mentalwelfare
commission for scotland

Not my problem

Summary report from our investigation into deficiencies in the care and treatment of Mr G

Contents

Overview of Mr G's case

Mr G was a 61 year-old man who we were asked to see in prison in July 2004. The prison health services and the visiting psychiatrist were very concerned about his condition. He had been charged with assault and was thought to have a "personality disorder" that explained his behaviour. We disagreed and intervened to make sure he received hospital care. He was found to have a form of dementia (fronto-temporal dementia) that affects behaviour and judgement but, in the early stages, does not seriously affect memory. Mr G died in April 2006 while in hospital care.

We looked into the events leading up to our involvement, to find out why Mr G ended up in prison. We found that he had several contacts with mental health services in the past, but were most interested in his care and treatment from 2000 onwards. Before this, he had relationship problems and spells of depression. He had some sexual difficulties and was charged once in 1979 with indecent exposure. Apart from this, there were no other reports of inappropriate sexual, aggressive or antisocial behaviour before 2000.

Mr G came to the attention of mental health services when he panicked while attending a sporting event. He then had difficulties at work and was depressed and anxious. He spent nine months in hospital in 2001. During this time, he behaved in strange ways. For example, he showed serious sexually inappropriate behaviour at a swimming pool, talked and behaved inappropriately to women in the ward and behaved strangely in public places such as pubs and supermarkets. Although there was no evidence that his behaviour had been as unusual as this in the past, it was all attributed to a "personality disorder".

When Mr G was discharged from hospital to new accommodation, he clearly wasn't coping. He was "barred" from his local supermarket, he was arrested for inappropriately touching a stranger on the bus and he assaulted a care worker with a knife. Psychiatrists still attributed this to personality disorder and discharged him from their care. This was in spite of reports that he was now urinating and defaecating in public. His behaviour was so severe that he was evicted from his house in June 2002.

From then until November 2003, Mr G was either in prison or in various forms of homeless accommodation. His original home area (covered by Local Authority A) had no accommodation so he moved to a neighbouring area (covered by Local Authority B). He was still the responsibility of social workers from area A and they offered him "voluntary throughcare" to support him when he left prison. His behaviour became even more inappropriate – he went out in public in a state of undress, jumped in front of buses, masturbated in public and had more convictions for indecent exposure and lewd behaviour. Social work and homeless services struggled to manage the situation. He was seen further by psychiatrists, often following emergency referral, but the diagnosis of personality disorder was never properly questioned and he was never followed up by mental health services.

After a spell in prison in October 2003, social workers from area A found a care home that might be suitable for Mr G. They placed him there in November and paid for his care. The following February, he was charged with assaulting staff in the home. He was taken to prison and then admitted to hospital. While he was there he had a brain scan and some basic tests of brain function, but psychiatrists still thought that his problem was a personality disorder. He was sent back to prison.

In prison, he was found to be wandering, taking other people's food and hallucinating. Prison staff were very worried about him and he had a further assessment by a psychiatrist but no change of diagnosis. At the beginning of June 2004, he was found not guilty of assault and released. He went to homeless accommodation in Local Authority C, but was admitted to mental health care a week later under the Mental Health Act. He was disorientated and incontinent of urine and faeces. The psychiatrist allowed his detention to lapse. Mr G assaulted staff when they tried to stop him eating sugar directly from a sugar bowl. The police were called and he went back to prison. In spite of the obvious changes in him, the medical notes still recorded his diagnosis as personality disorder.

During this time, a social worker from area A kept in touch with Mr G's situation. However, his managers now denied any further responsibility for Mr G. In prison, he would only eat very sweet foods, assaulted staff when they tried to help him, was incontinent and displayed further sexually inappropriate behaviour. The prison staff and visiting psychiatrist were so concerned that they contacted us.

One of our doctors saw Mr G and looked back over information in the prison notes. While depression couldn't be ruled out, we thought that Mr G had a dementia with significant frontal lobe problems. We sent our opinion to all the practitioners who were involved and were very pleased when Mr G was admitted to hospital. He had good hospital care and further tests showed that he did appear to have dementia. He developed signs resembling Parkinson's disease. Doctors tried treating him for depression, as his mood was still low, but without much success. He eventually died, in a unit for younger people with dementia, when he became unable to swallow.

Findings from our investigation

We read through all Mr G's mental health and social care records and interviewed many of the staff who saw Mr G during this period. We thought that there were five aspects of Mr G's care that we needed to look at.

1. Psychiatric assessment and diagnosis

We looked at:

- His admission to hospital in 2001;
- A seven month period of community follow-up by Dr 1;
- Five further hospital admissions;
- Ten court reports;
- An independent forensic mental health report requested as a "second opinion";
- At least four emergency psychiatric assessments;
- Three psychiatric assessments at the request of prison staff.

We had a number of concerns about the way many psychiatrists assessed Mr G and made a diagnosis.

- Dr 1 did not keep good enough records during Mr G's nine-month hospital admission in 2001. We have taken action on this, by informing Dr 1's present medical management;
- There was evidence of too much reliance on dementia screening tests that are not accurate enough;
- The diagnosis of personality disorder was based on wrong or distorted information and was not checked for accuracy;
- Too many assessments accepted the previous diagnosis and did not consider other possibilities;
- Several psychiatrists appeared not to be aware of how to test for, or diagnose, this particular form of dementia and were not up to date with the most recent guidance;
- We found inconsistent practice among psychiatrists who visited prisons, in relation to their role in diagnosis and treatment.

2. Impact of a diagnosis of personality disorder

There is evidence from research that people with a diagnosis of personality disorder get poor care from mental health services. We found this in Mr G's case when we examined records and interviewed staff. We heard that the diagnosis of personality disorder was seen as a "death-knell", as it implied that the person was "untreatable" and was used as a "get-out clause" for services. Our findings were:

- Mr G was seen as "untreatable" and specialist services were therefore either not offered, or withdrawn;

- We found no evidence of the use of structured psychological treatments, despite good evidence supporting their use;
- There were repeated claims that contact with services “fostered dependency” and worsened the situation;
- Mental health services gave Mr G little help to alter his behaviour and assumed he was capable of choosing how to behave;
- Mr G was treated with medication for depression but this was not reviewed by psychiatrists;
- Despite psychiatrists’ claims, other agencies perceived a diagnosis of personality disorder as a barrier to services;
- Once a diagnosis of personality disorder was made, all future behaviour was regarded as being consistent with this diagnosis;
- Information about Mr G’s past became distorted in a way that supported the diagnosis of personality disorder;
- Overall, we were left with the impression of a man who was seen as difficult and challenging. Faced with this, many practitioners and services appeared keen to accept any opportunity to distance themselves from his care.

3. Information-sharing and continuity

There were many agencies and practitioners across different areas of Scotland that were involved in Mr G’s case. Good sharing of information is essential in such a situation. Sometimes, this worked quite well and we found many people who worked very hard to help Mr G. Unfortunately, information was not always passed on as it should have been.

- We found information in general practice and mental health records, prior to the year 2000, that did not support later assumptions made about Mr G’s behaviour and social functioning.
- Several practitioners appeared to make insufficient efforts to identify and consult previous records. Had they examined all records, they would have been less likely to make false assumptions about Mr G’s past.
- Mr G was removed from the Care Programme Approach, despite evidence of significant problems and need for services. This was on the basis that mental health services believed they had nothing to offer. An important effect of this was to remove clear lines of communication with the police.

- While Mr G lived in area A, he was discharged from various forms of mental health care. Most importantly, he was discharged from the consultant's case-load, and from the care of other practitioners within the mental health team, without a discharge summary. Primary health and social care agencies were left without a clear summary of mental health opinion and had no guidance on circumstances that would merit re-referral.
- We found no evidence of a Community Care Assessment, risk assessment and risk management plan that was shared between agencies and which would have informed various individuals involved in Mr G's care as to how to respond when he presented problematic behaviour.
- While most social care agencies shared information reasonably well, this was not always the case in relation to Mr G's increasingly inappropriate behaviour. On one occasion this led to an inappropriate placement in the care of nuns.
- We found little evidence that the totality of information about escalating concerns was transmitted from social work to specialist mental health services. No operational manager, or senior manager, took full responsibility for this case and chaired a multi-agency case conference. No contingency plans were put in place when Mr G moved to the care home.
- There were times when it was not clear which social worker was Mr G's overall care manager. This was notable when he was receiving voluntary throughcare.
- Local Authority A failed to follow complaints procedures and did not respond to a written complaint about their actions.
- During changes of residence from Mr G's own home through prison, homeless accommodation, residential care and hospital, there was an absence of core information that followed Mr G and informed all parties about his history and care needs.
- We found that psychiatrists who saw Mr G in prison had no access to prison social work records. Those records contained information that would have helped make a diagnosis.

4. Out-of-area specialist placement

Local Authority A arranged homeless accommodation for him in a different area (area B). They then placed him in a care home in another different area (area C). These placements were not successful and we had concerns about why this was the case. We also had concerns about the Local Authority's actions.

- Local Authority A had a dearth of homeless accommodation. Arrangements to obtain access to such accommodation within other Local Authorities appeared loose and did not foster continuity of management.

- Mr G's placement in the care home was not resultant of planned, needs-led care management. It happened because someone suggested to Local Authority A that the home tended to accept complex cases.
- There was poor transfer of information from Local Authority A to the care home. It appeared that minimal information was provided and the manager of the home failed to insist that important details, such as a formal Community Care Assessment and care plan, be provided.
- There was no transfer of mental health information to the local NHS mental health service when Mr G was placed in the care home.
- We found that the manager and care staff of the home and the covering general practice had varying information about Mr G.
- Local Authority A failed to transfer information about Mr G to Local Authority C, in whose area Mr G was placed. This was a clear breach of national policy.
- Local Authority A had clear responsibility for Mr G's ongoing care management. The absence of properly conducted reviews following transfer to the care home demonstrates that this function was not properly carried out.
- Local Authority A had no contingency plan in place, should the placement fail. When the care home decided to terminate the placement, there was no appropriate action on the part of Local Authority A to review the situation.
- Local Authority C acted entirely appropriately as 'authority of the moment' in providing services for Mr G when he was released from prison, but we found no evidence that Local Authority A acted to support them in this.
- Given that Local Authority A had arranged the placement in the care home, we find the attitude of operational and senior managers within Local Authority A when the placement failed extraordinary, unacceptable and in breach of national guidance. There is a process to resolve disputes, but it was not used after Mr G was re-admitted to hospital.
- The care home seems to attract referrals from across Scotland. We found no evidence that the need for specialist mental health input had been properly quantified prior to the home opening.

5. Management of challenging behaviour

Mr G often behaved in ways that risked injury to himself, risked injury to others, or caused alarm and distress. There were very few occasions when staff tried appropriate ways of helping Mr G with some of his problem behaviour. Our findings were:

- There are evidence-based approaches to the management of challenging behaviour, based on learning theory, which are useful regardless of diagnosis;
- The diagnosis of personality disorder appears to have resulted in assumptions about choice and control and, in most instances, appeared to impede an objective analysis of his behaviour;

- There were very few attempts to provide a framework for behavioural management. When a strategy for this was attempted, however, it did appear to have some beneficial effect;
- There appears to be a lack of understanding and knowledge of behaviour management principles and practice among staff in the NHS and private care homes;
- Expert intervention and advice from psychology was in short supply in many areas. It is particularly worthy of note that, despite his history of unusual and challenging behaviour, no psychologist saw Mr G until July 2004 (prison visit for court report). There appeared to be no opportunity for social work staff to make a direct referral to a psychologist.

Recommendations

We have summarised all of our recommendations in this section. We believe that implementing these recommendations would significantly reduce the chances of others suffering the same deficiency of care experienced by Mr G. Many services in more than one area of Scotland were involved and we suspect that the failings we identified could have occurred in other areas. The services and individuals involved in Mr G's care must examine their own practices very carefully. Our partners in the framework of inspection and regulation of care must also take careful note of our recommendations. In addition, we believe that all working in mental health care across Scotland should take note of our findings.

Recommendations to the Health Boards involved in Mr G's care

Recommendation 1

Medical Directors of the Health Boards must ensure that all psychiatrists dealing with patients over the age of 18 are competent in the assessment and diagnosis of the full range of dementias they may encounter. The section on diagnosis, in SIGN Guideline 86 on Management of Patients with Dementia, is of particular value in this regard.

Recommendation 2

The Health Boards must ensure that staff working with patients over the age of 18 years are appropriately trained in the use of behavioural management principles, including education as to the ethical and legal issues involved and how to properly address issues of consent.

Recommendation 3

The Health Boards must ensure the availability of clinical psychologists to support staff in the design and implementation of behavioural interventions and to provide direct assessment, formulation and intervention for complex cases.

Recommendation 4

Health Board A should audit discharges from the caseloads of teams and individual practitioners, and from the care programme approach. They should ensure that discharge information is completed and communicated to all relevant agencies.

Recommendations for the Health Boards and Local Authorities involved in Mr G's care

Recommendation 5

Health Board A and Local Authority A must ensure that people with a diagnosis of personality disorder, who present a significant challenge to care services, receive a review of diagnosis and management by a suitably qualified mental health practitioner. The appropriate time periods for review should be detailed within the integrated care pathway.

Recommendation 6

Health Board A and Local Authority A must have robust procedures to resolve disputes over diagnosis and management of individuals who appear to have mental health problems.

Recommendations for the Local Authorities involved in Mr G's care

Recommendation 7

Local Authority A must ensure that all people with complex social care needs have a comprehensive assessment of need, including a risk assessment and management plan, which is reviewed on a regular basis. An identified care manager must also be in place.

Recommendation 8

Local Authority A must ensure that all people identified as vulnerable and/ or with complex needs are discussed at multi-agency case conferences, in line with the requirements of the Adult Support and Protection (Scotland) Act 2007.

Recommendation 9

Local Authority A should ensure that prior to voluntary through-care coming to an end, a re-assessment of the adult's needs has been completed with a referral made to community care services if required.

Recommendation 10

Local Authorities A and C must ensure that their employees are aware of Ordinary Residence Guidance and use the agreed processes to settle disputes.

Recommendation 11

Local Authority A must ensure that all out-of-area placements are subject to regular, consistent care management arrangements. These arrangements, in line with Scottish Government Care Management Guidance CCD8/2004, must also address contingency planning and ensure that this is shared with the "Local Authority of the moment."

Recommendations for NHS Quality Improvement Scotland (NQIS)

Recommendation 12

NQIS are producing standards for accreditation of integrated care pathways (ICPs) for people with "borderline personality disorder". These standards should be extended to include people with other forms of personality disorder.

Recommendation 13

ICPs developed under NQIS guidance should contain a core requirement that an individual's history and chronology of events are checked for accuracy with the individual or, where possible, a reliable informant. All such histories must follow the person through the care system.

Recommendation for the Social Work Inspection Agency

Recommendation 14

The Social Work Inspection Agency should take note of our findings and recommendations, especially when inspecting services offered by Local Authority A.

Recommendations for the Care Commission

Recommendation 15

When inspecting provider agencies, the Care Commission should ensure that personal plans are in place and that information about the health needs of service users has been collected to provide fully informed decision-making on healthcare provision.

Recommendation 16

The Care Commission must ensure that staff working within care homes are appropriately trained in the use of behavioural management principles, including education as to the ethical and legal issues involved. This training must address issues of consent and ensure that, either by agreement with the local Health Board Area or by securing its own expertise, staff are supported in designing and implementing interventions.

Recommendation 17

The Care Commission should ensure that any need for specialist mental health input had been properly quantified and arranged prior to registration of a care home.

Recommendations for the Scottish Government

Recommendation 18

Following changes to legislation on ordinary residence, as introduced by the Adult Support and Protection (Scotland) Act 2007, the Scottish Government should review guidance on Ordinary Residence and ensure that all Local Authorities and the Confederation of Scottish Local Authorities are fully aware of procedures to resolve disputes.

Recommendation 19

The Scottish Government should develop minimum standards for care management for people in care homes. This should include standards for information transfer from Care Managers to provider agencies and standards for ongoing review.

Recommendation 20

The Scottish Government should specify in national care standards that, when specialist care homes that may attract out-of-area placements are being planned, the provision of specialist mental health services has been addressed with the appropriate NHS Board.

Recommendation 21

The Scottish Government should provide guidance to local authorities on regional planning for homeless services to ensure that smaller local authority areas do not simply rely on neighbouring areas to accommodate their residents.

Recommendation for the Scottish Government and the Scottish Prison Service

Recommendation 22

The Scottish Government Mental Health Division and Scottish Prison Service (SPS) should jointly review the nature and purpose of specialist mental health input to prisons and arrangements for sharing health and social care information within the SPS, including systems for ensuring that visiting mental health practitioners have ready access to this.

Recommendation for the Scottish Personality Disorder Network

Recommendation 23

The Scottish Personality Disorder Network should produce guidance on appropriate interventions for people with a diagnosis of personality disorder. This guidance should seek to challenge the assumption that such disorders are “untreatable”.

Recommendation for the Royal College of Psychiatrists and the British Psychological Society

Recommendation 24

SIGN Guideline 86 contains little direction on the specific assessment of executive functioning. The Royal College of Psychiatrists and the British Psychological Society should, together, examine the need to produce guidance for clinicians on appropriate neurological and psychological testing where impairment of executive function is suspected. This should include indicators of when more specialist neuropsychological assessment should be sought.

Recommendation for the Royal College of Psychiatrists, the Postgraduate Medical Education and Training Board and NHS Education Scotland

Recommendation 25

We recommend that all organisations providing medical education in mental health take note of our findings. They should ensure that educational programmes address the issues of diagnosis, cognitive testing and the attitudes we have identified to a diagnosis of personality disorder.

A full list of references is available at the end of our full report which can be downloaded from www.mwcscot.org.uk

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