Annual report 2022-23

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

Sandy Riddell

I am very proud of the Commission's achievements throughout 2022-23 and our commitment to evolve and respond to changing landscapes. We are always looking to make changes and improvements in the way we work, and I hope this annual report is useful in outlining some of them. At the same time, we are careful not to lose sight of our core activities.

One of those is visiting people in one specific hospital ward or other place and spending the day there, hearing about their experience of care and treatment. We also talk to staff and check records, all of which allows us to assess how well that treatment is delivered locally.

Every year we have one or two national visit reports based on a particular theme, so we can consider how one area of treatment is delivered across the country.

Ending the exclusion

In 2022-23 our theme was the care and treatment of people who have both mental ill health and issues with drug or alcohol use.

Scotland has the worst drugs deaths rate in Europe, and the highest number of deaths due to alcohol misuse in the UK. It is estimated that alcohol or drugs are a factor in around half of all suicides in Scotland.

For our report, called *Ending the exclusion*, we spoke to individuals struggling with these issues, and with their families. We examined services, heard from health care professionals working in a range of roles, and surveyed GPs. We found that strategies, standards, and guidelines were all in place, but they were not being translated into practice. Families told us they felt excluded and dismissed.

We made recommendations for urgent change to health and social care partnerships. We asked Scottish Government to take an overarching role by monitoring the delivery of all of our recommendation to others, and by addressing any barriers to delivery within 12 months. This was a major report on a very important subject; we will continue to follow it through.

Pressures on staffing

Last year I raised concerns over staff pressures across mental health services and I do so again this year. We regularly find that wards and services are understaffed, which can mean that activities for people being care for are curtailed or postponed. In many cases there is a long-term reliance on bank and agency staff, which can be disconcerting for patients and is not sustainable for continuity of care.

Amidst these concerns, I am always amazed and heartened to see feedback from people receiving care and treatment, and from families, on how kind and compassionate they find ward and services staff to be. That is ever more difficult when working under such pressure. We at the Commission will do all we can to encourage staff recruitment and retention in mental health and learning disability services.

Law reform

The Scottish Mental Health Law Review report was published in autumn 2022. We welcomed that document, and we are clear that Scotland's laws in mental health and incapacity are outdated and in need of reform. I hope the year ahead sees real progress on bringing forward a new Bill and plans for legislative reform. This is important to us because we firmly believe it can result in better protections and better care and treatment for vulnerable people in our country.

"We regularly find that wards and services are understaffed, which can mean activities for people being cared for are curtailed or postponed."

Chief executive's message

Julie Paterson

One of the most interesting aspects of working at the Mental Welfare Commission is the way that every day we are operating at different levels, with some colleagues dealing directly on very local, sometime individual cases, while others are working on national strategies and plans.

Individual support

Our work on individual cases is often, by its very nature, private and never published. In these situations, our health or social work professionals will respond to a request for help from a caller to our advice line, for example, or review a case highlighted by another organisation.

They will talk to the individuals and services involved to fully understand the situation. If they have concerns, they elevate their enquiries until they are satisfied with the response.

Our engagement and participation team likewise speak to individuals, often by travelling to local support meetings where they can explain how the Commission works and what help it can offer.

They will highlight information we publish that might be useful, such as our good practice guide on carers and confidentiality, which clearly states that families and carers should be listened to by health and social care teams.

Safeguarding medical treatment

An example of our national work includes our role in appointing designated medical practitioners (DMPs), who give second medical opinions when people are detained for treatment under the Mental Health Act.

Having those second opinions is an important safeguard in care and treatment, and it is the Commission's responsibility to ensure we have the right number of well-trained doctors ready to undertake this role. Last year we ran a recruitment drive and held a training seminar for new DMPs and updated their handbook. Responses were positive and engagement with the training was helpful to all.

Joint work with NES

Another national role was our joint project with NHS Education for Scotland (NES) to offer and promote new training materials about the Adults with Incapacity Act. Together we ran a number of highly popular masterclasses for people working across a range of health, social work and social care roles, adding more due to demand. Feedback tells us that this work is making a real difference for people who've been working in the area for a long time, and in training new staff too.

Reviews for Scottish Government

We completed work on two projects for Scottish Government. One was related to deaths of people detained for care and treatment under the Mental Health Act. The other was connected to homicides by people who were, or had recently been, in receipt of mental health services.

For both projects the purpose was to propose new systems of investigation in Scotland. Our work included a mix of reviews of other jurisdictions' systems, consultation, and individual investigations into cases in Scotland. A lot of learning went into these projects, and we will use that in our continuous improvements of the Commission's own investigations work, as we await the government's decision on the continuation of the broader projects.

What happens after we publish a report?

While a significant amount of work goes into each of our reports, we are very aware that publication is not the end of the process. We need to keep in contact with every organisation we have asked to make improvements to make sure our recommendations are implemented. To help that process, we now publish closure reports outlining how well our recommendations have been acted upon, usually a year after every national report. You can find these on our website.

"While a significant amount of work goes into each of our reports, we are very aware that is not the end of the process."

Influencing and empowering

- **Working in collaboration with NHS Education for Scotland, we continued our drive to improve understanding of the Adults with Incapacity Act by devising and delivering new learning for health and care staff across Scotland.**

- **We welcomed the final report by the Scottish Mental Health Law Review and will do all we can to encourage true transformation of Scotland's mental health legislation.**

- **We published a national review of advocacy services for adults, children and young people across Scotland; progress is being made, but we found issues with planning, budgets and staffing.**

- **We share expertise and intelligence with other organisations where collaboration can lead to better decision-making and better outcomes.**

Authority to Discharge – ensuring long term change

Ensuring long term change can often mean working for a number of years with national and regional partners to follow up the recommendations we made in our original work.

Our 2021 report - *Authority to Discharge*; decision making for people in hospital who lack capacity – considered the rights of people who lacked capacity to make some or all of their own decisions being moved from hospital to care homes during the pandemic.

Our final report raised significant concerns that were not exclusively the result of the pandemic. It found evidence of a lack of understanding of the Adults with Incapacity Act across the health, social work and social care workforce, particularly in the areas of capacity and assessment and associated legislation, deprivation of liberty and human rights. We made recommendations for change to health and social care partnerships, the Care Inspectorate and Scottish Government.

What happened next?

We received responses from all 31 health and social care partnerships and worked to support those where details were not SMART (specific, measureable, achievable, relevant and time bound). In 2022 we published a closure report showing complete responses.

We built stronger links with the Care Inspectorate to share expertise. We published a joint position statement with Scottish Government, who supported best practice nationally and agreed to fund a new collaboration between our team at the Mental Welfare Commission (offering expertise in the law), and NHS Education for Scotland (offering expertise in education), to create a national approach to learning.

"Our final report raised significant concerns that were not exclusively the result of the pandemic."

Latest initiatives – masterclasses, new online learning site, bulletin

In February 2023 the collaboration project ran a live masterclass for health, social work and social care staff across the country on the legislation. It was heavily subscribed to and led to further masterclasses later in 2023.

The joint team launched a new online learning resource specifically designed to address the issues raised in Authority to Discharge. It offers an easily accessible, practical, set of materials for health, social work and social care staff. It should result in better knowledge of the Adults with Incapacity Act among professionals, and better outcomes for individuals receiving care and support.

The project team publish a quarterly bulletin with updates on the work, with the aim of encouraging feedback and sharing good practice.

Feedback from the masterclasses

"This was an extremely thought-provoking seminar which has now guided me to further reflect on practices regarding the discharge of people from hospital."

"The pressures placed on us to avoid delayed discharges should never be the guiding factor to get the best possible outcome for individuals."

"Very helpful and presented in a way where examples helped me make sense of the changes and reinforced the areas to be cautious about."

Scotland's mental health laws – major opportunity for change

We welcomed the final report of the Scottish Mental Health Law Review, published in September 2022.

Scotland's laws in this area are over 20 years old, and in many ways are no longer aligned with the rights, expectations and needs of people requiring care and treatment. We agree with the report's finding that Scotland's mental health and capacity laws need to be updated to focus much more on the individual and their rights.

We also welcomed the view that the Mental Welfare Commission should be given more responsibility and a stronger role. The Commission is increasingly concerned about the capacity and ability of our health, social work and social care services to provide the care and treatment that is needed in Scotland. We can assist this work by doing more to support and challenge services. We wish to work with Scottish Government to drive forward change.

Julie Paterson, chief executive, Mental Welfare Commission

"This review report is a major opportunity to get it right for the future."

The right to advocacy - a review of advocacy planning across Scotland

Independent advocacy is important because it ensures that everyone matters, and everyone is heard.

We published our first review of advocacy services in Scotland since 2018. The report showed that the planning and provision of advocacy services across Scotland was progressing, but also found issues with planning, with budgets, and staffing, highlighting a difficulty in recruiting and retaining advocacy staff in the third sector.

The review examined advocacy services for adults, children and young people across Scotland, and included an appendix with details of every response received.

The results show the majority of advocacy services are planned and commissioned at health and social care partnership (HSCP) level or jointly with health boards and local authorities.

Half of the areas said their advocacy budget had not changed in the last two years, and those who had received an uplift (for cost of living or wage increases) reported there has been no change to their services.

Compared to 2018, more authorities said their plans referenced the provision of independent advocacy services for children and young people, but despite this increase, it amounts to less than half of responses.

The full report is available here.

"Half of the areas said their advocacy budget had not changed in the last two years..."

Sharing expertise and intelligence

The Commission continues to contribute to the Sharing Intelligence for Health & Care Group which aims to improve the quality of health and social care by allowing members to share and learn from existing data, knowledge and intelligence.

The Commission is one of seven national organisations that make up the group, along with Audit Scotland, the Care Inspectorate, Healthcare Improvement Scotland, NHS National Services Scotland, NHS Education for Scotland and the Scottish Public Services Ombudsman.

A new group has been created involving the Mental Welfare Commission, Healthcare Improvement Scotland and the Care Inspectorate called the National Mental Health and Learning Disability Coordination Group.

This group is evolving currently and its focus is on sharing information to ensure a coordinated, informed approach to scrutiny of mental health services and to avoid duplication. The Commission chairs this group.

As an observer of the Scottish Mental Health Partnership we work with other organisations to promote a rights-based approach to the government's new Mental Health and Wellbeing Strategy, which was published in June 2023.

We also continue to participate in professional networks including the Mental Health Nursing Forum, the Royal College of Psychiatrists' Scottish Committee and Social Work Scotland, and key interest groups such as the Scottish ECT Accreditation Network and the Alzheimer Scotland Policy Committee. Our chief executive is also an observer at the Scottish Mental Health Law Society's Mental Health and Disability Sub-Committee meeting and our senior staff represent the Commission across a range of key national work streams including mental health estates work, the dementia strategy and mental health quality standards.

Our engagement and participation officers continue to build their networks across Scotland, meeting carers and people with experience both virtually and face to face (294 contacts with people with experience and 487 with families/carers were made this year exceeding the target of 250 for each group) and this will inform our revised engagement and participation strategy of 2023.

Feedback to our engagement and participation officer:

"Thank you for your presentation to Families on the Frontline yesterday. We are huge supporters of the work of the MWC, and of course your role in particular, and its lovely to continue to work together."

"... we work with other organisations to promote a rights-based approach to the government's new Mental Health and Wellbeing Strategy..."

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. The Commission has always been represented on the UK wide group and the Scottish sub-group, however this year the Commission was also invited to join the national UK steering group as the Scottish representative.

Membership of the NPM provides a mechanism for the Commission to collaborate with other organisations that monitor settings of and rights for people who are subject to detention. After attending the UK NPM in Belfast, the Commission is undertaking work on 'Task and Finish' groups looking at actions to improve access to treatment for mental health conditions in prison settings, and that between the NPM organisations we can ensure that there are no gaps in monitoring settings where people may be deprived of liberty.

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.

"... this year the Commission was also invited to join the national UK steering group as the Scottish representative."

Effective and targeted visiting

- **We carried out 140 local visits to hospital wards, units and prisons and care services, compared to 95 the previous year - an increase of 45 visits (47%). Eighteen per cent of our visits were unannounced.**
- **We met 790 individuals who were receiving care and treatment across the country on our local visits, exceeding our target of 650.**
- **We published *Ending the exclusion*, a national themed visit report on mental ill health and substance use services in Scotland, examining whether care and treatment are available for people struggling with these issues.**
- **We undertook visits for two further themed reports – one on people receiving care and treatment outwith Scotland's NHS services, and one on people subject to community based compulsory treatment orders.**

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

A core part of our work is undertaking local visits to hospital wards, units and care services. We particularly focus on places where there is a deprivation of liberty; where intelligence gathered from themed visits, previous visits, patients' concerns and other sources raise issues about care and treatment; or where it has been some time since our last visit.

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. We publish these reports, and share our findings with other 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.

Between 1 April 2022 and 31 March 2023 we carried out 140 local visits, an increase of 45 visits (47%) compared to the previous year; we made 504 recommendations for improvement, an increase of 275 (120%). There were nine services which had no recommendations for change, one less than the previous year.

For those services where recommendations were made, these ranged from one recommendation to 14 recommendations. On average, the number of recommendations made was four.

When we make recommendations, we ask the service for a response within three months, to 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.

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.

Ending the exclusion

Scotland has the highest level of deaths due to problem drug use in Europe, and the UK's highest numbers of deaths due to problem alcohol use. The Mental Welfare Commission's own data, and that of government and health authorities in Scotland, show rising rates of mental ill health.

In September 2022 we published a report looking at the combination of mental illness and substance use, and asked if care, treatment and support are in place for people struggling with these issues.

We found that services are not meeting the needs of people who have both mental ill health and problems with substance use. Strategies, standards and guidelines are in place, but are not being translated into practice. The Commission found little awareness of the Drugs Death Task Force standards on engagement and joined-up working so that people with a substance (drug or alcohol) use problem can access mental health care at the point of treatment.

Ninety per cent of the 89 GPs who responded to us had experienced difficulties in referring individuals to both mental health services and addiction services, including when patients presented in crisis.

The overriding message from families was that there was a lack of support, care and treatment available to their relative and themselves. They describe patchy, inconsistent services who fail to properly engage. The lack of crisis support, advocacy and rehabilitation services were also highlighted. Staff shortages reportedly impacted delivery of care and treatment and in the continuity of care.

We made recommendations for change to health and social care partnerships and to NHS Education for Scotland, and added one overarching recommendation to Scottish Government asking that they monitor the delivery from the others and address any barriers to that delivery over the following 12 months.

Read the report here.

"Staff shortages reportedly impacted delivery of care and treatment and in the continuity of care."

Closure reports

We now publish closure reports for every national themed visit report we publish, usually a year later. The purpose of each closure report is to assess whether the Commission has achieved its objectives (including outcomes, learning, quality and impact) and completed all deliverables on time and as planned.

This year we published closure reports for four themed visit reports.

Care and treatment for people with alcohol related brain damage in Scotland

The Commission has long standing concerns about the availability of specialist support for people with a diagnosis of alcohol related brain damage (ARBD) and published good practice guidance on this subject.

This themed visit report, published in 2021, looked specifically at 50 cases where people had been given a diagnosis of ARBD who were also subject to a welfare guardianship order.

One aim of this themed visit in 2021 was to determine the impact of the Commission's guidance in practice; another aim was to gather information from people with ARBD, family/carers, welfare guardians and support staff and highlight their views.

A mapping exercise of ARBD specialist services across Scotland will be completed with HSCPS in 2023. We will aim to visit the 50 individuals subject to guardianship orders we met as part of this themed work again in 2023 to review and seek feedback on how things are going for them and their families.

Our closure report includes a summary of responses, including the comment that the quality of responses from health and social care partnerships varied significantly. We were particularly impressed by those areas who undertook their own audits in response to recommendation 1 and satisfied themselves that commissioned resources appropriately met the needs of all those with a diagnosis of ARBD in their particular area.

We will request updates on progress in advance of our 'end of year' meetings with health and social care partnerships.

"We were particularly impressed by those areas who undertook their own audits..."

Racial inequality and mental health in Scotland: a call to action

In September 2021 the Commission published this report which explored how well Scotland's mental health sector was performing in relation to racial equality. This was the first time a comprehensive report on the issues was undertaken in Scotland.

The report found differences in the ways the Mental Health Act was applied when people from ethnic minorities were detained for care and treatment compared with white Scottish people. It found they were more likely to be seen as a risk to other people, and were less likely to have safeguards under the Act. It also showed staff from minority groups were less likely to be in higher bands in nursing and in senior roles in the medical profession. Data from a staff survey showed evidence of racism towards staff from minoritised groups across all mainland health boards. This report included 30 recommendations for change directed at organisations including Scottish Government, health boards, NHS National Education for Scotland, and the Royal College of Psychiatrists.

Our closure report summarised responses from all of those asked to make improvements. It shows the many actions that have been taken by respondees, including actions on training and improving equalities.

Concerns about the care of women with mental ill health in prison in Scotland

This report began with a retrospective review of the records of nine women who were receiving mental health care in HMP Cornton Vale during the time of a visit by the European Committee for the Prevention of Torture (CPT) in 2019, who had serious concerns over what they found. Themes emerged which linked with casework we were already carrying out, particularly in relation to delays in transferring women with acute mental illness from prison to hospital care. We broadened the scope of our review and included these cases.

We too were very concerned about the care and treatment of these women. Our report highlighted a lack of beds in key units, missed opportunities with early intervention and a revolving door of prison for some women. We made 15 recommendations for change.

Our closure report for this work gives details on progress and after examining responses and updates we are reassured that 10 of our recommendations have been actioned by Scottish Prison Services and NHS respondents. We were advised that follow up work on the remaining recommendations is underway, and a number of these are incorporated into the work of other reviews such as the Independent Review into the Delivery of Forensic Mental Health Services and are being led by Scottish Government. We continue to liaise with key teams.

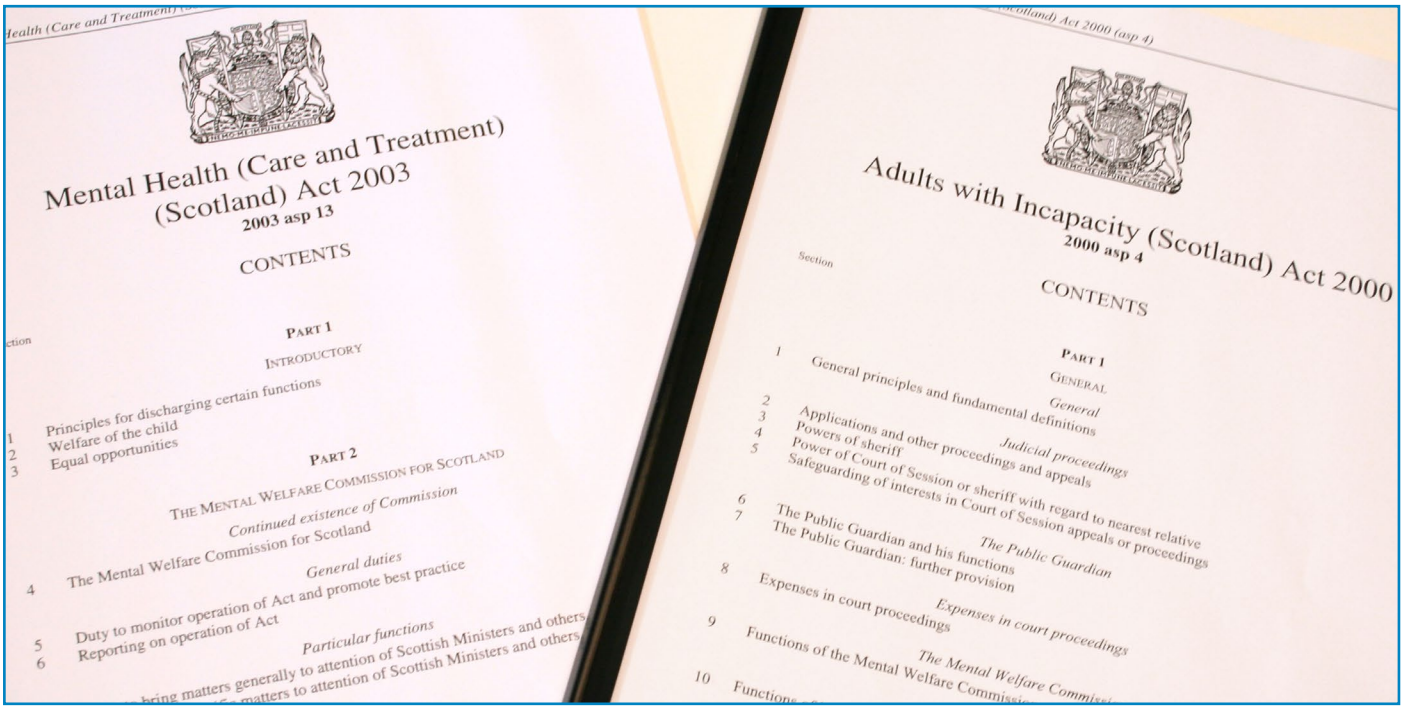
Mental health in Scotland's prisons in 2021: under-served and under-resourced

NHS Scotland took over the role of providing mental health services in Scotland's prisons to make improvements to services for prisoners in 2011. We'd published a report on how mental health services were working in prisons before that change, and last year we published a follow-up report looking at how this was working in 2021.

We found that little improvement had taken place over that decade. Access to, and the delivery of, mental health support across Scotland's prisons was inconsistent and lacked cohesion. Prisoners who were seriously and acutely mentally ill were still not being transferred to hospital care without delay. We described mental health services in Scotland's prisons as underserved and under resourced. We called for urgent action and made 10 recommendations for change.

Our closure report summarises responses to our report at the 12 month point of a 12 to 24 month timeframe we gave for our recommendations to be actioned. We gave a two year timeframe because we recognise the two separate systems – NHS and prison services – attempting to achieve the one objective of improving mental health care for prisoners. Nevertheless, at the midpoint stage, this closure report finds considerable variation across the prison estate in meeting our recommendations.

Monitoring and safeguarding care and treatment



We have a statutory duty to monitor the use of the Mental Health Act in Scotland.

- **6,713 detention episodes began in 2022-23 (1.7% more than in 2021-22)**
- **We have a statutory duty to monitor the use of the Adults with Incapacity Act in Scotland. There was a total of 17,849 individuals subject to a welfare guardianship order in Scotland on 31 March 2023 compared to 17,101 in 2022.**
- **We monitor all cases where a child or young person under the age of 18 is treated for mental ill health in a non-specialist ward, usually an adult ward.**
- **As part of our safeguarding role, we are responsible for appointing designated medical practitioners, who provide authorisation for certain medical treatments set out in 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 every year. 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 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 the law.

We are also 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 the Mental Health 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 June 2022 we published a report that explored the trends in the use of Compulsory Treatment Orders (CTOs) showing how the proportion of community-based CTOs has risen over time, how minoritised ethnic communities are overrepresented amongst individuals subject to CTOs and showing how the median length of these orders corresponds to the statutory review of these orders. We made several recommendations to the Scottish Mental Health Law Review on how these orders might be more effective. We are following this work up with a themed visit to understand the experience of people subject to these orders, those important to them, and the professionals who work with them.

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 publish a report annually which focuses on young people under the age of 18 years who are admitted for treatment for mental ill health to non-specialist wards in Scotland, usually adult wards. 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 report on admissions of children and young people to non-specialist wards later in the year.

"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..."

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 authorisation for certain medical treatments as set out under Part 16 of the Mental Health Act; and provide reports for sections 48 and 50 of the Adults with Incapacity Act. These are important safeguards and are the highest priority for recovery under our business continuity plans.

The DMPs provided face to face assessments and if necessary, some assessments by phone or video (due to tight timescale, availability or the preference of responsible medical officers or their patients). In 2022-23, designated medical practitioners undertook 2,571 second medical opinions: 2,545 under part 16 of the Mental Health Act; and 26 under the Adults with Incapacity Act. There were 55 active DMPs during this time.

To support this work, in 2022 the Commission's DMP team reviewed and shared their comprehensive DMP handbook. A DMP recruitment drive took place, and the Commission's annual training seminar in March 2023 involved over 40 delegates in person.

Comments from delegates

"Really helpful overview of DMP work, clarity around role, and example paperwork etc. Handbook is comprehensive and really useful."

"Everything was useful, informative and thought provoking."

"It's one of the most useful and enjoyable seminars in the calendar, thanks."

Four DMP newsletters have been sent so far to update DMPs about developments, ways to minimise errors or improve the quality of their work. This together with an ongoing audit of (T3) forms and the training seminars, are part of the efforts for quality assurance. A new second opinion request form was created in October 2022 after consultation with colleagues and stakeholders. It is comprehensive and the feedback from DMPs confirmed that it improves the efficiency of their work.

Detentions

6,713 detention episodes began in 2022-23 (1.7% more than in 2021-22) and lower than the average year-on-year increase in the previous years of 4.9%. Just over half of all episodes of detention began under a short term detention certificate (STDC), 48% with an emergency detention certificate (EDC) and 1.2% with a compulsory treatment order (CTO).

We continue to monitor detentions by the level of deprivation based on the home address of the person being detained according to the Scottish Index of Multiple Deprivation (SIMD) to facilitate discussion about resource planning and the wider determinants of health and mental health. For all three order types there was a clear gradient with a higher proportion of detentions of individuals from the most deprived parts of Scotland.

The Commission monitors how the law works in practice. For some time now, we have been concerned that for detention under an EDC, the safeguard of a mental health officer (MHO) consent has been falling. MHO consent in 2022-23 was the lowest we have seen over the last 10 years at 36.6%. We are raising this issue with relevant services through our end of year visits. Our Mental Health Act monitoring report was published on 12 October 2023.

Welfare guardianship orders

When a person lacks capacity to take decisions for themselves, a court can appoint a 'welfare guardian' under the AWI Act to do that for them. It is usually a relative, but can be a local authority. Welfare guardianship orders are most commonly used for people with learning disabilities or those with dementia.

Welfare guardians can make a decision about where a person lives, as well as about their personal and medical care. Local authorities have a duty to supervise all welfare guardians.

We have a duty to monitor the use of the AWI Act across Scotland and will be publishing a full monitoring report towards the end of 2023, however we can confirm that:

- There was a total of 17,849 individuals subject to a welfare guardianship order in Scotland on 31 March 2023 compared to 17,101 in 2022.
- A total of 3,501 guardianship orders were granted in 2022-23, 2.9% more than in 2021-22.

The Scottish Mental Health Law Review (SMHLR) made a number of recommendations in relation to AWI reform in its report dated September 2022; we welcome the Scottish Government's stated commitment to prioritising responding to these recommendations. Our AWI Act monitoring report will be published later in 2023.

Investigations

- **We completed two investigations as part of our proposals to Scottish Government for a new system of reviewing the deaths of people who died while detained under mental health legislation.**
- **We also completed an investigation related to a further Scottish Government project about reviewing situations where someone who is receiving mental health services, or had done in the previous year, commits homicide.**
- **We began an investigation into a case that has learning for services across Scotland.**
- **We made enquiries using our powers of investigation in a total of 79 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 usually involved.

Usually a review of a significant incident 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 learning for services across Scotland.

All of our investigations are anonymised. That way, we seek to protect the individual, and we concentrate on highlighting the lessons learned by health or social work practitioners and organisations across Scotland.

During 2022-23 we made further enquiries using our powers of investigation in a total of 79 cases. We closed 45 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 34 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.

Our practitioners may have a significant level of involvement and oversight in casework, sometimes over a number of years.

Whilst this work will not routinely lead to published reports, the outcomes and learning remain critically important for individuals, families, carers and mental health services.

We follow this work through to conclusion and an example of the impact of this type of work following advice, guidance and oversight is noted below:

Feedback from a family member to a practitioner

"It's the understatement of the century to say that I simply could not have arrived at this point without you, supporting and advising from your expert and compassionate position.

"Your guidance and patience have been absolutely extraordinary and your professional friendship and advice have been literally second to none.

"There is no way on earth that I could have got to this juncture in one piece without your hand on my shoulder."

Investigation into the care and treatment of Mr TU - homicide by a person in receipt of mental health services

As part of our homicide review for Scottish Government, we investigated the circumstances leading up to a homicide by a man, Mr TU, who had been in contact with mental health services prior to this tragic incident. The report was anonymised, as all our investigations are.

Mr TU was 32 years old when he had four relatively brief admissions to psychiatric hospital in 2018. He was diagnosed with drug induced psychosis.

On each admission, he was taken there by the police and on three of these admissions he was in possession of a potential weapon. On each admission, Mr TU presented with paranoid delusional beliefs and was detained under the Mental Health Act.

There was increasing concern about the risk of future violence. In 2019, Mr TU was admitted to inpatient forensic mental health services and also had a further brief admission under the care of general adult mental health services. He spent most of the year in prison.

In December 2019 he was on remand in prison and was liberated by the court with no support package in place and no accommodation. On the evening of his release, Mr TU killed a man who had offered him overnight accommodation at his flat.

We found that if Mr TU had been offered accommodation in December 2019 this is likely to have reduced the risk to the specific victim, but further violence could not have been prevented with any certainty.

In relation to health services, we found many aspects of Mr TU's care in 2018 were of high quality, but we found issue with other aspects.

We made 12 recommendations for change. Read the full report here.

Investigation into the care and treatment of AB

We investigated the care and treatment of AB, a vulnerable person with learning disabilities and physical ill health, who died in hospital after being under the influence of another individual for many years and despite multi-agency concerns about the impact of this influence.

The investigation was part of our proposal for Scottish Government into how deaths of people detained for mental health care and treatment are reviewed across Scotland.

Concerns had been raised by AB's family, by social work and health services and by others, leading to AB being subject to three Adult Support and Protection investigations and two periods of detention in hospital under the Mental Health Act in the five years leading up to their death.

Despite this, actions which could have been pivotal in ensuring there were statutory protections in place for AB and which could have helped their access to and provision of medical treatment were not taken. Instead, AB remained under the influence of the individual throughout, and access to needed treatments was impeded up to the time of their death.

We made six recommendations for change jointly to the NHS health board and local authority involved in this case, and one recommendation to Scottish Government.

Our recommendations covered social work and health care, but also addressed the issue of legal authority and power of attorney, recognising that someone who may lack capacity for decision making about their health or welfare needs may be under the undue influence of another person.

You can read the report here.

"... AB [was] subject to three Adult Support and Protection investigations and two periods of detention in hospital .."

Investigation into the care and treatment of Mr D – a young man who died in hospital

Our investigation into the death of an 18-year-old man in hospital found that there were aspects of his care and treatment that, had they been conducted differently, might have prevented his death.

This investigation was also part of our work done on behalf of Scottish Government. Mr D died in hospital in December 2018 from the consequences of drinking an excessive quantity of water while he was detained under the Mental Health Act for urgent treatment on an adult ward.

Mr D had previous contact with child and adolescent mental health services (CAMHS), where he had been treated after drinking an excessive quantity of water. He was diagnosed with early onset psychosis and received two years of community based CAMHS care.

Mr D turned 18 while still under the care of the CAMHS specialist psychosis service. The service was moving away from a treatment model that supported young people with first onset psychosis for at least three years from the point of diagnosis, towards one in which transition to adult mental health services began around the age of 18 years.

At a point of crisis in early December 2018, Mr D was admitted out of hours to an adult mental health service inpatient unit in a neighbouring health board to his own, as there were no local beds available.

During the 70 hours of this admission Mr D's case records from his years of contact with the CAMHS community team were unavailable. Relevant clinical information was passed to members of the new treating team and there was contact between Mr D's parents and the receiving adult ward consultant and staff. Not all of this valuable clinical information made it into the care plan in use during Mr D's admission. Mr D's family told us they felt their concerns were not given due credence.

We made 10 specific recommendations for change to, amongst others, the health boards involved, the Royal College of Psychiatrists, NHS Education Scotland and Scottish Government. The report is available here.

Scottish Government reviews

Further information on our review of deaths in detention can be found here.

Details of our homicide review are available here.

"Mr D's family told us they felt their concerns were not given due credence."

Providing information and advice

- **We received 3476 calls in 2022-23 compared to 3347 the previous year.**
- **A sample audit of advice given showed an accuracy rate of 98%, against a target of 97.5%.**
- **We published a new good practice guide for landlords, on tenancies for people with additional support needs.**
- **We updated six good practice guides and two advice notes, all published on our website.**
- **We publish our reports widely and promote them via the media and 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 offers advice to a wide range of callers seeking help, including health and care professionals, people with mental ill health or learning disability and families and carers.

The number of telephone calls logged during 2022-23 was 3476 with the top number of calls received from relatives/ carers/guardians, followed by people with experience of using services with the third highest caller group being psychiatrists.

Most calls received related to the Mental Health Act (1767 calls), fewer calls related to the AWI Act (685).

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.

We regularly carry out a sample audit of advice given out by individual practitioners and this year the accuracy rate was 98% against a target of 97.5%.

Nurse

"I have to say a thank you for the support and advice received from the Commission as it was a tricky situation we were in in terms of the legal status and responsibilities."

Psychiatrist

"Thank you so much for taking the time to give such a helpful and comprehensive reply."

Advocacy worker

"Many thanks for your call back and advice this week with regards to me accessing my client within a closed (due to Covid) Mental Health Ward …
"I contacted the ward again after your advice and was able to arrange a visit to see my client today. Senior charge nurse apologised for the "miscommunication" with the staff that I had spoken with citing that it was a hangover from when Covid was at its peak and there were no visitors allowed at all.
"She went on to say that there had been a number of discussions with senior management and absolutely they understand and accept that Advocacy should have access to their clients to ensure that their rights are upheld."

Good practice guides

Tenancies for people with additional support needs – advice for landlords

This new guide is intended for all landlords and social work departments, advocacy and third sector organisations; it may also be of interest to relatives and carers of people with additional support needs who are tenants or prospective tenants.

Increasingly, people with additional support needs are supported to live as part of communities, enjoying the benefits and experiences community living brings. Consequently, we have seen an increase in enquiries from housing association, local authority and private landlords, and from social work services, about how these arrangements can be supported legally, and how those organisations can ensure that the person's rights are upheld and promoted.

One area which can challenge landlords and social work services is how an individual who potentially lacks capacity can be supported to understand the contractual arrangements inherent in a tenancy agreement in order to sign it. The individual gains the security of tenure and safeguards, while the landlord gains the assurances that the rent will be paid, the accommodation maintained to an acceptable standard, and the individual understands their responsibilities as a tenant.

There are many challenges facing vulnerable people entering into tenancy agreements in Scotland. We hope in this document to provide some guidance for staff practising in this area. Our focus is on supported decision making.

LGBT inclusive mental health services – good practice guide update

We updated our good practice guide aimed at raising awareness of the rights of LGBT people in hospital and in the community. The guide is primarily for staff working in mental health wards, community services and primary care services, but may also be helpful for people who identify as LGBT as well as their families and friends.

LGBT people have higher rates of mental ill health, particularly anxiety, depression, eating disorders, and thoughts of suicide or self-harm than the general population. LGBT people reported that they have experienced a lack of understanding of their needs through their experience of healthcare.

Our updated guide was co-produced with LGBT Health and Wellbeing, and includes practical recommendations for making services more accessible and LGBT-friendly. It includes real life case studies and it advises on terminology and the law.

While giving practical advice on real life situations, the guide recognises that LGBT people are a diverse community who at times experience prejudice, whether intentional or not, and inequalities. We hope it will help equip mental health and social care professionals with the information they need to provide the best possible care and support to LGBT people.

The key points of the guide are to focus on the individual being cared for, to take their lead from how they describe themselves and their identity, and to make sure the environment is supportive.

The guide has been shared with health boards, health and social care partnerships and other services across Scotland.

Read the guide here.

Supervising welfare guardians and powers of attorney

We updated this good practice guidance because we were concerned that some private welfare guardians were not getting the information and support they need to fulfil their role. (In the guide, a 'private welfare guardian' is used to denote any non-local authority welfare guardian.)

This guide is aimed at local authority front line staff, line managers and chief social work officers. We know that officers' preparation to undertake their role is variable across Scotland, with many officers unaware of their duty to visit both the welfare guardian and the adult on welfare guardianship.

The Adults with Incapacity (AWI) Act provides the opportunity for people to become welfare and/or financial guardians for adults with impaired capacity and sets out how some or all decisions can be made for them. The AWI Act also gives responsibility to local authorities to support and supervise private welfare guardians. The intention is that guardianship supervisors ensure that private welfare guardians understand their new role, follow the principles of the AWI Act, and access the support they need to make proxy decisions.

Covert medication

We updated our good practice guide on covert medication, along with case examples and scenarios. Covert medication is when medicines are administered in disguised form so that the person is not aware that they are taking medication.

This usually involves disguising medication by administering it in food and drink. The most common scenario in which this happens in practice is due to a refusal to take medication when it is offered and where treatment is deemed necessary for the individual's physical or mental health and where the person does not have the capacity to understand the consequences of not taking the covertly administered medication. Covert medication must never be given to someone who is capable of deciding about medical treatment.

Medication is administered covertly in hospitals, care homes and sometimes by carers for people living at home. We issued our original guidance on covert medication in 2006, taking account of the requirements of Scottish legislation. Since then, we have found that most hospitals and care homes are aware of our guidance on covert medication and refer to it when considering covert administration of medication.

Drug-induced psychosis and the law

This good practice guide was reviewed and republished without changes. It uses case examples to demonstrate when it is appropriate to use mental health legislation for 'drug-induced psychosis', and some of the dilemmas in using mental health legislation for people whose episodes of psychosis appear to be provoked by taking street drugs.

The dilemmas include considering the grounds for compulsory treatment, as set out in the Mental Health (Care and Treatment) (Scotland) Act 2003; and making a diagnosis when it can be hard to distinguish from mental illnesses that occur without being provoked by drug use (interactions between mental illness and substance misuse are complex).

Social circumstances reports

This good practice guide was first issued in 2009 and was updated in 2022. The provision of SCRs is an area of practice where practitioners and managers have difficulty in achieving consistency in the circumstances in which responsible medical officers and the Commission could expect a report to be prepared.

A social circumstances report (SCR) is produced by a mental health officer (MHO), as a qualified and experienced social worker, under the Mental Health (Care and Treatment) (Scotland) Act 2003.

The SCR is an extremely important document which should examine the interaction of an individual's social and family circumstances with their mental health condition. It will comment on issues that the MHO feels will need to be addressed when planning care and treatment.

Our guidance provides eight recommendations which aim to help enhance the quality of the reports, and achieve greater consistency in the circumstances in which the Commission and responsible medical officers could expect to see one.

Introduction of an updated diagnostic classification system for mental health and intellectual disability services in Scotland – ICD-11

We published a new advice note on the eleventh edition of the International Classification of Diseases (ICD-11) which has been used by healthcare professionals and services since 1900 and provides doctors and other healthcare professionals with clear definitions of all diseases and conditions.

Chapter 6 of the ICD-11 deals with mental health conditions, and lists the "diagnostic criteria" for each one (these criteria are the essential features of a disease or condition that must be present in order to diagnosis it). This provides standard definitions of diseases and consistency in how diagnoses are made.

The introduction of ICD-11 will mean different things for different people. Doctors and other health care professionals involved in making diagnoses will required to familiarise themselves with the changes in ICD-11. There are some changes to the way certain conditions are described and diagnosed. There are also some new diagnoses that have been added.

In line with the new ICD-11 coding structure, the Mental Welfare Commission worked with Scottish Government to update the Mental Health Act forms that were introduced in September 2023.

For patients, the impact of ICD-11 will most likely depend upon how involved they wish to be in discussing their mental health diagnosis with professionals. The most important thing is that they feel listened to by professionals and that their views, wishes, and concerns are respected and discussed.

Adults with Incapacity: supporting discharge from hospital

This advice note was issued after a joint statement made with the Scottish Government. The purpose was to highlight actions that can be taken to support the discharge of adults with incapacity from hospital, whilst respecting and protecting their human rights. The note explains the statutory framework within which people may be moved from one hospital to another (based on their needs), or discharged; interim orders; applications made by local authorities; and prescribed lists of solicitors for private applications.

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 2022-23 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.

Social media

Our X (or Twitter) following has continued to increase despite changes to the platform, and this year our follower count increased by 319 from April 2022 to March 2023.

We published 196 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 4,096 times (this includes link clicks, likes, retweets and replies).

The average number of engagements per tweet each month was 21; although this is lower than the previous year, it should be noted that major changes to the platform mean a direct year-on-year comparison is not possible in this case.

Improving our practice

- **Our Board continue to set our strategic direction and ensure efficient, effective and accountable governance.**
- **We consulted widely on our strategic plan 2023-26 and this was agreed by our Board in February 2023.**
- **We seek to learn and improve as a result of the complaints we receive. In 2022-23, we received and responded to six complaints, two fewer than last year.**

Strategic plan

We wanted to engage and consult as broadly as possible during the development of our new strategic plan and to ensure all stakeholders had the opportunity to express their views on the scope and to contribute to our strategic plan priorities for the next three years. We contacted more than 2000 organisations and individuals seeking their input.

We used a number of methods of engagement, focus groups, surveys, sessions with staff and our Board but we also pulled together the rich feedback received from other sources of engagement; our stakeholder survey, our Board development session and from our advisory committee, all of which informed our draft strategic plan.

The draft strategic plan was then issued to everyone on our register of interest, our staff, executive leadership team, the advisory committee, and the Board for comments.

The Strategic plan was formally approved by the Board in February 2023.

These are some of the comments received on our draft plan

"This is a targeted strategic document that focuses in on the right areas and is current, responding to the changing policy landscape with both Scott and the national care service on the horizon and influencing change in health & social care services."

"HMIPS look forward to seeing the published version of the strategic plan and continuing to work with you to highlight issues where the mental health of those in the care of the Scottish prison system is not being as well supported as it should be."

"The work you have done to reach this point is hugely impressive, in particular, the levels of engagement."

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

We said goodbye to **Safaa Baxter**, who has contributed greatly to the work of the Commission, and who completed her nine year term on our board on 31 March 2023, after an extension.

We welcomed **Kathy Henwood** to the Board in 2023. She has 35 years' experience in social work, working across local authorities and the third sector, in Scotland and England. Kathy has predominantly worked with children and families, though started her career working in mental health services and in residential care with older people. She has worked across child protection committees, been a guardian ad litem and an associate assessor in inspections as part of the Child Protection Reform programme. She has also been an associate lecturer for the Open University for over 15 years, teaching courses around leadership and management across health and social care. Kathy is Service Director, Children's Services and Justice Services with Edinburgh City.

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 having worked in Public Health within Glasgow for twenty five years leading a portfolio of work programmes to improve population health, with particular focus on reducing health inequalities.

Nichola left Glasgow in December 2022 to take up the role of CEO of the North Lanarkshire community organisation, PlayPeace. The service offers play sessions and outings to support families of children with additional needs during school holiday periods. It continues to grow and develop its services, driven by families and the children and young people engaged.

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.

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.

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. She 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 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.

Alison White joined the Board in October 2019. She qualified as a Social Worker from Robert Gordon University 20 years ago. Alison was Head of Adult Services and Chief Social Work Officer for Midlothian Health and Social Care Partnership before taking up the role of Chief Officer of the West Lothian Integration Joint Board in July 2021. Alison is passionate about developing person centred, human rights based services.

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 committee is a standing committee of our Board.

Our advisory committee currently consists of representatives of 32 stakeholder groups from across Scotland. The Committee meets twice a year and at times holds ad-hoc meetings to inform the Commission's priorities with regards issues that are time-sensitive and this year continued to make 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.

Information management system

Our work on a new information and casework management system is a detailed and complicated project for an organisation of our size and we are working with various partners to elicit the expertise we need.

The project was delayed in May 2022 in order to ensure that all appropriate actions were being taken in advance of procurement to ensure successful delivery.

During this time, our staff engaged and fed back on their 'blue sky' thinking around how the Commission could digitalise and transform and after addressing a number of recommendations, the project is now in a strong position to move towards the procurement phase of this critically important work.

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 2022-23, we received and responded to six complaints, two fewer than last year.

At stage 1, or front line, we resolved two complaints of the two considered at this stage (100%).

At stage two, we investigated a total of four complaints. Three of them were partially upheld (75%), the other one not upheld (25%).

As a result of the complaints we have received in 2022-2023 we have:

- Amended one section of our website about the Mental Health (Care and Treatment) (Scotland) Act with regard mental disorder definition within the Act.
- Reminded practitioners about the importance of undertaking concluding communications with those who contact the Commission to ensure transparency and clarity for those seeking information and advice from the Commission.
- Improved how designated medical practitioners (DMP) record the degree to which they manage to speak with and assess individuals when carrying out assessment.

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 £5.174 million. This included £4.716 million for the Commission, £0.286m for the reviews of deaths in detention and mental health homicides and £0.172m for the information management system 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

In the aftermath of the pandemic restrictions, our staff and the organisation have successfully adapted to remote and hybrid working and review on an ongoing basis.


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

SG/2023/254

October 2023