Regulation of mental health care
About the Scottish Consumer Council

The Scottish Consumer Council (SCC) was set up by government in 1975. Our purpose is to promote the interests of Scottish consumers, with particular regard to those people who experience disadvantage in society. While producers of goods and services are usually well-organised and articulate when protecting their own interests, individual consumers very often are not. The people whose interest we represent are consumers of all kinds: they may be patients, tenants, parents, solicitors’ clients, public transport users, or simply shoppers in a supermarket.

Consumers benefit from efficient and effective services in the in the public and private sector. Service-providers benefit from discriminating consumers. A balanced partnership between the two is essential and the SCC seeks to develop this partnership by:

- carrying out research into consumer issues and concerns;
- informing key policy and decision-makers about consumer concerns and issues;
- influencing key policy and decision-making processes;
- informing and raising awareness among consumers.

The SCC assesses the consumer perspective in any situation by analysing the position of consumers against a set of consumer principles. These are:

ACCESS
Can consumers actually get the goods or services they need or want?

CHOICE
Can consumers affect the way the goods and services are provided through their own choice?

INFORMATION
Do consumers have the information they need, presented in the way they want, to make informed choices?

REDRESS
If something goes wrong, can it be put right?

SAFETY
Are standards as high as they can reasonably be?

FAIRNESS
Are consumers subject to arbitrary discrimination for reasons unconnected with their characteristics as consumers?

REPRESENTATION
If consumers cannot affect what is provided through their own choices, are there other effective means for their views to be represented?

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Executive summary

**Aims**
The Scottish Consumer Council commissioned the Scottish Development Centre for Mental Health to undertake a short piece of research to inform thinking and discussion in the area of mental health care regulation. The research aimed to review the roles and responsibilities of the various national bodies that are currently involved in the regulation of mental health care and to consider in particular the extent to which these bodies protect and promote the interests of those who use services.

**Methods**
The paper presented here has been produced based on a series of discussions in January and February 2001 with:

- the main bodies that play a role in regulating the activities of mental health services: Clinical Standards Board for Scotland, Social Work Services Inspectorate, Scottish Health Advisory Service, Mental Welfare Commission for Scotland, Audit Scotland and the Mental Health and Well Being Support Group
- a range of stakeholders including users and carer groups and organisations and professional networks involved in mental health services in Scotland, and on
- a seminar held on 30 April 2001 attended by a wide range of stakeholders.

The different types of regulatory activity are considered along three different dimensions: role and scope of the regulatory body, focus of attention, and function. The research also explores the extent to which the activities of each of the regulatory bodies included in the research incorporate the features and core principles that have been associated with the consumer interest.

**Findings**
Drawing on the perspectives of key stakeholders – users and carers groups, service providers and professional bodies – a number of key issues and challenges are raised. These include:

- the critical importance of ensuring the effective protection of consumer interests in mental health, where people may be vulnerable and ill-placed to safeguard their own interests or those of their family member
- the need to devise approaches to regulation that accommodate the complexity and the inter-agency nature of much mental health provision
- the confusion among many of these stakeholders about the roles, responsibilities and powers of regulatory bodies and frustration about the ‘burden’ of regulation, particularly in the light of the creation of new bodies
- standards are diverse and there are variable approaches to standard setting and to their application
- the need to achieve greater and more meaningful involvement of users and carers in regulatory activity in mental health
- concerns about accountability and independence.
The main concerns of service users and carers were:

- lack of clarity about where to take concerns
- lack of clarity about where responsibility lies for quality
- the impact of differing standards on inequities in provision and access
- variable opportunity for participation and influence
- frustration at limited powers of regulators to enforce change.

The main concerns of service providers were:

- burden of regulation perceived to outweigh benefits
- having to work to various standards, sometimes within same service
- standards which do not easily accommodate joint services or services developed outside the traditional domain of mental health.

The concerns of those commissioning services were:

- overlap and duplication which were burdensome
- regulation sits uneasily with the increasing trend towards more joint working.

Finally, the Scottish Parliament and Scottish Executive have concerns about:

- lack of linkages between differing regulatory bodies
- the relationship between democratic accountability and ongoing accountability and responsiveness to direct users of services.

These issues pose significant challenges and opportunities for the future, not least in view of the implementation of the Regulation of Care Bill and proposals to review the roles and functions of other regulatory bodies, such as the Mental Welfare Commission for Scotland.

Since the research was carried out a number of changes have been made which will have an impact in this area.

Structure of the report

This first part of the paper sets the context by providing a brief overview of policy, arrangements for regulation in health and social care and an introduction to principles and features of regulation from the consumer perspective. Part 2 provides a description of each of the bodies identified above and reflects on their roles and the way they work with reference to the key features of regulation. Perspectives from stakeholders are introduced here as they relate to specific bodies. Part 3 provides a fuller, more discursive, account of the views and issues presented by stakeholders. A draft of Parts 1-3 of this paper was used as the basis for discussion at a seminar in April 2001. All those who took part in the project by agreeing to be interviewed were invited to the seminar. Details of those who contributed to the research and of those who attended the seminar can be found in appendices 1 and 2. Part 4 summarises the themes of the discussion that took place at the seminar.
1 Regulation and the consumer interest

1.1 Definitions of regulation

Regulation is intended to ensure that a system works in accordance with standards, and in a way that is fit for purpose. Regulation tends to presuppose that the operation of the free market to provide particular goods or services is not sufficient to assure the quality of service or the protection of consumer interests required. It has come to have an increasing role in areas where, for various reasons, there may not be a well-developed, competitive market: for instance, where there is a monopoly provider (utility provision), where consumers may be particularly vulnerable (residential care homes), or where there is a public interest in the way a service is provided (safety of air travel, broadcasting). The National Consumer Council has described regulation as:

A means of achieving defined goals, by adopting rules directed at shaping conduct or controlling behaviour in some way, and then putting machinery in place to enforce those rules. ¹

Traditionally, governments used legislation to regulate, for example by passing laws prohibiting the use of child labour. These laws would be backed up by inspectors to ensure that regulations were observed. 

Regulation is an activity which has grown in the UK in recent years, and can be seen as one of the means through which the government seeks to assure certain standards are attained in the way in which a range of functions are carried out in both public and private sector organisations.

Various tools can play a part in the regulatory process, from charters of consumer rights, through self-regulatory bodies, to more formalised regulation carried out by bodies created expressly for that purpose. The range of different terminology used appears at times to cloud the issue of who does what and for what purpose – performance management, audit, quality monitoring and accreditation, review, good practice development, regulation and inspection. Each of these functions contributes – in different ways – to the overall aims of protecting vulnerable individuals who use services, promoting service quality and ensuring effective use of public resources.

There is a distinction between regulation of service provision and regulation of the workforce, although the two are inter-linked. In medicine, for example, the way in which standards of service provision are maintained is through a system of professional regulation which seeks to ensure that only those who are properly qualified can offer the service in question. Doctors have regulated the service provided through self-regulatory professional bodies such as the General Medical Council. There is, however, an increasing recognition that if these systems of professional self-regulation are considered to be failing to guarantee satisfactory standards of service, then government may act to introduce systems of independent regulation of services.

Entirely free markets can fail consumers in a variety of ways, and regulation is one of the main ways to ensure consumers are properly protected. However, regulation also brings with it burdens and inflexibilities which can work against consumers; and costs, which individuals usually shoulder, whether as tax payers or as consumers.

In looking at the regulation of mental health care, this discussion paper takes a particular stance by considering current arrangements for the regulation of mental health care from the perspective of the consumer – the individual or family who uses mental health services. The main focus of discussion here is on those national bodies that have a remit to review and inspect provision or to monitor service quality. The paper does not cover professional regulation although it is recognised that this is an important component in the overall regulatory system.

One of the factors that instigated the research project was recognition that there is a plethora of bodies contributing in various ways to regulation and quality monitoring. In view of the recent developments in the landscape of mental health provision in Scotland and in view of expected changes in how service performance and quality is to be monitored, it seems timely to take stock and encourage debate on these issues.

**Regulation of service provision**

In most areas of public service delivery there are processes which seek to ensure that services are fit for purpose, and meeting the standards which have been set. These processes include inspectorates like HM Inspector of Schools and the Social Work Services Inspectorate, as well as bodies which may not call themselves inspectorates, but work in a similar manner, such as the Scottish Health Advisory Service. Inspection is one aspect of the process of regulation of public service provision.

In some areas, a process of registration is required before someone can offer a service (for example, to open a residential care home). The process of inspection is accompanied by the sanction that the service provider can lose their registration.

**Regulation in health care**

Traditionally, regulation of health care provision has been limited to the professional self-regulation of service providers, covering matters such as education and training, registration, professional ethics and discipline. Increasingly, however, there have been moves towards independent regulation of service provision, for example with the creation of the Clinical Standards Board for Scotland, and through the work of the Scottish Health Advisory Service. The Regulation of Care Bill includes provision for the regulation of independent and voluntary health care provision.
Regulation in the area of social care
In relation to social care, there is an increasingly mixed economy of provision, with similar services provided directly by local authorities, and by the private and voluntary sectors. The primary concern of the regulatory system is with the quality of service, although cost is also a consideration. The current system of regulation of social care has been subject to criticism on the grounds that it is fragmented, partial and lacking in consistency and independence. A further criticism is that there has not been any professional self-regulatory scheme for those working in the field of personal social services. The Regulation of Care Bill is expected to address many of these deficiencies.

1.2 Regulation for the 21st century
The direction of mental health policy was set out in A Framework for Mental Health Services in Scotland (The Scottish Office, 1997). The Framework laid emphasis on the importance of developing a joint approach to the planning, commissioning and provision of integrated mental health services. The Framework referred to the role of the Scottish Health Advisory Service (SHAS) and the Mental Welfare Commission in ‘supporting’ these developments, and also established a Mental Health Reference Group to provide an oversight of the development of mental health services in Scotland.

A series of recent policy initiatives from the Scottish Executive provides important pointers for the development of regulation and related activities in health and community care that have implications for mental health care.

Recent policies on community care place renewed emphasis on the development of structures and systems that can assure the delivery of integrated services for people who require support and care in a range of settings. The Joint Future Group (JFG), built on the recommendations of Modernising Community Care (Scottish Executive, 1998) was set up to identify ways in which existing policies might work better, to achieve better and faster decision making, more flexible and better quality home care and more robust partnerships between health and social work. The main recommendations proposed (Scottish Executive, 2000) focus on strengthening local collaborative working in all aspects of care from strategic planning to service delivery. Health and social work are expected to draw up local partnership agreements that include a programme for joint resourcing and joint management. Although the JFG refers primarily to services for older people the intention is that these joint agreements would have application to other client groups, including mental health.

Our National Health: a Plan for Action, a Plan for Change (Scottish Executive, 2000) sets out the Executive’s proposals to improve Scotland's health, tackle health inequalities and promote social justice. The Scottish Executive is developing a new performance and accountability framework for the NHS to take account of the aims of the Health Plan. This seems likely to involve giving added weight to quality and health outcome as well as assessments of activity and financial performance. However the Performance Management Framework continues to relate to health services only.
The Regulation of Care Bill, now before the Scottish Parliament, proposes a two-fold approach to regulation covering both the staff providing care services, and regulation of service provision itself, with the creation of two new bodies, the Scottish Social Services Council, and the Scottish Commission for the Regulation of Care, which will regulate care and early education services.

Regulation in this area involves the protection of the interests of service users through:

- setting and monitoring standards
- encouraging continuous improvement in standards
- making information available to the public about standards etc
- ensuring that there is a system of redress for service users.

The power of the regulator lies in its ability to revoke the licence of the service provider. So, in social care there will be a process of registration run by the regulatory body, the Commission for the Regulation of Care, which will have the power to cancel the registration if there is a failure to meet the standards required.

The Commission's remit will extend to cover day services, services provided to people in their own homes and residential and nursing home services. Providers in all sectors – statutory, private or voluntary – will be required to secure registration.

1.3 Regulatory functions

The following schema distinguishes the various types of regulatory activity along three different dimensions: role and scope, focus and function.

**Role and scope**
- financial audit – costs, value for money
- management arrangements – planning and strategy, systems to support service delivery
- outcomes for users (and carers) – health gain, satisfaction, user experience, quality of life, protection of individual rights
- professional/service standards – service registration and accreditation, performance audit
- professional accreditation/validation/registration – individual practitioner standards.

**Focus**
- individual user experience of services
- discrete services – day services, home care, in-patient services
- agency/organisation – NHS Trust, voluntary organisation
- sector – health services, social work services
- service system, perhaps within a defined geographic area.
1.4 Principles of good regulation

The goal of any system of regulation is to ensure that people using services, and their families, are confident that the services they receive will be of good quality and appropriate to their needs.

The Scottish Consumer Council has recently outlined 13 good practice points which should be observed in self-regulatory schemes. These can be broadly applied to regulation in general. They include the following:

- clear objectives and clear rules which set standards
- the core ingredients of regulation: rules, monitoring and enforcement, and redress
- wide consultation
- a dedicated structure
- independent representation: the governing bodies should include a majority of independent representatives
- public accountability, for example, by publishing an annual report
- good publicity
- effective sanctions

1.5 Regulation and the consumer

For service users to feel confident that regulatory bodies are acting in their interests, the regulatory body should incorporate the following features:

- authority – its findings are taken account of; the body has powers to enforce change and effect redress
- independence from those providing services
- accountability – both to parliament and to those who use services

• transparency - to ensure its role and work can be understood
• participation - to ensure that account is taken of user views and experiences.

In viewing regulation from the consumer perspective, it is useful to consider the extent to which the regulatory regime contributes to the achievement of the consumer principles used by the Scottish Consumer Council: access, information, safety, redress, representation, choice and equity. These principles are developed more fully below.

• Access
  What role does the regulator have in ensuring that people who need them have access to appropriate services (ie the right services, in the right place, at the right time)? What powers does the regulator have to encourage the provision of services where they do not exist, to increase the level of provision, or to make those which do exist more accessible to those who might benefit from them?

• Information
  What role does the regulator have in ensuring that accessible, current and appropriate information is available to service users, potential service users and their families and carers, both about the services which are available and about the standards which those services are required to meet?

• Safety
  Does the regulator ensure that services are safe, and that those providing services do not pose any risk to service users?

• Redress
  What role does the regulator have in the system of redress operated by the service providers who are subject to regulation? Does the regulator play any role in the investigation of complaints which have not been resolved by the service provider? Can the regulator refer cases to any ombudsman? What redress do service users have if a regulator fails to protect the interests of service users?

• Representation
  How are service users, their families, carers and representatives involved in the process of service regulation? Are they involved in setting standards, in monitoring and inspection?

• Choice
  Does the regulator have a duty to ensure that, where there is no choice, the service provider does not abuse a dominant market position?

• Equity
  Does the regulatory system ensure that inequities in service provision are identified and addressed?
2 Overview of regulatory bodies

2.1 Clinical Standards Board for Scotland

Role and scope
The Clinical Standards Board for Scotland (CSB) is a statutory body established as a special health board in 1999 in the wake of the Acute Services Review. The Board's role is to promote public confidence that services provided by the NHS are safe and meet agreed national standards. The Board is also charged with demonstrating that, within the resources available, the NHS is delivering the highest possible standards of care. The CSB describes itself as a quality accreditor and not an inspectorate.

To these ends, the CSB is responsible for developing and running a national system of quality assurance and accreditation of clinical services encompassing the setting of standards, the assessment of performance and reporting findings. Peer review is a central element in this process.

Focus
The CSB covers all clinical sectors. It focuses directly on the care and treatment provided by healthcare professionals, while taking account of the wider aspects of organisations and service systems that are likely to impact on care and treatment. The CSB works to explicit standards and the reviews undertaken provide a rigorous account of performance against standards.

In the first instance the Board has been taking forward work in each of the NHS priority areas – cancer, coronary heart disease and mental health. Its initial remit was to concentrate on clinical services for defined diagnostic groups, and in mental health the Board has been working on schizophrenia standards. Schizophrenia was chosen in recognition that it is one of the most severe and enduring mental illnesses and that it presents considerable challenges for services, as well as absorbing a significant proportion of NHS resources.

This focus on specific diagnostic conditions is now being reconsidered and the Board may focus on broader service areas. Standards are service focused rather than directly related to individual patient experience. The CSB is currently debating the criteria it uses to determine priorities for its future work programme to ensure this can address areas of public interest as well as those areas that are designated clinical priorities for the NHS.

Function
For each topic (for example, schizophrenia) the Board appoints a project group made up of health professionals and lay people to oversee the process of accreditation. Project groups are expected to adopt an open and inclusive approach in setting standards to involve a wide range of lay and professional people.

A set of eleven schizophrenia specific standards was developed following a process of extensive consultation with healthcare professionals and users and carers across Scotland. Standards were drafted based on initial consultation, circulated for comment and discussion, revised and were then subject to further consultation before the current version was developed for use. The standards were also informed by a review of the evidence base. The two themes covered are:
• journey of care
• treatments and interventions.

Following the publication of the schizophrenia standards in January 2001, the Board will assess performance of trusts throughout Scotland. The review process has several elements to it. Firstly each trust is asked to undertake a self-assessment exercise of their service against the standards. A CSB review team then visits each trust to conduct what it calls a peer review. Peer review teams are multidisciplinary and have professional and lay membership. The Board reports the findings for that trust based on the self-assessment exercise and on external peer review.

In addition to the standards developed by project groups for specific conditions, the Board has set generic standards that apply to all clinical services. Standards are designed to be evidence based, explicit, measurable and realistic and are intended to be results oriented in order to achieve improved outcomes for patients.

Generic standards cover two themes:
• patient focus – to ensure that services respond to needs, and that patients are involved in decisions about their own care
• safe and effective clinical care.

Generic standards are to be used with all trusts and health boards as part of a baseline review of current performance. In addition they will be used in the context of condition specific reviews, to home in on issues of particular relevance to the service under review.

Links and relationships with other bodies
The Mental Health Project Group has been chaired by the Chief Executive of the Scottish Health Advisory Service (SHAS), and membership includes the Director of the Mental Welfare Commission (MWC), an inspector from Social Work Services Inspectorate (SWSI) as well as a range of professionals from the health services, health council representation and those from national user and carer organisations.

The CSB is currently looking at how it manages its interface with the National Care Standards Committee and the Scottish Commission for Regulation of Care. The CSB networks regularly with other bodies to exchange information and reports and to ensure each works from a common information base. The CSB is conscious that there may be scope in the future for different bodies to commission each other to undertake specific tasks.
Key features

Accountability
• CSB produces national reports and trust-specific reports, all of which are published
• CSB is accountable to the Scottish Executive.

Independence
• has been able to operate autonomously and at arms length, resisting influence by virtue of its formal status as a Health Board and as a result of the style it has forged under its Chairperson and Chief Executive
• budget for its work is sufficient to allow it to pursue work programme without requiring recourse to the Scottish Executive.

Transparency
• accreditation operates in relation to explicit standards that are published
• specific trusts will be identifiable in the published national reports.

Authority
• all reports are to be in the public domain
• CSB is to play a more central role in the process of accountability review within the Scottish Executive to review the performance of health boards and trusts. This is likely to have implications for how it is perceived.
• this builds on the Health Plan proposals to give greater weight to health gain and health outcomes in addition to the continuing attention to financial performance and management.

Lay involvement
• users and carers are extensively involved in all parts of the CSB work programme. In mental health this includes membership of project group and review teams
• review teams meet with local users and carers in the course of trust review visits
• trusts are asked to demonstrate what efforts have been made to gather feedback from, and consult routinely with, users and carers
• results of any exercises of this type are considered as part of the review.

Stakeholder issues
• service users report they do not know enough about the role of the CSB
• lack of consistency in the approach to standard setting adopted by the CSB and by the National Care Standards Committee
• confusion among a number of users, carers and professionals about potential duplication of function between the CSB and SHAS
• others recognise as important the differences in focus and responsibility – CSB on clinical and service standards, SHAS on organisations and systems of care, the MWC on individuals and the Commission for Regulation of Care on regulation of provision
• some concern that, although the CSB is independent, it also purports to promote public confidence in the NHS.
2.2 Scottish Health Advisory Service

Role and scope
SHAS was first established in 1970, following concerns about the quality of care in long-stay hospitals in England. SHAS is an inspectorate, whose remit is to cover health services provided for vulnerable people, including people with a mental illness, older people and people with a learning disability or physical disability. Since 1995, this remit has been extended to cover both hospital and community health services. SHAS is charged with giving information and advice to the First Minister. It not only inspects services but also aims to promote and encourage high standards of patient care.

SHAS undertakes a rolling programme of visits around Scotland. It can be asked to visit a particular area or service where there is cause for concern. It is not a statutory body and is independent of the Scottish Executive. The latter cannot determine its priorities or influence what it reports.

Focus
SHAS conducts in-depth reviews of local services taking a systems-wide perspective on the range of factors that can influence care provision and people's experience of using services. Reviews include aspects such as interagency and interdisciplinary working as well as strategy and planning. Although its primary focus is on health care it is also able to look at the role of social work and the voluntary sector in the context of local service systems, as partners with the NHS in developing and delivering care.

Function
SHAS has developed a set of quality indicators to guide its mental health reviews, drawn from the Framework for Mental Health Services in Scotland and further informed by the SHAS User and Carer Reference Group. These quality indicators are used more loosely than the standards-based approach of the CSB. There are plans to review and, if necessary, update SHAS indicators, as two years have elapsed since first developed and there is felt to be a need to reconsider them in the light of work on standards that has been undertaken by other bodies in the interim. SHAS has been keen to avoid a checklist approach to standard setting and performance assessment.

SHAS review teams are made up of a range of professionals including people working at different levels – service staff, operational management, senior management. The review team spends a week on site visiting the local NHS trust and undertaking discussions with a wide range of local personnel, service users and carers. The cycle of review takes in the region of six months from preparatory phase to report writing. Draft reports based on the visit are sent to boards and trusts for factual correction.

Three months after a SHAS review visit, the local health board and the relevant NHS trust and social work authorities are expected to submit a joint action plan to SHAS, who then check on implementation at the twelve-month stage. If progress is considered satisfactory, a four-year period will elapse before a subsequent visit. If problems seem more intractable, SHAS may decide to visit more frequently until improvements are achieved. In 1999-2000, SHAS undertook four full visits and three follow-up visits to mental health services.
SHAS has published a set of six quality indicators in mental health that cover:

- assessment of need – considered from both an individual and strategic level
- delivery of care – all aspects of the patient experience through the system from assessment to discharge
- community mental health teams – the processes CMHTs should have in place
- mental health day-services – the concept of a comprehensive day-service
- clinical governance – the strategic approach required to ensure that clinical governance agenda is achievable
- corporate governance – the strategic approach required to ensure corporate accountability is achieved.

SHAS produces an annual report that recounts the work it has undertaken and discusses the main themes and issues that emerge from the year's review programme. The annual report also highlights aspects of good practice identified on the visits.

**Links and relationships**

In addition to the role played by the SHAS Chief Executive in chairing the Clinical Standards Board Mental Health Project Group, SHAS has also contributed as a member of the National Care Standards Committee mental health working group. SHAS participates in regular liaison meetings with other agencies.

**Key features**

**Accountability**
- reports to the First Minister.

**Independence**
- independent of the Scottish Executive.

**Transparency**
- uses a published set of quality indicators
- annual report details visits undertaken and main themes and issues emerging
- reports of local review visits published.

**Authority**
- requires boards and partner agencies to produce action plans to address concerns arising from review visits
- process in place to follow these up
- lacks powers to enforce change – more developmental in focus
- reports and recommendations are not directly drawn on by the Scottish Executive in performance management functions.
Lay involvement

• SHAS has a mental health reference group for users and carers, which acts in an advisory and consultative capacity and was involved in the development of the quality indicators.
• Review teams have some lay involvement, although only a small proportion of the SHAS Reviewer Network is made up of lay people.

Stakeholder issues

• Duplication of role with CSB
• Mixed views about its authority: for some, it remains unclear whether SHAS has the necessary authority to enforce change: ‘People wring their hands and then what?’ Others consider the publication of reports of its reviews is an important impetus for improvement.

2.3 Audit Scotland

Role and scope

Audit Scotland was set up in April 2000 to carry out audits for both the Accounts Commission (which covers local authorities and joint boards, such as police and fire services) and for the Auditor General (who covers all other public sector services, including NHS boards and trusts). Together they ensure that the Scottish Executive and public sector bodies in Scotland are held to account for proper, effective and efficient use of public funds. Audit Scotland conducts two main roles: to conduct financial audits to ensure that public bodies adhere to the highest possible standards of financial management and secondly, to carry out performance audits to ensure that public bodies achieve the best possible value for money.

The relationship between the Accounts Commission and the Auditor General is important in relation to services such as mental health, where audit has to span both NHS and local authority activity.

Focus

Audit Scotland’s work covers a wide range of bodies in the public sector, including health and local authorities but also the departments of the Scottish Executive, further education colleges, water authorities, and executive agencies such as Historic Scotland and the Scottish Prison Service.

Audits of performance and financial management do not make direct comment on professional standards. Audits consider economy, efficiency and effectiveness and through the latter address outcomes for users. Audit activity is focused on corporate level rather than on services, service systems or professions. The indicators used are based in value for money measures.

Value for money studies can look at issues such as access to services and information, that are of direct relevance to consumers. For examples, a current study of home care is looking at access to, and gaps in, services.
Options to ensure that audits have a stronger consumer focus are currently under consideration in areas where there is the potential to make a difference to people's lives.

Function
The Accounts Commission has a statutory duty to look at value for money, and management arrangements, and to set performance indicators which local authorities are required to publish. The Auditor General does not have the same power to require the publication of performance indicators. In the mental health work undertaken in 1999, focus groups of users and carers were used to assist with the formulation of indicators.

Typically, traditional audit studies can take 12 to 18 months to complete. Audit Scotland also undertakes other projects of differing duration and is looking increasingly at the balance between different styles of audit.

Links and relationships
Increasingly, under Best Value, there is a requirement for inspectorates and regulatory bodies to work together to minimise the burden on public sector agencies. Audit Scotland already works with inspectorates covering education, fire and police services. It is also in discussion with Social Work Services Inspectorate (SWSI), Scottish Homes and the Clinical Standards Board about potential areas for joint working.

Key Features

Accountability
• the Accounts Commission is accountable through Scottish Ministers to the Scottish Parliament
• the Auditor General is accountable through the Scottish Parliament to the Crown
• Audit Scotland is overseen by a board of five members, including the Auditor General and the Chairman of the Accounts Commission.

Independence
• the Auditor General is a royal appointment. This post is independent of the Scottish Executive and of the Scottish Parliament.
• the Accounts Commission is independent of both central and local government.
• areas for study can be selected independent of external influence, and are guided by a number of considerations – for example, areas of high expenditure or areas of topical public interest. Study topics are developed in consultation with stakeholders
• there are no restrictions on what Audit Scotland collects and publishes. However, it cannot question the merits of policy objectives.

Transparency
• national audit reports are published on the web. Local audit reports are not public documents but may form part of material that is subsequently discussed at open meetings and would therefore be part of the documentation available to the public in attendance at the meeting.
Authority

- the Auditor General reports findings of his work to committees of the Scottish Parliament.
- the Accounts Commission has the power to make recommendations to Scottish Ministers and to local authorities.

Lay involvement

- the Accounts Commission work on mental health involved users and carers in focus groups to assist with the development of the indicators. Lay involvement was not a feature of the audit itself. Carer representation was included in the Advisory Group through representative voluntary bodies.

Stakeholder issues

- the fact that Audit Scotland covers the NHS and local authorities and is able to look both at service commissioning and at delivery of services is perceived to be of considerable potential benefit
- clarity of information on agency expenditure is viewed as important in any moves toward joint commissioning
- essential to have an independent body that reports to Parliament.

2.4 Mental Welfare Commission for Scotland

Role and scope

The Mental Welfare Commission for Scotland (MWC) was created in 1960. The Mental Health (Scotland) Act 1984 introduced a number of changes to its constitution, powers and duties. The MWC is independent of the NHS and of local authorities.

It has a general statutory duty to protect those who, by reason of mental disorder (as defined in the Act, and including both mental health problems and learning disabilities) are not capable of protecting themselves and their own interests. This duty extends to all mentally disordered patients, whether in hospital, in community facilities (including those run by a local authority, the health service, the voluntary or private sector) or their own home.

The MWC has a duty to visit people who are detained under the Act or are liable to detention, guardianship or Community Care Orders. It is also required to respond to requests for a visit from those cared for by mental health services and to enquire into any case where it appears there may be ill-treatment, or deficiencies in care or treatment.

Further, the MWC has a duty to bring to the attention of a health board, trust or local authority any matters relating to the welfare of people with a mental disorder. It may also make recommendations to the First Minister on the discharge of any patient who is under a restriction on discharge.
Focus
The MWC is distinguishable from other regulatory and inspection bodies insofar as it has a clear remit to focus on the welfare of individuals. The MWC has a specific role in relation to people on guardianship and on Community Care Orders. Recently the MWC has been developing a systematic programme of visits to community facilities, in recognition of the trend to provide care and treatment in non-hospital settings.

Most enquiries into deficiencies of care are initiated by the MWC although it can be asked by Ministers to look into a particular case or issue.

The Commission is able to span both primary and secondary health care, hospital and community services, and health and social work. It has the capacity to look at the patient's journey through different parts of the service system. It can look into and help with complaints to both health and social work bodies.

Function
The Commission does not work to identified standards but adopts a pluralistic approach to good practice using published guidelines, standards and other good practice material from a range of sources. The various commissioners have expertise in psychiatry, mental health nursing, social work and the legal system as well as user perspectives.

Visits and direct patient contacts cover the following:
• annual visits to all mental health hospital and units
• monthly visits to the State Hospital at Carstairs
• interviews with all patients detained for more than two years
• anyone who wishes a review of their detention will be seen on request
• interviews with all those who request one. The local service is expected to give prior warning to patients of an impending visit and of the opportunity to request a private meeting with a member of the Commission.
• visits are also made to wards where no one has requested an interview as a safeguard to protect the interests of those least likely to ask for a meeting.

In addition to the visiting programme, the MWC can make unannounced visits.

The MWC offers a telephone duty system for enquiries and this is used by a range of callers including service users, carers and professional staff seeking advice or raising issues in relation to the implementation of the Mental Health Act.

Deficiency of Care enquiries are designed to be conducted in a manner that aims to investigate, advise and learn from the experiences rather than to apportion blame. On occasion the MWC adopts a theme in its visits and interviews with users and carers. In 1999-2000, physical health care was the topic selected for consideration.
Links and relationships
The MWC director has been a member of the CSB Mental Health Project Group.

The Commission regularly exchanges information with SHAS. Sometimes the two bodies meet a trust jointly and agree a process to share follow up.

The Mental Health and Well Being Support Group regularly seeks information from the MWC prior to visiting a health board. The MWC liaises on a regular basis with local registration and inspection units and anticipates that this will continue with the establishment of the Commission for the Regulation of Care.

Key Features

Accountability
• the Commission publishes an annual report which is presented to Scottish Ministers who take it to Parliament
• the content of this report is determined by the MWC
• the MWC remains operationally independent of the Scottish Executive
• the MWC is accountable to the Queen but in practice to the First Minister
• the MWC has a duty to bring matters concerning patient welfare to the attention of the relevant health board, local authority or Scottish Ministers.

Independence
• commissioners are by royal appointment.

Transparency
• the MWC recognises that there are misunderstandings and lack of knowledge among users and carers about its role
• a series of leaflets about the Commission has been distributed through services
• further information on its visits and activities is to be provided on the new website.

Authority
• the MWC does not have powers of enforcement to require services to change but it can point out deficiencies and expect these to be rectified. It can have recourse to the Scottish Executive where remedial action is not taken. The matter would then be followed up through the accountability review process within the Health Department
• the MWC is moving increasingly to guide services and professionals into good practice – for example, it has produced guidance on the use of restraint.
2.5 Social Work Services Inspectorate (SWSI)

Role and scope
SWSI is part of the Scottish Executive. Its role will be reviewed with the establishment of the Scottish Commission for the Regulation of Care (SCRC). It is likely to retain its role as a source of professional social work advice to Ministers with an additional remit to provide an overall evaluation of social work nationally and to continue to undertake thematic inspections. The SCRC is likely to assume responsibility for inspections of many local services, although its remit does not include field social work. The Chief Social Work Inspector produces an annual report, with the first of these due to be published in the near future.

Focus
SWSI covers social work in community care, criminal justice and children’s services.

Function
The Inspectorate identifies priorities for its inspection programme arising from current policy. These are discussed with relevant stakeholders. Inspections fall into several categories:
• national thematic inspections where one aspect of service is reported across Scotland
• overall inspections of an authority’s social work services
• local service inspections
• statutory inspections that are required by law
• investigations initiated at the behest of the First Minister.

SWSI takes account of existing standards in their inspections (for example, those used locally (although these will now be replaced by National Care Standards). Standards are compiled when looking at a specific service. For thematic work, the approach is looser and broader questions are used to elicit the information required.
Links and relationships

- SWSI links with other bodies. It has experience of carrying out collaborative work with other Inspectorates (for example, Schools) and with other bodies such as Audit Scotland.

Key features

Accountability
- the Chief Social Work Inspector answers directly to the First Minister and reports on inspections to the First Minister.

Independence
- SWSI is part of the Scottish Executive.

Transparency
- local inspection reports are available on the web. The annual report will be published.

Authority
- SWSI derives its authority from Ministers’ power to inspect social work services.

Lay involvement
- SWSI inspections include lay inspectors. Advisory groups established for each inspection or review tend to include service user representation. A review of mental health day services in 1997 involved service users as part of the review team.

Stakeholder issues
- how to regulate services that are increasingly joint?

2.6 Scottish Commission for the Regulation of Care

The Commission comes into existence in April 2002, and aims to modernise and standardise the regulation of care services, and to ensure that these services are of high quality. The new system will be people-focused, independent, consistent, and integrated. The care services covered by the Commission will include: care homes for adults, residential care for children, early education, day care and childminding, care at home, fostering and adoption agencies, nurse agencies, and independent healthcare services.

The Commission’s task will be to review operation of standards through registration and inspection. It will have legal powers to enforce conformance with standards and to impose sanctions. This denotes a shift in emphasis in that providers will have to prove competence, and in that priority is given to service user rather than provider interests. Inspections results will be published.
Key Features

Stakeholder issues
• general welcome for the consistency of approach in that it will do away with local registration and inspection arrangement which meant variation in standards applied
• reassurance wanted that the draft standards will converge to produce greater uniformity
• essential that the Commission has powers to impose sanctions to control provision standards.

2.7 Mental Health and Well Being Support Group

Role and scope
The Mental Health and Well Being Support Group (MHWBSG) was set up in March 2000 to help address implementation of the modernisation of mental health services in Scotland. Its remit is to support, influence and help care agencies advance the strategic development of mental health services in Scotland. It works with health boards, local authorities, NHS trusts and other voluntary and statutory service providers, as well as with user and carer groups. A ministerial summit on mental health in January 2000 confirmed government policy as set out in the Framework and stressed that equal emphasis should be given to the promotion of well-being and to care and treatment. This is reflected in the Support Group's remit.

The MHWBSG undertakes visits to each health board area, to meet those with responsibility for commissioning mental health services. The visits are used to review local progress in relation to the implementation of the Framework for Mental Health Services in Scotland, and to national policy guidance and good practice material covering key aspects of strategic planning and service development. The Support Group provides advice and guidance to local care agencies on best practice.

The Support Group also advises the Scottish Executive on the implementation of national policy and provides updates on local activity and progress. In addition, it undertakes a number of related activities: a working group has produced a report on risk management and others on needs assessment and outcome measurement are awaited. A sub-group has conducted a census of psychological therapies as part of the National Waiting Times Initiative.

Focus
The MHWBSG sets out to ensure the continuing implementation of the Framework for Mental Health Services. Its primary aim is to provide support and advice to local agencies in relation to strategy development and the translation of strategy into local service development and delivery.

It also has an interest in the identification and promulgation of good practice and ways of working that address the difficult issues associated with the management of change in translating strategy into service development.
**Function**
The Support Group is currently chaired by a Consultant Psychiatrist and has a core membership of eight people drawn from healthcare, local authorities and the voluntary sector and includes advisers from the Scottish Executive (psychiatry, mental health nursing and social work).

Prior to Support Group visits, the agencies in local areas are asked to supply information on local progress by completing a template covering each of the elements of the Framework. This looks in particular at achievements and log-jams in the local joint planning and strategy development process. The Support Group makes use of a wide range of other information sources to inform its work with local areas, including ISD activity and cost data, reports from SHAS, the Mental Welfare Commission and SWSI.

The Support Group’s one-day visit follows a relatively standard format that includes time to meet with users and carers and advocacy services. The visiting team is drawn from a core group membership, with additional members co-opted by the Chair as required for each visit. On every visit, users and carers have been included in the team. The main themes and issues that arise from the series of discussions are brought back to the senior officers of the Health Board and local authority at the conclusion of the visit and are published within four weeks.

**Links and relationships**
The Support Group makes routine use of information from other bodies. It also takes part in regular network meetings with other review bodies.

**Key Features**

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<th>Accountability</th>
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<tr>
<td>• the Support Group is accountable to the Minister for Health and Community Care</td>
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<td>• it regards itself as being accountable to local agencies</td>
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<td>• the Support Group's first Annual Report to Ministers was published in April 2001.</td>
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<th>Independence</th>
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<tr>
<td>• members of the Support Group are approved by the Minister. Three core members are employed by the Scottish Executive (the advisers), the rest (the majority) are not</td>
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<td>• the Group's remit is closely tied to the implementation of Scottish Executive policy</td>
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<td>• the Group considers itself to be sufficiently robust to withstand direct influence.</td>
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Transparency
• reports of local visits are sent to local chief executives for circulation to all those present at the visits and are available on the web
• additional information collected on visits, but not used in the feedback and reports to local areas, tends not to be used or made available to others.

Authority
• the role of the Support Group is to advise and support
• it is able to identify and draw attention to a lack of local strategic vision or blocks in decision making that impact on the type and quality of services people are getting locally
• it is anticipated that findings from the Support Group visits will be taken up by the Scottish Executive in the context of ongoing performance management.

Lay involvement
• the core membership of the Support Group does not include service users and carers
• the Support Group draws on a number of users and carers who are co-opted to take part in up to two local visits each per year. Support is made available to facilitate their participation
• local user and carer groups can feed issues and concerns into discussions in the course of a Support Group local visit
• feedback is mainly directed at statutory strategic planning partners - health boards and local authorities - but copies are available for those who participated in the day's visit.

Stakeholder issues
• professionals and service users report they are not clear about the role and purpose of the Support Group
• health boards and partner agencies are responsible for setting up the Support Group's programme, for notifying local groups and inviting them to attend.
3 Key issues in regulating mental health care

This part aims to draw out the main themes and issues raised by the range of stakeholders who were interviewed, to inform wider debate and discussion about possible ways forward. It is important to recognise that stakeholders include those who are responsible for regulation, those who provide services (organisations and professional groups) and those who use services or care for people who use services, and that there are differences in perspectives among these groups. This section covers issues raised in relation to the key features and principles set out in Part I and also explores a number of additional areas that emerged from discussion with stakeholders.

3.1 Complexity of service provision and of regulation

One of the dilemmas highlighted in interview with service providers and professional groups was the challenge of devising a system of regulation that kept pace with the evolving nature of provision and the increasing diversity of services. The health and social care divide is becoming increasingly blurred at the point of service delivery and also in service planning, commissioning and management. This poses significant challenges for regulation and requires that we consider whether the solution is to bring together elements of current health and social care regulation and whether, in addition, there is a need for regulation to focus on 'whole systems' of care for the client group.

Organisations that provide services on a national basis find that the current system of local registration and inspection is not satisfactory. Some organisations manage projects in every local authority area in Scotland and report the frustration caused by the differing interpretations of legislation and the use of different local frameworks for the setting of standards, as well as being asked to provide very different information about their organisation and its services for each different geographical area. The introduction of a national approach to the regulation of social care therefore represents an important step forward.

Organisations such as the General Medical Council (GMC) and the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) which regulate individual medical and nursing practitioners are regarded as important elements in the regulatory system, but there is concern that their place in an evolving system is not clear, as new regulatory structures are being set up, and major changes made to others. In addition, there are major challenges ahead in considering whether and in what way the regulation of single professions has to be adapted to keep pace with multi-disciplinary service provision and more genericism.

In terms of staff training and the maintenance of professional standards, there are different national training organisations for different areas of work – for example, health care, voluntary sector, personnel services, criminal justice and special needs housing etc. They all have a jurisdiction in setting standards and all overlap. This causes particular problems for organisations that provide several different types of services.
For some agencies providing mental health services, the main regulatory bodies that have an impact on their work are local registration and inspection teams, to be superseded by the Scottish Commission for the Regulation of Care. Many mental health services also operate outwith the traditional health services arena and have developed training and employment services for those with mental health needs. For these services, Local Enterprise Companies and the Department of Employment are the main regulatory bodies.

3.2 Consequences of complexity
Public understanding of the way services are regulated

While the various agencies gave a coherent account of what they did, those who work in services and who use them were more confused. The agencies themselves summarise the primary focus of each body as follows:

- Clinical Standards Board – clinical and service standards within the NHS
- Scottish Health Advisory Service – health care organisation and systems of health care
- Mental Welfare Commission – individuals whose 'mental disorder' may render them vulnerable
- Social Work Services Inspectorate – local authority social work services
- Scottish Commission for the Regulation of Care – regulation of social care provision
- Audit Scotland – audit and value for money in both health agencies and local authorities
- Mental Health and Well Being Support Group – policy implementation and strategic development of mental health services.

The multiplicity of bodies involved in some way in the process of regulation, and the fact that some individuals are involved in work for several different regulatory bodies, have contributed to confusion about roles and functions among users and carers, professionals and service providers. There is commonly perceived to be overlap, duplication and fragmentation within the current regulatory system and a lack of clarity among professionals and among users and carers about roles. There also appears to be a lack of precise understanding among those with responsibility for providing services about who does what, when, why and to whom and how the different bodies relate to each other.

Further, there is perceived to be a lack of clarity about the status and powers of current regulatory bodies. Opinions differ among service users and among some professionals as to which organisations have a regulatory function and which provide guidance or act as quality accreditors.

It is difficult enough for people working within the system of mental health service provision to understand what the regulatory bodies are about, but even more difficult for people who are 'outside the system' such as service users, carers and the public. If someone has a problem or difficulty with a service and wants to take issue with it - which door should they knock on?
Duplication
Duplication of effort is experienced in a number of ways in relation to: visits by regulatory organisations to services; the collection of data; repeated consultations, which cause concern to small voluntary organisations that struggle to find the resources to respond. Concerns about fragmentation arise from the observation that different bodies used different standards or indicators and that this could stand in the way of the development of joint pieces of work.

3.3 Towards a more coherent system
While there is recognition among stakeholders of the complexity of the regulatory function in all its differing aspects there is a perceived need for a more coherent structure, with possible harmonisation and re-alignment of the current roles and relationships.

The multiplicity of regulatory bodies means that service providers are not clear where to derive their benchmarks and indicators for performance and quality. This has repercussions for the quality and consistency of service provided. This has particular import in view of the increasingly multidisciplinary and multiagency characteristics of mental health services and the aspiration to make greater use of social inclusion opportunities for people with mental health problems. Mental health provision can no longer be considered solely as NHS or social services based.

3.4 Underlying principles
User and carer participation
There is an acknowledgement that involving users and carers is the way forward to ensure services are better attuned to needs and to reinforce accountability of those providing services to those who use services. This principle also extends to the functions involved in regulating service provision. People who have had experience of services themselves are much more able to describe the standards of service which are relevant to them than either the general public or professionals. The development of national care standards was cited as an example of work that drew on the experience of a wide body of service users as well as providers.

Regulators drew attention to the fact that standards serve a number of purposes: they provide clarity for service users and potential users about what they can expect; they act as a guide for providers and they serve as a tool for those who are regulating and inspecting. These different functions may have implications for the choice of areas covered in standards and for the way in which they are produced and presented. Standards may be set for certain aspects of services, as a type of proxy measure, based on professional expectations about what makes for better quality, but may bear less relation to direct user experience. This might include, for example, standards on aspects of management arrangements, or record keeping.
Stakeholders had a range of views on the extent to which existing regulatory bodies achieve user involvement satisfactorily. Users and carers consider that, despite best intentions, practice remains patchy across most regulatory organisations. The challenge for mental health services is to make this capturing of service user experiences integral to everything that is done.

It was contended that regulation, monitoring and evaluation are essential aspects of running a service and should not be limited to the occasion of a visit from an external authority every three years. User perspectives should be central to the whole process.

The use of collective advocacy was viewed as important in this continuous monitoring and evaluation of services. Service users from other areas can also participate in the regulation and inspection process for a local area. Benchmarking in this way can help raise expectations and awareness that services elsewhere may be better.

Efforts to promote greater understanding of the roles and responsibilities of different bodies, and information about the standards they use, will affect how able service users feel to contribute to the process of setting and monitoring standards. Some standards, such as those used by the Department of Employment are very technically worded, and relate to issues such as compliance with Health and Safety legislation rather than service delivery. There is little user involvement in drawing them up and little opportunity for client experience to be taken into account.

There is a perception among some service user and professional groups that regulatory bodies (and other organisations) are overly exercised by concerns about tokenism. It was generally considered that each of the regulatory bodies should have lay involvement. In some, there should be a balance of lay and professional membership, and in others a majority of lay people because professional dominance and rigidity of thinking still need to be challenged.

The experiences recounted by several of the regulatory bodies and by user and carer sources highlighted a number of significant concerns about the principles underlying involvement, the processes employed to engage users in the work of regulatory bodies and the expected outcomes of their participation. Key points included:

• being clear about the purpose and expectations of involvement (for example, to provide information, to act as a conduit to wider networks, to contribute to the shaping of ideas and priorities)
• clarifying the status and authority of the user and the extent to which they can liaise with wider user networks
• being explicit about how people are selected to take part
• ensuring that appropriate support, including funding, is provided to facilitate participation.
Accountability
Enhancing accountability for the quality of mental health services was viewed as imperative. Regulatory organisations are public bodies, and as such are responsible through Ministers to the Scottish Parliament. The expectation that services and their regulators might also be accountable to service users and carers was perceived to create a tension. This was an area that was felt to require further debate to explore the relationship between democratic accountability and ongoing accountability. The responsiveness of the regulatory system to service users and carers and the extent to which users, carers and their representatives are included in the processes of regulation are of key importance in this regard.

Accountability is affected by how transparent the agencies are, and how well they provide information. Where do reports go, what is done with them, and how does the information change things? How accessible are reports to members of the public? People with the greatest interest in the work of regulatory bodies may, due to the severity of their condition, the nature of their treatment or the side-effects of their treatment, be least able to access or understand the reports that are currently being issued.

Transparency
Transparency is required to promote clarity and openness in a number of areas:

• to provide information about how the regulation of both professionals and services is undertaken
• to publicise the standards used by regulatory bodies
• to make available the findings and outcomes of regulatory activities

Professional groups and users and carers indicated some difficulties with the ways in which different regulatory bodies provide information about themselves and the processes they use. In some parts of the system, for example, in the regulation of supported accommodation and supported employment projects, 80-page documents of legal jargon are produced. These can be very difficult to understand for someone who wishes to make a complaint about a service. Standards should be in clear, plain English, and assistance should be given to people in accessing complaints systems.

It was also reported that although organisations are making efforts to publicise their work, information is not always reaching all the places it should. There is also an assumption that all organisations and individuals have access to the internet.
Independence

Agencies involved in the regulation of services should be independent of government, and also of those who provide services, and there was support for the principle that independence should be safeguarded. However, it was also believed that these agencies had to achieve credibility and win confidence among service providers and users, by demonstrating their awareness of service and practice issues and the wishes and expectations of those who use services. It was argued that the regulatory system should also have sufficient links with service providers to be able to carry out benchmarking, peer review, and encourage working to standards as a learning process.

Political independence was perceived as a difficulty for many of the regulatory bodies as government ministers often set the agenda as well as providing instructions as to the issues to be explored.

Authoritativeness

Opinions differed on the authoritativeness of current regulatory bodies. Some are seen to have ‘teeth’, with capacity to use legal powers and to make constructive recommendations. Others are believed to lack teeth or to be reluctant to use the powers that they have. The organisations that regulate professionals are seen to have 'bite', and the new bodies being set up under the Regulation of Care Act are also thought to have a greater degree of authority.

A number of stakeholders stated that it might not be appropriate for some of the regulatory bodies to wield undue power. There was concern that over-reliance on regulation that required compliance might have a detrimental effect on the drive and enthusiasm of service providers.

There were mixed views among the professionals and the user and carer groups interviewed about the relative value of other approaches (such as publication of review documents and reports) in identifying problems and, importantly, in achieving the desired service changes. Some had little faith in this approach, others gave more credence to the merits of peer review processes.

Paradoxically, in order to be effective, regulatory bodies need to be able to 'stalk the corridors of power', but also have to be seen to be in touch, and have to gain the acceptance of professionals and users. In this regard some concern was expressed about the extent to which the Scottish Executive made best use of the intelligence acquired by the various regulatory bodies in a systematic way. It appears that professionals and users and carers are often unclear about how (or whether) these linkages happened and to what effect.

3.5 Developing a regulatory system that promotes consumer interests

Discussions with professional groups, service providers and user and carer sources highlighted a series of important questions concerning the capacity of the current regulatory system to address and uphold consumer interests in line with the principles set out in Part I. These are set out below.
Access
• whose responsibility is it to ensure that service provision is of a satisfactory level? Is the role of regulatory bodies to identify and comment on gaps in service provision? Should regulatory bodies set minimal levels of service?
• everyone should have access to services that they need, but the reality is that some people often do not. If you do not have a right to receive services, can access be ensured?
• can the issue of equity be reconciled with local democratic processes which, for example, enable local authorities in different areas to choose to set different levels of Council Tax?

Information
• providers should make information on their services publicly available. Do regulatory bodies have a role to play in ensuring that this is done? To what extent is this a joint responsibility?
• in order to be effective, information has to be in the right place at the right time, pitched at different levels and in different formats. Could regulatory bodies be more user-friendly in the information that they provide on their function and on standards?

Safety
• is safety used as another barrier to put between service users and what they want?
• should regulators of service provision have the power to identify unsafe services, a duty to comment and an ability to suggest improvements? If a service has been identified as unsafe, how far should the powers of regulatory bodies go?
• who should take an overview in ensuring that services are made safe? What role should the Health and Safety Executive play?
• what role should regulatory bodies play in ensuring that procedures for the employment of staff in mental health services are satisfactory?

Redress
• people who use services need a mechanism by which it is safe to complain and make sure that practice is improved and that their experience is not repeated. What role should regulatory bodies play in this?
• what linkages are required between organisations that regulate service provision and those that regulate different professions in ensuring that complaints are handled satisfactorily?
• in terms of the handling of complaints and redress, should mental health services be any different from, for example, providers of consumer services such as gas or electricity?
Choice
• where there is no choice, what role should regulatory bodies play in ensuring that the service provider does not abuse a dominant market position?
• should a lack of choice be accepted in any sector?

Equity
• do regulatory bodies have a duty to comment on issues of equity? Or do the mechanisms for ensuring equity of service delivery lie more properly elsewhere? What role should the judicial review system play? What role does equal opportunities legislation (in terms of gender, disability and ethnicity) play?
• can we have equity of service in remote and rural areas? To what extent should the cultural and religious diversity of Scotland be taken into account? Do different people require different care?
• is it possible to ensure equality of treatment at the same time as providing service responses that are unique to individuals?
4 Seminar on the regulation of mental health care

Parts 1-3 of this paper were circulated to key bodies that had contributed to the research or had an interest in regulation. Each was invited to a seminar on the 30 April 2001 to discuss the issues raised and explore the implications for the future regulation of mental health care.

The research findings were used in the seminar as the starting point to explore the case for change in current arrangements for the regulation of mental health care. The seminar discussion also focused on the principles that should underpin regulation in mental health and the challenges of achieving more effective consumer involvement. In addition a number of issues that emerged from the Scottish Consumer Council (SCC)/Scottish Development Centre for Mental Health (SDC) research were developed further. This final section of the paper draws out the main themes and issues and conclusions that were highlighted at the seminar.

4.1 The vision for the future regulation of mental health care

Exceptionalism

It was considered important in exploring the future of mental health care regulation to be clear about the grounds for treating mental health as a special case and the reasons why it might or might not differ from other areas where consumer interests are to be protected. It was posited that mental health may require special consideration for three principal reasons:

- people with mental health problems may not, for a variety of reasons, be well placed to protect their own interests and are likely to be vulnerable when most reliant on services
- the mental health care system is complex and many aspects of care cut across agency, service and professional boundaries
- levels and standards of service have tended historically to be low and there remains a considerable distance to travel to ensure a uniformly acceptable standard of service is available across the country.

Gradualist approach to strengthen regulation

The view from the seminar was that there should not be a ‘big bang’ approach to revolutionise the current system of regulation. Regulatory bodies recognise that the arena can seem congested. However, it was argued that the number of bodies could be seen as a mark of progress, as previously there were few protections in place to safeguard the interests of those who used mental health services. It would be important not to lose the gains achieved.
A gradual approach to changes in the system of regulation was therefore proposed. In addressing the need for a more holistic approach to regulation, realism and caution were urged. The process should start with the development of better links between health and social care, before widening the network out to other players. A great deal could be achieved by improving information sharing, communication and increased joint working among the existing health and social care regulatory bodies. It was noted that the cross boundary issues are not unique to mental health, but are perhaps more marked and need to be addressed.

**Streamlining regulatory activity**

Closely related to the previous section was the suggestion that there was considerable work to be done to ensure that the regulatory bodies worked more effectively together, both by improving communication on details of their work programme, on the outcomes of visits and inspections undertaken and by making better use of information collected. It was recognised that the current system imposes considerable demands on services and there is a need to review how this might be streamlined. The dearth of good local information systems is a major block for regulation – better systems would mean regulation imposed less of a burden on local services.

**Making sense to service users**

Concerns were raised about how the system of regulation and inspection, which has become increasingly complex, could be understood by service users, their carers and families who may need to be able to contact the agencies involved. If there continue to be several bodies involved in ensuring that services meet the quality expected, there was an argument for a one-door approach for service users and carers seeking information about services, the standards they could expect, and the ways of complaining when services fall below the standards expected.

**Maximising impact**

It was considered that the impact of regulation and inspection on service improvement and in achieving better outcomes for users and carers remains unclear. Regulators could also be more explicit about findings, and disseminate information on what has been done and improvements that have been achieved.

Further there was seen to be a need to reconsider approaches to regulation and inspection to move beyond the current practice of taking a series of snapshots of services, in order to track developments and persisting problems over time. It was recognised that this might involve bodies like SHAS undertaking shorter visits, with a sharper focus on particular issues.

The review of the performance management and accountability arrangements for NHS bodies is timely. Both the Scottish Health Advisory Service (SHAS) and the Clinical Standards Board for Scotland (CSBS) are expected to make a significant contribution to the Scottish Executive's performance reviews of local health services. Ensuring that the work of bodies like SHAS and CSBS are an integral part of the performance management will be an important development in encouraging the implementation of their findings and recommendations.
4.2 Principles

Discussions highlighted the challenges in seeking to implement the principles of regulation that protect and uphold consumer interests.

Transparency

While the regulatory bodies are clear about their role and place in the system of regulation and inspection, consumers and providers of services remain confused and unclear. It will be important therefore to determine how current arrangements can be made more open and more readily understandable.

Accountability

The current position is that many of the regulatory bodies are directly accountable to the Scottish Executive alone and this may be seen to compromise independence and constrain their capacity to be critical. It would be preferable for regulators to be accountable to the Scottish Parliament. The proposals made by the Millan Committee in the Review of the Mental Health (Scotland) Act to make the Mental Welfare Commission (MWC) accountable to Parliament were therefore supported.

It was noted that, while current developments undertaken by the Scottish Executive in accountability and performance management of NHS organisations are welcome, these centre on health alone and do not cover other essential parts of mental health services such as social care and housing. The inclusion of local authority members on health boards was seen as a positive move. However mental health is rarely an area in which local councillors take a proactive interest.

Authority

Regulators have to be able to protect the interests of vulnerable people. Mental health service users and carers often do not have a lot of influence or power. Regulators can only be powerful where minimum standards are clearly identified. It can be difficult for providers to follow through service improvements, when priorities are so many and so diffuse.

The authority of regulators needs to be supported by a credible evidence base and by ways of gathering information and conducting reviews that are respected, to ensure their judgements will be respected in turn.

Independence

Structure, make up and ways of working can influence perceptions of independence. For example, the peer review system used by SHAS is not seen by some as open or transparent. MWC is also seen as overly dominated by professional interests.

4.3 Protecting consumer interests

The seminar picked up on two areas in which there was a strong service user interest.

Information

Users need to know about services they can receive and about the standards they can expect. They also need to be aware of how the system of regulation works, to be able to raise concerns and seek redress.
**Involvement**

Commitment to involvement needs to be translated into practice. This requires greater investment in building capacity locally and nationally to facilitate involvement and make it meaningful. This would also require the development of an appropriate infrastructure to support consumer involvement as an integral part of the regulatory system.

Accountability processes should require health and social services to demonstrate the steps taken to promote involvement. This could include showing how they are supporting advocacy (individual and collective) in their area and how they are acting on issues raised through advocacy.
## Appendix 1

### Organisations interviewed

#### Regulatory bodies

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbara Hurst</td>
<td>Audit Scotland</td>
</tr>
<tr>
<td>Dr David Steel</td>
<td>Clinical Standards Board for Scotland</td>
</tr>
<tr>
<td>Dr Fiona Lang</td>
<td>Clinical Standards Board for Scotland</td>
</tr>
<tr>
<td>Dr Ian Pullen</td>
<td>Mental Health and Well Being Support Group</td>
</tr>
<tr>
<td>Dr Jim Dyer</td>
<td>Mental Welfare Commission for Scotland</td>
</tr>
<tr>
<td>Dr Sandra Grant</td>
<td>Scottish Health Advisory Service</td>
</tr>
<tr>
<td>Dr John Loudon</td>
<td>Scottish Executive, Department of Health</td>
</tr>
<tr>
<td>Robert Samuel</td>
<td>Scottish Executive, Department of Health</td>
</tr>
<tr>
<td>David Pia</td>
<td>Social Work Services Inspectorate</td>
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</table>

#### Groups and organisations

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<tr>
<th>Name</th>
<th>Organisation</th>
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<tr>
<td>Colin O'Doherty</td>
<td>Association of Directors of Social Work</td>
</tr>
<tr>
<td>Adrienne Chalmers</td>
<td>Consultation and Advocacy Promotion Service</td>
</tr>
<tr>
<td>Mary Weir</td>
<td>National Schizophrenia Fellowship (Scotland)</td>
</tr>
<tr>
<td>Colin Poolman</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>Dr Richard Caplan</td>
<td>Royal College of Psychiatrists</td>
</tr>
<tr>
<td>Pat Dawson</td>
<td>Scottish Association of Health Councils</td>
</tr>
<tr>
<td>David Bovaird</td>
<td>Scottish Association of Mental Health</td>
</tr>
<tr>
<td>Paul Lucock</td>
<td>Scottish Association of Mental Health</td>
</tr>
<tr>
<td>George Ronald</td>
<td>Scottish User Network</td>
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## Appendix 2

### Seminar participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Institution</th>
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<tbody>
<tr>
<td>Graeme Millar</td>
<td>Chairman, Scottish Consumer Council</td>
</tr>
<tr>
<td>Susan Browne</td>
<td>Researcher, SCC</td>
</tr>
<tr>
<td>Adrienne Chalmers</td>
<td>Consultation and Advocacy Promotion Service</td>
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<tr>
<td>Dr Jim Dyer</td>
<td>Mental Welfare Commission</td>
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<tr>
<td>Martyn Evans</td>
<td>Director, Scottish Consumer Council</td>
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<tr>
<td>Dr Sandra Grant</td>
<td>Scottish Health Advisory Service</td>
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<tr>
<td>Phil Harley</td>
<td>Scottish Executive</td>
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<tr>
<td>Gregor Henderson</td>
<td>Director, Scottish Development Centre for Mental Health (SDC)</td>
</tr>
<tr>
<td>Barbara Hirst</td>
<td>Audit Scotland</td>
</tr>
<tr>
<td>Bridget Johnson</td>
<td>Resource Officer, SDC</td>
</tr>
<tr>
<td>Fiona Lang</td>
<td>Lothian Primary Care NHS Trust</td>
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<tr>
<td>Paul Lucock</td>
<td>Scottish Association for Mental Health</td>
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<tr>
<td>Liz Macdonald</td>
<td>Policy Manager, Scottish Consumer Council</td>
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<tr>
<td>Allyson McCollam</td>
<td>Research Director, SDC</td>
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<tr>
<td>Colin McKay</td>
<td>Scottish Executive</td>
</tr>
<tr>
<td>Ian Murray</td>
<td>National Board for Nurses Midwifery and Health</td>
</tr>
<tr>
<td>Christine Naismith</td>
<td>City of Edinburgh Council, Social Work Department</td>
</tr>
<tr>
<td>Colin O’Doherty</td>
<td>Scottish Borders Council Social Work Department</td>
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<td>Colin Poolman</td>
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<td>Mary Weir</td>
<td>National Schizophrenia Fellowship</td>
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<tr>
<td>Lesley Wilkes</td>
<td>Scottish Health Advisory Service</td>
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### Appendix 3

#### Acronyms

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<tr>
<td>CAPS</td>
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<td>CSB</td>
<td>Clinical Standards Board for Scotland</td>
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<td>JFG</td>
<td>Joint Futures Group</td>
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<td>MHWBSG</td>
<td>Mental Health and Well Being Support Group</td>
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<tr>
<td>MWC</td>
<td>Mental Welfare Commission</td>
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<td>SAMH</td>
<td>Scottish Association for Mental Health</td>
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<tr>
<td>SCC</td>
<td>Scottish Consumer Council</td>
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<tr>
<td>SCRC</td>
<td>Scottish Commission for the Regulation of Care</td>
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<tr>
<td>SDC</td>
<td>Scottish Development Centre for Mental Health</td>
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<td>SHAS</td>
<td>Scottish Health Advisory Service</td>
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<tr>
<td>SUN</td>
<td>Scottish Users Network</td>
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<td>SWSI</td>
<td>Social Work Services Inspectorate</td>
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