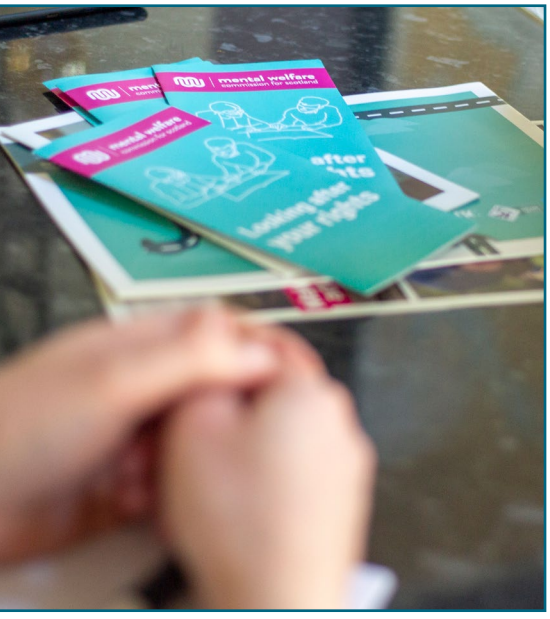
Annual report 2021-22

mental welfare commission for scotland




Public health – liste
those most affecte
by Sandy Riddell, Chair, Mental Welfare Commission
Improving public health is a short phrase with a huge agenda.
the importance of lis
60 years – a brief h
Mental health services in Scotland affected by racial inequalities, says report
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Scots prisons criticised over mental health support
The Scottish government must implement "ambitious and transformative" change to mental health support, the head of a leading campaigning organisation said.
Julie Paterson (pictured), chief executive of the Mental Welfare Commission, said: "With all of the pressures government is under, they must continue to keep mental health as a priority
transferring homes using
Speaking
healthandcare.sc
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Thursday 8 September 2022
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Alcohol brain damage care a human rights concern
Thursday 16th September 2021
by Esmé Pringle
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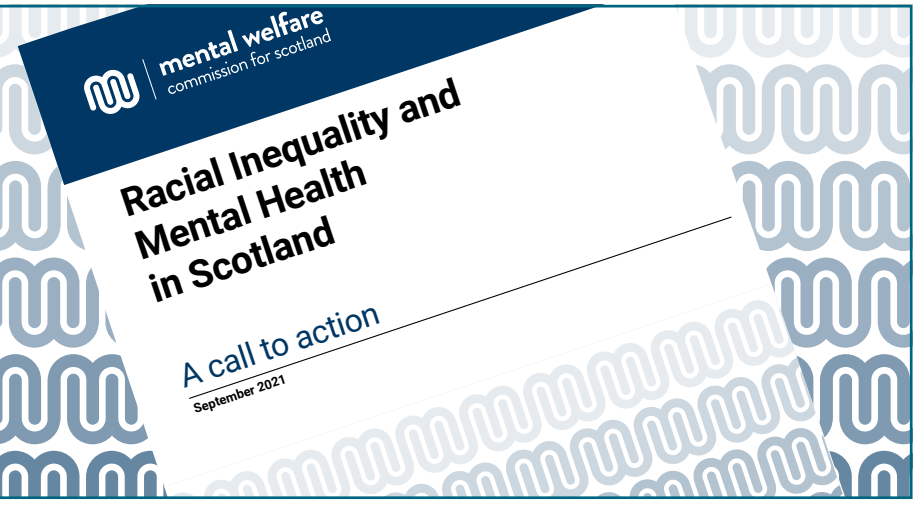

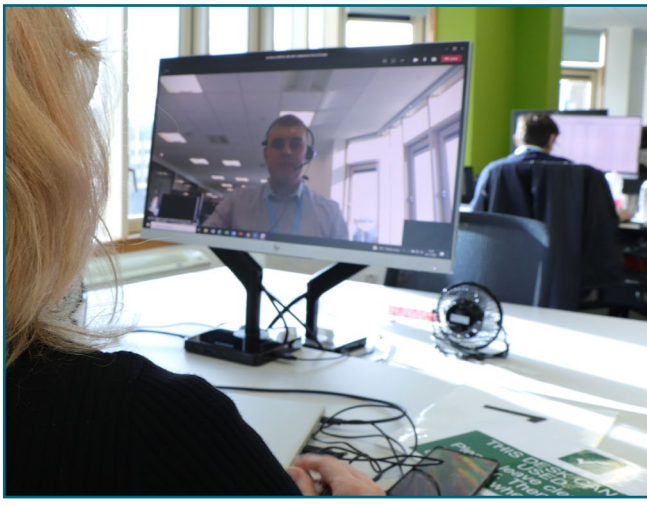

Our purpose - we protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions

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

Contents

Who we are and what we do

Our mission and purpose

Our Mission

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

Our Purpose

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

Our Priorities

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

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

Our Activity

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

Chair's foreword

Sandy Riddell

Post pandemic

As the immediacy of the pandemic receded, we – like others across the globe – moved towards the new normal of hybrid working.

As soon as it was safe to do so, we began to reintroduce in-person visits, with our health and social work professionals going back onto wards and into other locations, meeting individuals, patients and staff.

As the need abated, we ceased producing regular Covid-19 advice notes. Instead, in response to requests for guidance, we published position statements, for example on how to address a situation when a person is unable to give consent for vaccination.

Ensuring long term improvement

One of our own areas for improvement has been a drive to show more transparently the outcomes and impact of our work.

As part of this, we published a closure document on the previous year's *Authority to discharge* report (see here), which had looked at the rights of people who were not able to express their own views on being moved from hospital to care homes.

Our closure report gives details of how health and social care partnerships across Scotland and the Care Inspectorate have taken on board each of our recommendations for change.

Scottish Government were also key to the success of this piece of work, and together we published a joint position statement on our *Authority to discharge* commitments.

The Mental Welfare Commission relies on others to make our recommendations a reality, and we were impressed by the commitment each of these organisations showed to working with us to make long term improvements for a particularly vulnerable group of people.

Concern over pressures on health and social care staff

We are seeing more examples of increased pressure on health and social care staff while demand for services remains high, and we are increasingly concerned about this.

It is partly due to the impact of the pandemic, but many of the difficulties experienced by mental health and social care services were evident before 2020. Staff vacancies and the resultant reliance on agency and bank staff only increase the pressure.

Pressure on staff of course has a direct impact on vulnerable individuals and patients. On our ward visits, patients often tell us how supportive and professional the staff are; there is a clear appreciation of the skilled individuals working in the NHS and social services. But patients and relatives also tell us of how care and treatment can be negatively affected by staff shortages.

While the economic outlook is increasingly difficult, we must never lose sight of the need to ensure that mental health and social care services for adults and children are safe, and people who need care and treatment are protected.

60th anniversary

2022 is the 60th anniversary of the Mental Welfare Commission and you can read further into this annual report to see how we sought to mark the occasion.

While so much has changed over 60 years, the Commission remains the only external body in Scotland that regularly visits patients in specialist mental health and learning disability care, with powers to access documents. This is where we meet individuals, offering them a private interview; hearing about what matters to them. We also talk to their families or carers if they wish, and to staff.

We visit people in the community too, and are increasing our focus on engaging with people with mental ill health and their families and carers more widely. Look out for more of this work in future.

"... we must never lose sight of the need to ensure that mental health and social care services for adults and children are safe, and people who need care and treatment are protected."

Chief executive's message

Julie Paterson

Continuous improvement

In 2021-22 we continued to develop the organisation itself in tandem with developing our ways of operating post-pandemic.

This meant scrutinising the ways we work to deliver the best possible service with tight resources. One outcome is that we are changing our approach to investigations work, aiming to increase our learning from investigations at all levels.

We reviewed the vital input of our advisory committee, which includes representatives from 32 external organisations from across Scotland, aiming to increase their involvement and plan earlier connections on our future strategy.

We continued the process of increasing our engagement work, which is about connecting better with people in communities across Scotland. We developed two new roles for people with lived experience focusing on autism and learning disability. I'm really looking forward to seeing the impact this strengthened team has within the Commission and on our external roles.

Working together

We continued to build on our links with other national public sector organisations by creating new memorandums of understanding and agreeing regular strategic meetings. These actions create efficient routes of communication, and ensure we can effectively share expert advice and good practice – all vital activities, particularly during the very difficult times services are now facing.

Scottish mental health law review

We advised and supported the Scottish Mental Health Law Review team throughout the year, undertaking a research project for the Review on the use of compulsory treatment orders in Scotland.

The Review completed its work. We will study it carefully. We hope that it will be ambitious and transform the legal framework for the care and treatment of people with mental ill health or incapacity in Scotland for many years to come.

Racial inequality in mental health services

Our own programme of work continued apace. In a major national project, we examined racial inequality across mental health services in Scotland. We found differences in the ways the Mental Health Act is applied when people from ethnic minorities are detained for care and treatment compared to white Scottish people.

There was a real need and desire for training for staff on ethnicity and diversity, with over 70% of staff surveyed saying there were gaps in training available in Scotland's NHS.

Almost a third of health professionals who took part said they had seen or experienced racism directed at their NHS colleagues. We will follow this report through with a closure report showing outcomes and next steps.

New proposals

We worked on two very specific new projects for Scottish Government. One was to develop proposals for how Scotland reviews the deaths of people who had been detained for mental ill health treatment at the point of their death.

The other being to develop proposals for how Scotland undertakes investigations into homicides involving people who are, or have recently been, in contact with mental health services.

Proposals for both of these projects were completed and submitted to Scottish Government.

Thank you

It has been a very busy year for the Commission and I want to thank all of our staff, and every individual – whether you are someone who uses services, a patient, a relative, a carer or a health, social work or social care professional - who has connected with the Mental Welfare Commission during the year and helped us in our work.

"We continued ... increasing our engagement work, which is about connecting better with people in communities across Scotland."

Influencing and empowering

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Scots prisons criticised over mental health support

SERVICES and treatment of prisoners in Scotland with mental health conditions must be urgently addressed, a report by the Mental Welfare Commission has said. A decade after making recommendations for changes in 2011, MWC visited Scotland's 15 prisons and found they continue to fail staff and prisoners. The research showed 77 per cent of staff who were interviewed said they had concerns about mental health

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SCOTLAND'S HEALTH AND CARE NEWS CHANNE

Thursday 8 September 2022

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Alcohol brain damage care a human rights concern

Thursday 16th September 2021

by Esmé Pringle

A new report from the Mental Welfare Commission (MWC) finds people with alcohol related b damage are living in care homes where they are much younger than other residents; compel they would never choose.

rangements, the watchdog suggests, could be in breach of their human right dependency and isolation.

ublished today, the MWC spoke to 50 of the 553 people in Scotland who had both brain damage (ARBD) diagnosis – where the structure and function of the brain ha g-term alcohol use - and a guardianship in place.

Commission's concerns at the availability of specialist support to those with ARBD - sh guidance for clinicians back in 2019 - today's report looks at care arrangements, ng used and at whether good practice is being followed.

- **2022 marked the 60th anniversary of the Mental Welfare Commission. We used this opportunity to look back at how attitudes and expectations have changed, but also to confirm core values such as listening to the individual, and to express our hopes and concerns for the future.**

- **We published a joint position statement with Scottish Government on supporting discharges from hospital for adults with incapacity following the previous year's *Authority to discharge people from hospital to care homes* report, and we published a closure report showing the impact of this work.**

- **As a member of the UK National Preventive Mechanism (NPM) we supported their stance on Scotland's lack of progress on improving the situation of women in prison with severe mental illness.**

- **We published a position statement on how to address a situation when a person is unable to give consent for vaccination.**

- **We contributed throughout the year to the ongoing Scottish Mental Health Law Review.**

- **We appeared before Holyrood parliamentary committees to give evidence on issues related to the pandemic and on mental health detentions in Scotland.**

Continuity and change, but always putting the individual first – 60th anniversary

While its history can be traced back to the 19th century, the Mental Welfare Commission came into existence in its current form in 1962, making 2022 our 60th anniversary.

Much has changed in that time, but the core focus of the organisation remains protecting and promoting the rights of people with mental ill health or incapacity.

To mark this anniversary, and to emphasise the ways in which the Commission adapts to current challenges while continuing to focus on the individual, we produced a new short film on our history, current work and future focus.

We also published a series of podcasts created by historian Professor Rab Houston featuring interviews with current and past leaders in the fields of mental health and the law.

The anniversary was marked at a reception at the Scottish Parliament, hosted by Gillian Martin MSP.

Kevin Stewart, Scottish Government minister for mental wellbeing and social care, gave the keynote speech and Adrian Ward MBE, expert on incapacity law, gave an international perspective on the Commission's role and responsibilities.

You can watch our film here, and listen to our podcasts here.

"Because of (its) adaptability, the Commission remains a core part of the mental health landscape in Scotland; flexible and focused. At times of increasing pressure across the health service and across the economy, we need organisations that can deliver for our communities, shining a light on good practice that can be shared quickly, and reporting on poor practice, calling for change, where change is needed."

Gillian Martin, MSP

"…with the increased focus on the importance of human rights across all areas of policy, the role of the Commission will only increase in importance too. I look forward to continuing to work with the Commission across a range of issues.

"By working in partnership with stakeholders and those with lived experience we will continue to develop and enable the human rights of the most vulnerable in our society. The Commission has a unique overview of mental health, dementia and learning disability services in Scotland so let's hope the next 60 years continue to be as rewarding as the first 60 have been."

Kevin Stewart, minister for mental wellbeing and social care, Scottish Government

Authority to discharge people from hospital to care homes

We followed up the recommendations of our 2021 *Authority to discharge: report into decision making for people in hospital who lack capacity*.

That report followed numerous concerns raised with us about the rights of people who lacked capacity to make their own decisions being moved from hospital to care homes during the pandemic.

We had sought to check - via detailed examination of sample moves from across the country - that those moves were done in accordance with the law. Our report found 20 examples of unlawful moves, but also raised significant concerns that were not exclusively the result of the pandemic. These included a lack of understanding of the law, lack of understanding of good practice, confusion over the nature of placements, and misunderstandings over powers of attorney.

We had made 11 recommendations for improvement; eight for health and social care partnerships, two for the Care Inspectorate and one for Scottish Government.

What happened next?

We published our follow up closure report this year. In it, we confirmed we had received responses from all 31 health and social care partnerships, the Care Inspectorate and the Scottish Government.

The quality of responses from health and social care partnerships varied significantly, from simple emails saying the report's recommendations would be taken into account, to specific, measureable, achievable, realistic, time bound (SMART), robust action plans providing evidence of assurance.

We scrutinised all responses using agreed standard criteria. Where action plans were not SMART and did not give assurance, follow up contacts were made, including meetings with key people. Where follow up was required it was often evident that a number of post holders had moved on since the response was due in August 2021. There is clearly a significant challenge for health and social care partnerships given the apparent high turnover of senior managers and leaders.

The outcome is that all action plans now evidence clear objectives in relation to recommendations and timescale to delivery. Health and social care partnerships will be expected to monitor progress through their existing governance arrangements and we will seek further updates later in 2022.

We have been impressed by the commitment shown by health and social care partnerships across Scotland to ensure appropriate actions are in place to deliver on the eight recommendations.

There has also been excellent engagement with the Care Inspectorate in response to both recommendations made. We now hold regular meetings with the Care Inspectorate to share expertise and the Care Inspectorate has committed to additional resource to address specific recommendations related to the Social Work Scotland Act.

Likewise Scottish Government has taken full interest in this report by supporting best practice nationally at meetings with health boards and through submission of a joint position statement with the Commission.

Joint statement with Scottish Government

In October 2021 we issued a joint statement with Scottish Government on supporting discharges from hospital for adults with incapacity. The statement outlined actions that can be taken to support this vulnerable group on discharge from hospital, and highlighted key points of the law to ensure individuals' rights are respected. It acknowledged that it was issued at a time of pressure on the hospital system and consequent focus on delayed discharge.

National Preventive Mechanism

We are a member of the UK National Preventive Mechanism (NPM), a body that brings together independent monitoring organisations that have a role in protecting people in detention. Our chief executive sits on the UK groups and our medical officer sits on the Scotland sub-group. Our local visits, where we visit in-patient units where people may be detained, and our visits to mental health services in prisons, link with our role as an NPM member.

In autumn 2021 we welcomed an NPM report on Scotland's progress in the prevention of ill-treatment in places of detention. This followed an original report by the NPM's European Committee for the Prevention of Torture (CPT) after their visit to Scotland in 2018 and 2019. That original report contained alarming findings in relation to the care and treatment of women with mental ill health in Scotland's prisons.

In welcoming the progress report, we noted the critical issue of women with severe mental ill health who were still not being transferred to a psychiatric ward in the two week maximum transfer period. We agree with our NPM colleagues that this needs to happen as a matter of priority, and we continue to raise this issue in our own work.

"... we noted the critical issue of women with severe mental ill health who were still not being transferred to a psychiatric ward in the two week maximum transfer period."

Vaccination for people who cannot give consent

In entering a different phase of the pandemic, rather than frequently publishing updates to our Covid-19 advice notes, we committed to publishing specific statements to restate, clarify or update existing guidance.

In February 2022 we published a position statement on how to address a situation when a person is unable to give consent for vaccination.

The guidance was a response to an increase in calls to our advice line from health and care professionals who were seeking advice on vaccinations for people who are not able to provide consent due to a mental health condition or learning disability.

Our concern was that people who were unable to consent to the vaccine should not be disadvantaged because of any uncertainty about how to proceed in these situations.

The position statement discusses the issues that should be considered to protect the individual's health, and the importance of taking account of the person's wishes and feelings, and consulting with relatives and relevant others.

The full statement is available here.

"... people who were unable to consent to the vaccine should not be disadvantaged because of any uncertainty about how to proceed in these situations."

Effective and targeted visiting

- **Our visiting activity was again affected by the ongoing challenges of the pandemic. Whilst we were able to plan a programme of local visits throughout the year, many of the visits were cancelled at short notice if the service had an outbreak of Covid and was restricting all visitors.**
- **We nevertheless carried out 95 local visits to hospitals and care services, slightly short of our typical 110 visits a year pre-pandemic.**
- **We were only able to visit one service on an unannounced basis. Pre-pandemic we aimed to do 25% of local visits in this format and hope to recommence some of these in the coming year.**
- **We undertook two themed visits in the year – racial inequality and mental health services, and mental health services in Scotland's prisons.**

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 and social care partnerships (and their respective health boards and local authorities) 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.

Themed visits – to people with similar health issues or 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 chief social work officer.

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

Local visits

Between April 2021 and March 2022 we carried out 95 local visits to hospital wards, units and care services. We particularly focus on units where there is a major deprivation of liberty, where we have gathered information from themed visits, previous visits, patients' concerns and other sources about care and treatment, or where it has been some time since our last visit.

Our visiting activity was again affected by the ongoing challenges of the pandemic. Whilst we were able to plan a programme of visits throughout the year, many were cancelled at short notice if the service had an outbreak of Covid-19 and was restricting visitors.

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

We provide feedback, highlighting good practice where we find this, and recommendations for improvement to the services involved. We publish these reports, and share our findings with other 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.

Publication of all reports

All of our local visit reports are published on our website 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 also promote and share them on social media.

Our 95 local visits between 1 April 2021 and 31 March 2022 resulted in 229 recommendations; there were 10 services where no recommendations relating to these visits were made. For those services where recommendations were made, these ranged from one recommendation to nine recommendations. On average, the number of recommendations made was three.

When we make recommendations, we ask the service for a response within three months, which would include a robust action plan as to how the recommendations are to be met. If the recommendation is particularly serious and urgent we reduce the response time accordingly.

Living with alcohol related brain damage

We undertook visits across the country to people with alcohol related brain damage (ARBD) who are subject to a welfare guardianship order.

We found many individuals living in care homes where they are much younger than other residents; compelled to live in a setting they would never choose.

For those aged under 65, living in inappropriate community care homes with much older residents can create dependency and isolation.

Discriminatory perceptions of a 'self-inflicted illness' can also lead to people with a diagnosis of ARBD being marginalised and socially isolated.

The report looks at care arrangements, at how the law is being used and at whether good practice is being followed.

There were many positive examples of good care, but also areas of concern.

Many of the relatives/carers were positive about the care and support that their relative was receiving, although some said that caring for someone with ARBD had had devastating and long-lasting effects on the whole family.

Recommendations

The report has four recommendations for health and social care partnerships. The first asks that they commission suitable, age appropriate, and where possible, specialist alcohol related brain damage services.

The second says the critical role of delegated officer in a local authority must be held by a named person who maintains regular contact with the individual subject to the order.

The third focuses on multidisciplinary reviews, saying they should be dynamic, coordinated and informed by the principles of the law.

The final recommendation relates to advocacy support, an important safeguard to ensure respect for the rights, will and preferences of the person.

The full report *Care and treatment for people with alcohol related brain damage in Scotland* is available here.

"We found many individuals living in care homes where they are much younger than other residents; compelled to live in a setting they would never choose."

Mental health services in Scotland's prisons

Ten years after a similar series of visits, we visited all 15 of Scotland's prisons, and found many changes to structures and organisation, but little improvement in the outcome for prisoners' mental health.

We looked at arrival and early days in prison, when people are particularly vulnerable. We examined the experience of segregation, the transfer of very unwell prisoners to hospital, mental health care, and addictions to drugs or alcohol. And we heard from relatives and friends.

There were pockets of good practice, and the workforce were committed to their roles. But despite a range of existing guidance, policy and local arrangements to support prisoners' mental health, significant improvement is needed.

Our new report called for urgent action.

Key concerns

All prisoners who are seriously and acutely mentally unwell should be transferred to hospital care without delay, yet we found this is still not happening. Ten of the prisoners we visited were segregated; some were acutely mentally ill.

Staff said they would like in-depth training for working with increasing numbers of prisoners with complex mental health needs.

A majority of prisoners had been receiving support for mental illness before arriving in prison, and a significant majority reported addiction issues, to alcohol or drugs.

Coping with the pandemic

Prison governors acknowledged how well their staff had coped with the extreme difficulties they have faced during the pandemic. Issues included staff absences, a deterioration in the mental health of prisoners, and visiting restrictions adding to pressures on prisoners.

Recommendations for change

We made nine recommendations for improvement to the Scottish Prison Service or the NHS, or often to both.

We made one overarching recommendation to Scottish Government, asking that they monitor the delivery of those nine recommendations, and work with the prison service and NHS to deliver better outcomes for people in prison with mental ill health.

> "*Thank you to you and your team for such an excellent report. The findings and recommendations... add a powerful voice to drive improvements.*"
> **Wendy Sinclair-Gieben,**
> **HM Chief Inspector of Prisons, Scotland**

The full report is available here.

We shared the report widely, and undertook a webinar to allow for a 'live' briefing event, where our audience could ask questions of the report's authors and share views.

"Our new report called for urgent action."

Racial inequality and mental health services

For the first time, we examined racial inequality across mental health services in Scotland, looking at six themes: ethnicity and detention under the Mental Health Act; the views of people with lived experience; the experience and training of Scotland's mental health services workforce; racial equality in that workforce, and recording and reporting of ethnicity across mental health services, including in the Commission's own work.

We found differences in the ways the Mental Health Act is applied when people from ethnic minorities are detained for care and treatment compared to white Scottish people, particularly between black women and white Scottish women.

Half of the 32 people with lived experience of mental health difficulties who provided views were refugees. They wanted greater awareness in primary care of the impact of the asylum system on mental health.

People described the impact of micro-aggressions on their mental health. Many praised third sector organisations for building vital bridges between communities and services.

There was a real need and desire for training for staff on ethnicity and diversity, with over 70% of staff surveyed saying there were gaps in training available in Scotland's NHS.

Almost a third of health professionals who took part said they had seen or experienced racism directed at their NHS colleagues.

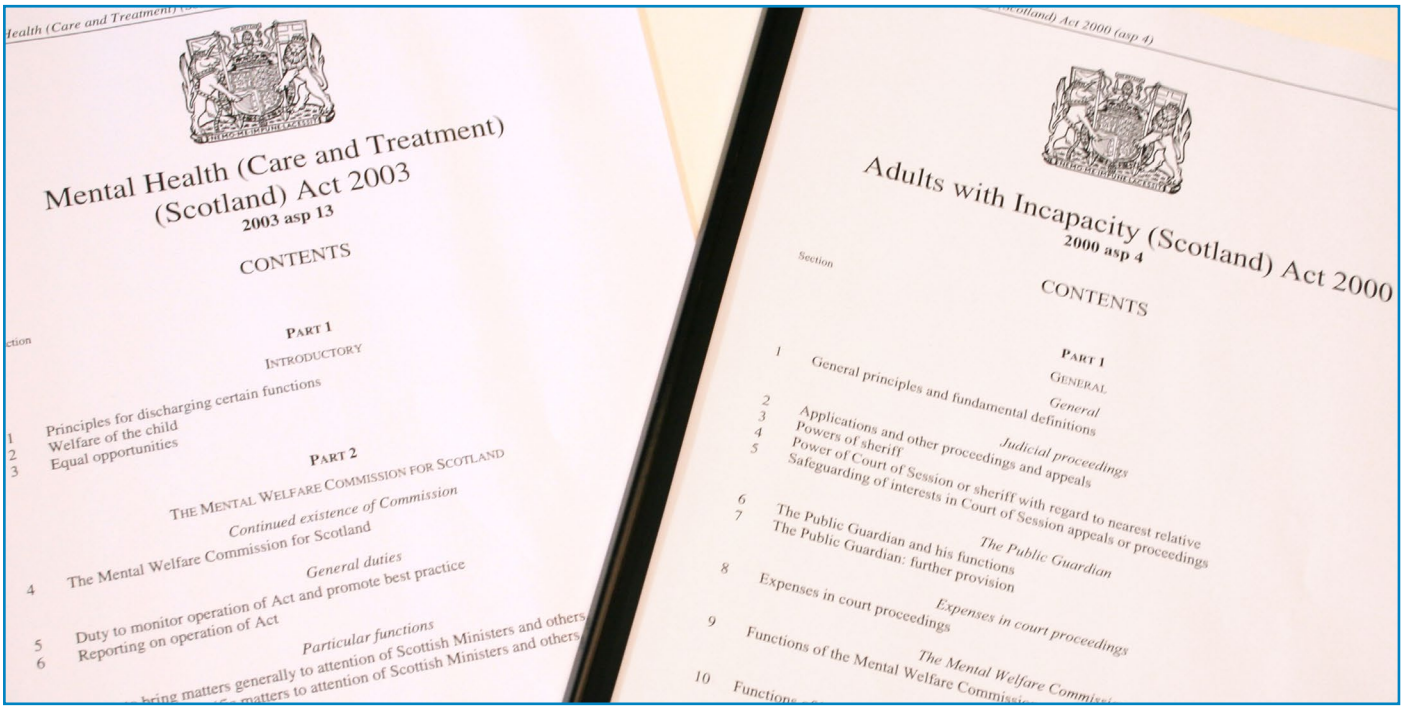
We found a need for better recording and reporting of information on ethnicity, including by the Mental Welfare Commission itself.

This report makes 30 recommendations across the public sector including health boards and Scottish Government.

The full report *Racial inequality and mental health services in Scotland; a call for action* is available here.

"Almost a third of health professionals who took part said they had seen or experienced racism directed at their NHS colleagues."

Monitoring and safeguarding care and treatment



- **We have statutory roles to monitor the use of the Mental Health Act and Adults with Incapacity Act in Scotland.**
- **We monitor all cases where a child or young person is treated for mental ill health in a non-specialist ward.**
- **We created three research briefs to inform and influence the Scottish Mental Health Law Review.**
- **As part of our safeguarding role, we are responsible for appointing designated medical practitioners, who provide a second opinion for certain medical treatments prescribed using legislation.**

We have a duty to monitor the use of the Mental Health (Care and Treatment) (Scotland) Act 2003, and the welfare provisions of 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.

When doctors or other 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. We are notified when a guardian is appointed with powers to take welfare decisions for an adult with incapacity.

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

Monitoring of Mental Health and Incapacity Legislation

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

In 2021-22 we processed 38,163 forms and other notifications related to mental health and incapacity legislation (compared to 39,514 in 2020-21); and 3,688 guardianship and intervention orders (compared to 2,418 in 2020-21).

Children and young people monitoring

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

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

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

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

We will publish our adults with incapacity and mental health act monitoring reports, and our detailed report on the instances of non-specialist admissions of children and young people, later in 2022.

Scottish mental health law review

The review of Scotland's mental health and incapacity legislation (Scott review) continued throughout the year and remains of paramount importance to us.

We created three research briefs to inform and influence the Scott review.

One focused on the impact of the role of designated medical practitioners (DMPs). These are experienced psychiatrists, appointed by the Commission to give a second opinion on specific medical treatments planned for people detained under the Mental Health Act. Our research confirmed their impact – DMPs make changes to treatment plans in more than a third of cases. Read the DMP research brief here.

We produced research examining the calls coming into our advice line – a core function of the Commission - which runs five days a week and is delivered by our health and social care professionals; mental health nurses, social workers/mental health officers and psychiatrists. The research confirmed the bespoke nature of the advice provided and the uniqueness of each call. It also demonstrated the level of expertise required to run the advice line:

> *"...no such independent statutory service specifically aimed to provide advice at the intersection of ethics, law and clinical work as it applies to people who might be subject to provisions of mental health legislation exists elsewhere in the UK."*

Read our advice line research here.

Both of these documents were produced by higher trainees in psychiatry, working with the Commission on secondment.

Our third paper analysed the use of compulsory treatment orders over a 13 year period. It confirmed a sharp rise in the use of these orders in the community, compared to a more steady increase in their use in hospitals. The research showed a higher than representative number of people from minority ethnic groups were subject to compulsory treatment orders. This document made specific recommendations for the review team. Read the compulsory treatment orders analysis here.

Our chief executive and medical director remained active participants on review subgroups throughout this year. We demonstrated our ability to respond and influence consultations and evidence sessions of the Scott review, including those looking at the role and powers of the Commission.

"We created three research briefs to inform and influence the Scott review."

Designated medical practitioners

Under Section 233 of the Mental Health Act, we are responsible for appointing designated medical practitioners (DMPs). Their function is to provide a second medical opinion when medical treatments are prescribed under Part 16 of the Mental Health Act (and section 48 of the Adults with Incapacity Act). These are important safeguards and are the highest priority for recovery under our business continuity plans. We were able to keep this safeguard functioning by facilitating phone or video second opinion visits during the pandemic. A consequence of these opinions being completed remotely was a higher percentage were authorised for a shorter period (e.g. for one year rather than three years). This may have implications for the number of second opinions required in subsequent years. During the year, we organised, and our designated medical practitioners undertook, 2,599 second medical opinions (2020-21: 2,266).

Investigations

- **One of two major projects for us during the year was to develop a proposal, on behalf of the Scottish Government, for reviewing the deaths of people who died while detained under mental health legislation.**
- **Our second major project, also on behalf of Scottish Government, was to develop a proposal for appropriate levels of review for situations where someone who is receiving, or has received within the last year, mental health services commits homicide.**
- **We produced a report – *Learning through review: a summary of our investigative role, and looking to the future* following a review of our investigations work.**
- **We made further enquiries using our powers of investigation in a total of 89 cases.**

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 published investigations are anonymised. That way, we seek to protect the person the individual, and we concentrate on highlighting the lessons learned by practitioners and organisations across Scotland.

During 2021-22 we made further enquiries using our powers of investigation in a total of 89 cases. We closed 48 individual cases during this period noting them as complete, with the Commission satisfied with the outcome or responses of services after our investigation. We continued to direct enquiries into 41 other cases. Inquiries related to circumstances which included where an individual had died, circumstances involving support and protection issues and matters relating to concerns about apparent deficiencies in care.

Deaths in detention

At the request of Scottish Government, we produced a report outlining a proposed new system of investigating deaths that take place when people are receiving compulsory care and treatment under mental health legislation in Scotland.

We consulted widely from December 2021 to February 2022, and a report with proposals and costs was submitted to government in March 2022.Through our consultation we had heard of dissatisfaction with current arrangements, and were asked to consider that the Mental Welfare Commission should do more.

Our proposal recommends that the Mental Welfare Commission itself should be responsible for initiating, directing and quality assuring the process of investigating deaths during compulsory treatment in all cases, as part of its investigations role.

We also proposed that the Commission develops national guidelines and standards for use by local services when undertaking reviews into deaths during compulsory treatment. Read more about Deaths in detention here.

Mental health homicides

Scottish Government had also asked us to develop a Scottish model for investigating the care and treatment of perpetrators of homicide who had been in touch with mental health services prior to the homicide.

While the number of such homicides is small, the impact on those involved is devastating. In Scotland there is currently no established system for investigation.

In developing our proposal, we held discussions with several stakeholders, including bereaved family members; analysed feedback from the Scottish Government consultation in 2017, and considered the system created by NHS England. A report with proposals and costs was submitted to Scottish Government in March 22.

Our proposal includes new responsibilities for the Mental Welfare Commission, better collaboration between organisations involved, a clear definition of a mental health homicide, and the involvement of the victim's family and family of the perpetrator and the perpetrator during investigations where appropriate.

Read the proposals for the investigation of mental health homicides here.

Learning through review

Calls for us to consider, or investigate, concerns about care and treatment come to us in a variety of ways. Individuals themselves, or families or carers, will contact the Mental Welfare Commission seeking help in resolving a problem in mental health or social care services.

Sometimes health or care professionals contact us directly when they are concerned about an individual. And our own teams will raise issues when they are visiting wards or visiting people at home.

As part of our drive for continuous improvement, we reviewed our own internal systems. While the lessons learned in our national investigations are widely shared, this report seeks to identify how we can extend that work, sharing lessons learned from every level of investigation – from relatively straight forward situations to the most complex. Read our *Learning through review* report here.

Providing information and advice

- **We received 3347 calls to our advice line, slightly down from 3370 the previous year.**
- **A sample audit of advice given showed an accuracy rate of 97% against a target of 97.5%.**
- **We published a new good practice guide setting out how and when appeals against excessive security can be made by people who are being treated for mental ill health in high and medium secure hospital units in Scotland.**
- **We updated 11 good practice guides and three advice notes, all published on our website.**
- **We publish our reports widely and promote them via the media including social media.**

One of our key roles is to provide information and advice on the 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, individuals, 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.

Advice line

From Mondays to Fridays we run an advice line staffed by mental health and learning disability nurses, social workers (mental health officers) and psychiatrists. Our team of professionals offers advice to health and care professionals, people with mental ill health, learning disability, dementia and related conditions and families or carers.

During 2021-22, we received a total of 3347 calls to our advice line, 845 of the calls came from relatives/carers/private guardians, 737 calls from people with lived experience, 604 calls from responsible medical officers/psychiatrists, and 495 calls from mental health officers and social workers. Other categories of call included those from advocacy, nurses, medical records, care homes etc. with six calls received from GPs.

Most calls received related to the Mental Health Act (1831 calls), with the second highest relating to incapacity legislation (706 calls). The breadth was wide however, with queries ranging from elections, to housing, income maximisation, policing, warrants and treatment.

As noted previously, our research confirmed the bespoke nature of the advice provided and the uniqueness of each call.

Relative/Friend

"Thank you very much for your speedy and comprehensive reply. It is very helpful and I will be pursuing your suggestions and hopefully make progress along these lines".

Family/person with experience

"Thanks so much for contacting my mum and your advice.... Really appreciate your help."

Pharmacist

"As you say it's not something that we prescribe very often so it's really helpful to have your advice".

Psychiatrist

"I found your email extremely helpful and forwarded it to colleagues.....who asked me to feedback how much they appreciated your guidance".

Good practice guide: Patients' rights to appeal against excessive security

We published a new good practice guide setting out how and when appeals against excessive security can be made by people who are being treated for mental ill health in high and medium secure hospital units in Scotland.

The guide also outlines the responsibilities of health boards and other public bodies to find beds on more suitable wards for patients who have won their appeal and are waiting to move.

The Commission is concerned over delays for many of those patients, and is concerned about the impact that being held in excessive security can have on an individual.

Scotland has one high security hospital, the State Hospital, and three medium secure units. All individuals in these settings are detained, meaning they are so unwell that their treatment is compulsory.

People receive care and treatment on high or medium secure wards only when their condition is deemed to be such that this is the best setting for them.

We created this guide because we are regularly contacted about patients who have won appeals but are waiting to move, often because a suitable bed elsewhere has not been identified.

The full guide can be found here, and a shorter version is available here.

Webinars

During the pandemic, we began to host webinars on key topics such as rights based issues and on issues arising from the *Authority to discharge* report. These were well received and are now to form a part of our ongoing business planning.

Reviews and updates

During 2021-22 we also looked at 11 good practice guides and three advice notes which we reviewed, revised and in some cases rewrote.

Updated guides included medical treatment under Part 16 of the Mental Health Act, delivering physical healthcare to people who lack capacity and refuse or resist treatment, power of attorney (including a separate guide for staff in hospitals and care homes), treatment under section 47 of the Adults with Incapacity Act, preparation of care plans for people subject to compulsory care and treatment, suspension of detention, and social circumstances reports, as well as our advice on cross-border transfers.

Media

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

In 2021-22 we continued to attract strong media coverage for our work, in print, broadcast and online. Our directors regularly took part in print and broadcast interviews, and our media work attracted responses from government, health boards and other key organisations.

Our report on racial inequality gained significant coverage on national TV and radio news coverage, with print outlets all quoting our executive medical director and using sections of the report.

Scottish TV, radio and print media gave extensive coverage to our report on concerns about women with mental ill health in prison. The report generated media response from politicians, organisations and individuals and instigated widespread discussion on our social media account.

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

Social media

Our Twitter following has continued to increase, and this year we gained 540 new followers from April 2021 to March 2022.

We published 192 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 in a meaningful way 5577 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.

The average number of engagements per tweet each month was 29, which is consistent with the previous two years and demonstrates a consistent level of engagement from our followers.

Improving our practice

- **Our Board continue to set our strategic direction and ensure efficient, effective and accountable governance.**
- **We seek to learn and improve as a result of the complaints we receive. In 2021-22, we received and responded to eight complaints, three fewer than last year.**

Our Chair

Sandy Riddell trained in social work and has held director level posts in social work, housing, education, and health and social care, including his final role before retirement as Fife's director of health and social care. Sandy has substantial experience at a national level in shaping policy and legislation in adult health and social care, children's services, substance misuse, and justice services. He was president of the former Association of Directors of Social Work and founded Social Work Scotland, and has been a member of the Mental Welfare Commission since 2017 before his appointment as chair in April 2019. He is a member of Grampian NHS Board. Sandy is passionate about the need to develop a rights-based approach for services and to fully involve the public in service design and delivery.

Our Board members

Safaa Baxter (vice chair) 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.

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, policy development and organisational development. Gordon is involved in many third sector organisations and is currently chair of Bipolar Scotland and a director of Voices of experience (VOX). He has also been a member of the delivery group of the Scottish Patient Safety Programme: Mental Health since its inception. Gordon was also appointed as a non-executive Board member and Whistleblowing Champion of NHS Forth Valley by the Cabinet Secretary for Health in February 2020. He is a Steering Group member of the UKRI funded Closing The Gap Network and a member of the Scottish Government's Mental Health Strategic Delivery Board and Mental Health Research Advisory Group.

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 15 years. Originally studying for degrees in Physics at university, and after time out to focus on her health, she joined NHS Lothian at the end of 2015 as a Peer Support worker at the medium secure forensic unit, The Orchard Clinic; where she helped build the first Peer Support Service within a medium secure forensic unit in the UK. In her role she uses her own lived experience to help others in their recovery from life changing periods of mental ill health. As part of the multi-disciplinary team she helps maintain the recovery focused ethos of the clinic within the complexities of working in a forensic setting.

Cindy Mackie is an independent consultant with occupational experience in the public, private, and voluntary sectors and currently performs a number of Associate roles within the area of regulation. She is a tribunal member with the Medical Practitioner Tribunal Service, where she is engaged in a decision making role in Fitness to Practise proceedings, she has also served in this capacity with the Nursing and Midwifery Council and the Health and Social Care Council. She is a lay examiner in membership examinations for the Royal College of Obstetricians and Gynaecologists, and is engaged in a chairing role in quality assurance / educational standards inspections across the UK with the General Dental Council. She holds a position of Independent Assessor in Public Appointments and is also involved in school governance in a voluntary capacity. Cindy brings knowledge of health regulation, public protection, safeguarding, and human rights.

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

He has held a number of national roles including National Clinical Lead for the Mental Health Collaborative, and for almost 10 years till, 2019, as National Clinical Lead for the Scottish Patient Safety Programme. He has gained an international reputation in Quality Improvement in Mental Health, and has worked with the Danish and New Zealand governments.

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

Nichola Brown joined the Board in April 2019, as carer representative. She cares for her son who has severe learning disability and complex needs, and brings experience of the challenges for families of navigating services. She has a background in community development and has worked in Public Health within Glasgow for over twenty years.

Nichola is employed by NHS Greater Glasgow and Clyde as a Health Improvement Manager in Glasgow City Health and Social Care Partnership. She leads the Health Improvement Team in North East Locality and has a city role for children aged 0-8. Nichola manages a portfolio of work programmes to improve population health, with particular focus on reducing health inequalities.

She established a community organisation in North Lanarkshire, PlayPeace, and is chairperson in a voluntary capacity. The service offers play sessions and outings to support families of children with additional needs during school holiday periods.

Alison White joined the Board in October 2019. She qualified as a Social Worker from Robert Gordon University 20 years ago. She is currently Director of Health and Social Care in West Lothian.

Our advisory committee

The Mental Health (Care and Treatment) (Scotland) Act 2003 states that the Commission must establish at least one committee (an "advisory committee") for the purpose of giving advice about matters connected to our functions. The Commission's advisory group is a standing committee of our Board.

Our advisory committee consists of representatives of 32 stakeholder groups from across Scotland. They meet twice a year, and this year made a valuable contribution to our thinking, particularly in relation to informing the Commission's business plan priorities for the coming year and further developing the Commission's engagement and participation activities.

Together, we refreshed and reviewed our advisory committee arrangements, which resulted in development of additional meetings through short life/ad hoc groups of the committee members, which will target specific areas of interest for the Commission's work and strengthen the involvement of our key stakeholders going forward.

Information management system

We continued our project for a new information and casework management system. We believe this will transform how we work digitally in the future.

Communications analysis

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

Learning lessons

We seek to learn and improve as a result of the complaints we receive. In 2021-22, we received and responded to eight complaints, three fewer than last year.

At stage 1, or front line, we resolved two complaints of the four considered at this stage (50%). The other two were escalated to investigation (50%).

At stage two, we investigated a total of six complaints. Two of them were partially upheld (33%), the other four were not upheld (67%).

Our commitment to equality

Under the specific duties, the Commission is required to:

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

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

Financial resources

Our revenue budget for the year was £4.529 million. This included £4.056 million for the Commission, £0.050 million for the National Confidential Forum (now ended), £0.256m for the reviews of deaths in detention and mental health homicide and £0.167m for the information management system replacement project

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.

Hybrid working

The second year of the pandemic continued to present us with many challenges as our staff and the organisation has adapted to remote and hybrid working and ongoing restrictions.


npm
national
preventive
mechanism

mental welfare
commission for scotland

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Service user and carer freephone: 0800 389 6809

mwc.enquiries@nhs.scot
www.mwcscot.org.uk

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