

NOT MY PROBLEM

THE CARE & TREATMENT OF MR G

“Instead of responding to the person, we typically react to the behaviour”
(Herb Lovett)

"We want the facts to fit the preconceptions. When they don't, it is easier to ignore the facts than to change the preconceptions."
(Jessamyn West)

Section 1

Background to the investigation

1.1 Introduction

1.1.1 The Mental Welfare Commission has a duty under section 11 of the Mental Health (Care & Treatment) (Scotland) Act 2003 to investigate the case of any person subject to ill-treatment, neglect or some other deficiency in care and treatment. Similar responsibilities and authority existed within The Mental Health (Scotland) Act 1984. This investigation, whilst conducted under the authority of the 2003 Act (implemented October 2005), is largely concerned with care and treatment that was delivered while the previous Act was in force.

1.1.2 The Commission became actively involved with the care and treatment of Mr G in August 2004. Following expressions of concern from prison staff and a visiting psychiatrist, we visited Mr G in prison. We were very concerned about his placement in prison and agreed with staff that he was in need of care in a mental health setting. Whilst initial involvement focused on securing

appropriate care for Mr G, preliminary investigations gave rise to information which suggested that he may have been subject to a deficiency in care and treatment. The Commission therefore decided to formally investigate the case. Whilst enquiry was made into Mr G's entire life history, the focus of the investigation was the period July 2000 until his death in April 2006.

1.2 Investigation Team

Ms Linda Graham

H.M. Commissioner, Mental Welfare Commission

Chair of the investigation

Ms Margaret Anne Gilbert

Social Work Officer, Mental Welfare Commission

Dr Donald Lyons

Director, Mental Welfare Commission

The investigation was assisted by Ms Beverley Burness, Administration Manager, Mental Welfare Commission

1.3 Method of undertaking the investigation

1.3.1 The investigation began with a detailed examination of medical, nursing and social work records. We also reviewed records pertaining to Mr G held by voluntary organisations and housing services.

1.3.2 The investigation team then interviewed those people it considered could contribute important information. Most interviews involved the team listening to the evidence of one person. However, group interviews were conducted where it was considered that an identified 'team' of people had been working closely together in managing Mr G and were likely to be offering similar information. A comprehensive listing of people who gave evidence is provided at the end of this report. Interviews took place at various places in Scotland and five were conducted by telephone conference call. We made a

written record of each interview and sent it to the person concerned for correction with regard to factual accuracy.

1.3.3 It was made clear to all those interviewed that we would publish the report of the investigation.

1.3.4 This investigation has involved an examination of the practices of three Health Boards, three Local Authorities, one private care sector provider, two prisons, the State Hospital and a range of voluntary sector agencies. In our recommendations, we have attempted to separate out problems that appear to exist within only one area or service provider from those deficiencies that appear much more systemic. We consider it reasonable, where there is evidence of the same 'mistakes' being made by multiple professionals or agencies, to assume that these problems may exist Scotland-wide and have made recommendations accordingly.

1.4 Acknowledgement

The investigation team received a high degree of co-operation from most involved parties and we are grateful for this. The team were struck by the considerable efforts made by front-line care staff, often in very challenging circumstances, to provide proper care and treatment for Mr G. They appear, in most instances, to have been let down by the same system failings that Mr G himself was subject to. It is our hope that these individuals do not feel criticised by the content of this report.

Section 2

Statement of facts

2.1 Early History

2.1.1 Mr G was born in 1943. He was an only child whose parents separated when he was very young. He was brought up by his mother, who is described in records as being somewhat domineering. Mr G's mother died in 1999 having been disabled by Parkinson's disease for a number of years. Mr G was an average scholar who worked in offices and libraries after leaving school and, other than a brief period of unemployment following hospitalisation in his twenties, he successfully maintained employment in a range of factory and then caretaker jobs over his adult life. Mr G's latter employment history included a job as a gardener/handyman at a school from 1994 until 1998. He apparently left this job after conflict with his employer but moved house and obtained a new job as a caretaker in 1999. Mr G remained in this job until his hospital admission in 2001 but did not work thereafter.

2.1.2 Mr G married in 1972 but the marriage was reportedly never consummated. His wife left in 1988 and he remained in contact with her by letter for some time. He appears to have been socially awkward when trying to form relationships with women and he continued to live alone. Although initially struggling with household tasks and debt, by 1992 Mr G appears to have become better established in his single life with good support from Church friends and pursuing hobbies of singing in various choirs and regularly playing golf.

2.1.3 Mr G had a hospital admission in the late 1960s when a depressive disorder was treated with ECT. Thereafter, he engaged in psychotherapy between 1972 and 1982 and also attended with his wife for sex therapy for a time. Mr G had further contact with psychiatric services in 1988 when he was 45 years of age, prompted by him not coping with the breakdown of his marriage. He was assessed as not having any diagnosable psychiatric illness at this time and no medication was prescribed, but a Community Psychiatric

Nurse (CPN1) was assigned to his case as he reported finding it useful to discuss his problems. Mr G was assessed each month by a Consultant Psychiatrist for three years and for four years by CPN1. The diagnostic position remained the same but a small dose of anti-depressant was initiated and maintained over the last two years of contact. The substance of the contact was to provide support and Mr G made no inappropriate demands on the service. Mr G was re-referred seven years later in 1998 but his situation improved again and he received no input after initial assessment.

2.1.4 Mr G had a history of offending behaviour. At the age of 36, he was found guilty of indecent exposure and admonished by the Sheriff Court. He had no further convictions of any kind between then and 2001. His psychiatric notes detail him as having made approaches to women that were sometimes clumsy and overenthusiastic but never involved sexually inappropriate behaviour.

2.2 Initial Contact with Services

2.2.1 In July 2000 Mr G travelled out-with his home area to attend a sporting event. When a casual acquaintance who had agreed to arrange overnight accommodation for him failed to turn up, he lay down on the ground asking God for help. His behaviour resulted in him being removed for psychiatric assessment by SHO1 where he was judged to be experiencing a situational crisis. In a letter to GP1, referral to his home psychiatric service was suggested in case Mr G was suffering from a relapse of a depressive disorder.

2.2.2 In October 2000, GP1 wrote to a Consultant Psychiatrist (Dr1) requesting an urgent out-patient appointment as Mr G was experiencing "paralysing anxiety." The letter noted a concern that Mr G was "unable to hold a conversation." Four out-patient appointments with a Senior House Officer (SHO2) between October 2000 and January 2001 led to a diagnosis of "Schizoid Personality Traits" and Mr G was encouraged to return to work. A week later, however, Mr G was admitted to his local psychiatric hospital, Hospital 1A (Hospital 1 in NHS Board A) with a range of depressive

symptomatology. He had not coped with the return to work and had self-harmed. There is no evidence of an assessment of cognitive functioning having been carried out when he was admitted to hospital despite the fact that nursing notes recorded him as “confused at times.”

2.2.3 Whilst an in-patient, Mr G was referred to the Community Care section of the local Social Work Department. This was within Local Authority A. As Mr G had been living in accommodation tied to his employment and was likely to lose this, it was recognised that he required a Community Care Assessment. He was allocated a Social Worker (CCSW1) and screened in April 2001 but no formal Community Care Assessment was completed. Legislation⁰ places a duty on Local Authorities to make such an assessment of need for services and then decide whether the needs of that person call for the provision of services.

2.2.4 Mr G remained in hospital throughout February and March 2001. His anti-depressant medication was changed and he continued to exhibit signs of anxiety and depression, requiring frequent reassurance from staff. Towards the end of March, SHO3 had Mr G complete the Mini Mental State Examination (MMSE)¹ on which he scored 28 out of a possible 30. The points lost were attributed to memory and concentration problems secondary to depression and no more detailed investigation was pursued.

2.2.5 Mr G began to exhibit inappropriate behaviour. He made attempts to climb over a fence onto a railway line and behaved in a sexually inappropriate manner during a visit to the local swimming pool, exposing his genitals by walking around in a state of undress and trying to climb into a cubicle occupied by the female Occupational Therapist (OT1) who had accompanied him there. Mr G did not respond to verbal instruction to modify his behaviour and made no response when confronted with the unacceptability of his behaviour. There is no written record of how the clinical team responded to these events other than Mr G being asked to remain in the Ward environment – which he did not.

2.2.6 Mr G was transferred to a Rehabilitation Ward within Hospital 1A at the end of April 2001. Improvements were noted in his self-care and level of anxiety during his stay but there continued to be both sexual incidents of concern (for example, exposing himself to a female patient, holding lewd conversations with female patients, inappropriately touching a domestic supervisor) and incidents of inappropriate social judgement (seeking help from strangers, discussing personal matters in the pub and refusing to leave the house of a friend he had been visiting). The Police were involved on one occasion. A junior doctor noted that he intended to discuss "CT/psychology" with Dr1. Notes do not indicate whether this discussion ever occurred but no brain scan was authorised and no psychology referral was made. In his evidence, Dr1 stated that he did not consider there to be sufficient grounds for requesting either.

2.2.7 Accommodation was found for Mr G in the community and a voluntary care provider (VCP1) contracted to provide support. Mr G was also to have input from a Community Mental Health Nurse (CMHN1), Dr1 and both CCSW1 and OT1 who had worked with him in the Rehabilitation ward setting and he was to be seen daily for the first week following discharge. Mr G was referred for the Care Programme Approach (CPA) but this was not fully in place at the point of discharge on 7th November 2001. Mr G was described as suffering a) Depression and anxiety; and b) Dependent Personality Disorder. A CPA meeting was arranged for 5th December 2001.

2.3 Attempts at Community Living

2.3.1 The period following discharge from hospital saw Mr G engage in a range of nuisance and sexually inappropriate behaviours which led to his arrest and prosecution on two occasions. This triggered the involvement of Criminal Justice Social Work from Local Authority A. Mr G was admitted to Hospital 1A following a period of heavy drinking and self-harm. His initial assessment detailed him as having "long-standing" problems with anxiety and sexual offending and that offending was motivated by the attention it generated. He was discharged from hospital two days later.

2.3.2 Mr G was examined by Dr1 for purposes of a Court Report. He was detailed as being fit to plead and as having Anxious Personality Disorder, Dependent Personality Disorder and Exhibitionism. Recommendation was made that the Court impose a deferred sentence in order that his current package of care could continue unchanged.

2.3.3 This recommendation was also made by CJSW1 in the social enquiry report. However, this should have been accompanied by a “risk of harm” assessment. This does not appear to have been carried out.

2.3.4 On 22nd February 2002, Mr G threatened a VCP1 support worker with a knife. There are conflicting accounts as to the exact nature of this incident and it did not trigger the completion of a formal incident report or risk assessment. Whilst the notes of CCSW1 detail Mr G as having “stabbed” a care-worker, Dr1 described Mr G as being “a bit silly.” The most accurate account suggests that Mr G held a knife to the care worker’s back and pricked the skin but did not break it. He was admitted to Hospital 2A as there were no beds in Hospital 1A.

2.3.5 Mr G’s sexually inappropriate behaviour continued in hospital but it was considered that there was not enough evidence to charge him. Instead, he was made subject to Section 24 of the Mental Health (Scotland) (Act) 1984², and transferred to an IPCU in Hospital 3B in a neighbouring Health Board area where he remained for four days without further incident. He was sent from there to Hospital 1A from where he was discharged the next day. The diagnoses detailed were Avoidant Personality Disorder and “Inadequate Personality”.

2.3.6 Mr G continued to have problems on discharge and VCP1 wanted to withdraw from his care. A thorough second opinion from a Forensic Psychiatrist (Dr 2) noted the recent escalation in behaviour and detailed an “extensive history” of exhibitionism. A good score was obtained on the MMSE and this was taken to indicate that he was “certainly not dementing”.

2.3.7 During the remainder of March 2002, numerous incidents described Mr G as having frightened women, having wandered into houses without invitation and having been apprehended by the Police twice for prowling in gardens. The Landlord organisation expressed concern that statutory agencies had not reassessed risk in respect of the sustainability of his tenancy and requested hospital admission until alternative accommodation could be found. Health, social work and care-staff all detailed Mr G's self-care as declining. VCP1 also expressed concerns about Mr G and a CPA meeting was arranged for 16th April 2002. VCP1 removed their support before this, however, effectively leaving CMHN1 and CCSW1 to manage Mr G by themselves.

2.3.8 CMHN1, CCSW1 and OT1 met with a staff counsellor to try to address the stresses they were experiencing in managing Mr G. Two of these professionals gave evidence that they were extremely concerned about Mr G's propensity for offending and the apparent escalation in his behaviour. Whilst this session clearly benefited staff morale, it was primarily to deal with staff stress and did not lead to changes in case management nor address the fact that front-line staff were acknowledging a lack of skills in managing Mr G's challenging behaviour. A CPA meeting detailed that incidences of sexually inappropriate behaviour were increasing and that Mr G had been urinating and defecating in public. It was formally noted that hospital admission was not necessary.

2.3.9 The Police were becoming ever more involved with Mr G and discussions took place with regard to whether an Anti-Social Behaviour Order (ASBO) should be put in place. Mr G was visited at home by Dr1 and CMHN1 that same day. They found him making stabbing gestures to his neck, arms and legs. He then attempted to hang onto the wing mirror of their car as they drove off. The Police were called and Mr G arrested and taken into custody. Two knives were recovered from his bedroom.

2.3.10 When arrested Mr G was seen by the Police Doctor who liaised with Hospital 1A to obtain a good picture of his mental state. Dr1 was advised of

Mr G's arrest by the Police but took no part in the assessment process. The Police Doctor judged Mr G to be of sound mind and he was charged with Breach of the Peace and bailed to appear in Court.

2.3.11 Over the next period, Mr G was noted to be making a high volume of telephone calls to health and social work agencies and to family and friends. Social work and the Police made attempts to secure psychiatric support from Hospital 1A but were informed that psychiatric services were no longer seen as an appropriate source of support for Mr G as he did not have "a treatable mental illness." The Police requested it be officially noted that they did not consider Mr G to be in receipt of appropriate management.

2.3.12 There was evidence of close liaison between CCSW1 and the CJSW team over this time. Services from VCP2 were secured and male workers were due to meet with Mr G with a view to helping him with practical tasks like shopping (Mr G having been banned from the local supermarkets). However, rumours were building in the community that Mr G was a paedophile and although the Police requested "immediate and urgent action" from Local Authority A, Mr G was assaulted before any action took place. When he refused to leave A&E after treatment, he was removed by the Police who took him to homeless accommodation in Local Authority area B. Although not happy to accept Mr G because of his level of personal vulnerability, he was placed in a hostel overnight with the Homeless Section taking over his case the next day.

2.4 Out-of-Area Placement

2.4.1 The housing authority in Local Authority area A who had been providing Mr G's accommodation refused to place him in alternative housing because of the apparent risk to "women and children". Contact was made with ward nursing staff in Hospital 1A who advised that "Mr G does not have a treatable mental illness and the Consultant has made the decision he will not be admitted to hospital. He should be referred to the Police if his behaviour gives cause for concern." Mr G was advised that he should go back to his own original tenancy, back to the Homeless Section or sleep rough.

2.4.2 A CPA meeting was held on 4th June 2002. Mr G had been arrested that day for jumping in front of buses and assaulting a Police Officer. It was noted that Mr G was to be evicted from his tenancy. At the CPA meeting it was stated that, as his behaviour was clearly criminal and not associated with a mental illness, psychiatric services intended to discharge Mr G and remove him from CPA. The CJSW team requested the involvement of a clinical psychologist but Dr1 considered this not to be appropriate. Not everyone in the clinical team was clear that CPA procedures had been removed.

2.4.5 Two separate Psychiatric Reports were then prepared for Court. Both documented that Mr G had a disorder of sexual preference and suffered Dependent Personality Disorder but that neither could be considered “mental disorder.” The opinions expressed were that Mr G would gain no benefit from psychiatric treatment and, indeed, that further treatment may “foster dependence and encourage further sexual deviance.” Mr G was assessed as “not dementing” as judged by MMSE despite poor performance on the memory test. The report of CJSW2 concluded that it was not possible to offer a community based disposal. When the matter came before the Sheriff Court on 5th June 2002, a warrant was issued for the arrest of Mr G and his removal to Her Majesty’s Prison A (HMP A). He was subsequently given a custodial sentence by this Court and a further custodial sentence by a different Sheriff Court for other outstanding matters.

2.4.6 Whilst in prison, community care social work tried to withdraw from the care of Mr G but this was subsequently abandoned. A pre-release case conference was held on 9th October 2002 in Local Authority A. CCSW1, CJSW2 and managers from Housing and Homeless services were also present. The outcome of the meeting was that CJSW2 would be Mr G’s allocated social worker and CCSW1 would arrange for a different Community Care Social Worker (CCSW2) to liaise with CJSW2 with a view for longer term funding and support provision for Mr G.

2.4.7 Mr G was released from prison on 25th October 2002 and was accommodated in a homeless hostel in Local Authority B for approximately one month, as Local Authority A had no suitable homeless accommodation to offer him. The placement collapsed because of Mr G's anxiety, agitation and constant need for attention. The project manager in the hostel suggested to CJSW2 that Mr G's presentation might be in keeping with early onset dementia but when this was raised at a subsequent meeting, previous MMSE results were offered as evidence that this was not the case. Case workers could find no alternative accommodation for Mr G and senior managers were informed of the difficulty. Notes contain no evidence of a response, however.

2.4.8 Homeless Services in Local Authority Area B attempted to accommodate Mr G. Although information with regard to his history of sexual offending was made available, CJSW2 sanctioned his placement in a hostel run by nuns. This broke down after only one night. There then followed a period where accommodation was being sought on a night-by-night basis and with Local Authorities A and B arguing over who retained responsibility for finding permanent accommodation. Senior social work management became involved in these discussions.

2.4.9 CJSW2 contacted the Mental Welfare Commission's advice line with concerns about diagnosis and management. Social work notes state that we suggested a second psychiatric opinion. Social work records also record that Dr1 refused to attend a case-conference to discuss the case and again refused to facilitate a referral for psychological services. There was no second opinion at this stage and we heard nothing more.

2.4.10 Day-by-day case management continued and emergency assessment by mental health services on three occasions did not lead to any on-going involvement despite the continued use of psychotropic medication.

2.4.11 Mr G was remanded to prison on 11th December 2002 following an alleged indecent assault. CJSW2 visited him in prison and suggested to the Court that a psychological assessment may be helpful but no-one could be

secured to prepare this. A pre-release case discussion was held with community care staff from Local Authority A and homeless provider agencies from Local Authority B in January 2002. The hostel that seemed to have most success in managing Mr G agreed to have him back (as long as funding was provided to enable one-to-one staffing) until a longer term solution was found. A behaviour programme was prepared by a social worker with no involvement in the case. This was passed to care staff who were not consulted about whether it was appropriate or guided in how to use it appropriately. It was never implemented.

2.4.12 Mr G's inappropriate behaviour continued and the hostel eventually terminated his placement as they could not cope with his behaviour. A 24 hour psychiatric admission on 22nd June 2003 was described as "deleterious" and Mr G discharged. He was complaining of subjective memory problems at this time.

2.4.13 Mr G was once again sent back to Local Authority A for a full homeless assessment as Local Authority B did not consider they had a legal obligation to house him. A solicitor for the Homeless team took on the case, as he was concerned that no one was properly accepting responsibility for Mr G.

2.4.14 Further offending behaviour led to Mr G being imprisoned in HMP A for a period of three months. A case conference was held in Local Authority A involving managers from criminal justice, community care social work, the homelessness section in Local Authority A and a consultant psychiatrist who appeared not to have seen Mr G nor to have had previous or subsequent involvement in his care. The purpose of the meeting was to reach agreement on a consistent approach by all the statutory authorities in dealing with Mr G. The action plan identified the need for a forensic psychiatric assessment via the court and a referral to a hostel for offenders.

2.4.15 When Mr G was released from HMP A in August, Local Authority B agreed to provide temporary accommodation. Homeless service records document that CCSW2 was asked to visit and reassess Mr G but that he felt

there was no point in doing so. Shortly after his release, the warden of the accommodation where Mr G was living found him wandering outside wearing just his socks and pants. He had called the warden forty five times that day and matters then escalated with Mr G climbing out onto a window ledge six floors up. The police were called and Mr G was taken for psychiatric assessment. Medical notes described him as agitated, vague and distractible. He was admitted to Hospital 3B but discharged the same day. The psychiatric examination did not include a cognitive assessment.

2.4.16 Following action by the solicitor for the Homeless agencies, Mr G was granted local connection with Local Authority B for housing purposes. The homeless team identified an out of area nursing home (NH1) as a possible resource for Mr G and Local Authority A agreed to arrange and fund the care package. In the meantime he was to receive support from social care workers. Despite the care package, Mr G was found wandering in a distressed state with lacerations on his wrist and the emergency social work services were contacted. A request was made for a Mental Health Officer (MHO2) to carry out an assessment. Emergency social work services contacted the psychiatric emergency team and were informed that he had already presented himself to that team twice that day. They were informed that he had a personality disorder and was not detainable, so no MHO assessment was arranged.

2.4.17 The next two months saw Mr G continue to engage in chaotic behaviour. There were regular incidents of sexually inappropriate behaviour and of poor social judgement. He had become frequently incontinent. The Homeless team asked for a copy of a Community Care Assessment but they were told that “a Community Care Assessment would not accurately reflect the complexity of Mr G’s needs.” Further, that a Community Care Assessment had been viewed as inappropriate as Mr G was “theoretically capable of living quite independently with no evidence of significant physical health problems, mental illness or cognitive impairment.”

2.4.18 Mr G frequently came to the attention of the Police who considered him a “high risk of dangerment to himself and others living nearby.” He was

eventually arrested and imprisoned in HMP A. The health care team in HMP A asked Dr 3 to see Mr G as an emergency as he was “rocking from side to side and urinating on the floor”. Dr 3 was unable to see Mr G, but examined his case notes and concluded that “Mr G was not thought to have a psychotic illness and there is no evidence of dementing.” An appointment was arranged for the following week, with a caveat that there would be no point in further psychiatric action unless the situation had changed significantly.

2.4.19 Mr G was subsequently seen in prison by a Specialist Registrar (SpR1) but Mr G refused to communicate and urinated on the floor. SpR1 recommended baseline investigations to consider any organic aetiology but took no steps to arrange and follow-up these recommendations. No further investigations were performed at this stage and no psychiatric review was arranged.

2.4.20 Prison staff struggled to manage Mr G but tried to ensure that proper discharge arrangements were made. Despite being invited, no-one from Local Authority A attended the pre-discharge meeting and support workers and the Homeless Team were left to manage him. The Homeless Team contacted the MWC advice line on 30th October 2003. It was suggested that Mr G may have an underlying psychiatric illness and that another psychiatric assessment would be required to determine if that was the case. Again, this appeared not to have taken place.

2.5 Nursing Home Placement

2.5.1 At this juncture, the nursing home (NH1) became involved. Mr G was assessed as suitable and a four week trial period, funded by Local Authority A and overseen by CCSW2, began on 7th November 2003. The nursing home was in the area covered by Local Authority C and NHS Board C. Neither service was informed that Mr G was being placed within their area. The staff at the home said that they had information about his history and the problems Mr G might present.

2.5.2 During his early days at the nursing home, Mr G appeared tense and frightened and was verbally aggressive. Staff thought he was displaying some psychotic features and, when he attempted to assault staff, Mr G was assessed by his new general practitioner (GP2) who prescribed chlorpromazine and referred him to psychiatry. GP2 stated that he had been given little information on Mr G but believed he had been anxious, depressed and sexually disinhibited in the past. He did not think that Mr G had been seen by a psychiatrist in the past.

2.5.3 Mr G's placement in the home was made permanent at the end of the four week trial period. Despite the above problems, he was said to have settled. CCSW2 took part in this review but produced little written documentation.

2.5.4 During the first week of December, there were several incidents of aggressive behaviour which seemed unprovoked and hard to predict. On 11th December 2003, Dr4, the Consultant Psychiatrist responsible for the catchment area of NH1, wrote asking for more information on Mr G's behaviour problems and offered an out-patient appointment on 5th February 2004. From then until the incident on 5th February (see below), there were three further incidents when he assaulted staff. Restraint was necessary during at least one of these incidents.

2.6 Removal to Prison

2.6.1 There was a serious incident on 5th February 2004 when Mr G was being escorted to his out-patient appointment with Dr4. When getting ready to leave NH1, he attempted to assault a nurse when she was left alone with him and then, by the account of staff, successfully assaulted the other escorting nurse, again appearing to have waited for an opportunity when they were alone. The staff contacted Dr4 and abandoned attempts to take him to the clinic.

2.6.2 There is some uncertainty as to the exact sequence of events subsequent to this incident. It is clear that Dr4 recommended that the police

be involved and reviewed his previous notes. The police visited NH1 that day and charged Mr G with assault but left him in the home. They then returned the following day and removed Mr G from the home. This may have followed a telephone discussion between Dr4 and the Procurator Fiscal. In a letter to GP2 and NH1 dated 12th February 2004, Dr4 advised that, on the basis of previous information, Mr G's aggression was unrelated to mental illness and that he may be a danger to female staff and patients. He wished to assess Mr G with a view to deciding whether secure mental health care or custodial care was more appropriate.

2.6.3 Mr G was remanded to prison (HMP B) on 9th February 2004. Prison health and social care staff recorded that he was depressed, agitated and "obviously confused". He believed that he had assaulted a nurse in a hospital and was unable to tell staff where he had been staying. It was only after several telephone calls that prison social work staff were able to find anything about his history and present medication.

2.6.4 Dr4 examined Mr G in HMP B one week later where he found him lying in bed, isolated from other prisoners, unkempt and agitated. He made no attempt at socially appropriate behaviour and demonstrated poor attention and concentration and depressive thought content. Cognitive assessment showed poor registration recall of new information and some mistakes on tests of orientation. Dr4 considered there was evidence of mental illness and that Mr G was insane and unfit to plead at the time of examination but appeared to be sane and in control of his actions at the time of the alleged offence. He recommended and arranged hospital admission under Section 52 of the Criminal Procedures (Scotland) Act 1995³ and investigations to exclude an organic cause.

2.6.5 Mr G was admitted to a secure ward in Hospital 4C. Although still anxious and depressed, he appeared orientated. Examination showed exaggerated reflexes and a CT brain scan was arranged. Over the next two days, Mr G was disturbed, described as "child-like" and barely coherent at times. He was treated with anti-psychotic medication and received at least

one intramuscular injection. A brief admission to a general hospital was required as Mr G was anaemic and having problems with low blood pressure. On return from the general hospital, all psychotropic medication was stopped but medication for physical problems was continued. He remained aggressive, sexually disinhibited and the need for seclusion was discussed. The responsible medical officer, Dr5, did not think that there was evidence of mental illness and set out basic behavioural guidelines for nursing staff to try and consistently manage Mr G's challenging behaviour. While noting that clinical psychology advice would be helpful and having made a telephone call to the Department of Clinical Psychology, no formal (written) referral appears to have been made and no psychologist was involved.

2.6.6 From the beginning of March 2004, Mr G appeared to improve and Dr5 thought this was due to consistent nursing management. Following a normal CT scan, a report was sent to the Procurator Fiscal on 16th April 2004 stating that Mr G was sane and fit to plead and that there was no evidence of a treatable mental disorder. Mental health disposal was not recommended.

2.6.7 Dr5 then left the employment of NHS Board C to work elsewhere and Dr6 became the responsible medical officer. It is not clear that Dr6 played any significant involvement in Mr G's care during the rest of that admission. Despite descriptions of an improving condition, there were clearly still episodes of inappropriate behaviour including aggression towards staff and time spent 'shadow boxing'.

2.6.8 Around this time, Mr G was seen in the ward by SpR1 who had previously assessed him in prison. SpR1's report, for Mr G's defence solicitor, recorded that Mr G had been openly masturbating and urinating inappropriately in his room. He scored 28 out of 30 on the MMSE. SpR1 concluded that Mr G was sane and fit to plead and not insane at the time of the offence.

2.6.9 On 13th May 2004, Mr G was discharged from hospital back to HMP B despite the fact that he had assaulted staff the night before and required IM

medication. His discharge letter stated that the ultimate plan was to transfer him back to NH1 but that there had been a delay in the transfer process. He was discharged on treatment with an antidepressant (citalopram), and iron and vitamin B12 for anaemia. The diagnosis was still one of personality disorder. The discharge letter was mistakenly sent to a previous GP but a copy was also sent to NH1.

2.6.10 On return to prison, it was stated that Mr G could return to NH1 if his mental state remained stable. Over the following week, social work staff at the prison noted that he was “wandering”, taking other people’s food and experiencing visual hallucinations. He did not have his reading glasses but appeared not to understand why print was blurred without them. From then until his release from prison on 8th June 2004, Mr G’s condition appeared to fluctuate. He was confused at times but appeared to have “moments of clarity”. He assaulted staff and required placement within the health care wing, being described by staff as “not fit for placement in the halls, let alone release.”

2.7 Breakdown of Nursing Home Placement

2.7.1 On 26th April 2004, NH1 informed CCSW2 that Mr G’s placement was to be terminated in one month. It was stated that whilst they were happy to have him back, they could not do so as the local General Practice were refusing to provide a primary health care service for Mr G. This information was communicated to the prison social work department.

2.7.2 Two days later, CCSW2 sent a summary of Mr G’s case to the social work department of Local Authority C. This described his care from the time he lost his own tenancy until the notice of termination of the care home placement but it was not clear what was being asked of Local Authority C.

2.7.3 Mr G was assessed by two further consultant psychiatrists (Dr7 and Dr8) over the next few weeks. Both detailed bizarre behaviour. Dr 7 expressed the view that Mr G was sane and fit to plead. Dr 8 noted the

number of previous assessments and thought there was nothing else he could do and offered no opinion on diagnosis.

2.7.4 On 8th June 2004, Mr G was found not guilty on one charge of assault and not proven on the other. He was therefore released from court. CCSW2 alerted emergency social work services to the situation and advised that homeless accommodation may be necessary. The responding social worker (ESW1) from Local Authority C took Mr G, with the assistance of security guards, to hospital for assessment. He was seen by a junior doctor and his case was discussed with consultant, Dr9, who in turn discussed him with Dr6. Mr G was agitated, unable to hold a conversation and did not give appropriate answers to questions. However, on the basis of previous diagnosis and information, he was not offered admission. ESW1 found accommodation for him in a homeless hostel.

2.7.5 Local Authority C asked staff in Local Authority A to take Mr G back on 10th June 2004. Local Authority A declined, but said that they would assess Mr G if he decided to return to that geographical area. Formal guidance (Scottish Office Circular SWSG 1/96 – referred to as “Ordinary Residence” Guidance)⁴ (also see appendix II) exists which clarifies which Local Authority has responsibility when a person moves between areas.

2.7.6 This situation continued with senior staff from Local Authority C e-mailing Local Authority A about Mr G and his future needs. Local Authority A denied any ongoing responsibility for Mr G.

2.7.7 Mr G’s condition and behaviour continued to cause serious concern in the homeless unit. On 16th June 2004, he was seen by GP3 and MHO2. He was agitated, uncooperative and covered in faeces and admitted to Hospital 5C under section 24 of the Mental Health (Scotland) Act 1984. On admission, he was described as “choosing to be calm or aggressive” but was disorientated for time and place and talked of feeling like he was from another planet. He was reviewed by Dr9 later that day but was drowsy and uncommunicative.

2.7.8 On 18th June 2004, Dr9 and MHO3 tried to review Mr G but he refused to talk to them. They decided not to detain him further as he was “physically frail and unable to run away”. Over the next few days, Mr G displayed bizarre behaviour and was urinating inappropriately and manually evacuating faeces. It was noted that Mr G apparently had insight into his behaviour. On the night of 22nd/23rd June 2004, Mr G was particularly disturbed. He made inappropriate sexual advances, tried to go into other peoples’ rooms and attempted to eat sugar directly from the bowl (subsequent descriptions of his eating behaviours consistently documented a craving for sweet foods). When staff intervened, he assaulted them. In light of the view that Mr G had no mental illness, the police were called and he was removed from the ward to police custody. This ultimately led to his remand to HMP B.

2.7.9 Dr5 went to see Mr G almost immediately that he was imprisoned but Mr G refused to speak to him. Dr5 made no recommendation for disposal, advised that Local Authority A should still be involved and wrote to Dr8, the visiting psychiatrist for the prison, suggesting that some follow-up might be necessary.

2.7.10 The Mental Welfare Commission were contacted by Dr8 and, independently, by the Healthcare team at HMP B over the first few weeks of July 2004. They expressed concerns that Mr G appeared to be suffering from mental illness but had been rejected by mental health services.

2.7.11 On 21st July 2004, his case was summarised by the criminal justice team of Local Authority C. They noted that, despite Mr G’s complex needs, Local Authority A had no ongoing care plan. On 10th August 2004, Local Authority A closed Mr G’s case. They justified this action by saying that as he was assessed as not having a mental disorder and showed no inclination to return to Local Authority A’s area he was the responsibility of whichever Local Authority he presented to at any given time

2.7.12 A consultant psychiatrist (Dr10) from the Mental Welfare Commission assessed Mr G on 12th August 2004. On the basis of a review of the history, descriptions of inappropriate urination and masturbation and an examination of his mental state, Dr10 thought it likely that Mr G suffered from dementia, probably of frontal type but that the possibility of a depressive illness could not be excluded. He wrote to Dr6 as hospital care appeared appropriate. Dr6 subsequently examined Mr G but whilst agreeing that hospital treatment was necessary, Dr6 thought that Mr G could only be managed in the State Hospital.

2.8 Detention in the State Hospital

2.8.1 Whilst negotiations about transfer to the State Hospital were under way, Mr G appeared in Court again. The Sheriff was sufficiently concerned that he contacted the Mental Welfare Commission and the State Hospital. A discussion between Dr10 and the medical director at the State Hospital resulted in immediate assessment and admission to the State Hospital under section 57(2) of the Criminal Procedure (Scotland) Act 1995³.

2.8.2 While in the State Hospital, Mr G remained unpredictably aggressive at times and went through spells of low mood and poor oral intake. He was treated with anti-depressant medication and given a trial of electroconvulsive therapy. Neither produced benefit.

2.8.3 Detailed examination and investigation, including neurological assessment, confirmed that Mr G had a significant degree of dementia and features of Parkinsonism. The Neurologist thought that Progressive Supranuclear Palsy (PSP) was a likely diagnosis.

2.8.4 During Mr G's admission to the State Hospital, Local Authorities continued to dispute who was responsible for his care. Local Authority A maintained that they had no ongoing responsibility. Despite considerable communication, including letters to the Scottish Executive requesting formal dispute resolution, the issue of which Local Authority should have ongoing responsibility was not resolved.

2.8.5 Mr G continued to decline physically and mentally. He became immobile but remained aggressive at times. He remained in the State Hospital until December 2005. Following a period in a general hospital, where feeding with a percutaneous gastrostomy (PEG) tube was considered, he was transferred to a unit for younger people with dementia. Mr G died there in April 2006. The issue of his 'ordinary residence' remained unresolved.

Section 3. Analysis of key problem areas

3.0 In reviewing all the information about Mr G's care and treatment, we identified five areas to address. These were:

- Diagnostic Assessment and Reassessment
- Impact of the Diagnosis of Personality Disorder on Care & Treatment
- Information Sharing and Continuity
- Out of Area Specialist Care
- The Management of Challenging Behaviour

3.1 Diagnostic Assessment and Reassessment of Mr G

3.1.1 We examined the process of diagnosis when Mr G came to the attention of mental health services in NHS Board A. Following this, there were numerous opportunities to reassess the diagnosis during contacts with mental health practitioners in various services, including practitioners providing Court reports.

3.1.2 Mr G was admitted to hospital in February 2001. He was regarded as having symptoms of depression and anxiety in the context of personality difficulties and problems at work. There is no evidence of an assessment of cognitive functioning having been carried out when he was admitted to hospital despite the fact that Nursing Notes detailed him as "confused at times." It was almost two months later when the SHO to Dr 1 performed a MMSE. While Mr G scored 28 out of 30, which is above the highest quoted cut-off point (27) for suspecting cognitive impairment, he was having difficulty with concentration and recall. This was presumed to be secondary to depression. Dr1 told us that it was standard to screen all patients for basic cognitive skills. At interview with the Inquiry team, Dr1 stated that the MMSE was used as a screening tool and he remained satisfied that the correct assessment had been made at the time. He reported that he did not consider Mr G's clinical presentation to warrant more detailed cognitive assessment.

3.1.3 It is unclear whether further cognitive investigation may have been appropriate at that time. However, we consider that a number of instances of subsequent behaviour during this in-patient stay should have triggered a reassessment of the diagnosis of Personality Disorder. These include Mr G:

- Displaying inappropriate sexual behaviour during a visit to a swimming pool
- Invading the personal space of female staff
- Walking about inappropriately whilst wearing night attire on several occasions
- Exposing himself to a female patient
- Attempting to hold lewd conversations with a female patient
- Inappropriately touching a domestic supervisor
- Showing poor social judgement (seeking help from strangers; discussing personal matters in the pub; butting into conversations; and refusing to leave the house of a friend he had been visiting).

3.1.4 Previous case notes contain no evidence that these behaviours were longstanding. While Mr G had difficulty forming relationships with women and had inappropriately followed one female acquaintance, he had previously worked as a gardener/handyman at a school. Had such behaviour been a long-standing feature, we consider it likely that it would have come to light during this period. We therefore find evidence that Mr G was displaying poorer social judgement in his interactions with others than had previously been the case. Unfortunately, during this important period of time, there was a nine month period when Dr1 made no direct entries in the case record and entries by junior medical staff made no reference to Dr1 actually examining Mr G. This clearly falls below acceptable standards of professional practice. The case record contains no explanation for either Mr G's behaviour or any consideration of differential diagnoses. In the absence of a clear record of the diagnostic process and any differential diagnosis that was considered, we therefore find evidence that the diagnoses of "depression and anxiety" and "dependent personality" given at the point of discharge were insufficient to explain all the behaviour that Mr G displayed during this admission. Even at

this early stage, there appear to have been enough clinical signs to raise suspicion of frontal lobe pathology.

3.1.5 There were many opportunities for Mr G's condition to be reassessed.

Subsequent contacts with mental health services included:

- 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

3.1.6 In examining these reports, we found three specific items of concern.

Namely:

A distortion of Mr G's history

- Five incorrect accounts of his forensic history, with statements such as "long history of anxiety and sexual offending" (Court report 2001), "displays aggression and sexual disinhibition in keeping with his behaviour over several years" (hospital admission February 2004) and "numerous convictions dating back to 1979" (Court report February 2004) distort the truth as Mr G was actually admonished in 1979 and never prosecuted or convicted again until 2002;
- A significant error in his personal history. From around April 2004, the account of his previous history recorded that his wife left in 1998. This was used as an explanation for his decline since then. She actually left in 1988;
- Distorted accounts of his previous psychiatric history. Most Court reports contained accurate accounts of his previous psychiatric contact. A significant exception is a report that alleged "extensive contact with the psychiatric services over the last forty years." It stated that this contact "has not brought about any modification in his behaviour. There is a danger that further treatment will just foster

dependence and encourage further sexual deviance” (Court report 2002). This report also referred to abnormal sexual behaviour in 1972 to support the claim that such problems were longstanding. This behaviour occurred once in the context of a brief spell of disturbance immediately following treatment with electroconvulsive therapy and was not a feature of his behaviour at any other time prior to 2001.

3.1.7 It was therefore evident that the lack of a complete and consistent longitudinal account of Mr G’s life and previous mental health contacts seriously impeded the process of accurate diagnosis. During our investigation, we found that the account of his history became distorted to become consistent with the accepted diagnosis of personality disorder.

Inadequate testing of cognitive function

3.1.8 The cognitive tests performed as part of Mr G’s psychiatric presentation were unlikely to identify significant frontal lobe pathology. We found three different approaches to assessment:

- No statement at all about cognitive function (for example, hospital admission June 2003) or only vague statements such as “cognitively appears intact” (emergency assessment December 2002) where no detail is given as to the process that led to this conclusion;
- References to tests of memory and concentration that only tested a part of cognitive functioning. For example, in a Court report dated June 2002 the psychiatrist asserted that “Mr G is not dementing” on the basis of good knowledge of current events despite the fact that he only recalled three items out of a six-item name and address when asked to retain it;
- Use of the MMSE (e.g. forensic opinion April 2002, court report by SpR 1 May 2003) with adequate scoring on this test accepted as definite grounds for excluding dementia as a possibility.

3.1.9 The MMSE ¹ is a much-used screening and assessment tool. However, it has its limitations and is a poor diagnostic instrument⁵. It is only useful once its limitations are understood.⁶ In the case of Mr G, we found extensive evidence of psychiatrists using the MMSE without realising its limitations.

3.1.10 Executive function is an interrelated set of abilities that include planning, cognitive flexibility, concept formation, abstract thinking, self-monitoring and inhibition of inappropriate actions. With impaired executive function, important activities of daily living (accounting, shopping, medication management, driving) and control of behaviour can be severely impaired whilst memory impairment is mild. When we interviewed Dr6, he was of the opinion that tests of executive function take weeks to complete. This is not true. There are brief tests of executive function, including clock drawing,⁷ the Zoo Map Test⁸ and Dex Questionnaire⁹ and a variety of other tests. The presence of primitive reflexes, if tested, would have increased the index of suspicion of fronto-temporal dementia. ¹⁰

Limited Diagnostic Statements

3.1.11 The diagnosis of personality disorder is notoriously unstable and many people can have other co-existing mental disorders¹⁰. In Mr G's case, we found evidence that diagnostic statements appeared to accept the previous diagnosis of personality disorder too readily and without proper consideration of other possibilities. Further, insufficient consideration was given to the possibility of co-morbid disorders. Significant exceptions are a forensic opinion in April 2002 that at least considered the possibility of depression and the assessment by Dr4 in Feb 2004 that gave an appropriately wide range of possibilities. Examples of concern include:

- Despite the range of diagnostic possibilities contained in Dr 4's report, there was no clear statement of differential diagnosis during the subsequent hospital admission. He had numerous physical investigations, including a CT brain scan, but the absence of a differential diagnosis made interpretation of the results difficult;

- When admitted to hospital 5C in June 2004, Mr G was disoriented and doubly incontinent. Despite this, there was no reassessment of his diagnosis and the possibilities of delirium and dementia were not considered.

3.1.12 We had concerns about the function and quality of mental health assessments in prison. In October 2003, the SpR who saw Mr G considered “an organic cause” for his behaviour and suggested baseline investigations but no investigations were performed and there was no psychiatric follow up arranged. When we interviewed SpR1, he stated that making diagnoses and giving advice on treatment were the major tasks of any visiting psychiatrist. Dr8 disagreed and thought that the role was simply to identify people who appeared to have a mental disorder (without necessarily making a clear diagnosis) in order to facilitate removal to a mental health facility. Despite this, and despite raising the matter with the Commission, Dr8 did not contact colleagues in NHS Area C who would have had ongoing responsibility for Mr G at that time. We were left with uncertainties about how mental health and prison systems worked together. A further issue was that there was good information in prison social work records, unavailable to the visiting psychiatrist, that may have influenced diagnostic and treatment opinions.

Findings on Assessment & Re-assessment

- We acted on Dr 1’s failure to keep appropriate medical records by alerting him and his present medical managers to this issue.
- There was evidence of too much reliance on screening tests for dementia that have limited reliability and validity;
- There was evidence that the diagnostic process was based on inaccurate and unsubstantiated information and assumptions that lacked corroborative evidence from a careful analysis of previous case records and/or information from informants.

- In many cases, there was a failure to consider and document a differential diagnosis that would have been useful as a guide to the need for further investigations and interpretation of their results. This includes an apparent failure to consider a second diagnosis in a person with pre-existing personality difficulties.
- Given that Mr G demonstrated many of the features of fronto-temporal dementia as described in SIGN guideline 86 (see appendix 1), we found evidence of a lack of awareness of this guideline. This is likely to have had a bearing on the failure on the part of several psychiatrists to consider this as part of a differential diagnosis. While this guideline was not in place at the time of Mr G's difficulties, we are concerned that this lack of knowledge could lead to future failure to consider this condition in differential diagnoses.
- We found evidence of a lack of consistency among psychiatrists as to the nature and purpose of the input to prisons from visiting psychiatrists in relation to diagnosis and treatment of people who appear to have a mental disorder.

3.2 Impact of the Diagnosis of Personality Disorder on the Care & Treatment of Mr G

3.2.1 In January 2002, a report produced for the court stated that Mr G was fit to plead and had a diagnosis of Anxious Personality Disorder, Dependent Personality Disorder and Exhibitionism. Recommendation was made that the Court impose a deferred sentence in order that his current package of care could continue unchanged. At this time, he was treated under the care programme approach and was being seen regularly by a number of mental health professionals. He was on psychotropic medication and it appeared that attempts were being made to offer treatment in the form of emotional support and practical help with tasks of daily living. We found no evidence

that Mr G had been offered structured psychological treatment for personality disorder.

3.2.2 In June 2002, psychiatric services withdrew from his care and Mr G was removed from CPA. We found no discharge summary by the mental health services, no clear statement as to why he was discharged and no detailing of what circumstances could lead to re-referral. It appears that there was a decision that Mr G was “untreatable.”

3.2.3 Around this time, two psychiatric reports stated that he did not suffer from a mental disorder (within the meaning of the 1984 Act). Here, and subsequently, we found statements that providing services to Mr G was likely to foster dependence and increase his offending behaviour. Social care services were being provided. We found no evidence of mental health services providing advice to social work services on what response, given the diagnosis of personality disorder, would be appropriate and would be likely to lessen his dependence and offending.

3.2.4 Following his release from prison in October 2002, Mr G was seen on two occasions by psychiatric emergency services. Despite the fact that he was on medication and some suggestions were made as to the dosage, no psychiatric follow up was organised. Given that follow-up would have been organised if the diagnosis had been, for example, schizophrenia or bipolar disorder, we consider that the diagnosis of personality disorder was a major factor in denying Mr G the benefit of psychiatric follow up.

3.2.5 From this time until his placement in NH1, there were several brief contacts with mental health services. Mr G had two brief admissions to hospital in the summer of 2003 and an assessment in prison in October 2003. He presented with self-harm and inappropriate behaviour that showed clear lack of social judgement. However, all assessments commented on his diagnosis of personality disorder and that further mental health contact was unlikely to help. We consider that, had such behaviours occurred in the

absence of such a diagnosis, Mr G would likely have received further assessment and treatment.

3.2.6 This unquestioning acceptance of a diagnosis of personality disorder was also evident in further forensic assessments from April to June 2004 and on his admission to hospital in June 2004 and subsequent arrest and return to prison.

3.2.7 The last of these is of particular concern. Mr G was described as being disorientated for time and place, incontinent of urine and manually evacuating faeces which he offered to staff. This behaviour was new and had not been a feature of his previous admission yet it was explained as another feature of his personality disorder. We are confident, had it not been for his previous diagnosis of personality disorder, that the emergence of these features would have aroused a high level of suspicion of an organic brain disorder. Unfortunately, we were not able to interview Dr 9 to explore this further.

3.2.8 Treatment for anxious/avoidant personality disorder includes social skills training and behavioural exposure^{11 12 13}. We found no evidence that these approaches had been considered and we are certain that they were never tried. There is some evidence of benefit from antidepressant medication¹⁴. There were numerous statements, mostly in court reports, to the effect that Mr G was in control of, and therefore responsible for, his actions. Whether or not this was true, there are behavioural approaches that could have been tried. The fact that these were not offered appears to indicate negative assumptions about personality disorders and the possibility of effective treatment. Any attempts at behavioural modification were rudimentary and unlikely to have had the rigour or consistency to be successful.

3.2.9 When we interviewed a variety of individuals and groups involved in Mr G's care, we were struck by the different perceptions of the impact of a diagnosis of personality disorder on the care and treatment a person receives. For example:

- Dr1 told us that he did not think it made a huge difference to the quality and quantity of care;
- CMHN1 however, who was part of the same team as Dr1, told us that the effect of the diagnosis was for Mr G to be viewed as “untreatable,” leading to the rejection of subsequent approaches for assistance by social care agencies;
- CCSW2 said that the diagnosis could be a “death-knell”, suggesting imperviousness to treatment or any investment of time;
- Staff from homeless services commented that the diagnosis was an obstacle to obtaining healthcare care and often used as a “get out clause” in managing difficult people.

3.2.10 Many of the people we interviewed from social care agencies expressed concerns about the diagnosis and told us that they had doubts as to whether it explained the range of problems that Mr G presented. However, senior staff admitted that they never put their concerns in writing. As a result, there was no opportunity to consider any process that might have existed to resolve disputes between health and social care services.

3.2.11 We believe that mental health services need to pay attention to the negative perceptions of the diagnosis of personality disorder. Our findings are in line with research evidence. People with a diagnosis of personality disorder are often excluded from care services¹⁵. The diagnosis is unstable and often changes¹⁶. We found insufficient evidence of systematic review of diagnosis after the spring of 2002 and ample evidence of mental health services distancing themselves as a result of the diagnosis. The report by the British Psychological Society on “Understanding Personality Disorders” highlights positive approaches¹⁷. We believe that many of the practitioners involved in Mr G’s case would have benefited greatly from having read this.

3.2.12 A particular impact of the diagnosis was the way that several practitioners made assumptions about Mr G’s abilities and function prior to

2001. These assumptions were made without evidence and, at times, evidence was ignored or altered in a way that made it more consistent with the diagnosis. We do not believe that this was done deliberately. The following examples appear to us to illustrate the way that a diagnosis of personality disorder distorted various practitioners' perceptions of Mr G.

- CCSW1 told us that Mr G had always struggled and only survived in the past with the aid of church friends. Notes contain no evidence to support this and this account is inconsistent with primary care and mental health records prior to 2001;
- A psychiatric report prepared for court in 2002 appeared to make the assumption that Mr G had been treated in the past for the offending behaviour. There was no evidence in case records to support this. One episode of disinhibition following ECT therefore began to take on new significance;
- Most importantly, we were struck by numerous references to his “long history of offending behaviour.” This is documented in the previous section of this report (page 26, section 3.1.6). The fact that examination of Mr G’s history does not support this leads us to believe that the diagnosis of personality disorder and the negative perceptions that followed from this resulted in distortions of historical information.

3.2.13 Mr G’s personal history therefore became distorted to support the diagnosis of personality disorder. A clear written account of his personal history, checked for accuracy with Mr G or a reliable informant, that followed Mr G through the health and social care system might have raised doubts about the diagnosis and mitigated against the effect of the negative perceptions that the diagnosis of personality disorder can produce.

Findings on the Impact of the Diagnosis of Personality Disorder on the Care & Treatment of Mr G

- There was regular assumption that Mr G was “untreatable” and specialist services were therefore either not offered or withdrawn.

- We found no evidence of the use of structured psychological treatments with Mr G despite a good evidence base supporting the use of social skills training and graded exposure.
- There were repeated claims that contact with services “fostered dependency” and worsened the situation. This assumption is not supported by Mr G’s history and is not supported by research or empirical evidence. Clarity over consistent management and limit-setting would have been appropriate, yet this was seldom implemented consistently, especially in the community.
- Mental health services made assumptions that Mr G had capacity in relation to his behaviour and was able to exercise choice and control. Regardless of whether these assumptions were correct, we found little evidence of assistance to Mr G to alter his behaviour.
- During much of the period of time covered by this report, Mr G was prescribed psychotropic medication, including anti-depressant and anti-psychotic drugs that were initiated by mental health practitioners. While this seems to be at variance with the diagnosis, we would expect that such treatment would be subject to specialist review. For long periods of time, it was not.
- 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. We consider it unlikely that such assumptions would have been made had Mr G had been given a different diagnosis.
- We found errors in recording of Mr G’s history that occurred during psychiatric assessments. These were then repeated in future

assessments. The effect was to distort Mr G's history in a way that appeared to support the diagnosis of personality disorder.

- When Local Authority A decided to withdraw from accepting any responsibility for Mr G's care, they stated the lack of an identified mental disorder as one of the major reasons for this. Had a person with another mental health diagnosis displayed the same level of apparent need, we do not think that the authority would have made such a decision.
- 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.

3.3 Information Sharing and Continuity

3.3.1 Given the number of professionals and different agencies involved with Mr G from 2000 to 2005, it was crucial that accurate information followed Mr G and informed all parties about his history and care needs. We found examples where systems worked well:

- When Mr G was receiving services from NHS Board A, all front line staff from health, social work and housing providers worked closely together and information, which was well documented, was shared on a daily basis.
- There was good liaison among front-line staff and first line managers in Local Authority A criminal justice and community care teams.
- The care programme approach worked well when used.
- The records from the homeless agencies in Local Authority area B were detailed and vividly described Mr G's deteriorating behaviour.

3.3.2 Faced with a very difficult situation, we found that many of the individual front line staff made great efforts to help and support Mr G. It is clear to us

that frontline community care staff felt frustrated and uncertain as to how to deal with the challenges he presented but did their best to stick to their task and find solutions. The lack of an accurate diagnosis made this very difficult for them. To quote the Head of Housing services for Local Authority A, “it was like treating someone for a broken arm when he had a broken leg”. The homeless agencies in Local Authority area B, in our opinion, performed their roles to a high standard. We also noted the immense efforts of the social worker in HMP B to find and record information and also in engaging with Mr G and doing her best to support him.

3.3.3 With regard to sharing information, one person who gave evidence stated that people shared information and were clear about the options available, “but it was a different matter how effective this was from the point of view of the outcome. It was not a good outcome for Mr G.”

3.3.4 We found that accurate information was not always available to assist staff. This was particularly true of information which described Mr G in a more positive light. In 1999, when Mr G applied for a job in Local Authority area A, his GP described him as “a pleasant genuine individual, quite idealistic about his work, but he is very much a worrier and really found it difficult to cope since his wife left him some years ago. He has been on Amitriptyline 25mg or 50 mg at night for some time now and he feels this is helpful. He has a good attendance record at work.”

3.3.5 Mr G was removed from the CPA despite evidence of significant problems and needs for services. This was on the basis that mental health services believed that they had nothing to offer Mr G. The effects of this included removal of clear lines of communication with the Police and Local Authority A left to try to support Mr G without psychiatric assistance.

3.3.6 While he lived in NHS Board area A, Mr G was discharged from various forms of mental health care. Most importantly he was discharged from Dr1’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 specialist mental health opinion and had no guidance on circumstances that would merit re-referral.

3.3.7 We found no Community Care Assessment, no risk assessment or risk management plan in the community care notes from Local Authority A. We also found no risk of harm assessment or risk of sexual harm assessment in Local Authority A's criminal justice records. These are serious omissions. The housing agency in Local Authority A requested a case conference as they had community safety concerns when Mr G was described as a 'paedophile' by neighbours. This never took place as he was remanded in prison. Local Authority A still had responsibility for his care and CCSW1 informed the service manager that "The problem is simply being shifted and not dealt with." There was no response to this memo in the case records, no multi-agency vulnerable adults care conference convened and the police were not part of any formal discussions despite their increasing involvement. There is insufficient evidence that anyone at an operational or senior management level in Local Authority A took charge of the situation. One of the operational managers told us that we were incorrect in assuming that the above memo required a response. There was no evidence of a shared approach between agencies as to how to respond when Mr G presented problematic behaviour.

3.3.8 When Mr G was released from prison, he was taken by CJSW2 to homeless services in Local Authority area B. Information about Mr G's inappropriate sexual behaviour was not passed on to the agency, and he was unwittingly placed in accommodation run by nuns. This placement immediately failed and he was moved to another provider. Once again accurate information was not passed on. Local Authority A staff tried desperately to find suitable permanent accommodation for Mr G to no avail and their homeless accommodation was unable to provide any resources to meet Mr G's needs. Local Authority A staff also tried to engage their psychiatric colleagues but they refused to get involved. There was no evidence, however, that examples of his deteriorating behaviour were put in writing to psychiatric services.

3.3.9 The homeless provider made a formal complaint in December 2002 to the Social Work Director of Local Authority A. The letter stated, "I wish to make a formal complaint about the inappropriate manner in which Mr G has been treated by your department. It became rapidly apparent that the current accommodation was unacceptable for Mr G's care. This was immediately brought to the attention of your staff and a case conference was requested to deal with the inappropriate behaviour of Mr G and to consider how we could access something more acceptable. We were constantly given assurances ... 'we accept responsibility for Mr G'. Unfortunately this did not materialise. In essence we believe that an extremely vulnerable man was off-loaded by your department because they were unable to address Mr G's complex needs." This complaint was never formally answered and no senior manager took responsibility for the situation.

3.3.10 We found evidence that when both CCSW2 and CJSW1 were involved, there were times when responsibility for overall Care Management responsibility was unclear

3.3.11 When Mr G was living in homeless accommodation in Local Authority area B, referrals were made to the psychiatric service in NHS Board B. Mr G was prescribed psychotropic medication, but there was no follow up. We found little evidence that the totality of information about escalating concerns was transmitted from social care services to specialist mental health services.

3.3.12 By chance, the housing agency heard of NH1 and a referral was subsequently made by CCSW2. A Community Care Assessment was requested, but not provided. The reason given was that, "a community care assessment is inappropriate due to Mr G's complex needs." Despite this, NH1 manager was satisfied with the information that was provided, confident that NH1 could meet Mr G's needs. In our opinion, a Community Care Assessment should have been completed, precisely because this was such a complex case, and a detailed care plan provided to the care home.

3.3.13 Prior to his move to the care home, Mr G came to the attention of the Police on several occasions. The Police passed on their concerns to social work colleagues, but no Vulnerable Adult's case conference was ever held. The Police Constable identified that "no-one wanted to take responsibility for Mr G, either social services or health, leaving the police to deal with an ill man." This was another missed opportunity for all the agencies concerned to share information and make management/contingency plans for Mr G.

3.3.14 After a four week assessment period, Mr G was offered a permanent placement in NH1, funded through Voluntary-After Care monies. CCSW2 facilitated the placement, but there was no record of a formal review having taken place in either the social work or nursing home records. Local Authority C was not informed that this placement had been made, which is a breach of ordinary Residence Guidance Circular SWSG 1/96⁴. Although the manager of NH1 was satisfied with the information received regarding Mr G, when a psychiatric referral was necessary GP2 had little background information to pass on. We were unable to access any GP records when Mr G was residing in the care home. No health records were passed on from NHS Boards A and B when Mr G transferred to NHS Board C. During changes of residence from Mr G's own home through prison, homeless services, residential care and hospital, there was an absence of core information that followed Mr G.

3.3.15 Following the assault on NH1 staff, Mr G was taken to HMP B. The prison social worker had to phone around to find out where he had come from. The manager of NH1 was surprised that Mr G was in prison. The social worker recorded that Local Authority A was the responsible Local Authority. The prison social work interview notes vividly recorded Mr G's behaviour, but these notes were not available to visiting psychiatrists. This information would have been of assistance to medical staff.

3.3.16 CCSW2 visited Mr G when he was admitted to Hospital 4C for assessment and passed on relevant information to Dr5. The multi-disciplinary team assumed that Mr G would be returning to NH1 following discussion with CCSW2 and the manager of NH1. The Court report stated that Mr G was

sane and fit to plead and did not recommend a psychiatric disposal. He was returned to HMP B awaiting his court appearance on 8th May 2004.

3.3.17 On 24th April 2004, the manager of NH1 informed CCSW2 that Mr G's placement would be terminated after the requisite one month's notice, stating that the visiting GP2 had refused to offer Mr G a service on the grounds the he was not susceptible to treatment and would continue to be violent. Without GP in-put, his placement could not continue. There was no reassessment of Mr G's social care needs at this time and no contingency plan was put in place. Local Authority A immediately withdrew their services. We were informed that this was the first time, from a front line perspective, that senior managers became involved. The decision was taken by Local Authority A that Local Authority C was now the 'Authority of the Moment'. Background information was faxed to Local Authority C and a dispute over 'Ordinary Residence' ensued (See Chapter on Out of Area Specialist Care). Local Authority A had sought legal advice concerning Mr G's Ordinary Residence but the legal advisor appeared to have an incomplete understanding of Mr G's history.

3.3.18 When Mr G was placed in Local Authority C, background information was requested from Local Authority A. They took over three months to reply. Following receipt of the request, a first line manager contacted the senior manager asking if existing information should be sent. The response given was: "No. I have spoken to ... who is preparing a report for them. In the meantime, least said the better as I have encouraged ... to take these issues of home authority up with the Scottish Executive as our duties have been discharged under criminal justice legislation". It is our view that this response was unacceptable. No one was thinking of Mr G's social care needs: he had needs other than those served by Criminal Justice services.

3.3.19 While Mr G was in the State Hospital, their social work department invited representatives from Local Authority A to attend case conferences and sent a copy of a social circumstance report for information, to assist with future care planning requirements for Mr G. A senior manager from Local

Authority A replied, “I appreciate that you have kept staff ... advised of Mr G’s progress. This was not invited as (we) continue to dispute any responsibility for him.” We find this response inappropriate as it, yet again, did not focus on the needs of Mr G.

Findings on Information Sharing & Continuity

- We found information in general practice and mental health records prior to the year 2000 that did not support assumptions made about Mr G’s behaviour and social functioning during that period. Had this information been sought and reported accurately, it may have been more evident that Mr G’s mental health had deteriorated significantly and prompted further consideration of alternative diagnostic possibilities.
- 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 CPA despite evidence of significant problems and need for services. This was on the basis that mental health services believed that 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 the area covered by NHS Board 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 informed various individuals involved in Mr G's care as to how to respond when he presented problematic behaviour. There was therefore little consistency in response and setting acceptable limits on his behaviour.
- While most social care agencies shared information reasonably well, this was not always the case with Mr G's increasingly inappropriate behaviour. This led to an inappropriate placement on one occasion. 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 and no contingency plans were put in place when he moved to NH1.
- During the period when both community care and criminal justice services were involved there were times when it was unclear as to who was the care manager for Mr G, especially when he moved to Local Authority area C.
- 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 information about Mr G's presentation in prison was held in separate records held by the health care team and the social work team. Some of the information held in the social work records could

have been valuable to visiting psychiatrists but was not available to them.

3.4 Out of Area Specialist Care

3.4.1 Mr G had complex health and social care needs and it was difficult to find an appropriate resource to meet these needs. Unfortunately there were no suitable resources in Local Authority A, where he was an Ordinary Resident, once his tenancy was terminated. When he moved into homeless accommodation in Local Authority B, Local Authority A continued to accept responsibility for his housing and social care needs, although Mr G was shunted between the two Local Authority housing agencies. Care management responsibilities were shared between CCSW2 and CJSW2. On examination of the facts, it was unclear who had the lead role and which manager had overall responsibility. In complex cases, we believe the line management responsibilities should be clear and understood by all concerned.

3.4.2 Staff involved acknowledged that they were desperate to find a resource willing to accept Mr G. The placement at NH1 was described by one respondent as “nothing more than a fishing expedition.” We believe that the available evidence indicates that placement in NH1 was service-driven than needs-led. Varying amounts of information were transferred to the NH1.

3.4.3 Ordinary Residence Guidance states that, “A Local Authority should not place a person for whom they are financially responsible in accommodation provided by a private proprietor or a voluntary organisation in the area of another authority without informing the other authority. Good record keeping will be essential ... All changes should be confirmed and recorded in writing at the regular review of each individual's needs.” We found that Local Authority C had not been formally notified that Mr G had been placed permanently in their area. We found no evidence that contingency plans had been put in place for him and no evidence that formal care management review took place.

3.4.4 Concerns were raised by psychiatrists in NHS Board C that their service was required to provide support to a large care home taking people from across Scotland with complex mental health needs, without formal discussions and contractual arrangements about the specialist mental health input that might be required. NH1 did not have staff trained in the use of behavioural management techniques and health information was not routinely transferred on admission to the care home. The GP notes were kept in the local surgery, so medical information was not readily available for nursing staff or visiting psychiatrists.

3.4.5 When GP2 covering NH1 decided to remove Mr G from the practice list, we found no evidence that NH1 attempted to secure the services of another GP in the surrounding area. The psychiatric team wrongly assumed Mr G would return to the care home. At this juncture, Local Authority A immediately withdrew their assessment and care management responsibilities without any formal review of Mr G's immediate needs. This decision was reportedly taken as Mr G had chosen not to return to Local Authority area A.

3.4.6 An email from the Director of Local Authority A was forwarded to Local Authority C. It stated, "I understand that Mr G has been assessed by medical professionals as not having a mental health problem. When previously resident in Local Authority A, his behaviour resulted in eviction and he has exhausted the services that the Council is able to provide. In these circumstances he is considered to be responsible for the consequences of his actions ... If he presents at any Council offices in Local Authority A, he should be advised that the Council will not take responsibility for his accommodation and that he must make his own arrangements." We formed the view that, by this juncture, it was highly unlikely that Mr G had the capacity to make decisions about where he wanted to live or the capacity to arrange accommodation for himself. We found no evidence that formal consideration of capacity issues had ever been undertaken. In any event, we believe that Local Authority A acted in breach of the Homeless Persons Advice and Assistance (Scotland) Regulations 2002.

3.4.7 Local Authority C took on the 'Local Authority of the Moment' responsibilities when Mr G was released from prison, but understood that Local Authority A was actually responsible, as it had funded the placement in NH1 and therefore still had assessment and care management responsibilities. Local Authority C wrote to the Scottish Executive expressing concerns regarding Local Authority A's care management responsibilities. The Scottish Executive's response stated that the two Local Authorities must find a resolution. When Mr G was transferred to the State Hospital, Local Authorities A and C did not formally take this matter any further.

3.4.8 Local Authority A told us that they assumed the matter still rested with the Scottish Executive, although no formal request for 'Dispute Resolution' had ever been made. They stated that they preferred to go straight to 'Dispute Resolution' when there are issues over 'Ordinary Residence' and believed that they advanced three to four cases each year to this position. On discussion with the Scottish Executive, however, we were informed that the Scottish Executive usually deals with only two such cases across Scotland each year.

3.4.9 Mr G was effectively left with no Local Authority prepared to accept ongoing responsibility for his care and treatment. The State Hospital social worker stated that he could think of no other similarly protracted case or one without resolution. CCSW2 also stated that, he was "aghast at the way his (Mr G's) case bounced around the Local Authorities at a senior management level." He sensed that energies were being spent in "passing the buck, rather than dealing with the situation."

3.4.10 We concur with this statement and find that Local Authority A eventually reached a point where they failed to accept ongoing responsibility for this vulnerable man, with complex health and social care needs. In our view, Local Authority C accepted appropriate responsibility for assessment and care management as the "authority of the moment". Local Authority A was responsible for Mr G's placement in NH1 but acted in breach of

paragraphs 11 and 12 of Scottish Office Circular No: SWSG 1/96. They neither accepted any ongoing responsibility for Mr G nor had they informed Local Authority C of his placement. Mr G did not “subsequently move without Local Authority involvement” – the placement broke down as a result of NH1 and primary health services being unable to meet his needs.

Findings on Out of Area Specialist Care

- 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 NH1 was not resultant of planned, needs-led care management. Instead, it appeared resultant of it being suggested to Local Authority A that NH1 was somewhere that tended to accept complex cases.
- There was poor transfer of information from Local Authority A to NH1. It appeared that minimal information was provided and the manager of NH1 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 NHS Board C when Mr G was placed in NH1. No mental health service was involved in Mr G’s care at the point of transfer.
- We found that the manager and care staff of NH1 and the covering GP2 had varying information about Mr G.
- Local Authority A failed to transfer information about Mr G to Local Authority C. 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 NH1, we find the attitude of operational and senior managers within Local Authority A when the placement failed both extraordinary and unacceptable and in breach of national guidance. Local Authority C invoked the mechanism to resolve the dispute but this was never followed through after Mr G moved to the State Hospital.
- NH1 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, with insufficient clarity as to the nature and outcome of discussions between NH1 and NHS Board C.

3.5 The Management of Challenging Behaviour

3.5.1 "Challenging behaviour" is a term used to describe difficult or problematic behaviours including aggression, self-injury and destructive behaviours. Characteristically, challenging behaviour puts the safety of the person or others in some jeopardy or has a significant impact on the person's

or other people's quality of life (Emerson et al., 1988)²². The term is most recognised in the learning disability and dementia fields but is applicable to all individuals and settings. The British Psychological Society Clinical Practice Guidelines "Challenging Behaviour: Psychological Interventions for Severely Challenging Behaviour Shown by People With Learning Disability" (August, 2004)²³ provides a comprehensive overview of the assessment and treatment principles and processes and ethical considerations that should be considered when managing difficult behaviour and these Guidelines are drawn upon here. Further work entitled "Challenging Behaviour: A Unified Approach" has been produced jointly by the Royal College of Psychiatrists, British Psychological Society and the Royal College of Speech and Language Therapists, which emphasises the need for proper multi-disciplinary working in the implementation of these principles. There are also a range of valid and reliable rating scales which may assist in the measurement of challenging behaviours (for example, the Challenging Behaviour Scale (Moniz-Cooke et al., 2000)²⁴; Modified Overt Aggression Scale (Alderman et al., 1997)²⁵).

3.5.2 Current research suggests that interventions based on psychological principles derived from learning theory are the most effective in reducing the incidence of challenging behaviour (for example, Scott et al., 1991)²⁶. These interventions require consideration of the person (all aspects of that individual including developmental, social and personal history, abilities, physical and psychological characteristics), the environment of that person (the physical environment and the social milieu including relationships, opportunity for activity and inclusion as well as the neighbourhood and wider social context) and the behaviour of that person (which needs to be understood and defined precisely). The focus is placed upon the *function* that behaviour serves. That is, there is an acceptance that the challenging behaviour exists for a reason, even though there may also be negative consequences of the behaviour for the person and those around him. It is essential that a thorough psychological assessment establishes the function of challenging behaviour in order to determine the correct basis for intervention. This is best achieved by a systematic *functional analysis* which examines the challenging behaviour, the antecedents which may be acting as stimuli for the behaviour

and the consequences which may be reinforcing it. Such functional analysis should ultimately lead to the development of a *formulation* which includes an understanding of the onset and reasons for the development of the behaviour, should identify personal, environmental and interpersonal factors which have increased or maintained the behaviour and, most importantly, should present a hypothesis as to the function the behaviour serves which can be tested out. The actual *intervention* must prescribe, in detail, both proactive strategies that try to prevent the challenging behaviour occurring (for example, changing the nature of preceding activities) and reactive strategies that guide the response to episodes of challenging behaviour (for example, how staff should react to assault). Crucially, these strategies must be applied consistently in response to all episodes of challenging behaviour and by all people dealing with the person and their behaviour. Staff and carers must therefore be familiar with, and confident in the use of, the prescribed strategies and interventions. Finally, the *effectiveness* of an intervention must be considered systematically and the hypothesis, formulation and intervention revised if need be. No intervention for challenging behaviour should be abusive or applied punitively.

3.5.3 There are two main advantages in placing a focus on *challenging behaviour*. Firstly, it is not dependent on the existence of, or accuracy of, a “diagnosis.” Whilst diagnosis is a factor that would be considered within person, environment and behaviour, it does not, in itself, guide the assessment and intervention strategies used. Secondly, the term *challenging behaviour* is seen to provide a reminder that problematic or socially unacceptable behaviour should be seen as a challenge to services rather than necessarily a manifestation of psychopathological processes within the individual (Felce & Emerson, 1996)²⁷.

3.5.4 Mr G presented with significant challenging behaviours. However, these were never properly classified within a challenging behaviour framework and, as a result, there was no definition of what these behaviours were, no systematic recording of their occurrence and no functional analysis of them. Instead, four assumptions were made at an early stage in his care and treatment:

- Mr G was *choosing* to behaving in inappropriate ways.
- Mr G was choosing to behave in inappropriate ways in order to gain “attention” (that is, that the function served by the behaviour was to secure interactions with other people).
- Mr G could choose to behave appropriately if he so wished.
- The responsibility for behaviour change lay with Mr G.

3.5.5 These assumptions appear largely to have arisen as a result of the diagnosis of personality disorder. The interventions driven by these assumptions ranged from attempts to provide a “blanket of support” in order that Mr G had all the attention he could possibly need at one extreme, through to the punishment of the behaviour by confining him to the ward, discharging him from the hospital environment and by having him arrested and charged for his behaviour at the other.

3.5.6 We found two attempts at adopting a behavioural management approach with Mr G. The first of these was made by a member of social work staff when Mr G was living in homeless accommodation in Local Authority area B. This member of staff never met Mr G, made no personal assessment of his behaviour and environment and did not meet with the care staff trying to manage him. Rather, a set of guidelines as to how to respond to inappropriate behaviour were drawn up on the basis of descriptions of behaviour provided by CJSW1 and CCSW2 and these simply passed to care staff to implement. The guidelines were never used

3.5.7 The second attempt was more systematic and made by Dr5 during an in-patient admission in 2004. Although still largely based on assumptions 1-3 above and lacking a rigorous functional analysis, Dr5 provided ward staff with written guidance as to how to respond to (that is, reactive strategies for) episodes of challenging behaviour. Staff appear to have been able to consistently follow this guidance. Dr5 reported that this appeared to result in a decrease in the frequency of challenging behaviour. In giving evidence, Dr5 stated that he did not consider himself to have the expertise to implement a

more comprehensive behavioural management plan, which he viewed as falling within the remit of a clinical psychologist, but that psychological services were extremely limited and unable to respond quickly.

3.5.8 A matter which requires special note is that NH1 has provided care for residents with challenging behaviour, often providing placement for people who have been considered too problematic for placement elsewhere. NH1 was used for Mr G for this reason. Mr G's care plan did not include the use of behavioural management principles for managing challenging behaviour. NH1 conceded that it does not have staff that are trained in the use of behavioural management principles beyond that offered as part of original RMN training. Staff closely involved with Mr G gave evidence that they did not consider themselves to have the expertise for such an approach.

3.5.9 We consider it likely that Mr G's challenging behaviour would have responded to intervention based on psychological principles derived from learning theory. A functional analysis of his behaviour may also have elucidated patterns to his behaviour which pointed to an organic aetiology. No person who gave evidence to the investigation considered themselves to have the necessary expertise in learning theory or in using this to deal with challenging behaviour in the ways outlined above. On at least three occasions referral to a clinical psychologist was requested by members of the multi-disciplinary care-team but this was refused by Dr1. Attempts were made to circumvent this by obtaining an assessment through the Courts but this failed as no suitable person could be identified. Other Consultants considered that clinical psychology intervention may have been useful but did not have this resource readily available and/or able to respond quickly during a period of in-patient assessment.

Findings on the Management of Challenging Behaviour

- 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 but when a strategy for this was attempted, 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 also the private care home.
- Expert psychology intervention and advice 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 him 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.

Section 4. Recommendations

We have summarised all our recommendations in this section. We believe that implementing these recommendations would significantly reduce the chances of others suffering the same deficiency of care. 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*¹⁰ 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 properly addressing 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 2007²⁰.

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 Guidance⁴ and use the agreed processes in the case of dispute.

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 Executive Care Management Guidance CCD8/2004²¹, must also address contingency planning and ensure that this is shared with the “Local Authority of the moment.”

Recommendations for NHS Quality Improvement Scotland

Recommendation 12

NHS QIS¹⁸ 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 NHS QIS¹⁸ 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 Residence⁴, 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 Network¹⁹ 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.

Appendix I

Clinical diagnostic features of fronto-temporal Dementia (from SIGN guideline 86)

Core diagnostics include:

1. *Behavioural disorder*

- insidious onset and slow progression
- early loss of personal awareness (neglect of personal hygiene and grooming)
- early loss of social awareness (lack of social tact, misdemeanours such as shop lifting)
- early signs of disinhibition (such as unrestrained sexuality, violent behaviour),
- inappropriate jocularity, restless pacing
- mental rigidity and inflexibility
- hyperorality (oral/dietary changes, food fads, excessive smoking and alcohol)
- consumption, oral exploration of objects
- stereotyped and perseverative behaviour (wandering, mannerisms such as clapping),
- singing, dancing, ritualistic preoccupations such as hoarding, toileting and dressing
- utilisation behaviour (unrestrained exploration of objects in the environment)
- distractibility, impulsivity and impersistence
- early loss of insight into the fact that the altered condition is due to a pathological change of own mental state.

2. *Affective Symptoms*

- depression, anxiety, excessive sentimentality, suicidal and fixed ideation, delusion
- hypochondriasis, bizarre somatic preoccupation

- emotional unconcern (emotional indifference and remoteness, lack of empathy and sympathy, apathy)
- amimia (inertia, aspontaneity).

3. *Speech Disorder*

- progressive reduction of speech (aspontaneity and economy of utterance)
- stereotypy of speech (repetition of limited repertoire of words, phrases or themes)
- echolalia and perseveration
- late mutism.

4. *Spatial orientation and praxis preserved* (intact abilities to negotiate the environment)

5. *Physical Signs*

- early primitive reflexes
- early incontinence
- late akinesia, rigidity, tremor
- low and labile blood pressure.

6. *Investigation*

- normal EEG despite clinically evident dementia
- brain imaging (structural or functional, or both) predominant frontal or anterior temporal abnormality or both
- neuropsychology (profound failure on frontal lobe tests in the absence of severe amnesia, aphasia or perceptual spatial disorder).

Supportive diagnostic features include:

1. onset before 65
2. positive family history of similar disorder in a first degree relative
3. bulbar palsy, muscular weakness and wasting, fasciculations (motor neuron disease).

Diagnostic exclusion features include:

1. abrupt onset with ictal events
2. head trauma related to onset
3. early severe amnesia
4. early spatial disorientation, lost in surroundings, defective localization of objects
5. early severe apraxia
6. logoclonic speech with rapid loss of train of thought
7. myclonus
8. cortical bulbar and spinal deficits
9. cerebellar ataxia
10. choreo-athetosis
11. early, severe, pathological EEG
12. brain imaging (predominant post-central structural or functional deficit, multifocal cerebral lesions on CT or MRI)
13. laboratory tests indicating brain involvement or inflammatory disorder (such as multiple sclerosis, syphilis, AIDS and herpes simplex encephalitis).

Relative diagnostic exclusion features include:

1. typical history of chronic alcoholism
2. sustained hypertension
3. history of vascular disease (such as angina, claudication).

Appendix II

Ordinary residence guidance

This was the guidance in existence when Mr G was moved to nursing home accommodation.



SWSG Guidance Package, Index Ref: F1

Chief Executives of Regional and Islands Councils Desk Officer 5389

Chief Executive of Unitary Authorities

Copy to: Directors of Social Work of Regional and Islands Councils

Chief Social Work Officers/Directors of Social Work of

Unitary Authorities

Chief Executives of NHS Trusts

General Managers, Health Boards

General Manager, Common Services Agency

General Manager, State Hospital

Directors of Housing

Chief Executive, Scottish Homes

Appropriate Professional and Voluntary Bodies

Association of Directors of Social Work

Convention of Scottish Local Authorities

6 February 1996

Dear Colleague

Ordinary Residence

Summary

1. This circular contains guidance on the identification of the ordinary residence of people who require social work services. The guidance is applicable not only to Local Authorities' responsibilities for residential and nursing home care but also for other types of care. Section 86(1) of the Social Work

(Scotland) Act 1968 sets out statutory functions with regard to the full range of accommodation, services and facilities which Local Authorities have a duty to provide for people "ordinarily resident" in their areas.

2. The purpose of the circular is to clarify, where responsibility lies between social work authorities and reduce the scope for disputes, benefiting both Local Authorities and service users. The principles set out in this circular are consistent with guidance previously issued by the Department of Health to Local Authorities in England and Wales (LAC(93)7). This consistency should assist the resolution of disputes between Local Authorities in Scotland, England and Wales.

3. Where disputes do occur, authorities should note that the provision of services for individuals requiring social work services should not be delayed because of the uncertainty about which authority is responsible, and that when an individual does not appear to have any

settled residence, it is the responsibility of the authority where the person is living at that time to arrange any care required to meet his needs. The circular sets out the procedure for referring to the Secretary of State for determination any disputes that cannot be resolved between the Local Authorities concerned. Nothing in the guidance affects the discretion of the Secretary of State in giving a determination.

Background

4. Section 86(1) of the 1968 Act makes reference to "ordinary residence" with regard to the statutory provisions conferring functions on a Local Authority in relation to the provision of social work services, including accommodation, services and facilities. The provisions are set out below:

a. Authorities have a duty to provide accommodation under section 12 of the 1968 Act, read with section 59, and under section 13A with regard to residential accommodation with nursing.

b. Authorities have a duty to provide services and facilities under Part II of the Act, under sections 12 and 14.

c. Under section 44 and subsection (5) authorities are responsible for giving effect to a supervision requirement made by a children's hearing.

d. Authorities have a duty to provide accommodation, services and facilities for persons under sections 7 and 8 of the Mental Health Act 1984.

Meaning of "Ordinarily Resident"

5. There is no definition of "ordinarily resident" in the Acts and the term should be given its ordinary and natural meaning subject to any interpretation by the Courts. The concept of ordinary residence involves questions of fact and degree, and factors such as time, intention and continuity, each of which may be given different weight according to the context, have to be taken into account.

Case Law

6. The meaning of "ordinarily resident" or "ordinary residence" has been considered by the Courts, and regard must be had to such cases as:-

i. Shah v London Borough of Barnet (1983) Lord Scarman stated that "unless it can be shown that the statutory framework or the legal context in which the words are used requires a different meaning I unhesitatingly subscribe to the view that 'ordinarily resident' refers to a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration".

ii Levene v IRC (1928) Viscount Cave said that "ordinary residence" connotes residence in a place

with some degree of continuity and apart from accidental or temporary absences.

7. In general, an adult with learning disabilities should be regarded as capable of forming his own intention of where he wishes to live. The case of *Regina v Waltham Forest London Borough Council, ex parte Vale* (1985) should be noted. In this case it was held that a person with severe learning disabilities who was totally dependent on his parents was to be treated as ordinarily resident at his parents' address since he was in the same position as a small child who is unable to choose where to live. This case will need to be considered if there is an ordinary residence dispute involving people with severe learning disabilities but its relevance will vary in accordance with the ability of the person with learning disabilities to make choices and the extent to which he relies upon his parents. In some cases some other person(s), or body, may be acting in place of their parents. In a decision of the High Court in December 1992 *London Borough of Redbridge ex parte East Sussex County Council*, the principles outlined in *Vale* were applied where the parents of young adult twins with learning disabilities who had been ordinarily resident in Redbridge left this country to live in Nigeria. Soon after the parents departure the residential school in East Sussex attended by the twins closed. At this point the twins were held by the court to have no settled residence. As they were in the area of East Sussex it was held that no duty to provide for them fell on Redbridge as they were not ordinarily resident there, but that there was a duty to make provision under the relevant legislation on East Sussex as they were in that county and had no settled residence.

Determination by the Secretary of State

8. Section 86(2) of the Social Work (Scotland) Act 1968 gives the Secretary of State the responsibility to determine disputes about ordinary residence where such disputes arise between Local Authorities and the authorities concerned cannot resolve the issue themselves. A determination by the Secretary of State should only be sought as a last resort and Local Authorities are expected normally to resolve disputes themselves. Authorities seeking a determination from the Secretary of State must indicate why the dispute cannot be resolved in terms of this guidance. (See paragraphs 26-32).

GENERAL GUIDANCE ABOUT PROCEDURES

Responsibility for Assessment

9. Local Authorities have a duty under Section 12A of the 1968 Act to undertake a care assessment where it appears to the authority that any person for whom they may provide or arrange community care services may be in need of services. However authorities also have a duty under Section 4(a) of the Disabled Persons (Services, Consultation and Representations) Act 1986 to decide on request whether the needs of a disabled person call for the provision of welfare services under Section 29 of the Chronically Sick and Disabled Persons Act 1970 which is taken as provision under section 12 of the 1968 Act. Authorities should be sensitive to the preferred choice of services by people so assessed and should be aware of their duty to comply with the guidance contained in Scottish Office Circular SW05/93 and the Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993. Identification of an individual's ordinary residence should not restrict his right to be accommodated or receive services in another area.

10. While a person may be "ordinarily resident" in the area of another Local Authority it is the responsibility of the Local Authority of the moment to make a care assessment if it appears to the authority that he may be in need of services. For example an urgent need might arise in the case of someone ordinarily resident elsewhere who is visiting or on holiday. The Local Authority where the person is ordinarily resident can arrange for the assessment and the provision of services to be carried out on its behalf by the Local Authority of the moment. A person who arrives in a Local Authority's area from abroad (including for example a person returning to this country after a period when he has been resident abroad and who had given up his previous home here) who appears to the authority to be in need of social work assistance may be ordinarily resident in the area of another authority. If the person is not ordinarily resident in any other authority then it is the Local Authority of the moment that should carry out the care assessment. If there is a dispute about the ordinary residence of a person in need of services it should be debated after the care assessment and any provision of service. The undertaking of an assessment and the provision of services by an authority under such circumstances should not be taken to imply acceptance of the individual's ordinary

residence in that area.

People Who Are Placed in Accommodation in the Area of Another Local Authority

11. Where, following an assessment, a Local Authority arranges a placement in a private or voluntary home in another authority's area or in a home provided by another Local Authority the placing authority will normally retain for that person the same responsibility that it has for someone living in its own area. The person so placed will not as a general rule become ordinarily resident in the other Local Authority's area. If the person subsequently moves, without Local Authority involvement, he will usually become ordinarily resident in the area of the Local Authority where he has chosen to live.

12. A Local Authority should not place a person for whom they are financially responsible in accommodation provided by a private proprietor or a voluntary organisation in the area of another authority without informing the other authority. Where the person is being placed on a permanent basis and has an assessed health need, community health services in the area should be informed. The placing authority should also ensure that satisfactory arrangements are made before placement for any necessary support services, such as day care, and for periodic reviews, and that there are clear agreements about the financing for all aspects of the individual's care. The Local Authority responsible for the placement may negotiate for these services to be provided by the host authority and reimburse the costs. It is for the placing authority to determine, with reference to Government guidance, the level of charges, if any, which the service user will pay. Except in an emergency situation, no host Local Authority should alter the accommodation or services provided for that person to a significant degree without consulting in advance the responsible Local Authority. It is recognised that there will be some circumstances where an urgent placement is necessary, and prior consultation will not be possible. In such cases the necessary consultation should take place immediately after the placement has been made.

13. Good record keeping will be essential, including recording oral agreements and confirming these with written agreements. When a care manager has been appointed he should usually be the main link between the responsible and host authorities. All changes should be confirmed and recorded in writing at the regular review of each individual's needs.

People who Move to Residential Accommodation of their own Volition

14. When an individual arranges to go into permanent residential or nursing home care in a new area, without any Local Authority having taken responsibility for the arrangements, he becomes ordinarily resident in the new area. If subsequently social work help is sought the person will look to the authority where the residential accommodation is situated. The Local Authority in the original area may become aware of the arrangements the individual is making and, with the permission of the person concerned, they may inform the Local Authority for the new area, particularly if it seems possible that social work help may later be required.

People Whose Accommodation is Partly Financed by a Health Board or NHS Trust

15. Purchasers of NHS health care might negotiate with Local Authorities to provide finance in respect of a person moving from long-stay hospitals to care accommodation including supported accommodation, in the community (see Scottish Office Circular - "Community Care: Joint Purchasing, Resource Transfer and Contracting: Arrangements for Inter-Agency Working" (NHS MEL(1992)55)). This might take the form of joint financial arrangements between the health board and the Local Authority (the Local Authority of ordinary residence and/or the Local Authority where the individual is to be settled). Funding may be provided to a particular Local Authority for a number of individuals regardless of their original 'ordinary residence'. In entering into such agreements Local Authorities must be clear about the responsibilities they entail. Such agreements should always be recorded clearly in writing. They should include a statement recording the ordinary residence of each individual concerned so that the question of future financial responsibility is addressed.

Discharge from Hospital, Nursing Homes, Prison and other Similar Establishments

16. Patients in an NHS hospital or NHS trust hospital could be deemed to be ordinarily resident in the area in which they were ordinarily resident before being admitted to hospital. If they were not ordinarily resident in any area prior to their admission, then the Local Authority of the moment would have responsibility. Local Authorities should apply this approach reasonably when considering responsibility for people leaving prisons, resettlement units and other similar establishments without a permanent place to live who will require social work involvement at the time of their discharge. No case law exists however, and any dispute must be resolved in the light of the specific circumstances.

People with 'Preserved Rights'

17. A person who, without the involvement of a social work department, has become a permanent resident in an independent nursing home or residential care home, meeting the costs from private resources (including any Income Support entitlement), is regarded as ordinarily resident in the area where the establishment is located. However, the extent to which social work help, in the form of residential accommodation, may be made available to such a resident who has preserved rights to the higher levels of Income Support will be affected by the limitations and exemptions set out in Scottish Office Circular SW11/1993.

Homelessness Legislation

18. The test of "ordinary residence" is not the same as that of "local connection" used in the homelessness legislation for establishing which housing authority has the responsibility for securing accommodation for unintentionally homeless applicants in priority need. For a person in urgent need, the social work department of the moment cannot argue that the possible existence of a "local connection" elsewhere excuses it from the duty to assess and provide any necessary social work services; decisions on where the responsibility for the funding of such services rests, based on ordinary residence, should be decided subsequently. Rules for determining responsibility under Housing Acts should not be used to identify ordinary residence for social work purposes. Any outstanding ordinary residence questions should be clearly recorded in social work records at the time they arise. Failure to do this may prejudice subsequent consideration.

19. "Local connection" for housing purposes (defined in section 27 of the Housing (Scotland) Act 1987, and discussed further in the Homelessness Code of Guidance) may be established by present or past settled residence in an area, by employment in that area, by family connections, or other special circumstances. Where the test of "local connection" results in the transfer of responsibility for securing accommodation to another housing authority, the social work department will wish to consider where "ordinary residence" then rests. The homelessness legislation provides that, where a person has no local connection, the duties to provide accommodation rest with the housing authority to whom he first applies. Even if a housing authority suspects that a person may have a local connection elsewhere, this does not absolve it from an initial duty to provide temporary accommodation if the immediate circumstances require it, pending the transfer of responsibility to another housing authority. Any dispute between authorities will be determined by agreement between them according to the procedures adopted by COSLA. Copies of the "Agreement on Procedures for Referrals of the Homeless" are available from the Convention of Scottish Local Authorities, Rosebery House, 9 Haymarket Terrace, Edinburgh, EH12 5XZ (Telephone: 0131 346 1222).

Responsible Health Board for People Needing Health Care

20. The responsible health authority is the one where a person is usually resident. The NHS Scotland - the Function of Health Boards (Scotland) Order 1991, sets out the means by which a patient's area of residence should be determined. For the majority of cases the arbiter of the patient's residence is the patient himself. If there is any doubt about where a person is usually resident, he is to be treated as usually resident at the address which he gives as being where he usually resides. If the patient is unable to give an address at which he considers himself resident, then the address at which he was last resident will establish the district of residence. In the very small number of cases where the position is still not clear, the Regulations provide that the patient should be treated as usually resident in the health district in which he is present, which means where he is found to be in need of treatment by the provider. It follows from this that in the majority of cases the area of ordinary residence for social services care and the area where a person needing health care is usually resident will be the

same.

Identifying Health Board Responsible for Providing Health Services to Residents in Homes

21. In organising a placement in a residential care or nursing home, Local Authorities, Health Boards and NHS Trusts should liaise in securing the provision of community services. This liaison should involve the health authority of usual residence. A Local Authority may place someone in a residential care or nursing home outside the health board of usual residence. If the move to the residential care or nursing home is permanent, then the health board for the residential care or nursing home would become the health authority of usual residence for the residents of the home, and responsible for providing the appropriate health services for the residents, ie the Local Authority should liaise with the "new" health board. If people are placed in a home for a temporary period, they remain usually resident in their own health authority. NHS Circulars Numbers 1989(GEN) 39 and SHHD/DGM(1991)(67) provide guidance to Health Boards about the entitlement of patients in private nursing homes to NHS supplies and services.

Young Adults

22. In the case of young people who cease to be cared for under the Social Work (Scotland) Act 1968 and sections 7 and 8 of the Mental Health (Scotland) Act 1984 on reaching the age of 18 years, authorities should agree where responsibility for the future delivery of services might most appropriately lie. Section 24 of the 1968 Act refers to Local Authorities' powers with regard to young people who are under 21 years old who have, at any time since ceasing to be of school age, been in the care of a Local Authority. Where such a young person is engaged in education, training, employment or the search for employment in an area Section 24 provides for any Local Authority to contribute towards the costs of the young person's accommodation and maintenance in that area.

In considering a person's place of ordinary residence, Section 86(3) of the 1968 Act provides that any period in which a child lives in any place -

- a. where he was a patient in a hospital (including NHS Trusts);
- b. where he was an inmate of a school or other institution;
- c. in accordance with the requirements of a supervision order or probation order or the condition of a recognisance or while boarded out under the 1968 Act or the Child Care Act 1980 or the Children and Young Persons (Scotland) Act 1937 by a Local Authority or education authority.

shall be disregarded in determining the "ordinary residence" of the child.

Aftercare Under The Mental Health (Scotland) Act 1984

23. Section 8 of the Mental Health (Scotland) Act 1984 places a duty on Local Authorities to co-operate with health boards and the independent care sector to provide aftercare for people who are or have been suffering mental disorder.

24. From 1 April 1992 health boards were required to initiate, in collaboration with local social work departments, explicit individually tailored care programmes for all in-patients about to be discharged from mental illness hospitals and all new patients accepted by the specialist psychiatric services. The care programme approach follows good professional practice. The essence of the approach is that the needs of each patient, both for continuing health and social care and for accommodation, are systematically assessed and that the appropriate arrangements are made. These include the appointment of a key worker to keep in close touch with the patient and to monitor that the agreed health and social care is given.

25. The Secretary of State's powers to determine disputes under Section 86(2) of the 1968 Act do not extend to any disputes regarding residence which may arise under the Mental Health (Scotland) Act

1984. However, Scottish Office Circular SOHHD DGM1992/9 (SW/1992/1) gives guidance on some of the key issues to be addressed in implementing the care programme approach.

DETERMINATION OF DISPUTES BY SECRETARY OF STATE

26. Section 86(2) of the Social Work (Scotland) Act 1968 provides that any question arising as to the ordinary residence of a person shall be determined by the Secretary of State. This relates to the provision by a Local Authority of accommodation, services, facilities and other matters to a person ordinarily resident in the area of another Local Authority, as described in section 86(1) of the Act. Section 97(1) of the 1968 Act extends the provision of section 86(1), providing for the Secretary of State to determine disputes between Scottish Local Authorities and those in England and Wales. Separate guidance has been issued to Local Authorities in England and Wales by the Department of Health (LAC(93)7).

27. Nothing contained in this guidance is to be taken to affect the discretion of the Secretary of State in giving a determination. Each case has to be considered in the light of its own facts. The Secretary of State's decision is final subject only to judicial review.

Procedures prior to seeking a Determination

28. Where disputes arise regarding the ordinary residence of individuals who may require social work services the Local Authority of the moment should accept interim responsibility.

29. The procedures set out below should be followed with a view to reaching agreement without reference of the case for determination by the Secretary of State:

(i) Operational management of the authorities involved should make every effort to reach agreement in accordance with the principles set out in this guidance.

(ii) If agreement is not reached at operational level, legal advice should be sought and senior management in the relevant authorities should seek to agree responsibility.

(iii) If agreement is still not reached, all relevant papers, including legal advice, should be referred to the Directors of Social Work or Chief Social Work Officers of the authorities involved to seek agreement.

Efforts should be made to resolve disputes as quickly as possible and unnecessary delays should be avoided in each of the stages set out above. Only once these procedures have been exhausted should a determination be sought from the Secretary of State.

Procedures for seeking a Determination

30. An agreed written statement of facts, signed by all the authorities involved, must be sent, together with the application for a determination. This agreed statement should be as detailed as possible, including (i) full information about the person to whom the services have been supplied; (ii) details relating to the prior residence of the person to whom services are provided; (iii) details of the statutory provisions under which services have been provided. Copies of all relevant correspondence between the authorities concerned should be annexed to the agreed statement and should clearly identify when the existence of a dispute was identified by the Local Authorities involved and the time taken to complete each of the stages set out in paragraph 29.

31. Each Local Authority may additionally provide separate written representations concerning the agreed statement, including for example a legal submission.

32. The agreed statement of facts, with any annexed documentation, and separate written representations should be sent to Social Work Services Group Division 2.

ENQUIRIES

33. All enquiries about this guidance should be directed to Mr Neil Rennick, Room 48C James Craig Walk, Edinburgh, (Tel: 0131 244 5389).

Yours sincerely

GAVIN ANDERSON

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People interviewed by Inquiry Team

Dr1

CCSW1

CMHN1

CJSW2 & immediate line manager

CCSW2

Dr5

Dr6

Dr8

The manager & charge nurse of NH1

Service Manager, Assessment and Care Management in Local Authority A

Head of Community Care Services in Local Authority A

Head of Criminal Justice and Children and Families Services in Local Authority A

The Associate Medical Director of Health Board C

Head of housing services in Local Authority A

Staff nurse from health care centre in HMPA

By telephone

SPR1

Dr4

The charge nurse of Mr G's ward in Hospital 5C

Social work team leader, State Hospital

By group interview

Six people from various homeless agencies

HMPB Health Care Staff