



# MENTAL WELFARE COMMISSION FOR SCOTLAND

## Annual Report 2003-2004 Executive Summary

### Implementation of the Mental Health (Care and Treatment) Act 2003 (Section 2.9)

We look forward to the new Act coming into force. Most of it is planned to come into force from 1 April 2005. We were very involved in the development of the Act and believe that it will benefit both those who use mental health services and their carers. It will increase the service-user's rights and recognise the carer's role. We are aware that some people have concerns about parts of the Act and we will take account of these concerns in how we carry out our new roles and responsibilities.

Under the Act, the Commission has an extended role, which includes monitoring how the Act works and how people are meeting its principles. We will refer people to the new Mental Health Tribunal for Scotland, if we have concerns about their compulsory orders. The Tribunal, not us, is the body set up to consider requests for discharge from compulsory orders. We will keep our power to discharge people from orders, but will not routinely consider cases. We will visit people in the community who are on compulsory orders as well as those in hospital and in other residential settings. We will continue to carry out investigations and to make recommendations.

### Comparison of the use of the Mental Health Act in Scotland and England and Wales (Section 3.1.3)

During the year, a newspaper article claimed that people in Scotland were twice as likely to be detained in hospital under the Mental Health Act, as people in England and Wales. We looked into this and, although differences in practice in England and Wales make comparison difficult, we can confirm that, overall, people in Scotland have about the same chance of being detained as people in England and Wales. In Scotland, people

have a greater chance of beginning a period of detention with an emergency order; in England and Wales, they have a greater chance of beginning a period of detention with a longer-term order. However, our research shows clearly that a person is no more likely to be detained here than he or she is in England and Wales.

#### Inside:

**About our work:**  
**Communications Work – page 2**

**Inquiry into the Care and Treatment of  
Mr A – page 3**

**Inquiry into the Care and Treatment of  
Ms H and Mr E – page 2**

**Scottish Executive Relocation Policy –  
page 3**

## ABOUT OUR WORK:

### Communications Work (Section 2.3)

In 2002-03, we consulted widely with service users and carers about improving the way we communicate with others, particularly service users. Some of the things we have done include:

- Appointing Douglas White as a Commissioner. Douglas has a learning disability and is one of four Commissioners from a user or carer background.
- Increasing the number of visits to service users in the community, including those using clubhouses and resource centres. Previously we mainly visited people in hospital.
- Producing two Executive Summaries, this one and an easy-to-read one for people with learning disabilities.

Other matters we are looking at include:

- Having a free phone number that people can use to contact us for advice or information.
- Producing a number of easy-to-read posters and leaflets.
- Producing information (similar to the information in our printed leaflets) on audio and video tapes.
- Reviewing how we deal with comments about complaints and enquiries.

### Inquiry into the Care and Treatment of Ms H and Mr E (Section 2.1.1)

The main aim of our work is to protect the welfare of individuals with mental disorders. One of the ways in which we do this is by investigating cases where we have concerns about the care and treatment individuals have received. We published two reports this year. The first involved Ms H and Mr E.

#### About Ms H and Mr E

Ms H and Mr E both had a learning disability and lived with others who were affected by learning disability. Mr E also had a serious physical disability. One of the people living with Ms H abused her over a long period. Mr E did not receive the assistance he needed to help him cope with his physical problems. The conditions in the house in which Ms H and Mr E lived were poor. A range of services had a great deal of contact with the people in the house, including Ms H and Mr E.

#### Why we got involved

We heard about this case in 2002 after four men were convicted of abusing Ms H. Each of them received a long jail sentence. The court case followed her admission to hospital in March 2002, with many injuries caused by physical and sexual assaults. We decided to carry out an investigation when we became aware that Ms H had a learning disability.

There had been an independent review of how social workers had been involved in this case and the Scottish Executive had inspected the local social work services. Therefore, our investigation was mainly about how the health service had been involved with the case and how health services and social services had worked together.

## Inquiry into the Care and Treatment of Ms H and Mr E (Section 2.1.1) (continued)

### Our findings and recommendations

What we found was that, although Ms H and Mr E were recognised as vulnerable, health and social services did not give them the protection they had a right to expect. In addition, they were allowed to live in conditions that were not acceptable.

We made a number of wide ranging recommendations to health and social work services, and to the Scottish Executive. We also invited bodies such as NHS Quality Improvement Scotland, Social Work Services Inspectorate and the Care Commission to act on the Report's findings.

## Inquiry into the Care and Treatment of Mr A (Section 2.1.2)

### About Mr A

Mr A was a young man who was admitted to hospital suffering from an acute psychotic illness which had led him to act impulsively and to put himself at risk. While in hospital, he expressed delusional beliefs, including that he could fly and that he was dead. He was not detained under the Mental Health Act, but was not allowed to leave the ward (though he tried to do so at least three times). His mental state varied during his 16 day stay in hospital, and got worse before his death.

### Why we got involved

On the day of his death, Mr A was allowed to leave the ward with his parents, despite the nursing and medical notes stating that he should leave the ward only if he were with hospital staff. Mr A ran away from his parents and shortly after

fell from a bridge. Mr A's parents contacted us, to express various concerns about the care Mr A had received in hospital.

### Our findings and recommendations

Our investigations led us to conclude that there had been clear grounds to detain Mr A, that a consultant was not involved in a large part of his care and that the records kept by the hospital were poor. We also criticised the NHS Trust's failure to deal effectively with the concerns of Mr A's parents.

We made recommendations to address the shortcomings that we found. We asked the Trust to write to his parents and suggested it apologise to them. We also suggested that NHS Quality Improvement Scotland monitor the problems concerning consultant cover in the Trust.

## Scottish Executive Relocation Policy (Section 2.10)

During 2003, Scottish Ministers announced that they would consider relocating the Commission in April 2006. Work is currently progressing with this. The timing of the relocation is unfortunate because we need to prepare for our extended role and responsibilities under the new Mental Health Act, which is due to come into force in April 2005. We are also working on a new system to process all our records and all the forms for the new Act. This must be in place for the start of the Act. Our auditors have said that relocation is a major risk to our business. However, we will work as hard as possible to maintain the level of service we currently provide to people with mental disorders.

## Adults with Incapacity (Scotland) Act 2000: the use of Welfare Guardianship and Intervention Orders – Part 6 (Section 4.1.1)

We are often consulted about when it is appropriate to apply for a welfare guardianship order under Part 6 of this Act. The situation is not straightforward as there are different legal opinions about this issue. On the one hand, there has been legal advice that if a local authority does not obtain an order for an action such as placing an adult to a care home, it could be challenged in the courts. On the other hand, there is a view that the Act does not intend that a court should have to authorise every action needed to protect a person's welfare.

We asked Ms Hilary Patrick to prepare a discussion paper about whether Part 6 of the Act should be used for all significant welfare interventions. She has suggested that local authorities should always observe the principles of the Act, but may not need to apply for a guardianship order in every case. The paper is a guide only, but we hope that people working in the mental health and legal fields will find the information it contains useful. The Scottish Executive received an early version of the paper and has now issued guidance to local authorities. The guidance says that local authorities must make their own decisions about individual cases, but that it may not be necessary for them to apply for guardianship every time.

### During 2003-04, we did the following:

- **Helped** to develop the new Mental Health Act and worked with the Scottish Executive to prepare for its introduction.
- **Visited** 1074 service users in hospital and 848 in care homes and in the community.
- **Visited** 6 national and 15 local organisations that help people from minority ethnic backgrounds.
- **Reviewed** 515 detentions, 211 accidents or incidents, and 172 suicides.
- **Carried out** two major investigations involving problems with care and treatment, and followed up an investigation from the previous year.
- **Continued** to improve our telephone advice service and how we record the information and advice we provide.

### Contact us

If you feel that you would like to discuss any matter with us, you can contact us, in confidence, in the following ways:

- **By phone:** 0131 222 6111.
- **By email:** [enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)
- **On our website:** [www.mwscot.org.uk](http://www.mwscot.org.uk) You can use our web site to ask for help or to get our full Annual Report and other publications.
- **By writing to:** Mental Welfare Commission for Scotland, K Floor, Argyle House, 3 Lady Lawson Street, Edinburgh EH3 9SH.