Mental Welfare Commission for Scotland

Report on announced visit to:
Community Mental Health Team (West), Bathgate Partnership Centre, Bathgate House, EH48 1TS

Date of visit: 29 August 2024

Where we visited

The Commission visits people wherever they are receiving care and treatment. Often this is in hospital, but it might be in their own home, or a care home or local community setting. With the shift in the balance of care, in that there is more of a focus of the delivery of mental healthcare in the community, rather than in mental health inpatient wards and units, the Commission's visiting programme has to reflect this change so that we can continue to find out about an individual's views of their care and treatment in the setting that it is provided in.

On this occasion, we visited West Lothian Community Mental Health Team (CMHT). We had the opportunity to meet with individuals who received care and treatment, as well as being able to meet with nursing, medical staff and their colleagues from the local authority.

The CMHT is an integrated service between health and the local authority of West Lothian. The CMHT forms part of a whole system approach to mental health services for the adult population of the West Lothian Health and Social Care Partnership (HSCP). The service is delivered in conjunction with primary care community mental health nurses, acute services (crisis/home treatment services and out of hours (OOH) services. This service supports individuals primarily in the age range of 18 to 65 years however, there are occasions where an individual will remain with the service beyond 65 years.

Wherever possible we invite individuals receiving care from mental health services to meet with us on the day of our visit. On this occasion we were able to do this while also having the opportunity to review the care records of several individuals and meet with their community mental health keyworkers. We also had the opportunity to talk with individuals who meet weekly as a group to socialise and are supported by members of the CMHT to discuss any concerns they may have.

We met with the senior leadership team from across the service, including senior medical staff.

Who we met with

We met with 14 in person and reviewed the care notes of seven people. We had contact with one relative prior to the visit.

We spoke with the service manager, general manager, nursing and social work team managers, consultant psychiatrists, community mental health nurses and support workers.

Commission visitors

Anne Buchanan, nursing officer

Lesley Paterson, senior manager (east team)

Paula John, social work officer/lead investigations officer

What people told us and what we found

We had the opportunity to meet with several individuals who had been receiving support and treatment from West Lothian CMHT.

Those that we met with were at different stages of their engagement with the service. For some, we were told the support provided by the team had been for a lengthy duration such was the complexities of the individual's circumstances and severity if their mental ill-health. For others, the input from the team had been relatively recent and they were in a position of developing therapeutic relationships in terms of working with their new community nurse, social worker or doctor.

We heard from individuals how much they valued the support they had received from staff working in the service. While there was a sense the team have a formal role to ensure people in the service were provided with care and treatment to meet their individual needs, there was also a sense the service had always been consistent and offered individuals a sense of belonging. This belief of feeling welcomed was discussed in a group we were invited to join.

In the group who met weekly, we were able to discuss how the service responded to people who had different queries, such as financial questions, tenancy issues or concerns with their mental health. The 'open door' model of welcoming people into the base where there was shared accommodation meant that for individuals accessing the service, this approach enabled them to feel safe. The social connection was the overarching theme throughout our conversations and was important to people. We also had the opportunity to meet with individuals who had home visits from members of the team. Typically, we heard where people had needed additional support, along with observation of their mental health and treatment, this was equally valued.

We spoke with nursing and medical staff throughout the day and were told the service had well-developed local connections with non-statutory services. Those connections were essential, as they offered people a range of recreational and therapeutic engagement opportunities. Furthermore, where individuals required support in relation to housing, financial information and community engagement with allied health services, there were local authority experienced staff to facilitate this.

Feedback from relatives

Prior to our visit, we were informed by a relative of their concerns in relation to the care and treatment of their family member. We made initial enquiries under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Section 11 gives the Commission the authority to carry out investigations and make recommendations to improve services across Scotland as it considers appropriate in

any circumstances, including where an individual with mental illness, learning disability or related condition may be, or may have been, subject to ill-treatment, neglect or some other deficiency in care and treatment.

The Commission met with senior managers from the service and during our visit to the service, we discussed how the multidisciplinary team had implemented recommendations from a significant adverse event review that had taken place. We were provided with the recently updated community mental health team operational policy, and it was positive to hear that the service had reflected upon several areas for improvement and recognised the importance of working with relatives, while maintaining confidentiality. However, it remains important to work with families to promote positive outcomes for individuals who may struggle to accept or engage with the community mental health service.

The service also recognised the need for all staff to have a sound knowledge base of legislative frameworks. This extends to providing staff training in relation to Adult Support and Protection (Scotland) Act, 2007 (Adult Support and Protection Act), Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) and understanding the statutory responsibilities of the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) in terms of the multidisciplinary team ensuring that specific functions of the Act(s) are undertaken to promote safe, person-centred care and treatment.

We will continue to seek assurance that the community mental health team remains committed to supporting individuals in West Lothian and working collaboratively with families to promote positive outcomes for all individuals.

Care, treatment, support, and participation

We were informed there were two CMHTs for the local authority of West Lothian. The catchment areas for each service were divided into specific towns and offered services to meet the needs of people in their districts of West Lothian. Expectations of a CMHT vary across the country; we were told the CMHT had designed their service to adapt to the needs of individuals living in West Lothian, whilst also taking in account the number of non-statutory support services people in this area had access to.

We heard referrals into the CMHT typically came from the admission wards based in St John's Hospital, from primary care services including GPs, unscheduled care/out of hours service and social work.

The service offered a multidisciplinary team (MDT) model of care, treatment and support. Referrals to the service were discussed in the team, and where an individual met the criteria for assessment, this was undertaken jointly by a member of nursing staff and either an allied health professional e.g. occupational therapist (OT) or with

a social worker. This approach, we were told, lent itself well to ensuring assessments were holistic and that they considered a mental health, social and economic model of enquiry.

Communication between the inpatient and community service was supported by regular meetings with senior staff across both services. Furthermore, with the addition of 'link' CMHT nurses who had responsibility for attending weekly MDT meetings and discharge planning meetings, this approach had improved outcomes for individuals receiving inpatient care and their pathways back into the community.

Individuals who were accepted for referral and subsequently required input from CMHT would have the opportunity to meet with members of the team. The CMHT had a range of professionals including OT, medical and nursing staff along with health care support workers. We were told psychology had been part of the service however, there had been vacancies for a period.

As part of an integrated service, the team also benefitted from having social work colleagues as part of the team, including mental health workers with local authority experience. Each individual who was supported by the CMHT had a keyworker and consultant psychiatrist. The keyworker would likely be a mental health nurse with experience of working in a community setting. Keyworkers had a range of experience and provided continuing assessment, support and treatment for individuals who presented with mental ill-health, co-existing substance use with support from specialist services.

Furthermore, the team provided psychoeducation, medication management and support for families and relatives, where appropriate. Individual nursing and social work caseloads varied in size, largely dependent upon complexity and specific interventions an individual may require. On the day of the visit to the community team there were 207 individuals open to the service, with several individuals also receiving input from substance use services.

Joint working between CMHT and community substance use service had commenced as part of a collaborative partnership between both teams. The Scottish Government's current Mental Health Strategy (2017-2027) has actions that aim to develop better mechanisms for the assessment and referral for people with dual diagnosis and to offer opportunities to pilot improved arrangements for their care (Actions 27 and 28). In 2021, the Scottish Government, following the work of the 'Drugs Death Taskforce', published ten standards for medication assisted treatment (MAT) for people with addictions. The standards are to help reduce deaths, promote recovery and ensure a patient-centred approach to the delivery of safe, effective and accessible treatments. Standard 9 of the MAT standards sets out that all people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery. This standard aims to ensure that those receiving

treatment for drug use have access to mental health care and do not fall between gaps in service provision.

With the introduction of MAT standards, we were interested to find out how these had been implemented in clinical practice and were pleased to hear there were several people receiving input across both mental health and addiction services, which included joint assessments and care planning, including participation from the individual and their families. Where an individual did present with mental ill-health and co-occurring substance use, mental health services and substance use services ensured communication was seamless, with both services taking responsibility for care delivery.

There were several organisations in the local authority that offered a range of opportunities for individuals to have additional support in their community. Statutory and non-statutory services working alongside each other has been part of the West Lothian model for several years. Individuals were supported to attend groups, with there being several that promoted life skills, education opportunities and access to employment or volunteering.

Relatives and family engagement

We asked the senior leadership team about engaging with carers, relatives and families of individuals attached to the CMHT. We had been informed by relatives that their views had not been sought and this had meant that working in collaboration with the service had been a challenge. We were keen to hear how the service invited families to participate in assessments and care planning, and how the views of families and individuals were gathered to support service improvements. We were told families were now actively invited to engage with initial assessments.

There was an understanding that not all individuals had consented for information to be shared, and this decision was respected. Nevertheless, the CMHT recognised the importance of gathering corroborative information including the views of relatives, as an 'open dialogue' between the CPN, individual and relatives has proven to reduce risks and promote recovery. The service was keen to improve communication, so senior managers had met with relatives, carers and collective advocacy to listen to their views and take forward suggestions about how to improve communication.

The Commission have published guidance for professionals and relatives: Carers, consent and confidentiality[1].

[1] Carers, consent, and confidentiality good practice guidance: https://www.mwcscot.org.uk/node/223

Care records
Documentation relating to care was held on the electronic system used in NHS Lothian, 'TrakCare'. We found care records easy to navigate and found all relevant information to support our visit to this CMHT.

Where an individual had been accepted onto the CMHT caseload or had been attached to the service for a period of time we would expect to find in their care records a range of assessments including risk assessments, person-centred care plans and information relating to one-to-one sessions. Health and social care had separate systems for collating and storing information.

We were pleased to hear where assessments had been undertaken between health and social care staff, those assessments were stored on healthcare and social work systems and were accessible for individual staff to review and update as necessary.

We were keen to review care plans, particularly for individuals who had been with the service for a several years. We could access care plan documents, review an individual's assessment and identify where there had been initial discussions with an individual and their keyworker in terms of goals to aid recovery.

However, where care plans had been put in place it was difficult to locate reviews, or to see where an individual had successfully reached a specific goal and where there may be additional needs. Where specific interventions had been identified to support an individual, we would expect to find details of the intervention, whether there had been improvements or if another approach was required. Unfortunately, of the care plans we reviewed there were several that would not be considered person-centred. This lack of detail meant we were unable to identify where progress had been made or an individual's subjective views in terms of their care and treatment.

Recommendation 1:
Managers should ensure care plans are person-centred and reflect the views of individuals who are receiving care and treatment.

Recommendation 2:
Managers should carry out an audit of care plan reviews to ensure they fully reflect an individual's progress towards stated care goals and that recording of reviews are consistent across all care plans.

The Commission has published a good practice guide on care plans[2]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

[2] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Multidisciplinary team (MDT)
The community mental health team had an MDT model of care, treatment and support for individuals based in West Lothian. The team included nursing and social workers, OT, pharmacist and referrals to other allied health professionals, such community dietician, speech and language therapy and physiotherapy when required.

There were close links with primary care services, as there was recognition that people with mental ill-health over a lifespan could present with physical comorbidities. Increasingly the CMHT team had been taking responsibility for monitoring individual's physical health and well-being, which included supporting individuals to attend primary care, or outpatient appointments throughout NHS Lothian hospitals.

There was a recognition that individuals under the care of the service could require additional support to ensure national screening programmes were available to them, therefore staff were committed to ensuring women were aware of and attended well-women clinic appointments and for men, that they were supported with specific physical and well-being assessments and monitoring programmes.

We noted a long-term willingness with available West Lothian mental health services, both statutory and non-statutory, to work together to encourage individuals to access a range of support options. People we met with and spoke to valued the contribution from all organisations, including access to social activities and peer support.

Use of mental health and incapacity legislation
On the day of our visit, there were 10 individuals who were detained under the Mental Health Act. Of the care records we reviewed, most individuals were subject to community compulsory treatment orders (CCTOs).

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We would expect to find consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act in place, where required. Unfortunately, we were unable to locate several of those on the day of the visit.

We discussed this with the team and senior managers on the day and there was some confusion in ascertaining what psychotropic medication was prescribed by the CMHT, what was prescribed by the GP and whose responsibility it was to ensure all psychotropic treatment was authorised; we were therefore unable to view treatment certificates during the visit.

It was of concern that in any case, CMHT nursing staff were administering intramuscular psychotropic medication without having sight of certificates that were required to legally authorise the treatment.

Recommendation 3:
Managers and medical staff must locate and review all current T2 and T3 treatment certificates to ensure they are compatible with all psychotropic medication which is being prescribed and administered and medical staff should pursue DMP visits urgently, where required, for T3 certificates.

Recommendation 4:
Managers should introduce a robust audit system to ensure that all medication prescribed under the Mental Health Act is appropriately and legally authorised.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found this paperwork in the care records.

Rights and restrictions

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. There were approximately seven individuals who had documented an advance statement. We were told the service recognised there had been a gap in terms of promoting sections 275 and 276 of the Mental Health Act and have arranged for additional training for the team.

The Commission has developed *Rights in Mind.*[3] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

There was an emphasis upon recreational and therapeutic activity provision across community services in West Lothian. We were informed that an event has been arranged to promote mental health services across the local authority. This event will include agencies and organisations that support individuals, their families and the wider community. People living in West Lothian have access to a range of activity provision, including one-to-one recreational activities and help to attend support groups. People we spoke to particularly valued and enjoyed groups held in the CMHT building; there was a sense of mutual support from people living with

[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

mental ill-health in that it was important and appreciated to have staff facilitate the groups.

The physical environment

There were two buildings available for use, both being accessible for individuals under the care of the CMHT and members of the multidisciplinary team. The CMHT base was in central Bathgate. This building was relatively large with consultation rooms, CPN office space and access to group rooms and a kitchen.

The CMHT had adopted a model of open access to the building. This was important, as people told us they felt welcome to attend groups, pop in to see support staff and engage regularly with their peers. Access to local agencies and organisations in the local community was encouraged, with support staff facilitating this.

While the CMHT building was welcoming, we were told that on occasion sound proofing was an issue. This was because it was not purpose built and had been adapted from two former Police Scotland offices. While the building was a homely and comfortable space, the issues around confidentiality in the clinic rooms was a source of frustration for the team. To overcome this the team had adapted some of the rooms however, we were told soundproofing remained a concern for everyone.

As this had been raised as a concern by several people, we would suggest that remedial work to improve sound proofing would be welcome.

Any other comments

There were two new team leaders for this integrated mental health community service. We were told there were plans to improve several areas of the service, including joint working with partners across the local authority. With improved communication and an appreciation of the work carried out by other teams, there was an expectation of improved outcomes for individuals living with mental-ill health across West Lothian.

Summary of recommendations

Recommendation 1:
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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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