

Who we are and what we do

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect;
- Have the right to treatment that is allowed by law and fully meets professional standards;
- Have the right to live free from abuse, neglect or discrimination;
- Get the care and treatment that best suits her or his needs; and
- Be enabled to lead as fulfilling a life as possible

What we do

- We find out whether individual treatment is in line with the law and practices that we know work well
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care
- We provide advice information and guidance to people who use or provide mental health and learning disability services
- We have a strong and influential voice in how services and policies are developed
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

About this report

This document is a summary of our investigation into the care and treatment of Mr F. We have a duty to investigate the case of any person with a mental illness or learning disability where there are concerns that he or she has been ill treated, neglected, or where there has been a deficiency in the care and treatment provided.

As well as fulfilling our duty towards the individual, our reports and recommendations can also highlight general issues for service users with particular needs in other services. We believe Mr F's case may highlight some of the challenges and issues in the effective care and treatment of individuals with a dual diagnosis of mental illness and alcohol misuse. A full version of the report with detailed findings and a full list of recommendations can be downloaded from our website www.mwscot.org.uk. We recommend that those with a particular interest in providing effective care and treatment for people with a dual diagnosis read the full report in addition to this summary.

About Mr F

Mr F is a 41 year old man who grew up in a small Scottish town with his parents and siblings. Despite a difficult childhood, Mr F went through school with no significant problems, leaving to take up paid employment when he was fifteen years old. Throughout his life Mr F had a complex and difficult relationship with his father. He described his father as a 'cruel man' who had been verbally abusive and physically violent towards him since childhood. Mr F senior had alcohol problems, poor health and was considered by other family members to be a 'strong' character who they loved, but who had a 'nasty side' which came out when he was under the influence of alcohol. Mr F had also been a victim of childhood sexual abuse, by a number of men, over a period of ten years. While there was no suggestion that Mr F senior had been involved in his son's sexual abuse, one of the perpetrators was a lodger who he had introduced to the household.

During his late teens and early 20s, Mr F developed a serious alcohol problem. He had his first contact with mental health services at the age of 22. As well as alcohol misuse, Mr F was experiencing chest pains, panic attacks and had problems managing his anger. Around this time, Mr F was diagnosed with a panic disorder and a personality disorder but was discharged from mental health services when he didn't turn up for his follow up appointments.

Two years later Mr F was again referred to mental health services. His problems were similar to those that had led to previous contact. These were regarded by the mental

health team to be largely related to his alcohol misuse and, on that basis, he was discharged without a diagnosis or follow up. Mr F moved to a different NHS Board area with his fiancée and two sons. He made contact with mental health services there and sometime later was diagnosed with schizophrenia and treated with anti-psychotic medication.

Mr F's relationship with his fiancée broke down and at this point he moved back to his father's house. Mr F clearly found the separation from his fiancée and children difficult. While he made efforts to stay in contact, his fiancée eventually took out an interdict against him after he forced entry to her home and assaulted her new partner. He was arrested, received his first serious conviction and was ordered to pay a large fine.

Soon after his conviction Mr F went to his local social work department and told them he was homeless. He was admitted to psychiatric hospital a few days later. Over the next ten years Mr F was in regular contact with mental health, addictions and social work services. While Mr F's mental healthcare was mostly provided in the community, on numerous occasions he needed care and treatment in hospital. This was almost always on a voluntary basis. Mr F's treatment was mainly provided by a Dual Diagnosis Team (DDT). The DDT specialises in providing care and treatment to people who have both a mental illness and problem with alcohol or drug misuse.

Mr F experienced a wide range of psychotic symptoms. He had paranoid delusional beliefs that people intended to do him harm

and delusional beliefs that television programmes and films were referring to him, that he could influence what was being shown on television and that he could hear and see his father on the programmes. Importantly, Mr F heard voices which told him that his father intended to do him harm and that he needed to protect himself from him. Sometimes he also had these ideas and voices in relation to other people. Mr F was known to have carried a knife around when these problems were bad and he assaulted another patient whilst in hospital because of them. Mr F openly told the people looking after him that he had these experiences, telling them that he often had 'bad thoughts' and heard voices that told him to stab his father.

Whilst Mr F sometimes saw his home situation as a major factor in his poor mental health and problems with alcohol, he was ambivalent about moving out to live by himself. Indeed, he had been given housing early on and placed in crisis housing on occasion but inevitably moved back in with his father. Much of Mr F's contact with social work services was related to his desire to be re-housed.

The professionals looking after Mr F differed in their opinion about the nature of his symptoms and, as a result, the degree of risk associated with them. Some of the care team thought the voices that Mr F heard were his own thoughts and, as such, that he was fully able to resist acting on them. Some others recognised them as psychotic symptoms but thought that since Mr F had been experiencing them for a long time without acting on them, he would continue to be able to do so.

As time went on, Mr F's psychotic symptoms relating to harming his father became more intense and more worrying both to Mr F and his family and to some of the professionals involved in his care. Mr F's mother contacted services with concerns about her son's deteriorating mental health and his threats to kill his father. Mrs F and other members of the family expressed concerns about the effectiveness of Mr F's medication.

In summer 2007, Mr F was arrested and admitted to an intensive psychiatric care unit (IPCU). This followed an incident which had resulted in the death of Mr F's father and significant injury to himself. We were contacted by Mr F's consultant who wanted advice about Mr F's care and treatment rights. We became concerned about the circumstances leading up to his admission and decided to look into Mr F's case. At this point the Minister for Public Health also asked us to investigate Mr F's care and treatment.

About our investigation

Our investigation began with a detailed examination of Mr F's health and social work records. We also looked at records held by organisations and housing services that had provided support to Mr F.

Following our review, we interviewed Mr F's close family members and those professionals that we thought could provide important information about Mr F's care and treatment. A total of 19 people were interviewed as part of this investigation. For reasons beyond our control we were unable to interview a community mental health nurse and a social worker involved in Mr F's care.

We were therefore reliant on written notes and evidence from a line manager as alternative sources of information.

What did we find?

The treatment of Mr F's illness

We found that while Mr F had received good care and treatment for his alcohol problems, his mental illness was undertreated. Those most closely involved in his formal care and treatment saw Mr F's psychotic illness largely as a consequence of alcohol misuse and this became the primary focus of their care. His immediate care team had a strong regard for Mr F, visited him regularly and responded to the numerous crises that occurred. However, their closeness to his case didn't allow them to recognise the true extent of his psychosis, or the level of risk arising from his past behaviour, his history of alcohol misuse and the particular psychotic symptoms that he experienced. We found that Mr F was viewed by many of those involved in his care and treatment as a troubled but 'gentle giant' who was not capable of doing harm and this coloured their judgement of risky behaviours.

Those providing care and treatment for Mr F's mental illness relied heavily on oral medication. This was despite the fact that Mr F was known to have paranoid beliefs that his medication may be tampered with as a way of poisoning him. This meant that he often did not take his medication. Mr F's mother had consistently offered her support to help her son to comply with his medication. This was not taken up by the professionals involved in his care. At the same time professionals knew that Mr F

senior was sometimes administering medication, despite Mr F's belief that his father may be trying to do him harm. We believe that the care team did not adequately consider how this might affect Mr F's compliance with medication.

Mr F was prescribed a number of different medications with regard to both his alcohol misuse and his psychosis. This is often necessary for people with complex mental health problems. When it does happen, the reasons for prescribing should be clearly documented and it should continue for as short a time as possible. We found it difficult to understand the rationale for some of the medicines prescribed to help control Mr F's psychotic symptoms. We also think there were other medications that could have been tried. We think this didn't happen because the team providing care and treatment to Mr F saw his alcohol misuse as the main problem. In our view, all these issues resulted in Mr F's mental illness being undertreated.

Mr F had two different psychiatrists, one when he was an in-patient and one when he was receiving care and treatment in the community. We are not convinced that this was the best approach to managing his care and treatment. The dual diagnosis team (DDT) involved in Mr F's care thought that hospital admission was not helpful to him. His in-patient team on the other hand believed that sometimes this was necessary and helpful. We believe that the view held by the DDT prevented them from considering the positive role that planned, recovery oriented hospital admission might have played as part of Mr F's programme of care.

Mr F's psychological needs were not fully assessed and as a result certain therapies which might have been of use were not offered. Mr F did engage in some psychological work with a member of the care team who was training in psychosocial interventions. This focused on how Mr F's difficult past had led to him holding a negative view of himself. The therapist also formed a view that Mr F had angry thoughts towards his father. One goal of his therapy was noted as being to assist Mr F with his 'confrontation skills' so that he could stand up to his father. This seems naive given the abusive nature of the relationship. We also believe that what was being treated as "thoughts" that Mr F could influence, were largely voices telling him what to do. This would have required a different treatment approach, especially in light of risk issues.

Mr F's home environment

We found that many of those involved in Mr F's care failed to recognise the importance of the home situation in contributing to his illness. Those that did recognise it failed to put in place measures that would deal with it.

Mr F had been emotionally and physically abused in childhood by his father. The emotional abuse continued into adulthood and was witnessed by many of the professionals who visited Mr F at home. They found visiting the house stressful and unpleasant and would meet with Mr F in his bedroom to try and exclude his father from the discussions.

In addition to these very particular problems, it is well known that the stress arising from

dealing with mental health problems can cause problems in the way that family members interact with each other and that certain patterns of interaction make relapse highly likely. This is the case even for families who do not have the complex history that Mr F and his father did. A high level of hostility and critical comments in families who find it difficult to keep appropriate distance and boundaries with each other is especially problematic. This means that people often recognise that their situations are problematic but find it extremely difficult to make changes that may prove helpful.

This pattern was clearly evident with Mr F. Mr F would tell people that he was unhappy at the way his father treated him but then appeared to resist spending time away from the family home and would seem ambivalent about moving into his own accommodation. He was viewed as choosing to continue to live with his father and the DDT viewed themselves as respecting this choice whilst gently encouraging him to live independently.

We believe that the risks associated with Mr F continuing to live at home were not properly recognised by the DDT. They were under-assertive in their search for appropriate accommodation and too willing to allow the situation to continue. We also believe that the risks associated with Mr F continuing to live at home were not properly spelled out to the family. We think that clear discussions about the combined risks of alcohol misuse, his psychotic symptoms and the potential for violence would have supported Mr F and his family to make an informed choice about their living circumstances. We also believe that

engaging with the family to help them understand their dynamics and the ways in which they were behaving with each other would have helped all of them to encourage and support Mr F with independent living.

Mr F's care team appeared to have tried to minimise the contact they had with the family. Difficulties in dealing with Mr F's father led to a 'hands off' approach to the whole family. This meant that the potential value of engaging Mr F's mother was not pursued. She was left providing daily support to her son and ex-husband with little direction in how best to do this and no recognition that her input may have been providing an important buffer in the stress that Mr F experienced. At no time was she offered a carer's assessment.

Mr F had two sons who visited and lived with him at various times. No-one involved in Mr F's care had an accurate picture of how often he cared for his two sons. One of Mr F's children witnessed a significant act of self harm and, while his extreme distress was noted, no action appeared to be taken to ensure Mr F's children were appropriately protected.

Risk assessment for Mr F and his family

It is our view that the risk of Mr F harming others was high. While schizophrenia in itself is not a significant risk factor for violence or homicide, Mr F had a combination of schizophrenia and alcohol misuse, a previous history of violence, paranoid delusions and command hallucinations in relation to his father and had previously armed himself with a knife. This was known to those services close to Mr F and should have indicated that there was a high risk

of harm and that a high priority needed to be paid to managing these risks. The risks to Mr F's family, however, were not consistently recognised by services. We found no evidence that risks were discussed with Mr F's family or that they created any sense of urgency in relation to his housing needs.

There was clear evidence from Mr F's behaviour that the levels of risk had increased in the months leading up to the assault on his father. While Mr F was scheduled to have his risk assessment 'reviewed' in January 2007 there is no evidence that this took place. NHS Board A had a formal process for risk assessment and management, but because this didn't capture the relevant information about Mr F's history or current events it was not translated into effective care and treatment.

It is our view that the DDT who were most closely involved in managing Mr F's care and treatment became too close to him to be objective. They could no longer distance their good relationship with him from the assessment and management of the risks he presented. When professionals who were more distant and objective assessed Mr F's risks, their assessment was more accurate. The importance of this information was, however, minimised by the immediate care team who believed their closeness meant they were better qualified to make a judgement.

Social work, who could have provided an alternative external view, did not become actively involved in the risk assessment process. They didn't form an independent opinion of Mr F's risks and instead relied upon assessments by health staff.

The involvement of social work and social care

Mr F's contact with social work spanned 11 years. Despite this prolonged contact there is no evidence that a full assessment of his needs, including his housing needs, was ever undertaken. The DDT had no dedicated social work input for their team and had to ask general social work services for input on a case-by-case basis. We believe that they were not assertive enough in their attempts to secure this for Mr F. When social work did become involved, the worker relied heavily on the information provided by a nurse within the DDT who was also new to Mr F's case. The social worker did not access the risk assessment information held by the DDT or complete her own risk assessment. As a result, that worker did not have the information needed to recognise the urgency of Mr F's housing needs. There was no special needs medical form attached to a housing application submitted in 2007 and Mr F was placed 369th on the housing waiting list as a result.

Mr F regularly took care of his two children. Despite clear potential risks to his children there were no reliable processes for sharing and reviewing information about these risks. In our view child protection social work practice did not meet an acceptable standard. Information was not shared and there were no reliable communication processes between health and social work to review and identify sources of potential harm and risk to Mr F's children.

Latterly, a social care agency was added to Mr F's package of care. They were contracted to provide nine hours of support

each week. This input was funded through 'Supporting People' funds and their role should have been to provide practical assistance to support Mr F towards obtaining his own tenancy. However, their role was defined as helping Mr F go into the community, to improve his independent living skills and to provide emotional support whilst living at home with his father. As a result of the complex situation that they encountered, support agency staff found themselves sitting in Mr F's bedroom for long periods of time with him often discussing his psychotic symptoms and his past history of abuse. Support agency staff were uncomfortable with this situation and recognised that they were not qualified to deal with the matters being raised. However, there was no evidence that the purchasers of this care had in place a system to review whether Mr F's needs were being met by this service.

The critical incident review process

Following the death of Mr F's father NHS Board A held a critical incident review. A critical incident review is a key tool for identifying service failures and for organisational learning and change. Where things go badly wrong, critical incident reviews are a way to identify issues and systematic failures and to put them right for the future.

Our investigation found that the critical incident review related to Mr F's case fell well short of an expected standard. NHS Board A had no policy or procedure for carrying out critical incident reviews. This meant there was no system in place for selecting an appropriately trained, skilled and experienced

person to chair the review. The Chairperson selected, although he did have experience in forensic nursing and had participated in a review, had no training or previous experience in chairing such reviews. The Chairperson also managed the service responsible for the ward that Mr F went to after the incident. Mr F remained on that ward until he was transferred to the State Hospital. We don't think this process provided the level of expertise and independence necessary for an effective review.

People involved in the review said they thought it lacked a clear agenda, structure and focus. Timescales were not adhered to and there was no meeting to discuss the findings of the review. The first sight of the review, for some participants, was when we provided it to them during our investigation.

While Mr F's family members had been closely involved in providing support to him and had a clear understanding of his issues and needs, they did not have input to the incident review. Despite being at the centre of a very distressing set of events and circumstances, at the time of the incident no systematic effort was made to identify whether Mr F's family needed any support from services. For the staff directly involved there was a lack of clarity about whether the critical incident review was a form of debriefing and support, or a forum for the analysis of the facts.

From our analysis of the critical incident review report the recommendations were not pertinent to the key issues raised. Most participants said they were surprised when the only recommendation from the review was about providing better

counselling services for adult survivors of childhood abuse.

Missed opportunities –using a care programme approach

In our view, the complexity of Mr F's care needs and his risks indicated a clear role for the use of the Care Programme Approach (CPA). CPA provides a Scottish Government backed approach to 'identifying needs, assigning an individual or organisation to meet those needs in an agreed co-ordinated way, and regularly reviewing progress with the people who receive the service and with those who care for them'. For Mr F this would have supported better co-ordination of his care across all the agencies involved. As well as creating a clear opportunity to involve his family, CPA would have provided a framework for formalising the links between the agencies involved in his care and kept a focus on risk assessment and management.

Research by the Social Work Services Inspectorate and the Accounts Commission in 1998 identified significant variation in the use of CPA across Scotland. More recent research in England has indicated that large numbers of people who meet the criteria are not being placed on CPA and have not been allocated a care co-ordinator. There is no way of knowing whether services across Scotland are using CPA for individuals who would meet the criteria, or whether the quality of CPA is providing benefits to those individuals who are subject to this care and treatment approach. We think this is a matter that the Scottish Government should consider reviewing.

Summary of recommendations

Recommendations regarding the treatment of Mr F's illness

- NHS Board A must critically review their model of care for people with dual diagnosis. This must include explicit consideration of whether a model of providing shared care between addiction services and general adult services would offer more safeguards than a stand alone dual diagnosis team. Also NHS Board A must critically examine whether the risks associated with patients receiving in-patient care and out-patient care from different consultant psychiatrists is too great for the practice to continue.
- If NHS Board A decides to continue with their current model, there must be a documented discussion on admission and again at discharge to set out the purpose of admission, develop an agreed treatment plan and proactively plan aftercare. Use of the care programme approach for all patients falling into this category might provide a useful framework.
- If NHS Board A continues with a separate DDT service, NHS Board A must define the criteria/point at which patients are moved on to general adult services, ensure that patients are moved on from the DDT to general adult services. They should also ensure that patients are subject to regular, formal case review which includes general adult psychiatry services in order that transition can be considered and planned for.

- NHS Board A should review the care and treatment of patients currently receiving treatment from the dual diagnosis team to ensure that their mental illness needs are being adequately treated.
 - NHS Board A must examine the availability of clinical pharmacy support to all mental health teams and this should include reference to current good practice guidance on the use of licensed medicines for unlicensed applications (Royal College of Psychiatrists CR142)
 - NHS Board A must address the clinical psychology provision to in-patient services and to small specialist teams such as the DDT. This provision should be of a level which allows the assessment and treatment of the most complex cases and the supervision of other staff conducting psychological interventions. With regard to supervision, care must be taken to ensure that the supervising clinician is close enough to the work of the team to be familiar with the cases being discussed.
- arrangements as to how this can be accessed from elsewhere.
- NHS Board A must ensure that all teams have access to expertise in psychological assessment – including risk assessment – in order to maximise the likelihood of the correct intervention being used. Many psychological interventions, including structured family interventions, can be implemented by staff from varying disciplines and do not require a clinical psychologist to conduct these. However, most teams will have cases of a complexity that do require this higher level of skill either to decide upon the appropriateness of a particular intervention and/or to implement this. NHS Board A must therefore examine the availability of clinical psychology to the DDT and other teams delivering care to people with severe and enduring mental health problems.
 - NHS Board A must put procedures in place that ensure that staff properly re-examine the home environment at key points in the care process. This must include documented consultation with carers and other people living in that environment.

Recommendations regarding Mr F's home situation

- NHS Board A must ensure that all staff are aware of the relationship between family environments and relapse in psychosis.
- NHS Board A must ensure that all teams dealing with people with severe and enduring mental health problems have access to evidence-based family interventions. Where teams are viewed as too small in their own right to support a worker trained in a structured family intervention, there must be clear
- NHS Board A and SWD1 must ensure that where teams do not have integrated social work provisions there is clear guidance as to why, how and when services can be accessed.
- NHS Board A and SWD1 must ensure that all workers involved in the Mr F case receive refresher training in child protection issues. They should also

consider whether this may equally applicable to the rest of their workforce.

- NHS Board A and SWD1 must ensure that the Care Programme Approach (CPA) is being used in line with its own current guidelines.

Recommendations regarding risk assessment

- NHS Board A and SWD1 should look to reviewing their agreed, shared risk assessment process. While the documentation to assist this is clearly established, documentation alone does not ensure the accurate recording of information or help individual professionals or groupings of professionals make the appropriate “assessment” or judgements about levels of risk. NHS Board A and SWD1 must therefore:
 1. Audit the process of risk assessment and management to determine whether this is taking place at the specified intervals and that significant new risk-relevant events trigger a formal re-visiting of risk assessment and management.
 2. Ensure that there is a regular cycle of training which clearly outlines contemporary knowledge and best practice with regard to risk to others and, importantly, covers the known problems and weaknesses that may creep into the process and lead to a systematic under-estimation of risk.
 3. Put in place processes whereby risk assessment and management information is shared by all people/

agencies involved in the care (including GPs).

- NHS Board A and SWD1 must give serious consideration to extending or clarifying CPA criteria to ensure that this process is put in place for any individual experiencing persistent psychotic symptoms or other factors which indicate elevated risk to others.
- Where risk involves someone to whom the patient has access, there must be a detailed assessment of that risk. Where families form an integral part of a patient’s life, the findings must be shared with the family in order that they can meaningfully assist in the risk management process and make fully informed choices about the type and frequency of contact to have with their family member.
- Where the risk involves a family member to whom the patient has access, SWD1 must ensure that a carers needs assessment is undertaken and that this is properly considered as an integral part of the original care plan.

Recommendations regarding social work and social care action

- SWD1 must put in place a system where staff absence does not result in cases being left for prolonged periods without review or intervention.
- SWD1 must ensure that an assessment of need is undertaken in line with the Social Work (Scotland) Act 1968 and Community Care and Health (Scotland) Act 2002 at the point of initial contact with the service.

- SWD1 and NHS Board A must ensure that all workers involved in the Mr F case receive refresher training in the systems and processes involved in the single shared assessment process and their role in it.
- NHS Board A and SWD1 must give serious consideration to the structures in place to support a co-ordinated approach to the delivery of a multi-disciplinary care package. The Care Programme Approach, for example, ensures active participation of all relevant parties, including carers, in the care planning and review process.
- SWD1 and NHS Board A must ensure that where services are commissioned, the service provided is scrutinised by the commissioner and reviewed regularly to ensure that the particular service remains appropriate to the assessed needs of the individual.

Recommendations regarding critical incident reviews

- NHS QIS should develop and oversee the implementation of a standardised process for critical incident reviews (CIRs) for use across all mental health services in NHS Scotland.
- Until NHS QIS guidance is available NHS Board A must, as a matter of urgency, develop and implement policy governing CIRs. This should include direction with regard to when CIRs are required; who should be involved; the expertise of the Chair; the scope and purpose of the CIR; and the need to involve families in the process at an appropriate juncture/level.

The Chair of any CIR must be, and be seen to be, independent to the service, have appropriate training in conducting CIRs and have expert knowledge of the subject area being reviewed.

- There must be clear splitting off of the function of staff support/debrief from an exacting examination of the facts. NHS Board A should develop guidance to issue to staff involved in CIRs to ensure that they are fully aware of the process and what will be involved.

Recommendations regarding the use of the Care Programme Approach (CPA)

- The Scottish Government should commission a review of the current use of CPA in Scotland with a view to establishing patterns of use across different regions and the quality of the processes being used. Where problems are identified, steps should be taken to rectify these.

