mentalwelfare commission for scotland

VISIT AND MONITORING REPORT

Our visits to adults on guardianship 2017-18

OCTOBER 2018

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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

Summary

In 2017-18, we visited 291 adults on welfare guardianship. We continued to target our guardianship visits towards individuals where we identified issues in relation to restraint, deprivation of liberty, or seclusion.

Of the people we visited 42% (121) were resident in care homes, 31% (91) in the family home and 22% (65) were in supported tenancies. We visited seven individuals (2%) who were in hospital at the time of the visit.

In almost all cases (92%, 267) the two categories—care and treatment, and accommodation—were judged as being good or adequate.

However, concerns were noted on 23% (67) of visits. In almost two thirds of these cases (64%, 43 out of 67) further ongoing casework was required by Commission visiting staff. We recorded issues which required to be followed up as a result of these visits. Our main concerns were:

- 23% (28) of individuals in care homes did not have a life history available to staff.
- In 5% (18) of all cases, the principles of the 2000 Act did not appear to be being adhered to. We followed these up and will continue to monitor the situations. In some cases we will visit the individuals again.
- In 19% (54) of all cases, there was no clear evidence that the guardian had visited the adult in the last 6 months. The picture was similar for both private (19%, 35) and local authority guardianships (18%, 19).
- In regards to private guardians, 50% (93 of 187) appeared to have had no recent supervisory visits. For many of these (68%, 63 of 93) there was no evidence that the adult had been visited by the local authority supervisor in the past six months. Supervisory visits by social work departments support guardians to properly use their powers in line with the principles of the 2000 Act.
- For 11 individuals, issues relating to Section 47 and medication were a cause for concern requiring follow-up. In other cases we provided advice to care staff concerning GP responsibilities for completing or updating an s47 form and directed them to the treatment plan template. We found 15 cases where medical powers had been granted to the guardian, and they had not been consulted in relation to the s47 certificate. This certificate (s47) is signed by the doctor making the treatment lawful.

For 8% (23) of individuals there were concerns about the appropriateness of the current placement. For a further 3% (9) the placement itself appeared appropriate but there were other issues.

As in previous years, we discussed our concerns with the individuals and care managers, and followed up with reviewing teams where appropriate.

Introduction

We visited 291 people on guardianship orders in 2017-18.

We engage with carers and relatives on all of our visits wherever possible. This ensures that we get a more complete picture of the care and treatment of individuals and that their rights are being respected.

We endeavour to visit all guardianships for people with mental health issues and all young people aged 18 to 21 years.

Number of guardianship visits per year

In 2017-18 we completed 291 guardianship visits, a 28.9% reduction on the number of visits completed in the previous year (409).

Recent business plans reduced the target number of guardianship visits (350 in 2018).

We carry out visits at Island Health Boards when our officers are conducting other business on the island. This year we conducted four visits on Orkney, but none on Shetland or the Western Isles.

Concerns were noted on 23% (67) visits. In 64% (43 of 67) of these cases further casework was required by Commission visiting staff.

The table below shows the 104 separate issues followed up as a result of these visits by category.

Issue	Number of issues	% of total issues
Mobility	0	0%
Communication	3	3%
Legislation	10	10%
Challenging Behaviour	5	5%
Restrictions	8	8%
Medication and consent	11	11%
Activities	23	22%
Finances	8	8%
Placement	23	22%
Environment	13	13%
Total	**104**	**100%**

Who we visited

Primary diagnosis	All visits		Local authority		Private	
	Number	%	Number	%	Number	%
Acquired Brain Injury	29	10%	9	31%	20	69%
Alcohol Related Brain Damage	28	10%	17	61%	11	39%
Autism Spectrum Disorder	42	14%	7	17%	35	83%
Dementia/ Alzheimer's Disease	67	23%	14	21%	53	79%
Learning Disability	103	35%	38	37%	65	63%
Other Mental Illness	19	7%	16	84%	3	16%
Other	3	1%	3	100%	0	0%
Total	**291**	**100%**	**104**	**36%**	**187**	**64%**

Of the people we visited, 64% had private guardians and 36% had local authority guardians.

In 51% (148) of visits we met with the relative/carer/private guardian. We issue a letter to all guardians to inform them of the visits. Sometimes we meet in person but often we discuss the visit by telephone. We were more likely to meet with private guardians 67% (126 of 187) than local authority guardians 21% (22 of 104).

Some individuals had more than one diagnosis. For example, whilst there were 103 individuals with a sole diagnosis of learning disabilities, a further 40 had learning disabilities as an additional diagnosis bringing the total to 143 seen.

Other diagnoses noted included ADHD, borderline personality disorder/EUPD, and physical conditions (Huntingdon's disease, cerebral palsy, fragile X, epilepsy, deafness).

Accommodation and living circumstances of individuals visited

Accommodation by local authority or private guardian

Accommodation	Local authority		Private		All	
	Number	%	Number	%	Number	%
Care Home	52	43%	69	57%	121	42%
Family Home	12	13%	79	87%	91	31%
Hospital	2	29%	5	71%	7	2%
Supported Tenancy	34	52%	31	48%	65	22%
Other	4	57%	3	43%	7	2%
Total	**104**	**36%**	**187**	**64%**	**291**	**100%**

Accommodation of individuals visited by primary diagnosis

	Care Home		Family Home		Hospital		Supported Tenancy		Other		Total	
	No	%	No	%	No	%	No	%	No	%	No	%
Acquired Brain Injury	13	45%	9	31%		0%	6	21%	1	3%	29	100%
Alcohol Related Brain Damage	23	82%	3	11%		0%	1	4%	1	4%	28	100%
ASD	5	12%	25	60%	1	2%	11	26%		0%	42	100%
Dementia/ Alzheimer's Disease	55	82%	7	10%	2	3%	3	4%		0%	67	100%
Learning Disability	18	17%	41	40%	2	2%	38	37%	4	4%	103	100%
Other	3	100%		0%		0%		0%		0%	3	100%
Other Mental Illness	4	21%	6	32%	2	11%	6	32%	1	5%	19	100%
Total	**121**	**42%**	**91**	**31%**	**7**	**2%**	**65**	**22%**	**7**	**2%**	**291**	**100%**

Of those adults on guardianship we visited, 42% (121) were resident in care homes and 31% (91) in the family home. We saw a similar proportion in supported tenancies as last year (22%, 65) and just 7 were in hospital at the time of the visit.

We met with some people in other places including a respite unit, a rehabilitation unit, a special secondary school, a temporary homeless hostel, and an advocacy or day service.

In almost all cases (92%, 267) both care and treatment and accommodation were judged as being good or adequate.

In 25 cases (9%) Commission visitors graded elements as poor—accommodation (2%, 5), care and treatment (2%, 6), professional input (7%, 20). Several of our cases studies illustrate actions taken by Commission visitors to improve the amount and quality of professional inputs.

Almost a quarter (23%, 66) were judged to be examples of particularly well-managed uses of guardianship.

Eight cases (3%) were seen as being examples of particularly poorly managed guardianship. For confidentiality reasons it is not possible to report these particular case studies here. All have been taken up as casework and one in particular is subject to full investigation by the Commission.

Respect for the individual

For residents in care homes, we found that 77% (93 of 121) had a life history available to staff. Both *Remember I'm Still Me*[1] and *The Standards of Care for Dementia in Scotland (2011)*[2] highlight the importance of an individual personalised approach including 'life story' work.

For 76% (152 of 200) of people in non-family accommodation (care home, hospital or other supported accommodation), a written care plan was available and in the majority of these cases (88%, 134) clearly included activities to meet the needs and interests of the adult. It was not always possible to ascertain individuals' views on activities, some people had no wish to participate in organised activities and some managed their own activities.

Some 49% (142) of people we visited had communication problems and in most cases (88%, 125 of 142) it was felt these issues were addressed adequately. In 12% of these (17 of 142) it was felt more could be done to address the individual's communication needs and at least six were followed up with ongoing casework.

Mobility impairment affected 50% (146) of people we visited. In most cases (95%, 138 of 146) this issue had been adequately addressed. However in 5% of these cases (8) the MWC followed up and one case led onto fuller investigation.

[1] Remember I'm Still Me. Care Commission and Mental Welfare Commission joint report on the quality of care for people with dementia living in care homes in Scotland (2009)
http://www.mwcscot.org.uk/media/53179/CC__MWC_joint_report%20Remember%20Still%20Me.pdf
[2] Scottish Government (2011) *Standards of Care for Dementia in Scotland*
http://www.gov.scot/Publications/2011/05/31085414/0

Legislation

We noted that the principles of the 2000 Act did not appear to be adhered to in 5% (18 of 291) of cases, which we followed up and will continue to monitor. In some cases, we will visit again.

Concerns about the principles included:

- Individuals felt that their views were not being listened to or not being taken into account e.g. where delayed discharge went against the individual's wishes to be in the community, or lack of discussion with the nominated guardian about the individual's wishes for the future.
- Where powers were not being used to benefit the individual e.g. a guardian appeared to make decisions which were not in the individual's best interests, or a guardian not utilising financial resources to improve the individual's environment or activity provision.
- Where care staff were not aware of the details of the guardian or guardianship powers.
- Conflicts between welfare and financial guardianship responsibilities.
- An individual also subject to MHA 2003 and lack of correct authorisation for administration of medications.

Case Study 1: Dementia

On one of our visits to a care home, we met with an adult that has dementia. They were unable to engage in discussion about their care and treatment.

We found that the patient was being generally well looked after in the care home—their room was suitable and personalised, and a care plan was in place and being followed. But we found that paperwork on incapacity legislation was missing and inaccurate in the records. It was unclear what powers of attorney or guardianship were in place.

This is important because it can ensure the correct processes are followed when an individual's rights to make certain decisions are taken over by others. It can also ensure there is appropriate consultation when decisions are made by health care staff. The adult was receiving medical treatment which, due to cognitive impairment, they were unable to consent to and correct s47 certification was in place. However there was no evidence that the guardian had been consulted during this process. In this case, a Commission officer followed up concerns about missing documents by raising the issue with the manager of the care home, and advised them to contact social work to obtain a paper copy of the local authority welfare guardianship. The officer also directed the care home manager to guidance on the Commission's website on the Adults with Incapacity Act, and a checklist for guardianship powers. The officer contacted the guardian, advising that they should make contact with the care home to clarify on the delegation and limitations of decision making powers of the Order.

Key learning points under the Adults with Incapacity Act (Scotland) 2000

- *A power of attorney can only be drawn up when the individual has capacity to understand what it means. It can only be used for welfare decisions where the individual has been assessed as having lost capacity to take decisions for themselves. A guardianship order is appointed by the court, after an adult has been assessed as having lost capacity to make certain decisions.*

For care providers:

- *If it is recognised that a proxy decision maker is in place, it is important that a copy of the powers is in an individual's records so it can be measured if powers are still being used or required, and that the correct parties are consulted in decisions.*

Working with the Adults with Incapacity Act: Information for people working in adult care settings (2007)
https://www.mwcscot.org.uk/media/51918/Working_with_the_AWI_Act.pdf

For local authorities:

- *Local authorities have a responsibility to provide care homes with information on local authority/delegate guardianship powers.*

Individual awareness of guardianship

Over a third (43%, 124 of 291) of individuals we visited were clearly aware they were on guardianship and most of those knew and could name their guardian (90%,112 of 124)—64 said they were aware of their rights in general terms and many of these individuals gave specific examples.

At least a third of people we visited (35%, 101 of 291) were not aware they were on guardianship due to their level of disability.

For the remaining 23% (66 of 291) this was not clear. In some cases people were aware of the supportive role of family members or professionals but did not necessarily see this in terms of guardianship or were unable to express this.

Case Study 2: Learning Disability and Autistic Spectrum Disorder
Following the renewal of a guardianship order, we arranged a visit to a young adult with a diagnosis of learning disability and autism living at home with their parent/welfare guardian.

The guardian struggled to interact with others. They did not have a copy of the Order and were unaware of the powers contained in it.

During the visit the adult presented as overly tactile, at times inappropriately so. The guardian advised that they knew this was inappropriate but the adult reacted very badly to their intervention to adapt the behaviour.

In addition we saw that the young adult's teeth were in a state of decay. However, the guardian advised that the adult did not like attending the dentist and was unsure what could be done to progress this.

The guardian told us the adult enjoyed spending the day watching the guardian play video games; and there appeared to be no other structured activity.

The guardian said they were not in regular contact with formal services and had not been advised if a Supervising Officer was allocated to support the role of guardian.

The Commission contacted the local authority, the case was allocated, and a needs assessment was commenced. A referral was also made to the Community Learning Disability Team for assessment of health needs to inform any future care plan.

In addition, the local authority allocated a Supervising Officer to support the guardian and to consider the guardian's capacity to fulfil the expectations of this role.

Key learning points under the Adults with Incapacity Act (Scotland) 2000

For local authorities

The principles say that any decisions made by a guardian:

- *must be of benefit to the person concerned*
- *will only be taken when it is really needed*
- *should restrict that person's freedom as little as possible*
- *should involve carers, relatives, and people who work closely with the person*

Key learning points from the Adults with Incapacity (Supervision of Welfare Guardians etc. by Local Authorities) (Scotland) Amendment Regulations 2014

For local authorities

Although the regulations set out the minimum supervision contact between the supervisor and the adult and guardian, the frequency of supervision should occur more regularly if the circumstances are such that this is considered necessary.

- *Where there is significant risk to the welfare of the adult, or other people, if the care arrangements break down*
- *Where the care arrangements are complex and there are no other care management review arrangements in place*

Supervision is intended to ensure that proxies are carrying out their functions properly. It should focus specifically on potential problems that might require action by the local authority. Supervision of individual guardians should relate to the particular circumstances of that case, within the context of general local authority guidance and procedures. Where joint welfare guardians have been appointed, the local authority is expected to provide supervision for each person appointed.

Visits should be recorded so that it is clear that the purposes of supervision listed above are being fulfilled. For example, written comments should be made following each visit, on the continuing suitability of the guardian and on whether the guardianship order requires variation or renewal or whether the guardian's powers should be recalled. In particular, relevant changes in the adult's circumstances should be recorded, such as major increases or decreases in the adult's resources.

When the casework/clinical team decide that they need to seek any additional powers (from a sheriff (s3)) all staff should keep clear records to evidence—why the power is necessary, how the power is to be used, and to monitor that this is being carried out. Information on this can be found in section 3 of the Adults With Incapacity (Scotland) Act 2000 "Powers of Sheriff".

Records should also note if any issues arise about the provision of services to the adult to enable appropriate action to be taken, in conjunction with the adult's care manager or key worker.

Concerns about care or use of legislation

Where we noted concerns about any issue relating to the individual's care or the use of the legislation, this always resulted in further discussion and correspondence with guardians, local authority supervisors, and service providers.

Our concerns included:

- 2% (4 of 200) of cases where contact details of the local authority guardian were not known to registered setting care staff.
- 15% (30 of 200) of cases where registered setting carers were not aware of guardianship powers.
- 21% (41 of 200) of cases where powers were not recorded in the case file in a registered setting.
- 19% (37 of 200) of cases where care staff in residential/supported accommodation had had no discussion with the welfare guardian about the potential need to delegate specific powers to the care staff in certain situations.
- In 19% (54) of all cases, there was no clear evidence that the guardian had visited the adult in the last 6 months. The picture was similar for both private (19%, 35) and local authority guardianships (18%, 19).
- 50% (93 of 187) of private guardians appeared to have had no recent supervisory visits, and for many of these (68%, 63 of 93) there was no evidence that the adult had been visited by the local supervisory supervisor in the past six months. Supervisory visits by social work departments support guardians to properly use their powers in line with the principles of the 2000 Act.

There was a single case where there was a need for a review and discussion as to whether the grounds for guardianship continued to be met.

Case Study 3: Mild Learning Disability and Autistic Spectrum Disorder Patient

On a routine guardianship visit, we met a young adult with a diagnosis of mild learning disability and autism who was able to engage in some conversation regarding their care. The adult told us that high levels of anxiety meant they needed support to access daily activities by public transport or to be driven to them. The guardian was actively involved in the adult's care.

Both adult and guardian expressed concerns that the adult's regular routine had been affected by changes to the care package. The reduction in support had affected transport to activities, reducing opportunities for social interaction. The guardian felt the changes to provision were due to funding reductions.

The Commission officer wrote to the local authority requesting an urgent review of the adult's care and a social worker contacted the guardian to agree a date for review. The local authority reassessed the adult's case and the original package of care was reinstated. The adult is now attending a varied programme of community based activities, contributing to their wellbeing on a daily basis.

The Commission officer also discussed with the guardian the role of support and supervision. The local authority supervisor had met the guardian for the initial three monthly review; but the guardian commented that the meeting was not helpful. The Commission officer took time to talk over the purpose of the annual review with the guardian, exploring the local authorities and the guardian's responsibilities.

Case Study 4: Brain Injury Patient

We met an adult in their early 50s who had suffered a brain injury, leaving them unable to communicate. We had contact with the adult's private guardian on multiple occasions who raised concerns about the suitability of the adult's placement in a particular care home.

The guardian was actively involved in the adult's care. They had requested the consideration of alternatives for the adult's care to the Health and Social Care Partnership who fund and monitor current care arrangements. They had also made formal complaints to the Care Inspectorate—however, these had not been upheld. On a routine guardianship visit, a Commission officer found concerns about the adult's current placement, including a lack of support for their communication needs and a lack of age appropriate activities and opportunities for social interaction. These same concerns were being raised by the guardian.

The Commission officer provided the private guardian with details of advocacy support. They contacted local authority social work to explain the guardian's concerns and role of the guardian, as they felt involvement of the private guardian could be significantly improved. They also requested an urgent review of the adult's care, which was a closed case, to be reviewed on an annual basis by the review team. This was agreed and a social worker contacted the guardian to agree a date of review.

The adult's case was reassessed and with the involvement of a social worker a new placement was found for the adult. The individual has made significant progress in their rehabilitation.

Key learning point under the Adults with Incapacity Act (Scotland) 2000

For local authorities:

Local authorities have a statutory duty to supervise and support private guardians.

Section 10(1)(a) of the 2000 Act advises that the local authority will supervise a guardian appointed with functions relating to the personal welfare of an adult in the exercise of that function. Regulations made under sections 10(3)a and 86(2) of AWIA stipulated those intervals. However, guidance from MWC (Supervising and Supporting Welfare Guardians) advises that the supervisor can, with the agreement of the welfare guardian, stop these supervision sessions if there seems to be little purpose.

However, if the local authority supervisor still sees a need, and if the three monthly and first annual reviews have not taken place, then they should keep written records of attempts to hold meetings and responses of the welfare guardian to these attempts. The code of practice points out that the 2000 Act does not allow a local authority to issue a direction to welfare guardians. Such information will be useful if it becomes necessary to return to court, either to apply to replace the guardian or to request that the sheriff give directions under section 3 of the 2000 Act.

Therefore, a case should not be closed following a care review as in Case Study 4. If passed to the review team where there is a live welfare guardianship, other supervision and support arrangements need to be made.
Supervising and Supporting Welfare Guardians (2010)
https://www.mwcscot.org.uk/media/51862/Supporting__Welfare_guardians.pdf

Key learning points under Mental Health Act (Care and Treatment) (Scotland) 2003 and human rights legislation

For care providers:

The provision of meaningful activity that contributes positively to an individual's care is central to care planning that affords an individual's human rights. The Commission's guide on 'Human Rights in Mental Health Care Services' provides more information on human rights in mental health care.
Human Rights in Mental Health services (2017)
https://www.mwcscot.org.uk/media/369925/human_rights_in_mental_health_services.pdf

For local authorities and health boards:

Individuals receiving care and treatment, as well as individuals involved in their care, such as their guardian, should be informed of and have access to independent advocacy services in their area.

Placement

In the majority of cases our visitors found individuals were appropriately placed.

However, there were at least 8% (22) of cases where there were concerns about the individual's placement. For thirteen of these the Commission undertook ongoing casework.

For a further 3% (9) the placement itself appeared appropriate but there were linked issues e.g. a flat being only a short-term let and in need of upgrading; anxieties about a new housemate moving in; wanting to be placed closer to family so their visits would be easier; the adult's overt sexual behaviour intimidating visiting support staff; delay in review of a large care support package.

Case Study 5: Mental Ill Health

We visited a young adult subject to guardianship who had been diagnosed as having schizophrenia in their late teens, and had a number of long periods of treatment in hospital. Admissions to hospital have always been associated with stopping medication and a deterioration in mental health; and often detention under mental health legislation. When unwell the adult becomes agitated, distressed with complex delusional thoughts, and neglects their self-care. They become more isolated and vulnerable to exploitation.

The most recent episode of compulsory treatment (CTO) started with a community-based CTO, authorising medical treatment while the adult was living in their own flat. Following deterioration in the community the tribunal varied the order to authorise detention in hospital. The adult subsequently moved to a rehabilitation ward with a plan to move into supported accommodation. Following careful in-patient planning a guardianship order was granted with the Chief Social Work Officer appointed as guardian. This order was necessary because the adult would need 24-hour care and support with intensive supervision in the community. After the guardianship order was granted, but while the adult was still in the rehabilitation unit, the psychiatrist revoked the CTO as compulsory treatment powers were no longer necessary.

The Public Guardian notified us of the guardianship order and we arranged a visit. During the visit the adult's thoughts were rambling but they were able to tell us the kind of place they would like to live in. As neither the adult nor the support worker seemed to be aware of the adult's rights under guardianship we discussed and explained this and left guidance regarding the principles of the 2000 Act.

Following the visit we contacted the local authority mental health officer, who is also the nominated guardian. The MHO visited the adult following our visit, confirmed that a supported accommodation place had just become available, and that the adult was agreeing to move. The adult was happy with this plan, that they would no longer be in hospital, and that benefit income would increase significantly.

The Commission will follow up the new placement.

Key learning points

One of the key principles of the 2000 Act is that the past and present wishes of the adult shall be taken account of.

When a local authority seeks guardianship powers this should be based on an assessment of the adult's personal welfare needs and a proposed care plan, and any intervention should be the least restrictive option.

In some situations a CTO and a guardianship order are both necessary measures.

Restraint

There were occasions where it appeared that adults were subject to restraint (5) or seclusion (3) without proper authorisation in guardianship powers. We would encourage welfare guardians to seek these powers where necessary and, if not authorised in the order, return to the sheriff to seek additional powers.

In one case the use of CCTV was in place without explicit sanction. There were 23 cases where it appeared some restriction on leave was in place but there was no specific authorising power.

The Commission also came across other issues (13) concerning restrictions and sanctions:

- No sanction for restriction of using gloves (to prevent the adult biting their own fingers) and lap strap. We advised care staff to discuss with local authority welfare guardian supervisor and to update us with new supervision report.
- The Adult's calls are being monitored due to previous history of exploitation from identified persons. Whilst care staff report they monitor and supervise calls there is no care plan within the file to confirm expectations or reporting requirements of this activity. Care staff will speak to guardian to confirm this.
- The guardian has the usual wide-ranging powers but does not specify anything in respect of a care plan to lock cupboards in the kitchen. The adult will overeat if they have unrestricted access. A small amount of snack foods and drinks are available, but the Commission officer was told they would empty a whole packet of biscuits or cereals in one sitting if not restricted. We discussed that at renewal the guardian should seek specific powers and raise the issue with the social worker (for the care plan) and the guardianship supervisor in the meantime. The social work report for the guardianship application talks about the need to restrict access to food as one of the triggers for the guardianship order, so we would have expected this specific power to have been sought. However, the officer was not so concerned to insist action be taken—if the adult was in a care home setting they would also not have access to a fully stocked kitchen. They were happy with the care and treatment, and the restriction was being applied sensitively and according to their needs.

Case Study 6: Risk and Absconding

The adult suffered a traumatic brain injury when in childhood. They became very impulsive, started to drink heavily and to engage in multiple risky sexual encounters. The adult appeared unconcerned by the consequences of their actions or the alarm that they caused in those trying to keep them safe. They were very vulnerable to financial and sexual exploitation, were using alcohol every day, and were in a physically neglected state. Without prompting and support they would not manage to shop appropriately or prepare food regularly. They required a significant level of support for budgeting and paying bills and at times needed to borrow money to pay for essentials, such as electricity, because they had overspent when buying things for themselves or when under pressure to buy things for others.

The elimination of risk would have required intrusive measures that would have been impractical to enforce. The adult gave the impression of being intellectually capable but their functioning was impaired due to an acquired brain injury which reduced their decision-making capacity. The absence of learning disability prevented them being supported by NHS learning disability services.

At a pre-guardianship case conference, all concerned with the adult's care discussed the risks and most appropriate practical responses to those risks. It was decided that a welfare guardianship should be sought, with powers to determine place of residence and to return them to that residence if necessary, under a Section 70 warrant in the event of non-compliance. The notes indicated that "the issue of risky behaviour is best managed by a combination of education, persuasion, compromise and contingency planning." However, there was no evidence of contingency planning. We asked for this to be acted on as soon as possible.

Our most serious concern was about the lack of any care planning around the adult absconding. The guardianship order was taken out to address this risk, and give the local authority the power to determine where they should reside and return them there. We heard from the care home manager that the adult regularly disappeared for a day or more, and they had no alert system or automatic agreed response in place for those absences. We asked them to address this in agreement with the local authority guardian.

The care home manager subsequently wrote to the Commission. They reported that they had discussed the issue of absconding with social work staff. It was decided that, if the adult visited friends outside the area, the care home would inform social work and keep them updated if the adult decided to stay away longer or did not return as planned. This was noted in the adult's current risk assessment.

Key learning points under the Adults with Incapacity (Scotland) Act 2000

For local authorities

In this case, powers to manage absconding had been granted by sheriff in the welfare guardianship order but had not been appropriately implemented in the care plan. Therefore, the adult's risk management plan needed immediate review. This was reviewed and appropriate plans agreed.

Medication and Section 47

The Code of Practice and Mental Welfare Commission guidance[3] is very clear in relation to the use of Section 47 certificates. Where an individual does not have the capacity to consent to the treatment they require, the doctor should formally assess their capacity and, on finding someone incapable of consenting, then complete a certificate. Where this treatment is complex, they should complete a treatment plan. If this is not done then the treatment given is potentially unlawful.

If there is a proxy decision maker, namely a welfare guardian or someone acting with a welfare power of attorney, then the medical practitioner should also discuss the treatment with them. There is a clear space on the certificate for the doctor to put the name of the proxy decision maker. Care staff should assist the doctor in identifying the proxy from their knowledge of the adult.

70% (203 of 291) of cases appeared to require an s47 certificate. These were in place for 76% (155 of 203) of those people and just four of these were potentially inappropriate. All paperwork appeared to be in order for 49% (100 of 203). Five s47's were out of date. In 22 cases there needed to be discussion with a general practitioner to decide whether an s47 certificate was required. In 28 cases the adult's care was thought to be complex and might require a treatment plan which was not present.

- For 5% (11) of individuals, issues relating to s47 and medication were a cause for concern requiring follow-up. In other cases we provided advice to care staff concerning GP responsibilities for completing or updating an s47 form and directed them to the treatment plan template.
- Some guardians (12 of 203), where there was an s47 certificate, did not appear to have been consulted about the adult's medical treatment despite having the power to consent to medical treatment (Part 5 of the Act).

Other issues include:

- S47 certificates not being completed when the adult clearly lacks capacity.
- S47 certificates being completed without discussion with the proxy decision maker.
- S47 certificates which are in relation to complex care where no treatment plan is attached.
- In some cases the s47 certificate was out of date. Sometimes there was a need for the s47 certificate to be more readily accessible and visible.

[3] Mental Welfare Commission for Scotland (2010) *Consent to treatment* http://www.mwcscot.org.uk/media/51774/Consent%20to%20Treatment.pdf

Finances

The Commission practitioners review the management of individual's finances on all visits.

For the individuals on guardianship orders that we met with, their finances were largely managed by their financial guardian (52%, 152) or via the Department of Work and Pensions (DWP, 37%, 107). Only a small number (2%, 5) managed their own finances and the remainder were managed via part 4 of the 2000 Act[4] (2%, 5) or informal (without the use of legislation) arrangements.

We were pleased to find that, in most cases, guardians had found ways that adults could benefit from their own money and that this was recorded on file where appropriate. Examples included:

- Augmenting the social support received within a placement by funding additional befriending or purchase of respite care
- Saving for the adult to have a holiday, getting tickets for a big pop concert, going to football matches, going out for tea, going to library, or buying books
- Enjoying selecting decor and furnishings for a new tenancy; refurbishment of a flat, buying a new mattress, or decorating a care home room with new pictures to adult's taste
- Purchasing a tablet to enable the individual to more easily keep in touch with relatives via video chat, a new video game console for room, or a new computer and printer to support creative writing
- Ensuring the adult is well presented and/or spends their finance on activities enjoyed including personal pampering, hairdressing, clothes shopping, toiletries
- Purchase of a mobility car or specialist wheelchair
- Enabling independence by relocating management from a central to a more local office, closer to the adult's home, enabling them to have easier access to their own funds;
- An adult being able to pick up funds from an office block in a hospital, ensuring an adult receives a monthly financial statement, supporting the individual to access and manage small amounts of disposable income, weekly trip to the bank with a support worker, or assist with repaying debts
- Enabling continuation of appropriate donations to charities favoured by adult

We were concerned, however, that in 13% (39 of 291) of cases there was a lack of evidence that the adult's funds were being used creatively to further their wellbeing.

In 5% (14 of 291) of cases, there were specific concerns about the management of an individual's finances. These were explored by the Commission practitioner and on the whole

[4] Part 4 of the 2000 Act deals with the management of a residents finances.

issues could be resolved on the day of the visit by discussion with care providers and guardians. Six required further follow up with the financial guardian, the care home, Social Work Department, or Office of the Public Guardian.

Examples of issues concerning finance included:

- Lack of personalisation of a room, a very old black and white TV needing to be replaced with an up-to-date colour TV
- Financial guardian's refusal to consider topping up care hours as they considered it to be wholly the local authority's responsibility, resulting in the adult remaining housebound and without appropriate stimulation
- A guardian finding it difficult to understand arrangements for funding as the spouse was moving to a care home, fearing they might be responsible for top-up funding. The Commission requested that the supervising social worker address the issue with the guardian.
- An adult not having a bank card to access benefits paid into their own bank account

Case Study 7: Financial

The adult was anxious about her financial situation. It is her understanding that she is borrowing money from the care staff to purchase day to day items when in fact staff are giving her money from her own account to make these purchases. This had not been explained to the adult. Staff have agreed to inform her of how much money the care home currently hold for her to allay concerns she has.

No issues with money as such, but the guardian told us that since the adult returned to the family home to be cared for, the family has had to pay an additional amount of council tax and monthly rent had also increased. The guardian thought this was because the adult was now considered to be an independent rather than a dependent adult. This was raised with his social worker and suggest they clarify if the adult is entitled to council tax exemption.

Issues around Self-Directed Support (SDS)

Self-Directed Support (SDS) puts the adult at the centre of their own support planning process. SDS enables people, carers and families to make informed choices about what their own social care support is and how it is delivered. Self-Directed Support ensures adults who are eligible for support are given choice and control over how their individual budget is arranged and delivered to meet their agreed health and social care outcomes. Where there is a proxy decision maker, i.e. a welfare attorney or guardian, they will support the adult to decide or make the decision themselves depending on the adult's capacity for specific decisions.

The Social Care (Self-Directed Support) Scotland Act 2014 places a legal duty on local authority social work departments to offer everyone receiving social care four options as to how that care is delivered. These options ensure everyone can exercise choice and control.

1. A Direct Payment (a cash payment);
2. Funding allocated to a provider of the adult's choice (sometimes called an individual service fund, where the council holds the budget but the person is in charge of how it is spent);
3. The local authority social services arranging a service for the adult; or
4. Choosing a mix of these options for different types of support.

Case Study 8: Self Directed Support

Family were encouraged to apply for financial powers on the basis that this was required for the purposes of receiving SDS. The adult receives his service under option three (services arranged by the local authority) so does not receive any direct payments, requiring this level of statutory intervention. His mother is the DWP appointee and manages everything through this authority. She was advised to write to the Office of the Public Guardian to relinquish financial guardianship if she feels this is not going to change over the course of the order.

Prior to the renewal of this Order, the relative was appointed as financial and welfare guardian. This was solely to fulfil the requirements of eligibility for Self-Directed Support (SDS). The adult received SDS option one for a year. The council terminated this arrangement because the guardian was not adhering to terms and conditions. We are seeking clarification on this, as the dispute is impacting on relationships between guardian and local authority. Without the financial transactions associated with these processes, the relative has no need to continue as financial guardian. The adult's income being solely derived from benefits can be managed by DWP appointeeship. This would be the least restrictive option given the change of circumstances.

Cross-border issues

There were four cases, concerning three private and one local authority guardianship; three in care homes and one in a private home, where there were cross-border issues.

In two cases we conducted a joint unannounced visit with the Care Inspectorate, and casework was ongoing. We would conduct joint visits where there was synergy for both organisations, and a direct benefit to the adult. Both these visits were regarding the management of challenging behaviour in registered care settings.

The visits confirmed that services were implementing the advice we had given earlier in the year regarding management of behaviour. They had sought support from their local NHS behavioural support team. We evidenced this in their care planning paperwork and entries in the daily recording in the adult's case files.


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