Annual report 2014-15

Photography in this document shows some of the work done by winners of our PIP awards 2015, including the IDEAS project in Dumfries, Enable in Edinburgh and Ceartas Advocacy in Kirkintilloch. It also includes Colin McKay speaking at Alzheimer Europe conference in Glasgow.

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

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Who we are and what we do

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

We do this by:

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

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

Chair's statement

The Very Revd Dr Graham Forbes CBE

At the heart of everything we do – every visit, every document we produce and every public statement we make – is our fundamental aim: to protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

This report contains information on the various activities we have undertaken in the year, and I very much hope you find it useful.

Much of our work is at the complex interface between an individual's rights – so often a vulnerable individual's rights – and the law and ethics that come into play when decisions are made about the care that person receives.

We work across the continuum of health and social care in Scotland, and we are the only organisation to do so. With local authorities and health services under increasing pressure, and with the introduction of integrated services, this aspect to our work is becoming more relevant than ever.

Key achievements include:

- Revising the Commission's aim as embedding human rights at the core of all of our work.
- Being intimately involved in the scrutiny of the Mental Health (Scotland) Bill, proposing amendments where we felt there was a danger of people's rights being reduced, and supporting new powers for the Commission. In September, our chief executive appeared before the Parliamentary Committee leading on the Bill to discuss our views in detail.
- Highlighting our concerns over the capacity of the mental health officer (MHO) service to fulfil its statutory duties. These specialist social workers, employed by local authorities, play a key role in ensuring that people get the right care and treatment. The number of MHOs is decreasing while the workload is increasing. We called for the Scottish Government to take action to address this issue.
- We made two senior appointments to the Commission. Kate Fearnley joined us in the new role of director (engagement and participation) as part of our commitment to building stronger links with people who have mental ill health or learning disability, and their families. Mike Diamond was promoted to executive director (social work) on George Kappler's retirement

Hearings are now taking place at the National Confidential Forum, a committee of the Commission. The Forum provides a safe and confidential setting for those who have been in institutional care to recount their experiences. The Forum has published a separate annual report, available on its website.

Looking ahead, we remain focused on continuous improvement. We will publish the findings of all of our local visits. We will employ two new members of staff from the communities we serve – one who has lived experience of mental ill health, and one who is, or has recently been, a carer. And we will continue to develop our joint working with other organisations, ensuring that we do not miss opportunities to combine forces to make our work more effective.

My thanks go to all of the people and organisations who have contributed to our work in 2014-15. Our advisory committee in particular brings a wealth of experience, which is much appreciated. My fellow Board members bring insight and challenge, which help make the Commission a more robust organisation; and our staff, so ably led by Colin McKay, ensure that our plans are turned into action.

“Looking ahead, we remain focussed on continuous improvement”

Chief Executive's key messages

Colin McKay

2014/15 was an important year in relation to the lawful and ethical care and treatment of people with mental health issues, learning disability and dementia.

The **Mental Health Bill** was the most significant revision of mental health law since 2003, and we significantly influenced its development.

Following briefing by us and others, several aspects of the Bill which we felt diminished the rights of patients and service users were dropped or substantially altered.

The Bill also gives the Commission new responsibilities: to monitor the discharge by health boards and local authorities of their duties to ensure that people have access to independent advocacy; to maintain a record of people who have made advance statements; and to oversee how health boards promote advance statements. We will also participate in the planned reviews of how the deaths of in-patients are investigated, the inclusion of learning disability in the Mental Health Act, and the investigation of homicides by people in contact with mental health services.

The Scottish Law Commission (SLC) published proposals for reform of the Adults with Incapacity (Scotland) Act 2000, following the decision of the UK Supreme Court in the ***Cheshire West*** case, which potentially widens the number of situations where an adult may be deemed to have been deprived of their liberty. We issued guidance on the case, and have pressed the Government to respond quickly. We believe reform may need to go further than the SLC propose to ensure Scotland continues to comply with international human rights norms, in a way which is proportionate, flexible and empowering.

Our investigations, visits and monitoring highlighted that, more than 10 years since mental health and incapacity law was reformed, there remain wide variations in the **understanding amongst health and care staff of how the law should operate**. This can lead to unlawful treatment, and to people not getting the care and support they should receive. We will continue to provide advice and good practice guidance, and we intend to work with others to increase the profile of these issues in training and professional development.

It is encouraging that the **recommendations we make when we visit services** are almost universally accepted, and we saw many examples of excellent, person-centred care. But the same problems continue to arise: too little purposeful activity, poor record keeping and a lack of a recovery focus in care planning. We hope that our decision to publish our local visit reports from 2016 will add to transparency, and encourage lasting improvement.

We welcome **the appointment of Jamie Hepburn** as the first Scottish Government Minister to have mental health listed in his title, and we have been encouraged by the attention paid to mental health across the political spectrum. We have an election looming, the Government's **mental health strategy is** due for renewal, and services face the huge challenge of **health and social care integration**. The work the Commission is undertaking with the Scottish Human Rights Commission will make an important contribution to enhancing respect for rights in mental health care in this fast-moving environment.

"The work the Commission is undertaking with the Scottish Human Rights Commission will make an important contribution to enhancing respect for rights in mental health care in this fast-moving environment"

Effective and efficient visiting

- We held individual meetings with 1,921 people across Scotland this year – listening to their experience.

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

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

We regularly visit every mental health and learning disability hospital service. We do this through either:

Themed visits – to people in similar situations, or with similar health issues, in different parts of the country. We produce national reports on themed visits, looking at services across Scotland. We published reports on two of these visits this year, meeting with 371 people.

Local visits – to people who are being treated or cared for in particular local services or facilities, such as a hospital ward, supported accommodation, a care home or a prison. We provide feedback to the managers of services, and follow up any recommendations where we feel progress is not being made. We met with 775 people during these visits. During our themed and local visits, we also met with 32 advocacy workers and 77 relatives/carers. We carried out 155 additional case file-only reviews during our local visits.

Welfare guardianship visits – where we visit people who have a court-appointed welfare guardian. That guardian may be a family member, friend, carer or social worker. We visited 552 people with welfare guardians this year.

Monitoring visits – where we visit people who are subject to specific areas of mental health and incapacity legislation. The Commission has a statutory duty to monitor the operation of this legislation. On these visits we are looking at compliance with the legislation, and for examples of good practice.

Other visits – We have a duty to monitor specific areas of mental health and incapacity legislation. We visit all instances of a cross-border transfer into Scotland and we try to visit every young person admitted to an adult ward. We may also receive correspondence which we follow up by visiting people. We carried out 71 of these visits to people across Scotland.

Our visits

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

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

Themed visits

We conducted two themed visits in the year.

Themed visit 1 – Enhanced observation

Enhanced observation can be an essential part of a care plan to keep patients safe during periods of acute illness and distress. It requires specialist and skilled intervention by competent staff.

In earlier visits to all adult acute mental health admission wards in Scotland, some patients told us they were concerned about the levels of enhanced observation they were subject to. This themed visit explored this specific issue in depth.

We spoke to 186 patients who were subject to enhanced levels of observation in 53 wards across 10 health boards. Forty four wards were admission wards for adults with mental ill health, and nine were admission wards for people with learning disability. We also spoke to 23 named persons – people chosen by patients to speak out on their behalf.

We found that enhanced observation can unintentionally result in distress for the patient. A balance needs to be struck between maintaining patient safety and respecting privacy and dignity.

There is variation across Scotland as to who in the health care team has the authority to reduce levels of enhanced observation.

Enhanced observation can amount to unauthorised deprivation of liberty in some cases, and this was often not being considered.

Staff training was inconsistent and often inadequate.

We made a series of recommendations. The full report is available on our website.

Themed visit 2 – Older people acute admission wards

We visited all 24 of Scotland's NHS wards for acute assessment for older people with functional mental illness, which cover a range of conditions, from depression and anxiety to schizophrenia and bipolar affective disorder.

We reviewed the care of 128 individuals, and spoke to 15 carers/family/friends.

We found that a third of patients were receiving compulsory treatment under mental health legislation.

Clear care plans were found for nearly all patients. A quarter had a good amount of individualised content, a quarter did not, and a half had some individualised content.

There was a considerable variation in levels of input from clinical psychologists in different wards.

Most patients said there was somewhere private for them to meet visitors.

Only a third of wards had arrangements for people to be able to keep possessions in their own locked drawer or cabinet, or to lock the door of their single room.

The full report, with our recommendations, is available on our website.

> "A balance needs to be struck between maintaining patient safety and respecting privacy and dignity"

Local visit overview

We carried out 125 local visits between January and December 2014, to hospitals, care homes, prisons and secure units. NHS hospital wards for older people with mental ill health was the largest grouping we visited, representing a quarter of all local visits.

Only 11 of the 125 visits resulted in no recommendations for improvement being made.

After those visits, we made 409 recommendations to those services, who were asked to take action and respond. We were satisfied with the response in 99.6 per cent of cases – an increase from 99.1 per cent satisfied in 2013-14.

Seventy seven of our recommendations related to assessment, care planning, review, and making sure that care should be centred on the individual.

Thirteen per cent of our recommendations related to improving compliance with the Mental Health Act – a rise from eight per cent of all recommendations in 2013-14.

Twelve per cent of our recommendations related to compliance with the Adults with Incapacity Act, the majority to services for older people, both in care homes and in hospital. This is a reduction on last year, from 16 per cent.

Forty nine of our recommendations related to the provision of therapeutic activity, a similar result to 2013-14. These mostly related to services for older people.

Nineteen of our recommendations related to medication and access to medical care and treatment; five per cent of all recommendations made.

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

Case study – welfare guardianship

We visited a young man who had learning difficulties, ADHD and significant behavioural issues. He lived with his mother, who was a single parent.

During term time he attended college, and the course gave him structure to his days, and adequate stimulation.

We visited at the start of the summer holidays. The young man was getting support for only five hours a week, and his mother had to manage alone, with some help from family and a friend. The situation was difficult; boredom was a trigger for angry outbursts from the young man, and his mother found this frightening.

The Commission visitor spoke with the young man's social worker and asked that additional support be provided during the holidays. We also asked for an assessment for respite provision. The social worker agreed to provide a further seven hours of support, starting the following week. He also agreed to visit and assess the situation further, with a view to arranging respite for the young man's mother.

Visits review

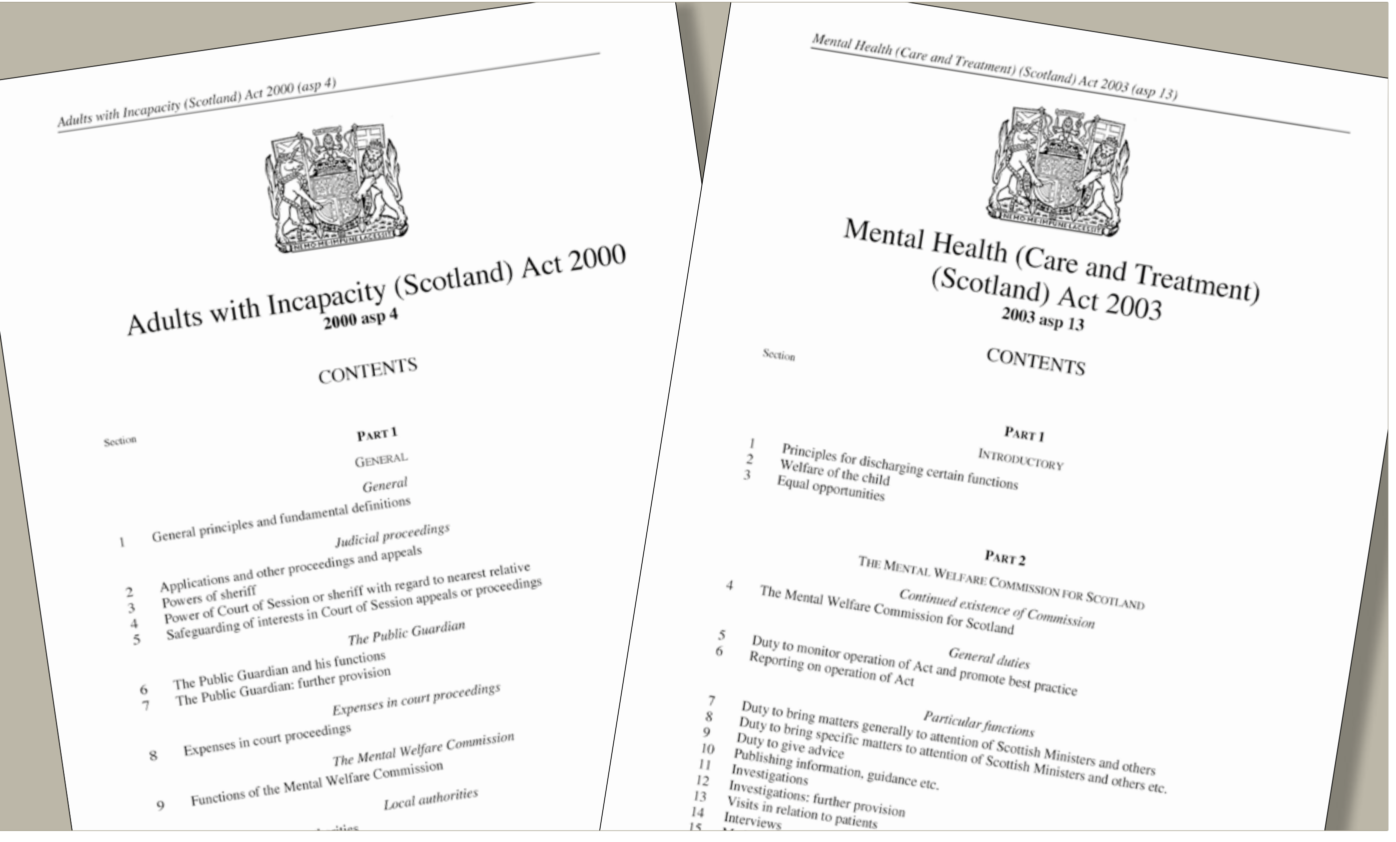
This year we consulted with people who use mental health and learning disability services and families/carers; practitioners, and our advisory group, on our visits.

This exercise resulted in changes. In the future, before we embark on themed visits – where we visit people across the country who receive the same type of service – we will consult with people who have past experience of those services and families/carers where appropriate, to discuss our approach.

We will reduce our target for the number of people we see annually from 1,900 to 1,500, due to more visits taking place in the community rather than in hospital, and to improved planning.

We will recruit two new staff members who as part of their role will help us prepare and carry out our visits; one with personal experience of mental ill health, and one with a family member who has mental ill health or learning disability. From 2016 we will publish our local visit reports.

Monitoring and safeguarding care and treatment



Adults with Incapacity (Scotland) Act 2000 (asp 4)

NEMO ME IMPUNE LACESSIT

Adults with Incapacity (Scotland) Act 2000

2000 asp 4

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NEMO ME IMPUNE LACESSIT

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- **The number of new episodes of compulsory treatment for mental ill health rose again, and is now at the highest level since the 2003 Act was introduced.**

- **Welfare guardianship orders continue to increase, and for the first time ever, there are more new welfare guardians in Scotland for people with learning disabilities than for people with dementia.**

- **Admissions of young people with mental ill health to non-specialist hospital wards and other settings rose to 207, the highest figure since 2011-12.**

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

When doctors or other health care professionals use the law to provide compulsory care or treatment, they must inform us. We check that information, ensuring their intervention complies with legislation. We are responsible for appointing designated medical practitioners, who provide a second medical opinion when medical treatment is prescribed under legislation. This year we organised 1,719 second medical opinions.

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

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

We also publish an annual monitoring report on care and treatment for young people admitted to non-specialist services with mental ill health.

Monitoring the use of mental health legislation

Compulsory treatment

The number of new episodes of compulsory treatment rose by seven per cent, following a year-on-year upward trend since 2009-10. This is the highest number we have recorded since the 2003 Act came into being.

The reasons for this are unclear. It could be due to an increasing diligence amongst medical professionals in using the legislation appropriately. That, in turn, could reflect greater awareness of patients' rights and unlawful deprivation of liberty.

Or it could be that, with increased emphasis on community care, people are more unwell when they need to come into hospital.

Seventy per cent of all episodes of compulsory treatment lasted 28 days or fewer.

Emergency detention

The use of emergency detention orders increased by just under five per cent and means that, over the past three years, there has been a 12% increase in their use. This concerns us, because they are meant to be used only in crisis situations. They can be issued by any registered medical practitioner, and are designed to be used only if it is not possible to get assessments of the patient by both an approved medical practitioner, who will be a psychiatrist, and a mental health officer, who is a specialist social worker.

"The number of new episodes of compulsory treatment rose by 7%"

Mental health officers and emergency detention

We place great value on the role of mental health officers in the decision to detain a person. They provide the important safeguard of looking critically at the proposal to detain a person, and can suggest alternative ways to support them without the need for compulsory admission. They can also explain the process and make arrangements easier for people who are to be detained.

Of the 2006 people who were subject to emergency detention in the year, 45% did not have the consent of a mental health officer.

It concerns us greatly that Greater Glasgow and Clyde – which has the highest use of emergency detention – did not have mental health officer consent in 72% of cases. We believe this is detrimental to people's care, and to their rights. We have raised this with the health boards and with local authorities, and we will continue to do so.

Young people

Admissions of young people up to the age of 18 with mental ill health to non-specialist settings as inpatients have risen slightly from last year – from 202 to 207. This usually means they are admitted to either an adult mental health ward, or a general paediatric ward.

This is the third consecutive year of rising figures for such non-specialist admissions. We will continue to raise our concerns over this, and continue to treat the monitoring of services for young people with mental ill health as a priority.

The full monitoring report, and a separate report that focuses on services for young people, are available on our website.

"We will continue to raise our concerns over this, and continue to treat the monitoring of services for young people with mental ill health as a priority"

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

A welfare guardian is someone appointed by a sheriff court after a person is no longer able to take their own decisions. The guardian can be a relative or a close friend, or it can be the social work department of a local authority.

Each time a welfare guardianship is sought, the Commission should receive copies of all of the statutory forms related to that application, including the assessment made by a mental health officer, two doctors, and a copy of the order granted by the court.

We analyse and publish an annual monitoring report on this data.

We also visit people who have welfare guardians, and in 2014-15 we visited 550 people, talking to them and their guardians.

We investigate cases where we believe a person on welfare guardianship may be at risk.

Our main findings this year are:

- Welfare guardianship orders are most often sought for people who either have learning disability or dementia, and usually dementia is the most common cause. In 2014-15, for the first time ever, we recorded more welfare guardians for people with learning disability than dementia – 45% compared to 43%.
- The number of young people with learning difficulty who have welfare guardians is increasing. We believe this may be due to changes in funding care, with the introduction of Self Directed Support. This new system gives greater control of their own care to people who receive services. In turn, if a person is unable to take decisions on their care, it can mean that formal arrangements are needed to allow family members to take decisions on their behalf.
- The number of existing guardianship orders has risen by seven per cent since last year. There has been an 84% increase since 2009-10.
- Rates of new applications increased most in East and South Ayrshire.
- Seventy six per cent of all applications were from private individuals, as opposed to local authorities. This is an increase of 15% on last year, and a 105% increase since 2009-10. Nevertheless, there was still a 19% increase in local authority applications.
- Local authorities have a duty to apply for welfare guardianship where it is needed and no one else will do so. In addition, they have a duty to supervise all private welfare guardians. The continuing increase in numbers of both forms of welfare guardianship places local authorities under increased pressure, as they have no control over this demand-led system. We recognise this issue, but warn that local authorities should guard against lowering their professional benchmark for making applications as default applicant due to workload pressures.
- Of the 550 people we visited, we judged that 98% had good or adequate care, treatment and accommodation.

The full report is available on our website.

The continuing increase in the numbers of private welfare guardians places local authorities under increased pressure

Survey of private welfare guardians

Private welfare guardians make decisions on behalf of other people, usually family members, who have lost capacity to make decisions themselves due to mental illness, learning disability, dementia or related conditions.

They play a key role in helping vulnerable people, and are appointed by the courts.

In our monitoring role, the Commission was aware of a rise in new private welfare guardianships being granted year on year, with over 1600 granted in 2013/14.

We decided to conduct a national survey, asking about how people found out about welfare guardianship, and about their experience of taking on this role.

Over a third of those who responded to our survey found out about welfare guardianship from a social worker. A quarter were made aware by a solicitor.

Over a third of those who responded told us they needed financial powers, and took welfare powers at the same time.

In reflecting on their experience, nine out of 10 people who recently applied to become welfare guardians would advise others in their situation to do the same.

The full survey is available on our website.

Monitoring report – Suspension of Detention

A guiding principle of the Mental Health Act is that care and treatment should be delivered in a way that is least restrictive of a person's freedom.

For people detained in hospital under the Act, a designated doctor can suspend their detention, allowing them to leave the hospital grounds while still providing care and treatment.

This can be of great benefit to patients in allowing them to leave hospital, but we are aware that the legal provisions can be complex and hard to understand. We carried out this monitoring programme, meeting with 49 people across the country (whose detention had been suspended for at least three months), to hear about their experiences.

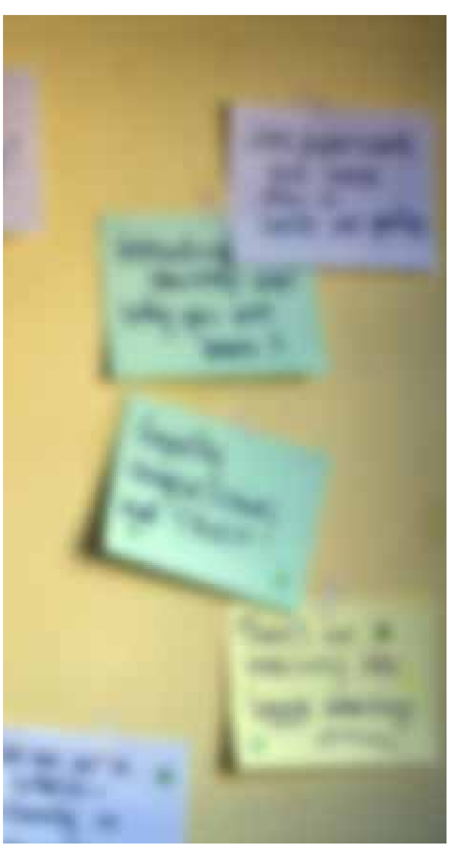
Our key finding was that support in the community tended to focus on maintenance of medication rather than promoting a recovery-based approach.

There were mixed views on a number of issues. Half felt they had too much interference and found the situation intrusive. The presence of a suspension certificate also seemed to create a general uncertainty for people about their status.

Over half either had an advocacy worker or had used advocacy in the past, and most spoke positively about this.

We made a range of recommendations following the visits. A copy of the report is available on our website.

Investigations



- **We worked on 21 investigations, 12 of which were started during the year.**
- **We sent eight of these cases back to local services, making specific recommendations for their further internal investigation.**
- **We continue to investigate nine cases.**

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

The Mental Welfare Commission is often contacted about such cases. We will initially contact the responsible organisations to find out more and, where necessary, make recommendations to them, and follow up their actions. We instigate our own investigations only when we believe the case appears to show serious failings, and has implications for services across Scotland.

Although they are about one individual, all of our investigations are anonymised. That way we protect the person the report focuses on, and we highlight the lessons to be learned by practitioners and organisations across Scotland.

"We highlight the lessons to be learned by practitioners and organisations across Scotland"

21 investigations

In addition to the one published report on Mr JL, the Commission investigated a further 20 cases.

Some of those cases came to the Commission from local health, social work or care professionals, some came from concerned family members, and some came from other routes.

Before deciding whether a case should become an investigation, Commission practitioners consider all of the information presented to them. If they then decide the case should be taken to the next stage, they raise their concerns with our Executive and formally advise local services of our decision to investigate. The Commission team then examines the case in detail, requesting further data if required, and meeting with practitioners, responsible organisations, and key individuals.

In eight of this year's 21 investigations, the Commission sent recommendations back to local services for further internal investigation.

In two cases we judged that there was no deficiency of care.

In one case we received a further review from the local services and were satisfied with their outcome.

We are continuing to investigate nine cases.

Although we did not meet our KPI this year, we revised our investigations guidelines, ensuring consistency throughout our approach.

We also understand the complexity of multiple agency involvement in some cases, and are working with the Care Inspectorate, Scottish Social Services Council, the Procurator Fiscal Service, Scottish Public Services Ombudsman, Health Improvement Scotland, the Health and Safety Executive and others to improve the coordination of investigations.

Left alone – the end of life support and treatment of Mr JL

Mr JL was admitted to hospital in May 2012 weighing 29kg (4.5 stone) and died there two days later, of cancer of the mouth and tongue.

Mr JL had lived alone in a remote area of Scotland. He had cognitive difficulties, significant communication difficulties, and a history of depression.

He had been in contact with health and social services for a number of years prior to his death, and died after refusing medical examinations, treatment and food and drink.

We had concerns that he may not have had the capacity to consent to, or refuse, treatment. We suspected that social care and health services may have missed opportunities to intervene.

We investigated this case, and found failures in the GP service, and with the social care provider.

There was also a lack of effective governance arrangements with the local authority which was responsible for assessment, care management and service provision.

We found poor knowledge on the part of the GP service and social care provider of relevant legislation, and of the options available to them under legislation.

We also had concerns about the failure to provide information to Mr JL's next of kin, including funeral arrangements.

We made recommendations for the GP service, the NHS Board, the local authority, Healthcare Improvement Scotland and the Scottish Government. The full report is available on our website.

> "We found poor knowledge on the part of the GP service and social care provider of relevant legislation"

Providing information and advice

- **We held five Excellence in Practice seminars, tailored to specific audiences, to discuss complex legal and ethical issues they may face in providing care and treatment.**
- **We received 5,143 calls to our helpline, of whom 4,629 sought our advice, an increase on the previous year.**
- **We performed better than our target for providing accurate advice on the helpline.**
- **62,852 people used our website, visiting 98,102 times, a significant increase on the previous year.**

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

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

This year we updated four of our good practice guides.

Good practice guide – money matters

This document is about managing the money of people who, due to mental ill health or learning disability, are unable to look after their own finances.

Aimed at doctors, nurses, social workers and care home managers, it gives a range of options, such as having advance arrangements which are enacted if a person becomes unwell, or having professionals apply to courts for the release of funds.

The guide shows points to consider for each, and refers to relevant sections of Scottish and UK legislation.

All of the options must be used in the best interests of the individual concerned and, where possible, decided in consultation with the person and his or her family.

The Commission regularly meets people whose quality of life could be significantly enhanced by better management of their funds. We are aware of several cases where people with a learning disability, for example, were leading chaotic lives, with bills unpaid, insufficient food and clothing, and where they were open to exploitation.

The guide was produced by the Commission in consultation with the Office of the Public Guardian and the Care Inspectorate.

It is available on the Commission's website, or in hard copy.

Good practice guide – care plans for people subject to compulsory care and treatment

When an individual is subject to a Compulsory Treatment Order or a Compulsion Order, the Mental Health Act requires their Responsible Medical Officer (RMO) to prepare a documented care plan. This is then updated at various times while the individual remains subject to the order, including whenever the order is renewed.

This care plan is an important document. It should be created and updated with the full participation of the individual, their named person (if they have one), and any involved family and carers.

The care plan should be person-centred, recovery-focussed and regularly and meaningfully reviewed. It should provide a good overview of what is happening for the individual, and the support, care and treatment they are receiving. It is particularly important that the Tribunal is provided with a comprehensive care plan when there are Tribunal proceedings.

The Commission has a statutory duty to promote best practice in the operation of the Mental Health Act. In 2014-15 we updated our guidance for RMOs on the preparation of care plans for individuals who are subject to compulsory treatment. This contains information and examples of good practice. We hope that this guidance will also prove useful in the wider context of care planning in all settings. It is available on our website.

Good practice guide – nutrition by artificial means

The Commission is sometimes approached by professionals who are seeking advice and guidance on situations related to providing nutrition by artificial means. It is most commonly used in the treatment of people with an eating disorder, but can be an appropriate part of the treatment plan in other situations, such as in cases of severe depression or psychosis.

This is often a complex and difficult area. On receiving such a call, the Commission explores the circumstances of the person who is unwell, reflects on good practice in relation to the law, and provides a view on a way forward that best safeguards the patient's welfare.

The aim of this document is to help practitioners take account of the relevant legal and ethical issues when they are considering this issue, in the absence of consent, in relation to someone with mental ill health.

The document does not constitute legal advice, but it gives the legislative context, addresses some of the scenarios that may arise, and gives links to further information.

It is available on our website.

Good practice guide – specified persons

The Mental Health Act allows certain restrictions to be placed on people who are detained in hospital. Before these restrictions can be applied, the patient concerned must be designated as a 'specified person' by their doctor.

The Commission has found large variation in both the understanding and interpretation of the legislation across Scotland. We produced this updated guide to help ensure that the operation of specified persons regulations is consistent with the law and its principles and that individuals' rights are respected.

The guide gives advice on the circumstances that may allow someone to be designated as a specified person, and outlines who has the authority to make such a designation.

The guide also considers the restrictions which can be applied, including restricting or withholding correspondence; restricting or preventing the use of telephones; and taking other measures to ensure safety and security in hospitals. It explains how doctors should notify the Commission once a designation is made. It emphasises that the use of specified persons regulations should not be seen as a routine aspect of care and treatment for the majority of people who are detained in hospital.

The guidance is available on our website.

Website and social media

We use our website to disseminate information on rights, care and treatment, and use of mental health and learning disability legislation.

In 2015-16 we saw a significant increase in traffic on both our website and twitter accounts, compared with the previous year.

62,852 people visited the website, 98,102 times. This compares with 45,504 people visiting 73,806 times the previous year.

They downloaded 48,258 publications, compared to 43,797 the previous year.

Our twitter following increased from 489 to 1,067 in the year.

Our advice line

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

Patients and people who use services, and their families and carers, can call our free phone number and speak to our practitioner staff for advice on care, treatment and the legislation surrounding mental health and adults with incapacity.

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

In 2014-15 our helpline received 5,143 calls. Of those, 4,629 callers sought our advice.

We conduct monthly audits of the advice given, and found that 99.5% of it was accurate, exceeding our target of 97.5% accuracy.

> "In 2014-15 our helpline received 5,143 calls"

Excellence in Practice seminars

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

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

During 2014-15 we ran four seminars, attended by a total of 90 people. The topics were:

- Medical treatment for those who lack capacity – rights, duties and the law.
- Restrictive management of individuals – rights, risks and legislative framework.
- Professional challenges – power of attorney and welfare guardianship.
- The Mental Health Act – consent to treatment, and significantly impaired decision making ability.

Feedback from participants included:

> 'I have arranged to spend time today reviewing the handouts and reflecting on my learning from the event. I will review my medical student teaching in light of the seminar.'
>
> 'Tricky questions. Brought real life dilemmas into the fore.'
>
> 'It was interesting to revise aspects of the Act over time that I have lost focus of, and to hear the views of the Commission, which sometimes surprised me.'

This year, for the first time, we ran a seminar for carers, including family members and/or close friends, in partnership with the Carers Trust and Support in Mind Scotland. The seminar focussed on the rights of carers, confidentiality and relevant areas of mental health and incapacity law. The seminar was attended by 20 people and feedback was very positive.

"Tricky questions. Brought real life dilemmas into the fore"

Influencing and empowering

- We were closely involved with the Mental Health (Scotland) Bill, and influenced its final content.
- We held our national awards event – Principles into Practice – showcasing the best projects and services from around Scotland that put the principles of legislation into practice.
- We worked with the Scottish Human Rights Commission and the Scottish Government to strengthen the links between human rights and mental health care.
- We responded to 10 Scottish Government policy or legislative consultation documents, including the Mental Health (Scotland) Bill.
- We continued to participate in cross party groups on mental health, dementia and learning disability.

"Every one of these fantastic projects is both creative and practical. They are all different, but one thing they have in common is their focus on the needs of the people who use their service."

Colin McKay,
Chief executive of the Mental Welfare Commission, speaking at the Principles into Practice awards

Principles into Practice awards

In March 2015 we held our national Principles into Practice event, celebrating some great examples of good practice in mental health and learning disability. Films of each project can be seen on our website.

The winners were:

Care and support of younger people – Skye House, Glasgow

The Skye House horse riding group is for young people with mental illness who attend Stobhill Hospital. By learning to ride, and learning about stable management, young people develop coping strategies.

Person centred/recovery approaches to long-term care and support – Fit for Life, Edinburgh

Designed for older people living with a mental health condition, Fit for Life bridges the gap between NHS and community services. Run by a physiotherapist, it helps people build self confidence and encourages social participation.

Care and support of people with dementia – IDEAS project, Dumfries

This team supports local care homes in improving the quality of life of people with dementia who experience stress and distress. Significant improvements for residents, staff and families mean the project is being expanded across the region.

Respect for diversity – MECOPP Gypsy/Traveller Carers' Project

MECOPP (Minority Ethnic Carers of People Project), works with carers who live in housing, on sites and on roadside camps. They address stigma and mental ill health by using the arts and film-making; casework and training; and community-led research.

Carer and young carer involvement and support – Support in Mind Scotland, Tayside – Carers Support Project

The group wanted to help people who are new to supporting someone with a mental illness, and who might not know the help available, or the terminology. They revised their literature, and train mental health nursing students at the University of Abertay.

Service user participation and influence – (The People's Choice Award) – Ceartas Advocacy, Kirkintilloch

Ceartas provides independent advocacy. It works with 10 service user groups, one of which is the ABI Cafe, for adults with acquired brain injury. Members support each other, and share their experience.

The Mental Health Bill

We were closely involved in the scrutiny of the Mental Health (Scotland) Bill. In August 2014 we responded to the call for evidence by the Health and Sport Committee, and in September 2014, our chief executive, Colin McKay, appeared before the committee to discuss our views in detail.

We generally welcomed the provisions of the Bill. We raised concerns in some areas, particularly where we felt there was a danger of people's rights being reduced. We supported new powers for the Commission. These views were highly influential on the report of the Committee, which was issued in January 2015.

In February 2015 we issued a briefing paper ahead of the Stage 1 debate at the Scottish Parliament, reiterating our earlier messages, and also voicing our concerns that a more thorough consideration of the full 2003 Act will soon be needed. Throughout the process, we worked closely with Government officials.

National Preventive Mechanism

The Commission is part of the UK's national preventive mechanism (NPM) under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The Convention is a United Nations human rights treaty, designed to strengthen the protection of people deprived of their liberty.

The Commission is one of 18 bodies in the UK that visit places of detention to monitor the treatment and conditions of detainees.

Commitment 5 – human rights and mental health

We worked with the Scottish Human Rights Commission (SHRC) and the Scottish Government on commitment five of the Government's Mental Health Strategy 2013-2015 to develop and increase the focus on rights as a key component of mental health care in Scotland. We held a consultation event with a wide range of organisations where we developed a draft logic model for rights-based care. The model sets out the impacts we hope ultimately will be achieved, and the short and medium term outcomes needed on the way to them. It details the key activities needed to achieve the outcomes.

Using the model, we will next undertake work with the SHRC to report to the Government on progress towards the outcomes. We will look at where progress is happening and where there are gaps in the work that the different organisations and services in mental health are currently doing. This report will inform rights based care for the next mental health strategy.

Events

We attend and speak at a wide range of events, explaining the work of the Commission and raising the profile of the issues that concern us.

In November, Colin McKay addressed Alzheimer Europe's annual conference, explaining how Scotland has moved to a jurisdiction where policy and legislation are explicitly rooted in a human rights approach.

Our work on supporting women offenders with mental health problems resulted in a speaking role for our lead social worker in this area, which in turn resulted in wider discussion of our findings.

We held a national event for heads of social work from across Scotland, involving the Mental Health Tribunal for Scotland, the Office of the Public Guardian and the Scottish Government.

Improving our practice

- Our Board continued to set our strategic direction and ensure efficient, effective and accountable governance.
- We have created two new roles, increasing our focus on patients, people who use services and their families and unpaid carers.
- Our advisory board continues to directly influence our work.

Our Board

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

Our Chair

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

Our Board Members

Paul Dumbleton has three grown-up children, one of whom has a learning disability. As well as his personal experience as a carer he has extensive experience working with people with learning disabilities and their families. He currently manages PLUS, a service for disabled children and young people and their families in Stirling. He is also a Disability Qualified Member of the Appeals Tribunal (Social Security and Child Support). Mr Dumbleton has served on the boards of voluntary organisations providing advocacy and training services to people with learning disabilities.

Jan Killeen was a part-time mental welfare commissioner before joining the board and is director of policy at Alzheimer Scotland. She has a long-standing interest in the rights and legal protection of people with dementia, and has taken a lead role in the development of policies which impact on the lives of people with dementia and their families/partners in Scotland. She initiated Scotland's first national dementia charity, Scottish Action on Dementia in 1985, and has helped to shape the Scottish Government's National Dementia Strategy. Between 2004 and 2007 she was seconded to the Justice Department of the Scottish Government to lead an action programme designed to improve the implementation of the Adults with Incapacity (Scotland) Act 2000.

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

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

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

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

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

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

Safaa also works with a number of local authorities as a consultant on the provision of children's services.

Elaine Noad OBE (no photograph) has worked in the public and voluntary sectors throughout her career. She was formerly the director of social work, housing and health at South Ayrshire Council. She has worked with a number of public and voluntary sector organisations, including acting as a non-executive director of the Scottish Government, a member of the Parole Board for Scotland, and as a lay member of the Scottish Solicitors' Discipline Tribunal. She brings experience in management, social work, audit and governance, and has a strong commitment to equality, diversity and human rights.

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

Towards greater engagement

In the past, we have contracted up to 10 part time visitors to work with us on our visits. They might be specialists in advocacy, individuals with past experience of mental ill health, or from a range of professional backgrounds.

This year we reviewed this system, in consultation with others, and decided to change our approach to strengthen our ability to draw on lived and caring experience and the expertise this brings. Instead of contracting visitors, we are creating two part-time staff posts in the Commission, one for a person with personal experience of mental health problems and of using services, and the other for an unpaid carer of someone with mental ill health, learning disability or a related condition.

We hope that by creating permanent posts, our new staff members' experience and expertise can be shared more broadly across the Commission, having an impact across our work. We are publicly advertising and recruiting for these roles in 2015.

Our advisory committee

A standing committee of our Board, our advisory committee consists of representatives of 25 stakeholder groups from across Scotland. They meet twice a year, and this year they made a major contribution to our visits review.

Our commitment to equality

The Commission is committed to the principles and practice of equality and diversity. We see our equalities duties as part of a wider strategy which puts equality and human rights at the centre of our work. Our Single Equalities Scheme, with full details of our approach, is available on our website.

Financial resources

Our revenue budget was £4.6 million. This included £3.6 million for the Commission, £0.6 million in respect of a cessation charge resulting from the Commission ceasing to be an employing authority in the Lothian Pension Fund, and £0.4 million for the National Confidential Forum (NCF).

Our capital budget was £0.2 million. This was for the NCF for setting up their offices and database.

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

Learning lessons

In 2014-15, we received 13 complaints.

Some people who contact us are upset, angry or dissatisfied in relation to the care which they or a relative are receiving. This means that it is not always easy to identify whether an individual is raising a complaint about us. If someone is clearly dissatisfied with something we have or have not done, then their concern will be treated as a complaint.

After investigation, one element of one complaint was upheld, and an apology issued. No complaints were escalated to the Scottish Public Services Ombudsman (SPSO).

In our commitment to continuous improvement, we reviewed our complaints handling system. From March 2015, we have introduced a new, more rigorous, set of complaint handling procedures, based on model procedures produced by the SPSO.

Environmental sustainability

Under the Climate Change (Scotland) Act 2009, the Commission is required to produce an annual report on sustainability. This was completed in September 2014 and is available on the website.

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