

# Our Annual Report Summary 2005-2006





# We look at care plans in detail to make sure they take account of individual needs.

## What we do

We find out whether individual care and treatment is in line with the law and good practice.

We challenge service providers to deliver best practice in mental health and learning disability care.

We provide information, advice and guidance to service users, carers and service providers.

We have a strong and influential voice in service and policy development.

We promote best practice in mental health law. We do this by building up a picture of how the Mental Health (Care & Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000 are being applied across Scotland.

## 1. A new year, a new law

October 2005 saw the introduction of the Mental Health (Care & Treatment) (Scotland) Act. One of the things the Commission is responsible for is checking that this Act is being properly applied. It has been a very busy year for us.

To monitor the new Act we introduced a new electronic information system which scans and checks paperwork on the use of the Act. Our staff review forms and take action if we think the law is not being used properly. Our computer system also allows us to collect statistics on how the law is being applied. Our professional staff then review these statistics to see what they tell us about the effect the law is having on people with a mental illness, learning disability or other mental disorder.

We put this knowledge together with the information we get from our visits programme and use it to promote good practice.

## 1.1 What we have found

### 1.1.1 Care plans

Care plans set out how a person should be cared for and treated. They are a way of making sure a person is cared for in a way that is right for them as an individual. When we visit a person who is being treated under a compulsory treatment order, we look at his or her care plan in detail to check that the plan takes account of the person's needs and that he or she has been involved in developing the plan.

This year we made a decision to visit each person who had been on a long-term detention under the old Mental Health Act, who had automatically transferred to a compulsory treatment order under the new Act. We wanted to check that these individuals had an up to date care plan that reflected the principles of the new Act. We thought that visiting these people would help us to see



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whether the Act was making a difference to individuals who had experienced treatment under the old and new Act. We are also starting to visit people who are on new Act orders, especially where they are being treated in the community.

On our visits we also check that people are aware of their new rights to independent advocacy, a named person and that they know about advance statements.

While it is too early to draw firm conclusions, early experience suggests:

- There are some very good care plans, but not enough evidence that individuals are taking part in deciding what should be in them;
- Not enough people have information about their rights under the new law and few have made advance statements;
- Mental health officers (MHOs) are not involved in developing care plans as much as we would like.

### 1.1.2 Emergency detentions

The new Act's principles say that people providing care must think about all the options for help that a person might need, and that an individual's freedom should be limited only as much as is necessary. The preferred route of entry into formal care should be through a short-term detention. This route increases the range of options for care and, by involving more practitioners in the decision, provides better safeguards for the individual. A short-term detention can only be issued after assessment by a specially qualified doctor, known as an Approved Medical Practitioner (AMP) and with the consent of a MHO.

When making a decision to detain someone on an emergency order, the person responsible should show that the detention is needed urgently. Any doctor can detain a person under an emergency order. However, the doctor must either get consent from a MHO, or explain why it was not "practicable" to do so. The doctor must explain why the order is urgent and what alternatives were considered. One important alternative is contacting an AMP so that a short-term order could be issued.

# After six months of the Act, emergency detentions went down compared with last year.

During the first six months of the Act, the number of emergency detentions were much less than for the same period last year. We looked at a sample of emergency detention certificates. In almost all cases adequate reasons for urgency were given. We think this is a very positive change and indicates that professionals are starting to put principles into practice. Our detailed review of these orders showed up some other issues that still need to be addressed.

- In 29% of cases there wasn't enough information about whether an effort had been made to obtain a short-term order by contacting an AMP.
- In 12% of cases there was no information, or not enough, about what alternatives to emergency detention had been considered.
- An AMP only attended in 18% of cases where an emergency detention was being sought within normal working hours. We think this is disappointing; better AMP availability would mean fewer emergency detentions.

**Table 1: Information about emergency admission**

	No		
	no.	%	number requiring follow up
Adequate reasons for urgency (n=297)	10	3	1
Adequate measures taken to obtain STD (n=296)	85	29	11
Adequate details of considered alternatives to EDC (n=294)	35	12	5

## 1.1.3 Care and treatment of young people

The Act says that when a young person needs treatment for a mental health problem, his or her particular needs should be paramount. We think this means that young people should have access to a service that is specially designed to meet their needs. This is especially true when a young person is being treated as a hospital in-patient.

We are aware that not all parts of the country have specialist services for children and young people. While we think these should be developed as a matter of priority, we are also aware that this can take time. In the meantime we want to make sure that children and young people can still get services that will help with their recovery.

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# We think services should be clearer about their responsibilities towards young people.

This year we updated our guidance on the admission of young people to adult mental health wards. When we visit young people in non-specialist settings we want to see that service providers have arrangements for giving them specialist support, keeping them safe and ensuring their rights are respected. It remains a source of great concern to us that in some parts of the country this has not been done. We know from experience what the lack of clear and appropriate arrangements can mean for a young person who may already feel damaged by the impact of his or her illness. We think services should be clearer about their responsibilities towards young people and should use what resources they do have to their full capacity. We are particularly concerned about the lack of appropriate secure care for young people especially those for young people with a learning disability.

**Table 2: Young people admitted to non-specialist facilities**

	All
No. of cases of young people admitted to non-specialist inpatient settings 05.10.05 - 31.03.06	69
No. of young people involved	60

## 1.1.4 Mental Health Tribunal for Scotland

The new Act saw the establishment of the Mental Health Tribunal for Scotland. We believe that a tribunal system is preferable to having to go to the Sheriff Court. This year we have helped the Tribunal to prepare for its role. We provided figures on how many requests to consider discharge from detention we received in previous years, so that the Tribunal could predict how many applications it would receive. We also discussed how best to exchange information so that we can each do our jobs properly. Exchanging information has proved to be a particular problem. The Act does not say that the Tribunal has to send information to us regarding the granting of compulsory treatment orders, only to tell us what decision they have made.

This has made it difficult for us to be sure that the information we receive about these orders is complete. This is why we have been unable to report on long-term orders in our annual report this year. While the Tribunal staff have been very helpful in getting most of the information to us, we think the Act or the Tribunal Rules need to be changed.

We have had reports of some early problems with the Tribunal system. We are also aware of the difficulties of setting up such a large and complex system. The Tribunal is a young organisation and we believe it is learning from experience.



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### 1.1.5 Promoting the principles of the Act

The principles say

- Your views about your care and treatment are important and should be listened to. You should get the information and help you need to take part in decisions about your care.
- You should get the treatment that gives you the most benefit.
- Your freedom should be limited only as much as is needed.
- Care and treatment should take account of who you are and respect your beliefs, abilities and background.
- People providing care must think about all the options for help that you might need.
- If you are being treated under the Act, your treatment should be no less favourable than anyone else's.
- If you have carers, their views should be taken into account.
- Carers should be given the information and back-up they need to help you.

We carried out several consultation meetings last year regarding our role and how we could promote the principles of the new Act. One of the suggestions that came out of the consultation was the creation of a network that would help organisations to share information and best practice around the principles of the mental health Act.

This year we agreed to support a 'Principles into Practice Network' which will provide a forum for service users, carers, service providers and professional groups to promote good practice by sharing information and examples of how the principles work in practice.

In the coming year we will be developing a website and a conference to support the aims of the network. Membership of the network will be recorded through registration with the website [www.mwscscot.org.uk/web/site/principlesnet](http://www.mwscscot.org.uk/web/site/principlesnet) or by postal or telephone request.

## 2 Making sure people get the right care and treatment

### 2.1 Visiting people

Visits to individuals are very important to us. Through these visits we find out most of what we know about how people are being cared for and treated. This helps us build up a picture of services locally and nationally. We listen to service users, carers, independent advocates and staff working in these services. We listen to their views and discuss any issues with their care staff. Sometimes we make recommendations about the care of the people we see. We may investigate in more detail if there is evidence of, for example abuse, neglect or deficiencies in care.

This year we visited fewer people than usual because of the work we needed to do in support of introduction of the new mental health Act. We needed more staff to be available to provide guidance and information through our telephone advice service.

Service users and carers seem to know little about named persons and advance statements.



# We are pleased to find far fewer wards that smell of cigarette smoke.

## 2.1.1 Recurring themes from our visits

- Lack of information on the new mental health Act

We found that users and carers were not being given enough information about the Act and what it means for them. People seemed to know little about named persons and advance statements. We supplied information and encouraged managers to make this more generally available.

- Access to independent advocacy

We routinely asked about access to advocacy services. Usually we found that advocacy services were available, although we often recommended that staff should do more to make people aware of advocacy. Some care groups were less likely to have access. Young people, people with a learning disability and older people were particularly affected.

- Smoking

Mental health wards are exempt from the smoking ban. However any person who smokes must do so in a smoking room. This has caused problems in some services. In some cases, there are no smoking facilities in in-patient wards. People may go outside to smoke but this can cause problems if there is a need for close nursing supervision.

We are pleased to find far fewer wards that smell of cigarette smoke. This will improve the health of all patients and staff. We are also pleased to see people getting help to stop smoking.

- Safety and security

We remain concerned about some practices. In particular we still see a few services that use timed checks as a means of observation, e.g. checking a person's whereabouts every 15 minutes. This is against national guidelines and we think it is an unsafe practice that should be stopped.

- Care package funding

Throughout the year, a number of situations have been brought to our attention where local authorities have been unable to fund care packages for some individuals. These individuals are most likely to be people who are waiting to leave hospital and for whom the necessary community services have not been put in place. We are concerned that this means that vulnerable people are not getting the care they have been assessed to need. We think there needs to be greater clarity around costing and funding free personal care. A review is taking place at the moment and we look forward to the Scottish Executive's response to this.

In the meantime we expect health and local authorities to allocate resources for the benefit of people in most need and greatest risk.

### 2.1.2 Improvements to services

Despite our concerns we were very pleased to see that there have been some improvements to those areas about which we expressed concern in last year's annual report. Here are some examples:

- Criticisms of the condition of long stay hospital wards have led to improvements that give people more dignity and personal space in two hospitals in the west of Scotland.
- Concerns over restriction of voluntary patients in an intensive psychiatric care unit and treatment of male patients in a female wing have resulted in upgrades to a hospital in the east of Scotland.

- Recommendations about staffing in one hospital have seen significant increases in nursing staff, the appointment of a liaison nurse for people with learning disabilities on general psychiatric wards, and increased social work input to the hospital.

## 3 Making sure care is in line with the law and good practice

### 3.1 Inquiries

We have a duty to investigate and undertake formal inquiries where we believe that something may have gone seriously wrong with a person's care.

### 3.1.2 Inquiry into the care and treatment of Mr L and Mr M

The First Minister asked the Mental Welfare Commission for Scotland to undertake an inquiry into the killing of a man by a patient who was on conditional discharge from a psychiatric hospital. Mr L was a restricted patient, which meant that decisions on his discharge had to be overseen by Scottish Ministers. He was receiving care and treatment from community mental health services when the killing took place in 2004. Mr M, the victim of Mr L's offence, had also had contact with mental health services. Our inquiry found that those involved in Mr L's treatment had failed to respond adequately to clear indications his illness had relapsed whilst he was in the care of community based mental health services.

Mr H had been allowed to live in squalid conditions, reportedly suffering financial and physical abuse.

Our Inquiry team closely examined medical, nursing and social work notes. 14 people involved in the care and treatment of Mr L and Mr M were interviewed, as was Mr L himself. They found that:

- Mr M's death was linked to a relapse in Mr L's illness;
- There was no evidence that Mr M's care and treatment had contributed to his death;
- There was a lack of any systematic approach to risk assessment and management in Mr L's case;
- There was insufficient clarity around roles and responsibilities in relation to Mr L's care.

Our Inquiry team made a series of detailed recommendations to the Health Board and social work department involved, and to the mental health division of the Scottish Executive. The report has already generated significant and positive response from all of the agencies involved. We are pleased that the recommendations we made have led to change for the forensic mental healthcare system. We expect that these changes will make for safer practice in future.

### 3.1.3 Inquiry into the care and treatment of Mr H

We found out about Mr H when a guardianship application was made by the social work department involved in his care. Mr H is a 70 year old man with dementia, which was believed to have been caused by alcohol abuse over several decades. From a review of casenotes we found that Mr H had been allowed to live in squalid conditions, reportedly suffering physical and financial abuse, despite having regular contact with social and medical services for over two decades. Our Inquiry found that more could have been done at an earlier stage to improve Mr H's health and welfare. In particular:

- Social and health services should have paid more attention to assessing Mr H's mental capacity;
- Social and housing service should have considered whether Mr H had the mental capacity to make decisions about his living and care arrangements;
- All agencies should have worked together to respond to his problems.

We believe that Mr H's case highlights many of the problems and confusion that exist in services that come into contact with people with alcohol related brain damage (ARBD). Alcohol is thought to be at least part of the cause in about 10% of people with dementia. It is widely acknowledged that services across Scotland do not give good care to people with this condition. Unlike other dementias, the effects of ARBD can be stopped and even reversed if the person stops drinking, has proper nutrition, and gets the care and support they need to help bring this about.

We think stigma around alcohol abuse might prevent services from acting quickly enough. We think services need to consider their legal obligations to people who have lost the capacity to make safe, independent decisions. We also think professionals need to act quickly and appropriately to reduce the impact of ARBD on the individual. We hope that our report will help this to happen.

## 4 Providing information, guidance and advice

### 4.1 Telephone advice

We provide a telephone advice service aimed at helping users, carers, professionals and others by giving them advice and providing information that is not available from other sources. This year calls to our advice and information service increased by 30%.

The proportion of calls from service users between October-December 2005 decreased by 23% compared to the same period in 2004. This is likely to have been because we no longer conduct reviews of detention. Users still call us for advice and to raise concerns about their care and treatment. The number of calls from advocates increased over the same period.

### 4.2 Website and publications

October 5th 2005 saw the launch of our new website and publications range. These information resources were developed to provide information about the new Act and our role. Since that date we have distributed around 20,000 user and carer information leaflets. We have also welcomed over 9,500 visitors to our website and distributed 300 DVDs for people with a learning disability. All of our information leaflets are now available to download from our website in English and easy-read formats. Our 'who we are and what we do' leaflet is also available in a range of languages.

### 4.3 Events

Following the success of Mental Health Today and Learning Disability Today events in 2004/05 we decided to sponsor both of these events again in 2005/06. At each event we met a wide range of frontline staff from across all sectors, we also made contact with a large number of service-users and carers many of whom have been added to our mailing list.

As well as these larger events, our Commissioners and staff have been invited to contribute to a large number of training and information events for health, social care and advocacy staff.





K Floor  
Argyle House  
3 Lady Lawson Street  
Edinburgh  
EH3 9SH

Tel: 0131-222 6111  
Fax: 0131-222 6112

Service user and carer freephone  
0800 389 6809

[enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)

[www.mwscot.org.uk](http://www.mwscot.org.uk)

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