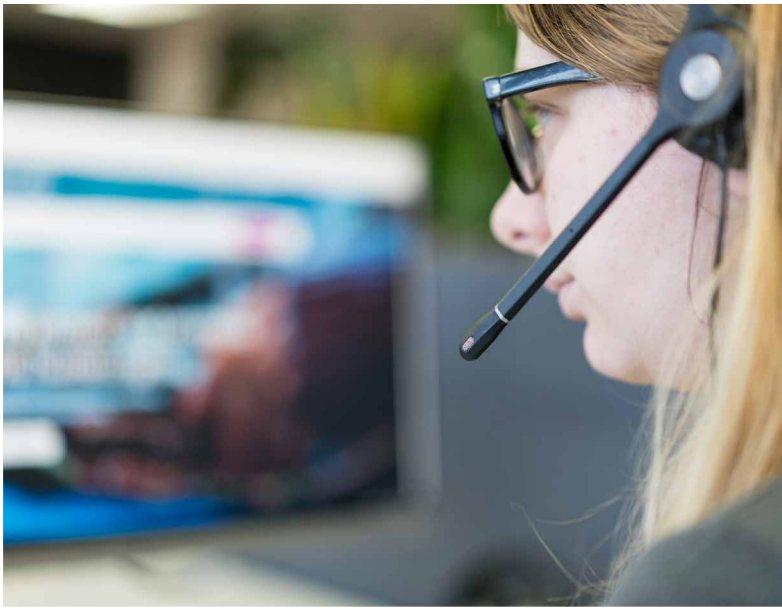
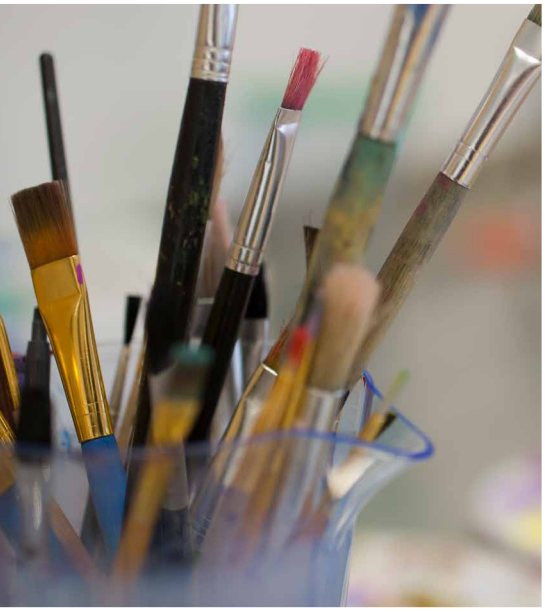
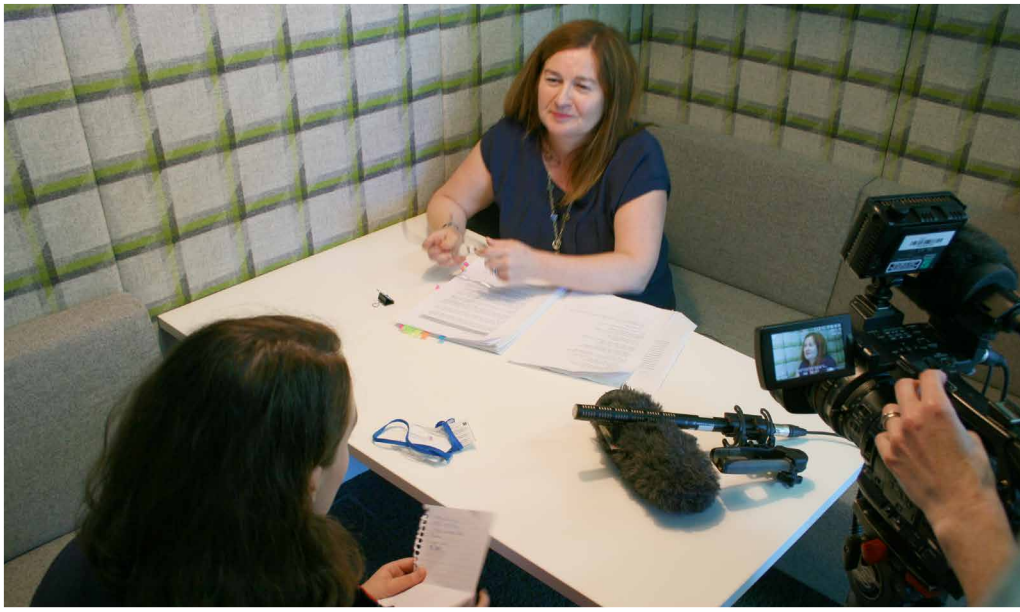
Annual report 2018-19

mental welfare commission for scotland







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

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

Contents

Who we are and what we do

Our mission and purpose

Our Mission

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

Our Purpose

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

Our Priorities

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

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

Our Activity

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

Chair's foreword

Firstly I'd like to pay tribute to my predecessor, the Very Revd Dr Graham Forbes, who chaired the Commission's Board from its first meeting in April 2011 to March 2018.

As a Board member since 2017, I have witnessed Graham's leadership and engagement skills in action. He, along with Board and Commission colleagues, has ensured that the organisation has had a huge influence over recent years, and is firmly established in its roles.

I was delighted to be appointed Graham's successor, and am determined to ensure we build on achievements to date, and ensure we are fit for the future.

I would like to recognise, too, the contribution of Paul Dumbleton, who also completed his term of office on the Board this year. The Board and the wider organisation benefited from Paul's considerable experience and knowledge and the invaluable carer perspective he brought to discussions.

Impact

This annual report demonstrates, yet again, the range of our work, including influencing policy, developing good practice, monitoring legislation and visiting wards and individuals. For the size of the organisation, the scope is both impressive and challenging.

Amidst this, I have a particular interest in assessing the impact of what we do. One standout achievement in this area last year was the government's announcement of a review of the Mental Health Act, with Colin McKay as one of the key team members. Readers of Commission publications will know how persistently we have called for reform of this and other legislation. While we are contributing to related strands of work now underway, having our chief executive so closely involved in the review of the Mental Health Act is a clear demonstration of our impact.

Another example is the work done on perinatal mental health. Following an investigation three years ago into a single tragic case, and a national themed visit on the care and treatment mothers-to-be and new mothers with mental ill health received across Scotland, we found gaps in services. We worked with others to highlight our recommendations for change, which the government accepted. This year's Programme for Government sets out their continued commitment to supporting the development of perinatal services, with clear finances attached.

The Programme for Government also commits to establishing a personality disorder managed network – another improvement we have been calling for following a national themed visit report.

Stakeholder survey

These are tangible examples of impact, but, looking ahead, I believe we can do more.

One challenge is to find better ways of connecting with the wide range of stakeholders we have including health and social work services, third sector organisations, community services and individuals and their families.

This year, we will conduct a survey of all of our stakeholders to gain insight into their awareness of our role, and to seek their views on improving our connections.

Health and social care

I have also met a number of stakeholders this year and been told that the Commission is viewed positively and seen as holding a unique role, but we could be better connected. This is a particular issue in relation to the evolving landscape of health and social care integration. This is important to us, and this annual report demonstrates why.

Our major investigation highlighted a case where a breakdown in the relationship between social work and health care meant a vulnerable woman was kept on a hospital ward unnecessarily for 18 months.

We also regularly highlight our concerns over other delayed discharge cases when we find them on our local or themed visits, such as the visit to people with autism and complex needs.

We raise our concerns with health authorities and social work teams, but I believe we have an opportunity to make new connections with Integrated Joint Boards.

Strategy

We will soon be working on our next strategic plan, for 2020-2023. This will be drafted in an environment of much discussion over reform of legislation. It is important for us to continue to seek to influence that longer term future, whilst focusing on priorities for the next three years.

"For the size of the organisation, the scope is both impressive and challenging."

Chief Executive's message

Last year in this piece my first comment was about the need for reform of Scotland's Mental Health Act. I am really pleased that our calls were heard and to now be part of John Scott's team working on a review of that Act, along with consideration of convergence with other legislation.

As we discuss options and listen to views about how best to create modern, forward looking legislation, it is critical to keep a strong connection with what is happening now for people across Scotland. On the pressures on services, the changing needs of the population, and the way the law is being used now.

Use of detention

Our monitoring report on the use of the Mental Health Act is a key document – the only publication that collates national data on how the law is being used to treat people with mental ill health. The 2018-19 report shows an increased use of the law to detain people for treatment. This reflects previous years and means we now have the highest rate of detentions yet recorded using the 2003 Mental Health Act, with variations in how it is happening across the country.

It also shows significant rises in detentions related to young people, particularly 16 to 17 year old young men being treated through emergency detentions, which last up to 72 hours, and young women under the age of 25 being treated through short term detention, which lasts up to 28 days.

The Commission intends to undertake a specific piece of work to understand better some of the reasons for increased detentions of young people.

The review of the Act will also look at why detentions overall are increasing, and why there are variations across Scotland. These are key questions which we must seek to answer before new laws can be put in place.

To support this, the Commission will work with the NHS Information Services Division to examine our respective data.

Sharing good practice

A key part of our work is to visit individuals in wards and units across the country and report on our findings. On these visits we talk to patients and staff and we examine documentation. We often found that care plans – a crucial part of helping support the process of recovery for patients – varied in quality and in detail. After a wide consultation last year, taking in views of nurses and others in clinical teams, we published a new good practice guide on care plans for people with mental illness, dementia or a learning disability. The guide has been widely circulated and well received. We continue to promote it.

We updated our good practice guide on seclusion. This is a difficult and complex subject, and we had found some misunderstanding as to its meaning, with some services misleadingly believing it related only to the use of a locked room. Our updated guide gives information on this, and also asks that all health boards have a policy on the use of seclusion in treating people with mental illness or learning disability, with consistent and comprehensive monitoring and review.

Office update

We also decided to adopt a smarter working policy and update our working practices. In 2018-19 we reduced the amount of office space we use and created a new office environment. Commission staff have now all adapted to hot desking, more remote working, and the introduction of (very popular) standing desks. This project reduced our costs and brought greater flexibility into our approach to work.

Gary Morrison

I would finally like to mention Gary Morrison, our executive director (medical) who died suddenly earlier this year. In addition to the many achievements in his career, Gary was greatly liked by colleagues in the Commission for his kindness, compassion and thoughtfulness.

He will live long in all our memories.

"A key part of our work is to visit individuals in wards and units across the country and report on our findings."

Influencing and empowering

– We welcomed the government's announcement of a review of mental health legislation, which followed calls from the Commission and others for our laws to be updated. We acknowledged this is an ambitious project, which we will support in every way we can.

– As we prepared to publish a number of our regular local visit reports, we identified particular concerns over the delayed discharge of people with learning disabilities, with some people waiting years to leave hospital. We highlighted this publicly, and urged integrated joint boards to develop clear plans to end delayed discharges for these patients as a matter of urgency.

– Our work in recent years on perinatal mental health, along with that of other organisations, has resulted in a government commitment to establishing a perinatal mental health network to provide better mental health care and treatment for mothers with young babies.

– Our membership of the National Preventive Mechanism ensured that key sections of our work was shared in its annual report. We also contributed to the group's submission to the UN Committee on the Prevention of Torture in advance of its visit to the UK.

– We met with health boards in Scotland and their health and social care partners to share our findings and discuss areas of mutual interest.

Legislative reform

The Commission and others have been calling for legislative reform for a number of years.

In March 2019, the Minister for Mental Health announced an overarching review of the mental health legislative framework, and appointed John Scott QC to chair this independent review.

Later in the year, it was announced that Colin McKay, chief executive of the Commission, would be one of a small group of core advisors to the review.

The terms of reference for this work confirm that it has a wide remit, and will consider previous and ongoing work in this field.

The review has been asked to produce an interim report by May 2020, which will identify priorities and an overall timeline for the next stage of the review.

This is a significant opportunity for Scotland. Our current legislative framework was seen as bold and innovative when it was introduced at the start of this century. It is now time for us to build on that work and learn from others and from changes in approaches to the care and treatment of people with mental illness. The increased focus on human rights in recent years is also reflected in the terms of reference.

We welcomed the announcement of this review, and will support it as an organisation, in addition to Colin McKay's specific role, as best we can in the year ahead.

"This is a significant opportunity for Scotland."

End year meetings

Once a year we meet with Scotland's health boards and their health and social care partners.

These meetings give each participant the opportunity to share information on work undertaken during the year, and to discuss areas of mutual interest.

The Commission might raise the findings of our local visits in the area, or discuss issues arising from our themed visits and our plans for future themed visits.

We highlight local data featured in our monitoring reports, and draw attention to the recommendations made for all health boards arising from our investigation reports. Health boards and other partners tell us about their current priorities, achievements and challenges.

The meetings always result in a valuable exchange of information. Attendees include senior managers from the Commission, from the health board, local authorities and integrated joint boards.

National Preventive Mechanism update

The Commission is a member of the UK National Preventative Mechanism (NPM), a body that brings together independent monitoring organisations that have a role in protecting people in detention. Our chief executive chairs its Mental Health and Scotland sub-groups.

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

The NPM's Ninth Annual Report 2017-18 was published in January 2019 and highlighted a number of the Commission's reports:

- thematic reports on medium and low secure forensic mental health services in Scotland;
- the monitoring report on the use of the Mental Health (Care and Treatment); (Scotland) Act in the last 10 years (highlighting increases in the use of detention);
- our report on *Human Rights in Mental Health Service;* and
- our report on *The Right to Advocacy*.

It also highlighted *Rights in Mind*, and our series of videos relating to rights in practice.

The Commission contributed to the NPM's submission to the UN Committee on the Prevention of Torture before its visit to the UK.

Learning disabilities/delayed discharges

We published four local visit reports on visits to units for people with learning disabilities, which each found unacceptable levels of delayed discharge, with some patients waiting years to leave hospital. Because of this, we published the reports together with a statement which emphasised our concerns.

Although their overall care and treatment was good, half of the 54 patients across the four wards no longer needed hospital treatment, and their discharge was delayed.

This followed a 2016 themed visit report we published on people with learning disabilities in hospital, which found that a third of patients in learning disability units had been identified as ready to leave hospital, but were awaiting a suitable move. It was particularly disappointing to find continued high levels of delayed discharge in the units we visited, despite specific recommendations to address this issue.

The Commission will continue to monitor the situation, and urge integrated joint boards to develop clear plans to end delayed discharges for these patients as a matter of urgency.

Perinatal monitoring

When a mother who has a baby under the age of 12 months requires inpatient mental health treatment, there is a legal duty in Scotland to provide for joint admission, where this is in the best interests of mother and baby. Scotland has two regional mother and baby units designed to care for mother and baby in this situation. We carried out a national perinatal themed visit in 2015, and found that over a third of mothers admitted to mental health care did not receive care with their baby in either of those units. We made recommendations to government, including a call to establish a national managed clinical network for perinatal mental health network, and worked with others to highlight this need. The Scottish Government established the network in 2017, and in their most recent Programme for Government confirmed their commitment to supporting services, with specific financial resources.

In a joint project with the Perinatal Mental Health Network, we have begun a national project monitoring perinatal admissions across health boards. The aim is to identify barriers to mother and baby unit care, inform national service development and improve women's access to inpatient perinatal care, wherever they live in Scotland. The first year's results will be reviewed in spring 2020.

"...half of the 54 patients across the four wards no longer needed hospital treatment."

Effective and efficient visiting

– We visited 1,402 people across Scotland this year, exceeding our key performance indicator to visit 1,350 people.

– Twenty-eight of our 103 local visits this year were unannounced. This exceeds our key performance indicator, which was to conduct 25% of local visits in this way.

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

We publish reports after most of our visits and make recommendations for improvement for services, for health boards and for government where we identify a need for change. We follow up on our recommendations.

Our visits are divided into:

Local visits – to people who are being treated or cared for in local services such as a particular hospital ward, a local care home, local supported accommodation or a prison. This year we visited people in 103 locations across Scotland as part of our local visits. Twenty-six percent of these visits were unannounced.

Themed visits – to people with similar health issues or situations across the country. We conducted a themed visit this year focussing on people with autism and complex care needs.

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.

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

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 their rights under these Acts?
- Has that person been involved in decisions about their care and treatment, and have they been given enough information to participate in those decisions?
- Have other relevant people, such as a carer, been involved in decisions about a person's care and treatment?
- Is the building, and are the facilities, suitable for the needs of the person we are visiting?
- Where the person is receiving compulsory treatment, are the appropriate safeguards being provided?
- Are care and treatment sensitive to issues of equality and diversity, and human rights?
- Is there a clear person-centred care plan, and is it being carried out?
- Can the person get access to advocacy and legal services? 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?

Autism and complex care needs

We carried out our first themed visit looking at support for people with autism.

The report focused on one of the most vulnerable groups with this diagnosis – people with autism and learning disability or other complex care needs who were subject to mental health or incapacity legislation.

Commission visitors met 54 people living in hospital or in the community across Scotland, and spoke to medical and care staff, along with family members and carers.

The Commission carried out these visits because it is aware that autistic people have particular needs that are not always met in settings designed for people with other conditions. We had concerns about people spending long periods in hospital, and about whether services were responding to challenging behaviours in a way which respected human rights.

For those who also have a learning disability or mental illness, they will often be treated in general learning disability or mental health wards or care services which are not designed for people with autism.

The people we met had a range of complex, individual needs, and there was a wide variation in the extent to which services were currently able to meet those needs well. Getting it right takes time and expertise, and can be expensive. But it was also clear that getting it wrong, and failing to design services around the individual, could be even more expensive in coping with problems which might otherwise be avoided. Equally importantly, it fails the individual, and leaves

professionals and care staff unable to give the high quality care and support we know they want to give.

The increased recognition of the needs of autistic people in recent years is extremely welcome. We know a lot now about what a good service should look like. The challenge is to deliver that everywhere, allowing autistic people to live fulfilled lives, and their families to be assured that they have the stability and personalised care that they deserve.

Local visits overview

Between January and December 2018, we carried out 125 local visits to individuals in hospitals, secure units, specialist units and prisons. Visits to NHS wards for adult acute mental health represented 33% of visits, the largest grouping.

We provide feedback and recommendations for improvement to the services involved.

We publish these reports, and share our findings with key scrutiny bodies – the Care Inspectorate, Healthcare Improvement Scotland, and Her Majesty's Inspectorate of Prisons.

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

We made 277 recommendations for improvement this year.

We usually allow service managers three months to formally respond to our recommendations. We were satisfied with 97.5% of responses received.

"Getting it wrong, and failing to design services around the individual, could be even more expensive."

We look closely at the recommendations we make to help determine our future visiting priorities, and if we need to carry out a particular themed visit or develop good practice guidance.

Twenty-eight per cent of all recommendations related to assessment, care planning, review and person-centred care.

Twelve per cent of recommendations related to the Adults with Incapacity Act, and/or the Mental Health Act. Fourteen per cent focussed on the physical environment, and 11% concerned the provision of therapeutic activities to patients.

Publishing our local visits reports

All of our local visit reports are published on of our website each month, and sent to people on our mailing list.

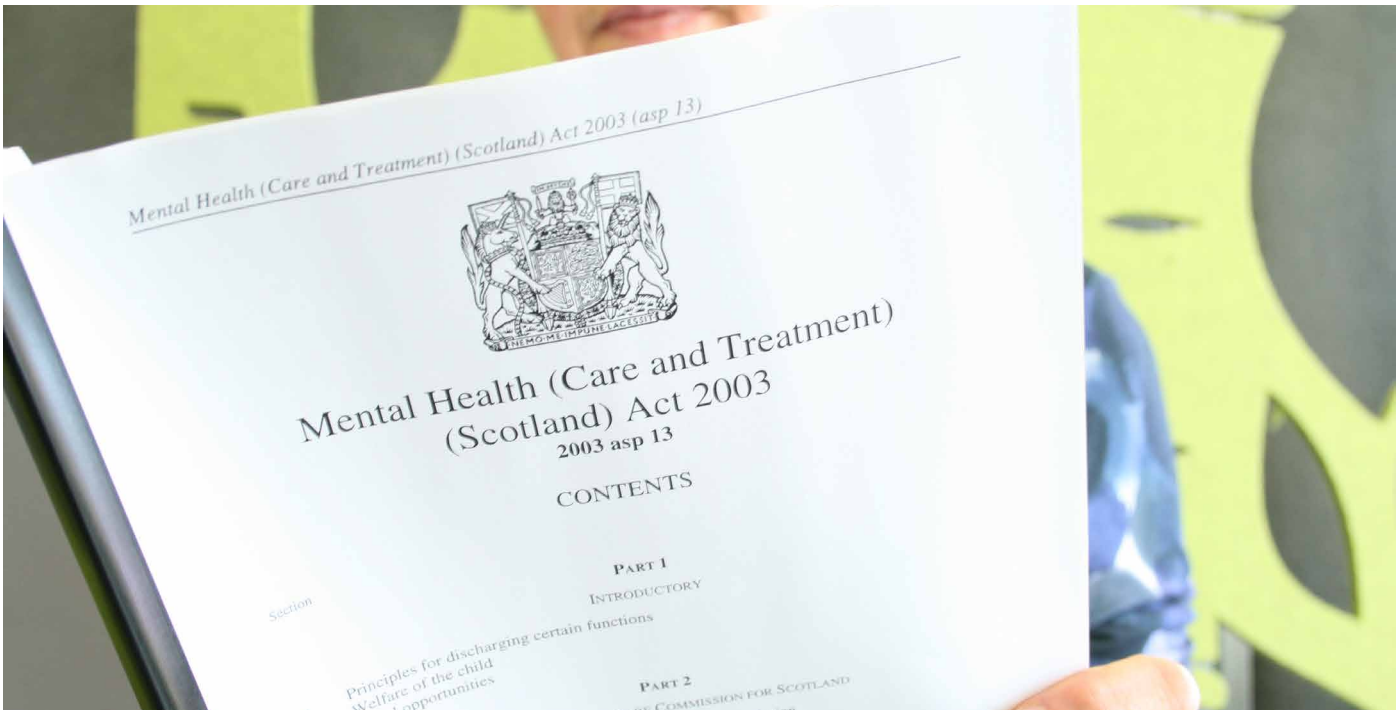
The reports are grouped by NHS health board, with separate sections for the State Hospital and prisons. For ease of reference, all non-NHS services and care homes are also listed under the relevant health board area.

We issue news releases for each set of reports, regularly generating media coverage, particularly in local media, which raises awareness of our findings in local communities.

We hope that by making these reports more easily accessible to the public, we provide valuable information to local people, promote the sharing of good practice and can influence calls for change where services are lacking.

"All of our local visit reports are published on our website."

Monitoring and safeguarding care and treatment



– **New episodes of compulsory treatment using the Mental Health Act reached their highest rates ever since the 2003 Act came into force.**

– **There was a rise in numbers of times detention was used in relation to young people, both in relation to emergency detention and to short term detention over the last 10 years.**

– **Variations in the use of compulsory treatment were shown across Scotland.**

We have a duty to monitor the use of the Mental Health (Care and Treatment) (Scotland) Act 2003, and we report on the Adults with Incapacity (Scotland) Act 2000. We publish reports on our findings. This helps us and our wider audience to understand how the law is being used across Scotland, and how it is being adhered to.

We have decided to publish the monitoring reports on the use of the Acts every second year. This year we produced the report on the use of the Mental Health Act and next year we will publish our report on the use of the Adults with Incapacity Act. Our intention is to review some more in-depth areas on the use of the Acts in the alternate years.

For example, in 2020 we intend to look at the increase in compulsory treatment of young people in more depth to find out why this might be happening.

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

We are also responsible for appointing designated medical practitioners, who provide a second medical opinion when medical treatment is prescribed by law.

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

Monitoring the use of the Mental Health Act

Our Mental Health Act monitoring report shows 6,038 new episodes of compulsory treatment using the Mental Health Act in Scotland in 2018-19, the highest figure since the Act came into force in 2003. The new data also shows rising figures for young people aged under 25 being given compulsory treatment.

The rates at which detention was used varied considerably across Scotland. There are three forms of detention. Emergency detention certificates are used for crisis care and last up to 72 hours. Short term detention certificates lasts up to 28 days. Compulsory treatment orders can last initially up to six months.

For the first time, the female age group with the highest rate of emergency detention certificates per 100,000 population was young women aged 18 to 24, totalling 185 certificates in the year. This compares with 105 for the same age group in 2009/10.

Young men age 16 to 17 have seen the greatest increase in rates of emergency detention per 100,000 population in the past year, and both young men and women aged 16 to 17 have shown the greatest increase in the rate of emergency detention across the 10 year period observed.

There has also been a rise in the number of short term detention certificates used in relation to young people. In women under the age of 25, there has been a 122.5% increase in the use of short term detention since 2009/10, rising from 142 to in 2009/10 to 316 in 2018/19.

Greater Glasgow and Clyde Health Board continues to treat more people per rate of population than any other health board using both emergency and short term detention. This has been an ongoing feature for 10 years.

Dumfries and Galloway remains above average, but in recent years is reducing its use of emergency detention in particular.

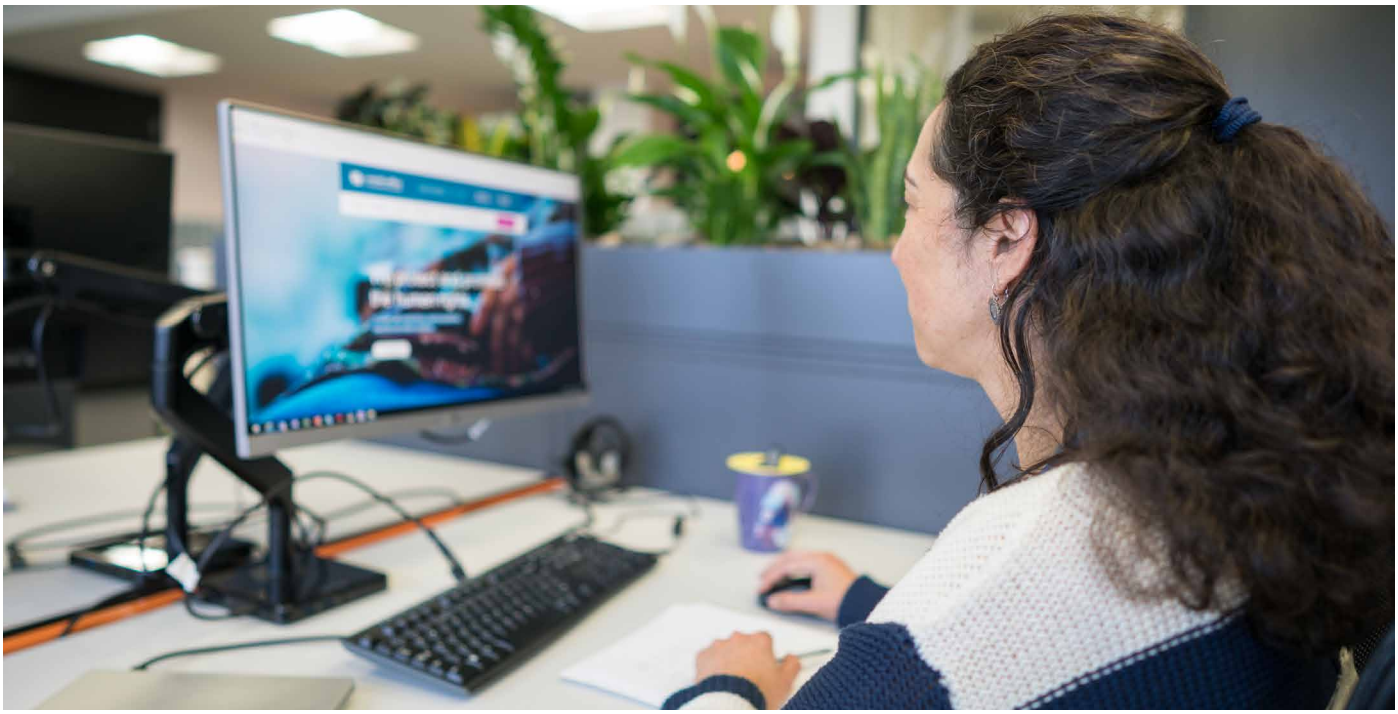
The use of new compulsory treatment by Tayside Health Board has risen markedly in the last two years and is above average for both emergency detention and short term detention.

The five health boards who issue fewer detention certificates than the national average are Highland, Ayrshire and Arran, Lanarkshire, Borders and Grampian. Low counts for the island health boards means their data is not easily comparable.

The Commission is concerned at the way emergency detention takes place in some parts of the country. Detentions are supposed to take place with the consent of a specialist social worker, called a mental health officer. The rates where this happens vary greatly, with 83% compliance in Dumfries and Galloway and only 33% compliance in Greater Glasgow and Clyde.

The Commission is interested in how the Act is applied to people from different ethnic backgrounds within the population. Four per cent of Scotland's population is minority ethnic. From the monitoring forms returned to the Commission in the last year, 5.8% of detention certificates related to people from ethnic minorities.

Investigations



– We worked on 21 investigations, eight of which were started during the year.

– We closed five cases as complete, with the Commission satisfied with the outcome or responses of services after our investigation.

– In three cases, we continued to ensure our local team kept a watching brief.

– We published one investigation into a case of delayed discharge involving a woman with learning disabilities.

– We continue to investigate nine cases, and follow up three previously published investigations.

When serious concerns are raised about the poor care and treatment of a person with mental ill health, learning disability, dementia or related conditions, a number of organisations are involved. Usually the primary investigation will have been conducted by the authority responsible for the services provided.

The Mental Welfare Commission is, however, often contacted about such cases. We initially contact the responsible organisations to find out more and, where necessary, make recommendations to them and follow up their actions. We do not handle complaints about services. We instigate our own investigations only when the case appears to show serious failings, and has implications for services across Scotland.

All of our investigations are anonymised. That way, we seek to protect the person the report focuses on, and we concentrate on highlighting the lessons learned by practitioners and organisations across Scotland.

Investigation into a delayed discharge – Ms ST

Ms ST remained in hospital until 18 months after she had been deemed fit to leave due to a prolonged disagreement between her family, health professionals and a Health and Social Care Partnership (HSCP) about discharge plans.

Ms ST has learning disabilities, cerebral palsy and diabetes and is registered blind. She was admitted to hospital in December 2015 following a neck fracture, and was judged fit to leave in March 2016.

She had lived in the family home all her life, cared for by her mother and brother, with additional social care support paid for by both the HSCP and the family since 2012.

The dispute arose primarily because the HSCP believed Ms ST should move to a care home, and the family wanted her to return home. The family bought a ground floor adapted flat in March 2016 specifically to make life easier once she did so.

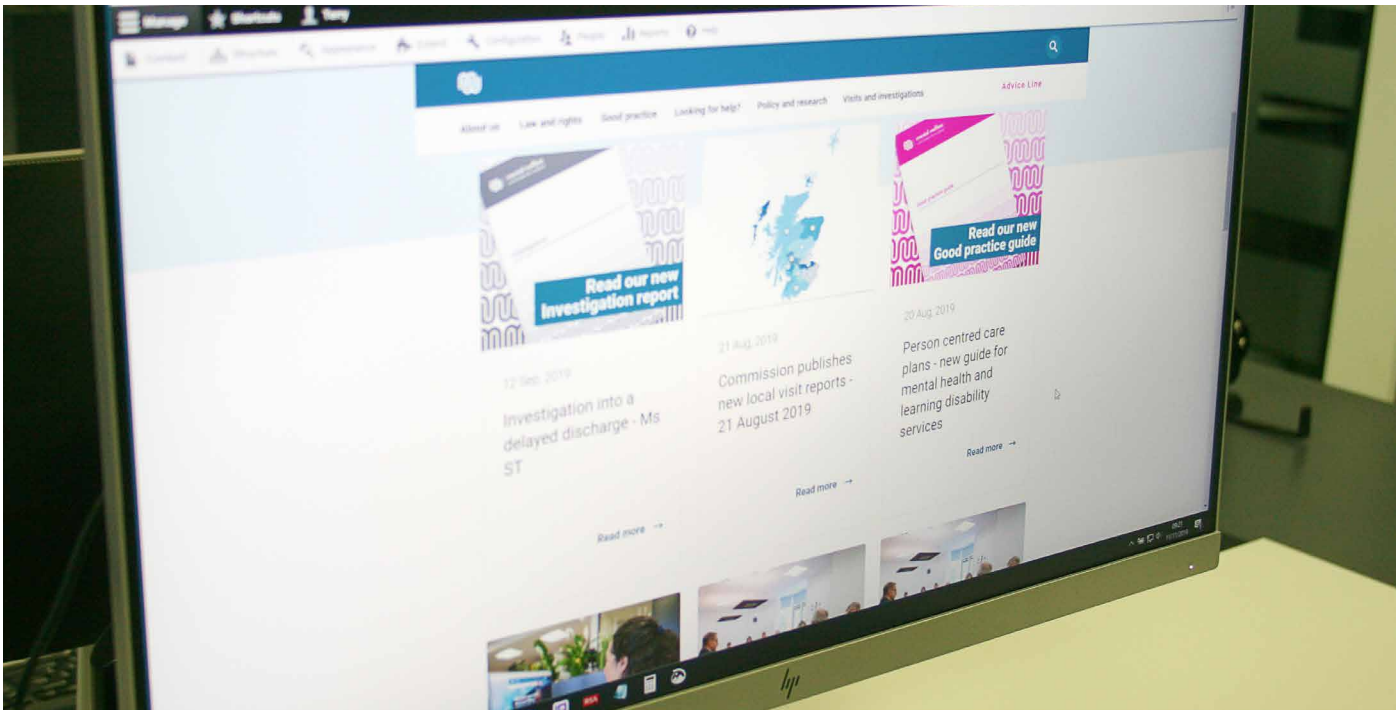
Ms ST was finally discharged home in September 2017 and continues to live there with her mother, with social care support, again funded by both the HSCP and the family, as well as direct care from her family.

We found that the principal underlying reason for Ms ST spending so long in hospital was the continuing disagreement between social work and the family on whether or not she could return home. Had a genuinely open and collaborative planning process taken place, there might not have been a need for other steps that lengthened her stay in hospital, such as an application for guardianship, which was a long process with many delays.

We asked all Health and Social Care Partnerships and local authorities in Scotland to read this report and to act on our recommendations. There were specific additional recommendations for the Partnership involved in this case which we expect to be followed.

"We asked all Health and Social Care Partnerships and local authorities in Scotland to read this report and to act on our recommendations."

Providing information and advice



– **We received 4,191 calls to our Advice Line, and a sample audit showed 100% accuracy in responses given, exceeding our key performance indicator which was to achieve 97.5% accuracy.**

– **We published a Good Practice Guide on *Alcohol-related brain damage* for healthcare professionals.**

– **We updated our *Carers & confidentiality* guide for unpaid carers and professionals, on respecting patients' confidentiality when sharing information.**

– **We drafted a new guide on *Person-centred care plans* for nurses and other clinical staff in Scotland.**

– **We updated our good practice guide on the *Use of seclusion* in hospitals and in the community for people with mental illness or learning disability.**

– **We updated our branding guidelines and redesigned our website.**

One of our key roles is to provide information and advice on use of mental health and incapacity legislation. It is the most popular search area for people who access our website.

We are constantly in touch with services across the country and with patients, families and carers, to offer new or updated advice, or to respond to questions about the law, human rights or other subjects.

We supply information and advice in person, through our Advice Line, on visits or at seminars, and by publishing good practice guidance and other information on our website.

Good practice – Carers & confidentiality

Unpaid carers – relatives or friends – can often feel they are not included when decisions are made about their loved ones. At the same time, health and social care professionals can be unsure of what information they can share with unpaid carers.

We published a good practice guide to help carers, families, and practitioners understand consent, confidentiality, and sharing of information for people with mental illness, dementia, learning disability, or other related conditions.

The publication provides advice to doctors and nurses on how to respect patient confidentiality while also involving families and carers in treatment.

The document also provides guidance on issues relating to capacity to make decisions around confidentiality, sharing information with carers that does not breach confidentiality, and the limited exceptional circumstances where breaking confidentiality may be necessary.

Good practice – Alcohol-related brain damage

We published a new good practice guide aimed at helping professionals treat and care for people with alcohol-related brain damage (ARBD).

ARBD is a condition where there are changes to the structure and functions of the brain as a result of long term heavy alcohol use. It can result in problems with memory, judgement, and a person's ability to live independently.

ARBD is often not recognised, and is under diagnosed. Patients can be stigmatised, with a perception that they are difficult to help, and a feeling in some cases that their problems are self-inflicted.

A further difficulty for medical staff, social workers and addiction workers can be balancing the rights of individuals to live as they choose, with their rights to get help that could improve their quality of life.

Our guidance sets out a range of ways in which the law can be used to strike this balance, with practical advice on how best to provide support to people with this condition.

"Unpaid carers can often feel they are not included when decisions are made about their loved ones."

Good practice – Person-centred care plans

We drafted a new guide for nurses and other clinical staff in Scotland on creating person-centred care plans for patients with mental ill health, dementia or a learning disability.

A care plan describes the care and treatment an individual should receive. It is a written record of needs, actions and responsibilities. Care plans are a crucial part of supporting and helping the process of recovery.

We wrote the guide because when visiting services we increasingly find that the quality of care plans, and the level of participation by the patient or person using services, vary considerably.

Everyone has the right to a care plan which is personal to them, and a right to be involved in developing their care plan.

It was produced after wide consultation. We heard from almost 150 people at a series of meetings across the country, including people with experience of mental illness, relatives/carers, people with dementia or acquired brain injury and advocacy workers.

We also held a specific event where 60 people including nursing staff, relatives/carers, educators and people with experience of mental ill health worked together to agree a view of what a good care plan should look like.

Good practice – Use of seclusion

We updated our good practice guide on the use of seclusion in hospitals and in the community for people with mental illness or learning disability.

The guide was written for health and social care professionals working with people who are being treated for mental illness, dementia, learning disability or related conditions in health and social care settings. Its purpose is to give clear guidelines on the use of seclusion and to ensure that, where this does take place, the safety, rights and welfare of the individual are safeguarded.

The Commission's new guide clearly identifies two main levels of seclusion – a locked room, but also a situation where staff are preventing a person from leaving where the door is not necessarily locked. This can apply in any setting, not just a specifically designed area.

The Commission recommends that every health board in Scotland now provides a policy on the use of seclusion, regardless of whether they say they use it or not. Currently some health boards have such a policy and others do not.

"Everyone has the right to a care plan which is personal to them."

New website

We updated our website, making it more secure and user friendly, and including a wider range of information and an improved search function.

The website now features quick routes into the site for people whose interest is personal, and for people whose interest is professional.

The site also uses new branding for the Commission, which reflects our current work and means that documents can be published from the site more efficiently.

New branding

We refreshed our branding for a more modern look, with an updated logo, corporate typeface and colour scheme.

Twitter

Our Twitter following has continued to increase, and this year we gained 597 new followers from April 2018 to March 2019 to a total of 3,424.

We published 287 tweets promoting our work, including new publications, films, consultations and attendance at events. We also regularly retweeted relevant content posted by accounts we follow.

This year, our Tweets were engaged with 5,433 times (this includes link clicks, likes, retweets and replies).

Our tweets were often retweeted by individuals and organisations with an interest in disseminating information and advice relevant to the field of mental health and social care in Scotland.

"We updated our website...including a wider range of information and an improved search function."

Media

Last year we continued to attract strong media coverage for our work, in print, broadcast and online. Our chief executive and directors regularly took part in print and broadcast interviews, and our media work attracted responses from government, health boards and other key organisations.

Publications that drew significant national media attention include our *Place of Safety* report, which showed Police Scotland officers demonstrated high levels of compassion and care in dealing with people in mental distress.

Our findings that the numbers of young people being treated for mental illness on adult wards had increased in the previous year also, understandably, attracted wide media interest.

Our visits to local wards and units were often picked up by local media, and attracted response from health boards and government.

Our investigation into the care and treatment of Ms ST had some of the strongest media coverage the organisation has attracted, with coverage not confined to Scotland, but instead reaching across the UK.

Advice line

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

People who are receiving care and treatment, families/carers, health and social care practitioners and others can call and speak to one of our health and social work staff for advice.

Callers are often looking for information to understand more about individuals' rights and effective use of mental health and incapacity law.

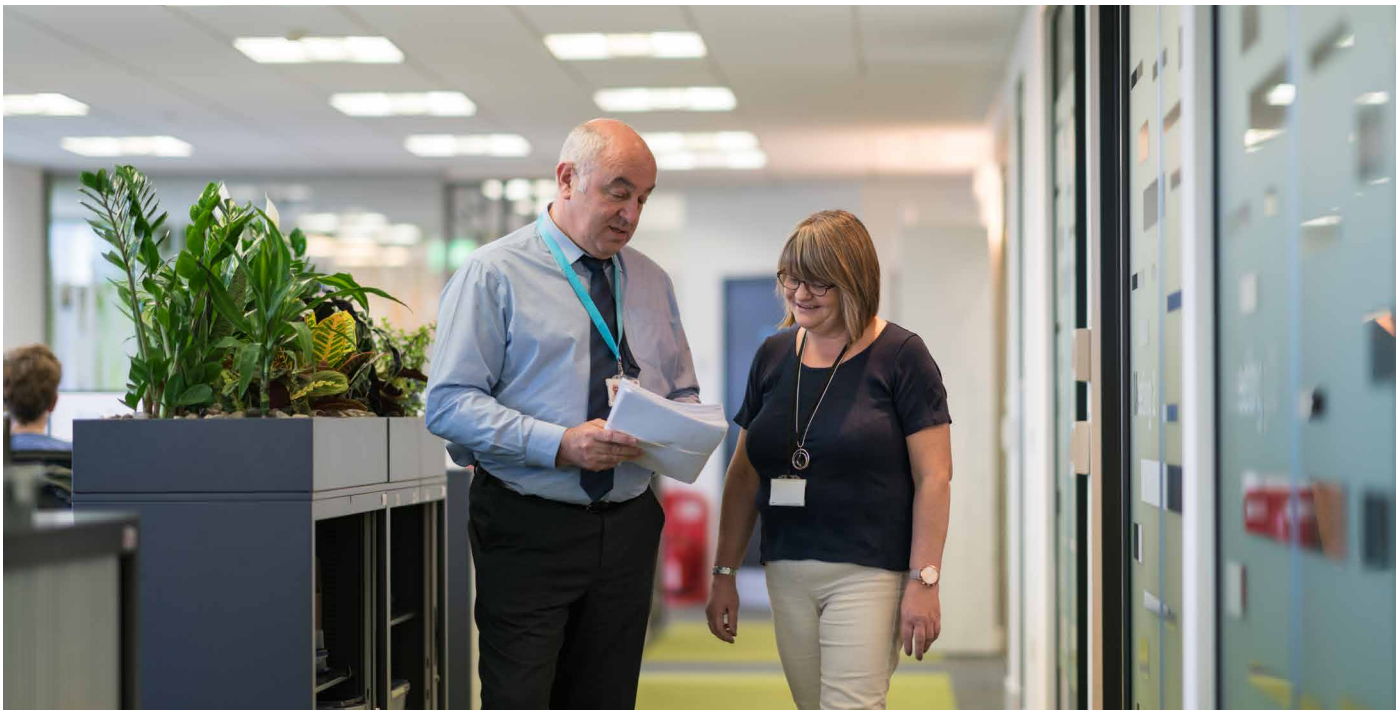
Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care and are the only organisation to do so.

In 2018-2019, our advice line staff gave advice in 3,822 of the 4,191 calls allocated as requests for advice.

A sample audit of advice given out by individual staff members, found an accuracy rate exceeding our target of 97.5%.

"Our chief executive and directors regularly took part in print and broadcast interviews, and our media work attracted responses from government, health boards and other key organisations."

Improving our practice



– Our Board continued to set our strategic direction and ensure efficient, effective and accountable governance.

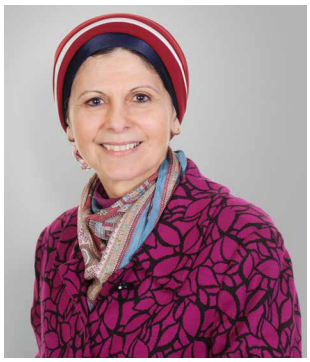
– Our major office refurbishment project reduced costs, supported a more flexible, sustainable, work environment and reduced our floor space by 45%.

– Our advisory committee continued to make a valuable contribution to our thinking and our work.

Our Chair

Sandy Riddell was appointed chair of the Commission on 1 April 2019. He originally trained in social work and has spent over 40 years in public service. He has held director level posts in social work, education, housing, and in health and social care in a variety of settings and retired from the post of director of health and social care in Fife in 2016. Sandy has substantial experience at a national level in shaping policy and legislation in adult health and social care, children's services, substance misuse and justice services. He brings to the Commission a wide range of experience and knowledge of public services, with particular skills in transformational change and the integration of frontline services. He is passionate about the need to develop a rights-based approach for services and to fully involve the public in service design and delivery.

Outgoing chair **The Very Revd Dr Graham Forbes CBE** combined his ecclesiastical duties with various public appointments, mostly in the areas of health or criminal justice. He served as chair of the commission from April 2011 to March 2019.



Our Board members

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.

Paul Dumbleton has lived in Stirling for 35 years and has three grown-up children, one of whom has a learning disability. The first twenty years or so of his working life was spent teaching in special education in schools and further education colleges. He then worked in higher education and educational development before moving to the voluntary sector. Since retiring from full time work, he has worked on a part time basis in a number of roles, including public appointments to the Council of the Scottish Social Services Council and as a member of social security tribunals. In 2014, he was awarded an honorary degree by Stirling University in recognition of his work in the voluntary sector. Paul completed his term on our Board on 31 March 2019.

David Hall has for the last 23 years been a consultant psychiatrist and medical manager in Dumfries and Galloway. For the last 10 years, he has been clinical lead for National Health Improvement Programmes and is currently national clinical lead of the Scottish Patient Safety Programme in mental health. David's skills are in clinical leadership and the application of improvement science to mental health systems.

Gordon Johnston has a background in community development, urban regeneration, project development and management, and managing major funding streams. He is currently an independent consultant in mental health, specialising in peer research, user/patient involvement and organisational development. Gordon is involved in many organisations and is currently chair of Bipolar Scotland. He was a director of Voices of Experience (VOX) for six years. He has also been a member of the delivery group of the Scottish Patient Safety Programme Mental Health since its inception.

Cindy Mackie is an independent consultant with occupational experience in the public, private and voluntary sectors and she currently performs a number of Associate roles within the area of regulation. She is a tribunal member with the Medical Practitioner Tribunal Service, where she is engaged in Fitness to Practise proceedings, serving in this capacity and also with the Nursing and Midwifery Council for eight years. She is a lay examiner in membership examinations for the Royal College of Obstetricians and Gynaecologists and acts as a chairperson/quality assurance inspector in dental education programme inspections across the UK. She holds a position of independent assessor in Public Appointments NI and is also involved in school governance in a voluntary capacity. Cindy brings knowledge of health regulation, public protection, safeguarding and human rights. Cindy is educated to graduate level with additional qualifications in human resource management and learning and development.

Mary Twaddle has lived experience of mental ill health and recovery and has been treated and supported by general adult mental health services for over 10 years. She currently works for NHS Lothian at the medium secure forensic unit, The Orchard Clinic, as a peer support worker using her own lived experience to help others in their recovery journey from life changing mental ill health. She joined the newly created Peer Support Service 15 months ago, helping build the first peer service within a medium secure forensic unit in the UK. In her role she works with patients directly (both individually and as part of recovery focused groups), and also works alongside all the other disciplines as part of the multi-disciplinary team using her experience to contribute to team meetings and discussions on maintaining the recovery focused ethos of the clinic within the complexities of working in a forensic setting.

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.

Our Advisory Committee

A standing committee of our Board, our advisory committee consists of representatives of 32 stakeholder groups from across Scotland. They met twice a year, and this year they made a valuable contribution to our thinking on how to develop and change our approach to monitoring mental health and incapacity legislation.

Office refurbishment

One of the primary aims to come from our previous Sustainability report was the realisation of the Accommodation Project.

Until March 2019, we held a lease on one floor of the Scottish Legal Aid Board building. The Accommodation project reduced our footprint by 45%, with the remainder being leased by Children's Hearings Scotland in a collaborative move including shared meeting and conference space. The project involved staff throughout its planning and implementation including office design, furniture and decoration selection, and revised flexible working policies and protocols. We decreased our workstations from 58 to 41, introduced more environmentally efficient equipment, and a modern working environment.

This will reduce costs from approximately £222,000 in 2018-19 to approximately £132,000 in 2019-20.

Involving people

We are acutely aware of the importance of maintaining good ongoing relationships with people who are affected by mental ill health, learning disability, dementia or related conditions.

Involving people who receive care and treatment in our work – and involving family members and friends who provide essential day-to-day support – ensures that we do not lose sight of our purpose.

Our engagement and participation officers, one person with lived experience of mental ill health, and one person with lived experience of caring for someone receiving care and treatment, continue to substantially increase our contact with individuals and with mental health and carer organisations.

They frequently meet with individuals and groups to consult, give talks and gather feedback on our work. They participate in local and themed visits, and contribute their own lived experience and expertise to our work.

Our Board and Advisory Committee, who help shape the work of the Commission, also have members with lived experience of mental ill health or as an unpaid carer.

Learning lessons

We seek to learn and improve as a result of the complaints we receive.

In 2018/2019, we received and responded to nine complaints. The same number as last year. After investigation, one of those complaints was upheld, three were partially upheld and five not upheld.

As a result of the complaints we have reminded staff to confirm with all parties if visit arrangements are changed.

Other partially upheld complaints resulted from individual administrative errors. Individual errors which resulted in complaints have been raised with members of staff involved and their line managers.

Our commitment to equality

The Commission is required to:

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

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

Our reports *Equality outcomes and how we plan to achieve them* and *Equality outcomes and mainstreaming progress* are on our website.

"We seek to learn and improve."

Financial resources

Our total revenue budget was £4.861 million. This included £3.790 million for the Commission, £0.882 million for the National Confidential Forum and £0.189 million for The Review of the Mental Health (Care and Treatment) (Scotland) Act 2003 for people with Learning Disability and Autism.

Our capital budget was £0.300 million.

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.

Environmental sustainability

We voluntarily report on progress in this area, where it is mandatory for some other Scottish public sector bodies to produce annual sustainability reports under the Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015.

The Green Group, drawn from all areas of the Commission, is responsible for consideration of sustainability issues and for reporting upon this.

The report for 2017-19 is available on our website and highlights achievements such as the Accommodation Project to reduce floor space and use more efficient equipment, recycling unwanted furniture and IT, flexible working to reduce commuting travel, improved food waste recycling and reduced plastic use.

"We are funded through the Scottish Government, and met all the financial targets set by them."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