mental welfare commission for scotland

Emergency detention certificates without mental health officer consent

Statistical monitoring

September 2026

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

Introduction

The Mental Welfare Commission (the Commission) has a statutory duty to monitor how Scotland's principle-based mental health law is used. We do this by publishing a transparent annual statistical report which includes data on mental health officer (MHO) consent to emergency detention certificates (EDCs). MHO consent is regarded as an important safeguard when someone is being detained in hospital.

In 2016, the Commission was asked by the Scottish Government to undertake analysis of the reasons for low reported MHO consent to EDCs. At the same time, the Chief Social Work Advisor to the Scottish Government was tasked with investigation of issues in relation to the apparent shortfall in MHOs in local authorities.

Ten years on, MHO consent continues to be lower than we would expect to see, although there was a slightly higher percentage of EDCs with MHO consent in 2024-25 than in the preceding two years. However, the proportion of EDCs with MHO consent remains low at 38.6%. This compares to 56% noted in our 2016 report based on 2014-15 data.

It is of significant concern that so many people are not receiving the important safeguard of an MHO in Scotland. The Commission has therefore undertaken analysis once again to understand the reasons for this using 2024-25 data.

MHO consent

An emergency detention certificate (EDC) can be issued by any registered medical practitioner and authorises detention in hospital for up to 72 hours. The Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) is clear that there should be consent from an MHO wherever practicable (s36 (3) and (6)).

A short-term detention certificate (STDC) is regarded as the preferred 'gateway' order when someone requires detention in hospital, as it requires assessment by an approved medical practitioner (AMP) (a psychiatrist with specific training and registered with the health board) and an MHO (a social worker with specific training and approved by the local authority).

EDCs should only be used if it is not possible to secure assessments by both an AMP and an MHO. They are likely to be used in crisis situations.

The Commission places value on the role of the MHO in the decision to detain a person.

The MHO provides the important safeguard of looking critically at the proposal to detain the person and can help to look at alternative ways to support the person without needing to use compulsory admission. Where the person needs to be admitted, the MHO can help to explain the process, their rights, including access to advocacy, and make arrangements to make admission easier and to safeguard the person's property and possessions.

We expect to see MHO consent in as many cases as possible, in line with the requirements of the Mental Health Act, though recognise that the nature of the situation and the person's individual needs do not always allow this. However, as per the Scottish Mental Health Law Review recommendation 12.8, "EDC without MHO consent should be exceptional".

National data reported by the Commission in relation to EDCs

Table 1 provides information on EDCs with consent by health board over the past five years. The table highlights (in green) improvements made in MHO consent last year (2024-25) in almost all board areas with the exception of Forth Valley, Lothian and Western Isles.

On Scotland's mainland, MHO consent to EDCs during 2024-25 ranged from 27.0% (Greater Glasgow and Clyde (GG&C)) up to 81.4% (Dumfries and Galloway (D&G)).

Table 1: EDCs with consent by health board in last five years (percentage), 2020-25

Health board	2020-21	2021-22	2022-23	2023-24	2024-25
	%	%	%	%	%
Ayrshire and Arran	59.0%	70.1%	63.8%	61.8%	62.5%
Borders	49.0%	43.8%	47.5%	39.2%	41.5%
D&G	79.5%	71.4%	84.2%	77.9%	81.4%
Fife	40.4%	44.0%	31.1%	31.7%	43.1%
Forth Valley	33.3%	33.2%	33.8%	40.6%	32.9%
Grampian	41.5%	43.9%	38.8%	31.0%	36.5%
GG&C	22.4%	22.0%	21.3%	24.3%	27.0%
Highland	39.6%	46.4%	49.4%	57.3%	59.4%
Lanarkshire	57.9%	58.5%	36.0%	40.2%	47.7%
Lothian	42.0%	44.0%	44.1%	36.0%	33.2%
Orkney	100%	100%	100%	100%	100%
Shetland*	100%	60%	X	X	X
Tayside	66.1%	62.3%	56.8%	41.2%	47.6%
Western Isles	57.1%	0%	33.3%	66.7%	33.3%
Scotland	40.5%	40.5%	36.7%	35.7%	38.6%

Note: No EDCs in Shetland from 2022-23 onwards.

GG&C also had the lowest rate of consent when analysed in 2016 (30%) and interestingly D&G have improved considerably from the 55% reported in 2016. All of the other mainland boards with the highest percentages of consent in 2016 have substantially lower percentages of consent now: Tayside, was 80% (now 47.6%); Fife, was 77% (now 43.1%); Highland, was 74% (now 59.4%). Highland, however, is the only board where performance has steadily improved over the past 5 years (see Figure 1).

Figure 1: EDCs with MHO consent, 2015-25

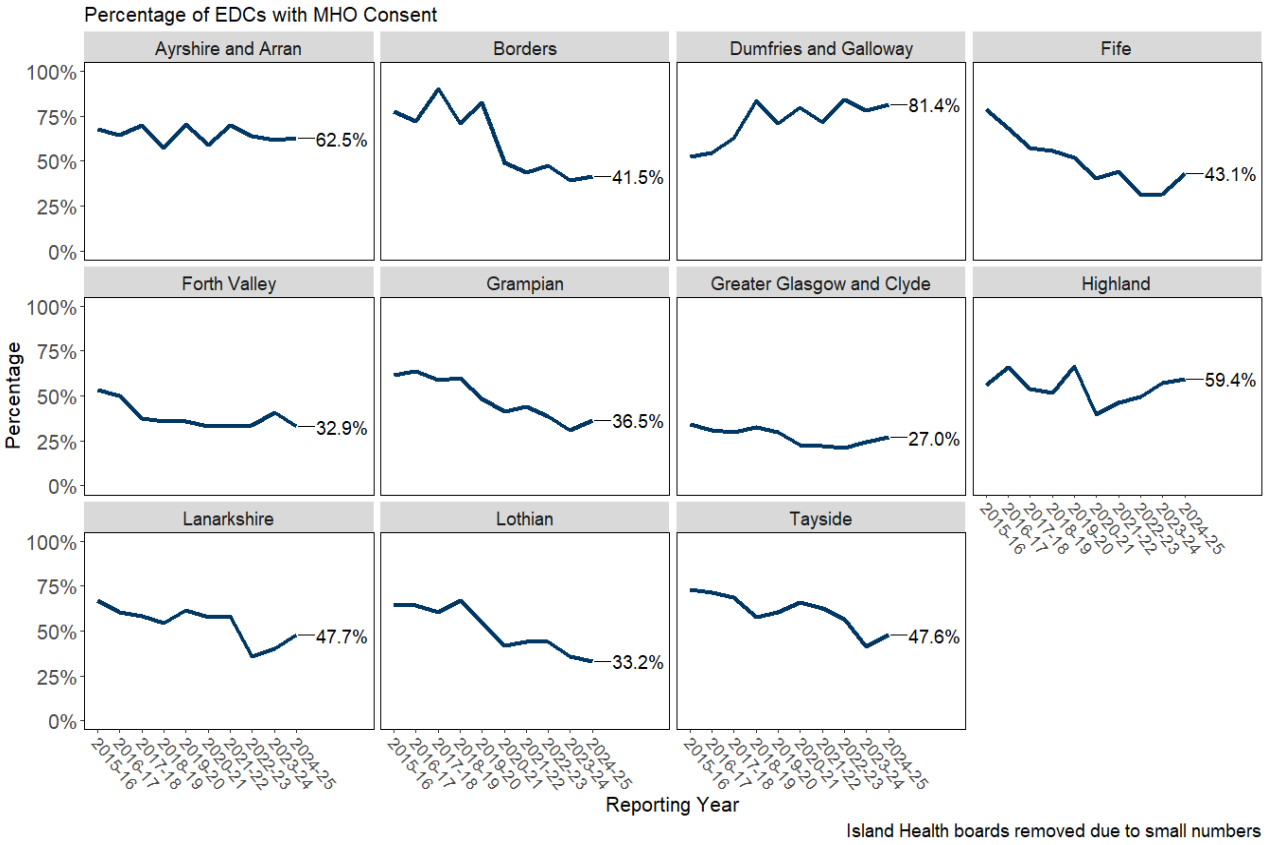


Table 2: All EDCs with and without consent by health board, 2024-25

Health board	Without MHO consent		With MHO consent		Total	
	n	%	n	%	n	%
Ayrshire and Arran	110	37.5%	183	62.5%	293	100%
Borders	48	58.5%	34	41.5%	82	100%
D&G	21	18.6%	92	81.4%	113	100%
Fife	151	56.9%	112	43.1%	260	100%
Forth Valley	111	67.1%	54	32.9%	164	100%
Grampian	61	63.5%	35	36.5%	96	100%
GG&C	1084	73.0%	400	27.0%	1480	100%
Highland	43	40.6%	63	59.4%	106	100%
Lanarkshire	208	52.3%	189	47.7%	396	100%
Lothian	419	66.8%	208	33.2%	626	100%
Orkney	0	0%	4	100%	4	100%
Tayside	140	52.4%	127	47.6%	267	100%
Western Isles	2	66.7%	1	33.3%	3	100%
Scotland	2398	61.4%	1507	38.6%	3905	100%

There is an assumption that poor levels of MHO consent are associated with out of hours service provision, that is, out with the working day and at weekends, when staffing capacity across health and social work is reduced. Table 3 data, however, confirms that the lack of consent of an MHO is similarly poor during regular working hours (57.6%) and out of hours (62.6%). Our data assumes that in hours is 9am-5pm Monday to Friday and out of hours is 5pm-9am, weekends, and on the following public holiday dates, 25 & 26 December, 1 & 2 January, and two days at Easter.

Table 3: Scotland MHO consent in hours and out of hours, 2024-25

Hours	Without consent		With consent		Total	
	n	%	n	%	n	%
In hours	532	57.6%	391	42.4	923	100%
Out of hours	1866	62.6%	1116	37.4%	2982	100%
Scotland	2398	61.4%	1507	38.6%	3905	100%

Table 4 shows that 76.4% (2982) of EDCs occurred out of hours and 23.6% (923) in hours in 2024-25. All health boards had more out of hours EDCs than in hours EDCs, apart from Western Isles.

Table 4: All EDCs in and out of hours by health board, 2024-25

Health board	In hours		Out of hours		Total	
	n	%	n	%	n	%
Ayrshire and Arran	82	28.0%	211	72.0%	293	100%
Borders	20	24.4%	62	75.6%	82	100%
D&G	20	17.7%	93	82.3%	113	100%
Fife	75	28.8%	185	71.2%	260	100%
Forth Valley	39	23.8%	125	76.2%	164	100%
Grampian	24	25.0%	72	75.0%	96	100%
GG&C	338	22.8%	1142	77.2%	1480	100%
Highland	26	24.5%	80	75.5%	106	100%
Lanarkshire	104	26.3%	292	73.7%	396	100%
Lothian	141	22.5%	485	77.5%	626	100%
Orkney	0	0%	4	100%	4	100%
Tayside	49	18.4%	218	81.6%	267	100%
Western Isles	2	66.7%	1	33.3%	3	100%
Scotland	923	23.6%	2982	76.4%	3905	100%

Table 5 below shows that, in hours, Borders (75.0%), Lothian (66.7%), GG&C (65.7%) and Forth Valley (64.1%) have the highest percentage of EDCs without MHO consent. The national average is 57.6%. In 2016, the national average was lower and better at 38%.

Table 5: In hours – EDCs with and without consent by health board, 2024-25

Health board	Without MHO consent		With MHO consent		Total	
	n	%	n	%	n	%
Ayrshire and Arran	34	41.5%	48	58.5%	82	100%
Borders	15	75.0%	5	25.0%	20	100%
D&G	6	30.0%	14	70.0%	20	100%
Fife	29	38.7%	46	61.3%	75	100%
Forth Valley	25	64.1%	14	35.9%	39	100%
Grampian	8	33.3%	16	66.7%	24	100%
GG&C	222	65.7%	116	34.3%	338	100%
Highland	11	42.3%	15	57.7%	26	100%
Lanarkshire	58	55.8%	46	44.2%	104	100%
Lothian	94	66.7%	47	33.3%	141	100%
Orkney	0	0%	0	0%	0	0%
Tayside	27	55.1%	22	44.9%	49	100%
Western Isles	1	50.0%	1	50.0%	2	100%
Scotland	532	57.6%	391	42.4%	923	100%

Table 6 shows that the highest percentages of out of hours decisions made without MHO consent were in GG&C (75.1%), Grampian (73.6%), Forth Valley (68.0%) and Lothian (66.8%). The national average for 2024-25 was 62.6% (compared with 48% in our 2016 report). The 2016 percentage for GG&C was 74% so almost exactly the same as 2024-25 with no improvement shown.

Table 6: Out of hours – EDCs with and without consent by health board, 2024-25

Health board	Without MHO consent		With MHO consent		Total	
	n	%	n	%	n	%
Ayrshire and Arran	76	36.0%	135	64.0%	211	100%
Borders	33	53.2%	29	46.8%	62	100%
D&G	15	16.1%	78	83.9%	93	100%
Fife	119	64.3%	66	35.7%	185	100%
Forth Valley	85	68.0%	40	32.0%	125	100%
Grampian	53	73.6%	19	26.4%	72	100%
GG&C	858	75.1%	284	24.9%	1142	100%
Highland	32	40.0%	48	60.0%	80	100%
Lanarkshire	149	51.0%	143	49.0%	292	100%
Lothian	324	66.8%	161	33.2%	485	100%
Orkney	0	0%	4	100%	4	100%
Tayside	113	51.8%	105	48.2%	218	100%
Western Isles	1	100%	0	0%	1	100%
Scotland	1866	62.6%	1116	37.4%	2982	100%

The data above confirms that the lack of MHO consent for EDCs is a long-standing concern and there has been no improvement nationally since 2016. Indeed, data confirms that the most vulnerable individuals requiring the protection of mental health legislation are now even less likely to have the important safeguard of an MHO involved in decisions about an EDC and the person's liberty.

When we break this down further, we find that people under age 25 years are less likely to have an MHO involved (32%), compared to those aged 25-64 years (36.8%) and the over 65 years age group (44.5%) who are most likely to have an MHO involved.

Further analysis in 2026

Engagement

To try to understand the ongoing downward trend, we first met with key stakeholders before auditing EDC paperwork.

Scottish Association of Social Work (SASW)

We met with SASW in January 2026 to discuss our work on EDC/MHO consent and background to this. SASW, in turn, invited us to attend their national MHO forum held on 5 March 2026 to hear the views of MHOs directly.

MHOs across Scotland were very keen to engage and told us:

- General practitioners (who rarely undertake EDC assessments), resident doctors (on short rotational roles), locum doctors and non-jurisdiction doctors all require training to ensure they are fully informed as to legislative requirements/how to contact an MHO. They told us that lack of knowledge and experience leads to failure to invoke the MHO safeguard.
- There is a lack of availability of approved medical practitioners (AMPs) in and out of hours and where they are available, they are unlikely to respond out of hours in the community.
- They (MHOs) rarely have sight of EDC paperwork and were concerned that their names may be added to forms when telephone calls had been made to discuss a case but the MHO had not been invited to assess. That is, noted to have given consent (when they have not) when only consulted with no opportunity to interview and assess.
- There is a lack of use of nurses' holding powers.

Royal College of Psychiatry

We also met with the Royal College of Psychiatry. We met in February 2026, following the winter meeting of the college and received feedback from members on what could usefully be included in our audit. There was recognition that general practitioners (GPs) and doctors in non-mental health settings may not be familiar with processes and the need for MHO consent. The college were keen to ensure that an EDC option without MHO consent would be preserved recognising that there are urgent situations which dictate the need for this option to remain.

Only the Royal College of Psychiatry suggested that individuals may prefer an EDC as a means to assessment as it does not last too long.

Royal College of General Practitioners

At our meeting with the Royal College of General Practitioners, we were asked to consult with their members directly and we did so via a two-question survey. The two questions were:

- Please share your views of the current EDC process and your experiences of it (good and bad).
- Please identify what additional support you think would help GPs fulfil their responsibilities in the EDC process.

GPs told us that they rarely carry out EDC assessments and when they do, they sometimes feel uncertain about what is required. They described it as a very time-consuming process and one which they sometimes feel pressured into because psychiatrists have not been able/available to undertake an STDC (the recommended route to use the Mental Health Act). There can be long delays waiting for an MHO to respond but GPs generally said they were able to get an MHO, albeit there were examples of the MHO declining to come and assess the person but agreeing to the EDC over the phone.

Ideally, GPs told us that they would have easy, quick access/support to a mental health professional for case discussion and assistance in detention of a patient.

Audit

After meeting with key stakeholders, we considered further by undertaking an audit of EDC forms.

GG&C and D&G context

We chose to examine the data further for the two key outlier mainland areas: GG&C (with MHO consent at a low of 27%) and D&G (with a high of 81.4%) and engaged with key staff of each area at the outset to advise of this plan.

It is important to note that D&G have not always been the highest performer in this area. The Commission meets with all health and social care partnerships (HSCPs)/health boards annually and in 2017-18, D&G committed to improve their 37% of EDCs with MHO consent. Their commitment, insight, including the setting up of their own out of hours arrangements (a move away from the West of Scotland model) has resulted in the 81.4% in 2024-25.

The differences between GG&C and D&G are absolutely acknowledged. The population of GG&C in 2024 was 1,217,270 and is the largest NHS organisation in Scotland. It employs around 41,000 staff and has six HSCPs (Glasgow City, East Dunbartonshire, East Renfrewshire, Inverclyde, Renfrewshire and West Dunbartonshire). The population of D&G in 2024 was 145,860. It employs around 4,500 staff with one HSCP. The population is spread over a large rural area of approximately 2,400 square miles. D&G has two towns with a population above

10,000[1]. However, we hoped to learn from both as national outliers in terms of performance in EDC and MHO consent.

Further context: EDC/MHO consent data

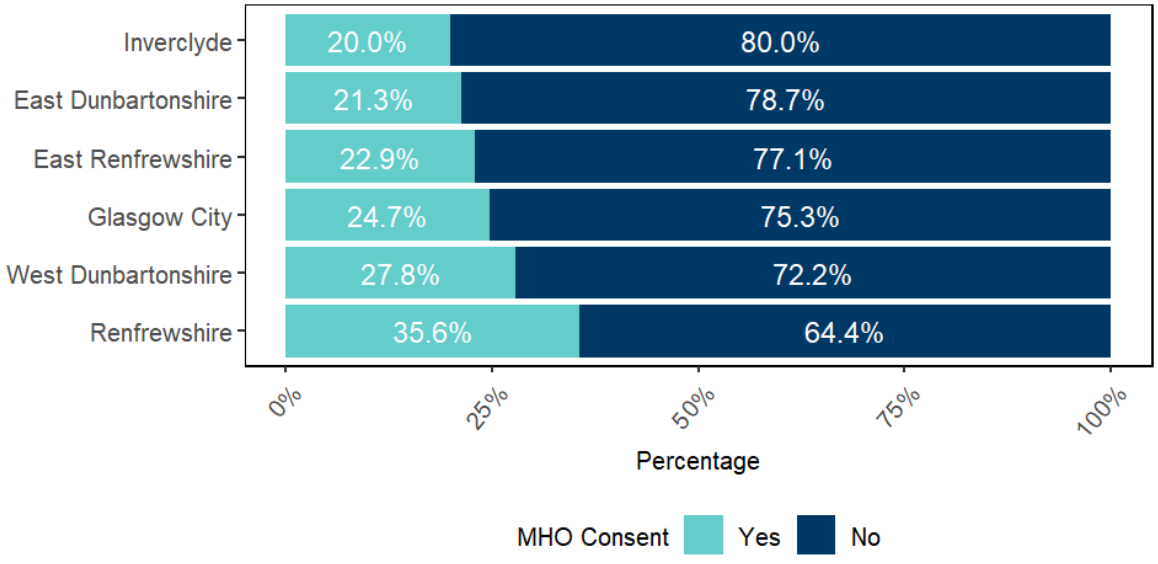
In 2024-25, there were 3905 EDCs in Scotland. Of these, 61.4% (2398) did not have MHO consent.

The overall rate of EDCs in 2024-25 was 69.8 per 100,000 population. GG&C was the health board with the highest rate of EDCs at 121.4 per 100,000 in 2024-25. D&G had the next highest rate at 76.1 per 100,000.

Over a third of all Scotland's EDCs (n=1480, 37.9%) took place within NHS GG&C. If GG&C were excluded, 49.8% of EDCs in the rest of Scotland did not have MHO consent.

In GG&C, 73.0% of EDCs did not have MHO consent (Inverclyde was the HSCP where MHO consent was least likely and Renfrewshire most likely out of all six HSCPs in GG&C)[2]. In D&G only 18.6% of EDCs did not have MHO consent.

Figure 2: MHO consent for EDCs by GG&C local authority



MHO workforce

The Scottish Social Services Council published a report on the 2025 MHO workforce and confirmed that the number of active MHOs in Scotland was "the highest number since records began in 2005"[3].

[1] Health board population source: Public Health Scotland Population Estimates - Datasets - Scottish Health and Social Care Open Data

[2] This data is based on post codes of individuals where available so there are caveats.
[3] Scottish Social Services Council Mental Health Officers (Scotland) Report 2025 | Scottish Social Services Council

An estimated number of MHO hours per week, per 10,000 population was provided for each local authority area. Scotland's national average was 25 hours in 2024 (Figure 3) and in 2025 it was reported as 26.5 hours (Figure 4). D&G exceeded this 2025 figure with hours estimated at 29.3 hours per 10,000 population. Three of GG&C's HSCPs also exceeded this (Glasgow City (33.2 hours), Inverclyde (35.1 hours) and West Dunbartonshire (31.4 hours)). East Dunbartonshire (20.1 hours), East Renfrewshire (23.3 hours) and Renfrewshire (23.4 hours) all had less MHO hours per 10,000 population in 2024 and in 2025 (See Figures 3&4).

Figure 3: MHO hours per 10,000 by GG&C local authority, 2024

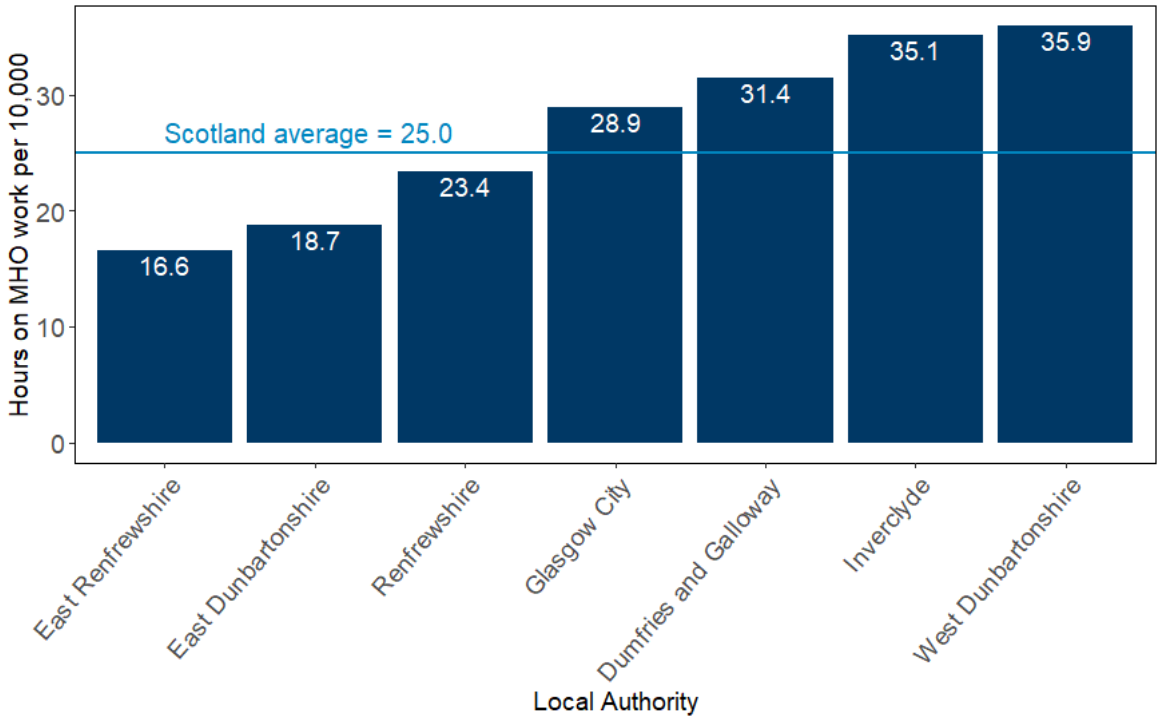
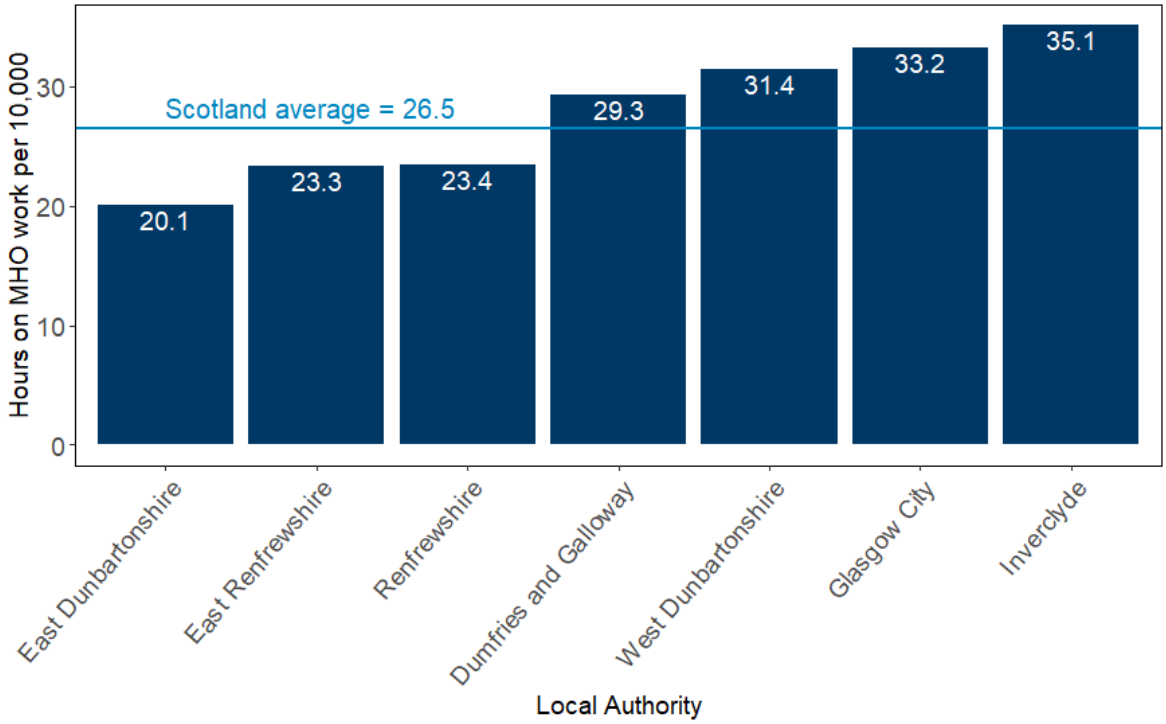


Figure 4: MHO hours per 10,000 by GG&C local authority, 2025



Glasgow City and East Renfrewshire (within GG&C) were also two of the four mainland local authorities (reported in 2025) who had reportedly not adopted a model of MHO service delivery which incorporated exclusive MHOs whose main job is MHO work. Instead, their model relied on non-exclusive MHOs who undertake both MHO work and non-MHO work (e.g. another statutory social work role). Midlothian and Perth and Kinross were the other two local authorities.

Audit of EDC paperwork in GG&C and D&G

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 chose to audit 320 EDC forms known as DET1s across GG&C and D&G.

We audited a 25% sample (299 forms) of GG&C EDC forms with no consent in 2024-25 in order to obtain a sufficient sample size. The sample was stratified by gender, in or out of hours, and whether the person was in hospital voluntarily or in a community setting prior to the EDC. Stratification was carried out to ensure a more representative sample was obtained. We were unable to stratify by age group due to resultant small numbers in each group.

The total number of EDC forms in D&G with no MHO consent in 2024-25 was 21. Therefore, due to small number size, all forms were selected to be examined as part of the audit.

There were 10 individuals aged 18 and under in our sample. Nine of the young people were admitted to Accident and Emergency, an adult acute/medical ward or adult mental health unit.

Table 7: Number of EDCs relating to HSCPs

(GG&C HSCPs highlighted in green; D&G in orange; to note some other detentions related to people with addresses out with GG&C and D&G; those not highlighted)

HSCP	**n=320**
Glasgow City	168
Renfrewshire	27
D&G	20
West Dunbartonshire	20
East Dunbartonshire	16
Inverclyde	16
South Lanarkshire	14
Not Known or out with Scotland	11

East Renfrewshire	10
Argyll & Bute	4
City of Edinburgh	≤3
Fife	≤3
North Lanarkshire	≤3
North Ayrshire	≤3
Falkirk	≤3
South Ayrshire	≤3
West Lothian	≤3

Table 7 relates to the 320-sample audited (299 EDCs from GG&C, and 21 from D&G). It can be seen that more than half the total sample of EDCs took place within Glasgow City HSCP. Numbers for all other individual HSCPs within GG&C were similar to D&G.

Of the 299 GG&C sample, 42 detentions related to people with addresses out with GG&C/not known addresses. Of the 21 D&G sample, only one address did not correlate with D&G postcodes and was unknown.

Our audit considered any differences between out of hours and in hours practice and:

- Type of medical practitioner undertaking the assessment for the EDC.
- The duration of EDCs once in place.
- Individual hospitals involved.
- The range of reasons given for non-attendance of an MHO (in hours, out of hours and where the person was in the community or in hospital on a voluntary basis).

Type of medical practitioner undertaking assessment for the EDCs in the audit sample

We started by asking, who is making the decision to detain without MHO consent?

Table 8: Type of doctor completing the form

Type of doctor	n	%
Doctor (non-consultant; resident doctor)	209	65.3%
Doctor on GP register	43	13.4%
Doctor on specialist register (consultant)	34	10.6%
More than one with the same name	23	7.2%
Not on register at time of audit	10	3.1%
Blank	1	0.3%

The audit involved crosschecking all doctors who signed EDC forms with the GMC register. Most doctors who completed EDC forms were not on the GP or specialist registers. In 23 cases, there was more than one doctor with the same name on the GMC register so it was not possible to determine which doctor completed the form. There were also ten examples where the doctor was not on the GMC register at the time of the audit or were listed as registered without a licence to practice. These doctors were, however, registered at the date of the EDC on inspection of the register. Most doctors on the specialist consultant register were psychiatrists, but some had other specialisms such as acute medicine.

Table 9: Was the doctor completing the form an approved medical practitioner (AMP)

AMP	n	%
No	194	60.6%
Yes	28	8.8%
Not on version of form	66	20.6%
Not provided	32	10.0%

The majority of doctors (60.6%) stated that they were not an AMP. However, there were some instances where a doctor stated that they were an AMP but are not listed as one. It would suggest that not all medical staff are aware of what an approved medical practitioner is, that is, doctors who are specially trained and accredited to perform duties according to mental health legislation (beyond EDCs).

The current version of the EDC form is v7.1. The question about AMP status was not included in earlier versions. The audit identified that 33.4% of detentions in D&G were recorded on older versions of the form compared to 19.7% in GG&C so information in relation to AMP status was missing in these instances.

The duration of EDCs once in place

Table 10: Duration of EDCs, D&G

EDC duration	n	%
Revoked within 24 hours	≤3	≤14.3%
Revoked 24-72 hours	≤3	≤14.3%
Expired	4	19.1%
Superseded by STDC <24 hours	7	33.3%
Superseded by STDC 24-72 hours	5	23.8%

Table 11: Duration of EDCs, GG&C

EDC duration	n	%
Revoked within 24 hours	56	18.7%
Revoked 24-72 hours	51	17.1%
Expired	33	11.1%
Superseded by STDC <24 hours	104	35.0%
Superseded by STDC 24-72 hours	54	18.1%

Note: n=1 missing outcome, on this occasion, a second EDC was put in place within 72 hours then a short-term detention certificate (STDC) the following day i.e. 84 hours following initial EDC. This is not good practice and is challengeable.

Table 10 and 11 highlight that 46.9% of EDC detentions in GG&C and 42.9% in D&G were revoked or expired without further compulsory assessment and treatment being required. The Commission does not hold information to confirm whether these people were then immediately discharged or continued to receive care and treatment in hospital on a voluntary basis.

Individual hospitals involved

Table 12: Consent in and out of hours by hospital, 2024-25, GG&C

Hospital	In hours				Out of hours				Type of hospital
	MHO consent		Total	% without consent	MHO consent		Total	% without consent	
	No	Yes			No	Yes			
	n	n	n	%	n	n	n	%	
Dykebar	5	9	14	35.7%	32	12	44	72.7%	Psychiatric
Gartnavel General	≤3	≤3	≤3	-	≤3	-	≤3	-	General
Gartnavel Royal	20	4	24	83.3%	88	37	125	70.4%	Psychiatric
Glasgow Royal Infirmary	65	27	92	70.7%	204	49	253	80.6%	General/acute
Glasgow Royal Maternity	-	-	-	-	-	≤3	≤3	-	Maternity
Graham Anderson House	-	-	-	-	≤3	-	≤3	-	Psychiatric (independent)
Inverclyde Royal	9	≤3	11	81.8%	22	8	30	73.3%	General/acute
Langhill (part of Inverclyde Hospital)	≤3	≤3	5	-	24	≤3	27	88.9%	Psychiatric
Leverndale	16	8	24	66.7%	95	41	136	70.0%	Psychiatric
Lightburn	≤3	-	≤3	-	-	-	-	-	Geriatric
Mackinnon House	-	-	-	-	≤5	-	≤5	-	Psychiatric
New Victoria Hospital	-	≤3	≤3	-	5	-	5	-	Ambulatory
Princess Royal Maternity	-	-	-	-	≤5	-	≤5	-	Maternity

Hospital	In hours				Out of hours				Type of hospital
	MHO consent		Total	% without consent	MHO consent		Total	% without consent	
	No	Yes			No	Yes			
	n	n	n	%	n	n	n	%	
Priory	-	≤3	≤3	-	≤3	≤3	≤3	-	Psychiatric (independent)
Queen Elizabeth	58	20	78	74.4%	188	50	243	77.4%	General/acute
Royal Alexandra	13	25	38	34.2%	63	22	85	74.1%	General/acute
Royal Glasgow Childrens	-	-	-	-	≤3	≤3	≤3	-	Paediatric
Skye House	-	≤3	≤3	-	≤3	-	≤3	-	Psychiatric (child and adolescent)
Stobhill	30	13	43	70.1%	124	50	174	71.3%	Ambulatory/ mental health units
Vale of Leven	≤3	≤3	≤3	-	≤3	≤3	≤3	-	General
All hospitals	**222**	**116**	**338**	**65.7%**	**856**	**284**	**1140**	**75.1%**	-

Notes: Percentage shown for hospitals with more than 10 EDCs only.

GG&C asked that Langhill data be separated from Inverclyde Royal Hospital data.

Table 12 shows that emergency detentions took place across 19 hospitals in GG&C during 2024-25. The percentages shown above are for those hospitals where there were 10 detentions or more. Most hospitals have high percentages of no MHO consent both in and out of hours. Only Dykebar and Royal Alexandra Hospitals have higher levels of EDCs with consent in hours than without consent, that is, in these two hospitals you are more likely to have an MHO involved in hours.

Data would suggest that the safeguard of an MHO is least likely at Gartnavel Royal Hospital (a psychiatric hospital) in hours with 83.3% assessments not involving an MHO. Out of hours, this appears least likely at Langhill (a mental health unit within Inverclyde Hospital) (88.9%) and Glasgow Royal Infirmary (an acute hospital) with 81% of emergency assessments not involving an MHO. They are higher than GG&C's overall 73% figure of no consent across the board area.

Table 13: Consent in and out of hours by hospital, 2024-25, D&G

Hospital	In hours				Out of hours				Type of hospital
	MHO consent		Total	% without consent	MHO consent		Total	% without consent	
	No	Yes			No	Yes			
	n	n	n	%	n	n	n	%	
Dumfries and Galloway RI	5	6	11	45.5%	6	25	31	19.4%	General/ Acute
Midpark	≤3	10	13	23.1%	7	45	52	13.5%	Psychiatric
Galloway Community	-	≤3	≤3	-	-	≤3	≤3	-	Community/ Acute
All hospitals	**8**	**19**	**27**	**29.6%**	**13**	**73**	**86**	**15.1%**	-

Emergency detentions took place across three hospitals in D&G during 2024-25. The percentages shown above are once again shown for those hospitals where there were 10 detentions or more. Across all three hospital settings in D&G, an MHO is more likely than not, to be involved in the decision relating to an emergency detention, whether in hours or out of hours.

The range of reasons given for non-attendance of an MHO (in hours, out of hours and where the person was in the community or in hospital on a voluntary basis).
Table 14: Reasons for no MHO consent, all hours (GG&C and D&G) n=320

Reason listed for no MHO consent	n	%
Patient was attempting to leave/unwilling to wait	114	35.6%
It would take too long for MHO to attend	83	25.9%
The situation was too urgent	57	17.8%
There was a risk to self or others	47	14.7%
Other reason	39	12.2%
Spoke to MHO post EDC	30	9.4%
MHO agrees over telephone	27	8.4%
Spoke to MHO but they could not attend for several hours	24	7.5%
Attempted to contact MHO but no answer	23	7.2%
No MHO available	15	4.7%
No reason given/Information not provided	13	4.1%
Spoke to other medical professional	7	2.2%

Place of safety needed	4	1.3%
Spoke to social worker as MHO not available	1	0.3%

Note: Total reasons are more than 320 as more than one reason listed

The most common reason listed for lack of MHO consent was that the person was attempting to leave or unwilling to wait (35.6%). The next most common reason was that it would take too long for an MHO to attend (25.9%). It was not always clear from the paperwork scrutinised that an attempt had been made to contact an MHO to ascertain this.

Table 15: Reasons for no MHO consent GGC only, all hours (n=299)

Reason listed for no MHO consent	**n**	**%**
Patient was attempting to leave/unwilling to wait	109	36.5%
It would take too long for MHO to attend	78	26.1%
The situation was too urgent	53	17.7%
There was a risk to self or others	43	14.4%
Other reason	35	11.7%
Spoke to MHO post EDC	29	9.7%
MHO agrees over telephone	27	9.0%
Spoke to MHO but they could not attend for several hours	23	7.7%
Attempted to contact MHO but no answer	19	6.4%
No MHO available	15	5.0%
No reason given/Information not provided	10	3.3%
Spoke to other medical professional	6	2.0%
Place of safety needed	4	1.3%
Spoke to social worker as MHO not available	1	0.3%

Table 16: Reasons for no MHO consent D&G only, all hours (n=21)

Reason listed for no MHO consent	n	%
Patient was attempting to leave/unwilling to wait	5	23.8%
It would take too long for MHO to attend	5	23.8%
The situation was too urgent	4	19.0%
There was a risk to self or others	4	19.0%
Other reason	4	19.0%
Spoke to MHO post EDC	1	4.8%
Spoke to MHO but they could not attend for several hours	1	4.8%
Attempted to contact MHO but no answer	4	19.0%
No reason given/Information not provided	3	14.3%
Spoke to other medical professional	1	4.8%

The reasons for no consent were similar between the two health boards; however, numbers are low in D&G.

We looked at the paperwork for the 96 people who were in the community or at home prior to the decision to invoke an EDC. The reasons for no MHO consent are as noted below.

Table 17: Community/home-based reasons for no MHO consent (n=96)

Reason listed for no MHO consent	n	%
Patient was attempting to leave/unwilling to wait	24	25.0%
It would take too long for MHO to attend	33	34.4%
The situation was too urgent	26	27.1%
There was a risk to self or others	25	26.0%
Other reason	8	8.3%
Spoke to MHO post EDC	9	9.4%
MHO agrees over telephone	10	10.4%
Spoke to MHO but they could not attend for several hours	8	8.3%
Attempted to contact MHO but no answer	3	3.1%
No MHO available	4	4.2%
No reason given/Information not provided	2	2.1%
Spoke to other medical professional	4	4.2%
Place of safety needed	3	3.1%
Spoke to social worker as MHO not available	0	0.0%

The substantial majority of the people in our sample were already in hospital prior to detention according to an EDC (see table 18).

Table 18: In hospital on a voluntary basis, reasons for no MHO consent (n=224)

Reason listed for no MHO consent	n	%
Patient was attempting to leave/unwilling to wait	90	40.2%
It would take too long for MHO to attend	50	22.3%
The situation was too urgent	31	13.8%
There was a risk to self or others	22	9.8%
Other reason	31	13.8%
Spoke to MHO post EDC	21	9.4%
MHO agrees over telephone	17	7.6%
Spoke to MHO but they could not attend for several hours	16	7.1%
Attempted to contact MHO but no answer	20	8.9%
No MHO available	11	4.9%
No reason given/Information not provided	11	4.9%
Spoke to other medical professional	3	1.3%
Place of safety needed	1	0.4%
Spoke to social worker as MHO not available	1	0.4%

For individuals in a community setting/at home prior to the decision to detain according to an EDC, the most common reason for no MHO consent was that it would take too long for an MHO to attend (34.4%) followed by the situation being too urgent (27.1%). This differed from those in hospital voluntarily where the most common reason was that the person was attempting to leave or unwilling to wait (40.2%) with 22.3% of decisions made because it would take too long for an MHO to attend.

The reasons for no MHO consent were broadly similar between EDCs in hours and out of hours.

It is important to note that where it was stated that the MHO was spoken to on the telephone or after the EDC was granted, the DET1 forms completed for the EDC stated this and did not record consent as given by the MHO. Indeed, some forms were explicit in stating that the MHO requested that this be confirmed on the form, that is, the MHO had **not** assessed, *"MHO asked for name not to be put on form as haven't given consent"*.

Other themes arising related to the handover between in hours and out of hours services. For example, *"Day MHO contacted but unable to attend as out of hours*

(8.15am)". There ended up being no response. It was also explained that there were gaps in service *"Out of hours MHO had already finished but day MHO not due to start for over an hour"*. There were also assumptions that there was no MHO service available out of hours or during public holidays, so no call was made, *"No MHO as bank holiday"*.

When reference was made to the MHO taking too long to attend, this ranged from taking 30 minutes to several hours.

Concerningly, one DET1 form sampled had no doctor name/details, pre-detention details or any MHO consent information – the sections were left completely blank and the signature was illegible. Part 2 of the form was completed two days following the date the EDC was granted. While there is no absolute statutory requirement to use the DET1 form, the content is required otherwise the certificate may be invalidated.

Summary points and recommendations

- The proportion of EDCs with MHO consent in Scotland was 56% when we reported on this in 2016.Ten years on, this has **dropped further** with a low of 38.6%.
- It is important to understand rates of EDC with MHO consent both in terms of health board area and HSCP areas.
- The Scottish Social Services Council published a report on the 2025 MHO workforce and confirmed that the number of active MHOs in Scotland was "the highest number since records began in 2005".
- MHOs require to undertake an individual independent assessment of the person and their circumstances and cannot give consent to an EDC over the telephone following discussion with the medical practitioner.
- Vulnerable individuals living in the GG&C health board area are still the least likely to receive the important safeguard of an MHO in Scotland. This has been the case for many years.
- Vulnerable individuals living in the D&G health board area are most likely to receive the important safeguard of an MHO in Scotland.
- GG&C health board has six HSCPs. Out of those six HSCPs, those people living in Glasgow City, Inverclyde, East Dunbartonshire and East Renfrewshire are least likely to have an MHO involved in an emergency detention decision based on our data held on 2024-25.
- A detention during office hours and a detention out of hours are both as likely to not have MHO consent. There are more EDC decisions made out of hours.
- The majority of EDC detentions without MHO consent in our sample of 320 (GG&C and D&G) took place when the person was already in hospital (this includes when in a psychiatric hospital).
- Given the location of the decision making, doctors making decisions without MHO consent were likely to be resident doctors within mental health settings or other doctors in other hospital settings i.e. not GPs and not consultant psychiatrists.
- Scottish Social Services Council data confirms that three of the six HSCPs within GG&G have more MHO resource per 10,000 population compared to the national average across Scotland; the national average is 26.5 hours, and Glasgow City have 33.2 hours, Inverclyde has 35.1 hours, and West Dunbartonshire has 31.4 hours. D&G have 29.3 hours.

- Glasgow City and East Renfrewshire are two of only four areas of mainland Scotland who have not reshaped their MHO resource to include exclusive and dedicated MHO roles (Perth and Kinross and Midlothian are the other two areas).

Recommendations

1. All HSCPs to undertake a similar audit to the one undertaken as part of this piece of work during February and March 2027 to identify real time, local challenges in each area.

   Each HSCP should ensure an action plan to address these challenges and share this plan with the Commission by 30 June 2027 (with reference to good practice questions at Appendix 1).

2. Greater Glasgow and Clyde health board also require to review the action plan they put in place in 2016 and report on why this has not achieved any improvements in relation to EDC/MHO consent. To be completed by 31 March 2027.

Appendix 1[4] Questions for audit purposes

1. Are the MHO national standards and associated actions fully embedded in your area? Specifically:
    a. Standard 1: responsive services;
    b. Standard 2: referral, assessment and admission procedures;
    c. Standard 4: inter/intra agency collaboration and cooperation; and
    d. Standard 7: organisation and management.
2. Is there an agreed timeline for MHO arrival as part of the above? For example, once contacted, the MHO will arrive within 60 minutes.
3. Is there understanding of nurses holding powers and the importance of co-ordinating calls for medical and MHO staff to assess?
4. Is there good mental health medical liaison in place supporting non-mental health ward staff?
5. Is there training material/mentoring/buddying in place for mental health locum doctors, resident doctors on how to fulfil their role in making EDC decisions?
6. Are there posters on walls (GP practices, hospital wards)/QR codes to guide medical staff on what to do in relation to an EDC, how to contact an MHO, how to complete the ED1 form?
7. Is the practice in your area to only use EDCs in exceptional circumstances? See Mr E investigation where some AMPs expected GPs to assess rather than themselves. Now resolved in HSCP A.
8. Are AMPs and MHOs available and responsive during office hours and out of hours?
9. Are there any time gaps in terms of 24/7 cover by AMPs and MHOs? For example, if the out of hours service starts at 6pm and the day service stops at 5pm, is there a gap for the hour?
10. Are regular audits of EDC forms undertaken to ensure continuous improvement and targeted actions?

[4] With thanks to MHOs in attendance at the MHO national forum in March 2026 who provided examples of what good practice looks like.

If you have any comments or feedback on this publication, please contact us:

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