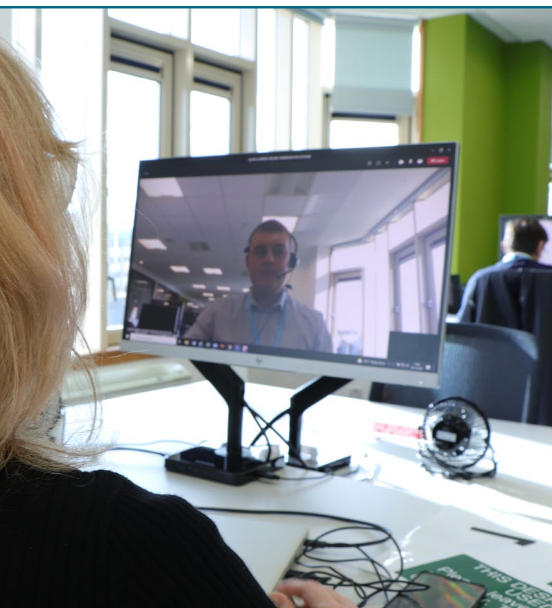
Annual report 2023-24

mental welfare
commission for scotland



Mental health detentions rise

'Eight years away from home for mental health patients'

mental welfare
commission for scotland

Out of NHS area placements

Themed report
September 2023

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 4
Our mission and purpose 5
Chair's foreword 6
Chief executive's message 8

Influencing and empowering 10
From shared ambition to delivery 13
Adults With Incapacity project 14
National Preventive Mechanism 15
Designated medical practitioners 16

Effective and targeted visiting 17
Local visits 19
Concerns over staff shortages 19
Out of NHS area placements 20
Compulsory treatment for mental illness in the community – how is it working? 21
Ending the exclusion: closure report 22

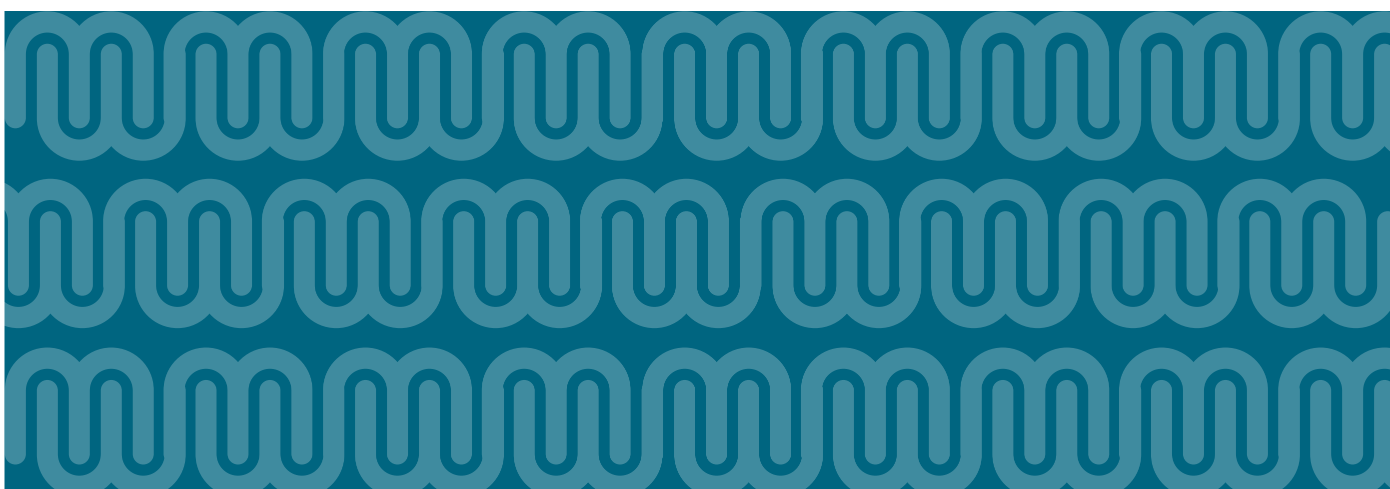
Monitoring and safeguarding care and treatment 23
Monitoring of mental health and incapacity legislation 25
Children and young people monitoring 26

Investigations 27
Casework 28
Case Summary 1: Ms A 29
Case Summary 2: Mr B 30
Investigation project team (Scottish Government pilot) 31
Investigation into the care and treatment of Mr E - failed by the systems and structures put in place to protect him 32

Providing information and advice 33
Advice Line 35
Engagement and participation 36
Good practice guides 36
Media 37
Social media 37

Improving our practice 38
Our Chair 39
Our Board members 40
Our advisory committee 43
Information management system 43
Communications analysis 44
Accessible communications 44
Supporting our workforce 45
Learning lessons 46
Equality outcomes 46
Financial resources 47

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

For the Mental Welfare Commission, and for individuals and organisations we work with, the growing disparity between demand and supply in Scotland's mental health and learning disability services is daunting.

Our work keeps us in very close contact with how people are experiencing their care, and how services are delivering that care. We see the pressures, from staffing to environmental.

Last year we took around 4,000 calls for advice from individuals, families, psychiatrists, social workers, mental health nurses and others.

Those calls sought help on issues related to individual cases, best practice in care and treatment, and mental health and social care laws in Scotland.

We made around 150 visits to local services and to people across the country, publishing reports on what we found.

Staff shortages

On a growing number of those visits we reported endemic staff shortages that we could see were having an impact on care and treatment.

They also affect people in the community who are waiting for help and support.

Staff shortages have high financial costs too, as public services spend precious budgets on expensive locum and agency staff.

Where once that solution would have been short term, we now see this as an ongoing part of the care mix. It does not embed confidence.

We found more wards running at full capacity, while promised upgrades to outdated environments have been stalled.

The impact of poor conditions on vulnerable people in need of care, and on staff who must work there, can be considerable.

Impact on other services

We heard how pressure on mental health and social care services is having a broader impact on services such as the Scottish Ambulance Service, hospital emergency departments, and the police.

They tell us they are spending increasing amounts of time and resource trying to support people with mental ill health.

This causes difficulties for the individual, who is often in distress and in need of care and treatment from specialist mental health professionals. And it puts additional strain on that wider service.

How to make change

Finances are of course vital. I know the strain on budgets across health and care services and I will always call for budgets to be protected.

But along with money, there is the question of what changes can be made to our systems of care and treatment, and how to make them.

Law reform

There is no greater example of an opportunity to act on reforms already proposed than in mental health and capacity law.

The Scottish Mental Health Law Review's recommendations for change were extensive, focusing on human rights and putting the individual at the centre of decision making.

A huge number of people and organisations replied to this and other consultations – it's understandable they now want to see action.

In our own response, the Mental Welfare Commission confirmed we would welcome any of the additional powers recommended for our organisation by the Review because we can see how they would help us drive forward improvements in care and treatment.

Let's use this opportunity to get things done.

This annual report gives just a snapshot of our work, and the work of the services we connect with.

With all of the challenges, an overriding message we hear time and again is that the care staff provide is really appreciated by those they care for.

I still believe we can make headway if we act now. We need to reassure the public that we mean business, that they have been listened to, and that change will happen and will happen soon.

"We found more wards running at full capacity, while promised upgrades to outdated environments have been stalled."

Chief executive's message

Julie Paterson

Investigations

This annual report includes three major investigations we published in 2023-24 as part of a pilot project on behalf of Scottish Government and one additional major investigation looking at deficiencies in care.

Each was tragic. Each highlighted how opportunities were missed. In addition to identifying clear failures by services at key points, each also uncovered issues with relationships between services and family members.

We found that the way services relate to family members of people with mental ill health can be critical but is often overlooked.

These are detailed and anonymised investigations on very specific cases, but they have lessons that can be learned across the country.

I would ask anyone with an interest in mental health and social care services to read these reports and reflect on whether there are any points that can help in their own practise.

In addition to our investigation work, we published two further major reports, this time in our themed visit category. Each covering a very different situation but on examination, we found a common strand.

Short term becomes long term

Our themed visit reports share the connection of solutions that were designed as short term, or medium term at most, but now have unintentionally drifted into the longer term.

One of these reports focuses on out of area placements. We were aware that a significant number of people with learning disability and complex mental health needs are being cared for many miles away from home, and we wanted to know how the system was working.

We found that people were living away from home for years at a time. While care was often good, we found little planning for a return nearer home, in costly arrangements that have no national budget oversight.

Our second report followed a steady increase in recent years of people living under compulsory treatment orders for

mental ill health in the community. This means they are obliged by law to receive medical treatment at home, often for many years. We found little evidence of planning to support the person to come off the order, or to receive care and support that might lead to a more positive future. Often all they get is compulsory medication and little opportunity to do more. Yet an increasing number of people find themselves in this position.

In both cases we made recommendations that asked for national oversight and a fresh take on whether better solutions can be devised that would improve the lives of the people involved.

Carers and confidentiality

Part of our role is to provide good practice guides that can be used across services in Scotland. Our latest such guide is equally aimed at anyone – usually a family member - who is supporting someone with mental ill health or learning disability.

The purpose of our guide is to impress upon services that it is critical to listen to family members when a person is mentally unwell or without capacity.

Far too often we hear about staff missing opportunities to listen to family members because they are concerned not to breach patient confidentiality. We want everyone – health and care professionals and the general public – to know that listening to family members should be part of the process.

This issue may seem smaller, but the impact it can have is huge.

A tough year

I wish to thank all of the organisations and individuals we work with for collaborating with us in what has been a tough year for everyone connected with health and social care, whether as a professional or as a person relying on care and treatment.

We will continue to do all we can to highlight good practice where we find it – and to share it widely with others – and to call for improvements where we see deficiencies in care and treatment.

Influencing and empowering

- **Our event ‘From shared ambition to delivery’ offered an opportunity to discuss and consider the way forward for the work of the Scottish Mental Health Law Review (SMHLR).**

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

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.

The National Mental Health and Learning Disability Coordination Group last met in 2023 and we look forward to working in partnership with Scottish Government and partners in 2024 to consider an alternative framework approach which has been proposed to ensure a coordinated, informed approach to scrutiny of mental health services and to avoid duplication.

We have attended parliamentary committees to give evidence when requested to do so and we have continued to attend meetings of the Scottish Mental Health Partnership working with other organisations to promote a rights-based approach to the Government's Mental Health and Wellbeing Strategy which was published in the June 2023.

We remain an active member of the National Preventive Mechanism attending both the UK and Scottish groups and we are now representing Scotland on the National Steering Group.

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. We have continued to contribute to training and learning across a range of fora, including the presentation of investigation reports to national adult support and protection groups, presentation of our themed work to the Mental Health Tribunal for Scotland and participation in the training programmes of Scotland's sheriffs.

Our engagement and participation officers continue to build their networks across Scotland, meeting carers and people with experience both virtually and face to face (413 contacts were made with carers this year against a target of 250 and 279 contacts with people with lived experience against a target of 250) and this work is now underpinned by our new revised engagement and participation strategy of 2023 and associated implementation plan.

From shared ambition to delivery

In August 2023, we hosted this event which brought together senior mental health, social work, and social care leaders from across Scotland. The agenda offered an opportunity to discuss national issues and challenges and to consider the way forward for the work of the Scottish Mental Health Law Review (SMHLR).

Maree Todd MSP, Minister for Social Care, Mental Wellbeing and Sport opened the event.

Our chair, Sandy Riddell spoke about the work that is progressing across mental health and emphasised the importance of delivery:

> *"I very much want to see some early progress. We need to reassure the public that we mean business, that they have been listened to, and that change will happen this time. Shared ambition and good intentions do not improve services – the public needs tangible reforms."*

Julie Paterson, chief executive spoke about the Commission's work over the past year, highlighting good practice and themes arising with specific reference to the key role of carers. Julie said the organisation was ready to do more:

> *"We will do all we can to try to uphold people's rights, including the rights of carers, and we would welcome any additional powers - such as those recommended by the Scottish Mental Health Law Review – that would help us drive forward improvements in care and treatment."*

Kathleen Taylor, engagement and participation officer, spoke about her personal experience as a family carer, and from consultation with carers across Scotland, listening to and hearing their views.

The event also included a panel discussion and Q and A session, with panel members from Scottish Government, Edinburgh Napier University, NHS Education for Scotland, Scottish Independent Advocacy Alliance, and the Commission.

Feedback following the event

"Just wanted to say how well I thought it had gone yesterday, really good engagement and the presentations all went down well. A huge thanks to everyone who was involved in organising the event."

"Congratulations on a great event. Well done to everyone and I think the balance of 'expert information' and lived experience worked extremely well."

"Well done all, you delivered with aplomb! An excellent representation of the Commission. So glad to be part of it."

Adults With Incapacity project

Our AWI project, in partnership with NHS Education for Scotland (NES), continued to develop a wide range of resources during the year. The aim of the project was for professionals across Scotland's health, social work, and social care landscape to gain better knowledge of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) and to achieve better outcomes for individuals receiving care, treatment, and support. The team provided regular bulletins about the progress of the project.

The following provides an indication of some of the work delivered through the project:

Learning site
The 'Once for Scotland: Adults with Incapacity' learning site on Turas Learn launched in June 2023. The site hosts all the resources that the project team have created, including recordings of the masterclasses, myth busting animation, and existing guidance and codes of practice.

The voices of people who are impacted by the AWI Act are reflected in the resources. We conducted interviews with people acting with Power of Attorney or guardians.

Myth busting
The project developed a myth busting animation with accompanying exercises to improve knowledge and understanding of core areas of the AWI Act. The animation has been used across services as a learning resource at local levels.

Masterclasses
The team delivered two masterclasses aimed at professionals. The first one provided an in-depth exploration of the key areas of the AWI Act and the second one explored capacity in detail, with input from external partners in a panel format.

Feedback from the two masterclasses

"Guest speakers were great. Very informative and interesting"

"The Q&A was really valuable to put into practice real lived experience of capacity assessments and challenges surrounding them. Thank you to all!"

"Really interesting to hear about the adjutant document Annex 5-I have never seen one of these in action despite a section 47 being in place!"

"This is so complex and learning about it is continuous! Thanks everyone for sharing their knowledge, experience and time and the opportunity to learn."

Webinar for all
The project team delivered a final webinar, along with the Office of the Public Guardian, in February 2024. This was primarily for families, carers, guardians, people acting with Power of Attorney, and those wanting to know more.

"Nice to have first-hand experience provided and how they have been affected"

"It was an easy to understand presentation and wish I had seen it sooner before I had been through the guardianship process"

"Great that this is running, as a parent of a child with a disability this information is not well known."

eLearning module
An eLearning module 'Introduction to the Adults with Incapacity (Scotland) Act 2000' was also developed. It provides educational content covering human rights, capacity, supported decision making, and deprivation of liberty.

Throughout the module, there are opportunities for reflective practice as well as signposting to further learning, wider reading, and knowledge development.

Impact and evaluation
Early indications have shown the project is having a positive impact on the workforce. Every resource that the project has delivered is hosted on the Turas Learn site, which attracted more than 33,000 page views. Materials are being referred to when describing good practice locally and are being used by partner organisations in their learning and development and induction programmes. People are also providing positive feedback on the engagement carried out by the project team and the resources being developed.

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 is a member of the Scottish sub-group and the UK wide NPM. Since July 2023 the Commission has been the Scottish representative on the national UK steering group that coordinates activity of the wider membership.

Membership of the NPM provides a mechanism for the Commission to collaborate with and learn with other organisations that monitor settings of and rights for people who are subject to detention. Members of the UK NPM that have an interest in mental health in detention settings have formed a task and finish group for projects related to this area. The Commission has participated in this and is co-ordinating work on considering how referrals for in-patient hospital admissions for prisoners with mental illness are monitored.

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.

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 AWI 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).

Demand for this service continues to be high and we expect that our figures for 2023-24 will show that DMPs have again undertaken over 2500 visits.

We have undertaken a DMP recruitment drive in recent years and we have 80 DMPs now on our register (an increase from 72 last year).

We undertake recruitment sessions once or twice a year and we hold an annual seminar for DMPs. We also send out regular DMP newsletters to update DMPs about developments, ways to minimise errors or improve the quality of their work.

Our DMPs are highly skilled psychiatrists, and we are grateful for the work they undertake in safeguarding the rights of people with mental illness across Scotland.

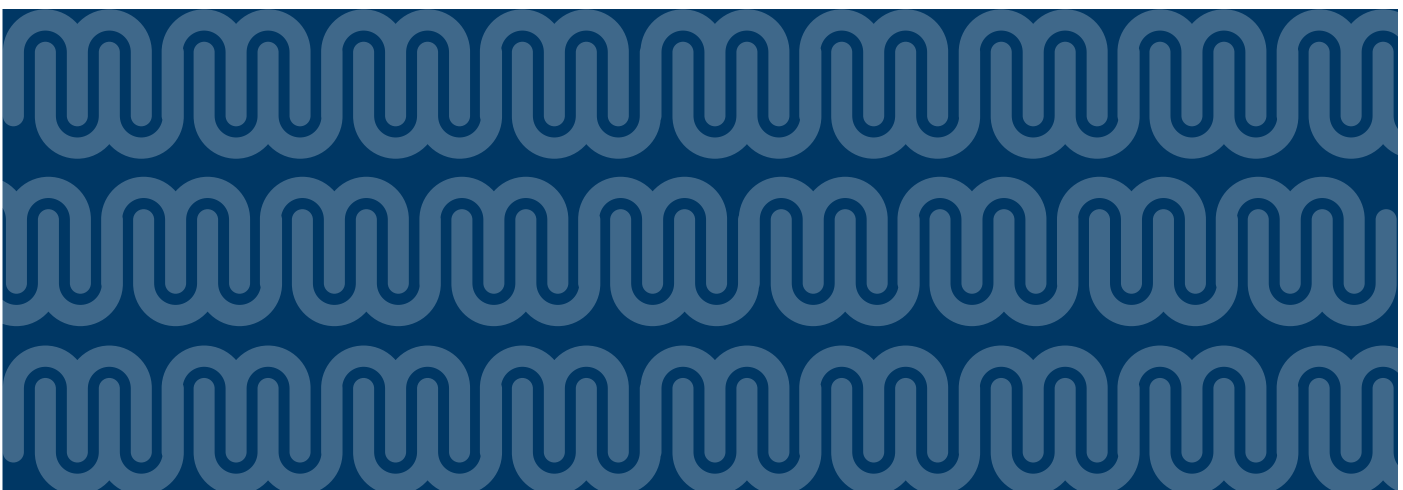
Feedback from the DMP seminar held in March 2024

"As always, a useful update and good discussion"

"Excellent seminar as always – stimulates thought and discussion"

"All the talks were great and useful for practice. A day to learn in a relaxed setting. Networking and peer support. Chance to discuss issues with others and share good practice."

Effective and targeted visiting



- **We visited 149 services including hospital wards, specialist units, independent sector services, and prisons**
- **We broadened our visit programme to include community services**
- **We increased the number of unannounced visits to 28%, exceeding our target of 25%**
- **We reviewed the care and treatment of 1,109 individuals during our local visits**
- **We had contact with 231 family members/carers**
- **We published two themed visit reports exploring out of NHS area placements and compulsory treatment for mental illness in the community**
- **We published a closure report for our 2022-23 themed visit *Ending the exclusion***

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 also listen to families and carers, speak to health and care staff, and examine records.

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 local authorities and health boards) and for government where we identify a need for change. We follow up on our recommendations.

Our visits are divided into:

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

Themed visits – to people with similar health issues or situations across the country. We conducted themed visits this year focussing on people subject to community based compulsory treatment orders and people receiving care out with NHS Scotland services as noted above.

Welfare guardianship visits – where we visit people who have a court-appointed welfare guardian. The guardian may be a family member, friend, carer, or social worker.

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

After we have completed a local visit, we may have to make a recommendation relating to a change we would advise around improvements to the way care is provided, or about the environment. 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.

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 increased the number of local visits again in 2023-24, where we met with individuals, families/carers, and staff in 149 hospital wards, prisons, specialist units, and independent sector services. Over the year, the Commission also broadened its visit programme to include community services delivered by mental health or learning disability teams, where we reviewed how care and treatment was being delivered across the range of services, from inpatient to community. Our engagement and participation officers joined us on a number of visits to services where their lived experience offered focused and informed understanding of care and treatment. We increased the number of unannounced visits to 28% (41 service visits), exceeding our target of 25%.

We reviewed the care and treatment of 1,109 individuals during our local visits and met directly with 1,023 people. As part of our visits, we meet or talk with families/carers who have agreed to speak with us; throughout the year, we had contact with 231 family members and/or carers.

Concerns over staff shortages

We publish all of our local visit recommendations every month, highlighting any key messages found, and use X (formerly known as Twitter) to increase public awareness. This year we regularly raised concerns over staff shortages and the use of bank and agency staff.

We also highlighted the negative impact of poor ward environments, and postponed upgrades. On a positive note, we were consistently given positive comments about staff and told about how much they were appreciated.

Out of NHS area placements

When people with mental ill health or learning disability are placed outwith their NHS health board area for care and treatment, they are likely to have highly complex, specialist needs that are not able to be met by their local NHS service.

Our report was published in September and focused on 59 of the 162 people from Scotland who are in this category; the majority being cared for in private sector facilities in Scotland, with a few in England. We wanted to know more about how these placements were working.

Most of the individuals and relatives we spoke to praised the quality of care and treatment received. Most felt that care was better than before they moved and felt involved in that care. On their current care, one person told us "I wish I had come here years ago as I would have not lost all these years...Staff are so committed." But being far from home had an impact on family relationships. One person told us "It's been a backward step for me. I can't see my mum I am so far away from home."

The average stay was over eight years, with one person living in out of area care for 28 years.

Discharge planning was a concern for both the current service providers and for the health boards who made the referrals. For the current providers, getting engagement from the funding health board could be challenging and slow. For the funding service, concerns relating to a lack of an appropriate local service and the risk of relapse for the individual.

We sought to estimate costs but found a lack of accurate information. We gave a very conservative estimate of over £13 million a year being spent by NHS Scotland on out of area care for the 59 people included in the report. We expect the figure to be higher in actual cost, and considerably higher for the total number of people living in out of NHS area placements.

Our recommendations included setting new standards, developing accurate data collection and creating a national oversight and scrutiny role. We also asked Scottish Government to take a human rights and health economics-based approach and consider whether a regional resource should be developed for those individuals who are considered at greatest risk of being out of area.

Compulsory treatment for mental illness in the community – how is it working?

In February, we published a report on how community compulsory treatment orders (CCTOs) are working in Scotland, 20 years after they were introduced.

We spoke to 92 people who had been on a CCTO for over two years, almost 30 family members, and heard from over 300 medical and social work staff.

The report raised concerns and showed there has been a 44% rise in the use of the orders over a decade, from 941 in 2012 to 1,333 in 2022.

Most strikingly, we found that almost three quarters of the orders had been in place for over two years, with some people subject to a CCTO for 17 years.

The orders were originally created to offer people with severe mental ill health the opportunity to get full support and treatment at home as they recovered.

Community compulsory treatment orders have the potential to treat and support people with severe and enduring mental illness in the community rather than in hospital.

We saw the law being used to make people take compulsory medication for many years, but little evidence of planning to support the person to come off the order or receive care and support that might lead to a more positive future – often all they get is medication.

We were really concerned to find that those responsible for reviewing community compulsory treatment orders don't always know the person on the CCTO very well or see them in person before renewing the order.

CCTOs remain a useful way of working in partnership with an individual and their family in their home surroundings rather than in a clinical environment. But we ask why so many people are on them, and for so long without therapeutic support leading to recovery and a better life.

The report made seven recommendations to health and social care partnerships and their respective local authorities and health boards. Whilst this report did not call for CCTOs to be abolished, it did raise numerous questions which need to be answered and therefore supports the Scottish Mental Health Law Review's recommendation to the Scottish Government on this issue.

We hope that government can use the detail of this report to further improve the management of these orders and improve the outcomes for this vulnerable group of people.

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

Ending the exclusion: closure report

The purpose of a closure report is to assess whether the Commission has achieved its objectives (including outcomes, learning, quality and impact) and whether all of our recommendations have been acted upon.

This year we published a closure report for our 2022-23 themed visit *Ending the exclusion: care, treatment, and support for people with mental ill health and problem substance use in Scotland*.

The original report looked at the experience of people who are living with both mental ill health and problematic drug or/and alcohol use. It considered whether their care was joined-up and holistic and was in keeping with existing policies and guidance.

Whilst we found pockets of good practice, and a real desire to improve care and treatment we were concerned to find that national guidance and standards that emphasise the need for services to work closely together to meet all the needs of a person had not been realised.

We made recommendations to Scottish Government, NHS Education for Scotland (NES), and to services calling for urgent change to health and social care partnerships.

The closure report details the response to our recommendations and actions taken. In summary, all HSCPs and associated health boards responded to our recommendations with clear time frames that mostly met our response recommendations.

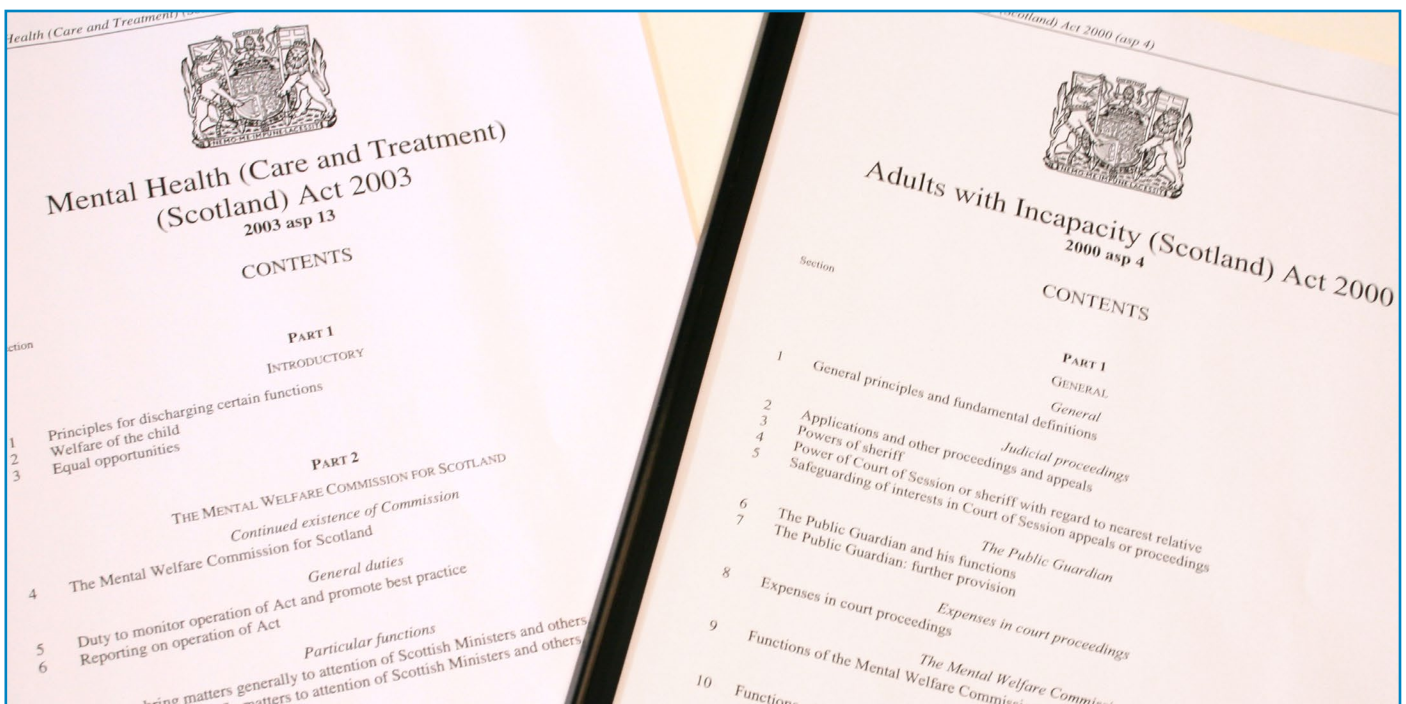
NES described a number of actions on how they are working to embed a trauma informed approach and address stigma.

Scottish Government commissioned Healthcare Improvement Scotland (HIS) to develop a 'Gold Standard' protocol against which local protocols will be assessed.

Going forward, we will be contributing to the reference group that HIS is leading to ensure that every area has a local protocol. We will also engage with Audit Scotland's forthcoming work in this area.

The closure report shows that our work is contributing to closing the gap that we identified and will reduce the 'bouncing' between services that leads to exclusion.

Monitoring and safeguarding care and treatment



- **We have a statutory duty to monitor the use of the Mental Health Act in Scotland and the Adults with Incapacity Act in Scotland. Our full monitoring reports are published in autumn.**
- **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 Act, and the welfare provisions of the AWI Act. 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 AWI Act.

Our monitoring work can involve 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 October 2023, we published a report that explored the trends in the use of 'recorded matters' – these are an important safeguard for patients' rights. The Mental Health Tribunal for Scotland can make a recorded matter when granting an application for a compulsory treatment order. Section 64 of the Mental Health Act defines a recorded matter to be "medical treatment, community care services, relevant services, other treatment, care or service as the Tribunal considers appropriate" and if the recorded matter is not provided the responsible medical officer (RMO) for the patient has to inform the Tribunal. We showed that the use of 'recorded matters' is falling. In 2006, 14.8% of Compulsory Treatment Order (CTO) cases specified recorded matter(s), compared to 2.4% in 2022. We concluded that there may be scope for recorded matters to be used more to realise the principle of reciprocity, prevent prolongation of detention, and focus on unmet care and treatment needs.

In November 2023, we published a report focussing on the role of police officers at times of crisis when they use their powers under the mental health act to bring people to a place of safety.

During the Commission's statutory duties to monitor the operation of the Act, we noted that some people can be repeatedly brought to the attention of mental health services by police services, using these powers (s297). We wanted to understand more about this and the group of patients who were subject to multiple detentions under place of safety powers. We wanted to explore whether these patients had care plans that addressed the repeated involvement of the police. Our work from this exercise helped inform our further work in this area with His Majesty's Inspectorate of Constabulary in Scotland (HMICS) as they led work in the wider role of policing and mental health. We discussed this work at an evidence session of the Criminal Justice Committee at Scottish Parliament in late 2023.

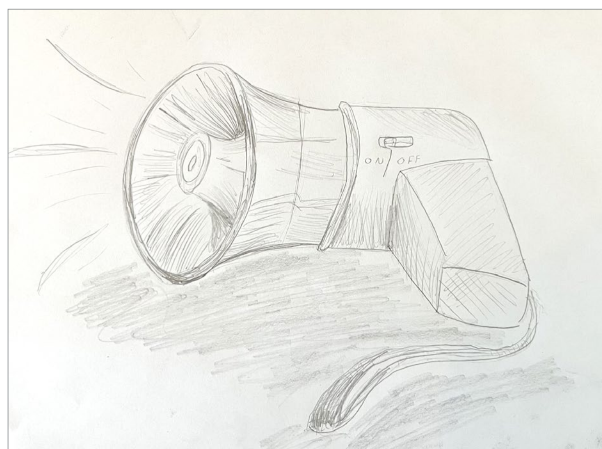
Children and young people monitoring

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 be reporting again on the admissions of children and young people to non-specialist wards in autumn 2024.



Above: two examples of artwork provided for our publications by children and young people.

Investigations

- **We completed the final three investigations as part of a pilot project for Scottish Government related to someone who was receiving mental health services, or had done in the previous year, and committed homicide and where someone died whilst subject to detention.**
- **We completed a further investigation into a case of long-term poor care that has learning for services across Scotland.**
- **We made enquiries using our powers of investigation in a total of 103 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.

Casework

Our staff 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.

The following are examples of work undertaken by Commission staff which have been identified through their ongoing casework.

All details below are anonymised and are illustrations of work completed. We would want to extend our gratitude to all services who worked in collaboration with us when reviewing and improving services ensuring better outcome for individuals, their families and carers.

Case Summary 1: Ms A

Ms A came to our attention via a routine internal administrative process. This work is part of our monitoring function.

A staff member found a number of discrepancies on an emergency detention certificate and following further enquiry with a series of professionals, discovered significant concerns in relation to care and treatment. The individual had been lying on the floor of their home, unable to get up, for almost a week. Delays in service and poor understanding of legislation led to this situation and took place across primary and secondary health services.

The individual was known to have an underlying physical health care issue and a diagnosis of a learning disability. They lived alone following the death of a relative but had refused social work support following an assessment which had detailed a number of needs. The social work team closed the case as a result.

Our concerns centred on the following:

- Overall poor application of mental health act legislation and understanding of the interplay across all 3 safeguarding Acts.
- Concerns around professional lack of understanding and knowledge of application of the law in relation to treatment of physical health care where a mental health issue also exists.
- Roles and responsibilities across ASP/AWIA/MHA legislation and lack of reference to psychiatric emergency plans.
- Concerns around closure of case in relation to someone with a learning disability who refuses help, but where capacity and decision making ability have not been fully assessed.
- Concerns regarding local application of ASP frameworks and the law.
- Evidence of a poor collaborative approach amongst professionals especially outwith normal working hours.

Our discussion with senior managers resulted in the completion of a learning review monitored by the local adult support and protection (ASP) committee. This review looked at how both health and social work services from primary and secondary care could improve their working, the impact on the individual and incorporated a number of points that we had raised.

Services were able to detail improvements and learning and implement these and we have continued to monitor these in practice.

In relation to Ms A, following a period of time in hospital, they improved and moved to a new home with support. This was their wish as they found living at home alone difficult.

Case Summary 2: Mr B

Mr B's circumstances came to the attention of Commission staff while they were undertaking a visit to a hospital. Part of any Commission visit will include sampling and reading of records by our staff. On this occasion Mr B's records were read including the application for a compulsory treatment order under the Mental Health Act (CTO). This application indicated that at admission there was clear evidence of self- neglect and hoarding.

Mr B's mental health was also found to be poor with short term memory issues, some fixed ideas, cognitive impairment and suspicions of staff at admission. A diagnosis of Alzheimer's dementia was later made.

The CTO application indicated that this situation had been ongoing for at least two years and that a number of professionals had visited but had been prevented access to the home by Mr B. Assessments and services were also refused.

Admission to hospital occurred following a routine visit by a utilities provider who was so concerned that they called the police, who at this point made an adult support and protection referral to social work services. It was this referral and a multi- agency discussion, which initiated a home visit and an assessment by a psychiatrist and a mental health officer. Mr B was admitted to hospital that same day.

We escalated our concerns to the services concerned as follows:

- A number of missed opportunities to intervene existed across an extended timeframe.
- There was no early identified application of the adult support and protection act or wider consideration of using other legislation.
- The multi -disciplinary team did not appear to come together early to identify concerns and risks.
- The closure of the case and transfers of staff meant that information and communication were hindered.

Through discussion with services, they recognised that input was required and undertook a learning review which assisted in identifying and improving practice for all staff as follows:

- A programme of training in relation to self-neglect and hoarding.
- Training in relation to exploring and understanding non-engagement.
- Ensuring that a lead professional is available to co-ordinate risk where multiple services are supporting one adult.

Mr B is now subject to a welfare guardianship order and we will be completing a follow up visit as part of our guardianship visiting programme.

Investigation project team (Scottish Government pilot)

In 2022, we presented two proposals to the Scottish Government on appropriate levels of review when:

- someone dies when subject to an order of the mental health act.
- someone receiving mental health care commits a homicide.

Further information on our reviews of deaths in detention can be found here. Details of our homicide reviews are available here.

We published our first homicide related report in March 2023 and during 2023-24, we published a further three 'pilot' investigations to test out these proposals.

1. *Investigation into the care and treatment of GH*
2. *Investigation into the care and treatment of Mr D*
3. *Investigation into the death of AB*

Our project proposals to continue this work have not been agreed by Scottish Government at this stage.

However, we think that they fit well into the Commission's overall investigations function.

From a family member:

"We also wanted to thank you for your professionalism and diligence while investigating. We always felt included and listened to."

Investigation into the care and treatment of Mr E - failed by the systems and structures put in place to protect him

After learning about the circumstances of Mr E, we investigated his care and treatment. Mr E was detained in hospital under the Mental Health Act in August 2020, having been physically and mentally unwell for a long time prior to this detention. He was subject to a local authority welfare guardianship order and lived in a care home for older people with dementia, despite being in his 50s and not having dementia.

The Mental Health Tribunal for Scotland alerted the Commission to the apparent lack of involvement by health and social work services in Mr E's care, despite his diagnoses of schizophrenia and diabetes.

We found that when Mr E came to the attention of services there was no coordinated multidisciplinary approach. Instead, individual agencies often assumed that the responsibility to support Mr E lay elsewhere. His condition deteriorated significantly and permanently without any active intervention.

By the time we made our investigation, his mental illness was reported to be partially treatment resistant; he was blind; and his mobility was poor - he needed to use a walking frame. Mr E was unhappy living in the care home; his mood was low and there was little stimulation for him.

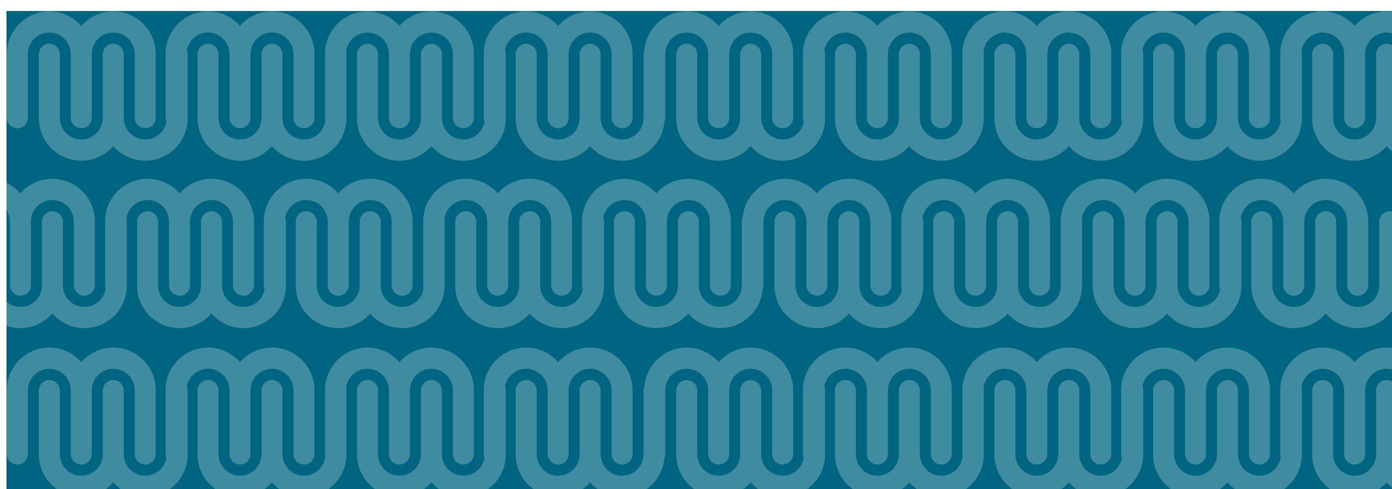
Amongst our recommendations for change, we asked for the health and social care partnership involved to review Mr E's care, accommodation, and finances and to do that as a priority.

Our report reflected Mr E's own views and gave some insight into who he is as a person, whilst ensuring anonymity. We shared this report to learn lessons, as we always do, and welcome feedback:

> *"Thought the Mr E report was excellent, and challenging. I suspect it reflects practice in many areas of Scotland and I worry about mental health services at the moment as this report reflects what I hear and see in the world of safeguarding. I have it on the Chief Officers Group agendas in my local areas."*

This was a difficult investigation for Mr E himself and he allowed us to take it forward because he wants no-one else to go through this again.

Providing information and advice



- **We received 3683 calls in 2023-24 compared to 3476 last year.**
- **A sample audit of advice given showed an accuracy rate of 98.5%, against a target of 98%.**
- **49% of our total calls were from relatives/carers/guardians/people with experience and 51% of calls were from people working in the field of mental health and learning disability.**

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. More and more people are also now seeking advice via email too.

The number of telephone calls logged during 2023-24 was 3683. The top number of calls were received from relatives/ carers/guardians, followed by people with experience of using services, with the third highest caller group being psychiatrists. Overall, 49% of our total calls were from relatives/ carers/ guardians/ people with experience and 51% of calls were from people working in the field of mental health and learning disability.

Most calls received related to the Mental Health Act (1891 calls), whether from health care professionals seeking advice related to care and treatment they might give, or from individuals, families or others seeking advice on the law or rights for those receiving care and treatment. We received 130 more calls this year in relation to the Adults with Incapacity Act (815 calls) compared to last year.

We categorised a significant number of calls this year as 'other'. The breadth of calls is often difficult to capture however the 'other' category might include discussions about medicines, care packages, relationships, or good practice guides.

We regularly carry out a sample audit of advice given out by individual practitioners and this year the accuracy rate was 98.5% against our increased target of 98% (set last year).

During 2024-25 we will be looking at a consistent approach to receiving feedback on the advice that we give. In the meantime, anecdotal feedback includes:

From a carer when calling about adult support and protection:
"Many thanks for taking the time to listen to our concerns and for forwarding on the information which is very helpful."

From a psychiatrist:
"Thank you for your helpful response and advice regarding suspension of a compulsory treatment order."

From a follow up call by a carer:
"Thanks for your advice and patience when talking with her. Really appreciate the help, advice, and safeguarding work that is done by Commission".

From a psychiatrist:
"Thank you. I will feed that view into the discussion we are due to have at our clinical governance learning event."

From a power of attorney:
"Thank you for listening and allowing me to talk through with you. You are a star."

Engagement and participation

Our engagement and participation officers continue to build their networks across Scotland, meeting carers and people with experience both virtually and face to face. They had contact with 413 people with experience and 406 with carers this year, exceeding the target of 250 for each group.

The engagement and participation team delivered a new engagement strategy 2023-26. This includes area engagement visits, which offers an opportunity for the Commission to hear directly from local communities about their experiences of services and aims to strengthen local connections between services and groups.

Feedback to our engagement and participation officers include:

From a carer organisation
Following an input around our *Carers and Confidentiality* good practice guide, stating simply about the engagement and participation officer, *"she gave us the power…"*

From a support group member:
"As ever, that was a stimulating and rewarding session last night. Thank you for coming and getting us thinking about our status and agency and many other facets of being in that patient/ professional relationship."

From a carer:
"I would just like to say a massive thank you for the help and advice you gave me, not only did it help the situation it also helped me mentally having that knowledge. I was able to quote you on different things which were noted and acted on, my son has been put back as a vulnerable adult too."

Good practice guides

We updated our *Carers, consent, and confidentiality* good practice guide, giving advice on how families can be involved when their relative is being treated for mental ill health and other conditions.

Some of the most common problems families have in trying to help their relative are around confidentiality and information sharing. It can be difficult for both families and professionals to know the boundaries of what information is appropriate to talk about, both with and without the consent of the person involved.

It is vital that staff listen to families and their experiences, they have valuable insight into the person's health and circumstances that should not be ignored.

We want families to feel confident in being able to challenge the staff team when they feel they need to - knowing their rights around consent and confidentiality can really help.

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 2023-24 we continued to attract strong media coverage for our work, in print, broadcast and online. Our executive team 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 we increased our followers by 207 to a total of 6041.

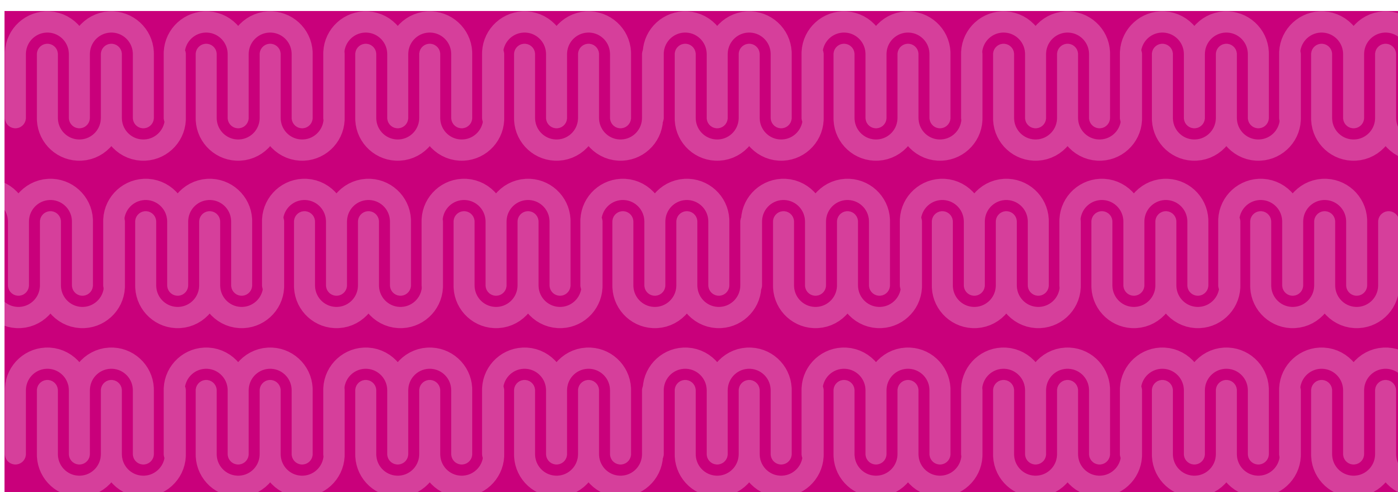
We published 238 tweets promoting our work, including new publications, films, consultations and events. We also regularly retweeted content posted by others.

This year, our Tweets were engaged with 6,372 times (this includes link clicks, likes, retweets and replies); this is our highest number since 2019, and our second-highest number of engagements in a year.

The average number of engagements per tweet each month was 27; this is higher than the previous year, closer to the levels we received before major changes were made to the platform.

We also re-established an account on LinkedIn as part of a plan to grow our social media presence.

Improving our practice



- **Our Board continue to set our strategic direction and ensure efficient, effective, and accountable governance.**
- **We completed a lengthy procurement exercise to secure a new information management system, which will transform the way we work.**
- **We began a new and wide-ranging project to improve the accessibility of our work.**
- **We appointed a head of culture and corporate services to join our executive leadership team**
- **We seek to learn and improve as a result of the complaints we receive. In 2023-24, we received and responded to four complaints, two 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

Nichola Brown (co-chair of the Advisory Committee) joined the Board in April 2019, as carer representative and is also a designated joint Stakeholder Engagement Champion. 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.

Kathy Henwood joined 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.

Gordon Johnston (vice chair of the Board) 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 (wellbeing champion) 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 (co-chair of the Advisory Committee) 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.

She is also a designated joint Stakeholder Engagement Champion. 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.

Advisory committee

The Mental Health Act 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 33 organisations from across Scotland. These key stakeholders include people with lived experience, carer organisations, mental health law experts, advocacy services and third sector service providers whose experience and guidance is invaluable to the Commission

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.

This year the committee 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.

IMP new information management system

Our work on a new information and casework management system is a detailed and complex project for an organisation of our size. We have engaged with various partners to gain the expertise required to inform a transformational digital system for the Commission.

During 2023-24, the project has prepared for and has gone through a lengthy procurement exercise, which has drawn on every corner of the Commission and been supported by excellent external partnership working.

There is much work to do to implement the new system over the coming year, which will bring a modern information management system to the Commission through digitalisation and transformation. The new system will bring a huge improvement to how we 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.

Above: the new design for our local visit posters is an example of more accessible communications being developed.

Accessible communications

We are determined to improve the accessibility of our work, making our information easier to find, to read and to share.

A pilot project involving our local visits was developed at the end of the year. This consists of a new, engaging, poster that will have a prominent place on wards and at other services ahead of our visits, with the purpose of showing photographs of who is coming from the Commission, and giving contact details ahead of our visits. We hope they will encourage even more engagement from people receiving care and treatment and raise awareness with families and carers.

The project also includes letters tailored to the service, individuals, staff, and family members. The aim of the project is to prepare people for our visits, and to ensure that people receiving care and treatment have access to our information in a way that they can easily understand and process.

We also published an easyread version of the report Investigation into the care and treatment of Mr E.

Further research and communications work is underway to make our monitoring reports and general information more accessible, in line with our business plan. We have focussed on improving our engagement with children and young people this year, including with young carers, but they tell us we can do more. We are committed to listening to children and young people and following their advice on how to improve our communications.

Supporting our workforce

The Commission progressed a number of initiatives designed to support our people, which included:

- Introduced 'right to disconnect' guidance to support the hybrid working policy.
- Established a colleague-led wellbeing group, which hosted a calendar of wellbeing events, complemented by the appointment of a head of culture and corporate services and a wellbeing champion on the Board (Cyndie Mackie).
- Launched an annual staff survey, based on the iMatter model used in many health and social care settings. There was an 80% response rate and the results highlighted areas of strength and areas for development, which were reviewed in staff focus groups and culminated in an action plan.
- Commissioned an external learning needs analysis, resulting in the development of a Commission-wide learning needs action plan.
- Hosted a staff conference in February to bring our people together to focus on embedding the Commission's strategy, business planning and to identify improvement opportunities. 98% of attendees rated the conference as somewhat or very helpful.

Staff feedback gathered at our conference

"We believe in what we do"

"Very supportive of each other - respect each other in our roles"

"Collaborative approach"

"Everyone is friendly and positive and supportive - someone will always help"

"Broad skillset of backgrounds enhances the Commission"

"Diverse and new staff brings new perspectives"

Above: therapet Bramble visits our office as part of the wellbeing strategy.

Learning lessons

We seek to learn and improve as a result of the complaints we receive. In 2023-24, we received and responded to four complaints, two fewer than the previous year.

Three complaints were received and dealt with at stage 1 (frontline). One complaint was investigated at stage 2, which was partially upheld.

As a result of the complaints we have received in 2023-24 we have:

1. Taken further actions where we agreed that our work was insufficient to address a complainant's concerns raised to us.
2. Agreed to reflect learning from the case anonymously within the Commission's lessons learned report in 2024.
3. Agreed to share the learning within the Commission to ensure improvements in our communication and to our processes.

Equality outcomes

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.

We will be publishing our equalities outcomes action progress report and our gender pay gap report summer 2024.

Financial resources

Our core revenue budget for the year was £6.342 million. This included £5.051 million for the Commission core budget and the remainder for three specific projects - £0.300m for the reviews of deaths in detention and mental health homicides, £0.155m for the joint adults with incapacity project with NHS Education Scotland and £0.836m for the Commission's new information management system project.

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

npm
national
preventive
mechanism

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
x.com/MentalWelfare

SG/2024/93

June 2024