

# Annual report 2015-16

mentalwelfare   
commission for scotland



Photography in this document includes images taken around Scotland as we undertook filming to help promote advance statements. We thank all of those involved.

Laid before the Scottish Parliament by the Scottish Ministers under Section 18 (2) of the Mental Health (Care and Treatment)(Scotland) Act 2003

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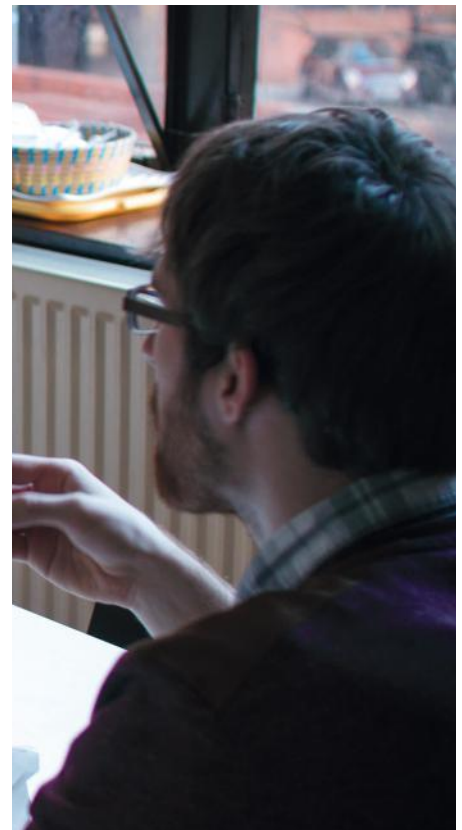
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# Who we are and what we do



**–We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.**

**We do this by:**

- Checking if individual care and treatment are lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy and service development.

We are governed by a Board, comprising a Chair and eight Board members, appointed by Scottish Ministers.

# Chair's statement



The Very Revd Dr Graham Forbes CBE

**Last year saw an increasing awareness of the prevalence of mental ill health in society. It also felt as though there was a stronger acknowledgement of the growing numbers of people with mental ill health, learning disability, dementia or related conditions who need support to live well in the community.**

We welcomed the appointment of Maureen Watt as the first dedicated Minister for Mental Health. We also welcomed the strong commitment seen across the political spectrum to improving mental health care and support.

So, the signs are that the need for change is recognised. For our part, we at the Commission are determined to play a constructive role in making that change a reality.

Some of the ways we have sought to drive change in 2015-16 include:

## **Empowering people**

We led a campaign to promote the benefits of advance statements, working closely with people who have experience of mental ill health. Advance statements are written by individuals who have been treated in the past for mental ill health. They set out the care and treatment that person would prefer or dislike should they become mentally unwell again in the future.

Advance statements allow people to have their say over their own treatment. They must be taken account of by health care staff. The Commission

will take on new responsibilities related to these statements next year, and we will continue to campaign to let people know their rights in this area.

## **Increased focus on engagement and participation**

Building on our promise to engage more with people affected by mental ill health or learning disability, we created two new part-time posts, one for a person with lived experience, and one for a non-paid carer. We were delighted to appoint Graham Morgan and Kathleen Taylor in October 2015. Their perspective and experience are already having an impact across the Commission.

## **Investigating gaps in service**

A serious gap in support for a vulnerable person was highlighted in our investigation into Ms MN, a woman with an autistic spectrum diagnosis who took her own life after being badly let down by services. We will continue to call for services to respond better to those who do not fit current health or care approaches.

### Greater transparency

We began to publish our reports and recommendations for improvement following our visits to local wards and NHS units across Scotland. This is a significant step in bringing even greater transparency to our work.

Amongst our ongoing work, the National Confidential Forum, a committee of the Commission, provides a means for people who were placed in institutional care as children to give confidential testimony of their experience of that care. The Forum held 60 hearings in the year, and continues to develop its role as part of the Scottish Government's Survivor Scotland Strategy.

My thanks go to all of the people and organisations who have contributed to our work, including our advisory committee, my fellow Board members, and of course, Colin McKay and all of the Commission's staff.

I especially wish to say thank you and farewell to Jan Killeen, who completed a second term on our Board in March, and who has always offered wise and expert advice.

**“We welcome the strong commitment seen across the political spectrum to improving mental health care and support”**

# Chief Executive's messages



Colin McKay

**This is an important time for mental health in Scotland. The Mental Health Bill was passed by the Scottish Parliament in June 2015, bringing new powers to the Commission, allowing us to do more to protect the rights of the people we work for.**

Ministers are currently consulting on a 10-year vision to transform Scotland's mental health services. The Commission published six priorities we ask to be included in that strategy.

Crucially, we believe the vision must be built around a rights-based approach, drawing on the recommendations of our report with the Scottish Human Rights Commission on embedding human rights in mental health care.

That means a real commitment to tackling inequality – including reducing the huge disparity in life expectancy between people with mental ill health and the general population.

It also means ensuring that people using mental health and learning disability services do not have to tolerate environments that would be unacceptable in general health services, or remain in hospital when they could be living a better life in the community. Nor should it be enough that people are safe and have their basic needs met, if they lack meaningful activity when in hospital, and are lonely and isolated in the community.

All of these issues emerged from our visits work this year – alongside many examples of high quality services with a real focus on recovery and empowerment.

We support a continuing focus in the strategy on children and young people, and very much welcome the sharp reduction in 2015/16 in the numbers of children being treated for mental ill health on non-specialist wards.

Our major study into perinatal mental health highlighted the excellence of Scotland's specialist in-patient services, but also showed the gaps in support for mothers who do not use these services. We are encouraged by the commitment of the Scottish Government to making improvements in this area.

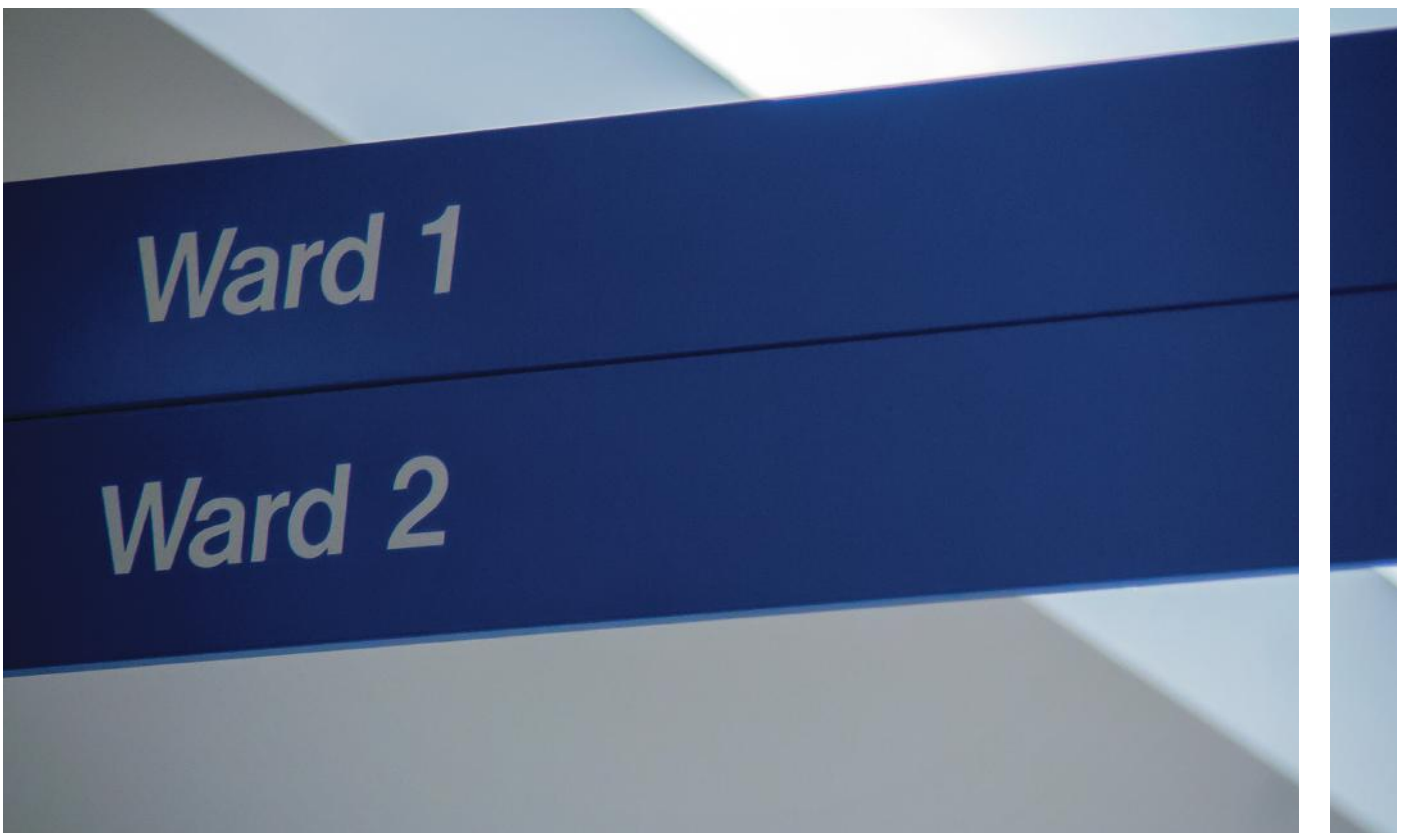


Scotland can be proud of the principles of the Mental Health (Care and Treatment) Act and Adults with Incapacity Act, but our monitoring of their operation has highlighted that legal protections are under increasing strain. We investigated the increasing number of emergency detentions taking place without the involvement of a mental health officer and we are now working with services on ways to improve this. We remain concerned that the mental health officer service must be properly resourced and supported.

The use of guardianship under incapacity law continues to rise sharply. We believe this law needs significant reform and we set out proposals for a new model of 'graded guardianship' in our response to the Scottish Government's consultation. Developing these ideas will be a priority for the coming year.

**“Ministers are currently consulting on a 10-year vision to transform Scotland’s mental health services. The Commission published six priorities we ask to be included in that strategy”**

# Effective and efficient visiting



## **– We held individual meetings with 1,670 people across Scotland this year, listening to their experience, and reviewed the files of a further 185 people.**

One of the best ways to check that people are getting the care and treatment they need is to meet with them, and ask them what they think.

We visit people in hospital, in their own home or in a care home, in secure accommodation or in any other setting where they are receiving care and treatment. Visits can be unannounced.

We regularly visit mental health and learning disability services. We do this through either:

**Local visits** – to people who are being treated or cared for in local services such as a particular hospital ward, a local care home, local supported accommodation, or a prison. We produce reports after each of these visits and make recommendations for change where necessary, which we will follow up if we feel progress is not being made. This year we began publishing local visit reports on our website, and will develop that process in 2016-17.

**Themed visits** – to people with similar health issues, or in similar situations, across the country. We published two reports on themed visits, and completed a further two for publication in 2016-17.

**Welfare guardianship visits** – where we visit people who have a court-appointed welfare guardian. The guardian may be a family member, friend, carer or social worker.

**Monitoring visits** – where we visit people who are subject to specific areas of mental health and incapacity legislation, due to our statutory duty to monitor the operation of the law in this area. On these visits we look at compliance with the legislation, and at the experience of people who are receiving treatment. We also look for examples of good practice that we can share.

**Other visits** – for example, we visit when someone who is detained in hospital in England, Wales or Northern Ireland is transferred to a hospital in Scotland. We also visit some young people admitted to an adult ward.

## Our visits

When we visit, the kind of questions we ask are:

- Are care, treatment and support in keeping with the principles of the Mental Health Act, or the Adults with Incapacity Act?
- Does the person we are visiting know his or her rights under these Acts?
- Has that person been involved in decisions about his or her care and treatment, and have they been given enough information to participate in those decisions?
- Is the building and are the facilities suitable in relation to the needs of the person we are visiting?
- Where the person is receiving compulsory treatment, are the appropriate safeguards being provided?
- Is care and treatment culturally sensitive?
- Is there a clear person-centred care plan, and is it being carried out?
- Can the person get access to advocacy and legal services, and has the person used those services and been given any help they need to do so?
- Is the person's money and property being properly looked after?
- Do we need to investigate further? For example, has the person been ill-treated, neglected, or improperly detained?

## Themed visits

We published two themed visit reports in the year, and completed a further two.

### **No Through Road – people with learning disabilities in hospital**

We visited all 18 hospital units for people with learning disability (excluding forensic units) from August to October 2015. We examined the records of 104 people, just over half the people in the Scottish service. We met with 46 people individually, and six others gave their views through their advocate or by other means. We also received comment from 47 carers of people in 14 of the 18 units.

On these themed visits, we looked at delayed discharge and discharge planning, and at the legal basis for treatment and any restrictions on people's freedom.

The outstanding issue for individual patients, carers and the service as a whole was the number of people whose discharge was delayed. Despite evidence of some excellent discharge planning, we were very concerned that almost a third of current inpatients (32%) were experiencing long waits for discharge.

The main reasons for delays in discharge were lack of funding, accommodation, or an appropriate care provider, or a combination of these issues. We called for the Scottish Government, as a matter of urgency, to work with the new integrated joint boards to end these long delays in discharge, and to ensure all learning disability inpatient units are fit for purpose.

Our report made 18 recommendations to Scottish Government, NHS boards and service managers.

### **Intensive psychiatric care in Scotland 2015**

We visited all 15 intensive psychiatric care units (IPCU) across Scotland providing care for adults. We met with and reviewed the care of 119 patients. We spoke to 19 carers, most often a family member, and spoke to staff.

An IPCU provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation. These units generally have a higher ratio of staff to patients, and a locked door. It would be expected that staff working in IPCUs have particular skills and experience in caring for acutely ill and often distressed patients.

We found general improvements in the physical environment in these units since our last series of visits. We found good access to levels of advocacy. The majority of carers we met said they were consulted and involved in discussions about care and treatment plans.

We also found that a quarter of patients had been admitted for longer than 90 days, and around 10% had been admitted for longer than 200 days. This number was much higher than we expected. Female patients were more likely to be admitted for lengthy periods of time.

Around a quarter of patients reported not feeling safe. There was a general lack of awareness about the right of appeal in relation to specified person restrictions.

We made recommendations for IPCU managers, Scottish Government, NHS boards and the Scottish Patient Safety Programme.

To ensure our recommendations are acted upon, we wrote to all IPCU managers following publication of this report and asked them to provide us with an action plan in response to the recommendations made. We will review progress made on our annual visits to each IPCU.

**“We called for the Scottish Government, as a matter of urgency, to work with the new integrated joint boards to end these long delays in discharge”**

from No Through Road report



## **Keeping mothers and babies in mind – perinatal mental health care**

We completed work on our national study of perinatal mental health care in Scotland.

For this report, we surveyed all 43 general adult acute wards and 11 intensive care psychiatric units in Scotland from July to September 2015, to identify women receiving inpatient care who had given birth in the past year. We also collected data from both of Scotland's specialist mother and baby units. Forty-four postnatal women received inpatient care during this period. We carried out in-depth interviews with 23 of these women, and interviewed ward staff.

We also surveyed consultant psychiatrists across the country, receiving 81 responses to an online questionnaire, and sought information on services from all of Scotland's health boards, every one of which took part.

We found a geographically mixed level of service in hospitals and in the community.

Over the three month period, two thirds of postnatal women who needed to be cared for in hospital were treated in one of Scotland's two specialist mother and baby units (one in Glasgow, the other in Livingston). Those women were positive about the specialist care they received, and they had their babies with them throughout their stay in hospital.

In contrast, a third of mothers who needed hospital care were treated in non-specialist mental health wards, without their babies. These women were less positive about their care, and were often separated from their babies for prolonged periods. Arrangements for a mother to have contact with her baby often depended on how often family members could bring the baby in to visit. The environment on those wards was often unsuitable for visits from children.

Only five of Scotland's 14 health boards offered a local specialist community mental health service.

Over 90% of the consultant psychiatrists surveyed said they would value local perinatal expertise when treating women during pregnancy and after childbirth.

One key recommendation was that the Scottish Government create a national managed clinical network for perinatal mental health in Scotland. Doing this would allow a much greater sharing of expertise, and a better chance of any woman receiving good quality care, whether in hospital or at home.

## **Living with severe and enduring mental illness**

We completed all visits for our themed visit report on living with severe and enduring mental illness in Scotland.

We interviewed people in every mainland health board in Scotland, and with one island authority. All of those interviewed were identified by local community mental health services. All had been diagnosed with a significant mental health illness for more than a year.

We found many positive aspects of care and support for people with severe and enduring mental ill health in Scotland who were in touch with community mental health services.

Most people interviewed were satisfied with their care and treatment, saw local mental health care teams regularly, and had good arrangements for crisis planning.

The large majority had regular physical health checks, and were satisfied with their housing.

But only three of the 59 people interviewed had jobs, and a significant number experienced some loneliness and isolation.

The report includes a range of recommendations, including a call for community mental health services to have a clear focus on recovery.

The report also commits the Commission to discussing with the Care Inspectorate the ways in which their inspections of community services can look at how those services are promoting wellbeing.

A further recommendation asks that the Scottish Government includes a stronger focus on employment support in the next mental health strategy.

We would also like to see more ambition from local authorities, the NHS and integrated joint boards in helping those with severe and enduring mental ill health to feel positively about their chances of getting back to work, and engaging more.

**“We would like to see more ambition...in helping those with severe and enduring mental ill health feel positively about their chances of getting back to work, and engaging more”**

## Local visit overview

We carried out 108 local visits between January and December to hospitals, care homes, prisons and secure units. NHS wards for older people with mental ill health was the largest grouping we visited, representing over a quarter of all local visits.

Our visits are not inspections and we do not grade services. Instead, we base our findings and recommendations on our observations on the day, the expertise and judgement of our staff, and what people tell us when we visit. We also take into account any national standards and good practice guidance. We allow service managers three months to formally write to us with their response to our recommendations.

Overall we made 409 recommendations from the 108 visits. Only five of the 108 visits resulted in no recommendations for improvement being made. We were satisfied with 97% of responses received.

Twenty five per cent of recommendations related to assessment, care planning, review and person centred care – a 4% increase on the previous year. We are planning a themed visit to adult acute admission wards in 2016/17 and this will be an area of focus.

Fourteen per cent of our recommendations related to the physical environment people were being treated in – down from 19% on 2014/15.

There was a significant reduction in recommendations related to improving compliance with the Mental Health Act – down to 7% compared to 13% the previous year.

Ten per cent of recommendations related to improving compliance with the Adults with Incapacity Act, down from 12% in 2014/15.

Eleven per cent of recommendations related to the provision of therapeutic activity, similar to the previous year.

Nine recommendations related to patient safety. The remainder covered a range of issues such as training, staffing levels and paperwork.

## **Publishing our local visit reports**



All reports related to local visits to NHS services from December 2015 are now published on our website, in sets of completed reports, once a month.

This is a new process for us, which increases the transparency of our work. In addition to highlighting areas for improvement, we hope it will encourage the sharing of best practice and help lead to improved standards.

A rise in downloads from our website and in media coverage suggest that we are already reaching a wider audience.

Reports of our local visits to care homes, independent hospitals and prisons from 1 June 2016 will also be published on our website, resulting in all of our local visit reports being publicly available.

# Monitoring and safeguarding care and treatment

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- **The number of new episodes of compulsory treatment for mental ill health rose again, and was at the highest level since the 2003 Act was introduced.**
- **Admissions of young people with mental ill health to non-specialist hospital wards and units has fallen substantially in one year, and was at its lowest level for at least eight years.**
- **Welfare guardianship orders continued to increase, with the number of orders rising by 15% on the previous year.**

We have a duty to monitor the use of the Mental Health Act 2003, and we report on the Adults with Incapacity Act 2000. This helps us understand how the legislation is being used across Scotland, and whether it is being adhered to.

When doctors and other health care professionals use the law to provide compulsory care or treatment, they must inform us. We check that information, ensuring their intervention complies with legislation.

We are also responsible for appointing designated medical practitioners, who provide a second medical opinion when medical treatment is prescribed under legislation. This year we organised 1,877 second medical opinions.

We publish this monitoring data annually. Analysing and sharing this information helps us protect and promote the human rights of people with mental ill health, learning disability, dementia and related conditions. It also helps compare activity in different parts of the country, and to understand where services are under particular pressure.

We publish an annual monitoring report on young people who are admitted to non-specialist, usually adult, services with mental ill health.

In relation to the Adults with Incapacity Act, authorities are legally obliged to inform us of specific welfare interventions. Again, we monitor and analyse that information, ensuring it complies with legislation.

### **Monitoring the use of the Mental Health (Care and Treatment) (Scotland) Act 2003**

The number of new episodes of compulsory treatment for mental ill health in Scotland rose last year to the highest level – at 5,008 new episodes – since the 2003 Mental Health Act was introduced. This continues the trend of recent years. Reasons for this are unclear, and could be due to increasing diligence amongst medical professionals in using legislation appropriately. Or it could be that, with increased emphasis on community care, people are more unwell when they need to come to hospital.

Close to half (44%) of emergency detentions initiated by a doctor did not have the support and expertise of a mental health officer at the point when that decision was made. This aspect of the data continues to raise concerns in the Commission about patients' human rights.

Other data, particularly the declining use of police stations as places of safety, was more positive.

One significant change in recent years is that many more people who are subject to the Mental Health Act are being treated in the community, rather than in hospital. In 2006, only 4% of people were treated through community based Compulsory Treatment Orders, but by 2015-16 that had risen to 40%.

There was a rise in the number of people detained by police to a 'place of safety'. This relates to people who are mentally unwell and are removed by police from a public place. Four years ago there were 591 such incidents, 18% of those detained were in a police station.

In 2015-16 there were 795 incidents, but only 1% of those detained were held in a police station. This is a positive step, as a police station should only ever be used as a last resort. The Commission plans to investigate in more detail how police officers use this power.

## Emergency detention audit

Emergency detention certificates (EDCs) are used in crisis situations to detain a person who is deemed to need urgent care or treatment for mental ill health. These certificates can be issued by any doctor, and allow someone to be kept in hospital for up to 72 hours.

The Mental Health Act states that there should be consent from a specialist social worker – known as a mental health officer – wherever practicable when these certificates are used.

Despite this, the Commission's annual monitoring report for 2014-15, published in September 2015, found a wide range of levels of non-consent in health boards across the country, from 14% non-consent in the Borders, to 66% non-consent in Greater Glasgow and Clyde. This followed a pattern of rising numbers of emergency detentions nationally, and rising numbers of non-consents. We expressed our concern at the situation.

Following publication of that report, Shona Robison, Cabinet Secretary for Health, Wellbeing and Sport, asked the Commission to analyse the reasons for low consent by mental health officers.

In addition to our ongoing monitoring, we undertook an audit of all emergency detention certifications issued between July and December 2015 across Scotland.

We sought to explore a number of issues, including the reasons why mental health officers did not consent to EDCs, any differences between out of hours and 'in hours' consents and, for Greater Glasgow and Clyde, the rates of consents in different hospitals.

Our audit was collated in the year, and published the following financial year. It included an action plan from NHS Greater Glasgow and Clyde.

## Young people

We report annually on young people who are admitted to non-specialist hospital wards or other units for treatment for mental ill health. These kind of admissions should only be made in exceptional circumstances. Our annual reports include information on what kind of hospital ward or facility these young people are being treated in, their age on admission, the reasons why they were admitted, and patterns of admissions around the country.

This year we expanded our report to include detailed information on the duration of admissions. We also undertook a six month study to assess the quality of care a young person receives once they are admitted to a non-specialist setting.

In 2015/16 there was a significant fall in the numbers of young people being admitted to non-specialist units, from 207 admissions the previous year, to 135 admissions in 2015/16. This is very welcome, and follows concerted effort by Scottish Government and local services. Our report considers the actions and/or improvements that have led to that reduction in different health board areas.

The main reasons for admission continued to be self harming and/or suicidal thoughts. However, we also noted an increase in admissions for psychosis.

We found a decrease in the proportion of young people who were able to access age-appropriate therapeutic help while in hospital compared to the previous year. There was also a reduction in access to age-appropriate recreational activity compared to 2014/15. We are disappointed with these changes and will monitor the situation closely.

As in previous years, there are a small number of complex cases where young people need specialist care that is not available in Scotland, and they are transferred to specialist units in England. Scotland has no beds for young people with learning disability, and no forensic secure beds, or intensive psychiatric care units for young people under the age of 18.

“There was a significant fall in the numbers of young people being admitted to non-specialist units. This is very welcome, and follows concerted effort by Scottish Government and local services”

## Monitoring the use of the Adults with Incapacity (Scotland) Act 2000

This Act relates to people who lack the capacity to make particular decisions. It includes legal safeguards to protect the rights of people who are on welfare guardianship, intervention orders and power of attorney.

The Commission monitors the use of welfare provisions of the Act, and we monitor the use of part of the Act related to consent to medical treatment and research.

We also publish advice and good practice guidance on the operation of the legislation.

Each time a welfare guardianship is sought, we should receive copies of all of the statutory forms related to that application. We analyse and publish an annual monitoring report on this data.

The majority of guardians are private individuals, usually a relative, carer or friend. Local authorities have a duty to make an application for welfare guardianship where it is required and no-one else is applying.

The main findings of our monitoring report this year are -

- The highest proportion of welfare guardianships were sought for people who had dementia (45%) or learning disability (41%).
- The number of guardianship orders has risen by 15% since the previous year, to 10,735.
- The number of new guardianship applications granted rose by 8% to 2,657. This represents a 99% increase since 2009/10.
- Seventy four per cent of all applications were from private individuals, as opposed to local authorities. This was an increase of 5% on the previous year, and of 117% since 2009/10.
- Twenty six per cent of applications were from local authorities. This is an increase of 17% on the previous year, and an increase of 60% since 2009/10.

“We believe the law needs to be modernised and streamlined, to ensure care can be provided when it is needed, and to better protect the rights of people with dementia and learning disabilities”



- Local authorities also have a duty to supervise all welfare guardians. We recognise that the continued increase in both forms of welfare guardianships places local authorities under increased pressure, but local authorities should continue to be the default applicant, when appropriate, where there is no private individual applicant available.
- Nineteen per cent of applications granted were from the 16-24 year age group. We assume these increasing figures are in part related to the continued uptake of Self Directed Support, which gives greater control over their own care to people who receive services. It can mean that formal arrangements are needed to allow family members to take decisions on their behalf.

Overall, we believe the law needs to be modernised and streamlined, to ensure care can be provided when it is needed, and to better protect the rights of people with dementia and learning disabilities. We welcome the commitment of the Scottish Government in their draft mental health strategy to a review of the law, and we hope to see early progress.

### **Visits to people with welfare guardians**

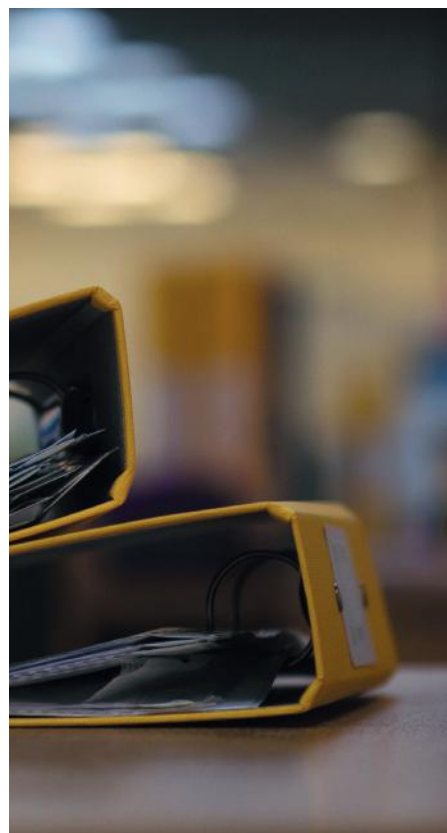
In 2015/16 we visited 472 people, talking to them and their guardians.

Of those we visited, 42% lived in care homes, and 32% in the family home. Twenty one per cent lived in supported tenancies, an increase on the previous year, and 3% were in hospital.

We found that in almost all cases – 93% – care, treatment and accommodation were good or adequate. However, we noted other concerns on 27% of the visits, including:

- 41% of private guardians visited appeared to have had no recent supervisory visits. Further, for 64% of these cases, there was no evidence that the person receiving welfare guardianship had been visited by the local authority supervisor in the previous six months.
- Twenty per cent of people in care homes did not have a life history available to staff.
- In 10% of cases, there was no clear evidence that the guardian had visited the person in the last six months.

# Investigations



- We worked on 26 investigations, 15 of which were started during the year.
- We sent a number of these cases back to local services, making specific recommendations for their further internal investigation.
- We continue to investigate 15 cases.
- In addition, we were asked by the Scottish Government to carry out an investigation into the care of a woman (Ms OP) who killed her baby while profoundly affected by postnatal depression.

When serious concerns are raised about the poor care or treatment of a person with mental ill health, learning disability, dementia, or related conditions, a number of organisations are often involved. Usually the lead investigator will be the authority responsible for the services provided.

The Mental Welfare Commission is, however, often contacted about such cases. We initially contact the responsible organisations to find out more and, where necessary, make recommendations to them, and follow up their actions. We instigate

our own investigations when we believe the case appears to show serious failings, and has implications for services across Scotland.

All of our investigations are anonymised. That way, we seek to protect the person the report focuses on, and we concentrate on highlighting the lessons to be learned by practitioners and organisations across Scotland.

“We instigate our own investigations only where we believe the case appears to show serious failings, and has implications for services across Scotland”

## Twenty-six investigations

Including the published report on Ms MN, the Commission investigated 26 cases.

These cases came to the Commission from concerned family members; local health, social work, or care professionals; the Scottish Government, or from other routes.

Before deciding whether a case should become an investigation, we consider all of the information presented to us. If we agree to take it to the next stage, we formally advise local services of our decision to investigate. We then examine the case in detail, requesting further information if required, and meeting with organisations and individuals involved.

At the start of the reporting year, we were working on 11 cases. During the course of the year, we concluded all of these investigations and closed the cases. One case led to the published report on Ms MN.

In addition, 15 new cases were identified as potential investigations for the first time during the year.

Nine of those were examined and reached a stage where we were confident that no further investigation was required by the Commission. Two cases were taken to a full investigation, and reports will be published in the 2016/17 year. The remainder of the 15 cases are ongoing.

## The death of Ms MN

Ms MN was a vulnerable 44 year old woman with an autistic spectrum diagnosis and complex needs. She took her own life in an independent care home in Scotland in December 2012.

She had recently moved from hospital to the care home, which was experienced in caring for people with learning disability, but not autism.

The circumstances of Ms MN's death, and the way in which her transfer to the care home had been managed, raised concerns at the Commission, and we decided to conduct a full investigation.

We found that the placement was not properly planned, and that arrangements for managing Ms MN's care, and the risk of suicide, were confused and unsafe.

We made recommendations for change for Scottish Government, the Care Inspectorate, health boards and joint health and social care bodies.

Our recommendations included a greater use of specialist assessments in cases where people have autistic spectrum disorder and complex needs. We called for better discharge planning, to ensure care homes and GPs have the right information and support to care for people in community settings.

We recommended a review of the availability of specialist services for people with autistic spectrum disorders who do not fit into mental health or learning disability settings.

“..the placement was not properly planned, and arrangements for managing Ms MN's care, and the risk of suicide, were confused and unsafe”

# Providing information and advice

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions

[More about us >](#)



## Latest news

All the latest news from the Commission, including news releases on our publications and wider work.

[Read our latest news](#)

## Local visit reports

From March 2016, we are publishing reports of our local visits to NHS wards and units across Scotland.

[Reports >](#)



## Advance statements

In advance statements, people who have received treatment for mental ill health can say what treatment or care they would like, or would not like, if they get ill again. They are about planning ahead - stating what you would prefer in case you get too ill to be able to make the best decisions for yourself.

[Learn more >](#)





- We received 4,727 calls to our Advice Line, of whom 4,320 sought our advice.**
- We reviewed our Advice Line service, ensuring it remains as effective as possible for users of the service.**
- We refreshed the design and appearance of our website, making it more user-friendly and easier to find documents.**
- We held seven Excellence in Practice seminars, tailored to specific audiences, to discuss complex legal and ethical issues they may face in providing care and treatment.**

One of our key roles is to provide information and advice on the effective use of mental health and incapacity legislation, with the focus on the rights of the person receiving care or treatment.

We are constantly in touch with services across the country, and with people who use those services. We supply information and advice in various ways – in person, through the Advice Line, by publishing and regularly updating our good practice guidance, and through our website.

# “The quality and content of care plans for people subject to compulsory care and treatment varies considerably”

## Good practice – power of attorney

We launched a campaign to explain powers of attorney to hospital ward staff, care home staff and GPs across Scotland.

People are increasingly using this legal route to give powers to someone they trust – usually a relative or close friend – to make decisions on their behalf when they become unable to do so themselves.

The Commission found that as powers of attorney become more commonly used, GPs and hospital and care home staff are not always aware of all of the issues involved.

GPs may be asked to take a role when someone is granting a power of attorney. Care home and hospital staff may be working with someone who has granted a power of attorney to a relative or friend, and should understand what is involved.

As part of our campaign, the Commission developed a leaflet for staff in care homes and hospitals that explains the purpose of powers of attorney, and gives a handy checklist.

We created a quick guide for GPs, listing issues for consideration when they become involved in certifying a power of attorney.

We also published guidance addressing common concerns that can arise for those dealing with power of attorney, and held three Excellence in Practice seminars on the subject.

The guide for hospital and care home staff is available on the Commission's website or in hard copy from the Commission. The common concerns guide is also available in hard copy and online.

The guide for GPs is available online.

## Good practice – working with independent advocates

Anyone with a mental illness, personality disorder, learning disability or dementia has a legal right to access independent advocacy.

We updated this guidance because, in the course of our work, patients and people who use services, carers and independent advocates have all told us of their concerns about the involvement of advocacy.

We have heard of situations where advocates were excluded from important meetings, or were not given the information they needed to fully advocate on behalf of an individual.

We have also heard from practitioners that they are often uncertain about what involvement the advocate should have, especially if an individual has impaired capacity in relation to involving the advocate.

For this update, we collected some of the difficult situations that we heard about, and used anonymised case studies which we discussed with practitioner, advocacy and service-user groups. We also considered the legal framework of mental health and incapacity law in Scotland and data protection legislation. We hope that our guidance and case examples will help practitioners to understand the role of independent advocacy, and assist them with difficult situations.

## **Good practice – preparation of care plans for people subject to compulsory care and treatment**

This updated guidance is primarily for responsible medical officers (RMOs), who have a legal duty to prepare care plans for people subject to compulsory care and treatment, but we hope it is of interest to other mental health professionals.

In mental health and learning disability services, care plans are a key mechanism by which a person's individual care and treatment can be developed, documented and shared with all those who are involved.

As part of our visiting and monitoring work, we often look at care plans. We expect them to give a good overview of what is happening for the individual, and the support, care and treatment they are receiving. Our experience is that the quality and content of care plans for people subject to compulsory care and treatment varies considerably.

This guidance document includes advice on what information these care plans should contain. It outlines who should be involved in the preparation of these care plans along with the RMO, and highlights who should have a copy of the care plan. It gives a general overview of good practice in relation to preparing these plans, and outlines when the RMO should update a care plan.

## **Good practice – decisions about technology**

This updated guidance is for those considering the use of technology to assist with care, and maintain independence, for people with dementia, learning disability and related conditions. It was developed after we held a consultation event to gather views and refers to assistive technology and telecare.

Assistive technology is a term that refers to a device or system that allows an individual to perform a task that they would otherwise be unable to do and to enhance the physical, sensory and cognitive abilities of people with disabilities to maximise independence.

Telecare is the use of equipment within and outwith the home to monitor changing needs and risks and to provide alerts and information that enables improved and informed responses to those needs and risks.

We first published guidance on the use of technology in 2007 because we have a role in ensuring that people have access to treatment, care and support that is most appropriate to their individual needs and their human rights.

Since then we have seen an increase in the awareness of, availability and affordability of new technologies.

Our guidance outlines important principles of the legislation that may prove helpful as the use of technology evolves.

Those principles include that intervention must provide a benefit that cannot otherwise be achieved. The past and present wishes of the person must be taken into account. The views of relevant others should also be taken into account.

## Website and social media

We use our website to share information, publications, advice and guidance.

In 2015/16 we redesigned the look of the site, making it more user-friendly and easier to navigate. We included one new area designed specifically for accessing our local visit reports, with a regional health board map. Another addition was a section designed to share information and promote the use of advance statements, ahead of legislative changes.

We created a series of short films for the site, featuring people who have experience of mental ill health, and health care professionals.

In 2015/16, there were 76,834 visitors to the site, 119,351 times. This compares with 62,852 visits, 98,102 times the previous year.

Site visitors downloaded 59,110 publications in the year, compared to 48,258 in 2014/15.

We had a split of 39.2% new visitors to the site, and 60.8% returning visitors.

Our Twitter following increased from 1,067 to 1,644.

“We redesigned the look of the website, making it more user-friendly and easier to navigate”

## Our Advice Line

We have a telephone advice service which is open daily from Monday to Friday.

Patients and other people receiving care and treatment, and their families and carers, can call our freephone number and speak to our health and social work practitioner staff for advice. Callers often seek advice on care and treatment, or on the legislation surrounding mental health and adults with incapacity.

Doctors, social workers, mental health nurses and other professionals also regularly call our advice line to discuss specific situations, legislation and good practice.

In 2015/16, our helpline received 4,727 calls. Of those, 4,320 sought our advice.

We conduct monthly audits of the advice given, and found that 97.5% of it was accurate, which is our target.

We conducted an internal review of the advice line system during the year, ensuring that it remains as efficient and effective as possible.

## Excellence in Practice seminars

Every year we hold a series of Excellence in Practice seminars, tailored to specific audiences, which focus on difficult legal and ethical issues that health professionals, care home managers, social workers and others may face in providing care and treatment.

These seminars cover issues that are commonly raised with us through our advice line, or through visits or investigations.

In 2015/16 we ran seven seminars, three of them on the same subject. The topics were:

- restrictive management
- the Mental Health Act and consent, significantly impaired decision-making ability
- welfare guardianship and power of attorney
- medical treatment for people who lack capacity
- power of attorney (three seminars).

For the three seminars on power of attorney, feedback came by way of a written form, and resulted in an overall positive view of the events. We reviewed our approach to these seminars in the year, and in future we intend to alter the current programme, and seek venues that are perhaps easier to get to for attendees, and are more cost effective. We also aim to replace some of the seminars with online materials.

# Influencing and empowering



- We welcomed new powers given to the Commission in the Mental Health (Scotland) Act, which will allow us to do more to protect the rights of people with mental ill health.
- We called for a comprehensive review of the Adults with Incapacity (Scotland) Act, which we believe urgently needs reform.
- We set out our six priorities for the Scottish Government’s next mental health strategy – due to be published in 2016.
- We launched a year-long campaign to promote advance statements, working with people across Scotland.

“Scotland needs a target to reduce the huge disparity in life expectancy affecting people with severe mental health issues.”

Colin McKay,

Chief Executive of the Mental Welfare Commission, outlining one of our six priorities for the new mental health strategy.



## **'My Views, My Treatment' – advance statements campaign**

Advance statements are written by people who have experienced mental ill health. They are written when the individual is well, and they set out the treatment they would prefer – or the treatment they do not want – if they become ill again and are unable to make their own decisions.

They give power back to the individual, and they must be taken account of by doctors before treatment is given. They can work well for people, but they are not often used, because people are often unaware of them.

In 2017, health professionals in Scotland will have a legal obligation to let the Commission know if a patient has an advance statement, and where it is held. Health boards will have a duty to promote these statements, and to let us know how they are doing that.

The Commission had recently benefited from a legacy fund, and decided that this project – aimed at giving more control to people who are unwell – was an ideal project to invest that funding in. In March 2016 we launched a campaign to promote advance statements to people who have experienced mental ill health, and also to psychiatrists, GPs, and other health care

professionals. This was important as they are often the people who can be involved in supporting a person who wishes to write one, or in witnessing, or acting upon, an advance statement.

The campaign included a launch event where a package of information was released, including a series of short films featuring people with first-hand experience of using advance statements, a community psychiatric nurse, and psychiatrists, who know the difference an advance statements can make.

We created a new area of our website where anyone can access sample forms, a guide on how to write an advance statement, and a book, postcards and other materials. We issued many hundreds of hard copies of these documents, and offered memory sticks which held copies of the films.

The campaign generated a huge amount of interest and positive feedback. We know that it is just the start, and we have more to do in ensuring that everyone who needs to know about advance statements get the opportunity to hear about them.

The campaign could not have got off the ground without the expert input of many people around the country. We thank all of those who participated.

**“The campaign generated a huge amount of interest and positive feedback. We know that it is just the start, and we have more to do”**

## Mental Health Bill

We were closely involved in the scrutiny of this Bill, welcoming much, and raising concerns in some areas. The legislation was passed by the Scottish Parliament in June. Amongst its provisions, it gave the Commission new powers that will allow us to do more to protect the rights of people with mental ill health.

Those new powers include a requirement that local authorities and health boards inform us about how they have ensured that people with mental ill health or learning disability have access to independent advocacy. We will monitor and report on the information we receive.

The Bill also required health boards to publicise advance statements, and notify us about what they are doing. The Commission will keep a national register of all advance statements in Scotland.

## Mental Health Strategy

We published the six priorities we are asking Scottish Government to include in Scotland's next mental health strategy, due in 2016.

Our first priority is to set a new target to reduce the huge disparity in life expectancy between people with mental health issues and the general population. The second is a call for more to be done for children and young people, and a third is to end the unequal provision of care for people with mental ill health as opposed to physical ill health.

We are also asking for the new strategy to be built around a rights-based approach. We want to see services responding better to those who do not fit current health or care approach. And finally, we want a new approach to workforce development, with a revised set of skills to deliver a modern mental health service.

## Adults with Incapacity Act

In response to a consultation on the Scottish Law Commission Report on Adults with Incapacity, we called for a comprehensive review of the legislation which protects people who are not able to make decisions on their own. This particularly affects people with a learning disability or dementia.

We believe the current system is too expensive and bureaucratic, and has not kept pace with developments in human rights. As one of the very first Acts of the Scottish Parliament in 2000, this legislation was a major advance at that time, but it urgently needs reform.

# Improving our practice



- Our Board continued to set our strategic direction and ensure efficient, effective and accountable governance.
- Two new members of staff, one with personal experience of mental ill health, and one who is a carer for family members, joined the Commission and bring new insight to our work.
- Our Advisory Board continues to directly influence our work.

#### Our Board

Our Board brings a wide range of experience and knowledge to the Commission.

#### Our Chair



**The Very Revd Dr Graham Forbes CBE** is Provost of St Mary's Cathedral, Edinburgh. After degrees in Russian and theology, Dr Forbes was ordained in 1977 and since then he has combined his ecclesiastical duties with various public appointments, mostly in the areas of health or criminal justice. He served on the General Medical Council for 12 years, chaired the Scottish Executive Expert Group on MMR, and was a Non-executive Board Member of NHS Quality Improvement Scotland. A former HM Lay Inspector of Constabulary for Scotland, a member of the Parole Board, and chair of the Scottish Criminal Cases Review Commission. Dr Forbes also chaired the UK body during the 2009 swine 'flu pandemic which advised the UK Government on ethical issues. He was awarded the CBE in 2004 for public service in Scotland.

## Our Board members



**Paul Dumbleton** has lived in Stirling for 35 years and has three grown-up children, one of whom has a learning disability. The first twenty years or so of his working life was spent teaching in special education in schools and further education colleges. He then worked in higher education and educational development before moving to the voluntary sector. Since retiring from full time work he has worked on a part time basis in a number of roles, including public appointments to the Council of the Scottish Social Services Council and as a member of social security tribunals. He also assess grant applications for *BBC Children in Need*, *Foundation Scotland* and *Shared Care Scotland*. He is the chair of Equi-Power – Central Scotland RDA. In 2014 he was awarded an honorary degree by Stirling University in recognition of his work in the voluntary sector.



**Jan Killeen** has been a part-time Mental Welfare Commissioner since 2007, and Director of Policy at Alzheimer Scotland since 1994. She has a long-standing interest in the rights and legal protection of people with dementia and has taken a lead role in the development of policies which impact on the lives of people with dementia and their families/partners in Scotland; she initiated Scotland's first national dementia charity, Scottish Action on Dementia, in 1985, and was recently involved with the National Dementia Strategy. Between 2004 and 2007 she was seconded to the Justice Department, Scottish Government to lead an action programme designed to improve the implementation of the Adults with Incapacity (Scotland) Act 2000. She brings to the Commission a substantial knowledge of mental health issues, with a particular focus on dementia, as well as extensive senior management skills. She completed her term of office on our Board in March 2016.



**Norman Dunning** had an early career as a probation officer and a social worker in child protection services. He was Chief Executive of ENABLE Scotland from 1991-2010, leading the largest voluntary organisation of and for people with learning disabilities in Scotland. He was at the forefront of moves to help people with learning disabilities be heard in their own right and to be considered as full citizens, as well as developing a wide range of community support services. He has held a number of trustee and management committee positions in other charities and has continued a number of these interests since his retiral. He brings to this position a substantial knowledge of learning disability, mental health and community care issues as well as experience in governance and management.



**Nigel Henderson** is Chief Executive of Penumbra, one of Scotland's most innovative mental health charities. He has over 30 years experience in the mental health field having originally qualified as both a mental health and general nurse.

He worked in the NHS before moving to the third sector in 1985. Mr Henderson joined Penumbra in 1991 and became its chief executive in 1999. He is also Vice Chair of the Health and Social Care Alliance (Scotland) and a Board member of Mental Health Europe (MHE).



**Professor Sivasankaran Sashidharan** is a consultant psychiatrist who has held senior clinical, managerial and academic positions in the NHS. He has been working in Scotland since 2007 and is currently involved with a voluntary mental health project based in Glasgow, Mental Health Rights. He brings to the Commission extensive experience working in the mental health field, a strong knowledge of and commitment to human rights and mental health issues, and wide experience of mental health and capacity legislation.



**Lesley Smith** works for the Scottish Recovery Network, with a particular responsibility to support the development of the peer support worker role. She has lived experience of mental health problems and using services. She believes in recovery and in people being involved and having their voices heard through participation and collective advocacy. She was actively involved with the Patients Council at the Royal Edinburgh Hospital. She was a Board member of Carr-Gomm Scotland for six years, contributing throughout the organisation, and was a member of the training team with the Lothian Recovery Network.



**Safaa Baxter** was born and educated in Alexandria, Egypt, where she obtained a BA degree in social work and community development in 1975. She worked as a volunteer in Clydebanks and as a social worker with Strathclyde Regional Council. As a local authority employee for over 36 years, Safaa has worked at various level of seniority in social work across a number of local authorities. Until her retirement in April 2014, she was East Renfrewshire Council's chief social work officer and head of the community health and care partnership children's, criminal justice and addictions services. Safaa was also chair of the child protection committee, children's services plan and alcohol and drugs partnership. Safaa also works with a number of local authorities as a consultant on the provision of children's services.

**Elaine Noad OBE** has worked in the public and voluntary sectors throughout her career. She was formerly the director of social work, housing and health at South Ayrshire Council. She has worked with a number of public and voluntary sector organisations, including acting as a non-executive director of the Scottish Government, a member of the Parole Board for Scotland, and as a lay member of the Scottish Solicitors Disciplinary Tribunal. She brings experience in management, social work, audit and governance, and has a strong commitment to equality, diversity and human rights.

These appointments were regulated in accordance with the Commissioner for Public Appointments in Scotland's Code of Practice and the Commissioner for Ethical Standards in Public Life in Scotland.



## **Towards greater engagement**

We are acutely aware of the importance of maintaining good, ongoing, relationships with people who are affected by mental ill health, learning disability, dementia or related conditions.

Involving people who receive care and treatment in our work – and involving family members and friends who provide essential day-to-day support – ensures that we do not lose sight of our purpose.

In 2014/15, we consulted with others and reviewed our system of contracting visitors to help with this role. We wanted to create a more long term approach, with better integration with our wider work. This year, we created two new permanent part time staff posts within the Commission, one for a person with personal experience of mental ill health, and one for an unpaid carer of someone receiving care and treatment.

Our new members of staff are in post and working with staff across the Commission. They are engaging with people with lived experience and carers across the country, hearing from them about their priorities and involving and consulting them in relation to different areas of our work. They are participating directly in visits and project work, and contributing their valuable experience and perspectives. They are widening our network and helping shape our communications with patients and carers. They are already making a significant contribution to our work overall.

## **Our advisory committee**

A standing committee of our Board, our advisory committee consists of representatives of 25 stakeholder groups from across Scotland. They meet twice year, and this year they made a major contribution to our engagement strategy and helped shape our themed visits and our work on promoting advance statements.

## **Our commitment to equality**

The Commission is committed to the principles and practice of equality and diversity. We see our equalities duties as part of a wider strategy which puts equality and human rights at the centre of our work. Our single equalities scheme, with full details of our approach, is on our website. We also began work on a guide to best practice in providing care and treatment for mental ill health to people from the LGBT community, working with LGBT Health and Wellbeing.

## **Financial resources**

Our revenue budget was £4.4 million. This included £3.688 million for the Commission, including £88,000 additional budget allocated to upgrade our patient information system and £0.7 million for the National Confidential Forum.

Our capital budget was nil.

We are funded through the Scottish Government, and met all the financial targets set by them. Our audited annual accounts are available on our website.



## Learning lessons

We seek to learn and improve as a result of the complaints we receive. In 2015/16 we introduced a new, more rigorous set of complaints handling procedures, based on a model provided by the Scottish Public Sector Ombudsman.

In this year, we received 15 complaints. After investigation, five of those complaints were upheld, one complaint was partially upheld, and nine were not upheld.

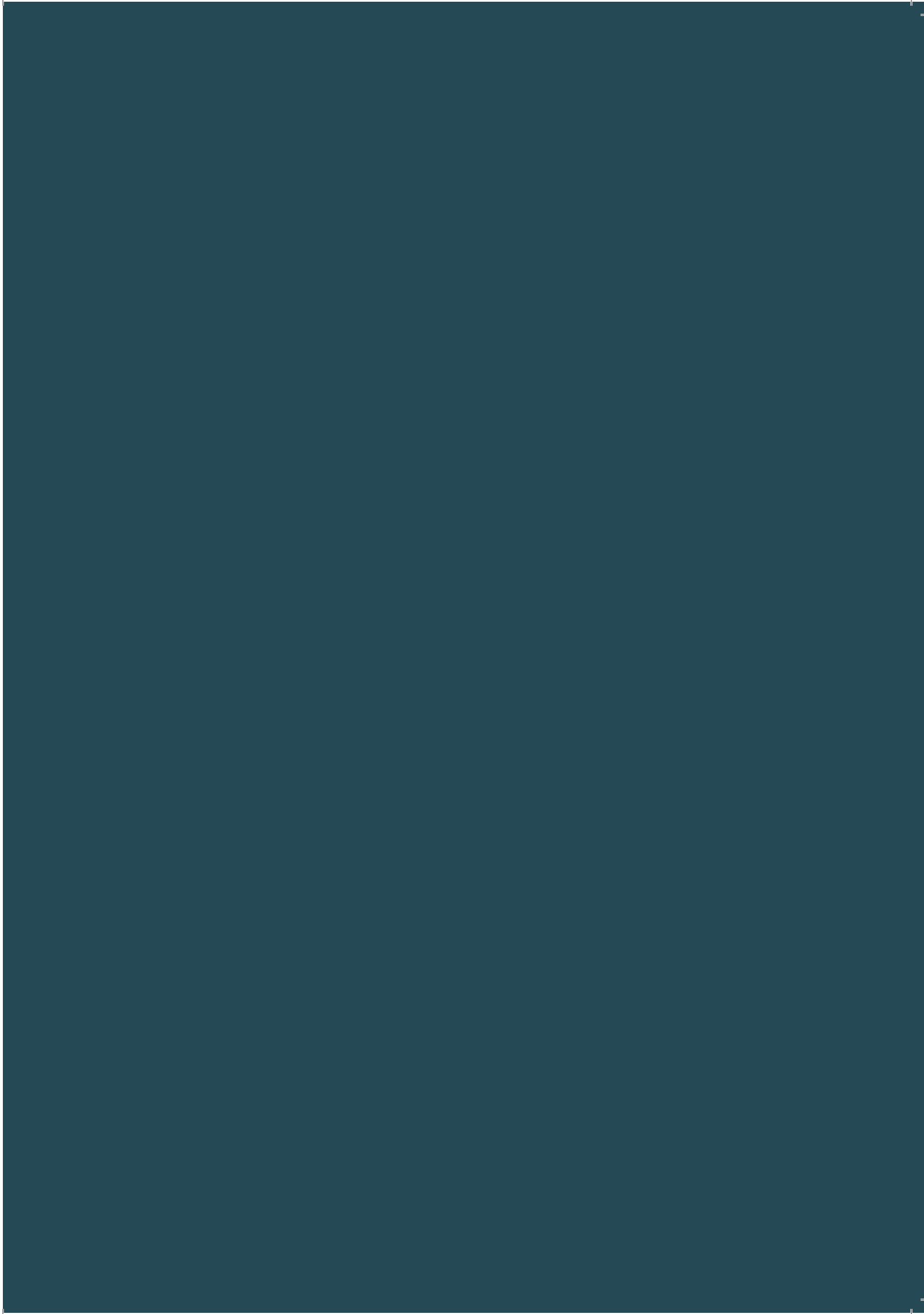
As a result of these complaints we have:

- made improvement to the way administrative work is overseen;
- increased management oversight of projects; and
- introduced new guidance about confidentiality for users of our advice line.

## Environmental sustainability

Under the Climate Change (Scotland) Act 2009, the Commission is required to produce an annual report on sustainability. This was published in November 2015 and is available on our website.







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