NHS Quality Improvement Scotland (NHS QIS) is committed to equality and diversity. We have assessed the performance assessment function for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. For this equality and diversity impact assessment, please see our website (www.nhshealthquality.org). The full report in electronic or paper form is available on request from the NHS QIS Equality and Diversity Officer.

Images and poetry supplied courtesy of focus group participants.

In collaboration with:

© NHS Quality Improvement Scotland 2010
ISBN 1-84404-593-5
First published June 2010
You can copy or reproduce the information in this document for use within NHSScotland and for educational purposes. You must not make a profit using information in this document.

Information contained in this report has been supplied by NHS boards, service users and carers or taken from current NHS board sources, unless otherwise stated, and is believed to be reliable on publication.

www.nhshealthquality.org
Intensive Psychiatric Care Units
Overview Report ~ June 2010
Acknowledgements

We gratefully acknowledge the work of the Intensive Psychiatric Care Units (IPCU) project group which oversaw the project from its inception to the publication of this report. Also, the work of the service user and carer experience subgroup which oversaw the parallel work to gather views and experiential information. The contribution made by every member of the teams that met with the NHS board areas was also crucial to the success of the project.

We would like to extend our thanks to those NHSScotland staff who contributed to data collection and the follow-up meetings; in particular, the IPCU contacts who were responsible for preparing staff locally for the meetings and for the compilation of comprehensive service profiling material.

We would also like to acknowledge the participation of the IPCU patients, former patients and carers who participated in the service user and carer experience work and the NHSScotland staff and representatives of local voluntary organisations who supported them to do so.

The poetry and artwork contained within this report have been reproduced with the kind permission of a number of the focus group participants.
I am very happy to contribute to this joint foreword for the Overview Report on Intensive Psychiatric Care Units in Scotland. Ivan and I decided at a very early stage not to attempt to produce a single statement but I am confident that our views on the findings of the report are consistent.

Overall the report has a good story to tell. In Scotland, patients who are suffering from mental illness, when in most need, will receive high quality treatment from dedicated staff. However, there is certainly room for improvement. In all IPCUs there is a need for a structured approach to ensure appropriate risk management but the downside is that this can result in a ‘one size fits all’ approach. There is a need for all staff working in IPCUs to ensure that care planning does take account of the individual patient needs and considers the impact on their family and friends.

I have welcomed the approach taken by the project to attempt to gain a 360 degree view of intensive psychiatric care. The very real involvement of the Mental Welfare Commission for Scotland and Voices of eXperience (VOX) Scotland in gathering user and carer opinions has added true value and I hope that this wealth of experience will be used in the development of future services.

Chairing the project group has been a pleasure given the level of enthusiasm displayed by the members. I would like to take this opportunity to thank all of them and on behalf of the project group to acknowledge the excellent support we received from the NHS Quality Improvement Scotland (NHS QIS) staff.

Dr James Hendry
Chair, IPCU project group
Joint foreword

I was privileged to be invited to co-chair the subgroup dealing with the experiences of patients and former patients of IPCUs and their carers.

The subgroup was responsible for what I regard as one of the most important parts of the report, namely the in-depth interviews of patients and focus groups with former patients and carers which were carried out by the Mental Welfare Commission for Scotland and VOX Scotland respectively. These interviews and focus groups gave patients and carers the opportunity to vocalise their experiences and express their opinions (in many cases for the first time) about IPCU services.

It is clear from the interviews and focus groups that, in general, there is a high degree of well-structured and compassionate care provided in IPCUs. However, the report does highlight some key areas of weakness where improvements could be made, especially in the provision of longer and more varied types of meaningful activities and in the strengthening of multidisciplinary teams. The relatively high proportion of patients in IPCUs who require specialist forensic mental health services is another area that may require to be given early attention.

From a patient perspective, the need for greater social interaction between staff and patients, and the avoidance of a ‘one size fits all’ mentality, were clearly identified as being of primary importance to patients.

The need for carers and families to have early access to clear, easily assimilated information was also regarded as essential, as was the need for clinicians and nurses to provide support to, and engage in a proper dialogue with them. This was seen as equally important both at the time of initial admission, and during the subsequent treatment phase.

One facet of care that has perhaps been under-appreciated in the past is how strange and frightening admission to an IPCU can be, not only for patients, but also for their families and carers. A friendly, sympathetic and understanding attitude on the part of doctors and other staff can go a long way in helping to alleviate any trauma.

Finally, I would like to join with James in paying tribute to the hard work and dedication of my colleagues on the project group and to the professionalism of our support team at NHS QIS.

Mr Ivan Carnegie
Co-chair, Service user and carer experience subgroup
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of IPCU provision in Scotland</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iii</td>
</tr>
<tr>
<td>Joint foreword</td>
<td>iv</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Executive summary</td>
<td>3</td>
</tr>
<tr>
<td>1 Setting the scene</td>
<td>11</td>
</tr>
<tr>
<td>2 National emerging themes</td>
<td>15</td>
</tr>
<tr>
<td>3 IPCU service provision</td>
<td>29</td>
</tr>
<tr>
<td>4 IPCU census</td>
<td>41</td>
</tr>
<tr>
<td>5 Patient experience – Mental Welfare Commission for Scotland interviews with IPCU patients</td>
<td>53</td>
</tr>
<tr>
<td>6 Service user and carer experience - focus groups</td>
<td>71</td>
</tr>
<tr>
<td>Appendices</td>
<td>81</td>
</tr>
<tr>
<td>1 IPCU project group members</td>
<td>81</td>
</tr>
<tr>
<td>2 Service user and carer experience subgroup members</td>
<td>82</td>
</tr>
<tr>
<td>3 Participating NHS boards and meeting dates</td>
<td>83</td>
</tr>
<tr>
<td>4 IPCU project follow-up meetings team members</td>
<td>84</td>
</tr>
<tr>
<td>5 Mental Welfare Commission interview questions</td>
<td>85</td>
</tr>
<tr>
<td>6 Reference list</td>
<td>87</td>
</tr>
<tr>
<td>7 Glossary</td>
<td>88</td>
</tr>
<tr>
<td>8 The Forensic Network</td>
<td>95</td>
</tr>
</tbody>
</table>
MERGING

We are all one
or are we all – all joined.
By the same air,
the same space
the same time,
made of the same colours
some brighter,
some dimmer.
Our breath leaves us
and mingles,
our heat, our heart
our thoughts.
We are all one
And all we are is one

Poem written by a focus group participant
NHS QIS is a Special Health Board whose purpose is to advise, support and assess NHS boards in order to help improve the quality of healthcare for the people of Scotland. NHS QIS has a lead role in supporting NHS boards and their staff in achieving this goal and does this by:

- providing advice and guidance on effective clinical practice, including setting standards
- driving and supporting implementation and improvements in quality, and
- assessing the performance of the NHS, reporting and publishing our findings.

We also have central responsibility to support NHS boards to deliver patient safety and clinical governance across Scotland.

For most of our projects, we establish a topic or service-specific multidisciplinary project group to advise on, steer and oversee the work.

We formed an IPCU project group in September 2008 under the chairmanship of Dr James Hendry, Acting Clinical Director, West Lothian Community Health and Care Partnership and Consultant Psychiatrist, NHS Lothian. Membership of the project group is given in Appendix 1.

The project group developed a service profiling questionnaire which was sent to each NHS board for completion in January 2009.

We met with each NHS board area* in Scotland between May 2009 and July 2009 to follow up on the information provided in the service profiling questionnaire. We produced a local report1 on each NHS board which includes information from the service profiling questionnaire, and information gathered at the follow-up meeting. We have already published these reports and they can be found on our website (www.nhshealthquality.org/nhsqis/7048.html).

To supplement the service profiling information, and to get a national ‘snapshot’ of the IPCU inpatient population, in November 2009, each IPCU undertook a census exercise.

We also formed a service user and carer experience subgroup. This group took forward a parallel project to gather the views and experiences of current and former IPCU patients and their carers. Mr Ivan Carnegie, Chair of Tayside Forensic Voices and Dr Deborah Mountain, Consultant Psychiatrist, NHS Lothian jointly chaired the subgroup. The service user and carer experience work was carried

---

1The meetings with the island NHS boards were conducted by video-conference.
out in collaboration with the Mental Welfare Commission for Scotland (hereafter referred to as the Mental Welfare Commission) and VOX Scotland and was supported by Better Together, Scotland’s Patient Experience Programme. The membership of the service user and carer experience subgroup is given in Appendix 2.

VOX Scotland organised a series of regional focus groups with former IPCU patients and carers. These were held between October 2009 and January 2010. A service user researcher from VOX Scotland facilitated the focus groups.

Between October 2009 and December 2009, the Mental Welfare Commission made announced visits to a number of IPCUs. Mental Welfare Commission practitioners met with willing volunteers to talk about their experiences of IPCUs.
Executive summary

This report presents our key findings of the first stage of a project that set out to audit IPCU provision across Scotland. To generate a comprehensive picture, we carried out this work in partnership with the Mental Welfare Commission and the service user led organisation VOX Scotland, and were supported by Better Together, Scotland’s Patient Experience Programme. In this way, we were able to collect and analyse information from NHS boards, mental health care managers and clinicians from across NHSScotland as well as the knowledge and lived experiences of past and present IPCU patients and carers.

Our key messages

Throughout this work, we have heard from service users and carers about the importance of:

- feeling safe and secure
- having access to meaningful occupation and a good range of therapies
- being listened to
- being involved in care and treatment decisions, and
- being respected when in an IPCU.

As we know, IPCUs by their nature are locked and highly risk managed environments. While this level of security is essential, the primary function of an IPCU should be a therapeutic one where care and support is provided for people in acute stages of mental illness. This is in the same way as an intensive care or high dependency unit in a general hospital provides care for people who are very physically unwell, until such a time as they have recovered sufficiently to move to a less intensive care setting.

We have developed a number of key messages and hope that these will help services to realise the Healthcare Quality Strategy for NHSScotland² quality ambition of ‘Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.’

Detailed information on what we did, what we found and areas for service improvement are discussed later in this summary and are covered in more detail in the body of this report.
Our key messages

- If they need to, everyone in Scotland should be able to easily access an IPCU. Their length of stay should only be as long as necessitated by their clinical needs.
- Everyone in an IPCU should be able to access the support that they need to enable them to recover including a range of activities, therapies and treatments and input from family, friends and carers.
- The specific needs of all people accessing an IPCU should be assessed and mechanisms put in place for people’s safe management. Particular attention should be paid to women and younger people who require intensive psychiatric inpatient care.
- Carers should be supported and provided with information that will assist them in their caring role. The needs of carers should be taken into consideration and their views taken into account as much as possible when any decisions about the service user’s care and treatment are made.
- Service users should be provided with information that they can understand and should be involved in the planning and review of their care as much as either they wish to be, or are able.

What is an IPCU and who uses them?

The Scottish Government’s national mental health benchmarking project Technical Appendix (January 2008) proposes the following definition for IPCUs:

‘…a multi-disciplinary team with specialised training; the ratio of nursing staff will be higher than a general psychiatric ward. The service is recovery focused; it provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation.’

The National Mental Health Services Assessment: Towards Implementation of the Mental Health (Care and Treatment) (Scotland) Act (2003) report highlighted specific challenges faced by IPCUs in light of changes in mental health legislation. That report concludes that:

‘IPCU provision is a small but important part of services… and should remain central to planning decisions when implementing the Mental Health Act.’

In Scotland, IPCUs provide care almost exclusively for compulsorily detained patients in locked, secure conditions. Varying degrees of restrictions are applied as deemed necessary and proportionate to ensure the safe and therapeutic treatment of patients, and the management of clinical risk to self and others.
Contact with an IPCU should be a time-limited, short episode of care focusing on the management of acute mental health and behavioural disturbance. In reality, however, some people remain in IPCUs for longer than the time necessitated by clinical need.

IPCUs in Scotland accommodate a diverse client group. By virtue of the stage that people are at in terms of their mental illness, IPCUs often have to provide care for people who present with very challenging behaviour. Inevitably, the mechanisms in place to manage a challenging client group will impinge to some extent on patients who present a lower level of risk. There is no IPCU provision specifically for women in Scotland so a mixed gender group is common. From time-to-time, people who may be particularly vulnerable (for example young people under the age of 18 or people with learning disabilities) are admitted to an IPCU. In addition, IPCUs often fulfil a dual purpose whereby they function as both a low secure forensic unit and an extension of general adult psychiatric services. We know that in practice a significant proportion of patients being managed within the IPCU setting could be considered as requiring specialist forensic services.

We need to question the capability of IPCUs to simultaneously perform all of these differing functions satisfactorily and to meet the, at times, competing needs of the inpatient population without significant compromise for all.

What we did and why we did it

There is very little published Scottish data about IPCUs. Our work sought to enhance the available data regarding service provision and to get a sense of what it is like to experience an IPCU first-hand. Information was captured using:

- service profiling questionnaires and follow-up meetings with each NHS board
- a national IPCU census exercise
- semi-structured interviews with current patients, and
- regional focus groups with former patients and carers.

Our work has enhanced the information available and provides useful baseline data on the national picture with regard to IPCU provision. This data should be used as the basis of future benchmarking, audit and focused service improvement work. The two pieces of work that explored the first-hand experiences of service users and carers have given us a real insight into what it is like to be in an IPCU. People told us about what is good and what could be better. They also told us about the emotional impact, which for most people was significant.
What we found

Our findings can be grouped under three broad headings:

- **access** - both to an IPCU and to an appropriate therapeutic environment
- **client mix** - and the impact on care provision and the patient experience, and
- **involvement**.

The emerging themes chapter contains detail of the nine key themes that the project group identified from the work; these all fall under the above broad headings. The service user and carer experience runs through the majority of the emerging themes.

**Access - to an IPCU**

The service profiling exercise identified 14 IPCUs across NHSScotland with a total of 147 beds available at the time of the exercise. There are adequate numbers of IPCU beds relative to the adult population. However, occupancy rates and demand can periodically, and radically, fluctuate across, and within, NHS board areas. Only eight of the 14 NHS board areas have local IPCU provision. We found that getting access to an IPCU can be problematic for some, particularly for people in the areas where there are neither locally-based beds, nor a service level agreement (SLA) in place with another NHS board area. It is good to see that a new build IPCU is planned in NHS Dumfries & Galloway, one of the areas that does not currently have local provision.

**Access - to an appropriate therapeutic environment**

We found that the composition of multidisciplinary teams varies widely across the country. Often access to services, over and above medical and nursing input, is on an individual referral basis with varying degrees of responsiveness. Only one IPCU has dedicated input from a clinical psychologist. Dedicated input from the allied health professions (AHPs) also varies widely across the country. This can impact on the range and frequency of activities, therapies and specialist clinical services available to people while they are in an IPCU.

We have good evidence of a range of unmet needs. We found that many people in IPCUs do not have access to a good range of daily activities and therapies, in particular psychological therapies. Access to therapies is often dictated by availability of professionals to deliver such interventions. However, much of what service users informed us was lacking should be much simpler to achieve. They told us about things that most of us take for granted that would make a big difference to their quality of life when in an IPCU. These included:
Executive summary

- comfortable and homely surroundings
- being able to access fresh air and outdoor spaces
- opportunities for day-to-day social interaction, and
- access to personal belongings, private spaces and facilities to make a hot drink or snack.

While service users were very pragmatic and appreciated that there are some people for whom level of risk may be a preventative factor, frustration was expressed at the "one size fits all" approach often adopted with regard to risk management and the restrictions imposed on them.

We were able to identify ongoing work in a number of NHS board areas to provide a better and more innovative range of activities and therapies for people both on and off the ward. Despite this, availability of a good range is far from commonplace across NHSScotland. Due to the uncertain nature of the IPCU environment, staff are often called away unexpectedly to manage situations that may arise suddenly on the ward. This can detrimentally affect planned activity programmes that rely on the same staff to deliver the sessions and support people to participate.

Client mix

We know that some IPCUs serve a dual function as both a low secure forensic unit and as an extension of general adult psychiatric services. This may be for a number of reasons, including lack of inpatient forensic provision locally or uncertainty regarding the level of risk that might be considered sufficiently significant for a person to be accepted into specialist forensic services. The interface between IPCUs and forensic mental health services generated much discussion during the follow-up meetings with NHS boards. This included issues relating to mixing of offenders, who may not be acutely unwell at the time, with vulnerable adults.

The behaviour of acutely unwell patients can be disturbing to others and the manner of some patients perceived as intimidating. While most service users said that they felt safe in an IPCU, a number reflected on how the client mix on the ward at particular times can affect the atmosphere and feeling of safety. In addition, there are no IPCUs specifically for women in Scotland and a proportion of the women who shared their experiences said that they were uncomfortable being in a mixed gender, predominantly male, environment; a small number of the men who participated also said that they were uncomfortable with mixed gender services. Service users also felt that an IPCU was not an appropriate setting for some groups, for example people with dementia.
Involvement

An imperative of modern day mental health care is that provision is person-centred. Person-centred care should ensure that assessments, care planning and care delivery are based on the needs of the individual and the recovery outcomes identified by the service user rather than on the availability of services and treatments. Many of the people that we spoke to said that they felt left out of the care process. There was a range of reasons for this including:

- limited opportunities for involvement
- opportunities being offered at the wrong time, and
- lack of accessible and understandable information to allow people to make informed choices about their care and treatment.

A burning issue for carers was the lack of accessible information and formalised mechanisms for them to share their expertise and knowledge regarding the person that they provide care for with the clinical team. Carers really wanted to be involved in care and treatment decisions as appropriate and also for their needs to be considered. As many carers pointed out to us, the experience of an IPCU can have as significant an emotional impact on them, and on family and friends, as it does on the patient.
Conclusions

It is clear that there are many dedicated staff across NHSScotland who are doing their very best to provide a good standard of care that meets the therapeutic and wellbeing needs of the diverse range of people who have contact with IPCUs. As previously outlined in this summary, it is not easy to simultaneously perform all the functions required, to a satisfactory standard, in an environment that is already by its very nature a challenging one.

Our work has identified a number of areas where service improvements are required. Some of these improvements need to be taken forward by NHS boards at local service delivery level, others require to be considered on a national basis. While by no means exhaustive, the specific local and national service improvements that we have chosen to highlight should be achievable. Realisation of these improvements would improve the experience of IPCUs, not just for patients and carers but also for the staff who work in this complex and demanding environment. The key service improvement areas are summarised below and are covered in more detail within the emerging themes chapter of this report.

- **National improvement areas**
  - A set of nationally agreed criteria for admission to forensic services should be developed with the involvement of all stakeholders.
  - All instances of inappropriate admissions, including patients who require specialist forensic mental health inpatient services who are admitted to an IPCU, should be reviewed, considered and addressed on a national basis.
  - A national IPCU dataset should be developed to enable routine monitoring of services.

- **Local improvement areas**
  - NHS board areas with no local IPCU provision should develop and agree an SLA for provision of IPCU care with a neighbouring NHS board area that provides this service.
  - Care planning and delivery should have a recovery focus. Service users should be provided with understandable information and supported to be actively involved as much as either they wish or are able in the planning of their care when they are in an IPCU.
  - Carers should be offered the services of a key named contact person who has been allocated responsibility for:
    - involving the carer in care planning as appropriate
    - ensuring that the carers needs are considered while the person they provide care for is in an IPCU
    - liaison between the carer and the wider clinical team, and
    - ensuring that relevant, accessible information is provided.
● A range of therapies and activities, including opportunities to regularly access fresh air and outdoor areas, should be available to people when they are in an IPCU.

● The availability of such opportunities should be actively communicated to patients and they should be supported to participate if they wish.

● The range of therapies and activities should be monitored with regard to uptake and effectiveness.

● All instances of inappropriate admissions, including patients who require specialist forensic mental health inpatient services who are admitted to an IPCU should be recorded locally.

● In line with the Millan principles\(^8\) of equality and respect for diversity, admission protocols must address the needs of all people being admitted to an IPCU specifically in relation to the six equality strands\(^13\) of race, religion/belief, gender, sexual orientation, disability and age.

● Where admission of patients who fall outwith the core group is unavoidable there should be agreed protocols in place for the safe management of those people when in an IPCU.

● NHS board clinical governance arrangements should include mechanisms for the recording, monitoring and review of all invasive and/or restrictive interventions (for example seclusion, restraint and specified persons measures) applied in the IPCU setting to ensure that usage is appropriate and to identify any emerging trends.

● Care staff should look for ways to reduce unnecessary restriction and personalise care as much as it is safely possible to do so.

● NHS boards should monitor and review length of stay in the IPCU. If a person’s stay reaches 3 months there should be a review, involving all those providing care, to consider whether the person’s needs continue to be best met in the IPCU environment.
1 Setting the scene

In 2001, the Department of Health commissioned the Psychiatric Intensive Care Unit (PICU) Policy Research and Development Group, based at the North East London Mental Health NHS Trust, to produce national PICU standards for services in England and Wales. The Department of Health published National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments (hereafter referred to as ‘the PICU standards’) in 2002.

The PICU standards have not been formally adopted within NHSScotland. They are, however, cited in this document as a reference point for analysis, both of the Scotland-wide IPCU data collected during the service profiling exercise and the service user and carer experience work.

The PICU standards say that, for successful implementation within the PICU environment, specialty associations may help clinicians and managers to keep up to date with current best practice. The standards advocate that organisations such as the National Association of Psychiatric Intensive Care Units (NAPICU) can help to facilitate this process. NAPICU is a multidisciplinary clinician-led organisation committed to the development of psychiatric intensive care and low secure services, primarily in the UK. NAPICU aims to make advances in care and treatment through:

- promotion and sharing of good practice
- providing education and training
- encouraging clinicians to establish networks, and
- undertaking research and audit.

While NAPICU does have Scottish clinicians within its membership, there is no comparable organisation leading on the development of IPCU care in Scotland.

1.1 The IPCU project background and context

Our 3-year strategic work programme, Improving the Quality of Mental Health Services 2005–2008, recognised that there is little published information about Scottish IPCUs. The work programme included a commitment to undertake an audit of IPCUs in Scotland. Before undertaking any work to assess how services are delivered within IPCUs, it was important that we had a clear picture of:

- how many IPCUs there are across Scotland
- the arrangements in place in NHS board areas that do not have local IPCU provision
- how the IPCUs are structured and staffed
• the relationships between IPCUs and other mental health services, and
• the referral pathways both in and out of IPCUs.

In order to gather this background information, the project group agreed that the IPCU project would be delivered in two distinct stages. Stage 1 has been a national service profiling exercise covering all the territorial NHS boards in Scotland.

In a parallel piece of work during Stage 1, we sought the views and experiences of people who have received IPCU care and their carers.

1.2 Approach to information gathering

In order to obtain as full a picture as possible about service provision we adopted a three strand approach. This allowed profiling of services from the perspective of service providers and also from the perspective of people who have used IPCUs in the past and those who are current patients and carers. The service profiling aspect of the project considered whether The Ayr Clinic, a privately operated facility in Ayr, might be performing some similar functions to an IPCU for some patients. A meeting held with managers and clinical staff, followed up with a profile of patients and their care, established this not to be the case. Therefore, we have not included the information in this report. More detail on the methodologies used can be found below.

1.3 Service profiling and census

The service profiling process had two key parts: local information gathering and follow-up meetings. Using our service profiling questionnaire, each NHS board gathered information on the IPCU(s) in its local area. These data were submitted, together with supporting evidence if applicable, to us prior to the follow-up meeting. Follow-up meetings were held with local staff to discuss the responses provided by the NHS board and seek clarification on any issues.

We used the information gathered from the follow-up meetings, together with the service profiling questionnaire to produce a draft local report detailing IPCU provision in each NHS board area. We sent the draft reports to each NHS board for factual accuracy checking and sign-off before publishing on our website in November 2009.

To supplement the information provided in the service profiling questionnaire, we asked NHS boards to undertake a 1 day census exercise in November 2009. The census was carried out in consultation with the national Forensic Mental Health Services Managed Care Network (the Forensic Network). The Forensic
Network is trying to establish the level of need across Scotland for long-term care forensic services.

1.4 Focus groups

Following a tendering process, we appointed VOX Scotland to undertake a series of focus group sessions with service users and carers with experience of IPCU care. The focus groups were led by a service user researcher and supported by VOX Scotland staff. A range of people were encouraged to take part in the groups in order to gather as diverse a range of views as possible. VOX Scotland used a grounded theory approach to develop the questions to ensure a focus on the correct areas, and to make sure that the sessions were adaptable based on the responses received.

Creative methods were used to support information gathering during the sessions and to help provide some insight into people’s experiences at an emotional level. In addition, participants were asked to bring along any poetry or art work which showed how they felt about their experience of IPCU care.

1.5 Mental Welfare Commission interviews

The Mental Welfare Commission conducted interview sessions in selected IPCUs with patients who had self-selected to be involved. The interview sessions were led by Mental Welfare Commission practitioners and took place in 11 IPCUs across the country.

The Mental Welfare Commission made initial contact with link staff in each IPCU and asked them to help to publicise and identify IPCU patients who may wish to be involved. The link staff member then ensured that the patient had sufficient background information to allow them to make an informed decision about sharing their views and experiences.
EXCERPT FROM MADDENING SILENCE

Tenseness building up in great depths of emotion.
Rooms of fullness or emptiness with no helping hand for the lonely one amongst the crowd

MIND IN TURMOIL

In the lonely oceans of my mind,
The wind blows strong,
The thunder roars to fill the empty void.
Turmoils of turmoils’ stirring in the whirlpools of my mind.
Praying for tranquillity to be bestowed upon my restless mind
I hope to find emotional splendour
2 National emerging themes

The IPCU project group agreed the following nine national emerging themes. The themes are drawn from the work to gather the experiences of people who have used IPCUs and carers, and from the service profiling and census exercises.

Two separate pieces of work explored first-hand experiences of IPCUs. IPCU patients were invited to share their experiences through semi-structured interview sessions with Mental Welfare Commission practitioners. Fifty current patients from across 11 IPCUs participated (for the full report see Chapter 5). People who have previously used IPCUs and carers shared their experiences in regional focus groups; these were facilitated by a service user researcher from VOX Scotland. A total of 30 service users and carers participated (for the full report see Chapter 6).

These two separate exercises allowed us to capture the experiences of people at different stages of their journey of care. This has given us a wide perspective on what it is like to experience an IPCU, from the point of view of both service users and carers. The service profiling and census work gathered information on the services available from the perspective of NHS boards and those delivering services.

Where applicable, the emerging themes reflect both the service-based data and the service user and carer experience. We have tried to group the information under common themes. Much of the information, particularly from the experience gathering work, cuts across a number of themes. Unless specifically referenced, the service user and carer experience relates to information gathered across both the focus groups and the inpatient interviews.

2.1 Availability of local IPCU provision

The number of IPCU beds available across NHSScotland (43 per million of the adult [aged 16–64] population) slightly exceeds what little published guidance there is\(^6\). However, there are some NHS board areas with no local IPCU provision nor a formalised SLA in place with another NHS board area. Even where an SLA is in place, there can be issues around availability of beds. There may not always be a bed available in the unit that is closest geographically and arranging for the safe transfer of people, across what can be significant distances, can be complex. Safe and speedy transfers also rely heavily on members of staff being available to provide an escort. In addition, transfers may require co-ordination and collaboration with other services, including the Scottish Ambulance Service and the police.
Significant travel for people who are in an acute phase of mental illness and often distressed is not ideal. Neither is moving people so far from the area in which they live that they become isolated from family and friends and from familiar mental health practitioners. Information from service users echoed this. They talked about continuity of clinical input when transferred to an IPCU, even within the same NHS board area. In the Mental Welfare Commission interviews, 17 of the 30 patients who answered the question said that they were not seeing the same consultant as they had been before admission to the IPCU. Some people considered this lack of continuity of care detrimental to them as they had to form new relationships and repeat their clinical history many times.

As previously reported, in some areas there are issues regarding availability of local IPCU beds, and lack of safe, appropriate and easy to co-ordinate transport to move patients to out-of-area provision. In some cases, this has resulted in a proportion of patients who meet the criteria for admission to an IPCU, remaining on the acute wards and receiving more intensive care in that setting. This seems to work satisfactorily in most cases. However, some people who may benefit from admission to an IPCU are not getting that treatment option. In NHS Dumfries & Galloway, one of the two mainland NHS boards concerned, there are plans in place to build an IPCU.

### Key service improvement area

#### Key finding

Referral and admission to an IPCU of people from areas where there is no local provision is more straightforward when a formalised SLA is in place.

#### Local improvement action

NHS board areas with no local IPCU provision should develop and agree an SLA for provision of IPCU care with a neighbouring NHS board area that provides this service.

### 2.2 Experience of IPCUs

The experience of being in an IPCU can be unsettling and frightening, both for the patient, and for their family and friends. In fact, carers noted that the emotional impact can be as significant for them as for the person in hospital. Personal views of care during the acute phase of a mental illness varied greatly, and appeared to be influenced by previous experiences and the person’s stage of recovery. Amongst those former patients who were reflecting on what had clearly been a very difficult time in their life, the focus group facilitators highlighted the strength and sense of humour that came across.
Generally, people thought that the care they had received was acceptable. Some people spoke movingly about the degree of compassion they had experienced from staff; this was viewed as a very important part of their care. The issue of power balance was often raised, however, in relation to a number of different issues. Some service users said that they found it difficult to challenge decisions or make a complaint or request; it was perceived by some that doing so would have a detrimental impact on how they were treated. A few service users did, however, speak positively about how requests that they had made had been acted on. Feedback from a number of service users also indicated a perception that some staff used their position in a controlling rather than a therapeutic way.

A number of service users raised concerns about respect for diversity and freedom of choice. In particular, service users who were keen to explore non pharmacological interventions said that their wishes were not respected. In terms of religious and spiritual needs, one person said that he had not been able to follow the diet specific to his culture and religion; another was unable to see his parish priest when he wanted to. Service users spoke often about the blanket approach to some aspects of care that they felt was frequently adopted in managing people within the IPCU setting.

Generally, in the experience gathering work, service users and carers articulated the primary significance of the emotional impact of being in an IPCU. Service users described feelings of frustration, isolation, and feeling trapped and powerless. Carers highlighted a lack of appreciation of their own emotional needs and used words like ‘devastating’ and ‘emotionally draining’ to describe their experiences.

2.3 Involvement

There were mixed views from service users and carers about how well they were involved and kept informed. About half of current patients said they understood why they were in an IPCU, and what was happening with regard to their care and treatment. Half did not know and consequently felt very much left out of the care process. Service users said that lack of accessible and timely information made it more difficult for them to understand the particular interventions they were receiving. They felt that this detrimentally affected their ability to participate in care and treatment decisions. A small number of people said that their requests for information were not responded to.

In terms of involvement in care and treatment decisions, again a range of views was expressed. Some service users felt that opportunities for involvement came at the wrong time, before they were well enough to participate meaningfully. Others felt that they were not given the opportunity to be involved when they were ready
and able. Carers had similarly mixed views about the extent to which they were able to be involved. A strong theme coming from carers was that clinicians were missing out on lots of useful information and support by not involving them more. Carers felt that a formalised mechanism to allow them to raise concerns or express views would be of benefit.

<table>
<thead>
<tr>
<th>Key service improvement area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding</td>
</tr>
<tr>
<td>Service users told us about the importance to their wellbeing of being included and involved in care and treatment decisions when in an IPCU. Carers said that better communication and appropriate two-way information sharing would benefit them, the clinical team and the patient.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local improvement actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care planning and delivery should have a recovery focus. Service users should be provided with understandable information and supported to be actively involved as much as either they wish or are able in the planning of their care when they are in an IPCU.</td>
</tr>
<tr>
<td>Carers should be offered the services of a key named contact person who has been allocated responsibility for:</td>
</tr>
<tr>
<td>• involving the carer in care planning as appropriate</td>
</tr>
<tr>
<td>• ensuring that the carers needs are considered while the person they provide care for is in an IPCU</td>
</tr>
<tr>
<td>• liaison between the carer and the wider clinical team, and</td>
</tr>
<tr>
<td>• ensuring that relevant, accessible information is provided.</td>
</tr>
</tbody>
</table>

### 2.4 Therapeutic environment

Over a third of patients who met with the Mental Welfare Commission practitioners said that they felt that there was benefit from being in an IPCU. A similar number felt that there was no benefit. A small number of people had mixed views and felt that there had been benefit at first, but not any more. Some also said that while they had felt benefit in some areas, in other ways they had suffered.

#### 2.4.1 Multidisciplinary team

From the service profiling exercise we know that, overall, each IPCU is adequately served in terms of level of dedicated nursing and medical input. However, on occasions, nursing and medical resources can be stretched when the levels of clinical activity on the ward are particularly high. At the service profiling follow-up meetings, some NHS board areas reported additional pressures relating to recruitment, unfilled posts and covering staff absences,
particularly among the nursing staff. Service users and carers highlighted variation in the skills and attitudes of nursing staff. In the main, people thought that staff attitudes were good and that they were treated with kindness and respect. However, some staff groups and individuals were singled out as being less caring and supportive; this included night staff and staff from the nurse bank. In addition, institutional type behaviour by staff, such as ‘key swinging’ was reported by a few people.

Dedicated input from occupational therapy (OT), pharmacy and social work also varies considerably across NHSScotland and few units have a dedicated core IPCU team which includes all of the disciplines recommended in the PICU standards. Most IPCUs do have some dedicated weekly input from OT and just under half have pharmacy as part of the multidisciplinary team structure. Social work input tends to be arranged by referral or through community social work teams.

2.4.2 Physical environment

People talked about the physical IPCU environment which they felt was often not conducive to recovery. A lack of colourful and homely surroundings, unkempt communal areas and uncomfortable furniture were all mentioned. About half of the patients interviewed were satisfied that they could meet friends, family and other external contacts in private. About a fifth were dissatisfied with availability of private meeting space. They said that often they have to use communal areas on the ward where others might interrupt or overhear their conversations.

2.4.3 Social interaction

The importance of social interaction for personal wellbeing came through very strongly from service users who participated in the focus groups. This included being able to meet with and contact friends and family, maintain contact with their usual supports and the availability of peer support. Day-to-day social interaction with members of staff was also mentioned. In many cases people felt that it would be of benefit to them if staff made an effort to do small things like stopping to say hello or for an informal chat, rather than only interacting during formal care delivery encounters.

2.4.4 Activities

One of the very strong themes coming from the service user and carer experience work was of a lack of meaningful and enjoyable activities available in IPCUs. This included lack of access to fresh air and outdoor spaces as well as opportunities to take part in organised individual and/or group activities such as:

- art therapy
- life skills training
- cookery
- gardening, and
- computing.
The following quote from one patient illustrates the above points.

‘you need......more space, more comfort, more time and staff to get occupied and get well again. When you come into an IPCU you are really unwell. You need time to heal and the environment is not a healing environment. You also need something to stimulate and exercise your brain. Some educational input would be really helpful. A life skills group in IPCU would be really good. Some of the patients in this ward have been here for over a year.’

Carers said that where opportunities do exist, staff could better encourage and support people to participate. People talked about how the lack of time allocated for meaningful activity is often detrimental to the recovery process.

On a more positive note, some service users spoke about how they were able to access outdoor spaces and participate in activities and the positive impact that this had.

The service profiling exercise did identify ongoing work in a number of NHS board areas to provide a better and more innovative range of activities and therapies for people, both on and off the ward.

2.4.5 Talking therapies

Service users who participated in the focus groups also highlighted a lack of ‘talking therapies’ within the IPCU setting. They considered this type of intervention as essential for successful recovery and viewed this as a fundamental gap in the service available to them. Regular access to psychology services is extremely limited across Scotland with only one IPCU having dedicated input from a clinical psychologist. In the other areas, psychological therapies are accessed by referral to local generic psychology services. NHS boards reported some issues with availability and waiting times. A number of units have now trained staff to deliver brief psychological and psychosocial interventions.

Key service improvement area

<table>
<thead>
<tr>
<th>Key finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of therapeutic input and activities in the IPCU setting varies widely across NHSScotland. Patients, past and present, highlighted the importance of meaningful activity and access to therapies and outdoor spaces to their wellbeing and recovery.</td>
</tr>
</tbody>
</table>
Local improvement actions

- A range of therapies and activities, including opportunities to regularly access fresh air and outdoor areas, should be available to people when they are in an IPCU.
- The availability of such opportunities should be actively communicated to patients and they should be supported to participate if they wish.
- The range of therapies and activities should be monitored with regard to uptake and effectiveness.

2.5 IPCUs and forensic mental health services

Forensic mental health is a specialist tertiary service that is committed to working in a multidisciplinary and multi-agency way to ensure safe practice. It provides care and treatment for individuals who have a mental illness or learning disability and demonstrate serious offending behaviour or present a significant risk to others. The service offers assessment, consultation, care and treatment, which is proportionate to the situation, and underpinned by risk assessment and management and treatment of offending behaviour. The provision of such services across NHSScotland varies considerably, as does the role and responsibilities of IPCUs in the provision of inpatient care for individuals considered to fall within the remit of specialist forensic mental health services. This includes those NHS board areas with medium and/or low secure forensic mental health inpatient provision.

The completed service profiling questionnaires and follow-up meetings raised a number of issues relating to the interface between IPCUs and forensic mental health provision. There appears to be a general, broad acceptance of the benchmarking exercise definition of forensic mental health services. However, it is also apparent that there is no national consensus as to how this is to be put into practice at the clinical level. There are clear variations in practice across, and within, Scottish NHS boards. The service profiling exercise and follow-up meetings revealed that there is some uncertainty regarding the level of risk that might be considered sufficiently significant for a person to be accepted into specialist forensic services. In part, this is determined by what provision, and access, there is to specialist medium and low secure forensic mental health inpatient provision. A greater, mutual, understanding and acceptance of agreed criteria for the admission to specialist forensic inpatient units and IPCUs would go some way to ensure that these services are used more effectively for the benefit of service users and their carers.
There is general recognition that the mixing of patients requiring forensic provision and patients requiring IPCU provision is unsatisfactory except in urgent acute circumstances and then only for a short period. There are a number of issues relating to the patient mix in IPCUs which were raised at the service profiling follow-up meetings with NHS boards. Particular difficulties can arise when some offenders are patients along with vulnerable adults - for example sex offenders with younger people and women. Notwithstanding this, it needs to be acknowledged that some mentally disordered offenders may be equally vulnerable and at risk from others in the IPCU setting and beyond. Further, some patients detained under civil procedures of the Mental Health Act can also present real risks to others and may have an offending history. IPCU teams are frequently stretched to balance what are often competing demands of meeting the needs of individuals:

- detained for assessment
- those with primarily rehabilitation and resettlement needs, and
- those admitted for the safe management of acute mental health and behavioural disturbance.

This can compromise the care and treatment of each of these groups of individuals, challenge services and raise concerns for patients, their families and carers. For some in an IPCU, the security they are subject to, and subsequent restrictions, is determined by a judicial requirement for security rather than by clinical need.

The service profiling exercise indicated that approximately 1 in 10 people admitted to IPCUs were detained under the provisions of criminal law. The census exercise identified 19 patients (12 of whom were restricted patients) detained in this way on the days of the census:

- fifteen were detained under Section 52 of the Criminal Procedure (Scotland) Act (1995),
- one under Section 57, and
- three under Section 136.

This gives some sense of the number of patients who potentially may be better served within specialist forensic mental health services being admitted to IPCUs. However, consideration needs to be given to the fact that not all people detained under the criminal provisions of the Mental Health Act would be managed by specialist forensic mental health services. Similarly, people detained under civil provisions may be considered as requiring specialist forensic services by virtue of the risks they may present. Respondents to the Forensic Network questions, which were sent out with the census questionnaire, identified nearly a quarter of IPCU patients on the days of the census, as meeting forensic criteria given by the Forensic Network (see Appendix 8).
### Key service improvement area

#### Key findings

The mixing of patients requiring specialist forensic mental health services and patients requiring IPCU services is unsatisfactory. This practice does happen, to varying degrees, across NHSScotland.

#### Local improvement action

All instances of inappropriate admissions, including patients who require specialist forensic mental health inpatient services who are admitted to an IPCU should be recorded locally.

#### National improvement actions

- A set of nationally agreed criteria for admission to forensic services should be developed with the involvement of all stakeholders.
- All instances of inappropriate admissions, including patients who require specialist forensic mental health inpatient services who are admitted to an IPCU, should be reviewed, considered and addressed on a national basis.

### 2.6 Safety

Most people said that they felt safe when they were in an IPCU. Focus group participants related this to the increased ratio of staff to patients which meant that risks were rigorously managed. Of the people who said that they did not feel safe, the majority felt threatened and/or frightened by other patients. Some service users and carers raised the issue of patients taking advantage of more vulnerable patients, for example by encouraging them to trade valuable belongings for less valuable items.

Service users spoke about how the client mix on the ward at particular times can affect the atmosphere and feeling of safety. People also said that the environment can be unpredictable and situations can escalate very quickly. Service users who had experience of dormitory style accommodation said that this could be unsettling depending on who you were sharing with. Even in units with single bedrooms, the fact that other patients and staff could come into your bedroom at any time was felt to be a safety and privacy issue. Concern was raised that the use of sedation could leave people particularly vulnerable. A further few said that they were frightened by staff members.

There were mixed views from female service users about being in a mixed gender IPCU. The majority either did not mind or preferred the mixed gender environment. A smaller proportion felt particularly vulnerable and had experienced some unpleasant encounters with regard to male service users. A small proportion of male service users said that they would prefer a male only environment.
There is no IPCU provision specifically for women in NHSScotland and with the exception of the IPCU at the Carseview Centre, Dundee, all of the IPCUs will accommodate a mixed gender client group if required. Ensuring the safety, privacy and dignity of women is challenging in an environment that has a much higher proportion of male patients and staff. Female patients can be more vulnerable both in relation to their own clinical presentation and the presentations of the male patients on the ward with them. Specific risk assessment is always carried out for female patients. Levels of observation and nursing gender mix are adjusted accordingly to ensure safety. However, practical issues such as provision of women only bathroom, toilet and sitting room facilities can be problematic, particularly in older style units. Some women said that there was nowhere for them to go to get away from male patients, particularly in the units where access to bedrooms was not allowed during the day. A number of new IPCUs were being planned at the time of the service profiling exercise. It was good to see that the safety, privacy and dignity requirements of women have been factored into the design requirements for these units.

All of the IPCUs operate either informal or formal criteria which outline the features of the core group of patients who would normally be eligible for admission to an IPCU. In addition, informal or formal ineligibility criteria (including older and younger people, people with learning disabilities or those with organic brain damage) are also in place. In practice, however, a relatively small number of patients who fall outwith the core group are admitted to IPCUs each year. These groups can be particularly vulnerable within an IPCU and services endeavour to find a more suitable setting for them as quickly as possible. Again specific risk assessment is carried out by staff and levels of nursing observation adjusted accordingly.

In some cases, people with dementia may be admitted to an IPCU for short periods of time. Service users commented on this and some felt that IPCUs are an inappropriate place for people with dementia.

<table>
<thead>
<tr>
<th>Key service improvement area</th>
<th>Key finding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Despite having criteria which outline the features of the core groups of patients who would normally be eligible or ineligible for admission to an IPCU, from time to time most IPCUs admit individuals who fall outwith the core group. The inappropriateness of the IPCU environment for certain groups of people and the risks posed to more vulnerable patients was highlighted by both service providers, service users and carers.</td>
</tr>
</tbody>
</table>
Local improvement actions

- In line with the Millan principles\(^8\) of equality and respect for diversity, admission protocols must address the needs of all people being admitted to an IPCU specifically in relation to the six equality strands of race, religion/belief, gender, sexual orientation, disability and age\(^{13}\).

- Where admission of patients who fall outside the core group is unavoidable, there should be agreed protocols in place for the safe management of those people when in an IPCU.

2.7 Restriction and restraint

While most people felt safe in an IPCU, they also thought that the measures in place to ensure safety had a negative aspect. As previously mentioned, a recurring theme from service users related to frustration at the one size fits all approach which they felt was often adopted. This meant that restrictive measures were sometimes enforced on people who could manage equally well or better with a less restrictive approach. Service users thought that this made them more similar to rules, rather than measures to ensure safety. Examples included not being able to make a hot drink and having to ask members of staff for access to certain personal items. While most people appreciated that this level of risk management was warranted for some people, they felt that levels of restriction should be based on individual needs, not the ‘lowest common denominator’. Some people said that this had led to a feeling of complete loss of independence. A number of service users compared IPCUs to their experience of prison and felt that prison was a less restrictive environment.

There was acknowledgement from a few service users that the restrictions imposed on them were necessary and were contributing positively to their recovery. A higher proportion, however, felt that restrictions were sometimes used by staff as a mechanism to exert control. This was often with regard to cigarettes and access to smoking areas.

Many of the service users had experienced physical restraint when in an IPCU and understood that sometimes this type of intervention was necessary. Carers also acknowledged that sometimes physical restraint is the only option, but highlighted that the actual process can be distressing for friends and family to witness. Most people agreed that such interventions were used appropriately and applied with due concern for the service user. A small number of people, however, felt that physical restraint had been used inappropriately and some of them said that the experience had caused them significant pain.
A few people reflected on their experiences over a number of years and said that, in more recent times, staff will try to de-escalate situations in other ways before resorting to physical interventions.

### Key service improvement area

**Key finding**

The service user experience is better when restraint is used appropriately and the staff members are skilled in application of the techniques.

**Local improvement actions**

- NHS board clinical governance arrangements should include mechanisms for the recording, monitoring and review of all invasive and/or restrictive interventions (for example, seclusion, restraint, and specified persons measures) applied in the IPCU setting to ensure that usage is appropriate and to identify any emerging trends.

- Care staff should look for ways to reduce unnecessary restriction and personalise care as much as it is safely possible to do so.

### 2.8 Delayed discharge

The average length of stay in an IPCU tends to be short, however there are occasionally patients who are admitted to an IPCU for longer periods of time. These may be people who have particularly complex needs that are unable to be met elsewhere. For most, their contact with an IPCU is a time limited, short episode of care focusing on the management of acute mental health and behavioural disturbance. The census data show that around two thirds of the patients in an IPCU on the day of the census had been in for less than 2 months. As risk allows, people are able to move on to more open, less secure and restrictive mental health care settings appropriate to their needs at the time. For the most part, this is welcomed by patients and carers as their experience of care and treatment in an IPCU can be a particularly difficult part of their journey. While aspects of IPCU care are accepted as necessary, and valued, the emotional impact, restrictions, loss of autonomy and safety concerns are not inconsiderable.

Data from the service profiling exercise indicated that, on occasions, a patient’s stay in an IPCU may be extended beyond the time necessitated by clinical need. While the extent and degree of this varied across, and within, NHS board areas, all IPCUs reported this to have arisen at one time or another. The census data indicate that around one in five patients at the time of the census were considered to no longer require IPCU care but their discharge had been delayed. A number of reasons were proposed for this including:
● lack of, or pressure on, beds in low secure, continuing care, forensic and acute mental health services, and

● differences in opinion between the IPCU clinical team and the clinical team in the proposed discharge destination regarding risk assessment and management of the person being discharged.

These issues may be further complicated when the IPCU is outwith the patient’s home NHS board area.

The census exercise identified six people who had been patients in an IPCU for more than 1 year. For four of these people, their current length of inpatient stay in an IPCU was in excess of 2 years.

<table>
<thead>
<tr>
<th>Key service improvement area</th>
<th>Key finding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The primary function of an IPCU is for the short-term management of acute mental health and behavioural disturbance. In some areas, IPCUs are fulfilling a rehabilitation or continuing care function for some longer stay patients. This is inappropriate and creates a potential conflict and compromise between the necessary care and treatment regimes required to meet the needs of different patient groups.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local improvement action</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS boards should monitor and review length of stay in the IPCU. If a person’s stay reaches 3 months there should be a review, involving all those providing care, to consider whether the person’s needs continue to be best met in the IPCU environment.</td>
</tr>
</tbody>
</table>

### 2.9 Data collection

NHS boards used a range of methods to gather the demographic and admissions information requested in the service profiling questionnaire. Some areas have NHS board-wide electronic patient administration systems or local electronic databases; others gathered the data manually by extracting the relevant information from paper records, for example the ward admissions book. There is no consistent approach to capturing and reporting IPCU admissions information across NHSScotland. Similarly, the dataset routinely collected for each patient varies both between and within NHS board areas. Collection of a nationally consistent dataset could facilitate routine monitoring of services.
Key service improvement area

Key finding

There is wide variation in both the quality and extent of data collection relating to IPCU admissions. Routine collection of a nationally agreed dataset would help with service planning and ensure that the services provided best meet the needs of the IPCU client group.

National improvement action

A national IPCU dataset should be developed to enable routine monitoring of services.
This chapter presents the findings from across Scotland in terms of service provision. The data included here is drawn directly from the local reports for each NHS board. A number of examples of innovative local solutions and areas of good practice are highlighted throughout the text. These examples are not exhaustive – examples of good practice were noted during each of the meetings and these were often in place in more than one NHS board.

There are 14 territorial NHS boards across NHSScotland, eight of which have local IPCU provision. Some NHS board areas have more than one unit; the total number of IPCUs across Scotland is 14*. For those NHS board areas that have local provision, total bed numbers range from six to 44.

Of the six NHS boards that do not have local IPCU provision, three have a formal SLA with another NHS board area for provision of IPCU care.

Figure 1: IPCU provision across NHSScotland (at the time of the service profiling exercise)

<table>
<thead>
<tr>
<th>NHS board area</th>
<th>Number of units</th>
<th>Bed numbers</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>1</td>
<td>7</td>
<td>Ailsa Hospital, Ayr</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>(SLA with NHS Lothian)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>1</td>
<td>10</td>
<td>Stratheden Hospital, Cupar</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>1</td>
<td>12</td>
<td>Falkirk and District Royal Infirmary</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>1</td>
<td>11</td>
<td>Royal Cornhill Hospital, Aberdeen</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td>4</td>
<td>8</td>
<td>Dykebar Hospital, Paisley</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td>Gartnavel Royal Hospital, Glasgow</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td>Leverndale Hospital, Glasgow</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td>Stobhill Hospital, Glasgow</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>2</td>
<td>9</td>
<td>Argyll &amp; Bute Hospital, Lochgilphead</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td>New Craigs Hospital, Inverness</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>2</td>
<td>12</td>
<td>Royal Edinburgh Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td>St Johns Hospital, Livingston</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>(SLA with NHS Grampian)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>(SLA with NHS Grampian)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>2</td>
<td>12</td>
<td>Carseview, Dundee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>Sunnyside Royal Hospital, Montrose</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Sunnyside Royal Hospital has a small locked ward which performs many of the same functions as an IPCU. NHS Tayside included data on this unit in its service profile return and for the purposes of the service profiling exercise it was considered as an IPCU.
In the NHS board areas where there is no SLA in place, IPCU beds are sought in other NHS board areas on a case-by-case basis as the need arises.

The Reed Report recommends 40 IPCU beds per million (0.4 per 10,000) of the population. IPCU beds available per 10,000 of the catchment population served by each unit ranges from 0.3–1.6 (see Figure 2). The data for NHS Grampian includes population numbers for NHS Orkney and NHS Shetland as an SLA is in place. Similarly, the data for St John's Hospital, Livingston, includes population numbers for NHS Borders.

There were a total of 147 IPCU beds available across NHSScotland at the time of the service profiling exercise. This equates to 43 beds per million of the adult (aged 16–64) population based on an estimated Scotland wide adult (16–64) population of 3,413,148.

Figure 2: IPCU beds/10,000 of population (aged 16–64) served by each unit
3.1 Admission to an IPCU

Formalised admission protocols and standard operating procedures (SOPs) are in place in a number of the units. These documents outline both eligibility and ineligibility criteria for admission to an IPCU. Most of the IPCUs stipulate that people should be detained under an appropriate section of the Mental Health Act to be considered for admission. The ineligibility criteria cover groups such as:

- young people, under the age of 16
- people with learning disabilities
- people with dementia
- people with substance misuse problems in the absence of serious mental disorder, and
- people whose physical condition is too frail to allow their safe management in an IPCU.

While formalised admission and ineligibility criteria are in place in a number of NHS board areas, it was reported that people who fall outwith the core group would be admitted in exceptional circumstances. This usually happens if a more appropriate placement is unavailable and there would be some therapeutic benefit to the individual being considered for admission.

While it is usually stipulated that people being admitted to an IPCU should be detained, admission data from 2008 showed that most of the IPCUs had admitted some informal patients.

Admissions tend to be negotiated on a consultant-to-consultant basis with involvement of nursing staff as required. In a few areas, straightforward admissions from the local area are considered by the nursing staff.

All of the IPCUs will accept referrals from outwith their catchment area if there is a lack of availability of beds in the person’s home NHS board area. There were 67 out-of-area admissions to IPCUs during 2008. For areas where there is an agreed SLA in place, people would be transferred in line with the local psychiatric emergency plan (PEP). Management of out-of-area referrals from areas where there is no SLA is more ad hoc. Beds are sought on a case-by-case basis in other NHS board areas. In practice, people often remain in the acute setting and are supported using increased staffing levels rather than sourcing an IPCU bed that may be some distance from the person’s place of residence.

3.2 Models of care provision

The PICU standards state that the multidisciplinary team is a crucial factor in the provision of an effective quality service. The standards recommend a core team, staffed by the following key disciplines:

- medical
- nursing
experience psychology
occupational therapy
social work
pharmacy, and
dedicated social workers for long stay low secure environments.

All of the IPCUs operate a similar model of multidisciplinary care with a core medical and nursing team. Dedicated input from the recommended range of other relevant professionals varies between units.

### 3.2.1 Medical

The PICU standards recommend that each unit should have a dedicated lead consultant. All of the IPCUs operate either a single or multiple consultant-led model. In most areas, the consultants work across a number of settings which can include forensic, rehabilitation, acute inpatient, outpatient and community mental health services, as well as IPCUs. In addition, their time is also spread across other duties including provision of court reports. Generally, the consultant staff complement is supplemented by a range of other medical staff including core trainees, specialist registrar and staff grades.

It is difficult to attribute whole time equivalent (WTE) consultant psychiatrist time to each IPCU from the data supplied by NHS boards. On average, each IPCU has 0.05 WTE of dedicated consultant psychiatry input per bed and an average of 0.1 dedicated WTE input across the medical grades as a whole. However, the extent of input required is dependent on numbers of beds occupied and the differing presentations of patients.

In addition to consultant time dedicated to IPCUs, consultants from other sectors may input to the IPCU setting if they have responsible medical officer (RMO) and approved medical practitioner (AMP) accountability for people who are patients.

#### Example of a local initiative…

In NHS Grampian, IPCU patients can attend weekly GP clinics held within the Royal Cornhill Hospital, Aberdeen, to address any issues with their general healthcare needs. They can also get advice and support on health screening and health promotion.

### 3.2.2 Nursing

All of the IPCUs have a dedicated nursing team. The teams in each area comprise a range of staff including unregistered Agenda for Change (AfC) band 2 and 3 nursing assistants, and registered staff ranging from AfC band 5–7. See Figure 3.
While the numbers of WTE nursing staff does appear to vary across the units, there were some vacant posts at the time of the service profiling exercise which may, to some extent, account for this. In addition, depending on the needs of the client group, nursing staff levels and skill mix are increased accordingly. For example, if there are patients who require enhanced levels of observation.

In some units, staff are shared between different services, for example across the acute and forensic settings. This allows added flexibility in terms of nursing skills and gender mix. Some NHS boards also operate a staff rotation scheme whereby nursing staff can gain experience across a range of mental health inpatient settings.

Most of the IPCUs employ higher nursing staff levels during the day with slightly reduced numbers overnight (see Figure 4). The number of staff on shift at any time varies between units and is determined locally related to factors such as the number of beds in the unit. As previously reported, depending on needs, staffing levels are often increased. All of the IPCUs try to always ensure a minimum of two registered staff on every shift. As far as possible, an appropriate staff gender mix is also sought. The staff numbers in Figure 4 reflect the ‘usual’ or in some cases ‘minimum’ number of staff on each shift, according to information supplied by NHS boards as part of the service profiling exercise.
3.2.3 Clinical psychology

Dedicated clinical psychology input to IPCUs is uncommon across NHSScotland; only one IPCU reported dedicated input from a clinical psychologist. In this NHS board area, the IPCU is located within the same unit as the forensic admissions and forensic rehabilitation units: the one WTE clinical psychologist also covers these services.

In the other areas, arrangements for accessing clinical psychology are locally determined. Psychology input is usually arranged on a case-by-case basis through referral to the local psychology service. Some NHS boards highlighted difficulties with accessing psychology; this was a particular issue for people whose detention order required a psychological assessment within a prescribed timescale. In some areas, members of the nursing staff had undertaken additional training to allow them to deliver some psychological interventions.

3.2.4 Allied health professions

Dedicated input from the AHPs varies widely both between, and within NHS board areas.

Twelve of the units have dedicated OT input delivered by either occupational therapists, OT assistants, OT technical instructors or a combination of these. In the other two units, OT is available by referral. A few units also have dedicated physiotherapy input.
Dedicated input from art and recreational therapists is also available in a few IPCUs, however this is not commonplace across NHSScotland.

In some areas, local initiatives are under way to allow patients to access a wider range of therapies and activities.

### Examples of local initiatives...

In NHS Ayrshire & Arran the use of complementary therapies is encouraged and there is a policy in place developed by the practice development department. One of the IPCU nursing assistants leads on this and IPCU patients have access to one-to-one weekly sessions with a reflexologist.

In the Royal Edinburgh Hospital, classes and activities such as the snack group, creative group, women’s group and a relaxation class are available to IPCU patients.

### 3.2.5 Pharmacy

Just under half (six) of the IPCUs reported dedicated input from pharmacy to the IPCU setting. Where there is this dedicated input, the pharmacist and/or pharmacy technician attends the multidisciplinary team meetings.

#### Example of a local initiative...

In the IPCU at New Craigs Hospital in Inverness, the principal pharmacist, who is also an independent prescriber, can produce clinical management plans and has direct contact with patients regarding their medications. He also works closely with nursing and junior medical staff and supports them with regard to pharmacological matters when the consultant psychiatrist is unavailable.

### 3.2.6 Social work

Dedicated social work input to IPCUs is uncommon across NHSScotland; only one IPCU reported dedicated input from social work by way of mental health officer (MHO) resource. In this NHS board area, the IPCU is located within the same unit as the forensic admissions and forensic rehabilitation units and the dedicated MHO function also covers these services.

More commonly, social work input is sought as required. For people who do not already have a social worker, input is usually arranged by referral to the generic hospital or community-based service. Often social workers will continue to input to the care of people already on their caseload while they are in an IPCU.
3.3 Demographics and nature of IPCU admissions

There were 975 admissions to IPCUs in Scotland during 2008. The majority of these were men, with 720 (74%) admissions compared to 255 (26%) women.

Figure 5: IPCU admissions per 10,000 of population from each NHS board area (2008)

3.3.1 Ethnicity

The most common ethnicity recorded was white Scottish, followed closely by white British and white other. There were very small numbers of various other minority ethnic groups. Although data on ethnicity were available from the majority of NHS boards, this was often recorded as 'not known'.

3.3.2 Age profile

The age breakdown chart (Figure 6) shows that 31–50 was the most common age group admitted to IPCUs in 2008, followed by the 18–30 group.
3.3.3 Women in IPCUs

All of the IPCUs, with the exception of the unit in the Carseview Centre, Dundee, admit women. As part of service development, NHS Tayside plans to address this when the IPCU provision is moved to new premises. There is no women-only IPCU provision in Scotland.

Women constitute approximately a quarter of the annual admissions to IPCUs. When women are patients in an IPCU, special arrangements are put in place to ensure their safety, privacy and dignity. These arrangements include ensuring that female nursing staff are available, enhanced observations if necessary, and separate bathing and toilet facilities. In the older units where the bedrooms do not have ensuite bathrooms, staff acknowledged that arranging separate bathing facilities for women was more of a challenge. In addition, at the time of the service profiling exercise, only a small number of the units had women-only sitting/lounge areas.

3.4 Management of other population groups

As previously reported, many of the IPCUs operate formal ineligibility criteria. Although these criteria are in place, all of the IPCUs do, from time to time, admit patients who fall outwith the core group. Such admissions are specifically risk assessed and are managed on a case-by-case basis. Enhanced levels of observation would normally be established to ensure the safety of both the patient and other people in the IPCU. In line with accepted good practice\textsuperscript{15}, IPCU staff would maintain close contact with the applicable specialist service, for example child and adolescent mental health services (CAMHS), older adult mental health services and/or learning disability services, if available locally. While the person is in the IPCU, there would also be in-reach from these services. In these cases, more appropriate provision for the patient would be sought as soon as possible.
All of the IPCUs do admit patients who require specialist forensic mental health services from time to time. This is covered more fully in Section 3.6.

3.5 Moving on from an IPCU

The majority of IPCUs have a written discharge protocol in place which covers the key procedures to be followed when patients are ready to move on from an IPCU.

In practice, discharge planning usually includes a full needs and risk assessment undertaken by the multidisciplinary team. This is combined with liaison with staff from the setting that the person will move on to. Most people would first move on to an acute mental health inpatient ward. Patients occasionally return directly to a community setting.

NHS boards highlighted that moving on out-of-area patients can be more complex. This is often due to the practicalities of the person having to be transported across what can be significant distances, back to their home NHS board area. Availability of appropriate staff members to accompany the person can also sometimes be problematic.

3.6 Overview of links with other secure provision

There is one high secure inpatient mental health facility in Scotland, the State Hospital in Lanarkshire. There are also two medium secure units, the Orchard Clinic within the Royal Edinburgh Hospital and Rowanbank Clinic within Stobhill Hospital, Glasgow. A third medium secure unit is planned within Murray Royal Hospital, Perth; this is due to open in 2012–2013.

At the time of the service profiling exercise, there was low secure forensic mental health inpatient provision in the following NHS board areas:

- NHS Grampian
- NHS Tayside
- NHS Greater Glasgow and Clyde, and
- NHS Lanarkshire.

These areas, with the addition of NHS Fife and NHS Lothian, also have low secure forensic beds for people with learning disabilities. Some areas also have low secure rehabilitation beds.

NHSScotland secure provision is supplemented by 34 low secure beds provided by the independent sector. These beds are almost exclusively occupied by people whose placement is funded by various NHS boards from around Scotland.
In the service profiling exercise, NHS boards reported a total of 112 (11%) admissions to IPCUs of people who were detained under criminal law during 2008. However, the index offence is not known.

In areas where there are medium and/or low secure forensic beds, the preferred option for patients stepping down from higher levels of secure care would be to step down to those facilities. In practice, however, all the IPCUs reported that step down patients are sometimes admitted. Some concerns were raised by staff about the difficulties presented when trying to meet the differing needs of individuals with acute mental health care needs and those with rehabilitation needs.
Between worlds – artwork by a focus group participant
The completed service profiling questionnaires and follow-up meetings with NHS boards have for the first time generated centrally, rich and comprehensive information relating to the function of and organisational structures within Scottish IPCUs, and their relationships with other services. Information that was not specifically sought in detail during the service profiling exercise included:

- the social circumstances of patients
- mode of admission
- the clinical profile of patients
- treatment regimes, and
- where people move on to from an IPCU.

To supplement the service profiling demographic information, and to get a national ‘snapshot’ of the IPCU inpatient population, we asked all IPCUs to undertake a census exercise. We provided a data collection tool, guidance notes and telephone support. On a given day between 24 and 26 November 2009, a nominated staff member in each IPCU systematically collected the requested dataset for each patient in the IPCU. The anonymised census data were returned to NHS QIS for collation and analysis.

We would like to thank the IPCU staff who took part in this process and gathered this valuable information.

### 4.1 Bed numbers and occupancy

At the time of the census, 116 IPCU beds were occupied out of a total complement across NHSScotland of 147. This equates to 79% occupancy. Of the 116 patients in IPCUs at the time of the census exercise, the dataset was not provided for four patients. For a number of other patients, some aspects of the requested data were not provided. Where this is the case, it is noted in the report text.
At the time of the census exercise, seven IPCUs had out-of-area patients (see Figure 8 below). Reasons for this included no IPCU or no available beds in the patients’ home locality or the person had been detained and hospitalised when they were outwith their home NHS board area. Of the 11 out-of-area patients:

- six were recorded as normally residing within Scotland
- four were recorded as normally residing outside of Scotland but within the UK, and
- one was recorded as normally residing outside of the UK.
4.2 Demographics and social profile

4.2.1 Gender

Of the 112 patients for whom gender data was provided, 85 (76%) were men and 27 (24%) were women.

Figure 9: Gender split (n=112)

- Women: 82%
- Men: 18%

82% of patients had marital status listed as single.

4.2.2 Age

The average age of patients on the day of the census was 36. Only one patient was under the age of 18, and there were no patients over the age of 65. Figure 10 shows the age split by category. The most frequently occurring age in the list was 26.

Figure 10: Age split (n=112)

- Under 18: 9%
- 18-30: 23%
- 31-50: 32%
- 51-64: 26%
- 65+: 13%

95% of patients were identified as unemployed.
4.2.3 Ethnicity

Ninety-eight (88%) of the 112 patients for whom ethnicity data was provided, had their ethnicity listed as white Scottish. Of the remaining 14 patients, the largest groups were other white British with five and African with three. One patient was listed in each of six other ethnic groups: Caribbean; Irish; Indian; Mixed; other White; and Pakistani.

4.3 Admission to an IPCU

Forty-seven (45%) patients were admitted to an IPCU from an acute inpatient ward, while 18 (17%) patients were admitted from prison or from the Sheriff Court. Admission data was not provided for 11 patients.

Figure 11: Where patients were admitted from (n=105)

21% of patients were identified as homeless, while only 7% were identified as owner/occupier.

4.3.1 Previous known admissions to IPCUs

Fifty-six percent of patients (62) had been in an IPCU on two or more occasions, with 26% (29) having at least six or more previous known admissions to an IPCU. Previous admissions data was not provided for five patients.
4.3.2 Primary reason for admission

The most common primary reason for admission to an IPCU was violent/aggressive behaviour. Thirty-five percent (37) of patients for whom primary reason for admission was recorded were listed as having been admitted for this reason. For the purposes of the census, ‘acute’ behaviour was described as those behaviours that had lasted less than 8 weeks, and ‘chronic’ as those with a duration of more than 8 weeks. Primary reason for admission data was not supplied for nine patients.

![Figure 13: Primary reason for admission (n=107)]
4.3.3 Primary diagnosis

The primary, and secondary if applicable, diagnoses of each IPCU patient, as documented by the psychiatrist in charge of their care, were recorded by those undertaking the census data collection.

Forty-eight percent (54) of patients had presented with a primary diagnosis of schizophrenia on this admission to an IPCU, while 15% (17) of patients were still under assessment for primary diagnosis at the time of the census.

Figure 14: Primary diagnosis (n=112)

4.3.4 Secondary diagnosis

Of the 57 (around half) with an identified secondary diagnosis, 33 of these related to the use of substances:

- substance dependence (3)
- substance-induced state (6), and
- substance misuse (24).

Other secondary diagnoses identified included:

- personality disorder (6)
- learning disability/borderline learning disability (5)
- schizo-affective disorder (5), and
- depression (3).
4.3.5 Detention status

Eighty-two percent (91) of patients for whom detention status data was provided were recorded as being in an IPCU on a civil detention at the time of the census exercise; 17% (19) were recorded as being on a criminal detention. One person was recorded as an informal patient at the time of the census. Data regarding detention status was not provided for five patients.

Figure 15: Detention status (n=111)

32% of patients were listed as 'specified persons'. This means that, for security, a patient may be restricted in additional ways.

Of the 112 people in IPCUs at the time of the census for whom data was provided:

- 96 had an identified mental health officer
- 85 had an identified named person, and
- 8 were known to have made an advance statement.

About one in three patients (36) included in the census were designated as specified persons under the Mental Health Act. This allows for certain additional powers to be enacted if required in the care of detained patients in certain situations. Individuals may be subject to more than one of the set of additional powers that relate to:

- safety and security (29 people). These powers can allow for the search of a person and their possessions; the restriction of certain possessions in hospital and the removal of any possessions in breach of this; the taking of samples – but not by physical force; restrictions on visits and the kind of things visitors may bring with them; the search of visitors and what they bring with them if they give informed consent.
- restriction of telephone use (22 people).
- sending and withholding mail, opening and inspecting postal packages and withholding the content of postal packages (3 people).
4.4 In an IPCU

4.4.1 Length of stay

There was significant variation in the length of stay. Forty-six percent of patients (51) had been in an IPCU for less than 1 month, while six patients (5%) had been in an IPCU for over 1 year, as illustrated in the table below. Length of stay data was not available for six patients.

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>Number of days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortest</td>
<td>1</td>
</tr>
<tr>
<td>Longest</td>
<td>2072</td>
</tr>
<tr>
<td>Average</td>
<td>110</td>
</tr>
<tr>
<td>Average*</td>
<td>56</td>
</tr>
</tbody>
</table>

*average figure minus the six patients who had been in IPCU for over 1 year

Figure 16: Length of stay in an IPCU (n=110)
4.4.2 Medication and interventions

Data related to medication and interventions was not provided for 12 patients. For those for whom data was provided, 84% (87) were on antipsychotic medications. Of those, 38% (33) were prescribed more than one antipsychotic, and 18% (16) of patients were on a ‘high dose’ - that is, a dose above the upper limit recommended by the British National Formulary.

Thirty-six percent (37) of patients had received rapid tranquillisation, with 89% (33) of these patients receiving rapid tranquillisation on more than one occasion.

4.4.3 Additional staffing input

We asked which other staff groups had input to patient care in an IPCU. Information was provided for 111 patients:

- four percent (4) received psychology input during their current episode of IPCU care
- twenty-five percent (28) received physiotherapy input, and
- sixty-four percent (71) had contact with an occupational therapist.

4.4.4 Time off the unit

Data related to time off the unit was not recorded for nine patients. For those where data was recorded, 51 patients were not allowed time off the unit at the time of the census exercise. Fifty two patients were allowed time off the unit and of these, 13 were able to leave the unit without an escort.

23% of patients had been subject to two or more instances of seclusion

Around 25% of patients were prescribed a mood stabilising drug and just over 10% an anti-depressant

49% of patients were subject to physical restraint by staff in IPCU. Of these, 75% were restrained on more than one occasion

Just over 20% of patients were subject to enhanced observation levels - on one-to-one nursing or more than one nurse
4.4.5 Behaviours when in the IPCU

Data about behaviours during the stay in an IPCU was captured for 112 patients. For 64 patients, more than one of the range of behaviours was recorded.

- Forty-nine patients (44%) had documented instances of violence towards staff, while 38 patients (34%) were identified as having been violent toward other patients during their current IPCU admission.
- Twenty-one patients (19%) were recorded as having used non-prescription drugs, while 17 patients (15%) had instances of alcohol use in their current stay in an IPCU.
- Twenty-seven (24%) people were recorded as not having any documented instances of the behaviours identified here during their current stay in an IPCU.

Figure 17: Behaviours when in the IPCU (n=112)
4.5 Moving on from an IPCU

4.5.1 Anticipated moving on destinations

The census questionnaire asked where patients were likely to move on to after their stay in an IPCU. Data regarding moving on destination was not provided for six patients. Sixty-three (57%) patients for whom data was provided were due to be transferred to an acute inpatient psychiatric ward. For nine (8%) patients, it was anticipated that they would be able to return directly to their own home.

Figure 18: Anticipated moving on destination (n=110)

4.5.2 Delay in moving on

At the time of the census, 25 patients were identified as having a delay in moving on from the IPCU.

Figure 19: Reason for delay in moving on (n=25)
TOW

Time
Out
Walk
A privilege!
Am I a criminal?
If so, what was my sin?
The garden like a cage
For people in a rage
And no wonder!
Time Out Walk – a privilege!
And how it must be to work in there
The low hum,
Designed to numb
Control Room calling
Enemy falling
Shock proof glass
Sit behind it the staff
For I’m sure they know
This is not the way to go
Gotta go – time for my TOW!

Poem written by a focus group participant
This piece of work was undertaken by the Mental Welfare Commission to complement the national audit of IPCUs being undertaken by NHS QIS. The Mental Welfare Commission wrote this part of the report.

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

One of our legal duties is to visit services and provide the opportunity for patients to meet with Mental Welfare Commission representatives to discuss any concerns that they may have.

We are made up of people who have understanding and experience of mental disorder. Some have a background in healthcare, social work or the law. Some are carers or have used mental health and learning disability services.

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

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

Within this context, in early discussions with NHS QIS we thought that there were key issues regarding care in IPCUs that we should ask of people being cared for there. These should focus on principles of legislation. Broad areas would be:

- information given about the IPCU, including the route into the IPCU and what it felt like for the individual
- participation in the individuals' own care and treatment (including access to advocacy, advance statements, input to care plans)
- restrictions on freedom, including experiences of restraint, being designated a ‘specified person’, searches and any restrictions on visitors and communication
- continuity of care and support
- respect for diversity, eg age, gender, sexuality and religion/culture, and
- personal safety (especially for women in mixed-gender IPCUs).

During November and December 2009, we visited 11 IPCUs across Scotland and interviewed 50 patients (questions asked can be found at Appendix 5). We chose to visit IPCUs to include some that admit from a wider area than the hospital’s own catchment population and also possibly from other NHS board areas. We also wanted to ensure the people we visited would include women, people transferred in from other hospitals or NHS board areas and people from minority ethnic backgrounds.

Mental Welfare Commission practitioners made announced visits to IPCUs and asked for willing volunteers to talk about their experience in the units. Some background information about interviewees was also provided by nursing staff. As with all visits undertaken by the Mental Welfare Commission, practitioners raised issues of concern with staff there and then and followed these up as appropriate.

Of the 54 people who agreed to be interviewed, four were subsequently not able to participate. Fifty interviews were conducted of which eight were not fully completed because the person chose to stop before the end or was too unwell to answer coherently. One interviewee was accompanied by an independent advocate and another by both a friend and an independent advocate.

Notes from the interviews were analysed thematically. Some excerpts quoted in the report have been altered in minor ways to minimise the possibility of people being identified.

Excerpts from the interview notes are used extensively in the report. These include some direct verbatim quotes from interviewees within inverted commas. Other excerpts are indirect quotations or summaries of what was said as recorded by the Mental Welfare Commission visitor. These latter excerpts appear without inverted commas.

Profile of interviewees

The age and gender of the 50 people interviewed is summarised in Table 1.
Table 1: Interviewees age and gender

<table>
<thead>
<tr>
<th>Age group</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–24</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>25–34</td>
<td>9</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>35–44</td>
<td>15</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>45–54</td>
<td>9</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>All</td>
<td>39</td>
<td>11</td>
<td>50</td>
</tr>
</tbody>
</table>

The age and gender of all IPCU patients at the time of the interviews was not available. Therefore we cannot comment on whether the sample of people we met was representative in this respect.

- **Ethnicity**

  Of the 34 interviewees whose ethnicity was recorded, 32 were White and two Black or Asian.

- **Legal status**

  Nine interviewees were subject to criminal proceedings and 40 were detained under the Mental Health Act. Of the civil law cases, 14 were on short-term detention orders and one on an emergency detention order.

- **Transfer to IPCU**

  Most of those interviewed had been transferred from other wards including IPCUs (see Table 2). Nine people had been admitted directly from the community. One person was an ‘informal’ patient admitted from his own home - lack of beds in the acute ward was the reason for admission given by the nurse.

Table 2: Where interviewees were transferred from

<table>
<thead>
<tr>
<th>Where interviewees were transferred from</th>
<th>Number of interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison</td>
<td>5</td>
</tr>
<tr>
<td>Court</td>
<td>4</td>
</tr>
<tr>
<td>Immigration centre</td>
<td>1</td>
</tr>
<tr>
<td>Police station</td>
<td>2</td>
</tr>
<tr>
<td>Accident &amp; emergency</td>
<td>1</td>
</tr>
<tr>
<td>Home</td>
<td>9</td>
</tr>
<tr>
<td>Other hospital ward</td>
<td>25</td>
</tr>
<tr>
<td>Other IPCU</td>
<td>3</td>
</tr>
<tr>
<td>All interviewees</td>
<td>50</td>
</tr>
</tbody>
</table>

Half of those interviewed had been in the IPCU for longer than 1 month. The longest stay was over 2 years. Four people had been the IPCU for only 1 or 2 days and therefore could not answer some of the questions.
Table 3: Length of time spent in IPCU at time of interview

<table>
<thead>
<tr>
<th>Length of time spent in IPCU</th>
<th>Number of interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–2 days</td>
<td>4</td>
</tr>
<tr>
<td>3–7 days</td>
<td>5</td>
</tr>
<tr>
<td>8–30 days</td>
<td>16</td>
</tr>
<tr>
<td>1–3 months</td>
<td>16</td>
</tr>
<tr>
<td>Over 3 months – 1 year</td>
<td>8</td>
</tr>
<tr>
<td>1–3 years</td>
<td>1</td>
</tr>
<tr>
<td>All</td>
<td>50</td>
</tr>
</tbody>
</table>

Views about stay in IPCU

The interview started with some questions about how the person felt about being in the unit, both when they were transferred and at the time of the interview. Much of what people told us in response to these initial questions is reported under separate headings later in the report. Most interviewees commented on whether they felt any benefit in being in the IPCU.

- Eighteen felt there was benefit.
- Sixteen felt there was no benefit.
- Seven had mixed feelings.
- Nine gave no answer.

Benefits and the number of times each was mentioned are listed below.

- Medication (7)
- Feeling safe and secure (6)
- Talking to staff (5)
- Peace and quiet (2)
- Facilities (2)
- Control of problem behaviour (2)
- Observation by staff (1)

The seven with mixed feelings included two who felt they had benefited at first but not any longer, and two who felt they benefited in some ways and suffered in others. Another ‘felt resigned’ to accepting treatment and another that they would benefit once medication was started. One person was able to explain clearly that
while benefiting from greater security, they felt the environment was not therapeutic.

‘My behaviour is unpredictable and I know when I come here the doors will be locked and I will be safe. I get the impression that no one really cares about what the day to day experience of a patient on this ward is like. The lack of exercise is really unhelpful. I struggle to exercise when I am in the community but I know it has a positive effect and makes me feel happy. There is nowhere to exercise here.’

**Participation in care and treatment decisions**

Seventeen of those interviewed said they understood what was happening about their care and treatment since coming into the unit, and 18 said they did not. One person stated specifically that they did not receive a care plan. We did not ask directly about care plans and there were no other references to care plans in the interviews. The following examples illustrate how some people feel left out of discussions about their care and treatment.

One interviewee said she did not understand her treatment. She had only been in the IPCU for 2 days and was experiencing some problems which she said she had not told any of the staff about. The interviewer noted her description of these problems as follows:

New medication caused side effects: loss of muscle control and dribbling. Could not feed herself at first - very shaky.

She felt she had been better off on the ward she had been on before where she had been given information and shown around. Another person said there had been no response to their requests for information about their treatment.

We asked people if anyone had explained how they would move on from the IPCU and who they would discuss that with. Half appeared to have had some discussion about this and knew who they would speak to, the doctor in most cases. Of the other interviewees, most identified someone they would speak to about moving on, although there were four who were uncertain who their key workers were or whether they had any. From all interviewees, four identified independent advocates, three solicitors and three social workers as people they would talk to about discharge plans.

One person who had spent a month in the IPCU said no one had sat down to talk with him in that time and that the discussion with the Mental Welfare Commission practitioner was the longest conversation he had in hospital. He was not the only one who seemed to feel left out of the care process. In another case, the interviewer records that the person:

Feels not getting right medication. Has not told anyone yet. Will talk to Dr X. Does not feel can talk to staff. Would like
to do art. No activities in day. Not told about groups. Not told about key worker.

We also asked people if they had made any requests to staff and what response they had received. Answers indicated how able people felt approaching staff to make simple requests as well as complaints. Some clearly felt that they did not want to ask for anything. As one person put it, it was ‘easier to go along with things’.

In another case the interviewer noted:

As it was his first experience as an inpatient he did not want to contradict. He wanted, in his words, ‘to do everything by the book’ and to be co-operative.

In another case that:

… he cannot make a complaint or it will impact on any future relaxation of restrictions.

One person thought there should be more support for people who wanted to make a complaint, suggesting a direct phone line to someone in the hospital for patients to use to make complaints, as an alternative to having to arrange an advocacy appointment.

On the other hand, there were seven people who felt that staff were responsive to requests. Things they had successfully asked for included escorted time out on grounds, hot chocolate before going to bed, and a football. In one case the interviewer noted there were:

No requests - states that staff are friendly and helpful and feels they would respond to any request he might make.

In three further examples, interviewees indicated they were aware of reasons for staff not granting their requests.

Three people in response to this question complained that they had been made Incapax* and had lost control over their finances.

According to 12 interviewees, they had been given written information about the IPCU. Twenty-one others said they had not received any information at all.

Half the people interviewed said they had seen an independent advocate since being in the IPCU (Table 4).

**Table 4: Involvement of independent advocacy**

<table>
<thead>
<tr>
<th>Advocacy involvement</th>
<th>Number of interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25</td>
</tr>
<tr>
<td>No</td>
<td>22</td>
</tr>
<tr>
<td>not known</td>
<td>1</td>
</tr>
<tr>
<td>missing</td>
<td>2</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

Advance statements appear to have been made by five of the people interviewed and in one case this had been overridden (the person did not want to be in a locked ward).

**Views about IPCU care and environment**

**Care regime**

One recurring theme in many interviews was the perception of a blanket approach to some aspects of care. In two interviews this view was recorded as follows:

- Objects to one size fits all approach to privileges. Everything reduced to lowest common denominator - regarding risks.

- Has to ask for everything, no independence. Recognise some patients need this protection but feels results in one rule for everybody, these are the rules; not (based) on individual necessity.

Rules about smoking, access to bedrooms and to fresh air and lack of meaningful occupation were causes of frustration expressed by many of the people interviewed. In some cases, there was a perception that staff use smoking restrictions in particular as a means of controlling patients’ behaviour. Experiences of this type of control were recorded by the interviewer in the following two cases.

- Smoking is used as motivation to get up, showered… this has to be done before… if someone is caught with a lighter then no one gets out… no set time for getting out for cigarettes… all dependent on the mood of the staff and used as a reward system.

- Cannot smoke when he wants and ‘if you miss the time the staff say you can smoke then it may be hours before you can get into smoke room again. Need to ask staff for a light all the time.’
It seemed that some IPCUs did not allow people to go outside at all except at restricted times for smoking. Six people said they missed the opportunity for being outdoors. These direct quotations illustrate their experience:

‘Meals okay. Environment okay. I think there should be more time in the garden and in the fresh air. Only 10 minutes at a time.’

‘There should be more trips out to parks in the hospital mini-bus just to get used to being out. The lack of fresh air is really unhelpful. You are allowed out every hour and a half for a smoke break for 10 minutes. In that 10 minutes I am trying to inhale as much fresh air as I can (whilst smoking at the same time) and I feel panicky. I sometimes just want to sit outside and think and watch the sky but that isn’t encouraged.’

‘I would like to be outside all the time. The garden is too small. I feel trapped in when I am in it.’

On a more positive note, one person was enjoying some time outdoors:

‘I enjoy art therapy and getting out into the grounds... (I am) escorted with one member of staff... (I) enjoy getting fresh air.’

Lack of meaningful occupation was another source of frustration for some, as indicated in the following direct quotations.

‘Not enough to do here.’

(misses) cooking, cleaning, social life, home... ‘feels like just walking the hallways’.

‘There is nothing stimulating for your mind in here if you are not allowed out. Feel as if I’m getting stupider everyday. Activities available are not real activities as such for a grown man. Prison had education, library, sport, more like life. The days are so long, and you are so watched. Lack of exercise makes you pace, then staff comment on pacing.

One particularly articulate interviewee linked the lack of meaningful occupation to patients’ needs more widely in the following direct quotation:
‘...more space, more comfort, more time and staff to get occupied and get well again. When you come into an IPCU you are really unwell. You need time to heal and the environment is not a healing environment. You also need something to stimulate and exercise your brain. Some educational input would be really helpful. A life skills group in IPCU would be really good. Some of the patients in this ward have been here for over a year.’

One interviewee says that she does not use the dining room because she finds it ‘claustrophobic’. Her family bring her food in but she says she cannot have tea or coffee as there is nowhere she can make it herself and staff will not make it for her.

Three women had specific criticisms of the care and environment provided. Two of the three commented on the lack of privacy: it was stated by one that they had access to their own rooms only between 10pm and 8am. As one of them explained:

‘When you are heavily sedated and I was when I came in, all I wanted to do was lie down and I was desperate for my bed - but I couldn’t go to my bed and ended up lying down in the corridors.’

As well as needing a place to sleep, she felt that patients being kept all together in one space was not helping her recovery.

‘I think we should either have a quiet room or be allowed to go to our rooms - even just for a lie down in the afternoon. With all of us being around all day with nothing to do, people get on each others backs. This can be upsetting.’

Both concerns regarding lack of privacy and restricted access to bedrooms were raised with the service manager and clinical director and will be monitored by the Mental Welfare Commission.

Privacy for visitors

The dining room was the most commonly mentioned place for meeting visitors with the option in some cases of asking for the use of a private place, eg a quiet room or interview room. Two people said they could meet visitors in their own rooms.

Over half (27) of those interviewed said that it was possible to meet visitors in private. For example:

His 15 year old daughter did visit occasionally - he felt there was enough privacy and that the patients respected your need for privacy if you had visitors.
Most visits take place in communal dining room but if private business to be discussed then small sitting room reserved for doctors, meetings etc can be accessed.

In an interviewees own words:

‘Visits take place in the dining room but when my children visit, we meet in the small sitting room normally kept for doctors.’

Eleven people said that there was no privacy (the remainder either said they had not had visitors or did not answer the question). Interviewees described what it could be like to meet visitors in communal areas, as follows:

‘(you) can hear everyone’s conversation and nothing is private.’

(visits from) sister, brother, mate, cousins, auntie. ‘I met them in the dining room. You can’t have a decent conversation in the dining room because other people are there with their visitors. I feel someone is controlling me.’

One woman said she did not see her young son because there was nowhere suitable in the unit, but said she might be allowed to go to a cafe soon to be with her son along with her own parents.

Another participant wanted to have privacy to meet with lawyers and felt this was impossible in the IPCU. He said he could be overheard in his own room. He had been offered somewhere else to meet but said that constant interruptions meant meetings were abandoned.

Two people objected that visitors were not allowed to smoke in the garden (as patients could).

Physical environment

Four people made comments on aspects of the physical environment which are reproduced here:

‘... place is not kept cleaned properly. Slippers get dirty from floor. Some patients are not always clean.’

‘... use of plastic cutlery reduces any pleasure from eating. No private space. Everything is very shabby.’

‘Not liking it here. Chairs uncomfortable. Carpet dirty. Cannot get to lie down whenever you want.’
‘There is only lino on the floor of the TV room and some people tap with their feet all the time. This can be really irritating and it can ring in your ears. The seats in the living room are hard and uncomfortable.’

**Personal safety**

Most (29 of the 50 participants) said they felt safe in the IPCU including two people who said they felt safer there than on other wards. Another felt that staff could cope with any patients who ‘snapped’.

People who said they did not feel safe (18 interviewees) were mainly afraid of threats from other patients. Three people however specifically stated they were afraid of staff – in two cases because of how they had seen others treated. In the first of these cases, the interviewer recorded the following account of what was said:

> When he doesn’t feel safe it’s to do with the staff. Seen people being restrained several times. He feels the staff have been overly abusive when restraining. He feels that staff use restrictive hand locks which are very painful.

In the second case the person expressed himself as follows:

> ‘… physically I’m okay, but mentally it’s scarring me. I see other weaker people being picked on by staff’.

In the next two, direct quotations, the fear of staff expressed was more general:

> ‘I don’t feel safe with the nurses… a bit feart of them… I don’t know what it is’.

> ‘Too feart to go to sleep or take a shower.’ Feels really scared of staff (interviewer comment).

A few people said they felt unsafe because staff were not able to protect them from other patients. These examples illustrate situations described in interviews:

Other patients can be threatening. Staff sometimes intervene ‘if they have time’.

> ‘… verbal abuse from men.’ (regarding one particular patient) ‘all the female staff had to keep out of his way.’

Two women did not feel safe because of being on a mixed-gender ward. This particular issue is covered next.
Women-only environment

Of the 10 women who answered the question four said there was no women-only area in their unit. One woman was noted as saying there was:

No place to get away from the men. Sometimes sits in toilet but one of the cubicles has broken lock.

Four other women said their own bedroom was the only place they could be away from the men. Only two said there was women-only space apart from their own rooms.

Three women said they were upset by being in a mixed-gender care unit. The others did not mind and four said they preferred it. The first two of the next excerpts relate to women who were staying in IPCUs where access to their own bedrooms was not allowed during the day. As noted by the interviewer, they had been upset by:

… experiencing uninvited sexual approach by one male patient on two occasions

… witnessing male patient masturbating in lounge

… having to put up with gross language and uncouth behaviour

Three of the men interviewed said they would have preferred a single-gender environment.

Restrictions and restraint

Specified persons

Twelve people interviewed were specified persons and told us they were experiencing searches, restrictions on mail and visitors and, in one case, urine testing. One person said that he had not been told he was a specified person but had found out that all of his consultant’s patients were specified. Most did not comment on whether they found restrictions helpful. One person who was having his phone calls supervised said:

(Restrictions) ‘were right in the beginning but I don’t feel it’s nice now’.

One person of the 50 interviewed was being restricted without being formally ‘specified’. In the next excerpt, the interviewer reports how he described these restrictions:

Feels he is been put in his room quite a lot. Nothing in his room. He is told to ‘chill out’. Doesn’t always get a cigarette every hour – thinks because he’s spoken out of turn. Gets
one eventually. Told he’s not allowed to make any phone calls – doesn’t know anything about specified person.

Restrictions in general

We have already seen the range of views expressed about care environments in the IPCUs which are of necessity fairly restrictive. Of the 38 who were not specified persons, 14 people responded to a direct question about restriction that they were more restricted since admission to the IPCU. Four said they had mobile phones taken away, and three mentioned restrictions on going out. A few thought that being restricted was helpful or necessary. As one interviewer notes:

… he is being helped to ‘get clean’ as he put it.

One interviewee said that restrictions ‘have been helpful – I was very ill’, while others gave the opposite view. In the interviewer’s words, one person

Feels confined – need to ask for razor – treated like a child.

In a second case, the person described the restrictions on them as follows:

‘…can’t go out, no passes and haven’t been able to see a doctor to ask how I get out and I’ve been here for weeks. I feel like a mouse in a trap not knowing which way to turn. Others have all control over me.’

Physical restraint

Just under half of the people interviewed (18) said they had been physically restrained since being in the IPCU. Twenty-nine said they had not been physically restrained although in one case ward records contradicted what the person told us.

Of the five women who described instances of physical restraint, two said they felt they had been well treated in the circumstances - in their own words:

‘I attacked a nurse with a chair. Two staff removed the chair then held my hands by my side then took me to my room until I calmed down. They were not rough with me, no bruises. Of course I understand why they needed to do this.’

‘When I tried to strangle myself, staff had to remove ligature. They did this as gently as they could, they were nice to me.’

A third woman talked of being physically restrained several times without the use of medication. In her own view ‘nothing else would have worked’.
The remaining two women were less accepting of their treatment. One described how she was left ‘covered with bruises’ after being restrained for medication to be given. The other who felt that the restraint was unwarranted, gave the following account:

‘… held down yesterday for what seemed like an hour. Two male staff and two females… I asked to be let go and shouted for help. It was not needed. Given a jag later because I could not stop crying. It made me feel awful and was not needed. I was crying not fighting.’

One of the male interviewees felt that he had been restrained on a few occasions ‘beyond the point where he was resisting’. Three men stressed how painful physical restraint was. Their accounts were noted by the interviewers as follows:

Been restrained twice. Can’t really remember but does know it was painful. Restrained in ward to be brought here then twice in his bedroom and put down on the bed with three or four staff. He reiterated how painful it was.

He kicked one of the patients. Two staff then restrained him using wrist locks then he was given oral medication. He thought the staff were too forceful - all he could remember about the incident was how painful it was.

The third man, quoted earlier in the context of his fear of staff, said he did not agree with the restraining locks. He said he was:

‘… in excruciating pain and the more you move the more you are restrained. Sometimes 90%.’

**Continuity of care and support**

Eleven people interviewed said they were seeing the same consultant as before their admission to the IPCU. Seven of the 11 had been transferred from another ward and the remaining four had been at home. One who had been in the unit for several months said he had not seen his RMO since his transfer – the IPCU doctor confirmed that they were not the RMO but was making day-to-day decisions while the patient was in the unit.

Seventeen people said they were not seeing the same consultant as before and two said that they had not had a psychiatrist prior to admission. In the remaining 20 cases, the question was not answered.

One person who had been transferred from prison for assessment said that changing doctors was a disadvantage. In his own words:
‘I would like to see my usual doctor’ (who patient saw outside IPCU)… I think they’ve not got the time to get to know you and assess you. I’m only here for 3 weeks – not long enough…’

Another person raised the issue of seeing a number of doctors during his admission – he felt he had to tell the same story several times to different doctors.

Six people said they still had contact with their community psychiatric nurse.

### Family contact

Most people (29) said they were getting visits from family members. Several people were getting frequent, even daily, visits from relatives. Some said they were seeing their children. Of the 10 people who said they were not getting visits, none said they were prevented from seeing friends or relatives. Some chose not to and others had some relatives who could not visit because of the distance involved. Two people said they had been in too short a time to receive a visit and nine did not answer the question.

One interviewee stated:

‘If we do something bad we’re not allowed visitors.’

He said that his mother (who is his named person) had been stopped from visiting as a punishment to him.

### Views about staff attitudes

Nineteen of the 50 people interviewed felt that staff attitudes were good and many of them said they were well treated. The following direct and indirect quotations from interviews illustrate this.

He feels the staff are good to him. Try to teach him when he’s being inappropriate.

‘Staff very respectful and pleasant to everyone.’

‘The staff treat me well. If I was not happy, I would maybe speak to a nurse or the ward manager.’

‘The staff are all very good and nice to me, very respectful. I sometimes am not keen on the bank staff, they can be rude. Regular staff are excellent.’

On the other hand, there were 12 people who did not like staff attitudes in general, and a further eight said that while most staff treated them well there were particular individuals who did not. This group included two who singled out night nurses for criticism. In the first excerpt, the interviewer summarises the person’s response.
Day staff very supportive, treat everyone the same. Night shift spend their time at pool table, bring goodies, do not speak to patients. Don’t seem to engage.

‘Day staff absolutely brilliant - happy, supportive, can’t do enough for you. Night staff completely different - not like bad but all about security, authority, rules, enforcing timetable. More serious… (they) won’t do more than make sure you’re not swinging from the ceiling!’

‘Some are friendly, some are angry and controlling towards me.’

Some comments about staff attitudes are suggestive of a controlling rather than a therapeutic approach. One Mental Welfare Commission practitioner observed:

The staff seemed to be sitting in a central point in the corridor, right beside the patient phone and any calls patients are making are listened to by the staff. Staff were overheard making comments about patients and it could be quite intimidating for a patient to approach a group of staff sitting in this way.

One person interviewed on this same unit described staff as being ‘cheeky’ on occasions. Other examples of people’s negative experiences of staff attitudes include the following interviewers’ notes:

‘Terrible’ - mainly to do with their attitude around cigarettes being used as a means of controlling a patient. Quite forthcoming in his views about the staff. Some nice people but overall the staff use the restricted facilities to control the patients.

Believes staff deliberately engineer situations to provoke him so that he can be restrained.

In interviewees' own words:

‘Sometimes they can be a bit fearsome. Pushy. The way they pin you down. You do something wrong and they say you’re not getting this, you’re not getting that.’

‘I am hyperactive and I think they think I am annoying.’
Some comments referred to a lack of respect for patients in the interviewees’ eyes.

‘Have seen other patients manhandled.’

‘(Staff) don’t call me mister when I request this.’

‘Not all staff (are respectful) - bad from some. Jokey stuff - joke about you.’

One person was reluctant to approach staff as she and a relative visiting her had both experienced rudeness from nurses. As she stated:

‘It isn’t just one nurse, it can be a few, night and day but probably worse at night. You feel really trapped when it happens. There isn’t anyone to talk to and you don’t know if you will be believed.’

People were asked in the interview if they felt they were treated in any way differently from others in the unit. Most of the answers given were about some aspect of their treatment, eg not being allowed to go out for a smoke with the others, not being given particular medication because of ‘problems with drugs’, and in one case, not being transferred out of the unit. One woman felt that women’s needs were not catered for in the IPCU and one man of Asian origin said he was not able to follow the diet specific to his culture and religion.
FAR AFIELD

Far afield she lay and stared,
at the grasses and the moon beam.
Dreaming of horses and hooves of thunder,
Chariots of fire, fire, fire.
And when it quickened
She had space to think.
The land went far into the distance and in it
she was merely a dot
and that made her smile.

Poem written by a focus group participant
6 Service user and carer experience - focus groups

As previously described in this report, VOX Scotland facilitated a number of regional focus group sessions. We invited people with a lived experience of IPCU care and their carers to participate to share their views and experiences. We greatly value the contribution of all those who attended the sessions. It is appreciated that spending time in an IPCU can be unsettling and stressful for the person and their family and friends. The focus group facilitators praised the strength and sense of humour which came across in each of the groups and helped to keep the sessions alive. The strategies that people had worked out for themselves to cope with their experiences were also admirable.

The enthusiasm and willingness of all participants to share their thoughts and recollections about this period of the journey of care, and their openness to talk about their experiences is invaluable. It adds an important integral dimension to this report about IPCU services in Scotland. We also greatly appreciated the support of local independent advocacy and voluntary organisations and NHS boards in organising the focus group sessions and supporting and encouraging people to participate.

A total of 11 focus group sessions were held between October 2009 and January 2010. Sessions were held in all NHS board areas where there is local IPCU provision. In addition, sessions were also held in two areas where there is no local provision; these will be reported separately. A total of 21 service users (17 men and 4 women) and nine carers participated.

Each focus group followed the same format. The facilitators explored the views and experiences of participants relating to the following areas:

- support provided in the IPCU and areas for improvement
- involvement in care and treatment decisions
- continuity of care and support
- respect for diversity
- safety
- restriction and restraint, and
- emotional impact.

Participants were also invited to raise any other areas that they wished to discuss that were not already covered under the above. What follows is a summary of the key emerging themes across all the focus group sessions.
6.1 Support provided in the IPCU and areas for improvement

There was general agreement among both service user and carer participants about what is important within the IPCU environment. It was also agreed that the higher ratio of staff to service users, compared to the acute wards, ensures that safety needs are adequately addressed during acute phases of mental illness; other needs, however, are not as well catered for. A number of points raised by service user and carer participants that would improve the experience of being in an IPCU were highlighted.

6.1.1 Physical environment

Service user participants said that the physical environment of the IPCU can have a detrimental effect on recovery. The lack of colourful and homely surroundings and stimulating inputs, such as music, can lead to a feeling of emptiness. Participants who had experience of more than one IPCU highlighted variation in the physical environment, for example some IPCUs have shared bedrooms whereas others have all single bedroom accommodation.

6.1.2 Availability of activities and interaction

Service user participants felt very strongly about the lack of availability of appropriate activities and social interaction in an IPCU; this was raised in all the sessions. Participants expressed a need for a wider range of activities and projects within the IPCU setting. Cookery, joinery, computing and gardening were mentioned. Participants also said that more opportunities to access outdoor spaces were required. Carer participants highlighted that staff could better encourage and support people to get involved in the activities that are available.

In areas where group activities and therapies were available, service user participants saw these as beneficial and said that they helped to alleviate boredom.

Some service user participants also said that it would be good to be able to access facilities to make a cup of tea or a snack when you want to. They did appreciate, however, that there may be risks associated with this for some people.

Service user participants felt that regular social interaction was often lacking. Whilst it was acknowledged that staff are often very busy, participants noted that simple things like taking time to say hello and stop for a quick chat would really make a difference. Better opportunities for in-reach from voluntary organisations and interaction with people...
with lived experience of IPCUs who have since recovered were also mentioned. Service users felt that this could provide opportunities for peer support and would lessen the feelings of isolation and of being judged because of your mental illness.

In terms of day-to-day care, some service user participants highlighted variation in the behaviours and attitudes of members of staff. All participants agreed that sometimes staff might not be aware of the negative impact that small things can have on service users; for example, having bunches of keys visible about their person, which can create the feeling of a prison-like environment. In addition, the issue of staff being in a perceived position of power was raised. This had led to some service user participants feeling unable to challenge any decisions made about them or to make a complaint.

### 6.1.3 Communication and accessibility of information

Both service user and carer participants highlighted a need for better communication with staff. For service users, this related to a need for more day-to-day social interaction with staff members.

Carers highlighted that often they know the person much better than the staff do and, with better two-way communication, they may be able to provide advice, and have more input to care and treatment decisions.

Service user participants said that information is often difficult to obtain. It would have been better for them if their symptoms and the reasons for being admitted to an IPCU were explained clearly to them on admission.

Carer participants highlighted that support for them is just as important. This was particularly with regard to information about symptoms, medications and their side effects. It was suggested that establishing links to carers through the acute inpatient forums could be a mechanism for improving communication and information provision.

### 6.1.4 Therapeutic interventions

All participants felt very strongly that there was a lack of ‘talking therapies’ within IPCUs. Service user participants considered this type of intervention as essential for successful recovery and viewed this as a fundamental gap in the service available to them. Some participants felt that this gap in services is contributory to an over-reliance on medication.
Feedback from participants also indicated that access to occupational therapy was very important, particularly for those with more complex needs.

Participants suggested a number of ideas for other therapies that would be of benefit including:

- recovery-focused interventions
- exercise
- calming therapies
- anger management, and
- training in strategies to help people manage situations better and come up with solutions and strategies for themselves.

### 6.1.5 Support for co-morbid conditions

Participants raised the issue of co-morbid conditions and other issues associated with mental illness at a number of the sessions. Participants felt that sometimes staff were not well equipped to properly manage and provide appropriate interventions for problems such as alcohol and other substance misuse, self-harm, suicidal tendencies and inappropriate sexual thoughts and behaviours.

### 6.2 Involvement in care and treatment decisions

Service user participants had mixed views about the extent to which they were involved in decisions about their care and treatment when in an IPCU. Some service user participants felt that they were not given any opportunity to have their say; some felt that they had been too unwell at the time to be meaningfully involved. Others said that they were involved in discussions around medication options. However, the lack of accessible information on the range of medications, the benefits and any side effects meant that they were not able to make an informed choice. None of the service user participants had the opportunity to participate in decision-making about interventions other than medication.

Carer participants had similarly mixed views about the extent to which they were involved in decision-making. Both service user and carer participants noted that the extent of involvement and participation in care and treatment decisions was very much dependent on the staff involved. Some service user participants felt that the desire to escape from...
the IPCU was so strong that they were not motivated to be fully involved; rather they would just accept the treatment plan suggested by the clinicians so that they could get out of the IPCU more quickly.

Both service user and carer participants felt that clinicians were really missing out on lots of rich and relevant information by not involving them more in decision-making.

### 6.3 Continuity of care and support

Again there were mixed views from service user participants about continuity of care and support. Some participants felt that appropriate support was lacking when they moved on from an IPCU. Others viewed the intensity of support, and numbers of professionals involved, as overwhelming and invasive.

It was agreed that continuity of care needs to be addressed across the service, not just in the IPCU environment. Participants highlighted that the appropriateness of the ward that people are discharged to initially, and the support made available to people in the community when they return home, are all interrelated. All of these factors can have an impact on recovery. If an appropriate support infrastructure is not in place, it can lead to people quickly becoming unwell again and requiring to be re-admitted. Service user participants felt that more multidisciplinary team meetings were required leading up to discharge. This will ensure that all the potential issues have been considered and an appropriate support package is in place.

Some participants noted that continuity of care and support is, however, improving with the introduction of new initiatives such as integrated care pathways (ICPs) in mental health services.
Both service user and carer participants said that information sharing between staff was an issue both at admission and at discharge from IPCUs. Frequent turnover of staff was also raised as an issue. This can make it difficult to form relationships and also leads to service users and carers having to repeat the same information numerous times. Service user and carer participants noted that while most people do have care plans, the degree of implementation of these varies.

### 6.4 Respect for diversity

Some service user participants spoke about their religious beliefs not being fully respected. For example, one participant was unable to leave the IPCU to attend the funeral of a close friend. Another was not able to see their priest when they wanted to and this was something that they saw as very important to their spiritual wellbeing.

A more common emerging theme relating to respect for diversity was that service user participants felt that if they had a differing view on how their mental illness should be treated, this was not respected. This was particularly with regard to people who were keen to explore treatment options other than medication. While participants appreciated that staff were working within the limitations of the services available, in some cases, participants felt that their wishes with regard to alternative treatments were not respected or taken seriously.

### 6.5 Safety

Service user participants had mixed views about how safe they felt when in an IPCU. Some of the discussion in the focus group sessions was around how the client mix at a particular time can affect the atmosphere on the ward and the perception of how safe it is. Mixing groups of service users with very specific needs, for example dementia, was also not seen as ideal. It was noted, however, that ‘once you get to know the other service users better you don’t tend to feel as threatened by the way that they sometimes behave’.

Participants said that sometimes, situations can escalate very quickly and this can be frightening. Carer participants in particular noted that it can be quite distressing when the alarms go off.

The issue of dormitory style accommodation was raised. This is now fairly uncommon in IPCUs. In those units where there are still shared bedrooms, service user participants said that this was not ideal and, depending on who you were sharing with, could be quite unsettling. Even in single bedroom accommodation, the fact that other service users could open your bedroom door at any time was seen as a concern. Service user participants also had

‘I think IPCU is safer than anywhere else when you are unwell.’

Service user participant
concerns that being under sedation could leave people particularly vulnerable.

Participants discussed mixed gender wards in a few of the sessions. One female service user participant said that she had felt particularly vulnerable in a mixed gender IPCU.

Carer participants said that sometimes service users will trade belongings and some service users may be taken advantage of depending on how unwell they are at the time.

### 6.6 Restriction and restraint

A small number of service user participants noted that they felt that they had been inappropriately placed in an IPCU.

While service user participants appreciated that there were risk issues to be considered, they said that it could be distressing to have certain personal possessions taken away whilst in an IPCU. Some participants also noted that they were only allowed to have a limited selection of clothing. Smoking restrictions were discussed. Some participants felt that it was unfair that they were not allowed to smoke when they wanted, for example if they woke up in the middle of the night.

Participants discussed the difficulties of respecting the views of everyone in the IPCU. An example to illustrate this was service users having the freedom to choose to watch television late into the night which could disturb the sleep of those who choose to go to bed early.

Service user participants had different experiences of physical restraint being used when in an IPCU. Most had experienced this at some point in their journey of care and acknowledged that this type of intervention was sometimes warranted to ensure the safety of the person and those around them. Some service user participants also felt that medication was sometimes used as a means of restraint.

Participants felt strongly that access to non-pharmacological interventions, and sufficient activities within IPCUs, would open up more options and could reduce the over-reliance on medication.

Service user participants discussed that recently some staff will try to de-escalate the situation before resorting to physical interventions.
Participants agreed that some staff members are better at doing this than others.

Service user participants had mixed views about physical interventions. They said that there is a range of expertise in the application of physical interventions and knowledge of when they should be applied. The issue of staff attitudes to the use of restrictions and physical interventions was also raised at a number of the sessions. Service user participants felt that some staff used these inappropriately as a form of punishment.

Carer participants acknowledged that in some situations physical restraint is warranted, however this can be distressing for friends and family to watch.

6.7 Emotional impact

The emotional impact of IPCU care is obviously a very personal matter; different people will have very different feelings and perceptions about this period of their life. Both service user and carer participants said that the emotional impact of experiencing an IPCU is difficult to fully express in words. Carer participants also highlighted that experiencing an IPCU as a carer can have as significant an impact as it does on the service user.

Service user participants used the following words to describe their experience:

- lost
- frustrated
- trapped
- angry and powerless
- isolated, withdrawn, numb
- wanted to escape
- resentment, and
- helpless.

Carer participants used the following words to describe their experience:

- devastating
- emotionally draining
- it grinds you down and takes up a lot of time and energy, and
- carer’s emotional needs are neglected.

Service users also spoke about a lack of understanding about mental illness among some family members and friends, and about the stigma of mental ill health which can impact on all areas of life.

‘There was only one nurse I really trusted. If they restrained me it was done in the right way.’
Service user participant

‘It was months before I cried, or smiled.’
Service user participant

‘Carers suffer just as much, although they are pushed to the side.’
Carer participant
6.8 Areas without IPCU provision

Sessions were held in two areas where there is no local IPCU provision or an SLA with another NHS board area to provide such a service. These sessions followed the same format. The majority of participants in these sessions had received intensive support within the acute wards rather than be transferred out-of-area to an IPCU; some also had experience of IPCUs.

The themes emerging from both service user and carer participants at these sessions were very similar to those from the NHS board areas with IPCU provision.
Evil to good – artwork by a focus group participant
Appendix 1 — IPCU project group members

IPCU project group members

Dr James Hendry (Chair)
Acting Clinical Director, West Lothian CHCP/Consultant Psychiatrist, NHS Lothian

Mr Ivan Carnegie
Chair, Tayside Forensic Voices

Dr Denise Coia
Principal Medical Officer (Mental Health), Scottish Government

Ms Carol Dobson
Chief Nursing Officer, Mental Welfare Commission for Scotland

Dr John Ferguson
Specialist Registrar, NHS Lothian (until September 2009)

Mr Iain Fisk
Association of Directors of Social Work

Mr Bob Gillies
Inpatient Services Manager/Lead Nurse, NHS Greater Glasgow and Clyde

Ms Beverley Grantham
Head Occupational Therapist, NHS Greater Glasgow and Clyde

Dr Alistair Hay
Consultant Psychiatrist, NHS Highland

Dr Deborah Mountain
Consultant Psychiatrist, NHS Lothian

Ms Irene Sharkie
Lead Principal Pharmacist (Mental Health), NHS Tayside

Dr Ruth Stocks
Head of Forensic Clinical Psychology, NHS Greater Glasgow and Clyde

Ms Helen Walker
Senior Nurse (Practice Development), The State Hospitals Board for Scotland
Appendix 2 — Service user and carer experience subgroup members

Service user and carer experience subgroup members

Mr Ivan Carnegie (co-chair)
Chair, Tayside Forensic Voices

Dr Deborah Mountain (co-chair)
Consultant Psychiatrist, NHS Lothian

Ms Carol Dobson
Chief Nursing Officer, Mental Welfare Commission for Scotland

Support from VOX Scotland and the Mental Welfare Commission was provided by:

Ms Tracy Laird
Consultant Service User Researcher, Voices of eXperience Scotland

Ms Wendy McAuslan
Development Co-ordinator, Voices of eXperience Scotland

Ms Charlotte McDonald
Researcher, Mental Welfare Commission for Scotland

Support from NHS QIS for the IPCU project and the user and carer experience work was provided by:

Mr Sam Atkinson
Project Officer (until May 2009)

Mrs Jane Byrne
Programme Manager

Ms Pamela Campbell
Project Administrator

Mr Sean Doherty
Performance Assessment Manager

Mr Kevin Hodgson
Project Clinical Support

Mrs Susan McGaff
Project Administrator (until April 2009)

Ms Joyce Mouriki
Senior Public Partnership Officer

Dr Alastair Palin
Clinical Advisor Adult Mental Health

Mr Sam Poullain
Project Officer
<table>
<thead>
<tr>
<th>NHS board area</th>
<th>Meeting date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>04/06/2009</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>18/06/2009</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>04/06/2009</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>16/06/2009</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>09/06/2009</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>28/05/2009</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td></td>
</tr>
<tr>
<td>Dykebar Hospital, Paisley</td>
<td>21/05/2009</td>
</tr>
<tr>
<td>Gartnavel Royal Hospital, Glasgow</td>
<td>21/05/2009</td>
</tr>
<tr>
<td>Stobhill Hospital, Glasgow</td>
<td>21/05/2009</td>
</tr>
<tr>
<td>Leverndale Hospital, Glasgow</td>
<td>21/05/2009</td>
</tr>
<tr>
<td>NHS Highland</td>
<td></td>
</tr>
<tr>
<td>Argyll &amp; Bute Hospital, Lochgilphead</td>
<td>19/05/2009</td>
</tr>
<tr>
<td>New Craigs Hospital, Inverness</td>
<td>27/05/2009</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>14/05/2009</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td></td>
</tr>
<tr>
<td>Royal Edinburgh Hospital</td>
<td>23/06/2009</td>
</tr>
<tr>
<td>St John’s Hospital, Livingston</td>
<td>08/07/2009</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>05/05/2009*</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>05/05/2009*</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td></td>
</tr>
<tr>
<td>Sunnyside Royal Hospital, Montrose</td>
<td>25/06/2009</td>
</tr>
<tr>
<td>Carseview Centre, Dundee</td>
<td>25/06/2009</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>07/05/2009*</td>
</tr>
</tbody>
</table>

* via video conference
IPCU project follow-up meetings team members

Mr Ivan Carnegie
Chair, Tayside Forensic Voices

Dr John Ferguson
Specialist Registrar, NHS Lothian

Mr Iain Fisk
Association of Directors of Social Work

Mr Bob Gillies
Inpatient Services Manager/Lead Nurse, NHS Greater Glasgow and Clyde

Ms Beverley Grantham
Head Occupational Therapist, NHS Greater Glasgow and Clyde

Mr Kevin Hodgson
IPCU Project Clinical Support (seconded to NHS QIS)

Dr Alastair Palin
Consultant Psychiatrist, NHS Grampian

Ms Irene Sharkie
Lead Principal Pharmacist (Mental Health), NHS Tayside

Dr Ruth Stocks
Consultant Forensic Clinical Psychologist, NHS Greater Glasgow and Clyde

Ms Helen Walker
Senior Nurse (Practice Development), The State Hospitals Board for Scotland
Mental Welfare Commission interview questions

Transfer to the IPCU
- Where were you before you came here?
- Why do you think you’re here in the intensive care unit?
- What did it feel like to be moved here?
- How do you feel about being here now?
- How do you think you benefit from being here?
- What are you no longer able to do because of being in the IPCU (compared with previous setting)?
- Is there somewhere in the unit where you can meet your visitors in private (including children)? If not, how do you feel about that?
- Has anyone explained to you how you move on from this unit?
- Who would you talk to about that?

Personal safety
- Do you feel safe here?
- Is there anywhere in the unit you can go that is women-only?
- Does it bother you being on a mixed sex unit?

Participation in care and treatment decisions after transfer to the IPCU
- Do you understand what is happening about your care and treatment since you came into this unit?
- Were you given any written information about the unit?
- Have you seen an (independent) advocate since you have been here?
- Do you have an advance statement? If so, do you think your doctor is taking account of that?
- Have you made other requests about your care and treatment? If so, what happened?

Restrictions and restraint
- Since you’ve been here (in the IPCU) have you been more restricted?
- Do you think these restrictions are helpful to you?
- Have you been physically restrained in any way since you’ve been in this unit?
Continuity of care and support

- Do you still see the same consultant that you saw before?
- What about other staff?
- Could you tell me about the contact you have with family and friends (since being in the IPCU)?

Respect and diversity

- What do you think about staff attitudes to you?
- Do you feel that you are treated in any way differently from other people in the IPCU?

Interviewer’s general observations

Present at interview:

- Independent advocacy worker
- Key worker or other member of staff
- Friend or relative of patient
- Other (please specify)
- Detail if ‘other’ present

Information from ward staff about the service user

- Service user name
- Age at interview
- Gender
- Ethnicity
- Legal status
- Diagnosis
- Date of transfer to the IPCU
- Where transferred from
- Reason for transfer to the IPCU
- Date of discharge from the IPCU (if known)
- Has independent advocate been involved with the service user since transfer?
- Does the service user have an advance statement? – has it been overridden?
- Has the service user participated in decisions about their care and treatment while in the IPCU?
- Is the service user a specified person?
- Is there a named carer?
- Is there a named person?
Reference list


## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>advance statement</td>
<td>A written and witnessed document which is made when a person is well. It sets out how the person would prefer to be treated (or not treated) if they were to become ill in the future. The Mental Health Tribunal and any medical practitioner treating the person must take the advance statement into account. Medical practitioners must also send the Mental Welfare Commission a written record of the reasons why the wishes set out in the advance statement have not been followed.</td>
</tr>
<tr>
<td>allied health professions (AHPs)</td>
<td>The allied health professions include registered healthcare professionals such as physiotherapists, occupational therapists, dietitians, speech and language therapists, podiatrists, orthoptists and art, music and drama therapists. The AHPs are often part of multidisciplinary teams and bring specific expertise to caring for the patients across hospital and community settings.</td>
</tr>
<tr>
<td>approved medical practitioner (AMP)</td>
<td>A medical practitioner who has been approved under section 22 of the Mental Health Act by an NHS Board or by the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder. Approved medical practitioners are often consultant psychiatrists. Only an approved medical practitioner can grant a short-term detention certificate; and at least one of the two mental health reports forming part of a compulsory treatment order application must be provided by an approved medical practitioner.</td>
</tr>
<tr>
<td>bipolar disorder</td>
<td>A complex mental disorder which affects different people in many different ways. It is characterised by significant disturbance of mood (highs and lows), activity levels and behaviour. Psychosis may be part of the experience for some people.</td>
</tr>
<tr>
<td>British National Formulary (BNF)</td>
<td>The BNF is a joint publication of the British Medical Association and the Royal Pharmaceutical Society of Great Britain. The BNF aims to provide prescribers, pharmacists and other healthcare professionals with sound up-to-date information about the use of medicines.</td>
</tr>
<tr>
<td>CAMHS</td>
<td>See child and adolescent mental health service.</td>
</tr>
<tr>
<td>carer</td>
<td>A person who looks after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.</td>
</tr>
<tr>
<td>child and adolescent mental health service (CAMHS)</td>
<td>CAMHS is a term used to refer to mental health services for children and adolescents. CAMHS are usually multidisciplinary teams including psychiatrists, psychologists, nurses, social workers and others.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>clinical governance</td>
<td>Ensures that patients receive the highest quality of care possible, putting each patient at the centre of his or her care. This is achieved by making certain that those providing services work in an environment that supports them, and that the organisation places safety and quality of care at the top of its agenda. Risk management at an organisational level is an important aspect of clinical governance. It recognises that risk can arise at many points in a patient’s journey, and that aspects of how organisations are managed can systematically influence.</td>
</tr>
<tr>
<td>clinical psychologist</td>
<td>A clinical psychologist aims to reduce psychological distress and to enhance and promote psychological wellbeing. They deal with a wide range of psychological difficulties, including anxiety, depression, relationship problems, learning disabilities, child and family problems and serious mental illness. Clinical psychologists work largely in health and social care settings including hospitals, health centres, community mental health teams, child and adolescent mental health services and social services.</td>
</tr>
<tr>
<td>community mental health team (CMHT)</td>
<td>A group of professionals from a variety of different disciplines, eg medical, nursing and social work who work together to provide a range of mental health services outwith the hospital setting.</td>
</tr>
<tr>
<td>community psychiatric nurse (CPN)</td>
<td>CPNs are registered nurses who work with people with mental health problems in the community. They work as part of a mental health team and, like other members of the team, may see people in a variety of settings such as at a GP surgery, in a clinic or health centre or in a client’s own home.</td>
</tr>
<tr>
<td>co-morbid/ co-morbidity</td>
<td>The presence of two or more disorders at the same time. For example, a person with depression may also have co-morbid obsessive compulsive disorder.</td>
</tr>
<tr>
<td>consultant psychiatrist</td>
<td>A qualified doctor who has completed special advanced training in diagnosing and treating mental illnesses.</td>
</tr>
<tr>
<td>CPN</td>
<td>See community psychiatric nurse.</td>
</tr>
<tr>
<td>Criminal Procedure (Scotland) Act 1995</td>
<td>This Act has provisions for the use of compulsory powers in relation to mentally disordered offenders. Website address: <a href="http://www.opsi.gov.uk/Acts/acts1995/ukpga_19950046_en_1">www.opsi.gov.uk/Acts/acts1995/ukpga_19950046_en_1</a></td>
</tr>
<tr>
<td>dementia</td>
<td>A progressive illness which affects the brain. It can affect memory, thinking and actions. People of any age can develop dementia, although it is more common in older people.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>depression</td>
<td>A mental disorder with varying degrees of severity. The person often suffers from low mood, reduced energy and activity levels. Capacity for enjoyment, interest, and concentration can be reduced. Sleep and appetite are usually disturbed. Self-esteem and self-confidence are usually reduced. Often, to some degree, ideas of guilt or worthlessness are a feature. The lowered mood varies little from day to day and is often unresponsive to circumstances.</td>
</tr>
<tr>
<td>Forensic Mental Health Services Managed Care Network (Forensic Network)</td>
<td>The Forensic Network was established by ministerial directive in 2003. The Network’s aim is to provide communication links between all disciplines and agencies involved in forensic mental health services in Scotland. The Forensic Network is multi-agency and multidisciplinary in its approach, with strong links with the Scottish Prison Service, Social Work Services, Police and Criminal Justice Agencies, The Scottish Government and carers amongst others.</td>
</tr>
<tr>
<td>forensic services</td>
<td>Forensic mental health is a specialist tertiary service that is committed to working in a multidisciplinary and multi-agency way to ensure safe practice. It provides care and treatment for individuals who have a mental illness or learning disability and demonstrate serious offending behaviour or present a significant risk to others. The service offers assessment, consultation, care and treatment, which is proportionate to the situation, and underpinned by risk assessment and management and treatment of offending behaviour.</td>
</tr>
<tr>
<td>informal patients</td>
<td>An informal patient is a person in hospital voluntarily. Most people admitted to hospital are informal patients.</td>
</tr>
<tr>
<td>integrated care pathways (ICPs)</td>
<td>A way to compare planned care with care actually given. An integrated care pathway is an explicit agreement by a local group, both multidisciplinary and multi-agency, of staff and workers to provide a comprehensive service to clinical or care groups on the basis of current views of good practice and any available evidence or guideline. For more information on the development of ICPs for mental health, please visit: <a href="http://www.icptoolkit.org">www.icptoolkit.org</a></td>
</tr>
<tr>
<td>intensive psychiatric care unit (IPCU)</td>
<td>A recovery focused service, which provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation. This service will be delivered by a multidisciplinary team with specialised training. The ratio of nursing staff will be higher than a general psychiatric ward.</td>
</tr>
<tr>
<td>IPCU</td>
<td>See intensive psychiatric care unit.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>learning disability</td>
<td>A learning disability is a life-long condition that starts before birth or while a child is growing up. The term learning disabilities covers lots of different things. People with learning disabilities often find it hard to understand new or complicated information, or learn how to do things. They sometimes find it hard to do day-to-day things without support. NHS QIS published 'Tackling Indeference' a national overview report in December 2009 on Healthcare Services for People with Learning Disabilities which is available at: <a href="http://www.nhshealthquality.org/nhsqis/files/LD_NOVER_DEC09.pdf">www.nhshealthquality.org/nhsqis/files/LD_NOVER_DEC09.pdf</a></td>
</tr>
<tr>
<td>low secure unit</td>
<td>A low secure unit includes intensive care wards and forensic services such as longer term low or semi-secure care. For example, forensic hostels or remand assessment beds. In addition, pre-discharge wards may be designated at this security level.</td>
</tr>
<tr>
<td>medium secure unit</td>
<td>A medium secure unit delivers intensive, comprehensive multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of serious mental disorder and who require the provision of security. Patients will be detained under the Mental Health Act and may be restricted on legal grounds needing rehabilitation in the medium term.</td>
</tr>
<tr>
<td>Mental Health (Care and Treatment) Act 2003</td>
<td>This law came into effect in October 2005 and deals with how people with a ‘mental illness, learning disabilities or other mental disorder’ can be given care and treatment. It says: • when a person can be taken to hospital against their will • when a person can be given treatment against their will • what rights a person has when they are receiving care and treatment, and • what safeguards are in place to protect a person’s rights. The law is based on a set of principles, and these principles should be taken into account by anyone involved in a person’s care and treatment. Website address: <a href="http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1">www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1</a></td>
</tr>
<tr>
<td>Mental Welfare Commission for Scotland (MWC)</td>
<td>An independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. The Commission’s duties are set out in mental health law. Website address: <a href="http://www.mwscot.org.uk">www.mwscot.org.uk</a></td>
</tr>
<tr>
<td>multidisciplinary team</td>
<td>A group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors, including the particular needs of individuals.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>named person</td>
<td>A named person is someone nominated by a person to support them and protect their interests. The named person is entitled to receive certain information about the person and to act on their behalf in certain circumstances.</td>
</tr>
<tr>
<td>National Association of Psychiatric Intensive Care Units (NAPICU)</td>
<td>The aim of NAPICU is to advance the care and treatment of those people who require psychiatric intensive care in low secure units in acute services. They achieve this through promoting and sharing good practice, providing education and training, encouraging clinicians to establish networks and by undertaking research and audit.</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NHS board</td>
<td>There are 21 NHS boards in Scotland – 14 are territorial boards responsible for healthcare in their areas. The remainder are special health boards which offer supporting services nationally. See NHS board (territorial) and special health board.</td>
</tr>
<tr>
<td>NHS board (territorial)</td>
<td>There are 14 territorial boards, the mainland being covered by 11 and the island groups (Orkney, Shetland and the Western Isles) by three. They are responsible and accountable for strategic planning, service delivery, performance management and governance within their local areas. Each NHS board uses the organisational building blocks of NHS direct care, such as community health partnerships or operating divisions, in a way which suits its geography and population. NHS boards work together in regional planning arrangements for those services which require that wider perspective. Website with board directory - address: <a href="http://www.show.scot.nhs.uk/organisations">www.show.scot.nhs.uk/organisations</a></td>
</tr>
<tr>
<td>NHS Quality Improvement Scotland (NHS QIS)</td>
<td>NHS QIS was established in 2003 and leads the use of knowledge to promote improvement in the quality of healthcare for the people of Scotland. It performs four key functions: providing advice and guidance on effective clinical practice; setting standards; driving and supporting implementation of improvements in quality; and assessing the performance of the NHS, reporting and publishing the findings. NHS QIS also has central responsibility for patient safety and clinical governance across NHSScotland. Website address: <a href="http://www.nhshealthquality.org">www.nhshealthquality.org</a></td>
</tr>
<tr>
<td>occupational therapy (OT)</td>
<td>The treatment of mental and physical health problems by encouraging people to participate in specific activities that will help them to reach their maximum level of function and independence in all aspects of their daily life. An occupational therapist is a person specially trained to provide such assessment and treatment.</td>
</tr>
<tr>
<td>PEP</td>
<td>See psychiatric emergency plan.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>personality disorder</td>
<td>A term that covers a complex group of disorders. These can be characterised by difficulties in making or sustaining relationships and keeping control of feelings and behaviour. This can cause much distress and unhappiness for the person and upset and potentially harm others. These traits are usually evident from childhood or adolescence. People with personality disorder can find life difficult and can be prone to other mental health problems, for example, depression or harmful use of drugs or alcohol.</td>
</tr>
<tr>
<td>PICU</td>
<td>See psychiatric intensive care unit.</td>
</tr>
<tr>
<td>primary care</td>
<td>Family health services provided by a range of practitioners, including family doctors (GPs), community nurses, dentists, pharmacists, optometrists and ophthalmic medical practitioners.</td>
</tr>
<tr>
<td>psychiatric emergency plan (PEP)</td>
<td>Each NHS board should have a plan in place should an emergency occur. Core skills, competencies and minimum staffing levels are required, along with clear arrangements for the availability of Mental Health Officers. Website: <a href="http://www.nes.scot.nhs.uk/mhagp/three.htm">www.nes.scot.nhs.uk/mhagp/three.htm</a></td>
</tr>
<tr>
<td>psychiatry</td>
<td>A branch of medicine concerned with the diagnosis, care and prevention of mental illnesses.</td>
</tr>
<tr>
<td>psychosis</td>
<td>A mental disorder where a person does not experience reality in the same way as most people do. It is characterised by signs and symptoms including hallucinations, delusions, disordered thinking and agitated behaviour. These can affect all areas of daily life including sleep, appetite, thinking, decision making and behaviour. Often the person does not think or believe that anything is wrong.</td>
</tr>
<tr>
<td>rapid tranquillisation</td>
<td>The use of medication to calm a person to reduce immediate risks to self and/or others from aggressive and agitated behaviour. The medicine may be given orally or by injection and administered with or without the consent of the person. While the intention is to calm the person rapid tranquillisation may result in deep sedation.</td>
</tr>
<tr>
<td>responsible medical officer (RMO)</td>
<td>The consultant psychiatrist with medical responsibility for a service user.</td>
</tr>
<tr>
<td>restricted patient</td>
<td>A patient who has been made subject to a compulsion order and a restriction order by the court. Website: <a href="http://www.nes.scot.nhs.uk/mha/glossary.htm">www.nes.scot.nhs.uk/mha/glossary.htm</a></td>
</tr>
<tr>
<td>restriction order</td>
<td>An order imposed by a criminal court under Section 59 of the Criminal Procedure (Scotland) Act 1995 at the time of disposal and is added to a Compulsion Order. It means that the measures specified in the Compulsion Order will then be without limit of time.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>RMO</td>
<td>See responsible medical officer.</td>
</tr>
<tr>
<td>schizophrenia</td>
<td>A complex, serious mental disorder which affects different people in many different ways. A person with schizophrenia may experience 'positive symptoms' including hallucinations, delusions and disordered thinking. They may also experience 'negative symptoms'. They may lack energy and lose interest in friends and family and doing things they previously enjoyed. They may become withdrawn and not take care of themselves. The person may believe that there is nothing wrong and not seek help or want treatment.</td>
</tr>
<tr>
<td>schizo-affective disorder</td>
<td>A mental disorder that combines the symptoms of schizophrenia and bipolar disorder and may be difficult to differentiate from these. It may be characterised by recurrent episodes of marked mood swings that alternate or occur together with episodes of psychosis.</td>
</tr>
<tr>
<td>special health board</td>
<td>Special health boards provide national clinical and non-clinical care and services to NHSScotland. There are seven special health boards: NHS 24, NHS Education for Scotland, NHS Health Scotland, NHS Quality Improvement Scotland, Scottish Ambulance Service, State Hospitals Board for Scotland, and The National Waiting Times Centre Board. Website with special health board directory - address: <a href="http://www.show.scot.nhs.uk/organisations/special_hbs.html">www.show.scot.nhs.uk/organisations/special_hbs.html</a></td>
</tr>
<tr>
<td>specified persons</td>
<td>‘Specified persons’ may be subject to restrictions of correspondence or telephones, and other measures taken to ensure safety and security in hospitals.</td>
</tr>
<tr>
<td>standard operating procedure (SOP)</td>
<td>A set of protocols that specify in detail the procedures to be followed in defined circumstances.</td>
</tr>
</tbody>
</table>
The Forensic Network

The following questions were asked as part of the IPCU census.

The Forensic Network is seeking to establish the level of need across Scotland for long term care forensic services. At present, some such need is being addressed in a variety of settings, eg general audit psychiatry (GAP) and rehabilitation wards, community etc but is particularly relevant here in IPCUs. It would be most helpful if you could answer the questions below.

For the purpose of the first two questions a ‘forensic’ patient is considered to be a patient meeting detention criteria under the Mental Health Act, who has a history of significant offending behaviour and/or represents significant risk to others, such that the patient requires care under conditions of greater security and/or more specialist ‘forensic’ expertise in their management.

1  “Based on the above criteria, how many of your current inpatients would be better served in a secure forensic ward rather than the IPCU?”

2  “How many of the forensic patients you have identified above how many will require longer term (12 months+) care?”

3  What distinguishes a ‘forensic’ patient from others in your service?
The Scottish Health Council, the Scottish Intercollegiate Guidelines Network (SIGN) and the Healthcare Environment Inspectorate are also key components of our organisation.

You can read and download this document from our website. We can also provide this information:

by email | in large print | on audio tape or CD | in Braille (English only) | in community languages.