# CONTENTS

<table>
<thead>
<tr>
<th>Photograph</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>2</td>
</tr>
<tr>
<td>Role of MWC</td>
<td>3</td>
</tr>
<tr>
<td><strong>Section 1: INTRODUCTION</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Chairman’s Statement</td>
<td>4</td>
</tr>
<tr>
<td>1.2 Director’s Report</td>
<td>6</td>
</tr>
<tr>
<td><strong>Section 2: SERVICE ISSUES</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Deficiency in Care and Treatment</td>
<td>9</td>
</tr>
<tr>
<td>Inquiry into the Care and Treatment of Mr B</td>
<td>9</td>
</tr>
<tr>
<td>Inquiry into the Care and Treatment of Noel Ruddle</td>
<td>15</td>
</tr>
<tr>
<td>2.2 Psychiatric Services for Children and Adolescents</td>
<td>16</td>
</tr>
<tr>
<td>2.3 Issues of Race and Culture</td>
<td>17</td>
</tr>
<tr>
<td>2.4 Visiting Programme</td>
<td>20</td>
</tr>
<tr>
<td>2.5 General Practitioners and the Commission</td>
<td>22</td>
</tr>
<tr>
<td>2.6 Nursing Issues</td>
<td>26</td>
</tr>
<tr>
<td>2.7 Social Work Issues</td>
<td>29</td>
</tr>
<tr>
<td>2.8 Issues arising from Complaints</td>
<td>36</td>
</tr>
<tr>
<td>2.9 Accidents and Incidents Reported to the Commission</td>
<td>38</td>
</tr>
<tr>
<td>2.10 Consent to Detention</td>
<td>41</td>
</tr>
<tr>
<td>2.11 Changes in the Commission’s Procedures</td>
<td>44</td>
</tr>
<tr>
<td><strong>Section 3: ADVICE AND GOOD PRACTICE</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 The Use of Guardianship</td>
<td>47</td>
</tr>
<tr>
<td>3.2 Places of Safety</td>
<td>50</td>
</tr>
<tr>
<td>3.3 Early Responses to Recurrent Severe Mental Illness</td>
<td>51</td>
</tr>
<tr>
<td>3.4 Access to Mobile Phones</td>
<td>53</td>
</tr>
</tbody>
</table>
## Section 4: National Reviews and Changes in Legislation

- **4.1 Report of the Millan Committee** 54
- **4.2 Regulation of Care Act** 57
- **4.3 Adults with Incapacity Act** 59
- **4.4 Review of Services for People with Learning Disabilities** 60

## Section 5: Business Reports

- **5.1 Requests for Discharge from Detention** 62
- **5.2 Complaints Panel** 63
- **5.3 Neurosurgery for Mental Disorder** 65
- **5.4 Section 98 Work** 66
- **5.5 Telephone Advice Service** 67
- **5.6 Social Work** 69
- **5.7 Patients Seen** 69
- **5.8 Detention and Guardianship Statistics** 70

## Section 6: Financial Statement

- **73**

## Section 7: Further Information

- **7.1 Liaison with Other Bodies** 75
- **7.2 Information about the Commission** 75
- **7.3 Bibliography** 76

## Section 8: Practitioners' Index 1996-2001

- **77**

(Standing - left to right) Tom Keenan, Alison McRae, Shainool Jiwa, Adrian Lodge, Archie Robb, Faith Cotter, Pramod Jauhar, Margaret Whoriskey, Malcolm Murray, Margaret Ross, Jamie Malcolm.

(Seated - left to right) Linda Pollock, Juliet Cheetham, Ian Miller, Norma Bennie, Bill Gent, Madeline Osborn.

(Not in photograph) Jim Dyer, Colin Campbell, Joe Morrow, Elizabeth McCall-Smith.
COMMISSION MEMBERSHIP
1 APRIL 2000 TO 31 MARCH 2001

Chairman
Ian J. Miller
OBE MA LLB

Vice Chairman
Norma Bennie
MBE DipCOT

Director
James A T Dyer
MB ChB(Hons)FRCPsych

Full-time Commissioners
Medical:
James A T Dyer
MB ChB(Hons)FRCPsych
Adrian M Lodge
BSc (Hons) MB ChB FRCPsych
Madeline Osborn
MB ChB FRCPsych

Social Work:
Juliet Cheetham
OBE MA Dip SAS

Nursing:
Jamie Malcolm (from December 2000)
RMN RGN

Part-time Commissioners
Norma Bennie
MBE DipCOT
Colin Campbell QC
Faith Cotter
MBE LLB T.E.P.
William Gent
OBE R N M H
Pramod Jauhar
MBBS DPM FRCPsych
Shainool Jiwa
BA MA PhD
Tom Keenan
MCC CQSW CSWM
Donald J Mace dan (until May 2000)
M R MN RGN
Elizabeth D A McCall-Smith
MB ChB FRCPsych DRCOG
Joe J Morrow
JP O St J
Malcolm D Murray
CA

Linda C Pollock
Nursing Cert Dip in Clinical Nursing
RMN BSc PhD M BA
Archie Robb
CQSW DipSW ACIS Hon D. Litt
Margaret Thomas (until April 2000)
MB ChB DR C OG DCH MR CGP
Margaret Whoriskey
BA (Hons) M Phil CPsychol PhD

Professional and Administrative Staff
Medical Officers:
Elizabeth Calder
MB ChB M R CPsych
Helen Cash
MB ChB M R CPsych
Christopher Fleming
MB ChB M R CPsych FR C PEd
Carolyn Greenwood
MB ChB M R CPsych
Flora Sinclair
MB ChB M R CPsych

Social Work Officers:
George Kappler
MSW
Marion Shawcross
BA (Hons) Dip ASS

Nursing Officer:
Alison Thomson (from February 2001)
RMN BSc

Secretary:
David Hogg (until April 2000)
Alison M Car ae (from May 2000)
MA (Hons) Grad IPD MBA

Assistant Secretary:
Charlie Burns

Complaints Officer:
Yvonne Osman

System Administrator:
Stuart Crowther

Executive Officers:
Richard Paluchowski
Elaine Buchanan
Katrina Thompson

A register of interests for Commissioners is available on the website – www.mwcscot.org.uk
THE ROLE OF THE MENTAL WELFARE COMMISSION FOR SCOTLAND

Under the Mental Health (Scotland) Act 1984, the Mental Welfare Commission for Scotland has a statutory duty to protect persons who may, by reason of mental disorder (defined in the Act as mental illness or mental handicap) be incapable of adequately protecting themselves or their interests. This duty extends to all mentally disordered persons whether they are in hospital; Local Authority, voluntary or privately-run accommodation; or in their own homes. In appropriate cases, the Commission’s powers include the discharge of patients from liability to detention or guardianship and the revocation of community care orders.

Visits and Enquiries

The Commission is required under the Act to enquire into any case where it appears to the Commission that there may be ill-treatment, deficiency in care or treatment, or improper detention of any person suffering from mental disorder, or where the property of any such person may be exposed to loss or damage. It is also required to visit regularly patients who are liable to be detained in hospital, or who are subject to guardianship or community care orders.

Other Duties and Responsibilities

The Commission has a duty to bring to the attention of Scottish Ministers, a Health Board, an NHS Trust, a Local Authority or any other body the facts of any case where it is considered desirable for that body to exercise its functions to secure the welfare of the person concerned. This may be by preventing ill-treatment, remedying any deficiency in care or treatment, terminating improper detention, or preventing or redressing loss or damage to property.

The Commission must be notified of all episodes of compulsory detention and community care orders under the terms of the Mental Health (Scotland) Act 1984 and the Criminal Procedure (Scotland) Act 1995. In carrying out its responsibility to receive and record this information the Commission is able to produce a statistical overview of the operation of detention procedures in Scotland.

The Commission may also recommend to Scottish Ministers the discharge of any patient who is detained in hospital under a restriction on discharge.

Formal Inquiries

The Commission has the power to call witnesses under oath to any formal inquiry it sets up under the Act and the proceedings of any such inquiry have the privilege of a court of law.

For further details see Mental Health (Scotland) Act 1984, Sections 2, 3, 4 and 98.

From April 2001, the Commission acquires additional duties under the Adults with Incapacity (Scotland) Act 2000.

For further details see Adults with Incapacity (Scotland) Act 2000, Sections 9, 50 and 73.
I ended my statement last year by noting that a lot of the good work done by the Commission was largely unsung and that it was my intention to attempt to raise the profile of the Commission throughout Scotland. The Millan Committee report reinforced this view and suggested that the Commission should strengthen its efforts to make its work more widely known. During the year we have gone some way towards meeting these objectives. To coincide with the publication of last year’s Annual Report we held three Roadshows in different parts of Scotland to meet a range of people interested in the Commission and its services and to hear their views on how the Commission operated. We will be taking these views into account in the next series of Roadshows in the autumn.

During the year, the Commission organised two very successful conferences for Complaints Officers and Medical Records Officers from around Scotland. We have continued to hold meetings with a wide range of voluntary bodies and interest groups and the Commission was represented at the Mental Health Act Commission Conference in England and the Mental Health Commission Conference in Northern Ireland. At the Mental Welfare Commission’s own Annual Conference in February we were fortunate to have the Rt Hon Bruce Millan and Mr Malcolm Chisholm, the Deputy Minister for Health and Community Care, amongst those who addressed us.

The Commission has also developed its website which is now available at www.mwcscot.org.uk. This Annual Report will be available on that website together with other information about the Commission and its services, and links to other relevant websites. We will continue with our endeavours to make the work of the Commission more widely known and accessible.

The Commission welcomed the proposals of the Millan Committee reviewing the Mental Health (Scotland) Act 1984, which were published in January. It was reassuring to know that the Millan Committee’s consultation had revealed that “there was an overwhelming view that the Commission provided an important safeguard for the rights of people with mental disorders”. Millan also noted that “[the Commission] has unique expertise concerning the interface between issues of care and issues of...
human rights which is at the heart of the Mental Health Act”. Reference is made to the Commission’s response to the Millan Report in Section 4.1 of this Report. Although the Government’s Review of Public Bodies was published outwith the period covered by this Annual Report, the Commission was encouraged to note that Ministers believe that it has a continuing important role to play in safeguarding the interests of patients with mental disorder.

As recommended by the Millan Committee, the Commission will be participating in a review of its own organisation and internal management arrangements during the next year, in an effort to improve the efficiency of the Commission and the manner in which it delivers its services. The Commission has already proposed and piloted changes in its procedures for carrying out reviews of detention, guardianship, etc., in terms of ECHR requirements, and this is referred to in more detail in the Service Issues section in this report.

During the year we have established close working relationships with the Scottish Parliament and the Executive. Commissioners met with the Minister for Health and Community Care, Susan Deacon, and also the Opposition Health Spokespersons, Mary Scanlon and Nicola Sturgeon. The Commission was encouraged by the Minister’s response to last year’s Annual Report, in which she acknowledged the deficiencies in mental health facilities within Scotland and started to make additional resources available to deal with the problem. In his report, the Director refers to the increased resources which have now been made available to the Commission which have, of course, been greatly welcomed.

As ever there have been changes in the composition of the Commission during the year. Three Part-time Commissioners retired, namely Mr Colin Campbell QC, Mr Donald MacDonald and Dr Margaret Thomas and I would like to pay tribute to the time and effort they devoted to the Commission and the contribution which they made to its deliberations. During the year we were pleased to receive approval for the appointment of a Full-time Nurse Commissioner and the Commission welcomed the appointment of Mr Jamie Malcolm to that post. The Commission also welcomed Alison Thomson who succeeded Jamie Malcolm as Nursing Officer. I am again grateful to Dr Madeline Osborn for editing this Annual Report and also for creating a Cumulative Practitioners’ Index in the last Annual Report, which has been greatly appreciated.

Finally, in my first year as Chairman, I would like to express my thanks for the help and advice which I have received from my fellow Commissioners, both full-time and part-time, and from the professional, administrative and secretarial staff of the Commission. I have been greatly impressed by the enthusiasm, hard work and dedication which they have all given to the Commission.
The past year has been a busy, interesting and exciting one for the Commission. The MacLean Committee reported in June 2000, and the Millan Committee in January 2001, including proposals for the future of the Commission; the Adults with Incapacity Act moved towards its staged implementation from April 2001; legislation was being prepared for the Scottish Commission for the Regulation of Care and the new Scottish Social Services Council and development of National Care Standards was progressed. The Executive produced its blueprint for improving health and health services in Scotland, Our National Health: A plan for action, a plan for change (2000), and a review of learning disability services, The same as you? (2000). However, despite all this activity, and more, a major challenge remains. Some patients continue to live in very substandard conditions and some are failed to varying degrees by services (see Sections 2.1, 2.2 and 2.4 of this report).

Our National (Mental) Health

The Commission welcomed Our National Health with its emphasis on co-operation to produce a more satisfactory patient journey. In our view, Health Boards’ accountability reviews have failed, in the past, to tackle some of the persistent deficiencies in the mental health service, and we were therefore very interested in the outline of a new Performance Assessment Framework, which will be implemented from October 2001. This seems to indicate a more effective process for ensuring that areas that are declared to be priorities by the Executive are in practice given priority in local service and spending plans. We also noted the new priority for the health of children and the promise to “provide all children and their families with equal and easy access to comprehensive, combined and integrated services”.

In terms of mental health and learning disability we noted the promise to accelerate the implementation of the Framework for Mental Health Services (1997) and to look for ways to overcome stigma. We were very interested in the intention to develop a National Framework to address unacceptably high rates of suicide, especially among younger men, and we have contributed to seminars addressing this. We were also pleased that there was to be a financial investment to assist implementation of the Learning Disability Review Report The same as you?.

Raising Standards and Regulatory Fatigue

The new approach places an increasing reliability on setting standards and monitoring the degree to which these standards are achieved in practice. The Commission is fully behind this approach, but also recognises that there is some resistance to it in the field associated with the development of “regulatory fatigue”. Mental health services and practitioners complain of serial visits from an increasing number of agencies and sometimes having to collate similar but different information in advance of these
visits. It would be a pity if this regulatory fatigue obscured the value of approaches such as that of the Clinical Standards Board to standards of services for those suffering from schizophrenia. In my view this approach offers a major opportunity to improve the standard of these services, an aim we would all subscribe to; this includes being able to compete for the necessary resources to do so. The same approach could then be extended to other areas of mental health services.

Recognising and responding to the feedback from practitioners, the Commission got together with four other organisations who are involved in visiting and monitoring services, to discuss how all five of us could best avoid duplication, clarify our different roles and share information so as to ease the burden on services. The other organisations were the Scottish Health Advisory Service, the Clinical Standards Board for Scotland, the Mental Health and Well-being Support Group and the Social Work Services Inspectorate. For ease of reference, the organisations were collectively termed the Mental Health Improvement Network (though some remits extend beyond mental health). This is not a new organisation in itself, and it does not claim a monopoly of mental health improvement. The Network has produced a leaflet available from all its members trying to clarify their different origins and roles and it is also attempting to rationalise visits so that they are reasonably spaced. It is also aware that the Chief Medical Officer has been given the task of reviewing the number of organisations providing visiting, monitoring and regulatory services.

**Psychiatric Services for Children and Adolescents**

One benefit from these organisations coming together is that they are able to discuss common concerns. One such concern is the current patchy and relatively unplanned provision of services for children and adolescents. With the new priority being given to children's services in Our National Health, the Commission and the four other organisations believe that the time is ripe for the Executive to produce a national strategy for child and adolescent psychiatry services. There is a gap to be filled between the Executive statement to the Network that "nowhere in Scotland is there a properly resourced and manned multi-disciplinary and multi-agency child and adolescent mental health service" and the quote from Our National Health reproduced in the second paragraph above (see Section 2.2 of this report).

**“Joint Future” and Delayed Discharge**

The Commission welcomed the report of the Joint Future Group in November 2000 and the speedy and positive response of the Executive in January 2001. The focus on joint assessments and joint resourcing and management of services, together with a recognition that a national planning and financial framework is required to give impetus to developments, gives encouragement that improvement will occur in community care services.

There are considerable obstacles to overcome, however, including the causes of the delayed discharges from hospital referred to in our last Annual Report (1999-2000, Section 2.3). We have been pleased to note that the Executive, through ISD, are now producing regular bulletins of national data on delayed discharges from psychiatric hospital care; these are broken down by cause, including shortages of places and shortages of funding. This allows monitoring of national changes, as well as comparison between local authorities, some of whom appear to have considerably more difficulty with delayed discharges than others. As anticipated in the last Annual Report, the Commission has now decided to give close scrutiny to one case of delayed discharge in the form of an enquiry under Section 3(2)(a) of the Mental Health (Scotland) Act 1984.
Millan and the Mental Welfare Commission

Millan's recommendations on the future of the Commission were received, as might be expected, with acute interest. (The Commission's general response to the Millan report is dealt with in Section 4.1 of this Report.) Broadly, the recommendations would strengthen the Commission, recognising its human rights role and extending its powers and duties. While the Commission is making a detailed response to the Executive, in general we are very much in agreement with what is proposed. We welcome the recommendation that the Commission's accountability should be extended to Parliament, in addition to Ministers.

The Report proposes that two of the Commission's existing powers are made more selective. Assuming the development of more user-friendly tribunals in relation to appeals against detention, it is suggested that the Commission should retain its powers to discharge from detention but be able to use them more selectively. It is also suggested that all NHS complaints about mental health services should be dealt with, beyond the local mechanism, by the NHS Ombudsman, but that he or she and the Local Government Ombudsman should consult the Commission, where complaints fall within its general remit. It is recommended that the Commission should be given new powers with qualified privilege in publishing its reports of inquiries and powers to carry out follow-up inquiries and publish reports on whether or not recommendations have been implemented. New powers are also proposed for the Commission to visit community services and facilities, and for staff to inspect case records in various settings.

A large range of new roles and duties are recommended for the Commission including the promotion of the principles of new mental health legislation. They range from duties to conduct unannounced and prison visits through consideration of appeals against restriction of access to use of mobile phones and electronic communication, to publishing more statistical information and receiving reports on the use of police powers, including the use of CS gas on mentally-disordered people. In general, while we will make some detailed comments, we very much welcome these proposals, as long as the resource implications are realised.

New Commission Secretary

I would like to express welcome to the new Commission Secretary, Alison McRae, and say how much my colleagues and I appreciate her able and hard-working contribution to the Commission in her first year. She has particularly contributed to our staff policies and played a big part in the Commission achieving Investor in People status during the year.

Resources - Good News

I have ended the last few Director's Reports with sad accounts of the gap between the Commission's resources and its workload, and expressions of hope that this will be addressed. I am pleased to depart from tradition this year and announce that the Commission has been successful in arguing for a substantial increase in resources for 2001-2002 and the succeeding two years. This increase will allow us not only to address workload pressures and extend into previously relatively neglected areas such as services for children and adolescents and services for older people outside psychiatric hospitals, but also to fulfil our new roles and duties in relation to the Adults with Incapacity Act. The Commission moves forward therefore with renewed strength and optimism, though conscious of much to be done.
2.1 DEFICIENCY IN CARE AND TREATMENT

REPORT OF THE INQUIRY INTO THE CARE AND TREATMENT OF MR B

Under Section 3(2)(a) of the Mental Health (Scotland) Act 1984 the Commission has a duty to make enquiry into any case where it appears there may be ill-treatment, deficiency in care or treatment, improper detention of any person suffering from mental disorder or where the property of any such person may, by reason of his mental disorder, be exposed to loss or damage. The Commission also has a further duty under Section 3 to bring such matters to the attention of Scottish Ministers or relevant Health Board, NHS Trust or Local Authority.

The following is a brief report on a major inquiry the Commission completed during the past year.

Brief Background

In 1998, when he was 21, Mr B's situation came to the Commission's attention via a Social Circumstances Report (SCR) following his detention in hospital for psychiatric treatment under Section 26 of the Mental Health (Scotland) Act 1984. The SCR described Mr B as learning disabled. He was the oldest of seven children. He attended special school as a child. His father died when he was four and his mother was noted as having a learning disability as well as poor parenting skills. All her seven children were taken into care on Place of Safety Orders. Mr B himself lived in a number of children's homes between the ages of 13 and 18. During his teenage years Mr B was reported as having been involved in many incidents of minor offending as well as some more serious offences.

When Mr B left Local Authority care at the age of 18, he was initially supported by social work staff in his own flat. This, however, was short lived and he subsequently went to stay with his mother and her partner in another Local Authority area. Around this time he was placed on probation and his probation case was eventually transferred to the new Local Authority/Social Work Department. The situation with his mother and her partner broke down and later that year, at the age of 19, he went to live with his maternal aunt and her partner in a third Local Authority area.

In the SCR it was reported that their father had left a considerable amount of money to Mr B and his brother. This had been placed in a Trust, through which, at the age of 18, Mr B had access to approximately £58,000. This money had been almost exhausted within 15 months. It was not clear where it had gone but there was reference in the SCR to it having been spent on furniture and cars for his aunt and her partner. It was not evident that Mr B had substantially benefited from the use of the money.

Following his admission to hospital, a further £600 was withdrawn from his account while on a day's Leave of Absence with his aunt and her partner, leaving him with just £5 in his account. Later during the admission he was declared Incapax, because of his learning disability. After being discharged on Leave of Absence to his aunt and her partner, a sum of nearly £2,000 in interest on his previous savings was credited to his account. This was also withdrawn shortly afterwards without evident benefit to Mr B.

The Commission made initial enquiries of the three social work departments involved and reviewed the social work case-files. From the information received and the files reviewed, it was evident that Mr B's capacity to manage his inheritance responsibly had been the subject of concern to social work staff over a number of years. The question of seeking a Curator Bonis when he reached the age of 18 had been mooted but this was not pursued by the Social Work Department. There was no record in the case files of any decision-making process to support this lack of action. Power of Attorney was granted to the solicitor who had been acting as judicial factor in relation to Mr B's Trust fund.

On the basis of an initial investigation, the Commission decided to undertake a formal Inquiry under its Deficiency in Care and Treatment Inquiry procedures.
Terms of Reference

The Inquiry focused on the following concerns:

1. Whether Mr B had an appropriate Community Care Assessment directly before leaving local authority care in 1995 and whether adequate arrangements for care and support were put in place at that time.

2. Whether the Social Work Department was aware that Mr B had a learning disability prior to leaving local authority care in 1995 and, if so, whether Mr B’s community care needs were fully assessed prior to leaving care.

3. Whether the Social Work Department properly executed its responsibilities in respect of the protection of Mr B’s property?

4. Whether there was sufficient communication between social work, medical and legal professions around the question of Mr B’s capacity to manage his inheritance?

5. Whether consideration was given to the appointment of a Curator Bonis prior to Mr B’s detention in hospital in January 1998?

Summary of Findings

1. The confusion and lack of agreement and understanding over the terminology used in describing Mr B’s learning disability played a key role in adversely affecting the quality of his assessment and care planning.1

2. Had there been greater clarity over the terminology used and its meaning, those involved might well have pursued a different course of action in attempting to assist Mr B in the safe and responsible management of his finances.

3. The Local Authority failed to meet its statutory obligation to provide a Future Needs Assessment. Had Mr B received a formal Future Needs Assessment and a Community Care Assessment, specialist health service personnel, who would have participated in these assessments, could have made a crucial contribution to the decision making about Mr B’s capacity to manage his inheritance.

4. The Social Work Department failed to carry out its responsibilities under Section 92 of the Mental Health (Scotland) Act 1984, in not securing a medical assessment of Mr B’s capacity to manage his own finances and affairs.

5. Key social work line-managers, both of whom were MHOs, did not appear to have sufficient knowledge of mental disorder and the Mental Health Act and failed to consult with those in the Department who had such knowledge. This was responsible, in part, for the Department’s failure to carry out its responsibilities under Section 92 of the Act.

6. The Central Council for Education and Training in Social Work guidance on Core Competencies in Mental Health Officer training does not specifically address the importance of MHOs having the skills to assess the social factors relevant to a person’s capacity to make decisions about finances, welfare or medical treatment. Given the nature of the task and responsibilities, and the possible implications of taking or not taking action under the legislation, this should be seen as an area of knowledge and skill essential to MHO practice and be included in the Core Competencies for Mental Health Officer training.

7. Mr B’s solicitor, having been made aware of concerns about Mr B’s capacity to manage his own financial affairs, should have advised the Social Work Department and Mr B that he would only be able to act on Mr B’s instructions if his capacity were first assessed by a medical practitioner.

8. After the solicitor decided to accept Mr B’s instructions, the Powers of Attorney were not specifically drafted to take account of Mr B’s particular circumstances.

9. We found there was a break-down in communication between the solicitor and the Social Work Department once Mr B left Local Authority care, despite the solicitor believing that he had passed relevant information on to the appropriate social worker. This resulted in lost opportunities to reassess Mr B’s capacity.

---

1 Some professionals described him as suffering from “learning difficulties”.

---


and the possibility of petitioning the court for a Curator Bonis, after there was further evidence that the administration of the Power of Attorney was not working to the benefit of Mr B.

10. We question whether sufficient steps were taken by the solicitor to protect the interests of Mr B. He could have made a formal request either to the Social Work Department to act on their responsibilities under Section 92 of the Mental Health (Scotland) Act 1984 or to the Mental Welfare Commission to exercise its authority under Section 93 of the Act. He did not pursue these options.

11. The transfer of case-work responsibility from one Local Authority Social Work Department to another was badly handled insofar as key information was not passed on. Insufficient information was given to the receiving department’s Probation Officer upon taking on the supervision of the Probation Order and this significantly affected her ability to properly monitor Mr B’s situation and provide him with the advice and assistance he required.

12. Following Mr B’s referral by the Social Work Department to the Community Learning Disability Service, no comprehensive multi-disciplinary assessment was undertaken to determine the nature and extent of his learning disability and what supports and services the Community Learning Disability Team may have been able to provide to meet his needs. No specialist psychological or psychiatric assessment was undertaken to inform the conclusion that Mr B had a borderline learning disability and was too able to fall within the remit of traditional learning disability services.

13. The staff of the psychiatric hospital to which Mr B was admitted failed to implement procedures under Section 94 of the Mental Health (Scotland) Act 1984, to the consequent detriment of Mr B’s financial welfare.

14. There was a breakdown in the implementation of Care Programme Approach procedures prior to Mr B’s discharge from psychiatric hospital on Leave of Absence, which resulted in home and financial circumstances not being assessed adequately.

15. There appeared to be difficulties in the transfer of full clinical information when medical responsibility for Mr B was passed from one consultant psychiatrist to another.

Recommendations

Social Work:

1. The primary Local Authority Social Work Department involved in this Inquiry, as the successor authority to the Council in whose care Mr B was placed, should review the findings of this report, particularly in relation to the original Council’s failure to carry out its responsibilities under Section 92 of the Mental Health (Scotland) Act 1984, and Mr B should be compensated for any loss which may have been a consequence of this failure. The Commission makes this recommendation in carrying out its duty under Section 3(2)(d)(iv) of the Mental Health (Scotland) Act 1984.

2. All Social Work Departments should review procedures and guidance on Assessment and Care Management to ensure that they address the issue of assessment and review of capacity in relation to welfare, medical and financial decisions. This will be essential in advance of the implementation of the Adults with Incapacity (Scotland) Act 2000.

3. All Departments should review the expertise of MHOs operating in management positions, child care and criminal justice teams to ensure they have up-to-date knowledge of relevant legislation, particularly as it relates to learning disability, issues of capacity and the protection of property.

4. All Departments should develop a system of routine refresher training courses for all Mental Health Officers.

5. All Departments should ensure that staff are aware of how to access specialist Mental Health Officer advice and guidance.

6. All Departments should develop and/or review policies and procedures for the protection of property and the management of finances for people with mental disorder. These policies and procedures should provide guidance to staff about the social work role in the assessment of
an individual’s capacity to manage his or her finances, and when medical and legal advice should be sought in this process.

This work will be essential given the implications for social work practice of the Adults with Incapacity (Scotland) Act 2000.

7. All Departments should ensure that all staff have basic information about the Mental Health (Scotland) Act 1984 and the Adults with Incapacity (Scotland) Act 2000, and the associated professional and departmental responsibilities.

With the implementation of the Adults with Incapacity (Scotland) Act 2000, it will be essential that all social work staff are made aware of the Department’s responsibilities to take forward applications for Intervention Orders, welfare guardianship and financial guardianship where necessary. These responsibilities in relation to financial matters will, in future, replace those which currently exist under Section 92 of the Mental Health (Scotland) Act 1984.

8. All Departments should develop clear guidance to staff as to when and how they should consult with the Council’s legal advisors.

9. All Departments should ensure that all staff are aware of when and how to consult specialist staff in the field of mental disorder about the assessment of capacity in relation to decisions affecting welfare, finances and medical treatment.

10. All Departments should develop and/or review multi-agency procedures and guidelines for the protection of vulnerable adults, which address the protection of their finances and property, as well as the issue of assessment of capacity.

11. The three specific Local Authority Social Work Departments involved in this Inquiry should review procedures for transferring/receiving essential information when the supervisory responsibility for a Probation Order is transferred from one Authority to another.

12. The Local Authority Social Work Department with care-management responsibilities for Mr B upon his discharge from hospital on Leave of Absence should review, on a multi-agency basis, existing Care Programme Approach procedures to ensure they adequately address the assessment of home and financial circumstances prior to discharge.

13. All Departments should review the specific arrangements, and associated guidance, for the transfer of young people with disabilities from child care and educational services to adult community care services. They should specifically review with education and health colleagues the process by which children with special educational needs are assessed to determine whether Records of Needs and Future Needs Assessments are necessary. Procedures should address the relationship between these education-led assessments and the Local Authority’s assessment and care-management procedures.

**Education Departments**

14. With Health and Social Work colleagues, all Education Departments should review the process by which children with a Record of Needs are assessed for the purposes of providing formal Future Needs Assessments. Procedures should address the relationship between these Education-led assessments and the Local Authority’s assessment and care-management procedures. Departments should also review the terminology used in the statutory assessment of needs. All statutory assessments should take account of the provisions of the Adults with Incapacity (Scotland) Act 2000, as well as the Mental Health (Scotland) Act 1984.

15. Educational psychologists should be given basic information and training to familiarise them with those aspects of the Mental Health (Scotland) Act 1984 and the Adults with Incapacity (Scotland) Act 2000 which are relevant to their practice.
Primary Care Trust

16. The Primary Care NHS Trust should review the findings of this report, particularly those relating to its failure to carry out procedures under Section 94 of the Mental Health (Scotland) Act 1984; Mr B should be compensated for any loss which may have been as a consequence of this failure. The Commission makes this recommendation in carrying out its duty under Section 3(2)(d)(iv) of the Mental Health (Scotland) Act 1984.

17. The Primary CareTrust should review existing procedures to protect the finances of Incapax patients, to identify where they can be enhanced; it should re-issue guidance to relevant staff, following any changes which may be required. Its procedures should specifically describe the responsibilities of key staff, both clinical and administrative, and it should give guidance about the assessment of the capacity of individuals, in respect of financial, welfare and treatment decisions at both the post-admission and pre-discharge stage. This guidance should also address the timescales for such assessments, and take account of guidance issued by the Scottish Executive in Circular No CCD2/1999: The Protection of the Finances and Other Property of People Incapable of Managing their own Affairs.

18. The above guidance should also specify the responsibilities of hospital management, administrative staff and clinical staff under Section 94 of the Mental Health (Scotland) Act 1984, as well as the Adults with Incapacity (Scotland) Act 2000.

19. The Trust should review its training strategy in relation to these procedures, to ensure that staff are aware of their legal and clinical responsibilities in relation to the assessment of capacity in individual patients.

20. With relevant agencies, the Trust should review the implementation of existing Care Programme Approach procedures to ensure that home and financial circumstances are adequately assessed prior to discharge, and that assessment and planning is on a multi-disciplinary, cross-agency basis.

21. The Trust should review the criteria on which specialist services accept people with learning disabilities for assessment. It should ensure that the needs of individuals are responded to and addressed by the most appropriate services. This is in line with recent national policy, as outlined in The same as you?

22. The Trust should develop a joint team with social work colleagues to implement the provisions of the Adults with Incapacity (Scotland) Act 2000. Such a team should consider the organisational, clinical, legal and training implications of the Act.

23. The Trust should review its procedures for transferring relevant patient information between clinical staff when the responsibility for a patient's medical care is transferred between consultant psychiatrists.

Scottish Executive

24. The Scottish Minister should consider issuing a directive that Local Authorities must re-approve all Mental Health Officers at three-year intervals in accordance with requirements to be established by C.C.E.T.S.W.

25. The Directorate of Planning and Performance Management should ensure that all NHS Trusts regularly review arrangements, and the associated training, for implementing guidance on the responsibilities of managerial and clinical staff in assessing the capacity, and protecting the property, of vulnerable patients.

26. The Social Work Services Inspectorate should update existing guidance on Assessment and Care Management, to address the assessment of capacity in respect of financial, welfare and treatment decisions. Such guidance should examine the role of social work (and other local authority) staff, in the assessment of capacity, including when to seek medical and legal advice.

This would be extremely helpful for Local Authorities in responding to the new statutory

---

27. The drafting of the guidance and Codes of Practice for the Adults with Incapacity (Scotland) Act 2000 should be informed by findings and recommendations of this report.

28. The Social Work Services Inspectorate should review the National Standards and Objectives in relation to Probation Orders to ensure that:
   i. consideration is given, where appropriate, to the individual’s capacity to understand and comply with the proposed action plan, particularly with those aspects relating to welfare, finances and/or medical treatments;
   ii. all transfers of the supervisory responsibility for individuals on Probation Orders are accompanied by information about any existing concerns or arrangements arising from his or her lack of capacity in respect of financial, welfare or medical decisions.

29. The Scottish Executive should give urgent attention to the development of a Vulnerable Adults (Scotland) Bill.

30. The Special Educational Needs Forum should take account of the findings of this report with particular reference to issues relating to the assessment and recording of special educational needs.

Central Council for Education and Training in Social Work

31. Current guidance on the training and appointment of Mental Health Officers should be reviewed. The core competencies required of Mental Health Officers should include skills in assessing the aspects of social functioning and background which are relevant in determining capacity to make decisions about money, welfare or medical treatment. They should also be required to know the relevant legislation relating to the protection of property.

The Law Society of Scotland

32. The Law Society of Scotland should review the circumstances set out in this Report and advise the Mental Welfare Commission for Scotland about the action it proposes to take in response to those of its findings which are relevant to the Society. Without prejudice to that generality, the Law Society is invited to consider the following matters:
   a. The need to ensure that all solicitors acting as Attorneys undertake adequate annual training, specific to this area of practice, as a requirement of Continuing Professional Development Regulations.
   b. The need for advice to members of the Society on the importance of seeking a medical determination of capacity, whenever this is in question when taking instructions from a client. This is a matter of particular importance given the changes associated with the Adults with Incapacity (Scotland) Act 2000, which extends the powers of an attorney to include welfare matters.
   c. The desirability of recognising mental health Law as an accredited specialist area of expertise.
   d. The question of whether Mr B’s solicitor provided an adequate professional service to Mr B, and, if not, the action which will be taken in that respect by the Society, in the interests of Mr B.

Enable

33. Enable should consider offering legal advice to Mr B about his rights and the remedies available to him, in respect of the failings identified in the report. It should take such further action as is in his interests and he might wish, in that regard.

Action on Recommendations

The actions taken by the responsible authorities in respect of these recommendations will be reported in next year’s Annual Report.
INQUIRY INTO THE CARE AND TREATMENT OF NOEL RUDDLE

Last year’s Annual Report included a summary and the recommendations of this Inquiry. The full text is available from the Stationery Office or on the Commission website (www.mwscscot.org.uk). The Inquiry was carried out at the request of the Minister for Health and Community Care following the discharge of Noel Ruddle, a patient at the State Hospital, by the Sheriff at Lanark, on appeal. The Minister accepted the findings and recommendations of the Inquiry. Twelve recommendations were made to the State Hospitals Board, the Scottish Executive and the Mental Welfare Commission. (Annual Report 1999-2000 p.11-p.13). The following is a brief account of the progress which has been made in implementing each of these recommendations:

1. The State Hospitals Board has written to Mr Ruddle to acknowledge the deficiencies identified in the Inquiry Report which occurred while he was a patient in the State Hospital.

2. The State Hospital has reviewed communication between the Security Department and Clinical Teams to address the findings and recommendations of the Inquiry.

3. External consultants have reviewed the management systems and style within the State Hospital. Recommendations have been made and some changes have taken place but, due to a number of changes at senior management level, there has been delay in implementing some of the proposals.

4. A comprehensive model for the delivery and organisation of specialist psychological therapies has been agreed but it is not possible to implement this fully within current resources and priorities for implementation are being considered.

5-6. The role of the Clinical Board at the State Hospital has not developed as anticipated by the Inquiry Team. Steps have been taken to identify patients whose primary diagnosis, like that of Mr Ruddle, falls within Section 17(1)(a)(i) of the Mental Health (Scotland) Act 1984 and to monitor their care plans.

7. The purpose and procedures of the State Hospital’s Medical Sub-Committee have been reviewed. Alternative structures are being put in place and the Sub-Committee no longer exists.

The State Hospital and the Scottish Executive

8. Responsible Medical Officers at the State Hospital have not reported any problems with the availability of security and medical information.

The Scottish Executive

9. The Memorandum on Procedure on restricted patients is under review, in line with the Inquiry recommendations.

10. The recommendation for the development of a National Care Plan was accepted by Ministers, who set up a Working Group to develop a National Discharge Protocol. The Working Group has completed its consideration, and a Mentally Disordered Offenders: National Discharge Protocol issued for consultation in August 2001.

11. New Directions, the report on the review of the Mental Health (Scotland) Act 1984, was published earlier this year and its recommendations accord with those of the Inquiry.

The Mental Welfare Commission

12. The Mental Welfare Commission has appointed a Co-ordinator for the State Hospital and regular meetings with State Hospital clinical staff are held. The Commission’s visiting programme to the State Hospital is being modified to bring it more in line with the visiting programme for other hospitals; it will include unannounced visits.
2.2 PSYCHIATRIC SERVICES FOR CHILDREN AND ADOLESCENTS

Historically, the Commission has not been as involved in services for children and adolescents as it has in services for adults. There is no good reason for this difference and we have recently been trying to address it. Having received the resources to allow an increase in professional staffing, we are preparing a strategy for greater involvement with child and adolescent patients. Over the past year, we have obtained information on services and have included adolescent inpatient facilities in our annual hospital visits. At the time of visits, we have been requesting information on patients under 18, currently in adult wards, and have endeavoured to meet with a proportion of them.

For some time, we have been concerned that psychiatric services for children and adolescents in Scotland are provided in a relatively unplanned and excessively patchy manner. This period of information-gathering has strengthened our concern. We believe there is a need for a national strategy for psychiatric services for children and adolescents.

Due to the nature of its work, the Commission has been most directly aware of deficiencies in services for inpatients. The Framework for Mental Health Services in Scotland (1997) requires that "children and young people should not be admitted to adult general psychiatry wards". In the Commission's experience with detained adolescent inpatients, this requirement often is not met. For example, our data show that over a twelve-month period, out of 30 episodes of detention of under 16 year olds, 21 were in adult wards. Over the years, we have also been aware of other children having to go large distances away from their families, in order to be admitted to appropriate accommodation. There is no adolescent psychiatric intensive care unit or forensic inpatient facility in Scotland and young people, who need this type of service, have to be admitted to one of two units in the north of England.

A 14 year old from Glasgow, with a psychotic illness, had to be admitted to an adolescent unit in Dumfries when there was no bed in the local adolescent unit.

A 15 year old with psychosis in West Lothian was admitted compulsorily to an adult unit in Livingston then moved to the adult IPCU there after attacking a member of staff. She spent several weeks in the IPCU before getting a bed in the regional Young People's Unit in Edinburgh.

A 14 year old from Highland had two informal admissions to an adolescent unit in Fife, about 160 miles from home. He then required further urgent admission on a compulsory basis. There was no bed in the Fife adolescent unit and he and his family were opposed to going there. He was detained for ten days in an adult ward in Inverness.

Although the focus of our concern has been on inpatient provision, we fully accept the tiered model of approach to provision of services for children and adolescents, as described in the Health Advisory Report "Together We Stand", in 1995. Four tiers are identified in this model, ranging from non-psychiatric professional help in primary care, schools, etc., in Tier 1, to services, including inpatient and secure provisions, for those with severe and complex problems in Tier 4. Service provision, as a whole, in Scotland appears patchy, depending more upon the influence of charismatic pioneers than central strategic planning.

The Commission has discovered that its concerns are shared with four other organisations involved in visiting, monitoring and regulating psychiatric services. They are the Scottish Health Advisory Service, the Mental Health and Well-being Support Group, the Clinical Standards Board for Scotland and the Social Work Services Inspectorate. The organisations collectively have written to the Scottish Executive to express their concern and to argue the case for a national strategy for child and adolescent mental health services.

Our letter noted that, while child and adolescent services had been included in the Framework for Mental Health Services in Scotland, it had been left to local commissioners to interact with each other in terms of providing services at a supra-Board level. This approach had not been successful in providing a properly planned and comprehensive service. Child and adolescent services had been deliberately omitted from important reviews such as the National Strategy for Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland (1999). In our letter, we outlined our perception of deficiencies in provision of inpatient services.
We argued that now would be an opportune time to set up a mechanism for producing a national strategy. As well as mental health being a priority for the NHS in Scotland, services for children and adolescents have also been made a priority in the recent plan for improving health and health services in Scotland, ‘Our National Health: A plan for action, a plan for change’ (2000). We also understood that child and adolescent psychiatric services are currently being considered in the Scottish Needs Assessment Programme (SNAP) and there will be a need to drive forward the resulting recommendations. We also noted that Recommendation 18.5 of New Directions, the report of the Millan Committee (2001), stated that “Health Boards should be placed under a statutory obligation to provide or secure age-appropriate mental health services, including secure services, for children and young people in their area”.

Our five organisations received a detailed and encouraging response from the Executive. It appeared to accept that a problem exists, in its statement that “we are aware that nowhere in Scotland is there a properly resourced and manned, multi-disciplinary and multi-agency child and adolescent mental health service”. It indicated that a survey, carried out two years ago, showed that Health Boards had a three-fold variation in the amount they spent, per head of population, on non-inpatient child and adolescent mental health services. It was encouraging to learn that the new Performance Assessment Framework, the process by which the Executive will monitor the performance of the new NHS Trusts, will require NHS Boards to indicate what proportion of their budget is to be spent on the mental health services mentioned in Our National Health, including those for children and adolescents.

Reference was made in the Executive’s response, to the four-tiered model of care for children and adolescents, and the deficiency in services at Tier 2 level. This results in specialist services being distracted from their task of meeting the specialised needs in Tiers 3 and 4 by competing demands for care from those with less severe, but just as disabling, problems. The response also made reference to the Mental Health and Well-being Support Group and due priority being given to strategies for child and adolescent mental health services during its visits. It was also noted that some improvements were taking place or being planned in relation to inpatient provision. It was suggested that, for a population of 5 million, the provision of highly specialised facilities such as a forensic inpatient unit could not be justified and it was hoped that the forthcoming SNAP report would confirm or deny this impression.

The five organisations welcome the response and note the progress that can potentially be made through the various measures suggested. We recognise that, at present, the Executive has to deal with a number of mental health issues with price tags attached. However, we hold to the belief that services for children and adolescents should have the highest priority and that this would best be expressed in a national review, leading to a fully co-ordinated national strategy.

2.3 THE MENTAL WELFARE COMMISSION’S RESPONSE TO ISSUES OF RACE AND CULTURE IN SCOTLAND

The Commission’s Statutory Duty

Under the Mental Health (Scotland) Act 1984, the Mental Welfare Commission for Scotland has a statutory duty to protect people who, because of mental illness or learning disability, are unable adequately to protect themselves or their interests. This duty extends to people in hospital, in community-based resources and their own homes. The Commission carries out its duties through visits to individuals, making enquiries where there are matters of concern and bringing matters which need to be addressed to the attention of responsible authorities.

The Impact of the Macpherson Report

The Commission’s primary role concerns the quality of care and treatment of individual patients, who may come from many different backgrounds. In recognition that Scotland is a multi-ethnic, multi-cultural society, the Commission has been reflecting on issues of race and culture for some years now. One of the concrete steps it has taken in this regard, was the appointment, in April 1999, of a Part-time Commissioner with experience of racial and cultural issues. By the time the Macpherson Report was published in February 1999, the Commission’s
recruitment for the above post was well underway. Nonetheless, the recommendations of the Report have had a significant bearing on the Commission’s approach to matters concerning race and culture. In particular, the identification and definition of institutional racism, articulated by the Macpherson Report, and the responsibility it places on each institution to inspect its policies and practice, has provided an effective incentive for the Commission to examine these aspects of its own functioning. The Report defines institutional racism as follows:

“The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.”

In paragraph 46.27, the Report states:

“It is incumbent upon every institution to examine their policies and the outcome of their policies and practices to guard against disadvantaging any section of our communities.”

The Race Relations (Amendment) Act (2000)

The Commission recognises the Race Relations (Amendment) Act 2000 as a major change in the approach to race relations in the U.K. It particularly endorses the Act’s imposition of a positive duty on public authorities to actively promote race equality, equality of opportunity and good relations between persons of different racial groups, so as to avoid racial discrimination.

Other significant features of the 2000 Act are the outlawing of indirect racism and victimisation, the compilation of the Commission for Racial Equality (C.R.E) Code of Practice for public bodies and the enforcement of action for non-compliance. These are meant to pave the way to ensuring that each individual in society will be treated equitably, regardless of his or her race, ethnicity or culture.

The 2000 Act imposes on every major public authority a general duty to promote racial equality. Specifically, it states, “In carrying out its functions [it should] have due regard to the need: to eliminate unlawful racial discrimination [and]; to promote equality of opportunity and good relations between persons of different racial groups.”

The Situation in Scotland

The Commission recognises that Scotland faces a number of challenges in the field of race and culture. In comparison to England, there are significantly fewer people from minority ethnic backgrounds living in Scotland and, except in cities such as Glasgow and Edinburgh, they tend to be more sparsely dispersed. Hence their specific needs and requirements, far from being met, are often not even recognised.

Currently, there is a dearth of information about people from minority ethnic backgrounds, in Scotland, and, therefore, little research into the problems they face. This has clearly had an adverse effect on policy development. Interventions to address the needs of the minority ethnic communities have tended to remain at exploratory and community development levels. For similar reasons, there is a lack of professional expertise in the field of race and culture.

Because of the lack of information, the mental health needs of people from minority ethnic backgrounds are marginalised to the extent that they are often invisible. Monitoring the ethnic background of patients would provide much needed information about Scottish trends and patterns in the mental health of minority ethnic groups. These statistics could consequently form the basis for the development, by the Scottish Executive, of sound strategies for planning and effective provision of services for the minority ethnic communities of Scotland. The Race Equality Unit of the Scottish Executive also has a crucial role in increasing national and local knowledge about social and health needs among minority ethnic groups, particularly as they relate to mental health.

The development of a Code of Practice by the C.R.E, in the key fields of education, police, health, local and central government, is an important step forward. The Commission looks forward to contributing to the aspects of the Code of Practice which deal with health issues, so as to promote better mental health services for people from ethnic minorities throughout Scotland.
Action by the Mental Welfare Commission
In Relation to Patients and Carers

As a Scotland-wide independent public body that exists to safeguard the welfare and rights of people with mental illness or with learning disability, the Commission is deeply committed to improving the experience of mentally disordered people from minority ethnic and cultural backgrounds. In May 1999, it set up a Working Group on Race and Culture with the specific remit to examine the needs of ethnic minority people who suffer from mental disorder, and the ways in which these could best be met by the Commission. This group has examined ways in which access to the Commission could be enhanced for people from the minority ethnic communities. These include more effective ways of publicising the Commission’s role among the minority ethnic communities and the creation of effective networks with people from these communities. It has focused on the need to provide appropriate, professional interpreting services, across Scotland, for all minority ethnic patients who require them and the need to develop ways of examining the quality of care and treatment received by minority ethnic patients in psychiatric hospitals and other mental health care settings. An important aim of this Working Group is to encourage the Commission, and the other public bodies with which it interacts, to act positively in ascertaining and addressing the needs of people from minority ethnic backgrounds. The Commission will seek to identify, and promote, good practice in this area and look for solutions, when poor practice has been identified.

The Commission is examining the use of suitably trained interpreters, as one way of improving access to its services for patients and carers from minority ethnic groups. We are currently monitoring the demand for such an interpreter service. Another approach is the development of Commission leaflets in relevant minority ethnic languages, and appropriate style. Currently, these leaflets have been translated into Arabic, Bengali, Cantonese, Hindi, Punjabi and Urdu. They have been circulated, for consultation, to a wide range of statutory agencies as well as community-based mental health centres. If any organisations or individuals require leaflets in any of the above languages, the Commission would be glad to supply them. Leaflets are also available in Gaelic.

The Commission is aware that there has been a recent influx of refugees to Scotland, from a number of eastern European countries, as well as countries such as Afghanistan. Accordingly, it hopes to liaise with the various interpreting services and the Scottish Refugee Council, to ascertain the most common language needs so that it can begin to provide information about the Commission in the appropriate languages.

The Commission has been holding consultation meetings with a range of community-based minority ethnic agencies so as to ascertain grass-root mental health issues and the best way to facilitate Commission services to people of minority ethnic backgrounds. The Commission hopes to pilot its leaflets through this network of agencies to ascertain its impact and effectiveness among the minority ethnic communities in Scotland.

These changes are by no means fully implemented, but the Commission is making progress in achieving them. Although they appear straightforward, in practice they require considerable thought and discussion with a range of agencies. For example, when the Commission began to discuss the provision of interpreting services, it soon came to realise that there is no consistency of provision in Scotland. Hence, in some regions, where there are few people from minority ethnic groups, such services are non-existent. Yet, the case may be argued that, precisely because of the small numbers and the ensuing sense of isolation, the need for interpreting services may be greater in these areas. Even in regions where there are established services, there are very few interpreters trained in mental health issues. There is disparity in the way the interpreting agencies are funded in different regions in Scotland and this may add to the patchiness of services. Clearly, this issue affects access to the interpreting services, not only by members of the minority ethnic communities, but by professionals offering help. For Scotland-wide agencies such as the Mental Welfare Commission, it is a major barrier to offering equality of service across the country.

The Commission has increased the attention it pays to the care of patients from minority ethnic backgrounds, through changes in the Visiting
Programme. To inform Commission representatives on annual hospital and community visits, it has obtained policies on service provision for such patients from all Scottish Local Authorities, Trusts and Health Boards. During its annual visits, the Commission has endeavoured to meet at least one patient whose first language is not English and, where deficiencies in care are noted, to draw these to the attention of the appropriate staff and managers.

At the end of the year, the Commission decided to hold a Deficiency in Care Inquiry into the care and treatment of an elderly Asian patient, who was in hospital for several years and for whom communication in English was a problem. The Inquiry is currently underway and the findings and recommendations will be published in next year's Annual Report.

In Relation to Commission Staff

The Commission has implemented a training programme on issues of race and culture, for all members of the Commission. To date, five training sessions have been undertaken, including one on the impact upon the work of the Commission of the Race Relations (Amendment) Act 2000.

The Commission has also developed an Equal Opportunity Policy Statement that has been circulated to all its staff. Clearly, the value of such a document lies in its implementation. This is a matter to which the managers of the Commission are attaching importance. The Commission is determined to carry out its general duties under the Race Relations (Amendment) Act 2000. It will audit its work, in the light of the Act, and develop performance indicators to try to ensure that there is no indirect discrimination within the Commission and that, more importantly, it is actively promoting equality of opportunity for users of mental health services, regardless of their race or culture.

2.4 COMMISSION VISITING PROGRAMME

The Commission's Visiting programme is one of the main ways in which it carries out its statutory responsibilities under Section 3 of the Mental Health (Scotland) Act 1984. Section 3 requires the Commission to visit patients who are detained under the Act for more than two years, if they have not been seen in the preceding year. The Commission also has responsibilities to bring to the attention of senior managers of Trusts, Health Boards and Local Authorities and other relevant bodies matters concerning the welfare of persons suffering from a mental disorder which fall within its remit: potential deficiency in care, loss or damage to an individual's property, ill treatment or improper detention.

Hospital Visiting Programme

Structure of Visiting Programme

The Commission makes announced visits to all the psychiatric and learning disability hospitals in Scotland and other care establishments and services throughout the year. As well as seeing patients, the visits afford an opportunity to meet with relatives, advocates and front line staff. Each visit usually concludes with a meeting with the local operational managers. This year the Commission also carried out three unannounced visits to hospitals in line with the policy described in last year's annual report.

In addition to the hospital visits, the Commission visits patients who are on Leave of Absence, Guardianship and Community Care Orders as well as those who have requested the Commission to consider their discharge from detention or Guardianship.

In each visiting area (based on Health Board areas), annual meetings take place with senior managers from Trusts, Health Boards and Local Authority Social Work Departments. General issues that have arisen from the visits to individual patients are discussed at these meetings.

A validity in 2000-2001

Excluding the State Hospital, the Commission visited 60 hospitals' NHS units during this period and also carried out a further three unannounced visits. Including those seen during unannounced visits, a total of 764 patients were seen, an increase of 12% over the 685 patients visited in 1999/2000 and an increase of over 45% from 1998/99. Most of this increase is attributable to the Commission being more proactive in making contact with patients. The aim is that a Commission representative will visit every ward in each hospital visited. As well as visits to patients who have been detained over two years and patients who have requested an interview, the
Commission now asks to see patients who may not be capable of requesting a visit or who may not receive visits from relatives or do not have an advocate. Overall, 11% of the visits to patients this year were initiated by the Commission. In addition, over the last year, the Commission has visited at least one person in each hospital for whom English is not the first language. Details of the numbers of patients seen during the visit programme are given in Table 5.9, in Section 5.7 of this Report.

In addition, the Commission made 12 visits to the State Hospital and carried out 156 interviews there, an increase of 56% since the previous year. Of these visits, 37 were routine statutory visits, and 41 were requests for discharge.

Unannounced Visits
The Commission carried out three unannounced visits this year, two to mental illness hospitals and one to a learning disability hospital. All of the visits took place in the early evening. The visits appeared to be well received by patients and nursing staff and in total 39 patients took up the opportunity of an interview with a Commission representative. In one large mental illness hospital, where the Commission visited all the acute admission wards, the problem of lack of available beds was very clear with patients having to be "boarded out" to other wards or hospitals. The Commission believes that this practice can lead to disruption for the patient and to discontinuity of care as an individual is passed from one care team to another.

The Commission will continue to carry out unannounced visits during this coming year.

Quality of Life in In-Patient Settings
Environment, activities and food play an important part in the overall quality of life for anyone while they are in hospital. The care given to these areas of a patient's life while they are in hospital can have a major impact on that person's sense of well-being. From its visits this year, the Commission believes that service providers require to consider the impact of in-patient treatment on the patient's quality of life and to ensure that the service maintains high standards in the provision of the aspects of care noted below.

(i) Environment
The Commission has seen many new developments in service provision throughout the country and is aware of the efforts that have been made by staff to improve the service they provide. The closure of some old hospitals and the move to new facilities has brought a marked improvement in the quality of the physical environment for many patients. However, improvements in some areas serve to highlight the inadequate physical condition and maintenance of other facilities. Patients continue to complain about, and Commission representatives continue to see, wholly inadequate environments for the provision of care. While the Commission is told of efforts being made to improve décor in some wards, we have seen, and have received complaints about, dirty and untidy wards, windows not cleaned and patients' wardrobes and lockers that are unacceptably dirty. Many of these problems appear to stem from inadequate arrangements for maintenance and cleaning. The impact on patients and their relatives of such poor environments must not be underestimated.

(ii) Appropriate Activities
The Commission has previously reported on the inadequate provision of appropriate recreational and therapeutic activities in some facilities. We have heard of and seen many initiatives to improve the situation and we recognise the efforts that have been made in some services. However, many patients continue to say to Commission visitors that the activities available are not of interest to them or are insufficient or are not available at times they need them such as the evening or weekends. Individual care planning should identify appropriate therapeutic interventions, including recreational activities, but can only do this if these activities are available. In its meetings with managers and clinical staff, the Commission has suggested more direct user involvement in the development of appropriate recreational activities for in-patients.

(iii) Quality of Food
This year there has been a marked increase in the number of complaints made by patients about the quality of food in hospital. The complaints are about monotonous menus, poor taste and inadequate quantities. Also, comments have been made by patients of inadequate facilities to make or access hot drinks and snacks, especially at night. The Commission believes that it is wholly unacceptable
that poor food is provided to in-patients who may have little choice in where they can eat.

Community Visits

The Commission has continued to visit patients in the community in a variety of settings either as part of the visiting programme or because an individual is on Guardianship, Leave of Absence or a Community Care Order. This year some visits were made to persons discharged from learning disability hospitals as part of planned hospital closures. The Commission has decided to introduce a programme of “focused visits” where people who are receiving a particular category of care provision will be visited throughout the country. As well as making the Commission available to individuals this approach will allow for some comparison of care provision throughout the country. This year (2001/2002) the focus will continue to be on persons discharged from learning disability hospitals.

Advocacy

This year the Commission carried out a survey of all the patients it visited for any reason. This included people in the community on Leave of Absence or Guardianship, as well as those in hospital. Information was sought about a number of areas, including whether the patient had an advocate. Of the 1081 patients on whom Commission visitors collected this information 127 (12%) had an advocate; 627 were seen in hospital and of these 101 (16%) had advocates. Of the 433 people seen by the Commission outwith hospital, a low proportion had an advocate. Of the 101 patients in hospital who had an advocate, 34 were assessed as Incapax. It was of note that, of the 17 patients from a minority ethnic background who were seen, none had an advocate. A fuller breakdown is given in the Table 2.1.

### Table 2.1 Patients with Advocacy Support, in Hospital and Community Settings

<table>
<thead>
<tr>
<th>Living Circumstances</th>
<th>Number of Patients</th>
<th>With Advocate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>140</td>
<td>6</td>
</tr>
<tr>
<td>Home with someone</td>
<td>106</td>
<td>6</td>
</tr>
<tr>
<td>Supported accommodation</td>
<td>54</td>
<td>4</td>
</tr>
<tr>
<td>Residential home</td>
<td>38</td>
<td>1</td>
</tr>
<tr>
<td>Nursing home</td>
<td>95</td>
<td>9</td>
</tr>
<tr>
<td>Hospital</td>
<td>627†</td>
<td>101*</td>
</tr>
</tbody>
</table>

†166 of these were Incapax; *34 of these were Incapax

Prison Visiting Programme

By agreement with the Scottish Prison Service (SPS), during 2000-01, the Commission continued with its programme of visiting prisons. The Commission aims to visit mentally disordered prisoners and meet with mental health staff in four prisons each year. During 2000-2001, we visited prisoners and staff in HMP Perth, Barlinnie and Aberdeen. A fourth prison, Greenock was due to be visited, but this was cancelled because of weather conditions. We hope to reschedule this visit as part of our visiting programme in 2001-2002.

During its visits in 2000-01, Commission representatives were impressed by the efforts of prison health care staff, in their attempts to provide an appropriate range of mental health services for prisoners, and by the way prison and NHS services were trying to work together in assessing and treating offenders with a range of mental disorders. However, it was our impression that the relationship between the prison service and local NHS mental health services was better developed in some areas than others. A consistent concern, expressed to Commission visitors by prison staff, was that mentally disordered people were having to be cared for in prison, when this was inappropriate to their needs. They suggested that a lack of suitable NHS in-patient services had led to mentally disordered offenders being inappropriately placed in prison by the courts and sometimes delayed the transfer of mentally ill prisoners to hospital, when they could not be adequately treated in prison.

2.5 GENERAL PRACTITIONERS AND THE COMMISSION

The Mental Welfare Commission (MWC) remains committed to extending its involvement with General Practitioners. Again this year, the GP section of the Commission’s Annual Report will be circulated to all GP Principals. GPs may request the full report if they wish it and will also be able to locate it on the Commission’s website at www.mwcscot.org.uk. The website also contains the Annual Report for 1999-2000, which has a GP section. We hope these GP sections contain useful information for GPs about use of mental health legislation, and that they will also be appropriate teaching material for GP registrars.
GPs are welcome to attend the regional road shows in November at which the Annual Report is now launched. This year they will be held in Aberdeen, Stirling and Ayr. This is an opportunity to hear from Commission staff about their work, to put questions to them and participate in discussion with other professionals, users of services and carers.

The MWC carries out community visits (with the main aim of seeing patients) throughout Scotland. Commission visitors usually see community mental health staff on these visits but it has not proved easy to meet with GPs. The Commission would welcome approaches from groups of GPs who would wish to meet Commission representatives visiting their region.

Adults with Incapacity (Scotland) Act 2000

This new legislation contains much improved provisions for decision-making about personal welfare, treatment and financial matters, in relation to individuals aged 16 and over, who are incapable of making such decisions because of mental disorder or inability to communicate. It is described more fully in Section 4.3 of this Report. Its implementation began on 2 April 2001 with Part 2, which deals with continuing and welfare powers of attorney, and Part 3 which deals with authority to access funds and the operation of joint bank accounts. Part 5, dealing with medical treatment and research, is expected to come into operation in the autumn of 2001. Part 4, management of residents' finances, and Part 6, intervention orders and guardianship orders, become operational on 1 April 2002.

GPs need to be familiar with this legislation and their roles in it. It will be particularly relevant to the treatment of many patients with dementia, learning disability and other mental disorders, who accept treatment without resistance, but cannot legally consent to it. From some time in the autumn of 2001, the doctor primarily responsible for the treatment of an adult will also be legally responsible for assessing his or her capacity in relation to decisions about treatment.

If an adult patient is incapable of giving consent to treatment, the Act gives the doctor a general permission to do what is reasonable, under the circumstances, to safeguard or promote his or her physical or mental health. This does not include treatments subject to special safeguards or treatment requiring force or detention, unless in emergency. After considering the principles of the Act, the doctor primarily responsible for the medical treatment will be required to issue a certificate that the adult is incapable, in relation to a decision about the treatment concerned. This certificate can last for up to a year. Welfare attorneys, welfare guardians and those exercising intervention orders, with welfare powers, can have a power to consent to treatment. Provisions exist for dealing with disagreements between the doctor and the proxy decision-maker.

Medical opinions and certificates may be needed in a number of different situations in the Act. GPs may be asked to provide certificates of capacity in relation to applications for continuing or welfare powers of attorney. Certificates of incapacity will be required in relation to accessing funds and supporting the management of funds by residential establishments. Two doctors, one Section 20-approved, will need to provide reports to the court, in relation to applications for guardianship or intervention orders.

Continuing (financial) and welfare powers of attorney have been available, under the Act, since April 2001. A welfare power of attorney is a means whereby a person, while still capable of understanding what he or she is doing in this respect, can select someone else to take certain personal welfare decisions on his or her behalf, should he or she become incapable of taking such decisions in future. Welfare powers of attorney only become active when the grantor becomes incapable of making the sorts of decisions that are contained within the Power of Attorney document. These can include personal welfare matters and consent to treatment, but the welfare attorney cannot place the grantor in a hospital for treatment of mental disorder against his or her will or, if the grantor is detained, consent on his or her behalf to any form of treatment to which Part X of the Mental Health (Scotland) Act 1984 applies. In addition, the attorney cannot consent, on the grantor’s behalf, to treatments with special safeguards identified by regulations under Section 48 of the Adults with Incapacity Act. A welfare attorney can only be an individual, and not include someone acting as an officer of a Local Authority or other statutory body.
GPs will need to be aware of the principles underlying the Act and ensure that they act in accordance with them. It is important to understand that the Act sees incapacity as functional and situation-specific. Incapacity may depend on the type of decision being made and the magnitude of the decision: it is not an all-or-nothing thing. It may also vary over time.

Broadly, the Public Guardian (a new role for the Accountant of Court) has oversight of the financial aspects of the Act, and Local Authorities and the MWC have oversight of the welfare aspects. Helpful guidance material and Codes of Practice are available from the Scottish Executive Health Department and the Office of the Public Guardian, both in print and on their respective websites, at www.scotland.gov.uk/justice/incapacity and www.publicguardian-scotland.gov.uk. The Health Department has produced an aide-memoire for doctors on assessment of incapacity and this is available on the Chief Medical Officer’s website at www.scotland.gov.uk/health/cmo/incapacity_act_toc.asp.

The Millan Committee Report

The Millan Committee was set up in 1999 to review the Mental Health (Scotland) Act 1984, including the role of the Mental Welfare Commission. It reported in January 2001. The Scottish Executive aims to produce a policy statement on its plans for new legislation in the Autumn of 2001, and is committed to introducing a bill to the Scottish Parliament in 2002.

The Millan Committee, which included a GP in its members, has not recommended any major changes in the role of General Practitioners with respect to compulsory measures. It proposed that any registered doctor should continue to be able to make an emergency recommendation. There have been concerns about GPs’ knowledge of, and experience of using, mental health legislation, and changes in the organisation of primary care services, which make it less likely that the GP will have long term knowledge of an individual patient. For these reasons, the committee carefully reviewed the role of the GP in giving the second recommendation. It concluded that GPs should continue to be involved, because of the desirability of having an independent medical opinion and the value of the GP’s prior knowledge of the patient, even if this is not universally present.

A recommendation, which would affect GPs, is that there should no longer be a provision for relatives to give consent to compulsory measures; only the MHO would be able to give consent. Practice has been moving towards this in recent years.

Other recommendations include direct entry into 28 day detention, in an attempt to reduce the reliance, in Scotland, on emergency detention. The doctor involved in this would have to be approved under the equivalent of Section 20 of the Act. At present, Section 20-approved doctors are virtually all psychiatrists. In future some GPs, perhaps in more remote areas, may wish to seek training, with a view to Section 20 approval.

The Millan Committee supported the introduction of a community treatment order, in recommending that long term compulsory measures could be exercised either in hospital or the community. The community order would be intended for a small number of patients, who would currently be detained in hospital but could be safely cared for in a less restrictive situation in the community, if they were under a legal compulsion to comply with treatment. Patients who have shown that they respond to treatment, stop it when not required to take it, relapse without it and act dangerously when ill, would be expected to be helped by this provision.

To grant long-term compulsory measures, the Committee proposed that a broader legal forum, such as three-person tribunal, should take over the current role of the sheriff; this body should consider the appropriateness of a care plan, as well as the legalities of the detention. It also proposed an updating of the criteria for compulsory measures, and continuing and strengthening the role of the Mental Welfare Commission.

There are more detailed discussions of the Millan Committee’s recommendations in the Director’s Report and Section 4.1 of this Annual Report.
Emergency Detentions under Section 24

The initiation of emergency detention is the GP’s main area of involvement in the current Scottish Mental Health Act. In the year covered by this report, there were 4288 emergency detentions, of which 2166 were under Section 24.

The MWC has a duty, under Section 3 of the Mental Health Act, to make enquiry into any case where there may be improper detention, and to discharge from detention where appropriate. Because of the short duration of emergency detention (up to 72 hours), it is not practicable for the Commission to visit patients detained under this Section and assess whether their detention is improper, so this safeguard is not available for these patients. It is therefore extremely important for GPs to take care that procedures are followed correctly and to seek advice, if in doubt about any aspect of the detention. Sources of advice might be: a consultant psychiatrist; a Mental Health Officer; or the Commission’s own telephone advice service, which is available during working hours. All emergency detentions must be notified to the Commission by the managers of the hospital in which the patient is detained, by forwarding copies of the forms. The Commission examines all these forms to make sure that the detention is lawful.

The Commission is aware that the process of emergency detention can present difficulties for medical practitioners. In order to examine some of the problems experienced by GPs, those who had recently detained patients were sent a questionnaire, in which they were asked about their experiences. Of the 120 questionnaires sent out, 38 completed questionnaires were returned. The findings suggested that experience of carrying out emergency detention is very variable. Some GPs have done many; some of these doctors are also police surgeons. For other GPs, this is a very infrequent occurrence.

More than two-thirds of the GPs reported that they spoke to consultant psychiatrists for advice before detaining patients and that the advice received was usually helpful. Less than half of the GPs received advice from an MHO. In many of the cases in which an MHO was not involved, consent to the detention was given by a relative. The Commission considers that it is normally desirable for MHOs, rather than relatives, to give consent, where practicable. At least, the relative should be aware that the alternative of an MHO consent is available. If the recommendation from the Millan Committee is accepted, relatives will no longer have the power to give consent for emergency detention. The surveyed GPs did make some comments about availability of MHOs. This can certainly be a problem in remote areas, where it is likely that an MHO will have to travel a long distance to attend. This problem will have to be addressed, if the power of consent to detention is to be removed from relatives.

The main difficulty reported by the GPs was the process of getting the patient to hospital. Often GPs felt that it would have been helpful for hospital staff to attend and assist in the process of admitting the patient, but such help was not always available. Psychiatrists were not always able to assist. It is usually in patients’ interests for them to be brought into hospital with the help of hospital staff, but it appears to be sometimes impossible to release staff for this purpose. On the few occasions in which staff had been involved in bringing patients to hospital, this had made the process easier.

A number of GPs commented on the difficulty experienced when they had a long wait for help (ambulance, CPN, MHO, etc.) to arrive. They had often had to leave their practices with many patients waiting, and this is clearly a matter of concern. Booked surgeries may have to be cancelled, or much delayed, and where doctors are on call out-of-hours, seriously ill patients with other illnesses may be neglected. Rural and isolated areas can be particularly problematic. In a climate of increasing complaints, uncertainty about their responsibilities is a source of considerable stress for GPs. At times, they are unclear about whether they may or may not leave the patient, who is awaiting transfer to a psychiatric hospital or assessment by an MHO. Under the terms of the Mental Health Act, they are not obliged to remain with the patient until they reach hospital. They must simply have examined the patient on the day that the recommendation is made. However, sometimes the circumstances are so fraught, that the GP’s presence may be necessary, and the GP does have a responsibility to ensure the safety of the patient.

These matters had previously been discussed at a meeting in 1999 between the Mental Welfare
Commission and the Scottish General Medical Services Committee (now the Scottish General Practitioners Committee). The Mental Health Act Code of Practice states that the GP and the MHO should agree on how the patient is to be managed until the ambulance arrives and that the GP, perhaps after discussion with a consultant psychiatrist, should discuss, with escorting nursing staff, the patient's management during the journey. Guidance is also given in Paragraph 87 of the Notes on the Act. The Mental Welfare Commission is always interested to hear about individual cases in which delays have been problematic and will, if necessary, take this up with appropriate authorities including ambulance services.

Section 24 does not confer power to treat the patient against his or her will. If any medication is given without the patient's consent, such emergency treatment should meet the common law requirement of being necessary to prevent serious suffering, serious deterioration of the patient's condition or serious danger to the patient or others.

Patients with Mental Health Problems who are Long-Term Residents in Care Homes

The MWC is very interested in these patients but, because of resource constraints, it has not been possible to see as many of them as we would like. We regularly visit psychiatric hospitals, as patients who are detained must, under the Mental Health Act, be visited by the Commission at regular intervals. We will often initiate visits for other reasons and patients themselves may, and do, ask to see Commission representatives. However, people who have mental disorders who reside permanently in nursing or residential homes are seldom visited, unless they are subject to Guardianship or are on Leave of Absence from detention. The Commission recognises that nursing home residents with mental illness may be disadvantaged by this, and has made enquiries into a number of cases in which the care of such patients has appeared to fall short of what is desirable.

Problems which have been encountered include: questionable standards of physical care; poor quality of the environment; and lack of psychiatric follow-up. Residents, who are not subject to the Mental Health Act, may effectively be detained, because doors are locked or physical disabilities prevent their leaving. A resident's mental disorder may prevent him or her from recognising that nursing home care is needed. If such a resident indicates a wish to leave the home, it may be appropriate to use the power of Guardianship in order to detain him or her legally.

Excessive use of tranquilising drugs may be a problem. At times, it may be necessary to treat a very agitated person with a sedative drug. This decision should be preceded by a thorough assessment of the person's mental and physical condition. Sedative drugs should never be a substitute for adequate staffing levels.

People who are resident in nursing or residential homes should have their own wishes taken into account, as far as possible. They should expect to have some of their own possessions with them and should expect to have appropriate activities to fill their days. There is sometimes a shortage of nursing home places and care options for individuals may be restricted because of this, but they should still have choice. Nowadays advocacy services are available and people with mental disorder ought to be able, if they wish, to have the help of an advocate, to express their views and wishes.

GPs may be in a unique position, in that they may be the only independent professionals to visit patients with mental health problems in nursing or residential homes. If they are unhappy with what they find there, they should be prepared to act on the patient's behalf. They should consider discussing problems with staff of the home or the local Health Board's Registration and Inspection Team, or helping the patient to access an advocate. In cases of doubt, they are welcome to telephone the Mental Welfare Commission for advice.

2.6 NURSING ISSUES

In previous reports the Commission has commented on deficits in some nurses' knowledge and understanding of the way mental health legislation is applied. The Commission has been encouraged by the development of a number of training initiatives in mental health legislation for nurses, and other staff, throughout the country and our staff have been pleased to contribute to some of them. In order to protect the interests and rights of patients in their care, nurses must be aware of the legislative framework in which they practise. Nursing staff are
involved in decisions about a patient’s care at all stages of his or her treatment. They are directly involved in providing treatment to non-consenting patients; for example, giving medication to non-consenting patients and, at times, preventing detained patients from leaving a ward. In nursing homes they are involved in decisions about locking doors and the use of restraint. In all of these situations nurses must recognise the need to be fully aware of the appropriate legislation and guidance.

This year the Commission has produced guidance for nurses on the practical application of mental health and related legislation. This was made possible by the assistance of Ms Bernie O’Hare, a senior clinical nurse, who was seconded to the Commission from the Glasgow Primary Healthcare Trust, to whom we are very grateful. This work is intended to provide a resource for nurses in producing local guidance and will be updated regularly to reflect forthcoming changes in legislation. Copies of the Commission’s guidance will be distributed to relevant bodies later this year.

Nurses and the Use of Illegal Substances by In-Patients: Searching and Discharge Policies

In its 1996-97 Annual Report, the Commission commented on its awareness that the use of illicit drugs and substances by in-patients in psychiatric units was presenting increasing problems to staff in maintaining acceptable and safe care environments. Many staff were voicing concerns to the Commission about the appropriate course of action, if they suspected or discovered that a patient had been using an illegal substance. At the same time, the Commission was aware of complaints from patients and relatives, who were being exposed to drug-misuse in in-patient units. There were particular concerns about vulnerable patients being exposed, not just to substance misuse, but also to a culture associated with drug-misuse. Such a culture included financial exploitation and theft, both in hospital and in the community, where the patient might be “targeted” by drug dealers, who were aware that he or she was receiving particular financial state benefits.

Nursing staff have continued to report problems of managing substance misuse amongst their patients and difficulties treating in-patients, in whom psychosis and substance misuse is combined. The Commission does not have precise information about the prevalence of illegal substance use in in-patient settings, but it is clear that certain areas appear to be affected more than others and that nursing staff report that the problem is an intermittent one in many wards.

Nurses have referred to particular problems in managing substance misuse. These include: in-patient staff having to take on a policing role that can be seen as counter-therapeutic; uncertainty among staff about their position in carrying out searches of patients and their belongings; increased risk of violence and aggression from patients; exacerbation of patients’ symptoms and protracted recovery rates due to the influence of drugs and alcohol; staff feeling ill-prepared in dealing with the problems of drug and illness co-morbidity; difficult decisions about whether to discharge patients from hospital because of their illegal substance or alcohol misuse; and difficulties in dealing with complaints from patients about “double standards” in relation to decisions about discharge, resulting from substance misuse.

The Mental Health Reference Group (which subsequently evolved into the Mental Health and Well Being Support Group) refers to substance misuse, in its guidance on risk management. It recommends that service providers need to consult with their legal advisors and the police, in developing clear policies and guidance for staff on such issues as situations in which it is appropriate to search in-patients and their belongings; and how patients’ legal status affects their civil liberties.

In its report on the review of the Mental Health (Scotland) Act 1984, the Millan Committee recognised that it may sometimes be necessary to search a patient’s belongings, particularly in forensic psychiatry settings. It drew attention to the lack of any specific framework for this in the existing Act.

The Committee referred to the English case of R v. Broadmoor Hospital Authority, in which these patients objected to the hospital’s policy of random searching. In judgement, Mr Justice Potts concluded that since “detain” means “keep in confinement”, a general power to search patients, in order to prevent escape from detention, must be implicit. A general power to search patients must necessarily be implied as part of the duty to create and maintain a safe and
therapeutic environment. The legal issue was whether the exercise of that power was reasonable. It would seem that this principle could apply to all detained patients, not only those in secure hospitals. However, the reasonableness of such searches would depend on the particular circumstances. The Committee went on to say that, if this is also the legal position in Scotland, it may not be necessary for a new Act to make specific provision in relation to searches. However, it recommended that all services, which accommodate detained patients, should be required to have clear policies in relation to this issue. It also recommended that the Code of Practice to a new Mental Health Act should set out the general parameters of these policies and the Mental Welfare Commission should monitor the operation of search policies.

The Commission is aware of situations in which patients, who repeatedly abuse alcohol or use illegal substances in hospital, have been discharged because of non-compliance with hospital rules and, as a consequence, the therapeutic relationship has broken down. The decision to discharge a patient, in such circumstances, is a difficult one and must take into account the patient's behaviour, mental state, social situation and legal status. Nurses are often closely involved in such decisions, as it is they who are directly managing the particular patient's behaviour. The Commission is concerned that, in such situations, insufficient attention might be paid to the discharged patient's follow up and aftercare. Whatever the reason for discharge, there should be a care plan, which is clear to the patient and all those who might be in professional contact with him or her.

The Conveyance of Detained Patients to Hospital

The Commission is frequently contacted by nurses asking about their powers in relation to bringing detained patients into hospital. We have received enquiries from hospital-based nurses going out to patients who have been detained under an emergency order at home, and also from nurses based in community settings, such as resource centres. Section 24(3) of the Mental Health (Scotland) Act 1984 gives authority for the removal of the patient to hospital, but does not confer this duty on any specific professional. The guidance in the Code of Practice and the Notes to the Act emphasises the role of the doctor, in ensuring that there are proper arrangements for the conveyance of the patient. Section 120 explains the powers given to a person authorised to take the patient into custody and convey him or her. This is discussed further in Section 2.5 of this report. Section 122 gives protection to professionals carrying out duties under the Act; provided they do so in good faith and exercise reasonable care. In the case of patients requiring a nursing escort to hospital, it is likely that hospital-based nurses will be involved. In the case of patients who have been detained while they are attending a community facility, clear local protocols should exist to determine who is responsible for escorting the patient to hospital. The Commission believes that the escorting nurses should have access to the detention papers, before bringing the patient to hospital.

Nurses' Holding Power

Managers of hospitals are required to report the use of Section 25(2), the nurses' holding power, to the Commission. This year there were 156 episodes reported compared with 145 last year. This is a slight rise but still lower than the figures for 1998-99 (181) and 1996-97 (202). As can be seen from Fig.2.1, hospitals continue to vary widely in the use of the nurses' holding power; this cannot be fully explained by relative bed numbers. The Commission continues to monitor the use of Section 25(2) and plans to collaborate on research into its use.

Nurses and Complaints

When patients are dissatisfied with some aspect of their care and treatment and wish to complain about it, nursing staff are often the first to hear of their concerns. The Commission, which currently has a particular role in relation to complaints, has heard that complainants felt their initial complaint was not taken seriously by the person they first spoke to or that, having made the complaint, they received no further information about any action taken to address their concerns. The Commission thinks it is important that nurses are trained to recognise when a patient is making a complaint and respond appropriately, in line with the hospital's complaints procedures. Many complaints are resolved satisfactorily when there is a prompt acknowledgement and response from the front-line staff concerned.
2.7 SOCIAL WORK ISSUES

GUARDIANSHIP

During 2000-01 there has been a major increase in the use of Guardianships. Table 2.2 shows that, on 31 March 2001, there were 266 Guardianships in Scotland. This is an increase of nearly 31% since the previous year. The reasons for this are not clear.

Table 2.2 also shows that there continues to be great variation between Local Authorities in the use of Guardianship. The average rate is 5 per 100,000 of the population aged 16 and over. However, in Highland region it is 26/100,000, while in ten Authorities it is 0 to 3/100,000.

In 2000-01, the highest proportion (60%) of new Guardianships was for people with dementia; 15% of Guardianships were for people with a learning disability and 12% for mentally ill people.

In February 2001, the Commission wrote to the 11 Authorities who used Guardianship least. We enquired whether they had recent experience of people with dementia, learning disabilities or alcohol-related brain damage, who had persistently refused to accept the help they needed in their own home, or who had refused to enter residential or nursing home care, when it was thought this was necessary for their welfare. If so, the Commission asked how they provided help for them.

Replies were received from ten Authorities. All acknowledged they had experience of people with the needs outlined above. They argued that such people were encouraged to accept help through the relationships developed with them.

Several Authorities stated, perfectly properly, that it was their objective to pursue the least restrictive intervention. Because they saw Guardianship as restrictive, they used other measures, including the Care Programme Approach. Three or four Authorities indicated that Guardianship was regularly considered at case conferences, but nearly always rejected as unnecessary. Two Authorities indicated that more Guardianships might be sought, as additional local psycho-geriatricians were appointed. This suggests that the Local Authorities were not fully aware of the lead role they should take in making Guardianship applications. With the implementation of the Adults with Incapacity Act, Local Authorities will have a duty to take forward applications for Intervention Orders and Guardianship, for cases in which a mentally incapable individual needs them, and no other individual is seeking the relevant powers. These duties will mean that every Local Authority will need to consider carefully whether Guardianship, or alternative measures under the Adults with Incapacity Act, would be appropriate to protect the interests of a vulnerable adult with mental disorder. Given this duty, the present variations between Local Authorities’ use of Guardianship should decrease.

All over Scotland, the Commission visits people on Guardianship; for those in whom Guardianship had allowed placement in a care home, against their will,
this move had been taken only after a full assessment of the medical and welfare needs of the individual and after the grounds had been properly scrutinised by a sheriff. In Authorities where Guardianship is not used, the Commission can only assume that people may be moved into residential care against their will, without any legal protection.

Table 2.2: Guardianship Cases by Local Authority

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Number Approved 00-01</th>
<th>Number Discharged 00-01</th>
<th>Number at 31-03-01</th>
<th>Rate per 100,000 Local Authority Population 16 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highland</td>
<td>34</td>
<td>18</td>
<td>34</td>
<td>26</td>
</tr>
<tr>
<td>Fife</td>
<td>18</td>
<td>17</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Falkirk</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>11</td>
<td>16</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>East Lothian</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Glasgow City</td>
<td>33</td>
<td>27</td>
<td>33</td>
<td>19</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>9</td>
<td>1</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>West Lothian</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Borders (Scottish)</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>15</td>
<td>17</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Stirling</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Angus</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Clackmannashire</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Dundee City</td>
<td>7</td>
<td>3</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Midlothian</td>
<td>8</td>
<td>1</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Aberdeenhire</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>6</td>
<td>9</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Moray</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Orkney Islands</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shetland Islands</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>202</strong></td>
<td><strong>160</strong></td>
<td><strong>96</strong></td>
<td><strong>266</strong></td>
</tr>
</tbody>
</table>

The responses of some Local Authorities to the Commission’s enquiries suggested that use of Guardianship was largely unnecessary, if good standards of practice were being pursued. We disagree with this view. In our experience of visiting people subject to this measure (over 300 visits in 2000-01), Guardianship is usually based on the most careful assessment; and there have often been previous attempts, through the use of the Care Programme Approach and other measures, to provide the individual with acceptable services. We rarely, if ever, find that there are inadequate grounds for Guardianship. If that were the case, the Commission would have the power to discharge the individual from the Guardianship Order.

Guardianship under the Adults with Incapacity Act

From April 2002, all new welfare Guardianships must comply with the provisions of the Adults with Incapacity Act. An important innovation in this Act is the duty placed on the applicant to indicate those powers which will be necessary for the guardian to secure the welfare of the individual. This should allow flexibility in devising care plans, and encourage imagination and foresight in determining which powers are both consistent with the

Table 2.2: Guardianship Cases by Local Authority

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Number Approved 00-01</th>
<th>Number Discharged 00-01</th>
<th>Number at 31-03-01</th>
<th>Rate per 100,000 Local Authority Population 16 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highland</td>
<td>34</td>
<td>18</td>
<td>34</td>
<td>26</td>
</tr>
<tr>
<td>Fife</td>
<td>18</td>
<td>17</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Falkirk</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>11</td>
<td>16</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>East Lothian</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Glasgow City</td>
<td>33</td>
<td>27</td>
<td>33</td>
<td>19</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>9</td>
<td>1</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>West Lothian</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Borders (Scottish)</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>15</td>
<td>17</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Stirling</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Angus</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Clackmannashire</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Dundee City</td>
<td>7</td>
<td>3</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Midlothian</td>
<td>8</td>
<td>1</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Aberdeenhire</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>6</td>
<td>9</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Moray</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Orkney Islands</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shetland Islands</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>202</strong></td>
<td><strong>160</strong></td>
<td><strong>96</strong></td>
<td><strong>266</strong></td>
</tr>
</tbody>
</table>
principles of the Act and appropriate for the individual's needs.

Local Authorities need to be aware of the new Act's transitional provisions for existing Guardianships under the Mental Health Act. Those in operation on 1 April 2002 will continue with their previous three powers until their renewal date, unless discharged in the meantime. However, after that date, renewals will have to be through new applications, made under the Adults with Incapacity Act, and take account of the principles of that Act. The Commission would like to remind Local Authorities of the need for systems to alert Mental Health Officers, in advance of such renewals falling due, so that consideration can be given to the decision to renew or not. As it does now, the Commission will carefully monitor the reasons for discharging an individual from Guardianship, or allowing the order to lapse, and will enquire into decisions not to renew Guardianships, under the Adults with Incapacity Act.

Continuity of Care for People Transferred from Section 18 to Guardianship Orders

When an individual is transferred from detention under Section 18 of the Mental Health Act to Guardianship, the administration of medication is no longer subject to close scrutiny, or monitored under Part X of the 1984 Mental Health (Scotland) Act. At this time, the person may be moving from hospital to a nursing or residential care home. This can involve transfer to a different geographical area and a change of general practitioner. In these circumstances, continuity of care may be lost and the appropriateness of treatments may not be monitored adequately.

Careful multi-disciplinary planning can help to provide continuity of care, during times of transition. If care staff are concerned about an individual's care and treatment, they should inform the relevant MHO or Responsible Medical Officer and request a review of the care plan.

MENTAL HEALTH OFFICER ROLE IN DETENTIONS

MHOs are called upon to consent to emergency detentions, under Sections 24 and 25, and short-term detentions, under Section 26. They make applications under Section 18, when a person needs a longer period of compulsory treatment. MHOs also prepare reports on the social circumstances of people detained under civil law or criminal proceedings.

Consent to Emergency or Short-Term Detention

Tables 2.3, 2.4 and 2.5 show detentions under Sections 24, 25 and 26, respectively, which had received MHO consent. The proportions of emergency and short-term detentions initiated with MHO consent remain similar to previous years. MHOs are involved in the great majority of Section 26 consents, demonstrating improvements in joint working between Responsible Medical Officers (RMOs) and MHOs. The Code of Practice advises that relatives should be told about the possibility of an MHO providing consent and the report of the Millan Committee, on the reform of the Mental Health Act, recommended that relatives should no longer be asked to give consent.

Table 2.3: Consents to Section 24: 2000-01

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total detentions</td>
<td>2166</td>
<td>100</td>
</tr>
<tr>
<td>MHO consent</td>
<td>1225</td>
<td>56.5</td>
</tr>
<tr>
<td>Relative consent</td>
<td>637</td>
<td>29.4</td>
</tr>
<tr>
<td>No consent*</td>
<td>304</td>
<td>14</td>
</tr>
</tbody>
</table>

* No consent because of MHO unavailability 30 (9.9% of non-consents).

Table 2.4: Consents to Section 25: 2000-01

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total detentions</td>
<td>2122</td>
<td>100</td>
</tr>
<tr>
<td>MHO consent</td>
<td>1523</td>
<td>71.7</td>
</tr>
<tr>
<td>Relative consent</td>
<td>284</td>
<td>13.4</td>
</tr>
<tr>
<td>No consent*</td>
<td>315</td>
<td>14.8</td>
</tr>
</tbody>
</table>

* No consent because of MHO unavailability 15 (4.6% of non-consents).

Table 2.5: Consents to Section 26: 2000/01

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total detentions</td>
<td>2600</td>
<td>100</td>
</tr>
<tr>
<td>MHO consent</td>
<td>2423</td>
<td>93.2</td>
</tr>
<tr>
<td>Relative consent</td>
<td>165</td>
<td>6.3</td>
</tr>
<tr>
<td>No consent*</td>
<td>12</td>
<td>0.5</td>
</tr>
</tbody>
</table>

* No consent because of MHO unavailability 2 (17% of non-consents).
The Commission follows up each instance of detention in which the doctor reports “MHO unavailability”, as a reason for non-consent. There are logistical problems providing comprehensive MHO cover in rural areas but, surprisingly, a significant number of these problems arise in urban areas.

The Commission is not in a position to know of situations, where a compulsory detention was considered but not pursued, because alternative ways of safeguarding the individual were found or the MHO declined to support the detention for other reasons. Local Authorities should consider collecting these figures from MHOs, to ensure that this important element of statutory MHO work is recorded.

Consent Issues Frequently Raised with the Commission

Simultaneous Consent to Section 24/25s and 26s

MHOs frequently contact the Commission because they are uncomfortable about requests to consent to an emergency detention and short-term detention simultaneously. The purpose of 72-hour detention is to allow time for assessment, during which acute symptoms might remit or the patient might agree to stay in hospital informally. In the Annual Report of 1994-95, the Commission advised that assessment for the detention under Section 26 should normally occur “fairly late” in the 72-hour period. In a very limited number of cases, it might be in the patient’s interest to give both consents simultaneously, for example where both the RMO and MHO know the patient, but may not be available towards the end of the 72-hour period. The reasons for this course of action should be clearly agreed between the MHO and RMO, taking into account the views of carers and family. Where a relative consents to emergency detention, it is expected that the 72-hour period gives time for the nearest relative to discuss with an MHO whether he or she would prefer the MHO to take on the formal role of consenting to detention under Section 26.

Sometimes, it is reported that the RMO has asked the MHO to consent simultaneously to a Section 24/25 and a Section 26, in order to begin treatment without the patient’s consent. It should be noted that the Section 26 only takes effect from the expiry of the 72-hour period and therefore confers no authority on RMOs to begin treatment before this.

Transition between Daytime and Out-of-Hours Services

In a number of cases, patients have been admitted without consent, due to lack of MHO cover between daytime and out-of-hours services. It is important that Local Authorities have clear guidelines to protect patients’ rights and provide support for relatives, at these times.

Section 26 Forms Already Signed by the RMO

Some MHOs are concerned to find that a Section 26 form has been signed before they have given consent. However, it is important to remember that detention under Section 26 does not take effect until the expiry of the emergency section. In these circumstances, it would not be in the patient’s interest for the MHO to refuse to see the patient. This would deprive him or her of the MHO’s contribution, in assessing the need for continuing detention.

Telephone Consent

Where there are distance and/or timing problems, the Commission accepts that telephone consent may be appropriate, provided the MHO already knows the patient and there is no doubt about the grounds for detention. In these cases, it is expected that the MHO will see the patient at the earliest opportunity.

Further discussion of consent to detention issues can be found in Section 2.10 of this Report.

Section 18 Applications

Table 2.6 shows the rate of Section 18 applications for each Local Authority, per 100,000 population. Generally these figures suggest higher rates of Section 18 applications in urban and post-industrial communities, than in rural areas. However, there are exceptions. For example, North Lanarkshire has a very low rate of Section 18 applications, in comparison to similar geographical areas. One authority, Inverclyde, has an extremely high rate, in comparison to similar communities. When rates differ from comparable communities, Local Authorities and Trusts should enquire about environmental factors that might explain the differences and also examine local practice to see what part it might play in explaining them.
Table 2.6: Section 18 Applications By Local Authority 2000-01

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>N</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inverclyde</td>
<td>35</td>
<td>41.5</td>
</tr>
<tr>
<td>Dundee City</td>
<td>45</td>
<td>31.0</td>
</tr>
<tr>
<td>Aberdeen City</td>
<td>65</td>
<td>30.7</td>
</tr>
<tr>
<td>Argyll and Bute</td>
<td>26</td>
<td>29.0</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>128</td>
<td>28.4</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>41</td>
<td>27.9</td>
</tr>
<tr>
<td>Glasgow City</td>
<td>170</td>
<td>27.6</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>36</td>
<td>25.8</td>
</tr>
<tr>
<td>West Lothian</td>
<td>39</td>
<td>25.3</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>29</td>
<td>24.0</td>
</tr>
<tr>
<td>Midlothian</td>
<td>19</td>
<td>23.5</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>24</td>
<td>22.6</td>
</tr>
<tr>
<td>Perth and Kinross</td>
<td>30</td>
<td>22.5</td>
</tr>
<tr>
<td>Highland</td>
<td>45</td>
<td>21.6</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>23</td>
<td>20.1</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>35</td>
<td>19.7</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>18</td>
<td>19.1</td>
</tr>
<tr>
<td>Moray</td>
<td>15</td>
<td>17.5</td>
</tr>
<tr>
<td>Stirling</td>
<td>14</td>
<td>16.9</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>51</td>
<td>16.7</td>
</tr>
<tr>
<td>Angus</td>
<td>17</td>
<td>15.5</td>
</tr>
<tr>
<td>Fife</td>
<td>53</td>
<td>15.2</td>
</tr>
<tr>
<td>Clackmannanshire</td>
<td>7</td>
<td>14.4</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>14</td>
<td>12.8</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>11</td>
<td>12.4</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>28</td>
<td>12.4</td>
</tr>
<tr>
<td>East Lothian</td>
<td>11</td>
<td>12.2</td>
</tr>
<tr>
<td>Falkirk</td>
<td>17</td>
<td>11.8</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>38</td>
<td>11.6</td>
</tr>
<tr>
<td>Eilean Siar</td>
<td>1</td>
<td>3.6</td>
</tr>
<tr>
<td>Shetland</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Orkney</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Scotland - Total</strong></td>
<td><strong>1085</strong></td>
<td><strong>21.2</strong></td>
</tr>
</tbody>
</table>

Professional Issues Arising From Section 18 Applications

Under the Advice and Assistance (Assistance by Way of Representation) (Scotland) Amendment Regulations 2000, patients are entitled to legal assistance, without means-testing, to contest an application. The Regulation does not make any comment on whether relatives have this entitlement, and it remains untested. The Sheriff has the power to apportion the costs in any hearing, and could apportion them to the patient, who can receive legal assistance, regardless of means. Where there is no conflict of interest, the lawyer representing the patient may also be prepared to put forward the views of relatives; where there is conflict, it would be advisable for relatives to seek independent legal advice about a possible application for legal assistance.

Timing of Medical Recommendations

Under Section 20(1)(a) of the M H (S)A 1984, no more than five days should separate the two medical recommendations for detention under Section 18. On the basis of its legal advice, the Commission’s view is that, if the first examination occurs on day one, the second can follow at any time up to, and including, day seven, that is with five days in between. However, it would be wise for applicants to seek their own legal advice, where there is any uncertainty, as interpretations of Section 20 may vary between sheriffs.

Second Medical Recommendation

When the doctor making the second medical recommendation for detention under Section 18 is not one who knows the patient, the reasons for this should be clearly stated in the application. Section 20(2) states that a doctor employed by the same Trust as the doctor making the first recommendation, can be acceptable in certain circumstances if there is no other doctor with knowledge of the patient; the doctor spends less than half his or her contracted working time in the hospital and is not supervised by the R M O; and undue delay would cause serious risk to the patient or others.
Medical Treatment

The Commission is occasionally contacted by MHOs seeking guidance on their responsibilities, under mental health legislation, for people who require treatment for physical illnesses but are incapable of consenting, because of mental disorder. The Mental Health Act gives no authority to treat physical complaints. However, if the patient’s mental disorder is interfering with their capacity to understand the implications of not having such treatment, detention to improve their mental health may be appropriate. Part 5 of the Adults with Incapacity Act will address this kind of difficulty, when it comes into operation in the autumn of 2001.

Reports for the Court

It is the Commission’s view that information given to the Sheriff should be confined to those factors that relate to the application, the reasons why the detention is sought and the discussion of alternative options. The Social Circumstances Report usually contains more information than the Sheriff requires and it is not appropriate to place it before the court.

Social Circumstances Reports

Statutory Reports Required

When patients are compulsorily admitted for more than 72 hours, without any prior formal MHO involvement, an SCR is required by statute to ensure an MHO becomes involved in the case. Changes in practice since 1984 mean fewer statutory reports are required for people admitted under civil law, as MHOs now consent to the vast majority of detentions under Section 26 and make all Section 18 applications.

In 2000-2001, 177 statutory SCRs were required under Section 26(5), 165 of which were because relatives had given consent for detention and 12 because there was no consent, from either MHO or relations. There were 87 Hospital Orders or transfers from prison requiring statutory SCRs. These are usually notified to the Local Authority by the Trust’s hospital managers on Form K, although Form K is not a prescribed form.

Reports Received

It is not possible to publish a definitive figure of the numbers of SCRs received because this year, as last, we are concerned about the completeness of the data available to the Commission.

However, the Commission remains concerned about the apparent absence of statutory SCRs in a significant proportion of patients detained under the CP(S)A 1995. It urges that social work managers liaise with hospital managers over procedure and take steps to ensure all cases requiring a statutory report are identified and allocated. There may be problems, in some areas, about notification to Local Authorities, particularly where health and social work service boundaries are not coterminus. Some Form Ks may never reach their destination; for example, some current Form Ks are still addressed to “Strathclyde Region”, which has ceased to exist.

Some authorities do not allocate non-statutory reports to MHOs, despite the Code of Practice guidance, whereas other authorities give high priority to the preparation of SCRs for all patients detained beyond 72 hours.

Professional Issues in relation to SCRs

The joint MWC / ADSW / SWSI Survey

This SCR survey has been completed but, at the time of writing, the final report has not yet been circulated to Local Authorities. In brief, the survey found evidence of good operational practice in some areas but, in others, practice was very variable. From the Commissions perspective, there is a shortfall between stated policy and practice within Local Authorities, particularly in relation to allocation and completion of SCRs and the continuity of MHO responsibility. Authorities need to develop robust systems to monitor quality in these areas.

Continuity of Care

It is clear, not only from reports but also from Commission’s contact with detained patients, that in many areas there is no continuity of care. Many MHOs do not remain in touch with the detained patient beyond the initial stage of the detention.

Involvement of Relatives

Contact with relatives and carers is an important part of mental health work. Over the year a number of issues arose which merit further consideration.
Section 19(3) of the 1984 M H (S)A

This Section offers relatives the opportunity to request an M H O's assessment of a patient, to establish whether he or she needs compulsory admission. This part of the Act appears to be rarely used. Yet, the Commission frequently hears from relatives who see clear signs of recurring illness and its attendant potential risks, but find mental health services unreceptive to their concerns. The Commission may advise the relative to contact their local Social Work Department to request an appointment with an M H O to discuss action under Section 19(3). It is not known how often relatives follow up this advice, nor what response they receive. It would be helpful to hear the experiences of M H O's in respect of this section of the Act.

Communication and Confidentiality

Relatives repeatedly report a sense of exclusion from discussions about treatment and care. This may be because the patient has not agreed to contact being made with the family. This can happen even where the patient has had regular contact with family members before becoming unwell, and when the relative or carer is likely to be the first port of call when the patient leaves hospital. Professionals are rightly sensitive to patient's wishes, but there is a delicate balance to be made between a patient's right to confidentiality and the need for their relationship with the family to be accorded its due place. Information about mental disorders can often be given to relations in general terms, without breaching confidentiality.

M H O Contact with Relatives over SCRs and Section 18 Applications

It is good practice for M H O's to make every effort to contact relatives during the preparation of a Social Circumstances Report, and a legal requirement that the nearest relative is contacted during a Section 18 application. The patient does not have the right to veto these contacts. In a very few cases, where there is evidence that the patient has been abused by relatives and there is a strong professional judgement that contact would be detrimental to him or her, the M H O might decide to dispense with this duty. In these cases, it would be advisable to discuss this with the R M O, to take legal advice and to record the reasons for withholding contact clearly in the SCR and on the application.

An elderly man with a 40-year marriage developed persecutory symptoms. His wife looked after him at home until his assaults meant she could no longer manage. In the SCR, the M H O recorded that he had not spoken to the wife, because the patient had not given him permission to do so. Permission was not required. The wife would have an important part to play in informing the team and in supporting her husband as he recovered with treatment. She may also have needed care in her own right, and an explanation of what was going on.

Mental Illness Combined with Alcohol or Drugs Problems

The effect of misuse of alcohol and non-prescribed drugs on individuals with serious mental disorder has become an increasingly important issue. (The term 'dual diagnosis' is often used for ease of reference, but this term is also used in connection with mental illness co-existing with learning disability and other disorders.)

Problems for Treatment and Care Planning

The Commission is aware of many cases, in which the patient falls through the net of community care. There are particular problems for patients and staff, in establishing effective therapeutic engagement and, in addition, symptoms of mental illness are not always distinguished from those of drug and alcohol intoxication or withdrawal.

Drug and alcohol misuse complicates assessment and treatment. Community packages to support people with mental illness or learning disability frequently appear to fail because of the effects of substance misuse, rather than the effects of the primary disorder. Some mental health and addiction services operate selection criteria that, directly or indirectly, lead to people with combined mental disorder and substance misuse being excluded from treatment.

SCR Survey

The Commission has carried out a survey of 300 consecutive SCR's to examine the way M H O's report on these issues, and the range of services available to help patients with these problems.
Table 2.7: SCRs: Drug and Alcohol Problems Reported

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol problems noted</td>
<td>49</td>
<td>16.3</td>
</tr>
<tr>
<td>Drug problems noted</td>
<td>33</td>
<td>11</td>
</tr>
<tr>
<td>Problems with both alcohol and drugs</td>
<td>16</td>
<td>5.3</td>
</tr>
<tr>
<td>Absence of problems noted</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>No reference to alcohol or drugs</td>
<td>193</td>
<td>64.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>300</td>
<td>100</td>
</tr>
</tbody>
</table>

A total of 98 SCRs (32%) reported drugs and alcohol problems, as shown in Table 2.7. Of these 98, 65 reported alcohol and 49 reported drug problems, as shown in Tables 2.8 and 2.9. The problems shown are not mutually exclusive; for example some people had problems because of both their own and a partner’s drinking; further details are given in the tables.

The identified professional response to these problems is shown in Table 2.10. Approximately a quarter of the reports mentioned the use of specialist addiction services. However, these may be no more effective than generic mental health services, if the staff are not trained or experienced in working with mental illness. In a number of cases, MHOs reported that professionals had withdrawn because of the adverse effect of alcohol or drug misuse on the patient’s response to treatment. It is encouraging that some areas are beginning to appoint specialist “dual diagnosis” workers, in recognition that different skills and approaches are required for these patients with complex needs.

2.8 ISSUES ARISING FROM COMPLAINTS

As part of its protective duty towards people with mental disorder, the Commission has a responsibility to investigate complaints made by, or on behalf of, people with mental disorder. The focus of the Commission’s role is the investigation of complaints which remain unresolved, once the local investigations have been exhausted. The Commission fulfils a similar role to the Health Service Ombudsman, who is not permitted to investigate matters which fall within the Commission’s remit (see Section 5.2). The Commission can also investigate complaints about providers of Local Authority, independent and voluntary services, although the great majority of the complaints it receives relate to health services.

Table 2.8: SCRs: Types of Alcohol Problems Reported

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary problem alcohol misuse, mental illness secondary</td>
<td>6</td>
<td>9.2</td>
</tr>
<tr>
<td>Alcohol-related brain damage</td>
<td>8</td>
<td>12.3</td>
</tr>
<tr>
<td>Co-existent alcohol problem and mental illness</td>
<td>16</td>
<td>24.6</td>
</tr>
<tr>
<td>Primary mental illness: symptoms affected/exacerbated by alcohol</td>
<td>11</td>
<td>16.9</td>
</tr>
<tr>
<td>Primary mental illness: social stability undermined by drinking</td>
<td>10</td>
<td>15.4</td>
</tr>
<tr>
<td>Drinking in response to symptoms</td>
<td>3</td>
<td>4.6</td>
</tr>
<tr>
<td>Person affected by another’s alcohol problem</td>
<td>11</td>
<td>16.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>65</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 2.9: SCRs: Types of Drug Problems Reported

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary problem drug misuse, mental illness secondary</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>Drug related brain damage</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Co-existent drugs problem and mental illness</td>
<td>16</td>
<td>48.5</td>
</tr>
<tr>
<td>Primary mental illness: symptoms affected by drugs</td>
<td>10</td>
<td>30.3</td>
</tr>
<tr>
<td>Primary mental illness: social stability undermined by drugs</td>
<td>2</td>
<td>6.0</td>
</tr>
<tr>
<td>Person affected by another’s drug problem</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 2.10: SCRs: Information about Service Responses

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist services mentioned for substance misuse</td>
<td>24</td>
<td>24.5</td>
</tr>
<tr>
<td>Generic multi-professional approach implicit for all issues</td>
<td>40</td>
<td>40.8</td>
</tr>
<tr>
<td>No information about specific response to misuse problem</td>
<td>26</td>
<td>26.5</td>
</tr>
<tr>
<td>No information about treatment and care at all</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>98</td>
<td>100</td>
</tr>
</tbody>
</table>
Diagnosis and Treatment

Some of the complaints we receive involve concerns about past diagnosis and treatment. An examination of the patient’s records will usually indicate whether treatment and medication were appropriate to the diagnosis, given the information available at the time. However, issues about the accuracy of the diagnosis are much more difficult to resolve and, unless there are clear indications that an error has occurred, it will be difficult for the Commission to conclude there has been a misdiagnosis. Patients often find this very disappointing, particularly if the consequences of the diagnosis have had a significant impact on their lives and on those around them. These issues were central to a number of complaints the Commission has considered this year and the following case study demonstrates the difficult judgements, which sometimes have to be made by clinicians.

Mrs A

Mrs A was 45 years old and had been diagnosed as having a bi-polar affective disorder. When she was taking medication, most of the time she was able to continue her professional life as a teacher, with a private practice, and maintain an organised and satisfying social life; she was a known and respected member of her church and community. From time to time, when her illness recurred, she would become very disinhibited and disorganised and would reject her husband and family. She also refused to take her medication and it was necessary to detain her, in order to treat her. According to her family, when this was done, she quickly recovered and was able to pick up the pieces of her life.

On the most recent occasion when Mrs A became unwell, she was treated by a new consultant. She expressed to him very clearly, verbally and in writing, that she did not consider herself to be unwell and that she did not wish to take medication. Her consultant encouraged her to receive treatment but did not consider that there were grounds to detain her. Her family watched, in increasing distress, as her professional practice was lost and her social life disintegrated. She caused them continual worry and embarrassment by her actions, and her marriage crumbled.

After a period of about two years, matters came to a head, when Mrs A became very distressed by the actions of someone she had invited into her house. She was detained and, under medication, regained her former self. Mrs A’s parents and husband had already complained, to both the Trust and the Commission, they continued to be very distressed and angry that, as they saw it, through the failure to detain and treat Mrs A at an early stage, she had lost her career, her home and her marriage. As Mrs A became well again, she herself recognised, and very much regretted, the extent of her loss.

The Commission felt little would be gained by carrying out a formal investigation, since the circumstances were known and were not in dispute. Instead, a meeting was arranged between Mrs A, her parents (her husband declined to be involved) and the relevant clinicians. The meeting was facilitated by two Commissioners and focused on Mrs A’s wishes for her future care. As a result of the meeting, Mrs A was able to have inserted into her records a clear statement about how she wished to be treated, should she become unwell again. This statement will not bind a future clinician, who will still use his or her own professional judgement, but should be taken into account when considering what action to take. A year after this intervention by the Commission, this arrangement is reported to have had positive outcomes.

The Commission has also investigated complaints where the patient and/or their relatives believed that a decision to detain the patient for treatment had been inappropriate and damaging. In 2000-2001, none of these complaints was upheld; in one case, the complainant was advised of her right to have recorded, in her case-file, her objection to the diagnosis and treatment she had been given, and a statement saying how she wished to be treated in the future.

New Directions, the Report on the Review of the Mental Health (Scotland) Act 1984 (the Report of the Millan Committee) discusses in detail the issues surrounding advance statements, by which a person can plan for their future treatment. At present, there is considerable concern and confusion about the validity of these statements. The Millan Committee’s clarification of the present position, and recommendations for the future, are helpful.

Cardiovascular Effects of Neuroleptic Drugs

From time to time, the Commission’s enquiries result in recommendations which may be of general relevance to practitioners, as well as addressing the concerns of the complainant. One such case
involved the potential cardiovascular effects of neuroleptics.

Miss C

Miss C was 26 years old and had a learning disability, with a long history of difficult behaviour. She was admitted to hospital to assess her sleep pattern, to determine the presence or otherwise of any mental health problems, and to review her medication regime. Miss C had mild asthma and was very overweight, weighing about 25 stones on admission.

She was placed under constant nursing observation and received oral medication, to which she consented. The day after she was admitted, she fell asleep at about 14.15. At 15.50 the nurse who was observing her was unable to rouse her. Despite vigorous attempts to revive her, she was found to be dead, the cause of death being given as the combined effects of obesity, left ventricular hypertrophy and Chlorpromazine medication. A Fatal Accident Inquiry was not held.

Miss C’s mother, Mrs W, complained to the Trust that insufficient consideration had been given to the combined effects of Miss C’s obesity and her breathing difficulties, and the prescription of a combination of antipsychotic drugs. She also thought that, since Miss C’s breathing was very audible at all times, if she had been maintained under constant observations as stated, any change in her breathing pattern would have been noticed.

Mrs W’s request for an independent review was refused by the Trust and she asked the Commission to investigate Miss C’s medical and nursing notes were examined by medical and nursing Commissioners and an external opinion was sought from a senior psychopharmacologist. The Commission found that the nursing observations were adequate for the purpose recorded, which was “for the purpose of assessing her sleep pattern, to determine the presence or otherwise of any mental health problems and to review her medication regime” but not for closely monitoring and recording physical signs and symptoms related to potential cardiac dysfunction.

There was some difficulty in ascertaining precisely the total medication Miss C received but the psychopharmacologist concluded that “this very unfortunate sudden death could probably not have been anticipated, and the pharmacological strategies used were appropriate - though with the enormous benefit of hindsight it could be argued they might have been improved”. The Commission in its final report made the following recommendations:

1. that a tranquillisation policy for disturbed patients be put in place;
2. that the Kardex (drug prescription sheet) structure be revised to make more explicit the routes of administration of drugs;
3. that the attention of staff be drawn to the potential cardiovascular side-effects of neuroleptics.

2.9 ACCIDENT AND INCIDENTS REPORTED TO THE COMMISSION

Accidents and Incidents Reported by Health Services

During 2000-01, carrying out its duty under Section 3(2) of the Mental Health (Scotland) Act 1984, the Commission continued to receive reports of serious accidents and incidents from health services. The majority of the reports were made by consultants, with a few provided by service managers. In some cases, the Commission sought further information about incidents it had been made aware of through requests for discharge from detention, Social Circumstances Reports and the Visit Programme. The types of incidents on which the Commission wishes to receive reports were set out in the 1992-93 Annual Report, and are further described in the second part of this section.

Over the last year, the Commission received 74 reports of accidents and incidents involving patients, other than reports of suicides. The types of accidents or incidents are set out in Table 2.11.

Injuries Arising from Physical Restraint

Three cases were reported in which patients, who were being restrained, sustained injury. In two of these cases, the patients sustained fractures and, in the other, a dislocated elbow. One of these cases is the subject of a complaint, which is being reviewed by the Commission. One of the patients who was injured had a history of a previous fracture to his arm, arising from self-harming behaviour. The patient’s mental state was such, that it was likely that he might have to be restrained in the future, with a consequent risk of further injury. The Commission recommended that, while every effort should be
made to reduce the need to restrain the patient, staff should devise strategies to carry out restraint procedures while, at the same time, minimising the risk to his injured arm. It was suggested that the Trust’s trainers in techniques for the prevention of violence and aggression might be involved in the development of an appropriate plan of care.

Critical Incident Review

It is of note that, in past years, many of the incidents and accidents reported to the Commission share common characteristics. For example, many self-harm incidents involve patients gaining access to dangerous items, such as ligatures and lighters. Sexual incidents, involving vulnerable patients who have not been adequately supervised, and incidents related to deficiencies in the environment, such as inadequate window locks, have also featured. While the Commission appreciates that risk cannot be entirely eliminated from care, much can be learnt, if Trusts review the circumstances of incidents and ensure that the findings are effectively shared amongst all staff. Critical Incident Reviews are not new, but mental health services appear to vary widely in the way they carry out such reviews and the way they disseminate any lessons that have been learnt from them. The Mental Health R eference Group R eport, “R isk M anagement”, reiterates that all organisations providing mental health care should have a procedure in place to review critical incidents. The Report provides a template for carrying out reviews. It states that it is essential that any review should involve affected patients or carers, and involve advocacy services, if requested. The Commission supports the holding of Critical Incidents Reviews that are effective and seen by staff as a positive contribution to improving patient care.

Accidents and Incidents Reported by Local Authorities, Independent Providers and Voluntary Organisations

For many years, NHS authorities have been required to report accidents and incidents and sudden deaths to the Commission. There is, however, no similar requirement for local authorities, voluntary organisations or independent providers. Although the Commission has encouraged the reporting of serious incidents by these organisations, this has happened only rarely.

The Commission is aware that nursing and residential homes, supported accommodation and day-care facilities are required, by their supervising authorities, to report accidents and incidents affecting the users of these services, so that there can be appropriate monitoring and remedial action. Given the large number of people with mental disorder now resident in the community the Commission wishes to have the same information, about accidents, incidents and sudden deaths, for users of community services as it has for patients in hospital. Without this information, the Commission is hampered in exercising its protective functions, on behalf of people with mental disorder, and making any enquiry into cases where there may have been ill-treatment or deficiency in care or treatment, or where the property of a person with mental disorder may have been exposed to loss or damage. If the Commission is notified of incidents on a consistent basis, it can identify trends and circumstances posing particular risks for service users and those who help

---

**Table 2.11: Accidents and Incidents Reported to the Commission by Health Services, 1.4.2000 to 31.3.2001**

<table>
<thead>
<tr>
<th>Alleged assault</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>By other patient</td>
<td>2</td>
</tr>
<tr>
<td>By other patient (sexual)</td>
<td>4</td>
</tr>
<tr>
<td>By staff</td>
<td>3</td>
</tr>
<tr>
<td>On other patient</td>
<td>6</td>
</tr>
<tr>
<td>On other patient (sexual)</td>
<td>5</td>
</tr>
<tr>
<td>On Staff</td>
<td>8</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self harm</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutting</td>
<td>4</td>
</tr>
<tr>
<td>Overdose</td>
<td>6</td>
</tr>
<tr>
<td>Ligature</td>
<td>4</td>
</tr>
<tr>
<td>Fall</td>
<td>5</td>
</tr>
<tr>
<td>Burning</td>
<td>3</td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

| Accidental fall         |     |
| (resulting in serious injury) | 12  |
| Absconding (detained patient AWOL) | 4  |
| Restraint injury        | 2   |
| Involving equipment     | 2   |
| Death as a result of accident | 4  |
| **Total**               | **74** |

Critical Incident Review

It is of note that, in past years, many of the incidents and accidents reported to the Commission share common characteristics. For example, many self-harm incidents involve patients gaining access to dangerous items, such as ligatures and lighters. Sexual incidents, involving vulnerable patients who have not been adequately supervised, and incidents related to deficiencies in the environment, such as inadequate window locks, have also featured. While the Commission appreciates that risk cannot be entirely eliminated from care, much can be learnt, if Trusts review the circumstances of incidents and ensure that the findings are effectively shared amongst all staff. Critical Incident Reviews are not new, but mental health services appear to vary widely in the way they carry out such reviews and the way they disseminate any lessons that have been learnt from them. The Mental Health Reference Group Report, “Risk Management”, reiterates that all organisations providing mental health care should have a procedure in place to review critical incidents. The Report provides a template for carrying out reviews. It states that it is essential that any review should involve affected patients or carers, and involve advocacy services, if requested. The Commission supports the holding of Critical Incident Reviews that are effective and seen by staff as a positive contribution to improving patient care.

Accidents and Incidents Reported by Local Authorities, Independent Providers and Voluntary Organisations

For many years, NHS authorities have been required to report accidents and incidents and sudden deaths to the Commission. There is, however, no similar requirement for local authorities, voluntary organisations or independent providers. Although the Commission has encouraged the reporting of serious incidents by these organisations, this has happened only rarely.

The Commission is aware that nursing and residential homes, supported accommodation and day-care facilities are required, by their supervising authorities, to report accidents and incidents affecting the users of these services, so that there can be appropriate monitoring and remedial action. Given the large number of people with mental disorder now resident in the community the Commission wishes to have the same information, about accidents, incidents and sudden deaths, for users of community services as it has for patients in hospital. Without this information, the Commission is hampered in exercising its protective functions, on behalf of people with mental disorder, and making any enquiry into cases where there may have been ill-treatment or deficiency in care or treatment, or where the property of a person with mental disorder may have been exposed to loss or damage. If the Commission is notified of incidents on a consistent basis, it can identify trends and circumstances posing particular risks for service users and those who help
them. This information can then be used to help improve the quality and safety of services.

After consultation with the Association of Directors of Social Work, Community Care Providers Scotland and CoSLA, the Commission agreed that new guidelines for reporting accidents, incidents and sudden deaths, in community care settings, should be circulated. These guidelines apply to people with mental disorder, who use residential, day care or domiciliary services provided by Local Authorities, voluntary and private agencies; they were circulated in November 2000, to all Local Authorities and to community care providers throughout Scotland. Further copies can be obtained from the Commission.

The Guidelines

The Commission wishes to hear about serious incidents affecting people with mental disorder (including those with dementia or learning disability), which concern actual or alleged ill-treatment, deficiency in care and treatment, serious loss or damage to property or improper detention.

It is not possible to define serious incidents precisely, but the Commission has offered the following general guidelines. They include: any sudden or unexpected death, including suicide; incidents involving actual or intended physical or sexual assault; incidents of other ill-treatment or cruelty, neglect or abuse; incidents which may have involved improper detention or unlawful treatment; and incidents involving maladministration of service users’ funds or property.

The Commission thinks that any incident which has involved urgent medical attention, the involvement of the police or suspension of staff should be reported. The Commission also thinks that incidents which may be “near misses” may also be considered serious, because of their potential for causing significant harm.

How Should Serious Incidents be Reported?

To avoid unnecessary further work for reporting agencies, the Commission encourages them to make their reports in the format they already use for reports to their supervisory authorities. Reports should include the name, date of birth and address of the individual, a brief account of the incident and the action taken or planned.

Reports Made Following the Circulation of the Guidelines

During 2000-2001, the Commission received 11 reports of events involving people with mental disorder who used community services. Ten of these reports were made after the guidelines had been circulated, suggesting that they had some effect. However, the Commission thinks it likely that, given the large number of community services throughout Scotland, there were many more significant incidents which were not reported.

The 11 reports included four deaths, three from natural causes and one which may possibly have been a suicide. The Commission has made further inquiries in this case. In these four deaths, the reporting agencies had carried out appropriate reviews of the circumstances.

Three physical assaults were reported. Two were by users of learning disability services on other users; one was an assault by a member of staff. In all these cases, full inquiry reports were received. One included a detailed risk assessment on the perpetrator and a plan for managing her care. Another case had led, appropriately, to a review of the supervision arrangements for residents in supported accommodation.

Two other incidents were reported. One involved verbal abuse by a staff member, which led to his transfer to another establishment and to further training. The second case concerned an alleged rape of a woman with learning disabilities and very complex problems. The Commission has given advice on the care of this woman.

A near fire on a bus, transporting people with learning disabilities, was reported. This was a good example of a “near miss” report.

Overall, the Commission was pleased to see the thoroughness with which the enquiries had been made and the lessons which had been learnt from these incidents.

We recognise that, given the large numbers of bodies involved, complete and consistent reporting of serious incidents to the Commission is unlikely to be achieved. It is likely that more thorough and consistent reporting will be possible with the establishment of the Scottish Commission for the Regulation of Care. The Scottish Commission will
receive reports of accidents and incidents from all the providers it inspects and registers. We hope to establish a system with the Scottish Commission, whereby it selects significant events affecting people with mental disorder, for reporting to the Mental Welfare Commission. We are currently working with the Scottish Executive to establish a protocol for such reporting. When information is shared between the two Commissions, it will be possible for us to plan collaboratively to encourage the good practices that have been identified as necessary to prevent similar incidents in the future.

2.10 CONSENT TO DETENTION

Introduction

Emergency Detention, under Section 24 of the Mental Health (Scotland) Act 1984, is the most commonly used means of compulsorily admitting a person to hospital from the community. This year there were 2166 emergency admissions under Section 24, compared to 154 admissions from the community under Section 18. There were 2122 detentions, under Section 25, of people already in hospital on a voluntary basis and 2597 short-term detentions, under Section 26.

The purpose of emergency detention is to allow rapid admission to hospital, where delay in applying for a Section 18 would be detrimental to the health and safety of the patient or the safety of others. Obtaining consent to the detention from a relative or an MHO offers the patient a safeguard against inappropriate compulsion. Under the Mental Health (Scotland) Act 1984, consent to emergency detentions can be given by a relative or an MHO; consent to detention under Section 26 must be given by the nearest relative or an MHO. Section 53 of the Act defines relatives and nearest relatives. The Code of Practice to the Act advises that relatives should be told about the provision for the MHO to take responsibility for giving consent.

It is the duty of the MWC to enquire into any case where there may be improper detention; one way of meeting this responsibility is by closely monitoring the consent to all emergency and short-term detentions.

Emergency detention without consent

During 2000-01, the overall proportion of patients detained under Section 24, without consent, was similar to last year, as shown in Table 2.12. There was a slight increase in the number of patients detained under Section 25 without consent.

Figures 2.2 and 2.3 show the proportions of Section 24 and 25 going forward, without consent, for each mental health Trust. It can be seen that there is up to a twenty-fold variation between Trusts, which cannot be entirely explained by the geography of their catchment areas, which might be thought to influence the availability of relatives or MHOs.

Figures 2.4 and 2.5 show the proportions of Sections 24 and 25 going forward without consent in each Health Board area for this year, compared with those for each of the preceding three years. Compared with previous years, some Health Board areas have improved overall, in respect of Section 24 detentions; for example, the proportions without consent have decreased in Borders, Fife, Dumfries and Galloway, Grampian and Highland. In respect of Section 25 detentions, the picture is much less encouraging, with more going forward without consent, in a number of Health Board areas. In Ayrshire and Arran the proportion without consent has increased to over one quarter of all detentions under Section 25. This is the highest proportion of any area, over the last four years. Lanarkshire also

<table>
<thead>
<tr>
<th>Section of MH(SA)</th>
<th>Total Detentions</th>
<th>Detentions without Consent</th>
<th>Total Detentions</th>
<th>Detentions without Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 24</td>
<td>2123</td>
<td>301 (14.0)</td>
<td>2166</td>
<td>304 (14.0)</td>
</tr>
<tr>
<td>Section 25</td>
<td>2176</td>
<td>282 (13.0)</td>
<td>2122</td>
<td>315 (14.8)</td>
</tr>
<tr>
<td>Total</td>
<td>4299</td>
<td>583 (13.6)</td>
<td>4288</td>
<td>619 (14.4)</td>
</tr>
</tbody>
</table>

Table 2.12: Sections 24 and 25: Detentions without Consent
shows a significant increase, compared with previous years.

Though geographical factors may influence these figures, it seems very likely that variations in professional practice play a major part. In areas with high proportions of non-consent to emergency detention, the Commission hopes that social work and health services managers will examine clinical practice to identify the reasons for patients being detained without consent, and attempt to reduce their numbers.

The Commission examines the explanations given for lack of consent. These are shown in Figure 2.6. Where explanations include both risks of self-harm and absconding, the predominant factor has been counted.

It can be seen that, among emergency detentions going forward without consent, the majority did so because of an immediate risk of absconding, which might lead to significant harm. A significant proportion went ahead, without consent, because of the immediate risk of injury to the patient or others. Overall, in approximately two-thirds of emergency sections scrutinised, it is clear, from the explanation given by the medical practitioner, that it was impracticable to get consent, because of the risks that a delay would have caused.
Figure 2.4: Percentage of Section 24 Recommendations Signed Without Consent of Relative or MHO, by Health Board Area: 2000/2001 Compared With Three Previous Years

Figure 2.5: Percentage of Section 25 Recommendations Signed Without Consent of Relative or MHO, by Health Board Area: 2000/2001 Compared With Three Previous Years

Figure 2.6: Explanations for Non-Consent for Section 24 & 25 Detentions
The Commission makes enquiries where the explanation does not satisfactorily establish why obtaining consent was impracticable. In a small minority of cases scrutinised (12% of detentions without consent, 1% of all emergency detentions), it appeared that General Practitioners were not clear about their responsibilities under the Mental Health Act. The unavailability of an MHO was stated as the reason for non-consent, in a further 12% of cases. This included cases where, because of demand on the service, the MHO on duty could not attend and also cases in which there appeared to have been a breakdown in communication. Local managers of MHO services need to keep practice under review.

Emergency Detentions with Consent of Relatives

In the period of the report, of 2166 detentions under Section 24, 637 (29.4%) had consent given by a relative and, of 2122 detentions under Section 25, 284 (13.4%), had consent given by relatives. Though the Code of Practice expects that relatives will be informed that an MHO can give consent, it is not known whether this has happened in these cases. Occasionally MHOs bring to the Commission's attention situations in which a relative felt unhappy about giving consent, or did not realise that his or her name would be recorded on the form as giving consent. The Commission follows this up with the practitioners concerned.

Consent for Short-Term Detentions

During 2000-01, the vast majority of Section 26 detentions had MHO consent: that is 2423 detentions out of a total of 2600 (93.2%). There were 165 cases where relatives gave consent to short-term detentions, that is 6.3%. It is not known whether these relatives were advised of the MHO role in giving consent; the time scale allows for MHO involvement. It is hoped this figure will be reduced in the coming year. Of the 2600 detentions under Section 26, only 12 (0.5%) did not have consent from either the MHO or the nearest relative. In three of these 12 cases, the patient absconded before the assessment for consent had been undertaken. However, if the MHO had been involved in the emergency detention, or previously knew the patient, and was fully aware of professional and family opinion, he or she might have considered consenting in the patient's absence. This is fortunately a rare occurrence. Most of other cases of non-consent resulted from breakdowns in communication or planning arrangements.

2.11 CHANGING PROCEDURE FOR REVIEW OF DETENTION AND GUARDIANSHIP IN ACCORDANCE WITH THE HUMAN RIGHTS ACT 1998

The Commission is in the process of improving its procedure for reviewing detention and Guardianship, to give the patient a strengthened role in the process.

When the Human Rights Act 1998 came into force on 2 October 2000, it required the Mental Welfare Commission, as a public body, to exercise its powers in a way that is compatible with the rights and freedoms set out in the European Convention on Human Rights (ECHR). From that date, actions of the Commission could be challengeable in the courts on Convention grounds. This was helpful in stimulating the Commission to review its practices in relation to review of detention and Guardianship.

The procedure to date is that a medically-qualified Commission representative goes to interview the patient who is requesting discharge from detention, and also interviews nursing staff and any other relevant professionals and carers, and also consults the case records. Because the Responsible Medical Officer is often unavailable at the time of visits, information from him or her is usually obtained via a subsequent telephone call. A meeting of the Commission, at which at least five Commissioners, including one Medical Commissioner, is present, then considers a report based on the information gathered by the Commission doctor. The patient and the Responsible Medical Officer are then sent a brief letter to inform them of the Commission's decision.

While this approach is simple, relatively user-friendly and cost-free to the patient, it is open to a number of criticisms. They include: the patient not being aware of the information given to the Commission and therefore not in a position to challenge it; the patient's own views being channelled via the Commission's medical representative; the Responsible Medical Officer being approached on the telephone, perhaps when not best prepared to discuss reasons for the ongoing detention; the Commission's letter back to the
patient giving a decision, but not the grounds on which that decision was based.

In the last year, the Commission set up a Working Group to address the issue, convened by the Director. It quickly identified the articles of the European Convention which had the greatest implications for the Commission’s work. These were Article 5 (right to liberty and security of the person), Article 6 (the right to a fair and public trial within a reasonable time, which also deals with some civil procedure) and Article 8 (the right to respect for private and family life, home and correspondence). Reviews of detention and Guardianship were the areas thought most likely to be affected, though a number of other areas were relevant, including the Commission’s work in investigating complaints.

Legal advice was sought via the Scottish Executive, on how best to meet the requirements of the Act, and the Working Group also sought information from other relevant agencies about how they were dealing with these issues.

The Working Group decided to take a measured approach in relation to ECHR. Few of the Convention Articles are absolute. In relation to most of them, the rights given to individuals are balanced against other needs, such as a need to promote health and safety and to protect the rights of others. In addition, interpretation of the Articles of the Convention is very much dependent on case law, which is developing over time. In many respects, the Commission is also constrained by existing UK statute, principally the Mental Health (Scotland) Act 1984. Legal advice supported the Commission’s view that, in terms of Article 6 of the Convention, the Commission is not a tribunal and therefore does not have to meet all the requirements of a tribunal. Patients seeking review of detention, who wish to have a procedure that fully meets Convention requirements, have the choice of appeal to the Sheriff.

The Working Group produced proposals for change in relation to review of long-term detention, Guardianship and Community Care Orders. The central concern was to strengthen the role of the patient in the process. This involved ensuring that the patient was aware of the legal grounds for his or her detention and could make representations in writing about it to the Commission. In addition, we wished to ensure that the patient shared as much as possible of the information upon which the Commission bases its decision and had an opportunity to challenge that information. It was also important that the patient should get appropriate feedback about the Commission’s decision.

Ideally, we believed that the patient ought to be able to make personal representations to the Commission meeting at which his or her detention, etc. was considered. However, it was not thought practicable for patients to be brought from all over Scotland to the Commission’s offices, when they might be acutely ill and need nurse escorts. Neither was it practicable, without a huge increase in resources, for the Commission to go out across Scotland, to where patients live, in order to hold its quorate meetings.

A practicable way of proceeding was suggested, as follows. Patients requesting that the Commission use its power of discharge would have the grounds for detention explained in written form and would be invited, should they wish, to make a personal written statement (with appropriate help, if necessary), in addition to having a face-to-face interview with a Commission doctor. For review of Guardianship and Community Care Orders, the Commission would send a social worker, together with a doctor, unless the patient had previously been visited by a Commission doctor. Patients would also be informed that, when seen by the Commission representative, they could have a friend or supporter or a person from an advocacy service with them, if they would find this helpful.

The Commission would request written reports from Responsible Medical Officers (RMOs) and Mental Health Officers (MHOs), and these would be made available to the patient prior to the Commission’s interview with the patient, preferably being given to him or her by the writer. This would give the patient access to information before meeting the Commission representative and allow him or her an opportunity to challenge it. Arguably, it would also improve the quality of medical and social work information available to the Commission, in relation to the patient’s continuing detention. In order to make the provision of information easier and more reliable, forms with appropriate headings would be sent out to the
patient, MHO and RMO, to be completed either in writing or in type, and returned within two weeks. This timescale was chosen so that the patient would not experience undue delay in having his or her case considered.

Following the Commission's decision, a letter would be issued to the patient explaining the decision in terms of grounds for detention. Letters would therefore refer to: the existence and type of mental disorder; whether the disorder was of a nature or degree to warrant treatment in a hospital; the likelihood of treatment benefiting the disorder or preventing deterioration, where relevant; and whether treatment was necessary in the interests of the health or safety of the person and/or for the protection of others and whether treatment could not be provided without compulsion.

The timescale for review of short-term detention (Section 26) was considered too short to seek written reports from the RMO and MHO. However, in reviews of Section 26, the patient would still be invited to give a written statement of his or her own views and letters relating the Commission's decision would be as described above.

The Commission approved the above proposals and decided that it would be helpful to do pilot studies in two areas of Scotland, in respect of long-term detention and Guardianship. We are grateful to NHS and Local Authority managers and staff in Edinburgh and Glasgow for agreeing to the Commission's pilot study, which is underway at the time of writing. After lessons have been learnt from this, a new procedure is likely to be rolled out across Scotland.

We believe that the proposed new procedures will strengthen the human rights of patients subject to compulsion. We recognise that this might involve some extra work for hard-pressed practitioners, but it is necessary to view this in proportion. At present the Commission reviews about 230 Section 18 detentions annually, so the extra workload on any individual RMO or MHO would not be large. The new procedures would also give RMOs and MHOs the chance to put forward a well-considered justification for the patient's current compulsory measure and any other relevant issues.

The Millan Committee Report (New Directions, Chapter 23) welcomed the proposed reforms. It recommended that the Commission in future should retain its power to review detention and discharge from it, but that, subject to successful development of mental health tribunals, the Commission could use its power to review detention in a more selective and targeted fashion. The Commission is happy with this proposal.
3.1 THE USE OF GUARDIANSHIP: A CASE STUDY FROM A COMMISSION INQUIRY

The Commission visits many people with dementia subject to Guardianship, seeing nearly 100 with new Guardianships in 2000-2001. The care of people with dementia presents many challenges. Although there is a variable quality of services throughout Scotland, there is growing understanding of the components of good dementia care and increasing optimism about the possibility of providing services which will preserve people’s autonomy and a good quality of life. Scotland is fortunate in having the Dementia Services Development Centre at Stirling University, to assist in the development of good practice and research.

The Contribution of Guardianship

When arranging care, those responsible for people with dementia have to make difficult judgements about how to safeguard both physical and mental welfare. Risk to physical safety may seem the more pressing and, in such cases, arrangements are often made for the person with dementia to move immediately into a care home. When the individual resists this he or she may be admitted under Guardianship. In these circumstances, the Commission strongly supports such applications because they ensure that a Sheriff Court scrutinises the grounds for Guardianship, the powers of which, if granted, can be monitored by the Mental Welfare Commission. Elsewhere in this report (Section 2.6), we have argued that Guardianship should be used more consistently throughout Scotland. It is, however, important that full consideration is given to the different powers of Guardianship: residence, access and attendance. The Commission is aware of some cases where the power of residence has been used to effect a move to a care home, little thought having been given to the other powers, which could have been used to ensure that people received the services and supervision at home, which they needed but had resisted. Using these powers of Guardianship, may prevent or delay admission to a care home. They allow care workers to be in regular contact with the individual, so that risks can be continuously assessed and speedy admission to a protective environment arranged, if necessary. Full attention can be given to both physical and emotional welfare.

The Commission knows of some carefully planned home-care packages received under Guardianship; they include domiciliary help, at those times of the day and night when people have particular needs. These care arrangements can also include attendance at day centres and recreational resources and, for people with learning disability, educational and employment centres. Such care allows many people with mental disorder to remain in their own communities, if they wish to do so. It can also give them more varied experiences and opportunities than many care homes can offer.

From April 2001, the Adults with Incapacity Act will require all interventions under that Act, including Guardianship, to benefit the adult, to be the least restrictive intervention consistent with that person’s welfare and to take account of the adult’s wishes. The Commission hopes that the findings of a recent Inquiry into the case of a person on Guardianship will encourage it to be used in a more imaginative and flexible way which takes full account of the principles of the new Act.

The Commission’s Inquiry

In September 2000, the Commission visited a woman on Guardianship, who had recently been moved to a residential home. She was very upset and angry about what had happened to her, and asked for her Guardianship to be reviewed. Although the Commission decided that Guardianship was appropriate, it was concerned that the power of residence may have been used prematurely. It, therefore, decided to carry out an Inquiry into her care.

Mrs K’s Background and Needs

Mrs K, aged 89, is a widow with no children. Described as a “home body and loner”, she lived for over 40 years in a local authority flat, surrounded by treasured possessions, collected over many years. Her home was said to be “her pride and joy and her whole life”. She had worked outside the home throughout her adult life. Mrs K is a fiercely independent and ebullient woman with clear and
firm views; she is greatly liked by all who work with her.

In December 1999, Mrs K’s general practitioner and health visitor thought it might be difficult for her to care for herself adequately, because of some memory loss. She was quickly assessed by a consultant in old-age psychiatry, who diagnosed moderately severe dementia of vascular aetiology. Mrs K’s nephew and his wife, who had been giving her some regular help, confirmed that she was forgetful and that they had assumed some responsibility for shopping and household management. There had been instances of burnt pans setting off smoke detectors. Because of poor mobility, she had some difficulty in climbing the steep stone stairs to her flat. The Social Work Department carried out a community care assessment, as a result of which it was agreed that Mrs K should be supported at home. Overall, Mrs K was thought to care for herself and her home quite well, and could be adequately supported by domiciliary services. These consisted of home-helps, initially for three hours weekly, later for five. However, Mrs K had difficulty accepting this arrangement; she turned the home-helps away initially and, even after allowing access, was reluctant to let them do much for her. She was also visited regularly by a health visitor and community psychiatric nurse.

Around this time, there were reports that Mrs K was letting undesirable strangers into her house, that she locked herself in, and out, and had to be rescued by neighbours, and that she had been burgled. On occasions she was also reported to have left her house wearing slippers, and without a coat. Although she never became completely lost, she was sometimes said to have been helped home by neighbours. There was evidence that she was more forgetful, although she still cared for herself and her flat reasonably well.

Mrs K’s Guardianship and Residential Placement

In June 1999, following a further psychiatric assessment, the risks to Mrs K were discussed at a case conference. It was unanimously decided to apply for Guardianship, so that she could be moved immediately into residential care. The application was granted. Mrs K refused legal representation and did not attend Court; no Curator ad Litem was appointed. Three weeks later, she was placed in a residential home. Alternative placements were not explored because there was a shortage of vacancies and it was believed that she should go into residential care quickly. The tenancy of her flat was given up on her behalf, twelve weeks later.

When Mrs K was visited by Commission representatives, she was very unhappy about her new environment. She had shared a room for several weeks, but now had a small single room with a commode. She was very concerned about the whereabouts of her possessions and had few personal items with her. She left her home with very little and had only a small amount of money. She regarded herself, correctly, as much more able physically and mentally than most of the other residents, with whom she thought she had little in common. Mrs K denied there had been any problems in her caring for herself. She was very angry about her Guardianship and wished it to be reviewed. She said she had been given no alternative but to go into residential care, because she did not like to have help at home. She said she had never been told that, because she was on Guardianship, she could be required to accept this help; although she would not have liked this, compared to life in residential care, “it would have been brilliant”. Although she knew her tenancy had been given up, she still wished to live independently.

The Commission’s Findings and Recommendations

The Commission found that, in some respects, Mrs K had received a good standard of care. Health and social care professionals had visited her regularly, probably at least once a week. She had had thorough psychiatric assessments. All professionals had been very concerned about her welfare and anxious to protect her. There were, however, major flaws in making decisions about her care and the arrangements to implement these decisions.

(i) Risk Assessment

Although Mrs K was undoubtedly exposed to some risks, the extent of these, and their management, were never thoroughly and systematically reviewed and documented. For example, there was no attempt to identify the undesirable people coming into her flat, or to deter them. It was not known how often she had locked herself in, or out, of her flat and there
was no exploration of whether alternative locks, or safeguarding her keys, could have reduced these problems. There was a lack of clarity about the circumstances of the burglary and no follow-up with the police by the Social Work Department. There was no exploration of whether the neighbours who helped her climb the stairs could continue to do so; and there was no contemporary occupational therapy assessment of what adaptations might have made her house safer.

(ii) Consideration of Alternatives to Residential Care

At the case conference which concluded there should be an application for Guardianship, no sustained consideration was given to alternatives to residential care such as a more extensive care package or a ground floor tenancy or sheltered housing. Residential care was seen as the only viable option, though most of those who knew her appreciated that such a move would be very upsetting.

The conclusion of the case conference, that there was no alternative to residential care, seems to have been influenced by Mrs K’s denial of problems and her persistent refusals of help. Unfortunately, there was no discussion at the case conference, or on any other occasion, of using Guardianship’s powers of access, to insist that she receive more help at home; Mrs K was never confronted with the reality that she could only avoid residential care, at least for a while, if Guardianship was used to provide help, in her own home or a more suitable tenancy. Five of the eight people at the case conference, including the Mental Health Officer, had some knowledge of the powers of Guardianship. However, Mrs K’s care-manager was unaware of them and the Mental Health Officer did not offer guidance about the powers of access or attendance. He had not visited Mrs K prior to the case conference and so it did not have the benefit of his independent assessment.

Some of those working with Mrs K told the inquiry team that they thought that compelling her to accept help in her home would be inappropriately authoritarian, and her refusal of help was therefore accepted. Although Mrs K might have found the alternatives to residential care intrusive, residential care was a much more serious intervention. It was one which she strenuously opposed and which would radically, and probably permanently, change her life.

(iii) Application for Guardianship and Mrs K’s Move into Residential Care

Although she was strongly opposed to Guardianship, Mrs K refused legal representation. The MHO did not ask the Sheriff to consider appointing a Curator ad Litem. After the Guardianship order was granted, moving Mrs K quickly into residential care was seen as a priority. The Guardianship power of access could have been used to ensure she received homecare, while a suitable home was sought for her. In the event, because the situation was perceived as urgent, a vacancy was secured in a home which has many limitations, although Mrs K has expressed positive views about its staff. It has no garden, limited activities, rather drab surroundings, and, on occasions, a bad smell; these are matters which are being addressed by the Registration and Inspection Authority and the home’s owners. Attempts were made to find a more congenial environment for Mrs K but, after about ten weeks in the home, she was reluctant to move again, particularly since she would have had to share a room once more.

Following intervention by the Commission, some of Mrs K’s property was restored to her, to her great pleasure, and arrangements were also made for her to receive her personal allowance regularly and to have a few more outings. She had become estranged from relatives because of her hostility to them following Guardianship; it was hoped that they would resume visiting her. Their efforts to help Mrs K had been appreciated by the Social Work Department, but they had been offered no explicit help in understanding the emotional effects that Mrs K’s move to residential care might have on her.

(iv) Outcomes for Mrs K

At the time of the Inquiry, Mrs K was judged to have benefited physically from the nutrition and personal care she had received in the home. However, she had become less mobile, probably through lack of exercise. She appeared to need more stimulation and outings, a larger room, in which she could have more of her property, and renewed contact with her relatives. Though Mrs K was distressed for some months after her move, those who were with her regularly said that eventually she complained little about the home or Guardianship. However, up to 12 months after entering the home, these complaints were much in evidence when Mrs K had outside visitors.
Recommendations

The Commission recommended that there should be a full review of Mrs K’s care and efforts made to provide a better quality of life for her.

Its other recommendations are relevant for all Trusts and Local Authorities:

i. In the assessment of risk, careful attention must be paid to the evidence for each risk, with written records of significant incidents and responses to them.

ii. Decisions about statutory intervention must take account of this evidence-based risk assessment, and ways of managing each risk should be examined. Care plans for people with mental disorder must take account of a Mental Health Officer’s assessment.

iii. Managers should encourage health and social workers to use their statutory authority positively, to promote the welfare of individuals, when it is appropriate to do so. Account should be taken of whether such approaches might reduce the need for more disruptive interventions. There should be training in the powers of Guardianship under the 1984 Mental Health (Scotland) Act, and those allowed by the provisions of the Adults with Incapacity Act 2000.

iv. Trusts and Local Authorities should ensure that advocacy services are available for people with dementia. Serious consideration should be given to requesting the Court to appoint Curators ad Litem for such people, if they oppose application for Guardianship, but do not have legal or personal representation at the hearing.

v. Care Managers, Guardians and the staff of care homes should ensure that residents have access to their personal possessions and allowances. Those who plan and manage the care of people, who enter a care home, should endeavour to establish a quality of life which, at least, equals that which they have experienced in their own homes.

3.2 PLACES OF SAFETY

People with mental disorder sometimes come to attention by creating a disturbance in public places. The police may be involved in such circumstances and Section 118 of Mental Health (Scotland) Act 1984 allows them to remove the person to a place of safety, either in his or her interests or for the protection of others. The person can be detained in a place of safety for up to 72 hours, to allow a medical assessment to take place and arrangements for treatment or care to be made.

Section 117 of the Act defines “Place of Safety” as a hospital or a residential home for people with mental disorder, or any other suitable place. It does not include a police station unless it is such an emergency situation that no other suitable place is available. Unfortunately, local police and mental health services do not always have an agreed place of safety, and places of safety are not always suitably staffed and equipped.

One summer afternoon last year, a patient was violent and threatening to staff of an Edinburgh health facility. An emergency call was made to the police, who attended and tried to calm him down. This was unsuccessful, and the man appeared to the police to be suffering from a mental disorder. He was handcuffed and taken in the back of a police van to the Accident and Emergency Department at the Royal Infirmary. The facilities at the Royal Infirmary were considered inadequate to cope with his disturbed behaviour, so he was kept in the back of the police van outside the Department.

He was assessed by a psychiatric Specialist Registrar, who had to interview him through the bars of the cage in the back of the police van. He was thought to have a psychiatric illness and to need admission to an intensive psychiatric care unit (IPCU) bed. He was made liable to detention under Section 24 of the Mental Health Act and given tranquillisers. Efforts were made to obtain an IPCU bed for him at the Royal Edinburgh Hospital, but there was none available. The psychiatrist then spent two hours trying to locate a bed in an IPCU and, eventually, one was found at Falkirk.

The issue then became one of finding a psychiatrically-trained nurse to escort the patient to Falkirk. The Royal Edinburgh Hospital was not able to provide a nurse-escort, and neither was the Royal...
Infirmary, which also questioned the appropriateness of it providing an escort, as the patient had not been admitted there. Eventually, an off-duty Sister from the Accident and Emergency Department volunteered to accompany the patient and he was taken to Falkirk by ambulance, with police assistance. Whilst the arrangements for his care were being discussed, the police, out of humane concern, had taken the patient to a police station where he could obtain food and sanitation. He had been in the police van for a total of four hours, kept in a space in which he was not able to stand up.

The Commission raised a number of concerns with Lothian Primary Care NHS Trust and Lothian University Hospitals NHS Trust. The “place of safety” in this case had been a secure cage in the back of a police van, followed by a police station. No appropriate nurse escort had been available to assist the transport of the patient to an IPCU bed in Falkirk, and no IPCU bed had been available in Lothian. The Commission also wrote to Lothian Health Board, expressing its concern that the two Trusts’ lack of agreement over provision of a place of safety in Edinburgh was a long-standing issue, that did not appear to have been resolved.

Both Trusts accepted that what had happened was far from satisfactory. A Working Group was set up to produce guidelines for a place of safety in Edinburgh. The outcome to date is a proposal to identify two places of safety: one at the Royal Edinburgh Hospital, for those whom the police consider to be suffering from a mental disorder likely to require admission to hospital; and another at the Accident and Emergency Department in the Royal Infirmary, for mentally disturbed patients who require medical attention, such as those who have deliberately harmed themselves, those thought to be physically ill and those who are intoxicated. This arrangement has been agreed by the police in principle. If it is agreed by the ambulance service, it will be put in place for a trial period of a year.

The Commission describes this illustrative case to emphasise the importance of relevant agencies, including NHS, police and ambulance service, having agreed local protocols about the use of places of safety. These should address the location of a place of safety and its requirements, in terms of staff and facilities.

3.3 EARLY RESPONSE TO RECURRENT SEVERE MENTAL ILLNESS

Over the past year, the Commission has heard from relatives and carers who expressed concern about the arrangements for readmitting individuals to hospital, when their severe mental illness had recurred. These individuals had experienced many previous periods of in-patient treatment, almost invariably involving detention under the Mental Health (Scotland) Act 1984, because of the level of risk they posed, their limited insight into their illness and their inability to accept that they needed treatment. Following treatment, they improved, recovered their insight and returned to their families and normal ways of life. However, as their illnesses recurred, they gradually lost their insight and became increasingly opposed to treatment. These carers felt that they knew these people well, and from previous experience, recognised the signs that they were becoming ill again. However, they encountered difficulties in obtaining a prompt and appropriate response from their local mental health services. They felt that their concerns were not acted on, and, as a result, they and the patients were subjected to unnecessary suffering and risk. When the patients finally came into hospital, it was as the result of a crisis in the community, involving police intervention and emergency detention under Section 24 of the Act.

When the Commission made enquiries into these cases, it appeared that a variety of factors might have played a part in delaying admission. The patients were not willing to accept hospital treatment on a voluntary basis and psychiatrists did not appear to have sought compulsory admission early in the relapse; admission did not occur until the patient became so disturbed that he or she required emergency detention. Carers reported that they had difficulties communicating their concerns to the mental health teams dealing with the patients’ care. In addition, carers who were also the nearest relatives under the Mental Health Act did not appear to be aware that, under Section 19 (3) of the Act, they could require the Local Authority to arrange an assessment by a Mental Health Officer, to decide whether an application for compulsory admission should be made.

The right of the nearest relative under Section 19 of the Act is discussed in Section 2.7 of this Report. The other aspects of these cases are discussed below.

Application for Detention under Section 18

Section 82 of the Notes on the Act clearly indicates that detention under Section 18 is intended to be the normal route into compulsory treatment, with admission to hospital under Section 24 being reserved only for emergency situations. However, in practice, the great majority of admissions in Scotland are via the emergency procedure, as discussed in last year’s Annual Report. For example, in 2000-01, of 2320 compulsory admissions to hospital from the community, only 154 (6.6%) were under Section 18, compared with 2166 under Section 24. The possible reasons for this were discussed in last year’s Annual Report. Practitioners were reminded that, where a patient is to be admitted compulsorily from the community, due consideration should be given to the possibility of using the Section 18 procedure, with emergency procedures only being used where there is a genuine emergency.

In addition to the safety grounds, the criteria for compulsory admission, as defined in Section 17(1)(b) of the Act, include the provision that treatment is necessary for the health of the patient. In the Annual Report of 1994-95, the Commission gave its view that this does not mean that there must be an immediate threat to life or limb, but that severity of symptoms or severity of distress may be sufficient to justify admission, especially if the alternative is likely to be a worsening of an already distressing situation, and effective treatment or care is available in hospital. For a patient whose illness has recurred, early intervention with compulsory admission under Section 18 may be appropriate, providing that there is sufficient evidence to predict that his or her health would seriously deteriorate without hospital treatment, and the other provisions of Section 17 are met.

Communication with Families and Carers

As discussed in Section 2.7 of last year’s Annual Report, the issue of communication with carers and families is an element in numerous complaints to the Commission. We recognise that it is often difficult for mental health staff to evaluate information given by the carers or families of patients who are becoming ill, because carers do not usually have mental health training and their interpretation of the patient’s behaviour can be influenced by a variety of factors. In addition, in deciding whether to take action, staff have to balance the carer’s concerns against the patient’s rights and the need to maintain a working relationship with him or her.

However, in all but exceptional cases, the Commission takes the view that assessment and treatment should include careful consideration of information from carers and families. Compared with doctors, nurses and other professionals, they are often in a far stronger position to assess deterioration in the patient’s mental state, especially when they have witnessed the onset of previous episodes of illness.

Safety First, the five-year report of the National Confidential Enquiry into Suicide and Homicide by Patients with Mental Illness (2000), lists prompt access to services for people in crisis and their families, as one of its 12 recommendations for ensuring safer mental health services. Listening to carers is an important theme in the mental health standards published by the Scottish Health Advisory Service in 1999, and was described by the Royal College of Psychiatrists, in its document Good Psychiatric Practice (2000), as being one of the elements of good clinical care. The Millan Committee, in its proposals for a new Mental Health Act, has also emphasised the role of carers in the care of people with mental illness.

Among patients with severe mental illness, who have had repeated admissions to hospital, it is the Commission’s view that plans for dealing with possible relapse or other crises should be made before the patient is discharged from hospital. These plans should be clearly agreed between the patient, mental health professionals and the General Practitioner, and carers and families should be as closely involved as possible with their formulation. The Clinical Standards Board for Scotland published clinical standards for the care of people with schizophrenia in January 2001. Clinical Standard 6 advises that discharge plans should include the procedures to be followed in the event of a crisis or emergency, and that carers should be actively involved with planning and reviewing care arrangements. In the Commission’s view, these principles are equally applicable to other severe mental illnesses, such as mania.
One of the advantages of preparing such plans at the
time of discharge, when the patient is well, is that he
or she is not only able to contribute to them, but can
help resolve issues of confidentiality. At this point,
with the patient’s informed consent, carers can often
be given information which will help them respond
appropriately to future crises.

3.4 RESTRICTION OF PATIENTS’
ACCESS TO MOBILE
TELEPHONES

During the year, hospital staff have asked the
Commission for guidance on restricting patients’
access to mobile telephones. The queries have
largely been about situations in which patients,
whose judgement is impaired, are putting
themselves at risk by making inappropriate calls, or
running up large bills from excessive use. Situations
in which other patients pressurised the owner of the
mobile phone for its inappropriate use, have also
been reported. Concerns have been expressed about
inappropriate text messaging, as well as
voice communication.

The Commission commented on the restriction of
patients’ access to telephones in its 1998/99 Annual
Report. In summary, the guidance started from the
position that people have a right to communicate
with others, even when detained in hospital, and this
should be subject to the minimum interference and
only with good reason. However, people are
admitted to hospital, and may be detained there,
because they are mentally disturbed. Their mental
disorder may make them temporarily disinhibited
and irresponsible and they might harm themselves
or other people through inappropriate use of the
phone, while their judgement is impaired. The
Commission has been given examples of calls
causing undue distress to others, or being used to
arrange for harmful substances to be brought into
hospital, to enlist help in absconding or to
repeatedly dial 999, for no good reason.

The Commission believes that there can be
circumstances when it may be necessary to supervise
or restrict a patient’s access to a telephone. Any such
restriction must be applied on a case by case basis,
avoiding, if possible, “blanket” policies that would
unnecessarily inhibit any patient’s communication.
The Commission is aware that some forensic
services do have a “blanket” ban on access by

patients to mobile phones in in-patient settings. Any
such policies should be clearly set out for patients
and staff, and the Trusts concerned may wish to seek
legal advice on the operation of such policies.

Although the Commission’s guidance was written
with fixed land-line telephones in mind, it can apply
equally to the use of mobile telephones. However,
mobile telephones introduce some other elements
that need to be considered. Mobile telephones, by
their very nature, can be used anywhere and do
present staff with difficulties in monitoring their use
by patients considered to be at risk. Also, the mobile
telephone is likely to be the patient’s own
possession, which raises issues about removing the
patient’s property.

The Commission believes that any decision to
restrict a patient’s access to a mobile phone should
be taken by the clinical team, only where there is a
clear necessity to do so and it is clearly in the
patient’s best interests. Any decisions should be
mindful of the Commission’s previous guidance on
restricting access to telephones. The reasons for such
decisions should be clearly recorded and subject to
frequent review. In addition, there should be clear
local policies for staff in dealing with such situations.

It should also be noted that some Trusts have blanket
bans on the use of mobile telephones in hospital,
because of concerns about interference with
sensitive medical equipment. The Scottish Executive
provides guidance on this in NHS HDL (2001), issued
on 13 March 2001, and refers to Safety Action
Notice SAN (SC)97/26, which gives advice on
safety issues related to the use of mobile phones
in hospitals.

The Millan Committee’s review of the Mental
Health (Scotland) Act 1984, makes reference to the
situation in high-security hospitals, such as the State
Hospital, and also makes the recommendation that
any restriction of access to telephones should be
regulated by statute, on a broadly similar basis to
written communications.

It should be remembered that restriction of access
to telephones applies to a very small proportion of
patients in hospitals. In general, the emphasis for staff
should be on ensuring that patients do have easy
access to working telephones and have adequate
funds to maintain contact with friends and relatives.
4.1 REPORT OF THE MILLAN COMMITTEE ON THE REVIEW OF THE MENTAL HEALTH (SCOTLAND) ACT 1984

Introduction

When the Millan Committee was set up in 1999, mental health legislation in Scotland had not been fundamentally reviewed since the discussion which preceded the 1960 Mental Health Act. The Committee had the remit of carrying out such a review. Under the Chairmanship of Bruce Millan, the Committee included members from legal, health and social service backgrounds, and the user and carer movements. It met over a two-year period, during which it carried out extensive consultation with professionals, patients and carers. It also studied practice elsewhere in the UK and commissioned research to clarify issues on which there was insufficient existing information.

When New Directions, the Report of the Committee, was published at the beginning of 2001, it attempted, for the first time in Scottish mental health legislation, to separate the notion of compulsory treatment from that of detention in hospital. The Committee had the remit of carrying out such a review. Under the Chairmanship of Bruce Millan, the Committee included members from legal, health and social service backgrounds, and the user and carer movements. It met over a two-year period, during which it carried out extensive consultation with professionals, patients and carers. It also studied practice elsewhere in the UK and commissioned research to clarify issues on which there was insufficient existing information.

When New Directions, the Report of the Committee, was published at the beginning of 2001, it attempted, for the first time in Scottish mental health legislation, to separate the notion of compulsory treatment from that of detention in hospital. The Committee had the remit of carrying out such a review. Under the Chairmanship of Bruce Millan, the Committee included members from legal, health and social service backgrounds, and the user and carer movements. It met over a two-year period, during which it carried out extensive consultation with professionals, patients and carers. It also studied practice elsewhere in the UK and commissioned research to clarify issues on which there was insufficient existing information.

The Committee recommended that the Mental Health (Public Safety and Appeals) Act 1999 (the "Ruddle" Act) should be repealed and that, in time, there should be an integration of the Mental Health Act with other legislation relating to mentally-disordered offenders and adults with incapacity.

Following the publication of the Report, the Scottish Executive has been carrying out a consultation exercise, to which the Mental Welfare Commission has contributed. In the autumn of 2001, this is expected to lead to the publication of the Executive’s proposals for new legislation and, in 2002, the publication of a Mental Health Bill.

The Commission’s Response

The Commission greatly welcomed the Report, particularly the clear articulation of the principles on which the Act should be used. The Commission’s general views on those proposals which relate to the Commission’s roles and duties are described in the Director’s Report in Section 1.2. We think it is appropriate that, as recommended by the Millan Committee, the Commission should be the Guardian of these principles; if adopted, this recommendation would support the Commission’s role in protecting the human rights of people with mental disorder. In general, the Report’s recommendations strengthen the voices of patients and carers, and the Commission hopes this will help them to be heard more clearly by providers and commissioners of mental health services.
Grounds for Compulsion

Though the Commission broadly agrees with the Committee’s recommended grounds for compulsory treatment, we have some concern about its proposal to include lack of judgement as an indication of impaired capacity. We agree that the individual’s mental capacity to make his or her own treatment decisions should be taken into account when deciding whether he or she requires compulsory measures. However, adopting ‘lack of judgement’ as a criterion of impaired capacity has drawbacks. It is a wide concept, which could be interpreted to include, not only impaired mental capacity, but views of life which are merely eccentric or unusual. We think a more restricted criterion such as ‘impaired decision-making ability’ would be preferable. This would include individuals with significant thinking difficulties, but exclude those whose decisions might seem inappropriate to others, but are, nevertheless, based on unimpaired reasoning.

Applications for Compulsion

The Commission strongly supports the recommendation that applications for both short- and long-term compulsion should be legally supported by a Mental Health Officer, and that the nearest relative should no longer be able to be approached to give consent. We also welcome the intention to move away from reliance on emergency measures, towards the use of short-term detention. In our response to the Millan Committee’s second consultation paper, the Commission expressed some concerns about the proposal that, as now, short-term compulsion should be initiated by a single doctor, with the support of a Mental Health Officer. Compared with current procedures, this would give the patient better protection against inappropriate compulsion, because the doctor would have to be approved under the equivalent of Section 20 of the Mental Health Act. However, this offers less protection to the patient than he or she would currently receive under the Mental Health Act (1983) in England and Wales, where short-term detention has to be recommended by two doctors, in addition to a mental health social worker. The Commission recognises that, in a predominantly rural country such as Scotland, the need to protect the patient’s human rights has to balance against the availability of appropriate professionals. However, we hope that more thought might be given to this issue.

We also welcome the proposal that an application for a long-term compulsion order must be linked to an appropriate care plan, which has to be approved by the legal body granting the application for the order. (This is discussed further under Legal Forum.) This should mean that the patient receives not only the least intrusive or restrictive interventions necessary to ensure that he or she is treated effectively, but is also provided with an effective safeguard against inadequate or inappropriate treatment.

Compulsory Treatment in the Community

The question of whether there should be compulsory treatment in the community was considered in the Report. It recognised that the current Community Care Order is little used, partly because professionals consider it to be ineffective in ensuring that patients take prescribed treatments. The Committee recommended that it be abolished, and that a new treatment order be introduced, in which a care plan could be implemented in the community, with the same safeguards as those proposed for long-term compulsory treatment in hospital. It also proposed mechanisms by which a patient could move between community and hospital treatment orders, according to his or her needs.

The Commission recognises the reasons for some service users opposing this recommendation. Such reasons include: the possible stigmatising effect; the possibility that the order could be used excessively because it would not be limited by the availability of hospital beds; or the possibility that, because of inadequate in-patient resources, it could be used inappropriately for patients who need treatment in hospital. The Commission’s experience of visiting detained patients in hospital, and those on Leave of Absence in the community, suggests that individuals subject to compulsory measures would find community treatment a less restrictive alternative to detention in hospital, and also a less stigmatising one. In our view, if applications for compulsory measures are properly scrutinised, it should not be possible for the availability of hospital beds to inappropriately influence the use of these orders. We expect that the legal forum would have due regard to this issue, in carrying out its responsibilities for granting orders and approving care-plans. It is one about which
there should be firm guidance in the Code of Practice to the new Act.

Concerns have been expressed that, once a community treatment order has been applied, patients might find it hard to demonstrate that compulsory measures are no longer necessary to keep them well. The Millan Committee recommended that patients should have the right to appeal against the renewal of compulsory measures and that orders should automatically be reviewed every three years, if there had been no appeal in the meantime. However, the Commission is also concerned that there should be less formal ways of ensuring discharge, when this is appropriate, and hopes that the Code of Practice will give clear guidance about the circumstances in which the RMO should take this step.

Treatment Safeguards

In comparison with the current position, increased safeguards are recommended for patients who are treated under the Act, particularly with treatments to which they are not consenting. In addition to safeguards for electro-convulsive therapy, or treatment to reduce sexual drive, the Report addresses treatments involving forcible feeding, multiple drugs or unusually high dosages of medication, and medication prolonged beyond two months. It also recommends safeguards for children who are incapable of consenting on their own behalf, whether or not they are treated under the Act. All these protective measures involve second opinions from independent specialists. Although the Commission supports the need for these greater safeguards, it is aware that their administration will require considerable resources, in terms of finding and funding suitably qualified doctors.

Mentally-Disordered Offenders

A number of the Report’s recommendations address the needs of offenders who have mental disorders. They do not propose radical changes to the range of options available to the courts for this group of people, but suggest ways in which existing provisions under the 1995 Criminal Procedure (Scotland) Act could be better used. In particular, they draw attention to the value of interim hospital orders and hospital directions. The Report addresses a problem in current court procedures, by recommending that, in the case of a mentally ill, accused person who has been assessed as needing compulsory treatment but is found not guilty of any offence, the court can hold him or her for long enough to allow treatment to be arranged under civil procedures.

Since the publication of the Report, concern has been expressed about whether all its recommended criteria for compulsory treatment should be applicable to offenders, especially those who have committed violent or sexual offences. The inclusion of lack of judgement among the grounds for compulsion has raised the concern that, no matter how serious the offence, there would not be grounds to apply continued compulsory measures to an offender patient, once his or her judgement had returned to normal. Discussions about this issue are ongoing.

It was the view of the Millan Committee that, if its proposals were adopted, there would be no need for the Mental Health (Public Safety and Appeals) Act 1999, and it recommended its repeal. It also recommended that decisions about restricted patients should be taken out of the hands of ministers and placed in those of non-political bodies, the Parole Board taking decisions about discharge and the Risk Management Authority, proposed by the Maclean Committee, taking those about day-to-day management of these high-risk patients. The Commission thought that these proposals were entirely appropriate.

The Legal Forum for Imposing Compulsion

The Committee addressed the issue of what sort of legal forum is most appropriate to impose long-term compulsory treatment orders under civil procedures. It took the view that the forum would have an important role in approving care plans, as well as determining whether the grounds for compulsion are met. It did not recommend the retention of the present Sheriff Court, proposing two alternative models: a Sheriff sitting with suitably qualified and trained assessors, or a tribunal, consisting of a legal and a medical member and another member with professional or personal experience of mental health services. The Commission would very much favour the adoption of a tribunal model, having had concerns about the variability of procedures and policies adopted by Sheriffs across the country. We believe that this would promote uniformity of
training, standards and procedures, leading to a more equitable and user-friendly process. However, along with other professional groups, we have some concerns about the availability of suitable professionals to serve on tribunals.

The Report recommended that appeals to the Sheriff should be discontinued and that the new legal forum would hear appeals against renewal of compulsory orders. So far, it is not clear whether the new forum will have the power of discharge in the first six months of an order or how extensively it will hear appeals against compulsion. It also recommended that the Commission should retain the power to discharge patients in selected cases. The Commission believes that its power to discharge patients from compulsory measures is very important in enabling it to carry out its protective functions. In addition, retention of its power of discharge would give patients a measure of choice and an alternative route to possible discharge, should there be delays, or other problems, in appeals being heard by the forum. It would also allow vulnerable patients, who have difficulty in making their views known, to be discharged from inappropriate compulsory orders without being referred to the legal forum. Such patients come to the Commission's attention in the course of hospital or community visits.

Conclusions

By the time this Annual Report is published, the Scottish Executive's response to the Millan Committee's Report should be available. We hope that the inevitable problems of finding sufficient resources will not deter it from adopting the Committee's broad recommendations for reform. Mentally disordered persons are in an unique position, in that they can be deprived of their liberty and autonomy, without committing any offence or in disproportion to any offence they have committed. To protect their rights as well as those of society, the Commission believes that legislators have a great responsibility to ensure that future mental health legislation is as fair and effective as possible.

4.2 REGULATION OF CARE ACT AND NATIONAL STANDARDS

The Scottish Executive continued its major programme of health and welfare legislation with the Regulation of Care Bill which becomes an Act in July 2001 and will be implemented from April 2002. The Act establishes two new independent bodies. The Scottish Commission for the Regulation of Care will register and regulate care services in Scotland, including those provided by local authorities, against national standards for these services. The Scottish Social Services Council will register social service workers and promote and regulate their education and training.

The Commission gave its strong support to the proposal to establish these two bodies. Through its many visits to people with mental disorder living in a variety of establishments throughout Scotland, the Commission is aware of considerable variations in the quality of care available to them. There are also some variations in the expectations of the Registration and Inspection authorities across the country. The Mental Welfare Commission therefore believes that the Scottish Commission will promote greater consistency in the standards of care expected and, over time, this will improve the quality of care provided. Very large numbers of the people whose care will be affected by the Scottish Commission, will have mental disorder. They will include people with learning disability, dementia and other mental illnesses, and some mentally disordered offenders.

The Mental Welfare Commission and the new Commission will have complementary responsibilities. In exercising its protective function in respect of people with mental disorder, the Mental Welfare Commission must be closely concerned with the quality of services available to them. The Scottish Commission has the general duty of furthering improvement in the quality of care services. This will be carried out in various ways; the processes of registration and inspection will be particularly important, but so too will be its responses to information about deficiencies in the care being provided to individuals. The Mental Welfare Commission's focus on the individual provides an invaluable perspective on the impact of care arrangements on his or her welfare. When Mental Welfare Commission visitors have concerns about an individual, they will be able to seek further
information about his or her care home from the new Commission, or they may decide immediately to report a serious shortcoming and request an appropriate remedy. Equally, the Commission for the Regulation of Care will be able to approach the Mental Welfare Commission with concerns it may have about the care of people with mental disorder. The two Commissions will then be able to plan how to co-operate in protecting the interests of vulnerable residents. Such co-operation should, in future, be considerably more effective than was possible when the Mental Welfare Commission had to communicate with forty-seven registration and inspection authorities across Scotland, as has been the case.

Given the overlapping responsibilities of the two Commissions, and the Mental Welfare Commission’s new responsibilities under the Adults with Incapacity Act, we had hoped that the Regulation of Care Act would specify that the Commissions had a duty to co-operate in exercising their statutory functions towards people with mental disorder. We were not successful in persuading the Executive of the need for this. However, we are working with the Scottish Executive to establish a protocol between the two Commissions which will define the two bodies’ agreed obligations in respect of each other.

The National Care Standards

Because, the Scottish Commission will register and inspect all care services against National Care Standards, the Scottish Executive established a National Care Standards Committee to draft them. This Committee has set up a number of working groups for all the major care groups which fall within the remit of the Scottish Commission. The National Care Standards Committee and its working groups included users and carers, care providers from local authorities, the voluntary and independent sectors and academic and other experts. The Mental Welfare Commission has been represented on the National Care Standards Committee and on the working groups producing standards for the care of older people, people with mental health problems and those with learning disabilities. We have welcomed the careful approach that has been taken in drawing up these Standards which are currently in draft form. They represent contemporary views about good practice and the principles on which it should be based; they also take account of relevant research. They can therefore be seen as a clear statement of widely accepted standards of good quality care.

The Mental Welfare Commission also welcomes the presentation of these draft Standards in plain English and with distinctions made between what care the individual should expect and how these expectations should be met. For example, a person with learning disability living in supported accommodation can expect “to receive the support I need to run and manage my own home in a way that takes account of my preferences and abilities”. This Standard will be demonstrated by “a written person-centred plan that sets out your short, medium and long term goals and how you will be supported to achieve these”.

The standards, have not yet been agreed in their final form, and have been criticised as being aspirational and unattainable. The Mental Welfare Commission’s view is that they express aspirations which are widely shared and should be pursued. There is evidence that individual Standards have been met by many care providers, although perhaps few services meet all of them. The Commission believes that the Standards will be helpful for service providers, and for users and their relatives, in giving statements of good practice, ways of assessing how to provide it and criteria by which to judge progress towards better quality care.

The Scottish Social Services Council

The Commission has also warmly welcomed the establishment of the Scottish Social Services Council. This Council will regulate the education and training of social services workers and publish codes of practice for employees and employers. The Council will also set up a National register of social services staff. The Mental Welfare Commission looks forward to working with the Scottish Council in developing the education and training necessary for all grades of staff who work with people with mental disorder. We are aware of many problems which arise from care staff’s poor understanding of mental disorder and the essential issues in providing adequate care. These include knowledge of best practice in working with people with dementia; understanding of individuals’ rights and obligations; well-informed risk-assessment; mental health legislation; and the use of restraint. We think all those
with the responsibility for the care of people with mental disorder should receive such training, from the Scottish Commission’s inspection and registration teams to the managers of care services and care workers. The Mental Welfare Commission believes that the Scottish Social Services Council will be able to promote a more consistent and comprehensive approach to education and training than has been possible to date.

More information about the Regulation of Care Act and associated developments can be obtained at www.scottish.parliament.uk, or www.scotland.gov.uk/government/rcp.

4.3 ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000

As noted in last year’s Annual Report, the Adults with Incapacity Act was passed by the Scottish Parliament on the 29 March 2000 and received its Royal Assent on 9 May 2000. Its implementation began on 2 April 2001 with Part 2, which deals with the appointment of continuing (financial) and welfare powers of attorney, and Part 3 which deals with the authority to use the incapable person’s funds and the operation of joint bank accounts. In the autumn of 2001, Part 5, dealing with medical treatment and research, is expected to come into operation and on 1 April 2002, Part 4, management of the finances of persons living in residential accommodation, and Part 6, intervention orders and guardianship orders, will become operational.

Over the year 2000-2001, Codes of Practice have been in preparation and guidance material from the Scottish Executive and the Office of the Public Guardian has been issued. The Commission has been contributing and responding to these and preparing for its own role in relation to welfare powers of attorney.

The Commission’s duties under the Adults with Incapacity Act, mainly set out in Section 9, are principally to do with welfare issues, and only where the cause of the incapacity is mental disorder. Monitoring in relation to financial issues is carried out principally by the Public Guardian.

Guardianship will be removed from the Mental Health (Scotland) Act 1984, when Guardianship under the Adults with Incapacity Act becomes operational in April 2002. However, the Commission retains its general protective functions in relation to those vulnerable with mental disorder as set out in Section 3 of the Mental Health Act. The Commission therefore retains a duty to investigate circumstances in which a person’s property may be at risk of loss or damage because of his or her mental disorder. However, the Public Guardian has a duty to investigate circumstances in which he thinks there may be a risk to the property or financial affairs of an adult with incapacity. It therefore seems likely that the Public Guardian will deal with matters of finances, while the Commission will deal with threats to the property of people who are incapable by reason of mental disorder.

The Commission is required to consult the Public Guardian and Local Authorities about the exercise of its functions under the Adult with Incapacity Act, in situations where there might be a common interest. Over the last year, we have had regular meetings with the Public Guardian and a Memorandum of Agreement may be developed to clarify our respective functions in relation to property and financial affairs.

Under the new Act, the Commission has a duty to investigate circumstances in which the personal welfare of an incapable adult might be at risk. The Local Authority has an identical duty. The assumption generally built into the legislation is that the Mental Welfare Commission’s role will be a back-up to that of the Local Authority. The Local Authority is also required to investigate any complaints about welfare attorneys, guardians or persons authorised under intervention orders. The Commission has a duty to investigate such complaints when not satisfied with any investigation made by the Local Authority, or where the Local Authority has failed to investigate. The Commission also has a duty to provide a welfare attorney with information and advice about how he or she should function in safeguarding personal welfare.

When the Public Guardian registers documents conferring welfare power of attorney, he is required to send them to the Mental Welfare Commission. The Public Guardian and the Commission have agreed that, currently, the Commission should simply be informed that such documents are being registered and to whom they relate, but be able to
obtain the actual document when appropriate. The Commission is therefore maintaining a list of people with registered welfare attorneys and can refer, from this, to cases known to the Commission for other reasons.

A welfare power of attorney allows people, while still capable of understanding what they are doing in this respect, to select someone else who will take personal welfare decisions for them, if they become incapable of taking such decisions in future. The sorts of welfare decisions covered by this provision of the Act are described in the Power of Attorney document, which can only be acted upon when the grantor becomes incapable of taking these decisions him or herself. These can include personal welfare matters and consent to treatment. However, the welfare attorney cannot place the grantor in a hospital for treatment of mental disorder against his will, or consent on behalf of the grantor to any form of treatment to which Part X of the Mental Health (Scotland) Act 1984 applies, or to treatments with special safeguards identified by regulations under Section 48 of the Adults with Incapacity Act. A welfare attorney can only be an individual, and can not include someone acting as an officer of a Local Authority or other statutory body.

Helpful guidance material and Codes of Practice are available from the Scottish Executive and the Office of the Public Guardian, both in print and on their respective websites, at www.scotland.gov.uk/justice/incapacity and www.publicguardian-scotland.gov.uk.

The Commission looks forward to further implementation of the Adults with Incapacity Act which will greatly improve the range and flexibility of provisions to help adults whose mental disorder impairs their decision-making capacity. The Commission's Director represents it on the National Implementation Steering Group.

4.4 THE SAME AS YOU? A REVIEW OF SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

The Commission welcomed the publication of the Scottish Executive's review of services for people with learning disabilities, in May 2000. The Review provides a framework for the development of person-centred health and social care services for children and adults with learning disabilities in Scotland. The framework is based on a set of principles which focus on individuality, participation, choice, equality, access to local services and specialist support, if required. The Commission endorses these principles which should underpin the work of all those commissioning, and providing, services and of the bodies monitoring them.

The Commission supports the definition of learning disabilities adopted by the Review. We are aware of people who have not been able to access a service because of arbitrary decisions based on IQ or age. Clearly the skills and expertise of learning disability services need to be targeted appropriately but, as has been identified in the deficiency in care inquiries conducted by the Commission in the cases of Ms P and Mr B (Annual Report 1998/99, p. 10; and 2000-01, Section 2.1, respectively), people in need of these services can miss out on appropriate assessment and support. We also support the need for a greater interface between learning disability services and mental health, criminal justice, older people and children's services, to ensure that the needs of people with learning disability are not neglected because of rigid referral criteria and poor co-ordination across, and within, agencies.

The Review's focus on independent advocacy and better information for people with learning disabilities and their families is very positive. The Commission continues to support the role of independent advocacy for vulnerable individuals, commenting in the 1998-1999 Annual Report, on the poor provision in many areas.

The Commission visits all learning disability hospitals on an annual basis and, increasingly, has been visiting people with learning disabilities who live in the community. In recent Annual Reports, we have highlighted some concerns about patients remaining in hospital. These include: the quality of their accommodation; the quality of opportunities available to them; and delays in plans for their resettlement. The Commission therefore welcomes the Review's recommendation that all long-stay hospitals for people with learning disabilities should close by 2005. The Commission believes its visiting programme, which includes unannounced visits, continues to be of vital importance in ensuring that standards of care for the individuals living in hospital
are maintained while in-patient services generally are being scaled down.

The Commission has been striving to improve the way we fulfil our duties towards individuals with learning disabilities, who have either been discharged from hospital or have never been in-patients. We are developing methods of visiting people in the community and also trying to make individuals, carers and advocates more aware of our role and ways of contacting us.

In the Review, there is a recognition that some people with learning disability will require continuing support from health services; the Commission will continue its interest in the welfare and well-being of individuals with learning disabilities in both hospital and community settings. We agree that there requires to be robust community-based provision for people resettled from hospital and also for people living at home with family carers. We are concerned that some people remain in hospital because of a lack of appropriate community based services and support and this will require to be addressed by health and social work agencies.

The Commission welcomes the Review’s focus on services for people with complex needs, such as challenging behaviour, offending behaviour, mental health problems and autistic spectrum disorder. It is well recognised that people with learning disabilities are more at risk of developing mental illness. The need for a small number of assessment and treatment beds is identified in the Review. Some people with learning disabilities are admitted to acute psychiatric wards. While this may be appropriate in some cases, attention should be given to ensuring people with learning disabilities are not disadvantaged in this situation, and that services are appropriate for their needs. The Commission is in a position to highlight the plight of individuals with learning disabilities who are inappropriately placed in psychiatric hospitals and, through our prison visits, those within the criminal justice system. The Review’s recommendation, that the Scottish Executive should commission research into the number of people with learning disabilities in prison or in secure care, is therefore welcome.

The presence of local area co-ordinators should provide a source of local specialist advice and support to people with learning disabilities and their families. The Commission welcomes the suggestion that local area co-ordinators may be best placed within Local Healthcare Co-operatives; this should enhance the interface between learning disability and primary care services and provide opportunities for people to access other local services. Commission visiting teams would wish to establish links with both local area co-ordinators and expanding local advocacy services, as a means of making contact with the most vulnerable individuals.

The Commission is heartened by the real involvement of users and carers in the work of the Review and the Scottish Executive’s ongoing commitment to involve people in a meaningful and effective way. The Scottish Consortium for Learning Disabilities will provide a resource for people in Scotland; the Commission looks forward to developing links with it and to contributing to the ongoing improvement of services for individuals.
5.1 REQUESTS FOR DISCHARGE FROM DETENTION

During the year 2000-2001, 532 requests were made to the Commission for it to use its powers of discharge from liability to detention, Guardianship or a Community Care Order; or to bring to the attention of Scottish Ministers, a recommendation that they use their power of discharge of restricted patients. Table 5.1 gives a breakdown of reviews undertaken during the year. Though there has been a decrease in Section 26 and CP(S)A reviews since 1998-99, overall the 532 reviews undertaken last year represented an increase of 2% on the number the previous year. The overall trend has been upward over the last 11 years (the percentage increase 1990-1999/2000-2001 being 155%).

Table 5.1: Reviews of Detention 01.04.98-31.03.01

<table>
<thead>
<tr>
<th>Basis for Detention</th>
<th>1998-99</th>
<th>1999-00</th>
<th>2001-02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 18</td>
<td>235</td>
<td>200</td>
<td>233</td>
</tr>
<tr>
<td>Section 26</td>
<td>220</td>
<td>207</td>
<td>198</td>
</tr>
<tr>
<td>Section 71/72</td>
<td>7</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Section 74</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>CP(S)A 75/95</td>
<td>83</td>
<td>69</td>
<td>62</td>
</tr>
<tr>
<td>Guardianship</td>
<td>35</td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>Community Care Orders</td>
<td>10</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Conditional Discharge</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>597</td>
<td>521</td>
<td>532</td>
</tr>
</tbody>
</table>

Requests for Discharge

Requests from patients are received mainly by letter or by telephone call. Many requests are made during statutory visits to patients or on the Commission’s routine programme of visits. A number of requests come from solicitors, advocacy workers, relatives, hospital staff and mental health officers (MHOs). In all these cases, the Commission will check with the patient that he or she is wishing a request for discharge to be considered. In the case of a patient considered not mentally capable of making a request for discharge, a request from the nearest relative, or someone else closely involved, will usually be acted upon.

The Commission is unable to respond to requests for discharge from emergency detention under Section 24 or 25 of the Mental Health (Scotland) Act 1984. The 72 hour duration of the detention does not allow adequate time to visit, assess, discuss and formally consider a patient’s case. It is of course open to the patient, if he or she believes that the emergency detention was improper, to make a formal complaint to the hospital managers.

On receiving a request for discharge from short-term detention (Section 26), the Commission will arrange a visit to the patient within seven days and it will formally consider the case within ten days at its Weekly Commission meeting. It can be difficult for the Commission to respond to requests made late in the 28-day period of detention. Those who request to be discharged from Section 26 detention, or from renewal of detention under Section 18 or the Criminal Procedure (Scotland) Act 1995 are reminded of their quite separate right of appeal to the Sheriff. Those on Guardianship or Community Care Orders are similarly informed.

Commission Interviews

When a request for discharge from detention is received, the inquiry is allocated to a Medical Officer or Medical Commissioner (for requests for discharge from Guardianship or a CCO, both a medical and a social work representative see the patient). At interview, the representative of the Commission asks the patient (who may be accompanied by an advocacy worker or a friend) about his or her arguments against detention and what plans he or she has, if discharged from detention. A Report to the Commission meeting is based on these arguments and plans, together with an assessment of the nature or degree of mental disorder. The visiting doctor also seeks the views of nursing staff, the Responsible Medical Officer and any other relevant people closely involved with the patient’s treatment.

The Commission Meeting

The Commission has to consider whether the detention or other Order is proper or not. For detention, this will be based on the requirements of
Section 17 of the Act. The requirements for Guardianship are described in Section 37 and those for a Community Care Order, in Section 35A.

Outcomes

There were six cases in the last year in which the Commission discharged a patient, contrary to the wishes of the Responsible Medical Officer. Three of these had been detained under Section 26 and three under Section 18 (two on Leave of Absence). A recommendation to Scottish Ministers was sought by one restricted patient. The Commission recommended lifting of the restriction order. In the event, the First Minister granted absolute discharge.

During the careful consideration by Commissioners of each request for discharge from detention, a variety of other issues about the treatment and welfare of the patients may arise and be followed up.

Possible Changes in Procedure

The Commission is currently piloting possible changes to the procedure described above, to ensure that practice is in keeping with modern views and in concordance with the European Convention on Human Rights under the Human Rights Act 1998, which became fully implemented in Scotland in October 2000. For details, see Section 2.11 of this Report.

5.2 COMPLAINTS PANEL

Statistics

This year the total number of recorded new contacts with the Commission’s Complaints Officer has decreased from 126 to 98, as shown in Table 5.2. This has been the result of a new internal procedure within the Commission, which directs all new telephone contacts about complaints to the professional officer or Commissioner on telephone duty, instead of to the Complaints Officer. Many people who contact the Commission to complain are seeking to resolve current concerns about their own or their relative’s care, and the Duty Officer is the appropriate person to give professional advice and take any necessary further action. He or she will also advise about how to make a formal complaint if the person still wishes to do so, but because the emphasis is on resolving the problem, these calls are not necessarily recorded as a complaint. There is no evidence to suggest that the overall volume of complaints made to the Commission has decreased and the Commission is reviewing its recording procedures to ensure that comprehensive statistical information is captured.

The 98 complaints which were referred to the Complaints Office were received by letter and telephone and involved follow up action of some kind. Although the Complaints Officer is no longer able to offer routinely to monitor the progress of complaints through the local procedures, complainants whose complaints are complex, or which seem to be delayed in the local procedures, will frequently contact the Commission for further advice and clarification of the stage in the investigation that their complaint has reached.

Table 5.2: Number and Source of Complaints Received by the Commission

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>80</td>
<td>47</td>
</tr>
<tr>
<td>Relatives</td>
<td>40</td>
<td>35</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Anonymous</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
<td>98</td>
</tr>
</tbody>
</table>

Compared with the previous year, there was a higher proportion of complaints from advocacy workers and solicitors in 2000-01 (included under “other”). Table 5.3 shows the issues about which people complained.

Although the number of new complaints recorded during 2000/2001 was lower than last year, there was an increase in those which had completed the local NHS or Local Authority Complaints procedures. In 1999-2000 the Complaints Panel considered 12 new requests for investigation. This year, 15 new cases were put before the Panel; eight other complaints were on-going at the start of the year. Table 5.4 shows how these 23 cases were dealt with. In addition, the Panel considered four reports of investigations of significant complaints which had been reported to us by Trusts. The Panel rarely undertakes a full, formal, investigation of a complaint, but, in the majority of cases, makes further enquiries, often requiring the examination of clinical records. This year, one complaint merited
a full investigation, but it was subsequently withdrawn by the complainant. Substantial enquiries were made in all 15 new cases, before the Panel decided whether any further enquiries or investigations were to be carried out. Clinical records were examined in seven of these cases.

Table 5.3: Categories of Complaints

<table>
<thead>
<tr>
<th></th>
<th>1999-2000 %</th>
<th>2000-2001 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge, admission, transfer procedures</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Assault/ill-treatment</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Care in hospital</td>
<td>32</td>
<td>42</td>
</tr>
<tr>
<td>Community care</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Doctors</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Finances</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Improper detention</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Local authority services</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Loss/damage to personal property</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Medication</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Nurses</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Physical environment</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Other service provider</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sundry</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 5.4: Action Taken on Complaints

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No further enquiries</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Further enquiries made</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Formal investigation (complaint later withdrawn)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Referred back to convener</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Withdrawn before decision by Panel</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Not yet decided</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Intervention by MWC to resolve complaint</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td></td>
</tr>
</tbody>
</table>

The Complaints Panel

The Complaints Panel meets six times a year and considers individual complaints and matters of policy. The Panel consists of Commissioners and professional staff, with psychiatric, nursing, social work and legal experience. A place has been held open for the appointment of a Commissioner with experience of using mental health services. During the year the Panel has advised on a new complaints procedure for the State Hospital, revised its own complaints leaflet and advised the Commission on a policy for responding to habitual and vexatious complainants. The Panel has held meetings with the new Local Government Ombudsman, the Health Service Commissioner and the Scottish Executive. The Complaints Officer has been a member of the Scottish Executive advisory group for the evaluation of the NHS complaints procedure, and is now a member of the implementation group. During the year the Panel also carried out a review of the extent to which NHS patients, in beds contracted out to non-NHS providers, had access to the NHS complaints procedure.

In January 2000, the Panel organised a one-day seminar for Complaints Officers, which included discussion on conciliation, vexatious and habitual complainants and on the Commission's role and powers. It proved to be a valuable opportunity to hear the views and concerns of Complaints Officers and to exchange information and ideas.

Workload pressures have continued to be a concern for the Panel and have caused worrying delays in its investigation of complaints. However, the Commission believes that the thoroughness of its procedures, and the protection this affords complainants, means that the Commission's enquiries into complaints will inevitably be a lengthy process. All complainants whose complaints have completed local procedures, and who want the Commission to make further enquiries, are invited to meet Panel members to provide further background to their complaints and to discuss their desired outcomes. The Commission finds these meetings extremely helpful, and they are welcomed by complainants.

It is often necessary for several different professional staff, or Commissioners, to be involved in the examination of clinical records; it may be necessary to look at, for instance, psychiatric, nursing, GP and social work records. These records can be extensive and can take considerable time to assess. The detailed administrative and investigative work involved in dealing with complex complaints has also led to a backlog of cases and the Panel is pleased that, in the coming year, an Enquiries and Investigations Unit is to be set up. It will have two new administrative staff and deal with complaints; and deficiency in care and other inquiries.
In the light of the Human Rights Act, the Panel looked at its procedures for dealing with complaints. As a result, everyone whose complaint has been investigated under local procedures, and who asks the Commission to consider their complaint, has the opportunity to meet representatives of the Panel, before a decision is made about whether or not to investigate. Complainants also now receive a draft of the factual parts of the report which is made to the Panel, so that they can correct any errors or omissions.

Complaints Against the Commission

The Commission has a procedure for complaints against it. The complaint is referred to the Director, who delegates the investigation to a Commissioner, who makes a report to the Management Group of the Commission. If the complainant still feels dissatisfied after the Commission investigation, he or she has the right to put the matter to the Health Service Ombudsman. There was one complaint against the Commission this year. The complainant thought that a member of staff had not dealt with an enquiry appropriately. In this case, the complaint went through the Commission procedure and was not upheld.

Matters for the Future

The many changes taking place in mental health legislation and national complaints procedures nationally will have an impact on the Commission’s future role. The Millan Committee has recommended that, in respect of people with mental disorders, the investigation of NHS complaints beyond the local procedure should be the responsibility of the Health Service Commissioner, although he or she would be required to consult the Commission. The Commission would also be entitled to offer advice and guidance on dealing with such complaints and to make enquiries about the way in which they are dealt with. These recommendations have been made at a time when Modernising the Complaints System: Consultation on public sector ombudsmen in Scotland is considering the establishment of a one-stop shop for public sector Ombudsmen. The Commission has supported these proposals and its role in dealing with complaints may therefore be subject to substantial change, in the not too distant future.

5.3 NEUROSURGERY FOR MENTAL DISORDER

The Commission is required by the 1984 Act to be involved in the assessment of detained patients prior to neurosurgery for mental disorder in Scotland, particularly with respect to their consent to treatment. For a number of years, under a voluntary agreement with the treatment service in Dundee, which is the only centre in Scotland carrying out this work, the Commission has also been involved in assessing informal patients. A pool of six Commissioners is used to provide three people for each assessment. The group meets regularly to review assessments carried out and discuss other relevant issues.

Over the last year, four assessments were carried out. One man was seen twice, seven months apart. He had been seen before in 1998-99, when a detained patient, and the Commission representatives had issued a Form 8. He had an anterior capsulotomy which was followed by improvement in his severe depression for a number of months, then relapse. When seen in 2000, he was still detained and it was proposed that a cingulotomy should be carried out. The Commission issued a further Form 8, but treatment had to be delayed as a result of physical illness. Since the delay was greater than six months, he had a further visit from three Commissioners and, by that time, he had been discharged from liability to detention. Further neurosurgery was approved under the voluntary arrangement.

An informal female patient was seen in England. She had also had a previous capsulotomy in 1996-97, following Commission assessment. Following the earlier operation, she had shown great improvement in her depression, for about six months, before relapsing into a treatment resistant state, once more. A further operation was being considered and the Commission agreed consent and appropriateness.

The fourth assessment was of an informal female patient in Scotland, with treatment resistant depression, and the Commission agreed consent and appropriateness of the proposed treatment.

Summary from April 1993-March 2001

The number of assessments carried out each year, from 1993-94, is shown in Table 5.5. To date, 32 assessments have been carried out on 20 individuals.
Table 5.5: Assessments per Year - 1.4.93-31.3.01

<table>
<thead>
<tr>
<th>Year</th>
<th>Detained</th>
<th>Informal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993-94</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>1994-95</td>
<td>2*</td>
<td>4*</td>
<td>6</td>
</tr>
<tr>
<td>1995-96</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1996-97</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>1997-98</td>
<td>3*</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>1998-99</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>1999-00</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2000-01</td>
<td>1*</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>21</td>
<td>32</td>
</tr>
</tbody>
</table>

*One patient in each category was assessed twice in the year. In 2000-01 the patient was informal when reassessed.

Twelve individuals had two assessments four in the same year, and eight in different years. Hence, 32 assessments have been done on 20 individuals. There were 15 women and five men, aged 30-61 (mean age 43). Of the eight repeat assessments carried out in different years, four occurred because a second operation was being considered; in these cases, there had been improvement after the first operation, followed by relapse. Three occurred because the result of the first assessment by the Commission was negative, either because the patient was unable or unwilling to consent or other treatment approaches had yet to be tried. The eighth reassessment was because a detained patient seen in England, was transferred to Scotland prior to operation. She had to be seen again so that the appropriate form could be issued, under the Scottish Mental Health Act. A similar reason accounted for one of the in-year reassessments.

Though they were due to receive surgery in Scotland, three informal and two detained patients were resident in England, at the time of their assessments; the Mental Health Act Commission was given anonymised information on them. One informal patient was resident in the Irish Republic.

The Mental Welfare Commission seeks follow-up reports, one year after operation. A rough categorization of these shows that, out of 21 operations on which reports were available, nine patients showed marked improvement; eight had some improvement; or marked improvement followed by relapse, and four had no improvement.

One patient had a major complication of the operation, an intracranial bleed. Two of the 21 reports related to second operations in Scotland, following an earlier operation here. In one case, the second outcome was marked improvement followed by relapse, and, in the other, it was marked improvement.

These are only rough measures and one year is a limited follow-up period. More detailed outcome data, from research being undertaken in Dundee, are awaited with interest.

The Millan Committee Report on the review of the Mental Health (Scotland) Act 1984 recommends that the protection for patients undergoing neurosurgery should be statutorily required for informal as well as detained patients; as is currently the case in England and Wales (New Directions, Recommendation 10.3). We agree with this proposal.

The Millan Committee also recommended that neurosurgery for mental disorder should be available, with stringent safeguards involving Court of Session approval, to compliant patients incapable of consenting (New Directions, Recommendation 10.4). This is on the grounds that those most severely affected by illness, which could impair their decision-making ability, would otherwise be denied treatment from which they might benefit. Again, we agree that this would be appropriate. Our experience suggests that treatment without the patient’s consent would be a very rare occurrence. In eight years, of 20 people assessed prior to neurosurgery, the Commission found only two at the first assessment who were unable to give consent. Both were able to consent when revisited after an interval of time. There may, of course, be a few patients who are not currently referred for treatment because of their inability to give or refuse consent.

5.4 SECTION 98 WORK

Last year’s Annual Report noted a doubling of requests for Section 98 second opinions, over a ten-year period. This has not been matched by an increase in the number of psychiatrists carrying out Section 98 work. The usual methods of recruiting psychiatrists have been less successful in recent years.
than previously, perhaps reflecting an increase in the overall workload of psychiatrists. This year, the Commission wrote to all psychiatrists in Scotland, with the assistance of the Scottish Division of the Royal College of Psychiatrists. This has allowed a small increase in the number of doctors available for Section 98 work, but only because a number of Section 98 doctors have continued beyond the normal term of duty. The Commission is grateful to the following who have acted as Section 98-approved consultant psychiatrists during this year.

Dr M Al-Mousawi  
Dr C Aryiku  
Dr T Baekker  
Dr F Bell  
Dr A F Cooper  
Dr C Crawford  
Dr K Brown  
Dr J Duncan  
Dr L Emslie  
Dr J A Flowerdew  
Dr S Jaigirdar  
Dr D R Neilson  
Dr D Patience  
Dr E B Ritson  
Dr A Robinson  
Dr K Slaford  
Dr A Stewart  
Dr R A D Sykes  
Dr P Walker

Dr N Ali  
Dr S Backett  
Dr J Baird  
Dr I Berry  
Dr F Coulter  
Dr D Brown  
Dr W E Dickson  
Dr J Eastwood  
Dr P G Flanigan  
Dr M Götz  
Dr D Hall  
Dr R Hunter  
Dr J Martin  
Dr T Lock  
Dr M MacLeod  
Dr J McKnight  
Dr P Morrison  
Dr K Murray  
Dr P O'Leary  
Dr E Powell  
Dr P Robertson  
Dr A Scott-Brown  
Dr A Smith  
Dr J Strachan  
Dr D Taylor  
Dr A M West

Section 98-Approved Doctors’ Seminar

Two seminars were held during the year, the second of which was an induction seminar for new Section 98 doctors. Twenty-one doctors attended the first seminar in September 2000. A number of topics were discussed, including the monitoring of high-dose antipsychotic treatment (which is not always carried out in accordance with the recommendations in the British National Formulary), the approval of treatment protocols (e.g., the Maudsley Prescribing Guidelines) and the responsibility for providing feedback to patients following Section 98 visits. It was agreed that information would be collected more systematically by Section 98 doctors, to permit better monitoring of the work; the form summarising the visit has subsequently been redrafted.

### Table 5.6: Forms 9 and 10 issued: 1.4.00-31.3.01

<table>
<thead>
<tr>
<th>Form 9</th>
<th>Form 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>1213 (67)</td>
</tr>
<tr>
<td>ECT</td>
<td>53 (4)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1266 (71)</strong></td>
</tr>
</tbody>
</table>

* Figures in brackets indicate coexisting Form 9 and 10. Part of the treatment is covered by Form 9 and part by Form 10.

As shown in Table 5.6, during the year, 687 Form 10s were issued following second opinion visits. This is not significantly changed from the previous year.

### 5.5 TELEPHONE ADVICE SERVICE

The Commission provides a telephone advice service, aimed at helping patients, professionals and others, who cannot obtain the information they need from other sources. It is operated by the Commission’s professional staff and is available during normal office hours. It constitutes a significant proportion of the Commission’s work, since many enquiries require research or discussion with colleagues. Further action is often necessary, either within the Commission or in discussion with appropriate health, social work or legal services.

A brief note of each call is recorded by the member of staff dealing with it, with further documentation being undertaken, as necessary. Records of all calls received during a three-month period, between...
January and March 2001, were analysed to identify the role of the caller and the approximate nature of the enquiry.

Table 5.7: Identity of Callers in a Three-Month Period

<table>
<thead>
<tr>
<th>Callers</th>
<th>Calls</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>155</td>
<td>23</td>
</tr>
<tr>
<td>Social Worker</td>
<td>123</td>
<td>18</td>
</tr>
<tr>
<td>Patient/Service user</td>
<td>119</td>
<td>17</td>
</tr>
<tr>
<td>Relative/Carer/Friend</td>
<td>78</td>
<td>11</td>
</tr>
<tr>
<td>Nurse</td>
<td>59</td>
<td>9</td>
</tr>
<tr>
<td>Advocacy worker</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>GP</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>122</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>683</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5.8: Nature of Calls Received in a Three-Month Period

<table>
<thead>
<tr>
<th>Nature of call</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health (S) Act 1984</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detention</td>
<td>136</td>
<td>40</td>
</tr>
<tr>
<td>Guardianship</td>
<td>42</td>
<td>12</td>
</tr>
<tr>
<td>Request for review of detention</td>
<td>34</td>
<td>10</td>
</tr>
<tr>
<td>Part X (Consent to Treatment)</td>
<td>31</td>
<td>9</td>
</tr>
<tr>
<td>LOA/AWOL issues</td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td>Cross-border issues</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Incidents/deaths</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>34</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>338</td>
<td>100</td>
</tr>
<tr>
<td>Other legal issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial issues</td>
<td>32</td>
<td>68</td>
</tr>
<tr>
<td>AWI Act</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>100</td>
</tr>
<tr>
<td>Practice issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Ethics</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>MWC guidance papers</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>58</td>
<td>54</td>
</tr>
<tr>
<td>Total</td>
<td>108</td>
<td>100</td>
</tr>
<tr>
<td>Other Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns &amp; complaints</td>
<td>128</td>
<td>64</td>
</tr>
<tr>
<td>Miscellaneous information/advice</td>
<td>71</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>199</td>
<td>100</td>
</tr>
</tbody>
</table>

In this period, a total of 686 enquiries were received; this is equivalent to an annual rate of over 2,700, a significant increase over the previous year's total of just over 2,200. Of the 686 calls, the identity of the caller was recorded in 683. As shown in Table 5.7, the majority of these were from professionals. Psychiatrists constituted the largest single category though patients and relatives/carers together made up a large proportion of callers. The category of "Others" included solicitors, medical records officers, service managers, support workers and staff of voluntary organisations. A significant number of Consultant Psychiatrists had asked their personal secretaries to telephone us.

The nature of the calls is shown in Table 5.8. This is a rough categorisation, because many of the calls involved complex clinical, ethical and legal issues, and, in analysing the records, an arbitrary judgement had to be made about which appeared to be the predominant issue. In a small number of calls, there were two issues of equal importance, or more than one case was discussed. Thus, although there were 686 calls, a total of 692 issues were noted in the records.

It can be seen from Table 5.8, that there were 338 issues relating to the 1984 Mental Health Act; these constituted the biggest single category of topics discussed (49%). These calls included: requests for advice about detention; requests for reviews of detention; and issues related to the Commission’s statutory duties, under Section 3 of the Act, such as the monitoring of suicides and other incidents. Of the 692 issues discussed, a small proportion (8%) related to other legislation, such as the Criminal Procedure (Scotland) Act 1995, and the Data Protection Act; only a handful of these were calls about the Adults with Incapacity Act. This was disappointing, in view of the fact that the implementation of Parts 1 and 3 was imminent, starting at the end of the three-month period. It will be interesting to see whether the Commission receives more enquiries about it in the coming year.

As shown in the table, practice issues accounted for 108 (16%) of the topics discussed; within these, the greatest single category related to consent to treatment issues, usually involving treatment for physical disorders. Other issues accounted for 199 (29%) of the topics discussed. Amongst these, concerns and complaints about treatment and
services were predominant. These concerns were received from professionals, as well as patients and carers. Often the caller did not want to make a formal complaint, but to talk over treatment issues about which he or she was concerned, seek information about the appropriateness of therapeutic interventions, or express concern about inadequacy of services. A significant proportion of concerns were about the provision of community services. Some calls came from informal patients who reported that they were being threatened with detention, if they did not accept the treatment offered them. Many were from patients complaining about the side-effects of anti-psychotic medication. There were also complaints, from both professionals and patients, about the attitude and actions of the police.

Apart from complaints and concerns, the “Other Issues” category included requests for information about the rights of informal patients, and about rights in the fields of employment and state benefits. A significant number of callers telephoned to ask the Commission either to provide a second clinical opinion or suggest the name of a doctor who could do so. Many were not aware that, though the Commission arranges visits from Section 98 doctors to patients detained under the Mental Health Act, it does not currently have any other role in arranging independent medical opinions. When Part 5 of the Adults with Incapacity Act (2000) becomes operational in autumn 2001, the Commission will be responsible for nominating a medical practitioner to give an opinion, when there is a disagreement between doctor and proxy decision-maker about the medical treatment of an adult who is subject to the Act.

5.6 SOCIAL WORK

In the course of the year the Commission has had contact with many social work services staff over policy and practice issues.

In November 2000 the Commission met senior social work staff directly responsible for managing mental health social work. This was the second meeting, mostly concentrating on practice issues for Mental Health Officers (MHOs). It will become a regular meeting.

The Commission had its annual meeting with the Association of Social Work Directors (ADSW). These meetings focus on policy, developments and legislation; a representative from the Commission also attends ADSW’s mental health subgroup meetings.

Members of the Commission social work team contributed to MHO training courses, talking about the Commission’s role. We also responded to invitations, from groups of MHOs, to talk about areas of common interest. In the course of the year, there were also many discussions with social work staff, about the individual clients that the Commission sees in the course of routine work, and the Commission had its formal annual meetings with the Local Authority Social Work Departments across Scotland.

We are glad to report that Scottish Border Council agreed to second an experienced MHO to the Commission, for six months. This secondment is funded jointly by the Council, the Commission and the Social Work Services Inspectorate. We hope this secondment, on which there will be a full report next year, will be the first of many.

5.7 PATIENTS AND OTHERS SEEN

Table 5.9: Patients Seen on Hospital Visits (not including State Hospital)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory interviews</td>
<td>159</td>
</tr>
<tr>
<td>Requested interviews</td>
<td>483</td>
</tr>
<tr>
<td>Incapax</td>
<td>39</td>
</tr>
<tr>
<td>Commission initiated</td>
<td>84</td>
</tr>
<tr>
<td>Patients seen in groups</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total no. of patients seen</strong></td>
<td><strong>776</strong></td>
</tr>
<tr>
<td>Relatives/advocates seen</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total no. of interviews</strong></td>
<td><strong>807</strong></td>
</tr>
</tbody>
</table>

Table 5.10: State Hospital: Number of Interviews

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requests for discharge</td>
<td>41</td>
</tr>
<tr>
<td>Other requests</td>
<td>15</td>
</tr>
<tr>
<td>Statutory and routine interviews of restricted patients</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>156</strong></td>
</tr>
</tbody>
</table>

1 Patients seen after more than two years of detention and those seen at two-yearly intervals thereafter (see Section 3(c)(i) of Mental Health (Scotland) Act 1984).
Table 5.11: Non-Hospital Visits

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leave of Absence</td>
<td>241</td>
</tr>
<tr>
<td>Leave of Absence/statutory visits</td>
<td>15</td>
</tr>
<tr>
<td>Guardianship – initial</td>
<td>195</td>
</tr>
<tr>
<td>Guardianship – return</td>
<td>108</td>
</tr>
<tr>
<td>Community Care Orders</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>577</strong></td>
</tr>
</tbody>
</table>

5.8 DETENTION AND GUARDIANSHIP STATISTICS

Episodes of Detention Showing Section and Number of Patients Involved

Table 5.12: Section 24/25, to Discharge to Informal

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Number of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1470</td>
<td>1</td>
</tr>
<tr>
<td>88</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 5.13: Section 24/25 to 26, to Discharge to Informal

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Number of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1492</td>
<td>1</td>
</tr>
<tr>
<td>82</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 5.14: Section 24/25 to 26, to 18

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Number of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>918</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 5.15 Section 24/25 to 18

No episodes

Table 5.16: Direct to Section 18

<table>
<thead>
<tr>
<th>Number of patients</th>
<th>Number of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>154</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 5.17: Community Care Orders

<table>
<thead>
<tr>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
</tr>
</tbody>
</table>

Table 5.18: Guardianship approvals and discharges 1998-2001

<table>
<thead>
<tr>
<th>Cases at start of year</th>
<th>1998-99</th>
<th>1999-00</th>
<th>2000-01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged during year</td>
<td>82</td>
<td>100</td>
<td>96</td>
</tr>
<tr>
<td>Approvals during year</td>
<td>128</td>
<td>126</td>
<td>160</td>
</tr>
<tr>
<td>Cases at end of year</td>
<td>176</td>
<td>202</td>
<td>266</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Court procedure</th>
<th>Number of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remand to hospital before trial (CPSA 52)</td>
<td>126</td>
</tr>
<tr>
<td>Transfer Order from prison before trial or sentence (MHSA 70)</td>
<td>28</td>
</tr>
<tr>
<td>Remand Order (CPSA 200)</td>
<td>61</td>
</tr>
<tr>
<td>Interim Hospital Order (CPSA 53)</td>
<td>26</td>
</tr>
<tr>
<td>Temporary Hospital Order (CPSA 54(1)(c)</td>
<td>4</td>
</tr>
<tr>
<td>Hospital Order without a Restriction Order (CPSA 58)</td>
<td>68</td>
</tr>
<tr>
<td>Hospital Order with a Restriction Order (CPSA 58 + 59)</td>
<td>9</td>
</tr>
<tr>
<td>Not fit to stand trial or acquitted by reason of insanity (CPSA 57(2)(a))</td>
<td>5</td>
</tr>
<tr>
<td>Not fit to stand trial or acquitted by reason of insanity (CPSA 57(2)(b))</td>
<td>4</td>
</tr>
<tr>
<td>Transfer Direction from prison without a restriction order (MHSA 71)</td>
<td>10</td>
</tr>
<tr>
<td>Transfer Direction from prison with a Restriction Order (MHSA 72)</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>369</strong></td>
</tr>
</tbody>
</table>
Figure 5.1: Number of Detentions under Sections 24/25, 26 and 18 per 100,000 of Health Board Population: 1.4.2000 to 31.3.2001*

*Figures for Western Isles omitted, because of very low numbers

Figure 5.2: Episodes of Detention from 1.4.2000 to 31.3.2001 Compared with 1997/98, 1998/99 and 1999/00
Table 5.19 shows the number of detentions under the Criminal Procedure (Scotland) Act 1995. Last year we commented on the marked reduction in episodes of CP(S)A detention, compared with the previous year. The data were checked with the hospitals concerned, but the reasons for the decrease remain unclear. The Commission is currently collaborating in a project to investigate the reasons for the apparent reduction, and will report on this in next year’s Annual Report.

Figure 5.1 shows the incidence of episodes of detention under the Mental Health (Scotland) Act 1984, per 100,000 population, in each Health Board Region, during 2000-2001. The incidence of Section 24 and 25 detentions was evenly distributed across the regions, ranging from 50/100,000 in Forth Valley to 107/100,000 in Greater Glasgow. For detention under Section 26, there was also an even distribution across the regions, ranging from 30/100,000 in Forth Valley to 64/100,000 in Greater Glasgow. For detentions under Section 18, nine regions had incidences between 20 and 27/100,000. However, it is noticeable that one Health Board region, Lanarkshire, differed markedly from the rest, having a very low incidence of 11/100,000. Two others also had somewhat low incidences, Forth Valley and Fife, with figures of 14 and 16/100,000 respectively. The reasons for these differences are unclear. They may reflect socio-economic differences between the communities in these regions and those in other parts of Scotland or they may reflect differences in clinical practice between these regions and the rest.
Auditors’ Statement on the summary financial statement of the Mental Welfare Commission for Scotland

We have examined the summary financial statement on pages 73 and 74 which is the responsibility of the Commissioners. Our responsibility is to issue an independent opinion on the summary financial statement.

We conducted our examination in accordance with guidelines issued by the Auditing Practices Board and carried out such procedures as we considered necessary to support our opinion. Our report on the Commission’s full annual accounts describes the basis of our audit opinion on those accounts.

It is our opinion the summary financial statement is consistent with the annual accounts and Commissioners’ report of the Mental Welfare Commission for Scotland.

Remuneration of Commissioners

<table>
<thead>
<tr>
<th>2000</th>
<th>Salary/ Fee</th>
<th>Pension Contrib</th>
<th>Expenses &amp; Benefits</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>12,060 Chairman</td>
<td>17,375</td>
<td>0</td>
<td>0</td>
<td>17,375</td>
</tr>
<tr>
<td>70,624 Highest paid Commissioner</td>
<td>77,370</td>
<td>4,023</td>
<td>0</td>
<td>81,393</td>
</tr>
</tbody>
</table>

Number Other Commissioners remuneration (including superannuation contributions) Number

<table>
<thead>
<tr>
<th>Number</th>
<th>0-£ 5,000</th>
<th>£ 5,001-£ 10,000</th>
<th>£ 10,001-£ 15,000</th>
<th>£ 15,001-£ 20,000</th>
<th>£ 25,001-£ 30,000</th>
<th>£ 30,001-£ 35,000</th>
<th>£ 40,001-£ 45,000</th>
<th>£ 50,001-£ 55,000</th>
<th>£ 65,001-£ 75,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>9</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A copy of the full annual accounts is available on request.
Revenue Income and Expenditure Account for the Year Ended 31st March 2001

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allocation from the Scottish Executive</td>
<td>1,489,000</td>
<td>1,576,303</td>
</tr>
<tr>
<td>Allocation for additional NHS superannuation (debtor recoverable from SEHD)</td>
<td>9,373</td>
<td>1,585,676</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td>1,046,367</td>
<td>1,164,073</td>
</tr>
<tr>
<td>Personnel</td>
<td>169,443</td>
<td>164,234</td>
</tr>
<tr>
<td>Accommodation</td>
<td>282,574</td>
<td>253,727</td>
</tr>
<tr>
<td>Other</td>
<td>1,498,384</td>
<td>1,582,368</td>
</tr>
<tr>
<td><strong>Surplus/Deficit for year</strong></td>
<td>-9,384</td>
<td>3,308</td>
</tr>
<tr>
<td>Not Available for Carry Forward</td>
<td>-2,909</td>
<td>0</td>
</tr>
<tr>
<td>Net Movement in Funding Balance</td>
<td>-12,293</td>
<td>3,308</td>
</tr>
</tbody>
</table>

Balance Sheet as at 31st March 2001

<table>
<thead>
<tr>
<th></th>
<th>2000 £</th>
<th>2001 £</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Assets</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tangible fixed assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td>4,413</td>
<td>14,189</td>
</tr>
<tr>
<td>Stocks</td>
<td>4,161</td>
<td>13,934</td>
</tr>
<tr>
<td>Debtors</td>
<td>252</td>
<td>255</td>
</tr>
<tr>
<td>Cash in hand and at bank</td>
<td>4,413</td>
<td>14,189</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td>-36,833</td>
<td>-33,924</td>
</tr>
<tr>
<td>Creditors due within one year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Current liabilities</strong></td>
<td>-32,420</td>
<td>-19,735</td>
</tr>
<tr>
<td>Creditors due after more than one year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions for liabilities and charges</td>
<td>0</td>
<td>-9,373</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>-32,420</td>
<td>-29,108</td>
</tr>
</tbody>
</table>

Financed by:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scottish Executive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance brought forward</td>
<td>-20,127</td>
<td>-32,420</td>
</tr>
<tr>
<td>Income/Expenditure Account</td>
<td>-12,293</td>
<td>3,308</td>
</tr>
<tr>
<td>Balance carried forward</td>
<td>-32,420</td>
<td>-29,112</td>
</tr>
</tbody>
</table>

Adopted by the Commission on 30th July 2001

Signed [Signature] Director
7.1 LIAISON WITH OTHER BODIES/AGENCIES

The Commission maintains regular contact with the following bodies/agencies:

- Alzheimer Scotland – Action on Dementia
- Association of Directors of Social Work
- Association of Sheriffs
- Benefits Agency
- British Association of Social Workers
- Colleges of Nursing
- Convention of Scottish Local Authorities
- Clinical Resources and Audit Group (CRAG)
- Crown Office
- ENABLE
- Health Boards
- Health Service Commissioner
- Local Authorities
- Manic Depression Fellowship Scotland
- National Schizophrenia Fellowship
- NHS in Scotland Management Executive
- NHS Trusts
- Royal College of General Practitioners
- Royal College of Psychiatrists
- Scottish Association for Mental Health
- Scottish Courts Administration
- Scottish General Practitioners Committee (BMA)
- Scottish Health Advisory Service
- Scottish Law Commission
- Scottish Executive
- Scottish Prison Service
- Social Work Services Inspectorate
- (c) Information for detained patients
- (d) For People who are on Guardianship
- (e) For Guardians
- (f) For Staff of Local Authority Social Work Departments, Voluntary and Private Residential and Day Care Establishments
- (g) Dementia in the Community - For Sufferers and Carers
- (h) In Your Interests: A Guide to all Patients Admitted to Psychiatric Ward after Criminal Proceedings
- (i) Complaints about Care and Treatment - How the Commission can help
- (j) Charter Standard Statement

An information sheet on the role of the Commission is available in Arabic, Bengali, Cantonese, Hindi, Punjabi, Urdu and Gaelic.

Posters
Free A3 and A4 size posters are available for display in public settings.

Annual Report
Copies of the 2000-01 Annual Report are available on the website or on request.

For any of the above please contact:

Alison McRae
Secretary
The Mental Welfare Commission for Scotland
K Floor
Argyle House, 3 Lady Lawson Street
EDINBURGH EH3 9SH

Tel: 0131 222 6111
Fax: 0131 222 6112/3
E-mail: enquiries@mwscot.org.uk
www.mwscot.org.uk

7.2 FURTHER INFORMATION SOURCES ABOUT THE COMMISSION

Free Leaflets
(a) The Mental Welfare Commission – How it Works for People with a Mental Illness and Their Families
(b) For People with Learning Disabilities Living in the Community
7.3 BIBLIOGRAPHY

Legislation


Criminal Procedure (Scotland) Act 1995, Chapter 46. HMSO, 1995


Mental Health (Scotland) Act 1984, Chapter 36. HMSO, 1984


Mental Health Act 1983. HMSO, 1983


Other


Mental Health Standards. Scottish Health Advisory Service, Edinburgh, 1999


Our National Health: a plan for action, a plan for change. Scottish Executive, Edinburgh, 2000

The Protection of the Finances and Other Property of People Incapable of Managing their own Affairs. Scottish Executive, Edinburgh, 1999 (CCD 2/99)


76
SECTION 8
PRACTITIONERS’ INDEX 1996-2001

ABSENCE WITHOUT LEAVE 1996/7 36 – Involvement of GP 1998/9 18
- Power to return 1999/0 23 – Transfer to Hospital 1996/7 21
ABUSE OF PATIENTS 1996/7 38 – and Mr. B Inquiry 2000/1 11-13
- Sexual Abuse 1996/7 37-38

- Guidelines for reporting 2000/1 40

ACCIDENTS & INCIDENTS (see also REPORTS) 1996/7 39
- Reporting by Local Authorities 1996/7 39-40
- Reporting by Trusts 2000/1 38-39

- CARERS (see also RELATIVES) – involvement in treatment 2000/1 51-52

ACT OF SEDERUNT 1996/7 34 – Sexual Abuse 1996/7 37-38
- Awareness of 1996/7 15

ADOLESCENTS 1996/7 40 – and Dementia 2000/1 50
- Services for 2000/1 7, 16-17
- Health Advisory Service Report 2000/1 16

ADULTS WITH INCAPACITY ACT (see also CODES OF PRACTICE) 1996/7 52
- and Complaints 1999/0 52, 22, 51-52
- and Continuing (Financial) 2000/1 23-24, 59-60
- and Guardianship 2000/1 23-24
- and General Practitioners 2000/1 23-24, 36-31, 59
- and Guardianship 2000/1 36-31, 59
- and Mental Health Act 2000/1 59-60, 69
- and Mr. B. Inquiry 2000/1 23, 12, 13, 14
- and Welfare Powers of Attorney 2000/1 23, 59-60

ADVOCACY SERVICES 1996/7 40 – and Mr. B Inquiry 2000/1 10
- and Dementia 1997/0 17
- and Guardianship 2000/1 52
- and Learning Disability 2000/1 50
- and Nurses 1998/9 60
- Shortfalls 1997/8 34
- and State Hospital 1997/8 12
- and Visiting Programme 1997/8 19

ALCOHOL MISUSE 1996/7 40 – and Visiting Programme 2000/1 19
- and Discharge Policies 2000/1 22
- and Guardianship 1998/9 27-28
- and Mental Health Act 2000/1 52
- and Mr. B. Inquiry 1998/9 20
- and Probation Orders 2000/1 36
- in Social Circumstance Reports 2000/1 36-31

APPLICATIONS FOR DETENTION 1996/7 40 – and Mr. B Inquiry 2000/1 10
- and Act of Sederunt 1998/9 44
- and Curator ad Litem 1998/9 44

CAPACITY 1996/7 40 – and Mr. B. Inquiry 2000/1 9-14
- and Probation Orders 2000/1 11-14
- and responsibilities of Local Authorities 2000/1 9-12
- and responsibilities of solicitors 2000/1 10-11, 14

CARE HOMES (see RESIDENTIAL CARE) 1996/7 40 – and Mr. B Inquiry 2000/1 9-14

CARE PLANNING 1996/7 40
- and Discharge from Hospital 2000/1 9-12, 47-50

CARE PROGRAMME APPROACH 1996/7 40

1 Pages in bold denote a major entry.
- and Clozapine
- and CP(S)A
- in Dementia
- and LOA
- and MHOs (see MENTAL HEALTH OFFICER S)
- and Nearest R elative
- and Nurses
- simultaneous consent to s24/25 and s26
- by Telephone
- Treatment with Consent
- Unlawful Administration of Treatment

CONSENT TO TREATMENT
- and Continuation of Detention

CRITICAL INCIDENT REVIEW

CURATOR BONIS
- in M r. B. Inquiry

CURATOR AD LITEM
- and Guardianship
- Awareness of
- Payment of

DAY SERVICES AND ACTIVITIES

DEAF PATIENTS

DEATHS
- Audit/Reviews of Suicide
- Fatal Accident Inquiries
- by Suicide

DEFICIENCY IN CARE INQUIRIES
- Mr. B. Inquiry
- M S P Inquiry
- and Race
- R uddle Inquiry

DELAYED DISCHARGES
- Forensic
- Forensic in Glasgow
- and Funding Issues

DEMENTIA
- and Consent to Detention
- Services
- and Guardianship

DETENTION UNDER MH(S)A
- Alteration of Forms
- Choice of Sheriff Court
- Conveyance of Patients
- De facto Detention
- Discharge from

2000/1 31-32, 41-44 - Emergency Detention (S24/25) 1997/8 35, 38, 45
1997/7 55 - 1998/9 54-58
1997/8 34 - 1999/0 21
1997/8 56 - 2000/1 25, 28, 41-44
1997/8 14, 22-23 - and General Practitioners
1999/0 45-46 - in General Hospitals
1996/7 35, 41-43 - N otification
1996/7 34 - N otification of Hearings
1997/8 22 - Section 18
1999/0 20, 46 - 2000/1 32, 33, 52
2000/1 32 - 1997/8 35, 45
2000/1 31-32, 44
1999/0 23
- and Ms P Inquiry
1999/0 48
- and Race 2000/1 20
- Ruddle Inquiry 1999/0 6, 10-13
1999/0 2000/1 32-33
1999/0 2000/1 31-32, 44
1999/0 23
- and Treatment
- and treatment for physical disorders
- and Unlawful Treatment
- use of Detention by Health Boards
2000/1 71
2000/1 33
2000/1 31
1997/8 34
1999/0 48
2000/1 56

- Adverse Effects of Neuroleptics 2000/1 37-38
- Illicit Drugs (see also Social Circumstance Reports) 2000/1 27-28
- Searching for 2000/1 27-28
- Treatment 2000/1 37, 38

DUAL DIAGNOSIS (see COMORBIDITY)

EDUCATIONAL NEEDS
- Assessment in Mr. B. Inquiry 2000/1 12

ENVIRONMENT
- in Residential Care 2000/1 26
- and Guardianship 1999/0 31
- and Safety 1998/9 17
- and Visiting Programme 1999/0 7, 14, 16
2000/1 21

EUROPEAN CONVENTION ON HUMAN RIGHTS (see HUMAN RIGHTS ACT)

FATAL ACCIDENT INQUIRIES

FINANCIAL BENEFITS
- DLA 1996/7 14
- Income Support 1997/8 21

FINANCIAL PROTECTION
- in Mr. B. Inquiry 2000/1 9-14
- and R esponsibilities of Local Authority 2000/1 10, 11-12
- and R esponsibilities of Trusts 2000/1 11, 13

FORMS
- 9 and 10 1997/8 12-15
- Access to 1996/7 15
- Alteration of 1996/7 33-34
**FORENSIC SERVICES** 1997/8 7, 12, 19
- In Glasgow 1996/7 16-17

**FRAMEWORK FOR MENTAL HEALTH SERVICES IN SCOTLAND** 1996/7 6, 1998/9 18
- Services for Children and Adolescents 2000/1 25-26

**FUNDING ISSUES** 1999/0 7, 17-19
- and Mr. B. Inquiry 2000/1 14

**GENERAL HOSPITALS**
- and Risk Management 1998/9 34

**GENERAL PRACTITIONERS AND THE MENTAL HEALTH ACT**
- and Access to Forms 1997/8 48
- and Access to Mental Health Officers 1997/8 14
- and Adults with Incapacity Act 1999/0 48
- and Curators ad Litem 1997/8 33
- and Discharge from 1999/0 23
- and GPs 1999/0 31
- and M Alcohol Related Syndromes 1999/0 33
- and Curators ad Litem 1999/0 48

**GUARDIANSHIP**
- and Adults with Incapacity Act 2000/1 30
- and Alcohol Related Syndromes 1999/0 32-33
- and Curators ad Litem 2000/1 29-31, 47-50

**GUIDELINES**
(see also **CLINICAL STANDARDS**)
- Royal College of Psychiatrists 3.3 2000/1 52

**HOSPITAL CLOSURE/CONTRACTIONS**
1997/8 11, 12
1998/9 18

**HUMAN RIGHTS ACT** 1998/9 55

**INCAPAX**
- and Mental Health (Amendment) Act 1999 1997/8 8
- and Nurses 1998/9 17, 41, 62
- and Responsibilities of Local Authority 2000/1 10-12
- and Responsibilities of Trusts 2.1 2000/1 10, 13

**INFORMATION TO PATIENTS** 1997/8 12

**INTERPRETERS** 2000/1 19

**JOINT FUTURE** 2000/1 7

**LEGAL ASSISTANCE (ABWOR)** 1999/0 6-7, 45

**LOCKED DOORS** 1996/7 39

**MACLEAN REPORT** 1999/0 51

**MACPHERSON REPORT** 2000/1 18

**MENTAL HEALTH (SCOTLAND) ACT**
(see also **CODES OF PRACTICE, DETENTION, GUARDIANSHIP**)
- Places of Safety 2000/1 50-51
- Section 19 2000/1 35, 51
- Section 25(2) (see NURSES HOLDING POWER) 1999/0 48-49
- R recall from 1999/0 24
MENTAL HEALTH IMPROVEMENT NETWORK 2000/1 6-7, 16-17

MENTAL HEALTH LEGISLATION
- Mental Health (Scotland) Act 1984 (see Detention)
- Mental Health Amendment Act 1999 (the 'Clarke' Act)
- Mental Health (Public Safety and Appeals) Act 1999
- MacLean Committee (see MACLEAN REPORT)
- Millan Committee (see MILLAN REPORT)
- Notes on the Mental Health Act 2000/1

MENTAL HEALTH OFFICERS 1996/7 41-42, 46-49
- Access to
  - and Consent to Detention
  - and Continuity of Care
  - and Nurses Holding Power
  - Outside own Local Authority Area
  - and Relatives
  - and Sedated Patients
  - and Telephone Consent
  - and Timing of Consent

MENTAL HEALTH AND WELL-BEING SUPPORT GROUP 2000/1 7, 16

MENTALLY DISORDERED OFFENDERS 1996/7 55-57
- in Prisons
- National Strategy for
- and Millan Report

MILLAN REPORT 1999/0 51
- and Applications for compulsion
- and Community Treatment Orders
- and General Practitioners 2.5
- and Grounds for Compulsion
- and Mental Welfare Commission
- and Mental Health (Public Safety and Appeals)(Scotland) Act
- and Treatment Safeguards
- and Tribunals

NATIONAL ASSISTANCE ACT 1948 1999/0 20

NATIONAL CARE STANDARDS 2000/1

NEUROSURGERY FOR MENTAL DISORDER 1997/8 58-59
- and 1998/9 65
- and 2000/1 65-66

NURSES
- Escorts
- Staffing

NURSES HOLDING POWER 1996/7 22-24
- 1998/9 32
- 2000/1 25

NURSES KNOWLEDGE OF MENTAL HEALTH 1997/8 14
- 1998/9 32-33
- 1999/0 22-23

NURSING HOMES (see RESIDENTIAL CARE)

OBSERVATION HOMES (see RESIDENTIAL CARE)

OBSE RVATION OF PATIENTS 1996/7 27
- 1998/9 33-34

OMBUDSMEN
- Local Authority
- NHS

OUR NATIONAL HEALTH
- and Children and Adolescents' Services

PERSONALITY DISORDER
- Mental Health (Public Safety and Appeals) Act
- Ruddle Inquiry

PHYSICAL HEALTH
- and Learning Difficulties
- and Treatment of Incapable Adults

POWERS OF ATTORNEY (see ADULTS WITH INCAPACITY ACT)

PRACTICE GUIDANCE
- Access to Bedrooms
- Access to Mail/Telephones
- Access to Mail/Telephones at State Hospital
- Consent to Treatment
- Early Response to Recurrent Severe Mental Illness
- Restriction of Movement

PRISON SERVICE
- Barlinnie
- Cooke Report
- Visiting Programme

PUBLIC GUARDIAN
- Relationship with Mental Welfare Commission
- Website

RACE RELATIONS (AMENDMENT) ACT 2000/1 18

REGULATION OF CARE ACT 2000/1 57-59

RELATIVES (see also CARERS)
- Communication with
- in Emergency Detentions
- Nearest

RUGS (see also MENTAL HEALTH (SCOTLAND) ACT)
- Rights (see Section 19 Mental Health (Scotland) Act)