



The Mental Health Officer: capacity, challenges, opportunities and achievements

Sharing knowledge from practice 2017

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Executive Summary

The Mental Health Officer (MHO) is a “specially trained social worker who has the training, education, experience and skills to work with people with a mental disorder” (Scottish Executive, ‘[A Guide to the Role of the Mental Health Officer](#)’, 2006), as appointed under the [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#). Under section 32 of this Act, each Local Authority must appoint a sufficient number of persons for the purpose of discharging, in relation to their area, the functions of the MHO under the above Act, the [Criminal Procedure \(Scotland\) Act 1995](#), the [Adults with Incapacity \(Scotland\) Act 2000](#) and the [Mental Health \(Scotland\) Act 2015](#). Local authorities assign this responsibility in practice to the [Chief Social Work Officer](#).

This paper aims to give detailed information to chief social work officers, chief officers, and other senior leaders responsible for integrated partnership arrangements at a locality level, and to relevant others, to enhance understanding of the pressures inherent in the MHO role, to support senior leaders identify any areas in relation to corporate risk and to make informed decisions to strengthen delivery of a safe, effective and person-centred MHO and mental health service across health and social care.

Provenance of this report:

In 2016, Social Work Scotland completed a report to increase the knowledge base regarding capacity and challenges in the role of the Mental Health Officer (MHO) across Scotland. The report was undertaken as a desktop exercise, based on publicly available data at that time (since updated in 2017), including information from the Scottish Social Services Council (SSSC) and Scottish Government. Key themes arose from this 2016 report suggesting a workforce which was under increasing pressure due to the following:

- One third of the MHO workforce was over the age of 55 years and many were planning retirement over the next 2 – 5 years
- Increasing numbers of social workers were expressing an interest in undertaking the MHO Award, but these numbers were significantly lower than the numbers of experienced MHOs leaving the service annually
- Local authorities were reporting an increasing number of vacancies in the MHO service and a combined national shortfall of 40 whole time equivalents (WTEs) was reported
- MHOs were experiencing an increasing demand in workload, e.g. a 10-12% year on year increase in guardianship applications
- There were difficulties in recruitment and retention, linked to variations across

local authorities in salary scales, enhancements for the MHO role, training opportunities and ongoing development opportunities offered and terms and conditions for employment and deployment

- Poor succession planning

The Scottish Social Services Council has since published its report '[MHOs \(Scotland 2016 Report: A National Statistics Publication for Scotland](#)' in 2017 with updated statistics, and its key findings are as follows:

- A total of 60 MHOs left the workforce between 7 December 2015 and 5 December 2016, an increase of 13% over the previous year. Of these, just under half retired, about a quarter resigned and just under a fifth left for other reasons such as a career break or secondment
- For the first time in the period examined (2012–2016), the number of MHO Award programme completions (62 in 2015-16) is greater than the number of leavers
- In 2016, around two-thirds of Scotland's local authorities reported a shortfall in their MHO staff resources. The total additional hours per week required to address the shortfalls reported have reduced by 17% from 2015, although they remain high at around 1,290 hours, the equivalent of approximately 36 additional full time exclusive MHOs
- Adults with Incapacity (AWI) was once again the most commonly reported specific shortfall area
- The number of practising MHOs has increased by 5.4% to 722 in December 2016. The contracted whole time equivalent (WTE) has increased by 5.7%, from 602.2 in 2015 to 636.4 in 2016
- After reaching a reporting period low of 11.2 in 2015, the MHO WTE rate per 100,000 people has risen to 11.8 in 2016, similar to the level seen in 2013
- MHOs across Scotland spent just over half of their contracted hours on MHO work in 2016. Members of mental health teams spent around three-quarters of their contracted hours on MHO work, while members of non-mental health teams spent around a quarter. Exclusive MHOs spent about 95% of their contracted hours on MHO work

The Social Work Scotland 2016 report also highlighted the different ways in which local authorities had reported they were attempting to address these challenges.

In November 2016, the report was ratified by the President of Social Work Scotland, however, it was felt that it would be of benefit to undertake a further piece of work to find out in detail, from 3–4 local authorities, what the exact issues were and how these were being addressed in the day to day operation of the MHO service.

Accordingly, in January 2017, Chief Social Work Officers were asked to self - nominate their local authorities, if they wished to be involved and it was hoped 3–4 local authorities would come forward. 7 local authorities volunteered and interviews in these 7 areas were undertaken in February–March 2017.

Interviewees:

The 7 local authorities were located in both rural and urban areas, with both large and small populations, with varied local arrangements for the integration of health and social care and represented different ways in which the MHO service was structured and its MHOs deployed. Accordingly, these 7 local authorities were broadly representative of the MHO service across Scotland. In only 2 of the local authorities, did chief social work officers participate in interviews – 1 as sole interviewee, 1 with a group of MHO service managers and relevant others. The other 5 interviews were conducted directly with the service manager or team manager responsible for the day-to-day operation of the MHO service. 6 interviews were conducted face-to-face and 1 was conducted by telephone.

2017 Report:

Despite challenges raised, all those interviewed spoke very positively about their teams' intent to keep those using the MHO service at the heart of their working practice and to ensure social work values remained integral to the process, both at a single agency level and in an integrated context.

There were 3 key areas arising from these interviews:

1. Recruitment and retention:

A 2013 report for the Association of the Directors of Social Work (ADSW), the predecessor body of Social Work Scotland, highlighted differences in salary and enhancements and this 2017 report also reflects these differences, and the impact the variations have on the recruitment and retention of MHOs to the role in any one local authority. Some local authorities pay no additional increments on the salary

scale, others pay one additional increment and some others make additional one-off or annual payments to MHOs. There are also variations in training and development opportunities and career structures.

There is still interest expressed by social workers in undertaking the MHO Award as a career development opportunity but variation exists across local authorities with regard to support given to trainees and the ways in which they are deployed on qualification. This also reportedly impacts on the retention of MHOs, as there is evidence of MHOs moving to different local authorities with higher salary or enhancement offers.

Out of hours' services, and the role of MHOs in these, also reflects significant variation across local authorities: some operate an in-house service, others externally commission the service. Some out of hours' services have a requirement for a MHO to be part of these teams, others do not, some have a MHO in the team but they do not undertake MHO work, other local authorities have developed local arrangements for MHOs to undertake 'on call' duties as and when required and, similarly, there is variation in payments across the MHO role within out of hours' services.

There is also variation in how local authorities deploy MHOs: some operate dedicated MHO teams, others operate both a dedicated MHO team and have MHOs across other social work teams. Some MHO team or service managers in local authorities have differing experiences of allocating work to, overseeing the MHO work of, or providing supervision to, MHOs in other social work teams. Some local authorities have qualified MHOs across teams who are not undertaking MHO work, reportedly making it very difficult to ensure they are able to maintain their accreditation. Those interviewed felt that inability or lack of capacity to allocate MHO work to MHOs in other social work teams increased the workload of MHOs in dedicated teams, further exacerbating already significant challenges.

Chief social work officers should share learning about differing recruitment and retention approaches across local authority areas.

2. Increasing workload demand:

The Law Society and the Sheriffs' Association had both expressed views to Scottish Government prior to the publication of the Mental Health (Scotland) Act 2015 that proposals in the Act would result in a greater volume of guardianship applications and workload associated with legislative changes, especially for sheriffs, MHOs and medical practitioners. This increase is now being reported by the local authorities interviewed for this report.

The chief social work officer, as the person to whom the intention to make an application for any order is made, will have a keen interest in the impact of an increased workload on the ability of the local authority to meet statutory obligations and timescales. There is also recent evidence of a successful legal order having been sought in 2016 by a solicitor and granted by a Sheriff against a local authority which had missed the statutory 21 day timescale for completion of a MHO report following notification.

This Social Work Scotland report highlights increases in workload experienced by local authorities as a result of changing legislation, increasing expectations, target-driven cultures, raised awareness of guardianship, increasing older demographics with significantly higher complexity of need and often a lack of capacity. Increases in workload were also reflected in associated waiting lists.

3. The integration of health and social care and local governance arrangements:

Interviewees spoke about the impact of this on several levels, including working with others, governance and line of sight to the chief social work officer.

MHOs had experienced challenges through the variations in structures implemented as a result of the integration of health and social care. These challenges were felt to impact on inter-professional working and boundaries within and across professional roles. This experience was reflected for some across multi agency training opportunities, information sharing and barriers created by a non-alignment of ICT systems.

Local authority interviewees described variations in experiences of how, by whom and in what ways the MHO service was governed locally. Some experienced a tight structure, direct management by a qualified social work manager, some by a health manager, some managers were reported to have a robust knowledge of mental health issues, some were not, some managers had been MHOs, and some had not. There were differences expressed in the degree to which mental health services were felt to be discussed within the business priorities of integration authorities. There were also variations expressed by interviewees in the line of sight between the MHO service and the chief social work officer.

The chief social work officer, through the local authority, formally appoints MHOs then retains the accountability for the MHO service in each local authority, regardless of local arrangements made for integration authorities. The responsibility for the MHO service cannot be delegated to the integration authority.

The experiences of those interviewed reflected variation in the strength of this line of

sight between the MHO service and the chief social work officer. Some interviewees experienced regular, routine and active oversight of the service by the chief social work officer, while others experienced what was described as minimal contact, often only when specific information was requested or when providing information for the chief social work officer's annual report.

The role of sheriffs, Police Scotland, Health colleagues and other professionals is highlighted in relation to professional working relationships with the MHO service. Again, much variation was experienced by those interviewed about the professional relationships between the service and these colleagues.

These key areas are examined in further detail in this report and issues from practice are highlighted.

The role of the MHO and adult support and protection:

Interviewees described the complexity of the legislative landscape within which the MHO operated and supported others to operate. As well as undertaking specific duties in relation to mental health legislation, the role the MHO plays in navigating adult support and protection legislation to ensure the least restrictive intervention to support the adult to achieve the optimum outcome is also described.

Recommendations:

Finally, the report makes recommendations for consideration going forward, based on the findings from the experiences reported by these local authority interviewees.

The report is also complemented by 10 case studies reflecting different aspects of the MHO role.

Social Work Scotland
September 2017

1. About Social Work Scotland

Social Work Scotland is the professional leadership body for the social work and social care professions. We are a membership organisation which represents social workers and other professionals who lead and support social work across all sectors.

Social Work Scotland's vision is of a social work profession across Scotland which is led effectively and creatively, is responsive to the needs of the people it supports and protects, is accessible and accountable and promotes social justice.

Social Work Scotland's values are based on professional leadership to achieve social justice and public protection. We value each person we support as an individual, without judgement; we celebrate and actively promote the unique contribution and role of professional social work; we embrace change and encourage collaborative and integrated arrangements to deliver better outcomes for people; and we support and create opportunities for those within and those supporting the profession of social work, in order to develop effective and creative leaders for the future.

Social Work Scotland's objectives are to:

1. Influence and shape legislation and policy relating to social work and social care.
2. Promote the unique role, value and contribution of social work and social care.
3. Champion research and evidence-informed approaches in our work.
4. Provide professional leadership and increase leadership capacity across social work and social care.
5. Support and encourage workforce development (with a focus on celebrating success, promoting standards, achieving practice improvement and demonstrating continuous learning).
6. Recognise the value of continuous improvement through self-evaluation and performance improvement activities.

2: Background

2.1 Provenance of this report

In 2016, following discussions with the Scottish Government, Social Work Scotland, in partnership with chief social work officers, took a decision to develop a position paper regarding the status, capacity and challenges experienced by Social Work Scotland members and their organisations across Scotland in relation to Mental Health Officers' (MHOs) services.

The development of the 2016 report was undertaken as a desktop exercise using published data from relevant organisations, including data from chief social work officers' annual reports, the Social Work Scotland Community Care Standing Committee, the Social Work Scotland MHO Sub Group, the Mental Welfare Commission, the Scottish Social Services Council, the Care Inspectorate and research commissioned by Scottish Government. In October 2016, the report was ratified by the President of Social Work Scotland.

Simultaneously, work was ongoing by the Mental Welfare Commission regarding examining and scoping the potential to develop a 'graded guardianship' approach to support the increase in referrals being made to local authorities in respect of the Adults with Incapacity (Scotland) Act 2000 and an anticipated further increase in referrals in response to the proposed changes in the Mental Health (Care and Treatment) (Scotland) Act 2015.

In order to gain a more in-depth understanding of the issues for MHOs, the decision was taken to hold the original Social Work Scotland report and develop a supplementary report in 2017 which would involve undertaking more detailed interviews with approximately 3–4 local authorities. A request for local authorities' involvement was made at the chief social work officers' meeting in January 2017 and, subsequently, Social Work Scotland was contacted by 7 local authorities.

Interviews were undertaken with managers of the MHO services of these 7 local authorities in February-March 2017. This 2017 report is based on these interviews.

It will first be helpful to review the findings from the 2016 report, based on published data at that time.

2.2 Summary of the Social Work Scotland 2016 MHO report

The report written in 2016 included a background and context to the role of MHO, outlined issues for consideration, including positive aspects of practice from available data, as well as highlighting the challenges experienced in local authorities. It also included practice examples from local authorities of the ways in which challenges were being addressed and supports which were available. The key themes which emerged at the time of writing of the 2016 report were as follows:

- There was a 2% increase in whole time equivalent (WTE) practising MHOs between 2014-15
- Of the MHO workforce, 32.5% were aged 55+, and 12.3% were aged 60+
- There was an increasing trend in the numbers of individuals being admitted to, and completing, the MHO Award programme
- The average number of individuals qualifying on the MHO Award course in the years 2014–2015 and 2015–2016 was 47, however, the average number of MHOs leaving the service each year was 60
- There was a steady increase in MHOs in dedicated MHO teams (56%), and a corresponding decrease in MHOs deployed in non-MH teams (43%)
- Local authorities reported an increase in MHO vacancies: in 2015, 66% of local authorities reported a combined shortfall of 40 WTE exclusive MHO vacancies simply to undertake levels of statutory MHO duties at that time
- Local authorities reported an increase in demand on MHOs: year on year saw a reported 10-12% increase in guardianship applications, with approximately 80% of the workload of MHOs being Adults with Incapacity statutory duties. From 2013–2015, this workload increased by an average of 25%
- Cross-cutting reasons for difficulties in recruitment and retention were identified as low pay, conditions of employment, workforce skills, workforce diversity, changing models of health and social care and sector growth

The Scottish Social Services Council '[MHOs \(Scotland\) Report 2016: A National Statistics Publication for Scotland](#)' published on 29 August 2017, contains updated statistics on MHOs from the 2016 year which are referenced, as appropriate, throughout this report.

The 2016 report identified 2 key elements of operational requirements at that time which impacted on the role of the MHO:

1. Workforce development and succession planning in general, and for MHOs in particular, which would greatly benefit from further scoping work in order to gain an in depth picture of issues faced, similarities or differences across local authority approaches and a clearer understanding and up-to-date picture of how local authorities are addressing issues currently and for future planning.
2. Despite local authorities' efforts to address the issues regarding the MHO workforce, there remained the issue of increasing demand being placed on the MHO role through the implementation of additional legislative duties.

2.3 Scottish Government Mental Health Strategy 2017 – 2027:

The Scottish Government has published its [Mental Health Strategy 2017–2027](#) with the vision of a Scotland where “people can get the right help at the right time, expect recovery and fully enjoy their rights, free from discrimination and stigma” and the ambition that anyone can “ask once to get help fast”. The Strategy outlines 40 action points from the following 5 categories:

1. Prevention and early intervention.
2. Access to treatment and joined-up, accessible services.
3. The physical wellbeing of people with mental health problems.
4. Rights, information use, and planning.
5. Data and measurement.

Action number 35 from the Strategy states that Scottish Government will “work with key stakeholders to better understand Mental Health Officer capacity and demand, and to consider how pressures might be alleviated”. This report will contribute to the knowledge base around the role of the Mental Health Officer to support that greater understanding and, ultimately, better support good outcomes for those with mental health issues to “ask once to get help fast”.

This 2017 report, reviewing practice in 7 local authorities, was undertaken to provide this additional understanding and to support the relevant action point within the Mental Health Strategy 2017 - 2027.

This report also takes into account updated data from '[Mental Health Officers \(Scotland\) Report 2016: A National Statistics Publication for Scotland](#)'.

CASE STUDY 1: The role of the MHO in safeguarding rights to support a return home

A MHO became involved following concerns by hospital staff of the risks presented by an elderly woman who had initially agreed to a voluntary admission.

On admission, it had become clear that the woman was having delusional thoughts, including believing she had holes in her throat, and was refusing to eat or drink or take medication. The MHO became involved and agreed with the consultant psychiatrist's assessment that a Short Term Detention Order was the best way in which to secure treatment for the woman, who was diagnosed with psychotic depression, which the consultant believed was due to the recent death of her husband. Medication prescribed previously had had no effect and the woman was demonstrating severe weight loss and risk of dehydration.

The couple had had no children and the woman had been living a very insular life at home with little contact from others. In undertaking the assessment, the MHO had also identified a Named Person who could support the woman and liaise with her family members who lived in England and who initially were placing pressure on the MHO to arrange for the woman to be moved to England so she could be supported by the family. There was no Power of Attorney in place.

The MHO ensured that the woman was fully involved in all discussions and planning around her discharge, including her planned place of residence, and it was clear that she did not want to move to England. The MHO had a number of discussions with family members supporting the woman's right to be involved in decisions which she could make, her right to be heard and for her wishes to be taken into consideration and her right, as an adult, to take appropriate risks. The MHO also explained to the family that, without a Power of Attorney in place, the local authority could not take decisions as, once her health improved, the woman had appropriate capacity to make decisions about her own care.

The MHO also requested advocacy support for the woman in ongoing reviews of her care. Electric Convulsive Therapy had provided very positive improvements for her and, following an assessment by the physiotherapist and occupational therapist, with the involvement of the MHO, it was concluded that she would be able to return home with appropriate supports being put in place. The MHO worked in partnership with both hospital staff and family members to provide opportunities for trial periods at home before a full discharge could be made with a relevant plan of care. The woman remained in her own home, supported by an appropriate care plan and there were no further concerns about her mental health.

3: Knowledge from practice 2017

The 7 local authorities within this report represent both rural and urban communities, highly and less populated local authorities, different models for the integration of health and social care and different modes of deployment for the mental health services provided. Although small in number, they are broadly representative of local authorities across Scotland, so give a reasonable indication of wider applicability of findings.

The local authorities are not identified, but are referred to as Local Areas A – G.

3.1 Aim and vision for the MHO Service

It is important to state, from the outset, that all representatives of mental health services interviewed during the development of this report described a passion for the role and for delivering a service which had a clear and sustained benefit to those using services, despite the challenges and difficulties which arose.

When discussing what each individual's aim and vision for their own service was, interviewees spoke about a variety of themes which will be developed further during the report. In brief, they are:

3.1.1 Good quality and safe outcomes for people

Ensuring those who use, and will need, in the future, to use mental health provision are the focus of a service which, it is felt, makes a positive difference to people's lives.

Interviewees recognised that, by the nature of the service, it is reactive, often responding at a point of crisis in someone's life and at the point when everything else has been tried and not worked. Those interviewed would like to see more advice-giving, more developmental work, more preventative and proactive work, more work with colleagues across sectors and more engagement with communities.

3.1.2 Resources

It was, in the main, felt vital that the service must remain, or become, a stand-alone and dedicated mental health service, one which was adequately resourced to support statutory work but also to intervene to support people before the point of

crisis. The service must be consistently and widely promoted, both by those working in mental health and by the local authority senior managers. Those interviewed felt the service must use effective performance management complemented by clear standards and agreed measures to ensure service excellence without subscribing merely to target-driven cultures, within a framework which was clearly understood and shared between frontline staff and operational and strategic managers.

3.1.3 Confident MHO workforce

It was felt to be important that MHOs are confident, competent and sufficiently skilled to be able to effectively act in the interests of those using the service. This includes the ability to constructively challenge professional colleagues – and system issues – which may act as a barrier to the best interests of those using services. Nurturing the leadership of the MHO profession was seen as key to having an excellent workforce.

3.1.4 Inter-professional working and integration

Although some challenges were reported by interviewees for the service through the integration of health and social care, they also described some excellent inter-professional working relationships, particularly when all professionals recognised and maintained the focus on the individual using the service.

3.1.5 Operational and social culture

The ability for the service to engender and support a wider societal debate, particularly in the current financial climate, was another theme which was related to the aims of the MHO services: the ability to ensure that mental health was viewed as everyone's responsibility, with communities having greater debate about the expectations on services, and mental health services in particular. Visibility and transparency, supported by good local governance, with excellent internal and external links, were felt to be clear drivers for discussions about public and professional expectations.

This point was also made with regard to the inclusivity of language: particularly as a result of integration, it was felt important to ensure a consistent, shared and respectful terminology in developing a shared language within mental health services. Interviewees felt that they and their partners were working hard to ensure the 'medicalised model of care', with its accompanying terminology, was changing and that putting the individual and his/her needs at the heart of the process was the most important thing for all services.

3.2 A picture of the MHO workforce

National statistics on the MHO role are recorded and reported annually by the Scottish Social Services Council with regard to the deployment of MHOs across Scotland, and these are much more detailed than information gathered for this report.

The Scottish Social Services Council report '[MHOs \(Scotland\) Report 2016: A National Statistics Publication for Scotland](#)' acknowledges the wide range of operational models for MHO services across the 32 local authorities and the varying work patterns and hours spent on MHO work within each. While variations exist, the information collected here gives an indication of the picture in these specific local authorities at the time of writing and, by extension, are reflective to an extent of local authorities across Scotland, in relation to the themes raised.

3.2.1 Deployment

There was much variation in the ways in which MHOs were deployed across the 7 local authority areas: of the 7 local authorities' mental health services, 2 have only a dedicated mental health team; the other 5 define themselves as a MHO service, i.e. a mix of one centralised MHO team complemented by MHOs working across other social work teams. In these other teams, how MHOs are deployed and used by the MHO service varies. This will be examined later in this report.

Those responsible for the operational day-to-day management of the service were either dedicated mental health service managers or MHO team managers or, in one instance, a senior MHO. For some, allocating or overseeing the workload of MHOs out with his/her team has reportedly been a challenge and very much dependent on local relationships. In the main, managers across teams and services have been able to make local arrangements to support workload allocation but not in all cases, and this has contributed to the difficulties in, among other things, supervision, workload allocation, reviewing the service or providing support to colleagues.

3.2.2 Whole Time Equivalent (WTEs) and deployment

The Scottish Social Services Council report 'MHOs (Scotland) Report 2016: A National Statistics Publication for Scotland' notes that the number of WTEs increased by 5.7% from 2015, and there was a similar increase in the WTE rate per 100 000 of the population (11.8). Overall, the report notes that the number of practising MHOs increased by 5.4% in the year to December 2016.

The report highlights a slight increase in the number of unfilled exclusive MHO vacancies from 15 in 2015 to 17 in 2016 and a significant increase in 'unavailable MHOs' (those on maternity/paternity leave, career break, long term sick leave, compassionate leave or adoption leave, for a period of greater than 3 months) from 17 in 2015 to 24 in 2016.

In relation to a shortfall in MHO staff resources, the above report notes that two thirds of local authorities reported a shortfall with the total additional hours required per week to address these having decreased by 17% from 2015. This still means an additional 36 full time exclusive MHOs are currently required in order to address these reported shortfalls. The highest area reflected in the data on shortfalls was that of adults with incapacity, although the report notes that there are an increasing number of reported shortfalls in the areas of learning disability and mentally disordered offenders.

In relation to those interviewed for this report, there was variation recorded:

Local Area A has 24 WTE MHOs (out of a total of 27 MHOs) deployed as follows: 6 in specialist mental health teams, 7 across joint mental health/learning disability teams, 4 managers, 3 in community care teams, 3 in learning disability teams and 4 who are managers of non-mental health teams. The current shortfall is calculated at 2 WTE. This area has a MHO Co-ordinator, separate to the teams and whose role allows overview of the MHO service's needs, including training, supervision and ongoing development of the service.

Local Area B has 18.6 WTE MHOs from 21 staff, 3 of whom are part time. The newest was 1 year qualified at the time of writing, with the rest being experienced staff. A recent restructuring of the service meant a pan-local area approach was taken, with the creation of practice leads for Adults with Incapacity (AWI), General Adults work and Forensic work. These practice leads are at a senior level, one grade higher than main grade social work staff. Of the current complement, 10 team members (50%) are due to retire in the next 5 years. The shortfall calculated for the team is 1 WTE, just to manage the current level of AWI referrals.

Local Area C has 25 MHOs with 9 in management posts; with the dedicated mental health service having 8 WTEs from a team of 9. Of the dispersed MHOs, 5 are part time and located across community mental health teams, learning disability teams and locality teams. There are no MHOs within children and families' teams – this decision was actively taken as a direct result of their inability to undertake MHO work due to capacity. Most of the MHOs are under 40 years old, however, 30% are over 50 years old. Of the dedicated MHO team, 50% are under 50 years and 50% are over 50 years. The current shortfall, based on calculated hours of work and workload demand, is 1.3 WTE.

Local Area D's 23.6 WTEs are supported by 7 team leaders based across 4 community mental health teams, a state hospital and the emergency social work service, another team leader is in a central development officer post. The community mental health teams over the 4 local areas have between 4–7 WTEs, 1-2 social workers and an average of 2 trainees. The hospital team has 7 social workers, of whom 3.6 are MHOs. The MHO age profile has 9 MHOs under 40 years old, 6 MHOs aged 40–50 years, 12 MHOs aged 50–60 years and 4 MHOs who are over 60 years old. There are 2 imminent retirees and 5 MHO trainees joining the service in summer 2017. The shortfall for this local area is calculated at 16 MHOs.

Local Area E has a dedicated mental health team with 8 WTEs and a senior MHO who line manages the team and is also responsible for workload allocation to 8 MHOs across learning disability teams and community mental health teams, with local agreement. There are no MHOs in children and families' teams or criminal justice teams. Of the 8 WTEs in the dedicated MHO team, there are 2 imminent retirees and 2 individuals who have indicated they are seeking to pursue senior posts. 2 WTEs are aged 50–60 years old with the rest aged between 30–40 years old. Experience of a recent advert to recruit a MHO, however, was not positive: the advert elicited 6 responses, with only 3 of these meeting the basic recruitment criteria. 3 interviews were arranged but 2 candidates withdrew on the day. The remaining interviewee was not appointable, requiring a re-advertisement.

Local Area F has 6.8 WTE in a central dedicated MHO team plus 1 WTE Team Manager, with approximately 2–3 WTEs across community care practice teams. There are no MHOs in children and families' or criminal justice teams. In the last 5 years, 3 team members have retired and 1 team member left post then returned. Over the next 12 months, 2 team members are due to retire with another 4–5 team members in the following 4 years. In relation to shortfall, if the SSSC calculation of 12 WTE per 100 000 population is applicable to this local area, then the shortfall is reported to be 100%.

Local Area G has one of the lowest rates of MHOs per head of population with 5 WTEs in a dedicated MHO team, 1 of which is the team manager. A further 1 MHO is located within a community mental health team, with 3 additional MHOs located across other social work teams, however, these are team managers and, as such, struggle to maintain their accreditation due to their lack of capacity to undertake MHO work.

3.2.3 Enhancements

One issue which demonstrates the greatest degree of variation across local authority areas is that of MHO salary remuneration and the role's terms and conditions, including enhancements, offered across different local areas to attract social workers into the MHO role.

3.2.3.1 Previous report for ADSW:

In 2013, the Association of Directors of Social Work (Social Work Scotland's predecessor body) commissioned a report from its mental health sub group to ascertain the practice across local authorities with regard to remuneration arrangements, enhancements and out of hours' arrangements associated with the MHO role.

Out of 32 local authorities, 25 responded to the survey. At that time, there was much variance in terms of remuneration, salary enhancements and arrangements for out of hours' services in relation to MHOs, as below:

Remuneration

This was calculated on an hourly rate, based on gross salary and number of contracted hours: the basic hourly rate varied from £16.58 – £20.67.

Salary enhancements

Salary enhancements were, at that time, either additional financial payments or enhanced access to senior practitioner roles. 9 out of the 25 local authorities offered additional financial payments to MHOs (with variance in relation to the amount) while 11 offered opportunities to access senior practitioner roles.

Out of hours' arrangements for MHOs

9 out of the 25 local authorities which responded at that time indicated that MHOs contributed to an in-house 'out of hours' service. Some indicated the MHO received an 'on call' payment if they were called out, other local authorities paid an 'on call' payment regardless of call out. Other local authorities commissioned an external 'out of hours' service provision to which their MHOs did not contribute.

3.2.3.2 2017 findings re remuneration and enhancements

4 years later, there remains significant variation, with similar concerns expressed by those interviewed for this report:

In Local Area A, MHOs are paid an additional financial allowance, taken as a yearly sum, of approximately £1800 per annum.

In Local Area B, practice leads are at a senior level, one grade higher than main grade social work staff.

In Local Area C, MHOs are paid an additional financial allowance of approximately £136 per month. This is taxable, pensionable and index-linked.

In Local Area D, qualified MHOs receive one additional increment in addition to their social work salary. There are also senior practitioner posts available which are paid the equivalent of team leader salaries. Additionally, 'on call' rates are paid for MHO work undertaken out of hours.

Although local Area E offers no additional financial allowances for MHOs, at the point of single status arrangements within all local authorities, this local area increased the main grade social work salary post to meet that of MHOs. This area has lost 2 MHOs in the last year to other local authorities which pay higher salaries to MHOs.

Local Area F offers no additional financial allowances, nor is the post graded at a senior practitioner level. The team manager in this area reported difficulties with recruitment both from within and from out with the local authority.

In Local Area G, MHOs have their salary increased one increment on qualification.

There were concerns expressed by those interviewed about the ability of local authorities to recruit both externally and internally and retain the level of knowledge, skills, expertise and talent required for the role of MHO if the service is to attract competent and confident individuals, given the level of variation in salary remuneration and enhancements.

Several of the interviewees acknowledged that, while their local authorities were committed to ensuring the role of MHO remains an attractive option for continuing professional development, and supports workforce planning, it would be helpful for there to be a wider conversation about the remuneration, enhancements, terms and conditions of the MHO role, and the impact of this on recruitment, retention and succession planning.

It is recommended that chief social work officers share learning about remuneration and enhancement arrangements across local authority areas in order to support discussions and dialogue about recruitment, retention and succession planning for the MHO service.

3.2.4 MHO Award candidates and the role of practice assessors

MHOs must be officers of the Local Authority, with at least 2 years' post qualifying experience, and satisfy requirements as to their registration, education and training, experience and competence, with respect to persons who have (or have had) a mental disorder. In order to do so, individuals must successfully complete the MHO Award programme in Scotland.

The MHO Award is at SCQF level 11 and is delivered by 3 university partnerships: the University of Strathclyde and Glasgow Caledonian University, in partnership with the Learning Network West; the Edinburgh University partnership and the Robert Gordon University partnership.

Application to the MHO Award requires the individual's registration with the Scottish Social Services Council; a minimum of 2 year's post-qualifying experience at the start of the MHO Award programme with evidence of continuing professional development requirements as outlined by the SSSC and the nomination by their employing local authority, complemented by the local authority's provision of support and appropriate learning opportunities.

The Scottish Social Services Council report 'MHOs (Scotland) Report 2016: A National Statistics Publication for Scotland' notes that there had been a slight decrease in admissions to the MHO Award programme but, for the first time, the number of those completing the Award (62 in the 2015-16 year) is greater than the number of those leaving the MHO workforce (60), although the number of those leaving is, in itself, an increase of 13% from the previous year.

In relation to those interviewed for this report, there was variation in the take-up, promotion and support for the MHO Award programme reported.

Local Area A:

In the current cohort, in this area, there were 2 trainees: 1 from a children and families' team and 1 from a mental health/learning disability team. Applications for the 2017/18 Award course attracted 5 expressions of interest, 2 of which were withdrawn by the applicants for personal reasons and 3 of which progressed to university application (these applicants consisted of 2 from community care teams

and 1 from a community mental health team). Local Area A has no specified commitment to put forward a certain number of applicants to the MHO Award per year, this is dependent on workforce requirements.

Internally, expressions of interest for the MHO Award are sought every December, supported by opportunities to attend local information sessions with incumbent MHOs and encouragement to attend the university roadshows. Applicants are asked to write a 500 word summary of their interest in the course and the plans they will make to prepare for it. This is accompanied by a supporting statement from their line manager. They then attend an informal interview with the MHO coordinator and a service manager, following the framework of the MHO Award handbook. After this, if successful, their names are submitted to the university.

At the time of writing, there was 1 practice assessor, however, the MHO co-ordinator was progressing plans to increase the number of practice assessors to accommodate higher numbers of applicants.

Local Area B:

This local area reported difficulties in progressing candidates through the MHO Award because of the particular nature of the employing organisation. Because of salary scales for MHOs, there is often no financial incentive for individuals to pursue this route and previous candidates who have chosen this as part of continuing professional development have withdrawn their applications because of a lack of support to undertake this training from the employing organisation. The local authority tries to offer 3 candidates per year to the MHO Award course and support these individuals. For those undergoing the course and who wish to apply to the MHO team, the team has offered 'trainee' places to support a smooth transition to a full time position on qualification.

Local Area C:

This local area has no specific commitment to a minimum number of places per annum, however, has managed to put forward candidates each year. In 2009, there were 3 candidates, now there can be up to 9 individuals who express an interest each year. Annually, expressions of interest are requested then assessed and interviews held internally to assess suitability and preparation for the course. In the current cohort, there are 3 trainees – 2 from locality teams and 1 from a learning disability team. Practice assessors are drawn from the dedicated MHO team.

Local Area D:

Since 2013, this local area has trained 5 MHOs per academic year and, of the

resulting 15 MHOs, 2 have since left the local authority. Of the current cohort, there are 5 trainees completing the course in summer 2017, with 4 expressions of interest for the 2017/18 programme. Currently, there is a pool of 10 practice assessors, however, this is diminishing: the practice assessor role is extremely time and labour-intensive and also has an impact on other community mental health team members. Practice assessor training is, however, underway, with a projected 4 candidates being proposed. This local area undertakes a 'grow your own' approach to recruitment and has several internal promotional programmes to attract candidates to the MHO Award, including an online information hub, and a 'pathway to community mental health teams'. In-house mental health seminars, a mental health interest group and a dedicated centralised Mental Health Strategy Group oversees and supports the service as a whole, and recruitment and support in particular.

Local Area E:

This area averages 1–2 candidates for the MHO Award each year and, despite not offering any additional financial allowances, always attracts candidates to the Award programme (although a small number of qualified MHOs leave to join other local authorities which pay higher salaries for MHOs). Given the size of the mental health team, a maximum of 2 candidates per year is all that could be accommodated and supported. The Senior MHO who manages the team requests annual expressions of interest, holds internal interviews together with a practice assessor and meets the candidate's line manager to discuss the personal and professional implications of the course. The candidate writes a personal statement then, if successful internally, an application to the Award programme is put forward.

Local Area F:

This local authority has sought to fund 2 MHO trainees per year and, whilst funding has been ring fenced to facilitate 2 trainees per year, there has only been 1 occasion when 2 candidates undertook the MHO training programme at the same time. Most years, there is only 1 trainee undertaking the programme and some years there have been no candidates at all. The interviewee stated that some social work practice team managers were not particularly supportive or encouraging in allowing their team social workers to undertake MHO training. Having a MHO within their team was not viewed positively but rather, as distracting from the work of their team. Furthermore, this local authority does not pay any additional increments or salary grade and there is no senior practitioner status for MHOs, which the team manager believes demonstrates little incentive for workers to undertake MHO training.

Local Area G:

At the time of writing, this local authority had 3 trainees undertaking the MHO Award. This seems to still be viewed as an attractive option for continuing personal

development and there is an average of 2-3 applicants per year. The MHO Award is actively discussed during sessions focussing on continuing learning for social workers. In preparation for the course, applicants are offered sessions with incumbent MHOs, Frequently Asked Question sessions, shadowing opportunities then asked to complete an application form which includes a personal statement reflective of the formal Award course application. In this area, the practice assessor role is described as 'challenging', with the onus on the practice assessor to outline role protocols and terms. In this local area, the MHO workforce is ageing more than the larger social work workforce, and this is reflected in applicants to the MHO Award course, who tend to be older applicants (more so, for instance, than those applying to undertake the child protection award).

Despite numbers of those undergoing, and successfully completing, qualifying training to the MHO Award, interviewees also pointed out it was important to remember the context into which new MHOs were arriving: for most experienced MHOs incumbent in role, the Mental Health (Care and Treatment) (Scotland) Act 2003 defined the qualified social worker as the best person to undertake the role of a MHO, reflecting the breadth and depth of their generic social work experience. Since social workers now operate in specialist disciplines, interviewees felt that some will have lost, or have never had, this generic experience and newly qualified MHOs will, in these circumstances, be unable to draw on that breadth of experience to undertake the role. While this does not necessarily reflect in terms of competency, there was felt to be a loss in terms of the contextual changes to legislation and the development of approaches to supporting individuals with mental health needs.

Undertaking the MHO Award requires dedication, time, energy, commitment, academic acumen and local authority support during and after the duration of the course. Those interviewed fully appreciated the value of putting forward members of staff for the Award, however, their view was that recurring issues with regard to remuneration and enhancements and their variation across local authorities may impact on this initial commitment and the ability to retain highly skilled staff.

Chief social work officers should share learning in this regard to support recruitment, retention and succession planning in this area.

3.2.5 Out of hours services (OOHS):

For the local authorities which provided information on MHOs in out of hours' services, there was wide variation in the ways in which out of hours' services were commissioned and the availability and deployment of a MHO in the out of hours'

service:

Local Areas C, E and G externally commission an out of hours' service, with variation in the MHO work undertaken by the out of hours' service, the availability of MHOs and the ways in which MHO work undertaken in this way is recorded.

In Local Area G, for instance, the out of hours' service is externally commissioned via a service level agreement (SLA). There was no consistent or discernible pattern in the requirement for a MHO in this local area during out of hours, therefore, there is no written requirement in the SLA to have a MHO as part of the out of hours' service, although, by coincidence, one team member is a qualified MHO. Local Area G is a rural local authority and this was also reported to have implications for the ready availability of MHOs who are called out of hours, in terms of distance and time required to travel.

3.2.6 National data recording

The annual MHO (Scotland) report is published by the Scottish Social Services Council (SSSC) and is part of the larger local authority social work staff survey. Between 2005 and 2012 this survey was carried out by the Scottish Government's National Statistics branch, however, in 2012, responsibility was given to the SSSC.

The survey presents a 'snapshot' of the workforce at a point in time, however the data, whilst in many ways well defined by virtue of there being a relatively small group of staff, was described as difficult to interpret and extrapolate, given the differing ways in which MHOs are deployed across the 32 local authorities and how each records and accounts for staff. Whilst definitions have been established to assist, there were felt by interviewees to be ongoing challenges in producing a data set which gave a truly accurate reflection of the MHO staffing picture across the country. The challenges experienced around the integration of health and social care have also introduced complexities around how authorities collate and report data for the survey.

Accordingly, the Scottish Social Services Council report 'MHOs (Scotland) Report 2016: A National Statistics Publication for Scotland' has made some changes to the data which is gathered about the MHO service and workforce in an attempt to give more comprehensive detail. For instance, data on estimated average hours spent on MHO work per week is now included, as is a definition of a new team category 'dedicated MHO teams', better reflecting operational models for the service. The report acknowledges there may also be future changes in data collection and reporting, including a potential move to reporting solely on average weekly hours

spent on MHO work rather than the rate of WTE MHOs per 100 000 of the population, as this was felt not to reflect the time spent on MHO work.

Work has been progressing to review the questions asked with regard to MHOs and the consistency in answers expected across all local authorities. One example cited by an interviewee was that, simply asking 'how many MHOs are employed in the local authority?' is not the right question: it was felt that it doesn't account for a definition of Whole Time Equivalent (WTEs), or MHOs who do not undertake MHO work (i.e. many managers who are qualified MHOs), or MHOs who work within the out of hours' service but do not undertake MHO work. The Scottish Social Services Council report 2016 now includes further definition of this.

The national calculation of the rate of MHOs per 100 000 head of population was felt to fail to take account of local demographics and complex needs. There was recognition that this is a 'broad brush strokes' framework and a place from which to start, in reviewing workforce needs. The Scottish Social Services Council's 2016 report now gives further detail about the usage of this as a standard measure.

Practically, within local authorities, frequently the HR section must complete its own local authority-wide statistics before releasing data to the MHO service to complete this section. This was reported by some interviewees to impact on the time taken to complete national data requests. It was also commented that, when bodies such as the Mental Welfare Commission collect data, it can often be health board-specific, and not specific to local authority areas. This was also felt to contribute to any differentiation in data analyses.

ICT systems in local authorities were cited as contributory factors to the challenges in gathering data. Issues mentioned by interviewees included the difference in systems across authorities and disciplines, data quality, variations between HR and team data and inaccessible systems.

Those interviewed all acknowledged past issues with the ways in which data regarding MHOs was gathered nationally and welcomed the amount of work which had been undertaken to address and rectify this. There remained some concerns from interviewees, however, that data gathered at a national level may not necessarily be reflective of the local authority context. Some examples of this included:

Rural areas:

In rural areas, visits can be farther apart in terms of distance and, therefore, can be difficult to allocate and take more time to attend. Within the MHO service, this can be

more acute. This difference is not readily accounted for in national data recording.

Volume of MHO work undertaken by out of hours' services:

There were concerns expressed by interviewees regarding the inclusion of data relating to work undertaken by MHOs while working in out of hours' services as the amount of actual MHO work is so variable and, in some local authorities, negligible.

Local Area B, for instance, cited this at an average of 1 hour per month. There has, however, been agreement reached with the Scottish Social Services Council (SSSC) regarding the ways in which data about MHOs out of hours' services would be recorded in future.

National publications:

Several interviewees mentioned the report published by the Mental Welfare Commission (MWC): '[Scotland's Use of Emergency Detention without the use of Mental Health Officers](#)' in June 2016. The report showed variation in rates of MHO consent to detentions, however, those interviewed felt it did not reflect the actual picture. It was unclear from interviews whether this was because of local authorities' data recording, national analysis, the quality of data, none or all of these. This has been raised with the Mental Welfare Commission in end of year meetings with local authorities. Several interviewees felt it would be useful, when the Mental Welfare Commission is undertaking similar studies in the future, that they liaise directly with MHO team or service managers who can give a definitive local picture to support national reports.

Progress:

The Social Work Scotland mental health sub group continues to meet regularly with the SSSC workforce intelligence team and it has now been agreed that, following publication of the 2016 report, a 'short life working group' will be established to explore how the report and data collection can be further improved.

3.3 MHO workload

There was variation in workload described across the local authorities and also within local authorities, across dedicated MHO teams and other social work teams.

In all the local authorities interviewed, the core of the MHO workload is undertaken by MHOs within dedicated MHO teams, mainly the reasons given are of practicality, support and supervision and management arrangements. The main work undertaken by MHOs in other social work teams, where it is undertaken, is Adults with Incapacity work, predominantly assessment of guardianship applications.

3.3.1 2017 workload themes

Management of MHOs in other social work teams:

Management and supervision for MHOs in other social work teams is made by local arrangement and most local authority representatives interviewed spoke positively about this. One MHO team manager had been frequently challenged by colleagues so had some negative experiences of this, and expressed concern that, if MHOs in other social work teams are not enabled to undertake MHO work, they will have difficulties in maintaining their accreditation. The manager was also concerned about providing adequate support and supervision to MHOs in other social work teams.

Mentally disordered offenders (MDOs):

All interviewees who discussed work with mentally disordered offenders specifically stated this work remains within dedicated MHO teams due to the complexity of the work, the time and knowledge required, and the fact that skills for this type of work require constant updating and development, something which is not always achievable with MHOs in other social work teams due to their core team work. Some local authorities are, however, open to discussion, should a MHO out with the MHO team wish to undertake MDO work, and this would be discussed on its own merits.

CASE STUDY 2 : The role of the MHO with adults defined as Mentally Disordered Offenders under the Criminal Procedures (Scotland) Act 1995 section of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Restricted patients are persons detained in hospital under a compulsion order with a restriction order (CORO). They have usually committed an offence punishable by imprisonment but, as a result of mental disorder, are not imprisoned but ordered to be detained in hospital for treatment without limit of time. Individuals receive a programme of treatment and rehabilitation, with the aim being to prevent recurrence of offending by dealing with the mental disorder.

The MHO in the role of Supervising Officer for a Restricted Patient, has a duty, as has the Consultant Psychiatrist who has the role of the patient's Responsible Medical Officer (RMO), to provide regular reports to the Restricted Unit of the Scottish Government, within defined timescales. These monitoring reports must evidence progress made, challenges encountered and any risks identified.

The MHO became involved with an adult male who had killed his wife by drowning, believing she had mystical powers. He was assessed as suffering from a psychotic episode and, at the time, was hearing voices and responding to external stimuli. He was initially taken by the Police to the local police station, where he was examined by the police surgeon and transferred to the State Hospital for assessment. A diagnosis of schizophrenia was established. He was assessed as unfit to plead, and formally detained, under a CORO, to the State Hospital for care and treatment. He always referred to his wife's death as 'the incident' and never used the words 'killed' or 'murdered'.

Following a lengthy period of treatment in hospitals, under the conditions of the CORO, the man was discharged to an area which was neither his home area nor the area where the index offence (the offence with which he was charged) had taken place.

The discharge plan from the hospital, identified that the man was seen as able to take on a tenancy of a flat from a housing association and that he was required to attend the NHS Mental Health Day Hospital on a weekly basis. The day hospital was staffed by a team of clinicians which included a psychiatrist, community psychiatric nurse, physiotherapist and an occupational therapist. Staff delivered anger management, confidence building and cognitive behaviour sessions, one to one or in groups. They also ran various groups, in conjunction with the adults who used the services, in relation to budgeting, cooking, craft work, physical activities such as badminton, bowls, fishing and keep fit. The man also voluntarily attended mental health groups and enjoyed music and art classes in particular.

He met his new partner at the day hospital and would stay each weekend with her at her home. One condition of the CORO involved identifying his usual place of residence, therefore, this arrangement was required to be agreed by the multi-disciplinary team and the Restricted Unit of the Scottish Government.

The MHO was challenged by the man's resistance to change and his unwillingness to speak about the index offence. The MHO was aware that patients in the State Hospital must comply with the hospital rules, regime and routine. Step down care from the State Hospital to the local psychiatric hospital had offered the adult the opportunity to follow a less restrictive regime, with the focus on rehabilitation and discharge to a home of his own.

The MHO, however, had to find ways of establishing a professional relationship with the man to ensure that, not only were the risks managed, but also that he was encouraged to develop his potential, to consider what he would like to achieve in his life and how he could achieve these outcomes. Visiting him at his home, where he was most comfortable, was more effective and it also enabled the MHO to notice any changes in the home environment which may have reflected changes to his mental well-being. Using engagement and listening skills and giving the man time to consider his responses, allowed a relationship of trust to develop. The man's parents, who lived a distance away, visited every three months. The man, who had held a driving licence, wanted to be able to drive the family car but lacked confidence to even try. The MHO developed a confidence building programme with him, accessing support from day hospital staff to encourage his progress. This increased his confidence to book driving lessons and on successful completion, he was able to drive the family car.

The MHO and RMO were made aware of an incident which occurred at the home of the man's new partner: while they were both changing the bedclothes from the bed, the man's partner, who was struggling, sat down and refused to continue to help. At this point, the man became angry and slapped her across the arm.

Upset and frightened by his reaction, his partner had reported this to her community psychiatric nurse the following day, who reported it to the RMO and MHO.

Given the seriousness of the index offence, the MHO reminded the other agencies involved of its significance and the circumstances which surrounded it. One of the recognised triggers to the index offence was his anger, over a period of time, with his wife. She had previously expressed concerns to her GP that her husband was becoming mentally unwell. These concerns had not been acted on and as he had become more unwell, his actions had resulted in her death. Acknowledging the potential, the agencies met to consider what had happened and the next steps which should be taken. The MHO and the RMO, as required under the Memorandum of Procedures for the Management of Mentally Disordered Offenders, contacted the Scottish Government Restricted Unit to advise of the incident and the agencies' action to hold an immediate review.

It was recognised that, as this had been out of character for the man, his regular review would be brought forward in order to discuss the incident with him and consider his mental wellbeing at that time. He was unhappy that the incident has been reported and needed to be reminded that one of the recognised triggers to the index offence was his anger, over a period of time, with his wife.

The outcome of the review identified an action plan to manage the risk and an increase to the frequency of the multi-disciplinary reviews in order to monitor his mental and physical health. The community psychiatric nurse who supported the man's partner was required to maintain contact with the staff from the day hospital and advise them immediately of any further concerns.

The MHO also increased the frequency of home visits to weekly in line with the terms of the new reporting period to monitor progress and to inform the reports to the Scottish Government. The Restricted Patients Unit confirmed the action plan was appropriate in managing the potential risks to the man and others by his actions. The man was unhappy with the new restriction and the MHO and the RMO worked in partnership to appropriately challenge his views in recognising the risks to him and his partner. If he was seen to be less well, he could have been recalled to hospital for a further period of care and treatment. This was also a real fear for him, as a return to the "Big House" as he would refer to the State Hospital, would not only mean a loss of freedom, choice, and his relationships but also further restrictions under the CORO.

The man is no longer subject to CORO restrictions, maintains regular psychiatric appointments and remains in a relationship with his partner.

MHO duty service:

Provision of a duty service varied across the local authorities: In Local Area E, for instance, all MHOs undertake duty: MHOs within the MHO team do so once per week, MHOs in satellite teams, once per month. A local arrangement means that, if MHOs in dispersed teams undertake work on duty which looks set to continue for more than 3-4 weeks, that work will be progressed by a MHO in the MHO team.

Self-directed support:

Local authorities reported an increase in requests for guardianships relating to young people with learning disabilities, following legislation and promotion of the [Social Care \(Self-directed Support\) \(Scotland\) Act 2013](#). Some MHO team and service managers, aware of the potential impact this would have on increasing workload, undertook visits to local Transitions groups which consisted of parents and carers of young people with a learning disability moving between children's and adults' services to discuss implications of guardianship and the Act, in particular. This information-giving was reported by one interviewee to be well received by attendees and created better pathways for communication between those attending Transitions Services and the MHO service.

CASE STUDY 3: The role of the MHO in preventing unnecessary detention

A duty MHO was requested to assess the need for the immediate detention of an adult male while he was in a local psychiatric hospital. He had been in hospital voluntarily for 3 weeks, had been receiving treatment for mania, and was receiving a high dose of medication. He now wanted to be discharged. Medical staff wished to continue his treatment and to seek for him to be detained to be able to do so.

The MHO, in discussion with the man, found out that he held a season ticket to attend his local football team's matches and only wanted to be discharged so that he could attend a game the following day. On further discussion, he agreed to be escorted by nursing staff to the match and return to hospital afterwards.

Given the discussion and agreement between the man and the MHO, the MHO did not consider that detention was necessary to gain the best outcome for him – he was in agreement to returning to the hospital to continue his treatment, thereby preventing unnecessary detention.

4. Challenges

All those interviewed commented on challenges to delivering the optimum, highest quality, person-centred service and cited the following areas:

4.1 Increasing workload demand

All interviewees expressed concerns regarding increases in workload, specifically, but not exclusively, in relation to Adults with Incapacity and an increase in private guardianship applications. This is reflective of the reported shortfalls in MHO resources for this area of work as reported in the Scottish Social Services Council report 'MHOs (Scotland) 2016 Report: A national Statistics Publication for Scotland'. Interviewees also described MHO work as 'unpredictable' in nature, volume and duration, and this also accounted for its complexity.

Local Area A has experienced a 70% increase in guardianship applications between 2012 and 2016, and a 24% increase in the year 2015– 16 alone. The MHO service is currently working to support 2000 private guardianship applications.

To meet demand, Local Area B has a waiting list of approximately 40 cases. This is closely monitored daily by the service manager to ensure that the most vulnerable individuals are prioritised and work is agreed through effective communication and information-sharing.

Local Area C recorded 317 contacts with the MHO service between 1 April 2016–28 February 2017, of which 43% were in relation to Adults with Incapacity legislation and 57% were in relation to a MHO assessment. This amounted to 454 individuals being referred to the service over that period. There is a waiting list of approximately 4 cases, with the longest an individual has waited for a service being 23 days, but the waiting list is reviewed on a priority basis.

Local Area D described an upsurge in activity in Adults with Incapacity work and, whilst allocation of reports is negotiated with solicitors, statutory timescales for reports required for submission of applications to Court are always met. The longest wait for preparation of a report was 6 months but reports awaiting allocation are reviewed regularly by priority.

There remains a consistent volume of work from the Mental Health (Care and Treatment) (Scotland) Act 2003, similar to that in previous years. The new Mental Health (Scotland) Act 2015 imposes additional duties on MHOs, including a duty to prepare and submit an additional report under S86 and S92 in response to the Responsible Medical Officer's determination to extend a Community Treatment Order. It was felt by those interviewed in this area that this would not impact greatly

as this local authority has always prepared good practice reports under these sections.

Local Area E experienced an increase in guardianship applications. One client group in which interviewees reported to have seen an increase is young people with learning disabilities. The increase was specifically attributed to the implementation of the Social Care (Self-directed Support) (Scotland) Act 2013. The current ratio for guardianship orders in this local authority is approximately 65% for older people, 35% for younger people with learning disabilities and others. This area has a waiting list of 6 reviewed by priority, with an aim to allocate work within 4-6 weeks.

Local Area F's team manager stated that, in 2001, the ratio percentage of local authority to private guardianships was 80%:20%, but these figures have been completely reversed.

In Local Area G, there has been a 107% increase in guardianship applications since 2012, attributed in the main to legislative changes. There is a waiting list of approximately 11 cases, overseen by the team manager.

In all local areas interviewed, there were associated issues reported with the implementation of waiting lists and with challenges in meeting statutory timescales, particularly the 21 day timescale for the MHO report once notification of intent to apply is given.

In some areas, the role of the MHOs in other social work teams is pivotal in workload allocation through increased demand:

In Local Area F, the MHOs based in other social work teams do not undertake any Adults with Incapacity (AWI) work at all. All AWI work, including all MHO reports for guardianship applications plus all the supervision of guardians, are undertaken by the MHOs in the dedicated MHO team. The MHO team manager feels this is not viable or sustainable and is detrimental on a number of levels. It is well reported and evidenced that population demographics suggest a continual rise in the number of guardianship applications in the future and having all work contained within a small team of MHOs is not felt to be sustainable. The manager reported that having a significant number of MHOs who are practicing as MHOs but only in relation to the 2003 Act is deskilling for those MHOs and is particularly concerning for those newly qualified MHOs. AWI work has grown year on year and, therefore, the team manager believes that to restrict AWI work to the dedicated MHO team not only does not stand up to any degree of scrutiny but is also not a viable longer term option.

4.2 Working with other professionals

It is important to highlight any issues raised by interviewees in relation to the integration of Health and Social Care and, in particular, working relationships across sectors. During the consultation process, several interviewees commented that relationships across Health and Social Care which had been excellent had faced some challenges following local implementation of Health and Social Care integration arrangements. Most attributed this, not to personal relationships, but to an increasing (perceived or actual) complexity in local structures which were viewed as increasing barriers to effective partnership working.

4.2.1 Colleagues in Health:

All those interviewed were keen to stress the many positive relationships and interactions with colleagues across Health and, where there were challenges, those interviewed were keen to work together in order to provide the best outcome for the individual receiving the service.

In relation to applications for welfare guardianship, the Adults with Incapacity (Scotland) Act 2000 stipulates that 2 medical certificates are required to accompany a welfare guardianship application: one report from the adult's GP and the other from a S.22 doctor (an approved medical practitioner as outlined in the Mental Health (Care and Treatment) (Scotland) Act 2003), to determine the adult's level of capacity. Some interviewees had experienced delays in the formal process to request these section 22 reports which caused a subsequent delay in the MHO fulfilling their duties under the Act.

Interviewees recognised the importance of having early discussions with individuals receiving services and their relatives about Power of Attorney, in order to safeguard the individual's best interests. Those interviewed, from their experience, recognised that some Health colleagues had not always had these discussions with individuals at the point at which the MHO had believed it was most appropriate. Where interviewees offered a view as to the reasons behind this, a lack of confidence, a lack of knowledge of legislation or a lack of understanding about who was responsible for initiating those discussions, were viewed as the most frequent reasons. MHOs felt it would be helpful to ensure partnership working involves greater awareness and multi-disciplinary training opportunities around these types of discussions with individuals and family members.

Interviewees recognised that GPs are an influential group of colleagues with whom a more strategic national approach to communication regarding mental health needs would be of benefit, particularly in regard to capacity. Some interviewees were able

to give examples of occasions where a GP had felt it was in the individual person's best interest to remain at home, however, under the same circumstances, the MHO had felt that hospital admission would have prevented greater risk in relation to adult support and protection. In one example given, the GP felt that medical intervention was not required and that concerns related to social issues. Interviewees described a climate in which increasing older demographics, greater complexity of need and cases of a sudden deterioration in an individual's wellbeing, such as in instances of dementia, would require a co-ordinated, shared and comprehensive response by both Health and Social Care colleagues to best meet individuals' holistic needs.

Examples were also given about discussions which had taken place with Health colleagues about decisions being taken in the best interests of the adult, where decisions required greater shared conversations about appropriate risk-taking. For instance, examples were given of discussions about applications for guardianship: Health colleagues may have felt guardianship to be appropriate in certain situations, however, the MHO deemed guardianship to be unnecessary because sufficient safeguards for the adult's welfare were felt to already exist. In these circumstances, it was important that dialogue took place in order to enable a shared understanding of the benefits and disadvantages of guardianship for each individual.

One interviewee was able to give an example of discussions which had taken place with Health colleagues where assessment of an individual, which had been delayed, required to take place immediately to ensure the focus remained on supporting the individual to be discharged from hospital with the most appropriate level of ongoing care.

Interviewees agreed that working together with Health colleagues was vital in order to ensure that the best outcome for the individual remained paramount. One interviewee described discussions with Health colleagues about how the traditional 'boundaries' of their role – the medical treatment of an individual – had changed and how this had had to happen in order to consider the individual's care holistically. This had also meant that the 'medicalised' use of language: labelling an individual as a 'delayed discharge' without focussing on the individual's specific needs, had needed to change and required continued dialogue and shared learning and values across disciplines.

In one local authority, a high turnover of locum health staff in general adult psychiatry services was described as making long term relationships between the MHO service and medical staff difficult to maintain. In another local authority, there was felt to be too many repeat admissions and consultation and joint working with psychiatry colleagues was felt to be especially challenging in both these settings.

Most interviewees referred to the local structures associated with the integration of Health and Social Care as detracting from robust partnership working, although much effort was being delivered by both sectors to work better together. Associated issues to learning were also highlighted, including a lack of multi-agency training opportunities, poor access to shared ICT systems and a lack of co-located teams (which interviewees accepted does not solely lead to better integration, however, which interviewees felt did facilitate, and sometimes expedite, multi-agency working).

A willingness was cited by interviewees to continue to work better across sectors for the best outcomes for individuals and most were able to see positive results.

4.2.2 The 2007 amendment to the Social Work (Scotland) Act (1968): the introduction and usage of Section 13 ZA:

Local authorities have duties under the Adults with Incapacity (Scotland) Act 2000 to apply for a guardianship or intervention order where that is necessary to protect the welfare or financial affairs of an adult with incapacity and no one else is available or willing to apply. It was felt that, in some areas, a practice had developed in which the local authority required an order to be obtained in all cases where an adult with incapacity was to be moved to residential accommodation, even where the adult was compliant and there was no disagreement as to the appropriateness of the service to be provided. The Scottish Executive, at the time, believed this contributed to, and resulted in, unnecessary delays in discharging patients from NHS hospital care when they were medically fit for discharge.

Section 13 ZA was, therefore, introduced by Scottish Ministers in 2007 as an addition to the Social Work Scotland Act 1968 with the purpose of giving power to local authorities to provide care services to any individual with assessed needs who lacked capacity to give informed consent. It also gave the power to consider moving the adult from a hospital setting to residential accommodation without pursuing a route of guardianship.

Under Scottish Government guidance to ensure the protection of adults' rights, several assumptions are made:

- that the adult will already have a needs and risk assessment which evidences care needs and issues of capacity
- that agreement had been reached on the adult's care and support needs prior to consideration of legal authority
- that there has been a multi-disciplinary review in which the views of the adult and all relevant parties were taken into account
- that no existing proxy arrangements are already in place or being progressed

There was, and continues to be, wide variation in the use and prevalence of section 13 ZA. One interviewee reported that their service is situated in an area in which 1 NHS trust works across 3 local authorities, all interpreting legislation differently.

Of those interviewed, some MHOs had experience of medics trying to use section 13 ZA provision as the least restrictive option to expedite hospital discharge. While section 13 ZA can be used to facilitate hospital discharge more efficiently and to then seek guardianship to deliver the relevant powers to support care for an individual, MHOs interviewed were keen to stress the need for continued dialogue with Health colleagues to not only consider the use of section 13 ZA to expedite discharge but also to consider care beyond the point of discharge.

Interviewees had all experienced differences in advice given by the Mental Welfare Commission with regard to this aspect of legislation. Although the Mental Welfare Commission stresses that services must take their own legal advice as they judge appropriate in each circumstance and, although local authorities spoke about having very supportive internal Legal Services, there was concern expressed by interviewees at the difference in advice being given nationally and locally.

The [‘Cheshire West’ ruling](#):

In 2014, the UK Supreme Court was asked to make a judgement about whether the criteria under which an individual was living amounted to a deprivation of liberty. The Supreme Court judgement, applying to the whole of the UK, broadened the definition of ‘deprivation of liberty’ which impacted on the definition that had been used by Health and Social Care services in Scotland, and which had been implemented following the Scottish Government guidance on the use of section 13 ZA. The judgement ruled that deprivation of liberty was a fact, regardless of the purpose of any intervention or an individual’s circumstances, with the fundamental characteristics being that the individual is ‘under continuous supervision and control’ without freedom to leave.

This judgement came to be known as the ‘Cheshire West ruling’ and continues to impact and challenge legislation in relation to the Adults with Incapacity (Scotland) Act 2000. The [advice of the Mental Welfare Commission](#) is that:

“Services need to operate within the existing statutory framework, and be informed by the developing case law. If services are satisfied that a person who cannot consent will be deprived of their liberty, it is necessary to consider what lawful authority justifies that detention. At the same time, unless and until Parliament or the courts determine otherwise, current legislation remains in full effect, including the provisions of s13ZA of the Social Work (Scotland) Act 1968, and the principle set out

in s1(4) of the Adults with Incapacity (Scotland) Act 2000 that ‘There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention.’”

The Mental Welfare Commission goes on to state that “The ruling in Cheshire West should not be a justification for delaying discharge to a social care setting if that is agreed to be the appropriate care setting for an individual”.

An auditable trail for decision-making is, therefore, necessary in order to ensure that good practice determines the best outcomes for an individual, dependent on his/her individual circumstances.

The MHOs interviewed agreed that the MHO has a pivotal role in sharing expert learning and knowledge with partners to navigate the complexity of this ruling, and other aspects of legislation.

4.2.3 Solicitors and Sheriffs:

Several local authorities spoke about an increase in the ‘promotion’ of guardianships being undertaken by solicitors locally and the subsequent impact this has on the MHO service, as well as ensuring best outcomes for people. Those interviewed spoke about engagement with local solicitors and Transitions groups – groups established for families and carers of young people moving from care in children’s services to care in adults’ services. The purpose of engaging with these groups was described as offering opportunities to discuss guardianship and wider legislation in relation to supporting people, to put forward the role of the MHO in assessing the need for guardianship to secure the best outcome for the individual and to assess the suitability of the proposed guardian. There was agreement that the individual requiring care cannot be ‘lost in the process’.

Resources:

Where the issue was one of resources, some interviewees who discussed their relationship with solicitors felt that solicitors demonstrated clear awareness of tightened MHO resources. These interviewees felt that solicitors they worked with had adapted their approach accordingly, for instance, better co-ordinating the requests for reports from medics and from MHOs, following initial discussions with MHO service or team managers.

Statutory timescales:

As indicated elsewhere in this report, however, all local authorities interviewed expressed pressures in the MHO service which led to some statutory timescales being missed.

In the Adults with Incapacity (Scotland) Act 2000, section 57 (4), the chief social work officer (in practice, the MHO) has 21 days in which to prepare a report once notice has been given of the intention to make an application for an Intervention Order or for guardianship. As well as the impact on the individual for whom any order is being proposed, any delay also impacts on the process, resource allocation, partnership working and maintaining best outcomes for people. As the named individual to whom the intention to submit the guardianship application is issued, the chief social work officer will have a keen interest in the implications of any delays.

A 2016 report by the [Law Society's Mental Health and Disability Sub Committee](#) stated that anecdotal evidence at that time indicated widespread failures by local authorities in meeting their obligation under this section of the Act. The report acknowledged that, while there are variations from area to area, demands are outstripping available resources. The Law Society was clear that proposals in the [Scottish Law Commission 'Report on Adults with Incapacity' \(2014\)](#), and in the Mental Health (Scotland) Act 2015, would further increase MHO workloads. In a ['Response by the Sheriffs' Association](#) to the Scottish Government Consultation on the Scottish Law Commission Report on Adults with Incapacity and Deprivation of Liberty', the Sheriffs' Association made it clear that the view of the Association was that mental health officers and medical practitioners are best placed to assess the needs, and ensure the safeguarding, of vulnerable individuals. The Association recognised that the changes proposed at that time would necessitate an increased number of applications to the Sheriff and expressed its hope that the Scottish Government was aware of the cost and resource implications of these changes.

In November 2016, one solicitors' firm in Scotland successfully obtained an Order against a Local Authority to compel the completion of a MHO report after the local authority had failed to provide the necessary MHO report in a Guardianship application within the statutory timescale.

Powers:

Local Area F described significant experiences and examples of welfare guardianship applications being pursued by solicitors where the MHO believed it was clearly evident that welfare powers were neither required nor necessary. For instance, the MHO team manager gave examples of welfare applications being

pursued for elderly people who were already in residential care and, in many instances, had been perfectly settled in the care home for many years. The team manager questioned the need for such applications and whether the best interests of the individual and family were truly being served or whether there was a financial motivation for the solicitor. The team manager also described many instances where financial powers were necessary but no welfare powers were required and, in such situations, there were many examples of applications being lodged for both welfare and financial powers which attract legal aid funding.

Several interviewees spoke about the role of courts and sheriffs who, from interviewees' experiences, more often than not will grant a guardianship order despite the MHO arguing to the contrary. This was expressed as a 'default position', particularly where the application relates to a younger person with a learning disability and the proposed guardian is a parent. Some interviewees expressed a view that the role of the MHO appears to have become one of justifying why an individual should NOT be a guardian or why proposed powers should NOT be put in place, rather than the other way round. Interviewees expressed frustration at this process and concerns that not only could guardianships be granted which might not be the best outcome for the individual, but were the views of the MHO to be consistently rejected, a less confident or less experienced MHO may not feel competent enough to disagree with powers proposed, to the detriment of the individual receiving the service.

Other interviewees stressed that the role of the MHO in this situation is to emphasise what the young person CAN do, not what they cannot, recognising the challenges faced by parents when the young person moves from children's to adults' services through Transitions Services, where the same level of support previously experienced is no longer available and guardianship may be proposed to parents as the only option. One interviewee gave an example of an Education colleague informing parents that seeking guardianship was the right option to "keep their child a child". In this situation, the role of the MHO was to ensure a respectful dialogue took place with the parents and to promote positive risk-taking through the process, something to which the parents had not been readily exposed.

4.2.4 Police Scotland:

One interviewee highlighted issues regarding the challenges associated with having one centralised Police authority: all requests for police attendance by MHOs were recorded via a centralised switchboard and this had caused issues in this local authority area in relation to ensuring police officers attend the correct address, the time taken to organise attendance, and the impact on local relationships between MHOs and Police, although services worked very hard to maintain these.

CASE STUDY 4: A referral to the day duty MHO service - safeguarding human rights during detention (1)

A MHO became involved when a 15 year old girl, who was being supported by Child and Adolescent Mental Health Services (CAMHS) but was refusing to accept ongoing support, wrote a letter to her consultant psychiatrist stating that she wanted to die as she felt 'worthless' and saw 'no point in living'. The girl voiced fears about global terrorism and carried a knife in order to protect herself from terrorists. She was unable to accept that, by carrying the knife, she presented a risk to others or to accept the risk she presented to herself by her suicidal thoughts.

The young girl had attended an appointment to meet her psychiatrist at the local CAMHS unit. The girl's mother, who herself worked in a psychiatric unit, became increasingly concerned by her daughter's behaviour and, out of frustration, told her daughter that she would be "sectioned" if she didn't comply. As result, the girl was more frightened and refused to speak to anyone, and tried to hide herself by crouching on the floor in the corner of a room in the unit.

The psychiatrist believed the girl needed to be treated with specialist support and there was a place available for her in a specialist young people's unit, which was out of the local region. However, the young girl did not want to be admitted to any hospital, especially one in another local authority area, so she refused to engage in any further discussion.

The duty MHO was contacted and was asked to meet with the psychiatrist to discuss the concerns. The psychiatrist recognised the deterioration in the young girl's mental health and believed that formal detention under the Mental Health Act may be the only solution. The need to be mindful at all times of the rights of the young girl needed to be central to the assessment, particularly when detention in hospital might have been the only way in which the identified risks could be managed in order to keep her safe.

When the MHO arrived, the girl was refusing to speak to the psychiatrist or her mother, who also wanted to be involved in the assessment interview. The MHO recognised that the best way to ensure the girl felt comfortable to have a discussion with her was to ask her mother and the psychiatrist to leave the room, which they did.

The MHO asked the girl's permission to sit on the floor with her and introduced herself. The girl agreed with a nod of her head that the MHO could sit near her and, once prompted, began to slowly talk about her fears: the sudden death of her father several years before whom she still missed; her mother's new partner who now lived with the family and her attendance at a new school at which she was being bullied. All of this had culminated in the girl seeing her world as 'frightening'. Television and Facebook coverage of terrorist activity added to these fears and her feeling that she no longer wanted to live. She was unable to recognise that she needed medical treatment and remained reluctant to go to the specialist unit.

Following this discussion, the MHO asked the psychiatrist to come back into the room and join them on the floor. The MHO and the psychiatrist, still sitting on the floor, explained the detention process to the girl, the reasons behind the decision and what this would mean for her. The MHO advised her of her right to appeal against the detention and her right to advocacy, but also re-enforced that, as this was a lot of information to take in, the hospital staff in the new unit would also be able to answer any questions she might have. The girl was already supported by a local advocacy worker from the young people's service and the MHO said she would ensure that this worker was fully updated as to the detail of the transfer to a new hospital. This seemed to reassure the girl, in that someone she already knew would be in contact when she arrived in the hospital.

The consultant psychiatrist and the MHO had agreed that the criteria for detention in a hospital under Section 44 of the Mental Health (Scotland) (Care and Treatment) Act 2003 was met:

- The patient has a mental disorder
- That because of the mental disorder, the patient's ability to make decisions about the provisions of medical treatment was significantly impaired
- That it was necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient or giving medical treatment to the hospital
- That, if the patient were not detained, there would be a significant risk to the health, safety or welfare of the patient or to the safety of any other person
- That the granting of a short term detention certificate was necessary

The MHO then spoke with the girl's mother to explain the need for her daughter's care, her daughter's right to appeal the detention, her right as her parent to make any appeal on her daughter's behalf and her daughter's right to advocacy. The young girl was then taken by ambulance and nursing escort to the specialist unit.

On arrival at the specialist unit, the girl was uncommunicative and refused to speak to the staff in the unit. They were concerned about her withdrawal. However, when the advocacy worker visited, she informed the staff about the methods by which the MHO had been able to speak to the girl and which the girl had said she found helpful: through physically sitting with her on the floor, talking honestly to her about her situation and explaining everything, by listening hard to what she said and allowing her to tell her story at her own pace, all of which made the girl feel believed and not so frightened or intimidated. The staff in the unit mirrored the MHO's method of interaction, which facilitated an easier communication with the girl and, over time, she became more comfortable in talking to staff.

As it was the duty MHO service which had been accessed in this situation, the case followed the process for the service: the girl's case was then allocated to one of the MHOs in the MHO service. The allocated MHO had an immediate duty under Section 231 to complete a Social Circumstances Report detailing what is described as a "relevant event", offering background history, the circumstances which led to the detention and future care planning proposals. This report is required to be submitted to the Mental Welfare Commission and the psychiatrist, who has the role of the Responsible Medical Officer (RMO).

After a period of care and treatment, which included further detention under a Compulsory Treatment Order (CTO) under the Mental Health Act, the girl was able to return home. She remained subject to the CTO, which offered the safeguard that, if her mental health deteriorated and she needed treatment in hospital, she would be recalled back to hospital. Care planning identified the need for further engagement with services, including appropriate school support, children and families social work support and ongoing support from CAMHS. The MHO continued to be involved.

4.3 Resources, service culture and demographic challenges

All interviewees spoke about the impact experienced with an increasing older population, with an associated higher degree of need, and with those needs being more complex at the point of access, creating greater risk and need for intervention.

In several local authorities, ongoing care management which would, in previous years, have been undertaken by colleagues in community teams, was being undertaken by MHOs, and not social workers in community teams. In some local authorities, the availability of resources in the community and across other social work teams meant that MHOs were supervising guardianship reviews, while in other local authorities, this function remained with community teams.

In local areas which are mainly rural in nature, the impact of distance and time to attend visits, coupled with the lack of availability of, and accessibility to, community-based resources for ongoing support is challenging.

Local Area G has very few third sector agencies which can offer support to those with mental health needs requiring ongoing support and, where these do exist, facilities are concentrated in larger towns, creating transport and travel issues as well as issues of stigma for those using services in smaller areas.

Local Area B is an area which previously seemed to attract potential staff into the area and, once people came, they tended to stay, however, the area now experienced a reverse in this trend, with many people choosing to move back to more urban or central areas to live.

In one local authority, historically, the MHO team developed from an Adults with Incapacity team established at the point of the relevant Act being implemented. Despite much promotion on the part of the MHO team manager, the wider service still refers to the team as the 'AWI team' and, consequently, all AWI work is placed within this team and not across satellite teams. The team manager reported that this culture was proving difficult to challenge and was impacting on the current team.

4.4 Increased awareness

Interviewees felt there is much clearer and more readily accessible mental health information for members of the public and other professionals, particularly with regard to guardianship. This was felt to be very positive, reflecting an understanding that decisions cannot be taken about an individual lacking capacity without clear understanding and implementation of the relevant specific powers, however, it also meant that services were receiving an increase in the volume of referrals.

CASE STUDY 5: The role of the MHO in managing complexity

A man with a diagnosed learning disability who lived in his own home was refusing to allow his support workers to carry out agreed tasks with him, refusing to see a doctor, choosing to stay in bed all day, drinking heavily at home and neglecting his care and hygiene. He was felt to be at risk of fire due to smoking heavily while under the influence of alcohol and at risk of financial abuse from identified others.

The Adult Support and Protection process was initiated, and the case conference, involving the attendance of the duty MHO, identified the need to consider protecting the man by applying for guardianship. He had no family who were able to apply to take on the role of welfare guardianship. He was supported at the meeting by an advocacy worker, who conveyed his wishes to the case conference.

A planning meeting was called which involved the allocated social worker, the allocated MHO, the medical team and a solicitor from the Local Authority's Legal Services. The meeting members considered and assessed the risks and identified the legal intervention which may be required. The MHO progressed the local authority welfare guardianship application, which involved consultation with the man himself, his family members, advocate and all relevant professionals involved in his care. However, over this period, the man, who remained at home, required increased involvement and support from psychiatric medical and nursing staff.

The situation deteriorated. It became clear there was a need for formal detention in the psychiatric hospital, under a Short Term Detention Order (Mental Health (Care and Treatment) (Scotland) Act 2003). This period of detention enabled full assessments, including Occupational Therapy, to take place within the safe environment of the psychiatric hospital. A diagnosis of depression and an alcohol dependency was confirmed. An Interim Welfare Guardianship Order was applied for and this was granted. At all times, the man's rights to support from advocacy services, which included support with any appeals, were maintained throughout the use of the Adult Support and Protection, Adults with Incapacity and Mental Health Act processes.

5. The role of the MHO in Adult Support and Protection

In the areas of working with adults at risk, and managing that risk, the MHO role has been clearly established, specifically in the context of the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003, the Mental Health (Scotland) Act 2015 and specific duties under the Criminal Procedure (Scotland) Act 1995, which were amended under the Mental Health (Care and Treatment) (Scotland) Act 2003, specifically in relation to mentally disordered offenders.

In the [Adult Support and Protection \(Scotland\) Act 2007](#), this role is less clear, because the primary social work role is contained within the role of authorised Council Officer.

In the 2 reports highlighted below, the recommendations from the Mental Welfare Commission make clear the need for appropriate consideration of legislation to support and protect vulnerable adults: a role in which the MHO has specific knowledge and expertise.

The Mental Welfare Commission published its report into the [care and treatment of Ms A](#) in April 2008, one of the recommendations of which was that social work departments (as they were at the time) should “re-examine and clarify the role and function of the Mental Health Officer in adult protection case conferences to ensure that their specialist training, experience and skill is used to best effect in contributing to the assessment and risk management of vulnerable adults with mental disorder”.

The Mental Welfare Commission report '[Left Alone – the end of life support and treatment of Mr JL](#)' (2014), although not explicitly referencing the role of the MHO, made a number of recommendations highlighting the need for robust multi-disciplinary assessment in cases where there are concerns or doubts about an individual's capacity to consent to, or withhold consent from, medical treatment and possible risk of harm and subsequent concerns about adult protection.

In both of the above examples, the role of the MHO in supporting colleagues to navigate relevant legislation is of vital importance in ensuring consideration is given to the appropriate legal safeguards which can be used to protect vulnerable adults.

MHOs have expert knowledge of the relevant legislation and the key rights and duties offered by the above Acts. Specifically, they respond to inquiries, and only they can obtain warrants and removal orders under the 2003 Act.

In particular, the work of the MHO involves:

- Conducting inquiries
- Seeking and obtaining warrants for entry, medical assessments, and access to medical records
- Seeking and obtaining authorised person's warrants
- Making an application for, and seeking a removal order, from the Sheriff and making an application for, and seeking an urgent removal order to a Justice of the Peace
- Meeting duties under emergency and short term detentions: to provide consultation and consent (or not) to emergency detention and short term detention
- Meeting the duty and its associated tasks in applying for the provisions of a Community Treatment Order

5.1 The role of the MHO in legislation in relation to risk, harm and mental disorder

Adults affected by mental disorder have particular risks associated with the effect of mental disorder on their health, welfare and safety. They may lack insight into their predicament, as many people with mental illness such as bi-polar disorder, may have. They may have disordered thought processes, as many people with schizophrenia may have. They may lack memory and capacity to make/take decisions, as many people with alcohol related brain damage or dementia may have. They may display challenging behaviour, as many adults with learning disability or personality disorders may do. They may be particularly open to harm and abuse from others, sometimes to financial exploitation, as many people with dementia are, or open to sexual exploitation, as many people with learning disability may be. They may be open to self-harm, as many adults with mental illness, such as adults with severe depression, personality disorder, or eating disorder, may be.

Supporting and protecting adults at risk affected by a mental disorder can take on a number of forms and aspects. Some may need support to take steps necessary to respond to, and manage, risk. Others may need protection against risk arising from the effects of mental disorder on health, safety, welfare, property and finances, for themselves and to others. They may need care and treatment on a voluntary, or by exception, compulsory, basis, e.g. in relation to a risk to safety and protection, health, welfare, losing their house, home, finances, employment or relationships.

In the Adults with Incapacity (Scotland) Act 2000, section 10, the local authority has a responsibility to 'investigate any circumstances made known to it in which the

personal welfare of an adult (with impaired capacity predominately because of mental disorder) seems to be at risk', and where the local authority needs to take action necessary for the protection of the property, financial affairs or personal welfare of the adult, (section 57) and where there is an offence relating to the ill-treatment or wilful neglect' of an adult by a person exercising powers (section 83).

In the Mental Health (Care and Treatment) (Scotland) Act 2003, section 33 stipulates the local authority's duty to inquire into the case of a person with mental disorder where certain criteria are met. There are terms employed such as 'ill treatment', 'neglect', 'deficiency in care or treatment', 'property at risk' or 'has suffered loss or damage', 'living alone' or 'without care' and 'unable to look after property or financial affairs', and 'safety of some other person may be at risk'. Grounds for compulsory powers include section 44 (short term detention) where there is significant risk to an individual's health, safety or welfare, or the safety of any other person, and section 36 (emergency detention) where there is a matter of urgency. These are terms significant across the range of mental disorders and not just to adults with mental illness, accounting for the predominant use of orders under the Act.

In the Adult Support and Protection (Scotland) Act 2007, there are significant terms to be found, such as in the local authority's duty to inquire (section 4), if it knows, or believes, the adult is at risk of harm and it may need to intervene to protect the individual's well-being, property or financial affairs. Adults at risk (section 3) are defined as adults who are 'unable to safeguard their own wellbeing, property, rights, other interests', and are 'at risk of harm' and 'because they are affected by disability, mental disorder, illness or physical or mental infirmity, they are more vulnerable to being harmed than adults who are not so affected'. Where 'another person's conduct is causing, or likely to cause the adult harm, or the adult is engaging, or likely to engage, in conduct which causes or is likely to cause, self-harm. Here harm includes (section 53) all harmful conduct, conduct which causes physical harm, conduct which causes psychological harm (fear, alarm, distress), unlawful conduct which appropriates or adversely affects property, rights or interests (theft, fraud, embezzlement or extortion) and conduct which causes self-harm.

Given the consistency in phrases which define 'risk' across legislation and for which statutory intervention is legislated, there can be a defined list of risks associated with mental disorder from which MHOs draw on when considering a legislative response:

- Risk from others (abuse, assault, neglect), to personal welfare
- Risk from self (self-harm, self-injury, self-neglect)
- Risk of harm caused from lack of (or deficiency in) care or treatment, from neglect, or living alone, or unable to care or protect oneself, or to care for one's health and personal welfare

- Risk to welfare, health and well-being – risk to housing or physical health problems or quality of life
- Risk to safety – risk of causing, or placing oneself in, a risky situation
- Risk of harm to property and/or finances – risk of financial exploitation and abuse, and to property and finances
- Risk to, or harm from, others – causing a risk to carers, children, family members, the public, because of mental disorder and arising from incapacity

No one legislative framework will either meet the needs of an adult with mental disorder, or will allow a professional to respond to all risks associated with the effect of the mental disorder on an adult's, or on other people's, lives. Practitioners working across the range of mental disorders must navigate a course through the legislation, looking for resolutions to meet particular needs. The expertise of the MHO is in assessing the risk, or potential risk, and working in partnership with others to make decisions based on professional judgement of the best use of the existing legislation and associated powers to achieve the best outcome for the adult.

5.2 MHO resourcing of adult support and protection:

It was acknowledged by those interviewed for this report that there is variation across local authorities in the capacity of the MHO service to regularly attend adult support and protection case conferences, however, there was general agreement that, where MHO attendance took place, decisions could be made on a more holistic basis, involving all relevant professionals at the earliest stage.

One local authority stated they always included a MHO and a representative of legal services at every initial adult support and protection case conference as a matter of course, another does not, due to the service's lack of capacity to provide a MHO at what was described as a high volume of initial case conferences for adult support and protection. Some other local authorities described situations in which they made an assessment of the need for MHO attendance when invited to attend.

One of the interviewees spoke about improvements in relationships between MHOs and Health colleagues, including Responsible Medical Officers (RMOs), in the area of adult support and protection. MHOs' existing and increasing confidence in dealing with this highly specialised area of practice allows them to assist medical colleagues in the interpretation and implementation of the law.

Additionally, being viewed as 'independent' of both Health and Social Work was felt to enable the MHO to appropriately advise and facilitate in relation to the underlying principles of the Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003. An example of this can regularly be seen in

relation to the use of the 'least restrictive' principle. One interviewee believed that lack of familiarity or confidence in interpreting legislation can sometimes result in professionals becoming risk averse and part of the emerging role of the MHO has been in supporting medical and social care teams and professionals to make decisions predicated on the underlying principles of the Acts.

In one Local Area in which MHOs do not hold case management duties, the service manager felt that this allowed the MHOs to work closely with the individuals' families and carers in a clearly defined MHO role. This was felt to have resulted in a more productive, and less challenging, relationship between the individual's family and the hospital/care team. Similarly, in this area, individuals identified by hospital teams as 'delayed discharge' are referred to the MHO service and quickly allocated, enabling medical and social care staff to work closely with all involved to ensure plans are put in place to facilitate appropriate outcomes for the individual.

CASE STUDY 6: The contribution of the MHO to adult support and protection

A MHO became involved with a 74 year old woman whose son contacted social work requesting support for her, as he was moving to his own home. Over several weeks, carers and district nurses noted that the woman was low in mood, not eating and had evident weight loss. An Adult Support and Protection (Scotland) Act 2007 referral was made when a carer noted bruising to her arm. When questioned, the woman said she had walked into a door. There was evidence of someone else living, or having lived, in the house, but the woman denied this. She was assessed by a Council Officer using the 3 point test defined in section 3 of the Act (the individual 'is unable to safeguard her/his own well-being, property, rights or other interests; is at risk of harm; and because s/he is affected by disability, mental disorder, illness or physical or mental infirmity, is more vulnerable to being harmed than adults who are not so affected) but it was decided that she did not meet the criteria. No MHO was involved in the woman's assessment. Although additional support was offered to her, she declined. A few weeks later, her son again requested support and, while care was offered at lunch time and tea time, access was often difficult.

Weeks later, a carer reported that the woman was anxious and "weepy" with dried blood on her face. The social worker visited and found her to be anxious, dishevelled and unwashed, and wearing a night dress which bore evidence of a nose bleed. There was no food in the fridge, the house smelled of urine, and further weight loss was evident. The woman's GP was requested to undertake a capacity assessment. A professionals' meeting led to another home visit 3 days later. The social worker found the woman was fearful, unsettled and unkempt stating that "police were hiding in the kitchen". The GP was contacted and a nurse visited. The woman was prescribed antibiotics and the social worker was advised that, if her paranoia continued, a review should be held. The nurse made a referral to psychiatry colleagues.

The next day the carer arrived to find the woman's house doors open, her care at home folder in the garden, her antibiotics scattered on the floor and the woman herself was confused, fearful and anxious. Her GP was contacted and she was taken to hospital where she received treatment and care over a long time. She was assessed as lacking capacity and a local authority guardianship was applied for, and granted, allowing the woman to be moved to a long term care placement.

The involvement of a MHO at the point of the initial Adult Support and Protection referral would have allowed for consideration of appropriate legislative options in order to safeguard and protect the woman at an earlier stage and, perhaps, have facilitated a better and quicker outcome to an appropriate care placement.

6. How local authorities are addressing challenges

6.1 Recruitment to the MHO role

Interviewees felt that the level of promotion a local authority makes to actively recruit to the role is a key driver to attracting suitable candidates and, where a local authority offers little or no additional remuneration or enhancements, the methods by which this promotion is undertaken are even more important.

Information to support recruitment highlights the benefits of undertaking MHO training for continuing professional development. MHO teams participate actively in local authority events to attract social work students to the local authority.

Some of those interviewed have an internal peer mentoring programme in place for MHOs which includes ongoing training, quarterly meetings and learning fora, as well as regular development days with input from identified speakers.

Local Area D's 'Mental Health Information Hub' provides recent and relevant information on mental health matters, an online 'Pathway to Community Mental Health Teams' has been created to promote interest in mental health, and there is a Mental Health Interest Group which captures those considering MHO training. The local Health and Social Care Partnership has identified mental health as an area of priority and there is continuing support to the recruitment, training and retention of MHOs.

Succession planning

The Scottish Social Services Council report 'MHOs (Scotland) 2016 Report: A National Statistics Publication for Scotland' noted that the MHO workforce has a slightly older age profile than the wider social work workforce. In 2016, 74.2% of the MHO workforce was over 45 years of age (a slight reduction from previous years); and 35.3% of the MHO workforce was over 55 years of age (a slight increase from previous years and one third of the MHO workforce).

Among interviewees, there was widespread recognition that, although local authorities undertake workforce planning across social work as a sector, this was largely reactive and often based on filling vacancies from agreed staff complements only as and when they arise. In relation to MHOs, a move to better workforce commissioning approaches at a local level, combined with a national overview of deployment and wider needs was proposed to support excellent succession planning.

In local authority re-structuring, some services have become shared. Some interviewees felt the principle of shared services could be applied at a national level to a wider national MHO service. This could also be considered geographically – some neighbouring local authorities are in very different positions with regard to recruitment and retention issues related to remuneration and enhancements, a more strategic approach either nationally or across geographical areas was felt to be one way forward.

While the current framework of measuring the rate of WTE MHOs per 100000 of the population ([National Records of Scotland](#)) offers a basic framework for calculation, all interviewees recognised that adequate current and future resourcing of the service is more nuanced and requires a much more strategic approach. The Scottish Social Services Council report 'MHOs (Scotland) Report 2016: A National Statistics Publication for Scotland' also notes the need for a more comprehensive measure in future data collection.

6.2 Resourcing the MHO service

All interviewees recognise the commitment required to support uptake of the MHO Award and the internal support required throughout and after the course and have accommodated capacity in the MHO service, and some in other social work teams, to do so. Newly qualified MHOs are further supported with extended induction programmes in some areas.

Some local authorities have used agency workers at times of need, however, the financial cost to the local authority is high – often a minimum of £80 per hour. This has been acknowledged as a short term intervention at times of crisis and not a long term solution.

Local Area B is projecting a loss of 10 of its 18.6 WTE MHOs to retirement in the next 5 years. Despite putting forward individuals for the MHO Award, these are small numbers and will not address the future issues of capacity or loss of knowledge from older MHOs when they leave.

Local Area C has a Resource Officer appointed to the MHO service to assist the team manager in the management of AWI and delayed hospital discharge cases, including completing reports in relationship to local authority guardianship applications where only financial powers are being sought or Intervention Orders are required, co-ordinating links to solicitors, ensuring families of those in hospital have the relevant information, particularly if the individual is medically fit for discharge but remains in hospital. The Resource Officer can ensure the family know what information a solicitor will require to progress a guardianship application. The MHO

will follow up this initial contact with the family, but the Resource Officer can remain involved to assist with supporting family with further information as required, where private applications are being pursued.

Local Area D has a Mental Health Strategy Group which discusses pressures on the service regularly and seeks joint ways forward, tracking this 6 weekly via monitoring processes complemented by the daily oversight of team leaders. Team leaders manage the MHOs' workload through monthly supervision and will step in and avert a crisis, if necessary. Senior managers consistently provide encouragement, advice, guidance and commitment. This area's 5 year strategic plan is at the point of review which will also take into account current issues and context. Case conferences allow discussion to ascertain the least restrictive measures for an individual and these can avoid formal processes and give an audit trail about decision making.

Local Area G had a wider workforce planning initiative underway at the time of this report, of which the MHO service is a part.

6.3 Working with others:

The benefits of true partnership working were emphasised by all interviewees.

Earlier examples in this report of the MHO service proactively arranging discussions with multi-disciplinary colleagues support this ideal and help promote the service and alleviate some of the time pressures involved in the process. Discussions have included the need for medics to arrange an initial assessment of individuals at the point of admission to hospital and an early linking with the MHO service from that point.

Some other actions have included the following:

In Local Area A, a MHO Co-ordinator was appointed, separate to the team managers and this has benefitted the area enormously in enabling the post to take a wider view of the service's needs, workforce deployment, training, supervision and development. The Co-ordinator also deals centrally with more global concerns, for instance, data collection, practice assessing, local and national training, attendance at local and national fora and keeps an overview of patterns or trends in practice which require a specific response. The Co-ordinator has also undertaken the role of linking with solicitors every Christmas and New Year period to remind them this is a period of leave for the MHO service, that the service will be reduced and workload capacity may be diminished. This has been well received and, consequently, letters from solicitors over these periods have also reduced.

In Local Area E, the senior MHO gave an example of work he had undertaken 3-4 years previously to address challenges in capacity to meet timescales: he wrote to the clerk of court to outline the issues leading to challenges in MHO capacity linked to the statutory role, explaining that he would write to all solicitors to seek flexibility in co-ordinating the letter for request process to enable statutory timescales to be met. The Court and solicitors were reported to be receptive to this as it supported them to meet demand from their perspective too. This has helped with professional relationships as well.

Interviewees were aware of work being undertaken at a national level to investigate the appropriate use of 'graded guardianships' and it was widely welcomed as one approach to support increased demand and, by extension, support more timely help for individuals who require a service.

Nationally, it was widely felt that any reviews of legislation must include those delivering operations working together with relevant colleagues from other agencies. At the moment, the Mental Welfare Commission or the Office of the Public Guardian are often the only 2 bodies involved and, although they have oversight nationally, interviewees felt that staff actually delivering day to day work in mental health would be able to offer real insight into issues and be in a unique position to make suggested changes to practice which would have greater impact on outcomes for people using services. They could also offer creative ways to introduce changes to the benefit of those using services.

It was also felt that, whereas previously the Mental Welfare Commission used to hold meetings with MHOs in each local authority and now these only happen regionally, reinstating local meetings would be very helpful.

CASE STUDY 7: A referral to the Out of Hours' MHO Service: safeguarding human rights during detention (2)

A MHO became involved when a young mother presented herself at her local out of hours' clinic. The woman had a 19 month old son but was separated from her partner and had an older child from a previous relationship who lived with his father. Both her parents were deceased and, although she received some support from her 2 sisters who lived relatively nearby, she reported that she was lonely, eating increasingly less, very tired, not sleeping and struggling to look after her child. She stated she had been treated for depression in the past and had been given further anti-depressants but was not taking these as she didn't 'see the point' any longer.

While at the clinic, staff noted that she appeared to be responding to stimuli: having conversations with what she believed were various individuals who kept telling her she was "ugly, a bad person and not fit to look after her child". The on-call consultant psychiatrist diagnosed a possible post-natal depression which had not been previously diagnosed or treated and wanted to secure the woman's admission to the local psychiatric hospital for treatment. The woman was refusing to go as she feared losing her child.

The out of hours' MHO was contacted to undertake an assessment of the woman, with a view to implementing a Short Term Detention Order in order to seek further medical treatment.

Following the assessment, the MHO agreed with the psychiatrist that a Short Term Detention Order was the best means by which the woman's needs could be met at that time. However, the woman's concerns about losing her child meant that suitable arrangements had to be made to enable the woman to see that her child would be cared for and not removed from her care into the care of the local authority permanently, as she feared.

Accordingly, the MHO contacted various members of the woman's family to make arrangements, concerned that all the while, the woman's mental health was deteriorating and risks were escalating. With no success from contact with family members, the MHO and psychiatrist contacted the hospital to request the woman be admitted with her child, with the MHO looking after the child until other arrangements could be made. The hospital, however, were concerned that their staff were not subjected to suitable checks which would have allowed them to take care of the child. The MHO contacted the out of hours' social work service manager to request the support of the on-call children and families social worker. The out of hours' manager was eventually able to identify an emergency foster care placement for the child, but the placement was not available until later that evening.

The woman became increasingly distressed and, when the nursing escort team arrived to take her to the hospital, refused to go, clutching her child to her.

The MHO and the social worker spent time talking to the woman, reassuring her that arrangements were being made for her child, what the detention meant, her right to appeal and her right to an advocate. Eventually the woman, who by this time was showing signs of extreme tiredness, became less resistant and gave her child over to the MHO. The escort team stepped in to take the woman to the psychiatric hospital. The MHO and the social worker were able to take the child to the foster carer and assist in settling him in. The MHO had promised the woman that she would return to the psychiatric hospital later in the evening to update her about her son, which she did. She was able to talk to the woman about her son and how he had settled in with the foster carer, providing her further reassurance of her care and that of her son. On the next working day, the MHO made a referral to the local advocacy service on the woman's behalf.

The woman required a lengthy stay in hospital, and further detention under the Mental Health Act. Full assessments confirmed that the diagnosis was, in fact, schizophrenia, a mental disorder characterised by abnormal behaviour and failure to understand what is real. The woman had exhibited the positive symptoms of experiencing things which are not real (hallucinations), and having unusual beliefs (delusions), combined with her negative symptoms of lack of motivation and being withdrawn. Her treatment required changes of medication to ensure that her symptoms were appropriately managed and staff also needed to be mindful of the impact of the side effects of her medication. Her child remained with the foster carer, as family members were unable to look after him in the longer term.

A MHO from the MHO service was allocated to take over the role. This MHO provided ongoing support to the young mother and also fulfilled all statutory duties in relation to the need to safeguard the woman in hospital for ongoing treatment. The child was, at that time, legally accommodated by the local authority and subject to the Children's Hearing System.

The MHO was required to attend Hearings and relevant meetings with regard to his care. This allowed the MHO the opportunity to speak to panel members and partner agencies about mental disorder, about schizophrenia in particular, how it had impacted on the child's mother, her abilities and limitations, and the ways in which the woman could still care for her child, allowing the needs of both the mother and the child to be fully explored. Following good partnership working and care, the woman was able to return home with her child. She continued to accept the support of the multi-disciplinary team, the consultant psychiatrist, the community psychiatric nurse, the MHO and family support workers from children and families social work services.

6.3.1 Location of MHOs:

Having dedicated MHO teams has been described positively by all interviewees who had this and it was felt to support consistency in practice, learning and expertise.

Co-locating multi-disciplinary teams had been described as beneficial. Some areas have the MHO team located beside other allied health professionals and other adults' services teams.

Locating MHOs in specific teams has worked very well for some local authorities, although, in most instances, this was not a new development but, rather, one in which the positives were more readily evident at a time of increased workload and demand.

Services which had a MHO within a hospital team, were finding particular benefits:

Interviewees spoke about the benefits, not only of expediting care for individuals, but also in breaking down barriers and supporting the learning of Health colleagues in the role of the MHO and the MHO service. Some areas have also capitalised on this and have been able to bring together multi-disciplinary colleagues in training sessions, although there remain difficulties in attracting some medics to sessions, dependent on their capacity, availability and interest.

In Local Area C, on admission to hospital, the hospital social work team take responsibility for co-ordinating all hospital discharges, regardless of whether or not the patient has an allocated worker from the community. All health staff are encouraged to contact the hospital social work team once a date of discharge is established for an individual. The hospital has a 'rapid response' team, supported by occupational therapists, which supports the establishment of home care packages. For all local authority guardianships, a case conference is convened within 5 days of the referral from hospital.

6.3.2 Joint training, learning and development:

Local Area B has a protocol in place to ensure every case conference has an in-house solicitor and MHO present.

Local Area C has delivered a lot of joint training with health staff and medics, for instance on capacity, the use of section 13ZA and discharge processes and this has resulted in more robust decision-making.

Local Area G offers routine training for solicitors and other partners to raise awareness of the MHO role and service and other local areas have utilised local authority Legal Services colleagues to deliver joint training in legislation to MHOs, and non-MHOs as well as multi-disciplinary training sessions with partner agencies.

Most interviewees acknowledged the importance of ensuring MHOs have the chance to attend local and national events, including the annual MHO Forum organised by the British Association of Social Work, the Social Work Scotland sub group for mental health (where individuals are members) and most local authorities offer in-house events for MHOs.

Local Area C holds an internal MHO event 6-8 weekly. This is designed by the MHOs themselves. The service organises an annual fully funded MHO study day which takes place out of area with invited speakers and MHOs are also encouraged to attend the centrally organised child and adult protection events.

Local Area D has a dedicated Training and Development Officer for Mental Health, coordinated MHO Fora quarterly and additional resource seminars through the year.

Team and service managers were often unable to give the same offers to MHOs who work within other social work teams as they are not directly responsible for their management and the ability to ensure these MHOs are aware of these events is dependent on local arrangements and, often, budgets.

To support a vision of a competent and confident workforce, interviewees felt that meaningful additional opportunities for continuing professional development for all qualified social work staff, beyond statutory updates, would show greater investment. Difficulties of releasing staff for training in the current climate were acknowledged, however, the use of technology should offer more online learning options. It was recognised that colleagues in Health can access a lot of national online training, however, although barriers between ICT systems can prevent social work staff from accessing these, it was proposed that modelling additional training at a national level would be very supportive in creating a consistency to workforce development.

6.3.3 Supervision:

Supervision in social work practice is a key determinant of an organisation's role in learning to align theory to practice, in supporting professional development and wellbeing, in safeguarding competent and ethical practice and in maintaining an oversight of case management approaches. Allowing protected space and time for practitioners and managers to focus on how they make sense of practice issues enhances skills in critical thinking and decision-making, all to the benefit of those using services.

Excellent supervision is widely recognised as being key to an individual's development and, in a role which is complex, demanding and unpredictable, such as the role of MHO, robust and regular supervision is necessary. Although interviewees recognise this and, to varying degrees, discussed their ability to deliver this in practice to those they directly managed, their own experience of being supervised as managers of the MHO service varied significantly. Management and governance of the MHO service will be discussed elsewhere in this report.

Local Area A's MHO Co-ordinator offers regular supervision to all MHOs, separate to the team manager. This also supports the Co-ordinator's overview of service development and professionals' needs.

6.4 Service evaluation

Undertaking better and regular self-audit and self-evaluation of services both within local authority areas and with benchmarking partners was felt to be a positive way forward. The local authorities in this report were reported to be at very different stages in considering how to measure their own performance, both internally, and in benchmarking against other local authorities or at a national level. Some had not begun a formal process of evaluation, some had utilised ways of reflecting on their service delivery via feedback from colleagues and those using their service, and one had been successful in gaining a prestigious customer service award.

Although services can undertake further work, it was felt that this required a much more strategic approach at a local level, and there was also a call for there to be national co-ordination and support to maintain a global overview.

Interviewees suggested that using the National Standards for MHOs to measure individuals' practice would, if the current standards were to be reviewed, be beneficial in ensuring effective learning and robust service delivery. This would also reinforce the local authority's role in taking a robust approach to supporting MHOs.

6.5 Practical issues

ICT systems:

In order to sustain the aim and vision for the services, most interviewees recognised the practical issues which, if not addressed, can create additional barriers to the provision of excellent services: supportive ICT systems which can be shared across disciplines, the effective collation and reporting on performance and standards, supported by the means to offer relevant and ongoing training through web resources were some of the issues highlighted. Interviewees noted that Health colleagues appeared to have better and more regular access to online training resources and, if local authority ICT systems were upgraded to offer this, or local authority colleagues given access to these systems, this would be of immediate benefit to the MHOs and the wider service. One local authority area was, however, clear that their online learning resource was good and had no issues in this regard.

Financial charges:

All interviewees recognised that, in relation to providing reports regarding guardianship applications, the MHO Service is the only service involved which does not apply a financial charge for its service. The Responsible Medical Officer (RMO) makes a charge for his/her report, as does the solicitor. When a solicitor applies for welfare guardianship, the solicitor can apply to legal aid for funding; the solicitor charges the client for writing the application and receives payment. One local authority interviewee gave a recent example of a RMO charging £180 for a 2 line report for an individual for whom the RMO was already the named medic and knew well. While the service profits, this interviewee questioned the benefit to the individual subject to the guardianship application.

One local area assessed the cost of a MHO undertaking a guardianship application at £800 per application, based on an average of 35 hours per report, not including travel time.

Consideration of local authorities charging for the work of a MHO in relation to guardianship applications elicited mixed views from interviewees: while charging might support longer term sustainability of the service, most interviewees felt that mental health practice should be focussed on ensuring individuals' human rights are respected and upheld in the process, not about seeking ways to put money 'back into the system'.

CASE STUDY 8: The role of the MHO in supporting others to navigate legislation

A care assessor was working with a patient in hospital deemed to be a 'delayed discharge', who wanted to leave hospital but did not want to go back home, as he understood and accepted that he could no longer cope. The family were given information, prior to an Adults with Incapacity (AWI) meeting, that they could apply for guardianship and, although aware of section 13 ZA, the care assessor did not think it could be used. The family instructed a solicitor to seek financial and welfare guardianship, although the man did not own property or have a lot of equity.

The AWI meeting was held and the MHO advised the meeting that using section 13 ZA would be the least restrictive option by which to achieve the best outcomes for the man. The MHO felt that guardianship did not appear to be necessary as there were no assets, and that an application under the 'Access to Funds' procedure would deal with the small amount of savings he had. The MHO also advised the meeting that an Intervention Order would deal with any issues about the man's tenancy and give power to close relevant accounts, such as a telephone account etc. The son could, therefore, become his father's appointee and there would be no need for the individual to be subject to a formal order.

Those present then assessed any potential risks: the man had not tried to leave the hospital, he was not assessed as a danger to himself or others and he was very compliant with his care plan. He clearly stated, on a regular basis, that he wanted to settle in a place in which he would be cared for. The MHO was firmly of the belief that any delay in discharge could be dealt with expeditiously, as a care home had been identified and it was likely a bed would become available in the near future.

Within five days of the meeting, a bed became available in the care home the man himself had chosen and the family were in support of the use of section 13 ZA at this point. The man is now settled in his new care setting. In order to share learning, the MHO also spoke to the care assessor afterwards to clarify the use of section 13 ZA for her future understanding of legislative options available.

7. Governance of the MHO service in integrated arrangements and line of sight to the Chief Social Work Officer (CSWO)

The importance of good governance:

In 2011, the Practice Governance Group established following '[Changing Lives: Report of the 21st Century Social Work Review](#)' (Scottish Executive, 2006) developed a Practice Governance Framework to support practitioners and employers to develop and sustain a confident, competent and valued workforce which delivers safe, effective and personalised support and services.

Much has changed in the delivery landscape since the framework was published, however, the need for effective and supportive governance arrangements for services to people remains key.

In order to deliver good outcomes for people receiving services and in communities, social work and social care services must have rigorous, confident, competent and valued services in place, delivered by skilled, knowledgeable and effective staff who are well supported to ensure service delivery is safe and meets individuals' needs. This can only be achieved through creating an environment where people have a shared vision about delivering professional services through the complex interdependencies which exist in the current delivery landscape. Excellent leadership can only be delivered through an effective governance framework.

Governance in integrated arrangements:

To support the implementation of the [Public Bodies \(Joint Working\) \(Scotland\) Act 2014](#), Scottish Government released guidance stating which services MUST or MAY be part of local integration arrangements. This guidance stated that mental health services MUST be integrated into integration authorities, however, the requirement to appoint and train a sufficient number of Mental Health Officers to discharge the functions under the relevant Acts remains solely with the local authority. In relation to local authority mental health services, this function is delegated to the chief social work officer (CSWO) to ensure the delivery of an effective MHO service. The chief social work officer remains a non-voting member of the integration joint board.

The nature of the inclusion of mental health services in integrated arrangements and the separation of the responsibilities for the MHOs' associated functions to the local authority alone, have led some interviewees to describe challenges with the service's governance arrangements.

There was wide variation in the governance arrangements for the MHO services in each local authority area in which interviews took place, including the management arrangements for teams themselves and the direct line of sight between the MHO service and the chief social work officer (CSWO).

In Local Area A, the MHO Co-ordinator is line managed by a service manager for mental health and learning disability, who liaises with the CSWO and all 3 meet formally 2-3 times per year, however can meet on an ad hoc basis if this is required. The CSWO in this area is reported to be keen on developing individuals' capacity for autonomous leadership and was felt to have a clear and direct line of sight to the MHO service. The MHO Co-ordinator issues a monthly report to the CSWO outlining the volume of guardianships, associated authorised officers and any other relevant information which the MHO Co-ordinator wishes to raise at that time. The CSWO is reported to be active in this arrangement and will often respond and engage with the service directly. The MHO Co-ordinator described having a sense that the Integration Joint Board (IJB) in this area has mental health services as a priority.

In Local Area B, prior to integration, MHOs were part of community mental health teams and the service manager described this as a positive working arrangement. Since integration, the MHO service has been separate and, although the service manager described benefits in having a dedicated MHO service, there were also felt to be drawbacks in relation to integrated and partnership working: the MHO service is physically separate from community teams and this lack of co-location was felt to frustrate communication. The lack of cross-sector access to ICT systems was felt to be a real disadvantage and created challenges in information sharing. There was also reported to be clear line of sight from the service manager and the service to the CSWO who was also reported to be supportive and responsive to the service. When issues regarding capacity of the service or succession planning were raised, however, the service manager was not always aware of how these were being addressed by senior managers.

In Local Area C, the team manager reports to the senior management team of the Health and Social Care Partnership monthly which, in turn, reports to the Chief Officers' Group. The team manager feels the MHO service is well supported and 'protected' in the local authority, because lots of awareness raising and educative work has been undertaken with senior managers. Should the service be 'at risk' or have particular pressures, completion of a 'service risk form' will ensure that senior managers are informed and the risk register is updated and issues escalated appropriately. In the integrated arrangements for this local authority, the CSWO has no direct line management of the MHO service as this has been devolved to the Health and Social Care Partnership but the CSWO retains statutory responsibility for the service and functions of the MHOs. The team manager, however, meets the

CSWO formally every 6 months and more frequently if issues arise of which the CSWO needs to be made aware. The MHO service falls within the operational responsibility of an Adults' Services Manager, who is a social worker. The 2 areas of social work and health are, therefore, separate and mental health services are managed differently, dependent on whether they are line managed via social work or health. Again, the different ICT systems in use between social work and health were reported to cause challenges in communication: the systems are not integrated and this caused issues when neither one can access the other.

In Local Area D, all 4 team leaders in the 4 geographically located Community Mental Health Teams are all MHO qualified and managed by 4 separate social work Field Work Managers. Mental health services are hosted by the Health and Social Care Partnership and members of the Partnership are also members of the Mental Health and Learning Disability Strategy and Planning Group which covers 2 areas on a pan-area basis. This group oversees mental health delivery intentions within the Partnership. There is also a Mental Health and Wellbeing Group within this local area, the remit of which is to oversee the development and delivery of mental health, learning disability and substance misuse services within the local area Health and Social Care Partnership. The Group monitors the delivery of mental health services, including having an overview of the number of qualified MHOs and has responsibility for delivering on the commissioning intentions within the local area's strategic commissioning plan as they relate to mental health services. This Group reports to the Joint Management Group of the IJB. The CSWO also chairs the social work Practice Governance Group which receives regular reporting from the MHO service in relation to service delivery and the numbers of qualified MHOs.

In Local Area E, the senior MHO is directly managed by an Operations Manager from Health who, in turn, is directly managed by a Head of Service in Social Work and who was a MHO, so has direct knowledge of the service. The senior MHO is at senior social worker level and is the most senior practicing MHO in the local authority. The Senior MHO regularly reports to the CSWO and uses the opportunity to raise any issues or challenges for the service. Where capacity has been raised as an issue previously, this was very quickly addressed by the CSWO. The MHO service is accountable to the Health and Social Care Partnership, however, the senior MHO is unclear how the service is viewed or prioritised by the IJB as there has been no direct feedback or any requests for reports to the IJB. Work with mentally disordered offenders, for example, is very high profile, particularly if an individual is rehabilitated back into the community as had happened in the area, however, the senior MHO has never been asked for reports to the IJB.

In Local Area F, the MHO team is managed by the MHO Manager who is a qualified and practising MHO. The manager described a 'fudge and uncertainty' about who line manages the MHO work of the satellite MHOs. The MHO Manager does have

periodic meetings with the CSWO but would like to see these meetings better developed. It was reported that the management structure does not lend itself well to providing support for the MHO service, resulting in the MHO service feeling isolated and not receiving the appropriate level of support from senior managers. The MHO Manager felt the MHO service would benefit from the effects of closer joint working when the integration of health and social care agenda has had time to fully evolve. Services, at the time of writing, were felt to remain disjointed. The MHO service is not co-located and, while the team manager acknowledged that co-location alone does not support integration, it was felt to be a strong contributory factor to smoother and more joined-up working practice.

In Local Area G, MHOs are managed via the Health and Social Care Partnership and directly line managed by the Head of Service, who is a Health colleague, but whose professional background is mental health.

In the areas where the MHO team or service manager's direct line manager is not a MHO, or not located within the social work service, there were challenges expressed in terms of the team or service manager receiving clinical MHO, or even social work, supervision; as well as challenges in ensuring the service is adequately supported, resourced, prioritised and promoted. Team and service managers in these settings have made local arrangements for what was described as 'good enough' supervision, through peers and colleagues, although this was said to be entirely dependent on local relationships. Much has been written about the integral nature between good, robust, regular supervision and effective service delivery, and interviewees found the ad hoc, ineffective nature of their own supervision highly frustrating.

From the current incumbent group of chief social work officers, the majority have a background in children and families' services and, although they have oversight of the MHO service, most interviewees felt that, because of the chief social work officer's own particular background, expert knowledge and experience, they may have had limited direct knowledge or experience of everyday operational imperatives in mental health. Interviewees felt it was even more important that there were clear, routine opportunities for discussion between the MHO service manager and the chief social work officer.

The chief social work officer participates in governance arrangements through a wide variety of fora: as a non-voting member of the integration authority for integrated arrangements and some local authority areas have social work governance groups which the chief social work officer also attends or leads. Line of sight between the chief social work officer and the MHO service, therefore, is integral to the chief social work officer gaining assurance about how the safe, effective delivery of the service is being applied and how it is meeting good outcomes for people using the service.

From the interviewees' experiences above, professional relationships with, and line of sight to, the chief social work officer and integrated partnerships are not consistent and not always clearly or robustly understood or applied.

The majority of interviewees, particularly where management and governance arrangements were not felt to be direct or strong enough, described a real need for robust senior management understanding and championing of the MHO service, especially at an integrated level. This was described as disconnected and it was felt that better leadership and a clearer governance framework in which there was direct governance of the service and regular and clear line of sight to the chief social work officer would engender a sense of worth in the service, as well as create consistency in approaches and assure service quality.

As with all statutory social work services, the mental health service carries out its duties on behalf of the local authority, yet some interviewees felt that local authority senior managers would benefit from a better understanding of their responsibilities in effectively supporting the service to meet, not only its statutory duties, but also support early intervention, education and ongoing support with individuals in communities.

Interviewees questioned whether one MHO service was enough, whether a MHO team should have closer alignment to Health colleagues (including associated systems and practices) and whether its management should be from an integrated health and social care service manager post, where it was not.

CASE STUDY 9: The role of the MHO service in developing shared training and learning

In one local authority area, the MHO service was asked by senior social work management to develop awareness raising and training sessions for multi and single agency colleagues in relation to legislation relating to Adults with Incapacity (AWI), issues of capacity and consent and, in particular, the legal orders of Power of Attorney, Intervention Orders, Guardianship, Section 47 medical certificates and the application of the Social Work (Scotland) Act 1968 - Section 13Za. Given the expertise within the service, the MHOs were uniquely placed to deliver the detailed information necessary to support the learning of others in this complex practice area.

Working in partnership with solicitors from the Council's Legal Services, powerpoint presentations were developed which supported the training sessions and sessions were delivered using an interactive format to single agency, multi-disciplinary and multi-agency stakeholders, as well as those using services and their carers.

The benefits, particularly across multi-agency sessions, were that participants had the opportunity to better understand the legislation in relation to their own work setting, share case studies, discuss and understand each other's responsibilities and consider the challenges inherent in circumstances in which practice is complex and meeting people's needs requires flexible and coherent working. MHO team members all participated in the delivery of sessions across the partnerships. Sessions have been extended out across localities, to include adult care social work staff, NHS staff from community teams and third sector colleagues and will continue to be rolled out.

In this local area, there is a NHS Dementia specialist team comprising of a psychiatric nurse team leader who manages the team, a speech and language therapist, psychologist, occupational therapist, psychologist and social worker. The manager of the MHO service has professional management of the social worker. This multi-agency team offers interventions in dementia, education, assessment and support, training sessions in managing stress and distress, challenging behaviours, initially to care home providers and various hospitals. This team has further developed robust links with the MHO Service to jointly further develop and deliver training sessions on Adults with Incapacity (AWI), in line with their particular 'Stress and Distress' programme of training.

Given the ongoing increase in the number of welfare guardianship applications being experienced in this area, this particular training offers the opportunity to consider the AWI legislation, roles and responsibilities for staff in the care setting, what the granted orders mean, what powers and duties are necessary in order to offer effective care and treatment and support the adult who is subject to an order.

Feedback from training has been positive, the sessions have been well received and the input from staff offering their own experiences has enhanced programme delivery. Staff who attended reported being better able to understand the legislation, consider people's human rights and their role in supporting these rights.

8. Outcomes for people

Despite the acknowledged challenges for MHO services, all interviewees were committed to providing the best service possible to individuals and felt that issues of resourcing, increased demand, changed legislation, integration and governance should remain internal to the service and should be kept discrete to avoid impacting on individuals.

'Quality' was a word used many times in relation to the level of service provided in straitened times. Interviewees felt their services delivered high quality practice and standards and offered the following examples:

Local Area A makes referrals for assessment and care management when required and monitors work after completion of a statutory intervention. MHOs always consider advanced statements and named person nominations, as outlined in the Mental Health (Care and Treatment) (Scotland) Act 2003, as a matter of course. Advanced statements, written when an individual is well, outlines how he/she wishes to be treated when they become unwell. A Named Person is an individual chosen by the individual to protect his/her interests. Services in this area were felt, by the interviewee, to be meeting need, delivering statutory functions and ongoing review work was being well monitored in other teams.

Local Area B felt the service is supporting people. The emphasis is on statutory intervention and it is the service's regret that there is not enough time to support people under sections 25 and 26 of the 2003 Act, for instance (the provision of care and support services and the provision of services to promote the wellbeing and social development of individuals who have, or have had, a mental disorder and are not in hospital). These sections of the Act have been delegated to adult social work services but good communication supports partnership working. Where people return to the service, there is a good commitment from the service to not walk away simply because people are removed from a statutory order – the service still maintains links with people who're not coping, although capacity to do so is a challenge. There is a daily MHO huddle which includes professionals from Health and the duty MHO, in which the duty MHO talks through the situation of individuals who have come to the attention of professionals and this keeps the communication channels open. This was established following cases of individuals who'd committed suicide and it was discovered they'd had significant contact with services in the days prior to their deaths, but where there had not been contact between services to flag up concerns following presentation or contact by the individual attending the service. There are weekly meetings held with all professionals which MHOs attend.

MHOs also respond to a number of requests for advice and guidance to individuals, professionals and colleagues. Often the MHO is able to 'lessen the impact' of a restrictive order on individuals, for instance, being able to advise solicitors that there is no need to seek a full order, perhaps a community based order would be better, for instance, and support better outcomes for people where this is in their best interest.

In-house training supports the service and all MHOs have a mentor. The service also links with a local mental health advocacy group. The manager feels the service spreads itself very wide to support individuals and professionals, and responds to requests for advice, guidance, support and formal referrals.

Evidence of good outcomes for people is gained from the receipt of positive feedback from those using the service.

Local Area C is undertaking work to measure the experience of those using services but the manager acknowledges the service is at the start of this process. There is a service user forum and in-patient services have patient consultation surveys. Meaningful engagement is described as 'difficult' with this particular client group – often contact is at the point of crisis: the local area has 90-100 people subject to Mental Health Act legislation at any given time and, after the MHO deals with the immediate crisis, ongoing work is undertaken by the community mental health teams so ongoing relationships between the MHO service and the individual are challenging. The team manager would be keen to use a reviewed set of national MHO standards to benchmark team performance.

Colleagues in the local area use the Health 'i matters' model', one which provides a framework for measuring the staff experience in order to provide a better experience for the patient – the team manager is assessing if this could be transferable. There is a local users' group and carers' centre and both are a good source of focus groups to assess the experience of those using services. When working with Health colleagues, the team manager – and those from other local authorities – acknowledged that the language of 'patient' can be challenging, however, it is what medics understand and use, so often, he felt that social workers can be drawn in. Where this local area is not meeting its statutory duty is in the supervision of private guardianships (currently approximately 450 in the local authority). Although this is not a statutory MHO function, there is difficulty in allocating these to other social work teams, although, as it is a local authority responsibility, the team manager will approach other social work team managers for assistance in allocating these because, where these are not being supervised, this creates a risk for the local authority and for the individual concerned. This local area has also experienced

issues in accessing accurate data about the supervision of private guardianships – the Caldicott Guardian for the Mental Welfare Commission has, in the past, in the interviewee’s experience, refused to share this information.

Local Area D had, at the time of writing, recently been re-awarded a Customer Service Excellence (CSE) Award which endorsed the quality of services. The quality and standards of MHO reports were not felt by the interviewees to be an issue and this was supported by survey returns contained within the CSE Award framework.

Local Area E acknowledges the difficulty in measuring outcomes because of the nature of MHO work. An example of the challenges in measuring ‘good’ outcomes was given as follows: senior managers will review statistics about the numbers of people detained in the long term and, if they think this may be ‘too high’, they will ask questions. The senior MHO is able to say that, in fact, detaining an individual, using a human rights-based approach, might be the best way to offer a structured and safe approach to address their needs; and that a short term detention might perpetuate the ‘revolving door’ of crisis – immediate input – crisis.

The senior MHO recognised that a proper consultation process around the service, involving those using the service and their carers is needed, but this hasn’t yet been done (mainly due to operational pressures); and the interviewee queried how best to do this meaningfully.

Anecdotally, the interviewee reported that there had been positive feedback from family members over the years about work done by MHOs – helping to explain processes or powers and intervening sensitively to support their loved ones.

Local Area F feels the MHO service supports people in the community very well. However, feels that this particular point should be considered in the wider context of the MHO service working in tandem with Health colleagues and, in particular, psychiatry colleagues. The MHO team manager is less confident that the service supports people well when taken in that wider context. In the interviewee’s view, there were too many repeat admissions and almost a complete absence of consultation and joint working with psychiatry colleagues. MHOs frequently experienced challenges in relationships with psychiatric colleagues. The service works hard to provide a good service but many individuals using the service have their liberty deprived so are often not in a position to reflect on how well their needs have been met by the service. The MHO service is working hard to keep people at the centre of the process.

CASE STUDY 10: The role of the MHO in supporting the local authority to address financial challenges

There is a clear financial impact which can be generated for local authorities when they invest in their MHO service. This financial impact not only results in savings for local authorities and partnerships, but impacts positively on workforce planning and, more importantly, the quality of lives of people using MHO services.

Investment to support workforce planning:

One local authority undertook detailed analysis in 2008 which identified service vulnerabilities arising through the MHO age demographic and an increasing workload being generated as a direct result of new or enhanced duties imposed on the MHO service through the Criminal Procedure (Scotland) Act 1995, the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003. National budget pressures, however, meant that the local authority was unable to implement the agreed action plan.

Following further analysis in 2011, the vulnerabilities identified in 2008 were confirmed and service risks highlighted. This led to the creation of a MHO team manager post, and a commitment to train 5 new MHOs per year to include a 50% backfill of their substantive posts whilst training. This commitment has attracted candidates from across all social work functions and secured 13 new MHOs since 2013. In 2016, the local authority attracted 9 applications with 7 applicants successful in securing a training place on the 2016/17 and 2018/19 cohorts. A further 5 MHO trainees will commence the MHO Award in September 2017 for the 2017/18 cohort.

This commitment, developed from detailed workforce analysis, has addressed a 35% attrition rate previously experienced by the MHO service and seen significant improvement in MHO engagement and cover, particularly with out of hours' services – this figure was 97% for 2016.

Investment to support people using the MHO service:

In this local authority, at June 2016, 522 people were subject to guardianship, demonstrating a continual increasing figure since 2003. In 2016, guardianship applications resulted in 284 private guardianships and 44 local authority guardianships.

In 2016, 61% of out of hours' service call-outs involved MHOs, including 34 short term detentions. 30% of these were emergency detentions. In this local authority area, 6 detentions took place without MHO consent (11%). With the investment in, and the improved engagement of, the MHO service, 89% of detentions took place with MHO consent - a positive contrast to the national reported average of 56%, and a significant impact on safeguarding the rights of vulnerable individuals subject to detention.

In 2014, this local authority also reviewed the MHO contribution to priority discharge. In the 4 year period between June 2009 and November 2013, there were 119 people in this area whose delayed discharge code as recorded was related to 'Adults with Incapacity'. This resulted in a combined total of 8198 excess bed days, with the average cost of an excess bed day at this time being £273. This equated to a total cost of £2,236,689.

Analysis of these figures contributed to the creation of a 0.5 WTE MHO post in one area within the local authority following application of priority discharge monies. The team manager noted that the priority discharge MHO had been an invaluable addition to the team. The MHO had taken on a number of guardianship cases and followed them through to conclusion which had had an impact on the priority discharges, demonstrating an overall reduction in figures. The MHO had also been invaluable in supporting the team where a second opinion was necessary to help formulate effective pathways for effective intervention for those using services who had particularly challenging behaviour. Due to its success and impact, this MHO post has been extended for a further 2 years.

9. Key findings and recommendations

From the evidence and experiences of the interviewees of the local authorities involved, several key findings influenced the following recommendations, both at national and local levels:

For consideration at national level:

Recommendation 1:

A national review of the existing Standard for MHOs must take place, with the input of frontline MHO practitioners and managers, and this renewed Standard must be part of localised audit and evaluation processes, complemented by robust quality assurance and performance measures.

Recommendation 2:

It is clear there are wide variations and interpretations across the country on the application and understanding of section 13ZA. Nationally, a dialogue about the interpretation and use of section 13 ZA should be initiated to create a shared and consistent understanding based on a robust definition and a joint responsibility in supporting people to move on from hospital, supported by one consistent national response. This should drive clear revised national guidance for multi-agency staff to be implemented locally on the interpretation and implementation of section 13 ZA.

Recommendation 3:

Those involved in the operational day-to-day delivery of mental health and MHO services must maintain a structured involvement in national consultations, publications or reviews of legislation.

Recommendation 4:

The support of Scottish Government is sought in nationally championing the MHO role. Its recognition within the Mental Health Strategy 2017–2027 notwithstanding, further national promotion of the role would raise its profile exponentially.

For consideration at local level:

Recommendation 5:

Further work must be undertaken at local level to review the efficacy of current approaches to mental health service delivery, planning, governance and priorities in integrated arrangements. .

Recommendation 6:

A more strategic and structured commissioning approach needs to take place on a multi-agency basis to support robust succession planning in mental health services. Discussions must consider the potential to share services in relation to supporting mental health service delivery.

Recommendation 7:

Multi agency learning and development in mental health services must be supported by accessible systems and shared learning resources. It is recommended that local audits of learning be undertaken in order to design a framework of support for a competent and confident workforce.

Recommendation 8:

There must be greater local investment in dedicated MHO services and development towards more preventative and proactive delivery, enhancing approaches to community engagement and community-capacity building.

Recommendation 9:

It is vital that local reviews of the MHO service include a focus on the means by which effective, regular and robust supervision takes place for practitioners, managers and senior managers of MHO services, incorporating all aspects, as relevant to each individual, of professional discussion, mentoring, professional development and case management.

Recommendation 10:

Local reviews of the MHO service must consider the optimum use of qualified MHOs within non-mental health teams, recognising the significant benefits in mental health training across all sectors.

Recommendation 11:

Local MHO services must implement clear strategies and frameworks to evaluate MHO service delivery and outcomes for people.

Recommendation 12:

Local governance processes must be clear for all staff in mental health service delivery across integrated partnership arrangements and there must be explicit and understood links between the MHO service and the chief social work officer.

10. Summary

The impact of the Mental Health (Scotland) Act 2015 and the Mental Health Strategy 2017 - 2027 is still to be fully experienced, however, the local authorities' MHO services representatives interviewed for this report have described the current and future challenges from their own service perspective, and the ways in which they are working towards meeting these.

Regardless of the issues and challenges raised in this report, MHO services remain committed to delivering excellent services, within a context of integrated services, for people who are mentally unwell, who can become well then perhaps become unwell again and who need responsive, supportive and adaptable services to meet their needs. Individuals deserve a service which supports them to remain resilient and sustain good mental health where possible, to "ask once to get help fast".

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