mental welfare commission for scotland

INVESTIGATION

dignity & rights ethical treatment respect care & equality

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Introduction

This investigation was conducted under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Section 11 gives the Mental Welfare Commission for Scotland (the Commission) the authority to carry out investigations and make related recommendations as it considers appropriate in a number of circumstances. Among these circumstances are those set out in sections 11(2)(d).

Section 11(2)(d) relates to circumstances where an individual with mental disorder may be, or may have been, subject, or exposed, to:

(i) Ill-treatment;

(ii) Neglect; or

(iii) Some other deficiency in care or treatment.

How we heard of Mrs CD

We first became concerned about Mrs CD when we received a telephone call from a clinical nurse manager at prison 1 in February 2010. Mrs CD had been remanded to prison because she breached bail conditions following previous charges of breach of the peace. The nurse manager described a woman in her sixties with a history of mental health contact and no previous criminal record. She was very concerned about her health. Mrs CD appeared very depressed and withdrawn, and the prison healthcare staff thought that she ought to be in hospital. They were concerned that she had been remanded to prison.

We expressed concern and contacted the visiting psychiatrist before and after his examination. He also told us that he found her profoundly depressed and that he would be recommending remand to hospital. He discussed her case with psychiatrists in hospital 1, where Mrs CD was well known. Within five days, she was admitted there under an assessment order (section 52D of the Criminal Procedure (Scotland) Act 1995).

We had further concerns when we heard that police were frequently involved after her transfer to hospital. We heard that Mrs CD had assaulted staff and, on occasions, other patients in the hospital. We visited her on several occasions and gave advice to staff. We found that she had significant contact with mental health services over an 18 month period before her imprisonment. We were concerned that her remand to prison followed a decision to withdraw some of the services she had been receiving. The consultant psychiatrist who knew her best had not recommended remand to hospital after her arrest.

We decided to conduct an investigation:

- To document the care and treatment of Mrs CD, paying particular attention to the period from July 2008 to her imprisonment in January 2010 and her subsequent care in hospital;

- To examine her care and treatment up to January 2010 and the reasons for her remand to prison;
- To examine her subsequent care in hospital, with particular regard to ongoing involvement of criminal justice;
- To make recommendations for improvements to services and practices.

The investigating team consisted of
Mrs Margaret Christie, Social Work Officer
Mrs Mary Hattie, Nursing Officer
Dr Donald Lyons, Chief Executive.

We conducted a full review of all relevant case records from NHS Board 1, local authority 1 and Constabulary 1. We then interviewed key practitioners individually or in groups. These included staff from hospital and community multidisciplinary teams, medical practitioners and Mrs CD's husband. We have met Mrs CD on several occasions but she declined to be involved in the production of this report and we consider that she lacks the capacity to do so at the time of writing.

Background

Mrs CD was the younger of two children. Her father was from a high achieving family background but suffered from stress/depression. Other relatives paid for Mrs CD to attend a private school where she felt she did not fit in because she was not as academic as her peers. She left school with one higher qualification. She worked successfully in secretarial posts.

She married twice. Her first husband was violent towards her. Her second husband told us that she was aggressive at times towards him. She had conflicts with some neighbours but got on well with other neighbours and friends.

Mrs CD's father had a history of depression and her older brother took his own life by drowning in 2006, but there are no records pertaining to his mental health. There is also a suggestion that a cousin may have suffered from bipolar disorder.

Mrs CD suffered from post-natal depression in 1980 at the age of 34 following the birth of her only daughter. Her husband's account was that she was clearly unwell, significantly depressed and was admitted to hospital. She had ECT then and responded well. She may never have made a full recovery from this episode and has been on medication for depression for most of the time since then.

BRIEF CHRONOLOGY OF EVENTS

Between 1995 and 2002, Mrs CD and her family had contact with adult mental health services, child and adolescent services and social work services. There was disharmony within the family and Mrs CD was violent towards her husband at times. This became so severe that he considered leaving the home. Psychiatrists considered that her behaviour was not related to mental illness. Mrs CD rejected marriage guidance, but the situation improved after 2002 and there were no further problems until 2008. She had no contact with mental health services during this time but continued to be seen and treated for depression by her GP.

In July 2008, Mrs CD was admitted to hospital when she took an overdose. She said that she had been on antidepressants for about 20 years. She complained that her agitation and anxiety had been worsening and that she had been experiencing low mood, irritability, loss of appetite and disturbed sleep with early morning wakening and poor concentration. She reported feeling unable to cope with troubles with her neighbours, many of whom shunned her as a result of previous disputes, and experiencing feelings of worthlessness, which culminated in her taking an overdose with the intention of ending her life. She had increased her antidepressant (imipramine) for a couple of weeks, which she felt usually helped, but on this occasion it did not, and she had been planning her suicide attempt for four weeks. Having been unsuccessful in this suicide attempt she now felt relieved and said she would like help.

Since then, she consistently complained of sleep and appetite disturbance and expressed suicidal ideation and feelings of worthlessness and anger, often related to her poor relationships with her family, and lack of friends and support network. She has been in constant contact with mental health services. Suicidal thoughts and self harm were constant features. Violence towards staff and other service users became an increasing problem.

From August 2008 until February 2009, she was supported at home by the community mental health team (CMHT) with admissions to hospital after episodes of self harm, including several overdoses and apparent attempts to drown herself. She always summoned help after taking overdoses. She often threatened to drown herself, resulting in police being called. She did end up in rivers but always got herself out. Community psychiatric nurse (CPN) support, antidepressant medication and electroconvulsive therapy (ECT) produced no lasting benefit. Attempts at social supports also proved unsuccessful because of her difficulty engaging with others. She was under the care of consultant 1 who took the view that there were depressive features, although personality factors were also important.

From March until September 2009, she was treated under mental health legislation. She continued to express distress by threats or acts of self-harm, such as putting plastic bags over her head while in hospital. Despite this, she never inflicted any serious harm on herself. When detention was suspended, she often took overdoses or created disturbances by threatening to harm herself in public. Various antidepressant drugs were tried. She was assessed for psychological treatment and cognitive behaviour therapy (CBT) was started. She started to assault staff on occasion and other service users were distressed by her suicidal talk and some of her behaviour. During this time, her care passed from consultant 1 to consultant 2 when the former left the service.

From September to December 2009, mental health practitioners, notably consultant 2, took the view that Mrs CD's presentation was purely the result of a personality disorder. This was supported by opinions from colleagues (although one previous opinion had supported an additional diagnosis of a depressive illness). Risk of suicide was thought to be high although this would be more likely to be by accident. All attempts were made to keep her out of hospital. Police were often involved when she continued to attempt or threaten self harm in public, e.g. by threatening to jump from a bridge or stepping in front of traffic. She was admitted to hospital for short periods. No specific treatments were being offered and assaults on staff worsened. She grabbed a nurse's scarf and caused significant bruising to the nurse's neck. Police were informed and she was discharged. Her behaviour became increasingly

bizarre, e.g. entering a neighbour's house and hiding under the bed. She was arrested and charged with breach of the peace.

There were two meetings convened under the care programme approach (CPA) and adult protection procedures were invoked. Before the second CPA meeting in December, the consultant and CMHT decided to withdraw the offer of in-patient care and CMHT support, although the consultant would continue to see her. Despite the change in diagnosis, the consultant was still considering ECT as an out-patient. Minutes of the meeting record that the police considered that Mrs CD could be "unnecessarily criminalised". Her husband disagreed with the assertion that hospital treatment had not been of benefit. The consultant advised the husband that he was at risk and should consider moving out of the house.

The specific sequence of events at this time was:

2/11/09. First care programme approach meeting. Outcome was:

- *All need a clear detailed approach to Mrs CD*
- *Consultant 2 to refer to psychology*
- *Social work to pursue 2 weeks respite care*
- *Social work team leader suggested contact Procurator Fiscal (PF) to seek diversion from prosecution. Consultant 2 disagreed, he believes Mrs CD does respond to prospect of prison and is responsible for her actions. We have not been able to find evidence of any approach to the PF*

24/11/09. Detained under a further short-term detention certificate. Behaviour becoming increasingly bizarre, e.g. answering door to police when naked and believing her house was flooded.

8/12/09. Serious assaults on staff. STDC revoked. Charged with assault. Discharged from hospital with clear instructions that she was not to be readmitted without direct consultant involvement. Decision reported to community mental health team meeting on 14/12.

16/12/09. Charged with breach of the peace when she entered a house uninvited, hid under a bed and refused to leave.

17/12/09. Second care programme approach meeting. Consultant 2 stated that diagnosis was of personality disorder and that Mrs CD was responsible for her actions (although he was still considering offering out-patient electroconvulsive therapy). Mrs CD appeared in court and was remanded on bail.
11/1/10. Community mental health team records state that there will be no further CPN involvement and no requirement for a further care programme approach meeting.
12/1/10. Consultant 2 provided a report for the court. Mrs CD had refused to see him when he tried to visit her to prepare the report. Based on previous knowledge, he did not recommend mental health care and treatment.
13/1/10. She failed to attend court and a warrant for arrest was granted. Given the psychiatric opinion, the court appeared to have no option other than to remand her to prison ten days later.

She spent three weeks in prison. She lay naked and confused in her cell. An experienced training grade psychiatrist tried to examine her without success and arranged review by a consultant forensic psychiatrist. She remained distressed, incontinent and was aggressive at times to prison staff. Healthcare staff contacted the Commission. After assessment by a consultant forensic psychiatrist and discussion involving the Commission and the forensic consultant (consultant 3) at her previous hospital, she was readmitted to hospital under an assessment order granted by the court.

Mrs CD has remained in hospital since then and remains detained on a compulsion order. For much of the time, she remained in the intensive psychiatric care unit (IPCU). She spent some time in a rehabilitation ward but the severity of violent episodes resulted in return to the IPCU. In August 2011, she was transferred to a secure mental health unit in another NHS Board area.

Her persisting problems have been:

- Violence. There were numerous assaults on staff. These included unprovoked assaults on domestic staff. The police were often contacted.
- Suicidal thoughts. These were almost constant. She continued to put plastic bags over her head. Even if staff did not intervene, she did not come to serious harm.
- Poor self care. She neglected her hygiene and often refused to eat or drink. She assaulted staff when they tried to offer assistance. This gave staff a dilemma: allow her to neglect herself or risk physical assault and injury?

She did not engage with any attempts to help her address the reasons for her unhappiness and anger. Various combinations of medication and further courses of ECT have not been successful.

ANALYSIS

Throughout all our involvement in Mrs CD's care and treatment, and when we decided to investigate her care, we recognised the difficulties that she presented. These would have challenged any mental health service. We commend the efforts of practitioners to try to provide Mrs CD with care and treatment under very difficult circumstances.

Their efforts proved unsuccessful. In the end, Mrs CD went from having a comfortable life with husband, family and a good home to requiring secure mental health care in her mid-sixties. She had numerous contacts with police and courts when she threatened self harm and assaulted staff and other patients in hospital. We doubt that any intervention would have been successful in altering this course of events.

While her presentation was highly unusual, some of the issues raised by her case were familiar to us. Services can find it difficult to respond to individuals who communicate distress by self-harm or other behaviours that cause alarm, distress or harm to others. This was an unusual case of a person in her 60s with deteriorating ability to function with no clear explanation as to why.

When we first heard of Mrs CD's case, we found it hard to understand why she had been remanded to prison and why there had been so much police involvement. The more we examined her case, the more we understood the reasons for this, although we thought that there may have been opportunities to care for her differently. We wanted to use her case to highlight the difficulty that services have when faced with difficult or complex presentations.

We commend the staff who were trying to care for Mrs CD in very difficult circumstances. She assaulted staff on a regular basis. Some assaults were severe. Others, whilst not as severe, were on domestic staff who would not be expected to attempt to deal with this. Despite this, nursing staff worked hard to provide care for Mrs CD.

There were four areas where we thought that services had significant difficulties when managing Mrs CD. These were:

- Diagnostic uncertainty
- Management of behaviour
- Decisions to withdraw services
- “Zero tolerance” of violence

Diagnostic uncertainty

Mrs CD presented a difficult diagnostic problem. This was a significant factor in her overall treatment. From reading her case records and hearing from practitioners, we think there was uncertainty over her diagnosis. At the time of writing, there still is.

Mrs CD had factors in her upbringing and early life that affected her personality development. The diagnosis of “borderline personality disorder” was used by some staff when she started to harm herself in her 60s. We do not think this was a safe diagnosis to make, although we are in no doubt that personality factors were important in her presentation.

It is important to stress that Mrs CD had not behaved in this way all her life. She was not constantly violent to her husband, but could become violent at times of low mood and distress. Also, her presentation in 2008 was two years after her husband retired. Many practitioners drew a direct link between these events, but this seems less likely given the husband’s account to us.

For at least some of this period of care, features of major depression appeared to be present and she was receiving biological treatments for depression for most of this time, and indeed for many years before this. There was a family history of mood disorder. In our view, there was evidence of significant depression, perhaps related to the lack of full recovery from an episode of postnatal depression. The way this manifested was affected by personality factors. Also, it is possible that chronic or recurrent depression led to permanent changes in personality. We do not think there

was clarity over this, nor was there a shared understanding among staff of the interaction between the two.

The possibility that Mrs CD may be developing some form of dementia has been properly considered but appears unlikely. All reasonable steps were undertaken to attempt to investigate this further.

The lack of clarity on diagnosis was a problem. Practitioners had to live with this uncertainty and adopt a pragmatic approach to treatment. This required good communication and adherence to an overall care plan, which includes responses to be taken in crisis situations when key aspects of care plan fail or prove insufficient. In subsequent sections, we address these issues further.

Management of behaviour

Probably the most striking feature of Mrs CD's case was that, despite efforts to provide care and treatment, her behaviour became more problematic. She presented an increasing risk to her own health, safety and welfare, and to the safety of others. We analysed the reasons for this.

Mrs CD was a very difficult individual to help. While the diagnosis was uncertain, the combination of anger, despair, suicidal ideas, self harm (probably without clear suicidal intent but more to convey distress) and assaults on staff made her care very difficult. Also, she did not engage with the therapeutic approaches on offer and showed little desire to work on the difficulties she was presenting.

While Mrs CD was being treated by the CMHT, practitioners admitted that they responded to crisis situations. They had tried to help her address her problems but this approach failed due to Mrs CD's lack of ability to engage. This made care planning very difficult, but we thought that the CMHT could have done more to devise a more proactive care plan to anticipate her many crisis presentations by having a care plan for anticipating and responding to distress and self-harm.

The only psychological approach on offer was cognitive behaviour therapy. It was evident that Mrs CD could not use nor benefit from this treatment. No other approach was on offer. The availability of practitioners with expertise in a range of psychological therapies was poor. Recent visits to individuals receiving care and treatment in this NHS Board area have shown that this has improved.

There was poor communication among teams, notably between the hospital and community team and between the CBT therapist and the rest of the service. While CPA was used, it did not lead to the greater coordination of care that it was designed to achieve.

Mrs CD was eventually transferred to a secure mental health facility in a different area. There was no appropriate facility to continue to provide her care within NHS Board 1.

Decisions to withdraw services

This part of our report refers specifically to the decision to withdraw care and treatment services in December 2009. By this time, she was expressing her unhappiness, anger and distress by repeated acts and threats of self-harm and episodes of violent behaviour. Response to physical treatment was poor and she did not engage with attempts at psychological therapy and support.

The lack of therapeutic options available to both the inpatient and community teams treating Mrs CD, and her failure to engage with the services which were available, were significant contributing factors to the decision by Consultant 2 that Mrs CD would no longer be admitted to hospital and would not be supported by the CMHT.

The team felt powerless in the face of Mrs CD’s inability to accept any responsibility for her actions and her refusal to work with staff who were trying to support her in changing her behaviour. These feelings of failure and helplessness, combined with the impact of her assaults on staff appear to have driven the decision to withdraw services and effectively abandon her to her fate.

The care programme approach (CPA) is a mechanism for managing complex cases such as Mrs CD's. It is designed to ensure a co-ordinated approach involving all the partner agencies in multidisciplinary decision making. It is our view that in this instance this did not happen, a unilateral decision was made to withdraw access to mental health services and CPA was used as a means of informing other agencies of this decision and passing responsibility for managing Mrs CD's behaviours over to criminal justice.

Decisions appeared to be made on the basis that mental health services had been unsuccessful in their attempts to help Mrs CD. It seemed a sudden change of approach, based on a previously documented decision by Consultant 2. Subsequent discussions at CPA meetings showed that not all agencies agreed with this approach.

Consultant 2 obtained opinions from others and had taken this decision to the multidisciplinary team meeting. We agree with him that a better action at that point would have been to pass her care to a colleague. Also, we found that multidisciplinary considerations of the initial decision to withdraw treatment were kept separately from Mrs CD's case record. This is not good practice.

We accept that she was difficult to help and that mental health services had proved ineffective. Withdrawal of service in this way left her to the criminal justice system. There was no agreed may of diverting her from prosecution. Other mental health services may well have done the same, but we consider that this was an inappropriate response to the difficulties she presented. We also accept Consultant 2's views that service provision, as presently constructed, did not offer a solution. Effectively, we believe that the outcome was that she was punished for this by imprisonment. We cannot agree that this was appropriate.

“Zero tolerance”

Mrs CD presented increasing levels of violence towards staff and other patients within the inpatient setting. From late 2009 onwards, her behaviour became very challenging for staff who were struggling to understand what was driving her frequent assaults on staff and other patients. Police were often involved because of her violent behaviour. This did little to change the situation, much to the frustration of staff who were subject to assaults. Staff felt great frustration at Mrs CD’s failure to engage and respond to their therapeutic approaches. Many assaults were serious. We had great sympathy with staff who were trying to provide care and treatment in very difficult circumstances.

There was a lack of a written policy around when to involve police following violent incidents in the ward, resulting in inconsistencies in response from staff. Since then, the Mental Welfare Commission produced the guidance document “Zero tolerance: measured response”. We have been assured that staff now follow this guidance when deciding whether or not to involve the police.

In examining case records, we found instances of pejorative descriptions of Mrs CD’s behaviour. We also found that some staff recorded relatively minor incidents and reported them on the internal adverse incident system in a way that they would not have done for other individuals. While we recognised that staff faced great difficulties, we remind them to be objective in what they record and report.

Women in prison: a national problem

Mrs CD's case is highly unusual. We found it very surprising that a woman of her age with no previous criminal record was remanded to prison in her 60s when distressed and harming herself, although we accept that her assaults, mostly on staff, made her care in hospital very difficult.

In compiling this report, we were also mindful of two important recent reports. While these were published after Mrs CD's spell in prison, we highlight them here to demonstrate why we were so concerned about this case and why there needs to be better solutions for women who express emotional distress in ways that mental health services have difficulty managing, especially where there appears to be no clear "major mental illness".

The Commission on Women Offenders, chaired by Dame Elish Angiolini, issued its report[1] in April 2012. It states:

"Cornton Vale is not fit for purpose. Overcrowding has caused significant problems for the management and staff, and has inhibited opportunities to rehabilitate women and reduce their reoffending on release. The mental health needs of women are not being addressed adequately. There are high levels of self-harm and there is a lack of constructive and meaningful activity. Staff working in Cornton Vale also find it very challenging due to the nature and complexity of women's needs."

There are messages in the report for the Scottish Government's mental health strategy. In relation to Mrs CD, it is hard to see how remand to prison was likely to be of any benefit to her.

These issues were echoed in the report from Her Majesty's Inspector of Prisons on Cornton Vale Prison[2], also in April 2012. It states:

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[1] http://www.scotland.gov.uk/Resource/0039/00391828.pdf

[2] http://www.scotland.gov.uk/Publications/2012/04/2166/0

"I also want to comment about the challenges the establishment faces with prisoners who have complex mental health issues. Some of these women might be better located in alternative specialist facilities. I have often argued that prison officers are not sufficiently well trained or equipped, even with support from mental health nurses, to deal with the most challenging of these prisoners. On many occasions, I have observed the staff in Ross House (specialist remand and support facility within the prison) face up to these issues with patience and common sense, which results in good care. But Cornton Vale is a prison, not a specialist mental health facility and however hard staff try to deal with these challenges, a visit to Ross House is still a harrowing experience. This is a situation that will require review at the highest levels of government and I urge that a long-term solution for this mental health issue is found."

We recently met the Governor and staff of Cornton Vale Prison to discuss how we can help to make progress on these problems. For Mrs CD, it is clear that Cornton Vale Prison could not have offered her appropriate care and support.

Summary

Mrs CD presented many difficult challenges to mental health, social work and criminal justice services. We acknowledge that she was a very difficult person to help and that any service would have found difficulties in providing her with care and treatment. Notwithstanding, we are concerned about her spell in prison which seemed to be a consequence of withdrawal of mental health support. All attempts to provide care and treatment appeared to have been ineffective and there was an absence of apparent alternatives.

We commend those who did their best to provide care and support for Mrs CD, especially hospital staff, who had to cope with her episodes of violence, and police, who were particularly praised by her husband. She presented with emotional distress. When distressed, she could behave violently. Some of her assaults on staff were serious.

Some of the clinicians did not consider that mental health care and treatment were appropriate responses. While we have great sympathy with all practitioners who were attempting to provide care and treatment in these circumstances, we draw attention to the plight of women in emotional distress for whom the criminal justice system does not provide the support needed.

Mrs CD’s case is tragic. Even if the recommendations at the end of this report are implemented, we cannot say that anything would have altered the course of her decline. However, it should have been possible to provide a more coherent approach among agencies and avoid the use of prison.

Conclusions and recommendations.

The main reasons that services struggled to provide care and treatment for Mrs CD were her difficult and complex presentation with unhappiness and anger, reluctance to engage with practitioners to deal with her problems, self-harm and assaults on staff. This was in the setting of long-standing mood and relationship difficulties, but with a progressive worsening in her early 60s that has defied adequate explanation.

We think there are some lessons for this and other NHS Boards, local authorities and criminal justice agencies from this case. These are:

- A lack of appropriate responses to her increasingly problematic behaviour resulting in a withdrawal of services at a critical point. This was our greatest concern;
- A lack of clarity over policy on involving criminal justice agencies following violent incidents in mental health in-patient care;
- A lack of a flexible range of evidence-based psychological approaches;
- The use by some staff of inappropriate diagnostic terms such as “borderline personality disorder” to describe her deteriorating mental state and behaviour;
- Some poor communication among practitioners, particularly between in-patient and community teams, and a lack of integration of the work of specialist therapists.

Recommendations

We make our main recommendations to the Scottish Government. This report emphasises the plight of women who enter the criminal justice system when emotionally distressed. Mrs CD, while being an unusual and extreme example, reflects the problems of addressing the needs of people who communicate distress in a manner that services find challenging.

Commitment 19 of the Scottish Government's mental health strategy 2012-2015[3] states: *We will take forward work, initially in NHS Tayside, but involving the Royal College of General Practitioners as well as social work, the police and others, to develop an approach to test in practice which focuses on improving the response to distress. This will include developing a shared understanding of the challenge and appropriate local responses that engage and support those experiencing distress, as well as support for practitioners. We will develop a methodology for assessing the benefits of such an approach and for improving it over time.*

Mrs CD demonstrates why this commitment is important. Withdrawal of mental health care and treatment at a time when she was at her most distressed was inappropriate but, in our experience, not uncommon. Mental health services, as presently constructed, may not always be the solution. But neither is prison. New multi-agency initiatives may be needed to ensure that individuals like Mrs CD have safe and effective care and support.

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[3] http://www.scotland.gov.uk/Resource/0039/00398762.pdf

Recommendation to the Scottish Government

We recommend that the Scottish Government takes note of our findings when considering further development and implementation of mental health strategies. The particular issues that require a strategic direction are:

- **a) Crisis and ongoing support services for people who are in distress but may not require treatment for a major mental illness.**
- **b) Related to this, guidance on decisions to withdraw or withhold mental health treatments and supports on the basis of problematic behaviour.**
- **c) Availability of a range of evidence-based psychological therapies, with a particular focus on in-patients and individuals in secure or forensic mental health services;**

Recommendations to service

We make recommendations to local services. We also draw them to the attention of all NHS Boards, local authorities and criminal justice agencies.

Recommendation 1

NHS Board 1 and its partners should provide guidance on decisions to withdraw or withhold mental health treatments and supports on the basis of problematic behaviour. This may help to inform Government guidance and should include:

- **Standards for multidisciplinary discussion and recording of all such decisions;**
- **The need for external review of any such decision.**

Recommendation 2

NHS Board 1 and its partners should review services for management and support of individuals presenting with emotional distress, regardless of whether or not there is thought to be a "treatable mental disorder". We would like this review to address:

- **Mental health and social work input to A&E departments;**
- **Options for treatment at home or within other settings for individuals for whom admission to hospital is not offered;**
- **A review of available care settings for individuals, especially women, who continue to present problematic behaviours.**

Recommendation 3

While we know that there have been improvements over recent years, we still recommend that NHS Board 1 and its partners should conduct a review of the availability of a wide range of psychological and behavioural treatments. This review should include:

- **An assessment of needs for psychological and behavioural treatments, paying particular attention to needs of individuals receiving care and treatment from in-patient and forensic services, with particular attention to the need for, and availability of, forensic psychological input into the care and treatment of people with mental illness who display violent behaviour;**
- **Evidence-based treatments[4] that may be required and availability of these treatments at present, including waiting times;**
- **An action plan to improve access to treatments, including an analysis of workforce requirements needed to implement this plan.**

Recommendation 4

NHS Board 1 should review and improve relevant practitioners' knowledge and understanding of personality disorders. In particular, they should remind practitioners of:

- **The diagnostic criteria for personality disorders (general and specific);**
- **The possibility that personality disorder and mental illness may coexist;**
- **Treatments available for the disabling effects of some personality disorders.**

Recommendation 5

NHS Board 1 and the local authority should examine systems of communication among teams and specialist practitioners. We are aware that there have been improvements since these events, but wish to be reassured that:

- **Community staff are involved in planning for spells of leave and for discharge;**

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[4] http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix/the-psychological-therapies-matrix.aspx

- **Specialist therapists who work alongside teams communicate appropriately with other team practitioners. Guidance and audits of communication would be helpful;**
- **All multidisciplinary team discussions are recorded in individual case files.**

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk

Mental Welfare Commission (   )