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common themes in published inquiries and investigations undertaken by the mental welfare commission 1998-2007

individuals were on the margins of services. Diagnosis was often not made early enough or not communicated well. This also affected outcomes for individuals. Where a diagnosis was inaccurate or not undertaken, there was a knock-on effect in terms of assessment of capacity.

Capacity and dementia – The issue of assessment of capacity, when and how it is undertaken, is significant, particularly within the reports dealing with those with dementia (including ARBD) and significant disability. There are clear examples where capacity was assumed without proper assessment and this affected outcomes for individuals, particularly in terms of financial and sexual exploitation. It is interesting to note that in a number of cases there was an apparent lack of awareness about the best mechanisms to put in place to protect individuals, particularly with regard to property and management of finances. There appears also to have been an issue with regard to what factors should be taken into consideration when determining capacity. There were also concerns over the reliance on screening tests that were not accurate as well as a low understanding of the limitations of mental state tests.

Carers – In a number of examples, there was no clear consideration given to the information and support needs of carers, including little use of carers' assessments and the potential impact of these on the situation within which individuals were living. There were clear indications of the importance of staff being made aware of support available for carers and for carers' assessments which could, in effect, provide the means by which someone could continue to be cared for in their own home or by which ongoing contact between the individual and their family could be facilitated.

The role of the individual – There were a number of clear examples of investigations/inquiries where the lack of co-operation from the individual at the centre of the investigation directly contributed to a delay in achieving an effective outcome. This was particularly relevant where the individual did not provide consistent evidence of whatever abuse or exploitation was at the centre of the case or where they regularly refuted what they had previously stated. Also, where

individuals were unwilling to co-operate with their support plans or co-operate with community-based treatment options, there was evidence of a lack of effective challenge, follow-up or sustained effort from services.

Issues for those from an ethnic minority background – Only one of the reports under consideration indicated that the person at the centre of the case was from an ethnic minority background. Despite this, it is perhaps worth indicating the key themes here in terms of cultural needs. The individual's cultural and social needs were neglected; there was inappropriate use of family as interpreters on very personal and intimate issues; and the individual's communication difficulties were marginalised to the extent that he was dealt with as though he would not/could not speak any language.

Inappropriate placements – Some cases had evidence of individuals placed in inappropriate settings, eg residential care, often against their will, where there were, for example, few appropriate activities or intellectual stimulation available to the individuals. This appeared to be linked to lack of appropriate assessment of need and/or carers' assessment, limited availability of placements and, on one or two occasions, a lack of knowledge of other options both by legislative means and with the co-operation of the individual.

System failures – There were a number of examples of system failures, particularly in one instance with regard to the issue of delayed discharge and the system (or lack of it) that matched funding to placements.

Recommendations were made by the Commission in all the investigations and inquiries considered within this report, which should have ensured that the above issues were dealt with across a range of agencies including local authority social work departments, NHS health boards and central government in Scotland.

However, as themes persist within the broad headings outlined above, it is clear that the recommendations being made are not being implemented effectively. It may be that the systemic change required to resolve some of the issues is proving to be problematic or that the messages about

the changes required are not being heard. It could also, of course, be a combination of these factors.

It is clear from the key themes identified how closely linked they are in terms of the overall experience of someone moving through the care system. If assessment and care management, including the recording and communication of information, are at the heart of health and social care systems and these are among the key problem areas, then perhaps systemic changes may be required.

conclusion, recommendations and the future

There are clearly identified themes which recur throughout the investigations and inquiries under consideration in this study, which are presented in the foregoing. The challenge now for the Commission is to work with key stakeholders to understand, and perhaps influence, the process by which recommendations made by them are considered and taken forward with individual organisations. In addition, it needs to be made clear how recommendations made are disseminated at a national level to those not involved in the specific inquiry in order to ensure that future recommendations are influential in challenging ineffective practice and the inadequate protection of individuals throughout the Scottish health and social care system.

The full report on the case of Ms A described on pages 6 and 7 of this newsletter by George Kappler can be obtained from the Mental Welfare Commission website at the following address:

www.mwscot.org.uk/web/FILES/Publications/Justice_Denied_Summary_FINAL.pdf

A summary version of the report is also available in the publications section of the website.