Mental Welfare Commission for Scotland

Report on announced visit to:
Murray Royal Hospital, Rohallion Forensic Community Mental Health Team, Birnam Day Centre, Muirhall Road, Perth PH2 7BH

Date of visit: 21 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 hospital, but it might be in their own home, or a care home or a local community setting. As the balance of care shifts from mental health inpatient wards and units to delivery of mental healthcare in the community, the Commission's visiting programme has been adapted 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 Rohallion Forensic Community Mental Health Team (FCMHT). We had the opportunity to meet with individuals who received care and treatment, as well as meeting nursing and medical staff, the occupational therapist (OT) and the FCMHTs social worker from the local authority.

The FCMHT is a multidisciplinary mental health service which specialises in assessment and risk management of adult male and females aged between 18-65 years (although there are exceptions in the upper age limit), community-based care and treatment and on-going support. Individuals in contact with the FCMHT have a mental illness and present, or there are grounds to believe that they would pose, a significant risk to others.

This was the first time the Commission has visited the Rohallion FCMHT.

Who we met with

We met with, and reviewed the care of 12 people, seven who we met with in person and five who we reviewed the care notes of.

We spoke with the team leader, the community mental health nurses (CMHNs), the social worker, the forensic social work assistant, the OT and consultant psychiatrists.

Commission visitors

Gordon McNelis, nursing officer

Lesley Paterson, senior manager (practitioners)

Denise McLellan, nursing officer

Sandra Rae, social work officer

What people told us and what we found

The individuals we spoke with were very positive about the service they received and there was a common theme from those that we spoke with where we heard that individuals had a good relationship with the FCMHT staff. We were told staff were "always there to support us", "perfect, really good and I'm thankful for their support", "they respect our choices", "in addition to talking about my mental health, I can talk to them about most things for reassurance" and "they put me at ease".

Care, treatment, support, and participation

The FCMHT staff visited individuals mostly in their homes, although individuals also attended the Birnam day centre for appointments with their responsible medical officer (RMO) and other FCMHT staff. They also attended Birnam for care programme approach (CPA) meetings, clozapine clinic appointments, when depot medication needed to be administered and for physical health monitoring. Individuals with complex needs also attended the day centre for additional support.

Referrals to the FCMHT

There was no-one waiting to be seen by the FCMHT service. Once a referral had been accepted and assigned to a CMHN, care, treatment and support would begin promptly with the individual.

Most referrals came from Rohallion low secure care clinic, and all internal and external referrals were presented for discussion at the weekly Rohallion low secure bed management meeting. This was attended by an FCMHT member of staff, and each referral was reviewed in line with the low secure service referral policy.

Referrals were considered on a case-by-case basis and in some instances, additional information was required, and further assessment or discussion was needed, with the referring agency or MDT before a decision to accept the individual was made. If a referral is not suitable and does not meet the criteria for the FCMHT, the individual will not be taken on to the caseload; the reason(s) for this will be clearly documented and communicated in writing to those referring.

The FCMHT would be aware of the individuals who were approaching discharge from the low secure care wards and who were likely to be considered for referral. Other referrals came from general adult psychiatric services, Police Scotland, the courts and criminal justice services, prison and the procurator fiscal service.

Care records

Information on individuals' care and treatment was held electronically and easily located on the EMIS system.

In the care records we reviewed, we found that entries were detailed and gave a comprehensive account and understanding of the individual's situation and

circumstances during their contact with the FCMHT. We noted that discussions took place between each FCMHT discipline and the individual on a continuous basis, with a focus on support, setting goals, giving guidance and advice to help achieve these.

We found that individuals who were prescribed psychotropic medication had annual physical health reviews or these took place more frequently, if clinically indicated. In addition to the reviews, regular physical health observations and high dose monitoring were undertaken, with the GP being notified of any relevant findings.

We had feedback from both staff and individuals about the positive impact the social work staff had on the individuals on the FCMHT caseload. However, there was limited evidence in the care records to support this. We raised this with the team at the end of our visit and were advised health and social care partnership (HSCP) colleagues' access to EMIS was restricted due to the alternative record keeping systems in the NHS and HSCP.

We heard that while the different systems was a common issue, the social workers had found a solution where they documented their contact with individuals and their NHS colleagues in the FCMHT recorded these interactions on their behalf on the EMIS system; this process had potential risks in that valuable information could be missed. We were told a training schedule was needed for other disciplines to have access to EMIS systems. We consider it to be necessary for all MDT members to provide their own clearly documented account of contact with individuals, and that a solution should be identified.

Care plans

We were told the FCMHT care plans had undergone a recent change and had been transferred to the person-centred care plan format that was used in Rohallion secure care clinic.

We found most care plans were detailed and robust and gave the reader comprehensive information so that they could understand the historical and current areas of need and risk. However, we felt these were developed from a service-based perspective rather than in collaboration with the individual. We acknowledged that some individuals may choose not to engage with staff in contributing to their care planning, or that they may have the ability to do so due to the progression of their illness; we would however, advise that this to be documented, with consideration given as to how they can contribute when they are able to.

Recommendation 1:

Managers should ensure that individuals are involved in developing care plans, where possible. Their participation should be recorded in the care records, and they should be offered a copy of their care plans. If individuals chose not to or cannot be involved, this should be recorded

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.

Risk assessments

We found various risk assessments frameworks in use (RSVP, RAMP, BEST, CPA, HCR20) and the risk management plans we reviewed were thorough and linked with areas of risk, although the frequency of risk assessment reviews and updates that reflected newly identified risks was unclear. We raised this at our end of day meeting with the FCMHT service leads and were advised that there was no risk policy was in place to determine a standard frequency to review risk assessments. This also applied to the Rohallion secure care clinic site.

We were told that forensic psychology had started developing a risk policy but this was at an early stage. We were advised the basic standard for reviewing each risk assessments was 'regular' and that assessment of an individual's risk took place during each contact with them and was discussed during MDT meetings. We were told of additional safeguarding in relation to risk measures that included historical, current and future risk management of individuals during the multi-agency public protection arrangements (MAPPA) process. There was also a co-ordinated multi-agency response to address those individuals' with a high level of risk through the high risk adult review group (HRARG). We would still recommend that there should be an agreed risk policy in place to underpin risk assessment and risk management in this complex group of individuals.

Recommendation 2:

Senior managers should expedite a forensic risk policy to formalise the requirements around risk assessment and risk management for individuals receiving care and treatment from the FCMHT.

Multidisciplinary team (MDT)

A range of professionals were involved in the provision of care and treatment in the FCMHT.

The team included psychiatry, who also covered the low secure wards in neighbouring Rohallion secure care clinic. We were told psychiatry sessions were allocated to the FCMHT to ensure scheduled appointments with individuals in the community went ahead, and psychiatry representation at team meetings was ensured.

Psychology input and dedicated time from a cognitive behavioural therapy (CBT) therapist was shared with Rohallion low secure wards, which provided low intensity

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

psychological work and groups, motivational interviewing, offence focused therapy, schema therapy and CBT. They attended MDT meetings and CPA meetings. Any psychological work that individuals started in the inpatient areas was continued in the community, based on individual need.

Other professionals in the MDT were the nurse team lead (which was being covered on a 12-month secondment basis), CMHNs, nursing support workers, OT, an activity nurse and a forensic social work assistant. The team also had support and guidance from Perth local authority social work; although not attached to the FCMHT service, social workers attended and contributed towards the individuals' support at MDT meetings and CPA meetings.

We reviewed MDT meeting records and found a consistent approach in recording details from the weekly meetings. There was focus on setting out action points and it was clearly identified which MDT member of staff would take these forward. The documents from the MDT meetings included a clear and robust summary from a nursing and psychology perspective. We noted that other members of the MDT had not provided a similar level of information about the individual. We raised this with the team at the end of our visit to emphasise the importance of each professional discipline in the MDT ensuring that their reports were included for discussion at these meetings.

Care and treatment with the FCMHT, similar to what takes places across the Rohallion site, was carried out under the CPA. The CPA is a framework used to plan and co-ordinate mental health care and treatment and there is involvement of a range of different professionals, with the aim of keeping the individual and their recovery at the centre of this approach.

For certain groups of people, enhanced CPA can be used as a mechanism for regular review of their care, treatment, needs and risk management. We found the CPA documents were robust, thorough and provided the reader with detailed information on all areas of the individuals' care and treatment and identified areas of risk. Each discipline provided an informative summary of the support they offered to the individual, which was goal orientated and future focused. It was evident that their input encouraged the individual to identify and build on their strengths.

Use of mental health and incapacity legislation

The FCMHT had a caseload of approximately 33 individuals and on the day of our visit, most of them were subject to the Mental Health Care and Treatment (Scotland) Act, 2003 (Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act).

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting

to specific treatments. We would expect to find consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act in place, where required. During our review of T2 and T3 certificates, we found the electronic versions for these stored on the hospital electronic prescribing and medicines administration (HEPMA) system. Duplicate paper copies were also kept and on our review of these, we found they corresponded with the electronic versions. We noted that a T3 certificate included the wrong first name of an individual. This was raised with senior medical staff and we asked for this to be rectified by the designated medical practitioner (DMP) who completed the form.

During our visit we noted that there were cases where general practitioners (GPs) had prescribed additional psychotropic medication without the RMO being made aware. This resulted in these medications not being legally authorised by T2 or T3 certificates. We were told that there was ongoing communication between the RMO and GPs, but that it was a challenge for the RMOs to stay informed of medication changes made by community-based GPs. We advised that the correct legal authority should be in place for all prescribed medication. To address this, the RMOs agreed to write to GPs reminding them to discuss the prescribing of additional psychotropic medication prior to be being prescribed. We were reassured by this plan which we hope will result in improved communication and awareness between primary care and specialist services.

Rights and restrictions

When we reviewed the available records, we looked for evidence 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.

We were told out of the 33 individuals on the FCMHT caseload, there were 18 who had advance statements in place. The FCMHT encouraged individuals to plan and make an advance statement; this was normally carried out as part of the CPA process but could take place during care plan reviews, transitions in care, or anytime the individual had contact with the RMO or CMHN.

We heard that when the RMOs corresponded with the GPs in relation to prescribing medication, this contributed towards establishing enhanced links with them and raised awareness of the benefits of advanced statements; this had led to an increase of individuals making an advance statement. The individuals we spoke with had varying levels of understanding of advance statements, with some having one in place and other choosing to not have one.

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

The FCMHT included a dedicated Band 6 OT and a Band 4 activities nurse who led the coordination of the activity programme. They provided in-reach to the individuals referred from Rohallion's low secure service. This was beneficial for individuals as it helped them to maintain structure throughout their day, during a time where there was a transition of their care from the inpatient environment to the community.

This approach also offered the individuals the opportunity to build connections with FCMHT staff and become involved with activity planning. In addition to therapeutic activities, weekly social groups were organised and took place as close to the individual's local areas as possible to encourage attendance.

CMHNs also supported the individuals to attend and access activities with a view to encourage their attendance autonomously and maximise their independence.

The physical environment

The FCMHT was an integrated part of the Rohallion low secure service, based in the Birnam Day Centre on the Murray Royal site. It is a purpose-built community facility which the FCMHT shared with the integrated drug and alcohol recovery team (i-DART).

The building was modern, bright and provided a welcoming environment for the individuals attending the day centre. It included interview rooms, space to enable meetings and a comfortable, less formal waiting area for individuals attending the facility.

Any other comments

The Commission has been visiting the medium and low secure wards across Rohallion secure care clinic since it opened in September 2012. This was our first visit to the FCMHT. It was positive to see and hear about how individuals were supported with their transition to the community and how the MDT collaborated to meet their needs and promote their ongoing rehabilitation.

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

Summary of recommendations

Recommendation 1:
Managers should ensure that individuals are involved in developing care plans, where possible. Their participation should be recorded in the care records, and they should be offered a copy of their care plans. If individuals chose not to or cannot be involved, this should be recorded.

Recommendation 2:
Senior managers should expedite a forensic risk policy to formalise the requirements around risk assessment and risk management for individuals receiving care and treatment from the FCMHT.

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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