

# **National Mental Health Services Assessment**

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## **Towards implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003**

### **Final Report**

**Dr Sandra Grant, OBE**

**March 2004**

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**Towards implementation of the  
Mental Health (Care and Treatment)  
(Scotland) Act 2003**

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# **national mental health services assessment final report**

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**executive summary**

## EXECUTIVE SUMMARY

The Mental Health (Care and Treatment) (Scotland) Act 2003 was passed in April 2003 and will be implemented by April 2005 (apart from the right to appeal against the level of detention, which does not come into force until the following year). Given that the new legal requirements will add to existing pressures on services, the Minister for Health and Community Care proposed an assessment of the current ability and readiness of the partner agencies to implement the new provisions. A small team was established, seconded from the care services, and was given a very broad remit:

*“To undertake a comprehensive assessment of existing mental health service provision and consider how the current range of facilities, augmented by the substantial additional resources now coming on stream, can meet the objectives of the Mental Health (Care and Treatment) (Scotland) Act 2003”.*

The National Mental Health Services Assessment Interim Report (December 2003) focused mostly on services for adults. However, the individual locality reports which were published at the same time captured other services. This Final Report expands on this and includes chapters and sections on client groups, care needs and services available for all age groups.

The Review Team involved and consulted service users and carers, NHS bodies, local authorities, the voluntary sector and other interested parties. A wide range of available information on existing services was also taken into account. The focus was on the current provision of services, although likely changes in demand for services resulting from demographic trends, changing patterns of morbidity, changing patterns of care and other factors were also anticipated. A multi-faceted approach was followed gathering information from a range of sources and wherever possible more than one source of corroborating information was sourced. The assessment worked from 3 principles: *Focus on people; use of existing information; and validation.*

### The new Act

The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the new Act") received Royal Assent on 25 April 2003. The Act was also developed with the co-operation and participation of patients, those who care for them, the statutory and voluntary sectors and other interests. The provisions are designed to bring real benefits to people with mental disorder and for those who care for them. *An Introduction to the Mental Health (Care and Treatment) (Scotland) Act<sup>1</sup>* provides a straightforward guide to the new Act.

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<sup>1</sup> Scottish Executive Health Department, *An Introduction to the Mental Health (Care and Treatment) (Scotland) Act*, November 2003 , <http://www.scotland.gov.uk/library5/health/mhsa-00.asp>

The main provisions of the new Act will be introduced in April 2005 and will ensure that compulsory measures of detention and other care may only be applied where strict criteria have been met. A new forum, the Mental Health Tribunal, will be appointed to make important decisions in relation to such compulsory measures including powers for the Tribunal to intervene where important elements of a Compulsory Treatment Order are not being provided. Wherever possible the objective will be to treat offenders who enter the mental health system in the same way as civil patients.

The Act establishes key care and approach principles including: recognition of the present and past wishes and feelings of the patients; the importance of patient participation in the design of care; and the need for services to respond directly to patients' assessed needs and to the needs and circumstances of the patient's carer.

The Act also sets out principles relating to the way in which the care must be delivered. That will involve approaches designed to include the minimum restriction on personal freedoms; the promotion of equal opportunities; and, in the case of children, will ensure their best interests and welfare.

Additional duties will be placed on NHS Boards including: services and accommodation for children and young people in hospital; for mothers admitted with their babies; and a duty in collaboration with local authorities to ensure access to independent advocacy services for *all* with mental disorder in their area.

New duties are also placed on local authorities including, among others, a responsibility to provide care and support services and services to promote well-being in social development. Assistance with travel for people with mental disorder is included together with duties designed to contribute to the avoidance and reduction of the risk of harm. Local authorities will also have a duty to provide education for children subject to the new Act or the Criminal Procedure (Scotland) Act 1995.

### Meeting the requirements of the new Act

The new Act will require a comprehensive range of responses organised on a joint agency basis and involving service users, carers, the voluntary sector and others in the assessment, planning and delivery processes. This report comments on these approaches, focuses on the current organisation of mental health services and offers conclusions and recommendations on what changes are needed to meet the main provisions by April 2005.

This report concludes that for the statutory agencies, their partners and other interested parties to combine to implement the provisions and objectives of the new Act, will require urgent and continued attention on the planning and, most importantly, the delivery of comprehensive mental health services, care and support as set out in the *Framework for Mental Health Services in Scotland*<sup>2</sup> and its successor documents. That solid grounding and range of provision will be required as the foundation on which to build the new services and approaches called for in the new legislation. The minimum range anticipated by this report should include joint agency and other partners' approaches to cover:

- A range of crisis and responsive services available throughout the 24 hours.
- Multi-agency and multidisciplinary community mental services, including the voluntary sector, for the range of care groups, including people with a learning disability.
- Access to a range of appropriate inpatient facilities through local and regional planning and managed care networks (e.g. young people, mentally disordered offenders, mothers with perinatal illness and their babies)
- A range of therapies including psychosocial interventions, structured daytime activities and employment, and support for recovery.
- A local consensus on the way forward for workforce planning and development, including independent advocacy.
- Training in the specific requirements of the Act, and appropriate arrangements for administration.

The principal conclusions and recommendations of the Assessment are set out overleaf.

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<sup>2</sup> Scottish Executive Health Department, *The Framework for Mental Health Services in Scotland*, 1997

## CONCLUSIONS AND RECOMMENDATIONS

The Mental Health (Care and Treatment) (Scotland) Act 2003 enshrines recent developments concerning human rights. Extensive consultation by the Millan<sup>4</sup> Committee with people who use the services and those who care for them, as well as with those who plan and provide services, helped to develop the principles behind the new Act. This has ensured a degree of awareness about what is needed in addition to the changes in statutory procedures.

These underlying principles provide the basis for a new style of service delivery designed to have a major impact on improving the experience of service users and those who care for them. The new provisions link to the range of initiatives underway to progress mental health and well-being and to improve health and social inclusion generally, reflecting the broader approach to mental health policy and practice in Scotland and the work being done to improve treatment and care services.

### The Act

#### Conclusion

The process of consultation and involvement has worked well and people are waiting for further training and guidance. The new Act is recognised as being part of a broader range of mental health initiatives and the Joint Local Implementation Plans will reflect this.

#### Recommendation

The Scottish Executive should continue with the current implementation process and provide central guidance to inform the priorities in local training action plans and Joint Local Implementation Plans, to be implemented by the agencies within set timescales.

### Organisational Culture

#### Conclusion

There are major staff morale, attitudinal and cultural problems which, unless attended to consistently, will inhibit full implementation of the underlying principles of the new Act.

#### Recommendations

People who use the services and those who care for them should work together with staff who share the same values, to jointly bring about change and ensure that the principles behind the Act are adhered to.

Front-line staff should lead on bringing about the changes required by the new Act, using it as a development opportunity for the service, those working in it and those receiving care.

The senior managers in local authorities and NHS Boards should devolve more authority, responsibility and accountability (including budgets) to front-line staff, with a clear objective to work closely with the voluntary sector and service users and carers.

The Scottish Executive should focus on the implementation of existing policies in mental health services and the implementation of the Act and avoid creating additional policies at this point in time.

### Information

#### Conclusion

There are serious and major problems in accessing adequate data about mental health services. However, there are a number of significant developments that should improve this.

#### Recommendations

The Scottish Executive should continue with its current work on developing a Mental Health Information Strategy and ensure that it is locally adopted, resourced and fully implemented in the medium term (3 years).

The work of the *Improving Mental Health Information Programme* should continue and expand so that it can become an expert resource for local services as well as providing national data.

Staff and managers across agencies should agree on the minimum set of data to be recorded to help improve service delivery and quality and ensure that this is collected.

Information that informs decision-making should be made available to all stakeholders.

### Inequity

#### Conclusion

Mental health services in Scotland have some way to go before every citizen has access to the same level of high quality service, including services mentioned within the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003.

## Recommendations

Flexible and responsive 24-hour support services should be developed locally and planning should involve service users.

By the time the Act is implemented in 2005, everyone with a serious mental health problem should have their assessed community needs met by a multidisciplinary and interagency team, which should include the voluntary sector.

Admissions to hospital for reasons other than appropriate regional service provision (i.e. where the local facility has no spare capacity) should be monitored and analysed by regional planning groups, with the aim of improving national bed management.

The accommodation where care is delivered should provide a good environment. When necessary, people should have planned and timely access to age appropriate facilities and specialist services, including mother and baby units.

Day activities and therapeutic opportunities should be available both in the hospital and community, including psychological and social interventions.

## Workforce

### Conclusion

Workforce gaps are probably the most difficult issue to address in the short-term (one year) but this must be done in order to fulfil the obligations of the Act from 2005. This will mean major changes to personal roles, responsibilities and job plans. It will also have an impact on the strategic and structural issues involved in redesign initiatives.

### Recommendations

At a national level, work should be carried out to clarify issues about roles, responsibilities and pay scales between different disciplines, organisations and levels of seniority and experience. This must involve the staff-side as well as senior management and should be compatible with ongoing human resource development strategies and life-long learning strategies.

Locally, there is no time to wait for a national directive so interim compromises and solutions should be found in order to ensure the legal rights of people using the services are met. It is essential that this interim work and experience informs and shapes the national guidance and regulations.

The National Mental Health Workforce Group should lead on these issues.

## Finance

### Conclusions

There is insufficient standardisation and clarity about the funding of mental health services and how the money can be tracked into services at a local level.

There is insufficient expertise within the statutory sector at a care delivery level about how to develop a business case and obtain resources to fund it.

There is a perceived under-funding of mental health services. Until it is clear exactly what is being spent, how well and to what effect, an unanswerable case for an increase is difficult to make. The need for resources will become greater in order to implement the new Act.

### Recommendations

The Scottish Executive, NHSScotland and local authorities should ensure that there is a standardised and transparent system for recording financial data that contains not only national data, but regional and local spend.

A system should be developed whereby money spent can be tracked to local service provision and accounted for within the monitoring systems

Staff as well as managers should take responsibility for understanding financial issues in relation to improving outcomes, including the concept of opportunity cost.

Robust business cases should be put forward for increasing resources within the statutory sector and voluntary sector.

NHS Boards and local authorities should give increased priority to mental health service resource allocation especially in relation to the pressures and commitments associated with the new Act.

# **national mental health services assessment final report**

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**introduction**

## 1. INTRODUCTION

### Remit

1.1. The Mental Health (Care and Treatment) (Scotland) Act 2003 was passed in April 2003 and will be implemented by April 2005 (apart from the right to appeal against the level of detention, which does not come into force until the following year). The new legal requirements will put pressure on already hard pressed services and concerns were raised in Parliament about the capacity and capability of the services to meet the demands. The Minister for Health and Community Care therefore proposed an assessment of the current ability and readiness of the partner agencies to comply with the Act and to report on the implications for local services. A small team was established, seconded from the care services.

1.2. We were given a very broad remit:

*"To undertake a comprehensive assessment of existing mental health service provision and consider how the current range of facilities, augmented by the substantial additional resources now coming on stream, can meet the objectives of the Mental Health (Care and Treatment) (Scotland) Act 2003".*

1.2.1. The project work included:

- mapping existing services for people with needs for mental health services in Scotland
- identifying gaps or duplication in the provision of services, including areas where re-prioritisation would be possible, or shortcomings in the quality of services
- reviewing available evidence about the organisation, management, efficiency and effectiveness of mental health services
- assessing the implications for services of the introduction of the new Act
- considering priorities for development of services in light of these implications

1.3. What was not included, because it is covered elsewhere, was examination of:

- training needs
- the functioning of the new Tribunal system
- the work of the Mental Welfare Commission for Scotland

## Methodology

1.4. We were asked to involve and consult service users and carers, NHS bodies, local authorities, the voluntary sector and other interested parties at the same time as taking into account the wide range of available information on existing services. Although the major focus was on the provision of current services, it was important to take account of likely changes in demand for services resulting from demographic trends, changing patterns of morbidity, changing patterns of care and other factors. Not least was the difficult question of resources.

1.5. Given the wide remit and relatively short timescale, we adopted a multi-faceted approach. Obtaining information from a number of sources in different ways was necessary to ensure that all components of the remit were addressed and that wherever possible there was more than one source of information before reaching any conclusion. We worked from 3 principles:

### a) Focus on people

- those who use the services and those who care for them
- staff and managers who provide care
- people who have responsibility for planning services

### b) Use existing information

- previous consultation
- joint community care plans and other strategic documents
- community care statistics
- annual reports
- publications from monitoring and inspectorate organisations

### c) Validation

- data should be collected from more than one source
- discrepancies should be clarified and understood

1.6. The main part of the project consisted of 3 overlapping exercises, based on prior review of the literature and a questionnaire. First, a member of the team (himself a service user) visited users and carers throughout Scotland seeking their views about current services and priorities for the future. Some of these people were prepared to share their experiences of detention under the current Act and we are extremely grateful to them. Chapter 3 summarises the views of users and carers and the full account can be found at <http://www.show.scot.nhs.uk/mhwbsg/>.

1.7. The second phase involved field-work by visiting every NHS Board and local authority area to learn about local service provision and potential problems that would need to be resolved in order to implement the new Act. This formed the basis of the locality reports published with the Interim Report in December 2003. At the request of the Royal College of Psychiatrists, we concentrated on local services for adults, aged 15-64, because this was the group of people most likely to be detained. We had been tasked with producing a relatively brief report linked to the Act, not a definitive review of all mental health services. It was with regret that we were unable to visit services for older people or those with a learning disability, for whom the Act has particular relevance also. These services were, however, included in the third phase and are reported on in Chapter 4.

1.8. In the third phase we looked at national themes and issues, the final strand of the work. The information was not obtained from site visits, but was based primarily on the opinions of multidisciplinary groups from the different agencies. It became clear that there was a false perception that if a particular group or issue was not going to be mentioned then it would be excluded from future planning and resource allocation. This is not the case and we are sorry we did not have enough time or space to include everything that is important.

1.9. The assessment process involved contact with a wide range of people and every effort has been made to capture and convey their views and experience. Although not all the information is reflected in its entirety in this report, contributors can be assured that all points were given due consideration and influenced the report.

1.10. The volume of documentation that we obtained is a testament to the commitment and dedication of all concerned. This in itself became something of a problem. There was a wealth of information that had to be rigorously condensed and edited to a manageable size, therefore much of the detail had to go, especially for some sections such as Older People or Mentally Disordered Offenders, where considerable research had been undertaken.

1.11. We ended up with the paradox of being swamped with information, yet unable to obtain some basic data. For example, it was not easy to obtain workforce numbers, out-of-hours detentions under the Mental Health Act (Scotland) 1984 or the percentage of inpatients detained. The principle of validating information was much more difficult than imagined as a lot of data was contradictory and there was considerable discrepancy between figures obtained locally and those held centrally. This is discussed in Chapter 5.

### General Adult Psychiatry: Conclusions from the Interim Report

1.12. In many ways it is artificial to separate the different components of a service because they all relate to one another. The conclusions in the interim report from the locality visits, which focused on general adult psychiatry, cross-over into the national overview of other parts of the service and vice versa. The interim and locality reports can be found at <http://www.show.scot.nhs.uk/mhwbsg/>.

- 1.13. The following is a summary of the conclusions in the Interim Report:
- a) There would be value in central guidance to inform local training action plans that must be implemented within a fixed timescale. This should include consideration of the human resource and organisational issues. Funding for continuing training should be reviewed.
  - b) There may be merit in a national or regional review of out of area admissions, with the aim of rationalising the management of mental health beds in Scotland. Correlations between the development of community services and admissions to hospital should be explored.
  - c) Flexible and responsive 24-hour support services should be developed and planning should include service users.
  - d) By the time the new Act is implemented in 2005, everyone with a serious mental health problem should have their assessed community needs met by a jointly provided multidisciplinary community mental health team, or its equivalent, and the voluntary sector should play a significant role.
  - e) A full range of treatments and activities, including psychosocial approaches, should be available at the appropriate times for people both in hospital and in the community. The need for, and access to, these services should be monitored as part of performance management.
  - f) There should be greater clarity about the roles of different organisations and different staff groups. Across staff groups, issues need to be clarified about generic versus specialist roles and about senior responsibility. Users and carers need to know who can do what, the limits of their skills and responsibility and how to contact the right person, whether in advocacy, health, social work, the voluntary sector or mainstream local authority services.
  - g) The organisation, management and training of mental health officers should reflect the importance of their extended role.
  - h) The National Mental Health Workforce Group should work closely with all professional groups and others to seek solutions to the workforce issues.
  - i) The administrative infrastructure to support the new Act needs to be considered in all planning for delivering the new Act. The grading of staff also needs to reflect the responsibility involved.
  - j) There should be greater transparency, monitoring and accountability of financial resources for mental health. Additional money for the new Act needs to be negotiated in detail and tracked accordingly.
- 1.14. The prime reason for undertaking this review was to assess the readiness of the services to meet the provisions of the Act when it comes into place in 2005; therefore the next chapter summarises the Act.



# **national mental health services assessment final report**

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legislation

## 2. LEGISLATION

### 2.1 RECENT HISTORY AND PROGRESS

2.1.1. Since the launch of the *Framework for Mental Health Services in Scotland*<sup>2</sup> in 1997, NHS Boards, local authorities, the voluntary sector and others have been expected to work together with local service users and carers to **jointly** design and agree mental health strategies to fit local needs. As part of this process the local partners were expected to agree funding responsibilities and to use the *Framework*<sup>2</sup> as an agreed template for service assessment and development.

2.1.2. This process (which, in short, was all about having local agreement on a costed, timetabled strategy for change) has progressed at different speeds across the country. A review in 1999<sup>3</sup> outlined some of the reasons behind the lack of overall progress.

2.1.3. There followed, in January 2000, a *Mental Health Summit* in Edinburgh (an event led by Ministers) which called for accelerated and better coordinated implementation of the *Framework* objectives and for the early development of comprehensive mental health services in keeping with the move toward community based care.

2.1.4. At the same time Ministers appointed the *Mental Health and Well Being Support Group* which, during 2000-03, completed two rounds of visits to all NHS Board areas. The process involved meeting local representatives of service users and their carers, as well as the local authority, NHS and voluntary agency partners. A review of the Support Group findings in the published outcome reports and 3 annual reports shows that while Joint Planning structures had indeed been set up in all areas, their effectiveness varied widely. The reports also showed:

- that despite 90% of mental health care being provided in primary care settings, joint local planning processes had generally been unsuccessful in setting up robust working arrangements with Local Health Care Cooperatives
- great variability in the extent to which staff groups from all services were involved in a meaningful way in service planning and development
- service users and their carers complained of 'consultation fatigue' and frustrations with the level of impact their contributions made
- a lack of systematic and shared information on current and planned services and their effectiveness
- a resistance to local devolution of budgets and control, leading to stagnation of service redesign initiatives and innovation
- widespread shortages of skills in key professional groups, at all levels, leading to caution over change

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<sup>3</sup> Health Bulletin, *The Framework for Mental Health Services in Scotland – a progress report one year on, 1999*

## 2.2. THE NEW LEGISLATION

2.2.1. The Mental Health (Care and Treatment) (Scotland) Act 2003 (the new Act) represents the most radical change to mental health provision in Scotland for 40 years, and shows a shift towards a greater human rights perspective for those who are obliged to receive treatment against their will. The Millan Committee report<sup>4</sup> on the review of the current mental health legislation set out a number of principles that it considered should underpin any new mental health legislation. These are:

- Non-discrimination
- Equality
- Respect for diversity
- Reciprocity
- Informal care
- Participation
- Respect for carers
- Least restrictive alternative
- Benefit
- Child welfare

2.2.2. These principles informed the Scottish Executive's thinking while developing the new Act. Not all of the Millan principles could be fully expressed in terms of statutory duties or powers, but the new Act does contain a range of provisions that will have a significant and meaningful effect in regard to those principles.

2.2.3. In summary, under the new arrangements, short-term detentions will be initiated by a mental health officer, as well as a doctor who is experienced in helping people with a mental disorder. If neither is available emergency detentions by any doctor will still be possible. Relatives will no longer be asked to formally contribute to the process. Decisions about long term detention and treatment will not be made through the Sheriff Court as now, but by a Tribunal made up of a legal member (chair), a medical member (usually a psychiatrist) and a general member (someone with knowledge and understanding of care planning and mental health services).

2.2.4. For the first time, the new compulsory treatment orders may be community based as an alternative to hospital detention and from 2006 a patient will have the right to appeal against the level of security in which they are held. Service users will also have a greater say in their future care by making advanced statements and having the right to advocacy support.

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<sup>4</sup> Millan, *New Directions – Report on the Review of the Mental Health (Scotland) Act 1984*. January 2001

2.2.5. The new Act forms one part of a framework of policy, legislation, guidance and initiatives that inform how we care for people with a mental disorder. In broad terms, the provisions in the new Act are primarily concerned with the care, protection and treatment of all service users with a mental disorder. It is designed to complement existing legislation and guidance to offer a broad framework designed to **protect and improve** the mental health and well-being and daily lives of those with a mental illness/disorder and give regard to their carers. Related legislation, health and social work policy and guidance are listed at Annex 2.

### The new arrangements

2.2.6. The Mental Health (Care and Treatment) (Scotland) Act 2003 (the new Act) includes a range of measures relating to the care and treatment of people with mental disorder which broadly fall under four headings:

- principles, roles and responsibilities
- compulsory powers
- people with mental disorder within the criminal justice system
- rights and safeguards

2.2.7. The new Act sets out principles under which the new provisions have to be delivered, including:

- the present and past wishes and feelings of the patient
- the views of the patient's named person, carer, guardian or welfare attorney
- the importance of the patient participating as fully as possible
- the importance of providing the maximum benefit to the patient
- the importance of providing appropriate services to the patient

2.2.8. Principles are also set out relating to the way in which the functions of the new Act must be discharged. For example, the functions are to be delivered in a way that:

- involves the minimum restriction on the freedom of the patient that appears to be necessary in the circumstances
- encourages equal opportunities
- best secures their welfare (particularly if the patient is a child)

2.2.9. The new Act places further duties on those discharging functions under the act, including:

- a duty to have regard to the Code of Practice on the Act, to be published by Scottish Ministers. (This duty does not apply to the Mental Welfare Commission for Scotland, the Mental Health Tribunal for Scotland, or any court.)

- a duty to lessen any harm to child/parent relations, where relevant
- subject to a number of safeguards, a duty to provide Scottish Ministers with relevant information (e.g. research)

### Roles and responsibilities

2.2.10. The new Act defines the nature, powers and duties of a number of organisations and individuals, including:

- the nature, powers and duties of two organisations: the Mental Welfare Commission for Scotland, and the Mental Health Tribunal for Scotland
- specific duties on NHS Boards and local authorities in relation to persons with mental disorder (in addition to their more general duties) and gives some corresponding powers:
  - duties on hospital managers in relation to a person who is subject to compulsory measures
  - duties and certain powers to Scottish Ministers
  - a number of special professional roles: approved medical practitioners, designated medical practitioners and mental health officers
  - provision for a Code of Practice on the new Act

### Mental Welfare Commission for Scotland

2.2.11. The new Act also sets out provisions relating to continuation of the Mental Welfare Commission for Scotland. The Commission will have new duties to monitor the operation of the new Act and to promote best practice; specific powers and duties in relation to carrying out visits to patients; investigations; interviews; medical examinations; inspection of records; powers and duties to publish information and guidance; and power to give advice or bring matters to the attention of others in the mental health law system.

### Mental Health Tribunal

2.2.12. The Mental Health Tribunal for Scotland ('the Tribunal') will be a new body, established by the new Act. The Tribunal will make decisions covering a wide range of situations – for example, on applications for a Compulsory Treatment Order. Given the nature of the decisions to be made, the Tribunal will require expertise in both mental health law and the provision of care and treatment to people with mental disorder.

2.2.13. NHS Boards (including The State Hospital) and local authorities are required, where practical, to provide accommodation where hearings can be held.

### Special professional roles

2.2.14. The new Act defines some special professional roles that require a person to be appointed by the relevant body before they can discharge certain key functions under the legislation. These include mental health officers (MHOs) who will be required to play a significant role under the new provisions which extend their current role. Approved medical practitioners (AMPs) will authorise periods of short-term detention. NHS Boards will only be able to appoint doctors as AMPs when they meet certain requirements on qualifications, training and experience (to be specified by Scottish Ministers). The role of the responsible medical officer (RMO) and the approved medical practitioner designated by hospital managers for a particular patient is also defined, including various duties in relation to the ongoing review of compulsion.

### NHS Boards

2.2.15. NHS Boards already have wide-ranging duties to provide services for people with mental disorder, mainly through the provisions of the National Health Service (Scotland) Act 1978. However, the new Act places further duties on NHS Boards. Specific provisions are included for NHS Boards to cover the needs of children and young people detained in hospital and also to provide inpatient care for mothers who have postnatal depression, in particular to enable them to be admitted with their babies into an appropriate environment. NHS Boards will also have a duty, in collaboration with local authorities, to ensure independent advocacy services for all persons with mental disorder in their area who request it. A further duty on NHS Boards will be that they appoint approved medical practitioners for their area.

### Hospital managers

2.2.16. Hospital managers will have a number of general duties under the new Act in relation to a person subject to compulsory measures. In particular, they will have a duty to appoint a responsible medical officer (RMO) for a person with mental disorder. The RMO is always a consultant psychiatrist.

### Local authorities

2.2.17. Local authorities already have a range of general duties to support people with a mental disorder, mainly set out in the Social Work (Scotland) Act 1968. Under the new Act further specific duties and corresponding powers will be placed on local authorities to provide services for people with a mental disorder. These include care and support services; services to promote well being and social development; and assistance with associated travel. Local authorities will also have a duty to inquire into the case of those with mental disorder where certain criteria arise – essentially, where the individual is at risk of harm. Local authorities will also be able to apply for a range of warrants (such as a warrant to enter premises) to allow them to carry out their inquiries.

2.2.18. Local authorities will be required to appoint sufficient mental health officers for their area and to designate a mental health officer to be responsible for an individual's case on particular occasions (such as a person being detained on a short-term order). The new Act amends the Education (Scotland) Act 1980 to confirm that local authorities have a duty to provide education for children who are subject to the new Act, or who are subject to the mental disorder provisions of the Criminal Procedure (Scotland) Act 1995.

### Scottish Ministers

2.2.19. The Scottish Ministers have a number of general duties and powers under the new Act, including powers to make secondary legislation (such as Regulations) which will provide the detail of certain aspects of the new legislative framework. The Act places a duty on Scottish Ministers to consult and publish a Code of Practice on the Act to provide guidance on the new arrangements. This Code of Practice will be made available widely and will help professionals to adhere to the new Act.

### Compulsory detention and treatment

2.2.20. The new Act comprehensively reforms and modernises the legal framework for compulsory detention and treatment. In doing so, it sets out clear criteria that must be met before compulsion can be authorised, as well as the detailed procedures that must be followed.

2.2.21. The new Act provides additional rights and increased safeguards for people needing mental health services. The new arrangements include:

- a duty on local authorities to undertake an assessment of needs where certain conditions are met, and gives patients, their carers and their named persons the right to request an assessment of needs from the local authority or NHS Board
- a right of access for all people with mental disorder to independent advocacy services and a duty on NHS Boards and local authorities to ensure availability and accessibility of advocacy services
- the right for patients to nominate a named person to be kept informed of the patient's status in certain circumstances set out in the new Act and who may act on behalf of the patient, including making applications and appeals to the Tribunal
- the right for patients to make an advance statement regarding how they would wish to be treated or not treated
- the right for informal patients to apply to the Tribunal for an order requiring hospital managers to release patients held unlawfully
- a framework of safeguards for different kinds of treatment, including neurosurgery for mental disorder and electro-convulsive therapy (ECT)
- the right of appeal for patients (and others on their behalf) against detention in conditions of excessive security

2.2.22. The new Act provides for several forms of compulsion:

- emergency detention (72 hours)
- short-term detention (28 days - this may be extended)
- Compulsory Treatment Orders (6 months – this may also be extended)
- other powers in relation to entry to premises, removal and detention

2.2.23. The new provisions also substantially reform the law relating to people with mental disorder who enter the criminal justice system. The new Act amends the Criminal Procedure (Scotland) Act 1995 to give courts new options in how they deal with people with mental disorder. It provides new orders that a court may make:

- an Assessment Order
- a Treatment Order
- an Interim Compulsion Order
- a Compulsion Order

2.2.24. A court will still be able to make:

- a Hospital Direction
- a Restriction Order (in combination with a Compulsion Order)

2.2.25. The new Act retains Scottish Ministers' power to transfer a prisoner to hospital for treatment of a mental disorder, introduces the *Transfer for Treatment Direction*; sets out how some of these new orders will be reviewed once made; and details procedures for the transfer of patients and the suspension of detention of patients subject to certain orders.

# **national mental health services assessment final report**

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**the views of people who use services and  
those who care for them**

### 3. THE VIEWS OF PEOPLE WHO USE SERVICES AND THOSE WHO CARE FOR THEM

#### 3.1. SERVICES NOW – PRIORITIES FOR THE FUTURE

3.1.1. The new Mental Health Act is extremely important for service users, their families and other carers, perhaps especially when it will be applied to vulnerable people who have to receive treatment on a compulsory basis.

3.1.2. The first phase of our work was to seek feedback from users and carers throughout Scotland about their views on the implications of the Act, including their views about current services and what they see as priorities for future developments. This was achieved by holding meetings with groups of service users and carers across the whole of Scotland, organised and led by a full-time Review Team member, who works with advocacy services and is himself a service user. On some visits he was accompanied by a colleague.

3.1.3. These visits were separate from the visiting programme that formed the second phase of the project, because we were told by some service users and carers that they wanted their own separate meetings. In addition, however, on all the locality visits carried out by the other Review Team members we met with users and carers as part of the general programme.

3.1.4. Although this was probably the most comprehensive consultation with mental health users and carers undertaken in Scotland, there were still gaps. Contributors were mainly adults and their relatives, with less involvement from older and younger people. Time did not allow people with learning disabilities and their carers to be visited, despite inclusion of their interests in the new Act. Such feedback is already publicly available<sup>5</sup>, especially for people with learning disability.

3.1.5. The users and carers greeted this review with enthusiasm, tinged with cynicism. There was an undercurrent of anger about their experience of illness, the quality of care received and the lack of response to earlier feedback. They felt they had said everything before and constantly emphasised that they needed to know that something tangible would result if they were to continue to have faith in such consultations. As we quoted in the interim report: *“this is your last chance (to make things better)”*. Planners from all the agencies should take account of how draining it can be when constant lobbying and repetition leads to minimal change, even when the requested changes are relatively small.

3.1.6. Comments made at these meetings were recorded virtually verbatim and returned to the local groups for confirmation and to allow them to be used in local planning if they wished, rather than users and carers having to go through a similar process again. A detailed record of what was said will be made available on the website, but this chapter provides a summary with some direct quotes. This is the voice of service users and carers.

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<sup>5</sup> Scottish Executive Health Department, *The same as you?: A review of services for people with learning disabilities in Scotland*, 2002

## The main issues for users and carers

### Stigma

3.1.7. This was the most frequently mentioned issue and it was reported that there is a need for:

- continuing work with the “see me...” campaign<sup>6</sup>
- user-led mental health awareness training with professionals, employers and the public (including young people) to discuss positive mental health, as well as illness and the concept of recovery
- responsible and positive reporting by the media
- openness from mental health services
- acceptance of diversity and difference

### Hospital services

3.1.8. Although the vast majority of people with a mental illness never have to go near a psychiatric hospital, there may come a time when they can no longer cope at home and have to be admitted.

3.1.9. There are people for whom hospital can be a place of peace and sanctuary after living at home in growing fear and desperation. Some of the newer hospitals are bright, clean and airy with single en-suite rooms and calm places to relax. There are activities during the day, as well as treatment and people to speak to. Overall, most people realise that hospitals are necessary and that hospital is part of a continuum of care and should not be seen as being completely distinct from community services. Both hospital and community services need investment.

3.1.10. Nevertheless, for many people being admitted to hospital is a bewildering and frightening experience. Some will find the actions of other patients (and staff) hard to cope with and there may be little to do and few people to talk to. While most staff will be very helpful, others may be less so. These are a few of the comments we heard, made mainly by people who were in hospital against their will. The conclusion must surely be that a great deal needs to be done before people who are deprived of their liberty in order to receive treatment get the reciprocal care and treatment that the law will now require.

*“There is absolutely nothing to do on the ward except watch TV.”*

*“You can sit in your room alone all day and no one will come and see how you are.”*

*“The nurse who showed me around was nice, but didn’t seem to realise that I’d never been on a psychiatric ward before so he didn’t explain much. I had no idea what I was meant to do. I could have asked questions but I was too frightened.”*

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<sup>6</sup> <http://www.seemescotland.org/>

*"In hospital they take over your life and give us the message that we don't know how to deal with life. They're almost saying we will shut the door on life for you and put you in a protective environment – it makes us more scared of the outside world."*

*"Hospital rules and regulations are hard to conform to"*

*"The environment is stressful, overcrowded, under-resourced and understaffed"*

*"The noise and bustle is off-putting when there is a real need for peace and refuge"*

*"I was scared stiff as I'd never been in this hospital before. The place was horrendous, the patients could do what they wanted, there was little staff supervision and they didn't engage with the patients. The TV was on very loud, there was shouting and arguments and abuse, the cups were unwashed and stained, patients just stubbed their fags out on the floor—it was a hellish place"*

3.1.11. Taking these views into account and the wider perspective, service users and carers and the Review Team, are of the view that hospitals should:

- make admission as easy as possible and as local as possible
- have good procedures and provide information about admission and discharge
- be attractive, with privacy and peaceful places
- provide single sex wards and mother and baby units or bedrooms (see chapter 4)
- minimise the constraints of detention and provide sanctuary with reasonable, rather than restrictive, rules and regulations
- organise activities, minimise boredom and have staff that routinely mix with patients

### Crisis services

3.1.12. This has been talked about for many years and what is still required is:

- crisis cards to explain and summon help in public, in an emergency
- facilities that respond to distress, not just illness
- access to a person (maybe by phone) whom we can talk to, relax with and regain equilibrium
- a place of sanctuary, a safe house or respite in which we can calm down and get support from people who know what we are going through
- sensitive outreach at times when people have lost insight into their illness
- professionals who come and see us as a matter of urgency when necessary
- access to conventional 9-5 services at all times of day and night, seven days a week
- help for carers who may also be under huge pressure

3.1.13. The theme of recovering and moving on was apparent in many meetings. As hospitals no longer cater for large numbers of long stay patients, most users now live in the community, but many believe that 'Care in the Community' is just another institution without walls.

3.1.14. Taken together, investment is especially required in:

- recovery
- prevention
- meaningful activity
- services that will support those who may not 'recover'

### The main issues for carers

3.1.15. Many of the issues raised by users were also common to carers. We have tried not to duplicate the views, but have included additional perspectives where possible.

### Accessing help on behalf of the user

3.1.16. Carers are very keen that:

- their expertise is acknowledged
- professionals respond to crisis when carers say it exists
- it is acknowledged that the whole family is affected by mental illness
- professionals realise they have a duty to the family as well as the user

### Hospital services

*"Nurses and other support workers are often in the nursing station and seem reluctant to talk with the patients; surely a nurse should provide support and therapy as patients recover, but how can they do this if they're sitting apart and leaving them to their own devices?"*

3.1.17. With this in mind, carers need to be sure:

- they will be welcomed as visitors and have the system explained to them
- that hospitals are easily accessible and sited as locally as possible
- there will be attractive visiting areas
- their relative will receive good treatment and have things to do
- their relative will have an adequate income

### Stigma

3.1.18. Carers are affected by stigma just as users and some staff are. They find it painful to see the way people react to mental illness and the way users are treated. Sometimes there is the suggestion it is the carers fault. Some members of the wider family may stop referring to the user:

*"They don't ask after him or include him in Christmas cards. He might just as well be dead for all the interest they show in him."*

*"The 'see me...' campaign<sup>6</sup> has cheered us up enormously – at least it's a start to changing people's attitudes. As it progresses with other initiatives perhaps we'll learn from the examples of other illnesses, such as cancer. Then stigma will become just a sad memory".*

### Information about illness, rights and services

3.1.19. To help make informed choices and contributions, as a minimum, carers need:

- information to be provided in an accessible format in an accessible place
- more made available from the voluntary sector, which provides good information

### Emotional and mental health of carers

3.1.20. Carers can feel isolated when left to care for their relative or friend:

*"They saw her for 1/2 hour every week and we were with her 24/7. Surely we could have helped and been given some guidance about how to help?"*

*"I'm his mother and will care, but I don't have the knowledge or skills to deal with someone with a mental illness. However, I have to provide all the care now, as he won't accept it from anyone else."*

*"How do we cope when we seem to be the only person providing support, yet no one listens to us and we have no additional support for ourselves?"*

*"Most of us do cope, but we may go on to develop mental health problems ourselves. Some of us eventually just cannot cope and have to give up".*

3.1.21. Some carers have had access to support groups and workers, and attended stress awareness or anger management events, and these have proved invaluable. Support for carers is now beginning to increase and the Review Team was told this was much appreciated:

*"I found the carers' project to be a very good experience and very helpful. As carers in a scattered community you can feel very isolated, largely as a result of public ignorance and the stigma attached to all kinds of mental illness."*

*"The first carers' support worker proved to be very helpful and informative. She obviously knew a lot about the illness. She was very humane – you could ring her and she would respond quickly and get right back to you. She would ring you herself just to see how you were doing."*

*"The carers' project has been excellent, superb in every way. They're willing to listen and to give advice and visit us, even in the evening."*

### 3.1.22. Carers need:

- people to recognise the strain on their emotional and mental health
- access to activities and therapies which will enhance their mental health
- access to support, for instance, through support projects and groups

### Investment

3.1.23. The strain of being a carer would be less if there was confidence in the range of facilities and services that are there to help. They state that there is a need for increased financial investment in mental health services generally, especially in community facilities and grass roots services, including self help, support groups, the voluntary sector and services for carers. There was a view that, without adequate new investment, people affected by mental illness will continue to suffer:

*“The resources put into mental health care are totally inadequate. I dread to think what would have happened to my son had he not had the support of his family and circle of friends. This huge network of informal, unpaid carers must save the country millions of pounds. But it imposes an enormous strain on the whole family and the family circle.”*

### Confidentiality

*“They should listen more to carers. Common sense should prevail over confidentiality. My family and I have been treated as if we’re of no account in my son’s life.”*

*“We should be included in the plans to help them. There are obviously parts of the doctor-patient relationship that are confidential, but we should be told the things that will help us to care.”*

*“I had no idea where the doctor was trying to guide my daughter. I knew nothing about her medication, the right things to say, or what I should do to help. Or even what I might do that might be damaging.”*

*“My son has a very good GP who rang me when he first saw my son. I gave a background history and he was very sensitive and sensible. I can ring him if I have any problems instead of clogging up the surgery with appointments. He recognised the need for carers to talk, but also dealt with my son very sensitively.”*

### Psychiatrists

3.1.24. While psychiatrists offer considerable help and support, they can sometimes be unaware of the full effect they and their decisions can have on carers and users:

*“Psychiatrists wield an enormous influence and power over their patients. They have access not only to drugs that can influence the state of the patient’s mind, but also to the patient’s privacy and that of his family.”*

*"On a recent visit to my son's consultant psychiatrist, I asked her if she had read my son's notes. Her response was, "Some of them." I then asked her if she was aware that my son had made two serious suicide attempts. Her reply was, "We lose some every year." She then informed me that my son hated her. It occurred to me that my son should have treatment from another professional."*

*"There are one or two psychiatrists that I could praise, but there are several that I couldn't. The latter are those that I've found to be occasionally aloof and patronising. The good ones demonstrate genuine concern, a caring quality and a desire to see the patient improve and get back to normality."*

## Police

3.1.25. Police were on the whole seen as helpful and were praised for the manner in which they perform their duties.

*"On occasion, when my son has gone missing from hospital, I've found the police more helpful, sensitive and informative than any of the professionals who were dealing with his care."*

*"The police gave me a special direct number to contact if I needed to. When my son returned and I informed them, they were as sensitive as possible. They just sent one policeman who was quiet and sensitive and just chatted with my son when he turned up here."*

*"The police have been brilliant. They've been out a few times and have helped with the situation at home very well. They didn't take sides and were very understanding."*

## 3.2. THE EXPERIENCE OF BEING DETAINED

3.2.1. This part of the report is based around quotes from people who have been detained, and their families. As far as possible, the users' and carers' words are again used to convey the emotion expressed. We are very grateful to everyone for sharing these painful experiences, thereby helping to ensure that the new Act is implemented in the most effective and humane way.

### Prevention

3.2.2. People talked about trying to get help when they were first getting ill, and how intervention at this early stage could possibly have prevented compulsory treatment eventually being necessary.

3.2.3. There was a strong feeling that if services were geared to recovery and prevention, fewer people would need to be detained:

*"If society looked at mental health problems differently and didn't stigmatise us, and if there were proper services with a genuine interest in prevention, we wouldn't have to experience such long term effects."*

*"I went to A&E and they treated me perfectly well. They also allowed me to sit in a quiet area and saw me quickly. I was transferred by ambulance...the ambulance man was kind."*

3.2.4. Despite their best efforts, people did not always get the early support they felt they needed:

*"I had gone voluntarily to the emergency team and was willing to stay in hospital and be admitted. It felt strange. I had gone to them and said, "Please take me in until I am well enough to go home again," and instead of just admitting me they Sectioned me."*

*"I said I just wanted to speak to someone and she said, "Well in that case I can't do anything." I was very upset and ended up taking an overdose."*

*"I was told that if I went to the A&E department with an overdose that they would be told not to admit me to the psychiatric hospital or to Section me. It felt like they had completely washed their hands of me, although later they changed their minds."*

*"I was advised to phone social work when I became ill, so I did. It takes a lot to phone but I was told my call was not appropriate – to be dismissed like that feels awful. I felt worthless and it exacerbated my illness. I felt humiliated and rejected."*

### Being detained

3.2.5. In spite of the unpleasantness of being detained, most people agreed that detention could be in their best interests. However, there was concern that the procedures could be used too routinely for those who had been detained before. Sometimes the necessary support to help cope with detention is missing:

*"Some people do need Sectioned. I did, as I was a danger to myself. The doctor could have done it more humanely though and explained what was going on. I felt they were abrupt and dismissive."*

*"Without Sectioning we would be lost – sometimes you can no longer control people who are violent or self-harm. But it can be used frivolously and routinely. Staff use it as a threat to make you do what they want you to do."*

*"Sectioning can be in your best interests if it works. I was ill for seven years and now take olanzapine. If I had got that first, I might not have gone through this."*

*"I feel that I've been criminalised for having poor health and I don't see why I should be locked up."*

*"When I was Sectioned I had this feeling of disbelief that they could do this to me. It was like they went against me and my human rights. I hadn't done anything wrong – how could they take my life and throw it away?"*

*"We all get into states where we need to cry or shout, whether we are ill or not. I feel that sometimes they don't let you go through this, they don't want to take the risk. So if you've been on Section before they're prone to Section you more readily again."*

### Being understood

3.2.6. Although there was general agreement on the need for detentions in the right circumstances, there was also a great deal of resentment that the realities and experiences of those directly affected are not properly acknowledged.

3.2.7. There is a feeling that if people are believed and better understood then services could react more appropriately, and there would be less need for compulsory treatment:

*"I do have problems but not all my experience is meaningless. I want a chance to make sense of my experience rather than to have it dismissed."*

*"I've never denied that I have a mental illness, but there's more to me than that. I'm also a person in my own right."*

*"Conventional psychiatry doesn't acknowledge my reality. Yet Joan of Arc heard voices and she's a saint."*

*"I dress and look different; my clothes are good quality and in good nick but staff interpret this as bizarre behaviour."*

*"They (staff) are a different class of people. Their world is mortgages and bills; my world is where I have had to steal for food. There is no meeting of minds. They don't approve of illegal drugs, but I think they're no worse than alcohol and mild drugs. There's a complete culture clash."*

*"People need help dealing with their circumstances, things like jobs, housing and divorces. People deal with different situations and stresses in different ways, and some of us can't cope with certain situations very well at all."*

*"The over reliance on drugs, treating people as objects and the pre-eminence of the psychiatrist knowing what's best for the patient is wrong. Yes, we do need medication, but equally we need our reality acknowledged."*

*"They often see us as a biomedical problem, as flawed objects. If they looked at us differently they'd see us as people, and know that we need a caring approach, some refuge, sanctuary and security, and people to listen to us."*

## Being supported

3.2.8. Being detained usually occurs at a time of heightened emotion. People may not believe that they are ill, so having their liberty removed can be very harrowing. It is important therefore that the process is carried out as sensitively as possible and that the impact on a person is acknowledged and respected:

*"If you're to be Sectioned it needs to be done with dignity and respect."*

*"I've been Sectioned a lot and usually it's been justified, but sometimes it doesn't feel like it. To be Sectioned, the best practice is if they carry it out with love and warmth. In a sense it keeps you alive, but they can't Section you all the time to keep you alive."*

*"No one explained why I was arrested and I didn't feel I had any human rights. The police pounced on me in the street and forced me down. I had bruises all up my arm. To all intents and purposes I was assaulted."*

*"They said they were "very worried" about my mental health and had to detain me. They didn't seem worried. They seemed part angry, part triumphant. All my protests that I hadn't been climbing out were ignored. They left and I just cried."*

*"I felt I was being treated as a criminal. Why the bouncer? I'm not dangerous! The [general] nurses all lined up in the corridor whispering as they watched me being led away. It was so humiliating."*

*"When I was Sectioned the doctor visited and agreed I needed treatment, so the police were called. I was handcuffed and injected. It was demeaning and insulting."*

*"Being in hospital can make you feel very safe and secure, but being Sectioned can make you feel unsafe and controlled, and make you want to leave. In my case, when the Section was lifted and I had more freedom I wanted to stay."*

*"When I first had a breakdown at 17 or 18, I remember lying in my bed in hospital and seeing a bright light for the first time in my life. I felt I was being looked after – it was great, but it was also a critical moment."*

3.2.9. Most of the time other service users can be the main support, but sometimes the actions of other patients can be very unhelpful:

*"You need peace and quiet and room to sit in a peaceful atmosphere, but you can't get this because other patients can be very disturbing."*

*"We're often admitted because we've faced the worst that life has thrown at us and yet instead of safety and peace we're faced with the extremes of other people's behaviour. We're expected to put up with any form of behaviour from other people in the hospital."*

3.2.10. Similarly many staff are very helpful, although the actions and opinions of others can be hard to cope with:

*"My key worker was good and agreed to an appointment where I would have enough time to ask the questions that I needed to ask about the Section, which was good."*

*"My key nurse was really good; he listened and respected my wishes, responded to me and did what I asked."*

*"Nurses can be a law unto themselves; we need to screen nurses – some of them are unsavoury personalities. We need them to treat us properly, not just as inmates."*

*"It's no use, you can't speak to them, you don't even want to speak to them. They sit in the office and text and gossip or watch TV, but they don't deal with the patients. However, some of them are excellent. They speak with you, they notice you and how you are, whether they're your allocated nurse or not."*

*"The doctor gave me the strong impression that I was wasting her time. She wasn't interested in what was going on or how I felt."*

*"My consultant is very good. He's very honest and has respect for us, but isn't frightened to speak his mind. He doesn't treat you like dirt or fob you off."*

*"At one stage I was lying on the ground because I was so distressed and sad. All the staff did was walk over me in the corridor."*

3.2.11. Users who have been detained sometimes feel that staff make sweeping judgments about their abilities to think rationally and about how they want to live on the ward:

*"When I was in hospital I felt that I was fully capable of making everyday decisions, yet decisions were routinely taken out of my hands. Changes in medication weren't explained to me, I was just confronted with them. Staff made comments that made me feel I had no control. For instance, if I wanted to go out for a walk they might say, it's raining—it wouldn't be a good idea, or it's getting late—don't you think you should go to bed?"*

## Restraint

3.2.12. In some cases, restraint may be necessary, but the way in which restraint procedures are carried out can be crucial to the user's feelings about their treatment:

*"I was protesting and was pinned down and jagged up."*

*"Sometimes restraint seems excessive. Once I was held to the ground by six male staff and I was so scared I wet myself. We do occasionally need restrained, but it shouldn't always be by men and shouldn't be an over-reaction."*

*“Different staff react to crises in different ways. For some, a standard response is to jag me up straight away, while others take time to talk to me and calm me down. Others sit me down to listen to music to settle me.”*

*“When there’s a problem the staff always seem to assume that I’m the cause of it – perhaps they should take the time to find out what’s happening before they come to drag me off.”*

*“Can you imagine the terror this [forcible injection] awakens in a person who’s been sexually assaulted in the past? By far the majority of forcible injections I’ve witnessed—and all that I’ve been subjected to myself—could have been avoided by the nurses showing patience, and trying to de-escalate the situation with a bit of calmness and common sense.”*

## Medication

3.2.13. Although most people generally agreed with the need for medication they were not in favour of over-reliance. They believed there should be alternatives and that patients should have more control over their care regime:

*“I said that I would go to my room and behave quietly and wanted to just take tablets. But at the ward round they forced me to have depot. I hadn’t refused medication, I had asked for alternatives.”*

*“I do need to take my medication now, even just as a common courtesy to the community. I need medication if I’m to get well and avoid distressing others.”*

*“Mental illness can make life interesting. It was far more interesting when I was ill – it was a world of excitement – medication has put me back into the drudgery of life.”*

*“They use drugs, not just to help with symptoms but to stop the way you’re behaving, without sitting down to discuss what’s happening.”*

*“Some people get so doped up they can’t think properly. They can be so out of it that they can’t do anything. It’s like their life has been taken away from them.”*

*“Most psychiatrists would never put up with the effects I’ve had to live with throughout my adult life—severe weight gain, lack of libido, incontinence, dry mouth, headaches, sweats, palpitations, chronic fatigue, dribbling, shuffling legs and feet. And psychosis.”*

## Women

3.2.14. Women who are detained and in an Intensive Psychiatric Care Unit can feel particularly vulnerable. This may be because they are among a predominantly male patient group and, as mentioned before, because of the actions of other patients:

*"The staff have been brilliant in the IPCU. Yet I've been there with staff on either side of me and still been punched in the face by a fellow patient, even though I'm meant to be there for my own protection. I've also woken in my room to find a naked man staring at me."*

## Representation and complaints

3.2.15. Users felt that advocacy and other representations were very important, but had doubts about the performance of the Mental Welfare Commission and whether their complaints were dealt with appropriately:

### a) The Mental Welfare Commission:

*"There should be an alternative to the Mental Welfare Commission that has power and is on our side. We need something that's user friendly. It shouldn't be a collection of people from the same class and background as the doctor who put people on section. They shouldn't be the sort of people who go round to dinner with each other."*

### b) Complaints:

*"As soon as they knew that I'd made a complaint they stopped calling me by my first name and started calling me by my second name."*

*"It feels dreadful when people in power turn against you. It should be easy for a well trained professional to avoid their personal feelings towards you overpowering their professional conduct."*

### c) Advocacy:

*"Make an advocate available as a matter of course. Make them come and see you to see if you want their help. They're needed both when you're ill and when you're a bit better."*

*"They often say that people can speak up for themselves so they don't need advocates, but equally they often don't listen when we speak."*

## The aftermath

3.2.16. Serious mental illness and the experience of detention can have a devastating effect on people, leaving them feeling bitter. Some may feel forced into a routine from which they see no escape:

*"It's like you lose trust with others and they don't trust you. Your opinions are no longer valid. You feel outcast."*

*"You fall into feeling that you're a reject. Even if you had a real life before, the real life doesn't seem important to them, so how do you get back to your real life? This is not real life. We're not participating in life. You're put on one side and don't feel that you're a participant anymore because you've been Sectioned and neglected."*

*"The routine chores, children, work that keeps you busy... in our world people don't work and the simple things stop that used to take up your time. This lack of things to do removes you from life."*

*"It may be good to have a car but I have no reason to drive it anywhere."*

*"It's pointless having a phone as I don't need one. No one would call anyway."*

3.2.17. We discussed what might be done to help:

*"We could get more help in practical coping skills from OTs, psychologists, social or childcare services and so on. Doctors should be somewhere right down the hierarchy and should just deal with the symptoms of illness."*

*"Find out what we want out of our lives before you start anything. It could be a whole range of things. For some of us it may be having a job to go back to, or an altered working environment, or maybe the chance to do something different. Whatever we do it has to feel worthwhile, but at present it feels too far off."*

*"I feel that I've now earned the right to suffer in silence. I don't want people poking about in my life."*

*"A lot of what works for us is very ordinary; it's being around people who care for us."*

*"I was promised support at home five days a week. I only got three days but it's good, especially the support in the evenings which is very good."*

*"Supported accommodation is a good place. It's a place to sleep, to have a bed... it's a lot better than hospital."*

*"People have helped me believe in myself. Sometimes they've helped me when I've needed to be in hospital, but they've also helped me with independence and the knowledge that I can live out of hospital with help if needed."*

*"It's like good parenting that many of us never had. They need to help you move on happily with support and the knowledge that they're still there for you. The balance between support and protection is a very, very difficult one to achieve safely."*

3.2.18. These comments stand alone to demonstrate how important the principles behind the new Act are - and perhaps they also show how difficult it will be to meet them.

# **national mental health services assessment final report**

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different mental health services for different people

## 4. DIFFERENT MENTAL HEALTH SERVICES FOR DIFFERENT PEOPLE

### 4.1. SERVICES FOR MOTHERS AND BABIES

4.1.1. Section 24 of the new legislation includes provisions to improve the hospital care and surroundings of mothers admitted with a mental illness around the time of childbirth (perinatal mental illness, including postnatal depression) and, specifically, to allow mothers to be admitted to hospital with their child when appropriate. The exact provisions within the legislation are as follows:

- (1) *A Health Board shall provide for any woman who:*
  - a) *is the mother or adoptive mother of a child less than one year old*
  - b) *cares for the child*
  - c) *is not likely to endanger the health or welfare of the child*
  - d) *has been admitted to hospital, whether voluntarily or not, for the purposes of receiving treatment for postnatal depression. Such services and accommodation as are necessary to ensure that the woman is able, if she wishes, to care for the child in hospital*
  
- (2) *Each Health Board shall collaborate with other Health Boards to whatever extent is necessary to fulfil its duty under subsection (1) above.*

#### Current work

4.1.2. The Review Team welcomed the appointment of a Short Life Working Group which, since May 2003, has been working to produce outline guidance to help inform the preparation and planning processes required by agencies to comply with these new provisions, and through that process contribute to the successful implementation by April 2005.

4.1.3. The guidance will anticipate what will be needed in terms of care, quality standards and accommodation to comply with the legislation and will serve as an agency planning and audit tool for this important service.

4.1.4. The Short Life Working Group has reached an advanced stage in its considerations and the planned guidance is expected to be published in March 2004.

## Current and planned services

4.1.5. NHS Greater Glasgow is advanced in the preparation of their perinatal mental health accommodation and service. It is planned that this will be operational from May or June 2004. Other NHS Boards are/will be considering their own responses to the new statutory requirement, whether through area provision or within a consortia arrangement with partner agencies to provide a regional service. Once published, the guidance will help the associated planning, implementation and ongoing quality monitoring processes.

4.1.6. In terms of the overall organisation of provision it is for NHS Boards, in consultation with their partner agencies, to consider how best to respond to the assessed and anticipated needs of their area(s). This will involve discussions on whether a regional or local provision and service support is the more appropriate in each case. These considerations will include bed numbers, length of stay trends shown elsewhere with estimates translated to the Scotland population. The Royal College of Psychiatrists<sup>7</sup> suggests that around 30 beds will be needed in Scotland.

4.1.7. Beds and accommodation are only part of the overall joint care and support needed for the mothers and babies, and of course for their partners and wider families, which will be reflected in the coming guidance. This *whole person and family* approach should include support and interventions from early screening, through inpatient stay in both maternity and the planned new dedicated units, discharge planning, continuing care arrangements and ongoing follow up and support. The range of agencies and inputs that may be involved will include among others, health (including primary care and the role of the health visitor in addition to specialist mental health services), social services, housing, child services, justice, the voluntary sector, advocacy, transport and the Scottish Ambulance Service. Effective co-ordination between all these services will be essential.

## 4.2. SERVICES FOR CHILDREN AND ADOLESCENTS

4.2.1. A review of child and adolescent mental health child has already been undertaken through the Scottish Needs Assessment Programme (SNAP)<sup>8</sup>. The report, published in March 2003, provides a comprehensive assessment of the mental health needs of children and young people in Scotland and what action is needed to strengthen support for them throughout childhood and adolescence.

Almost 25% of Scotland's population is under 18 years old and 9.5% of younger people (around 100,000) have mental health problems that are severe enough to affect their daily lives<sup>9</sup>. Many become involved with specialist mental health agencies, and a small number require residential care. Recent years have seen more effective use of community services and day treatment programmes for this important care group.

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<sup>7</sup> Oats, M, *Perinatal maternal mental health services Council Report: CR88*, London, Royal College of Psychiatrists, 2000

<sup>8</sup> Public Health Institute of Scotland, *Needs Assessment Report on Child and Adolescent Mental Health*, 2003

<sup>9</sup> Meltzer H, Gatward R, Goodman R, Ford T, *Mental health of children and adolescents in Great Britain*, The Stationary Office, Office of National Statistics, London, 2000

4.2.2. Section 23 of the new Act will introduce from April 2005 and, for the first time, specific responsibilities on NHS Boards in relation to those under age 18, whether they are being treated on a compulsory or voluntary basis.

4.2.3. The exact provisions in the new legislation are as follows:

- (1) *A Health Board shall provide for any child or young person who:*
- a) *is detained in hospital under Part 5 or 6 of this Act;*
  - b) *has been admitted to hospital, whether voluntarily or not, for the purposes of receiving treatment for a mental disorder, such services and accommodation as are sufficient for the particular needs of that child or young person.*

4.2.4. In this section "*child or young person*" means a person under the age of 18 years.

### Current services

4.2.5. A number of themes emerged from the 2002-03 Performance Assessment Framework exercise undertaken with NHS Boards. It is clear that current child and adolescent psychiatric service capacity is insufficient to meet existing need. Most NHS areas reported significant waiting times for children and adolescents, particularly for young people with a learning disability who have mental health problems. A key contributory factor is difficulty with recruitment and retention of key skilled staff and the funding of specialist training. Significant investment has been made in some parts of the country to address these issues, while elsewhere services remain under developed.

4.2.6. Most areas and services accept child and adolescent referrals from a variety of sources including: educational psychologists; social workers; GPs and health visitors. The services provided are multidisciplinary and multi-agency so that younger people's global needs can be addressed, including their needs for education and family contact. Outpatient clinics are well established throughout the country and are provided from a number of bases in the larger NHS Board areas, with the island NHS boards receiving added visiting support service from the Scottish mainland. Outpatient and community services form the backdrop of the service.

### Inpatient provision

4.2.7. Compared to 127 in 1994, there are currently 44 NHS beds in dedicated units for children (9) and adolescents (35). Inpatient services are provided in Glasgow, Edinburgh and Dundee and are accessed by other NHS Boards across Scotland. An increase to 24 adolescent beds is planned in Glasgow. However, access to psychiatric beds for children and adolescents will continue to be limited, with emergency admissions likely to remain a particular problem, especially for NHS Boards who rely on out of area provision.

4.2.8. In some places, for example the West of Scotland, formal arrangements exist between NHS Boards for the commissioning of inpatient beds. However,

commissioning arrangements across Scotland are neither consistent nor stable and together with staff recruitment and retention difficulties, this means that the current level of inpatient provision is insecure.

4.2.9. The SNAP report<sup>8</sup> on child and adolescent mental health highlighted the need for investment in and expansion of residential or hospital beds for children and young people with severe mental health difficulties. The report also noted that it is not appropriate to locate those beds in wards designed for adults unless specific arrangements have been made to adapt that environment and provide appropriate care to meet young people's needs. The SNAP review found that this could not be said of the majority of adolescent admissions to adult wards.

4.2.10. Effective assessment will always be crucial to ensure appropriate placement. Some children are admitted to paediatric wards for assessment and treatment and sometimes adolescents go to adult wards. This may lead to some difficulty given the different needs of younger people. A 3 year study<sup>9</sup> in central Scotland of early onset psychotic illness in people between 5 to 18 years old found that most were admitted to psychiatric units and 80% of the young people were first admitted to adult wards. Most NHS Boards appear to have a protocol for care for such situations.

4.2.11. The Mental Welfare Commission for Scotland<sup>10</sup> found that of the 127 young people under 18 years old compulsorily detained under the 1984 Act, only 1 in 4 was cared for in an adolescent unit. In 2002 the Commission requested that they be informed routinely when an adolescent is admitted to an adult bed (even if a voluntary admission), but only 3 NHS Boards indicated that they complied. When the new Act is implemented this will have to be monitored systematically.

4.2.12. Establishing a national multidisciplinary outreach service would be valuable. This would provide consistent and comprehensive assessment and treatment in community settings, including local authority secure units.

### Current work

4.2.13. The Scottish Executive's Child Health Support Group (which draws on the expertise of colleagues from NHSScotland, education, social work and the voluntary sector) has established a Child and Adolescent Mental Health Development Group to promote development in child and adolescent public mental health and support a strategic approach to development of specialist child and adolescent mental health services in Scotland. The major focus of the Group's work is to support implementation of the recommendations made in the SNAP report<sup>8</sup> on child and adolescent mental health. The Review Team welcomes this focus and, in particular, the work now underway to develop a "template" for child and adolescent mental health services, expanding on the Child Health Support Group Template for Child Health Services<sup>11</sup>. The template will set out the essential components of a comprehensive CAMH service and will serve as an important agency planning and audit tool. The template is being developed in consultation with service-users and multi-agency staff and is expected to be launched later this year.

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<sup>10</sup> Mental Welfare Commission for Scotland Annual Report 2002-03

<sup>11</sup> Scottish Executive Child Health Support Group, *A Template for Child Health Services Within Unified NHS Board Areas*, 2001

4.2.14. The Child Health Support Group has also established a separate focus group to consider a strategic approach to commissioning psychiatric inpatient services for children and young people, expected to report with recommendations in 2004. NHS Boards and Regional Planning Groups will need to consider these recommendations carefully in the context of the new duties under section 23 of the Act.

### 4.3. SERVICES FOR OLDER PEOPLE

4.3.1. There are 804,900 people aged 65 and over in Scotland, 20% of all adults<sup>12</sup>. While the Mental Health (Care and Treatment) (Scotland) Act 2003 does not specifically refer to services for older people, age is one of the features that must be taken into account to avoid discrimination and prejudice<sup>13</sup>. As well as this new Act, the Adults with Incapacity (Scotland) Act 2000 will continue to have a significant role in the care of older people. Figures from the Office of the Public Guardian show the vast majority of applications for both Intervention and Guardianship Orders to be for people over 60.<sup>14</sup>

4.3.2. Robust inter-agency working is a crucial requirement for older people and must involve general medical services, old age psychiatry, social work services, housing and benefits agencies and the voluntary sector. Carers need full support and may be elderly themselves.

#### Mental Health (Scotland) Act 1984

4.3.3. The number of older people subject to detention under current legislation is broadly in the same proportion as for adults. In August 2003, 357 older people were detained under Section 18<sup>15</sup>.

4.3.4. Sometimes older people with dementia may be subject to what is termed 'de-facto detention' when wards are sometimes locked and the Mental Welfare Commission has repeatedly expressed concerns about this. This situation is addressed in Section 291 of the new Act which allows for applications to Tribunals in relation to 'unlawful detention'.

#### Provision

4.3.5. As community based services have developed, the number of Old Age Psychiatry staffed beds in Scotland has reduced from 6,000 beds in 1991 to about 3,500 in 2003<sup>16</sup>. There is considerable local variation, ranging between 217 and 648 beds per 100,000 in different parts of Scotland. The change in NHS bed numbers must be considered alongside the expanding care home sector although there is little correlation at a local level between the number of hospital beds and the number of care home places.

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<sup>12</sup> 2001 Census, General Register Office for Scotland

<sup>13</sup> Mental Health (Care and Treatment) (Scotland) Act 2003, Section 1 (3) (h)

<sup>14</sup> Office of the Public Guardian 2003; [www.publicguardian-scotland.gov.uk](http://www.publicguardian-scotland.gov.uk)

<sup>15</sup> Mental Welfare Commission

<sup>16</sup> ISD Scotland, *Mental Health in Scotland: Information Sources and Selected Insights*, 2002

4.3.6. Nationally, there has been an increase in care home beds of over 7% since 1995. The rise is in nursing home beds, the number of residential home places having actually reduced (the services are no longer separate, becoming generic 'care homes' in 2003). In the last 7 years there has been an increase of 3,060 care home places, despite only 2,500 hospital beds being closed over the last twelve years. The system is complex and many other variables influenced the rise in nursing home places, including the changing pattern of services for frail older people and the increasing proportion of older people in the population. It is possible that the rate of rise will slow down when the balance between hospital and community places becomes stabilised.

4.3.7. Last year 52% of the 7,051 older people discharged from NHS Old Age Psychiatry inpatient services (both acute and continuing care) were able to return home; 14% transferred elsewhere in the NHS; 22% moved into care homes; and sadly the remaining 12% died<sup>16</sup>.

4.3.8. The introduction of *National Care Standards* and the phased extension of service inspections carried out by staff of the *Scottish Commission for the Regulation of Care* will regulate services for older people living in care homes. Early indications from the Care Commission<sup>17</sup> suggest that while care homes are relatively small in number, they generate more complaints than other services. More work needs to be done before firm conclusions can be drawn, but among the issues identified is the difficulty in recruiting and retaining good quality trained staff and support workers.

4.3.9. The number of significant changes aimed at improving the delivery of care has put pressure on many people, users and carers as well as staff and managers. This includes not only the major transition from hospital to community care, but also the introduction of the Adults With Incapacity Act and the Joint Future agenda, including the single shared assessment policy. Impending organisational change will put further stress on the service. At a time of such flux it is important to support staff in the task of ensuring an optimal quality of life for older people with mental health problems.

4.3.10. Services for older people are predominantly geared towards dementia or physical frailty. There are 57,000 people in Scotland with dementia and this is expected to increase to 192,000 by 2040 given the demographic changes<sup>18</sup>. Early assessment and diagnosis, the establishment of memory clinics, and a range of treatment and care options, are essential.

4.3.11. To comply with the new Act, more robust assessment and follow up procedures must be created to address the needs of older people with severe and enduring mental illness and those with a late onset of illness. Such protocols should consider needs before age, and incorporate the needs of any carer or supporter.

4.3.12. Provision of services for older people must continue to include the statutory voluntary and private sectors. Each has a significant role to play.

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<sup>17</sup> [www.carecommission.com](http://www.carecommission.com)

<sup>18</sup> Dementia Services Development Centre, *Dementia and Older People*, Stirling University, 2003

### Community teams

4.3.13. Three broad models of Community Mental Health Teams (CMHT) exist for Old Age Psychiatry:

- **Fully integrated** - with joint funding, care budget availability and joint management. Links with primary care will be clear and may include the GP as a team member
- **Health led, dual-agency** - co-located with local authority staff
- **Health multidisciplinary** - health staffing only, with social work services provided through liaison (the most common arrangement seen).

4.3.14. A challenge for all is to ensure appropriate collaboration for the benefit of users and carers.

### Single shared assessment

4.3.15. Nationally, progress toward Single shared assessment for older people (a Joint Future initiative) remains patchy and incomplete. This needs to be addressed, especially given the planned extension of these arrangements to mental health generally (from April 2004) in order to support successful implementation of the new legislation.

### Care pathways

4.3.16. Some areas have adopted care pathway approaches for their dementia services, some based on models developed by Alzheimer Scotland – Action on Dementia.<sup>19</sup> The Dementia Services Development Centre has also traced a patient journey and care pathway.<sup>20</sup> That guidance places Primary Care and Acute Services in the vanguard of provision for early diagnosis and recognition and appropriate treatment of people with dementia in general hospitals. Similar pathways need to be developed for older people with other mental health problems. The Review Team welcomes the attention being given to dementia services by SIGN (Scottish Intercollegiate Guidance Network) and it was interesting to hear from the platform at the 2 February SIGN event that "...sometimes, more important than *who does what*, is of course, *what is done*."

### Transitions

4.3.17. Older people in psychiatric hospitals are more likely to experience delays in their discharge arrangements: 64% of discharges delayed for 13 weeks or more were for older people.<sup>21</sup> Lack of finance and continuing care complexity are contributing factors.

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<sup>19</sup> Alzheimer Scotland Action on Dementia, *Planning Signposts for Dementia Care Services*, 2000

<sup>20</sup> Dementia Services Development Centre, *Dementia and Older People*, Stirling University, 2003

<sup>21</sup> ISD Scotland, *April 2003 survey*, 2003

4.3.18. While informal arrangements exist, no examples were seen across Scotland of protocols to manage the care of people who enter old age with an enduring mental illness. Good practice dictates early, planned transitions, which take account of age and needs for all people, at all times.

4.3.19. Those with an enduring mental disorder who are graduating from 'adult' to 'older people' services can sometimes experience a reduction in support choices given that some support projects restrict services to the under 65 age group. Continuity of support is important and the transition needs to be carefully managed. In some small rural or island settings, services are generic and offer continuity of support.

### Advocacy

4.3.20. The advocacy services' map for 2003/04<sup>22</sup> shows a lack of provision for both older people and for all people with dementia. Age restrictions arise again with some projects limiting provision to those aged 18-65. There are few services specifically for older people.

## 4.4. SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

4.4.1. It is estimated that there are around 120,000 people in Scotland who have a learning disability. About 20 people in every thousand have a mild to moderate learning disability and 3-4 in every thousand have a severe or profound disability.

4.4.2. A detailed Learning Disability Needs Assessment Report is due to be published in spring 2004 which will provide information on the needs of children and adults with learning disabilities in Scotland. Studies elsewhere point to:

- a cumulative annual increase of about 1% in the prevalence of people with learning disabilities over the past 35 years, with this trend continuing over the next 10 years<sup>23</sup>
- an increasing number of older people with learning disabilities
- people moving away from home in order to receive treatment
- hospital closure programmes leading to some parts of the country having significantly higher numbers of people with learning disabilities than would be expected, although these trends have not necessarily informed service development and investment

4.4.3. People with learning disability have a high prevalence of mental illness at all ages. Children and young people with learning disabilities have a 30% to 40% risk of experiencing mental ill health and the prevalence of mental illness is higher amongst adults with learning disabilities than among the general population (an estimated 40-50%). Psychiatric morbidity is found in 62% of adults over the age of 65 and there is also a significantly higher number of people with Downs Syndrome

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<sup>22</sup> *A Map of Independent Advocacy across Scotland, Edition 2003-04*, Advocacy Safeguards Agency

<sup>23</sup> McCrother, C; Thorp, C; Taub, N; Machado; *Prevalence, disability and needs in adults with severe learning disability*, Tizard Learning Disability Review 6, 4-13; 2001

who suffer early onset dementia as opposed to the general population. Between 10% and 40% of people with learning disabilities display problem behaviour.<sup>23</sup>

### Mental Health (Scotland) Act 1984

4.4.4. *The same as you?*<sup>5</sup> reported that a small number of people with learning disabilities were detained under the current procedures. Around half were detained on the basis of having a learning disability plus a co-existing mental illness, and half on the grounds of mental impairment or severe mental impairment. Of this group:

- most people were on a Section 18 order, with very few short term detentions
- very few request a review of their detention (two in the last year)
- very few appeal to the Sheriff
- the use of the detention procedures varies significantly across Scotland, raising questions about the criteria used for detention

4.4.5. In addition there are around 30 people with a learning disability detained in The State Hospital under current civil and criminal orders.

### Policy context

4.4.6. *The same as you?* set the national policy framework for health and social care services for learning disabilities in Scotland. During 2003-04, *The same as you?* Implementation Group, (SAYIG) will consider services for children, advocacy and day care. A 2003 report<sup>24</sup> on hospital closure and community based reprovion suggests four beds per 100,000 population are needed for assessment and treatment for people with mental health needs, offending behaviour or challenging behaviour. The Review Team was told that better long-term outcomes are achieved with individual support plans in community settings. A robust community infrastructure is essential.

### Other developments

4.4.7. There are a number of initiatives being taken forward, including:

- The Association of Directors of Social Work sub-group, looking at the needs of individuals who offend and those with challenging behaviour.
- A managed clinical/care network (MCN) has been established for the NHS Board areas of Forth Valley, Lothian, Borders and Fife to focus on the needs of people with very severe challenging behaviour, autistic spectrum disorder and offenders.

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<sup>24</sup> Scottish Executive Health Department, *Home at last? A Report of the hospital closure service reprovion group*, 2003

- The *Right Place; The Right Time*<sup>25</sup> recommends the establishment of a national managed care network for mentally disordered offenders. Linked to this, a network across Northern Ireland and Scotland is being established to focus on the needs of people with learning disabilities/intellectual disabilities who offend.
- A survey of people with learning disabilities in prisons and secure settings is underway, commissioned by the Scottish Executive in the context of *The same as you?*<sup>5</sup> recommendations.

### Progress with hospital closure across Scotland

4.4.8. There has been a major reduction in learning disability beds from over 7,000 in 1980 to 1,000 in 2002, and all long stay hospitals are scheduled to close by 2005. A small number of people have been identified as requiring NHS continuing care, but this varies across the country. People with similar assessed needs may be considered for continuing care in one area but not in another. 652 people in long stay beds are to be discharged to alternative suitable care and support, when available, excluding those in forensic and assessment beds. The majority will be discharged during 2004. Within these numbers are 89 in out-of-area NHS hospitals or other NHS funded services, awaiting transfer, including specialist assessment/treatment, long stay and forensic services. Their particular needs will have to be taken into account in any future service/location change.

4.4.9. There is very limited provision for mental health services for children and young people with learning disabilities.

4.4.10. In the context of hospital closure, people with learning disabilities are now more likely to be admitted to adult psychiatric wards, although all areas have retained, or are developing, some assessment and treatment inpatient learning disability services. Difficulties are often experienced by people with learning disabilities in acute psychiatric wards, and in most places there is no agreed protocol or joint working between mental health and learning disability services.

### Mental Health (Care and Treatment) (Scotland) Act 2003

#### Tribunals

4.4.11. Extra demands on staff are anticipated from the new provisions and staffing shortages in all professions give rise to concern. The shortage of consultants in the psychiatry of learning disability will lead to added pressure. There are 28 in post compared to the 50 recommended by the Royal College of Psychiatrists.

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<sup>25</sup> Scottish Executive Health Department, *The Right Place, The Right Time: A review of the governance and accountability of The State Hospitals Board for Scotland*, 2002

4.4.12. There is a need to increase access to independent advocacy, with access to information in appropriate formats and better support for communication.

Independent advocacy is probably already best developed in the area of learning disabilities. It is available, to some extent, in all learning disability hospitals and there have been developments supported partly by the Change Fund Initiative. However, the continuity of advocacy provision for people leaving hospital and for those already in the community is an issue needing attention.

4.4.13. Tribunals may have to consider using technology such as videos and providing information on interactive CD-ROMs in order to assist and support people with learning disabilities. The Scottish Consortium for Learning Disabilities (SCLD) and others could assist with the development of suitable information.

### Care/Treatment Plans

4.4.14. Preparation of advance statements and the preparation of accessible information will need specialist support. The provision of age appropriate facilities for children and young people with learning disabilities and the care to be attached to transitions are especially important for this care group.

4.4.15. With regard to offences (Section 311/319) there is a need to integrate the development of relevant policies (in the context of wider vulnerable adult policies) across health, local authority and criminal justice services, along with the provision of appropriate guidance and training.

4.4.16. Appeals against conditions of excessive security will be available to people with learning disability as well as other forms of mental disorder and this must be borne in mind especially in the development of regional forensic psychiatry units.

## 4.5. MENTALLY DISORDERED OFFENDERS (FORENSIC SERVICES)

4.5.1. Mental health forensic services have two complementary objectives, to ensure safe, fit for purpose services, care, support and accommodation that meets the assessed needs of mentally ill people who have been involved with the criminal justice system, at the same time as promoting staff, patient and public safety.

4.5.2. The 1999 policy statement on services for mentally disordered offenders<sup>26</sup> set out proposals for the organisation of safe care and accommodation, supported by joint working between all the relevant agencies. A care pathway document (2001)<sup>27</sup> provided a planning and audit tool on which to base service design or measure progress toward the overall objectives.

4.5.3. The policy includes the development of forensic psychiatric units and services with a level of security that used to be called 'medium secure', although the term most commonly used now refers instead to the site of the service e.g. 'local forensic psychiatry units' or 'regional forensic psychiatry units'. To date, the Orchard Clinic in Edinburgh, established in January 2001, is the only fully operational unit.

<sup>26</sup> Scottish Executive Health Department, *Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland*, 1999

<sup>27</sup> Scottish Executive Health Department, *Services, Care, Support and Accommodation for Mentally Disordered Offenders in Scotland: Care Pathway Document*, 2001

## Background

4.5.4. As of July 2003, the majority of people in forensic inpatient facilities were liable to detention either under the Mental Health (Scotland) Act 1984, or the Criminal Procedure (Scotland) Act 1995.

4.5.5. This report focuses primarily on services currently led by consultant forensic psychiatrists for adults between 18 and 65 with a mental illness. This includes multidisciplinary assessment and treatment of people who have severe and enduring mental illness, including schizophrenia and affective disorders. Substance misuse and a history suggestive of personality disorder are common co-morbid disorders. At present there is no service in Scotland designed specifically for patients with a primary diagnosis of personality disorder.

## Mapping services

4.5.6. Conventionally, forensic services are seen as a pyramid providing inpatient and outpatient services across the range of security. The service in Scotland has The State Hospital at the top of the pyramid, then forensic psychiatric units and services (of which the Orchard Clinic is the first), then local units (low security) and finally community services and accommodation.

4.5.7. The provisions of the new Act will allow appeals against the level of security in which the patient is held, coming into force in 2006. The development of more forensic psychiatric accommodation and services will offer a range of options, help prevent inappropriate admissions to The State Hospital and facilitate speedier discharges.

4.5.8. A national review of forensic provision was commissioned by the Scottish Executive in October 2000 and informed policy thinking but there is no current national needs assessment for forensic patients.

4.5.9. Hospital accommodation alone will not deliver the safety, quality and ongoing holistic care required. This is described by MacCullough and Bailey<sup>28</sup> as a "continuum of care which commences in maximum security and ends with patients living in the community where possible". Forensic day hospitals, assertive follow up by joint agency community forensic teams and the provision of a wide range of accommodation helps avoid facilities and services becoming "blocked".

4.5.10. Forensic services also provide inpatient assessment and treatment and some longer stay care for people with learning disabilities who show offending behaviour. Specialist secure inpatient services for people with learning disabilities are provided at The State Hospital, Carstairs. Of the 30 people with a learning disability at The State Hospital, 11 are currently ready to leave, but whose discharge is delayed because there are no services locally to meet their needs, apart from the Dykebar Learning Disability Close Supervision Unit in Paisley.

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<sup>28</sup> MacCulloch M and Bailey J, *Issues in the management and rehabilitation of maximum secure hospital patients*. J. For. Psych 4: 25- 44, 1993

4.5.11. There is limited experience in Scotland about the potential role of secure services within the full spectrum of care. The recent development of a National Forensic Care Network will enable clearer criteria to be produced for determining the need for high secure services, forensic psychiatric units and services, or for low secure facilities. The criteria must be sufficiently broad to embrace reasonable clinical judgement, but within parameters that are sufficiently tight to minimise clinical disputes, and inappropriate placements. A system of resolving conflict where it exists is important.

4.5.12. The issue of security placement depends, in part, on a robust assessment of risk. There appears to be a significant gap in the provision of risk assessment training, except at the highest levels of security. The main instrument used is the HCR20<sup>29</sup>, in full or in part. Risk assessment training is important and it is possible that the risk management authority proposed by the MacLean Committee<sup>30</sup> will provide advice on the approval of risk assessors and their training.

### The State Hospital

4.5.13. The State Hospital (240 beds) provides conditions of special security for both Scotland and Northern Ireland. It provides a separate ward for women and a dedicated unit for patients with learning disability.

4.5.14. In 1997 a survey<sup>31</sup> of the diagnostic and detention characteristics of the patient population concluded that significant numbers of The State Hospital population at that time could be managed in a less secure environment were the option available. This remains the opinion of psychiatrists at The State Hospital today.

4.5.15. An assessment of the numbers within The State Hospital population who could be transferred safely to care in lower secure surroundings suggests a need for between 126 and 256 forensic psychiatric beds. These figures cover the needs for Scotland and Northern Ireland and require adjustment for the Scotland only population. The existing and the planned additional facilities to follow the Orchard Clinic in 3 other areas of Scotland will go some way to address this need, but these are unlikely all to be available by 2006 when the right to appeal against the level of security comes into operation.

### Regional forensic psychiatric accommodation and services

4.5.16. The Orchard Clinic accepts people for assessment or treatment of mental disorder who require medium levels of security. This does not include people with a primary diagnosis of learning disability, personality disorder or sexual disorder. It is a supra-regional service and of the 126 admissions since opening, 11 have been out of area transfers from NHS Boards outwith the South-East consortium. There is a high number of admissions for assessment, reflecting the policy of admitting all Section 52 committals (remand to hospital before trial) from Lothian to the Orchard Clinic. The average length of stay is less than one year, with only a small number

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<sup>29</sup> Webster CD, Douglas KS et al, *HCR-20 assessing risk for violence (Version 2) Mental Health, Law and Policy Institute, Simon Fraser University, Vancouver, 1995*

<sup>30</sup> Lord MacLean, *Report of the Committee on Serious Violent and Sexual Offenders*, June 2000

<sup>31</sup> Thomson L, Bogue J et al, *The State Hospital Survey; a description of patients in conditions of special security in Scotland*. J. For Psych 8: 263-284, 1997

staying more than 2 years. Experience in England suggests that the population varies from site to site in forensic psychiatric units and services, but is evolving towards an increased length of inpatient stay. Low secure services, supported accommodation that meets the needs of this client group and a wide range of community supports are essential to enable people to be discharged safely and appropriately.

### Local inpatient forensic services

4.5.17. Although further forensic psychiatric units and services still need to be developed, nationally there are 131 low secure beds (122 occupied at the time of the review, including 8 women patients) in designated adult forensic services. Length of stay varies significantly, the average being around 18 months.

### Intensive Psychiatric Care Units (IPCUs)

4.5.18. These units are discussed elsewhere in this Chapter. IPCUs tend to provide forensic services in the absence of local alternatives.

### Community services

4.5.19. As at 2003 there are only 2 dedicated forensic day care facilities in Scotland (Tayside and Greater Glasgow, a total of 46 places). Forensic day hospitals provide a useful aid to discharge from a low secure inpatient service and offer important transitional support for people moving from inpatient care to community support, as in Tayside, where patients with complex needs are managed safely in the community.

### Nurse-staffed accommodation

4.5.20. A range of accommodation for discharged mentally disordered offenders exists, principally tenancies in mainstream accommodation or supported accommodation, usually from a voluntary sector provider. The latter tend to be generic providers and vary in their expertise in managing mentally disordered offenders. Designated nurse-staffed accommodation is only available in Grampian (8 places), which accepts detained patients. Wider availability of appropriate supported accommodation will contribute to the speed with which patients can be safely discharged from hospital care. There are particular problems in securing accommodation for people who have sexually offended.

### Community forensic teams

4.5.21. There are community forensic teams in Greater Glasgow, Ayrshire and Arran, Argyll and Clyde, Forth Valley, Lanarkshire and Grampian. One community psychiatric nurse (CPN) is attached to the Orchard Clinic service. CPNs under the supervision of a consultant forensic psychiatrist normally support the court liaison schemes where these exist. There are recognised difficulties in recruiting psychologists, social workers and CPNs and in some areas this has compromised the ability to set up a court liaison scheme.

4.5.22. CPNs normally have 10-15 clients needing intensive involvement. At present community forensic teams have very few social workers or psychologists.

### Court liaison schemes

4.5.23. Formal court liaison services operate in Greater Glasgow, Forth Valley, and in parts of Ayrshire and Arran and Lanarkshire. These arrangements act as filters to ensure offenders with a mental disorder are identified quickly and the Department of Health (England and Wales) has advised that mentally disordered offenders should not be routinely remanded in custody solely for the preparation of psychiatric reports (as can happen in Scotland).

4.5.24. An audit of the Forth Valley service in 2002 showed that 55 individuals were referred, 89% men, the majority aged between 20 and 40 and charged with public order offences or theft. A significant minority (14%) were charged with sexual, murder or attempted murder offences. Many had previous contact with Forth Valley mental health services, usually related to alcohol/drug dependence although a few had a history of major mental illness. 14% were admitted formally to hospital after the court liaison.<sup>32</sup>

4.5.25. Audits of the Glasgow service between 1994 and 1997 showed a fall in hospital admissions from 46% to 14% over this period when a liaison scheme was established.

### Prisons

4.5.26. Forensic services also provide specialist input to a number of prisons. Nationally, the Scottish Prison Service purchases 32 sessions per week of consultant psychiatrist/consultant forensic psychiatrist time.

4.5.27. Davidson et al<sup>33</sup> reviewed remand prisoners in Scotland. Many complained of minor affective disturbance, but only 2.3% were assessed as having a major mental illness. Despite this there remains serious concern about the number of suicides within prison, particularly with respect to women.

4.5.28. The mental health input to prisons normally involves a multidisciplinary team, although this is limited partly by staff shortages. The size and makeup of a team varies considerably between institutions.

4.5.29. The role of the prison mental health team includes:

- identification of mentally disordered offenders and arrangements for the safe transfer to hospital of those acutely unwell
- management of less severe mental disorders
- participation in the assessment of suicidal behaviour
- advising on the management of difficult prisoners

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<sup>32</sup> White T, Ramsay L & Morrison R, *Audit of the Forensic Psychiatry Liaison Service to Glasgow Sheriff Court*, Med. Sci. Law, 42: 64-70, 2002

<sup>33</sup> Davidson M et al, *Prevalence of Psychiatric Morbidity among remand prisoners in Scotland*, B. J. Psychiatry: 167, 545-548, 1995

4.5.30. During 2001/02, 27 remand and 34 sentenced prisoners were transferred to hospital<sup>33</sup>. There appeared to be little difficulty in securing transfer to hospital of mentally ill men, but it is less easy finding places for women prisoners, especially if there is significant self-harm and personality problems. Agreement for transfer to the local psychiatric service varies significantly across Scotland.

### Multidisciplinary working

4.5.31. The core assessment and treatment for mentally disordered offenders in hospital lies with nursing and consultant medical staff, usually supported by doctors in basic or higher specialist training. While there are mental health officers (MHOs) attached to teams at The State Hospital, Lothian, Greater Glasgow and Grampian, other services have ad hoc arrangements or other contact with local teams, so there may be little sense of continuity of involvement by MHOs in the management of detained offender inpatients. Routine involvement of social work happens where the Care Programme Approach (CPA) is adopted, but Care Programme Co-ordinators are not in post throughout the service.

4.5.32. The new Act attempts to ensure the provisions which relate to people detained via the Criminal Procedure Act are as similar as possible as those for civil detention. In doing so, local authorities will have to appoint a 'designated mental health officer' in all substantive interventions under the Act that involve assessments and detentions for psychiatric care, which originate from the criminal court or prisons. These MHOs will be responsible for contributing to the patient's assessment and future care planning throughout the period of detention. The new local authority responsibilities will help ensure greater multidisciplinary working for this vulnerable client group.

4.5.33. The Review Team found that access to psychological or "talking therapies" was easier for those in higher levels of security and there was a concern about the discontinuity of treatment approaches on transfer, particularly for patients coming from The State Hospital. Particular concerns surround the dynamic risk assessment and management of sex offenders. A few services had trained nursing staff to deliver:

- cognitive behavioural treatment for residual psychotic symptoms
- psycho-educational and relapse prevention groups to manage substance misuse
- cognitive behavioural individual work to manage anger
- cognitive skills

4.5.34. Some forensic teams can access such treatment through generic services, but there are waiting lists for clinical psychology services nationally, sometimes amounting to as long as one year. In Ayrshire and Arran, Greater Glasgow and Lanarkshire the dual diagnosis services can be accessed by forensic teams.

### Services for women

4.5.35. The only single sex forensic facility for women in Scotland is in The State Hospital, where substantial expertise has been developed for those with complex mental health needs, and in particular for those with borderline personality traits. Only Ayrshire and Arran and Forth Valley NHS Boards have female beds, although within mixed sex wards. There are proposals to re-provide a small single sex unit in Forth Valley and preliminary discussions about creating another forensic facility for women in Tayside. Otherwise female mentally disordered offenders are admitted to intensive care units. Staff at Cornton Vale Prison are concerned about the lack of national agreement on the detainability and management of women with serious self-injury. The national Forensic Care Network could facilitate regional planning for this small group of people.

### Emerging picture

4.5.36. Forensic mental health services are entering a development phase with the establishment of a managed care/clinical network as proposed in *Partnership for Care*<sup>34</sup> and the *The Right Place; The Right Time*<sup>25</sup>. The Forensic Mental Health Services Managed Care Network Advisory Board has now been established, there are forensic management groups (at NHS Board level) and the 4 supra-regional consortia are planning for care across NHS Board areas.

4.5.37. Lanarkshire, Ayrshire and Arran, Argyll and Clyde and Dumfries and Galloway NHS Boards have undertaken a joint needs assessment for forensic psychiatry accommodation and services (36 beds). Grampian, Tayside, Orkney, Shetland and Highland NHS Boards are also jointly exploring the need for a supra-regional service. Greater Glasgow NHS Board has funding and planning permission for a 72 bed forensic facility designed to include long stay beds and a specific resource for women and those with learning disability.

4.5.38. Forensic services have suffered in the past from a lack of co-ordination and national planning. This is now being addressed and the new Act means that the full range of forensic services need to be put in place as a matter of urgency.

## 4.6. MEETING THE NEEDS OF PEOPLE WITH CO-OCCURRING SUBSTANCE MISUSE AND MENTAL HEALTH PROBLEMS ("CO-MORBIDITY")

4.6.1. The origins of co-occurring substance misuse and mental health problems are complex and it is often difficult to determine which came first. Co-morbidity is a major and growing social, clinical and service issue:

- up to 3 in 4 people who use drugs have mental health problems
- up to 1 in 2 patients with alcohol problems may also have a mental health problem
- up to 2 in 5 people with mental health problems may have a drug and/or alcohol problems

<sup>34</sup> Scottish Executive Health Department, *Partnership for Care*, 2003

- co-morbidity in general practice has risen by 62% (in England 1993 to 1998)<sup>35</sup>

4.6.2. People who have both substance misuse and mental health problems can be troubled by other complex social problems, including unemployment, homelessness, exposure to violence and the long-term effects of childhood trauma.

### Provision in Scotland

4.6.3. Recent policy developments have not led to a consistent improvement across the country in collaborative planning, delivery and accountability of services for people with co-morbidity, including those with mild to moderate mental ill health. Separate planning processes exist for different components of services through local Drug and Alcohol Action Teams, (DAATs) and Joint Mental Health Commissioning Groups, inhibiting joined-up service provision.

4.6.4. The Joint Future Agenda offers the prospect of better outcomes through integrated approaches to the management, financing and day to day running of services. Integrated care for drug users, based on the principles of Joint Future, is now gathering momentum following the 2002 report by the Scottish Executive Health Department Effective Interventions Unit<sup>36</sup> (EIU).

4.6.5. There is agreement that individuals with personality disorder are at high risk of becoming dependent on substances, but there is a lack of professional consensus on the treatment role of secondary mental health services. With only a few exceptions, service provision is rudimentary, despite the available evidence base for effective practice, intervention and management. Apart from policy initiatives for mentally disordered offenders, there is no Scottish guidance.

4.6.6. The Review Team was told that key staff are sometimes uncomfortable with their level of skill in treating this care group. The Review Team welcomes the Scottish Executive Health Department examination of the range of necessary services that should be provided.<sup>35</sup>

4.6.7. The provision of services varies across Scotland for those suffering from mental health and substance misuse problems. Issues include:

- most secondary mental health services are working on a too narrow and too short-term model of assessment and care
- a need for improved communication at both operational and planning levels between addiction and mental health services
- clarity is needed in defining the appropriate service
- specified core competencies need to be identified to address training gaps

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<sup>35</sup> Scottish Executive Health Department, *Mind the Gaps: Meeting the needs of people with co-occurring substance misuse and mental health problems*, 2003

<sup>36</sup> Scottish Executive Health Department, *Integrated Care for Drug Users: Principles and Practice*, 2002

- there is a perception that it is professionally unrewarding to work with this care group, which sometimes results in treatment not being offered or abbreviated or inappropriate and rapid referrals on to other services
- a need for aftercare support to be planned as an integral part of treatment to prevent recurrence
- a need for better partnership with the voluntary sector

### Assessment, intervention and support

4.6.8. There has been a history of a separation at both planning and operational levels between mental health and substance misuse services, resulting in disjointed services and support. A shared view is needed on what care is appropriate, how it should be delivered and by whom, regardless of professional and organisational boundaries.

4.6.9. To deliver this change will require:

- a sufficiently diverse skill mix that allows ready access to both specialist and generic services as a client's needs become apparent
- workers confident of their own abilities to construct practical care plans in the face of complex needs
- care plans that are set out clearly and understood by generic workers to allow them to contribute to tackling the less complex issues
- care plans that are understood and accepted by other potential providers, as well as care funders and commissioners.

4.6.10. Thorough assessment is needed of health needs (physical and mental); social needs; housing; and employment among others. Engaging with the client and meeting basic needs will increase the person's willingness to change.

### Planning and delivery of services

4.6.11. People with co-occurring substance misuse and mental health problems present a challenge and deserve access to the most appropriate and timely services. Treatment and care can and does work for this client group, although there is no clear evidence about which model of care is most effective.

4.6.12. NHS Boards and partner local authorities should consider jointly the needs of this care group and work in partnership and across professional and geographic boundaries to ensure adequate and integrated provision of services.

4.6.13. Planners and commissioners of services need to be aware of the nature and scale of the problem for this population. The needs of individuals should be met, where possible, through mainstream generic services, with easy referral to meet more specialised needs. The voluntary sector should play a key role in both planning and delivering care to this client group, and be resourced accordingly.

4.6.14. The following should be key features of service provision:

- **early intervention**, which is likely to be cost-effective, avoiding inappropriate referrals to more expensive specialist services
- **broadly based interventions**, to include social, education, and employment elements
- **person-centred interventions**, not based on existing service availability
- **advocacy**, with key workers helping service users through treatment and care services
- **positive expectations** of what can be achieved through treatment and intervention being emphasised to client and to service providers alike

4.6.15. Staff, whether in mental or substance misuse services, need to develop the skills necessary to identify and understand clients with co-occurring problems, to develop the confidence to deal with these problems, and to be given the capacity to cope. Training and continuous professional development should include:

- **development of assessment skills** based upon substance misuse and mental health assessment frameworks
- **integration of knowledge** of drug and alcohol trends for individuals with mental health problems
- **effective working** with a range of mental health interventions and treatment modalities

4.6.16. Effective staff supervision, both clinical and managerial, is equally important. Support mechanisms should also be in place for staff at all levels to help them cope with this particularly challenging client group.

#### 4.7. LIAISON PSYCHIATRY (Services for People in a General Hospital)

4.7.1. Liaison psychiatry services are services for people who present to any care setting with a physical illness but who also have a mental health problem. Such services may also serve as a conduit for access to social services.

4.7.2. Those with a mental health problem are no different to the rest of the population in their needs for admission to a general hospital or to attend Accident and Emergency Units. They may also have need for general hospital admission for a range of other reasons including; deliberate self-harm; attempted suicide; the physical consequences of mental health problems such as drug and alcohol misuse; or unexplained symptoms that may have a psychological origin.

4.7.3. Service users have said they feel their mental health problems are not fully understood or appreciated when they go to a general hospital setting and they can feel stigmatised by staff for not having a 'real' illness (examples of these concerns are set out at the end of this section).

## Facts and figures

4.7.4. In 1999-2000 the number of short-term detention orders under the current legislation that took place within general hospitals amounted to over 25% of all emergency detentions in that period. In 1999-2000 the Royal Infirmary of Edinburgh, which has no psychiatric beds, had the fourth highest emergency detention rate under the current Mental Health Act, when compared with other NHS hospitals around the country.<sup>37</sup>

4.7.5. The level of staff training and expertise in mental health in general hospital settings is limited and patients may have been detained due to a lack of awareness of alternative treatment options. The new Act will ensure that wherever possible a psychiatrist will be called in before a detention order is invoked. Therefore, awareness training for medical staff is required to help identify and respond better to patients presenting with physical needs and who have associated or non-associated mental health needs.

4.7.6. People with a diagnosis of schizophrenia can now expect to be provided with a full annual medical examination and to have their needs for psychological and palliative care assessed<sup>38</sup>.

## Suicide and self harm

4.7.7. The Public Health Institute for Scotland<sup>39</sup> reported a Scottish average of 157 women and 456 men committing suicide per year over recent years. The previous pattern where women were much more likely than men to attempt suicide or harm themselves is gradually changing, with men now presenting nearly as often.

4.7.8. There are many reasons for people deliberately injuring themselves that are not connected with suicidal intent, consideration of which requires specialist expertise and insight given that one in a hundred people known to have hurt themselves go on to commit suicide within a year.

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<sup>37</sup> Mental Welfare Commission for Scotland, *Annual report 1999-2000*

<sup>38</sup> NHS Quality Improvement Scotland, *Clinical Standards for Schizophrenia*

<sup>39</sup> Public Health Institute For Scotland, *Liaison Psychiatry and Psychology Needs Assessment Report*, NHS Scotland, 2002

Table 1 – Patterns of physical health needs in people with a mental illness<sup>40</sup>

- 20% male medical admissions are due to substance misuse complications
- 30% medical and surgical new outpatients in various specialties have some type of mental disorder
- 20% frequent outpatients have medically unexplained symptoms
- 20% medical inpatients have a diagnosis of depression
- 10-20% medical inpatients have a significant cognitive impairment (delirium or dementia)
- People with a diagnosis of schizophrenia have higher rates of mortality alongside lower rates of contact with their General Practitioner
- There are around 600 suicides in Scotland each year
- 25% or so of suicides in the UK have been in contact with psychiatric services in the year before death; this represents about 1,500 people per year in the UK

## Issues

4.7.9. The Public Health Institute needs assessment report commented that acute health services often do not pick up unmet psychological or physical needs in the 'non-mental-health' parts of the NHS. Given that rates of mental disorder are already high within people admitted to general hospital beds, the move towards establishing more trauma and ambulatory care units may make access to liaison services more difficult, given the additional travel involved.

4.7.10. Currently there are a limited number of liaison psychiatry posts in Scotland, with some people employed and managed directly by the acute hospital and others employed by the local Primary Care Trust. Most are part-time positions with commitments in other geographical locations. One of the principles of the Act is that where practicable a person should be detained after examination by a person experienced in psychiatry with the aim that there should be less use of emergency detention which can be initiated by any doctor.

4.7.11. The new Act requires the doctor initiating a short-term detention order be an approved medical practitioner (AMP) and that this is most likely to be the liaison psychiatrist, although some accident and emergency consultants may be in a position to take on board the additional training to become approved. Awareness training is needed for all medical, surgical and psychiatric staff with responsibilities under either the Adults with Incapacity or emergency detentions in the new Act.

<sup>40</sup> *Safety First: Report of the National Confidential Inquiry (NCI) into suicide and homicide by people with mental illness*, Department of Health, 2001

4.7.12. For many patients presenting in a psychiatric emergency, the local general hospital is the site where initial psychiatric assessment will occur. Given this, it is also often the place where an emergency detention order is begun, or where existing orders may be reviewed. General hospitals often lack safe and private interviewing facilities where such sensitive procedures can be discussed and processed.

4.7.13. The review team has seen a "Self-injury Charter" produced by a service user which covers the following:

*"We should not as a matter of course be examined in detail for further evidence of self-injury, especially given the fact that many of us have experience of abuse and are not comfortable with nudity or being touched"*

*"It should not be assumed that we want to commit suicide, not even when we are feeling suicidal. Instead, we would like the opportunity to talk about suicidal feelings in an appropriate environment"*

*"If we end up in this department regularly, we should be channelled for better support, not labelled as a "persistent offender" and given worse treatment"*

*"If we choose not to accept an offer of a chance to talk, we should be able to leave the department without prejudice"*

*"If we are so unwell that we need to be detained under the Mental Health Act (1984) "sectioned", that this should be done as soon as possible, and we should be taken to a place more appropriate for psychiatric care"*

*"Sectioning" should never be used as a weapon of coercion to make us talk about issues so delicate we may never have talked about them before. Likewise negative attitudes towards self injury should not prevent us from accessing inpatient psychiatric care when required"*

*"It is wrong to be de-prioritised at triage when presenting at A&E for other things, just because evidence of \*SI comes up"*

*"Our rights need to be explained clearly and objectively, by someone who knows what they are talking about. If possible, we would like the option of talking to an advocate"*

\*SI = self injury

#### 4.8. INTENSIVE PSYCHIATRIC CARE UNITS: SERVICES FOR PEOPLE AT PARTICULAR RISK

4.8.1. Intensive psychiatric care units (IPCUs) are similar to intensive care units in acute hospitals which provide expert care with a high level of observation and skill.

4.8.2. This section was informed by the Review Team site visits and by published reports from monitoring agencies, in particular the findings of the Mental Welfare Commission for Scotland (MWC) when it undertook unannounced visits in 2000.<sup>41</sup>

##### Background

4.8.3. Most people within an IPCU are likely to be detained under the Criminal Procedure (Scotland) Act 1995 or the Mental Health (Scotland) Act 1984. Despite the wards being locked around 10% of the patients will not be under any legal compulsion to remain, but are there because of their being severely and acutely ill and needing the close observation and treatment that an IPCU can provide. This can amount to 'de facto' detention and these patients should clearly be able to leave the IPCU ward<sup>41</sup>.

4.8.4. To be admitted to an IPCU people are usually:

- too ill to be cared for safely in an acute ward (both formal and informal patients)
- on remand for assessment from the courts
- in need of a higher level of supervision because of a forensic history
- stabilised in their illness, but on a step-down programme from the special security of The State Hospital

4.8.5. An IPCU may therefore function both as a forensic ward and an extension of general psychiatric services and this duality of function may lead to some problems for both care groups. Other issues arise in providing adequate, appropriate and safe care for women patients (the MWC census<sup>41</sup> found 21% of beds were occupied by women) which can present a significant challenge.

4.8.6. Some of these issues will be resolved when more local forensic psychiatric units and services are developed, allowing IPCUs to focus more on acutely ill patients rather than those with forensic needs. A difficulty will remain in providing an appropriate care environment for adolescents and older people, or for people with a learning disability. This consideration needs attention, especially since the new Act requires that adolescents receive care in an age-appropriate facility. There is currently minimal access to alternative secure care within local settings.

4.8.7. One quality criterion of treatment and care is that it should be delivered as close to the person's home as possible. Yet local IPCU facilities are not viable for small or dispersed populations. Very ill people may have to travel long distances

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<sup>41</sup> Mental Welfare Commission for Scotland Annual Report 2000-01

under escort to be admitted to a hospital they do not know. This, sadly, is unavoidable in small island or rural areas that have to contract services from other NHS Boards. It is much less acceptable for people from urban settings, where IPCUs are located, sometimes having to travel across Scotland, because of lack of available local beds.

4.8.8. This general bed management problem was identified in the Interim Report. Despite the fact that this issue was raised locally as a significant problem, the published statistics suggest a different picture. The MWC (in 2000)<sup>41</sup> found only 6 people (out of 142) in an IPCU that was not in their area. This underlines the need for better routine data collection to help inform planning and management decisions about service provision.

4.8.9. There are currently 17 IPCUs in Scotland and 181 beds (down from 219 beds in 1992).

**Table 2 – Number of IPCUs and beds by population per NHS Board**

NHS Board	Adult population (18-64)	Number of IPCUs	Number of beds
Argyll and Clyde	288,800	2	20
Ayrshire and Arran	238,970	1	6
Borders	68,000	0	0
Dumfries and Galloway	93,000	0	0
Fife	229,000	1	10
Forth Valley	184,700	1	12
Grampian	350,200	1	11
Greater Glasgow	577,511	4	35
Highland	132,800	1	12
Lanarkshire	414,200	1	22
Lothian	528,560	2	24
Orkney	12,300	0	0
Shetland	14,300	0	0
Tayside	252,000	3	26
Western Isles	16,400	0	0
<b>Scotland</b>	<b>3,400,741</b>	<b>17</b>	<b>181</b>

4.8.10. A key finding from the 2000 Mental Welfare Commission survey<sup>41</sup> was the very poor physical environment in many places. Three years on the Review Team found significant improvements in the new buildings, but problems remain elsewhere. Old cramped facilities offer little opportunity for exercise or privacy, especially where there is no enclosed garden area. The layout in some places makes nursing observation difficult; for example where the premises are on several floors. Often the decoration and furniture lack colour and imagination, offering little by way of stimulation. There are difficulties in ensuring both a smoke-free environment and a smoking area that are congenial.

4.8.11. In 2002 the Department of Health (England) produced 15 National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and low secure environments<sup>42</sup>. One set of standards covered physical environment (too detailed to summarise here). In Scotland, a few newly built intensive care psychiatric units meet most of the criteria, but others fall far short. This is an acknowledged problem within the service which is often rationalised by the long lead-in time until new developments can take place. Although the structure of the existing buildings cannot be altered very much in the interim, there must be significant and continuing attention to the décor and furnishing. Where units suffer high wear and tear, repairs should not be delayed.

4.8.12. A challenge for the staff is providing the right balance of privacy and peace alongside activities and treatments. For some service users this balance is achieved; for others, either or both aspects are not adequate to meet their needs.

4.8.13. PICU provision is a small, but important, part of services but significantly important for those in most need and as such represents an important part of the spectrum of care for those in need and should remain central to planning decisions when implementing the new Act.

## 4.9. CRISIS SERVICES AND 24-HOUR SUPPORT

4.9.1. Service users and carers attach great importance to the ready availability of crisis services and 24-hour support. This was raised at all the user and carer meetings and has already been well documented.<sup>43, 44</sup> The need for attention to these services is recognised within *A Partnership for a Better Scotland*.<sup>45</sup>

4.9.2. Crisis services and 24-hour support are part of the essential spectrum of mental health care delivery. Integrated services are needed, organised on a tiered basis so that an individual can move between primary care, mental health specialist care, intensive care outside hospital, hospital admission and long-term or tertiary specialist care, according to need.

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<sup>42</sup> Department of Health, *Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments*, 2002

<sup>43</sup> Highland Users Group, *Crisis Services*, 1997

<sup>44</sup> The Mental Health Foundation and The Sainsbury Centre for Mental Health, *Being there in a crisis*, 2002

<sup>45</sup> Scottish Executive, *A Partnership for a Better Scotland: Partnership Agreement*, 2003

4.9.3. Robust and comprehensive crisis prevention and resolution services, coupled with the availability of 24-hour support, help reduce inappropriate hospital admissions and facilitate early safe discharges.

### Facts and figures

4.9.4. Over recent years informal admission numbers have reduced marginally and currently stand at approximately 20,000 people with 30,000 episodes of admission. The high level of re-admission within 28 days, shown in the published locality reports, may be an indication that there is insufficient intermediate care between hospital and community services. One problem in interpreting the data is the recognition that setting up community services can lead initially to increased admissions, mainly due to previously unidentified need. This position changes over time. It is in crises that emergency detentions within the community are initiated. In 2002-03 1,461 people were compulsory detained in hospital in this way.

### Mental Health (Scotland) Act 1984

4.9.5. Between 1985 and 2003 there was a 47% rise in the number of emergency detentions<sup>46</sup> under the existing legislation despite the gradual development of community services. However, international comparisons show that detention rates for people with mental health problems have risen consistently and one of the major factors is thought to be that society generally is becoming more risk averse. This contributes to the stigma that service users experience.

4.9.6. One major change with the new Act, under the '*least restrictive alternative*' principle, is the option of a community-based Compulsory Treatment Order, making the availability of robust 24-hour support and crisis services essential. The Tribunal will make judgements on the basis of need, not on current availability of services.

### Provision

4.9.7. Currently there is a confusing mixture of available (or not available) out-of-hours services ranging from the GP, duty social worker and duty junior doctor, to more specialist services. Often access is for known service users only. Several voluntary organisations provide considerable support, but this was not always known or acknowledged by the statutory sector. Crucial support comes from relatively informal networks of fellow users and carers, often insufficiently resourced.

4.9.8. In order to gather information about the different components of crisis services and 24-hour support a checklist was sent to NHS Boards, Trusts and local authorities (some users and carers also volunteered separate responses). The responses produced the following results on availability:

- Assertive (intensive) outreach from the service is provided when vulnerable people fail to turn up for appointments or activities (50%)
- Rapid response, following an expression of need (66%)
- 24-hour support available when required (49%)

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<sup>46</sup> Mental Welfare Commission Annual Report 2002-03

4.9.9. While voluntary sector contributions may have been relatively under-reported, leading to an under-estimate of facilities, this is likely to be balanced by the replies about 24-hour support outside hospital. Some services consider 24-hour support as being fully available if access to generic services is provided, for example GP out-of-hours cover or the on-call social worker, who may not be based in a mental health setting. If this is all that exists except hospital admission, it is not adequate. Contacting the junior psychiatrist on-call at hospital is usually seen as a retrograde step in conflict with the move to community care, especially when the junior doctor has little alternative to admission.

4.9.10. Access and provision are particular problems in dispersed communities. In some cases the distance travelled by the patient may result in an 'inappropriate' admission to offset a tiring return journey the same day. Incidence can be estimated by looking at the number admitted to hospital, but discharged next day.

4.9.11. For best provision people require a range of 24-hour options, including brief respite care or user-led crisis houses. Given the range of cost-effective options failure to develop these response needs cannot be attributed solely to resource constraints. An estimated average daily cost of a crisis house can be as little as £100 per person<sup>44</sup>. Feedback from the organisations that provide residential places for people with increasingly severe mental health problems is that funding allocations and access to health and social work support in crisis are inadequate. Quality and appropriateness should however always dictate care choices with attention to risk an issue also. Any service must ensure appropriate staff skills and readily accessible specialist back-up.

4.9.12. Service users and carers are prepared to participate and contribute to such services and not just be on the receiving end. This is a prime area where service user feedback has been given many times and yet not responded to adequately in every case. Service users and carers have insights into what might help them cope better in a crisis or to prevent one arising and they have practical and pragmatic suggestions about arrangements for drop-in, crisis houses, places of safety and transport support.

4.9.13. Despite some examples of very good practice, it is clear that currently, there are significant gaps in the provision of comprehensive community crisis services and 24-hour support. This is not new information.

4.9.14. Gaps in any part of the system have an effect on other parts and this includes informal carers. One of the principles of the new Act is respect for carers. Carers have their own needs and should have access to help, especially in emergencies. Their views and opinions must be taken into account as they are often experts about what is required. Too often the carer's experience of help is a restricted response, sometimes under the guise of patient or other confidentiality.

4.9.15. As community services have expanded in densely populated areas, some specialist teams have come together with expertise about particular client groups. Conversely in sparsely populated areas more generic and flexible skills are necessary. It is not possible to provide direct access to highly specialised care for all groups and needs, 24-hours a day. Generic skills need to underpin specialist skills to ensure the best care. A tiered approach reflecting different needs and specialist skills is acknowledged by service users and carers to be appropriate.

However, even where a range of services is available from different agencies, integration and clear communication routes are rare.

4.9.16. Particular difficulties seem to occur when a problem arises for someone in a minority group or a person who has multiple problems. This applies not only to ethnic minorities and those with sensory impairment, but to those with learning disabilities, children, adolescents and their families. Older people and others may have multiple problems and it can be confusing to know where and how best to refer for those needs to be addressed. Sometimes the crisis is actually physical, but service users talked of not being taken seriously by staff and symptoms being attributed to a mental or emotional problem or even attention seeking (see the separate section on Liaison Psychiatry).

4.9.17. People experience significant problems travelling to services, especially in outlying areas. The use of telephone helplines and video-links can compensate to some extent. Predictably, there are conflicting views about such services, some linked to personal preferences, but undoubtedly sometimes due to the quality of the service. NHS24 was described by some service users as excellent for providing information, but less so at reflective listening, though this is not their primary function. NHS24 recognises the need for skills in handling calls from people with mental health problems and is tackling this through training. The Scottish Executive funds the *Breathing Space* helpline, set up as part of the *Choose Life*<sup>47</sup> initiative. There are a surprising number of services provided by voluntary organisations including some small volunteer befriending schemes but it is not always clear where monitoring and accountability lies.

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<sup>47</sup> Scottish Executive Health Department, *Choose Life: A National Strategy and Action Plan to prevent suicide in Scotland*, December 2002

# **national mental health services assessment final report**

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**wider issues**

## 5. WIDER ISSUES

### 5.1. POSITIVE MENTAL HEALTH

5.1.1. Historically health services have tended to respond to illnesses and their treatment, but have placed lesser importance on promoting healthy life styles. While mental health services have a crucial role to play in responding to the needs of people who develop mental health problems, there is of course a much wider public policy agenda on illness prevention and health promotion.

5.1.2. Work taken forward through the National Programme for Improving Mental Health and Well-being initiative is demonstrating the importance and commitment at a national level to this broader agenda. Mental health promotion is an important issue against a backdrop of limited national awareness of the prevalence of mental illness.

5.1.3. This assessment has focused on the role of mental health services in relation to the new Act. In a broader context it is clear that more can be achieved in preventing serious problems through improved public awareness, better understanding and changes to the attitudes and behaviours of people across Scotland.

5.1.4. The key aims of the National Programme are to:

- raise awareness and promote mental health and well-being
- eliminate stigma and discrimination
- prevent/reduce suicide
- promote and support recovery

5.1.5. The Millan Committee<sup>4</sup> recommended there should be a campaign of public education designed to improve public understanding of mental disorder and the “see me...” campaign<sup>6</sup> has undoubtedly made a positive start to tackling the issue of public awareness, and will continue to promote better understanding and help to eliminate stigma. Progress has also been made in improving public awareness, for example through the introduction to Scotland of the innovative Australian training programme *Mental Health First Aid*, which will be evaluated this year. That initiative is all about approaching and understanding mental ill health in the same way as for physical ill health.

5.1.6. Most people, with the appropriate medical, social and family support can and do recover from mental health problems, however those most likely to be detained under the new Act may need longer term contact with psychiatric services. It is especially important that these people gain from the greater emphasis on positive mental health and from a greater public understanding of mental illness.

## 5.2. SUICIDE PREVENTION

5.2.1. Many service users, their carers, wider families and voluntary and statutory organisations are acutely aware of the potential stress and difficulties that make suicide an option for many people at some points in their lives.

5.2.2. Undoubtedly those with mental health problems who are likely to be at risk of suicide may at some stage become subject to the conditions of the new Act, if it is thought they suffer from a mental disorder. The aim always is to provide support, care and treatment well in advance to help promote good mental health, promote recovery and reduce (and hopefully remove) the risk of suicide wherever possible.

5.2.3. During this Review, it was shown that access to services in times of crisis is of course a high priority for service users and carers and this issue is discussed in more detail in the separate sections on liaison psychiatry and crisis services.

5.2.4. In the UK approximately a quarter of all suicides (1,500) involve those who had already been in contact with mental health services.<sup>47</sup>

5.2.5. Not everyone who commits suicide has had a mental illness. Nevertheless those with serious mental health problems are perhaps more likely to have suicidal thoughts and are therefore more likely to attempt suicide and harm themselves. A recent UK survey, those with a diagnosis of psychotic illness were over ten times more likely to attempt suicide.

5.2.6. There were nearly 900 suicides and undetermined deaths in Scotland in 2002, with a ratio for men to women of more than 2:1, and this gender pattern continues to increase<sup>48</sup>. The rate in Scotland is higher than the UK as a whole and the reasons for this are complex. With this background, the Scottish Executive in December 2002 launched '*Choose Life*<sup>47</sup>', a national strategy and action plan for preventing suicide in Scotland. An additional £12 million is being spent over 2003–06 to support the first phase of local and national action in implementing the objectives of *Choose Life*.

5.2.7. One of 7 priority groups identified for action under this initiative covers those with mental health problems. This covers those in contact with mental health services, those with a severe mental illness, usually with a diagnosis of psychotic illness and those with severe depression or severe anxiety disorders.

5.2.8. There are a range of issues to be addressed in helping prevent suicide of those already in contact with mental health services including:

### a) Admission and discharge from psychiatric inpatient units

All admitted to psychiatric inpatient services should have their potential risk of suicide assessed. On discharge a full risk assessment should be repeated and any social support and follow up care and treatment arrangements should be in place prior to discharge.

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<sup>48</sup> General Registry Office

#### b) Training and development for mental health service staff

Training is required for all staff working in mental health services to enhance skills in prevention, risk assessment and risk management. This training needs to be available to people working in the community as well as hospital services and should include both professionals and those working in community organisations who work with people at risk.

#### c) Critical Incident Reviews

In order that staff and services as a whole are able to learn lessons when someone with a mental health problem commits suicide, a Critical Incident Review must always be carried out. This is partly to learn facts from a governance perspective, partly to create an 'organisation with a memory' to help avoid making any similar mistakes if any are found, but also to deal with the powerful emotions that inevitably arise.

The needs of relatives and friends and other service users must be a top priority, but it should be recognised that staff feel sad and guilty when someone they have been working with dies and they have their own sense of loss. Reviews should be thorough, but not punitive.

#### d) Environment

Everyone needs a measure of privacy and personal space, even when unwell and for those with ideas of suicide, a balance needs to be struck. It is important that all health premises are checked for anti-ligature points to limit ready access to ways of harm. Observation, however, should be more a case of engaging with the person rather than being a guard.

5.2.9. The Review Team is of the view that while there has been investment and progress at a national level there is no room for complacency. Efforts need to be consolidated and lessons learnt taken further. The issues are complex and it is critical to have a long-term integrated approach to the prevention and reduction of suicide.

### 5.3. INFORMATION

5.3.1. Information and its management are core components of planning, delivering and managing health and social services, including those delivered by the voluntary sector. The new Act places significant new demands on services and the availability of quality information will be an important contributor to successful implementation.

5.3.2. The day to day responsibilities of administering the legal requirements of the new Act will lie with health and social work administrators, responsible medical officers (RMOs) and mental health officers and The Mental Welfare Commission for Scotland will continue to have a central role.

5.3.3. The main new development will be the operation of the new Tribunal system, which is not discussed in detail in this report. NHS Boards and social work departments will need to contribute to monitoring the implementation of the new

Act and make early decisions about how, where and why resources are being spent and used.

5.3.4. The Scottish Executive Health Department will monitor the implementation and impact of the new Act and will need information for that role and for advising Ministers and others on progress.

5.3.5. It is clear that Scotland's mental health services are generally data rich, yet information poor. Within the overall mental health system a lot of data is collected both at a local and national level but sometimes it is not used to best effect or seen as being of value to practitioners. Some information that would be useful in planning and monitoring of services is not being collected or appears to be inaccurate and contradictory, depending on which source is used.

5.3.6. Basic details about bed numbers proved difficult to access, including those for intensive psychiatric care, adult acute admission or longer stay. National data streams do not discriminate at a level below the general psychiatric specialty and often it was necessary to phone wards direct to get the data needed for this review. The sheer complexity and size of local authority and voluntary sector provision is such that the Review Team learnt not to attempt a comprehensive list. This is not to disparage the determination and success of some staff and managers to draw up directories of care – in some places fairly detailed local information was available. However, across Scotland this is not systematically collected and updated.

5.3.7. Information will be needed on the number of consultant psychiatrists (and their specialty) and the number of mental health officers. The Royal College of Psychiatrists could not initially provide data on the former with any degree of accuracy and on more than one occasion NHS Trusts suggested that the only people with accurate information would be the pay office. Systems have now been put in place to rectify this and the Royal College of Psychiatrists will shortly be able to make baseline data available that will be regularly updated. Information supplied by local authorities regarding the number of MHOs practising in mental health differed somewhat when compared with the Scottish Development Centre's survey in June 2003<sup>49</sup>, although this seemed to be due mainly to different definitions of what constituted working within a mental health field.

5.3.8. This significant lack of available and consistent information is acknowledged throughout the service and appears to be taken for granted; it is as if no-one expects accurate data. However, better information is available for and from the acute sector and all others concerned must work to improve the information available for mental health services.

5.3.9. With this in mind, the Improving Mental Health Information Programme<sup>50</sup> is already making significant strides in developing better quality mental health information, by working with the agencies and others on information culture, sites and systems. This work must continue as a high priority. Some specific additional data analysis has been undertaken on behalf of this Review.

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<sup>49</sup> Scottish Development Centre for Mental Health, *Mental Health Officer Services: Structures and Supports*, 2003

<sup>50</sup> Information and Statistics Division, NHSScotland.

5.3.10. A major cause for concern is inconsistent financial data (discussed in Chapter 7). It is vital that better information is used to ensure that best value for money is gained from the services, and that service planners and managers can use the information to inform and enhance their decision-making. Better information leads to better decisions and of course better care.

## 5.4. MEDICAL RECORDS ADMINISTRATION

5.4.1. Medical records administration staff provide a pivotal role in ensuring the proper administration and legislative compliance of all related paperwork. They are the central information base for interested parties and for enquiries relating to detentions.

5.4.2. In some cases they are undervalued in consideration of the contribution they make and the pool of knowledge they represent. They are essential to the smooth operation of the issues and protections attaching to the detention procedures under specific legislation.

### Overview

5.4.3. The Medical Records staff perform a range of duties on behalf of Managers, including: processing completed papers from wards, courts etc; accuracy checks and ensuring process completions within set time limits; informing relevant parties in those cases where papers are void; complying with the legislative requirements and informing relevant bodies of detention/continuation arrangements; ensuring all receive proper and timely notification and completed paperwork and ensuring 'Consent to Treatment' and 'Second Opinion' forms are sent to the responsible medical officers and are completed within the set time scales.

5.4.4. On behalf of the responsible medical officers the Medical Records staff will remind of all requirements due for detained patients at appropriate times and will alert of any outstanding issues/requirements.

5.4.5. Otherwise the Medical Records staff will routinely; provide sector general managers with regular reports on outstanding issues for detained patients; liaise with the Mental Welfare Commission for Scotland, Central Legal Office and courts on any matters arising; provide statistical and patient identifiable information as required; and provide guidance and advice to relevant parties on issues surrounding the relevant legislation.

5.4.6. Medical secretaries will also ensure that consultants receive all relevant papers within the appropriate time periods; where consultants are unavailable, will ensure the papers are re-routed to the covering RMO; and will make sure Medical Records staff are aware of all covering arrangements.

5.4.7. Local areas will have to ensure there is very close liaison between hospital Medical Records Officers/Departments and the lead contacts in the local authorities who are responsible for monitoring mental health officer activity. Local protocols should exist between all local authorities and their health service colleagues to ensure timely, efficient systems for referrals, reminders of deadlines for reports, applications and renewals. This is an area that the National Service Standards for mental health officer services should address.

5.4.8. There is a wealth of knowledge held by the current administrators within the NHS and local authorities, who also have invaluable experience in learning to deal with groups/individuals that other staff may find daunting. This experience is crucial for a successful transition to the new arrangements and should be utilised accordingly.

## 5.5. THE VOLUNTARY SECTOR

5.5.1. The term 'voluntary sector' is used to distinguish services from those directly provided by the 'statutory' bodies (health services and local authorities) although often a considerable amount of funding comes from these sources. One frequent source of confusion is with the term 'volunteer.' The voluntary sector employs a range of paid and trained staff. The private sector also provides care services.

5.5.2. Around a third of all social care staff in Scotland are employed through the voluntary sector and in the region of 40% of local authority spend on mental health services is on services provided by the voluntary sector.

5.5.3. *Partnership for Care*<sup>34</sup> states that:

*"Sometimes the views and experiences of patients can be expressed effectively through voluntary organisations. The health service does recognise the valuable role of the voluntary sector, not just as advocate, but in providing a range of services for patients and carers."*

### The mental health voluntary sector

5.5.4. The contribution currently made by the voluntary sector is wide ranging and extensive and their potential role should not be underestimated by any of the statutory organisations. They should be recognised, and in many cases are, as a full partner in the planning organisation and delivery of mental health services and should be recognised for the contribution they make also to innovative thinking and policy direction.

5.5.5. Some services are small, while other much larger organisations employ a salaried workforce. Some employ hundreds of staff, deliver a range of services, and have multi-million pound turnovers. The term 'voluntary' therefore is a misnomer and 'not for profit' perhaps better describes their position.

5.5.6. Voluntary organisations are subject to the same regulations as others in respect of employment law, health and safety legislation, accounting procedures and reporting. They have to meet quality and care standards and ensure staff training.

5.5.7. Like other sectors, voluntary sector staff are drawn from a variety of backgrounds and experience in fields such as nursing, social work/social care, psychology, occupational therapy and speech and language therapy. Others have experience and qualifications in diverse fields outside health and social care for example in the arts, education, community development, horticulture, information technology, law and business.

5.5.8. Some voluntary organisations combine two or more functions - being a lobbying group and a direct provider of services. For example, the **Scottish Association for Mental Health (SAMH)** is a membership organisation which campaigns, provides information and services for people across the whole spectrum of mental health. There are diagnosis specific groups such as the **Manic Depression Fellowship Scotland (MDF Scotland)**, **Depression Alliance**, **National Schizophrenia Fellowship** and **Alzheimer Scotland - Action on Dementia**.

5.5.9. Some organisations, including **Penumbra**, **Barony Housing Association** and the **Richmond Fellowship Scotland**, concentrate more on the provision of care, especially in supported accommodation and day care. Increasingly the voluntary sector is moving to complement the statutory sector especially with the developing focus on *Well-Being* and *Recovery*.

5.5.10. These large and well-known organisations are only a small part of a larger network of services. Around the country there are many local Mental Health Associations that are well established and highly regarded within their areas both with service users and mental health providers. They provide a local focus for many different organisations including other voluntary groups. One of the fastest rising groups of voluntary organisations is those providing advocacy services. These are discussed separately.

### What is unique about the voluntary sector?

5.5.11. The powers of the statutory agencies to make major decisions about service users, including detention under the Act, sometimes makes it harder for service users to develop a trusting relationship with those bodies. To some, the voluntary sector may seem more approachable and better equipped and more flexible to respond to service users' needs and views.

5.5.12. An additional advantage is the sector's capacity to respond quickly to identified and emerging needs innovatively and have access to alternative finance streams (e.g. Enterprise funds, European funds) that can bring additional resources into a voluntary/statutory organisation partnership. However the paradox is that such multiplicity of short-term contracts, not always linked to inflation or the need for additional training, can put considerable pressure on these services.

5.5.13. The "see me..." anti-stigma campaign<sup>6</sup> was assisted through an alliance of five voluntary organisations working together to highlight the importance of tackling the commonly found social exclusion experienced by many mental health service users. Many mental health voluntary organisations work with carers, the Benefits Agency, education providers, employers and communities as well as with service users to inform, increase awareness and integrate support within the social inclusion agenda.

5.5.14. The Review Team found some examples where there was a lack of acknowledgement of the important role the voluntary sector plays and some confusion about the different role of unpaid volunteers. Better understandings and better working together should be a priority for all concerned. At a time of major service change and development voluntary organisations have the opportunity to contribute on a more equal footing in partnership with NHSScotland and the local authorities.

## 5.6. PSYCHOLOGICAL INTERVENTIONS/THERAPIES

5.6.1. The new Mental Health (Care and Treatment) (Scotland) Act 2003 goes much further than before in stating that the full range of appropriate care and treatment options must be available to patients who are detained under the Act. This will apply to medication and psychological treatments as well as a range of care and support services. Psychological approaches are implied or explicit in the new legislation and Section 329 states:

*“medical treatment means treatment for mental disorder and for this purpose treatment includes nursing, care, psychological intervention, habilitation (including education and training in work, social and independent living skills) and rehabilitation.”*

### Definition

5.6.2. Psychological ‘therapies’, ‘interventions’ or ‘approaches’ are interchangeable terms with considerable overlap and are often described more simply as ‘talking treatments’. The term ‘intervention’ is most commonly used to describe care based on cognitive behavioural therapy for specific problems, for example psychosocial interventions for people with schizophrenia, for which guidelines have been developed by the Scottish Intercollegiate Guidelines Network (SIGN)<sup>51</sup>.

5.6.3. Providing such services calls on a broad range of skills and competencies based on identified psychological concepts and theory which have been acquired through training and maintained through supervision. Services should be provided at different levels of specialisation, by a wide range of skilled and trained professionals, in a tiered approach where the level of skill matches the level of identified need. Services may be provided by clinical and counselling psychologists, psychotherapists (medical and non-medical), psychiatrists, mental health nurses, occupational therapists and other allied health professionals, social workers, voluntary organisation workers and counsellors, all working within a variety of services and settings.

5.6.4. Psychological approaches include work not just with individuals, but also with families or with groups of people. Self-help groups with peer support are increasingly being developed by service users to share knowledge and learn how to manage their condition.

5.6.5. Although psychological approaches are appropriate in helping a wide range of mental health problems this section will focus on services for people with more severe problems who may be directly affected by the Act.

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<sup>51</sup> Scottish Intercollegiate Guidance Network, *Psychosocial Interventions in the Management of Schizophrenia: A National Clinical Guideline*, 1998

### Severe and enduring mental illness

5.6.6. It is known that psychological factors predict emotional adjustment, recovery and staying well following an episode of psychosis and that preventative work may reduce or remove the need for hospital admission<sup>52</sup> and may lessen the likelihood of a serious breakdown<sup>53</sup>.

5.6.7. Acute admission for a severe illness can be traumatic and the experience of post-traumatic symptoms, depression and suicidal thinking is linked to the way an individual perceives the illness in terms of shame, entrapment and humiliation, including the extent to which compulsory measures were necessary<sup>54</sup>. This has been recognised by the National Institute for Clinical Excellence (2002)<sup>55</sup> which published good practice guidelines about the psychological needs of individuals following involuntary procedures such as rapid tranquillisation.

5.6.8. Decisions about treatment must always include assessment of a person's psychological needs and strengths within a social context and this is of particular importance when a Compulsory Treatment Order is being considered. In situations where conventional pharmacological treatment has failed or is not appropriate (as in some people with a personality disorder) then specific, evidence-based psychological therapy is of prime importance. Traditionally people with a psychotic illness<sup>55</sup>, major personality disorder<sup>56,57</sup> or a learning disability<sup>58</sup> were not usually offered such treatments - it is now known that such approaches can be of added benefit. Drug treatments and psychological approaches are not in conflict and a holistic approach will ensure that all factors are borne in mind when drawing up the Plan of Care with the service user.

5.6.9. The guidance on psychological interventions in the *Framework for Mental Health Services*<sup>2</sup> gave agencies baseline to use as a planning and audit tool for the delivery of services, which can inform what will be needed to comply with the expectations set out in the new legislation.

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<sup>52</sup> British Psychological Society, *Recent Advances in Understanding Mental Illness and Psychotic Experiences*, 2000

<sup>53</sup> National Institute for Mental Health in England (NIMHE), *Expert briefing: Early intervention for people with psychosis*, 2003

<sup>54</sup> Iqbal, Z., Birchwood, M., Chadwick, P & Trower, P, *Cognitive approach to depression and suicidal thinking in psychosis: 2 Testing the validity of a social ranking model*, *British Journal of Psychiatry* 177: 522-528; 2002

<sup>55</sup> National Institute for Clinical Excellence, *Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care*, 2002

<sup>56</sup> Davidson, K. & Tyrer, P, *Cognitive therapy for antisocial and borderline personality disorders: single case series*, *British Journal of Clinical Psychology*: 35, 413-429; 1996

<sup>57</sup> Bateman, A. & Fonagy, P, *Effectiveness of partial hospitalisation in the treatment of borderline personality disorder: a randomised controlled trial*, *American Journal of Psychiatry* 156: 1563 – 1569; 1999

<sup>58</sup> Taylor, J.L, *A review of the assessment and treatment of anger and aggression in offenders with learning disability*, *Journal of Intellectual Disability Research* 46: 57-73; 2002

5.6.10. The national overview of treatment for schizophrenia, carried out by the Clinical Standards Board for Scotland<sup>59</sup> reported on performance against 6 of 11 standards. The report states that *“most service users do not have their need for psychological interventions assessed”* and *“access for people with schizophrenia to clinical psychology services is variable.”* A recommendation was made that *“assessments of need for psychological interventions are undertaken by a clinical psychologist, and that NHS Trusts develop guidelines to be used for the provision of psychological interventions for people with schizophrenia.”* It also recommended that the skills and composition of multidisciplinary teams are reviewed. The recent workforce planning survey of psychology services<sup>60</sup> acknowledged that the need and demand for psychological approaches could not be met by the present workforce and that service redesign was necessary to develop a skill mix that reflected client need and that training and supervision should take place on a multidisciplinary basis.

### Personality disorder

5.6.11. Patients with a diagnosis of personality disorder have been disabled by their diagnosis and by the lack of specific treatment interventions available. This is surprising when one considers that figures suggest 11%<sup>61</sup> of the adult population may have a personality disorder, accounting for approximately 300,000 adults in Scotland. In 1998 personality disorder accounted for 2% of the 32,000 psychiatric admissions in Scotland. Although this is a condition five times more common than schizophrenia it is currently neglected therapeutically. Patients suffering from these conditions are variously referred to as having ‘behavioural disorders’, or ‘mild to moderate mental health problems’ or can also be included under the umbrella term ‘severe and enduring mental health problems’.<sup>30</sup>

5.6.12. The MacLean Committee for Serious Violent and Sexual Offenders<sup>30</sup> noted the recommendations of the Ashworth Inquiry<sup>62</sup>, which described key features in providing services for people with personality disorders. These in turn were very similar to the recommendations of a 2003 report from the National Institute for Mental Health, England (NIMHE).<sup>63</sup>

5.6.13. For best outcomes, interventions should be well structured, coherent, focused, long term and well integrated. The services should also devote effort to achieving ownership of the task by the service user and develop a clear treatment alliance between therapist and patient.

5.6.14. Discussions have started in Scotland about a needs assessment of such services, with the Mental Health Division of the Scottish Executive Health Department and NHS Health Scotland.

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<sup>59</sup> Clinical Standards Board for Scotland, *National Overview: Schizophrenia*, 2002

<sup>60</sup> NHS Education for Scotland and Information and Statistics Division, *Workforce Planning for Psychology Services in NHS Scotland: Characteristics of the Workforce Supply in 2002, 2003*

<sup>61</sup> NRCEMH and the Commission for Racial Equality (CRE), *Fair Enough? Review of Race Equality Schemes and Fair for All Action plans*, NHSScotland, 2003

<sup>62</sup> The Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, 1999

<sup>63</sup> National Institute for Mental Health in England, *Personality disorder: No longer a diagnosis of exclusion*, 2003

### Learning disability

5.6.15. Learning disability is classified as a mental disorder in the Act and people with a learning disability must also have access to psychological interventions as appropriate. In view of the current work on needs assessment this will not be discussed in this report.

### Current services

5.6.16. In many areas training of clinical staff in some form of psychological intervention is either taking place or is at a planning stage. However, this encouraging position is not happening systematically based on assessed service or client need and individual staff interest has sometimes been the main reason for undergoing training. Up to 50% of newly trained staff may not be applying the training in everyday practice and services are not always being reshaped to allow this to happen. The result is a patchwork of provision that is not always fully integrated into mainstream services and lacks ongoing support and supervision.

### Pilot projects

5.6.17. In 2000 and 2001 the Scottish Executive Health Department supported Psychological Interventions Projects in four areas (Ayrshire and Arran, Dumfries and Galloway, Forth Valley and Greater Glasgow). The projects had input from the Scottish Development Centre and the Glasgow Institute of Psychosocial Interventions (GIPSI). This work was restricted to interventions provided by psychologists and therefore was not inclusive of the broader multidisciplinary provision of psychological interventions. Difficulties were found in the development of service links and a need for short, medium and long-term strategies to address delays in access. A lack of systematic supervision was discovered in all areas and the projects also found problems with data collection systems and identification of entry points. It was stressed that training must follow an assessment of service and user needs.

## 5.7. ETHNIC MINORITIES

5.7.1. The term 'ethnic minorities' covers diverse communities and includes different cultures, religion, colour and different socio-economic background.

5.7.2. According to the 2001 Census<sup>12</sup> there are about 102,000 people (around 2% of the population) in Scotland who regard themselves as being part of a black and minority ethnic group, the highest percentage being of Pakistani origin. Most live in large cities, (for example making up 5.5% of the Glasgow population). There are some demographic differences common to many groups which may impact on future care delivery, although the issues are always complex.

5.7.3. Perhaps most striking is the age structure:

- 56% of all ethnic minority communities are under the age of 30, compared with 36% of the white community
- 7% of all ethnic minority communities are aged over 60, compared with 21% of the white community.

5.7.4. Being in any minority is not necessarily a disadvantage. For some people, perhaps especially older people, being part of a small community may mean a clear identity and culture and a considerable support network. There is a danger of cultural stereotyping, where members of a particular community are seen not to require help from outside their community for cultural reasons and appropriate services are therefore not developed with their needs in mind. The reverse also applies where people do not seek help. This could suggest that any needs assessment based on overt demand is likely to underestimate requirements.

5.7.5. The central task is to ensure equality of assessment, and a service response that overcomes these limiting factors and eliminates unconscious or other racism. The Race Relations (Amendment) Act 2000 (RRAA) was in part a response to the Macpherson report<sup>64</sup> into the death of Stephen Lawrence. The report concluded that all UK institutions were affected by institutional racism – *“the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people”*.

5.7.6. An extreme example was reported in 2002 by The Mental Welfare Commission.<sup>65</sup> Following a Deficiency in Care Inquiry the Commission reported significant and serious shortcomings in the treatment and care of a patient (born in India in 1926, a Punjabi speaker, with very limited English). The Mental Welfare Commission adopted racial and cultural issues as the special focus for the visiting programme during 2003-04.

5.7.7. All NHS organisations now have a statutory duty to work to eliminate unlawful racial discrimination. The NHSScotland *Fair for All*<sup>66</sup> initiative obliges all NHS Boards and Trusts to produce *Race Equality Schemes* and *Fair for All Action Plans*. The National Resource Centre for Ethnic Minority Health (NRCEMH) was set up in order to support this work and is based within NHS Health Scotland (previously The Health Education Board for Scotland and the Public Health Institute of Scotland).

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<sup>64</sup> MacPherson, Sir W, *The Steven Lawrence Inquiry*, 1999

<sup>65</sup> Mental Welfare Commission Annual Report 2001-02

<sup>66</sup> Scottish Executive Health Department HDL 2002 (51): *Fair for all: working together towards culturally-competent services*

5.7.8. A review of progress was undertaken jointly by NRCEMH and the Commission for Racial Equality (CRE) in 2003. The *Fair Enough? Report*<sup>61</sup> described clear commitment and leadership, but noted local difficulties translating policies into action so that although there were examples of good practice there were definite gaps and weaknesses.

5.7.9. People from different ethnic groups should have their cultural and religious practices respected and provided for wherever possible. Some within black and minority ethnic communities, particularly women, only access services at the point of crisis due to lack of confidence and trust in the service. In some cases a mental health practitioner can lack the appropriate knowledge and language skills to communicate with a distressed individual and in this regard the development and support needs of interpreters and advocates must be acknowledged. There are 13 main areas where care could be improved. Understandably many apply to all care groups:

- Dietary requirements
- Spiritual care
- Interpreting and translating
- Advocacy
- Same sex facilities (and staff where possible) for women – taking into account the needs of children
- Suicide prevention
- Outreach, drop-in and community based services
- Culturally appropriate information, including on the new Act
- Psychological and self-help therapies
- Funding initiatives with the black and minority ethnic volunteer sector
- Unmet needs of refugees and asylum seekers
- Service users, carer involvement and activities
- Workforce development

5.7.10. In some cases the provision of interpretation and advocacy services may be complex because of family connections in small, close communities and ensuring truly independent services may prove difficult. The same can apply to remote island communities. A basic principle should remain one of choice. Some people may prefer to move away from their local area for treatment so as to enhance confidentiality. Wherever possible such requests should be respected and facilitated.

5.7.11. Improving the mainstreaming of ethnic community issues should focus on the patients their families, and also on the staff. Ethnic minorities contribute significantly to the workforce in the health and social services.

5.7.12. The Review Team noted that the National Resource Centre for Ethnic Minorities has received funding to conduct a stock take of mental health services across Scotland for individuals from black and ethnic minority communities and a final national report will be produced this year (2004) and will incorporate 15 NHS Board locality reports. Once available these should be read alongside the National Assessment published locality reports.

## 5.8. ASYLUM SEEKERS

5.8.1. Asylum seekers are of course entitled to have access to NHS care and support on exactly the same basis as UK residents. This entitlement continues through any appeal stage.

5.8.2. The remit of this Review includes consideration of demographic factors. One significant development that had not been anticipated fully is the increase in the number of asylum seekers in Scotland, many of whom have survived severe physical and psychological trauma and need considerable help. Asylum seekers are among the most poor and vulnerable care groups. Their weekly funding is about 70% of UK income support; they cannot claim other benefits and are not permitted to work. Difficulties in accessing health care services were highlighted as one of the main emerging health issues for asylum seekers and refugees in *Fair for All*.<sup>67</sup>

5.8.3. Most of those 'dispersed' to Scotland live in Glasgow, where there are about 10,000 asylum seekers. About 80% of those granted refugee status have remained in Glasgow. Neither group was included in the ethnic census data.

5.8.4. Glasgow has developed a designated service for assessing needs and assisting this group. In the last 4 years nearly 800 people were referred for specialist mental health help from 55 countries of origin and 33 languages (78% needing an interpreter). Over an 18 month period 46 people were admitted to psychiatric inpatient facilities, some more than once. The most common diagnoses were post-traumatic stress disorder and depression, although 5% suffered major psychotic illnesses.

5.8.5. Gender issues are especially important in all contact and support for asylum seekers and refugees due to the high incidence of sexual assault and rape that has taken place. The sensitivity and expertise of people working in sexual assault clinics provides an essential contribution to the support networks needed. A Scottish Executive report on sexual abuse services is due to report this year.

## 5.9. ADVOCACY

5.9.1. The Mental Health (Care and Treatment) (Scotland) Act 2003 includes the requirement for local authorities and NHS Boards to collaborate to ensure independent advocacy services are available for people with mental disorder.<sup>68</sup> Many current advocacy services are not wholly independent of provider organisations bringing the potential for a conflict of interest.

5.9.2. The Scottish Independent Advocacy Alliance, initially funded by the Scottish Executive, provides an umbrella agency for advocacy and offers support and training to individual projects and assists in developing services.

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<sup>67</sup> Scottish Executive Health Department, *Fair for All: Improving the Health of Ethnic Minority Groups and the Wider Community in Scotland*, 2002

<sup>68</sup> Mental Health (Care and Treatment)(Scotland) Act 2003, Part 17, Chapter 2

5.9.3. The Advocacy Safeguards Agency is funded by the Scottish Executive to ensure that good quality independent advocacy is available to anyone in Scotland who needs it.

### Current services

5.9.4. Although advocacy services are developing for adults aged between 18 and 65 years who have mental health problems and for people with a learning disability there is a general lack of advocacy provision for older people, people with dementia, young people and children, people with a physical disability and those from ethnic minorities. 'Hidden' need also arises for other groups, including homeless people and ex-prisoners.

5.9.5. People with mental disorder are among the most vulnerable, especially so when communication difficulties are a factor. The Act provides the right of access to independent advocacy services and they are crucial in ensuring that people can make their voice heard. In addition, advocacy services work with commissioning bodies to develop services and are involved with the evaluation of existing services and in offering suggested solutions to difficulties encountered in the work.

### Funding and spending

5.9.6. Advocacy services are primarily funded by the NHS and local authorities, although there is significant variation in statutory funding across the country (table 3) and a significant proportion of funding (18%) comes from other sources such as the Scottish Executive, charities, trusts and community funds. About 70% of the total advocacy spend is on independent or sole focus services. The Advocacy Safeguards Agency notes that while the increase in statutory agency spend has increased by 36% in the last year, and there has been an increase of 61% in spend on independent services, there remain many gaps in service.

Table 3 - Statutory advocacy spend per head of population, NHS and local authorities, 2003/04

NHS Area	Population <sup>69</sup>	Statutory spend (£) <sup>70</sup> (% on independent advocacy)	Per head (£)
Argyll & Clyde	420,163	501,085 (50.1)	1.19
Ayrshire & Arran	371,056	542,963 (71.2)	1.46
Borders	106,644	69,500 (100)	0.65
Dumfries & Galloway	144,278	139,272 (0) <sup>71</sup>	0.97
Fife	350,954	388,583 (100)	1.11
Forth Valley	279,156	342,690 (100)	1.23
Grampian	519,688	330,064 (100)	0.64
Greater Glasgow	900,156	1,222,470 (53.9)	1.36
Highland	208,480	287,826 (34.7)	1.38
Lanarkshire	561,666	760,594 (44.5)	1.35
Lothian	790,484	1,241,473 (74.2)	1.57
Orkney	19,290	12,760 (100)	0.66
Shetland	22,068	15,680 (100)	0.71
Tayside	380,651	267,945 (91.6)	0.70
Western Isles	26,528	25,000 (100)	0.94
State Hospital	-	98,003 (0) <sup>72</sup>	-
<b>SCOTLAND</b>	<b>5,101,262</b>	<b>6,278,898</b>	<b>1.23</b>

5.9.7. A further £1,405,763 is received from other sources.

5.9.8. Given that the Act gives the right of access to independent advocacy, there may need to be significant increases in services to meet the anticipated needs. People with mental disorder benefit from the services of an advocate in several ways. This might be to assist with representation at a Tribunal or other specific situations. Other people may require assistance in representing their views in the longer term due to ongoing difficulties getting their point across. Group or collective advocacy might be appropriate for people with mutual concerns. Advocacy services are organised so that these differing situations can be addressed with professional, volunteer, citizen, collective and self advocacy services available.

<sup>69</sup> Population figures as supplied to Advocacy Safeguards Agency by SEHD.

<sup>70</sup> NHS and local authorities only. Advocacy Safeguards Agency. The total reflects that in the final ASA 2003/04 map. Some figures are provisional and will be subject to minor correction.

<sup>71</sup> The primary advocacy service is now close to independence

<sup>72</sup> The State Hospital service is managed by SCVO and not 'sole focus'

5.9.9. It is estimated that there will be 3,000 Mental Health Tribunals per year.<sup>73</sup> In August 2003, 1,921 people were subject to long-term detention under the 1984 Act and in 2002-03 there were 2,795 short-term detentions.<sup>74</sup> All of these people could request the services of an advocate and will be informed of this by their mental health officer. In addition, there were about 25,000 admissions to psychiatric hospitals in 2002<sup>75</sup> and this number of people could also request a service. People receiving outpatient services might further add to these totals. It was not possible to get information about how many people actually used the services and this is important data to collect.

5.9.10. It is very difficult to estimate future demand and the likely requirements for additional advocates. There will almost certainly be an increased demand. Work on identifying gaps and planning new and increased services is very much work in progress for local commissioners in conjunction with the Advocacy Safeguards Agency and the Scottish Independent Advocacy Alliance. However, given the finite workforce available, recruitment of both paid and unpaid advocates is expected to be problematic. There is a risk that the statutory requirement for mental health advocacy might divert available human resources away from other forms of advocacy. The training of new workers will also place demands on the limited resources of the Scottish Independent Advocacy Alliance and other training sources.

5.9.11. Given the complexity of the new legislation and the significant involvement of advocates, among the challenges for advocacy will be consideration of the roles of paid and unpaid advocates. Training about the Act will be vital along with an appreciation of mental illness and how this might manifest itself. It is important for an advocate to be able to understand and represent the interests of the client even when, or especially when, the person is acutely unwell and perhaps expressing unusual ideas.

5.9.12. Advocacy organisations may need to consider the level to which the service can and should 'professionalise' and develop a career structure. This would help to address a common complaint that health and local authority professionals do not give due regard to independent advocacy and would bring a sounder footing to the process. For some service users, however, this could have the disadvantage of making it appear that advocates had joined the formal caregivers.

5.9.13. Advocacy services do not have the capacity to provide a service to everyone who might request it. Planning partners within each NHS Board area are required to submit the next 3 year advocacy plan in February 2004 to the Executive and these plans will need to reflect the new requirements.

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<sup>73</sup> Financial Memorandum to the Mental Health (Scotland) Bill

<sup>74</sup> Mental Welfare Commission; Provisional figure

<sup>75</sup> ISD Scotland, IR2003-00292, 21 August 2003

## 5.10. ACCOMMODATION

5.10.1. The transfer of Housing Benefit funding to local authorities under the **Supporting People** initiative means that more people who are vulnerable can receive support to retain their tenancies and stay in their own homes and this will include significant numbers of people who have mental health problems. (Certain aspects of employment-related support are also eligible under Supporting People funding - see the separate Employment section of this chapter).

5.10.2. Closure of large numbers of psychiatric hospital beds for people with long term illness and the expansion of community based services has allowed finance to transfer from NHS Boards to local authorities through the resource transfer arrangements. This has contributed to the costs of care and support provided by the local authorities directly or commissioned from other providers,

5.10.3. In most cases 3 year service contracts are agreed between the local authority and supported housing providers, although commonly voluntary sector providers agree ongoing funding on a year to year funding. Some contracts will not include an increase for inflation. In such cases the provider will be placed under increasing financial pressure to keep pace with salary costs, new investment in equipment, training and other pressures.

5.10.4. The 2001 voluntary sector workforce survey showed that there were around 37,000 social care staff<sup>76</sup> in Scotland. The survey did not define the proportion who were working with the adult mentally ill, nor those employed in supported accommodation. However, the findings did confirm that around 15,000 staff had qualifications in social work, registered nursing, occupational therapy, or community education. There are concerns within the voluntary sector about their long-term ability to attract and retain experienced and trained personnel to their services given increasing competition over salary levels.

5.10.5. Information from the statutory to voluntary sector is not always wholly exchanged or explained, with the potential for leading in some cases to an unsafe position caused by the failure to provide essential basic facts. This point of view was expressed more than once by voluntary sector providers.

5.10.6. It is essential that voluntary sector providers of care and support become more integrated in the overall mental health teams, and be better valued for the role and contribution they make to sustaining people in their own homes and communities.

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<sup>76</sup> The Scottish Voluntary Sector Social Services *Workforce Survey* 2001

### Regulation of housing support

5.10.7. From April 2002 all registered supported accommodation, support services, day care services, residential homes and nursing homes fell under the quality, registration and inspection processes of the new Scottish Commission for the Regulation of Care (Care Commission). From October 2003 all housing support services were also required to be registered and inspected by the Care Commission. Care at home services came under the Commission's responsibility from December 2003.

### Support models

5.10.8. Models of supporting people in community housing were described in the Scottish Development Centre for Mental Health (SDCMH) briefing paper<sup>77</sup> under five main headings:

**Table 4 - Models of supporting people in community housing**

Housing management services	Core housing management services, limited help to tenants with support needs
Housing support workers	Employment of a specialist worker to provide support to tenants with special needs. This person does not carry out core housing management tasks, but concentrates on intensive housing management and support
Housing support teams	Teams of workers providing intensive housing management and support.
Floating support schemes	Support for tenants in ordinary housing
Home support services	Focus on specific client groups including people with mental health problems. Individually tailored services including practical help, support to run a household, domiciliary help, personal care and specialist support

<sup>77</sup> Scottish Development Centre for Mental Health, *Developing housing services for people with mental health problems*, January 1998

5.10.9. Strathdee and Thornicroft<sup>78</sup> estimated the number of supported living places that would be required for every 250,000 population, shown in table 5 below:

**Table 5 - Number of supported living places required per 250,000 population**

Type of service	Places per 250,000 population
24-hour staffed units	40-150
Day staffed residences	30-120
Unstaffed homes	48-80
Respite	0-5

5.10.10. In many cases local authority staff raised concerns about the lack of adequate and affordable housing stock in their area to allow supported accommodation to be developed. One solution now being employed in parts of the country is to include a Senior Housing Officer on the local strategic mental health planning forum, with some positive results in greater access to housing.

### Types of support people receive

5.10.11. Most people who receive support to live in a home of their own (whether single or shared tenancy) are generally happy with the services they receive. Service users understandably attach great importance to security of tenure, a place to call their own home, to being listened to and to having access to help if and when required. Individually and collectively these components are key to maintaining positive health. The Scottish Development Centre for Mental Health refers to the work of Carling<sup>79</sup> and 3 guiding principles for supporting people in housing:

- **Choice** – location, neighbourhood, convenience, space, privacy, accessibility to networks and services
- **Integration** – the opportunity to live in non-segregated stable housing with the necessary support provided
- **Normalisation** – the avoidance of approaches that accentuate differences from typical community practices and acceptable patterns of lifestyle

5.10.12. Voluntary sector providers have said to the Review Team that for any provider to deliver on all 3 principles means going beyond the traditional 'medical model' of diagnosing and treating illnesses and ensuring a whole person approach to care. Supported housing providers regularly commented on a group of service users whose needs assessments were out of date and as a result the existing care packages no longer met needs. This absence or regular review of needs applies especially for the 'graduate' long-term population.

<sup>78</sup> Strathdee G, Thornicroft G, *Community sectors for needs led mental health services, Measuring Mental Health Needs* (eds Thornicroft G, Brewin C and Wing J K), Royal College of Psychiatrists, London, 1992

<sup>79</sup> Carling PJ, *Housing and supports for persons with mental illness*, Hospital and Community Psychiatry, 1993

5.10.13. The Scottish Association for Mental Health, one of the voluntary sector housing providers, notes a growing difficulty in accessing services for people in crisis situations, although they found that those on the Care Programme Approach (CPA) usually experience better responses.

### Benefits Issues for Users

5.10.14. Supporting people in the community through the Benefits system has recently undergone significant change. The introduction of *Supporting People* in early 2003 was to replace *Transitional Housing Benefits*. While this was expected to increase the availability of housing support, this has yet to be fully achieved.

5.10.15. Many existing supported housing projects have or are in the process of transferring to unregistered status with the Care Commission. A key feature of this will require transferring tenancy of a property from the service provider to the resident. The people most affected by this are often the most vulnerable, marginalised and at risk of social exclusion.

5.10.16. The effect of these changes has placed many potential tenants on their local mainstream housing list, rather than being in a home run and provided through a housing support provider. While these moves toward greater autonomy and independence are positive, the paradox is that vulnerable users will now have to negotiate with a variety of agencies, potentially the Department for Works and Pensions, Housing Benefits offices, Council Tax benefits sections, and separate utility providers. The housing support providers previously dealt with all such issues.

5.10.17. People who need furniture and housing equipment now need to submit applications for Community Care Grants. Previously housing support providers were able to secure value for money and other savings through bulk purchase and discount arrangements.

## 5.11. EMPLOYMENT

5.11.1. Employment policy is complex, involving many initiatives to drive the agenda forward for the population as a whole. There are particular issues facing people with a mental illness, who have historically been marginalised from the work force. Evaluative research to discover which employment interventions actually work best is hard to find in this country. American studies found that interventions based on supported employment models were significantly more effective than vocational training in achieving the desired outcomes of sustained open employment.<sup>80</sup>

5.11.2. Section 26 of the new Act places a duty on local authorities to provide support into employment for people with mental health problems. The actions required will have an impact on health, social work, employment, enterprise, education and social inclusion agendas. Surveys confirm that people with mental health problems want a range of employment services and opportunities. Up to

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<sup>80</sup> National Institute for Mental Health in England, *Employment for People with Mental Health Problem*, 1997

90% have said they would like employment of some kind<sup>81</sup>, but not everyone wants to be employed in the competitive mainstream setting. Some people may not be capable of joining or rejoining the workforce and a range of opportunities including sheltered, supported and voluntary settings may be attractive alternatives to ensure occupational activity.

5.11.3. In broad terms studies indicate that as well as financial reward, work offers added status, purpose and opportunities for relationships,<sup>82</sup> yet there is a paradox reflected in the rising incidence of work related stress disorders.

### Numbers and costs<sup>83</sup>

5.11.4. The number of people with a physical disability gaining work has steadily increased over the last ten years, but there has been very little increase in the proportion of working adults with acknowledged mental health problems. A recent report<sup>84</sup> estimated that 43% (117,000) of unemployed people in Scotland have a mental illness.

5.11.5. People with a mental illness who receive Incapacity Benefit comprise around 35% of the current 2.7 million registered in the UK and are 3 times more likely to be unemployed than all other disabled people. People with psychotic disorders are even less likely to be in employment.

5.11.6. For some people state benefits can act as a disincentive to work and this issue is being tackled through initiatives such as Disabled Persons Tax Credit and Pathways to Work Green Paper<sup>85</sup>. However, fear of losing benefits may for some remain a significant barrier to returning to work.

5.11.7. In addition to the personal costs for people with mental health problems who cannot work, there is the economic cost for the country of the inactivity of such a large group of people. In Scotland the estimated cost<sup>86</sup> is around £1 billion.

### Policy background

5.11.8. The Disability Discrimination Act 1999 (DDA) aims to tackle a wide range of discrimination against people with disabilities and prohibits discrimination against any person with any disability who either applies for a job or is already in employment. There is little evidence yet of the impact of the DDA on mental health service users in relation to employment.

5.11.9. Helping people with disabilities, including those with mental health problems to return or start work is an important factor in recovery. This is supported through a range of policy statements and practical initiatives, including the Welfare

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<sup>81</sup> Secker J., Grove B. & Seebomh P. *Challenging barriers to employment, training and education for mental health service users: the service user's perspective*; Journal of Mental Health 10:4: 395-404, 2001

<sup>82</sup> Schneider J. *Work interventions in mental health care: Some arguments and recent evidence*; Journal of Mental Health, 7: 81-94, 1998

<sup>83</sup> Employment statistics derived from *Pathways to Work or from the Labour Force Survey 2000*

<sup>84</sup> Durie S. *Pathways to Work*, Scottish Development Centre for Mental Health, 1999

<sup>85</sup> Department for Work and Pensions, *Pathways to Work: Helping People into Employment*, 2002

<sup>86</sup> Updated and extrapolated from Patel A. & Knaap M. *The Cost of Mental Health in England*, PSSRU Mental Health Research Review 5, Centre for the Economics of Mental Health, 4-10; 1998

to Work Task Force, New Deal for Disabled People and Pathways to Work. The National Programme for Improving Mental Health and Well-Being<sup>87</sup> has a key priority to improve mental health and well-being in employment and working life. This will raise the profile and support that mental health service users can expect to receive from employment initiatives.

5.11.10. The *Framework for Mental Health Services in Scotland*<sup>2</sup> includes a section on 'Services to promote personal well-being and social development', offering service elements relevant to employment and these should form a service matrix for strategic planning.

5.11.11. Finally, the *Mental Health and Employment Policy for Scotland*<sup>88</sup> addresses closing the exclusion gap, tackling discrimination, improving the mental health of the working population and solving labour force shortages.

### Service funding and availability

5.11.12. There is no obvious single secure source of funding for the various specialist employment services that target people with mental health problems. Historically many services operate with an unstable mix of funding sources with many receiving grants from the European Social Fund (ESF) Objective 3 and the New Futures Fund. The imminent termination of this type of funding will not help existing projects and some may close down.

### Service patterns

5.11.13. There is a diverse range of opportunities and although this is a very positive development the complexity means that understanding and co-ordinating such services is difficult. At a local level services are often patchy and the full range of options is rarely available. There is general consensus that an **employment spectrum** is required which means that people should have access to advice and brokerage; preparation for work; vocational and pre-vocational training; sheltered employment and transitional employment; and preventive strategies/work retention.

### Preparation for work

5.11.14. Within the health service (often located in old larger psychiatric institutions) occupational therapy centres, day hospitals, and industrial therapy units combine to offer service users structure and meaning to their week, and some work preparation skills.

5.11.15. Within health and social work the role of occupational therapists should be considered core to identifying the employment needs of service users, although some of these services would be better delivered by the voluntary sector or the many other providers of employment in the community.

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<sup>87</sup> National Programme for Improving Mental Health and Well Being; *Action Plan for 2003-06*.

<sup>88</sup> Durie S, *Mental Health and Employment Policy for Scotland*, Scottish Development Centre for Mental Health, 2003

5.11.16. As the emphasis on community prevention and recovery gathers momentum, many of these services have been redesigned or re-commissioned. Within the community, day centres and drop-in centres are valued by people with mental health problems. The majority are provided by the voluntary sector and advice, encouragement and active brokerage into work are features of such services.

5.11.17. There are 6 Clubhouse centres in Scotland, where service users determine the running of the projects as members of a club. Members participate in a variety of activities, usually within the Clubhouse and education and training courses build confidence and raise awareness of opportunities. Members can move on to Transitional Employment Placements - part-time entry level jobs negotiated by the Clubhouse with local employers. Clubhouse staff work alongside the member for as long as is necessary.

5.11.18. Voluntary work has great potential as a step on a 'ladder of opportunity'. A surprisingly high proportion of people with mental health problems are involved in voluntary work at some point in their lives.

### Vocational and pre-vocational training

5.11.19. Service user groups have noted that training is of little use if the likelihood of getting a job at the end of it is minimal<sup>89</sup>, and the extent to which training actually leads to employment is not clear and should be monitored if that is the specific objective.

### Sheltered employment and transitional employment

5.11.20. There is a wide range of sheltered workshops and sheltered employment factories give opportunities to people with a range of different disabilities. The proportion of places taken up by people with mental health problems is not currently known. 'Social firms' and 'social enterprises' are the best-known service models within a transitional employment market that has been evolving and growing over recent years. The aim is to increase job readiness while recognising that some service users will not wish or will not be capable of moving on to mainstream employment. Virtually all social firm initiatives have been taken forward by the voluntary sector.

### Preventive strategies/work retention

5.11.21. Early intervention and counselling services could minimise mental health problems and reduce the incidence of work related stress. Durie<sup>84</sup> argues that *"the overwhelming need is to stop people losing their jobs as a result of mental health problems, spending long periods inactive then needing significant help to overcome barriers to employment. Investment in job retention would eventually release resources to reallocate to supporting new labour market entrants and people with severe and enduring problems."*

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<sup>89</sup> Highland Users Group, *Employment – A Report on Employment for people with mental health problems and ways in which access to employment could be made easier*, 1997

## 5.12. TRANSPORT

5.12.1. There can be major difficulties in remote areas when people are dependent on public transport, often relying on benefit support. In a town or city, access to drop-in support and leisure or work opportunities may be difficult, but is possible. People with mental health problems who live in rural and island communities have little opportunity to travel to such services (even if they are available). How are they to reach help or get to hospital? How does a solitary staff member get from one island to another in time to respond to urgent calls for help?

5.12.2. Solutions centre mainly on time-tabling, co-ordination, ingenuity and community spirit reflected through volunteer rotas from car owners, including those with mental health problems themselves. The Review Team was impressed that one service had the flexibility to provide a bicycle for someone with long-term mental health problems.

5.12.3. Under the new Act<sup>90</sup> a clear duty has been placed on local authorities. The exact provisions are set out below:

*Assistance with travel*

*A local authority –*

*(a) shall–*

- (i) provide, for persons who are not in hospital and who have or have had a mental disorder, such facilities for, or assistance in, travelling as the authority may consider necessary to enable those persons to attend or participate in any of the services mentioned in sections 25 and 26 of this Act; or*
- (ii) secure the provision of such facilities or assistance for such persons...*

5.12.4. Mental health patients, like other service users, will sometimes need transported to hospital by ambulance because their state of health rules out alternatives. The Review Team heard concerns about the Scottish Ambulance Service (not about the ambulance staff), where delays were seen as being attributable to a too rigid reliance on protocols.

5.12.5. At the extreme end the Review Team was told about a few people, who would otherwise have agreed to an informal admission, being detained under the Mental Health Act in order to get the required escorts to allow transport from the Air Ambulance Service rather than wait for routine transport. This practice is unacceptable and illegal.

5.12.6. In remote places there will be infrequent need for such transport for people who are mentally ill and therefore little local experience in dealing with such situations. The stigma of mental illness includes for some a fear that the person concerned will be or become violent and it is appropriate that due caution be taken,

<sup>90</sup> Mental Health (Care & Treatment) (Scotland) Act 2003, Section 27(a)

especially in a small aircraft with access to the cockpit. However this needs to be done on an informed basis and we welcomed the fact that the Scottish Ambulance Service has recently issued guidance on *Emergencies in Mental Health*<sup>91</sup> to establish routine procedures.

5.12.7. It will be important that ambulance staff are given appropriate awareness training about the new Act, alongside relevant mental health training.

5.12.8. The Remote and Rural Areas Resource Initiative (RARARI) multi-agency report<sup>92</sup>, 2003, has 10 recommendations based on getting the right balance between respecting an individual's rights and needs and the responsibility to ensure the safety of others.

5.12.9. A key recommendation from the RARARI report is that *"When psychiatric patients are to be admitted to hospital, the need for transport and/or escort must be assessed separately from the need for detention under the Mental Health Act section, and clearly documented."*

5.12.10. All delays cannot be attributed to the ambulance service. Finding NHS escorts can be a time-limiting factor (as can the weather). The collection of systematic data about the process and outcome of ambulance transfers will lead to better informed discussion and resolution of some of the tensions that may arise.

5.12.11. When there is a delay in getting transport to hospital, there is a need for a safe place for the patient to wait in to reduce or remove any risk to self or others.

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<sup>91</sup> Scottish Ambulance Service, *Emergencies in Mental Health - A Guidance note for the Scottish Ambulance service*, September 2003

<sup>92</sup> Remote and Rural Areas Resource Initiative, *Recommendations for the safe management of acutely disturbed psychiatric patients in Scotland's remote and rural area*, 2003



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workforce

## 6. WORKFORCE

6.1. The progressive move of services from hospital to community based settings has led to changes in the hospital inpatient population, the settings in which care takes place and the range of staff involved. People stay in hospital for a much shorter time and many people who used to be treated in hospital are now actively supported in the community. Those needing to be admitted to hospital therefore tend to have more complicated problems (50% have co-morbid substance misuse or alcohol problems) so that staff skills need to be developed. There is considerable overlap between the roles performed by professional groups within the range of care settings and in the skills the staff are expected to have.

6.2. The advent of the community-based *Compulsory Treatment Order* under the Act will require additional skills and competencies, always underpinned by a therapeutic relationship based on ethical principles, including respect for the user's autonomy and respect for carers.

6.3. A service user should have access to:

- skilled psychological interventions (from different staff groups, not just psychology)
- social support, (including housing, opportunities for social activities and training or education)
- medication when indicated
- attention to alcohol problems and/or substance misuse
- help to minimise the impact of personality related problems
- support for recovery (including occupational opportunities)
- evidence-based interventions to alleviate the effects of previous trauma
- attention to their developmental needs (especially for young people and people with a learning disability)

6.4. In this complex system of care, the key to *who does what, when, why, who else needs to know and what was the outcome* issues are best addressed within the developing integrated care pathways and managed clinical/care networks.

6.5. Workforce considerations are not only about numbers and training, but also about a service redesign approach with examination of service structure and practice and the increasing development of the voluntary sector. Redesign implies joint local determination of how best the available workforce resource can be used to the greatest advantage of both the user of services and the carer. Inter-professional relationships in front-line teams have sometimes been governed by the need to avoid overt conflict and by confusion about applying shared and specialist skills across different professions and agencies. There are still difficulties over, and imperfect understanding of, how to set up, focus, manage and evolve multi-disciplinary teams, let alone multi-agency variants. There is a need to foster flexible working practices to better meet the needs of service users whose problems do not fit neatly into the categories envisioned by professions a decade or more ago.

6.6. An urgent task is to identify core competencies for staff (building on the Department of Health's UK initiative).<sup>94</sup> This will help to clarify what is needed for joint training and what for specialist training, which would address some of these issues.

6.7. A related and relevant factor, raised several times during the Review Team visits, is the difficult issue of differential rates of pay for very similar work. Even within the same profession there are differentials: some Mental Health Officers get additional payments, some do not. The introduction of the new consultant and GP contracts, new training patterns for junior medical staff, and the impact of the Agenda for Change for non-medical professions are major drivers for discussion about service redesign. The European Working Time Directive, age structure in professions and demography provide other pressures.

6.8. The most obvious constraint on the further development of mental health services in Scotland is the shortage of appropriately trained and qualified staff, affecting health, social work and voluntary organisations. Even if large additional sums of money were made available recruitment would not be possible. The workforce for mental health services should be sought from a wider pool, with better retention and more purposeful training. Clarity is required about the approach to be adopted with regard to maximising the benefit for the patient from joint working with voluntary organisations, many of whose staff are well qualified and highly skilled. Without consistent better overall management of services, any impact of a larger and more skilled workforce may be lost.

6.9. With the current workforce shortage, services away from large urban centres are beginning to suffer a drain of staff to centralised locations which are more accessible and may be better resourced. Joint policies sensitive to local needs will be needed to counter this.

### Staff groups for attention

6.10. The range of contacts and professional involvement will include, among others:

- Consultant psychiatrists
- Clinical (and other) psychologists
- Registered mental health nurses
- Allied health professionals, including dieticians, speech and language therapists, occupational therapists and physiotherapists
- General Practitioners and other primary care workers
- Social workers
- Mental health officers
- Pharmacists

### Next steps

6.11. The forward development of the workforce supply issue requires action on at least two fronts:

- The **longer term** issue of shifting the trend towards training focused on explicit defined professional competencies and the dissolution of artificial (sometimes professionally driven) service boundaries; thus emphasising skills held in common, instead of increasing differentiation.
- The **short term** issue of making better use of the available workforce through service redesign to address staff shortages/recruitment/ training/retraining and working better with those who can be recruited.

### Consultant psychiatrists

6.12. There are about 400 consultant psychiatrists in Scotland with around 8% of posts vacant.<sup>93</sup> There is a UK wide shortage of consultant psychiatrists in general psychiatry and most specialties.<sup>94</sup> Given the numbers currently in training, and the age profile of existing consultants in Scotland the position is likely to deteriorate further. Given the length of training required, there is not going to be any early change for the better.

6.13. The 2003 Act makes provision for and gives powers and duties to 'approved medical practitioners' (AMPs) in relation to compulsory measures. AMPs are similar to 'section 20 doctors' under the 1984 Act. NHS boards, including The State Hospital, must maintain a list of medical practitioners who have the necessary qualifications and experience and have undertaken appropriate training. This is not limited to psychiatrists and it is hoped that more GPs will take on this responsibility, although there was little expression of interest shown during the Review visits.

6.14. The workforce implications of the contributions to be made by psychiatrists to the panels for Tribunals arising from the Mental Health (Care and Treatment) (Scotland) Act 2003, plus the need to appear before them, has been looked at by the Royal College of Psychiatrists and although it is hard to predict, between 18.2 and 28.5 whole time equivalents<sup>95</sup> were estimated as being necessary on top of the numbers of current vacancies. Much will depend on what the Tribunal procedures demand of clinicians, and the opportunity costs in terms of time and the diversion of effort. In addition, these calculations fail to take account of the impact of the European Working Time Directive which will be in force for consultants by the time the Act is implemented. Subsequent consideration by the Royal College of Psychiatrists suggests 30 whole time equivalents might be a better estimate of need.

<sup>93</sup> Royal College of Psychiatrists

<sup>94</sup> Mental Health Services - Workforce Design and Development - Best Practice Guidance  
<http://www.nimhe.org.uk/>

<sup>95</sup> Royal College of Psychiatrists, Scottish Division, *Renewing mental health law: A scoping exercise in respect of the impact on psychiatrists' time*. Feb 2002

6.15. At the time of writing, it is not clear what will be the impact of the new consultant contract. It gives an opportunity for the detailed re-evaluation of the tasks that can only be undertaken by a consultant, and those that can be performed by other staff, which is implicit in the concept of service redesign.

6.16. The Royal College of Psychiatrists is looking at training, recruitment and retention issues.

### Clinical psychologists

6.17. Training is now the responsibility of NHS Education for Scotland (NES). Work is in hand to:

- increase the number of clinical psychologists (currently around 360 WTE (2002)<sup>96</sup>)
- increase the numbers in training within the two existing schools
- incorporate the existing group of assistant psychologists into an additional modular based training, leading to the DPhil over 5 years
- initiate a year-long training leading to a diploma for graduate psychologists to enable them to work in the primary care environment
- improve the training of other professionals by making places available to take modules on the 5 year course
- consider how to retain the >25% of the workforce who will be eligible to retire in the next decade, and improve the working conditions of 1/3rd of the workforce who are part-time
- move to a competency based training model
- approach all Primary Care NHS Trust (PCT) Chief Executives to engage them in partnership with NES in taking this forward

6.18. There are increasing numbers of counselling and health psychologists, who also make valuable contributions to care.

### Nursing

6.19. The net of pre-registration nursing recruitment is now cast much wider than the traditional school leaver group to incorporate mature students and alternative routes into the programme. Service redesign teams need to bear these in mind.

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<sup>96</sup> NHS Education Scotland, *Clinical Psychology Workforce Planning Report*, 2003

6.20. All entrants to pre-registration programmes must have the Nursing and Midwifery Council (NMC) minimum educational requirements, the equivalent of 5 points. This can be achieved in a variety of ways apart from the normal school educational attainment;

- achievement of Scottish Vocational Qualification (SVQ) in Care at Level 3
- specific pre-nursing Access programmes are provided by Further Education Colleges
- Higher National Certificate (HNC) (non-NES endorsed pathway)
- achievement of HNC Health Care (NES endorsed pathway)

6.21. In addition, National Education Scotland (NES) has commenced a mapping project to allow Accreditation of Prior Learning (APL) for appropriate SVQs against the new HNC Health Care (NES endorsed pathway) which will allow students to enter part way through the 1<sup>st</sup> year of the pre-registration programme.

6.22. Pre-registration nurse education leading to registration in mental health nursing is provided from 7 universities across Scotland. Overall the Scottish Executive Health Department (SEHD) contracts for approximately 400-500 mental health students each year. Recruitment to mental health nursing programmes is slightly problematic with difficulty recruiting the required numbers. The Student Nurse Intake Planning (SNIP) process has recommended increased numbers of mental health students for the last 6 years (1997/98), but there has been an under-recruitment of approximately 10%.

6.23. There are 1200 to 1500 students undertaking pre-registration nurse training leading to first level registration in mental health nursing in any given year.

6.24. Child and Adolescent Mental Health Services – Napier University has also developed two Level 3 modules by flexible learning, which are proving very popular with a multidisciplinary audience. The uptake is Scotland-wide, and includes inpatient, outpatient and day care nurses, social work staff, independent sector providers, health visitors, school nurses, primary care workers, and allied health professionals. NHS Education for Scotland also has a multidisciplinary group developing CAMHS competencies, which will be set at 3 different levels and will lead to the development of suitable courses to meet the aforementioned levels of staff.

6.25. A commitment to improve the current position on recruitment and retention of nurses is being taken forward under the umbrella of *Facing the Future* which is a national group chaired by the Minister for Health and Community Care. A particular focus has been in the areas of return to practice and the one year guarantee that ensures all newly qualified nurses gain employment in NHSScotland if they wish.

### Allied health professions

6.26. The 5 allied health professions (AHPs) most associated with mental health services are art therapy, dietetics, occupational therapy, physiotherapy and speech and language therapy. In March 2003 there were 6043 AHPs (including support workers) employed in NHSScotland<sup>97</sup>. Many AHPs have assistants supporting their work. Some of the professions are identified nationally and UK wide as shortage professions.

6.27. All AHPs are educated to degree level leading to state registration. Some of the professions offer post-graduate diplomas and MSc entry courses. Training standards and development are organised on a UK wide basis. Psychotherapeutic post-graduate qualifications (for example cognitive behaviour therapy, counselling, person centred therapy etc) are recognised by some of the therapy professions and required for some areas of specialist practice.

6.28. The Health Professions Council (HPC) is the regulatory body for all the allied health professions and registration gives the right to practice.

6.29. It is not clear what shortages there are within the current AHP workforce. There are several initiatives underway in Scotland to address recruitment and retention issues and the national workforce survey will provide some baseline information to inform future planning.

6.30. Occupational therapists will be members of mental health teams alongside other professionals such as speech and language therapists, physiotherapists and dieticians. All will have significant roles mainly with younger people, adults with learning disabilities and older people but the profile of each mental health team will vary between local health care systems according to the client group.

### Primary care

6.31. The exact numbers of different professionals required to deliver mental health services in primary care settings is not known. However, mental health is a priority for primary care in several areas and insights on national needs may arise from local redesign of mental health services in primary care.

6.32. Opportunities for further development include:

- GP education, including their role in operating provisions in the Act
- education/training of other staff working in the community such as public health practitioners, community/practice nurses, midwives, staff in care homes and staff from voluntary groups/helplines, etc
- availability of information about the care/referral routes
- links to NHS out-of-hours services

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<sup>97</sup> Information Statistics Division, March 2003

### Social workers

6.33. There are at present (2003) approximately 450 social work students in Scotland. The current professional qualification is the Diploma in Social Work (DipSW) but from 2004 the DipSW will be replaced by an honours degree qualification<sup>98</sup>.

6.34. The Standards in Social Work Education (SISWE) set out what student social workers must achieve to gain the honours degree and to become professionally qualified. SISWE reflect the importance of core transferable knowledge and skills and integrated service delivery.

6.35. A pilot scheme is being developed to fast-track graduates through the DipSW course in 15-18 months rather than the usual 22-24 months.

6.36. The Scottish Social Services Council came into operation in October 2001. It has the duty of promoting high standards of conduct and practice among social services workers, and in their education and training. It will establish registers of key groups of social services staff and regulate the training and education of the workforce. In doing so it will determine the criteria for accreditation and re-accreditation and continuous professional development.

6.37. At present there are approximately 4,918 social workers and senior social workers (WTE as at December 2003<sup>99</sup>) employed by local authorities in Scotland. Many are employed in the independent sector as well. The total social services workforce is thought to include around 100,000 staff.

### Mental health officers

6.38. Mental Health Officers are professionally qualified social workers who have had two years post-qualification experience, are employed by local authorities, have successfully completed additional training established by the Scottish Social Services Council and who subsequently have been appointed by the Director of Social Work/Chief Social Work Officer to carry out specific duties under the Mental Health (Scotland) Act 1984 and Adults with Incapacity (Scotland) Act 2000. The requirements for training, approval and appointment are set out in Directions by Scottish Ministers. At present there are approximately 700 social workers who have been appointed to act as MHOs. Not all are using this qualification in practice because career progression usually means a person moves into a managerial role without direct client contact. This is discussed in more detail in the interim and locality reports.

6.39. Recruitment and retention of social workers and MHOs in particular is an acknowledged problem that is beginning to be addressed on a national level.

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<sup>98</sup> Social Work Services Inspectorate, *General Social Care Council Datapack 2002-03*

<sup>99</sup> Scottish Social Services Inspectorate

6.40. The Act places additional responsibilities on local authorities and the mental health officer service. The equivalent of an additional 50 or so full time MHOs will be required to meet these new responsibilities and £2.5m has been allocated in the local authority revenue settlement to increase the MHO establishment in 2004-05 and subsequent years<sup>73</sup>.

6.41. The Scottish Executive commissioned research from the Scottish Development Centre on the capacity of the mental health officer service to meet existing and future statutory demand<sup>100</sup>. This research examined service structures, supports and service models in place throughout Scotland and it is intended that the report will help local authorities in examining and redesigning existing MHO service structures. The development of National Service Standards for Mental Health Officer Services will also help to drive forward the development of MHO service structures to provide a more efficient and responsive service.

### Pharmacists

6.42. Overall in pharmacy in Scotland there is thought to be around a 14% vacancy rate of hospital based pharmacists; the exact number of clinical pharmacists working within mental health as an area of special expertise is not known. Registration as a pharmacist takes five years, with a Masters degree in pharmacy followed by one year's practical training in community or hospital pharmacy.

6.43. Effective management of medication and its side-effects is a key factor in the treatment and long term success of the rehabilitation of people with a mental illness who require drug treatment. Side-effects such as weight gain or impotence can cause serious concerns and the pharmacist's knowledge and input can help doctors decide whether alternative drugs or approaches might be as effective, but with fewer side-effects.

6.44. The Review Team is aware that many hospital admissions are caused by preventable medicine-related problems. Patients, especially older people and those with chronic conditions, often receive treatment with 4 or more medicines (polypharmacy). These patients are more likely to develop side effects.

6.45. A lack of a systematic approach to the pharmaceutical care may lead to distress for the patients and their families, unnecessary hospital admissions and unnecessary cost. Clinical pharmacists can make a significant contribution to the management of psychiatric and other medicines and can help promote user compliance.

6.46. Some pharmacists are community based and integrated with their local community mental health team and outreach service, including the social and voluntary sectors. They provide information and advice to patients in drop-in centres and day-care centres, and can offer training on medication issues.

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<sup>100</sup> Scottish Executive, *Mental Health Officer Services: Structures and Supports* 2003

### The English experience

6.47. Skills for Health was formed in April 2002 with the support of the four UK health departments, independent health sector, voluntary sector and staff organisations to create a new organisation to develop the skills of the workforce of the whole health sector through the competency framework for the services for various care groups, called the National Occupational Standards for UK. The *National Occupational Standards for Mental Health* were published in June 2003<sup>101</sup>. These Standards do not immediately assist in resolving the workforce problem but can be used as a tool for job descriptions and promote the use of a common language to describe competencies for the planning, delivery and evaluation of services. Department of Health (England) has since published their *Mental Health Services - Workforce Design and Development - Best Practice Guidance*.

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<sup>101</sup> National Occupational Standards for Mental Health (2003) <http://www.skillsforhealth.org.uk/>

# **national mental health services assessment final report**

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finance

## 7. FINANCE

7.1. A considerable amount of money is spent on mental health services in Scotland. The NHSScotland spend in 2002-2003 was £573.9m<sup>102</sup> (excluding primary care mental health services provided within general practice). The data gathered by the Review Team indicated that NHS Trusts in Scotland invested around £85m in the same year on community services (not hospital services) for adults with mental health problems.

7.2. The new Act gives local authorities responsibility for providing a range of care and support services that cannot readily be linked to mental health, but which will form part of the important prevention and recovery network. Even for more direct client related social work services it is not easy to establish with any degree of accuracy the total expenditure on mental health services, because current local authority financial reporting systems do not separately identify all the relevant spend. For example, the costs of local authority mental health services for children, young people, and older people, cannot be identified separately.

7.3. Any presentation of total local authority spend on mental health would represent a significant underestimate of actual spend on mental health.

7.4. In financial terms fulfilling the duty within the Act to provide services for people with mental disorder will be difficult to monitor. Net expenditure on identified mental health services by local authorities rose to around £32.5m<sup>103</sup> in 2001-02, (compared to £30.7m in 2000-01).

7.5. One area of local authority expenditure that is clearly identified for spend on mental health is the Mental Illness Specific Grant (now retitled *Mental Health Specific Grant*). £20m was made available in 2003-04. (70% comes from the Scottish Executive and 30% from the local authorities own resources). This expenditure can be tracked and accounted for in detail, and is in addition to the figures set out in the previous paragraph. Over 400 projects are supported through these arrangements. Approximately 20% are focused on services for older people with dementia, but the funding has also 'pump-primed' many important community services for younger adults, including drop-in centres, day services, counselling, information and advice, education and employment schemes, advocacy, befriending, and respite and home-based care. The level of detail available on this part of the service spending is welcome and illustrates the need for the same level of transparency in the way in which resources are used across mental health services in general.

7.6. Over and above the amounts spent by the statutory agencies should be added the grants paid direct by the Scottish Executive to the voluntary sector. For example this year £650k was issued under the Section 10 grant scheme to support core activities provided by mental health voluntary organisations.

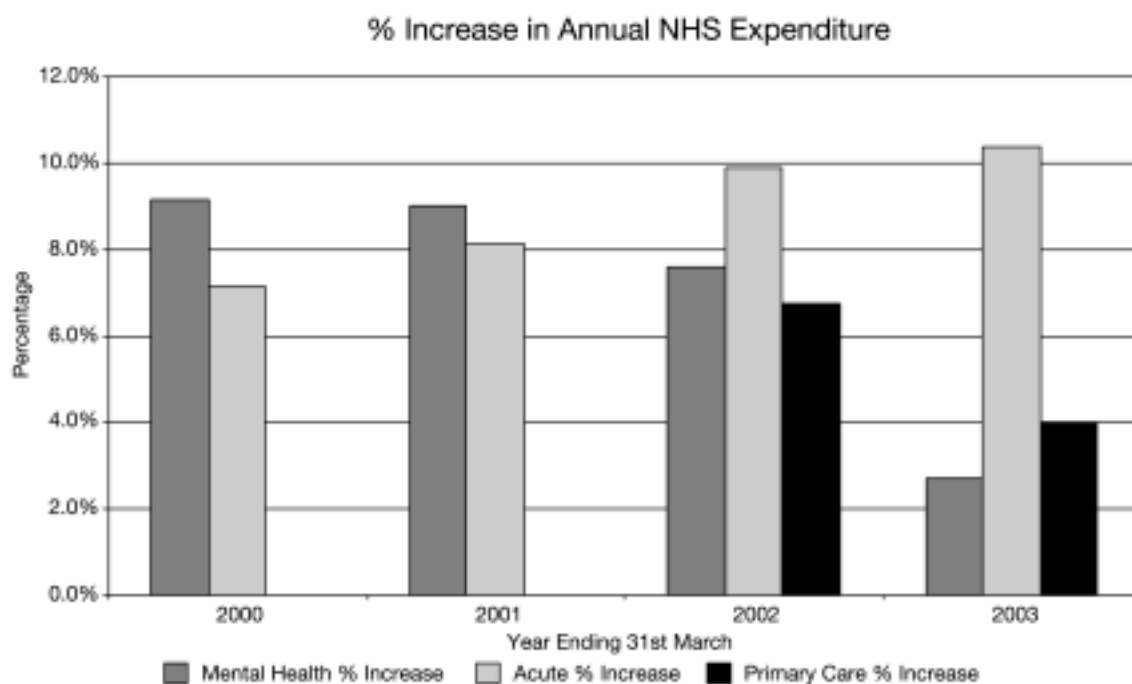
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<sup>102</sup> Performance Management Template, Scottish Executive

<sup>103</sup> Local Financial Returns (LFR 3) Scottish Executive, Community Care Statistics

7.7. Decisions on spend priorities are primarily a matter for the local agencies. Although mental health is one of the 3 national priority areas for NHSScotland, local decisions on spend showed an increase in spend on NHS mental health during 2002-03 at 2.7% compared to a 10.4% for acute care and 4.0% for primary care. This is illustrated in Table 6 below. The amount of additional funds going into the acute services each year grew between 2000 and 2003 from 6.5% to over 10%. Over the same period additional funding going into the mental health services fell from 9% to 2.25%.

**Table 6: Percentage increase in annual NHS expenditure**



Source: Performance Monitoring Template, SEHD

Notes

1. Each NHS Board is given a budget to spend as they see appropriate. They receive no central steer on where to invest.
2. The Mental Health figures include the mental health resource transfers and community mental health teams, as well as inpatient services.
3. The Primary Care figures are the total of the expenditure for Total General Medical ( Non Cash-Limited), Total General Medical (Cash-Limited), Total Prescribing Costs, Total General Dental Services, Total General Ophthalmic Services, and Total Pharmaceutical Services (Cash-Limited & Non Cash Limited). These figures were obtained from the FHS return of the PMT, which was introduced for 2000/01

7.8. NHS Trusts provided unpublished data on local mental health spend on services for adults between the ages of 15 to 64 years. The local authority spend, classified specifically as being for mental health, was taken from central data and recalculated according to the population size within the boundaries of the NHS Board area<sup>104</sup>. The aim was to try and get some comparable data for health and social services to minimise the problems caused by the fact that most local authorities do not share the same boundaries as health services (they 'lack co-terminosity').

<sup>104</sup> General Registry Office

7.9. In the early stage of the Review, our *financial findings* were in most cases returned to the NHS agencies to be cross-checked for accuracy, including details of the differential health spend on adult hospital and community services. Those who replied confirmed the accuracy and found the detail helpful. In the case of the local authorities that responded, the replies received again stressed the problem of using the narrow definition of mental health services mentioned above.

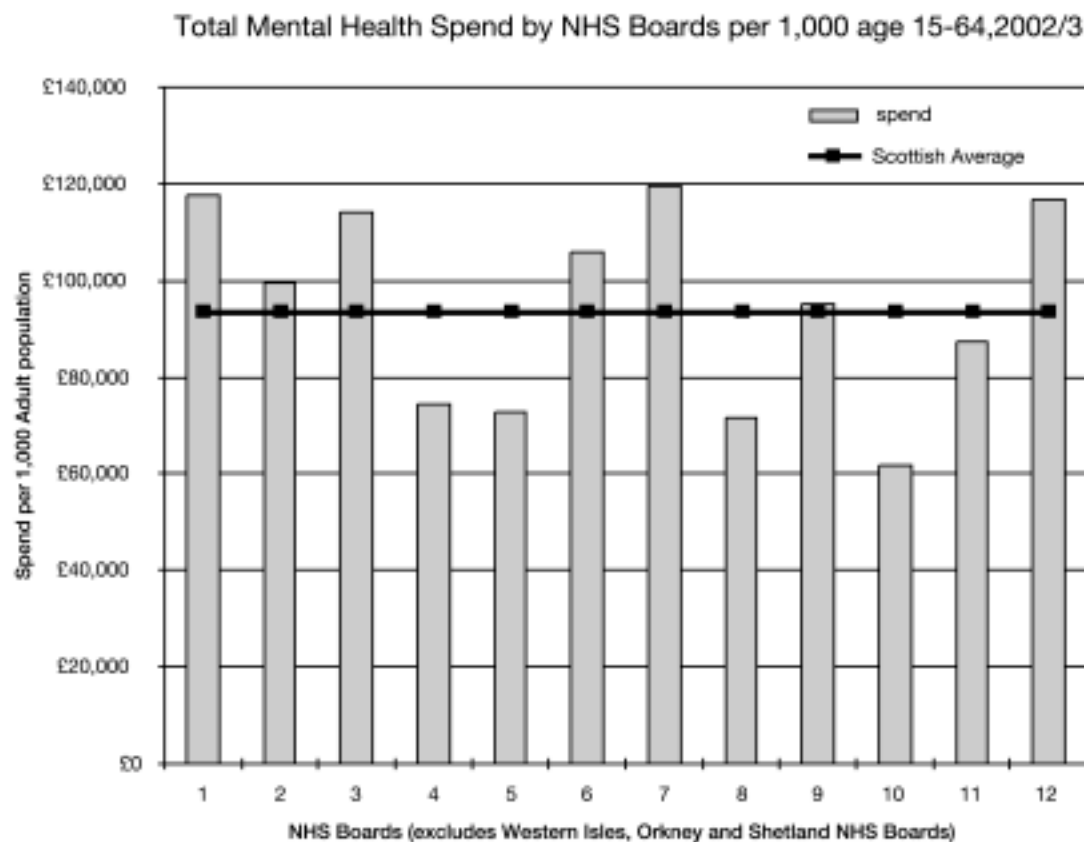
7.10. Problems arose when we tried to validate that locally agreed financial information data against centrally collected NHS data. The most accurate information comes from the national Performance Monitoring Template data. However, this reflects all mental health spend and could not be disaggregated into ages or specialties. The two sources were therefore not comparable, nor did they seem to correlate in any way in terms of proportionate spend between different parts of Scotland. Sometimes the relative figures provided locally were higher than those recorded centrally, sometimes lower. Given the difficulty validating our findings we decided to discontinue reporting on this work and recommend instead that more detailed and standardised data be collected locally and nationally.

7.11. We would stress that obtaining accurate, reliable data about local spend is as essential as it is difficult. The difficulties are also partly due to the complexity of inter-agency working and joint funding, partly because of the lack of clarity about what is being measured and partly because of the lack of ring-fencing (protecting the agreed level of spend) of some funds, both at NHS Board and local authority levels. The absence of reliable data consistent at both central and local levels means that planning and monitoring of services centrally, regionally and locally will be compromised.

7.12. Many of the differences between the figures can perhaps be explained by the fact that it was only at a local level that information could be obtained about component parts of the service, for example, acute and long stay inpatient services and community services for adults. We even had to determine the number of hospital beds locally because central data does not differentiate sufficiently between the different parts of the service, or is out of date.

7.13. It is important to avoid league tables about differential spend across the country, given that there are different starting points, different configurations of services and little correlation between spend and quality. Nevertheless we think it important to show the national variation of spend, without identifying NHS Boards.

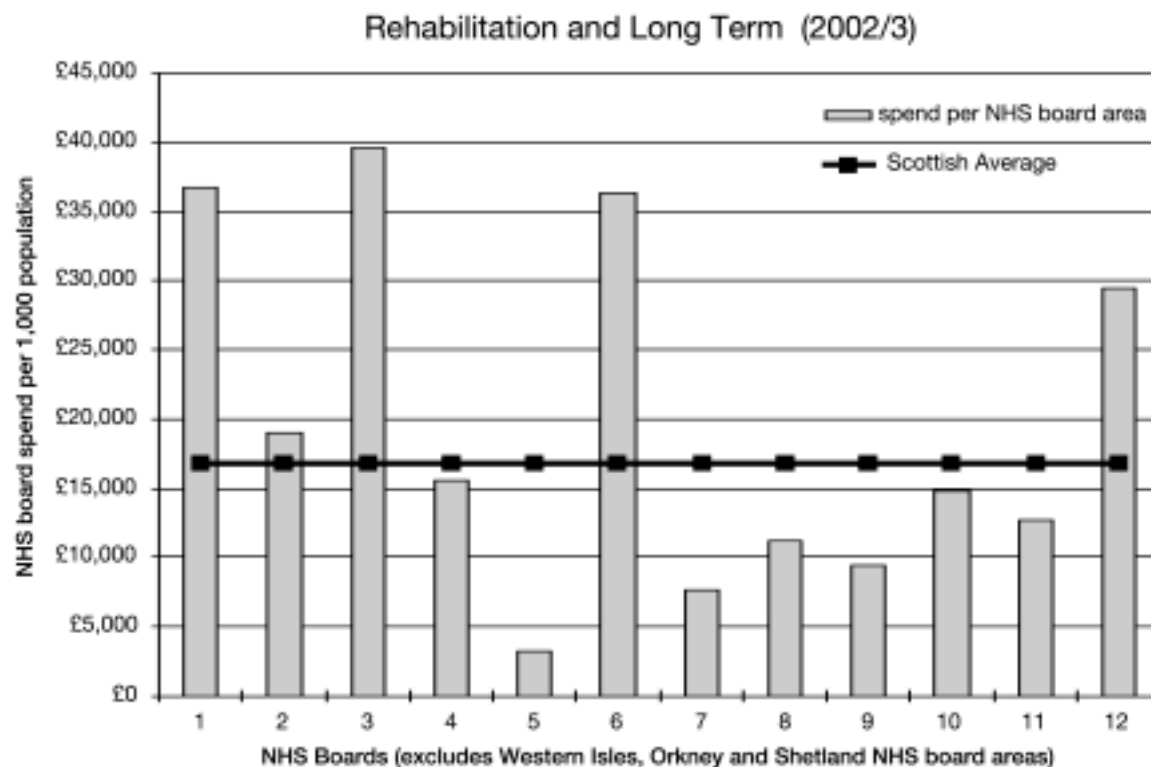
Table 7: Total mental health spend by mainland NHS Boards per 1,000 age 15-64



7.14. Comparison between services in different areas of Scotland is further complicated as the proportion of (the not inconsiderable) overheads allocated to different parts of the service vary from area to area. There is also variation in the criteria for making the allocation. It was surprising to find that information about the allocation of overhead costs was often not known by local senior managers of health services.

7.15. Despite all these problems, tentative conclusions can be drawn from our local data. In broad terms there appears to be considerable variation in the mental health resources spent per head of the adult population in Scotland, with an almost two-fold difference between the highest and lowest spending areas. This variation is most marked when parts of the service are considered separately. For example, the spending allocated to 'Rehabilitation and Long-Stay Inpatient Care' shows about a ten-fold variation between the highest and lowest spending areas in the country. Not surprisingly the higher figures correlate with a higher number of beds and a greater proportion of the budget spent on hospital as opposed to community based services. This suggests that a lot of resources remain tied up in hospital beds, some of which properly managed and planned could be released to expand community based care. This is entirely consistent with the published findings of the Mental Health and Well Being Support Group

Table 8 - Total spend by mainland NHS Boards on long-stay and rehabilitation inpatient beds aged 15-64 (To avoid any double counting, this table excludes separate information on expenditure by the island NHS Boards where care has been provided by a mainland NHS Board.)



7.16. We found no obvious consistent connection between high spending and high quality, as assessed by inspection bodies such as the Mental Health and Well Being Support Group or the (former) Scottish Health Advisory Service and Clinical Standards Board for Scotland (the latter two both now part of NHS Quality Improvement Scotland). As mentioned before high spend does not always mean better care.

7.17. Two topics came up several times as a bone of contention at service delivery level: **resource transfer** and **bridging finance**. While these issues will be understood at very senior levels, we encountered a significant degree of ignorance and myths throughout the service and it seems sensible to briefly clarify the processes.

7.18. When long-stay mental health hospital beds close, a contribution from the resources released is negotiated and agreed between the NHS Board and the local authority(ies) towards the revenue costs of expanded community services. Neither the amount nor any formula are fixed nationally, the amount is always negotiated and agreed between the local organisations and varies significantly across the country.

7.19. In all cases the Chief Executive of the NHS Board remains accountable for the money transferred and each year the same amount continues to be transferred from the Board to the local authority for the purposes agreed, unless renegotiated to reflect changes in provision or configuration of services. It is open to all parties to re-negotiate the terms at any time in the year.

7.20. In some cases the bed reduction and the negotiations originated many years ago and local authorities had to cope with hospital downsizing and establishing community services, before the formal resource transfer arrangements were introduced. (Arguably, however, at that time there were fewer people with very severe or complex problems needing to be resettled in the community).

7.21. Most of the “unknowns” encountered during the Review centred on the *when* and *how much* money was transferred and *where it went*. It is worth mentioning again that the negotiated resource transfers, by their very nature of supporting ongoing services, are revenue (very roughly this means continuing costs of services and staff).

7.22. The Review Team was asked about where the money went when hospitals or land was sold (‘one-off capital receipts’). Given the one off nature, these do not form part of the formal resource transfers, as subsequent years’ funding for alternative additional services would need to be found from other sources. In these cases, where a hospital or other fixed asset is sold the income is kept by the local NHS Board for spend on local priorities, including mental health. Every asset owned by NHS Boards has a value attached to it for accounting purposes (net book value). When an asset is sold, the amount to that value is kept by the NHS Board to spend on other capital needs, (hospital improvements, equipment, furniture, etc.). Any profit above that net book value is also kept locally for spend by the NHS Board<sup>105</sup> on revenue costs (continuing services, etc).

7.23. Resource transfer accounts provide good information on the actual amount transferred, but little information about how it is spent by local authorities (except on ‘mental health’ in general). However as before the negotiations between the NHS Board and the local authority are about money and about the services on which it is to be spent. There should be no confusion, however a lack of clarity locally was seen by the review team as one of the problems that has led to distrust. The review team found that even when it is possible to find out where the money goes, it was difficult to find out what it was spent on.

7.24. Bridging finance which was designed to enable the development of community services *before* hospital wards were closed is the other issue that appears to be widely misunderstood locally. Initially NHS Boards had to bid for bridging finance funds from a central resource. In any year there were perceived “winners and losers”. The central funding mechanism that was based on applications made by or through NHS Boards was revised in 1998<sup>106</sup> so that the (then) £18m annual resource was (and is now) distributed to each NHS Board as part of its overall financial allocation, based on the standard formula. It is for NHS Boards to decide what amount to devote to local bridging finance.

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<sup>105</sup> NHS HDL (2003) 32 Budgeting for Property Transactions: Effect on Revenue and Capital Resource Limits

<sup>106</sup> NHS MEL (1998) 83: *Bridging Finance*

7.25. The element for bridging finance therefore remains within each NHS Board budget, but as with other areas of spend, it is not separately identified. In two areas when the review team questioned the lack of community developments at a senior level we were told that they were “waiting for bridging finance”, despite the formal scheme having wound up in 1998 (see above) and the resources transferred to the NHS Boards ever since.

7.26. The ‘Arbuthnott’ formula for the national allocation of NHS funding was another issue raised with the Review Team. An ongoing feature of Arbuthnott since the start is that it is kept under review to continue to reflect demographic and other changes. As mentioned above decisions about how local allocations are spent and on what health priority remains the responsibility of the NHS Boards.

7.27. It is clear that a major task for mental health managers is to continually put the needs of people with mental health problems high on the agenda, not least in terms of devolution of budgets and budgetary control. A recurring message from this review is that senior staff, perhaps especially consultants, need to provide robust information to planners and managers so that they in turn can argue the case for development in the face of competing demands. This needs to be based on evidence, needs assessment and service user and carer priorities.

7.28. The difficulty in getting robust financial information is of concern generally, but in this context it is of especial concern when attempting to cost and track the additional spending needed for the implementation of the new Act.

7.29. The *Financial Memorandum*,<sup>107</sup> which estimated the additional costs that would be incurred by the new Act, notes that cost estimates are subject to considerable uncertainty. This is especially true in regard to improving the quality of care to an acceptable standard. The Memorandum gave an estimate of what would be required to implement the new Act and proposed additional spending of £23.1m per year would be necessary, with a further £9.25m start-up costs before the end of 2007/08.

7.30. These costs relate to added spending by the Scottish Executive, local authorities and NHS Boards. The funding is not ring-fenced and much has to be provided from existing new money that has yet to be allocated. It is important that the Joint Local Implementation Plans to be prepared in each area set out a plan for implementation, contain robust cost projections, and describe the contributions to be made separately and collectively by the different agencies.

7.31. Our view is that the Financial Memorandum estimate is too low. Nevertheless the base-line data is not available for us to predict and estimate what might be required with any robustness. Nor does there seem to be an agreed way to track where new money is needed and how it is spent. One of the urgent recommendations will be to have greater transparency about funding at local as well as national levels.

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<sup>107</sup> Mental Health (Scotland) Bill. Explanatory Notes (and other accompanying documents). The Stationery Office 2002

7.32. Finally, in several areas, questions on finance were met with major cynicism. We were talking about how to do what was already being done in a different way and that this would free up resources to develop other services. We discussed how to argue for the new money. On the ground, however, the degree of overspend or financial deficit in some places is such that the local discussions are about savings and not for reinvestment. In that situation there will be very formidable challenges indeed in meeting the requirements of the new Act.



# **national mental health services assessment final report**

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**conclusions and recommendations – an overview**

## 8. CONCLUSIONS AND RECOMMENDATIONS – AN OVERVIEW

### THE ACT

8.1. The Mental Health (Care and Treatment) (Scotland) Act 2003 has been well received generally and it is a source of pride that Scotland is pioneering mental health legislation that enshrines recent developments concerning human rights. Extensive consultation by the Millan Committee with people who use the services and those who care for them, as well as with those who plan and provide services, helped to develop the principles behind the Act and this has ensured a degree of awareness about what is needed in addition to the changes in statutory procedures.

8.2. In many places training in the details of the Act has already begun, with considerable progress since we first started the Assessment. Although the Millan Report<sup>4</sup> was written in language accessible to most people, the new Act obviously had to be written in legal terms, causing difficulty for some with understanding. Publication of the Code of Practice will be very welcome, but there are perhaps overly optimistic beliefs that it will “explain everything”. This is new territory, not just an amendment of the old Act.

8.3. The principles underlying the new Act provide the basis for a new style of service delivery that will have a major impact in improving the experience of users and carers and will link with many other initiatives underway and planned which are designed to progress better mental health and well-being and to improve health and social inclusion generally. This broader approach to mental health policy and practice in Scotland includes work on stigma, mental health promotion and achieving greater social inclusion for people with mental illness and complements the work being done to improve treatment and care services.

8.4. The conclusions and recommendations that follow capture what is needed to bring about early change and improvement in the organisation and delivery of mental health services, and to the well-being of services users and their carers. The key themes from the users and carers perspective, gathered from a wider list and brought to the fore during the assessment, are as follows:

- *There is a real need for out-of-hours and crisis services*
- *There is insufficient support for those living in the community*
- *There is a need for easier access to services in the community which should be local not centralised and remote*
- *There is a need to continue the national and local work on tackling stigma*
- *Mental health awareness training would help to promote a better understanding of mental illness and mental health issues for staff in a variety of agencies who come into contact with people who have a mental illness*

## Conclusion

8.5. The process of consultation and involvement has worked well and people are waiting for further training and guidance. The new Act is recognised as being part of a broader and more integrated policy, both nationally and locally and the Joint Local Implementation Plans should reflect this.

## Recommendation

8.6. The Scottish Executive should continue with the current implementation process and provide central guidance to inform the priorities in local training action plans and Joint Local Implementation Plans, to be implemented by the agencies within set timescales.

## ORGANISATIONAL CULTURE

8.7. Despite the positive response to the Act per se, in many places we encountered a sense of paralysis or inertia among staff and managers, with people talking about exhaustion and work-overload. Although the importance of the new Act was acknowledged, there was genuine bewilderment about how to cope with the added demands. Some people responded with anger, others with denial and the hope it would "all go away". Travelling round Scotland we found that this portrayal of helplessness was striking and reinforced what we were told about the effects of gaps in the workforce and other stresses.

8.8. We gained the impression that what we were finding was broader than the impact of the Act alone. As one person said "*the Act is a peg to hang things on*". Or another "*this is the straw that will break the camel's back*". There was cynicism about increased resources or increased support being made available.

8.9. While there was agreement that many policies had not been fully implemented, including the *Framework for Mental Health Services in Scotland*,<sup>2</sup> this tended not to be accompanied by a sense of any personal or local responsibility (or funding) to start making a difference.

8.10. So why are mental health services within the health and social care sector, plus to a lesser extent the voluntary sector, under such strain? There appear to be six main reasons:

- Perceived chronic under-funding, yet very apparent rising needs, demands and expectations from the public and politicians
- A continuous change agenda and restructuring, which is seen as being in the way of getting on with the work rather than assisting the process
- Increasing monitoring and accountability, which can be seen as bureaucratic and unhelpful, not ways of improving service quality
- Lack of clarity about accountability, roles and responsibilities, which is seen by some as an attack on professionalism

- Continuing negative feedback from people who use the services, which leads to low morale
- The perception of increasing centralisation and control from the Scottish Executive and local senior management, despite rhetoric about devolved power

8.11. Although this overall picture is a source of major concern, we were partly reassured by meeting some people with energy and enthusiasm, who are planning and providing very good services; people who are entrepreneurial about accessing all funding streams and people who are working creatively across traditional service boundaries. In order to achieve this they have needed close partnership with users and carers. How to ensure that this approach becomes more mainstream is a significant challenge.

8.12. People who use the services often say that one of the worst problems is being treated with disdain and restraint (both overt and covert) rather than dignity and respect and this is one of the essential cultural issues that must change. There is a growing number of staff who completely agree and whose practice demonstrates commitment to a service user focus, even though they may be part of a group that is frequently denigrated by service users and carers. Part of the challenge is for people with like minds, whether users, carers or staff, to work together without compromising the radical momentum of the service user and carer movement.

### Conclusion

8.13. There are major staff morale, attitudinal and cultural problems which, unless attended to consistently, will inhibit full implementation of the underlying principles of the new Act.

### Recommendations

8.14. People who use the services and those who care for them should work together with staff who share the same values, to jointly bring about change and ensure that the principles behind the Act are adhered to.

8.15. Front-line staff should lead on bringing about the changes required by the Act, using it as a development opportunity for the service, those working in it and those receiving care.

8.16. The senior managers in local authorities and NHS Boards should devolve more authority, responsibility and accountability (including budgets) to front-line staff, with a clear objective to work closely with the voluntary sector and service users and carers.

8.17. The Scottish Executive should focus on the implementation of existing policies in mental health services and the implementation of the Act and avoid creating additional policies at this point in time.

## INFORMATION

8.18. Throughout the visiting and review process we were considerably hampered by lack of accessible information and financial data as described in Chapters 5 and 7. Although this had been anticipated, the extent of the problem had not. Better information for managing services locally, regionally and nationally has been sought for many years. Why is it not available?

- Lack of consistency and standardisation of terminology and methods of collecting data
- A continuing focus by ISD on the collection of inpatient and consultant-centred data, despite the change in emphasis of the service to multidisciplinary provision in the community
- The complexities of data linkage across health and social services
- A hope that “new software” will solve everything – and waiting for it to be provided
- Insufficient information fed back in time for it to make any difference to the people who have to fill in forms, who therefore see this as a bureaucratic burden without direct benefit
- Lack of investment and resources in equipment and training, plus recognition of the time involved in providing data

8.19. Our sense of frustration and exasperation about not finding information was in contrast to the help we received from people throughout the services (and from the General Registry Office also) who undertook specific pieces of work for us, especially the ISD sponsored *Improving Mental Health Information Programme*. Better data is now being collected and information shared in the monthly bulletin that can be accessed at <http://www.isdscotland.org/imhip>. A Mental Health Information Strategy for Scotland is being developed, which will take this work forward.

## Conclusion

8.20. There are serious and major problems in accessing adequate data about mental health services. However, there are a number of significant developments that with consistent application should improve this.

## Recommendations

8.21. The Scottish Executive should continue with its current work on developing a Mental Health Information Strategy and ensure that it is locally adopted, resourced and fully implemented in the medium term (3 years).

8.22. The work of the *Improving Mental Health Information Programme* should continue and expand so that it can become an expert resource for local services as well as providing national data.

8.23. Staff and managers across agencies should agree on the minimum set of data to be recorded to help improve service delivery and quality and ensure that this is collected.

8.24. Information that informs decision-making should be made available in time for it to be relevant to all stakeholders.

## INEQUITY

8.25. The quality and quantity of available services for people with mental health problems differs across Scotland. Some services are very good and some use innovative ways of delivering care. Nevertheless some services are below what would be expected were they adhering to the template within the *Framework for Mental Health Services in Scotland*.<sup>2</sup> The deficit in the provision of good quality care has several causes, one of which may be a lack of managers with the range of skills required in this complex area. Resources (usually funding) may not have been adequately accessed or applied to service improvement, nor staff supported in professional development. The challenges to senior management in the health and social services is immense and our comment is not about blaming individuals, but a reflection on a system that does not provide enough personal support or training for managers.

8.26. Another highly significant factor leading to inequity is inadequate funding for the major task of ensuring that all inpatient provision (including that provided in old or out-worn buildings) is fit-for-purpose. This has to be done at the same time as the proportion of the budget spent on hospitals goes down in favour of developing an adequate range of local community care options. Some responsibility for this must lie with Chief Executives of NHS Boards who have to choose between funding mental health or other pressing priorities. The Chief Executives of local authorities do not make prioritisation decisions, these are for the elected council members, who set budgets, (both capital and revenue) according to their priorities and local authorities.

8.27. For people with mental health problems living in some parts of Scotland this may unfortunately mean one or more of the following:

- Lack of 24-hour and crisis support
- Minimal community care
- Excessive stays in hospital
- Inappropriate admission to a hospital far from home
- Poor hospital environment, including décor, facilities, privacy and separate provision for younger people and mothers and babies
- Lack of day activities and opportunities
- Lack of advocacy and other support

- No access to psychological approaches and interventions

8.28. These services are all essential components of good mental health care. Local service providers, together with those who use the services and those who care for them, should decide how these requirements can be met. When the numbers of people requiring some specialised aspect of inpatient care are low (meaning that providing a local service would have a disproportionate effect on the overall allocation of resources) services should be planned and provided through managed care networks and regional consortia.

8.29. The high cost, low volume specialist services that will have to be provided at a regional level include:

- Inpatient child and adolescent services
- Hospital provision for mothers with post-natal depression and their babies if appropriate
- Regional forensic psychiatric units and services

8.30. We also found that many Intensive Psychiatric Care Units serve multiple purposes in unsuitable accommodation. There continues to be a debate about how to balance the available resources (skills and finance) against the demand for a range of services to be provided locally when numbers are very small. Providing intensive care facilities for adolescents and people with a learning disability is a particular problem.

8.31. The provision of privacy and security for women seems to be a problem in some areas, especially when the layout and size of wards makes it difficult to find easy solutions. It is clear that many women find being cared for in a mixed-sex environment threatening, especially if they come from a Muslim community or if they have been sexually abused and we were disappointed that this is still a problem several years after finance was made available to services for this purpose.

8.32. An issue that was raised in the Interim Report was the large numbers of people who are admitted to hospital outside their local area, because beds are not available locally. We saw this as a bed management problem rather than the total number of admission beds in Scotland. It needs to be addressed.

## Conclusion

8.33. Mental health services in Scotland have some way to go before every citizen has access to the same level of high quality service, including services mentioned within the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003.

## Recommendations

8.34. Flexible and responsive 24-hour support services should be developed locally and planning should involve service users.

8.35. By the time the Act is implemented in 2005, everyone with a serious mental health problem should have their assessed community needs met by a multidisciplinary and interagency team, which should include the voluntary sector.

8.36. Any admission to hospital remote from the local area for reasons other than planned regional service provision, because the local facility has no spare capacity, should be monitored and analysed by regional planning groups, with the aim of improving national bed management.

8.37. The accommodation where care is delivered should provide a good environment. When necessary, people should have planned and timely access to gender and age-appropriate facilities and specialist services, including mother and baby units, as required by the Act.

8.38. Day activities and therapeutic opportunities should be available both in the hospital and community, including psychological and social interventions.

8.39. The Scottish Parliament should continue its interest in the welfare of people with mental health problems following the implementation of the Act.

## WORKFORCE

8.40. One of the most obvious impacts of the Act is the need for experienced staff to contribute more time to assuring the rights and meeting the needs of people who are detained, or who are subject to the provisions of a community-based Compulsory Treatment Order. This will include presenting comprehensive plans of care to the Mental Health Act Tribunal on the basis of meeting assessed needs, rather than fitting in with what current services happen to be able to provide. This is what the Millan<sup>4</sup> principle of *Reciprocity* demands.

8.41. Although the implementation of the Act will involve many people from different care settings, the major implications in the short-term are for responsible medical officers and mental health officers who have leading roles in meeting statutory requirements. Quite simply, there are not enough of them.

8.42. With the current vacancies and problems in recruitment and retention, plus the delay in training new staff, the only solution is to determine what are the core tasks that can only be carried out by these scarce staff members, so that their time can be freed up. This change in roles and responsibilities and the reallocation by discussion and agreement of other responsibilities to the rest of the workforce is what is meant by the “redesign” of services. This is an agenda that has been emerging from a number of sources and the legal requirements of the Act mean that such change is no longer optional.

8.43. Another significant development need is in the provision of advocacy services, which must expand considerably, with major training implications.

## Conclusion

8.44. Workforce gaps are probably the most difficult issue to address in the short-term (one year), but this must be done in order to fulfil the obligations of the Act from 2005. This will mean major changes to personal roles, responsibilities and job plans. It will also have an impact on the strategic and structural issues involved in redesign initiatives such as the move to Community Health Partnerships.

## Recommendations

8.45. At a national level, work should be carried out to clarify issues about roles, responsibilities and pay scales between different disciplines, organisations and levels of seniority and experience. This must involve the staff-side as well as senior management and should be compatible with ongoing human resource development strategies and life-long learning strategies.

8.46. Locally, there is no time to wait for a national directive, so interim compromises and solutions should be found, in order to ensure the legal rights of people using the services are met. It is essential that this interim work and experience informs and shapes the national guidance and regulations.

8.47. The National Mental Health Workforce Group should lead on these issues.

## FINANCE

8.48. The comments in Chapter 7 were mainly about insufficient financial information being available. During the visits we also developed concerns about the lack of knowledge about how to get access to funding.

8.49. At the beginning, some concerns were expressed by the Scottish Executive that we would arrive back with an enormous wish-list. Despite giving people open opportunities to express such wishes, little was forthcoming (even at very senior levels) except in the most general way and it was often about things that did not cost money, such as better communication.

8.50. People said they were worn out asking and not getting, so did not ask any more. This 'poverty of aspiration' is part of the cultural problems mentioned at the beginning of this Overview. This applies mainly to the statutory sector, where people providing services in the front line are not experienced in presenting properly set out and costed business cases to managers. If managers do not have that kind of information in support, how can they argue for increased resources?

8.51. In contrast, the voluntary sector has vast experience in securing funding from a variety of sources – that is how it survives. Despite the fact that there is considerable opportunity cost in the time spent applying for money and there are negative aspects in short-term funding, there is an expertise and resilience that should be learnt by workers in the statutory sector.

8.52. These observations relate to relatively large sums of money. Yet resource allocation problems can arise when even small amounts of money are refused. There are groups of service users and carers who have asked for relatively small amounts of money that could make a difference to their quality of life, for example for support groups, creative projects and for disseminating information. The money required is nowhere near the size to merit formal grant application (nor is there the knowledge to do so). We found that when attention was brought to this at high levels there was a degree of surprise and money was rapidly forthcoming. Until budgets are devolved to local levels, with flexibility and a priority to resource and support such initiatives there will continue to be problems.

8.53. Behind all the financial concerns two things stand out: the lack of ring-fencing of money and insufficient investment in mental health services generally.

### Conclusions

8.54. There is insufficient standardisation and clarity about the funding of mental health services and how the money can be tracked into services at a local level.

8.55. There is insufficient expertise within the statutory sector at a care delivery level about how to develop a business case and obtain resources to fund it.

8.56. There is a perceived under-funding of mental health services. Until it is clear exactly what is being spent, how well and to what effect, an unanswerable case for an increase is difficult to make. The need for resources will become greater in order to implement the new Act.

### Recommendations

8.57. The Scottish Executive, NHSScotland and local authorities should ensure that there is a standardised and transparent system for recording financial data that contains not only national data, but regional and local spend.

8.58. A system should be developed whereby money spent can be tracked to local service provision and accounted for within the monitoring systems

8.59. Staff as well as managers should take responsibility for understanding financial issues in relation to improving outcomes, including the concept of opportunity cost.

8.60. Robust business cases should be put forward for increasing resources within the statutory sector and voluntary sector.

8.61. NHS Boards and local authorities should give increased priority to mental health service resource allocation especially in relation to the pressures and commitments associated with the new Act.

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**annex 1**

**ANNEX 1 - NATIONAL MENTAL HEALTH SERVICES ASSESSMENT MEMBERS**

Dr Sandra Grant, OBE	Project Director Consultant Psychiatrist/Psychotherapist, NHS Greater Glasgow
Gill Urquhart	Deputy Project Director Head Occupational Therapist, The State Hospital
Graham Charlton	Social Work Services Project Manager, South Ayrshire Council
Graham Morgan	Advocacy Project Manager, Highland Community Care Forum

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**annex 2**

## ANNEX 2 - RELATED LEGISLATION

### Legislation (by date order)

- **The National Assistance Act 1948 (Section 47)** applies to persons suffering from “grave chronic illness” which could include dementia and other forms of mental illness and offers a place of safety provision.
- **The Social Work (Scotland) Act 1968** requires Social Work Authorities to provide, guidance and assistance to people who are in need of care and attention arising out of infirmity or age or those suffering from illness or mental disorder.
- **The Chronically Sick and Disabled Persons Act 1970** obliges the local authority to provide certain services if a disabled person needs them.
- **The Race Relations Act 1976** makes it unlawful to discriminate on racial grounds in relation to the provision of goods, facilities or services.
- **The Disabled Person (Services, Consultation and Representation) Act 1986** provides a right of assessment for disabled people.
- **The Housing (Scotland) Act 1987** identifies certain homeless people who have a priority need for accommodation. Those who are vulnerable as a result of mental illness are included.
- **The NHS and Community Care Act 1990 (Section 55)** amends the Social Work (Scotland) Act 1968 (“the 1968 Act”) and confirms the right which certain persons will have to an assessment for services. This includes those with mental illness and learning disability and obliges local authorities to provide after-care to help relieve illness and to care for ill people.
- **The Carers (Recognition and Services) Act 1995** further amended section 12A of the 1968 Act and introduced a power for carers to request local authorities to carry out an assessment of carers’ ability to provide and to continue to provide care. This right applies where the needs of the person being cared for have already been assessed. It has particular significance to carers of mentally disordered people.
- **The Disability Discrimination Act 1995** introduces measures aimed at ending the discrimination experienced by many disabled people. It covers those with mental impairment where that impairment has a substantial and long-term adverse effect on the person’s ability to carry out normal day to day activities. It makes unlawful discriminatory treatment in relation to employment, the provision of goods, facilities, and services and the selling, letting or managing of land or premises.

- **The Criminal Procedure (Scotland) Act 1995**, among other things, makes provisions for the court to make non-custodial orders for mentally disordered offenders. This can include intervention and guardianship orders under the Adults with Incapacity (Scotland) Act 2000. The Mental Health (Care and Treatment) (Scotland) Act 2003 amends the provisions in relation to assessment and disposal of cases in relation to mentally disordered offenders.
- **The Children (Scotland) Act 1995** provides provisions in relation to the care and protection of children and a duty to provide children's services. The Act makes different provisions for different ages.
- **The Human Rights Act 1998** has particular implications for public authorities making it unlawful for a public authority to act in a way that is incompatible with any of the Convention rights.
- **The Adults with Incapacity (Scotland) Act 2000** provides a broad legislative framework for protecting the welfare, property, finance and health of adults who lack capacity because of mental disorder or physical disability.
- **The Regulation of Care (Scotland) Act 2001** established the Commission for the Regulation of Care and The Scottish Social Services Council.
- **The Community Care and Health (Scotland) Act 2002** makes provision for a range of measures designed to meet the care needs of Scotland's older population as well as others. Its main provisions are: free personal and nursing care for older people; and carers' right to an independent assessment on their ability to provide care. It gives a legislative framework for enhanced joint working between the NHS and local authorities.

### Policy and Guidance (by date order)

- *Care Programme Approach* (1992) provides revised guidance on joint arrangements for implementing the Care Programme Approach; an intensive form of discharge and continuing care management for those in greatest need.
- *Community Care: The Housing Dimension* (1994) confirms a housing department's obligation to community care client groups, including mentally disordered people.
- *Children and Young Persons with Special Educational Needs: Access and Recording* (1996). Future needs assessments for young people with learning disability, whereby the local authority must assess the needs of the learning disabled child.
- *A Framework for Mental Health Services in Scotland (1997, as amended)* provides a comprehensive template for the organisation of co-ordinated mental health care and services, including a service profile section on services for mentally disordered offenders.

- *Interviewing People who are Mentally Disordered: Appropriate Adult Schemes* (1998) introduced schemes across Scotland to cover all instances where the police have occasion to interview a person who appears to have a mental disorder. An “appropriate adult” will be provided to assist communication.
- *Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland* (1999) set an overall policy to co-ordinate care, support and accommodation services for mentally disordered offenders.
- *Joint Future (Community Care: A Joint Future)* (2000) gave guidance to improve partnership working between agencies and to secure better outcomes for people who use services and their carers. Joint resourcing, joint management and single shared assessments for people with mental health problems to be introduced by April 2004.
- *The same as you?* (2000) reported on services for people with learning disability and introduced key recommendations for health and local authorities with timescales, such as closing all long-stay hospitals for people with learning disability by 2005.
- *Our National Health: a plan for action, a plan for change* (2000) states national priorities; reaffirmed the review of mental health legislation and made a commitment to publish the Mentally Disordered Offenders Care Pathway Document.
- *Services, Care, Support and Accommodation for Mentally Disordered Offenders in Scotland: Care Pathway Document* (2001) describes what needs to be in place where, when and provided by which agency in terms of organising safe care, support and accommodation for mentally disordered offenders.
- *Partnership for Care* (2003) and *Primary Care Modernisation* (2003) provide a key role for primary care in the planning and delivery of mental health services.

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**annex 3**

## ANNEX 3 - GLOSSARY OF TERMS

### **AMPs: Approved Medical Practitioners**

A new term established by the new Act. An AMP is a doctor with additional specified psychiatric training in the *Mental Health (Care and Treatment) (Scotland) 2003 Act*, who is approved by an NHS Board. He/she is then qualified to undertake short and longer term detention orders under the new Act.

### **ARTs: Area Redesign Teams**

Teams formed from local groups of professionals, service users and carers who look for better ways to organise their local services. This is not a standard term, and there are variations across the country. ARTs are similar to the Joint Commissioning Teams that were described in the Framework for Mental Health Services in Scotland 1997.

### **Bridging Finance**

Resources allocated by NHS Boards from within their overall funds to cover the double running costs incurred as wards and hospitals reduce in size and patients transfer to care in community settings.

### **The Care Commission**

The Scottish Commission for the Regulation of Care is a new national regulatory and inspection body established following the *Regulation of Care (Scotland) Act 2001*. Its principal responsibility is for the regulation and inspection of all residential Scottish care services provided or commissioned from social work departments

### **CAMHS: Child and Adolescent Mental Health Services (see SNAP Report)**

*For Scotland's Children* was published in 2001 by the Scottish Executive and looked at the health needs of vulnerable children leading to the setting up by the Health Minister of the Child Health Support Group.

### **Capital Receipts**

The sale proceeds arising from the disposal of property, buildings etc.

### **Change Fund Initiative**

A funding mechanism set up to help local authorities put in place the recommendations made in *The same as you?* for services for people with a learning disability, and to help deliver this change agenda.

### **Code of Practice**

A Code of Practice sets out the *who, what, where and when* for professionals and others for the delivery of an Act's objectives, in this instance the Mental Health (Care and Treatment) (Scotland) Act 2003.

### **CRE: Commission for Racial Equality**

An independent body set up under the *Race Relations Act 1976*. It aims to eliminate racial discrimination, promote equal opportunities, encourage good relations between people of different racial/ethnic backgrounds, and monitor the Race Relations Act.

**CHPs: Community Health Partnerships**

*Partnership for Care* stated that Local Health Care Co-operatives (see LHCCs) should evolve into CHPs, which will have a new role more consistent and enhanced in the planning and delivery of services, working as part of a decentralised but integrated healthcare system.

**Co-morbidity**

This is a rather confusing term, which is similar to 'co-occurring' and 'dual diagnosis' (see below). The most common use is when a person has both a serious mental health problem/illness at the same time (co-occurring) as a problem with drugs or alcohol.

**CMHT: Community Mental Health Team**

Care in the community is now provided by a range of professionals and support staff from the health service, social work and voluntary sector. This is done through teams that outreach from secondary care and connect and work in their local community areas and provide a bridge between 'primary' care and hospital care.

**CPA: Care Programme Approach**

A way of co-ordinating the multidisciplinary and interagency planning and provision of care for people with severe mental illness (including dementia) who require structured arrangements for their care and supervision. It ensures that staff from different agencies regularly meet together to review progress with a service user and his/her carers, and also record unmet need. It has been government policy since 1992 (*Scottish Office Circular SWSG16/96*) but has not been applied in a systematic way throughout Scotland.

**CPN: Community Psychiatric Nurse**

A registered mental nurse (RMNs) who has had additional training to work in community settings as well as hospital. In the past this involved a college diploma, but over the last few years when services have increasingly been provided in the community, the term has come to mean specially trained nurses who work in the community as part of a team. A CPN will have a 'case-load' of people with mental health problems who receive direct support, but will also spend time liaising with the primary care team, social work and hospital services.

**'De-facto' Detention**

Sometimes people who are not officially detained under the Mental Health Act 1984 may in practice be detained when a ward is locked for the safety and security of another individual, especially in an Intensive Psychiatric Care Unit, or for their own safety; for example, when they have dementia and may wander out of the ward and get lost. The latter situation is increasingly being resolved by having an 'open' (unlocked) ward that has a difficult way of opening the door, unlikely to be mastered by someone with dementia. The Mental Welfare Commission has continually expressed concerns about locked wards and the new Act places greater emphasis on a person's right to the lowest appropriate level of security.

**Delayed Discharge**

A 'delayed discharge' is the term used when a person has to remain in hospital after the time their responsible medical officer says that they are clinically able to leave, but the agreed community care arrangements are not available (usually due to lack of appropriate accommodation).

**Designated Medical Officer**

This new term replaces that of the 'second opinion' doctor set out in the 1984 Act. Designated medical officers are doctors appointed by the Mental Welfare Commission. They are consultant psychiatrists of a least 3 years experience and receive special training for this role.

**Dual Diagnosis**

This term is similar to 'co-morbidity', described above, which now refers mainly to people with co-occurring mental health problems and substance misuse. However, traditionally the term was applied also to people who have a mental illness in addition to a learning disability. People with a learning disability are more at risk of a mental illness than the general population. People with a learning disability also often have considerable physical disabilities although this is not usually consumed under the term 'dual diagnosis'. A focus on needs rather than diagnosis is probably best at an individual level, but harder to summarise at the level of service planning.

**ESF: European Social Fund**

A significant source of European funding which helps disadvantaged groups in the community who, for a variety of reasons, are excluded both economically and socially. These funds are used to add value to policies introduced by Governments with the aim of a more inclusive society.

**Forensic Services**

Applies mainly to the range of services, care, support and accommodation for mentally disordered offenders. The skills and expertise of the staff may, however, also be called upon to treat people with serious problems who have not committed an offence just as general psychiatrists will work with offenders and provide aftercare. In Scotland general psychiatric services and forensic services are less separate than in England. The social service input comes from both the criminal justice system and local authority social work teams, and close links are made with other agencies such as courts and prisons.

**Healthy Living Centres**

Projects that offer information, advice and practical support for the improvement of healthy living. These centres are funded by Lottery money, and so far Scotland has been allocated around £34.5m.

**ICP: Integrated Care Pathway**

A formalised and agreed interagency and multidisciplinary programme to enable people to receive the best care in the best possible way. It shows what should happen when, who does what and when, to ensure progress to better health.

**Care Pathway**

As above

**HRC20. Assessing the Risk for Violence Version 2**

One of the commonly used tools used by professionals in assessing the risk of violence presented by people who usually have a forensic presentation.

**IPCU: Intensive Psychiatric Care Unit**

Small wards that provide an environment and level of care necessary for people who are severely or acutely ill, needing close observation and more intensive treatment, or who may require higher levels of supervision because of a forensic history.

**Joint Future**

The strategic policy for providing improved joint planning and working between the statutory organisations; namely health and social work. This initiative was introduced following the publication of the Scottish Executive's report; *Community care: A Joint Future* in November 2000.

**LHCC: Local Health Care Co-operative**

Currently the key building blocks for primary care services; they have made good progress in developing into responsive and inclusive organisations that are the main focus of planning and development for community health services.

**Liaison Psychiatry**

Within psychiatry this term is used to describe the sub-specialty that provides psychiatric assessment and treatment to patients attending general hospitals (whether inpatients or outpatients or Accident and Emergency). It is concerned with the interface between physical and psychological health and this involves many more professions than doctors alone, especially psychologists and nurses. Liaison health services work closely with the social services in terms of family and local authority support.

**MHO: Mental Health Officer**

Mental health officer; a social worker trained and approved to carry out statutory duties under the Mental Health Act.

**Medium Secure Unit**

Can also be referred to as a regional forensic psychiatric unit and includes some community services or supports. The security is at a level between an IPCU or low secure local forensic services and the special security at The State Hospital.

**Millan Report**

*New Directions: Report on the Review of the Mental Health (Scotland) Act 1984* was the findings of a committee chaired by Rt. Hon. Bruce Millan. This report and its recommendations led to the new Mental Health Bill being introduced to Parliament during 2002.

**MDO: Mentally Disordered Offender**

Mentally Disordered Offender is a term used for people who have a mental illness or a learning disability, and have come into contact with some element of the criminal justice system.

**New Futures Fund**

Launched in 1998 by the Scottish Executive, this funds projects that target problems of social exclusion and unemployment. Much of the funding is targeted at projects working with drug users.

**NES: NHS Education for Scotland**

Established in 2002, NES promotes multidisciplinary training and education of healthcare professionals across Scotland, bringing a strategic approach to staff development and supporting the NHS reforms across the country.

**NHS24**

A telephone health and advice helpline for Scotland available on a 24-hour basis.

**NMD: Neurosurgery for Mental Disorder**

Surgical procedure for the destruction of brain tissue to relieve specific mental disorders.

**Office of the Public Guardian**

Established under the *Adults with Incapacity (Scotland) Act 2000* (AWI Act), this supervises any guardian or authorised person carrying out functions relating to the property of financial affairs of another person. The Office of the Public Guardian also receives complaints under AWI Act and may consult the Mental Welfare Commission or any local authority on matters relating to the functions under AWI.

**OT: Occupational Therapist**

A state registered professional, an OT is primarily concerned with a person's ability to live as independent a life as possible, and uses various 'activities' as the treatment tool including leisure, creative, domestic and self care, and work related tasks to allow people to gain new or regain lost skills.

**Partner Organisations**

These are a range of organisations working together to provide the best possible care: NHS Boards, Trusts, GPs, LHCCs, Local Authorities, social work departments, voluntary organisations, and others that will include Community Health Partnerships, courts, Scottish Ambulance Service and the prison services.

**PAF: Performance Accountability Framework**

A process for assessing and comparing the performance of NHSScotland across a range of key services to improve accountability and services. The PAF is completed on an annual basis by the Scottish Executive Health Department and each NHS Board area.

**Perinatal Mental Illness**

A range of mental health problems or illnesses that women may experience during pregnancy or following the birth of a child.

**Pharmacist**

A specialist in issues concerning medication

**Psychiatric Morbidity**

A professionally understood term used to describe the presence of a significant mental illness.

**Psychiatrist**

A medical doctor who specialises in the care and treatment of people with mental health problems, and can prescribe drugs as well as providing psychological treatments. There is a long post-graduate training and exams before a person can apply for a consultant post.

**Psychiatric Specialties**

There are 6 recognised specialties within the Royal College of Psychiatry and these are; adult psychiatry, children and adolescents, forensic, learning disabilities, old age, and psychotherapy.

**Psychological Interventions**

Methods used to treat a range of mental health needs based around talking treatments involving one to one, group, family or counselling approaches, or psychosocial interventions (PSI) carried out by a range of professionals.

**Psychologist**

A chartered clinical psychologist aims to reduce psychological distress and enhance and promote psychological health and well-being and work with people with a mental or physical health problem and those with a learning difficulty or disability.

**RMO: Responsible Medical Officer**

The responsible medical officer is always a consultant or a locum consultant, who has overall legal responsibility for the care a patient receives.

**SAYIG: *Same as you?* Implementation Group**

During 2003-04 the *Same as you?* Implementation Group will consider services for children, advocacy and day care services.

**SIAA: Scottish Independent Advocacy Alliance**

Previously known as Advocacy 2000 this became SIAA in 2002 with a principal aim of ensuring advocacy is available to any vulnerable person who needs it in Scotland.

**SIGN: Scottish Intercollegiate Guidelines Network**

Established in 1993 to improve the quality of healthcare in Scotland by reducing the variations in practice and outcomes through the development and dissemination of national clinical guidelines, often referred to as SIGN guidelines.

**SNAP: Scottish Needs Assessment Project.**

A working group of professionals from a given field who report to the Scottish Executive on the needs both met and unmet in any specialty area of healthcare. Often referred to as a SNAP Report.

**Supporting People**

A funding arrangement introduced in 2003 to support vulnerable people needing support with a range of difficulties to live in the community.

**Mental Health Tribunal**

A new body established under the terms of the Mental Health (Care and Treatment) (Scotland) 2003 Act. The Mental Health Tribunal for Scotland ('the Tribunal') will be a new body, established by the new Act. The Tribunal will make decisions covering a wide range of situations – for example, on applications for a Compulsory Treatment Order. Given the nature of the decisions to be made, the Tribunal will require expertise in both mental health law and the provision of care and treatment to people with mental disorder. NHS Boards (including The State hospital) and local authorities are required, where practical, to provide accommodation where hearings can be held.

**Workforce Development**

An approach to addressing the existing problems in recruitment and retention of key staff in the NHSScotland workforce

**WTE: Whole Time Equivalent**

A term used to describe the number of people that would be employed if everyone worked full-time. For example, two half-time people make 1 WTE

# **national mental health services assessment final report**

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**annex 4**

## ANNEX 4 – REFERENCES

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