





## Who we are and what we do

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health and incapacity law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have worked in healthcare, social care or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect;
- Have the right to treatment that is allowed by law and fully meets professional standards;
- Have the right to live free from abuse, neglect or discrimination;
- Get the care and treatment that best suits his or her needs;
- Be enabled to lead as fulfilling a life as possible.

## Our work

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

This review was conducted using our powers of investigation under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. However, we decided to involve staff and managers from the services responsible for the care and treatment of Mr O in a meeting to jointly review the circumstances of his death. While the conclusions and recommendations in this report are ours, we are most grateful for the participation of staff from all agencies, and their willingness to think creatively about solutions to the problems that Mr O experienced.

## Introduction

Mr O ended his own life by hanging himself in July 2010. NHS Board A conducted an internal review of his contact with services in the year prior to his death. Mr O's father remained concerned about the process of care.

The Mental Welfare Commission for Scotland has a general safeguarding role for people with any form of mental disorder. It has the authority to investigate if there may have been deficiency of care and treatment. Mr O's father and (at that time) NHS Quality Improvement Scotland and the Scottish Government alerted the Commission to this case.

It was agreed that the Commission might conduct a review with local services and, if appropriate, make recommendations about changes to service responses.

We examined the internal review of Mr O's death. That review had examined case records made during his contact with services before his death and took note of concerns expressed by Mr O's father. While we had concerns about some specific actions or omissions, we recognised that many services across Scotland would have found Mr O's presentation difficult and may have responded in similar ways.

Mr O appeared to have pre-existing developmental problems and had previously been diagnosed as having attention deficit hyperactivity disorder (ADHD). Our information on his presentations in the months prior to his death suggests that he used recreational drugs. His presentations to A&E and mental health services were secondary to this. This is a common and difficult presentation to manage.

## Methodology of the review

Following notification of the death of Mr O and communication from his father, NHS Quality Improvement Scotland and the Scottish Government:

- The NHS Board A and local authority B provided a timeline of events and an internal review of Mr O's care and treatment;
- The Commission undertook a further review of Mr O's case notes;
- The Commission then coordinated a joint meeting involving relevant staff from NHS Board A and local authority B. The meeting reviewed the events prior to Mr O's death, discussed the recommendations from the internal review and considered wider and more creative solutions to the problems he presented.

The terms of reference for the review were:

- To establish the facts of the events leading up to Mr O's death;
- To determine whether any actions or omissions by any individual or organisation contributed to Mr O's death;
- To identify any wider learning points for health and social care services arising from Mr O's care and treatment prior to his death.

## Background information

Mr O was 22 years old when he died. He had a history of developmental problems. He had difficulty at school from the age of ten and was diagnosed as having ADHD. He had contact with child and adolescent mental health services at that time. He came to police attention on a frequent basis, most notably after an episode of deliberate fire-raising. As a result, he spent periods in residential care. He managed to establish himself independently in a flat, but he had financial difficulties and used drugs and alcohol.

It is worth noting that Mr O had difficulties from an earlier age and that he could be described as a “young person in trouble”, i.e. in need of extra help and support in progressing through teenage years into adulthood. This is a relevant point for later discussions. The relevant chronology leading up to his most recent presentation starts in June 2009.

## Chronology of events

NHS Board A provided the following timeline of events from June 2009 onwards.

25 June 2009

Community mental health team (CMHT) received a routine referral from the GP. Discussed at referral meeting and illness not considered to be severe and enduring. Referred back to GP with recommendation for referral to counselling service in first instance. GP advised to re-refer if considered necessary.

11 September 2009

Referral from short stay ward in a general hospital to liaison mental health service. Mr O had taken an overdose. Recommendation from liaison was for admission to mental health ward in hospital X for assessment/ review when medically fit.

16 September 2009

Admitted to hospital X and at that time, whilst maintaining an “informal status,” it was recorded that if he attempted to discharge himself, then medical staff were to be contacted with regard to review and subsequent detention if necessary. This status continued until 24 September 2009 at which time he was not considered to meet the grounds for detention.

25 September 2009

He requested discharge. He stated that he would cooperate with a treatment regime. As he was considered not to meet the grounds for detention, discharge was agreed with an outpatient appointment arranged within 10 days of discharge.

5 October 2009

Failed to attend appointment. Further appointment was arranged for 19 November 2009. Letter from consultant psychiatrist, Dr 1, stated that if required she would see him earlier. Did not attend subsequent appointment. Another appointment arranged.

11 December 2009

Telephone call from GP to duty worker, CMHT. Mr O had presented to the GP on 10 December 2009 describing feelings of self harm, some suicidal ideation and, although no planned intent GP was concerned as Mr O was described as "impulsive". GP requests that Mr O be seen earlier than the planned appointment on 19 January 2010.

Appointment arranged for 21 December 2009.

21 December 2009

Failed to attend appointment. Further appointment arranged for 29 December 2009.

29 December 2009

Attended outpatient appointment accompanied by mother. Outcome:

- Engagement with local counselling service due to commence 19 January 2010;
- New medication regime prescribed;

- Referral to CMHT which would support Mr O in regard to exploring areas of social interaction;
- Review with a view to referral to alcohol misuse service;
- Assessment of willingness to engage and cooperate with service provision and treatment;
- Further outpatient appointment in two weeks.

11 January 2010

Visited GP and an urgent referral/request made for attendance at Outpatient Services. Concern raised in regard to increasing aggressive behaviour, voicing intent to self harm, physically abusive to mother, paranoid ideation. Seen that day. No beds in hospital X, admitted to hospital Y and placed on constant observation. Level reduced to general observation the next day. Remained in hospital Y until 13 January 2010 then returned to hospital X.

13 January 2010

On admission to hospital X, constant observation status was reinstated until Mr O was reviewed by medical staff who decided that general observation status was appropriate. During his stay in the ward, Mr O continued to improve but constantly stated he wished to be discharged.

20 January 2010

He requested discharge. Despite attempts by nursing and medical staff to change his mind, he took his own discharge against medical advice. Again, he was considered not to meet the grounds for detention. According to his notes, he told the parents that the nurses asked him to leave and the medical staff discontinued all of his medication. He told staff he was going to live with his sister but in fact this was not true. It appears that he was given a note of his medication to take to his GP but not a supply to take home with him.

6 February 2010

Admitted to short stay ward, general hospital, subsequent to overdose.

Seen by Nurse Z the Senior Nurse, Liaison Service, who recommended admission. Mr O refused admission stating this would do more harm than good. Nurse Z spoke to staff in hospital X regarding Mr O's previous stay. They reported that, during last admission, spent most of his time with a fellow patient who was a known drug dealer. His behaviour was said to have been unproductive to any therapeutic intervention being maintained. He refused to engage in any therapeutic activity.

He did however state that he required help with drug and alcohol problem and he would engage with services. Nurse Z provided contact details for voluntary organisation C, a provider of services for people with drug or alcohol problems, and Breathing Space to Mr O.

8 February 2010

Urgent telephone referral made by GP to CMHT. Appointment arranged for 10 February 2010.

Follow up

Mr O did not attend the appointment on 10 February 2010 and did not inform the clinic that he was unable to attend. A further appointment was arranged for 15 April 2010. Letter to GP confirms this and also states that the Psychiatric Services would be happy to see Mr O at any time if referred by the GP.

No further contact or referral until the time of his death in July 2010.

### Review of the chronology from January 2010 onwards

While acknowledging the importance of previous events, the review focussed on events surrounding his spell in hospital in January 2010 until his death. This was the main focus of the meeting we held with staff from the NHS Board and local authority.

#### Admission to hospital 11/1/10 until 20/1/10

Mr O was admitted informally to hospital Y on 11/1/10 because there were no beds in hospital X. He was placed on constant observation on admission because of ideas of persecution, previous suicidal ideas and a perceived risk of violence. This was reduced to general observation the following day but with 15 minute checks. On 13/1/10, observation level was reduced to “general” and he was transferred to hospital X.

*Practice point – the practice of timed observation is not in line with “Engaging People”, the guidance on observing and engaging with people with mental disorders who present significant risks to themselves or others.*

He said that he had been using up to 40 capsules of mephedrone (bubbles) each day. After admission, psychotic symptoms settled very quickly. He was prescribed quetiapine, an antipsychotic drug, on admission. He remained on this drug throughout his stay in hospital.

The diagnosis was of drug-induced psychosis. The speed with which psychotic symptoms settled would be consistent with this diagnosis. He reported seeing images of his mother and others jumping on him when he closed his eyes. This would not be consistent with an ongoing major mental illness. Towards the end of his stay, he was expressing dissatisfaction about being in hospital. He felt that he was getting no treatment that was likely to benefit him. No specific work was undertaken to address his harmful use of drugs.

*Opportunity for engagement: during his time in the ward, there was an opportunity for brief work aimed at education and improving motivation to address his harmful use of drugs.*



### Self-discharge against medical advice on 20/1/10

On 20/1/10, he expressed a wish to leave the ward. He was interviewed by Dr 2, training grade doctor who discussed the case with the consultant psychiatrist, Dr 3. Given the lack of active symptoms of mental illness and the likely diagnosis of drug-induced psychosis, they decided that he did not meet criteria for compulsory treatment at that time

*MWC comment: given the information available, we think it unlikely that he met the criteria for detention.*

He could not be persuaded to stay in hospital. He left hospital to stay with his sister, against medical advice. Apparently, he returned to his own flat. He was not given medication to take with him, but a copy of the routine discharge notification and prescription form completed by hand by the junior doctor is in the patient's case notes. He would have been advised to give it to his GP to obtain a prescription. He must have done so, because he had quetiapine tablets in his possession before the GP would have received the typed discharge letter. His mother subsequently telephoned and was told of his decision to leave. She was also given advice about action she should take if the problem recurred.

He was still prescribed quetiapine and had just been started on carbamazepine (an anticonvulsant drug sometimes used as a mood stabiliser). Case notes contain no explanation as to the reason for starting carbamazepine.

### Practice points:

- *Pharmacy staff are available on call to dispense medication for people taking their own discharge outside normal hours. Nobody was contacted to dispense medication for Mr O;*
- *The discharge letter was sent, at the earliest, two weeks after discharge. The current target is for discharge letters to be sent to the GP within seven days of discharge.*

The discharge letter indicated that he would be sent an out-patient appointment. This would have been with a different consultant. At the time, there was a succession of locum consultants making continuity difficult. We heard that Mr O did not establish relationships with people in the ward, so the issue of developing a continuous relationship with the consultant may not have been of particular importance in this case as Mr O did not keep appointments.

The intention was that he should be referred to the NHS Board A drug problem service (DPS). The DPS would have been likely to have assessed Mr O and probably referred him on to voluntary organisation C. This organisation is contracted to provide a range of supports to people with a variety of drug problems including stimulant use.

There was some input into the wards by addiction services but this was very infrequent and on a case by case basis. It did not happen in Mr O's case while he was an in-patient.

*Practice point: the intention to refer Mr O to the drug problem service only to be passed on to voluntary organisation C seemed to be an unnecessary step.*

### Subsequent presentations to services

Mr O's next presentation was to A&E on 6/2/10. He had behaved oddly after taking alcohol and a variety of drugs, including a significant amount of his prescribed quetiapine. He had injured himself by hitting his face against an electrical socket and had broken his nose. His intermittent use of quetiapine could have been problematic and could have been a factor here.

He was assessed by the liaison nurse who identified that the primary problem was harmful use of drugs or alcohol. It was clear that he had been intoxicated when he had harmed himself. No clear signs of ongoing mental illness were apparent. The nurse offered Mr O admission in order to be absolutely sure that there was no mental illness, but Mr O declined the offer. The nurse did not think that follow up by the community mental health team would help. He gave Mr O information and contact details for voluntary organisation C, but did not arrange any direct follow up. Information provided on voluntary organisation C included details of its available "drop-in" support.

*Opportunity for engagement: it was left to Mr O to take action to engage with services. He had a history of non-engagement. Direct arrangement of appointments with mechanisms to remind him may have helped.*

Mr O attended his GP on 8/2/10. The GP made an urgent telephone referral to the CMHT. The information recorded in the CMHT notes was that the GP was concerned about ongoing suicidal ideation and possible visual hallucinations.

Mr O was given an appointment for 10/2/10, but did not attend. Had he done so, it was likely that the CMHT would have screened him for major mental disorder and have referred him to addiction services. Social work staff said that there would not have been direct social work involvement at that stage. The team would not have decided to visit him at home.

The locum consultant sent the GP a letter stating that Mr O did not attend and that he would be sent another appointment in due course. This was thought to be a way of at least "keeping the door open" for Mr O. There would be a risk that he and/or his carers might think this was the only option open and that there was no point in making any other approach to services. The appointment was for two months time. Again, Mr O did not attend. The locum consultant wrote to the GP saying that no further action would be taken, but that he would be happy to see Mr O again on request. There was no further contact with Mr O. He died by hanging himself in July 2010.

The GP did not participate in the review process although was invited to do so. To the best of our knowledge, Mr O had no further contact with his GP after 8/2/10.

*Practice point: the actions taken following his non-attendance on 10/2/10 seemed inadequate given the urgent nature of the referral. There should have been telephone contact with the referrer to discuss the best action to take.*

*Opportunity for engagement: the records contained Mr O's mobile phone number. The team could have contacted him by phone prior to the appointment. They could also have contacted him following non-attendance to check on his health.*

### General points on the case of Mr O

Mr O presented with problems of short-lived psychotic symptoms secondary to harmful use of drugs (and also alcohol). There was no evidence of major ongoing mental illness. This was set against a background of long-standing emotional and behavioural problems. Suicidal ideas and behaviour were a feature of his presentations and were linked to intoxication with drugs and/or alcohol. The Commission and staff from NHS Board A and local authority B considered the broad issues that arose from his case. Particular concerns included:

- Services are trying to manage more people's care and do it more efficiently. Individuals who are "hard to engage" may lose out if service responses become too rigid.
- Individual specialist services are unlikely to meet all the needs of young people with combinations of social, substance use and mental health problems. As currently configured, there is a risk that services have too rigid criteria on inclusion or exclusion.
- Individuals like Mr O may fall outside the criteria for specific mental health or addiction services.
- More effort is needed to encourage people with these problems into a treatment environment and to make the route of access to services easier to negotiate.
- As a general point, more needs to be done to engage communities or social groups where harmful use of drugs and alcohol is considered the norm.

The joint meeting examined recommendations made following the internal review and added several new ideas to address these points. Also, the meeting noted the establishment of a project to review the response of services to young adults at risk to themselves as a consequence of substance misuse. The project has involvement and support from NHS Board A adult mental health service, NHS Board A substance misuse service, the local University Department of Psychiatry, Scottish Government Health Directorate Mental Health Division, the local "Choose Life" group and the local Alcohol and Drug partnership.

The research project has only recently started. The Commission had agreed to facilitate the process of examining Mr O's case to generate ideas for service improvement. This would complement the research.

### **Response to the internal critical incident review**

The internal review recommended discussion between the drug problem service and general psychiatry in-patient services. The idea of a “link nurse” suggested in the review may not be productive. Mental health services need to manage drug and alcohol use. Drug and alcohol services need to recognise and manage mental illness. This was the intention of commitment 13 in Delivering for Mental Health and ongoing consultation over mental health strategic priorities.

It would be more productive to arrange cross over between nursing teams to train staff. Also, NHS Board A has appointed a new dual diagnosis lead consultant to lead on this area of work.

The review also recommended improvements in nurse training. There were gaps identified in core training, especially in knowledge of personality disorders and substance misuse. NHS Board A and a Scottish university are taking further action on this. It may be wise to involve national organisations such as NHS Education Scotland in this discussion.

## Improvements to the journey of care

### Specific recommendations to NHS Board A.

In relation to the practice points identified in this review, the Commission makes the following recommendations to NHS Board A. While they are important points for service improvement, none of these was significant in the eventual tragic outcome.

- The practice of timed observation is not in line with “Engaging People”, the still extant guidance on observing and engaging with people with mental disorders who present significant risks to themselves or others. NHS Board A should remind all mental health and learning disability units that timed observations are unsafe and are not recommended.
- Pharmacy staff are available on call to dispense medication for people taking their own discharge outside normal hours. Nobody was contacted to dispense medication for Mr O. NHS Board A should remind all mental health and learning disability units that pharmacists are available on call to dispense medication.
- The discharge letter was sent, at the earliest, two weeks after discharge. The current target is for discharge letters to be sent to the GP within seven days of discharge. NHS Board A should remind staff of this target and audit the provision of discharge letters from mental health and learning disability services.
- The intention to refer Mr O to the drug problem service only to be passed on to voluntary organisation C seemed to be an unnecessary step. NHS Board A should provide information for all mental health wards and community teams on appropriate routes of referral for people with drug or alcohol problems.
- The actions taken following his non-attendance on 10/2/10 seemed inadequate given the urgent nature of the referral. There should have been telephone contact with the referrer to discuss the best action to take. NHS Board A should provide guidance on steps to be taken following non-attendance for urgent appointments.

### General learning points

The internal review did not appear to deal with a fundamental problem with Mr O. To quote one participant in the joint review, “He either presented in crisis or not at all.” The service response in Board A was probably in line with practice in most other NHS Boards. He was assessed in crisis situations and given short-term intervention to assess and treat mental disorder resulting from harmful drug use. He was then given information on services for drug and alcohol problems and was expected to contact them himself. While we identified some practice that could improve, the fundamental problem of engaging young people like Mr O needs a more radical approach.

The joint group did not think that compulsion to receive care and treatment would have been appropriate in the case of Mr O. Nor did the group consider that extensive efforts to continue to attempt to engage would be an appropriate use of resources.

At the other extreme, the group thought that merely giving the person information about services and leaving matters to the motivation of the individual was not sufficient. The group looked at the opportunities that could have been taken to assist Mr O to engage with services and came up with some suggestions that might provide more help for people in similar situations in the future.

### Coordinated care for the “Young person in trouble”

Mr O had a long history of problematic behaviour and emotional difficulties. New procedures could be developed to provide a more integrated approach to care. This could include a “young person’s plan” shared by all agencies, subject to the individual’s agreement and the requirements of data protection legislation and the duty of medical confidentiality. One particular advance would be for each young person with difficulties similar to Mr O to have an identified practitioner as a point of contact for all involved in providing care and treatment. In Mr O’s case, this person would have been informed about all incidents and any non-attendance for appointments. He/she would then have used contacts available to find out how Mr O was doing and to offer to arrange further help. The meeting recognised that more work was needed on transition to adulthood, but agreed that an absolute age cut-off was less important than ensuring that services were available for as long as the person needed it. More work is needed on transition to adulthood and the provision of an ongoing main point of contact.

### Simplifying access to drug and alcohol services

One difficulty that emerged from Mr O's case was the interplay between different agencies providing services for people with drug and alcohol problems. Over time, different service approaches emerged for helping people with harmful use of alcohol, harmful use of recreational drugs, dependence on alcohol and dependence on drugs. This made it difficult for people with drug and/or alcohol-related problems, and the various practitioners who came into contact with them, to understand the best route of referral for help. A single point of referral is the ideal solution. In this particular area, voluntary organisation C will be the single point of referral for people with drug problems. After initial assessment, there will be a short-term intervention programme that may also involve inputs from or transfer to other agencies.

### Assistance to engage with drug and alcohol services

Better coordination of care and simpler access to services will only be successful if the person engages. In Mr O's case, we have already described opportunities that a redesigned service could take to encourage engagement. Relying on the person to make contact with voluntary organisation C is insufficient. Also, Mr O had a history of not attending arranged appointments and of presenting to emergency services in crisis. The joint group made several useful recommendations to assist young people with drug and alcohol related difficulties, especially in the setting of unsettled lives more generally, to engage with services. Some of these were already covered in the analysis of the timeline of events.

The recommendations were:

- Staff in in-patient wards should be able to deliver brief interventions on drug and alcohol use. Better shared learning between general adult and addiction teams may help. The same applies to staff in CMHTs and staff providing mental health assessments in A&E departments;



- Bridging of the transition on discharge by arranging some direct contact with voluntary organisation C during the in-patient stay. This could involve in-reach by voluntary organisation C to the wards or actively arranging appointments during or immediately after an in-patient stay;
- Text message to remind people of appointments. Mobile phone technology could be introduced to allow CMHTs to routinely use text messaging to remind young people (in particular) of appointments. (Recent GP research work on “virtual keyworker” using phone technology was discussed);
- For all people known to mental health services, there should be individualised actions that staff should take following non-attendance. Messages sent via mobile phones can also be useful to follow up on non-attendance;
- Software packages to provide advice and support with drug problems could be available as an app for smart phones. They could help to make inroads into the culture of harmful drug use.

## Conclusions and further action

The attempts made by the NHS Board, local authority and voluntary agencies to provide help for Mr O were similar to the likely responses by most services in Scotland. There was no specific service failure that directly contributed to his death. Any service would find Mr O's presentation a challenge to manage because it was difficult to engage him.

In collaboration with the NHS Board and local authority, we identified general learning points arising from the tragic death of Mr O. In general, services for young people with complex problems such as Mr O's may not be set up to provide an adequate response. The general learning points from this review, combined with initiatives already underway, would be likely to improve service responses for people with similar problems to Mr O.

### General learning points

*The NHS Board and local authority should take action to address the three general learning points identified in this report. They should provide a progress report to the Commission and the Scottish Government on their actions. They should act to improve:*

- *Coordinated care for the "Young person in trouble";*
- *Simplified access to drug and alcohol services;*
- *Assistance to engage with drug and alcohol services.*

The Scottish Government should take note of the outcome of this review and consider making recommendations to all NHS Boards

and local authorities on this subject. More assertive engagement of young people with drug and alcohol problems with associated mental health difficulties should form part of Scotland's revised mental health strategy.

The Commission will use this case, and the discussion that took place among agencies, to highlight the problems that services faced and to encourage others to adopt the measures taken by services in response to this individual case.

### Specific recommendations for NHS Board A.

The Commission had concerns about some specific actions or omissions. None of these would have been likely to have altered the eventual outcome, but there are important recommendations for service improvement.

#### *NHS Board A should:*

- *Remind all mental health and learning disability units that timed observations are unsafe and are not recommended;*
- *Remind all mental health and learning disability units that pharmacists are available on call to dispense medication;*
- *Remind staff of this target and audit the provision of discharge letters from mental health and learning disability services;*
- *Provide information for all mental health wards and community teams on appropriate routes of referral for people with drug or alcohol problems;*
- *Provide guidance on steps to be taken following non-attendance for urgent appointments.*



