Mental Welfare Commission for Scotland

Report on announced visit to:
Mid Argyll Community Mental Health Team, Arach Centre, Mid Argyll Community Hospital, Blarbuie Road, Lochgilphead, PA31 8JZ

Date of visit: 14 and 15 July 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

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

On this occasion, we visited the Mid Argyll community mental health team (CMHT), which is part of the wider Mid Argyll, Kintyre and Islay team.

The CMHT forms part of a whole system approach to mental health services for the adult population of Argyll and Bute Health and Social Care Partnership (HSCP). The service is delivered in conjunction with primary care mental health teams (PCMHT), acute services, urgent and emergency mental health team (UEMHT)and the out of hours services (OOH), alongside specialist mental health services and a range of statutory and non-statutory services that support the delivery of care.

Whenever possible, on the day of the visit, we will invite individuals receiving care and treatment to meet with us. We visited the service over two days and this enabled us on the first day to meet with the clinical team and advocacy services and on the second day, we focussed on visiting individuals, meeting with carers and telephoning some individuals who preferred this option for contact. We also had the opportunity to review the notes of individuals.

Some individuals chose to meet with us at the Arach Centre, based in Mid Argyll Hospital; for others we were able to accompany their community nurses (CPN) and visit them in their homes.

Who we met with

We met with, eight individuals in person and reviewed the care notes of 17 people. We also met with 5 relatives

We spoke with the head of mental health, addictions and learning disability (LD) services, the clinical service manager, members of the nursing and social work team, community mental health nurses, social workers and MHO lead, a support worker and the team administrator.

In addition, we met with a representative from the local advocacy services.

Commission visitors

Mary Leroy nursing officer

Audrey Graham social work officer

Graham Morgan engagement and participation officer

Gordon McNelis nursing officer

What people told us and what we found

We had the opportunity to meet with a number of individuals who had been receiving support and treatment from the Mid Argyll CMHT. The individuals we met with were at different stages of their engagement with the service. For some, we were told that the support that had been provided had been for a lengthy duration, such was the complexity of the individuals' circumstances and the severity of their mental ill health. For others, contact with the team was more recent and they were at the early stages of assessment and building therapeutic relationships.

While the team have a formal role to ensure people in the service were provided with care and treatment to meet their individual needs, there was a sense that the team were consistent in their approach. Many of the individuals we met with commented on the accessibility and responsiveness of the staff in CMHT.

Several of the people we met with were positive about the CMHT team and the care and treatment they received. Some individuals stated, "it's a very good service but it is underfunded ". Another said, "they have saved my life on more than one occasion; the service is very valuable but probably underfunded."

A further individual commented that support from her CPN "was lifesaving and helped maintain my mental health, keeping me well and out of hospital" while another person spoke about the role of the support workers "helping with practical day to day tasks."

We also heard about support from the social workers in the team who had "done lots for me, taking me to appointments, trying to get me more support, helping out with my benefits and finances."

When reviewing notes, we saw some examples of joint assessments carried out by the occupational therapist (OT) and social worker. The assessment of the care needs looked to improve community engagement, build confidence and to improve the individual's package of care.

There was one person we met with who was dissatisfied with some aspects of the care and treatment they had received. We raised this with the team on the day of the visit and they planned to make further enquiries.

We spoke with different members of the staff team throughout the visit. We met with a committed and enthusiastic staff group who were keen to progress developments in their service

The staff were knowledgeable about the individuals they supported, and they focused on building therapeutic and supportive relationships with them. All the staff on the day were able to answer and assist us with any information or with the documentation we sought.

Care, treatment, support, and participation

Mid Argyll CMHT supported individuals who have a range of mental illness difficulties and diagnosis. On the day of our visit, there were 107 individuals open to the service. Individual members of the team caseload varied in numbers and size, largely dependent on complexity and specific interventions that a person may require. The caseload numbers for each team member varied between 30 to 40 individuals. Depending on an individual's mental health presentation, contact could range from a single appointment to two or three contacts per week, when this was required.

We asked about patients who did not attend (DNA) for appointments and how the team responded. We were told that the response to individuals who did not attend was considered on a case-by-case basis. There were also discussions at the multidisciplinary team (MDT) meeting about all people who did not attend. Where a plan could be agreed, referrers were updated on the person's non-attendance. There is a standard operating policy to guide the management of non-attendance.

The CMHT team provides assessment and evidence-based treatment for individuals with suspected or diagnosed mental illness/ disorder. The team provided psychoeducation, medication management and low-level psychological therapies. They also provided support for families and relatives, where appropriate. Many of the individuals we spoke with stated that that they could telephone the clinical team anytime and speak to their CPN or any other member of the team.

We were informed that referrals to the service were responded to quickly. When we met with the team we discussed this and we heard that all referrals came through a single point of access The primary referrer is likely to be the general practitioner (GP). Referrals also may be from other primary care workers, mental health services (the admission ward in Mid Argyll Hospital), the local authority staff, Police Scotland, other statutory/non-statutory and third sector organisations.

The team operates a multidisciplinary (MDT) model for care, treatment and support. All referrals to the team are discussed at the MDT and should they meet the criteria for assessment, they are then allocated to a team member. We were informed that the team do not have a waiting list.

Individuals who were accepted for referral and subsequently required input from the CMHT would have the opportunity to meet with members of the team. The CMHT had a range of professionals including OT, physiotherapy, medical and nursing staff along with health care support workers; there is a consultant psychologist in the team. We also heard about two nurses that were trained in cognitive behavioural therapy (CBT) who can offer CBT techniques to help manage symptoms, improve coping strategies and promote overall wellbeing. As part of an integrated service, the team benefited from having social work colleagues as part of the team.

Every person who was supported by the team had an allocated keyworker and consultant psychiatrist. The keyworker was likely to be a mental health nurse with experience of working in a community setting. Keyworkers provide ongoing assessment, support and treatment for the individual's mental ill-health that could have a coexisting substance misuse with support from specialist services.

On the day of the visit, we discussed the opportunities for joint working with the locally based specialist services, staff commented on ease of access to the specialist teams. We heard of joint working with both The Drug and Alcohol recovery service (DARS) team, and the urgent and emergency mental health team (UEMHT).

The urgent and emergency mental health team provide assessment and resolution to people in a mental health crisis. Where the person is at risk of being admitted to hospital, this service provides an alternative to hospital admission and also supports and facilitates early discharge from hospital, if considered appropriate.

In our review of files that we accessed during the visit, we saw that for some individuals there was a crisis plan in place. On meeting with individuals, we were able to discuss and seek their understanding of their crisis plan. One person spoke about the challenge of reaching out for support when in crisis, and another individual said "I have had excellent support from the crisis team. I haven't asked to see them, they reach out and ask to see me".

There was an understanding that not all individuals had consented to their information being shared and this decision was respected. For the notes we reviewed, we noted that discussions regarding sharing of information took place between both individual and keyworker and was documented in the individual's file.

Care records

Information about personal care and treatment was held in a folder. The paper files were well organised and easy to navigate. On the day of the visit, we reviewed several care records for individuals who were receiving input from the community mental health team.

We were told by the senior managers about plans to introduce ECLIPSE, a digital platform, this is an electronic patient record system We were told that allied health professionals (AHPs) teams now use this digital platform. This service is at an early stage of planning.

The assessment and management of risk is an integral part of the individuals care and treatment when assessing and considering risk. When possible, this should be carried out in collaboration with the individual and any others involved in the person's life. Risk assessment is an ongoing process. In the individual notes reviewed we found the Sainsbury adapted risk assessment model was in use. This was regularly

reviewed, updated and supported by a brief formulation, along with a management plan, which supported the management of risk and informed the care plans.

In the care records we reviewed, we found meaningful and relevant chronological notes that provided a clear picture of everyone's needs and clinical involvement.

The care plans were accessible. We noted that the team were using a care plan template that assisted with some aspects of the care planning process, however, the level of detail in the care plans was variable. We looked at care plans to see where individuals had been invited to participate in their care planning. Unfortunately, this was not evident with all care plans we reviewed.

We could see that care plans were being reviewed, updated and amended for some individuals. Each time a care plan was updated, a new care plan was written; this meant it could be difficult to review the individuals' progress. We discussed the care plan process, particularly evaluations and reviews. We discussed that reviewing care plans can be more meaningful when this is linked with the outcomes and goals identified on the care plan.

The team recognised there was a need to improve the care plans. We were told that there had been a recent meeting with the local practice education facilitator (PEF). The team plan to review further their care planning processes in order to assist and ensure that the care plans are person-centred, with clearly defined outcomes and goals and that there is a meaningful reviewing process in place.

Recommendation 1:
Managers should ensure nursing care plans are person-centred, contain individualised information and evidence individuals' participation in the care planning process.

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

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

The Mental health strategy 2017–2027 has set out shared objectives to improve people's mental health and wellbeing and improve services for people with mental health problems. One of the key areas in the strategy is the physical wellbeing of people with mental illness. The strategy comments that we need to ensure provision

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

of screening programmes for all adults and give examples such as “breast, cervical and bowel screening”.

This is to make certain of the uptake of physical health screening amongst people with a mental illness diagnosis there should good practice in relation to physical health monitoring for individuals with mental illness. This should include regular assessment, lifestyle advice and appropriate follow up care. Annual physical health checks should be conducted and findings documented and communicated to all relevant parties.

We noted that physical health care needs were initially noted at the point of assessment and thereafter, addressed in some of the care plans. The team commented that there was a close link with physical health services. The staff commented positively on the accessibility of the local general practitioner (GP) services. We also saw appropriate links with specialist services if these were needed to meet the individual’s specific physical health care needs.

In the files we reviewed, we were unable to identify any physical health monitoring documentation. This assisted with highlighting the key risks in physical health, for example, the impact of smoking, the need for a healthy diet, the risk with obesity and cardiac conditions.

Recommendation 3:
Managers should ensure that physical health care monitoring and access to routine health screening is being provided by the CMHT or evidence this is being delivered in collaboration with the general practitioner

We heard how individuals were discharged from the service. The process commenced with early discussions with the person and their relative/carer. There was a discussion and planning that also took place with any others involved in supporting the person.

The discharge process was carefully planned to ensure that there was clear information regarding future access to services. A written discharge summary was also provided to the individual, with copies to the services and the GP. The summary consisted of the care and treatment provided, as well as risk assessments and the supporting relapse and crisis plans.

We heard that some individuals in the team are being managed through the care programme approach (CPA). We saw detailed and comprehensive CPA care plans that were dynamic and reviewed and updated at six monthly intervals. Minutes from the CPA reviews were held on the individuals’ care records. We saw evidence of detailed discussions and individuals’ participation, as well as when appropriate, involvement with relatives and other key people in a person’s life. One individual

commented “I have a CPA meeting, I bring my friend along, we talk about what is working well, and what needs to change. I feel listened to.”

Staff were aware of the framework Multi Agency Public Protection Arrangements (MAPPA) or Multi Agency Risk Assessment conferences (MARAC) restrictions. We also discussed how to refer to and manage Adult Support and Protection procedures, if there are any concerns regarding an individual’s risk, and unable to safeguard themselves from harm.

We discussed with senior management the local provision of adult support and protection training, and the need to ensure that all staff had knowledge of these processes and access to training.

Multidisciplinary team (MDT)

There was a comprehensive and cohesive multidisciplinary team that provided the CMHTs model of care. On the day of the visit, we had the opportunity to meet with various members of the team.

The MDT consists of one consultant psychiatrist, a resident doctor a senior charge nurse, community psychiatric nurses, a consultant psychologist, occupational therapists, support workers and social workers.

There is a weekly multidisciplinary team meeting. At those meetings all referrals to the team are discussed and allocated. There were also regular discussions about complex clinical situations. Staff members spoke about the increasing complexity of some individuals who have been referred to the service. We were informed if an individual’s mental health was concerning to the MDT, further discussion about care options took place at this meeting. The MDT meeting involved a range of members from the CMHT.

In the chronological notes, and in discussion with individuals in the service, we heard about and noted multidisciplinary working with the wide range of care, treatment and support being undertaken by the team. We heard from the team about the value of joint working with colleagues and the flexibility in their approach to ensure that people were not having to wait for care and treatment due to administrative reasons.

We found a record of what had taken place at the MDT meetings. The service kept a brief note that appeared just to outline the outcome of the discussion. We discussed on the day with the service that there was a need for a fuller minute to be kept.

Recommendation 4:
Managers should ensure that there is a comprehensive minute (template) ensuring that there is a record of who attended the meeting, the individuals view of treatment, the next steps (goals and outcomes) and a summary of how current treatment is progressing.

Use of mental health and incapacity legislation

When people were receiving their care and treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act), we could not find the relevant legal documentation in the individuals' files. We were informed that they were held in the medical records. We advised the service that this legal documentation should be filed and easily accessible to anyone who is delivering care and treatment to the individual.

On the day of the visit, there were seven individuals who were subject to treatment under the Mental Health Act.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

For the cases we reviewed, we noted that individuals subject to the Mental Health Act had this noted on file in the chronological notes and for some, this was recorded in their care plans.

Rights and restrictions

On the day of the visit, we spoke with the Lomond and Argyll advocacy service. They told us about the CMHT referrals to advocacy services. They described an open, positive relationship and good communication between their service and the local CMHT.

They also commented on some general challenges regarding the local area of Argyll and Bute, with increased levels of acuity of illness for some individuals being managed in the community. We heard there were challenges with accessing packages of care (after discharge from hospital), issues with accessing housing and pressures on third sector provision. The services also raised with us the pressure some community-based services were under relating to funding and provision. Senior managers informed us that there is a lack of community-based services in the community.

They commented that they historically had been able to support individuals with a range of issues including housing, financial concerns and appointments. However, at present they were attending primarily to "priority one individuals" that is, individuals who are in hospital or in the community who are subject to legislation.

For some of the people that we met with who were subject to the Mental Health Act, there were positive comments about the advocacy service provided, with one person

saying “the advocacy service is great. They are easy to contact and they will come to your home to visit you”.

We were also told about the local project “the recovery advocacy project”. This service focuses on advocacy with peer support, on rights, respect and recovery. It is funded by the local alcohol and drug partnership (ADP) and the Corra foundation.

When we met with people who had received treatment under the Mental Health Act, it was clear that they had support to understand their rights and could access advocacy and seek legal advice.

When we reviewed the available records, we looked for evidence of advance statements. We found copies of advance statements for two individuals. Health boards have a responsibility for promoting advanced statements.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We were pleased to hear about the therapeutic interventions, support and treatment being provided by the CMHT and about the non-statutory/ third sector provision that was available.

We met with the OT for the service; they were based in the team on a part time basis and the other half of the week they were based in the local ward. We were told that another band 5 OT has been employed and is due to commence in their role imminently.

In the files we reviewed, we found OT assessments for individuals of their functional abilities, limitations and environment. Following assessment, there were comprehensive care plans with personalised goals.

For some of the individuals we met with, they spoke positively about the support they had received relating to promoting community integration and building on their ability to travel independently. We heard from one person about “working voluntarily” and the impact this had on their confidence and skills.

In some of the individual files we reviewed, we saw that individuals were being supported through behaviour activation. This is a therapeutic approach that can be used to treat depression and anxiety disorders. It encourages individuals to engage in activities that are meaningful and enjoyable; it focuses on changing behaviours to improve mood.

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

We were pleased to hear that some individuals we met with had taken up positions in employment and voluntary work.

Community mental health nurses could also refer individuals to non-statutory or third sector services who provided recreational and therapeutic activities. We heard about some local provisions such as the Snowdrop Centre, a local service for individuals with multiple sclerosis which is described as a therapy centre. There was also the Soup Group, a local group funded by Argyll and Bute third sector that is funded by a community Health and Wellbeing fund. We were also told about a new initiative that had just commenced, the Living Well group, that promotes health and wellbeing.

The physical environment .

The community mental health team are on the site of Mid Argyll Community Hospital Based on a lower floor, the service has direct links with the adult admission ward located in the hospital. The proximity of the team to the inpatient ward was helpful with communication and provided accessible contact between the services, allowing community nurses to actively engage with individuals on their case load who required an admission to hospital.

There is office space that accommodates a variety of teams such as the CMHT team, the Urgent and Emergency team, a social worker and MHO staff offices, the primary care team, drug and alcohol recovery services, and offices for senior managers in the service. Staff commented on the advantages of having all the team in the one location, knowing their colleagues in other services, access to formal and informal discussion, support and assisting with teams when appropriate to meet the individual's needs.

Any other comments

We were grateful to the team for their commitment in supporting us by setting up opportunities to see the wide and varied work in the CMHT, as well as offering for us to meet with individuals in several settings. The meeting and the planning for this visit have allowed a good foundation on which to build future visits as the Commission focuses more on the delivery of care in the community setting

Summary of recommendations

Recommendation 1:
Manager should ensure nursing care plans are person centred, contain individualised information and evidence individuals' participation in the care planning process.

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

Recommendation 3:
Managers should ensure that physical health care monitoring and access to routine health screening is being provided by the CMHT or evidence this is being done in collaboration with general practitioner.

Recommendation 4:
Managers should ensure that there is a comprehensive minute (template) ensuring that there is a record of who attended the meeting, the individuals view of treatment, the next steps (goals and outcomes) and a summary of how current treatment is progressing.

Service response to recommendations

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

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

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

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

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

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

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

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

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

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

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

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

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