Mental Welfare Commission for Scotland

Report on unannounced visit to:
Larkfield Community Mental Health Team, Kirkintilloch Health & Care Centre, 10 Saramago Street, Kirkintilloch, G66 3BF

Date of visit: 19 and 20 January 2026

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 Larkfield community mental health team (CMHT). We had the opportunity to speak with individuals who received care and treatment, family members, nursing, and medical staff, as well as the wider multidisciplinary team (MDT).

The service provides community based mental health assessment, care and treatment to individuals who are under 65 years old and are living in the East Dunbartonshire area. The CMHT includes mental health nursing, psychiatry, peer support, occupational therapy (OT) and psychology.

This was the first time that the Commission has visited an adult CMHT service in NHS Greater Glasgow and Clyde (NHS GGC) area. Prior to this visit, the Commission has made several enquiries across NHS GGC CMHTs, including the East Dunbartonshire service, in relation to assessment and management of risk, as well how communication takes places with families and/or unpaid carers.

On the day of this visit, we wanted to look at whether there were any issues that had an impact on care and treatment, including the implementation of updated policy and procedures in relation to risk documentation, as well as communication with families and/or unpaid carers.

Who we met with

We met with and/or spoke to 16 people, reviewing the care of 12 of these individuals and we reviewed the care notes of a further two individuals. We also spoke with two relatives during our visit.

We met with professional leads and/or operational staff from nursing, social work, OT, psychiatry, peer support, advocacy, alcohol and drug recovery as well as learning disability services.

We also met with the clinical director, the chief social work officer and the service manager (SM).

Commission visitors

Gemma Maguire, social work officer

Mary Leroy, nursing officer

Laura Young, nursing officer

Sheena Jones, consultant psychiatrist

Justin McNicholl, social work officer

What people told us and what we found

People we spoke with told us that staff were “kind”, “caring” and “accessible”. We consistently heard that individuals and their families, felt “listened” to and that staff were “interested” in how people are doing. Some individuals felt being involved with the service has helped them to understand how trauma had an impact on their mental health and what best supported their recovery.

One person reported that peer support service had helped them overcome anxiety when leaving their home. Several individuals told us that they valued speaking to someone who they had a shared experience with. We met with the peer support service on the day of our visit and heard about individuals developing wellness and recovery plans, with referrals being made by staff across the MDT.

We were pleased to hear about the joint work between the MDT, peer support and local advocacy services. We heard how this has developed information and provides support for people to complete advance statements.

Many individuals we met with valued having a named nurse and input from health care support workers (HCSW). We were told that if the named nurse or the HCSW was unavailable, the person could contact the ‘duty’ service. Several people told us this service was ‘responsive’ and helped them to avoid either a crisis or a deterioration in their mental health.

When reviewing individual care records, we found detailed notes of home visits that had taken place, as well telephone calls.

Family members we spoke with told us they felt “involved” in their loved one’s care. One relative reported that the transition from the child and adolescent mental health (CAMH) team was “tricky”, but that support from the CMHT was “going well”. We were pleased to hear the service has been working to improve communication and support for family /unpaid carers, with links to local carer groups and that they provide information leaflets.

Larkfield CMHT has a standardised procedure to optimise attendance and provide appropriate follow up when someone does not attend an appointment. This includes informing people about appointments in advance by letter and text message, with reminders also being sent. Appointments can be offered by telephone or face to face with options for individuals to rearrange.

Where someone does not attend, and the reason for this is unknown, the service will consider the urgency of the referral including risk of harm. The service may then carry out a home visit and/or offer further appointments. Staff would also contact referrers to inform them when a person did not attend.

The Commission are aware of national concerns around access to assessment and support for neurodivergent individuals. NHS GGC have previously informed the Commission of increasing pressures on CMHTs with significantly high numbers of people waiting a service in relation to attention deficit hyperactivity disorder (ADHD).

We have been told that competing demands across all areas of care is challenging but that pathways for people with ADHD are being developed. During this visit we were pleased to hear that Larkfield CMHT were making improvements for people specifically referred to the service for ADHD support. Referrals are considered within the main functions of the service, including MDT and allocation meetings. We were informed that people with ADHD who are on the waiting list were provided with self-help advice and could access the telephone duty line. We were advised that physical health screening and access to health clinics was available to individuals. Staff across the MDT were also provided with training to support their understanding of neurodivergence.

We were pleased to hear the service provides complex case discussions which are led by psychology with contribution from the wider MDT. Several staff members told us discussions were 'helpful' when supporting individuals who may have complex needs and/or at be at significant risk of harm.

We heard that psychology and members of the MDT have steered a program of self-assessment to compare how well the service performs against core mental health standards. We were advised that this has led to meaningful improvements being made to the service, including the building being made more accessible for people with sensory needs and using media technology to help gather continual feedback from individuals and their families.

Care, treatment, support, and participation

Care records

We found detailed information about individuals' care and treatment, as well consultation with people and their families, in the chronological notes. We also found evidence in the care records that physical health screening was being carried out with individuals.

People we spoke with on the day of our visit told us they were regularly asked for their views. When reviewing care plans, we did not find that the views of individuals or their families, were explicitly recorded. We also found care plans to be written from a nursing perspective as opposed to language and terminology used by the individual.

Care plans provided details about an individuals' medication and their physical health needs. We found that wider needs, such as psychological or social needs, were not consistently covered in the plans. We discussed these issues with nursing

staff and managers on the day of our visit and heard that a new person-centred care plan template was introduced by the service last year. Some staff we met with told us they had difficulty understanding the new template, while others felt this has improved their practice. We heard how practice development leads were providing training and support regarding person-centred care planning. The SM and nurse team leader informed us about auditing processes being undertaken in relation to person centred care plans.

Recommendation 1:
Managers for Larkfield CMHT should audit care plans to ensure they address all individual care needs, with the views of individuals and/or their families clearly 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 assessment documentation was in place for all the individual care records that we reviewed on the day of our visit. While several records contained relevant historical information, we found that in some documents, historical information was missing, particularly following review.

We also found that some documents had not been reviewed timeously, and information on how staff could support individuals to manage risk to themselves or others was lacking in detail. We discussed this with managers on the day of our visit and were advised that a mental health 'dashboard' has been developed to support the audit of care records. We heard that that the dashboard identified where risk documentation required completion and review. We advised the SM and nurse team lead that information recorded in documents should also be audited to ensure that practice was in line with local policy.

Recommendation 2:
Managers responsible for Larkfield CMHT should audit risk assessment documentation to ensure historical risks are recorded, reviews are carried out timeously, and information on risk management is detailed.

Multidisciplinary team (MDT)
Larkfield MDT consists of consultant psychiatrists, junior doctors, higher trainee medics, nursing staff, HCSW, psychologists, and OT. The pharmacy service has a hub in the same building as Larkfield CMHT, offering advice and support regarding medication when required.

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

On the day of our visit, we met with staff from across the service and heard how being co-located with colleagues had strengthened MDT working. We were informed that staff from all disciplines were involved with the MDT, at allocation and with complex case meetings. We also found evidence from speaking with staff and in reviewing the care records that MDT decision making frameworks were regularly being used to support individuals and to manage risk of harm. This included appropriate use of the care program approach, adults with incapacity case conferences or adult support and protection case conferences. Staff we met with told us that MDT frameworks have been particularly effective in supporting individuals with complex needs.

MDT meetings happen weekly with individuals being invited to attend. Some individuals will be discussed at MDT meetings more frequently than others, based on level of need, risk and intervention. When we reviewed care records, it was not always clear when MDT meetings had taken place, particularly for those individuals whose mental health was stable.

We found that some staff used chronological notes to record MDT meetings, which made it difficult to review progress and any actions that had been agreed from previous meetings. Some records did not note who had attended meetings, as we would have expected to see. We discussed these issues with managers on the day of our visit and heard that the service has recently introduced an MDT template which records who attended meetings, as well as any actions agreed. We were advised that the template will be audited to ensure meetings are held timeously and that records are consistent.

Recommendation 3:
Managers from Larkfield CMHT should audit MDT records to ensure those who attend meetings and agreed actions are clearly recorded.

Use of mental health and incapacity legislation

On the day of our visit, 24 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). All individuals detained under the Mental Health Act were aware of their rights. Several people we met with had nominated a named person, were receiving legal advice and accessing advocacy services.

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. We heard from nursing staff that there was a standard document to record that the appropriate legal authority was in place when a person attended for their depot anti-psychotic medication, in addition to physical health monitoring.

We saw good evidence of this in the electronic care records and in the results of the audit which is completed by nursing staff in relation to consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We also heard from nursing staff that similar processes were being developed in relation to treatment with Clozapine, an oral anti-psychotic, when people attended the Clozapine clinic to have their bloods and physical health monitoring.

We did not find the same level of detail in people's care records in relation to other medication that was recommended by medical staff and prescribed by the person's general practitioner (GP). We found that medical staff sent a standard letter to the GP to request changes to medication, but this did not detail under what authority the medication was to be given, where the person was subject to the Mental Health Act.

In total, we found six errors in relation to T2 or T3 certificates. Errors included prescribed medication that was not included on a person's T2 or T3 certificate, and we found one certificate that had expired. We followed up on each of these issues with medical staff and provided advice to ensure audit processes were implemented.

Recommendation 4:
Medical staff in Larkfield CMHT should establish a process to ensure that the authority under which medication is prescribed and given under the Mental Health Act is recorded and that this is communicated with the person's GP.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where someone had nominated a named person, we found documentation to be accessible and the named person had been appropriately consulted.

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 (the 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. On the day of our visit, no one we met with or reviewed the care records for required to have a section 47 certificate in place.

Rights and restrictions

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.

Several individuals we spoke to and where we reviewed their care records, had a statement in place. We were pleased to hear about the work being undertaken by advocacy services and Larkfield CMHT in providing information sessions about advance statements. We also found that improvements were being made to ensure appropriate reviews of advance statements were taking place. Those with statements in place were sent letters about reviews, including contact details for independent advocacy services and specialist advocacy for those who had care experience.

Activity and occupation

Larkfield CMHT provided individual and group based psychological and occupational therapies which were delivered by nursing, OT, psychology and HCSW. Individuals we met with were attending emotional coping skill groups, talking therapy groups and self-help groups.

Several people told us they have developed wellness and recovery plans with the peer support service. Many people were also being supported with activities including attending the local gym, participating in art projects or undertaking further education or vocational training.

The physical environment

The Larkfield CMHT is in the centre of the town and shares a building with other community-based services, including a GP practice. The building was bright and welcoming. The waiting area had a display of posters and information that included online self-help guides, health and wellbeing advice, advocacy services, and carers support and information.

We were advised that managers and staff have applied the principles of trauma informed practice in relation to the environment, which had led to changes, including softer lighting and calm colours on the walls of interview rooms. We heard how this has been particularly helpful for those who have experienced trauma or who had sensory needs. The walls in the waiting and clinical areas of the service were beautifully decorated with artwork created by individuals involved with a local trauma informed art project.

Summary of recommendations

Recommendation 1:
Managers for Larkfield CMHT should audit care plans to ensure they address all individual care needs, with the views of individuals and/or their families clearly recorded.

Recommendation 2:
Managers responsible for Larkfield CMHT should audit risk assessment documentation to ensure historical risks are recorded, reviews are carried out timeously and information on risk management is detailed.

Recommendation 3:
Managers from Larkfield CMHT should audit MDT records to ensure those who attend meetings and agreed actions are clearly recorded.

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Medical staff in Larkfield CMHT should establish a process to ensure that the authority under which medication is prescribed and given under the Mental Health Act is recorded and that this is communicated with the person's GP.

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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