

Our Annual Report 2007-2008

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Our Commissioners

Chairman's statement

550 years. That's about the total number of years of mental health and learning disability experience that have been totted up by our staff and Commissioners. Experience which we use to shape mental health law, promote best ethical practice and act to directly improve services. It is perhaps not surprising that there is wide recognition of our unique authority in applying best legal and ethical principles to care and treatment in the field of mental health and learning disability. Our role was enhanced under the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003. The 2003 Act has been hailed as an international landmark in modern mental health legislation. It incorporates respect for human rights, dignity and equality and gives us the duty to safeguard and promote these rights. I want to focus on how we have done this over the past year and our plans for the future.

No other organisation visits individual people to take an independent view of their care and treatment the way we do. We think this is essential for people with mental health problems and learning disability. The risk to their rights and welfare is reduced by our independent, safeguarding role. We provide examples here of the many ways in which we have stepped in and spoken out on behalf of individual service users over the year. These range from preventing care and treatment that was not consistent with an individual's legal rights, to challenging service managers on poor accommodation and facilities. Our success in achieving improvements comes from the regard that the wider mental health community has for our views and opinions.

We recognise that this respect needs to be earned. The quality of our advice and guidance is crucial. This year we found that we gave accurate advice in 97% cases. Given the complexity of problems brought to our attention, we think this demonstrates how effective we are in giving the best possible guidance in difficult situations.

We are often described as a watchdog. It is true that we look into situations where something has gone badly wrong, but we also work to improve policy and to promote best practice in applying



the principles of the law. Where we find good practice we aim to share it. We also provide our own guidance on best practice and consult with practitioners, service-users and carers to ensure that our guidance is practical as well as challenging.

Where care and treatment goes badly wrong we can investigate, so that the services and others can learn and improve. This year, we have reported on four of our investigations. Our findings have wide implications as they relate to the care of individuals with mental illness, learning disability, dementia and personality disorder. We want to get the lessons from all of our investigations to the widest possible audience and have summarised the common themes in this

report. If service providers act on our recommendations and common themes, the risks to service-users will be reduced.


At the time of writing, the Scottish Government is consulting over a limited review of the 2003 Act. The information we have collected has been important in shaping this review. Overall, we believe that the Act has achieved many of its aims. However, we have found situations where the way the Act is working may be inconsistent with human rights legislation. We have raised these issues with the Scottish Government and have given examples in this report.

We are constantly adapting to new challenges. As a result of a detailed examination of our work and in response to the principles of the Crerar Report, we are making our visits more focused and better targeted. We will provide a greater number of national reports on themed visits and will focus our visits more on people whose rights and needs for care and treatment are at greatest risk. We will continue to play our part in discussions about scrutiny of public services. Our present work with the Care Commission to jointly examine a sample of care homes demonstrates our commitment to appropriate joint working. Whatever the future holds, we want to make sure that the mental health community continues to benefit from the independent judgement and expertise that we provide.

Our achievements and impact would be impossible without the expertise and diligence of our staff and Commissioners. I wish to record my thanks to them and also make special mention of Ian Miller OBE who, prior to his retirement as Chairman earlier this year, steered the Commission through some challenging times with his canny judgement and wise counsel.

Interim Chair

Jim Connechen



care

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Efficient and effective visiting

Our visiting programme is efficient and effective. We visited 99 services as part of our regular programme, 14 of these service visits were unannounced. We interviewed 2,025 individual service-users. Our strategic target was to meet with 2000 individuals in 2007-08. We visited 16 acute admissions wards as part of our large themed unannounced visit.

This year

99

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16

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289

We made 289 recommendations to improve the care and treatment received by individuals.

90%

We followed up on 90% of our recommendations. Over 50% were acted on within the year. We have action plans to follow up on those that have not been delivered at the time of writing.

We visit people who are receiving care and treatment for a mental illness, learning disability, dementia or other mental disorder. We have a legal duty to visit people who are receiving this care and treatment. People being treated under mental health and incapacity law lose some of their freedom of action and choice. Our visits focus on making sure that individual care and treatment is being delivered with respect for the person's dignity, equality and human rights. We also want to make sure that people get the care and treatment they need. We meet people in hospitals, care homes, prisons, in the community and in their own homes. If there are changes that need to be made for an individual, we will make recommendations to the services responsible and will follow up to make sure changes are delivered.

Our direct contact with a large number of service-users gives us a unique insight into the impact of law and policy in Scotland. Where we see common issues that require concerted action, we make recommendations to policy makers and service providers.

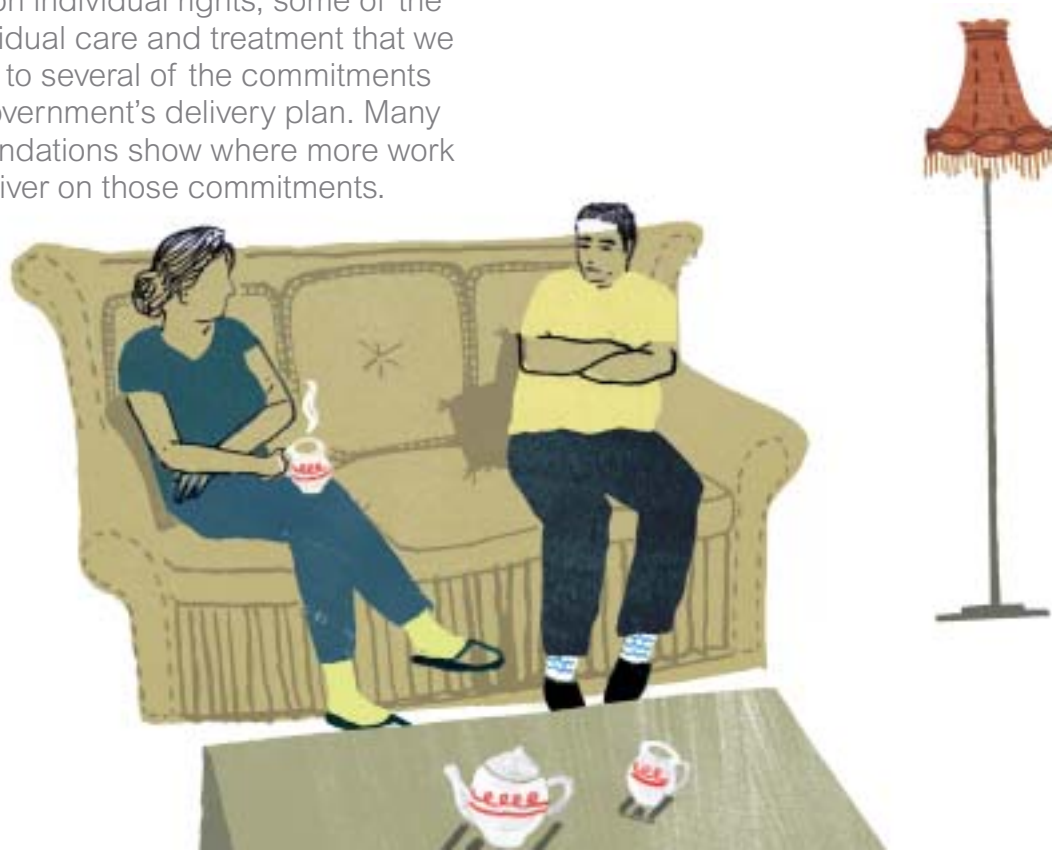
Is Scotland Delivering for Mental Health?

In December 2006, the Scottish Government launched 'Delivering for Mental Health' – their plan for mental health services in Scotland. While our visits focus on individual rights, some of the aspects of individual care and treatment that we ask about relate to several of the commitments set out in the Government's delivery plan. Many of our recommendations show where more work is needed to deliver on those commitments.

Improving patient and carer experience of mental health services

Commitment 1 in Delivering for Mental Health highlights the mis-match that often exists between the expectations, set out by mental health service policy, and the experiences of service-users and carers. Our visit programme highlights some of the experiences that individuals have in relation to their rights, recovery, equality and social inclusion.

Recovery is about responding to individual strengths and needs and being actively engaged in your own care and treatment. Some care plans we saw on visits did not highlight how an individual's skills are being retained or improved. Individual participation in care decisions varied greatly. We saw examples where there was clear evidence of full involvement and others where individuals were presented with a completed plan that professionals had written. Person-centred care plans often did not record individual needs and goals. This was a particular problem for people with acquired brain injury.



We found that the main therapeutic input in some rehabilitation wards – where one would expect a strong recovery focus – consisted of medication and nursing care. There was sometimes little evidence of approaches that addressed wider individual needs such as employment, social activities, education and training.

We made over 20 recommendations about the preparation, presentation and review of care plans. Our concerns about the quality of care plans led us to produce good practice guidance. We were told by most services that their approach and documentation were being changed. We hope that the Scottish Recovery Indicator (SRI), developed by the Scottish Recovery Network, will help services to make necessary improvements. Our independent assessment of this, by hearing directly from service-users, will be valuable in assessing whether this Commitment is improving the experience of service-users.

Responding better to depression, anxiety and stress

Under Commitment 4, the mental health delivery plan sets out a target to increase the range of psychological therapies available in a range of settings. From our visits this year we have serious concerns about the lack of such therapies, especially for people in hospital. In one hospital there was no psychologist attached to a rehabilitation service and minimal provision of psycho-social interventions for service-users. We believe that the range of options available could be extended by increasing the skills of nurses and allied health professionals and by providing more training on psycho-social interventions to these professionals.

We made a number of recommendations about availability of therapies to the services concerned. As a direct result, many services have increased their psychology input and invested in greater training for other staff in psychological interventions.

Improving the physical health needs of people with mental illness

There is evidence to say that people with a mental illness or learning disability have poorer all round health than the population as a whole. We welcome the profile given to physical health under Commitment 5 of the delivery plan and have used it to remind those services we visit about the importance of physical health assessment. We have seen a number of examples where continued focus on physical health is required, both for people with a mental illness and people with a learning disability who receive long-term care in NHS hospitals. In a number of the care homes and hospitals we visited, there was no evidence of routine physical health checks. Sometimes GP support was of a good standard, but this was provided reactively rather than proactively. We don't think this is appropriate for people who may not identify their own health needs. It also means that people who are in long-term care may not get equal access to community health screenings.

In one care home, where we identified concerns, a new standard form has been introduced across the provider's range of residential services and



a health check is now carried out every six months at residents' reviews.

Assessment is only one step in improving the health inequalities faced by people who are in the care of mental health and learning disability services. A number of people we met, who had been in hospital for a longer time, complained of substantial weight gain. They found it difficult to get time off the wards and often have to wait for an escort to become available because of lack of easy access to grounds. Gym facilities were often absent, or not in use because of a lack of suitably trained staff. In some hospitals smoking rooms were poorly ventilated and non-smoking residents were exposed to passive smoking. We think there is room for improvement in terms of health promotion in mental health services.

Manage better admission to, and discharge from, hospital

Commitment 8 refers to the avoidance of inappropriate admissions through better community-based and crisis services. We cannot comment directly on local arrangements for provision of crisis services, or the appropriateness of admissions, but we have looked at people who remain in hospital because other forms of care are not available. We made 17 recommendations on this issue, usually related to a lack of supported accommodation. In such situations, the people we met were not best served by still being in hospital.



Acute in-patient forums, to be set up under Commitment 9, will review local services and should also assess the environments and the information available for people in hospital. We hope that this will lead to improvements in hospital facilities. Poor physical facilities always feature highly in our recommendations. We believe that the standard of facilities that are often provided for mental health services would not be acceptable in other parts of the health service. We also think that poor environments contribute to the stigma of mental illness. The problems we see most often include poorly maintained furnishings and décor, lack of access to outdoor and garden space and lack of secure personal storage space.

This is an area where improvements can be made without huge cost or difficulty. It is therefore reassuring that our recommendations have resulted in improvements for service-users. For example:

- An older people's ward had commissioned a consultancy report from the Dementia Services Development Centre in the University of Stirling as they were aware that the environment was unsuitable for people with dementia. The recommendations in the report would not structurally change the environment, but would provide one which was much more habitable and user friendly. Despite most recommendations being low cost, very few had been implemented. We took this up with service managers as a matter of serious concern. We were pleased that most had been implemented when we went back two months later to check on progress.
- In one NHS Board area, we saw wards with mixed sex accommodation where female sleeping areas could only be accessed by passing through male sleeping areas. This was unacceptable as it infringed privacy and could place women at risk. It is important that women feel safe in hospital and we know from previous visit programmes this is often not the case. In this particular service, our recommendations resulted in the NHS Board committing money to improve facilities. We will be visiting this area again this year to make sure that improvements have been made.

_Child and adolescent mental health services

For several years we have expressed our concerns about the effect that being treated in an adult ward has on young people with a mental illness. We made monitoring this area a priority and are the only organisation in Scotland that monitors all admissions of children and young people to non-specialist wards. We believe our focus has raised the profile of the issues around meeting the needs of young people. We welcomed delivery plan Commitment 11, which aims to reduce the number of children and young people admitted to adult beds by 50% by 2009.

This year we were notified of 142 admissions of young people, under the age of 18, to adult psychiatric wards. This compares to 186 admissions last year and represents a 24% reduction and a good strong step towards the national target. While the 2003 Act requires NHS Boards to provide appropriate in-patient accommodation and services for people under 18, reducing admissions to adult wards is only part of the solution. Specialist adolescent services must be available to support young people admitted to adult wards. This does not happen in some areas.

_A hospital or a home?

This year we carried out a programme of visits to 39 NHS facilities for people with a learning disability. We wanted to review progress on moving people from long-stay NHS care into community-based accommodation. A target was set out to move people from NHS facilities to community settings by 2004. On our visits we identified 440 individuals who are still in NHS accommodation. Nearly a third of those individuals had no discharge plans in place when we visited. When we asked staff who was 'ready for discharge' we were told that 40% of their patients were ready to leave NHS care.

It is clear to us that a significant number of people throughout Scotland are in hospital unnecessarily, because homes with support are not yet available. There is a clear need for NHS Boards and local authorities to agree local strategies to enable people to move on to more appropriate care settings.

To order or download a copy of the full report 'A hospital, or a home?' go to www.mwscot.org.uk.

_Our unannounced visits to acute mental health wards

Acute mental health care in Scotland is developing to provide a range of services including crisis resolution teams, crisis centres and intensive home care and treatment. These services are provided by a range of agencies, including health, social care and the voluntary sectors. Some people, however, still need care and treatment in a hospital setting. There are 74 acute adult admission wards in Scotland. These provide medical care and support to people who are very ill and need help in hospital. This year we carried out an unannounced visit to 16 of these wards. When we visited there were 342 patients in the wards, 99 of whom were detained under the mental health Act.

62 patients helped us by completing questionnaires. They told us what they thought about the hospital environment, what activities were available to them and most importantly how they felt they were being treated.

We heard many positive stories, which indicated to us that some acute services in Scotland are improving. Most of the people we spoke to valued the help they were getting and were positive about the people providing their care and treatment. There were some concerns that we think could be sorted out fairly easily. The environment in some wards could be much better. Life can be boring in hospital and more meaningful activities could help a great deal with recovery. The provision of information could definitely be better in a number of wards.



A visit to Rachel

Rachel is a 26 year old woman with a learning disability and an eating problem. She was 35 stone and required 24 hour support. Her local authority had applied for a guardianship order to make sure she got the care and treatment that she needed, but very often resisted. They also wanted to help protect her from bullying by local youths. After the guardianship order was approved, Rachel moved to a safer community, where she made great progress. She enjoyed meeting new carers, chose furnishings for her new home and started to lose weight. A stay at home, however, led to a change in behaviour and significant weight gain. Rachel said she felt that she'd failed and was letting everyone down. Her self esteem had plummeted and her behaviour had become more challenging. We visited Rachel at a point where her carers were at a loss as to how to motivate her and get her back on track.

Our practitioner visited Rachel to check how guardianship was working for her. She talked to Rachel's carers and saw that they were finding it difficult to be as strict around Rachel's diet as they needed to be. Rachel's weight gain had serious consequences for her health and she did not have the ability to manage that herself. This

was part of why the guardianship order was in place. Our practitioner talked through the benefits of a strict dietary regime for Rachel and helped carers feel confident about being more active in managing her diet. Rachel's guardian was also encouraged to involve Rachel's parents more, so that they could support the efforts of care workers.

Ten months later, Rachel's guardian contacted us to thank us for our help. Clear guidance and 'permission' to restrict Rachel's freedom in relation to her food intake had made a huge difference. Rachel lost 10 stone which has had a hugely positive effect on her life. She has two work placements in charity shops and travels to these by herself, using public transport. Rachel's care package has been significantly reduced. She no longer needs overnight carers and she can now shower without support. She is much more independent and her self esteem has rocketed. Rachel has so many other interests, food is no longer the focus of her life. Consistent responses to her problem by her care team have led to far fewer conflicts and behaviour problems. At Christmas, for the first time in years, Rachel was able to go and see a pantomime as she can now sit in an ordinary theatre seat.

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_Providing advice and information

_This year

90,000 500

We recorded over 90,000 visits to our website.

We received around 500 e-mail enquiries.

5,437

We handled 5,437 telephone requests for advice and information.

_Who calls us?

- Mental health practitioners and professionals (53%)
- Service-users, carers and named persons (29%)
- Other types of caller (16%)



97%

The advice and information we provided was accurate 97% of the time. This is 7% better than the target set out in our strategic plan.

_Nature of call

- Mental Health (Care & Treatment) (Scotland) Act 2003 (48%)
- Adults With Incapacity (Scotland) Act 2000 (13%)
- Legal & practice issues (7%)
- Concerns & complaints (18%)
- Misc. information & advice (13%)



Our experienced staff provide telephone information and independent advice that aims to support service-users get care and treatment that is in line with the best clinical, ethical and legal practice. Our website also provides a growing information resource, where service-users and practitioners can access information out of office hours.

Most of the advice and information we provide relates to the Mental Health (Care & Treatment) (Scotland) Act 2003 and the Adults with Incapacity Act 2000. The questions that our advice staff are asked give us an important insight into how well mental health and incapacity law is being understood and applied. A call to our advice and information service can also lead to action on behalf of the individual concerned.

Every year we hold a programme of events across Scotland where we share findings from our monitoring, visiting and investigations work. We also use these events to consult on key aspects of our work programme. This year we held events in Edinburgh, Glasgow and Dundee. These were attended by a total of 241 people. Our events are attended by a range of stakeholders from service-users and carers through to service managers and Tribunal members. We ask people to rate our events on a scale of 1-10 – where 10 is the highest score. This year the average score for our information events was 8 out of 10.



—The quality of our advice

Over the last few years, we have become more aware of the importance of our advice service. Service-users, carers, advocates, practitioners and managers rely on us for accurate and timely advice. Our surveys of practitioners' views of the Commission told us that this is an important and valued service. While our advice is valued, people said that we could be more consistent in the advice we give. We have changed our systems to help our practitioner staff give more accurate advice. We also audit the quality of our advice on a more regular basis.

All of the advice we give is entered onto our information system. We record who asked us for advice, the topic we were asked about and the advice we gave. We have set up an internal "knowledge bank" of questions, answers and related information resources for our practitioner staff to consult. We also publish questions and answers that might be of interest to others on our website. We flag up tricky questions and answers, which then go to a monthly meeting of all practitioners for discussion. If we identify frequently recurring themes we produce best practice guidance for that topic area.

We audit advice given on two days each month. We then review our advice to decide if it is accurate and whether there was any additional advice we should have given. Any inaccurate advice is corrected and brought to the attention of all practitioner staff. If we can identify the caller we get in touch with them to advise them of any errors. We found that the advice we gave this year was 97% accurate. In around 14% of cases, we thought that we could have given additional advice.

Every individual's circumstances are unique. Many of the questions we are asked are complex and we often have to interpret how to apply best legal and ethical practice to difficult clinical situations. Sometimes we have to take legal advice ourselves. We don't always get it right. But, people who ask for our advice can be assured of an accurate response almost all of the time and a continuously updated and improving advice service.



A nurse calls about Eric

Eric was a man with dementia who needed to be transferred from a hospital to a care home. Eric was unhappy about plans to move him and it was clear that he would not consent to the move. The psychiatrist responsible for Eric had suggested that he could be given a sedative injection and moved while he was unconscious. The nurse was unsure of the ethical and legal basis of the psychiatrist's approach, so called our advice line. Our duty practitioner was very clear that the action proposed by the psychiatrist was illegal. Eric could not be moved without his consent, unless he was subject to a guardianship order which had been appropriately considered in court. We contacted the psychiatrist to advise him that he could not proceed as planned and advised on the legal safeguards that needed to be applied before Eric could be safely moved.

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_Monitoring the law

Scotland has a proud track record in legislating to safeguard and protect the rights and welfare of vulnerable people. The first major piece of legislation, passed by the devolved Parliament, was the Adults with Incapacity Act 2000. The Mental Health (Care and Treatment) (Scotland) Act 2003 has been hailed as an international landmark in modern mental health law. In order to ensure that services achieve the aspirations set out in the principles of the legislation, we have a duty to monitor the use of the 2003 Act and aspects of the Adults with Incapacity (Scotland) Act 2000.

Our monitoring activity shows:

-4%

A further 4% fall in the total number of new episodes of detention on 2006-07 figures. Last year, we reported an 8% fall.

-500

About 500 fewer people are given compulsory care and treatment under the 2003 Act, compared with previous legislation.

+13%

A 13% increase in welfare guardianship orders. This is a smaller increase than in previous years. Most applications are now from private individuals and many are for an indefinite amount of time. We think it is wrong that these orders can continue for years without going back to Court.



-24%

An overall increase in the total number of people receiving compulsory care and treatment, especially community based care and treatment.

Admission of young people to adult wards has gone down by 24%.

More detailed statistics and analysis are available from www.mwcscot.org.uk.

Our priority areas

Our priority monitoring areas focus on those parts of mental health law that cause most concern to stakeholders. These were identified through consultation, when the 2003 Act was introduced. This year we also paid special attention to the use of the Act amongst people over the age of 85. We wanted to know why the number of compulsory orders was so high amongst this population.

Advance statement overrides

Advance statements allow people to set out how they would and would not like to be treated should they become mentally unwell. They are a way to improve individual participation in care and treatment decisions. We monitor overrides of advance statements to check that any treatment that conflicts with an advance statement can be justified. Although we were told of 28 possible overrides of advance statements, we only found 13 cases where an individual had made a valid advance statement and had received treatment they said they didn't want. Seven of these were refusals of medication by depot injection.

Of the others, one was an advance refusal of electroconvulsive therapy (ECT). When we looked into this person's treatment, we found that the treatment was needed to save the person's life.

The doctor who authorised the treatment paid attention to the advance statement and ordered that the treatment could only be given while the person's life was in danger and not for any longer than that. We think this shows that even when doctors feel that, for clinical and ethical reasons, they can't act in accordance with them – advance statements can still influence individual care and treatment. The number of people receiving compulsory treatment who have advance statements has risen to 10%. We hope that more people will realise their value.

Emergency and short-term detention

Under the 2003 Act, short-term detention should be the usual way to start compulsory treatment. Short-term detention requires involvement of a Mental Health Officer (MHO) and an approved psychiatrist and provides better safeguards for patients. Emergency detention does not need an approved psychiatrist and consent from a MHO is sometimes not available at the time they are issued. This year, we found:

- The number of people subject to emergency detention continues to fall, especially short crisis admissions which fell by a further 8%. Rates of emergency detention almost halved when the Act was first introduced.
- During office hours, short-term detention is used in over 80% of compulsory admissions.
- Outside office hours, most compulsory admissions are usually emergency detentions. There was no consent from a MHO in about a third of these.

We were pleased to see that the use of emergency detention continues to fall. At present, it would be difficult for NHS Boards to provide specialist psychiatrists round the clock to assess people. However, we believe that anyone admitted under an emergency certificate should be seen by an approved specialist as soon as possible. We have consistently advised that a person should receive a psychiatric assessment within 24 hours of admission.



_Community-based compulsory treatment

The 2003 Act made it possible for people to receive compulsory treatment without being admitted to hospital.

We are pleased that practitioners have continued to use the provision for community-based compulsory treatment orders (CTOs). About a quarter of all people on CTOs are being treated in the community. Compulsory treatment in the community is a way to provide care and treatment in a less restrictive setting and can be helpful if the required services are there to provide support. About a third of people on community-based CTOs were readmitted to hospital at some point last year. This raises some concerns about whether the services that people need are available in the community.

Our monitoring has indicated that the overall number of people receiving compulsory treatment is going up. Since the number of new orders has come down, this might suggest that fewer orders than we would expect are being revoked. The Mental Health Tribunal reviews all long-term treatment every two years. In 2008-09 we will be examining the care of people who have had compulsory treatment for more than three years. We will check that individual needs are being met and that the grounds for compulsory treatment are being reviewed often enough.

_Younger people

In “Delivering for Mental Health”, the Scottish Government has made a commitment to a 50% reduction in the admissions of people under 18 to non-specialist mental health facilities. The target date for this is 2009. We found that these admissions fell by 24% this year. This is good news, however we are still concerned about the care of young people in adult wards. We asked

for details about specialist input to their care and found 21 people who had no specialist mental health input. Failure to provide appropriate facilities and accommodation is a breach of the 2003 Act. We also found that young people in adult wards did not get the access to education that they would in specialist units. This can have a serious impact on the longer term welfare of young patients. While we agree with the Government’s commitment in the delivery plan, we will continue to press for better specialist services where young people are in adult wards.

_Older people

Last year, we found that the use of mental health legislation had almost doubled for people aged 85 and over. This year the number is slightly lower. We were concerned about the impact of new legislation on older people and decided to look into the care and treatment of people aged 85 and over who were on CTOs.

We found:

- Compulsory treatment was usually appropriate. We found that people with dementia had better human rights safeguards when the Act was used.
- Some people had several different classes of drug treatment authorised. We wrote to some of the doctors who prescribed several different drugs asking them to check that all the treatments were necessary. We are providing more training on this for doctors to ensure that where people cannot give consent the medication they receive is necessary and safeguarded.
- No-one in this age group had made an advance statement. Only 11% had appointed a welfare attorney. We believe that better advance planning, and earlier use of guardianship, might have resulted in less restrictive care and treatment for the individual.

For more detailed data and analysis please go to www.mwcscot.org.uk.

_Our monitoring priorities for 2008-09

- Children and young people under the age of 18
- Individuals who have been detained for three years or more
- Individuals who are on short term detention certificates

closure of in-patient learning disability facilities, can affect the rate of applications in different areas. These still don't fully explain the differences. We think those local authorities, whose rates of guardianship are much higher or lower than the national average, should look into the reasons for this.

We are also concerned about the length of time people can be on a welfare guardianship order, without this being reviewed by the court. This year 71% of orders were given for an indefinite period of time. Under the 2000 Act, an order does not come back to court for review after a certain length of time. We don't think it can be right, for example, that a young person with a mild learning disability can be placed on an order – that gives another person decision-making powers over many aspects of his or her life – without this ever having to be reviewed again in court. This would not be the case for the same person being treated under the mental health Act. We think policy makers should look at whether new guidance to Sheriffs or a change in the law is needed.

_Welfare guardianship

We monitor the use of the Adults with Incapacity (Scotland) Act 2000 where this relates to welfare guardianship orders. Our monitoring this year raised a number of key concerns for service providers and policy makers. We are concerned that there appears to be a huge difference in the number of applications and approvals of orders in different local authority areas. We know that factors such as an older population, or the



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Investigations and inquiries

We carry out investigations and inquiries into cases where we feel there has been a significant failure in an individual's care and treatment. We will pursue an in-depth investigation if we believe there are valuable lessons to be learned, not just for the services involved, but for services across Scotland.

This year we carried out 4 investigations into cases where we thought individuals had not received the care and treatment that was right for them.

Justice Denied

We investigated the care and treatment of a 67 year old woman with a learning disability who had reported being subjected to a number of serious sexual assaults. The report from our investigation, 'Justice Denied', concluded that services responsible for Ms A's care failed to protect her from a series of serious sexual assaults, by a small number of men, over a period of years. Our report found that in addition to failures to protect her, the way services responded effectively denied Ms A access to justice.

A key reason for our investigation of Ms A's case was our strong belief that the circumstances surrounding her experiences are not unique. It is widely documented that people with a learning disability are more at risk of being victims of serious crimes. Among our recommendations, we called for expert training for social workers, NHS staff, the police and others working in the criminal justice system. We believe training would result in more reliable evidence being obtained from vulnerable witnesses and an increased opportunity to bring cases to court under existing legislation.

We believe that people with a learning disability and their carers must have the confidence to report serious crimes. We are aware of cases where people with learning disabilities have achieved justice through the courts and would like to see more done to build on these successes. Our investigation into Ms A's case shows that this is not just a matter for the criminal justice system, but for front-line professionals working in health and social care. Their early actions can determine the longer-term outcomes for a person in their care.

Our experience, from direct contact with service-users and service providers, suggests that we still have some way to go before we can say that people with learning disability are able to access justice on an equal basis to other Scottish citizens. We hope the findings and recommendations of our report take us closer to that point.

As a result of our investigation

- Justice Minister, Kenny Macaskill MSP and Deputy First Minister, Nicola Sturgeon, have asked officials from Health and Justice departments, the Crown Office and the Procurator Fiscal Service to work together to assess how best to take our recommendations forward.
- The Scottish Government and the Law Society of Scotland will hold a seminar for key stakeholders to consider the accessibility of the criminal justice system for people with learning disabilities and identify areas for improvement.
- The NHS Board, local authority and police force directly concerned have produced a joint action plan to address our recommendations.

'Justice Denied' can be downloaded from our website www.mwcscot.org.uk.



Not my problem

Mr G was a 61 year old man who had been diagnosed as having a personality disorder and who had come into contact with mental health services in the past, mostly for treatment in relation to depression. Our investigation focused on Mr G's care and treatment between 2000 and 2004. During this time, his contact with services increased and his behaviour became more challenging. Towards the end of this period Mr G was sent to prison several times. It was while he was in prison that we came into contact with Mr G. We were called by prison health services who were very concerned about his condition. Mr G was wandering, hallucinating, incontinent and displaying inappropriate behaviour. Staff were concerned that prison was not the right place for him, but were finding it difficult to find a solution.

One of our doctors went to see Mr G and thought it was unlikely that his behaviour could be explained by a diagnosis of personality disorder. When we reviewed his history it seemed his condition had clearly deteriorated since 2001. We thought Mr G had probably developed a form of dementia. We sent our views on Mr G's illness to all the practitioners involved in his care and were pleased when he was admitted to hospital for assessment. Mr G was diagnosed as having

dementia and depression and was transferred to a unit for younger people with dementia, where he was well cared for in the last years of his life.

Our investigation into Mr G's care and treatment highlights some key issues around the impact that a diagnosis of 'personality disorder' can have for an individual. Our findings support research that people with a diagnosis of personality disorder often get poor care from mental health services. We believe that Mr G's case shows how a diagnosis of personality disorder can effectively blinker professionals to alternative explanations for behaviour and can act as a barrier to appropriate care and treatment. Our findings also highlight a widely held assumption that personality disorder is untreatable, despite good evidence around the use of psychological treatments. We think services should be working in an evidence-based way in relation to personality disorder. We were also concerned that general and forensic psychiatrists did not know enough about the particular type of dementia that Mr G had and that services did not do enough to share information and work together to provide care for Mr G.

As a result of our investigation

- The Scottish Forensic Psychiatry Network has developed a training package for forensic psychiatrists to help make sure they can identify patients who suffer from the same kind of dementia as Mr G.
- Both NHS Boards involved have produced an action plan to address our recommendations.

A summary of our investigation report 'Not my problem' can be downloaded from www.mwscot.org.uk.





Wrong place, wrong time

We have expressed our concerns about the treatment of young people in adult psychiatric settings for several years and actively monitor inappropriate admissions to adult wards. It was through this monitoring work that we first became aware of Ms Y, a 16 year old who had been admitted to an adult ward. We visited Ms Y after the Mental Health Tribunal decided to make specialist services for young people a required part of her care. After our visit we were concerned that, despite Ms Y's good progress towards recovery and discharge, she had not received care and treatment that was suited to her needs as a young person. We decided to conduct an investigation.

We found that for large amounts of time between December 2006 and August 2007, Ms Y had been cared for in an adult psychiatric ward with little or no input from specialist services for younger people. It appeared to us that the failure to provide access to specialist services was due to difficulties in providing a qualified assessment of Ms Y. There was also a lack of flexibility on the part of the specialist services to find a solution that placed proper emphasis on Ms Y's welfare.

The NHS Board responsible for Ms Y's care only appeared to provide adolescent mental health services up to the age of 16. At the moment, only about half of Scotland's NHS Boards offer adolescent mental health services for people

aged 16-17. The remainder either offer no service, or only offer services if the person is still attending school. It is hard to see how these arrangements meet with the legal duty placed on NHS Boards to provide services and accommodation for individuals, under the age of 18, who need hospital treatment. We have asked all NHS Boards in Scotland to review their provision in light of their legal obligations.

As a result of our investigation:

- The Scottish Government has recognised that specialist services for younger people should be available for people up to the age of 18 and plan to review the operation of adolescent mental health services across Scotland.
- The NHS Boards involved have produced action plans to address our recommendations and a new consultant post has been created to co-ordinate specialist services for under 18s.
- There are plans to increase the number of child and adolescent beds in the NHS Board area that provides specialist in-patient care.
- Admission criteria to the child and adolescent ward have been changed to make it easier to transfer a young person from an adult service.

'Wrong place, wrong time' can be downloaded from www.mwscot.org.uk.

Our Investigation into the care and treatment of Mrs T

Mrs T was an elderly woman who was cared for by her son from 1997 until September 2005. We became aware of her case when her local authority applied for a welfare guardianship order in 2005. We were concerned about the circumstances which had led to this application and decided to conduct an investigation.

We found that, while Mrs T was being cared for by her son, she had been admitted to hospital twice and social work had received five referrals from her neighbours, concierge, housing officer and the local councillor. They had expressed concerns about Mrs T wandering at night in her nightclothes and her increased level of confusion and frailty. She was also heard crying and shouting. After her first spell in hospital, a range of services had been put in place to support Mrs T at home but these were cancelled by her son. When two case conferences were called to review the situation, records showed that professionals considered Mrs T to be alert, capable and in agreement with her son's wishes. On this basis, they decided there were no grounds for further intervention.

Among our many concerns about the response of services to Mrs T, the main issue was the adequacy of assessments of Mrs T's capacity to make decisions about her care. No psychiatric assessment of Mrs T's capacity was carried out until her second admission to hospital, when she was diagnosed with Alzheimer's dementia. Health-care workers had previously relied on inadequate tests to decide whether Mrs T had capacity and had based their decisions not to intervene on the results of those tests.

We were also worried that despite indications that Mrs T was a very vulnerable woman, probably lacking capacity and living with a potentially abusive son, no multi-agency adult protection case conferences were held. This meant that there was no clear strategy to monitor her risks or to protect Mrs T. We made a number of recommendations to services based on our findings.

As a result of our investigation

→ Glasgow City Council Social Work Department has developed a city wide action plan to act on all of our recommendations within 6 months.

The report from our investigation can be downloaded from our website www.mwcscot.org.uk.



Learning from our investigations

This year we asked Glasgow University to review our past 10 investigations. We believed that similar issues had been at the root of problems with care and treatment in all of the cases we had looked at. We wanted to identify those common issues so that we could share that information and help services to address their key risk areas. We identified 5 key risk areas for services:

Diagnosis and assessment of capacity

In all of our investigations, we found that problems around diagnosis and assessment of capacity had often prevented people from getting the right care and treatment.

Assessing and meeting individual needs

Many of the people whose care we investigated had complex needs. They faced situations where their health and safety were at risk. Assessment of needs and risks is key to good care planning. We found poor practice in assessment and care planning that had led to people being neglected and suffering harm.

Recording and sharing information

Failures in recording vital information about individual care and treatment can be found in all of our investigations. There are often problems with sharing information between health and social care providers. These can be made worse by incompatible computer systems.

Knowledge of relevant laws and safeguards

People who provide care and treatment often have limited knowledge of the laws which can be used to safeguard the welfare of individuals with a mental disorder. Often, laws that are designed to protect are not used at an appropriate time, leaving an individual at risk. Sometimes the failure to act at an early stage also means that more restrictive orders are put in place when legislation is, eventually, used.

Working across professional and organisational boundaries

Different professional cultures can get in the way of effective communication and can distract attention from the needs of the individual. Where staff from different organisations disagreed, our investigations often found there was no way to resolve conflict. This led to serious gaps in the care of people whose cases we investigated.



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_Influencing and challenging

_This year

3

We produced 3 new pieces of good practice guidance.

200

We welcomed over 200 new members to our Principles into Practice Network.



Care planning

Care plans are an important part of recovery planning for people who are detained. The law says a care plan should be completed, by the doctor responsible for an individual's care and treatment, within two months of that person being placed on a compulsory treatment order. As part of our general monitoring role, we review the content of these care plans and how they are being implemented. Our experience suggests that, despite the guidance in the Government's code of practice, the quality and content of care plans varies a great deal and that more detailed guidance on the preparation of care plans would be helpful. Our guidance aims to fill that gap.

Suspension of detention

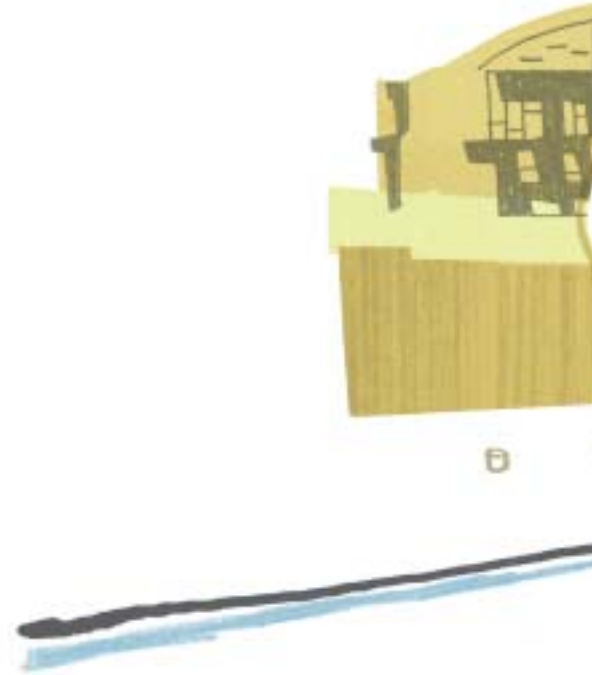
Suspension of detention allows people to leave hospital for short periods and is a key tool in individual rehabilitation and recovery. Despite the benefit that suspension can offer, we are aware that it has proved difficult for practitioners to operate. Our guidance uses case studies to highlight how the use of suspension interacts with the principles of the Act for individual care and treatment. It also provides advice on how to calculate and record suspension periods.

_ Good practice guidance

Our good practice guidance aims to ensure that individuals receive care and treatment that accords with the principles of mental health and incapacity law. Our good practice publications are one of the ways in which we seek to influence the policies and practices of service providers and professionals. Calls to our advice and information line, our monitoring work and our experience during visits, all provide a picture of where guidance would be useful. We aim to produce four good practice guides each year and consult widely to ensure that our guidance is useful as well as challenging. This year we consulted and drafted four areas of guidance.

Autonomy, benefit and protection

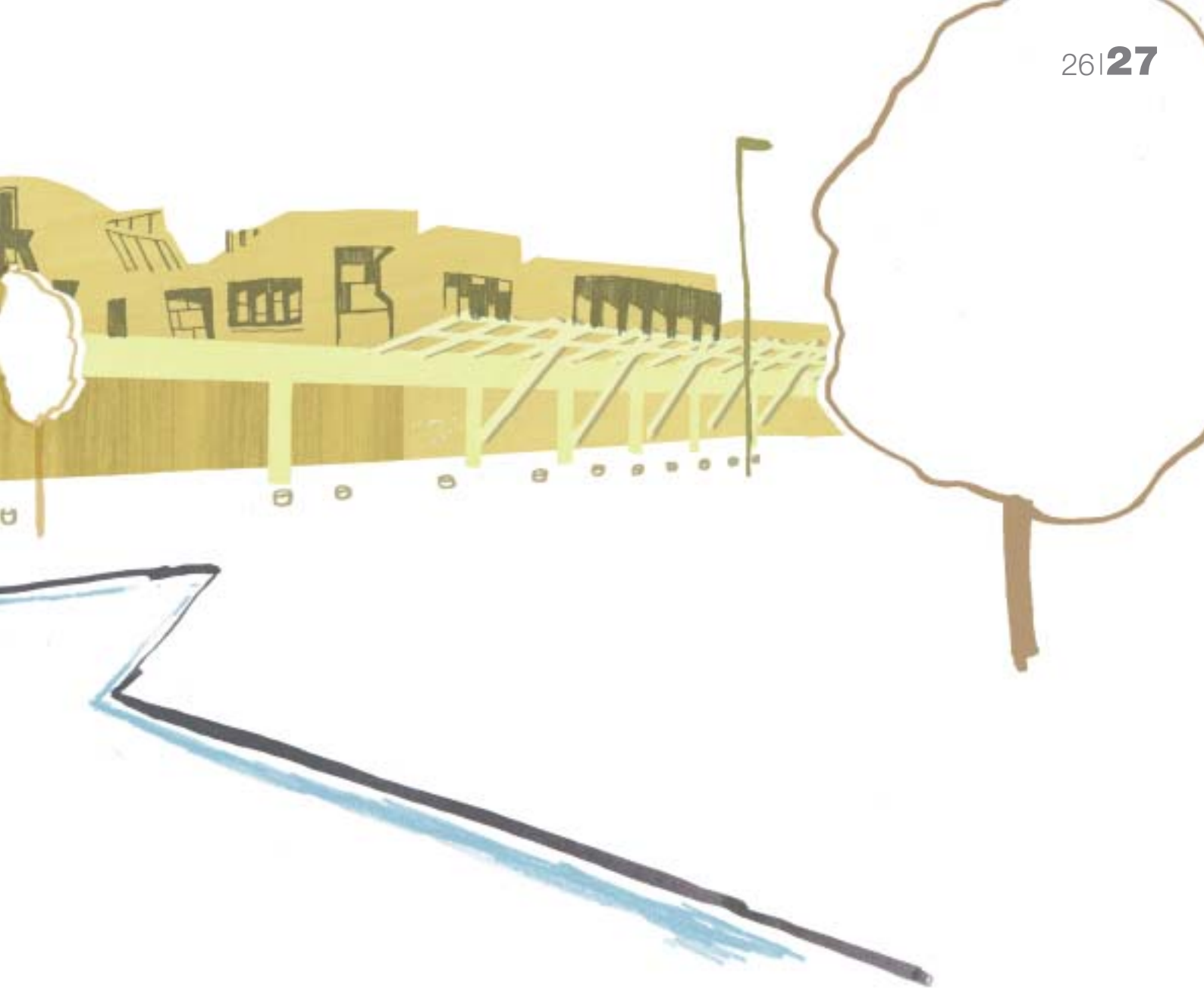
We are keen to ensure that mental health and incapacity laws are understood and used in ways that provide clear benefits to individuals. Scotland's laws have been designed to protect, but also to promote individual rights and autonomy. This year the Adult Support and Protection (Scotland) Act 2007 was introduced. This law makes it clearer when local authorities can step in and put community care in place for adults who may need help, but are unable to arrange this for themselves. The Scottish Government has said that this can only be done when help and support cannot be considered as a 'deprivation of liberty' under Article 5 of the European Convention on Human Rights (ECHR). We are aware that not everyone is clear about what 'deprivation of liberty' means in practice, or how to recognise it. To help make the situation clearer we asked Hilary Patrick, an expert on mental health and incapacity law, to provide an overview of laws and recent court rulings in relation to this topic. A background paper has been produced which will inform a good practice guide next year.



Mental health law and human rights

The Scottish Government has set up an independent committee to undertake a limited review of the Mental Health (Care and Treatment) (Scotland) Act 2003. The main areas that the review will address are: interim orders, suspension of detention and named persons. We have some concerns with all of these areas, especially where it appears that applying the letter of the law might conflict with the Act's own principles.

Over the course of this year, we identified some situations where the 2003 Act, or its procedures, may breach the European Convention for Human Rights (ECHR).



Appeals against excessive security

Under Article 5 of the ECHR anyone with a mental disorder who is deprived of his or her liberty must have the right to challenge this in court. In Scotland, the Mental Health Tribunal acts as a court for any appeals against detention. It also hears appeals against excessive security from people who receive care and treatment in the State Hospital. We believe that there are particular problems with the way appeals operate for some people in the State Hospital.

Following a successful appeal, the Tribunal can order that a person in the State Hospital is being detained in conditions of excessive security. Where this happens an NHS Board must find alternative accommodation for that individual. If the person is subject to a restriction order, Scottish Ministers and the NHS Board must both agree to the transfer.

When the person remains in the State Hospital despite the Tribunal's orders, an application can be made to the Court of Session to enforce the order. Scottish Ministers believe that an enforcement order, made by the court, only applies to the NHS Board. If their view is correct it would mean that, for a person subject to a restriction order, Scottish Ministers could refuse to agree to the transfer and the person would remain in the State Hospital, despite a successful appeal to the court.

We do not believe that this was the intention of the legislation. While no individual has yet found him or herself in this position, we believe that if it happened, he or she could make legal challenge under the Human Rights Act 1998. We believe that the 2003 Act should be clarified so that the court's decision is final.

Named persons

Article 8 of ECHR asserts the person's right to privacy and dignity. Any interference with this right has to be lawful and necessary. Under the 2003 Act an individual's named person is provided with a large amount of detailed information about that individual's history and care and treatment. If an individual has not nominated a named person, the law says that means the primary carer or nearest relative will become the named person. Even if the individual has chosen a named person, he or she is often unaware of the amount and nature of information that will be shared. The Act does not make it easy to have no named person. We also think that there are cases where it would be perfectly possible for a named person to perform his or her role without receiving much of the information provided. We believe there may be a risk of a breach of Article 8 if information that does not need to be shared is passed on.

We have urged the review group to consider this when examining the provisions of the 2003 Act.

Legal Aid for appeals

When a person appears at a Mental Health Tribunal, his or her legal representation is provided free through Legal Aid arrangements. There is no means test applied. However, if a case goes to the Court of Session, the person either has to pay out of their own funds for legal representation or, if they have insufficient means, they can apply to the Scottish Legal Aid Board for a legal aid certificate under the Civil Legal Aid scheme. Under this scheme, means tests are applied. This can result in a person having to pay from their own funds for legal representation, in order to defend an appeal which has been brought by the Scottish Ministers. In our view, this is unfair. We would urge the Scottish Ministers and the Scottish Legal Aid Board to look at ways of dealing with this particular problem.



_Principles into practice network

We have a legal duty to promote best practice in the use of mental health law. We can't do this alone. Last year we established the Principles into Practice Network to help share ideas for good practice, promote discussion and build a shared culture of commitment to the principles.

This year we saw membership of the Network increase by more than 200.

Network membership is drawn from across the spectrum. Of those who responded to a membership survey

- 25% were psychiatric nurses
- 24% were social workers
- 10% were service-users, carers, relatives or named persons
- 6% were psychiatrists
- 3% were speech and language therapists

Others were drawn from policy, training and administration disciplines.

The Network is supported through a website which contains case studies, discussion forums and resources. This year we took a new approach to presenting good practice, we gathered project information and then interviewed managers, staff and service-users to find out more about how projects worked, the challenges that were encountered and the outcomes for individuals. Interviews were edited and loaded onto the site as pod-casts. Feedback has been positive and we will continue to produce good practice podcasts in 2008-09.

_Our wider influence

The Commission has been involved in the International Initiative for Mental Health Leadership (IIMHL). This led to closer contact with the Mental Health Commission and mental health services in the Republic of Ireland. As a result, we have been involved in two investigations there this year. In addition, we have been helping the Healthcare Inspectorate in Wales and have played a major role in establishing UK-wide mechanisms for preventing inhumane and degrading treatment of people in places of detention.



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Operating cost statement

For the year ended 31 March 2008

	2008 £	2007 £
Clinical Services Costs		
Hospital and Community	0	0
Family Health	0	0
Total Clinical Services Costs	0	0
Administration Costs	4,045,091	3,759,517
Less: Administration Income	(107,695)	(5,920)
	3,937,396	3,753,597
Less: Other Operating income	(4,000)	(4,000)
Net Operating Costs	3,933,396	3,749,597
Summary of Revenue Resource Outturn	2008 £	2007 £
Net Operating Costs (per above)	3,933,396	3,749,597
Net Resource Outturn	3,933,396	3,749,597
Revenue Resource Limit	4,040,000	4,023,400
Saving/(excess) against Revenue Resource Limit	106,604	273,803
Statement of recognised gains and losses	2008	2007
For the year ended 31 March 2008	£	£
Actuarial gain/(loss) recognised in the Lothian Pension Fund	99,000	80,000
Total recognised gains and (losses) for the year	99,000	80,000

Balance sheet

As at 31 March 2008

	2008 £	2007 £
Fixed assets		
Tangible fixed assets	577,146	586,391
Total Fixed Assets	577,146	586,391
Debtors falling due after more than one year	0	0
Current assets		
Debtors	117,892	130,613
Cash at bank and in hand	328	763
	118,220	131,376
Current liabilities		
Creditors due within one year	(247,927)	(291,284)
Net current assets/(liabilities)	(129,707)	(159,908)
Total assets less current liabilities	447,439	426,483
Creditors due after more than 1 year	0	0
Provisions for liabilities and charges	0	0
Net Assets before Pension Liability	447,439	426,483
Pension Liability	(171,000)	(261,000)
Net Assets/(liability) after pension liability	276,439	165,483
Financed by:		
General Fund	434,439	422,483
Pension Reserve	(158,000)	(257,000)
	276,439	165,483

The financial information presented in this document does not comprise the statutory financial statements of the Mental Welfare Commission for Scotland for the financial year ended 31 March 2008 which were approved on 30 June 2008, but represents extracts from them. These extracts do not provide as full an understanding of the financial performance, or financial and investing activities of the Commission as the complete Commissioners' report and financial statements. The statutory financial statements have been reported on by the Commission's auditors, PricewaterhouseCoopers LLP, and delivered to the Commission, the Scottish Parliament and the Auditor General for Scotland. The report of the auditors was unqualified.

The full Commissioner's report and financial statements, including the auditors' report can be obtained on request to the Commission at K Floor, Argyle House, 3 Lady Lawson Street, Edinburgh, EH3 9SH.



Our Commissioners

Our Commissioners provide us with a range of fresh perspectives on mental health and learning disability in Scotland. This year Dale Meller was appointed as a Commissioner with a special interest in equality and diversity issues.

Commissioners 2007-08

Doris Aitken
Prof John Bain
Ian Clark
Jim Connechen
Shelagh Creegan
Carol Dobson
Lynne Edwards
Angela Forbes
Linda Graham
Deirdre Hanlon
Jan Killeen
Catriona Maclean
Myra Maguire
Dale Meller
Corinna Penrose
Colin Welsh
Douglas White



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