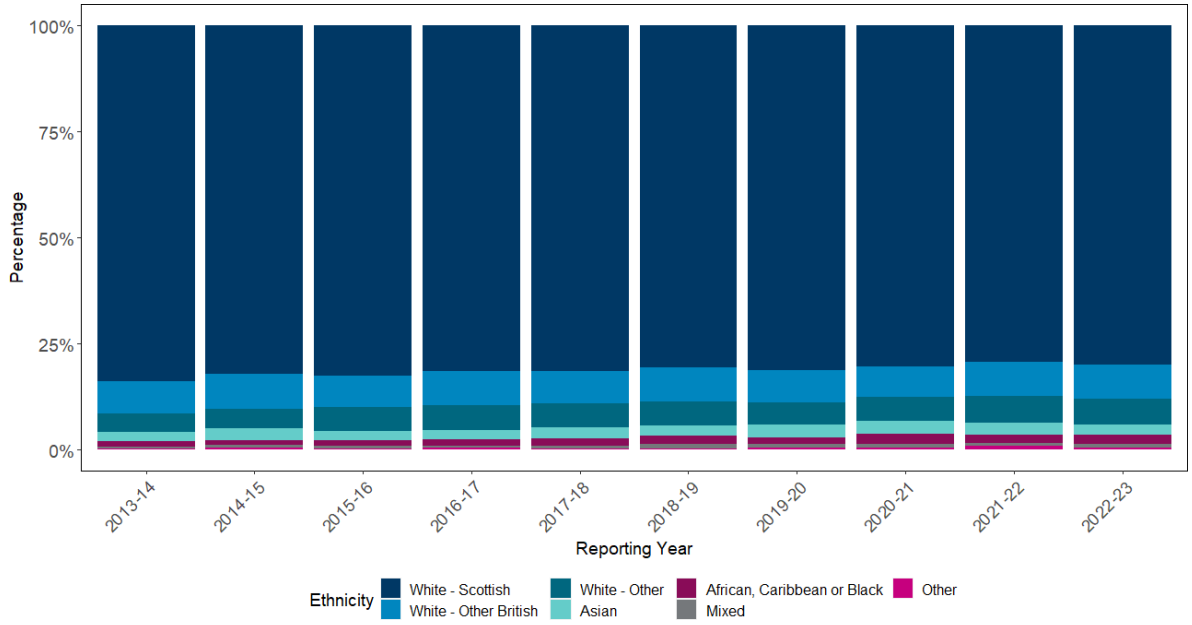
Figure 16. STDCs in 2022-23 by level of deprivation



Ethnicity

We had ethnicity information for 82.5% of STDCs in 2022-23. Figure 17 shows the breakdown of ethnicity categories of those detained under an STDC since 2013-14. There was little difference compared to previous years.

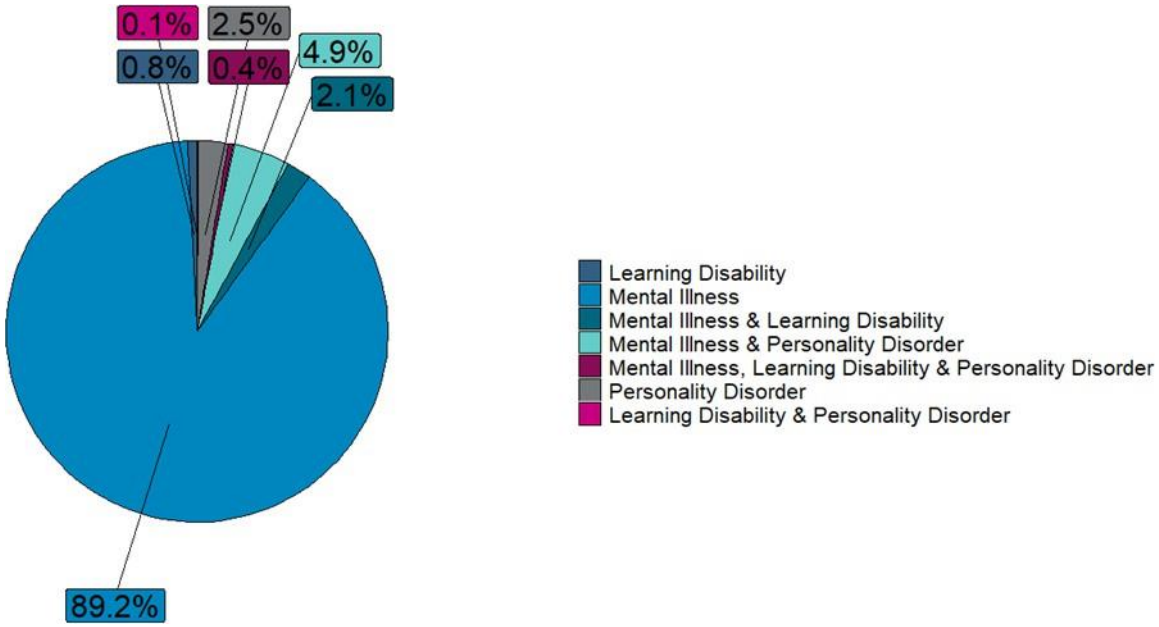
Figure 17. Ethnicity among STDCs by year



Diagnostic categories

All but 73 STDCs had broader level categories of mental disorder recorded. Figure 18 shows that the vast majority of STDCs were for the category mental illness (89.2%). For 4.9% the categories were mental illness and personality disorder, 2.5% had personality disorder, and 2.1% had mental illness and learning disability. Learning disability alone was recorded in 0.8% of short term detention certificates. Only 0.4% had a diagnosis of mental illness, learning disability and personality disorder and only 0.1% had a diagnosis of learning disability and personality disorder. The non-statutory forms that are used to record the diagnostic categories have recently been updated on the Scottish Government website to replace the World Health Organisation's International Classification of Disease-10 (ICD-10) coded primary diagnoses associated with the categories specified in the 2003 Act with ICD-11 codes. Although it is not a statutory requirement to complete this information, over time, if this data is properly and systematically recorded, it will allow a more specific recording of diagnosis associated with detention and safeguards.

Figure 18. Diagnostic Categories recorded on detentions under a STDC in 2022-23

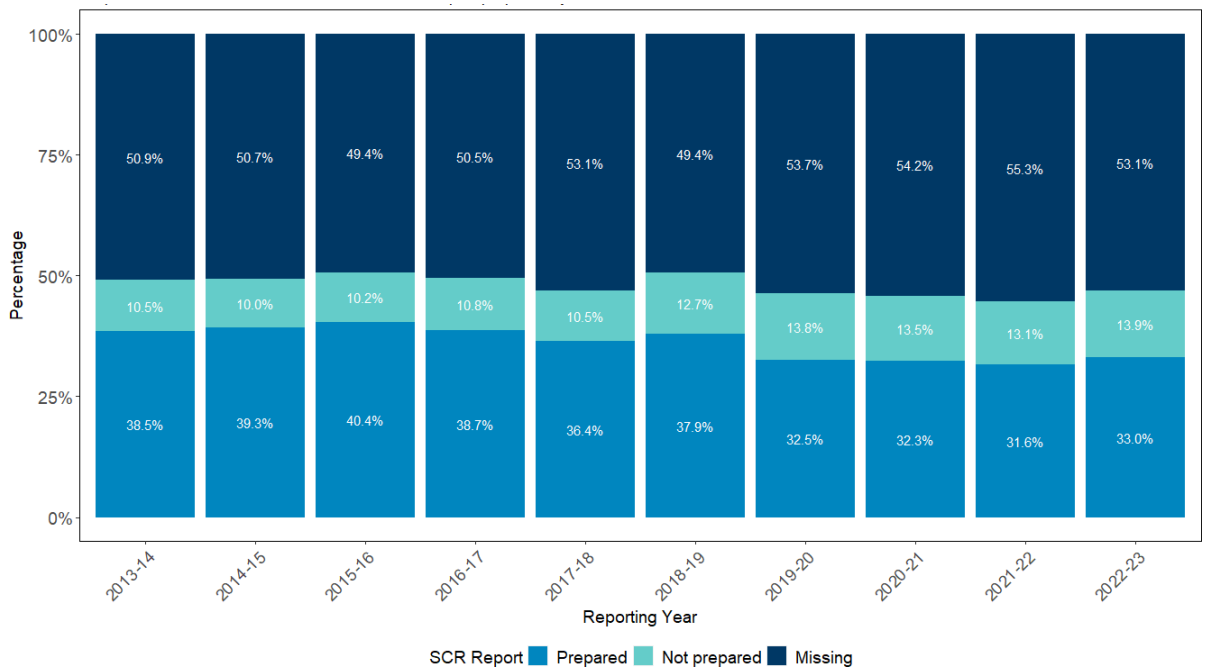


Social circumstances reports

Looking at the person's social circumstances is very important for mental health services to fulfil their duty to respect people's social, economic and cultural rights. One of these duties is for an MHO to write a social circumstances report (SCR), as described in section 231 of the Mental Health Act [1]. Understanding a person's wider circumstances is important to be able to consider the social context that might have contributed to the detention and what options might be available to help with treatment and recovery. The SCR aims to provide that detail on a person's circumstances.

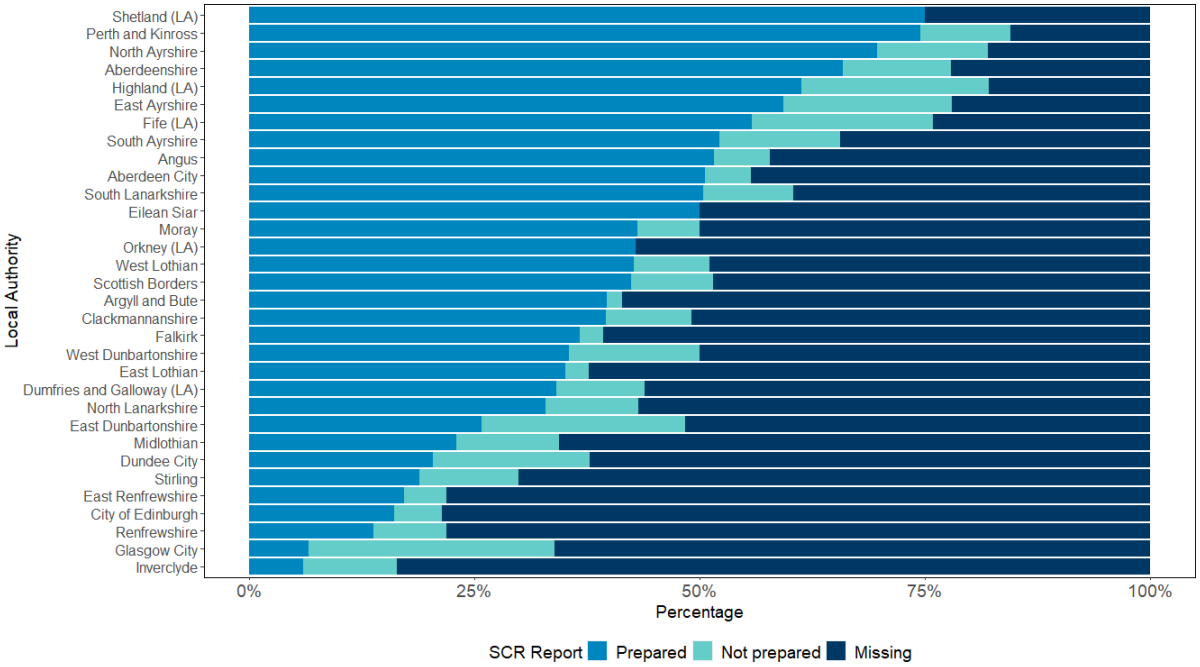
An MHO must prepare a social circumstances report within 21 days of a person being made subject to a STDC. In cases where the MHO considers such a report would serve little or no, practical purpose, the MHO must send a statement of those reasons to the Commission. For 46.9% of STDCs in 2022-23 the Commission received notification that an SCR had been prepared or that an SCR would serve no purpose (13.9% did not have a social circumstances report prepared as it was deemed that it 'serves no purpose' while 33.0% of all STDCs had one prepared). In 53.1% of cases we received no notification (termed "missing" in the discussions below). This is a slightly lower percentage than last year (Figure 19). This completion rate remains of significant concern. The Commission raised this concern at end of year meetings last year and will be discussing this once more with health and social care partnerships and their respective health boards and local authorities.

Figure 19. Proportion of STDCs with a social circumstances report prepared, by year



The proportion of completed social circumstances reports varied from 6.0% in Inverclyde to 75.0% in Shetland (Figure 20). Proportion of STDCs missing a social circumstances report all together ranged from 15.5% in Perth and Kinross to 83.6% in Inverclyde. Social circumstances reports that were returned but indicated as not completed as they 'serve little or no practical purpose' ranged from none in Orkney, Shetland and Eilean Siar to 27.2% in Glasgow City.

Figure 20. Social circumstances reports completed in 2022-23, by local authority



How short term detention certificates end

Work undertaken by Mental Welfare Commission staff in association with the University of Edinburgh's statistical department that aimed to demonstrate the average length of short term detention certificates using the Commission's 's database between 2006 and 2018 was published in *Social Psychiatry and Psychiatric Epidemiology* in 2023 and is available as an open access publication[3]. This work showed that over that period, 40% of STDCs ended by being revoked, 20% end by lapsing of the detention (this proportion has fallen over that time frame) and 40% of detentions are extended, most commonly onto CTOs.

Compulsory treatment orders

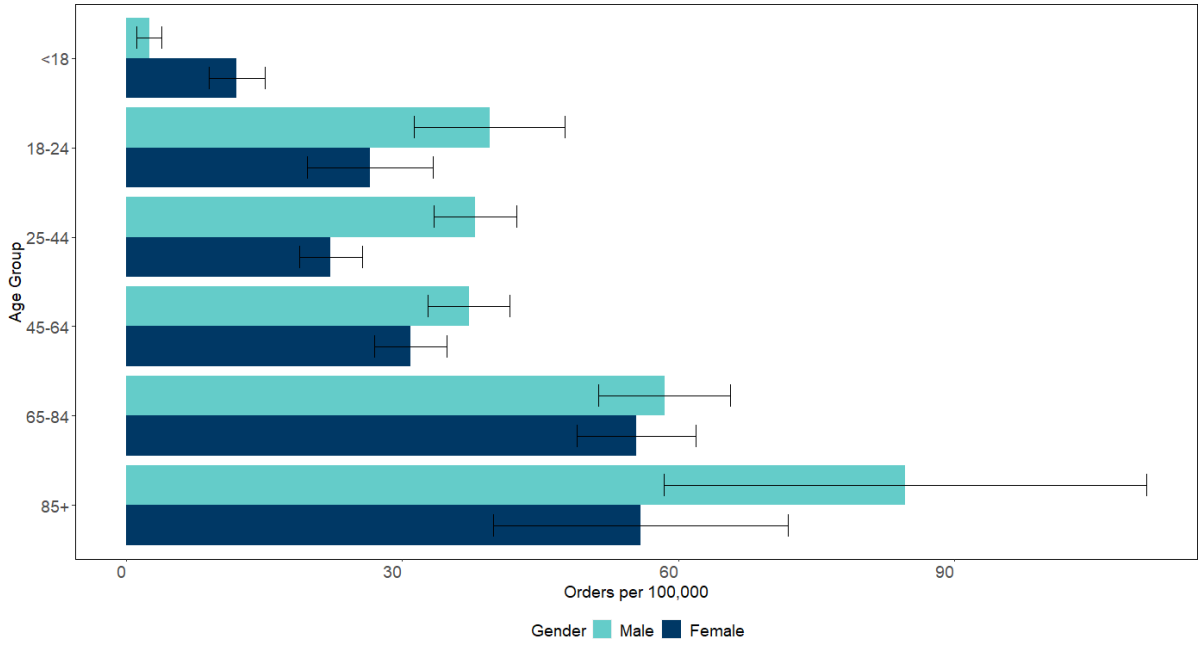
The overall rate of CTOs in 2022-23 was 32.5 (95%CI: 31.0-34.0), which was a slight increase in the 2021-22 rate of 31.5 (95% CI: 30.0–33.0) (Figure 4). The number of CTOs are shown in Appendix Table A6.

The rate of CTOs vary by gender. In 2022-23 the overall rate of CTOs was 30.1 (95% CI: 28.1–32.1) for females and 35.1 (95% CI: 32.9–37.3) for males.

Figure 21 shows a similar trend for EDCs and STDCs with higher rate among females under the age of 18 years. The wide CIs for several age groups should be noted and acknowledged when interpreting these differences. As with STDCs and EDCs, the confidence intervals for the oldest age groups were very wide and these rates should therefore be interpreted with caution.

[3] Length and associated characteristics of short-term detentions: an analysis of detentions under the Mental Health Act in Scotland, 2006–2018 - PMC (nih.gov)

Figure 21. Age- and gender-standardised rate of CTOs in 2022-23 with 95% CI



In the mainland health boards the rate of CTOs varied from 10.3 (95% CI: 4.5-16.2) per 100,000 in Borders to 45.7 (95% CI: 41.9–49.6) in Greater Glasgow and Clyde. Compared to our last monitoring report, rates increased in six of the 11 mainland health boards. The rate of CTOs decreased on our last reported figures in Borders, Highland and Lothian. Rates in Fife and Tayside were similar to last year. The rates across all health boards are shown in Figure 22a and 22b. The island boards have small number of orders, which leads to unstable rates with very wide confidence intervals. The rates for these boards should therefore be interpreted with caution.

Figure 22a. Rate of CTOs per 100,000 in 2022-23 with 95% CI, by health board

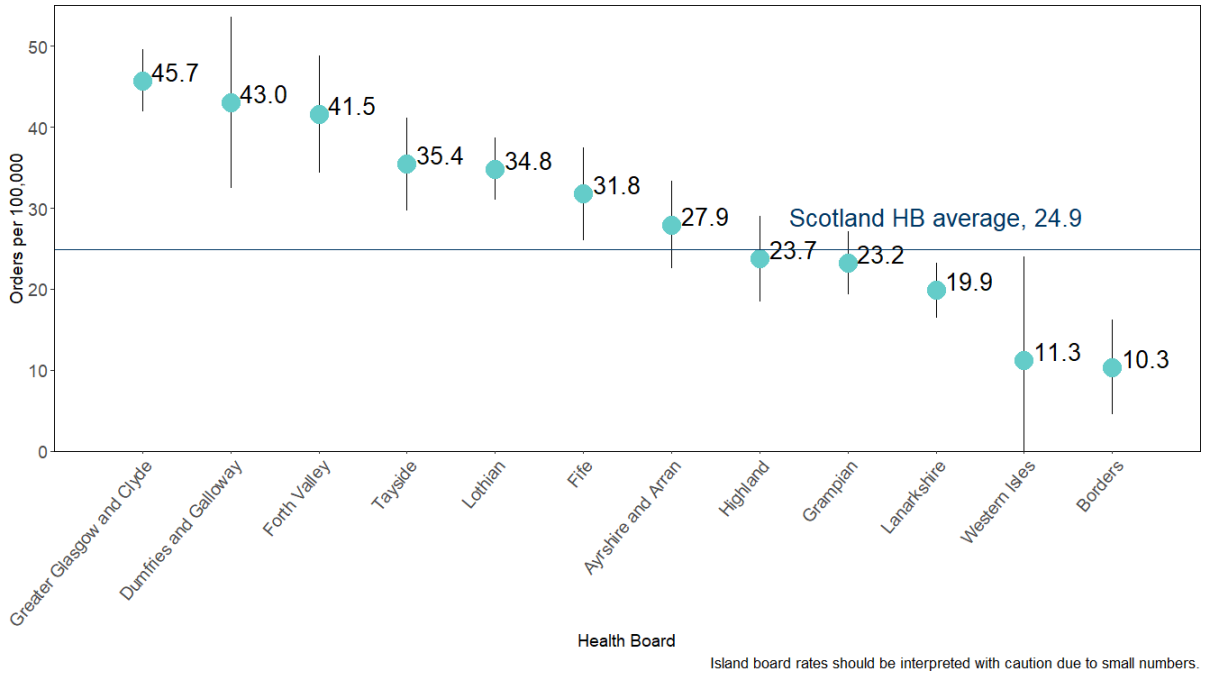
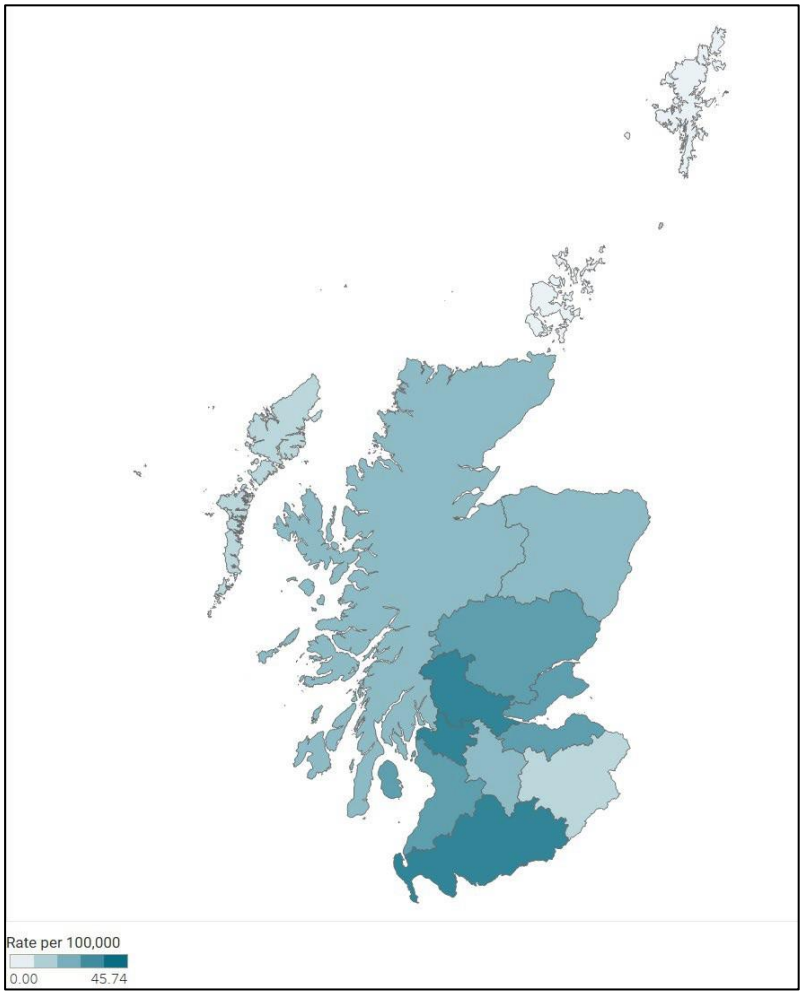


Figure 22b. Rate of CTOs per 100,000 in 2022-23, by health board



Health board	Rate
Greater Glasgow and Clyde	45.7
Dumfries and Galloway	43.0
Forth Valley	41.5
Tayside	35.4
Lothian	34.8
Fife	31.8
Ayrshire and Arran	27.9
Scotland HB average	24.9
Highland	23.7
Grampian	23.2
Lanarkshire	19.9
Western Isles	11.3
Borders	10.3
Orkney	0.0
Shetland	0.(

We also looked at the rate of CTOs by local authority. The mainland rates ranged from 13.8 per 100,000 (95% CI: 7.0–20.5) in Scottish Borders to 50.5 (95% CI: 45.0–56.1) in Glasgow City (Figure 23a & 23b). The number and rate of CTOs is shown in Appendix Table A7 and A8.

Figure 23a. Rate of CTOs per 100,000 in 2022-23 with 95% CI, by local authority

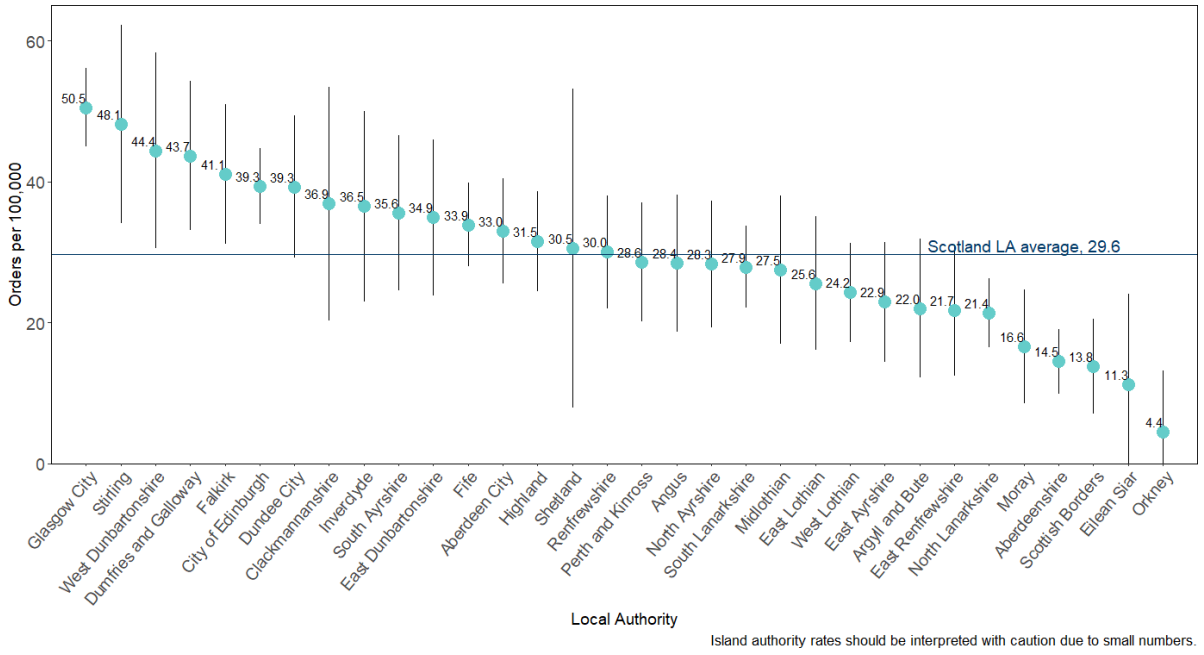
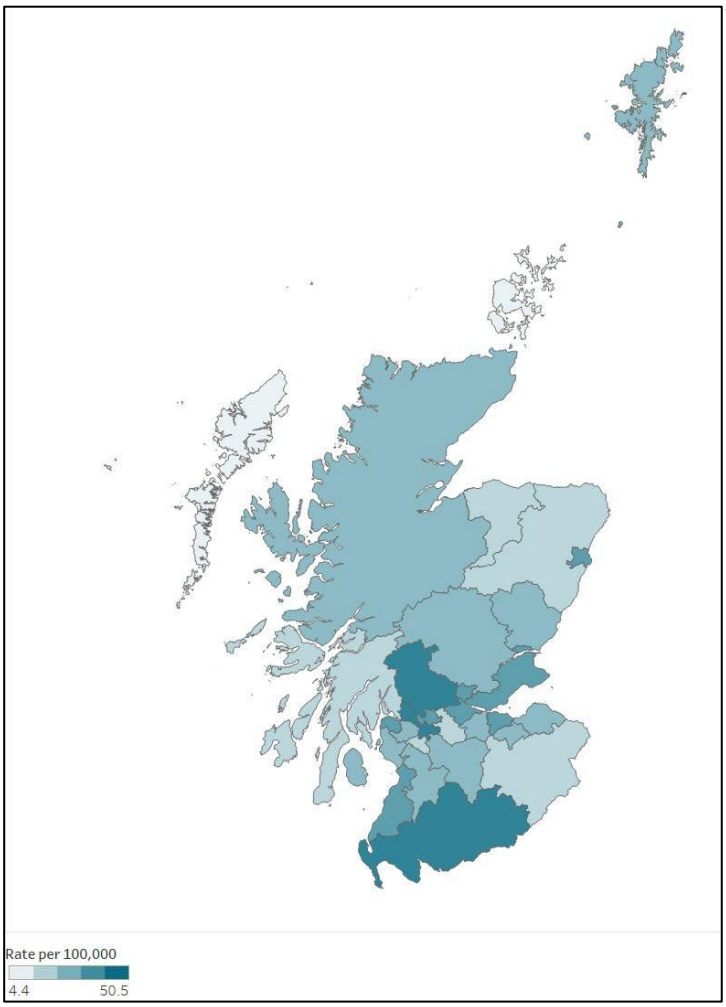


Figure 23b. Rate of CTOs per 100,000 in 2022-23, by local authority

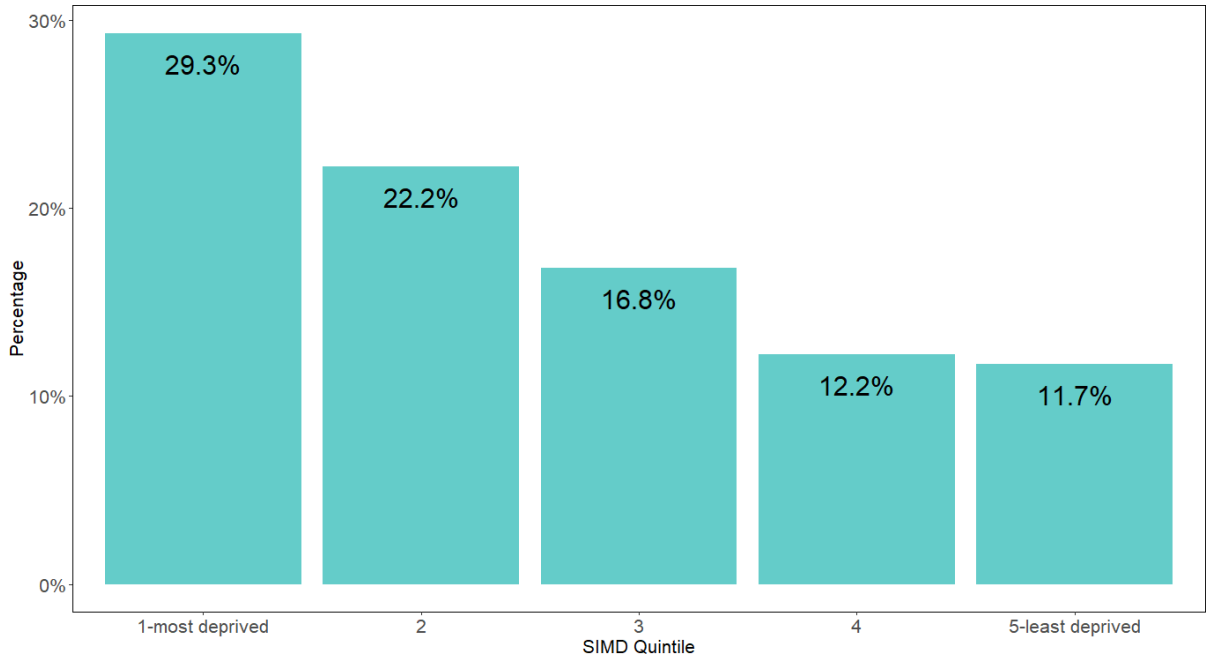


Local Authority	Rates
Glasgow City	50.5
Stirling	48.1
West Dunbartonshire	44.4
Dumfries and Galloway	43.7
Falkirk	41.1
City of Edinburgh	39.3
Dundee City	39.3
Clackmannanshire	36.9
Inverclyde	36.5
South Ayrshire	35.6
East Dunbartonshire	34.9
Fife	33.9
Aberdeen City	33.0
Highland	31.5
Shetland Islands	30.5
Renfrewshire	30.0
Scotland LA average	**29.6**
Perth and Kinross	28.6
Angus	28.4
North Ayrshire	28.3
South Lanarkshire	27.9
Midlothian	27.5
East Lothian	25.6
West Lothian	24.2
East Ayrshire	22.9
Argyll and Bute	22.0
East Renfrewshire	21.7
North Lanarkshire	21.4
Moray	16.6
Aberdeenshire	14.5
Scottish Borders	13.8
Na h-Eileanan an Iar	11.3
Orkney Islands	4.4

Deprivation

We were able to match 92.1% of CTOs with SIMD by using a valid home postcode. Figure 24 shows a clear gradient in level of deprivation for EDCs, with 29.3% of CTOs of people from the 20% most deprived areas of Scotland.

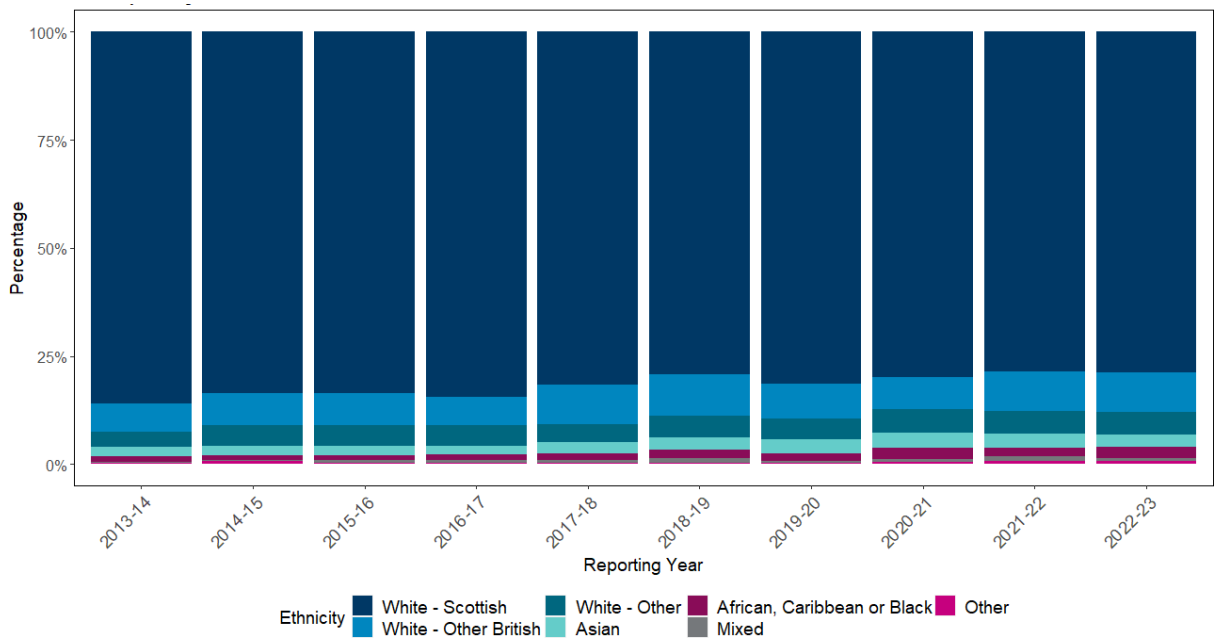
Figure 24. CTOs in 2022-23 by level of deprivation



Ethnicity

We had ethnicity information for 86.7% of CTOs in 2022-23. Figure 25 shows the breakdown of ethnicity categories of those detained under a CTO from 2013-14 to 2022-23. There was little difference compared to previous years, but we noted a lower percentage of Asian (2.7% vs 3.3%), African, Caribbean or Black (1.6% vs 1.9%), Mixed (0.7% vs 1.0%), White Other – British (8.1% vs 9.3%) and White Other (4.8% vs 5.2%) compared to previous years.

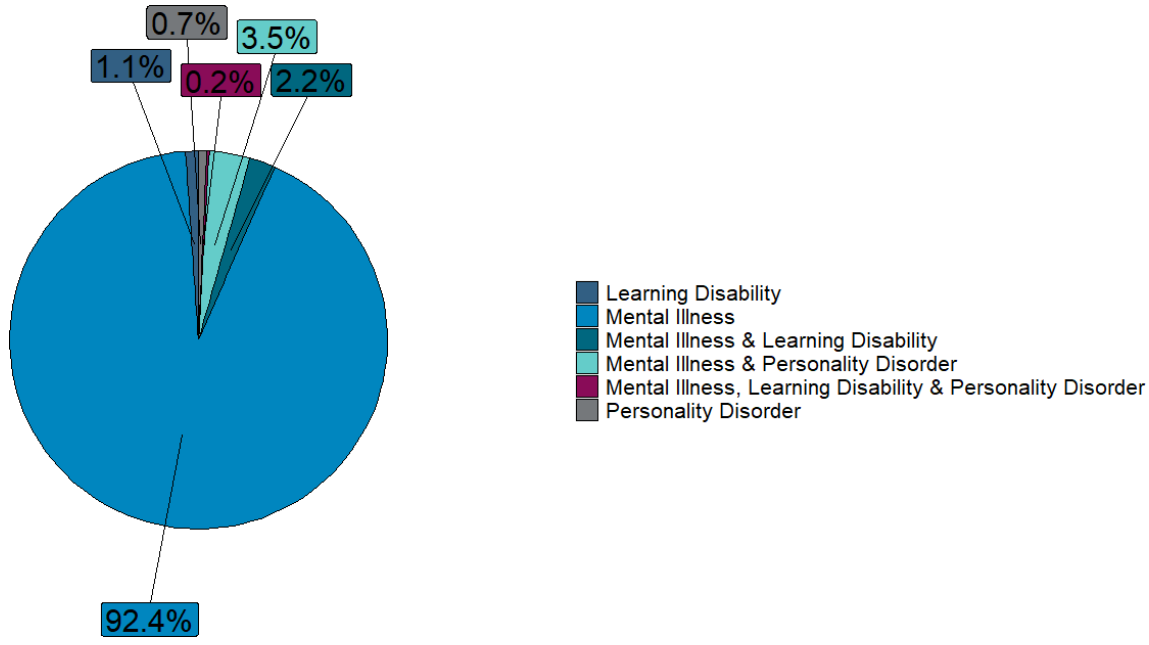
Figure 25. Ethnicity among CTOs by year



Diagnostic categories

We had categories recorded for all but three CTOs. Figure 26 shows that the vast majority of CTOs were for mental illness (92.4%). For 3.5% the diagnostic categories were mental illness and personality disorder, and 2.2% had mental illness and learning disability. Learning disability alone made up 1.1% of the CTO recorded categories. Only 0.7% of CTOs had categories of mental illness, learning disability and personality disorder, whereas personality disorder alone made up 0.2% of recorded categories.

Figure 26. Diagnoses recorded on detentions under a CTO in 2022-23



Recorded matters

An important safeguard for the rights of people when subject to a Compulsory Treatment Order is the making of a 'recorded matter'. When granting an application for a person to be detained under a compulsory treatment order (CTO), the Mental Health Tribunal for Scotland (MHTS) may make a "recorded matter." Section 64 of the Mental Health (Care And Treatment) (Scotland) Act 2003 (the 2003 Act), defines a recorded matter to be "medical treatment, community care services, relevant services, other treatment, care or service as the Tribunal considers appropriate." Further guidance in the 2003 Act Code of Practice[7] notes that in the making of such recorded matters the MHTS considers these aspects of care and treatment to be "essential to the care package." If a recorded matter is not provided, the responsible medical officer (RMO) must make a reference to the MHTS (via section 96 of the 2003 Act) and the Commission has the power to do so under section 98 to report the non-provision of the recorded matter which can be reviewed by the MHTS to consider next steps. We have published a survey of recorded matters between 2019 and 2022 to demonstrate how this safeguard is being used.

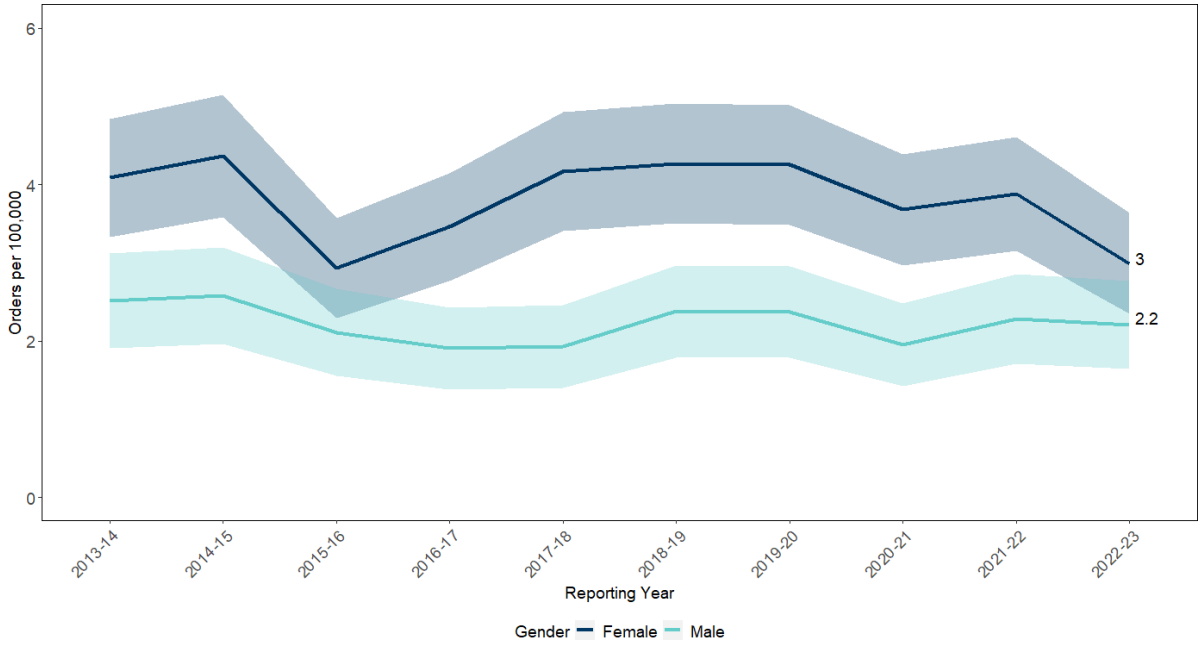
Nurse's power to detain pending medical examination

The Mental Health (Care and Treatment)(Scotland) Act 2015 [7] 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 [8].

In 2022-23, there were a total of 143 detentions under section 299, relating to 130 people, which was a 16.4% decrease compared to 2021-22 figures (Appendix Table A9). The overall rate of nurse's power to detain in 2022-23 was 2.6 per 100,000 (95% CI: 2.2–3.0), which was a slight decrease on the previous year's rate of 3.1 (95% CI: 2.7–3.6) (Appendix Table A10).

The rate of nurse's power to detain varies by gender. In 2022-23 the overall rate was 3.0 per 100,000 (95% CI: 2.4–3.6) for females and 2.2 (95% CI: 1.6–2.8) for males, Figure 27 shows these rates over the last 10 years.

Figure 27. Rate of use of nurse's power to detain by gender with 95% CI by year



There are also differences by age as well as gender (Figure 28), rates are higher for females under 18 years and between 25 and 64 years. Rates are higher for males aged 18-24 years and over 65 years. However, rates should be interpreted with caution given the small numbers involved.

We undertook to explore the rates of detention under this provision over time and by health board. Figure 29, shows the rate of nurse's power to detain by health board over the last 10 years, again the small numbers mean that rates should be interpreted with caution, although the rates in Dumfries and Galloway appear to have been higher than all other health boards since 2019-20. Further information is being sought by the Commission as to the reasons for the higher rates in Dumfries & Galloway.

Figure 28. Age- and gender-standardised rate use of nurse's power to detain in 2022-23 with 95% CI

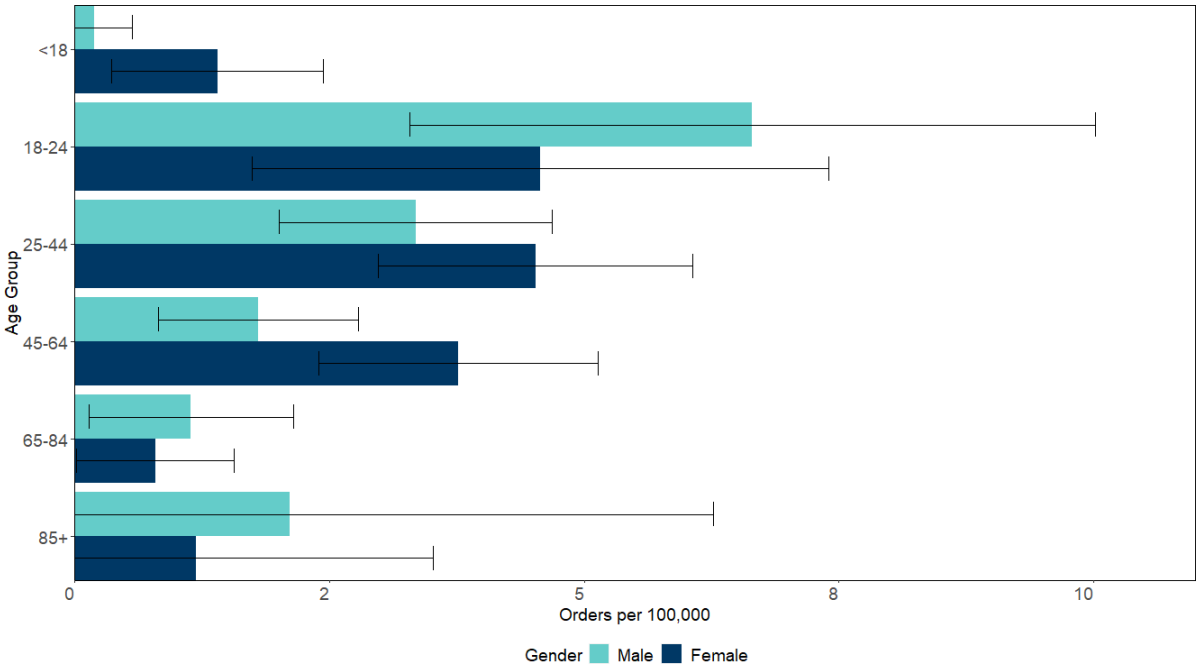
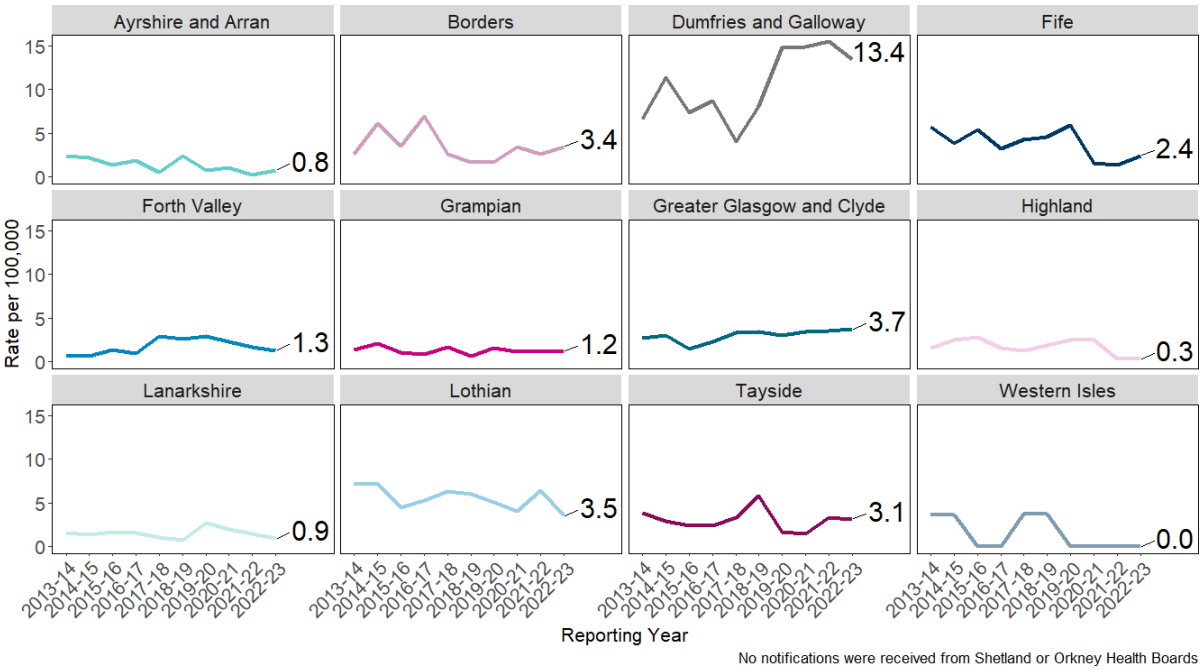


Figure 29. Rate of use of nurse's power detain over 10 years by health board



No notifications were received from Shetland or Orkney Health Boards

Place of safety orders

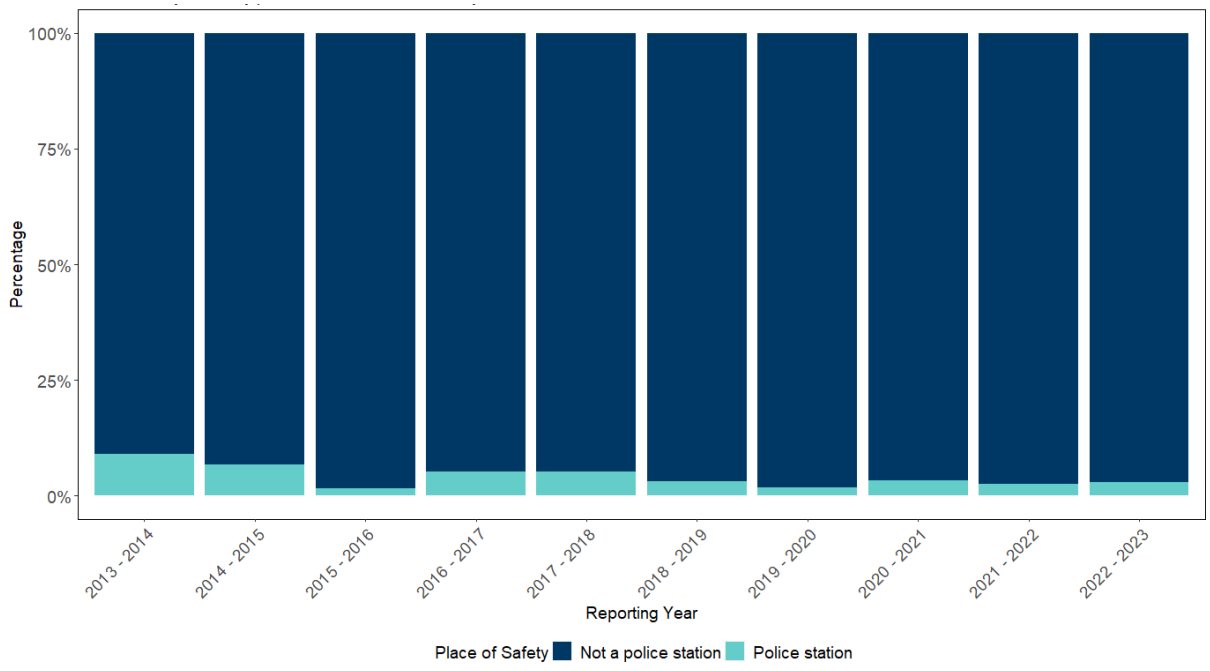
According to section 297 of the Mental Health Act a police constable can remove an individual from a public place and take them to a place of safety if they think the person has a mental health condition and is in need of immediate care and treatment. A place of safety can be, for example, a hospital 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 would expect the place of safety to be within a health care facility and welcomes data this year which evidences the continued reduction in the use of a police station (2.9%) (Figure 27).

There were 1,345 place of safety orders in 2022-23, which was a 7.2% increase compared to the year before (Appendix Table A11). These forms related to 948 individuals. Of note is that within the reporting period, there were individuals with multiple detentions under section 297. In particular, we note that nine individuals had been detained under Section 297 10 times or more. The Commission will report whether those who are subject to repeated place of safety orders have documented crisis care plans. The Commission is meeting with Police Scotland to discuss the findings from this work.

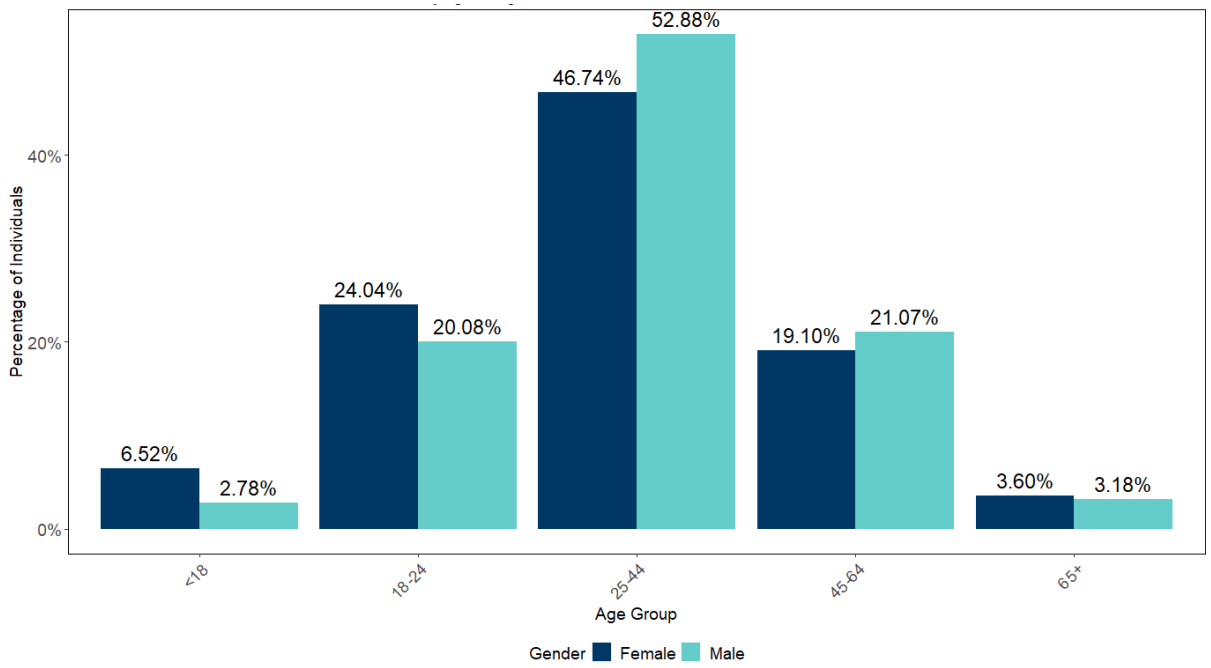
Figure 30 shows that the proportion of orders where the individual was taken to a police station as a place of safety has differed over the years but has decreased from 9.1% in 2013-14 to 2.9% in 2022-23 with a low of 1.6% in 2015-16.

Figure 30. Place of safety orders by place individual was taken to by year



The gender split of individuals detained under section 297 was 53.1% 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 <25 groups, and higher among males in the 25-44 and 45-64 age groups, the proportions were similar for both genders in the 65+ group (Figure 31).

Figure 31. Individuals detained under Section 297 in 2022-23, by age and gender



The number of place of safety orders varies by local authority. Table 1 shows both the number of orders in 2022-23 as well as the number of people detained under Section 297.

Table 1. Number of place of safety orders by local authority in 2022-23

Local authority	Number of orders	Number of people
Aberdeen City	483	312
Angus	19	15
Argyll and Bute	29	20
City of Edinburgh	94	84
Clackmannanshire	*	*
Dumfries and Galloway (LA)	17	17
Dundee City	30	24
East Ayrshire	*	*
East Dunbartonshire	*	*
East Lothian	*	*
East Renfrewshire	*	*
Eilean Siar	*	*
Falkirk	32	28
Fife (LA)	81	68
Glasgow City	74	63
Highland (LA)	225	124
Inverclyde	*	*
Midlothian	9	8
Moray	88	55
North Ayrshire	15	11
North Lanarkshire	8	8
Orkney (LA)	*	*
Perth and Kinross	9	8
Renfrewshire	13	11
Scottish Borders	14	12
Shetland (LA)	7	*
South Ayrshire	8	7
South Lanarkshire	14	14
West Dunbartonshire	30	28
West Lothian	25	24
Total	1,345	948

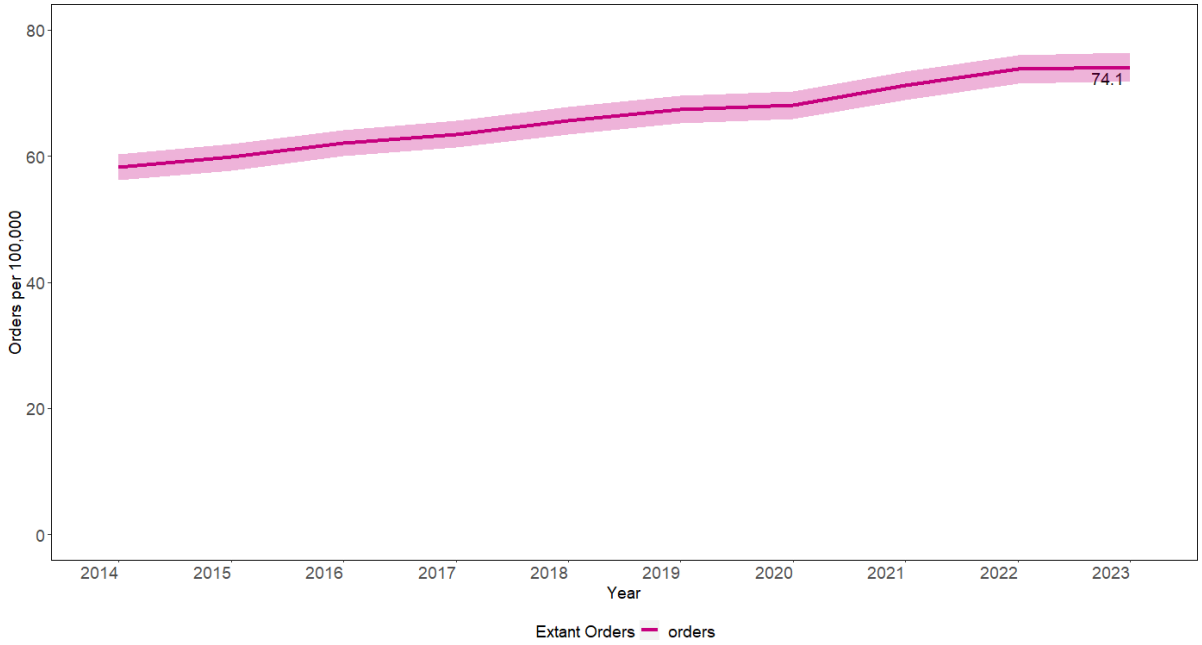
**n≤5*

Extant orders

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

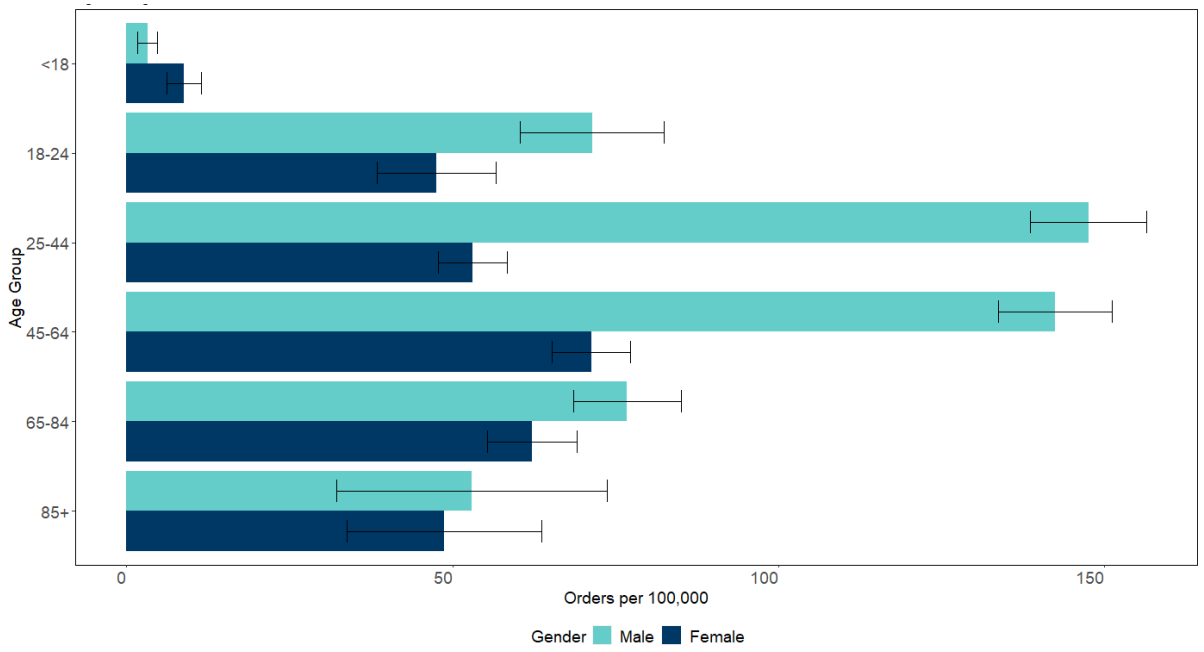
On Wednesday 4 January 2023 there were 4,061 extant orders. This was a 0.5% increase on the same day in 2022 (Figure 32, Appendix Table A12). The rate of extant orders has increased over time. The rate on 4 January 2023 was 74.1 (95%CI: 71.2-76.4) up slightly from 72.1 per 100,000 (95% CI: 69.8–74.3), on the same day in January 2022 (Appendix Table A12).

Figure 32. Rate of extant orders on the first Wednesday of January by year



Of the orders in place on 4 January 2023, 64.6% related to males and most people on orders were aged 25–44 years or 45–64 years. The age and gender standardised rates of orders in existence is shown in Figure 33.

Figure 33. Age- and gender-standardised extant orders on 4 January 2023 with 95% CI



The rate of orders in existence varied from 29.3 per 100,000 (95% CI: 19.5–39.2) in Borders to 107.1 (95% CI: 101.2–113.0) in Greater Glasgow and Clyde (Figure 34a & 34b, Appendix Table A13).

Figure 34a. Rate of extant orders per 100,000 on 4 January 2023, by health board

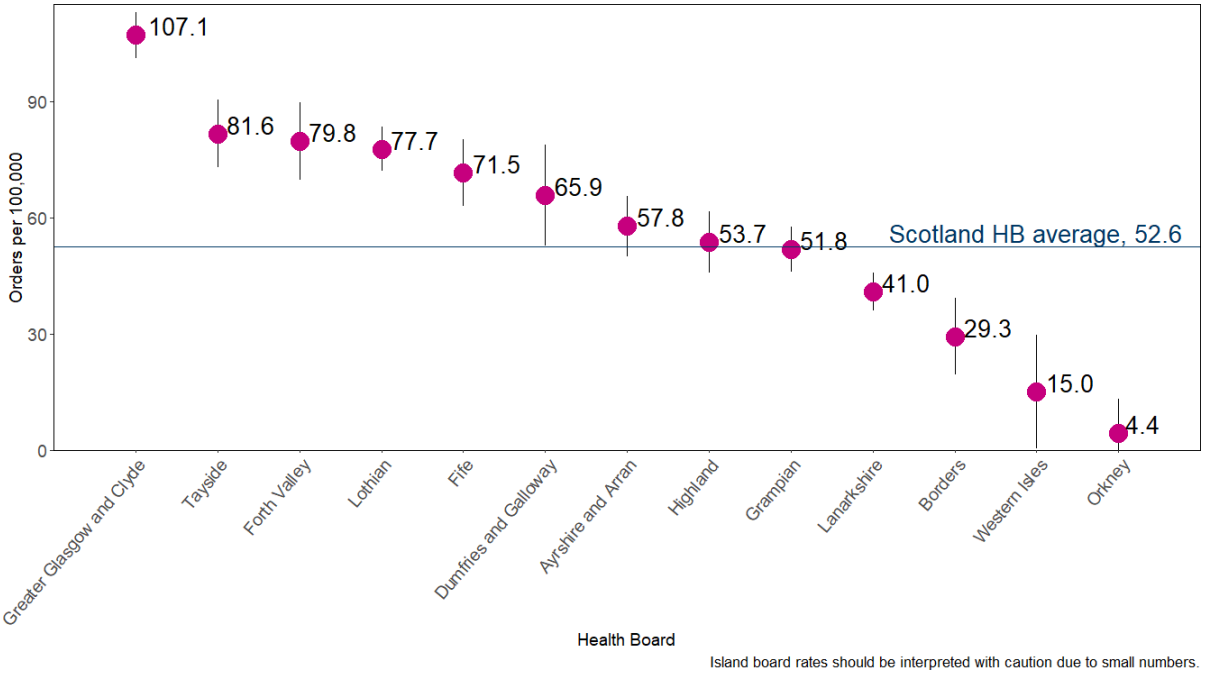
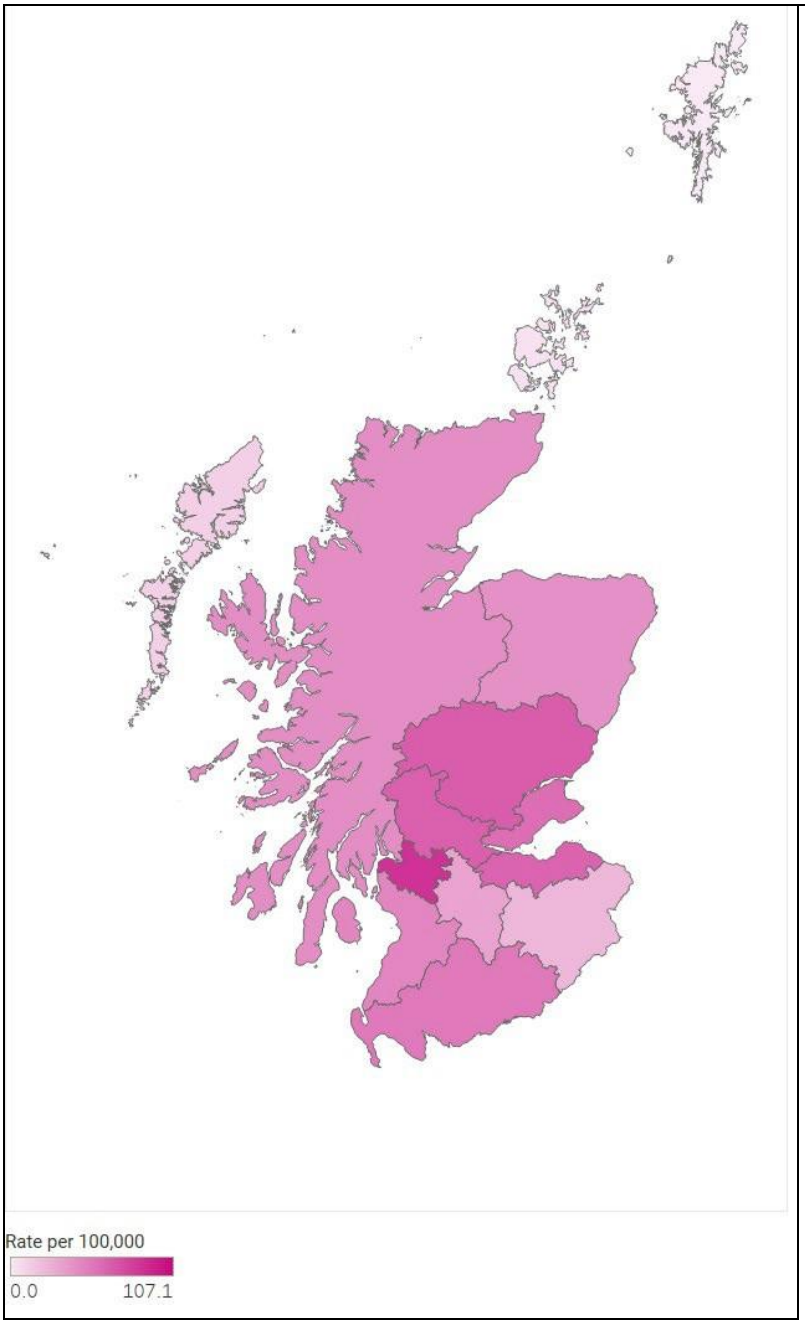


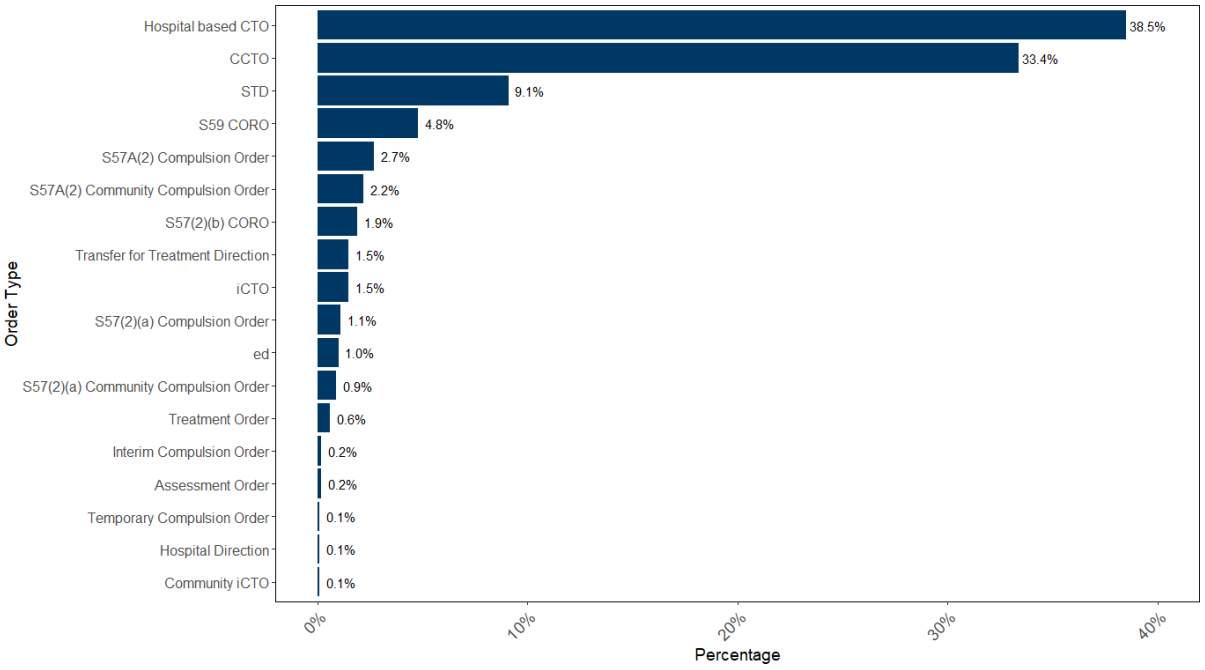
Figure 34b. Rate of extant orders per 100,000 on 4 January 2023, by health board



Health board	Rate
Greater Glasgow and Clyde	107.1
Tayside	81.6
Forth Valley	79.8
Lothian	77.7
Fife	71.5
Dumfries and Galloway	65.9
Ayrshire and Arran	57.8
Highland	53.7
Scotland HB average	**52.6**
Grampian	51.8
Lanarkshire	41.0
Borders	29.3
Western Isles	15.0
Orkney	4.4
Shetland	0.0

When we look at the orders in existence on a given day, this time on 4 January 2023, the majority of orders were CTOs (71.9%). A breakdown of the orders individuals were subject to are shown in Figure 35.

Figure 35. Type of order individuals were subject to on 4 January 2023



Compulsory treatment orders

A compulsory treatment order (CTO) allows for a person to be treated for their mental illness. The CTO will set out a number of conditions depending on whether the person requires to stay in hospital or is living in the community. CTOs are authorised by the Mental Health Tribunal for Scotland and are granted for 6 months initially.

As most orders in existence on 4 January 2023 were CTOs, we looked into these in more detail. The rate of all CTOs in existence was 53.2 (95%CI: 51.3-55.2), which was slightly higher than in the last year we reported (51.9, 95% CI: 50.0–53.8) (Figure 36). There was little change in rate of hospital-based CTOs, with a slight increase from 2020-21 (from 28.4 to 28.5) and a similar rate of community-based CTOs (from 23.6 to 24.7).

Figure 36. Rate of extant CTOs by year with 95% (shaded area)

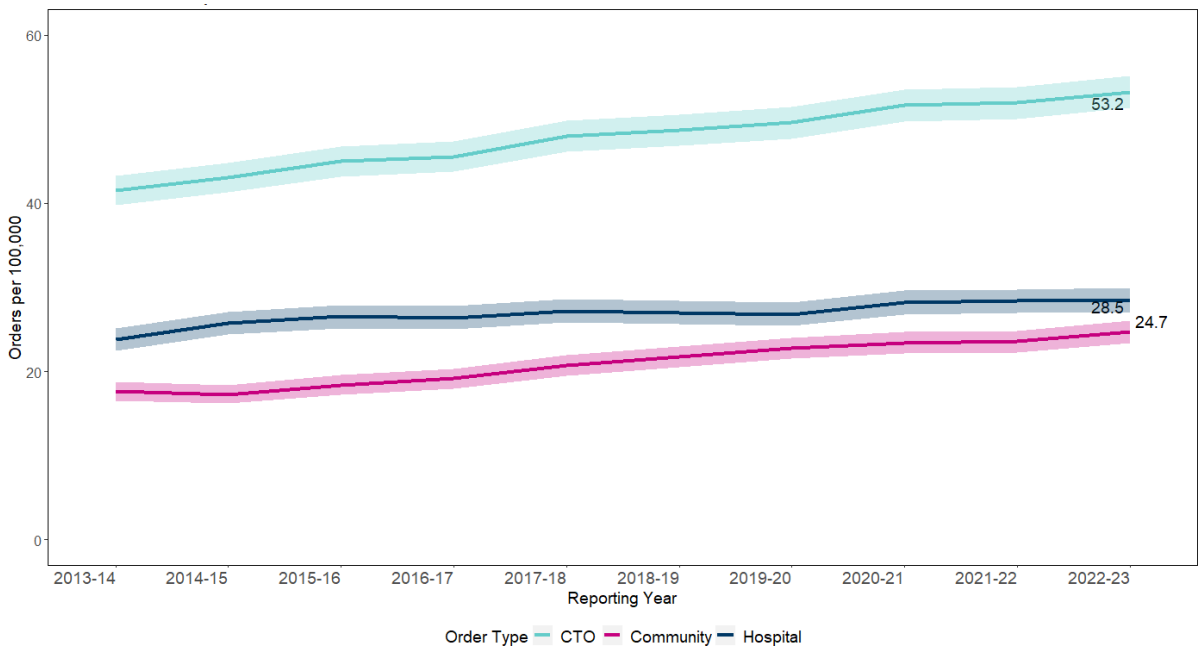
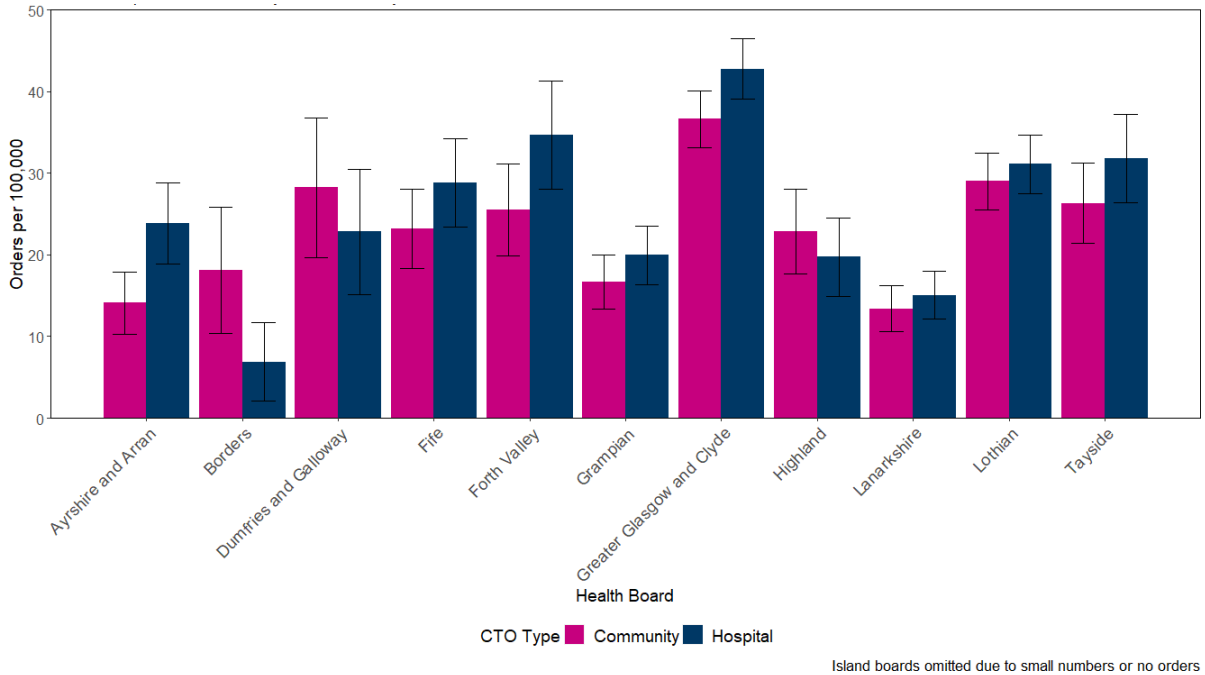


Figure 37 (Appendix Table A14) shows that the rate of hospital and community-based CTOs varied by health board, with higher rates of hospital-based orders in Fife, Forth Valley, Greater Glasgow and Clyde, Lothian, and Tayside.

Figure 37. Rate of hospital and community-based CTOs per 100,000 in 2022-23 by health board



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 (Scotland) Act 1995 ('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.

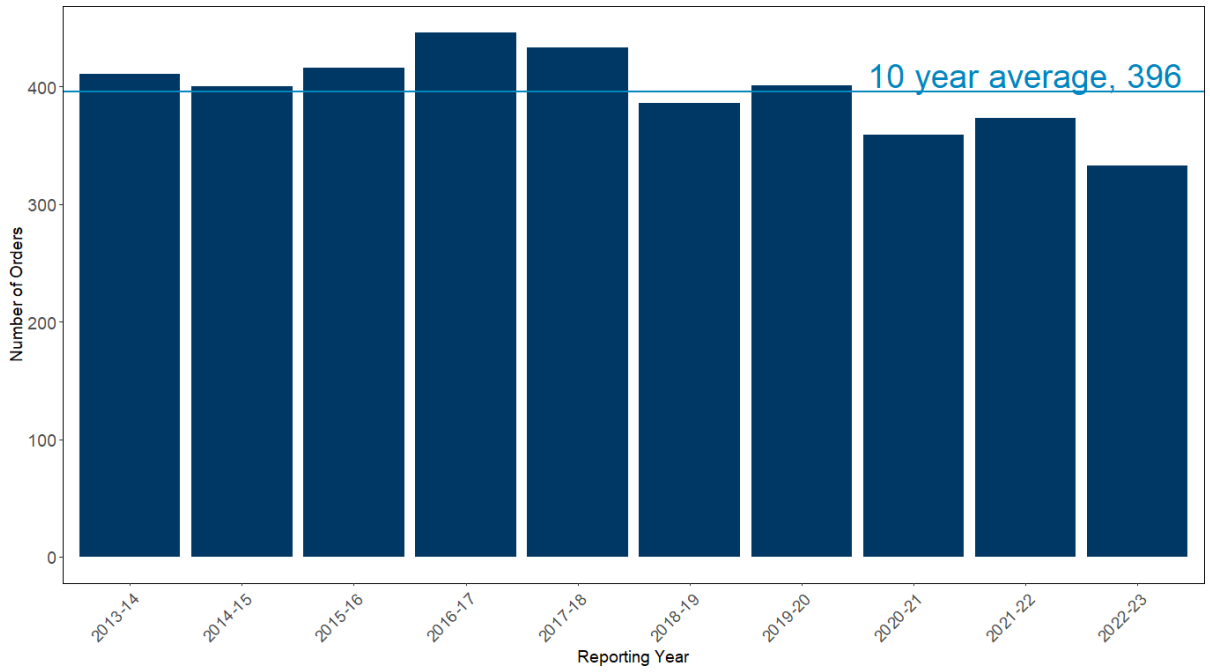
Mental health disposals
A disposal refers to a sentence that the courts may use when sentencing an offender with a mental illness, learning disability, neurodevelopmental disorder and related conditions. There are three types of disposals that can be given as a final disposal from the court. These are 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 were a total of 333 orders under the Criminal Procedure Act in 2022-23. The average number of orders was 396 in the previous 10 years (Figure 38). The 333 orders related to 196 individuals (Appendix Table A15).

Figure 38. Number of Criminal Procedure Act orders by year



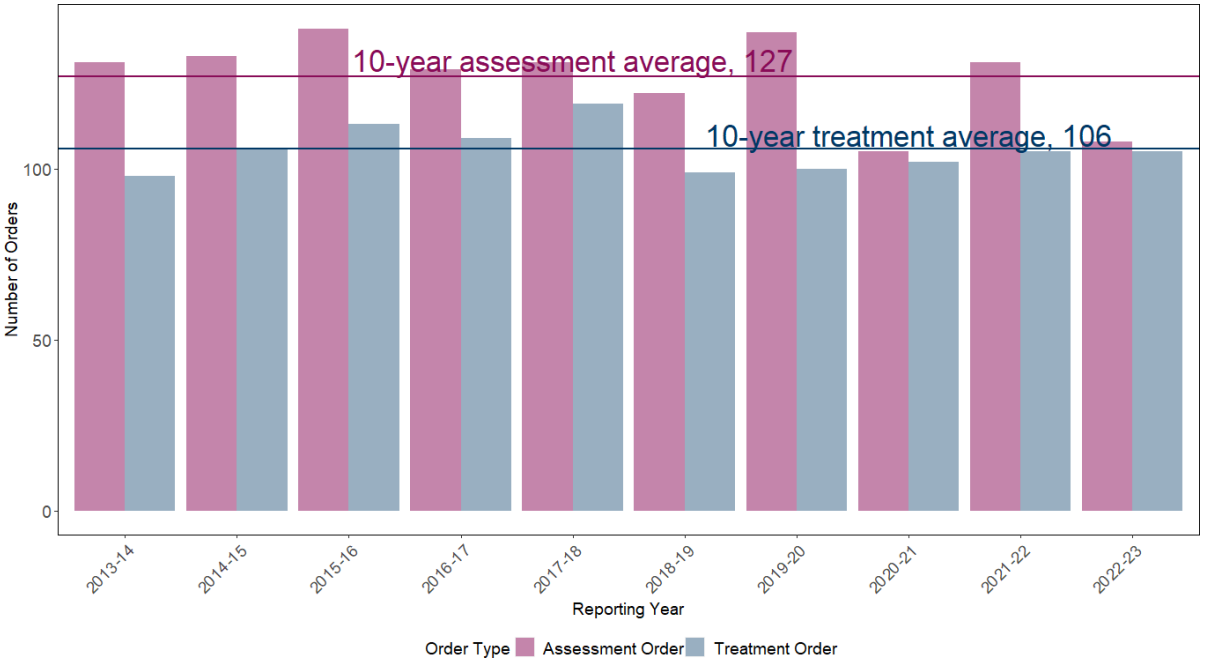
Compared to detentions reported under the Mental Health Act, individuals detained under the Criminal Procedure Act in 2022-23 were primarily male (86.2%). Most were aged 25-44 years (56.1%) with the average age of 39 years.

We had ethnicity information for only 43.4% of individuals in 2022-23 (with an average in the last 10 years of 47.4%) (for more information see **Methods**). For individuals where we had sufficient information to report ethnicity, 88.7% were White Scottish, 2.8% were White Other, 3.5% were African, Caribbean or Black. For other groups the numbers were too small to report (Appendix Table A16). The proportion of individuals of White Other and Asian ethnicity was lower than in previous years, however the high proportion of missing information about the ethnicity of individuals detained under the Criminal Procedure Act means these numbers should be interpreted with caution.

Assessment and treatment orders

In 2022-23 there were 108 assessment orders and 105 treatment orders, relating to 107 and 88 individuals, respectively. Figure 39 shows the number of assessment and treatment orders by year with the average for the last 10 years. There were fewer assessment orders compared to the 10-year average (average=127). The number of treatment orders is similar to the 10-year average (average=106).

Figure 39. Number of assessment and treatment orders by year with averages



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 were a total of 11 individuals, who in 2022-23 were deemed unfit for trial, which was lower than in 2021-22 (Appendix Table A17). Acquittal due to mental health condition occurred due to reasons reported under five disposals (see Box 2), was applied as reported in table A17 in the appendix.

Post-conviction predisposal

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

A total of 19 interim compulsion orders were recorded in 2022-23, slightly higher than the 14 interim compulsion orders in 2021-22. There were no individuals subject to section 200[4] in 2022-23.

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;

[4] 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)

compulsion order, guardianship order and a community payback order with a mental health treatment requirement.

There were a total of 41 mental health disposals in 2022-23, given as a final disposal by the court, which was lower than the average for the previous 10 years of 57 (Appendix Table A17).

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 were a total of 22 transfer for treatment directions in 2022-23. This was fewer than in the previous 10 years, for which the average was 41 (Appendix Table A17).

Consent to treatment

There are specific safeguards for specific forms of medical treatment including electroconvulsive therapy (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 2022-23 there were 95 DMPs on the register. DMPs are experienced, senior psychiatrists, with at least three years of experience at consultant level in Scotland. The register of DMPs is maintained by the Mental Welfare Commission and the Commission organises induction and provides training and an annual seminar for DMPs, however the DMPs are independent practitioners using their knowledge and experience to reach their own conclusions.

Consent to treatment under part 16 of the 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.

Section 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: (a) electro-convulsive therapy (ECT); (b) vagus nerve stimulation (VNS); and, (c) transcranial magnetic stimulation (TMS) where the patient's RMO, or a DMP, certifies that the patient is capable consenting to treatment and is not refusing consent for where the patient's RMO, or a DMP, certifies that the patient is capable of 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.

T3 certificates

A T3A certificate covers treatment under section 237(3) of the Mental Health Act: (a) electro-convulsive therapy (ECT); (b) vagus nerve stimulation (VNS); and (c) transcranial magnetic stimulation (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 designated medical practitioner 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.

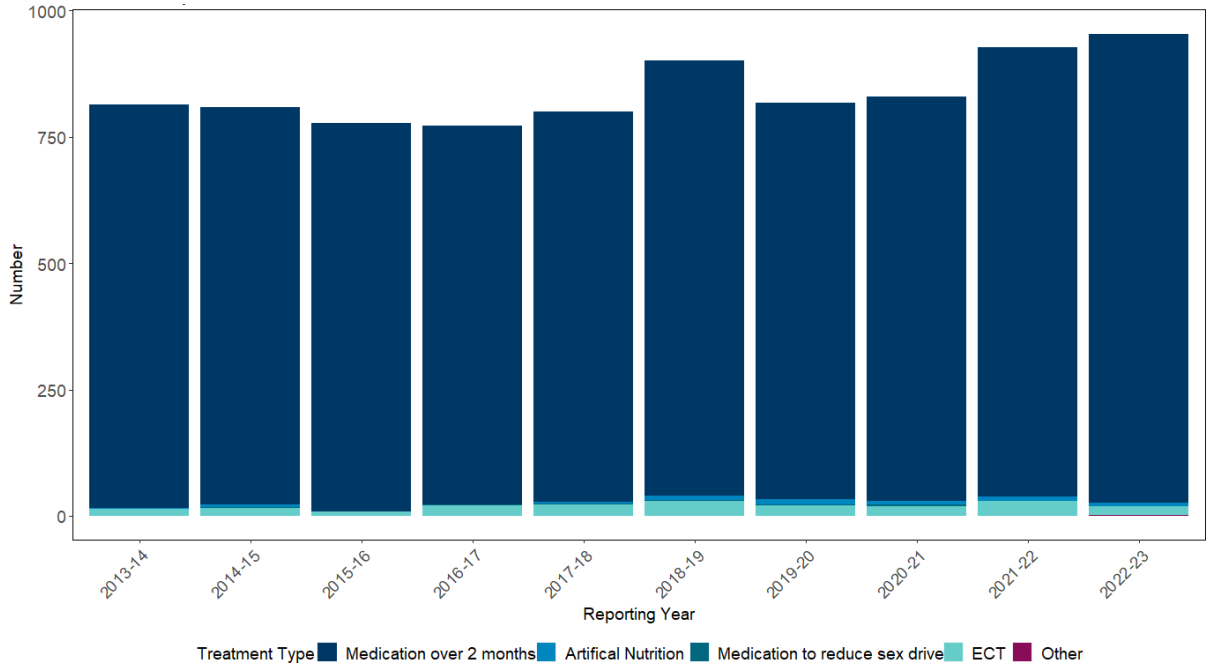
T1 certificate treatments

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

There were a total of 954 T2 certificates issued during 2022-23, which is the highest number recorded in the last 10 years (Figure 40). The average for the years 2013-14 to 2020-21 was 828 T2 certificates per year.

Figure 40. Number of T2 certificates by year



Most T2 certificates (97.3% n=928) were issued for medication over two months while 1.9% (n=18) were issued for ECT. There were a total of six T2s for artificial nutrition in 2022-23, slightly lower than in 2021-22 (n=9). The breakdown of certificates by type of treatment is provided in table A18.

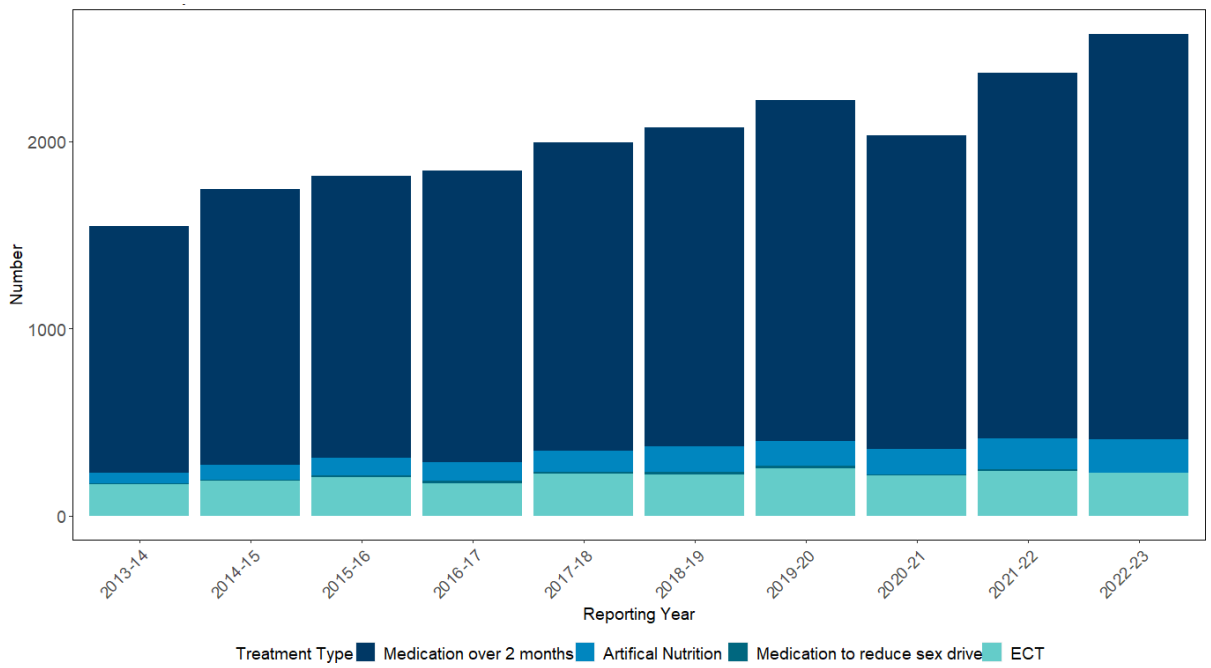
Of the T2s we received in 2022-23, 5.0% were for young people under the age of 18 years. The proportion of T2s issued for individuals under the age of 18 years has ranged from 3.3% (2013-14) to 5.1% in 2015-16 and 2020-21. For the years 2012-13 to 2020-21 the average proportion of young people issued a T2 certificate was 4.3%.

There were differences in gender for the various treatments under T2 certificates in 2022-23; for ECT most were female (83.3%) and medication over two months had a somewhat higher proportion of males (58.2%). Artificial nutrition and medication for sex drive are uncommon treatments, generally with low numbers.

T3 certificate treatments

There were a total of 2,573 T3 certificates issued in 2022-23, which was an 8.7% increase on the 2022-23 figure (Figure 41). Most T3s were for medication over two months (84.1%), while 8.9% were for ECT, 6.9% for artificial nutrition, and 0.1% for medication to reduce sex drive. This is broadly similar to previous years (Appendix Table A19).

Figure 41. Number of T3 certificates by year

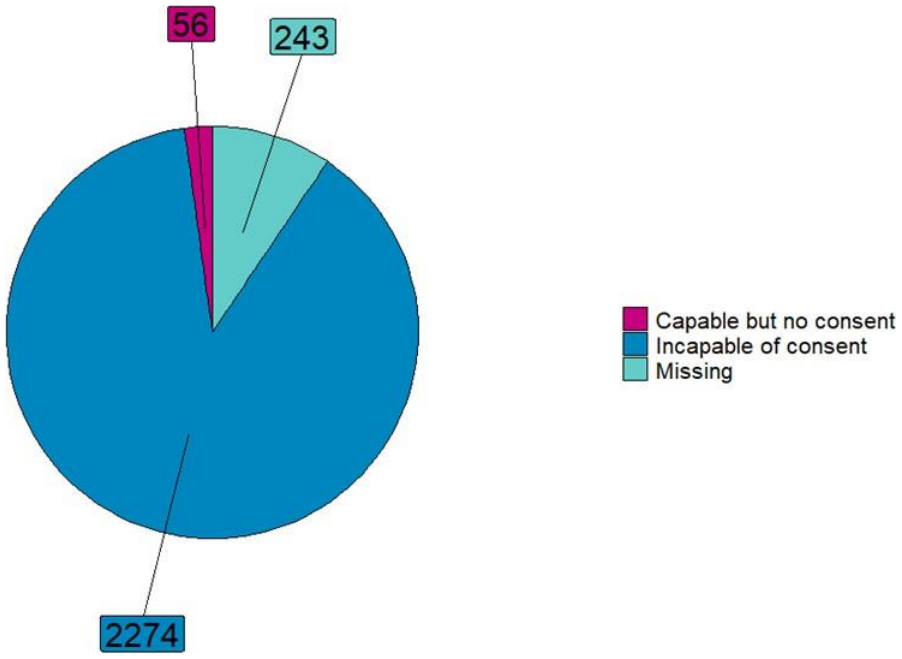


Of the T3s we received in 2022-23, 4.2% were for young people under the age of 18 years. The proportion of T3s issued for individuals under the age of 18 years has ranged from 4.1% (2019-20) to 6.3% in 2018-19. For the years 2013-14 to 2021-22 the average proportion of young people issued a T3 certificate was 5.0%.

There were differences in gender for the various treatments under T3 certificates; for ECT a higher proportion were female (66.1%) while medication over two months had a higher proportion of males (60.9%). T3s for artificial nutrition were predominantly issued for females (93.0%).

We noted the recommendation (9.8) made in the Scottish Mental Health Law Review that where a person is able to make an autonomous decision about a specific treatment and refuses this, it should not be possible to give this treatment and therefore we explored in more detail the use of T3s when the person was deemed to be capable of consent (Figure 42) to consider how often treatment is given under the Mental Health Act when a person is capable but refusing medication 2 months after treatment had initially commenced (this data is available through the recording of the designated medical practitioner safeguard) . We found that medication was authorised in 56 instances where the person was deemed capable of consent but did not provide this (2.2%).

Figure 42. T3 Certificate Consent to Treatment in 2022-23

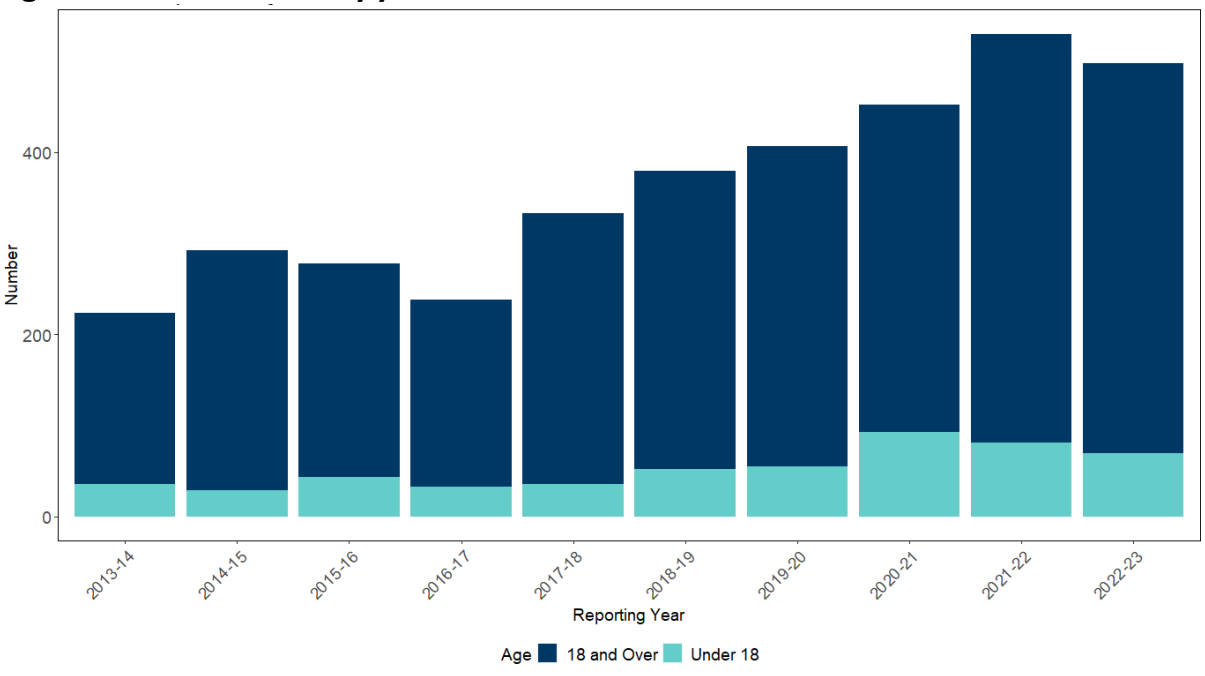


T4 certificate treatments

There were 498 T4 certificates notified to the Commission in 2022-23, which was a 6.0% decrease on the number of T4s in 2021-22 and follows an increasing trend since 2017-18 (Figure 43). Of the T4s issued in 2022-23, 14.1% were for individuals aged under 18 years. This is an 8.0% decrease compared to 2021-22 but is still higher than figures in the years prior to 2020-21 (Appendix Table A20).

Overall, 58.4% of all T4s were for females but the gender split for under 18 years was 84.3% female and 15.7% male, compared to 54.2% female and 45.8% male in the over 18 category. An overview of number of T4 certificates by health board is provided in Appendix Table A21.

Figure 43. Number of T4s by year



Advance statements

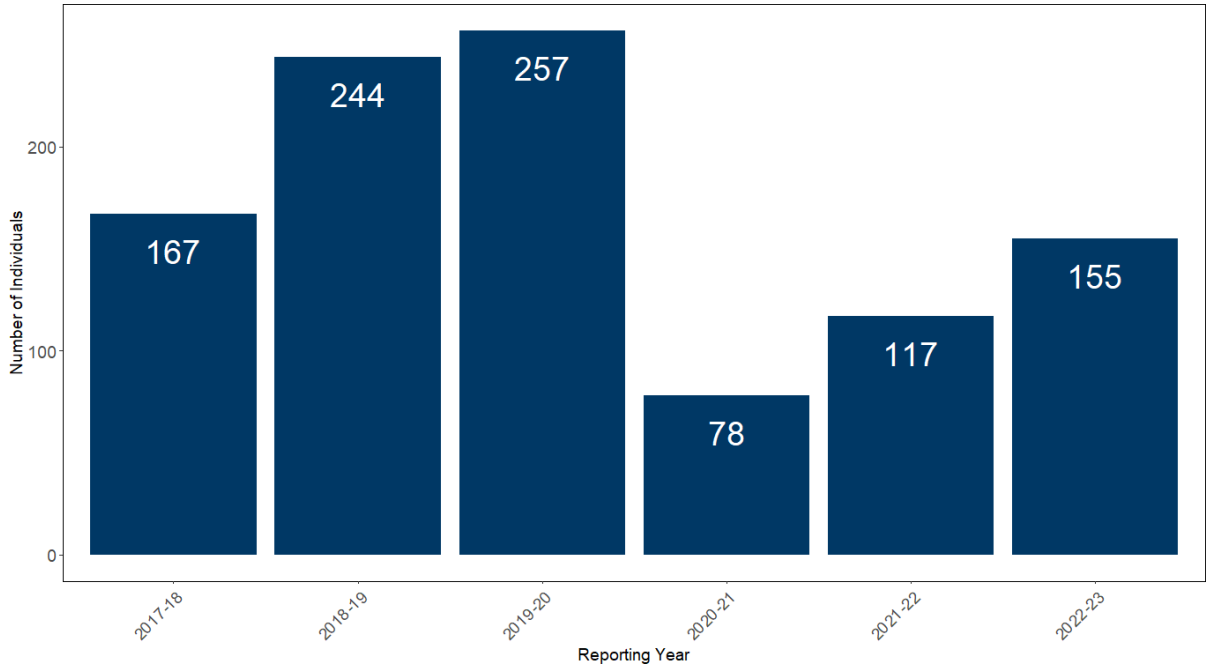
Advance statements are written statements made by a person when they are well, setting out the care and treatment they would prefer or would dislike should they become mentally unwell in the future. The Tribunal and any medical practitioner treating a person must have regard to their advance statement. If the wishes set out in an advance statement have not been followed, a written record (an advance statement override) giving the reasons must be sent to the Commission. Our last report on advance statement overrides was published in February 2021 [10].

The advance statement register has been in operation since 2017. Each time since 2017 someone either writes a statement or withdraws a statement, health boards should notify the Commission about this. This, however, does not include people who made an advance statement prior to the register being operationalised in 2017.

Over time, our work with the register has developed. We now look at the first ever form we receive relating to an advance statement (creation or withdrawal) and consider this as the point of engagement with the register.

For the first two years we had complete data for (2018-19 and 2019-20), there were 244 and 257 individuals where we noted a first engagement with the register (Figure 44). In 2020-21, this dropped to 78; it is assumed that this indicates a significant impact of the pandemic on services' abilities to engage with individuals on matters to do with advance care planning. In 2021-22, the figure increased to 116 and to 155 in 2022-23.

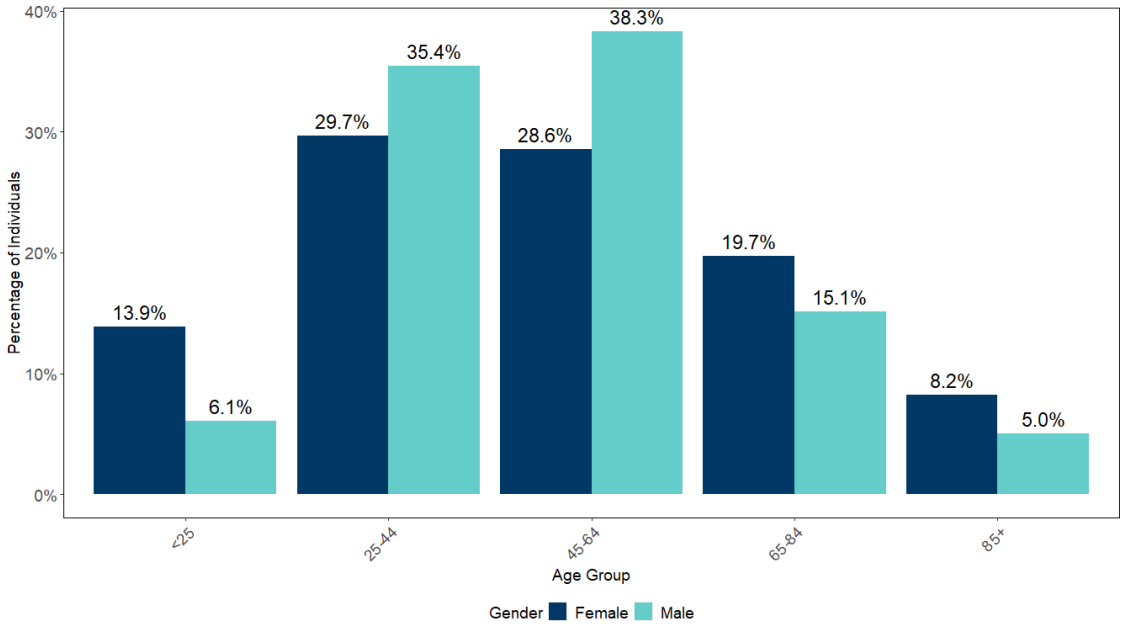
Figure 44. Number of individuals with a first engagement with the advance statement register by year



Characteristics

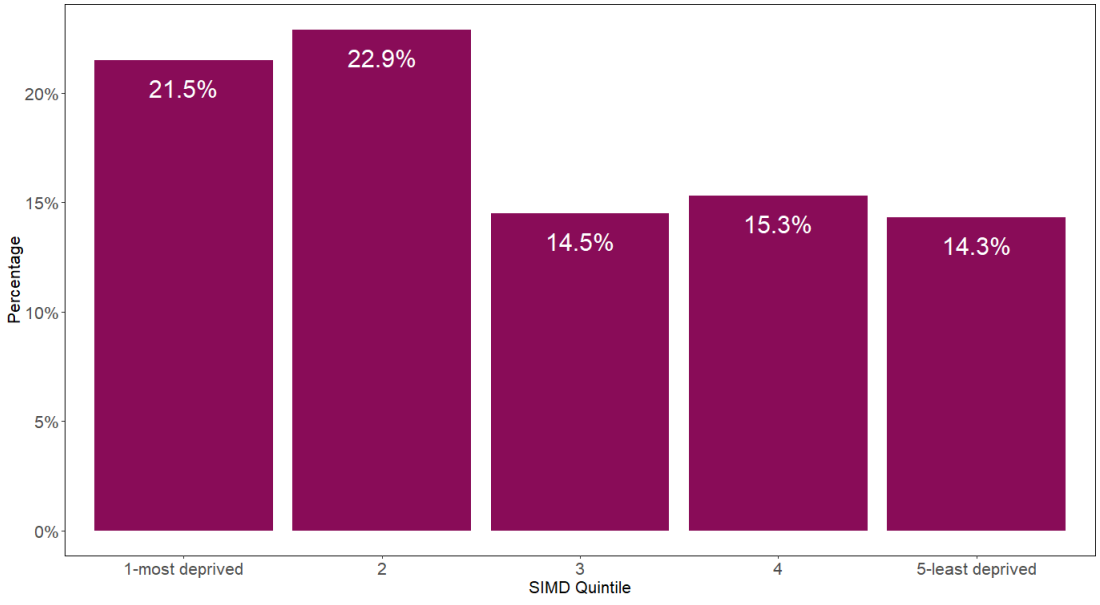
The individuals on the register as a whole have an average age of 50 years and 54.6% are male. The age distribution for males and females is shown in Figure 45 and indicates that more young females (<25 years) and older females (over 65 years) have engaged with the advance statement process.

Figure 45. Age and gender of individuals on the advance statement register



We had valid postcodes to match SIMD for 88.6% of all individuals (based on their first engagement) on the register. The 116 invalid postcodes were because the person's home address was listed as elsewhere in the UK, was a hospital, they were of no fixed abode, or no address had been entered on the form. Unlike detentions which are skewed towards areas of deprivation, when it comes to the safeguard available, there is a more even percentage of individuals from the most and least deprived areas of Scotland (Figure 46).

Figure 46. SIMD categories of individuals on the advance statement register

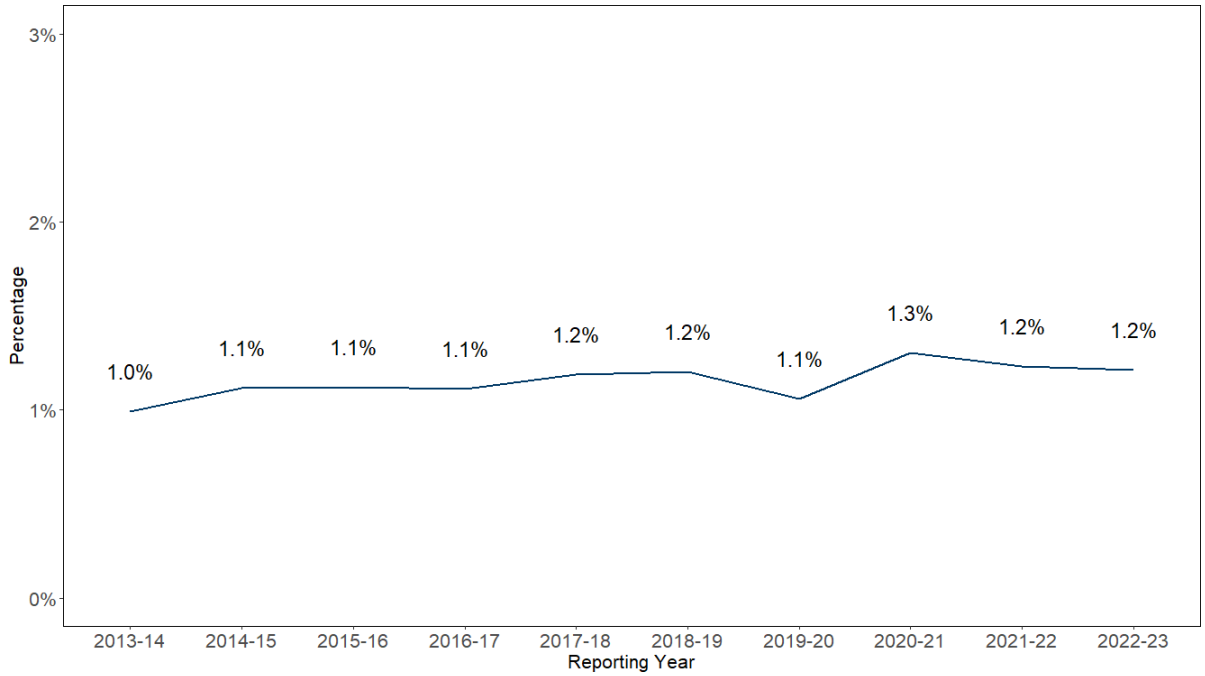


Deaths in detention

This year, we have 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 at the time of their death regardless of the cause of the death. Further information about the notification system is available on our website.

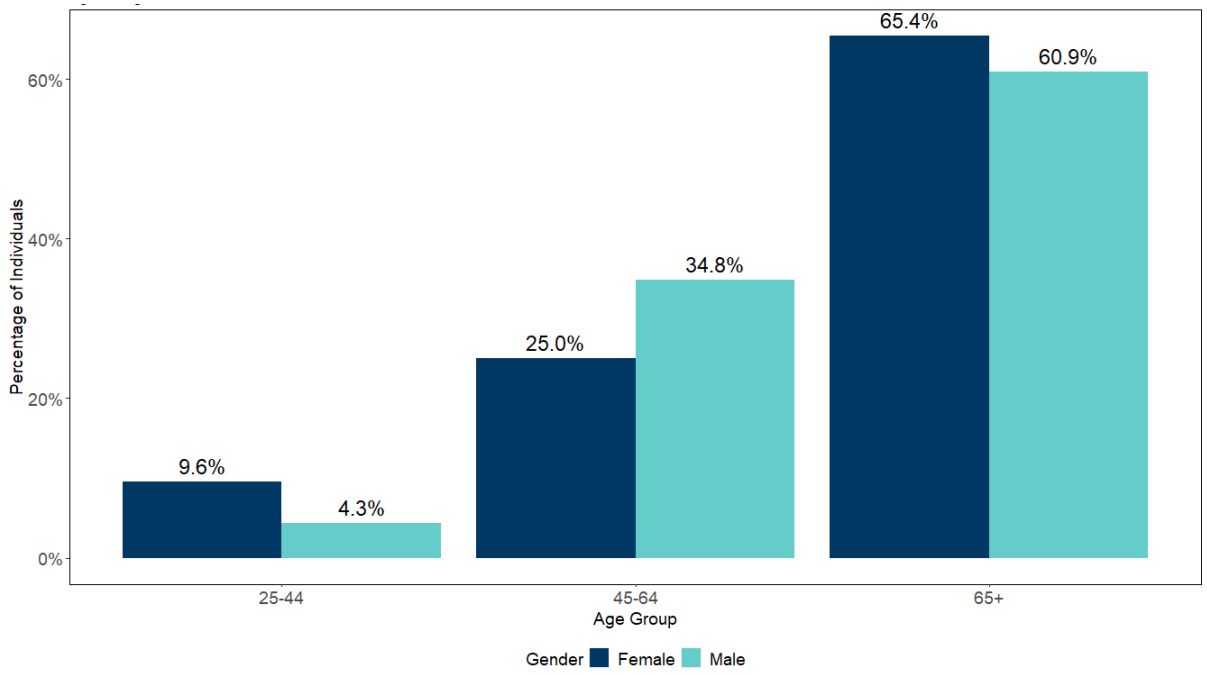
The percentage of deaths as a proportion of total orders remains consistent over time, ranging from 1.0% in 2013-14 to 1.3% in 2020-21. In 2022-23, there were 144 deaths reported to the Commission of people who were detained under the Mental Health Act, 1.2% of the total orders (Figure 47).

Figure 47. Deaths in detention as a percentage of total orders by year



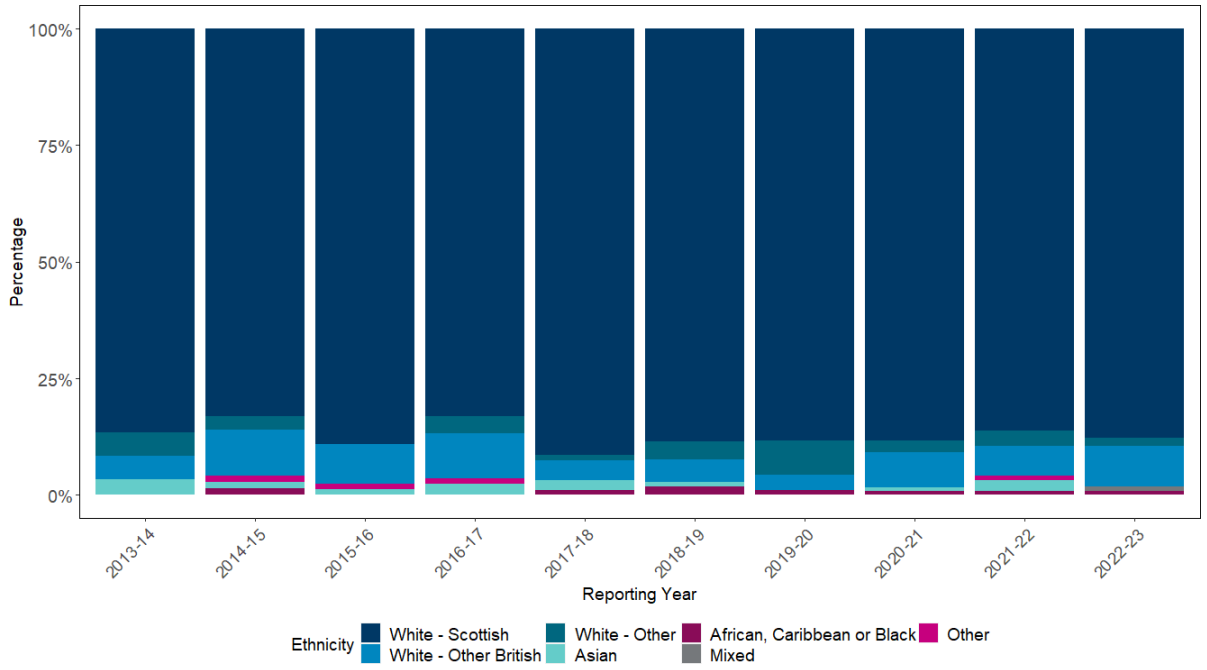
We looked more closely at age and gender of those who died while under the Mental Health Act, the average age of male deaths was 68.8 years and 66.2 years for females. This is lower than the average life expectancy in Scotland that was 76.6 years for males and 80.8 years for females in 2019-2021(the latest available data) [9]. Fewer female deaths occurred in the 25-44 and 65+ age groups, there were more female than male deaths in the 45-65 year age group (Figure 48).

Figure 48. Deaths in detention in 2022-23 by age and gender



We looked at ethnicity data for deaths in detention from 2013-14 to 2022-23, these can be found in Figure 49. The numbers in some categories are very low so should be interpreted with caution.

Figure 49. Deaths in detention by ethnicity by year



Concluding remarks

This report outlines data during 2022-23 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 the Mental Health and Criminal Procedure Acts.

This year our data shows a slight increase in the total number of Mental Health Act orders. We are concerned with the continuing low levels of MHO engagement in agreeing EDCs, and the lack of social circumstances reports. Both may relate to difficulties in recruiting to and retaining MHOs. Local area audits may identify additional challenges in relation to EDCs and MHO consent and we will be keen to learn about theses from health and social care partnerships. In July 2021, we made recommendations to health and social care partnerships, their respective local authorities and the Scottish Government regarding concerns about the capacity of the mental health officer workforce and the safeguards of this role not being realised in practice. The data in this report further evidences these concerns.

Our deprivation data shows clearly that detentions are much more common in areas with higher social deprivation. Considering the causes of why compulsion is more common in these areas might help to reduce the rising levels of compulsion and is in keeping with an emphasis on prevention.

The Commission will continue to provide the Scottish Government and wider stakeholders with up-to-date data on detentions annually to inform local scrutiny, analysis and understanding, including identification of the need for resource allocation.

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. The DMP can only give an opinion on the specific medical treatment. The 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 a mental health officer (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. A STDC cannot be issued without MHO consent.

MHTS

The Mental Health Tribunal for Scotland (MHTS) considers and determines applications for compulsory treatment orders (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)

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

Appendix – Data tables

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

Starting Order[a]	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
EDC	1888 (42%)	1969 (41%)	2165 (43%)	2411 (45%)	2705 (48%)	2811 (46%)	2867 (47%)	3218 (48%)	3180 (48%)	3219 (48%)
STDC	2530 (56%)	2801 (58%)	2752 (55%)	2905 (54%)	2859 (51%)	3130 (52%)	3082 (51%)	3371 (50%)	3261 (49%)	3415 (51%)
CTO	112 (2%)	90 (2%)	93 (2%)	99 (2%)	88 (2%)	120 (2%)	114 (2%)	137 (2%)	158 (2%)	79 (1%)
Total	**4,530**	**4,860**	**5,010**	**5,415**	**5,652**	**6,061**	**6,063**	**6,726**	**6,599**	**6,713**

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

Table A2. Number of EDCs by health board and year

Health board	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Ayrshire and Arran	113	142	107	138	113	131	161	160	184	225
Borders	18	29	18	32	30	24	34	49	46	37
Dumfries and Galloway	71	74	84	114	105	103	148	117	112	101
Fife	122	150	167	162	181	209	204	224	194	236
Forth Valley	92	95	130	146	179	185	159	166	187	151
Grampian	115	134	101	99	141	118	135	171	172	171
Greater Glasgow and Clyde	638	605	726	833	988	995	1029	1147	1248	1242
Highland	164	158	125	109	123	105	96	96	112	85
Lanarkshire	168	178	199	230	198	281	255	324	313	337
Lothian	238	249	334	390	402	440	451	537	430	466
Orkney	*	7	14	*	15	*	*	*	11	7
Shetland	7	9	*	7	8	*	*	*	*	0
Tayside	165	171	184	187	257	278	256	277	248	226
Western Isles	*	8	*	*	10	*	6	8	*	6
Total	**1,919**	**2,009**	**2,202**	**2,456**	**2,750**	**2,886**	**2,939**	**3,283**	**3,263**	**3,290**

*n≤5 and secondary suppression to maintain confidentiality

Table A3. Number of STDCs by health board and year

Health board	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Ayrshire and Arran	188	207	194	210	170	184	169	250	281	287
Borders	63	71	59	62	62	75	74	87	78	65
Dumfries and Galloway	82	105	105	134	97	142	138	140	123	132
Fife	255	276	272	282	266	289	271	342	339	367
Forth Valley	175	195	244	257	270	245	243	320	363	326
Grampian	367	385	399	451	410	399	487	500	447	516
Greater Glasgow and Clyde	1,024	1,095	1,173	1,249	1,422	1,420	1,506	1,639	1,636	1632
Highland	245	213	200	180	200	202	190	183	184	201
Lanarkshire	284	335	349	369	358	412	410	399	398	433
Lothian	677	751	732	806	753	846	837	936	889	962
Orkney	*	0	*	*	*	*	*	*	0	*
Shetland	7	12	8	7	9	5	11	16	21	10
State Hospital	*	*	*	*	*	*	*	*	*	*
Tayside	291	345	355	362	393	498	413	458	489	428
Western Isles	*	*	7	9	10	9	13	15	*	7
Total	**3,666**	**4,004**	**4,099**	**4,380**	**4,426**	**4,733**	**4,768**	**5,287**	**5,264**	**5,373**

*n≤5 and secondary suppression to maintain confidentiality

Table A4. Number of STDCs by local authority and year

Local authority	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Aberdeen City	180	174	210	258	209	209	262	281	243	273
Aberdeenshire	121	124	119	129	139	130	143	156	157	168
Angus	47	56	55	52	47	73	52	81	91	64
Argyll and Bute	66	68	53	46	82	59	51	49	72	58
City of Edinburgh	470	527	457	562	524	531	556	586	550	621
Clackmannanshire	21	26	51	47	43	59	39	64	70	53
Dumfries and Galloway	82	106	106	139	98	144	139	141	124	132
Dundee City	125	155	146	165	181	211	199	185	202	201
East Ayrshire	60	79	72	83	64	57	57	85	76	119
East Dunbartonshire	60	47	38	56	56	55	64	64	58	93
East Lothian	48	61	75	63	51	78	60	79	63	77
East Renfrewshire	34	40	36	57	55	63	76	65	67	64
Eilean Siar	*	*	*	9	11	9	13	*	14	6
Falkirk	100	112	129	153	155	126	112	132	171	151
Fife	266	276	271	284	266	291	275	344	337	369
Glasgow City	658	701	744	769	903	908	968	1080	1089	1057
Highland	177	162	159	151	148	162	155	164	146	173
Inverclyde	75	61	94	79	74	94	102	64	73	67
Midlothian	33	50	50	50	38	65	64	65	63	61
Moray	52	60	67	65	62	59	78	60	51	72
North Ayrshire	73	74	69	81	62	65	55	93	113	89
North Lanarkshire	163	209	206	221	206	238	239	247	242	243
Orkney	*	*	*	*	*	*	*	*	0	7
Perth and Kinross	121	138	158	146	174	215	167	194	196	161
Renfrewshire	97	120	115	119	145	133	148	183	149	160
Scottish Borders	63	74	58	65	62	74	79	88	80	66
Shetland	12	14	*	*	*	*	*	19	21	12
South Ayrshire	57	52	59	56	45	65	59	57	82	91
South Lanarkshire	155	180	200	209	227	250	234	224	241	270
Stirling	55	54	66	62	71	69	96	130	132	127
West Dunbartonshire	54	58	69	71	75	67	62	83	87	76
West Lothian	131	131	144	125	140	163	151	208	204	192
Total	**3,666**	**4,004**	**4,099**	**4,380**	**4,426**	**4,733**	**4,768**	**5,287**	**5,264**	**5,373**

*n≤5 and secondary suppression to maintain confidentiality

Table A5. Rate of STDCs by 100,000 population by local authority and year

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Aberdeen City	79.3	76.0	91.2	112.3	91.3	91.8	114.6	122.7	106.8	120.0
Aberdeenshire	46.9	47.6	45.4	49.2	53.1	49.7	54.7	59.8	59.8	64.0
Angus	40.4	48.0	47.0	44.6	40.4	62.9	44.8	69.9	78.4	55.1
Argyll and Bute	75.0	77.6	61.0	52.8	94.5	69.6	59.4	57.4	83.5	67.3
City of Edinburgh	96.4	107.0	91.6	110.8	101.7	102.0	105.9	111.1	104.5	118.0
Clackmannanshire	41.0	50.8	99.3	91.5	85.5	114.8	75.7	124.8	135.8	102.8
Dumfries and Galloway	54.6	70.7	70.8	93.0	65.7	96.8	93.4	95.1	83.3	88.7
Dundee City	84.4	104.6	98.5	110.6	121.7	141.8	133.3	124.3	136.7	136.1
East Ayrshire	49.0	64.7	59.0	67.1	52.5	47.6	46.7	69.9	62.3	97.5
East Dunbartonshire	56.7	44.0	35.5	52.1	51.8	50.8	58.9	58.9	53.3	85.4
East Lothian	47.3	59.8	72.8	60.5	48.6	74.7	56.0	73.2	57.5	70.3
East Renfrewshire	37.1	43.3	38.7	59.7	58.0	66.2	79.6	67.7	69.4	66.3
Eilean Siar	18.2	36.7	33.2	33.5	40.8	33.5	48.7	52.8	52.6	22.5
Falkirk	63.6	70.4	81.4	96.0	96.2	78.6	69.6	82.2	106.4	94.0
Fife	72.5	75.2	73.6	76.7	71.6	78.2	73.6	91.9	89.9	98.5
Glasgow City	110.3	116.9	122.7	125.2	145.4	145.0	152.9	169.9	171.5	166.4
Highland	76.0	69.5	67.9	64.3	62.5	68.8	65.7	69.7	61.3	72.7
Inverclyde	93.4	76.4	118.2	99.8	94.0	120.3	131.1	83.1	95.2	87.4
Midlothian	39.0	58.0	57.2	56.4	44.4	71.2	69.2	69.8	66.5	64.4
Moray	55.1	63.3	70.1	67.7	64.7	61.8	81.4	62.7	52.9	74.7
North Ayrshire	53.3	54.2	50.7	61.1	45.7	48.0	40.8	69.3	84.2	66.3
North Lanarkshire	48.3	61.8	60.9	65.1	60.6	70.0	70.0	72.4	70.9	71.2
Orkney[a]	23.2	23.2	23.1	4.6	13.6	22.5	9.0	8.9	-	31.1
Perth and Kinross	81.9	92.7	105.4	96.9	115.2	142.1	109.9	127.7	127.4	104.7
Renfrewshire	55.8	68.9	65.9	67.6	82.0	74.2	82.6	102.0	82.8	88.9
Scottish Borders	55.3	64.9	50.9	56.8	53.9	64.2	68.4	76.4	69.0	56.9
Shetland[a]	51.7	60.3	38.8	30.2	43.3	26.1	48.0	83.1	91.5	52.3
South Ayrshire	50.5	46.2	52.5	49.8	40.8	57.8	52.4	50.8	72.9	80.9
South Lanarkshire	49.2	57.1	63.2	65.9	71.3	78.4	73.0	69.8	74.7	83.7
Stirling	60.3	60.1	71.1	66.1	75.5	73.1	101.9	138.2	141.2	135.9
West Dunbartonshire	60.1	64.7	77.0	79.0	83.7	75.2	69.7	94.0	99.1	86.6
West Lothian	74.4	73.9	80.6	69.4	77.2	89.5	82.5	113.2	109.9	103.5

[a]The island boards have small number of orders, which leads to unstable rates with very wide confidence intervals. The rates for these boards should therefore be interpreted with great deal of caution.

Table A6. Number of CTOs by local authority and year

Local authority	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Aberdeen City	52	57	77	97	72	70	80	71	76	75
Aberdeenshire	37	40	39	43	32	48	41	26	38	38
Angus	22	22	37	26	30	34	35	40	38	33
Argyll and Bute	15	17	15	14	24	24	22	21	20	19
City of Edinburgh	127	143	132	130	156	148	151	216	188	207
Clackmannanshire	*	6	11	15	17	18	12	21	13	19
Dumfries and Galloway	30	34	28	41	30	40	40	59	59	65
Dundee City	41	46	50	39	47	40	43	50	48	58
East Ayrshire	15	18	24	11	21	20	17	24	30	28
East Dunbartonshire	18	22	15	24	21	22	24	20	30	38
East Lothian	20	23	33	26	18	31	24	32	42	28
East Renfrewshire	15	17	15	16	18	26	30	33	28	21
Eilean Siar	*	*	*	*	*	*	*	6	*	*
Falkirk	29	24	34	41	48	44	44	42	56	66
Fife	88	108	102	92	89	89	110	131	121	127
Glasgow City	184	183	222	176	213	256	292	271	309	321
Highland	71	69	57	65	61	88	68	57	76	75
Inverclyde	28	33	28	27	30	30	44	29	25	28
Midlothian	19	19	22	18	20	20	24	21	37	26
Moray	23	15	18	15	18	20	16	12	13	16
North Ayrshire	15	15	22	21	18	25	20	36	39	38
North Lanarkshire	63	64	52	57	67	75	65	80	80	73
Orkney	*	*	*	8	*	0	0	*	*	*
Perth and Kinross	38	50	56	61	62	87	59	64	53	44
Renfrewshire	36	39	40	52	60	53	59	57	56	54
Scottish Borders	19	28	24	26	28	30	22	27	24	16
Shetland	*	*	*	*	*	*	*	*	*	7
South Ayrshire	14	14	18	26	17	19	11	14	15	40
South Lanarkshire	63	51	80	62	86	80	63	63	74	90
Stirling	15	19	9	13	25	17	21	23	26	45
West Dunbartonshire	24	34	31	39	38	37	31	38	41	39
West Lothian	42	43	35	37	40	42	43	43	63	45
Total	**1,175**	**1,260**	**1,337**	**1,323**	**1,422**	**1,542**	**1,519**	**1,632**	**1,730**	**1,783**

*n≤5 and secondary suppression to maintain confidentiality

Table A7. Number of CTOs by Health board and year

Health board	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Ayrshire and Arran	45	45	65	57	51	58	46	73	79	103
Borders	17	24	19	21	25	27	20	23	21	12
Dumfries and Galloway	29	31	28	39	30	38	40	60	59	64
Fife	86	102	98	94	84	85	103	127	120	119
Forth Valley	48	48	54	67	87	74	76	86	96	127
Grampian	108	117	137	163	128	138	139	111	129	136
Greater Glasgow and Clyde	326	362	392	374	427	465	507	489	535	542
Highland	82	75	65	68	73	97	79	62	80	77
Lanarkshire	102	87	101	95	116	127	108	114	124	132
Lothian	219	243	229	214	245	252	250	315	333	319
Orkney	0	0	0	*	*	0	0	0	*	0
Shetland	0	0	0	0	0	0	0	*	*	0
State Hospital	*	*	*	*	*	*	*	*	*	*
Tayside	110	120	145	123	148	176	142	160	147	148
Western Isles	*	*	*	*	*	*	*	6	*	*
Total	**1,175**	**1,260**	**1,337**	**1,323**	**1,422**	**1,542**	**1,519**	**1,632**	**1,730**	**1,783**

*n≤5

Table A8. Rate of CTOs by 100,000 population by local authority and year

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Aberdeen City	22.9	24.9	33.4	42.2	31.5	30.8	35.0	31.0	33.4	33.0
Aberdeenshire	14.4	15.4	14.9	16.4	12.2	18.4	15.7	10.0	14.5	14.5
Angus	18.9	18.8	31.7	22.3	25.8	29.3	30.1	34.5	32.7	28.4
Argyll and Bute	17.0	19.4	17.3	16.1	27.6	27.8	25.6	24.6	23.2	22.0
City of Edinburgh	25.8	29.0	26.5	25.6	30.4	28.5	28.6	40.9	35.7	39.3
Clackmannanshire	9.8	11.7	21.4	29.2	33.0	35.0	23.3	40.9	25.2	36.9
Dumfries and Galloway	20.0	22.7	18.7	27.4	20.1	26.9	26.9	39.8	39.7	43.7
Dundee City	27.7	31.1	33.7	26.3	31.6	26.2	28.8	33.6	32.5	39.3
East Ayrshire	12.3	14.7	19.7	9.0	17.2	16.4	13.9	19.7	24.6	22.9
East Dunbartonshire	17.0	20.6	14.0	22.3	19.4	21.2	22.1	18.4	27.5	34.9
East Lothian	19.7	22.5	32.0	25.0	17.2	29.3	22.4	29.7	38.3	25.6
East Renfrewshire	16.4	18.4	16.1	17.1	19.0	27.3	31.4	34.4	29.0	21.7
Eilean Siar	14.6	18.3	14.8	11.2	22.3	7.5	15.0	22.6	18.8	11.3
Falkirk	18.5	15.2	21.5	25.7	30.0	27.4	27.3	26.2	34.8	41.1
Fife	24.0	29.4	27.7	24.6	24.0	23.9	29.7	35.0	32.3	33.9
Glasgow City	30.8	30.5	36.6	28.6	34.3	40.5	46.1	42.6	48.7	50.5
Highland	30.5	29.6	24.3	27.7	25.9	37.8	28.8	24.2	31.9	31.5
Inverclyde	34.9	41.3	35.2	34.1	38.1	38.4	56.6	37.6	32.6	36.5
Midlothian	23.6	22.0	25.2	20.3	22.2	21.9	27.0	22.5	39.1	27.5
Moray	24.4	15.8	18.8	15.6	18.8	20.9	16.7	12.5	13.5	16.6
North Ayrshire	11.0	11.0	16.2	15.5	13.3	18.5	14.8	26.8	29.1	28.3
North Lanarkshire	18.7	18.9	15.4	16.8	19.7	22.0	19.0	23.5	23.4	21.4
Orkney[a]	4.6	9.3	23.1	36.6	27.3	0.0	0.0	13.4	4.4	4.4
Perth and Kinross	25.7	33.6	37.4	41.1	41.0	57.5	38.8	42.1	34.5	28.6
Renfrewshire	20.7	22.4	22.9	29.6	33.9	30.4	32.9	31.8	31.1	30.0
Scottish Borders	16.7	24.6	21.0	22.7	24.3	26.0	19.0	23.4	20.7	13.8
Shetland[a]	8.6	4.3	8.6	8.6	17.3	30.4	17.5	8.7	21.8	30.5
South Ayrshire	12.4	12.4	16.0	23.1	15.1	16.9	9.8	12.5	13.3	35.6
South Lanarkshire	20.0	16.2	25.3	19.6	27.0	25.1	19.7	19.6	22.9	27.9
Stirling	16.4	19.7	9.7	13.9	26.6	18.0	22.3	24.4	27.8	48.1
West Dunbartonshire	26.7	37.9	34.6	43.4	42.4	41.5	34.9	43.0	46.7	44.4
West Lothian	23.8	24.3	19.6	20.5	22.1	23.1	23.5	23.4	33.9	24.2

[a]The island boards have small number of orders, which leads to unstable rates with very wide confidence intervals. The rates for these boards should therefore be interpreted with great deal of caution.

Table A9. Number of detentions under nurse's power to detain by year and gender

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Female	112	120	81	96	116	119	119	103	109	84
Male	65	67	55	50	51	63	63	52	61	59
Total	**177**	**187**	**136**	**146**	**167**	**182**	**182**	**155**	**170**	**143**

Table A10. Rate of detentions under nurse's power to detain by year and gender

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Scotland rate	3.3 (2.8-3.8)	3.5 (3.0-4.0)	2.5 (2.1-3.0)	2.7 (2.3-3.1)	3.1 (2.6-3.5)	3.3 (2.9-3.8)	3.3 (2.8-3.8)	2.8 (2.4-3.3)	3.1 (2.7-3.6)	2.6 (2.2-3.0)
Female rate	4.1 (3.3-4.8)	4.4 (3.6-5.1)	2.9 (2.3-3.6)	3.5 (2.8-4.1)	4.2 (3.4-4.9)	4.3 (3.5-5.0)	4.2 (3.5-5.0)	3.7 (3.0-4.4)	3.9 (3.2-4.7)	3.0 (2.4-3.6)
Male rate	2.5 (1.9-3.1)	2.6 (2.0-3.2)	2.1 (1.6-2.7)	1.9 (1.4-2.4)	1.9 (1.4-2.5)	2.4 (1.8-3.0)	2.4 (1.8-2.9)	2.0 (1.4-2.5)	2.3 (1.7-2.9)	2.2 (1.6-2.8)

Table A11. Number of place of safety orders by year

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Number of orders	660	696	831	1,140	1,181	1,114	1,136	1,142	1,256	1,345

Table A12. Point prevalence orders by year and health board

Health board	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Ayrshire and Arran	144	140	159	165	164	188	180	182	202	213
Borders	40	39	41	39	49	46	46	55	33	34
Dumfries and Galloway	53	52	57	61	60	75	70	90	93	98
Fife	224	239	229	254	262	242	249	267	276	268
Forth Valley	151	159	162	163	197	205	211	224	228	244
Grampian	229	227	248	282	278	284	288	279	304	304
Greater Glasgow and Clyde	882	932	984	1009	1044	1069	1132	1194	1240	1269
Highland	211	206	184	182	177	203	207	177	192	174
Lanarkshire	199	199	219	233	211	243	229	238	269	272
Lothian	519	534	563	559	626	618	633	683	722	712
Tayside	274	295	318	320	321	337	320	357	342	341

Table A13. Rate of point prevalence orders by year and health board

Health board	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Ayrshire and Arran	38.7	37.7	42.9	44.5	44.3	50.9	48.7	49.5	54.8	57.8
Borders	35.1	34.2	36.0	34.1	42.6	39.9	39.8	47.7	28.4	29.3
Dumfries and Galloway	35.3	34.7	38.1	40.8	40.2	50.4	47.0	60.7	62.5	65.9
Fife	61.1	65.1	62.2	68.6	70.5	65.1	66.7	71.4	73.7	71.5
Forth Valley	50.4	52.9	53.5	53.5	64.5	67.0	68.8	73.2	74.6	79.8
Grampian	39.5	38.9	42.2	48.0	47.4	48.6	49.2	47.6	51.8	51.8
Greater Glasgow and Clyde	77.5	81.6	85.6	86.9	89.3	91.0	95.7	100.7	104.6	107.1
Highland	65.7	64.2	57.3	56.5	55.0	63.1	64.3	55.2	59.2	53.7
Lanarkshire	30.5	30.5	33.5	35.5	32.1	36.9	34.6	36.0	40.5	41.0
Lothian	61.1	62.2	64.9	63.5	70.4	68.8	69.7	74.9	78.8	77.7
Tayside	66.5	71.3	76.6	77.0	77.1	81.0	76.7	85.7	81.9	81.6

Table A14. Rate of point prevalence CTOs by health board and CTO type

Health board	Community rate	95% CI	Hospital rate	95% CI
Ayrshire and Arran	14.1	10.3 - 17.9	23.9	18.9-28.9
Borders	18.1	10.4 - 25.8	6.9	2.1-11.7
Dumfries and Galloway	28.2	19.7 - 36.8	22.9	15.2-30.5
Fife	23.2	18.3 - 28.1	28.8	23.4-34.3
Forth Valley	25.5	19.9 - 31.2	34.7	28.1-41.3
Grampian	16.7	13.4 - 20.0	19.9	16.3-23.6
Greater Glasgow and Clyde	36.6	33.2 - 40.1	42.8	39.1-46.5
Highland	22.8	17.6 - 28.0	19.7	14.9-24.6
Lanarkshire	13.4	10.6 - 16.2	15.1	12.1-18.0
Lothian	29.0	25.5 - 32.5	31.1	27.5-34.7
Tayside	26.3	21.4 - 31.3	31.8	26.4-37.3

Table A15. Number of orders under Criminal Procedure Act and number of individuals with an order by year

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Orders	411	400	416	446	433	386	401	359	373	333
Individuals	234	222	234	252	227	220	221	214	221	196

Table A16. Ethnicity of individuals detained under the Criminal Procedure Act by year

Ethnic grouping	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
African, Caribbean or Black		*	6 (3.1%)	10 (4.7%)		*	7 (3.6%)	9 (5.6%)	6 (3.7%)	*
Asian	*	9 (4.2%)		8 (3.7%)	*	*	*	*	9 (5.5%)	
Mixed	*				*	*	*	6 (3.8%)	*	*
Other				4 (1.9%)	*	*	*	*		
White - Other British	12 (6.2%)	10 (4.7%)	10 (5.1%)	5 (2.3%)	15 (7.2%)	18 (9.6%)	21 (10.7%)	*	*	*
White - Other	7 (3.6%)	27 (12.6%)	13 (6.6%)	9 (4.2%)	14 (6.7%)	19 (10.2%)	7 (3.6%)	13 (8.1%)	24 (14.7%)	*
White - Scottish	171(88.6%)	166(77.6%)	167(85.2%)	179 83.3%)	173(82.8%)	136(72.7%)	153(77.7%)	124(77.5%)	116(71.2%)	126(88.7%)

*n≤5

Table A17. Number of Criminal Procedure Act orders by order type and year

Category	Order	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Treatment and assessment	Treatment order	98	106	113	109	119	99	100	102	105	105
	Assessment order	131	133	141	129	131	122	140	105	131	108
Unfitness for trial	Temporary Compulsion Order	7	20	18	20	20	16	11	12	18	11
Acquittal due to mental disorder	S57(2)(a) Compulsion Order	15	21	26	28	50	33	22	27	22	20
	S57(2)(a) Compulsion Order - Community	*	0	0	0	0	0	0	0	*	0
	S57(2)(b) CORO	9	*	*	*	*	*	*	*	*	7
Post-conviction pre-disposals	Interim Compulsion Order	32	21	23	26	23	15	24	13	14	19
	S200 Committal	*	0	0	0	0	0	*	0	0	0
	Hospital direction	*	*	*	0	*	*	0	0	*	0
Mental health disposals	S57A(2) Compulsion Order	57	44	45	60	43	46	52	45	39	35
	S57A(2) Compulsion Order - Community	*	*	0	*	*	0	0	*	*	0
	S59 CORO	10	8	9	10	*	8	8	6	*	6
Transfer for treatment	Transfer for Treatment Direction	47	38	36	58	36	40	38	44	33	22
Total		**411**	**400**	**416**	**446**	**433**	**386**	**401**	**359**	**373**	**333**

*n≤5

Table A18. Number of T2s by treatment type and year

Treatment	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
ECT	14	16	8	21	23	30	21	20	29	18
Medication to reduce sex drive	0	*	0	*	*	*	*	*	0	0
Artificial nutrition	*	*	*	0	*	8	11	7	9	6
Other treatment	0	0	0	0	0	0	0	0	0	*
Medication beyond two months	798	785	769	751	773	862	785	801	890	928

*n≤5

Table A19. Number of T3s by treatment type and year

Treatment	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
ECT	171	186	207	176	224	222	255	214	240	230
Medication to reduce sex drive	*	9	7	10	10	12	11	7	8	*
Artificial nutrition	55	77	98	99	116	137	132	135	164	177
Medication over two months	1,317	1,470	1,503	1,559	1,642	1,704	1,823	1,675	1954	2164

*n≤5

Table A20. Number of T4s by age and year

Age	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Under 18	36	29	44	33	36	52	55	93	81	70
18 and older	188	263	234	205	297	328	352	359	449	428
Total	**224**	**292**	**278**	**238**	**333**	**380**	**407**	**452**	**530**	**498**

Table A21. Number of T4s by health board and year

Health board	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Ayrshire and Arran	11	22	34	22	34	38	17	12	25	12
Borders	*	13	0	*	*	*	*	10	*	12
Dumfries and Galloway	8	24	9	6	9	22	13	20	19	*
Fife	26	21	19	15	11	32	32	34	40	37
Forth Valley	*	*	9	*	*	*	15	9	8	27
Grampian	15	27	16	21	27	28	36	39	39	47
Greater Glasgow and Clyde	47	67	56	37	68	97	120	106	137	154
Highland	25	13	*	*	10	10	*	*	18	27
Lanarkshire	6	8	7	15	14	13	19	13	30	17
Lothian	39	37	58	58	71	54	70	81	96	87
State	*	*	*	6	*	*	9	*	*	*
Tayside	42	52	60	47	78	69	66	117	106	72
Western Isles	0	*	*	0	0	0	0	0	0	0
Shetland	0	0	*	*	0	0	0	0	0	0
Total	**224**	**292**	**278**	**238**	**333**	**380**	**407**	**452**	**530**	**498**

*n≤5 and secondary suppression to maintain confidentiality

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