mental welfare commission for scotland

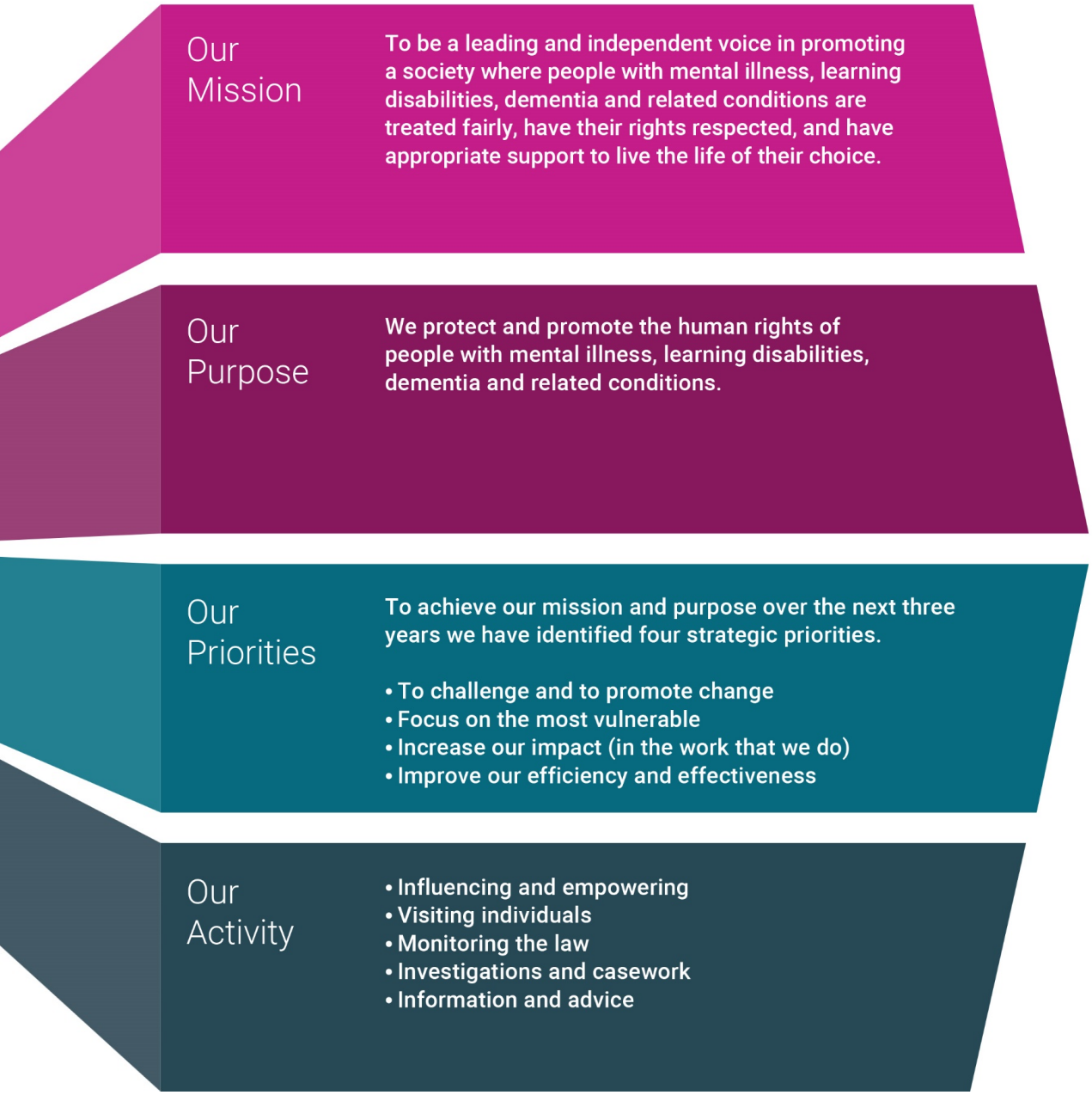
Closure report

Care and treatment for people with alcohol related brain damage in Scotland

A report on visits to people and services across Scotland in 2021

October 2022

Our mission and purpose



Closure report:

Care and treatment for people with alcohol related brain damage in Scotland. A report on visits to people and services across Scotland in 2021

Executive lead:
Julie Paterson, chief executive

Date of executive leadership team approval of project mandate:
Project Mandate was agreed on 2 March 2021.

Date of commencement:
March 2021

Date of publication:
16 September 2021

Date of closure report:
9 September 2022

Purpose of a closure report
The purpose of a closure report is to assess whether the Commission has achieved its objectives (including outcomes, learning, quality and impact) and completed all deliverables on time and as planned.

The report must summarise the findings and recommendations made in the themed visit report and identify the organisations and individuals to whom the recommendations were made.

The report should also identify the follow up actions and activities of the Commission in gathering in responses to the recommendations, and once in, identify how these responses were evidenced, assessed for impact and their success measured.

The report should assess the theme in terms of impact, resource commitment and outcomes and met organisational standards and expectations.

1. Summary of recommendations made in the report

The Commission has long standing concerns about the availability of specialist support for people with a diagnosis of alcohol related brain damage (ARBD) and published good practice guidance in 2019 on this subject to assist health and social care services across Scotland.

This themed visit report was the next stage. It looked specifically at 50 cases where people had been given a diagnosis of ARBD who were also subject to a welfare guardianship order.

The intention of this work was to understand whether the Commission's ARBD good practice guidance was being followed by health and social care services, and to learn more about the care arrangements in place, and the application of the critically important principles of adults with incapacity law.

We took some specific individual actions, as part of our casework approach, following our contacts with those 50 individuals (and their family/carers where appropriate) across 27 of Scotland's 31 Health and Social Care Partnerships (HSCPs). We highlighted many examples of good care and made four recommendations to Health and Social Care Partnerships. We make recommendations to Health and Social Care Partnerships, respecting and recognising their key delivery function.

The four recommendations directed at Health and Social Care Partnerships (with support from their respective Local Authorities and Health Boards) were as follows:

Recommendation 1: Health and Social Care Partnerships should commission suitable, age appropriate and where possible specialist ARBD services.

As described in our good practice ARBD guidance and further evidenced in this programme of visits to people subject to guardianship orders, inappropriate community care home placements can precipitate dependency and isolation for individuals with ARBD. Despite the advent of self-directed support and our guidance we saw limited development of specialist, innovative approaches and services in Scotland to meet the needs of people with a diagnosis of ARBD. Where we did find this, more positive outcomes were clearly evidenced.

Those commissioning services must consider whether they are breaching the person's human rights if the person is compelled to live in a setting which they would never choose.

Recommendation 2: Health and Social Care Partnerships should ensure allocation of the delegated officer role to a named individual to ensure consistency and continuity.

The Chief Social Work Officer delegates the role of guardian to a delegated officer; the Chief Social Work Officer remains accountable however. We found that the critical role of delegated officer was not always held by a named officer who maintained regular contact with the person subject to the restrictions of the guardianship order. We do not consider this to be in line with the spirit of the legislation. Where a decision has been taken by the local authority to intervene in a person's life on a statutory basis, there should be a named delegated officer building a trusting relationship and ensuring that the order is meeting the person's outcomes in line with the principles of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

Recommendation 3: Community care review activity within Health and Social Care Partnerships should be dynamic, coordinated processes which include review of personal outcomes, care plans, placement, the guardianship order and whether all or some of the powers remain relevant.

Multidisciplinary reviews should be dynamic, coordinated processes informed by the principles of the AWI Act, maximising both the contribution of the person and their carers/relatives where appropriate. We found that reviews did not always focus on outcomes, the placement and the powers of the order. It is important to ensure that those involved are not passive recipients of information but have ongoing relationships that allow them to actively contribute to the review process.

Recommendation 4: Health and Social Care Partnerships' strategic advocacy plans should include focus on accessibility of advocacy support at all stages of the care and support continuum.

We have highlighted the challenges of supporting the rights of people with a diagnosis of ARBD to live as they choose balanced with their rights to access support to maximise their quality of life. The offer of advocacy support is an important safeguard to ensure respect for the rights, will and preferences of the person and not what is considered by others to be in that person's best interests. Advocacy support is important prior to the guardianship application stage, post guardianship and throughout the provision of continuing care.

2. Summary of responses

The Commission received responses from all 31 Health and Social Care Partnerships. The quality of responses from Health and Social Care Partnerships varied significantly.

We were particularly impressed by those areas who undertook their own audits in response to recommendation 1 and satisfied themselves that commissioned resources appropriately met the needs of all those with a diagnosis of ARBD in their particular HSCP area.

All action plans were scrutinised by the Commission's project team using agreed standard criteria and where action plans were not SMART and did not give assurance, follow up contacts were made, including meetings with key people within Health and Social Care Partnerships as required.

The outcome is that all action plans now evidence clear objectives in relation to recommendations and timescale to delivery. Health and Social Care Partnerships will be expected to monitor progress through their existing governance arrangements and updates will be requested by the Commission in advance of 'end of year meetings' which resumed in September 2022. The updates will include request for information regarding the governance arrangements in place supporting delivery of recommendations made by the Mental Welfare Commission where this was not originally confirmed.

As noted previously, the Commission has introduced an action plan template to guide organisations in relation to the level of detail required in response to recommendations made. This template is not mandatory but intended to be helpful to ensure consistency of response and quality of response (see appendix A).

3. Summary of Commission follow up activity and actions

As noted above, and in our report (page 29) individual actions were taken at the time of our visiting programme, based on issues arising for individual people (informed by families/relatives as appropriate).

We discussed the criteria for care home registration with the Care Inspectorate on 6 September 2021 to both understand this and to support transparency and clarity regarding expectations of service provision. The Deputy Chief Executive completed an action thereafter to update providers.

Understanding of section 47 certificates was highlighted once again as an area that caused some confusion so on 1 October 2021 we issued a position statement titled: "The scope and limitations of the use of section 47 of the Adults with Incapacity Act".

We are working in partnership with the Scottish Independent Advocacy Alliance and have requested information from local authorities and health boards about how they have been fulfilling their duties to collaborate to secure the availability of independent advocacy services in their area as per the duty imposed under the Mental Health (Care and Treatment)(Scotland) Act 2003. As part of this process, we have asked for copies of the Health Board's/Local Authority's:

- Advocacy Strategic Plan
- Equality Impact Assessment for your Advocacy Strategic Plan
- Action Plan for the development of mental health, dementia, learning disability independent advocacy service
- Integrated Children's Services Plan

We will be publishing a report analysing the responses early in 2023, and all returns will also be published on our website as open data in addition to this. We had hoped to complete this work in April 2022 however the pandemic continued to provide challenges, hence the delay.

We intended to aim to understand the landscape of specialist ARBD services and teams across Scotland and work with Health and Social Care Partnerships to map this information and detail in 2022. However given the ongoing challenges of the pandemic and associated pressures, we have agreed with Health and Social Care Partnerships to complete this work in 2023. We are grateful to those who have already provided us with helpful information.

Throughout the past 12 months, the 'Care and treatment for people with alcohol related brain damage in Scotland. A report on visits to people and services across Scotland in 2021' has featured at a number of events with the next being Glasgow's ARBD Conference - "Supporting Recovery in Alcohol Related Brain Damage: Developing a System of Care" on 8 September 2022.

4. Summary of the impact of the themed report and wider learning

Media

This report drew particular interest in the north east, with a piece in the Aberdeen Evening Express, and also in the Press and Journal, headlining the Commission as a watchdog. It was also picked up by healthandcare.scot.

The Commission's CEO was quoted in these:

> *"There were many positive examples of good care, which we highlight in this report, but also areas of concern.*
>
> *"We found many of the people we met were living in care homes where they were much younger than the other residents. Those commissioning services must consider whether they are breaching the person's human rights if the person finds themselves compelled to live in a setting which they would never choose."*
>
> *"We make recommendations about areas of care and treatment we believe could and should work better, and we will follow those up.*
>
> *"I hope our report will be widely shared and discussed, and others will join us in seeking improvements for this vulnerable group."*

Twitter – first week

The report drew a lot more interest on twitter from groups directly involved in this subject. The original tweet received 195 engagements (meaning it was liked, retweeted, clicked on, or otherwise interacted with). 47 users clicked on the link to the news story, 27 users liked the tweet, and 23 retweeted it to their own followers. In its first week, it was the fourth-most engaged tweet of the previous 12 months.

Organisations whose accounts retweeted included Substance Rehab, SACASR Stirling, West Lothian HSCP Mental Health, Scottish Independent Advocacy Alliance, and Community Justice Glasgow.

Other organisations who tweeted about the report include healthandcare.scot, DDN Magazine, ARBD Awareness Scotland, and Alcohol Review.

Dr Richard Simpson retweeted the story from healthandcare.scot with the following comments:

> *Another grt report @MentalWelfare*
> *I supported William Simpson home in Plean as MSP & am now a 'member'. It's a charity which looks after ARBD residents*
> *WS built a superb new facility. @StirlingCouncil has helped in raising our payments National agreed £level keeping WS viable*

Scottish Health Action on Alcohol Problems tweeted about the report, in a blog post on their own website written by Julie Paterson, CEO and Dr Lisa Schölin, researcher.

Website

In the seven days following publication, the news story on the report was viewed 192 times, by 4.52% of users, making it the fifth most popular page in that time (the most popular being the main home page, with 563 views, or 13.26% of users).

Actions

The actions detailed above and the quality of responses received from Health and Social Care Partnerships evidence that the content of this ARBD report is known and understood.

Progress reports on actions will be sought at the Commission's 'end of year' meetings with all Health and Social Care Partnerships which resumed in September 2022.

The Commission's visit activity in 2022-23 will reflect learning from Authority to Discharge with particular focus on developing a detailed understanding of AWI legislation knowledge and application in practice including what a section 47 certificate is and is not, the difference between a power of attorney and appointee. The Commission will also support the Care Inspectorate in their scrutiny work to support the delivery of both recommendations made to them.

5. Conclusion – was the themed visit worth doing?

The Commission's good practice guidance 'Alcohol Related Brain Damage' was published in 2019 in response to stakeholders making regular enquiries/seeking advice from the Commission in relation to assessment, care, treatment and rehabilitation of adults with ARBD. The guidance offers key learning points and guidance for practitioners delivering care. One aim of this themed visit in 2021 was to determine the impact of the Commission's guidance in practice. Another aim was to gather information from people with ARBD, family/carers, welfare guardians and support staff and highlight their views. We were also keen to note practice examples of the use of guardianship orders for a group of individuals with ARBD related complex needs both from a best practice and constructive viewpoint.

The aims of the themed work were realised. Where there was no knowledge of the Commission's good practice guidance, this was shared and where there were issues relating to individual rights, these were raised and addressed.

There is no doubt that this themed piece of work was worth doing and has highlighted four key recommendations for improvement for HSCPs to ensure the rights of some of the most vulnerable and marginalised adults are respected, promoted and upheld.

It is important that the Commission continues to raise the profile of this small but significant group given, as the report states: "Discriminatory perceptions of a 'self-inflicted illness' can lead to people with a diagnosis of ARBD being extremely vulnerable, marginalised and socially isolated."

6. Outstanding actions and recommendations, and any future activity or options to satisfy these

As noted in section 3, work is progressing to gather information from Health Boards and Local Authorities requested information from local authorities to learn how they have been fulfilling their duties to collaborate to secure the availability of independent advocacy services in their area as per the duty imposed under the Mental Health (Care and Treatment)(Scotland) Act 2003. Once received, individual responses will be shared and an analysis report will be completed early in 2023.

A mapping exercise of ARBD specialist services across Scotland will be completed with HSCPS in 2023.

We will aim to visit the 50 individuals subject to guardianship orders we met as part of this themed work again in 2023 to review and seek feedback on how things are going for them and their families.

Appendix A

Action plan response to recommendations: suggested template and example recommendation response (Mental Welfare Commission)

Recommendation	**Self-Evaluation** (*where we are at currently in relation to this recommendation)*	**Activity** *(what do we need to do to meet this recommendation)*	**Audit** *(how will we know we have met this recommendation)*	**Timescale** *(when will this identified activity be implemented / completed)*	**Who is responsible** *(for driving this improvement activity)*
1.HSCPs should undertake a full training needs analysis to identify gaps in knowledge in relation to capacity and assessment, associated legislation, deprivation of liberty definition and the human rights of individuals (as detailed in	The HSCP ensures that we support safe and lawful hospital discharge planning and we have up to date guidance and protocols supporting this.	To support our staff further we have organised a series of extraordinary team meetings, which are already underway, to ascertain levels of training needs. This will help inform the development of a full AWI training needs analysis.	Regular 1:1 supervision is in place for front line staff will include audit of case files and practice to ensure training provided has been incorporated and	By 30 September 2021	Service Managers – mental health and community care older adults. This incorporates hospital teams which are multi-disciplinary

Recommendation	**Self-Evaluation** (*where we are at currently in relation to this recommendation)*	**Activity** *(what do we need to do to meet this recommendation)*	**Audit** *(how will we know we have met this recommendation)*	**Timescale** *(when will this identified activity be implemented / completed)*	**Who is responsible** *(for driving this improvement activity)*
this report) to inform delivery of training programmes to ensure a confident, competent multidisciplinary workforce supporting safe and lawful hospital discharge planning.	Our staff report that they are well informed of the rights of individuals and are able to confidently advocate on their behalf.		embedded in practice.		
	The skills, experience, and expertise within the Hospital Social Work Department and Locality and Specialist Services Teams ensures that staff are:	Following publication of the full training needs analysis a programme of training will be developed and delivered. This will be supported by a combination of webinar and e-learning which will be available to staff, with different levels of training offered based on the needs analysis/roles and responsibilities.		By 31 March 2022	Above named officers and Team Managers across Teams facilitating discharges

Recommendation	**Self-Evaluation** (*where we are at currently in relation to this recommendation)*	**Activity** *(what do we need to do to meet this recommendation)*	**Audit** *(how will we know we have met this recommendation)*	**Timescale** *(when will this identified activity be implemented / completed)*	**Who is responsible** *(for driving this improvement activity)*
	• Familiar with capacity assessment requirements.			By 30 June 2021	
	• Well informed and are able to provide advice to multidisciplinary staff in areas of capacity. • Sensitive to restrictions of liberty. • Confident in communicating with individuals with cognitive decline. • Skilled in working with families in crisis.			By 30 November 2021	

Recommendation	**Self-Evaluation** (*where we are at currently in relation to this recommendation)*	**Activity** *(what do we need to do to meet this recommendation)*	**Audit** *(how will we know we have met this recommendation)*	**Timescale** *(when will this identified activity be implemented / completed)*	**Who is responsible** *(for driving this improvement activity)*
	We know this because of our ongoing engagement with this staff group and their feed-back.	An immediate training session will be undertaken with the Hospital Teams. This will be followed up with a wider training session with our colleagues in NHS, hospital team discharge nurses and co-ordinators will also be invited to participate. Incorporate legislative, policy and practice issues into annual briefings to staff.		Ongoing	Service Manager - improvement

Recommendation	**Self-Evaluation** (*where we are at currently in relation to this recommendation)*	**Activity** *(what do we need to do to meet this recommendation)*	**Audit** *(how will we know we have met this recommendation)*	**Timescale** *(when will this identified activity be implemented / completed)*	**Who is responsible** *(for driving this improvement activity)*
	We are aware and alert to time constraints/pressure that reducing delayed discharges could have on standards of assessment and practice. However, in this HSCP we work to maintain our high standards and are flexible retaining a focus on the person at the centre.		Annual audit processes are already in place and will be adapted to ensure capture of compliance with legislation and good practice and any gaps identified within these audits will be incorporated into established training programmes.		

Recommendation	**Self-Evaluation** (*where we are at currently in relation to this recommendation)*	**Activity** *(what do we need to do to meet this recommendation)*	**Audit** *(how will we know we have met this recommendation)*	**Timescale** *(when will this identified activity be implemented / completed)*	**Who is responsible** *(for driving this improvement activity)*
	Locality Team supports are available to the hospital team at times of increased pressure to manage and maintain standards and focus on the individual.				

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