Mental Welfare Commission for Scotland

Report on announced visit to:
Western Isles Community Mental Health Team, Western Isles Health Centre, Springfield Rd, Stornoway, Isle of Lewis, HS12PS

Date of visit: 23 - 27 June 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 hospital, but it might be in their own home, or a care home or local community setting. With the shift in the balance of care, that is, delivery of mental healthcare 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 it is provided

On this occasion, we visited the Western Isles Community Mental Health Team. We had the opportunity to meet with individuals who received care and treatment, some family members, as well as nursing and medical staff and the wider staff group.

While the team is made up of general adult mental health staff along with staff who specialise in substance use, dementia and learning disability, our focus was on the service provided by the general adult mental health service.

This service consists of five community mental health nurses (CMHN) and a mental health Occupational Therapist (OT), supported by the nurse manager. The five nurses cover the islands of Lewis and Harris and provide a service from Monday to Friday, 9am to 5pm. They also cover the out of hours rota throughout the year, providing a response to those in crisis across all groups, including children and young people, learning disability and older people as well as the general adult population.

Additionally, they provide an assessment and diversion service as required for the Sheriff Court. One nurse specialises in perinatal care, and we heard that this was valued. The work of the mental health nurses is supported by input from two mental health support workers. Since April 2025, the team has been augmented by additional agency mental health nurses to provide more capacity to support people in the community and prevent hospital admission. This is due to the fact that the inpatient unit has been carrying out ligature reduction and refurbishment work and has been running with only two out of five beds being available. We heard that this has been manageable to date.

Who we met with

We met with and reviewed the care of 10 people and met with a further three people whose care notes were not reviewed. We also spoke with four relatives.

We met with the nurse manager, the associate clinical director for mental health and learning disability as well as several staff throughout the days we visited.

In addition, we met with one of the consultant psychiatrists and attended the weekly liaison meeting with medical and nursing staff, OT and clinical support staff.

Commission visitors

Audrey Graham, social work officer

Susan Hynes, nursing officer

Graham Morgan, engagement and participation officer

What people told us and what we found

Feedback from the individuals we met with and family members was overwhelmingly positive. People told us; “staff are brilliant”, “I always have a say in my treatment”, “I can tell them anything, I’m not judged” and “it’s all based around me”. One family member said, “it’s an open house, they’re open with us”.

Themes identified from the discussions we had with individuals on their care and support were about a good level of responsiveness and dependability, that they trusted staff and felt listened to, that there was a person-centred and relational approach taken. We heard examples of staff valuing the lived experience of individuals by asking them to educate students and by taking part in a group programme that the individual had previously completed so that they could share their experiences.

We heard that access to the service on initial referral was generally quick, apart from for those awaiting assessment for attention deficit hyperactivity disorder (ADHD), who may wait 12-18 months for this type of specialist assessment. It was good to hear that two nurses had been trained in carrying out these assessments, although unfortunately one had recently left their post.

Another key theme identified was a view that staff were knowledgeable, particularly about physical health issues and how this linked to mental health care and treatment. We heard examples of staff supporting access to physical health services for individuals, which was appreciated. We heard of a number of examples of staff linking people to groups and activities in their local communities and a good level of knowledge about what was available. People felt that staff really knew them and understood their family and social context.

Individuals and families seemed to feel more removed from their consultant psychiatrists, particularly as there had been a high number of locum consultants working in the service over several years. One individual told us, “there was a locum…a locum…and so on another locum, then one locum stayed for nearly 2 years, then I was admitted, and I saw a new psychiatrist and I thought ‘that’s good he’s the new one’, but now I have to see someone else”. This issue was discussed with managers during the visit.

Staff told us that they felt valued and well supported in the team and by their manager. We heard several times about the manager’s ‘open door policy’ and how much this was appreciated. Our impression of the team culture was positive in that there was respect amongst colleagues, individuals felt valued by the team and by the manager, they enjoyed their work and felt trusted in their role. This positive team culture was promoted by the leadership of the nurse manager and we thought that this was commendable.

Care, treatment, support, and participation

We found that the care plans we reviewed did not reflect the breadth and depth of the work that we were told that staff were doing. For example, there was good work done with several individuals to link them into their local community and meaningful activity and this was not part of the care plan. We heard from an individual about the plan agreed with their CMHN around managing anxiety, but we did not see a formalised care plan detailing this. We heard about support to improve and maintain individuals' home environments, and this was not reflected in care plan documentation.

The team used the electronic system MORSE for recording. We found that across the staff group, there was an inconsistent approach to completing the care plan template on this system. In several care plans, we noted that the interventions needed to achieve the desired outcome were detailed in the 'Expected Outcome' section. In the 'Interventions' section, several care plans noted a broad overarching action such as 'promote positive psychological status' rather than the specific actions required to do this. Individuals we spoke to were clear on what they were doing in partnership with their worker but were not aware of having formalised care plans. We were aware that there were agency nurses working with the team and in discussion with managers, noted the importance of having formalised care plans in place to assist them to provide continuity of care.

Review of care plans was also inconsistent in terms of frequency and in some records, there was no evidence of a review. The content of reviews was very brief and did not include an assessment of progress towards desired goals, or consideration of what interventions were working to inform re-focusing of the care plan. There was no evidence that we could see of care plans being reviewed in collaboration with the individual, family and multidisciplinary colleagues. The Commission advises that individuals are given copies of their care plans as a matter of routine and in accessible format, to aid ownership, understanding and focus on identified goals.

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

Recommendation 2:
Managers should carry out regular audit of nursing care plans to ensure they are person centred, collaborative and fully reflect the patients' progress towards stated goals. Audits should ascertain that recording of reviews are consistent across all care plans.

We saw a good level of detail in terms of assessment of mental state and risk in the continuation notes. We saw some detailed Level 1 and Level 2 risk assessments; however, the quality was variable and we did not see evidence of regular review and update. We would have liked to see these documents being more current and dynamic. The individuals that we met with were able to tell us what they would do in a crisis, and some had discussed this in detail with their nurse. However, we did not see any crisis plan documents in the care records. Having such plans formalised and accessible in records would aid agency nursing staff and staff on duty out of hours. It was good to note that there is a programme of audit of risk assessments in place, led by one of the Band 6 nurses. From the information available to us we saw that the approach taken is mainly quantitative. We felt it should be enhanced by focusing on qualitative factors relating to risk assessment documentation.

Recommendation 3:
Managers should ensure that where required, individuals have a formalised crisis plan in place and that this is regularly reviewed in partnership with individuals.

Recommendation 4:
Audit of risk assessments should be enhanced to include qualitative factors.

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. We discussed the guidance with the nurse manager during our visit and it was shared with the team.

Multidisciplinary team (MDT)
The general adult mental health service is located in a health centre along with substance misuse, learning disability and dementia nursing staff. While there was a team leader in place to support and supervise the substance misuse staff, the others were line managed by a different nurse manager. We heard examples of good joint working between nursing and OT, and across all the specialisms, particularly between mental health and substance misuse. Teams would often co-work with mental health support workers and we heard from those that we spoke with that this worked well.

We heard of CMHT staff supporting access for individuals to their GP and other physical health services and this seemed to be helped by co-location with the health centre and the ease that staff felt to 'pop across the corridor and have a conversation' with another professional. We heard from individuals that because of the strong relationships that they had with CMHT staff, they would often talk to them first about physical health issues.

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

The clozapine clinic was managed by the senior charge nurse (SCN) for the Acute Psychiatric Inpatient Unit (APU) and held in an outpatient clinic in the hospital. In total, there were 11 patients managed in the clinic and they were seen monthly. A further three patients were managed by their GP with the blood results and monitoring being reviewed by the team at the hospital, with medication being dispensed from there to local pharmacies. The system appeared to work well with individuals able to collect their medication within one to two hours of having bloods taken.

It appeared that there was good communication between the ward staff running the clinic, the hospital pharmacy and medical staff. Bloods were taken every month, along with appropriate physical health checks and side effect monitoring. There were yearly physical health checks, though these were delayed with some not being completed within the year. We were reassured that work was ongoing to manage this.

As an island health board, the remote location has led to significant issues for many years in the recruitment of psychiatry and psychology staff. However, the previous challenge with recruitment of clinical psychologists has moved on positively. A principal psychologist had been appointed, and interviews were imminent for a clinical psychologist role. The service currently has three consultant psychiatrists covering two posts on a locum basis, with one post being covered on a shared rotational basis; two months on and two months off. There had been a series of psychiatrist covering the role on a locum basis for the last few years.

We heard from individuals that they were unsure who their consultant psychiatrist was, that nurses were frequently acting as intermediaries and that establishing therapeutic relationships with consultant psychiatrists was difficult to achieve because of the constant change in psychiatry. We heard that decision making about diagnosis or longer-term treatment plans, including the use of compulsory measures, could be impacted by the change in personnel. We were reassured by the nurse manager that open dialogue did take place with medical staff and issues were raised where nursing staff who had a longstanding knowledge of an individual, felt that there was inconsistent decision making.

It was good to hear that MDT meetings took place on a Monday and a Thursday every week. These gave regular opportunities for the nursing, OT, clinical support staff and consultant psychiatrists to review and plan together. We noted that the Monday meeting focused on reviewing any significant events from the weekend and provided time with medical staff to raise any current concerns relating to individuals and to make decisions and plans. The Thursday MDT meeting provided the opportunity for a more detailed review of individuals; however records of these meetings were kept at the hospital and we were not able to review them.

We were told that records were not kept on an individualised basis and stored in individuals' care records but were kept as a whole minute document. We could not see evidence of how the MDT reviews linked to individuals' current care plans and risk assessments and we thought this required some consideration. We heard of a two-tiered approach to the use of the Care Programming Approach (CPA) for individuals, with less than 10 people being formally managed following the CPA process and another small group on a 'CPA light' approach; these reviews were annual and the approach less intensive overall. While we did not have the opportunity on this visit to look into this further, we thought that consideration should be given to a consistent approach and CPA being used for those who met the criteria.

Recommendation 5:
Managers should ensure that MDT reviews are recorded on an individual basis, stored in individual care records and are used to inform and update individual care plans and risk assessments.

We heard that while joint working between health professionals with the services, and with advocacy and third sector community services was positive, working relationships with social work services was variable and could be challenging. We agreed with the nurse manager that some focused work to improve relationships by managers across services would be beneficial.

Use of mental health and incapacity legislation

At the time of our visit, the service supported three individuals who were subject to compulsory treatment orders (CTOs) under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Mental Health Act paperwork relating to these CTOs was available and accessible.

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 unfortunately not in place and this was raised with the nurse manager on the day, who raised it with the RMO for urgent action. We spoke to the three people who were subject to CTOs. None were consenting to treatment and therefore required T3b certificates to be in place.

We would also expect to see prescription sheets ideally stored together with T2/T3 certificates and the current prescription. There were only old prescription sheets and the current prescriptions appeared to be done via email but were difficult to locate. We were concerned to see that there were also old drug prescriptions on the electronic recording system, MORSE and it was not clear they were no longer in use. This could cause confusion for a new staff member or for agency staff who may not know the system well and were required to administer medication.

Recommendation 6:
Managers should review the overall system for recording the administration of medication. This should include introduction of a robust prescribing and recording system to ensure that all medication prescribed under the Mental Health Act is appropriately and legally authorised.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form.

It was unclear from discussions and the records we reviewed whether any of the individuals supported by the CMHT had a guardianship order or Power of Attorney under AWI in place; we did not see any s47 certificates in the files reviewed. The importance of having copies of these documents in care records was discussed.

Recommendation 7:
Managers should ensure that s47 certificates where an adult lacks capacity are in place, current and have an individualised treatment plan.

Rights and restrictions

The three individuals who were subject to CTOs demonstrated a good level of knowledge about their rights with legal representation to appeal, to accessing advocacy support and to have a named person. All three had nominated a Named Person. From what people told us, advocacy was accessible and responsive.

It was good to hear that in discussions with individuals being treated on an informal basis, there was a good level of knowledge about diagnosis, medication prescribed and other treatments. There was a strong theme identified through discussions with individuals that they felt listened to and valued by staff.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. Three individuals told us they either had or were working on an advance statement. We also found there to be awareness amongst the staff group about the purpose of advance 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 heard from individuals about efforts by CMHT staff to encourage them to increase activity levels and to support them to link with a wide range of groups and services in the local community. This ranged from specialist counselling to autism support, social and peer groups and arts and crafts groups, to supports for their children. We heard frequently about Catch 23 run by Western Isles Association for Mental Health as being a good place to drop in, with much going on including groups in gardening, healthy eating, art and creative writing, as well as a weekly drop in run by one of the CMHT nurses.

It was good to hear about plans to run a Systems Training for Emotional Predictability and Problem Solving (STEPPS) course soon, with efforts being made to locate a venue in the community underway and a number of CMHT staff trained in the approach. STEPPS seeks to help people understand experience of dysregulated emotions and co-occurring problems.

The physical environment

Through the period of our visit, we found the CMHT area and health centre to be a friendly and welcoming place. The reception area was open and bright, with lots of useful information on the walls about health initiatives and local resources.

There was music playing which contributed to a relaxed atmosphere. While space for the CMHT was very limited, with only two rooms available to book for 20+ staff, they were making best use of what they had and were looking out to the local community for bigger spaces to run groups e.g. the STEPPS group, which was very positive.

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

Summary of recommendations

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Managers should ensure that where required, individuals have a formalised Crisis Plan in place and that this is regularly reviewed in partnership with individuals.

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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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