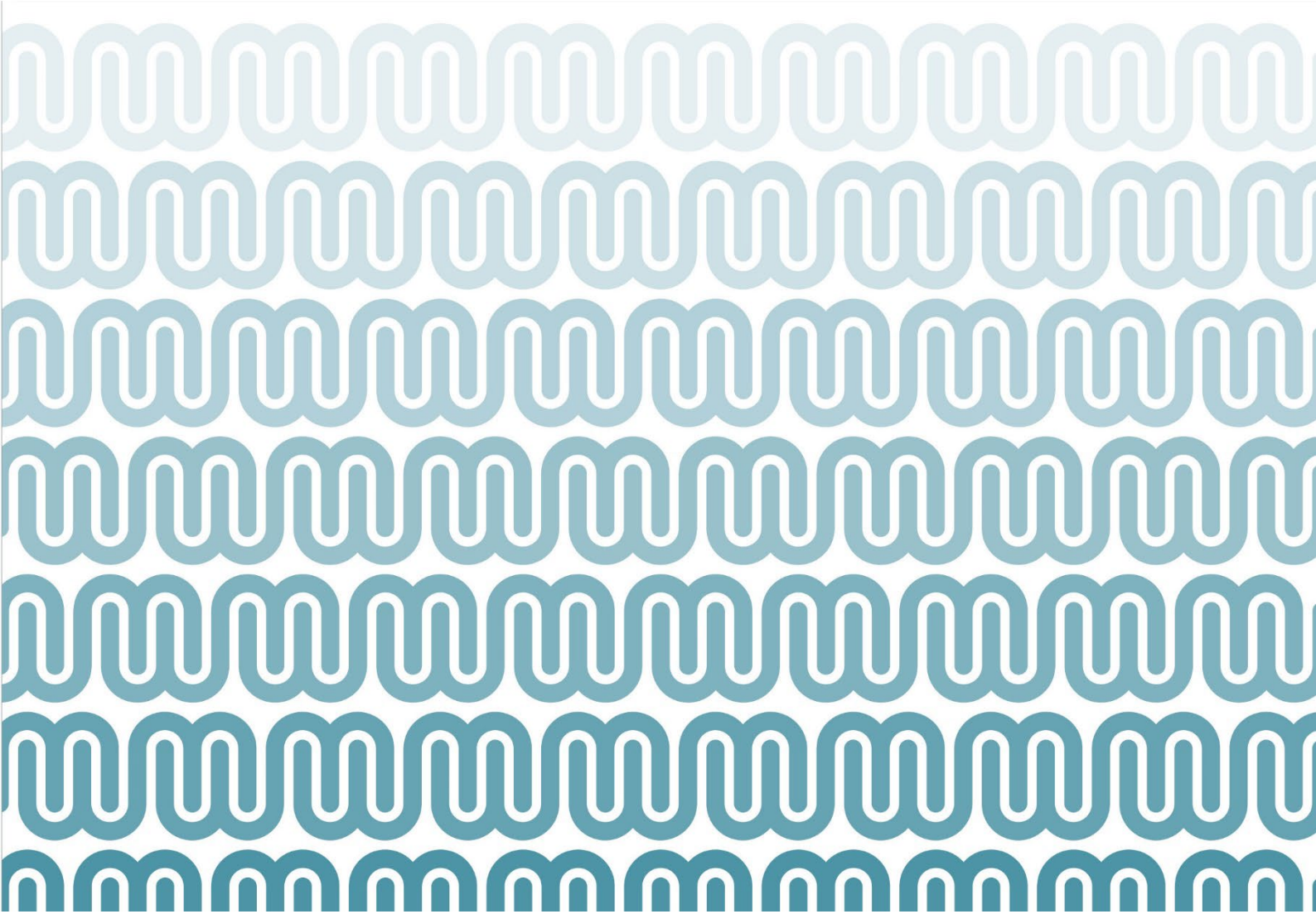
mental welfare commission for scotland

Draft Strategic Plan 2026-29

Consultation Document

November 2025



Contents

1. Background

The Commission launched its consultation in May 2025 to gather views on our current strategic priorities and our statutory functions to inform our new strategic plan for 2026 to 2029.

Based on what we heard we have developed this draft Strategic Plan for 2026 to 2029 for your consideration and comment.

Detailed below is our consultation process to ensure we engaged and consulted as broadly as possible.

2. Stage 1: Informing – explaining the case for change

2.1 Strategic Plan Briefing

We wanted to engage and consult as broadly as possible during the development of our new strategic plan and to ensure all stakeholders had the opportunity to express their views on the scope and to contribute to our strategic plan priorities for the next three years.

We prepared a briefing note (Appendix 1) which we sent out so that people and organisations could register their interest on how they would like to be involved (either through a focus group or completion of a survey or both).

Table 1: Details who we sent this briefing to

Stakeholders	**No of contacts**
Advisory Committee	33
Brevil: anyone can register their interest in the work of the Commission through our website (individuals/organisations)	1300
Combined list of stakeholder groups (individuals and national groups who had been involved with us on other projects)	149
National Board Chief Executives	7
Health Board: Chief Executives (incl State Hospital)	15
Local Authorities: Chief Executives	32
Local Authorities: Chief Social Work Officers	32
Health & Social Care Partnerships: Chief Officers	31

Briefing was also advertised on social media – Linkedin, X, Bluesky with two follow up reminders.

Table 2: Details the number of individuals/organisations who registered their interest

Stakeholders	No
Individuals	26
Voluntary/Third Sector Organisations (e.g. advocacy, autism, mental health, self-help)	33
National Organisations (e.g. NHS Education for Scotland, Social Work Scotland, etc)	15
NHS Boards	22
Local Authorities	7
Health & Social Care Partnerships	9

3. Stage 2: Engaging – developing the revised strategic plan

In this stage we used a number of methods of engagement, external focus groups, surveys, sessions with staff, our Advisory Committee and our Board self-assessment, all of which have informed our draft strategic plan.

3.1 Focus Groups

Focus Groups for staff and external stakeholders were set and at each of these sessions we asked the following two questions:

What does the Mental Welfare Commission do well?

What can the Mental Welfare Commission do more of?

Table 3: Details the number of individuals who attended our focus groups

Date	Present	No attended
10/07/2025	External stakeholders	21
16/07/2025	Staff	32
11/08/2025	Staff	7
13/08/2025	External Stakeholders	26
25/08/23025	External Stakeholders	15

3.2 Survey: What are your Views?

The survey was then issued to everyone on our register of interest who requested a survey (96), our staff (79) and our Advisory Committee (33). The survey is attached at Appendix 2.

We received 33 questionnaires, 12 from external organisations and 21 individuals.

Feedback from the survey:

79% (n=26) of respondents think our strategic priorities are still relevant.

70% (n=23) of respondents are aware of the visits undertaken by the Commission.

24% (n=8) of respondents have been involved in the visits undertaken by the Commission.

52% (n=17) of respondents have read our publications on the monitoring of the acts.

61% (n=20) of respondents have read our investigation reports or are familiar with our investigation work.

48% (n=16) of respondents do think the role of the Commission in investigations is clear.

52% (n=17) of respondents have accessed the Commission advice line or good practice guides.

About you section

Details about the individuals or organisations who completed the survey.

36% (n=12) respondents were organisations

64% (n=21) respondents were individuals

Organisations who responded:

Health & Social Care Partnerships	1
Local Authority	1
Third sector	6
Other	4

3.3 Other sources of information

Information was also collated from other sources:

- Board Self-assessment June 2025 for consideration in the development of our strategic plan.
- Feedback from Advisory Committee on 07/03/2025 and 29/08/2025
- Emails received from external stakeholders
- Emails received from staff

3.4 Collated feedback on each function of the Commission

The feedback below has been collated from all sources: external and staff focus groups. What are your views? Survey, and the other sources of information.

3.4.1 Strategic priorities

79% of respondents think our current four strategic priorities remain relevant (6% missing data). 15% answered no to this question. Suggestions for change/additions included:

i) Whilst we do consider that the current strategic priorities remain relevant, we also consider that an additional priority reflecting the Commission's leadership role would be helpful.

ii) Framing at least one strategic goal around human rights would be welcome and connect the strategy more clearly with the Commission's purpose. Considering the recent recommendations that there should not be more commissions and commissioners added to the Scottish accountability landscape it's important that the Commission centre human rights explicitly in the next strategy.

iii) These are incredibly generic strategic priorities to the point that they are almost meaningless and could pretty much cover any body working within health and social care.

iv) Impact across community services is lacking and considerably imbalanced with inpatients. I think the vulnerability is greater in the community than inpatients.

v) Focus on the most vulnerable does not promote ensuring best practice with all services users. There is a real need to expand the scope and reach of the Commission to improve care and outcomes for all. We want to be moving towards seeing less most vulnerable case scenarios.

3.4.2 Influencing and empowering

Feedback evidences that the independence of the Commission is highly valued.

“Because the Commission is separate from NHS and social services, it can speak up about problems without any conflict of interest. This makes it a trusted voice for patients and families”.

The size of the Commission compared to the impact was regularly referred to, particularly from staff internally.

The mental health professional and clinical ‘watchdog’ scrutiny/safeguarder/critical friend role is also regarded as unique with reviews, reports and advice influencing across the board. The Commission is regarded as an authoritative voice.

“This is just the tip of the iceberg really but suffice it to say that I consider the Commission to be important to me as a practitioner and as a supervisor and use its services regularly”.

“The fact that the Commission exists gives practitioners assurance”.

“I continually refer to different reports and share frequently to help prove a point. Much of the process for PEPs is informed by the commission’s presence and documents”. “As a Chaplain, I get to read your reports and look out for positive things I can make use of in my work situation, and also to share ideas with ward staff”.

Having paid roles with a focus on lived experience and carer lived experience was also raised as an important part of the Commission.

Visits are regarded as highly influential especially unannounced visits.

“By showing up at all of the various wards and units you make a difference with your presence”. Seeing how things are really working and calling out areas where resource is insufficient was welcomed; psychology was a key example. Visits were described as challenging and effecting change where highlighting both good and poor practice is welcomed.

Our focus on lawful treatment, human rights and helping people to claim their rights was also a key theme. Feedback centred on meaningful respect for and realisation of an individual’s human rights. Interventions under mental health and mental capacity legislation often have significant implications for the autonomy (including liberty and independent living) and dignity of an individual. The presence of the Commission and its duties under the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003 (the Acts), including its visits, closure reports, engagement & participation (E&P), monitoring the Acts, investigations, and provision of information and advice, as well as influencing and challenging was said to be essential to realising these opportunities and rights.

There was consistent and broad support for our good practice guides, participation in consultation processes and advice on complex case matters with a range of stakeholders giving examples of how they then share this information and influence others. The Commission is seen as a ‘leader’ in the field of mental health. There was an ask to develop training resources and delivery of training and to help health and social care partnerships (HSCP) have strategies and policies link to practice on the ground.

There were some gaps identified with someone saying the Commission is not doing enough for older people, focussing on younger people and leaving “elderly to rot”. At the same time a parent spoke about the Commission not doing enough in relation to CAMHS and waiting times.

There was some feedback about there still being a gap in what we discover and then what needs to happen in response. “The Commission is not going far enough”.

Internally there was support for Designated Medial Practitioner (DMP) work, its unique function, responsiveness and how promptly any errors are rectified.

Overwhelming support and encouragement for the Commission to put pressure on the Scottish Government (SG) re Scottish Mental Health Law Review (SMHLR).

3.4.3 Visiting individuals

There were a significant number of comments that noted that our visit programme (mostly the local visits and there were a couple of mentions about the guardianship visits) and the reports they produce are useful for a number of reasons. Comments indicated that reading about “how things are working”, that the reports “flag up where there is bad practice as well as good” and they “push for change”. There was feedback that not only do the teams from the service read them but other professionals, most notably advocacy, but we also heard from chaplains who shared the findings from the reports with others.

There were some recurrent themes noted. There was clearly a wish for the Commission to do more unannounced visits with responses indicating that this may give “a clearer picture of actual, everyday practice”. There were also a significant number of responses that asked for more detail about the follow up actions that services had taken in response to the Commission’s recommendations.

Another frequent comment was on the need for the Commission to expand our visits to community services, both NHS and independent sector, such as “supported housing environments”.

Other comments related to who should be available for visits, both from the Commission visiting team but also from the service that was receiving the visit. It was highlighted that the visiting team should be multidisciplinary and that when feedback was being given, that should also be to the full multidisciplinary team for that service; we heard that this would be “more reflective of the biopsychosocial service delivery”.

Feedback on the length of the reports noted that it was not always easy for teams to find the time to read through these and that an abbreviated version or different technology options – a 7-minute briefing idea was suggested - may be helpful to get the key points, “learning or outcomes, infographics” and recommendations across.

There was mention of standards that could be used to provide a baseline that would evidence change.

A number of the comments used the term “inspection”. The Commission however does not inspect against standards but undertakes visits to determine whether practice is in keeping with rights and law linked to the best practice the Commission produces and the intent of law in practice.

Feedback from the staff focus groups made reference to the changes in the visit programme, with a focus on enhanced visits and considering different ways to engage with people, other than approaching them directly only on the day of a visit.

3.4.4 Monitoring of the acts

Stakeholders strongly value the Commission’s independent role in monitoring use of the Mental Health (Care & Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000. Monitoring reports are widely used to understand national trends, benchmark practice and provide an evidence base for reform. However, several themes recurred: the need for clearer, more accessible presentation (summaries, infographics, easy-read, translations); deeper analysis of causes and impacts beyond headline numbers; and clearer outcomes on what happens after recommendations are made.

Concerns were raised about declining Mental Health Officer (MHO) consent to detentions, variable quality of social circumstances reports, the low prevalence and inconsistent respect for advance statements, and variation across regions.

Stakeholders called for monitoring of restraint and seclusion, post-discharge risk/readmissions, and deprivation of liberty under Adults with Incapacity Act (AWI). They also sought more systematic reporting on advocacy access, equality and intersectionality.

Internally, staff highlighted the success and workload of Designated Medical Practitioner (DMP) administration as a unique statutory safeguard that should feature prominently in the strategy.

3.4.5 Investigations

Feedback highlighted the value of investigation reports for learning and there was an ask to spread learning beyond ‘traditional audiences’.

In relation to investigations specifically, there was not a significant level of specific area to direct our investigations, except for ‘after care’, which appears to relate to both aftercare following a period of hospital detention and prison aftercare. The latter will be addressed through our Prison Themed Visit in 2027. A specific investigation emphasis of after care following hospital detention is quite a challenge given the individual subjects, more generally (Mr E is an exception) sadly relate to a person’s death following deficiencies in care, neglect and/or ill treatment. However, the point made by the contributor is valid and could be considered as a themed visit piece of work by the Commission.

There was a suggestion of completing a piece of investigatory work to highlight excellent work undertaken rather than deficiencies.

Key feedback points specific to investigations included:

- Continue to publish closure reports for all investigation reports.
- Continue work on deaths in detention, within the mental health system and homicides investigations and seek to ensure we have a system which fully complies with Article 2 European Convention of Human Rights and reflects SMHLR recommendations 11.11-11.15.
- Raise awareness, and reassurance, of anonymity being guaranteed where patients, residents, their families and unpaid carers, and health and social care staff raise issues of concern, either in the course of visits, investigations or at other times. Where this is not possible or appropriate for an effective outcome then the Commission should provide oversight to reduce the risk of adverse consequences for patients, family members and staff who raise concerns.
- When an investigation takes place, the work is detailed and thorough and contains useful learning points for practitioners.
- Some analysis of national themes etc arising from Investigation activity would be useful - perhaps linking this to Care Inspectorate analysis of ASP Learning Reviews etc. and making these available to relevant local and national contacts.

3.4.6 Information and advice

The feedback from the various sources can mostly be divided up into comments on the use of the advice line or our good practice guides/advice notes, although there were also comments on the way the Commission engaged with staff/organisations, internally and externally in relation to the information and advice it provides:

"I wonder if increasing an emphasis on celebrating success would be useful, although not detracting from the other valuable work you do - it would be nice to hear (say) condensed top tips of well designed, and delivered, services for others to learn from – bit like the 'bite size' info approach"

The other message that came through echoes what other sections have found that the visibility of the Commission needs to be stronger; we heard this message from both internal and external groups:

"Whether that's a lot of social media and just, you know, highlights of what/ who we are and what we do…just making ourselves more visible. So, more people know about us" and "Round table discussions, perhaps training or webinars on the guidance. Strengthening knowledge skills and professional networks"

For the advice line, there were 19 additional written comments provided.

The positive ones included “Well informed and empathetic call handler”, “Prompt when returning calls, sending resources which have been useful which equipped us (advocacy workers) with the knowledge we need to promote our partners rights”.

Where we asked about improvements we were told: “No actual advice was given above a level that I was already aware of as an experienced MH social worker” and “If we contact advice line regarding a patient situation, we are told that is not the Commission’s role also the adviser is often not able to answer the query”. This highlights the need for the Commission to be clear about the advice we give and the advice we do not give. For example, we do not expect the Commission to be the first point of call for researchers or staff before they have consulted their supervisors. We are also not legally qualified and will always direct services to their own legal advice.

In relation to our good practice guides, advice notes and the information the Commission has on its website, there were 40 comments, with the majority providing positive feedback and the remainder giving constructive feedback about what the Commission could do better, such as making the guides into accessible read versions, simplifying our website, having physical resources such as leaflets, identifying which ones are viewed/used most and developing these, either for more public awareness raising – roadshows were suggested, or with the use of short, time-limited podcast-style presentations so that staff/services who find it difficult to read our longer reports get the information in a more convenient way. For example: “I looked at some of the reports that you've got on the website, obviously they're brilliant and loads of detail, but I completely agree with these points around the ability and the time that folk have to read these things these days is so limited” and “Seven minute briefings from significant learning reviews, things like that where you can capture report into the sort of main take away. Some of that would be great. There's not enough time. The capacity is always low, so some short speak away, learnings would be great.”

There were some other comments that related to reviewing and looking at our annual reports, our use of social media, FAQ/Q&As on the website (that are kept up to date) and a You said, we did section on the website. There were a number of comments that indicated that our website needs “revamping”.

3.4.7 Engagement & participation

There was very limited information specifically provided for this particular section, but other sections such as information and advice had some comments from the internal and external groups.

The specific feedback came from the external groups and from the Commission’s Board assessment.

There were some comments that highlighted that much of the information from the Commission is generic and geared towards professionals. There was a suggestion that lived experience blogs or case studies would add to the advice given.

There were a number of comments about meaningful engagement by the Commission, with consultation being widely sought, extended engagement with organisations such as VOX, or

advocacy was also suggested, wider dissemination about what the Commission can/cannot offer and collaboration with key groups when developing guidance were also key themes throughout the feedback.

3.4.8 Digital transformation

The responses focussed on delivery of the new information management system (IMS). This is several years in the making and a significant undertaking for the Commission, which is intended to be transformational. It is due to be completely operational in 2026.

Other responses mention reviewing what data we collect and whether we can do more, and how we can harness AI.

3.4.9 Workforce

It was encouraging to see so many valuable contributions, particularly from our own workforce, identifying a number of areas where the Commission excels and is called out as a supportive environment in which to work.

The range of responses highlight some real strengths around:

- Expertise/knowledge
- Our reach and extent of activity for such a small organisation
- Approachable and supportive culture/colleagues
- Feedback and continuous improvement
- Staff engagement and consultation

This is a good foundation from which to build.

There appears to be a theme around needing to improve internal communications, to ensure our front facing colleagues are more informed about Commission business, upcoming publications and external activity.

Also of note are comments from external stakeholders around ensuring the Commission's externally facing workforce remains reflective of the modern Scotland health and social care workforce, in terms of roles that form part of our visiting teams, for example.

4. Stage 3: Consultation – to undertake a consultation on the revised strategic plan

We are grateful to everyone who contributed to this process and the next stage is to consult on our draft strategic plan. The consultation period will run for a period of four weeks from **10 November 2025 until 5 December 2025.**

The Consultation Response Form is attached at Appendix 3

5. Tell us what you think

A copy of the draft Strategic Plan for 2023 to 2026 is attached.

To respond to this consultation can you please complete the attached response form and return either by email or post by **5 December 2025** to:

Postal address:

Julie O'Neill

Business, Change & Improvement Manager

Mental Welfare Commission for Scotland

Thistle House, 91 Haymarket Terrace

Edinburgh, EH12 5HE

Email: julie.oneill2@nhs.scot

6. Making a decision and next steps

This is our first draft strategic plan for 2026-2029 and has not been considered or approved internally within the Commission. It may be subject to change both from the consultation which closes on 5 December 2025 but also from the internal governance and scrutiny processes at the Commission.

The final draft strategic plan for 2026 to 2029 will be submitted to our Executive Leadership Team in January 2026 with final approval at our Board meeting in February 2026.

Thank you to everyone for your valuable contribution to the development of our next strategic plan.

APPENDIX 1

Mental Welfare Commission
Development of the Strategic Plan for 2026 to 2029

We are nearing the end of our current Strategic Plan for 1 April 2023 to 31 March 2026 and will be undertaking an engagement and consultation process on the development of our next strategic plan.

We would like to engage and consult as broadly as possible during the development of the new strategic plan to ensure all stakeholders have an opportunity to express their views on the scope and contribute to our strategic plan priorities for the next three years.

To do this we will be holding focus groups and also sending out a feedback questionnaire.

We are currently preparing a register of interest and if you would like to be involved in the development of the new strategic plan could you please send your contact details and how you would like to be involved to: **mwc.ep@nhs.scot by 13 June 2025**

Are you responding as an individual or an organisation?	☐ Individual ☐ Organisation
Name:	
Organisation Name (if applicable)	
Address:	
Email address:	
Contact telephone number:	
How would you like to be involved?	☐ Focus group ☐ Feedback questionnaire ☐ Both

Sandy Riddell
Chairman

Privacy statement

The Mental Welfare Commission for Scotland fully respects your right to privacy. In strict accordance with the Data Protection Act (1998) and other, related legislation, we treat any personal information you supply to us with the highest standards of security and confidentiality.

APPENDIX 2

Deadline to return your completed questionnaire:

What are your VIEWS?

Preparing for the next 3 years ….

The Mental Welfare Commission's strategic plan is due for review.

The aim of this consultation is to seek your views on where we are now in relation to how we deliver on our duties according to mental health and incapacity legislation (activities) and where we need to be over the next three years.

We are ambitious for the people that we serve and want to be informed by everyone with an interest in the role of the Mental Welfare Commission and its responsibilities in law; this will help to develop and shape our priorities for our new Strategic Plan for 2026 to 2029. We thank you in anticipation of your contribution.

Please return your completed questionnaire by email to: mwc.ep@nhs.scot by **15 August 2025**

About Us

Our Purpose
We protect and promote the human rights of people (children, young people and adults) with mental illness, learning disabilities, dementia and related conditions
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.

To achieve our mission and purpose we currently have four strategic priorities:
Strategic priorities
- To challenge and promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

In order to achieve these priorities we have grouped our activities into five main categories:
- Influence and empowering
- Visiting individuals
- Monitoring the law
- Investigate and casework
- Information and advice

Activity 1: Influencing and empowering

We are often described as a mental health 'watchdog'.

We look into situations where something has gone wrong in mental health and learning disability services, but we also work to improve policy to help safeguard people and prevent things going wrong.

In our watchdog role, we draw attention to deficiencies in care and treatment in mental health services and areas of improvement in practice and ask people to learn from them. In this role, we use our unique overview of mental health, learning disability and dementia services to help Scottish Ministers and service managers shape policy. This way we aim to help develop services that safeguard rights, and improve care and treatment for people with mental illness, learning disability, dementia and related conditions.

Q1 In your opinion how is the Mental Welfare Commission making a difference?

Q2 Do you think our current four strategic priorities are still relevant?

Current Strategic priorities

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

☐ Yes

☐ No

If No, (please explain)

Q3 **In your opinion what does the Mental Welfare Commission need to do in future (next 3 years) to make a greater impact on its strategic priorities?**

Q4 **Are there any other actions that should be prioritised by the Commission for attention in the next three years?**

Q5 **Is there additional support that we can provide to Health and Social Care Partnerships/Health Boards/Local Authorities to support their own engagement and involvement of people with lived experience, their families and carers?**

Q6 **Any other comments you wish to make in relation to our influencing and empowering activity?**

Activity 2: Visiting individuals

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, in a care home, in secure accommodation, or in any other setting where they are receiving care and treatment. About a quarter of our visits are unannounced.

We produce reports on all of our visits to people using services, so that services can learn from them and improve the care and treatment they provide. We do this through either:

Local visits - to people who are being treated or cared for in/by local services, such as a particular hospital ward, a local care home, local supported accommodation, or a prison.

Themed visits - to people with similar health issues, or in similar situations, across the country.

Welfare guardianship visits - where we visit people who have a court-appointed welfare guardian. The guardian may be a family member, friend, carer, or social worker (on behalf of the Chief Social Work Officer).

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

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

Q7 Are you aware of the Visits undertaken by the Commission (themed, local, guardianship)?

☐ Yes (If Yes, please go to question 8)

☐ No (If No, please go to question 14)

Q8 Have you been involved in any of the visits undertaken by the Commission (themed, local, guardianship)?

☐ Yes (If Yes, please go to question 9)

☐ No (If No, please go to question 11)

Q9 What worked well?

Q10 What, if any improvements could we make to our visits?

Q11 Do you have any further comments about the Commission's visiting role?

Q12 Do you have any comments about the Commission's visiting reports that are published?

Q13 Do you have any other comments in relation to the Commission's visiting role?

Activity 3: Monitoring of the Acts

We monitor the use of the Mental Health (Care & Treatment) (Scotland) Act 2003 and the welfare parts of the Adults with Incapacity (Scotland) Act 2000.

The law says that the people providing care and treatment must let us know if a person has been:

- detained under the Mental Health Act
- detained without the consent of a mental health officer
- placed under a compulsory treatment order
- given care and treatment that is not in line with his or her advance statement, or if:
- a compulsory treatment order has been changed in an important way
- a welfare guardian has been appointed to make decisions on another person's behalf

We produce general monitoring and trend data on the use of mental health and incapacity law. These monitoring reports identify any issues with the way the law is used. We highlight these issues, and recommend changes to policy makers and to service providers.

Q14 Have you read any of our publications on our monitoring of the acts?

☐ Yes

☐ No (If No, please go to question 19)

Q15 Have these monitoring reports been useful to you? Please explain how.

Q16 What, if any, improvements could be made to these publications?

Q17 What other monitoring work can the Commission do to ensure the rights of individuals are protected and respected?

Q18 Any other comments?

Activity 4: Investigations

If we think that someone with a mental illness, learning disability, dementia or related conditions is not getting the right care and treatment, we will look into it.

We may conduct an in-depth investigation if we believe there are valuable lessons to be learned across Scotland.

We are particularly keen to investigate when we think other people may be having similar problems, and where there have been mistakes that we feel other professionals could learn from. We want to help make sure the same things don't happen again to other people in similar circumstances. Sometimes, after initial investigations, we find nothing of concern. Other times, we want to look further into the case.

When we do this we publish the results and recommendations from our investigations. We then follow up with services to find out what changes they have made in response to our recommendations.

Q19 Have you read any of the Commission's investigation reports or are you familiar with the Commission's investigation work?

☐ Yes

☐ No

Q20 What works well in relation to our investigations work and publications?

Q21 What, if any, improvements could we make to our investigations work?

Q22 Do you think the role of the Commission in investigations is clear?

☐ Yes

☐ No

If No, please explain

Q23 Any other comments?

Activity 5: Information and advice

If you need information or advice about your rights in relation to mental health care and treatment, or you are concerned about someone else's rights and welfare, we will try to help.

If we cannot help directly, we can refer you to other organisations who should be able to.

We give advice and information about rights and best practice in relation to two key laws:

- the Mental Health (Care & Treatment) (Scotland) Act 2003
- the Adults with Incapacity (Scotland) Act 2000

Our website provides answers to questions that patients and members of the public, carers, and professionals have asked us.

Q24 Have you accessed the Commission's advice line or good practice guides?

☐ Yes

☐ No (If No please go to 'About you' section on page 13)

Q25 What was good about the advice line or good practice guides/advice notes you accessed?

Q26 What, if any, improvements could we make to our advice line or good practice guides/advice notes?

Q27 Is there anything else we could be doing in relation to the provision of information and advice?

Q28 Within the Commission's role and remit, is there more the Commission could be doing with and for:

People with lived experience

Families, carers

Practitioners

Q29 Any other comments?

About you section
Finally, we'd like to ask some details about you. You don't have to fill this in, but if you do it will help us to ensure our consultation is inclusive. Anything you tell us on this form will be anonymous.

Are you responding as an individual or organisation?

- ☐ Individual
- ☐ Organisation

Organisation

Please specify which type of organisation you work for?

- ☐ NHS Board
- ☐ Health & Social Care Partnership
- ☐ Local Authority
- ☐ Third Sector
- ☐ Private Sector
- ☐ Other, please specify

If you are responding as an **Individual** can you please complete the following:

- ☐ Prefer not to answer

White

- ☐ Scottish
- ☐ Other British (English, Welsh, Northern Irish)
- ☐ Irish
- ☐ Gypsy/Traveller
- ☐ Polish
- ☐ Any other white ethnic group, please describe

Asian, Asian Scottish, Asian British

- ☐ Pakistani, Pakistani Scottish, Pakistani British
- ☐ Indian, Indian Scottish, Indian British
- ☐ Bangladeshi, Bangladeshi Scottish, Bangladeshi British
- ☐ Chinese, Chinese Scottish, Chinese British
- ☐ Any other Asian, please describe:

African

- ☐ African, African Scottish, African British
- ☐ Any other African, please describe:

_____

Caribbean or Black

- ☐ Caribbean, Caribbean Scottish, Caribbean British
- ☐ Black, Black Scottish, Black British
- ☐ Any other Caribbean or Black, please describe:

Other ethnic group

- ☐ Arab, Arab Scottish, Arab British
- ☐ Any other ethnic group, please describe:

Any mixed or multiple ethnic groups
Please describe:

How old are you?

☐ Prefer not to say

Age: …….

Gender identity - Are you:

☐ Prefer not to say
☐ Male (including trans man)
☐ Female (including trans woman)
☐ Other gender identity - please tell us:

Which of these best describes how you think of your sexuality?

☐ Prefer not to say
☐ Heterosexual or straight
☐ Gay or lesbian
☐ Bisexual
☐ Other sexuality – please tell us:

APPENDIX 3

mental welfare commission for scotland

CONSULTATION RESPONSE FORM

1. Our Strategic Priorities

Do you agree with the content is this section?

☐ Yes

☐ No

If no, please explain

2. Influencing and empowering

Do you agree with the content is this section?

☐ Yes

☐ No

If no, please explain

3. Visiting individuals

Do you agree with the content is this section?

☐ Yes

☐ No

If no, please explain

4. Monitoring of the Acts

Do you agree with the content is this section?

☐ Yes

☐ No

If no, please explain

5. Investigations

Do you agree with the content is this section?

☐ Yes

☐ No

If no, please explain

6. Information & advice

Do you agree with the content is this section?

☐ Yes

☐ No

If no, please explain

7. Engagement & Participation

Do you agree with the content is this section?

☐ Yes

☐ No

If no, please explain

8. Digital & Transformation

Do you agree with the content is this section?

☐ Yes

☐ No

If no, please explain

9. Workforce

Do you agree with the content is this section?

☐ Yes

☐ No

If no, please explain

Any other comments

Please return the response form either by email or post by **5 December 2025** to:

Postal address:

Julie O'Neill
Business, Change & Improvement Manager
Mental Welfare Commission for Scotland
Thistle House, 91 Haymarket Terrace
Edinburgh, EH12 5HE

Email: julie.oneill2@nhs.scot