Annual report 2024-25

mental welfare commission for scotland

Our purpose - we protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions

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

Contents

Who we are and what we do

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

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

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Chair's foreword

Sandy Riddell

This year's annual report underscores the Mental Welfare Commission's enduring commitment to safeguarding the rights of those most vulnerable because of mental illness, learning disability, dementia and related conditions. These are the people who are less likely to have their voices heard. The Scottish Government's Mental Health and Wellbeing Strategy provides a clear direction, and our work at the Commission aligns closely to the strategy. This report tells the story of our work over the last year, highlighting our role as a voice for fairness and making sure individuals and their families are involved in the decisions about their lives and care.

Learning from tragedy

The deeply distressing circumstances surrounding the death of Mrs F brought this into sharp focus. Our investigation revealed shortcomings in how risks were looked at and, crucially, in how much families were listened to. It's a powerful reminder that having good intentions isn't enough; we need solid ways to make sure things happen the right way for every individual, every family, every time.

Investing in impact

It is essential to acknowledge the broader context in which mental health operates. It is linked to societal values, economic resilience, and political priorities. The Scottish Government's National Performance Framework, with its focus on wellbeing and human rights, echoes much of what we aim to achieve at the Commission. As we navigate an environment characterized by increasing fiscal pressures, the imperative of safeguarding mental health as a non-negotiable priority becomes even more critical.

The true measure of this commitment lies in its tangible impact on our most vulnerable individuals, and their carers and families.

Advocacy for legislative reform

We actively inform and engage with policymakers to advocate for laws to stay up to date. The Scottish Government has been implementing the Mental Health and Capacity Reform Programme, which aims to modernize and improve mental health legislation and capacity laws.

The programme is part of the government's response to the Scottish Mental Health Law Review but the pace of change has been slower than all hoped for and expected. As the independent voice for people's rights, it's our job to keep everyone on their toes – not to point fingers, but to really drive things forward. Progress that ensures no one is left behind.

You will see in this report, our continued focus on making sure individuals who are going through mental health challenges or living with learning disabilities have strong advocates to speak up for them. We will stay an independent voice, working towards a future where every individual's rights are not only protected but actively advanced.

Chief executive's message

Julie Paterson

As we present this year's annual report, we reflect on the resilience of Scotland's mental health and social care systems amid continuous pressures. Staffing shortages, rising demand, and fragmented resources continue to strain services, yet transformative practices emerging across the sector offer cautious optimism. This report is not just a record, it is a testament to what is possible when we refuse to accept 'good enough' as the standard.

Advocate, influence and empower

The Commission's mandate — advocating for the human rights of some of the most vulnerable individuals in our society while influencing national policy — is the core of what we do. In 2024-25, our staff resolved 3,455 calls and engaged with over 3,000 individuals, ensuring questions were addressed and voices were heard.

We believe real, lasting change starts with empowering staff on the ground. That is why we continue to partner with NHS Education for Scotland to provide online training on Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), giving professionals the tools they need to protect and uphold the rights of those they serve. The online training has been used by more than 2,500 professionals, and that number continues to grow.

We also organised webinars to shared practical guidance with around 600 health and social care workers.

We find that people want to learn and do their best and when we empower the people doing the work across inpatient and community settings, we empower entire systems.

Hospital is not home

Our report shows a critical challenge: some individuals with learning disabilities or complex needs are spending more than 18 years in hospital placements. This is far beyond what should be considered acceptable. This systemic issue undermines their fundamental rights to independent living, right to autonomy, family life, and inclusion in their communities. More alarming still, we found that some patients remain overlooked, omitted from official registers and with hospitals erroneously viewed as permanent homes.

While progress has been made through initiatives like the Dynamic Support Register and peer support network, their inconsistent use represents untapped potential. Transforming this reality requires sustained commitment, from policy to practice. Only then can we build a system where individuals with learning disabilities or complex needs have the chance to live with dignity, independence, and connection.

A call for sustainable solutions

Staff shortages erode care quality. Wards and community teams continue to struggle to provide holistic care, leaving vulnerable people without consistent support.

Our visit reports provide vital snapshots of care standards, but they are not audits. They are calls to action; reminders that lasting change requires more than snapshots.

Amid challenges, hope does persist. We visited 149 services this year and witnessed progress in most. We saw services and professionals stepping up, implementing our recommendations. This proves that even in strained systems, innovation and progress can and must be made.

Within the Commission, we are practicing what we preach. We are investing in our staff by providing refreshed human rights training and leadership training. As part of our on-going accessibility improvement efforts, plain English training was also conducted. We are modernising our data system to safeguard the sensitive information we handle and to create greater opportunities to analyse data. Much has been achieved by our dedicated staff, and you will read more about it in this report.

Looking ahead

This annual report is a key part of our commitment to transparency and accountability. While challenges remain, the progress we have documented demonstrates that meaningful change is possible when we act with determination and in partnership.

With a shared purpose and unwavering commitment, we can transform challenges into opportunities to protect and uphold the rights of the most vulnerable people in our society.

Influencing and empowering

STAFF at a struggling ward in Dr Gray's Hospital in Elgin fear only "a significant incident" will lead to improvements.

A new report reveals NHS Grampian has been unable to address issues raised by multiple inspections of Ward 4, the mental health ward.

more than 25 years, according to a new report.

The Mental Welfare Commission's "Hospital is not home" report looked at the circumstances of 55 people who had been in a learning disability or mental health hospital for more than 10 years.

It found that such people are

Fears raised as detentions for mental health hit 7,100

BY NICK FORBES

There were more than 7,000 detentions for compulsory mental health care and treatment in Scotland last year, figures show.

The figures, i... published by t... Welfare Comm... Scotland (MW... there were a to... detentions betw... 2023 and March...

This is a rise... the year before... average yea... increase of 4.2%...

Just under...

consent provides a safeguard against ... arbitrary dete... called for local... assess why in m... the country ... clearly the nor... impractical to... mental health o...

figures each year as part of

Hospital ward still concerns inspectors

'Very little privacy for patients'

for this population (no... ...ough for people to have...

...PERSON

cut numbers

BY KIERAN WEBSTER

CONCERNS have been raised over the number of patients on a Fife psychiatric ward.

Staffing levels in the Muirview Ward at Stratheden Hospital are also "often" pushed to the limit, according to a Mental Welfare Commission for Scotland report.

Muirview Ward is a purpose-built unit with "uninterrupted views" of the countryside surrounding the hospital.

At the time of an unannounced inspection on July 25 it was home to 23 patients with a mix of diagnoses from mental illness to dementia and cognitive impairment.

The report said: "Muirview Ward could

accommodate in the region of 20, sometimes more than 20 individuals.

"We were concerned with limit... nursing and allied health profession... available, the current bed capacity cou... be considered as too high.

"We heard from staff that the wa... would, and often did, reach the thresho... of how staff could effectively provide th... care, treatment, and attention for eac... person.

"This was a source of frustration fo... staff as they endeavoured to provide care... that was person-centred, however, fel... that this could be hindered due to staffing... resources."

It has beer... review the ... numbers at t...

Mental health detentions up to over 7000

THERE were more than 7000 compulsory mental health detentions in Scotland last year, figures show.

The data, by the Mental Welfare Commission for Scotland, show 7109 detentions between April 1, 2023, and March 30 – a rise of 5.6 per cent.

The MWCS said it was "concerned"...

Throughout 2024-25 we:

- **Worked in collaboration with NHS Education for Scotland and continued our drive to improve understanding of the Adults with Incapacity Act by devising new learning for health, social work and social care staff across Scotland.**

- **Shared expertise and intelligence with other organisations where collaboration can lead to better decision-making and better outcomes.**

- **Sought third sector expertise to support us to embed peer support in our work.**

- **Contributed to the two priorities for the Scottish Government in response to the Scottish Mental Health Law Review (Adults with Incapacity Act reform and definition of mental disorder) and undertook a small piece of work to consider the circumstances of nineteen people with a diagnosis of learning disability detained according to a compulsory treatment order to inform this work.**

The Commission continues to contribute to the Sharing Health and Care Intelligence Network which aims to improve the quality of health and social care by allowing members to share and learn from existing data, knowledge and intelligence. The Commission is one of seven national organisations that make up the group, along with Audit Scotland, the Care Inspectorate, Healthcare Improvement Scotland, NHS National Services Scotland, NHS Education for Scotland and the Scottish Public Services Ombudsman.

The National Mental Health and Learning Disability Coordination Group, chaired by the Commission last met in 2023 and we await Scottish Government plans for an alternative framework arrangement to be put in place to support collaboration of scrutiny bodies following the publication in November 2024 of the Mental Health Scrutiny and Assurance Collaborative.

We have attended parliamentary committees to give evidence when requested to do so and we have continued to attend meetings of the Scottish Mental Health Partnership working with other organisations to promote a rights-based approach to the Government's Mental Health and Wellbeing Strategy and look forward to the interim report due in 2025 and plans for a refresh in 2026.

We remain an active member of the National Preventive Mechanism attending both the UK and Scottish groups and we will continue to represent Scotland on the National Steering Group. We also continue to participate in professional networks including the Mental Health Nurses Forum (Scotland), the Royal College of Psychiatrists' Scottish Committee and Social Work Scotland, and key interest groups such as the Alzheimer Scotland Human Rights and Public Policy Advisory Group.

We have continued to contribute to training and learning across a range of fora, including presentation of our Community Compulsory Treatment Order report findings to the Mental Health Tribunal for Scotland and Royal College of Psychiatrists, presentation and facilitation at the national Mental Health Officer learning event this year and presentation of our Hospital not Home project at the Scottish Human Rights Commission event on deinstitutionalisation in January 2025.

Our engagement and participation officers continue to grow and build their networks across Scotland, meeting carers and people with experience both virtually and face to face; our engagement and participation officers continue to be an essential part of the team of Commission staff doing local visits.

Adults with Incapacity project

In October 2022, the Scottish Government funded NHS Education for Scotland and the Commission to work in partnership to design and deliver workforce education. The aim of this 16-month project (October 2022 – February 2024) was to support workforce understanding of the AWI Act and its application in health, social care and social work practice across Scotland. This project has:

- Delivered an e-learning resource, *An introduction to Adults with Incapacity (Scotland) Act 2000 – module 1* via the Once for Scotland AWI Turas site. This has been successfully completed by 2050 individuals, with a satisfaction rate of 4.26/5.
- Developed the second AWI module 2, with launch anticipated Spring 2025.
- Produced three further podcasts in relation to the AWI Act in the context of people leaving hospital, exploring challenges and good practice in relation to social care settings.
- Delivered the Advanced Nurse Practitioner AWI/section 47 cohort with 61 participants from across health and social care.

This project was originally funded for 14 months but will now extend until March 2026, such is the evidence base of the impact of this work.

Good practice guides

We reviewed five existing good practice guides, including our guide in relation to supported decision making (with support from Napier University).

- *Nutrition by artificial means* (18 July 2024)
- *Consent to treatment* (5 August 2024)
- *Advance statements* (5 September 2024)
- *Easy read: Advance statements* (5 September 2024)
- *When and how to recall a welfare guardianship* (19 September 2024)
- *Supported decision making* (2 October 2024)

In addition, we compiled one advice note:

- *Cease and vary* (20 September 2024)

This new advice note aims to provide information about the ceasing and varying actions available to the local authority with regards to their responsibilities to supervise private welfare guardians. It affords an opportunity for local authorities to target their limited resources to the people and situations that need it most, thereby fulfilling their statutory duties under the AWI Act.

Using our good practice guides on R*ights, Risks and Limits to Freedom*, *Seclusion, Specified Persons, Right to Treat, Medical Treatment under Part 16* and *Nurses Power to Detain*, as well as our guidance on *Care Planning*, we ran a series of three webinars this year, where there were 755 attendees from a wide range of professional backgrounds.

National Preventive Mechanism

We are a member of the UK National Preventive Mechanism (NPM), a body that brings together independent monitoring organisations that have a role in protecting people in detention. Membership of the NPM provides a mechanism for the Commission to collaborate with and learn with other organisations that monitor settings of and rights for people who are subject to detention.

The Commission is a member of the Scottish sub-group, the UK wide NPM and represents Scotland on the national UK steering group.

Our local visits, where we visit in-patient units where people may be detained, and our visits to mental health services in prisons, link with our role as an NPM member.

Designated medical practitioners

Under section 233 of the Mental Health Act, we are responsible for appointing designated medical practitioners (DMPs). Their function is to provide authorisation for certain medical treatments as set out under Part 16 of the Mental Health Act; and provide reports for sections 48 and 50 of the AWI Act. These are important safeguards and are high priority for recovery under our business continuity plans.

DMPs are experienced, senior psychiatrists in Scotland and we are pleased to report that we recruited an additional five independent DMPs last year.

Demand for this service continues to be high and has been increasing over the past decade; 2,976 contacts were made during this year, a 1.1% increase on the previous year.

Corporate parenting plan

We published our *Corporate Parenting Plan 2024-27* on 7 November 2024, which set out our corporate parent activities carried out between 2021-24 and our planned activity until 2027. During this period, the UNCRC (Incorporation) (Scotland) 2024 was enacted and the Commission has aligned our children and young people activities, including our duties and activities in relation care experienced young people. We will be undertaking visits to the secure units across Scotland looking specifically at restrictive practices as part of shared scrutiny work with the Care Inspectorate during 2025-26 and have spent this period preparing for this, in partnership with the Care Inspectorate.

Effective and targeted visiting

Throughout the year, we:

- **made 149 visits to services, including the island communities in Orkney and Shetland. We visited hospital wards and community mental health teams for children and young people, adult and older adults, learning disability services, specialist units, independent sector services, high, medium and low secure forensic mental units and prisons.**
- **Visited 35 services without providing any notice of our intention to visit, this equates to 23% of our visits, just missing our target of 25% of unannounced visits.**
- **Reviewed the care and treatment of 1,342 individuals during our local visits.**
- **Increased the number of carers we spoke with by 9%, when we talked to 251 family members and/or carers during our visits.**
- **Published the final closure report for our themed visit, *Mental health in Scotland's prisons 2021: under-served and under-resourced*.**
- **Published a closure report for our themed visit, *Compulsory treatment for mental illness in the community*.**

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 also listen to families and carers, speak to health and care staff, and examine records.

We visit people wherever they are receiving care and treatment. Often this is in hospital, but it might be in their own home, in a care home, or in secure accommodation.

We publish reports after most of our visits and make recommendations for improvement for services, for health and social care partnerships (and their respective local authorities and health boards) and for government where we identify a need for change. We follow up on our recommendations.

Our visits are divided into:

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. This year we visited 149 services across Scotland.

Themed visits – for people with similar health-related issues or situations affecting people nationally. This year we published a report titled *Hospital is not home* and provide more detail below.

We also heard the views of around 400 carers throughout 2024-25 who provide unpaid support to those who have a diverse range of needs in relation to their mental health or who have a learning disability, or dementia or related conditions. These views will inform a themed report which will be compiled and published summer 2025.

Welfare guardianship visits – where we visit people who have a court-appointed welfare guardian. The guardian may be a family member, friend, carer, or chief social work officer. We exceeded our target number of 350 visits during 2024-25, with a total of 361 visits. During these visits, we often provided advice based on what we found, and at times, required specific actions to be taken.

Other visits – for example, we may visit young people who have been admitted to an adult hospital ward for treatment.

Local visits

Local visits are a core part of our work. We particularly focus on places where there is a deprivation of liberty; where intelligence gathered from themed visits, previous visits, patients' concerns, and other sources raise issues about care and treatment; or where it has been some time since our last visit.

When we visit an individual, we find out their views of their care and treatment. We also check that their care and treatment is in line with legislation. We make an assessment of the facilities available for their care. We expect to find that the individual's needs are met, and their rights respected. If not, we make recommendations for improvement.

We base our findings and recommendations on our observations from the day of the visit, the expertise and judgement of our staff, and what people tell us when we meet. Although our visits are not inspections, we take into account any applicable national standards and good practice guidance.

After we have completed a local visit, we may have to make a recommendation relating to a change we would advise around improvements to the way care is provided, or about the environment. When we make recommendations, we ask the service for a response within three months, to include a robust action plan as to how the recommendations are to be met. If the recommendation is particularly serious and urgent we reduce the response time accordingly.

We provide feedback, highlighting good practice where we find this. We publish these reports and share our findings with other scrutiny bodies – the Care Inspectorate, Healthcare Improvement Scotland, and Her Majesty's Inspectorate of Prisons.

We completed 23% of our visits on an unannounced basis and have continued to broaden our local visit programme during 2024-25 to include both adult and older adult community services delivered by mental health teams; we have also visited community-based services delivered by local authority/commissioned providers where we reviewed how care and treatment was being delivered using both the Mental Health Act and the AWI Act. Our engagement and participation officers have enhanced our visit programme, sometimes meeting with individuals before a Commission visit, or after, to gather views about people's experience of their care. Their experience of using services themselves or living with a diagnosis of mental illness or autism or as a carer continues to influence and inform what we hear.

We reviewed the care and treatment of 1342 individuals during our local visits and met directly with 900 people. As part of our visits, we meet or talk with families/carers who have agreed to speak with us; throughout the year, we had contact with 251 family members and/or carers as part of this process.

Concerns over staff shortages

We publish all of our local visit recommendations every month, highlighting any key messages found, and use social media and our own website to increase public awareness. This year we have regularly raised concerns when individuals or their families and carers have not had the opportunity to be fully involved in their care, where their rights have not been promoted and where treatment has not been provided lawfully. We also again highlighted the negative impact of staff shortages and environments that need to be modernised. On a positive note, we have consistently heard positive comments about staff and were told how much they were appreciated.

Themed visit reports

Hospital is not home

The Scottish Government asked the Commission to review the care and treatment of people with learning disabilities and complex care needs who had remained in either a learning disability or mental health hospital for more than 10 years.

In January, we published Hospital is not home; we considered the circumstances of 55 people who were identified as having been in a learning disability or mental health hospital for over 10 years.

We found that these people are staying in hospital for too long; on average 18 years and two months.

Whilst we found some evidence of commitment to inclusive and active discharge planning from hospital, there was also reluctance and concern regarding the availability and capacity of community care resources to safeguard the person and meet their needs.

One of the key actions identified in the Scottish Government's 2022 Coming Home Implementation report was the establishment of a Dynamic Support Register. This Register is to help to ensure that people remain in hospital only for as long as they need assessment and treatment.

We found that there is inconsistent interpretation across Scotland as to who should or should not be on the Register. We are therefore also concerned about those people in hospital for many years who have not made it onto the Register.

This small project answered the questions posed by the Scottish Government at the outset but has raised many more. We have found that the implementation of the Dynamic Support Register has yet to ensure that "people are only in hospital for as long as they require assessment and treatment" and that further work must be done to address why the intentions of this tool have yet to be realised for people.

Dr Lesley Sawyers, Scotland Commissioner, Equality and Human Rights Commission (EHRC) said:

> *"The Equality and Human Rights Commission (EHRC) is deeply concerned by the findings of this new report by the Mental Welfare Commission for Scotland, which gives much-needed insight into the experiences of people held in hospital for over 10 years".*

Feedback from an event we presented this report at included:

> *"It was a pleasure listening to your talk at X conference. I greatly appreciated hearing about the important work being carried out by the Mental Welfare Commission for Scotland, and found it both insightful and inspiring..."*

We will retain an interest in all 55 cases over the next two years to ensure rights are upheld and good outcomes are achieved.

Carers themed visit report

This year, a themed visit has focused on carers and the impact their caring role has on them. The work on this report has involved an online questionnaire, open zoom meetings and face to face meetings with carers to gather their views. The report will be published later this year.

Closure reports

The purpose of a Commission closure report is to assess whether the Commission has achieved its objectives (including outcomes, learning, quality and impact) and completed all deliverables on time and as planned. The closure report summarises the findings and recommendations made in themed visit reports and reports on the actions taken by the organisations to whom the recommendations were made.

This year we published closure reports for two themed visits and for the first time, we also published a closure report in relation to one investigation:

Compulsory treatment for mental illness in the community – how is it working?

In February 2024, we published a report on how compulsory community treatment orders (CCTOs) are working in Scotland, 20 years after they were introduced.

The report raised concerns and most strikingly, we found that almost three quarters of the orders had been in place for over two years, with some people subject to a compulsory community treatment order for 17 years.

The focus of our CCTO report was not on the number of admissions or bed days gained or lost but on the experience of those subject to CCTOs, their relatives and those who are charged with ensuring safeguards, care and support are in place.

Our report made seven recommendations for improvement to health and social care partnerships (HSCPs) and their respective local authorities and health boards. We received responses from all 31 HSCPs. The quality of responses varied from exemplary to very poor. The outcome is that all action plans now evidence clear objectives in relation to recommendations and timescale to delivery. HSCPs will be expected to monitor progress through their existing governance arrangements and updates will be requested by the Commission at 'end of year meetings'.

We shared our findings with the Mental Health Tribunal for Scotland (MHTS), the Law Society Mental Health and Disability Sub-Committee, and the Royal College of Psychiatrists in Scotland and presented at the Scottish Association of Social Work's Mental Health Officer conference. The MHTS now log two-year reviews where the person has been on a CTO in the community for more than five years. Our findings are also being considered in the Scottish Government's Mental Health and Capacity Reform Programme Delivery Plan October 2023 – April 2025.

We look forward to the Scottish Government's specific response to the Scottish Mental Health Law Review's recommendation 9.29 in the context of the detail provided in our report.

Mental health in Scotland's prisons 2021: under-served and under-resourced (Final closure report)

NHS Scotland took over the role of providing mental health services in Scotland's prisons to make improvements to services for prisoners. We'd published a report on how mental health services were working in prisons before that change, and we published a follow-up report looking at how this was working in 2021.

We found that little improvement had taken place and we described mental health services in Scotland's prisons as underserved and under resourced. We called for urgent action and made 10 recommendations for change.

We gave a two year timeframe because we recognise the two separate systems – NHS and prison services – attempting to achieve the one objective of improving mental health care for prisoners. The closure report published at the midpoint (12 month) stage, found considerable variation across the prison estate in meeting our recommendations.

We published the final closure report in January of this year. All 15 prisons responded, and we received a joint response from NHS Scotland and SPS, along with feedback from SPS on Recommendations 8 and 9, and from Scottish Government on Recommendation 10.

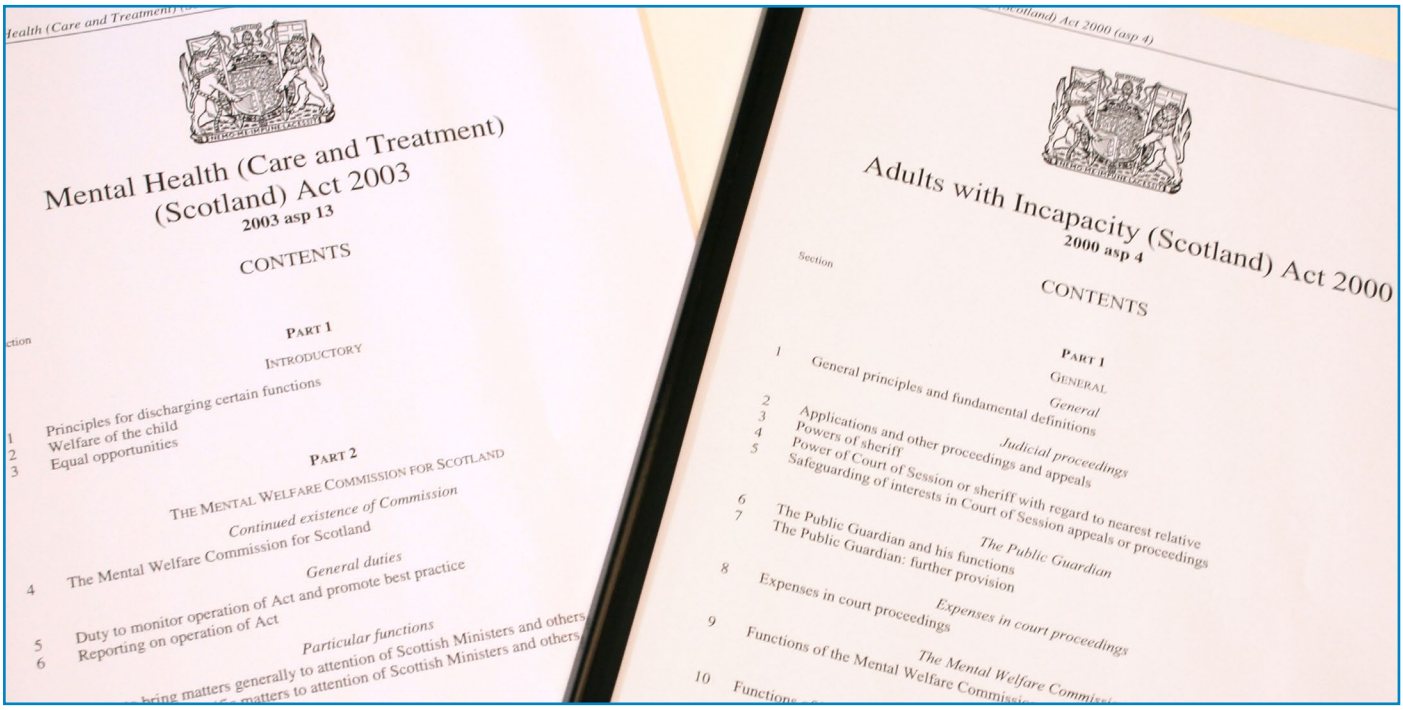
The analysis of self-reported SMART action plans indicated that for most recommendations for the Prisons, SPS and SG, these had been achieved, although some responses noted that there were still actions to be completed, such as the SPS Mental Health Strategy and the audit of the use of segregation.

A positive change that has been established since the report is the regular programme of meetings with SPS and the Commission, in addition to the local visit programme to HMP services across Scotland – there have been eight Commission visits to prisons completed in the 2023 to 2024 period; these activities will provide ongoing scrutiny and assurance of the progress of any recommendations that have still to be completed.

Overall, the level of detail in the action plans gave a clearer understanding of the work that had been built upon since the midpoint closure responses.

From the responses collated, there remains variation across the prison estate in meeting the recommendations which indicates that this workstream requires the Commission to retain an active focus.

Monitoring and safeguarding care and treatment



We have a statutory duty to monitor the use of the Mental Health Act in Scotland and the Adults with Incapacity Act in Scotland. Our full monitoring reports are published in autumn each year.

- **We monitor all cases where a child or young person under the age of 18 is treated for mental ill health in a non-specialist ward, usually an adult ward.**
- **As part of our safeguarding role, we are responsible for appointing designated medical practitioners, who provide authorisation for certain medical treatments set out in legislation.**

We have a duty to monitor the use of the Mental Health Act, and the welfare provisions of the AWI Act. We publish reports on our findings every year. This helps us and our wider audience to understand how the law is being used across Scotland, and how it is being adhered to.

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

We are also notified when a guardian is appointed with powers to take welfare decisions for an adult with incapacity.

When publishing and sharing this monitoring information, we give national and local breakdowns of data and comparisons with previous years. This helps us and other organisations to see activity in different parts of the country, and to understand which services are under particular pressure.

Monitoring of mental health and incapacity legislation

We have various duties under the Mental Health Act to receive, check and report on statutory interventions and notifications. We also promote the principles of the Mental Health Act. In addition, we receive statutory notifications of certain welfare interventions under the AWI Act. Our monitoring work can involve both checking the paperwork and records of people who are being cared for or treated under mental health or incapacity law, and analysing and reporting on trends and differences in the way the law is being used across the country.

Children and young people monitoring

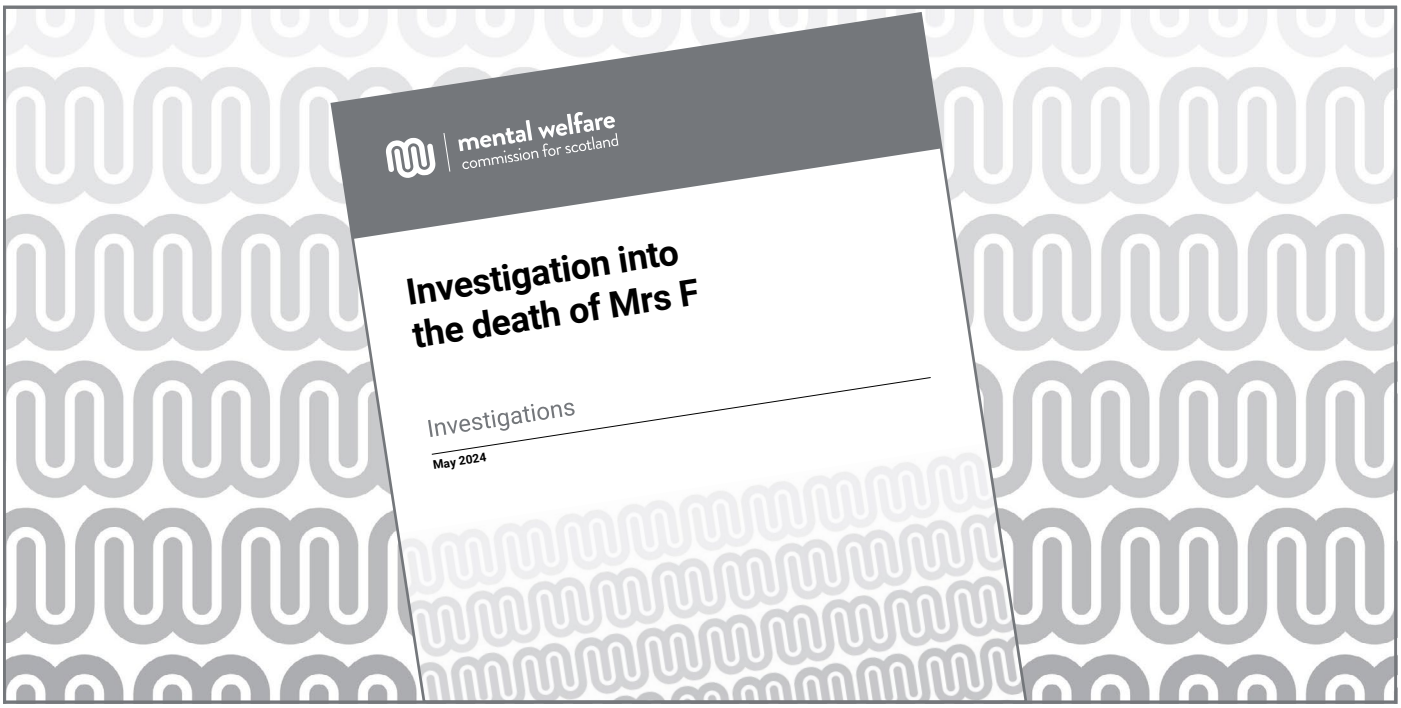
The Mental Health Act also places a legal obligation on health boards to provide appropriate services and accommodation for young people admitted to hospital for treatment of their mental ill health.

We monitor this and publish a report annually which focuses on young people under the age of 18 years who are admitted for treatment for mental ill health to non-specialist wards in Scotland, usually adult wards. We make recommendations for change where we see a need to do so, for example in relation to the rights of children to access education when in hospital, and their right to access advocacy services.

Most admissions in these cases are to adult mental health wards, with a minority relating to admission to general paediatric wards.

While there can be some instances when it might be in the best interests of a child or young person to be treated in an adult ward, this should only happen in rare situations.

Investigations



- **We identified shared themes across our six investigations reports published in 2023-24; understanding of duty of candour responsibilities remains at a low level.**
- **We published our closure report on the investigation into the care and treatment of Mr E (2024)**
- **We published our closure report on the investigation into the death of Mrs F (2024)**

When serious concerns are raised about the care and treatment of a person with mental ill health, learning disability, dementia or related conditions, a number of organisations are usually involved. Usually, a review of a significant incident will have been conducted by 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 do not handle complaints about services. We instigate our own investigations only when the case appears to show serious failings and has learning for services across Scotland.

All of our published investigations are anonymised. That way, we seek to protect the individual, and we concentrate on highlighting the lessons learned by health or social work practitioners and organisations across Scotland.

Our staff may have a significant level of involvement and oversight in investigation casework, sometimes over a number of years. Whilst this work will not routinely lead to published reports, the outcomes and learning remain critically important for individuals, families, carers, and mental health services.

Where necessary, the Commission will liaise with local services at all levels to seek resolution and provide guidance in relation to the rights of the individual, resulting in positive outcomes for the individual.

"Without [the Commission's] help this would never have happened. There is so much red tape these days, and so many times we faced decisions made by law, which actually went against the spirit the law was trying to uphold."
(Carer, 2024-25).

"Thanks for all your help and support and kind words over that period. You did a great job."
(Family member)

The following is an example of longer-term work undertaken by Commission staff which has been identified through their ongoing casework. All details below are anonymised and is an illustration of work completed.

We would want to extend our gratitude to all services who worked in collaboration with us when reviewing and improving services ensuring better outcomes for individuals, their families and carers.

Case Summary A

A was brought to the Commission's attention via our telephone adviceline by a family member whose relative, A, had sadly passed away while subject to a compulsory community treatment order.

Although the service had undertaken a significant adverse event review (SAER) into the circumstances leading to A's death, the family remained dissatisfied with the outcome and felt that community services had failed A in the months leading to their passing and despite best efforts, the family could not gain any further clarity from the service around the findings of the SAER. We undertook initial enquiries and our concerns centred of the following:

- To what extent there was a lack of a proactive approach to A's care, treatment and engagement with services.
- The application of Part 16 of the Mental Health Act around authority to treat A in the community.
- To what extent the SAER had addressed all key learning points.

Following initial enquires and interrogation of the SAER and the associated action plan, the Commission were not satisfied with the actions. The Commission met with senior managers of the service initially to discuss the family and Commission concerns.

Although we observed that the service had reflected on several areas for improvement, we also emphasised the fundamental importance of working alongside families and reinforced our Carers, consent, and confidentiality good practice guidance and our *Consent to treatment* good practice guide.

We further followed up with a visit to the community-based service to seek assurance that improvements with working with families and a robust understanding of legislative frameworks across staff groups was in operation, including delivering staff training around Adult Support and Protection (Scotland) Act 2007, Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment)(Scotland) Act 2003, in addition to highlighting required improvements to ensure robust care and treatment records were developed.

We saw evidence of improvements, and this was notable in relation to working with relatives and multi-agencies. The senior leadership team also recognised where the service had failed in terms of supporting staff to undertake their duties under legal framework(s).

The information provided by A's family through our adviceline influenced our decision to make initial enquires and to subsequently visit the service due to concerns raised. The family welcomed the Commission's involvement, taking their concerns about A seriously and was keen to ensure that their own challenging experiences would not be repeated.

The Commission continues to monitor the improvements in the community service and will revisit the service to review progress.

Follow up and recommendations activity

A fundamental aspect of the Commission's investigation activity occurs post publication of our reports to ensure the impact of our reports and recommendations are embedded in practice across Scotland. During 2024-25, investigation follow-up activity has focused on progressing and reviewing the 48 recommendations made in the previous year through the six published investigations (Mr TU, GH, AB, Mr D, Mr E and Mrs F). During this period, we have undertaken to follow-up, analyse and review our recommendations and have identified overarching themes in the following areas:

Clinical risk assessment, risk management and training needs

These themes were raised in Mr TU, GH and Mrs F reports and all made recommendations to the services concerned. In particular the links between past violence, non-engagement and substance abuse featured in both the homicide reports. Where required, services were asked to review their current risk training programmes and include the above interlinked aspects of risk, and to review existing risk paperwork where it had been identified as lacking comprehensive assessment.

Duty of Candour

Organisational duty of candour was raised in the Mr D report, Mrs F and Mr E. Only Mr D made a specific recommendation, but this related to two health boards. Families concerned expressed that they had not felt listened to, had not gained a clear apology or that the way in which an apology had been delivered had fallen short. In contrast services in discussion had a perspective that they had met this duty, when they had not and did not appear to fully understand their legal obligations.

Carers and confidentiality

This issue was identified in three reports, Mr TU, GH and Mrs F. In some instances, individuals had explicitly stated that they did not want information shared with their families. This created difficulties and heightened risk, particularly when relatives were attempting to share high risk information with services concerned. Comments were made by families that when raising concerns they were not listened to.

In our Mrs F report staff failed to share pertinent risk factors with a relative as they felt this compromised confidentiality. We have asked two boards to consider a protocol when working with adults and families where sharing of information is compromised.

Discharge planning

Two reports identified poor discharge planning arrangements. Mr TU and GH, in addition AB detailed this but did not make a specific recommendation. Key issues featured included no planning meetings, poor multi- disciplinary team involvement, no discharge letters to community services, poor follow up on discharge, not in line with policy standards.

Integrated working

This was a feature across all reports but especially highlighted in Mr E where a range of systemic weaknesses were identified across assessment, planning and delivery of services leading to poor integrated working. Social work services, primary and secondary care were all identified as struggling to work cohesively and there was a lack of understanding re roles and legislative duties. In a number of report interviews, AB, Mr D and Mr E interviewees commented on the lack of joined up working.

Learning and development

A theme across Mr TU and GH was risk training. It was wider in relation to the Adult Support and Protection (Scotland) Act 2007 with a lack of sufficient knowledge and the interaction of the three Acts, in relation to Mr E and AB. Across all investigations, legal literacy was poor on occasion with services often not knowing when to act or struggle with balancing the individual's rights of autonomy versus their protection.

Specific breakdown of recommendations /themes across health care and social work

Given the integrated positions of partnerships, all recommendations were directed at Health and Social Care Partnerships (HSCPs). The overriding attention was directed to health care/ clinical input level. This may not be surprising given the circumstances of some of the reports – for example, in relation to case responsibility held by health community or forensic mental health teams.

Social work emphasis was a particular feature in AB and Mr E where social work staff undertook adult support and protection enquiries /investigations and faced a number of systemic barriers. Also evident was a lack of professional curiosity, confidence in role and knowledge of local and national policy and legislation. Leadership and senior oversight were also a consideration in these reports.

Assessment, care planning and risk

While not a prominent issue across all six reports, this theme cut across both health and social work and social care. While we did note some strong practice, in some instances we found that assessments were often not completed, care plans were reactive and not person centred or were not recorded or documented. In some instances, for example in relation to adult support and protection there was a lack of risk assessment and protection plans.

Risk assessment issues centred on poor paperwork, failure to complete assessments and then implement proper risk management, and inability to make links between risk triggers such as past violence, substance misuse and acute psychosis.

Closure report: *"They didn't ask me": Investigation into the care and treatment of Mr E* (2024)

The Mental Health Tribunal for Scotland alerted the Commission to the apparent lack of involvement by health and social work services in Mr E's care, despite his diagnoses of schizophrenia and diabetes.

We found that when Mr E came to the attention of services there was no co-ordinated multidisciplinary approach. Instead, individual agencies often assumed that the responsibility to support Mr E lay elsewhere. His condition deteriorated significantly and permanently without any active intervention.

By the time we made our investigation, his mental illness was reported to be partially treatment resistant; he was blind; and his mobility was poor - he needed to use a walking frame. Mr E was unhappy living in the care home; his mood was low and there was little stimulation for him.

Amongst our recommendations for change, we asked for the health and social care partnership involved to review Mr E's care, accommodation, and finances and to do that as a priority.

There is clear evidence that the five recommendations made within the Mr E (2024) investigation report are being acted on and addressed by both the Care Inspectorate and HSCP A. A detailed action plan is in place and is being monitored via HSCP A's clinical and care governance arrangements. It will take time to shift the culture in HSCP A and embed practice and learning which is truly integrated and focussed on continuous joint improvement to achieve improved individual outcomes for some of the most vulnerable adults in our communities. However, the direction of travel is being led at the highest level and we are hearing positive reports from those working within HSCP A that they are noting welcome changes.

The Commission continues to visit HSCP A as part of our routine visiting programme and looks forward to continued positive feedback on the changes being made.

We are delighted to confirm that Mr E has now moved to alternative accommodation which meets his individual needs.

Providing information and advice

- **We received 3455 calls in 2024-25 compared to 3683 last year.**
- **A sample audit of advice given showed an accuracy rate of 98.5%, against a target of 98%.**

Advice line

From Mondays to Fridays, we run an advice line staffed by mental health and learning disability nurses, social workers (mental health officers), and psychiatrists. Our team offers advice to a wide range of callers seeking help, including health and care professionals, people with mental ill health or learning disability and families and carers. More and more people are also now seeking advice via email too.

The number of telephone calls logged during 2024-25 was 3455. The top number of calls were received from relatives/ carers/guardians, followed by people with experience of using services, with the third highest caller group being psychiatrists. Overall, 49% of our total calls were from relatives/carers/guardians/people with experience and 51% of calls were from people working in the field of mental health and learning disability.

Most calls received related to the Mental Health Act (1693 calls), we received 680 calls this year in relation to the Adults with Incapacity Act (135 calls less than last year) and we categorised a significant number of calls this year as 'other' (797). The breadth of calls is often difficult to capture however the 'other' category might include discussions about medicines, about care packages, about relationships, good practice guides and so on.

We regularly carry out a sample audit of advice given out by individual practitioners and this year the accuracy rate was 98.5% against our target of 98%.

During 2024-25 we looked at a consistent approach to receiving feedback on the advice that we give. We now aim to implement this. In the meantime, anecdotal feedback includes:

"Out of sheer desperation, X called the Mental Welfare Commission for Scotland and had a call back almost immediately… just one call changed it all. We were powerless to do anything… Thank you to [practitioner name] someone who does her job efficiently, humanely and is a great listener".
From Family members

"We really value and appreciate the guidance, direction and support from your organisation".
From a HSCP Chief Officer

"Thanks so much for this really comprehensive response - incredibly helpful and appreciated!".
From a consultant psychiatrist

Engagement and participation

Our engagement and participation officers continue to build their networks across Scotland, meeting carers and people with lived experience both virtually and face to face.

We meet with individuals, groups and staff members to gather information and concerns that we can feed back to the Commission to inform our work.

We continue to work on our engagement and participation strategy which includes engaging with harder to reach groups and young people.

We have given many presentations on varied topics including to the Royal College of Psychiatrists and the Mental Health Tribunal for Scotland.

Feedback from the people we've met has included:

"I could hear lightbulbs popping all over the place as family members listened to everything you had to say!"

"I just wanted to reach out again and just express my gratitude for you taking time out of your evening to join us on the course, you were fab."

"Very informative and useful. Take away message - to work alongside patients as mental health staff to ensure all patients are getting best possible person-centred care."

Good practice guides

As discussed earlier in this report, we published five updated good practice guides and one new advice note this year. Our guidance and advice includes information on the practical use of mental health and incapacity law. While we quote from the law and give our interpretation of best practice, our guidance should not be used as legal advice as we cannot anticipate every possible scenario.

Media

Sharing our work through the media and social media helps raise awareness of what we do, and helps widen the audience for our work, enabling more people to hear about our reports.

In 2024-25 we continued to attract strong media coverage for our work, in print, broadcast and online. Our executive team regularly took part in print and broadcast interviews, and our media work attracted responses from government, health boards and other key organisations.

Social media

This year we made some changes to our use of social media. Our X (or Twitter) following decreased for the first time, as users left the platform.

Our newly established account on LinkedIn grew in its number of followers and engagements, and we added accounts on BlueSky and Instagram to increase our social media presence and reach wider audiences.

The communications team also laid groundwork with the Commission's engagement and participation team, and the children and young people group, for future expansion.

Improving our practice

- **Our Board continue to set our strategic direction and ensure efficient, effective, and accountable governance.**
- **We worked through the procurement phase of our new information management system throughout 2023-24, awarded the contract in July 2024, agreed a draft implementation plan in February 2025 and continue to aim towards first stage implementation in August 2025.**
- **We have focussed on staff training and development which will contribute to organisational effectiveness.**
- **We completed a second annual staff survey based on the iMatter model, which had a response rate of 68%.**
- **We continue to improve the accessibility of our work by publishing easyread documents and organising plain English training for staff.**
- **We seek to learn and improve as a result of the complaints we receive. In 2024-25, we received and responded to 15 complaints.**

Our Chair

Sandy Riddell trained in social work and has held director level posts in social work, housing, education, and health and social care, including his final role before retirement as Fife's director of health and social care.

Sandy has substantial experience at a national level in shaping policy and legislation in adult health and social care, children's services, substance misuse, and justice services. He was president of the former Association of Directors of Social Work and founded Social Work Scotland, and has been a member of the Mental Welfare Commission since 2017 before his appointment as chair in April 2019.

He is a member of Grampian NHS Board. Sandy is passionate about the need to develop a rights-based approach for services and to fully involve the public in service design and delivery.

Our Board members

Nichola Brown (co-chair of the Advisory Committee) joined the Board in April 2019, as carer representative and is also a designated joint Stakeholder Engagement Champion. She cares for her son who has severe learning disability and complex needs, and brings experience of the challenges for families of navigating services.

She has a background in community development having worked in Public Health within Glasgow for twenty-five years leading a portfolio of work programmes to improve population health, with particular focus on reducing health inequalities.

Nichola left Glasgow in December 2022 to take up the role of CEO of the North Lanarkshire community organisation, PlayPeace. The service offers play sessions and outings to support families of children with additional needs during school holiday periods. It continues to grow and develop its services, driven by families and the children and young people engaged.

David Hall spent over 25 years as a consultant Psychiatrist and Medical Manager in Dumfries and Galloway, and during that time led the redesign of the local Mental Health service, culminating in the development of a new Mental Health facility at Midpark Hospital.

He has held a number of national roles including National Clinical Lead for the Mental Health Collaborative, and for almost 10 years till, 2019, as National Clinical Lead for the Scottish Patient Safety Programme.

He has gained an international reputation in Quality Improvement in Mental Health, and has worked with the Danish and New Zealand governments.

He has also held a number of roles with the Royal College of Psychiatrists, and is currently the RCPsych in Scotland Suicide Prevention Lead, and sits on the National Suicide Prevention Leadership Group.

Kathy Henwood joined the Board in 2023. She has 35 years' experience in social work, working across local authorities and the third sector, in Scotland and England.

Kathy has predominantly worked with children and families, though started her career working in mental health services and in residential care with older people.

She has worked across child protection committees, been a guardian ad litem and an associate assessor in inspections as part of the Child Protection Reform programme.

She has also been an associate lecturer for the Open University for over 15 years, teaching courses around leadership and management across health and social care.

Kathy is Service Director, Children's Services and Justice Services with Edinburgh City.

Gordon Johnston (vice chair of the Board) has a background in community development, urban regeneration, project development and management, and managing major funding streams.

He is currently an independent consultant in mental health, specialising in peer research, user/patient involvement, policy development and organisational development. Gordon is involved in many third sector organisations and is currently chair of Bipolar Scotland and a director of Voices of experience (VOX).

He has also been a member of the delivery group of the Scottish Patient Safety Programme: Mental Health since its inception. Gordon was also appointed as a non-executive Board member and Whistleblowing Champion of NHS Forth Valley by the Cabinet Secretary for Health in February 2020.

He is a Steering Group member of the UKRI funded Closing The Gap Network and a member of the Scottish Government's Mental Health Strategic Delivery Board and Mental Health Research Advisory Group.

Cindy Mackie (wellbeing champion) is an independent consultant with occupational experience in the public, private, and voluntary sectors and currently performs a number of Associate roles within the area of regulation.

She is a tribunal member with the Medical Practitioner Tribunal Service, where she is engaged in a decision-making role in Fitness to Practise proceedings, she has also served in this capacity with the Nursing and Midwifery Council and the Health and Social Care Council.

She is a lay examiner in membership examinations for the Royal College of Obstetricians and Gynaecologists, and is engaged in a chairing role in quality assurance/educational standards inspections across the UK with the General Dental Council. She holds a position of Independent Assessor in Public Appointments and is also involved in school governance in a voluntary capacity.

Cindy brings knowledge of health regulation, public protection, safeguarding, and human rights. She is educated to graduate level with additional qualifications in human resource management and learning and development.

Mary Twaddle (co-chair of the Advisory Committee) has lived experience of mental ill health and recovery and has been treated and supported by general adult mental health services for over 15 years.

She is also a designated joint Stakeholder Engagement Champion. Originally studying for degrees in Physics at university, and after time out to focus on her health, she joined NHS Lothian at the end of 2015 as a peer support worker at the medium secure forensic unit, The Orchard Clinic; where she helped build the first peer support service within a medium secure forensic unit in the UK.

In her role she uses her own lived experience to help others in their recovery from life changing periods of mental ill health. As part of the multi-disciplinary team she helps maintain the recovery focused ethos of the clinic within the complexities of working in a forensic setting.

Alison White joined the Board in October 2019. She qualified as a Social Worker from Robert Gordon University 20 years ago.

Alison was Head of Adult Services and Chief Social Work Officer for Midlothian Health and Social Care Partnership before taking up the role of Chief Officer of the West Lothian Integration Joint Board in July 2021. Alison is passionate about developing person centred, human rights-based services.

Advisory committee

The Mental Health Act states that the Commission must establish at least one committee (an "advisory committee") for the purpose of giving advice about matters connected to our functions. The Commission's advisory committee is a standing committee of our Board.

Our advisory committee currently consists of representatives of 31 organisations from across Scotland. The committee meets twice a year and at times holds ad-hoc meetings to inform the Commission's priorities with regards issues that are time-sensitive. This year the committee continued to make a valuable contribution to our thinking, particularly in relation to informing the Commission's business plan priorities for the coming year and further developing the Commission's engagement and participation activities.

IMP new information management system

Our work on a new information and casework management system is a detailed and complex project for an organisation of our size. We have engaged with various partners to gain the expertise required to inform a transformational digital system for the Commission.

We worked through the procurement phase during 2023-24, awarded the contract in July 2024, agreed a draft implementation in February 2025 and continue to aim towards first stage implementation in August 2025.

It is anticipated that the new system will significantly improve the efficiency and effectiveness of the Commission's data management through an improved automated system, with the addition of a portal to support our second opinion processes and designated medical practitioners. There is real enthusiasm for this new system within the Commission and we are all looking forward to its implementation.

Shared Services Programme

A significant amount of work has been undertaken this year to prepare for the new Scottish Government Shared Services Programme (SSP), the implications of which were in relation to our HR and finance functions. The new Oracle system went live on 1 October 2024 and the various challenges arising in practice have been addressed and learning is ongoing to maximise the benefits of this new system.

Consumer Duty

The Commission is considered a relevant public authority per the Consumer Scotland Act 2020 (relevant public authorities) regulations 2024. This means that we must meet the four requirements of the Consumer Scotland Act 2020:

- When making decisions of a strategic nature, have regard to the impact those decisions have on consumers.
- When making decisions of a strategic nature, have regard to the desirability of reducing harm to consumers.
- Publication of information about the steps taken to meet the duty.
- Having regard to the Consumer Scotland guidance on how to meet the consumer duty.

Throughout 2024 we considered action required to comply with the Consumer Duty effective from 1 April 2025 and following board approval, now have an implementation plan to address.

Communications analysis

We continued with our communications analysis reporting system for every major publication we issue. These are short, specific documents reporting on media and social media coverage and giving information on activity on our website and mail outs.

Accessible communications

We continue to improve the accessibility of our work, making our information easier to find, to read and to share.

We created and published easy read documents for our three monitoring reports, and for our good practice guides on advance statements and nutrition by artificial means.

In February staff members attended plain English workshops to help make our report writing clearer and more concise.

Further research and communications work is underway to make our monitoring reports and general information more accessible, in line with our business plan. We are also working on accessible communications for children and young people.

Supporting our workforce

We continued to progress various workstreams, some of which had been initiated in the previous year, including:

- Transitioned to a shorter working week (35 hours/pro rata for part time staff).
- Completed a second annual staff survey based on the iMatter model used in many health and social care settings. There was a 68% response rate and the results highlighted areas of strength and areas for development, which were reviewed in staff focus groups in January 2025.
- Made training/development available for all staff in leadership and team building, human rights, and plain English.
- One of the external trainers who met with over 80% of our staff described "a positive workforce committed to their work".
- Wellbeing representatives planned a calendar of wellbeing events.
- Made progress in updating a suite of HR policies.
- Our hybrid policy and 'Right to disconnect' guidance remains in place to support all staff across the Commission.
- We held an all-staff event on 1 April 2025 where we launched our organisational development plan and shared commitment to continue to embrace change and evolve to meet the needs of the people we serve.

Learning lessons

We seek to learn and improve as a result of the complaints we receive. In 2024-25, we received and responded to 15 complaints.

Thirteen complaints were received and dealt with at stage 1 (frontline). Two complaints were investigated at stage 2.

As a result of all complaints received this year, we have:

1. Followed up with staff to ensure that correspondence is allocated and responded to in timely manner.
2. Considered how we can improve communication with ward staff during our visits to ensure that all interviews take place at the time arranged.

Equality outcomes

Our commitment to equality

Under the specific duties, the Commission is required to:

- Report on mainstreaming the equality duty;
- Publish equality outcomes and report progress;
- Assess and review policies and practices;
- Gather and use employee information;
- Publish gender pay gap information;
- Publish statements on equal pay;
- Consider award criteria and conditions in relation to public procurement;
- Publish in a manner that is accessible.

Additionally, there is a requirement for the Commission, as a listed authority, to consider other matters which may be specified by the Scottish Ministers and a duty for the Scottish Ministers to publish proposals for activity to enable listed authorities to better perform the general equality duty.

We published our equalities outcomes action progress report and our gender pay gap report in July 2024.

Financial resources

Our revenue budget for the year was £7.552 million. This included £5.013 million for the Commission core budget and the remainder for two specific projects - £0.245m for the joint adults with incapacity project with NHS Education for Scotland and £2.294m for the Commission's new information management system project.

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


npm
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