Care Work with Mental Health and Substance Misuse Clients in Scotland UK

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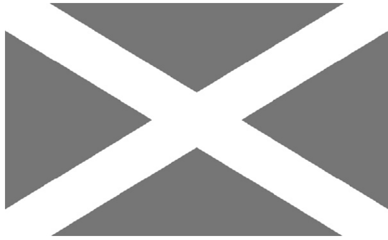
Introduction

Dear Student

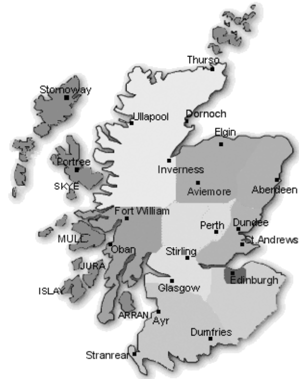
◆ *Welcome to Scotland! We are very pleased to have you here doing your practical study placement and hope it proves to be a productive and pleasant experience for you.*

Scotland is part of Great Britain and on July 1st 1999 Scotland got its own parliament, the first for 300 years. The population of Scotland is approximately 5,116,900 and the capital city is Edinburgh.



The other major cities in Scotland are Aberdeen, Dundee and Glasgow. Our flag is the Cross of St Andrew and our National Day is the 30th November (known as St Andrews day). The currency is the pound sterling (£) and the National Anthem is the Flower of Scotland.

Cross of St Andrew



The highest point in Scotland is Ben Nevis (1,343m) and we have many lochs (lakes) the most famous being Loch Ness where there is said to be a monster which lives in the depths of the loch.

The purpose of this handbook is to give you an overall view and understanding of the care, support and help which is available for those individuals who are experiencing mental health problems including those individuals who do so as a direct result of substance misuse. Substance misuse has focussed on drug and alcohol within this pack. Tobacco misuse has not been highlighted within this booklet but is another serious concern for the Scottish people. The pack ***has not*** *made specific reference to children's mental health service provision because it is unlikely that a work placement would be available in this specialised area. It must be remembered that with any care provision it is constantly evolving to meet the needs of the individual. Changes also occur in response to government targets and initiatives to support health in*

its widest sense. Mental Health and the promotion of mental health for the Scottish people are seen as a priority of the Scottish Government and as a result many new initiatives are being implemented throughout the country. Whilst every effort has been made to include up to date information which is accurate at the time of publication you may be introduced to new initiatives as a direct result of legislation and policy which has taken place since publication of this booklet.

We do not have a 'Practical nurse' in Scotland the nearest equivalent being a Health Care Assistant within the workplace. The HNC Health Care student is undertaking training in the workplace and would have a similar role to a Practical Nurse. These students usually complete two days per week in College and three days within the work place environment. You will be allocated a mentor and will be supervised and supported as you carry out basic care and support for those individuals you are caring for.

A case study of a family has been included in section 6.8 which will illustrate the type of service provision available for this family in Scotland.

Depending on where your placement is you may be working with individuals in a Statutory or Non Statutory organisation in either a Health or Social Care placement.

This booklet does contain a lot of information and it is hoped you will use it as an information guide prior to coming to Scotland and to provide additional information when you are undertaking your work experience. The contents page will allow you to locate the information you require with greater ease.

A glossary of terms in relation to Mental Health and substance misuse has been included to provide additional information for any terms which you may require additional clarification with.

We hope you enjoy your visit to Scotland and that this booklet assists in your learning experience.

1. Historical Overview

1.1 History and Development of Mental Health Care

◆ Devolution (when Scotland was granted its own Government) only took place in 1999. On the 6th May 1999 the first 129 Members of the Scottish Parliament were elected and many of the powers which had previously been retained by Westminster were devolved to the new Scottish Parliament. One area which the new Scottish Parliament had responsibility for was health care. This has resulted in many new pieces of legislation being implemented in order to cope with the ever increasing and changing demands of health care provision for the Scottish people.

Historical View Point

As we look back at how those with mental illness have been treated and the health care they have received it becomes apparent that for each period that is researched there has been an accepted way of '**dealing**' with those individuals. Despite how well intentioned those carers have been over the centuries many of the treatments were inhumane and unsuccessful. At the same time as the orthodox treatments were being carried out there were other, more enlightened, practitioners attempting to care those with mental health illness in a different way.

Initially mental illness was thought to be caused by '**evil spirits**' entering the individual's body. Mental illness presented itself in behaviour which was often bizarre, frightening and sometimes violent. Apart from those put forward by the early physicians and philosophers, the earliest explanations put forward for mental illness were supernatural and/or religious in origin rather than medical. In early societies it was therefore the **holy man, witch doctor or priest** who would be confided in and would be requested to cast out the devils or demons who had taken possession of the persons mind. Many people in these primitive times were cast out of the tribe if their behaviour caused fear amongst others.

In the **17th century** hospitals opened throughout the country which were extremely inhumane and brutal in the treatment provided. Some individuals were put in chains and restrained in cold, dark cellars with no treatment given at all for their illness.

During the **18th century** there was a change in the practitioner's views as to how those with mental illness should be treated. The need for appropriate medical and nursing care was recognised and appropriate hospitals required to provide this care.

In the early part of the **19th century** doctors such as Conolly, Kirkbride,

Bucknill and Hacke Tuke worked in the asylums to treat those with mental illness and were proud to do so. However as the century progressed so to did the population of inpatients in the asylums. This was largely due to the Lunacy Laws and the Mental Treatment Act 1930.

Many different treatments were introduced during the 1930's including electro-convulsive therapy, lobotomy and insulin comma treatment.

A psychiatrist, William Rivers, was involved in treating many of the soldiers who returned from the First World War with shell shock. He felt that talking to patients was essential and this has formed the basis for many treatments used now including post traumatic stress disorder. Counselling is used by many individuals who have experienced traumatic events in their lives.

In the years between the First and Second world wars both men and women became nurses who provided specific care for those with mental illness. The Asylum became known as the **mental hospital** and in 1931 The National Asylum Workers Union became known as the **Mental Health Institutional Workers Union**.

However it was only in **1923** that a years training became mandatory for all grades of nurses. All nurses had to sit an end of year examination. There was another form of nurse training which the mental health nurse could undertake known as the Medico-Psychological Association's training and it was not until 1951 that this form of training was no longer available.

In the late 1950's into the **1960's there was a dramatic move away from people being cared for in institutions**. The organisation of many of the mental hospitals changed at this time and an 'open door' policy was established. However this was a limited policy in many of the institutions because open door meant getting out into the grounds of the hospital not out into the wider community. During the 1960's and beyond there was a far greater emphasis on caring for people in the community. Many pieces of legislation were past to ensure that this was carried out and in principle it is a wonderful concept. However there was insufficient funding to ensure that care requirements could be met fully in the community and this has led to a great deal of frustration in behalf of those providing the services and those receiving them. The **Community Psychiatric Nurse** provided a service within the community for those requiring specialist support within their own home.

During the 1980's and beyond nurse training changed and the nurse was encouraged to provide a holistic approach in relation to the care provided and that was truly patient centred. The number of large

institutions where people are cared for has diminished during the last few years with individuals being cared for within the community whenever possible.

1.2 History and Development of Substance Misuse

1.2.1 History of Alcohol Consumption

Alcohol has been drunk by the Scottish people as far back in history as there are records. It is impossible to know exactly when it was discovered but it is thought that alcohol was discovered completely by chance. It must be remembered that fermentation occurs in any substance which contains sugar and is exposed to warmth so the possibilities are endless.

It is thought that in prehistoric times this would have occurred in fruit and which those that sampled it would have thoroughly enjoyed. The Egyptians in 3500 BC were able to produce their own wine.

Whisky has been produced for centuries in Scotland and many different types of whisky are now available.

Alcohol was used for medicinal purposes in the past and was often used as an anaesthetic if surgical procedures had to be carried out on a patient – they were so drunk that they would not feel the pain! Alcohol was also used as an antiseptic and preservative as well as providing nutrition for some individuals. The use of alcohol as a sedative declined as the medical staff became aware of its addictive properties and as alternative pain killers and sedatives became available. In some hospitals elderly patients can still be prescribed a glass of Guinness to build up their strength.

A Psychiatric hospital in Falkirk (Central Scotland) prescribed beer to its patients at lunchtime so that they were sedated in the afternoon – this took place in the 20th century so it was not so very long ago.

Beer has also been produced for many thousands of years in Scotland as well as throughout the world but spirits were only distilled in the 11th century by the Arabs. This is where the term alcohol came from 'alkuhl' means 'all things very fine'. Spirits were first used as a 'remedy' because they were cheap strong and addictive. Doctors first raised concerns regarding consumption of spirits as early as 1726.

It is thought that many people in the past drank alcohol as opposed to water as the water was very often contaminated. It was therefore healthier to drink beer than to drink water at this time.

Alcohol was in the past, and still is, drunk at many celebratory ceremonies including marriages as well as at Wakes which take place when someone dies.

Alcohol has been drunk by rich and poor people throughout the history of Scotland, frequently to excess. Unfortunately this is still the case in the 21st century. Scotland as well as Great Britain has a reputation as a binge drinking nation.

Following the law introduced by William 111 (17th Century) taxes were placed on all alcoholic drinks. This led to an increase in smuggling which took place along the coast line of Great Britain including East Anglia, the West Country and Scotland. From the 1690s the Government received more money from excise duties and licences.

By the 1800s there was a very profitable industry as far as brewing and distilling of alcohol was concerned resulting in a large colonial trade developing. In the 1830s the temperance movement criticised the amount of alcohol which was being consumed. The movement did however belief that beer was acceptable to drink and was indeed healthy.

By the 1800s (19th century) alcoholism was recognised as a disease. However in 1853 advertising duty was removed from alcohol and this led to a rapid expansion in advertising. In 1860 an act known as the Spirits Act allowed for the sale of single bottles of spirits, wine and beer.

By the beginning of the 20th century there were a number of doctors who started to make links between a number of diseases and social problems which were directly related to alcohol consumption. The addictive qualities of alcohol led to the development of Alcoholics Anonymous in 1935 and this organisation has been a very important support for many thousands of people world wide who misuse alcohol.

Consumption of Alcohol

As far as alcohol consumption in Scotland is concerned, in 2002 we were found to be 9th out of 23 European countries and also 9th in the world which is very worrying indeed.

Many factors can affect our mental health no matter where we live in the world and may contribute to poor mental health and well being. It must be remembered that human beings are all unique and as individuals we find different things stressful. Many social and economic factors play a complex part in how we react to and cope with these factors. For example an individual may experience relationship difficulties or even the breakdown of an important relationship and there is no question that this will have an impact on the individual's mental health. However the experience and the impact on an individual's mental health will be different for each person. Research has shown that many people with a mental health problem actually drink alcohol to try and hide their symptoms. For many individual's it is difficult to know if the alcohol dependency resulted in the mental health difficulties or if the mental health problem resulted in the alcohol misuse.

Scotland has been seen for many many years as a country where the men wear kilts, run after haggis and drink too much whisky. Unfortunately for the Scottish people the hard drinking culture image has spread throughout not only the United Kingdom but also throughout the world. The number of women who are now 'binge drinking' on a regular basis has increased dramatically in recent years and this lifestyle habit is causing grave concern to all concerned with health. In 2006 the amount of alcohol being consumed by the Scottish people was double that which our grandparents drunk. Recent research has shown that 59% of 15year-olds drink Alco pops and three quarters of these 15year olds say they have in fact been drunk. Many have bought alcohol from shops (24%) which is very concerning given that the minimum age to buy alcohol is 18years. As a direct result of those 15year olds being drunk they have then reported that 17% of the girls and 12% of boys have had unprotected sex (Scottish Executive, 2006).

In 2004 the Scottish Executive reported that 1,515 men in Scotland died of alcohol related causes. This equates to a 360% increase compared to the figures for 1980.

Scotland has been involved in brewing alcohol since before the Romans came to Scotland. It is deeply rooted in the Scottish Culture and when Scotland is mentioned Whisky is frequently one of the first things people think about. The Scottish people have always drunk alcohol but the difficulty in the 21st Century is that we are drinking too much and it is having a negative effect on our health, our communities and our economy. The Scottish Executive (2006) states that in 1980 13,892 licences for liquor were in place compared to 17,084 in 2003 – this is a 23% increase. In 2003 the police recorded 7,532 public drunkenness offences and in 2002 11,782 drink driving offences were recorded.

In 1995 the Department of Health issued guidelines in relation to alcohol consumption for both men and women.

One unit of alcohol is found in the following:

- A half pint of cider, lager or ordinary strength beer
- 25ml of spirits (small pub measure)
- A small glass of wine (125ml of wine has 1 ½ units)

	Weekly unit intake recommendation	**Maximum daily unit intake recommendation**
Men	21 units	No more than 4 units
Women	14 units	No more than 3 units
Pregnant women	Recommend that alcohol is avoided	

The Department of Health also recommended that people should not drink alcohol everyday and should not drink the maximum amount every day. It is also recommended that if an individual does drink excessively on an occasion then they should refrain from drinking alcohol for at least 24 hours. People lose their inhibitions when under the influence of alcohol and may indulge in risk taking behaviour that they would not have previously done. In Scotland there has been a dramatic increase in sexually transmitted infections in recent years and this has been shown to be related to the increase in alcohol consumption resulting in risk taking as far as sexual behaviour is concerned. This reduction on inhibitions may also result in experimentation with non prescription drugs.

Treatment Programmes

In the past those who misused alcohol were frequently admitted to a psychiatric hospital where there were not specialised staff to treat those with this type of addiction. In the latter half of the 20th and into the 21st century treatment programmes have developed to meet service user's needs. More specialised service provision has developed with joined up services between the Local Authority and National Health Service throughout Scotland. People are no longer admitted to hospital unless it is absolutely necessary. The preferred option is to treat people within the community setting with adequate support. Further information on current treatment programmes is included in chapter 3.

1.2.2 History of Drug Misuse

The use of drugs throughout the history of Great Britain and Scotland can first be related to controlling pain. People frequently used herbs to treat pain and herbs such as henbane and mandrake were used for this purpose. Mandrake was used as an anaesthetic for hundreds of years and henbane can bring on a narcotic trance in some people.

Opium has been used throughout history to for pain relief. It was only in the 20th century with the introduction of new drugs that opium became less significant as an effective treatment for pain. Opium is derived from the opium poppy and is very addictive. May of the drugs that are used today are derived from opium including morphine, laudanum and codeine. Laudanum was the most common pain relief used in the 1800s and many people became dependent on it.

Heroin (Diamorphine) was first synthesised from morphine in 1874. This drug is highly addictive and we have a significant problem in Scotland with people who misuse heroin. Diamorphine is used in many hospital environments to control pain but is only used for a short period of time so the patient does not become dependent on it.

Cannabis is a drug that has been used for thousands of years in Great Britain. Queen Victoria was said to have used this drug for may years as a method of pain relief. Many people who have multiple sclerosis have found cannabis to be very beneficial in relieving the pain they experience despite it being illegal to use it for such purposes. Cannabis became illegal in 1971.

Opium, morphine and heroin were all **freely available to purchase** in Great Britain in the 19th century. In 1868 the government introduced the first moves to control the purchase of opium (and its preparations), morphine and cannabis. Before this anyone could purchase these drugs as and when they pleased.

The Dangerous Drugs Act (1920) first controlled Heroin and in 1926 the **Rolleston committee** was instrumental in setting out the first drug misuse policy. This policy allowed the medical profession a much greater degree of flexibility in the treatment of those who misused drugs. The General Practitioner (GP) was given much more control over the prescribing of drugs in terms of treatment options. The Rolleston committee stated that addiction to drugs was a medical problem and if it was deemed appropriate that heroin should be prescribed to allow an addict to lead a normal life then this is what should happen.

Throughout the 20th century drug misuse has been of major concern to politicians, doctors and the public. The degree of concern has not always related to the degree of the problem, particularly in relation to illicit drug use. There has been a dramatic rise in the use of illicit drugs since the 1970s especially amongst young people.

In **the 1950s there were very few heroin addicts** (nearly all of the addicts were personally known to the Home Office) but this changed during the 1960s when a large number of young people began to misuse drugs.

In **1965 there was a recommendation** that treatment centres be set up to treat people with drug addiction. These centres would be run by psychiatrists who had a particular interest in treating people with drug addiction. GPs could also treat people and particular emphasis was placed on harm reduction including not sharing equipment and precautions for safe sex.

There has been an increase in the use of licit and illicit drugs since the 1970s.

Paracetamol is a licit drug that is often misused by people who want to commit suicide. It can be purchased from a pharmacy/supermarket and if taken in excess of the recommended dose can result in liver failure.

The Misuse of Drugs Act (1971) covers offences involving different classes of drugs and attracts varying penalties both for possession and

supply of any drug and there is a possibility of an unlimited fine but prison sentences are graded.

Solvents are not covered by the Misuse of Drugs Act (1971) the only offence is if a shop keeper sells solvents to someone under the age of 18years of age if they believe the young person is intending to misuse the solvent. In Scotland if someone is found to be misusing a volatile substance they can be reported to the Reporter of the Children's panel.

During the 20th century more specialised service provision has developed to treat individuals who misuse drugs. Many outreach services have evolved in both the statutory and voluntary sector as drug misuse has increased.

In 1995 a new initiative known as 'Tackling Drugs together' was established and this resulted in the establishment of multi agency **Drug Action teams** (DATs) in every health district. The **Drug Action Teams** comprise of senior representatives from health, local authority and criminal justice agencies.

The remit of the **Drug Action Team** at his time was to:

- Increase the safety of communities from drug related harm
- Helping young people to resist drugs
- Reducing health risk from drug misuse

There are a number of very good examples of how multi agency organisations have supported the 'shared care' of those who misuse drugs. Partnership approaches have included drug agencies, doctors and pharmacists for example working together to support those who misuse drugs.

In 1999 the Scottish Executive (now the Scottish Government) was established. The Scottish Executive set out its own agenda for tackling drug misuse in Scotland by publishing the document – **Tackling Drugs in Scotland: Action in Partnership**. This was followed in 2000 by the report **Drugs Action Plan: Protecting our Future** which highlighted the importance of:

- Joined up approach to tackling drug misuse
- Effective education
- Increased understanding of the epidemiology of drug misuse
- Provision of appropriate treatment and intervention.

2. The European Union's Policy on Mental Health And Intoxicant Misuse

◆ ***Public health is a major concern within European Union. Therefore health reducing and damaging factors have already been recognised when establishing The European Community. Thus the basis for European level co-operation and promotion of mental health and initiatives and measures to reduce health damages related to intoxicants lays with The Treaty establishing The European Community (in paragraphs 1-2, article 152 dealing with public health):***

"Community policies and activities complement and support national policies that aim to improve public health and prevent illnesses and diseases. These policies and activities include actions in both prevention and reduction of drugs-related health damage. Member States are encouraged to co-operate to reach stated goals. The Commission will support such efforts via different policies, initiatives and programmes." (a)

Extract of the Article 152 of the Amsterdam Treaty:
"A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and disease, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention."

The need for common programmes and policies promoting mental health derives from challenging situation. Approximately 25% of EU's population suffers from some form of mental ill health, most common ones being anxiety disorders and depression. Mental ill health on social level causes also significant economic and social losses, causes far too often stigmatisation and discrimination for people suffering from them. Furthermore their human rights and dignity are neither respected in acceptable manner. Thus Commission outlined launching of common strategy on mental health called **Green Paper: "Promoting the mental health of the population. Towards a strategy on mental health for the EU".**

Importance of mental health in Green Paper is crystallised in following key lines:

- good mental health is a resource for individuals and society – without it nor individuals or society as a whole can be considered well-being. Ill mental health prevents individuals to fulfill their intellectual and emotional potential to full and reducing quality of life – resulting also on social level to lesser social and economical welfare. Mental and physical health are also inter-related: e.g. depression is a risk factor for heart diseases.
- Ill mental health has significant economic and social effects: mental disorders are a leading cause of early retirement and disability pensions – and depression is expected to be the second most common cause of disability in the developed world by year 2020. Unfortunately social exclusion, stigmatisation and discrimination of the mentally ill are still a reality within the Member States.
- Currently, in the European Union app. 58,000 citizens die from suicide every year and there seems to be close connection to mental health as up to 90% of suicide cases are preceded by a history of mental ill health, often depression.

In accordance to Green Paper WHO European Ministerial Conference on Mental Health (Helsinki 2005) announce following priorities:

It is necessary to build on the platform of reform and modernization in the WHO European Region, learn from our shared experiences and be aware of the unique characteristics of individual countries. We believe that the main priorities for the next decade are to:

a) foster awareness of the importance of mental well-being;
b) collectively tackle stigma, discrimination and inequality, and empower and support people with mental health problems and their families to be actively engaged in this process;
c) design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery;
d) address the need for a competent workforce, effective in all these areas;
e) recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services.

(WHO European Ministerial Conference on Mental Health. Facing the Challenges, Building Solutions Helsinki, Finland, 12–15 January 2005)

The EU-Public Health Programme 2003-2008 constitutes the current instrument for action at Community level in the field of mental health and includes Green Paper's strategic aims. Member States outline their national policies in accordance of EU-level strategies and policies.

The Council of European Union set in 2005 “**EU Drugs Action Plan for years 2005-2008**”.

The drugs phenomenon was considered as one of major concerns of the citizens of Europe and as a major threat to the security and health of European society. The Action Plan was based on EU Drug Strategy (2005-2012).

From social and health care –viewpoint one of Strategy’s major aims is “to achieve a high level of health protection, well-being and social cohesion by complementing the Member States’ action in preventing and reducing drug use, dependence and drug-related harms to health and society.”

From social viewpoint emphasis is laid on prevention programmers: on reducing demand and also on improving methods of early detection of risk factors of potential intoxicant abusers. Furthermore one important result to be achieved in combating drug abuse is to “ensure the availability of and access to targeted and diversified treatment and rehabilitation programmes, referring to services and treatment available for people facing the problem.

3. Present Situation and Future Challenges

3.1 Most Common Mental Health Problems

◆ *'Good Mental Health is important to everyone living in Scotland. It underpins the Executive's vision for a healthier, more successful, Scotland. Mental illness takes away opportunity. We must work to promote health and prevent illness and where illness occurs to treat it or minimise the damage that it causes' (Delivering for Mental Health, 2006).*

It has been extensively reported that **depression, anxiety and stress** are the most prevalent mental health illnesses in Scotland. The World Health Organisation has said that if things do not improve they would expect that in the western world by 2020 the above will be **the most common form of disability.**

At the present time in Scotland it is estimated that between 25 – 30% of consultations that a General Practitioner (GP) undertakes will be for depression, stress or anxiety. A great deal of work is currently being carried out to support individuals who present with these disorders at the GP surgery.

Not only do we have an increasing number of people who are experiencing mental health disorders but those who suffer from mental illness also have an increased risk of other disease including heart disease, respiratory disease and diabetes. In Scotland those with mental illness smoke more, drink more alcohol and misuse drugs more frequently and will die younger.

The number of prescriptions issued for **antidepressant drugs has increased significantly during the last few years**. In 1992/93 £1.16 million was spent and in 2004/05 this had risen to £3.48 million. The Scottish Health Survey (2006) highlights this as an increase in daily use for those in the age group 15 – 90 years from 1.9% in 1993 to 8.3% in 2005 which is very significant (Scottish Executive, 2006).

In 2004 there were 835 suicides in Scotland, ¾ of who were males. Suicide is not a mental disorder but it clearly has a very strong link to mental health.

The National Statistics online (January 2006) produced statistics in relation to the whole of Great Britain. They identified that the **most common mental health disorder is mixed anxiety and depressive disorder**. The number of women suffering from disorders were in excess of men apart from the panic disorders where they were both the same. The number of

people suffering from a psychiatric disorder in 1993 and in 2000 was very similar the interesting thing was that **many more individuals were receiving treatment in 2000 (24%) than had been the case in 1993 (14%)**. In **1993 9% of people received medication** compared to **19% in 2000**. The survey carried out also highlighted that those individuals who were from a **socio-economic disadvantaged group** (those who were unemployed, living alone including those who were separated or divorced, individuals who did not have qualifications or who did not own their own home) **were more likely to suffer from a psychiatric disorder and suicidal attempt**.

Most Common Mental Health Disorders

The most common mental health disorders in Scotland are outlined in the table below.

The information in the following table has been obtained from the Scottish Executive publication National Programme for Improving Mental Health and Well-Being: Addressing Mental Health Inequalities in Scotland – equal minds (2005).

The population of Scotland is approximately **5.1 million people** and is comprised of **women – 52% and men 48%**. The life expectancy of women in Scotland is however the lowest of all European Union Countries. They do however live longer than the men in Scotland. The risk of experiencing mental illness is far greater for those individuals who are deprived, almost doubling the risk in comparison to those who have an average income. In 2001 30,000 individuals were admitted to hospital with a mental illness, 52% male and 48% female (Scottish Executive, 2004). Women

Indicator (source)	*Women*	*Men*
Proportion of discharges from mental illness specialities in Scottish hospitals *(March 2001, ISD Website)*		
Mood (affective) disorders	35%	21%
Neurotic and stress-related disorders	8%	5%
Schizophrenia	9%	21%
Other psychotic disorders	5%	6%
Alcohol and other drug related	10%	22%
Dementia	19%	15%
other	13%	11%
Anxiety: GP prevalence rates per 1000 population *(December 2002, ISD website)*	75.7	35.8
Depression: GP prevalence rates per 1000 population *(December 2002, ISD website)*	71.1	30.8

in Scotland are at an increased risk of developing a mental illness in comparison to their male counterparts and experience higher rates of depression. The **Disability Rights Commission (2001)** identified that across the United Kingdom those who are experiencing mental health problems are more than 3 times as likely to be unemployed in comparison to any other group of disabled individuals.

3.2 Facts and Figures Relating to the Use and Misuse of Alcohol and Drugs.

◆ When we think about the development of substance misuse and how it has increased in recent years throughout the World, there are many factors to consider. It must be remembered that the foundations of mental health are laid down very early in the lives of children and parents have a huge role and responsibility to enhance their child's mental health. Mental illness will have an affect on our mental health and therefore our ability to enjoy life. Alcohol even in 'normal' consumption can have an impact on an individual's emotional state in both a positive and negative manner. However when a person consumes an excessive amount of alcohol it can cause anxiety and depression. There is also a proven link between heavy alcohol consumption and suicide. Scotland is in the unenviable position of having one of the highest suicide rates in Europe, especially amongst young men and in 70% of cases they were found to have drunk alcohol.

Scotland has a very worrying trend in relation to excessive alcohol consumption compared to the rest of the United Kingdom. According to research

carried out by the Scottish Executive people in Scotland drank more than the rest of the UK between 1998 and 2003. The findings showed that the Scottish people drank less often but they exceeded the sensible drink limits regularly. In Scotland we are also in the unenviable position of having the highest number of health issues and problems and deaths in relation to alcohol.

We have many Distilleries in Scotland which are responsible for the production of whisky. Alcohol production and the sales which result throughout the world play a significant contribution to our economy. Almost 10,000 people work in alcohol production in Scotland and another 145, 000 work in alcohol-related industries.

In 2003, alcohol exports were worth £3.3 billion of which £2.6 billion were not UK based. However we also spend many millions of pounds each year trying to counteract and support those who have misused both alcohol and drugs. In 2001 £766 million was estimated to be the direct impact on the economy as a result of things like being absent from work and redundancy as a result of alcohol abuse. The indirect cost is thought to be in the region of £717.7 million each year. This has been broken down as follows:

- Dealing with alcohol misuse to the NHS (£110.5m)
- Social Work (£96.7m)
- Criminal Justice System and the Emergency Services (£276.7m)
- Human cost – early deaths (£233.8m)

Source: Information Scotland, 2006

Alcohol and drug use amongst young people is of major concern as the number of young people in the 12 -15 year old age group who are consuming alcohol on a regular basis has increased and the number of young people using drugs has remained static.

The Scottish Health Survey (1998) identified the following:

- More children are drinking and consuming an increased quantity of alcohol
- 40% of young people aged 15 had consumed alcohol in the previous week
- Girls were more likely to drink alcohol at least once a week but boys would drink more alcohol
- Young people in the 12 – 15 year old age group who drank alcohol were more likely to use drugs than those who did not drink alcohol.

Alcohol is drunk by 93% of the male population and 87% of women in the 16 – 74 year old age group in Scotland. This has led to an average of 25% of these individuals having an unhealthy intake of alcohol which is likely to lead to future problems with their health. The majority of this group are men – more than double the amount of men are consuming too much alcohol as compared to women (Survey of Psychiatric Morbidity of Adults in Private Households, 2000).

Drug Misuse

The following information has been obtained from **the Scottish Drug Misuse Database (SDMD)**. This database provides a great deal of information on the misuse of drugs in Scotland. This information is obtained from a variety of sources where individuals access services. It is important to emphasise that this information is in relation to what are described as new clients who are accessing service provision for the first time or for those individuals who are accessing the service after a break of at least 6 months. This service provision can be medical which includes general practice and hospitals and also specialist drug service provision which includes both statutory and non statutory services. Information included:

- Demographic information
- Presenting information
- Prescription profile
- Illicit drug profile
- Injecting/sharing details
- Social profile
- Dependent children
- Contact with services

In 2006 the following information was recorded by the SDMD in relation to the misuse of drugs:

- Cannabis was the most commonly misused drug – 32.9%
- Amphetamines – 14.2%
- Cocaine – 8.9%
- Crack – 1%
- Ecstasy – 10%
- Heroin – 1.2%
- Methadone – 0.8%
- LSD – 7.8%
- Magic Mushrooms – 7.3%
- Temazepam – 3%
- Valium – 4.8%
- Glues – 3.3%
- Anabolic Steroids – 0.8%
- Poppers – 9.8%

In all cases the percentage of men misusing a specific drug was greater than that of women.

3.3 Interaction between Mental Health and Substance Misuse

◆ The term dual diagnosis is often used to describe those individuals who are experiencing mental health problems and also misuse drugs and/or alcohol.

It can be very difficult for individuals to access specific service provision when they fall into this category because it involves accessing service provision from both substance misuse services and also mental health services. A draft report '**Delivering for Mental Health, Mental Health and Substance Misuse (June 2007)** outlines ways in which Scotland can take forward the joint delivery of service provision for those individuals who require support with both mental health impairment and substance misuse. This should improve service provision for all individuals who require support for a dual diagnosis.

A recent study identified that for adults living in their own homes in the United Kingdom 12% of men and 6% of women have a mental health illness as well as substance dependence. In Scotland more than 40% of people who sought help for their drug addiction did so because of mental health reasons. Alcohol Statistics (2007) identified that 28% of people admitted to a psychiatric hospital with misuse of alcohol were also found to have a secondary psychiatric illness. 14% of readmissions are due to substance misuse and the majority of these individuals are men. MIND (2006) states that it is thought that between 30 – 50% of individuals who are experiencing mental health problems also have a problem with drugs or alcohol.

Drugs which are linked to psychotic illness include amphetamines and cocaine and alcohol can also cause psychotic symptoms. Some studies carried out have shown a link between smoking cannabis and developing a mental illness. It is thought that in some cases it can double the risk of developing schizophrenia.

A recent article in the medical journal the Lancet highlights the research carried out by Bristol and Cardiff Universities highlighting that in the region of 800 people per year could develop schizophrenia as a direct result of using cannabis.

ABC Drug Classification System

The ABC drug classification system was designed to make it possible to control the misuse of particular drugs according to there level of harm to either an individual or to society. The Misuse of Drugs Act (1971) did not state which drugs were placed in which classification, this was the role of the **Advisory Council on the Misuse of Drugs (ACMD)**. The ACMD constantly keep the classification of drugs under review.

In the UK, illegal drugs are classified into three main categories.

They can be Class A, B or C, with A attracting the most serious punishments and fines.

Drugs are classified under the **Misuse of Drugs Act 1971**.

The following table shows the **classification of illegal drugs**.

Classification	Drugs	Maximum Penalties
Class A	Heroin, LSD, ecstasy, amphetamines (prepared for injection), cocaine and crack cocaine, magic mushrooms	For possession: 7 years imprisonment and/or fine. For supply: life imprisonment and or/fine.
Class B	Amphetamines, methylamphetamine, barbiturates, codeine	For possession: 5 years imprisonment and/or fine. For supply: 14 years imprisonment and/or fine.
Class C	Cannabis, temazepam, anabolic steroids, valium, ketamine, methylphenidate (Ritalin), gamma-hydroxy butyrate (GHB).	For possession: 2 years imprisonment and/or fine For supply: 14 years imprisonment and/or fine

Under the Misuse of Drugs Act (1971) it is an offence to possess with intent to supply; to supply or offer to supply a controlled drug (even where no charge is made); to allow premises to be used for the purpose of drug taking; and to traffic in drugs.

In 2004 cannabis was downgraded from a class B drug to a class C drug. However with the election of Gordon Brown as Prime Minister in July 2007 this may result in the drug being reclassified as so many different strains of the drug are becoming available which are much more potent.

Due to the conflicting evidence available many academics dispute the link between drug misuse and mental illness (particularly cannabis use and psychosis) it has led to a great deal of confusion and anxiety amongst the Scottish people.

National Statistics (2002) produced a report entitled **Tobacco, Alcohol and Drug Use and Mental Health**. This report found that the level of smoking, drinking and drug use and the dependence on these was much greater amongst those individuals who suffered from mental illness. Interestingly they did not find an increase in psychosis for those who abused drugs or alcohol. They did find that for those individuals who had antisocial personality disorder and obsessive compulsive disorder dependency on drugs and alcohol was highest.

Elderly and Mental Health

The number of elderly people in the United Kingdom who are experiencing mental health problems is increasing and for many of them the services are inadequate.

There have been two reports which have been published since 2006 – **Promoting Mental Health and Well-Being in later life (June 2006) and Improving Services and Support for Elderly people with mental health problems (2007)**. Both of these reports refer to the United Kingdom not just Scotland.

The scale of the problem in relation to the elderly has been described as a '**mental health pandemic**'. According to the Mental Health and Well-being in Later Life report **more than 3.5 million older people have mental health problems** in the UK. Most of these people are not diagnosed with a mental health problem but suffer in silence due to the perceived stigma attached to having a diagnosis made. Only **one in 7 people who are suffering from depression are diagnosed and treated** and fewer than half of those with dementia have it identified. Of the carers looking after a loved one with dementia it was found that **one in three** providers suffered from depression.

One in four people over the age of 65 and two in five people over the age of 85 are suffering from depression

and one in five people suffers from dementia. It is expected that by 2021 one in 15 people will be an elderly person experiencing a mental health problem.

The mental health problems which elderly people experience are very varied and include depression, anxiety, delirium (acute confusion), dementia, schizophrenia and also alcohol and drug misuse.

- 25% of older people living in the community have symptoms of depression that require treatment.
- Only 33% of older people with depression ever discuss it with their GP. Only half of them are diagnosed and treated, primarily with anti-depressants.
- Depression is the leading risk factor for suicide. Older men and women have some of the highest rates of suicide in the UK.
- Dementia costs the health and social care economy more than cancer, heart disease and stroke combined.
- Fewer than 50% of older people with dementia ever receive a diagnosis.
- Delirium or acute confusion affects up to 50% of older people who have operations
- There are 70,000 older people with schizophrenia in the UK.
- Individuals in the 55 – 74 age group have the highest rates of alcohol related deaths in the UK
- The use of both prescription and illicit drug misuse in the elderly is underestimated.

In relation to suicides the over 65 year old age group have the highest rates compared to any age group. Women over the age of 75 are most likely to take their own lives followed by men over the age of 75 years.

The Key recommendations from the report were:

- Set up a high level Government task force
- Eliminate age discrimination in mental health services
- Ensure suicide prevention strategies identify older people a priority
- Challenge stigma, ageism and defeatism
- Improve housing, health and social care services
- Overturn years of under-funding in older people's mental health services

Source: Improving services and support for older people with mental health problems (2007).

3.4 Preventative Work

◆ It is absolutely crucial that changes take place in order to support the elderly and that older people's mental health becomes more important.
The report **Improving services and support for older people with mental health problems (2007)** has identified a number of ways in which this can be done:

- End discrimination
- Prioritise prevention
- Enable older people to help themselves and each other

- Improving current services
- Facilitating change

Methods That Are Used in Working with Clients Who Misuse Drugs and Alcohol

There are a number of initiatives which the Scottish Government is implementing to combat drug and alcohol misuse. They have updated the **plan for Action on Alcohol** problems and the help line '**Know the Score' is now available 24 hours a day seven days a week**. This provides a directory of all service provision within Scotland for drug and alcohol misuse.

Preventative measures which the Government has implemented include:

- **Test purchasing for alcohol** – this makes sure that retailers are not selling alcohol to anyone under the age of 18 years of age. Most retailers should be asking for photographic identification if anyone looks under 21 years of age.
- **Raising the age of tobacco purchasing** from 16 to 18 years from the 1st October 2007.
- **Zero tolerance** on under age alcohol sales

The Government has stated that they need a greater level of service provision through the Alcohol and Drug Action Teams throughout Scotland. They also want to reduce the availability and attractiveness of alcohol by continuing with test purchasing and doing away with special offers and promotions in relation to alcohol purchasing.

Young people will be given accurate and credible information on the harmful effects of alcohol and drug misuse as part of the curriculum for excellence delivered in schools. More rigorous research will be carried out in relation to evidence based practice and the findings implemented.

3.5 Future Challenges

◆ Improving the mental health of the elderly in the UK has to be seen as a priority and is indeed a major challenge for the future. The demographic changes which are taking place mean that we are an ageing population and it is essential that age discrimination

is challenged in order that the elderly people who require the services receive them. The number of elderly people with drug and alcohol misuse will increase as will the numbers of people experiencing enduring mental health problems. It is important that the service provision is in place in order that the elderly people can enjoy there later life.

Alcohol and drug misuse is a major challenge for Scotland. The current Government is looking at many ways in which to control the sale of alcohol and also in relation to increasing the age at which alcohol can be purchased to 21 years. Scotland has a major crisis in relation to drugs and a recent report identified that those who misuse drugs are not getting sufficient support to manage this. There is a new drugs strategy for Scotland which places greater emphasis on getting people to stop taking drugs. One of the programmes identified to help those stop taking drugs is called 'cold turkey' abstinence. At the present time those who misuse drugs can wait up to a year to receive treatment – 25% of those who seek treatment are in this category. It is hoped the new drug strategy will address this problem. There does have to be sufficient funding and support to tackle these waiting times and ensure the services meet the needs of those who require them.

The **Scottish Advisory Committee on Drug Misuse (2008)** identified that service delivery for the future includes the following challenges:

- A range of services, additional to medical treatment service – ***essential services*** – are required in any area to promote recovery from problem substance use.
- Local systems of care treatment and rehabilitation must meet the identified needs of individuals and recognise that harm reduction and recovery form two aspects on the same continuum. The continuum contains all these aspects of care that will support people who use substances to improve their well-being and minimise harm to others.
- Recovery may not mean abstinence
- People must have access to a full range of support and care options to meet their assessed needs – whatever the substance they use or the severity and nature of the problem they experience.
- Any problems faced by the individual substance user cannot be seen in isolation from their family, local community and society.

4. Legislation and Policy

4.1 Historical Legislation Timeline

- Poor Law (1601) – every parish had to support those who were mentally ill and were unable to care for themselves
- The County Asylums Act (1808) – each county was encouraged to build an asylum to be funded through local rates
- Poor Law Amendment Act (1834) – this led to the establishment of workhouses because of the relief that now had to be provided in institutions
- Lunacy Act (1845)
- Lunacy Act (1890)
- Lunacy Act (1891)
- Mental Treatment Act (1930)
- Beveridge Report (1942) – this was a government report on Social Insurance and Allied Services. This report was instrumental in shaping social policy throughout the 20th century.
- National Health Service Act (1945)
- Mental Health Act (1959)
- Mental Health Scotland Act 1984
- NHS and Community Care Act 1990
- Mental Health (Care and Treatment) (Scotland) Act 2003

4.2 Important Pieces of Legislation

◆ The following legislation are the most important for you to have some understanding of:

National Health Service Act (1945)
The National Health Service Act (1945) established three nationally directed and funded services: hospitals, GPs and local authority services. Mental Health Services became part of the National Health Service. The National Health Service was officially born in 1948 but there was little effect on how those with mental health illness were treated and managed until the Mental Health Act 1959. This Act cancelled all previous legislation in relation to mental health and mental health professionals were returned control for their patients from the magistrates. This Act wanted people to be treated within the community whenever possible and local authorities were to provide facilities within the community to make this care possible.

Mental Health Scotland Act (1984)
The Mental Health Scotland Act (1984) was the equivalent piece of legislation for the Mental Health Act (1983) which applied to the rest of Great Britain. There were however

some differences between the two pieces of legislation but both embodied the same principles. The 1983 Act stated that those individuals with a personality disorder could be detained. However the 1984 Scottish legislation stated that such an individual could only be detained if treatment was going to assist their condition.

The NHS and Community Care Act (1990)

The NHS Community Care Act 1990 applied to the whole of Great Britain. This Act was instrumental in bringing about change and ensuring that the patient was central to all care provision. The Act contained many key components which brought about change for the better. Care was to be provided in the community so that people could remain as independently as possible within their own home. Some of the objectives for this piece of legislation were as follows:

- To enable people to live a life as normal as possible in their own homes or in a homely environment in the community
- To provide the right amount of care and support to help people to achieve maximum possible independence and by acquiring or reacquiring basic living skills, help to achieve their full potential

This legislation had a dramatic influence on how care was to be delivered for many different patients not only those with mental illness.

In October 2001 the National Programme for improving mental health was launched in Scotland. The aim of this programme was to improve the mental health and well being of the Scottish people. This is carried out in a variety of different ways and involves the funding and supporting a variety of initiatives and partnerships that are striving to improve Scotland's mental health.

Regulation of Care (Scotland) Act (2001)

The main aim of this piece of legislation was to ensure that standards of care were improved in social care services. All care establishments had to work in line with standards which had been established and each care establishment would be inspected on a regular basis to ensure that standards were being maintained. If it was found that standards were not maintained in line with legislation and policy then the establishment would loose its registration and would no longer be able to provide a service. The Care Commission is responsible for inspecting all of the care services. They inspect them against the National Care standards which are relevant to the particular care establishment to ensure consistency and standardisation throughout Scotland in relation to the care being delivered. The Scottish Social Services Council (SSSC) has a register of all social workers, social care staff and others employed who deliver care. The establishment of the SSSC has led to many more individuals gaining relevant care qualifications in order that they can register and work

within care to provide the highest standard of service provision.

The Mental Health (Care and Treatment) (Scotland) Act 2003
The Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect in Scotland in April 2005 This piece of legislation has had and will continue to have a great impact on service provision for all those with mental illness in Scotland. The principles included in this Act underpin a 'rights-based' care approach for all those people in Scotland who access mental health service provision. This Act applies to different people with a mental disorder including those with mental health problems, personality disorders and learning disabilities.

The main principles of this Act are as follows:
- Non-discrimination
- Equality
- Respect for diversity
- Reciprocity
- Informal care
- Participation
- Respect for carers
- Least restrictive alternative
- Benefit
- Child welfare

The Mental Health Tribunal replaced the Sheriff Court in Scotland where all previous cases were heard. This was as a direct result of the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Tribunal is involved in deciding on Compulsory Treatment Orders (**CTO**), carries out reviews and examines care plans in detail. A Tribunal is made up of 3 people one of whom is a doctor and also a legal person. The third person is usually a carer or an individual who has accessed service provision themselves to ensure a balanced view is taken.

As a direct result of this legislation each service user aged over 16 years will be able to choose a 'named person'

The Mental Health Act has three main kinds of compulsory powers:

• Emergency Detention	• This means that an individual can be detained in hospital for up to 72 hours if a doctor a recommends this should happen. In an ideal world a Mental Health Officers recommendation should also be obtained.
• Short Term Detention	• An individual could be hospitalised for up to 28 days on the recommendation of a psychiatrist and mental health officer.
• Compulsory Detention Order **(CTO)**	• This type of order involves an individual having a **CTO** approved by a Tribunal. There must be two doctors who recommend that a **CTO** is recommended. The patient and/or their named person can raise objections to the Tribunal and these will be listened to. Initially the **CTO** can last six months but can be extended for a further 6 months if required. In some cases the **CTO** can be extended for 12 months at a time.

to support them and make sure their rights are being upheld. The Act also ensured that each Health Board and Local Authority had to provide an Independent Advocacy service for all service users.

The Act also allows for service users to write an Advanced Statement. This allows the service user to write down the way the way they wish to treated and the type of treatment they feel is best for them as an individual. This is important for all service users care because if they become unwell at any time then they have written down how they want to be treated and this must be taken into account.

The Mental Welfare Commission has the responsibility to ensure that under the Mental Health (Scotland) Act 2003 individuals rights are being protected. This is an independent organisation and represents anyone who has a mental illness or a mental disorder as well as those with a learning disability.

The Mental Health Officer (MHO) has a social work qualification and has had additional training and gained further qualifications in order that they can work closely with those individuals who have a mental disorder. The Local Authority must ensure by law (Mental Health (Care and Treatment)(Scotland) Act 2003) that a MHO is assigned to work with an individual who is receiving care and/or treatment.

Delivering for Health was published by the Scottish Executive in 2005 and was a policy for the whole of Scotland. Mental Health was a key area which was identified.

A new mental health delivery plan has been published in Scotland. This plan is very important because it outlines how Scotland will meet the actions described in Delivering for Health (2005). Delivering for Health was produced in response to a report published by Dr David Kerr entitled 'Building a health Service Fit for the Future' in 2005. This report can be accessed via a search engine using the internet and requesting 'Delivering for Mental Health in Scotland'.

Disability Discrimination Act (1995)
This piece of legislation is important for all disabled people including those who are experiencing mental illness. This piece of legislation assists in stopping disabled people being discriminated against and ensuring that all disabled people are treated fairly. This may involve adjustments being made in that persons place of work so that they can work safely and comfortably or having additional aids to allow them to do their job effectively.

This piece of legislation may be relevant to some individuals who have a mental illness, particularly if it has had a major impact on their life. There are many different mental illnesses which can have a major impact on an individual's

life and may be covered under the Disability Discrimination Act (1995). The Act does not identify specific types of mental impairment but each person and the effect of the impairment on their life will be considered on an individual basis.

4.3 Drug and Alcohol Legislation and Policy

◆ The recent legislation outlined above also applies to those individuals who misuse drugs and alcohol.

In addition the following legislation may be relevant for those caring for individuals who misuse drugs and alcohol. The following legislation applies to the workplace and to individuals who may misuse drugs in the workplace. All employers must be aware of this legislation as misuse of drugs occurs in all areas of the workforce.

4.4 Licensing Laws

◆ The legislation which governs the sale of alcohol in Scotland is known as the **Licensing Laws**. This is an important concept to grasp because it means that in Scotland, and indeed the UK, you need to have a license to be able to sell alcohol legally. The **Licensing (Scotland) Act 1976** currently governs the sale of alcohol in Scotland. However a new piece of legislation – The **Licensing (Scotland) Act 2005 has been written and will be implemented in 2009**. This law

• **Health and Safety at Work etc Act 1974**	• All employers must ensure as far as is reasonably practicable the health and safety of their employees. The employer must ensure the safety of their employees and provide training for them.
• **Management of Health and Safety Regulations 1999**	• All employers must take care of the Health and Safety of everyone in the workplace. If an employer allows an employee to continue working under the influence of alcohol and drugs then they could be putting others at risk and they may be prosecuted in a court of law
• **The Misuse of Drugs Act 1971**	• It is illegal for anyone either at work or not to supply, produce or be in possession of illicit drugs. The only exception to this is if they have been prescribed a doctor for medical reasons. • If an employer allows illicit drugs to be taken at work then they can be prosecuted
• **The Road Traffic Act 1988**	• If a person drives a vehicle under the influence of drink or drugs then they will be prosecuted
• **The Transport and Works Act 1992** • **The Railways and Transport Safety Act 2003**	• If a person is working on the railway, tramway or any other transport system under the influence of drink or drugs then they will be prosecuted.

will have legal powers in relation to underage drinking and 'binge' drinking which are areas of major concern through out Scotland. The legal age for buying alcohol is 18 years and if anyone under that age is caught by the police the Crime and Punishment (Scotland) Act 1997 allows then to remove the alcohol from that young person and confiscate it.

Many cities in Scotland are now alcohol free meaning that you can no longer drink alcohol in the city centre in a public place or in the street.

4.5 Reports

◆ There are a number of reports which relate specifically to drug and alcohol abuse and which are being implemented nationally at local level and involve the statutory, voluntary and private sector.

• **Plan for Action on Alcohol Problems (2002)**	Aim to : • Change Alcohol Cultures • Prevention and education • Provision of services • Protection and controls
• **Delivering for Mental Health (2006)**	• To speed up and improve the mental health delivery service
• **A Fuller Life (2004)**	• A report of the expert group on alcohol related brain damage
• **Mind the Gap (2003)**	• Report on those individuals with mental health and substance abuse problems and how these can be addressed
• **Delivering for Mental Health and Mental Health and Substance Misuse (Draft document at present, 2007)**	• The principles identified in the reports Mind the Gaps and a Fuller Life will be put into practice in order that support can be delivered in a more 'joined up' way at local level for those people who are experiencing mental health impairment and substance misuse

5. Service Provision

5.1 Service Provision for Mental Health Clients

◆ Clients who experience mental health disorders and mental illness can be treated in a variety of different ways both in the community and also in a hospital environment depending on the severity of the condition. It is important that all service users/clients are treated as individuals and the care plan which is out in place meets the needs of the individual.

In Scotland care provision may vary depending on location and which National Health Service (**NHS**) Health Board/Local Authority is responsible for care delivery. In Scotland at any one time it has been estimated that about 25% of people experience mental health problems but the vast majority of people do not seek help from a professional. Of those who do seek help 80% of people are experiencing depression, anxiety or other stress related problems. 10% present with dementia and the final 10% with psychotic illness.

There are many different kinds of service provision in Scotland from a variety of different sources.

Statutory Services

The statutory services are provided by the NHS Health Board responsible for care delivery in the area where the client lives and also the local authority (council). Social work and health must work closely together and they may **request service provision from the voluntary sector** to meet the specific needs of a service user/client.

The very first point of contact for most people seeking help is their General Practitioner (GP), their family doctor. The GP may refer the person seeking help to a counsellor or prescribe drug therapy if they felt it necessary. They may feel it necessary to refer the person to a psychiatrist or other health professional to provide more specialised support. The professional who the person may be referred to could include a social worker, psychologist or a community psychiatric nurse. It is always a last resort to have to admit an individual to hospital but in some instances this is necessary.

All service users/clients that require mental health services will have a care plan and the individual should be involved in the construction of this as this plan is put together. The **single shared assessment** means that in Scotland the first professional who comes into contact with the service user/client is responsible for taking a **full medical and personal history** from the individual. With the service users consent this information would then be **shared with all other relevant**

professionals and prevents the person having to 'retell' the same information ion several occasions.

Service Provision in Dundee

The following description of service provision is in relation to Dundee and this has been used an example to illustrate the different types available in one particular area. This may vary from one health board and local authority to another.

Service provision in Dundee involves four community mental health teams. They are divided into East and West with two teams in each area.

There are a number of different teams with in each area including the following:

Acute Response Team

This team provides intensive care within the home in order that the person can stay at home and to prevent admission to hospital. The team also provide early discharge support once a person has been discharged from hospital. This is a nurse led service and is managed by a Senior Charge Nurse and a team of Community Psychiatric Nurses.

Assertive Outreach Team

This team support people with enduring mental health problems within the community. This involves supporting people with for example chronic schizophrenia living in the community. This is also a nurse led service.

Day Hospitals

There are two day hospitals which people can attend in the community and they may attend between 1 – 5 days per week depending on need. The demand for this service is high and people may have to wait until there is a vacancy to attend this type of service. There is also a 'drop in service' within the day hospital for those individuals who require additional support. The day hospital will provide intensive therapy for people and there is a multi-disciplinary approach to care provision. The professionals involved in the team could include and occupational therapist, nurses, consultant psychiatrist, speech therapist, psychologist. There will always be regular meetings with the consultant psychiatrist and service user/client to review progress and treatment.

In-Patient service provision

It is a last resort to admit people to hospital but for some individuals this is the only safe place for them to be treated when they are very ill. In Dundee there are two twenty four bedded admission nursing care wards. There is also a twelve bedded intensive nursing care unit. Within these wards all types of mental illness are treated and can include people who misuse drugs and alcohol. The age group of people treated in these wards is from 16 – 65 years of age. For those individuals over the age of 65 years they are assessed in a care of the elderly ward. There is very little

inpatient care provision for people with dementia because the vast majority are cared for in residential and nursing homes depending on the severity of the dementia and the degree of care required.

A multi-disciplinary approach is essential for the care of these individual's. The Occupational Therapist for example will be involved with assessing the person and supporting them with everyday living skills which can include shopping, cooking, social groups and money management. The physiotherapist will be involved in exercise programmes and within the in patient wards there is a gym which the client/service user can use. The nursing staff will be involved in specialised care for all people within the ward and will often work with one person at a time as part of their care plan.

A work placement in the admission wards is an option for some students.

In Angus, which is also part of Tayside, as is Dundee, there are a number of services which an individual can access. The service provision can be broken down as follows:

Help in a crisis situation/ emergency

In the case of a crisis situation ,particularly if it is out with normal working hours then the individual would have to call the out of hours service which is known as NHS 24. A service user who has a mental health crisis would have their details passed on to the Out of Hours Mental Health Service by NHS 24 if this was thought necessary.

If someone had taken an overdose of drugs and/or alcohol then an ambulance should be called and the person taken to an accident and emergency unit for treatment.

Children and Young People

In Dundee there is a young peoples unit, children's unit and also a large out patient day service. In the 'day in the life section' of this booklet an account has been included by a student undertaking a placement in this unit to give you an understanding of the type of activities a student may be involved in as part of their role.

The children and young people will present with many different types

Community Mental Health Team	This team comprises of both social work and health staff and its remit is to carry out the following with service users/clients: assessment, treatment and intervention, monitoring
Day Unit	Group therapy is carried out in relation to for example anxiety, assertiveness, communication skills
Day services	The day service will provide support with life skills and social skills for example.

of disorders including behaviour difficulties, Attention Deficit Hyperactive Disorder, bi-polar disease and eating disorders including anorexia nervosa and bulimia nervosa. By no means is this list exhaustive but it gives an indication of the range of disorders.

Long Term Care Provision

In the past the vast majority of people were cared for in a hospital environment. There has been a shift in policy to supported accommodation in the community. There are a number of supported accommodation units in Dundee and these units are much more like a home for people than an institutionalised hospital environment. They can be run by the local authority or a private provider and are often staffed by the social services department. They will have 24 hour support and the staff are always mindful that they are guests in the client/service users home.

People with long term mental health problems, as a last resort will be cared for in a hospital environment. The number of long term wards caring for people with dementia for example is decreasing. In Dundee there is an admission ward to assess an individuals needs but the majority of patients are cared for in nursing homes.

A work placement in a community supported accommodation unit or a care of the elderly ward is an option for some students.

Fast Track Rehabilitation

The support offered in this type of rehabilitation involves supporting people who have been in a hospital environment for many years. The individual is assessed to identify if they can cope with an accelerated programme of support to integrate them into community based supported accommodation.

Slow Stream Rehabilitation

This type of rehabilitation will be at a much slower pace and is most relevant for people who have been in hospital for a very long time and who are suffering from an enduring mental health problem such as chronic schizophrenia.

Care of the elderly

All people over the age of 65 years will be assessed and rehabilitated in a care of the elderly ward. There are two day hospitals within Dundee for care of the elderly, one for functional disorders (this includes bi-polar, schizophrenia etc) and one for people who have dementia.

Voluntary organisations

There are excellent voluntary organisations within the community who provide a range of services for individuals with mental health problems. For example an organisation called the Angus Mental Health Association promotes mental health within Angus and provides a variety of different services including drop

in services and an outreach learning programme to promote life skill development. They also run workshops which include stress management and relaxation.

Befriending service provision is also available throughout Scotland and is provided by a number of different voluntary associations. The befriending volunteers all receive training and support adults with mental health problems who often feel isolated and vulnerable.

Private Agencies

There are also private organisations that provide service provision for clients and the range of service provision depends on where an individual lives in Scotland. Many services can be purchased by the person themselves in relation to for example counselling, psychotherapy, cognitive behavioural therapy, stress management and complementary therapies. In some instances funding may be available to assist the service user/client to access these services.

Self Help/Voluntary Groups

Self help groups can be invaluable for individuals who are experiencing mental health problems as they will provide support and advice not only for the individual concerned but also for the family as well. Often an individual can feel that they are the only one who is feeling the way that they do and by talking to other people they often feel less isolated and alone. Examples of self help groups, which are often voluntary groups as well, could include the following:

- Survivors of sexual abuse support group
- Post-natal depression support group
- Hearing voices support group
- Mental well being and social peer support group
- Samaritans
- Eating disorders support groups
- Gamblers anonymous

This is only a very small example of the type of self help group which is available and when completing your work placement your mentor will be able to discuss this service provision more fully with you in relation to the client group you are working with.

An example of a voluntary organisation working with individuals experiencing mental health problems is PENUMBRA. They are based in our capital city Edinburgh but will accept referrals from many different areas in Scotland. The respite care service provision has been rolled out across Scotland. They provide a person centred approach to all care delivery and service provision and work with young people and adults.

There are many projects which can be found across Scotland including

'**Doing Well by people with Depression**'. The projects involved are

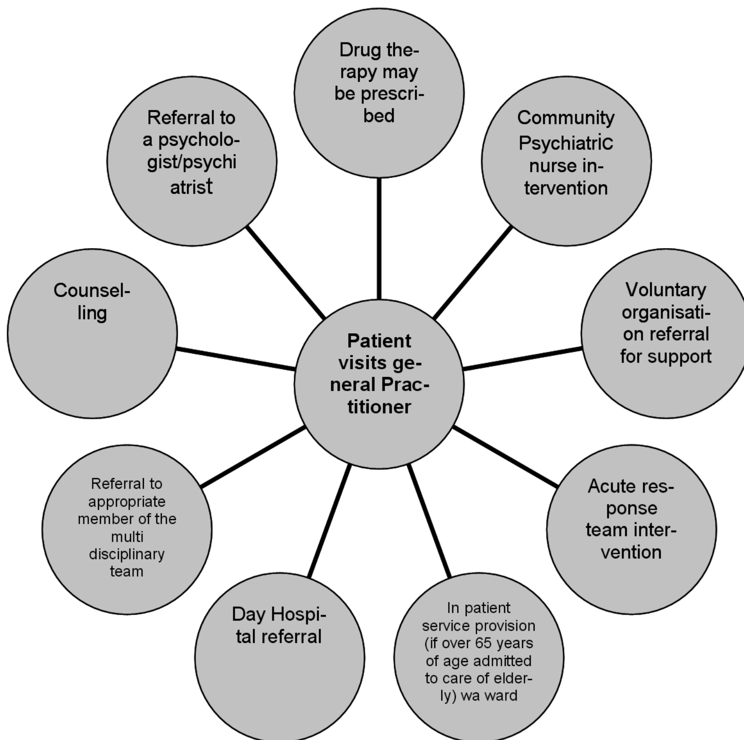
aiming to improve service provision for those who suffer from depression.

NSF (Scotland) is a registered charity, led by its members. The charity supports those caring for people who have schizophrenia or other serious mental illness.

Saheliya is a specialist mental health and well-being support organisation for women and girls of black, minority ethnic, asylum seeker/refugee or migrant backgrounds. It promotes positive mental health to develop women's confidence and self-esteem, reducing barriers of discrimination, isolation and depression. All services are free and confidential.

Patients Journey

The following diagram shows the possible service provision which a service user/client who has visited their General Practitioner (GP) with acute anxiety and depression may be referred to for care and support.



5.2 Service Provision for Substance Misuse Clients

◆ Drug and alcohol addiction takes time to develop and there are very few people who deliberately want to become dependent. Drug and alcohol dependency does not only impact on the physical and mental health of an individual but has a huge impact on the whole family and social environment of the person concerned.

Evidence suggests that the joining up of service provision to support individuals is crucial when delivering care for those who misuse drugs and alcohol.

The Scottish Government research has found that:

- Three out of four drug using individuals have a mental health problem

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- One out of every two individuals presenting with alcohol problems also has a mental health problem
- Two out of five people presenting with mental health problems had a drug and/or alcohol problem

The importance of the Drug and Alcohol teams in delivering and supporting the correct service provision is essential future provision.

Statutory

Scotland does have significant problems with both drug and alcohol misuse and tackling these problems is high on the Scottish Governments priority list. In order to tackle these problems effectively the Government must ensure that the correct policy and service provision is in place to meet the increasing demands placed on this service.

There are 22 **Alcohol and Drug Action Teams (ADATs)** across Scotland. They are highly valued by the Scottish Government and they are the local action on drug and alcohol misuse. The **ADATs** comprise of many different agencies and are addressing the misuse of alcohol and drugs in a more 'joined up' way.

Within each geographical area in Scotland there will be an **Alcohol and Drug Action Team (ADAT)**. These teams will implement the local policy within the area and will allocate funds to all service provision within that area. The range of service provision will be

very varied and include assessment, prevention, treatment and rehabilitation of service users.

Drug and Alcohol Misuse Service Provision

Current models for supporting people who misuse drugs and alcohol are all evidence based and many of the approaches used are based on Biopsychosocial approaches (Biological, Psychological and Social approaches), motivational interviewing and cognitive behavioural therapy. Many of the specialist service provision will provide support on alcohol **and** drug misuse, other service providers will focus on drugs or alcohol.

The National Health Service (NHS), Local Authority, voluntary and private providers must work closely together in order to provide service provision for those who wish to access it. These will all be expanded upon in this section.

The substance misuse centres are NHS led and the detoxification programmes are led by a Community Psychiatric Nurses (CPN).

Alcohol liaison nurses carry out brief interventions with people. These brief intervention sessions can last for approximately 15 minutes and will provide additional support for the person.

Motivational interviewing is based on person centred counselling. People will have relapses as they strive to make changes to their life. The support worker will make an assessment of where the person is in terms of wanting to make change:

- Pre-contemplative
- Contemplative
- Action stage

People will be supported for as long as they require to be supported and along with the motivational interviewing and brief interventions they may also be prescribed drug therapy such as Antibuse or Acamprosate for alcohol misuse. Alcohol dependency drinking and problem drinking is increasing and it is estimated that in Tayside alone there are 12 – 14,000 people who start their day with a drink of alcohol but only a fraction of these people will be seen for treatment and support.

Some people may access a residential unit for alcohol misuse and undertake a detoxification programme and take part in group work.

Those who misuse Opiate drugs are usually supported with motivational interviewing carried out by a CPN and methadone which is prescribed by the specialist prescription service. Those who misuse cannabis, amphetamines and ecstasy for example are mainly supported by the voluntary sector.

Cocaine is ten times more expensive than heroin in Scotland at the present time so many more people are

presenting with opiate misuse. There are high attrition rates as people try to detoxify and an individual may have several attempts before they are successful. Drug therapy is frequently used and may include chlordiazepoxide (Librium).

Harm reduction programmes are crucial to support people and needle exchange/ disposal is important for everyone.

Proactive Approach

A more proactive approach has been adopted by all service providers to identify those who are drinking too much alcohol and intervening to support them. This can be done for example at routine appointments with their doctor or nurse and support provided for that individual.

For those who misuse drugs it is more about identifying the person and referring them on to the correct support.

5.2.1 Drug Misuse Service Provision

Service provision can take place within the community or on occasions may require an individual to be admitted to hospital to receive specific treatment provision.

The Scottish Government is responsible for the Scottish drug policy and also to ensure that funding is available to provide services for those who need it. The Scottish Government's drug strategy is based on four themes:

- tackling the availability of drugs in Scottish Communities
- treating and rehabilitating those who have drug problems
- engaging with communities and protecting them from drug-related crime
- evaluating and informing young people about the risk from drug misuse

Scotland's drug strategy is delivered in partnership with the 22 drug action teams and also with the statutory and voluntary organisations providing services.

Social Work Services in many local areas provide a statutory service with their drug and alcohol teams. The team is made up of a number of different professionals including social workers/ care managers and social care officers. The social worker/care manager will assess an individuals needs and will build a relationship with that person by providing one to one support for them. The social care officer will assist the care manager/social worker/individual to

meet the needs of the individual which have been identified in the care plan.

There is a very useful website known as the National Drug Misuse in Scotland which may be of interest to you if your work placement is working with individuals who misuse drugs. This website allows for best practice to be shared with all those tackling drug misuse in Scotland.

The Scottish Drug Misuse Information Strategy has four key elements:

- To help young people resist drug misuse so that they can achieve their full potential in society
- To protect communities from drug related anti social and criminal behaviour
- To enable people with drug problems to overcome them and live healthy, crime free lives
- To stifle availability of illegal drugs on our streets

Scotland's NHS Boards and Primary Care Trusts

Each local area has a National Health Service Board and each area will support a similar but different range of service provision. They do not deliver services in isolation but do so in partnership with other organisations. These may include service provision for rehabilitation by the local authority or counselling and detoxification which a specialised voluntary organisation may provide. The Social Services provide in many areas in Scotland a drug and alcohol team who will work with and support adults in the 16 – 65 age range. General Practitioners and pharmacists may be involved in prescribing and dispensing substitute medication for those in a detoxification programme.

Scottish Drugs Forum – this is a national non government drugs policy and information agency.

Scottish Crime and Drug Enforcement Agency – this is an important organisation as far as the threat from drug trafficking and other serious crimes are concerned.

Drug Action Teams (DATs)
As has been said previously there are 22 **DATs** in Scotland and most of them also involve alcohol and volatile substance misuse and some also include smoking. At a local level the **DAT** is responsible for coordinating service provision to tackle drug misuse.

The Scottish Government works very closely with the **DATs** at local level to ensure that all service provision will meet the needs of the people within each local level.

Voluntary/self help groups

Throughout Scotland there are many and varied voluntary groups who provide an excellent service for this who misuse drugs and alcohol. As has been described above they will work in close collaboration with the DATs and will often receive funding from the Scottish

Government. Sometimes this funding is only for a short period of time and once the period of funding has ceased the voluntary organisation will cease to exist. This can be extremely frustrating for those involved with the project as it can often be some time before direct results of such an organisation can be appreciated and seen.

Self help groups can provide invaluable support to families and individuals whose lives are affected by drug abuse. You may be placed with a voluntary organisation to undertake your work placement experience.

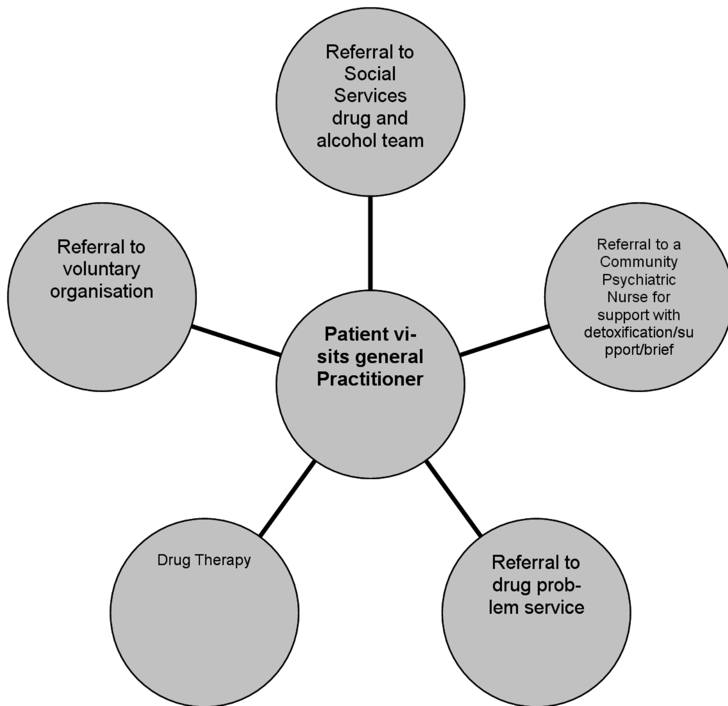
Addaction for example is a voluntary community based service found in a number of different areas within Scotland. Individuals can self refer to this service as can any agency, General Practitioner, Health Professional, Social Worker or the Court. They will provide advice and information on any form of addiction and provide counselling and family services. They will provide drop in sessions, education and training and sexual health services. **Addaction** provides services for addiction in many different areas across Scotland to approximately 25, 000 people on an annual basis. In Ayrshire for example there has been an alcohol rehabilitation service recently opened and also a SMART recovery programme for individuals who have ceased to use drugs and alcohol to allow people to support each other. In Dundee, **Addaction** have recently set up a direct access service for individuals within the city who are not at present accessing or using services. Addaction are working very closely with the Drug and Alcohol team (DAAT) and also the city council who are funding this project.

Private

Throughout Scotland and indeed the United Kingdom there are a number of private organisations who deliver care for those who misuse drugs. The cost of this service provision will vary. In some instances statutory service provision may purchase service from the private sector if this is felt to be most appropriate for a particular person. This does not happen very often.

Patients Journey

The following diagram shows the services a person may access who visits their General Practitioner requesting help to stop using heroin.



5.2.2 Alcohol Misuse Service Provision

Statutory Service Provision

Those who require assistance with alcohol misuse often have to wait up to 5 months to be seen within the statutory service provision if they are deemed not to be an urgent referral. They will be seen sooner if they are felt to be urgent.

Recent press reports have stated that more than a million Scots are drinking at potentially harmful levels. A survey carried out by Scottish Health Action on Alcohol Problems (SHAAP) found that 47% men and 36% women were drinking more than they should. Men were drinking more than 4 units on their heaviest drinking day and women more than 3 units. It is likely that the figures are greater because people tend to underestimate their alcohol consumption.

The newly elected Scottish Government and our First Minister Alex Salmond (elected May 2007) are determined to change the Scottish culture as far as alcohol is concerned. The government is looking at introducing

new policies to try and reduce alcohol consumption and improve the health of the Scottish people regarding alcohol. The supermarkets and alcohol shops frequently have cut price alcohol promotions and ministers are looking at this type of promotion stopping to try and decrease alcohol consumption.

As described above with those individuals who misuse drugs some will be treated within the community and other may require to be admitted to hospital to receive more specialised and intensive care.

Across Scotland there are specialised alcohol problem centres. Within Tayside there is a statutory service called Tayside Alcohol Problem Service (T.A.P.S.). This service is funded by Tayside Health Board and is provided by Tayside Primary Care.

The staff team comprises of both medical and nursing staff who work both in the community and residential settings.

As has been highlighted earlier service providers must work closely together. The Drug and Alcohol Teams along with voluntary agencies such as Alcohol Anonymous would all work very closely together to support an individual.

Anyone within the Tayside region can access the counselling and support service TAPS provides including carers and relatives. As with drug service provision the demand for these services outstrips the service provision and often an individual will have to wait to access the service.

TAPS will provide information and support and guidance for anyone who feels they need it. Any individual can contact the service or this may be done by the General Practitioner or by Social Services.

Support groups can provide essential support especially when discharged from hospital and TAPS will provide this service throughout Tayside.

For the first time ever, in October 2007, Scotland experienced an Alcohol Awareness week. This week came about as a result of the Scottish Government, alcohol industry, health professionals and the voluntary sector working together to raise awareness of how much the individual in Scotland is drinking and to encourage them to learn more about the number of units found in the alcohol they are consuming.

Voluntary Service Provision

There are many excellent voluntary organisations which support individuals and families as a direct result of alcohol misuse.

Many of the voluntary organisations have no waiting lists which allow individuals to access support exactly when they need it. Volunteers are

recruited and trained to meet demand for those requiring support,

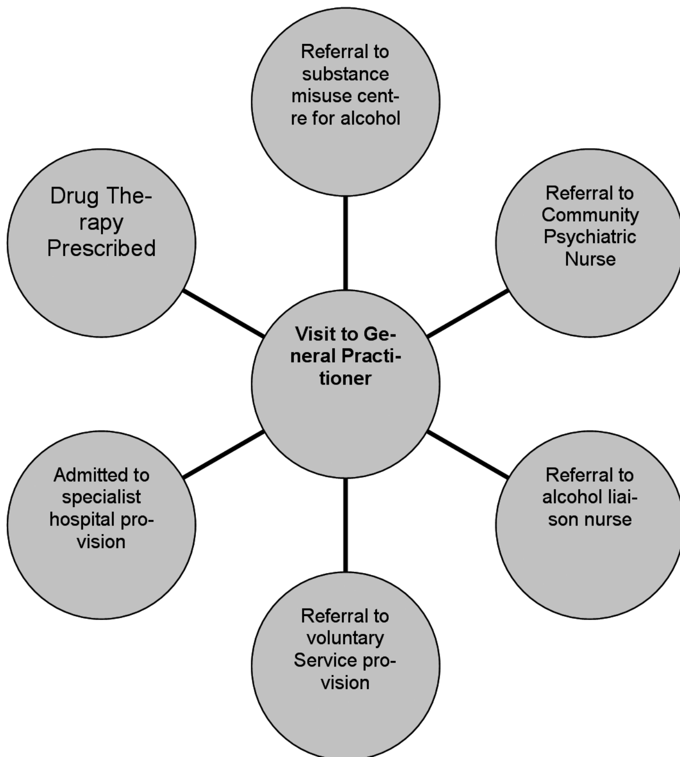
Alcoholics Anonymous is an example of a voluntary organisation which provides support throughout the United Kingdom not just Scotland.

Private

There are many private organisations who will charge money to support an individual who is misusing alcohol. Due to the significant waiting times for statutory provision some people/ families will use their savings to pay for this service.

Patient Journey

The following diagram shows the services a patient may access who visits his General Practitioner for help with his problem drinking.



6. Working with Clients

6.1 Principles of Working with Service Users.

◆ Since 1999 when Scotland got its own Parliament there has been a strong emphasis on delivering a more integrated approach for health and social care services, particularly for elderly people. The Scottish Executive established the Joint Future Agenda to ensure relationships developed to promote joint working between the local authorities, health boards, voluntary and independent organisations. It must be remembered that many of the people who experience problems with their mental health are elderly.

Many of the principles involved in working with a person who has a mental health disorder or who is misusing drugs and alcohol are outlined in the **Mental Health (Care and Treatment) (Scotland) Act 2003**. The main principle of this Act is that the patient/service user must be treated with respect at all times.

Role of the Client

The service user is central to all care that is being delivered and as much information as possible must be provided to ensure that they can make informed choices regarding all aspects of their care. This may not be possible if an individual is unwell and has to be detained against their wishes.

The service user is expected to work co-operatively with professionals, their care plan and adhere to any conditions applied if a legal order has been made. They must also comply with any medication which has been prescribed. The service user is also expected to nominate a named person and make an advanced statement if subject to the **Mental Health (Care and Treatment) (Scotland) Act 2003.**

Advocacy

As part of the Act all individuals can access independent advocacy services. This was included in the Act because service users felt that it was essential. The advocate will not put over their opinions but will be able to say, on behalf of the service user, what the service user thinks is best for them. The Health Board and Local authority have a duty to ensure that independent advocacy services are available to all those who request the service. Individuals may have to wait to have this service as there is a heavy demand for it.

6.2 Multidisciplinary Team

General Practitioner (GP) Doctor – The GP is often the first point of contact for people who request support for mental health issues and substance misuse. They will discuss issues/problems, prescribe medication if required and will refer the person to other service provision as appropriate.

Social Worker Social workers can work with all age groups of individuals in the community and provide support to people to help themselves. They often have to provide support at times of crisis in an individual's life.

Mental Health Officer (MHO) – A mental health Officer is a qualified social worker who has a minimum of 2 years experience and who has also completed the Mental Health Officer qualification. The local authority must ensure that there is a MHO available 24 hours each day. They ask questions about the care an individual is receiving and are totally independent of the National Health Service. They ensure that alternative treatment and support is examined before an individual is held in hospital against their will. If an individual is to be detained then the MHO must either grant consent for this to happen.

Community Mental Health Nurse (CPN) – A CPN is a registered mental health nurse who will provide support for individuals within the community. They will work with all age groups of people including children who are experiencing mental health problems including those with drug and alcohol problems.

Psychiatrist A Psychiatrist is a doctor who specialises in the care of people with mental health disorders and illness. The Psychiatrist will prescribe medication for the people they are caring for.

Psychologist A psychologist has a degree in psychology. A clinical or counselling psychologist will have completed additional education and training to support individuals with the appropriate therapy to assist in recovery.

Counsellor The counsellor has additional qualifications in counselling and will provide specialised counselling therapy which may include for example Client Centred (Humanistic) therapy. Usually the counsellor will specialise in one form of counselling and will work very closely with the psychiatrist.

Community Support Workers – Community support workers will provide support for individuals within the community in order that they can stay in their own homes or supported accommodation. Many support workers will have a social care qualification or be working towards gaining an Scottish Vocational qualification.

Care Manager A care manager is usually a qualified nurse or social worker who has a case load of individuals whom they are responsible for in the community. They are the individual responsible for managing a specific care package for each client and for providing support for that individual so they can make informed choices regarding the care they wish to receive.

Health Visitor A Health Visitor is a qualified nurse who has completed a further qualification in public health nursing and works in the community. They will help an individual experiencing mental health problems to stay in their own home by providing support an information relevant to them.

Psychotherapist The Psychotherapist is a professional who specialises in one type of therapy to assist an individual with mental health problems.

Occupational Therapist (OT) – The OT will work closely with a client either in hospital or the community and will assist them with a variety of skills to aid recovery. They can provide help with learning practical household tasks for examples and will assess the client for aids that may be required to assist with independence.

Speech and Language therapist (SALT) – The SALT plays a vital role in relation to assisting people with difficulties in relation to communication.

6.3 Ethical Questions/ Dilemmas

◆ When caring for any individual it is very important to try and be non-judgemental and to prevent your own values from influencing the care which you give to the service user/client. This can be very difficult in some cases because we all have a value base from which we live and work but it is essential that care workers adhere to a professional value base at all times and follow the professional code of practice which applies to them (6.6 for working codes of practice).

Students and staff within the work placement area will at times experience ethical dilemma's which they have to deal with. As a student you would discuss your concerns/worries with your mentor who would provide support, guidance and explanation as to why a particular treatment was being given/with held and the reasons for this. The legislation, policy and procedures regarding care delivery is different in each country and this may lead to misunderstandings regarding certain aspects of care delivery. You must therefore voice any concerns in a professional manner being mindful of confidentiality at all times.

Professionals can become upset and frustrated on behalf of those they are caring for when they know that for example they desperately need the services of a counsellor or therapist but due to the demands on that particular service there is a waiting list of 3 months and the service user/client will have to wait for this specific service provision. A recent article in a newspaper highlighted that for those living in Tayside who are misusing alcohol and have a drink problem they could wait up to 5 months to be seen by one of the main service providers in Tayside. This type of scenario if you are caring for someone who desperately needs professional help can lead the carer to question the appropriateness of the service provision.

Communication

Communication is crucial when caring for any individual. It is fundamental to all caring relationships and it is essential that the service user/client is treated with respect at all times and included in all decisions that are made about them and the care they receive. When an individual is mentally unwell their named person may need to be involved in making decisions for the person concerned as they are too ill to do so themselves. For those who have completed an Advance Statement their wishes and preferences will be recorded for all relevant health professionals to view and comply with.

It is essential that all professionals speak to those they are caring for in a way that does not patronise the service user/client and present the information in a

way that can be understood, allowing the service user to make decisions and choices.

We communicate with those we are caring for in many different ways including verbal and non verbal communication. It must be remembered that communication is only successful if both the sender of the information and the receiver understand the same information. This can be difficult and challenging for people who have a mental health disorder and even more challenging for those under the influence of alcohol or drugs.

It is essential that you are aware of this when on work placement and that a client may not remember a previous conversation you had with them. You must also be very aware of your non verbal communication and body language at all times. The client group you will be working with can become very upset and distressed if you look at them in a particular way which they perceive as offensive and this can lead to a potentially volatile situation.

The language that is used must allow the client as far as is reasonably practicable to understand exactly what is happening to them. This may be difficult in some instances particularly if the client/service user is ill. The tone of voice, the positioning of where you are sitting, language used, eye contact can lead to the interaction being positive or negative and this is something that you must be very aware of as a student in a foreign country on a work placement. It is essential that all care professionals listen to what is being said by the client/service user at all times.

6.4 Professional Codes of Practice

Professional Code of Practice for Nurses

Nurses have to follow a professional code of practice which is implemented by the governing body, **the Nursing and Midwifery Council (NMC)**. The NMC is an organisation whose role is to protect the public by making sure that all nurses and midwives deliver the highest standard of care to those they are caring for.

The code of conduct which all nurses, midwives and specialist community practice nurses must follow is known as **The NMC code of professional conduct: standards for conduct, performance and ethics (2004)**. This code of conduct underpins all care delivery and it clearly states the duties of every nurse and midwife who is registered to practice. During 2007 the code of conduct is being re written and the NMC hope that it will be easier for everyone, including the general public, to understand. You can access a copy of this code of practice by inserting ‘Nursing and Midwifery Council’ into a search engine and locate the most recent copy of the NMC Code of Conduct.

The main areas which are identified in the 2004 code of conduct can be summarised as follows. The code applies to all registered nurses, midwives and specialist public health nurses:

- Respect the patient or client as an individual
- Obtain consent before you give any treatment or care
- Co-operate with others in the team
- Protect confidential information
- Maintain your professional knowledge and competence
- Be trustworthy
- Act to identify and minimise the risk to patients and clients

Source of information: NMC code of professional conduct: standards for conduct, performance and ethics (2004).

Social Work and Social Care work code

The Scottish Social Services Council (SSSC) was established by the Scottish Executive in October 2001. The remit of this organisation was to 'raise standards in social work and social care' in line with government policy. By maintaining a register of all individuals who work in social services in Scotland and also ensuring that staff are well educated and trained to do the job of work expected of them standards of care delivery would be raised., The public would have more confidence in the service delivery and the register would increase protection of all those who accessed social services.

The registration of the 138,000 people who work for social services has not all happened at once but in stages, commencing in April 2003.

The following website may be useful to gain further information regarding the SSSC: **www.sssc.uk.com**

The code of practice for social service workers and employers of social service workers is similar to the NMC code of practice for nurses/midwives in that it describes the standards of conduct and practice within which all registered staff should work.

The code for Social Services is also a list of statements which the staff must follow in their every day care practice.

All staff and students have to adhere to the statements in the code and examine their own practice and ensure they are delivering the highest standard of care to those they are looking after.

6.5 Working Methods

Methods that are used with clients who have mental health problems

There are many different treatments for mental health problems and they may include therapies which are delivered by professionals as well as drug treatments and alternative complimentary therapies which have been found to be very beneficial. For example those

individuals who are suffering from depression anti depressant drugs may be prescribed as well as exercise, talk therapies, complimentary therapies such as massage.

The following table describes some of the most common treatments available but in no way is this list complete. When you attend your work placement you may well be introduced to a variety of other approaches.

Cognitive Behavioural Therapy – Cognitive Behavioural therapy is a psychological intervention and allows an individual to change how they think and what they do to help them to feel better. It has been found to be very useful in anxiety, depression, panic, Agoraphobia, Bulimia, Schizophrenia, Obsessive compulsive disorder and post traumatic stress disorder.

Counselling and Psychotherapy – Counselling allows an individual to talk to an experienced person who will listen to their feelings associated with an area/s of difficulty. There are many different techniques and disciplines involved in counselling and psychotherapy.

Drug Treatments There are many new and different drugs available. For some drug treatments it can take a number of weeks for the drug to take effect. Individual drug treatments will not be discussed here as this topic is so vast. Drug therapy will be full discussed with you in the work placement experience you undertake.

Electro-Convulsive Therapy (ECT) – ECT is carried out in many hospital environments throughout Scotland. It involves applying high voltages across the brain of the individual while they are under a general anaesthetic.

Exercise Individuals who present with mild to moderate depression are often prescribed a regular physical activity programme.

Psychological Treatments – Psychological treatments are not often used in isolation but are used in combination with for example drug treatment. Psychological treatments involve a therapist and the use of specific therapy techniques.

Hospital treatment Whenever possible people will be treated in the community but there will be occasions when an individual requires to be

admitted to hospital. Often these people are so ill that they are at risk of harming themselves. As discussed previously in section 4 (legislation) treatment in hospital can be voluntary or compulsory. The Mental Health(Care and Treatment) (Scotland) Act 2003 protects people through detention and subsequent orders.

Complementary Therapies – Alternative therapies are being used more and more alongside conventional treatments. Massage and reflexology for example are excellent to assist with stress and stress management.

Methods that are used in working with clients who misuse drugs and alcohol

Treatments

For some individuals who seek help they want to become drug and/or alcohol free but for some people they are unable to do this so harm reduction may be the focus of their treatment programme.

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Many of the approaches/treatments described above in relation to mental health also apply to those who misuse drugs and alcohol. The treatment of alcohol and drug misuse is about much more than just managing individual's withdrawal symptoms or administrating medication. People require to look at themselves very closely in relation to their past and their current behaviour to assist them from relapsing in the future.

- **Motivational Interviewing and Brief interventions** (please refer to chapter 5 where this was fully discussed)
- Young people and children may access service provision through the **child and adolescent psychiatry and psychology service provision** within the local area
- **Cognitive behavioural therapy and family therapy** are both very useful
- Those dependent on heroin may **be prescribed methadone** as an alternative. They are less likely to commit a criminal offence to fund their habit if this approach is adopted.

- Drug therapy programmes are available for individuals **misusing both alcohol and drugs**
- **Counselling** approaches
- **Needle exchange system** is in place to reduce the incidence of sharing injecting equipment and the spread of HIV and hepatitis

In May 2007 a report known as **Reducing Harm and promoting recovery: a report on methadone treatment for substance misuse in Scotland** was produced by the SACDM Methadone Project group. The aim of this report was to advise Ministers within the Scottish Government on the place of methadone in the treatment of substance misuse in Scotland. The report does highlight that as far as opiate dependency is concerned it is the most cost effective treatment. If psychosocial interventions (wrap around services) are available in conjunction with the methadone replacement prescribing service then the positive outcome of the programme will increase. The report also highlighted that treatments to detoxify and rehabilitate those misusing drugs should be available. The need for meaningful and supportive follow up service provision following detoxification was seen as crucial.

Psychotherapeutic approaches have been found to be most effective where the service provision is delivered by one person a continuous basis. If this is not present then it does not allow for trusting, therapeutic relationship to develop between the service user and the person providing the support.

Holistic care is essential when providing services. Substance misuse and mental health problems cannot be treated in isolation and the focus is now to treat the person and the difficulties they are experiencing in a holistic manner.

6.6 Case Study

◆ *The Jones family live in a three bed roomed council flat on the outskirts of the city centre. There is a high level of unemployment in the area where they live and many of the families in the neighbourhood are living in crowded conditions. There is no sense of community where they live and they have no family members who live near them to provide support.*

The Jones family comprise of Mrs Jones (33years), Mr Jones (34 years), Scott Jones (16years) and Lorna Jones (9 years). Mr and Mrs Jones married when they were very young and Scott was born when they were 17 and 18 years of age. Mrs Jones always wanted to go to college to study child care but having a young baby of her own prevented her from pursuing this dream. Mrs Jones currently works as a home help in the community which she enjoys. She has suffered from depression periodically during the last 5 years. She has had time off work in the past but has recently returned to her job as a home help.

Mr Jones worked as a bus driver until last year when he lost his job. He has been drinking heavily for the past two years and this was one of the reasons he lost his job. He has been unemployed since loosing his job and is having no success in obtaining new employment. He is continuing to drink excessively.

Scott Jones is studying at the local secondary school and is due to sit his standard grade examinations this academic session. He appears to have poor motivation to do well in school and he is no longer attending school on a regular basis. This is causing great concern to both the school and his parents as he was predicted to do well in these examinations prior to the recent behavioural concerns. Scott has recently been mixing with a group who experiment with illegal drugs and he has now started to experiment with these drugs himself.

Lorna Jones attends the local primary school and is a shy, quiet girl who has difficulty mixing in a large group. She is a bright girl but lacks confidence in her own ability.

Mrs Jones is extremely worried about her family, particularly Scott, but finds everything is getting her down and she feels unable to cope or to make any decisions about how best to support her family. She feels alone and her husband is unable to offer the support to her or the children at this time.

How can the Jones family be supported at this time?

Possible support system which could be put in place

Mrs Jones would likely approach her General Practitioner (GP) who would listen to her concerns and discuss possible support methods for the whole family. The GP would write a letter to refer the family to the Social Work department drug and alcohol team or to the local drug problem centre which is run by the local health board. In this instance the Jones family would likely be referred to the Social work drug and alcohol team. As has been discussed earlier access to statutory service provision can take time so the GP may discuss the voluntary service provision which is available within the local area and which the family could access as another support option.

The GP will discuss the concerns that Mrs Jones has fully with her and she may require to be prescribed anti depressant drugs depending on the assessment which is made of her current health status. Patient confidentiality is crucial and the GP cannot discuss Mr Jones with his wife but listens attentively about her concerns regarding her husband's alcohol misuse. He advises Mrs Jones to discuss this with her husband as Mr Jones has recently visited the surgery requesting help with his alcohol addiction. He has been prescribed medication to assist him in his struggle to stop drinking.

It can usually take about four weeks for a person to be seen once a referral is made by the GP to a statutory service but this will vary in different areas. After this initial consultation it can take another 12 weeks

for the person to begin their programme of support which is a very long time and this is where the voluntary service provision plays an essential role.

Mrs Jones has discussed her visit to the GP with the family and has asked the GP to refer the family to the Social work drug and alcohol team. She feels her family need the help and support now so has approached a local voluntary organisation as she is at breaking point. To her surprise the family all feel that they need help and so the family refer themselves to the organisation. Mr Jones also discusses his visit to the GP and his desire for help to control his misuse of alcohol. He discusses with is wife the possibility of having to be admitted to hospital to take part in treatment programme. He will have to be assessed as to his suitability for this type of programme and he is aware that he will have to focus on issues which have influenced his drinking habits and how he could deal with them in the future without resorting to drinking alcohol. He will have to take part in a number of different treatments including group therapy and counselling.

The Jones family visit the voluntary organisation and they find the person they speak to is extremely supportive and does not make any judgements regarding the information which they give to him about the current family situation.

Scott is a young adult and is spoken to on his own as this allows him to voice his concerns with the worker who has been assigned to him. It allows for a positive therapeutic relationship to develop between them which is based on trust. The worker and Scott are able to implement a realistic care plan which allows small steps to be taken in the first instance. Scott wants to stop taking drugs and one of the areas discussed is harm reduction. Scott used to enjoy taking part in sport before his dad lost his job and he would like to take up some of these interests again. The worker is able to access information for Scott about what is available in the local area and give this information to him to allow him to make choices about what he wants to enjoy. The worker has also been able to access a local support group for young people in a similar situation to himself and he is considering if he would like to join this group.

Lorna requires to have her confidence and self esteem built up and requires stimulating activities to enjoy as well as someone to confide in. The worker will explore possible clubs and activities that Lorna would enjoy in the local area. Lorna requires to talk to someone who will listen to her worries and concerns and this relationship will take time to build up.

Mrs Jones will be regularly monitored by the GP and her mental and physical health monitored.

During this time Mr Jones and his worker have been setting themselves small steps in relation to his alcohol reduction. He has been seen by a psychiatrist and is to be admitted to hospital for treatment. He is determined to succeed.

The voluntary organisation has greatly supported the family during the last few weeks and they are now to be seen by the drug and alcohol team. A member of the team has been assigned to the Jones family to work with them in their own home. The care manager who has been assigned to the Jones family will assess their needs and offer support to each of the family members. The care plan which is put into place is done so with the individual members of the Jones family and it highlights what each person wants to do and the support and help which is provided.

Financially things have been very difficult so the worker arranges for a Financial Advisor to speak to the family and assist them with their finances and possible benefits they may be entitled to.

As thing begin to improve and Mrs Jones begins to feel more positive about her family she discusses the possibility of achieving her ambition of becoming a child care worker. Emotionally she feels she has been well supported by the team. The local community centre has a programme of courses which are delivered by the local college which the organisation Working for Families supports and funds. She is currently researching this possibility with a social care officer

Mr Jones has been admitted to hospital and although it is 20 miles from where the family live they have been able to visit twice a week. He is sticking to the programme as he is determined that he has to stop drinking not only for himself but also for his family. This is the first step in what will be a very long journey. His ambition at the moment is to take part in a Training for Work programme to assist his transition back into the workplace.

Scott has grown in confidence and the school have been very supportive. He has been attending some catch up sessions to help him with his studies and has not taken any illegal drugs for a number of weeks. He has been seeing a psychologist and he has been able to discuss his feelings with her. Scott realises that he has only begun on his road to recovery but he is determined, with the appropriate support, to continue to make positive changes to his life.

Lorna is making slow progress as she still finds it difficult to talk about how she is feeling. She also sees a psychologist but is wary of discussing how she feels. She misses her dad very much and she is frightened that he will not be coming home again.

7. A Day on the Life of an HNC Health Care Student

The following account is providedby an HNC Health Care student who was completing their workplace experience within a Young Peoples unit.

About the Young Peoples Unit

The young peoples unit is a six-bedded inpatient service for young people between 12 and 18 who experience mental health difficulties which require inpatient treatment and support. There are only 3 specialist inpatient services provided by the National Health Service in Scotland, therefore the unit covers a wide geographical area and operates on a referral system. Being admitted to hospital can be a traumatic experience for both the young person and their family therefore, many admissions are planned, with members of the team carrying out home visits and assessment and providing information and choice to visit prior to admission. This is obviously unavailable in emergency situations.

The hours I work on this placement in the young peoples unit are from 7.30 am – 2.30pm.

On arrival in the unit the staff who are coming on duty receive a report from the night shift communicating the previous night's presentation of all the young people. Prior to going off duty the senior nurse hands over the drug keys to the senior nurse coming on duty. At every shift two staff members check and countersign all money in the unit safe. I observe this process being carried out.

My mentor then explains that that under supervision by her today to further my personal development and organisational and managerial skills I would be allocated the task of shift coordinator. This involved me, under supervision and guidance by my mentor, in planning tasks for all staff members for the day including myself. These tasks once discussed and verified by my mentor were written on to the communication board in the duty room. Before I recorded my findings I had to check the diary to see what meetings and appointments for example were planned and to match up each child with a team member for structured supportive time throughout the day.

I had completed this task by 8am and under supervision from my mentor I was allocated a child to care for. The young lady I was looking after had been diagnosed as having anorexia nervosa and obsessive compulsive disorder (OCD). She has been placed in the unit on a Compulsory Treatment Order under the Mental health (Care and Treatment) (Scotland) Act 2003.

MY first task was to assist this young lady with her personal hygiene. On entering her bedroom I suspected that she had been incontinent of urine and assisted her with having a shower. Her OCD can make this problematic due to her only wanting to wear certain clothes. This was indeed a problem this morning as she became very upset whist having her shower and I had to enter the shower room to assist her. Due to the level of distress which she was experiencing I had to summon assistance from my mentor.

Once we had calmed her down and reassured her this young lady was able to get dressed. I then had to supervise her eating her breakfast. I have to stick very closely to the care plan which has been recorded highlighting that the breakfast must be eaten within 30minutes otherwise she will be fed by Nasogastric feeding. I have to keep my own feelings at bay and supervise and encourage this young lady to eat her breakfast. She manages to do this and I give her positive reinforcement. I also have a responsibility to record all that she has eaten and drunk on her daily food and fluid balance chart.

At 9am I attend the community meeting. This takes place daily and all members of the multidisciplinary team and young people are present. As I was allocated the responsibility of being coordinator of the shift by my mentor that morning I had the responsibility of coordinating the meeting. A number of issues were brought up by the young people and with support from my mentor I was able to summarise the discussion which had taken place and facilitate in the decision making process regarding the issues raised.

At 10am I accompany the young people to the school within the unit and at 11am supervise the young people having their snack. The young people who have eating disorders have individually devised menus and treatment plans which must be adhered to.

12 mid day and I am taking over the nursing observations of a young lady who had recently been admitted to the unit having had an acute psychotic episode. I was given a pin point alarm and knew that if I did require assistance then I was to sound the alarm. My observation of this young lady ceased at 1pm and before leaving her and passing over my findings to the nurse taking over from me I recorded all of my findings and this was countersigned by my mentor.

I go for my 30 minute lunch break and return to the unit to discuss my days experience with my mentor. She has been extremely supportive and encouraging and I discuss and reflect on what I have done today. I recognise that I must research eating disorders in more depth and the variety of treatment options which are utilised in the unit.

My mentor suggests that I have some time this afternoon to begin my research as the late shift have arrived on duty and there are additional staff available to allow me to have this opportunity. At 2.30pm it is time to go home and complete more research into an illness which I find fascinating.

First Example:

The following account has been completed by a student who has undertaken their work placement experience in an acute Mental Health ward.

I am an HNC Health Care student in my second placement since commencing this programme of study. I previously worked as an auxiliary nurse for a number of years. I am currently on placement in an acute ward for individuals who are experiencing a range of mental health problems. It is a mixed ward which means that both men and women of all ages are treated and cared for by a multidisciplinary team.

My placement involves working shift patterns, an early shift is from 7am – 2.30pm and a late shift from 1.30 – 9pm. I do not work night shifts at present but later in my training and when I am qualified I will rotate to working night shifts.

When I arrive on duty at 7am the first thing that happens is that we are given a report by the night staff. I try to work the same shift pattern as my mentor as I have found this to be the most beneficial way of learning. If there is anything that I am unsure about I will discuss this with my mentor who is a staff nurse with many years of experience. Any new patients who have been admitted to the ward are fully discussed and this allows me to ask questions in a safe environment to ensure that I am fully aware of what is wrong with the patient and the treatment programme. It also allows me to read the care plan so that I am as fully informed about the patient as possible before I introduce myself to them.

This morning a new patient was admitted to the ward and a full assessment is made of her needs. This lady has bee detained under The Mental Health (Care and Treatment) (Scotland) Act 2003.

I work closely with my mentor to complete all of the necessary documentation and complete the relevant care plan. This takes much longer than I had expected and my mentor guides me through this with great patience. I have been asked to contact the Psychiatrist on duty so she can come and review this lady. I accompany the Doctor while she carries out all of the relevant medical examinations.

The Doctor spends time with me after the medical examination to discuss

what she had done and why so that I was fully aware of the correct protocol. The multidisciplinary team work very closely together and I find this to be very rewarding.

It is now lunchtime and I am asked to go for my 30 minute break. I can't believe how quickly the morning has passed and feel I have learned a great deal.

After returning to the ward after lunch I assist my mentor to observe a patient very closely. This patient has recently tried to commit suicide. When you 'special' a patient this involves having the patient in very close proximity to the nursing staff observing them. I am never left to do this on my own as a student but assist my mentor with this observation. It can be quite stressful as you have to be extremely observant at all times.

My mentor supervises me administering the medication to this patient and we discuss the drug treatment prescribed and possible side effects. This allows me to broaden my knowledge regarding all drug treatments and my mentor makes a continuous assessment of my clinical skills and theoretical knowledge.

It is now 2pm and my mentor and I give the report to the staff who have come on duty for the late shift. We give the report on the patients we have been looking after and I find this to be quite stressful as I am always frightened I forget something. My mentor constantly supervises me so if I do forget something she is there to help me. It is now 2.30pm and time to go home.

Within the ward setting this week I have accompanied a patient for their Electro Convulsive Therapy treatment (ECT) and monitored the patient on their return to the ward.

I have also had the opportunity to attend case conferences and multi disciplinary team meetings for individual patients. I was nervous about attending these meetings but have learned such a lot about how the team works to assist the patient.

I am thoroughly enjoying my placement and look forward to extending my knowledge and developing my skills.

Second Example:

The following account has been written by a student undertaking their work placement experience in a care of the elderly ward with patients who have a variety of mental health disorders including dementia. The ward is the patients home now as they will are too ill to be able to return to their own home in the community.

This is my first placement within the clinical area and I am very nervous as I have no previous experience within a ward environment.

My shift patterns are an early shift from 7.30 – 3pm and a late shift from 2 – 10pm.

I try as far as possible to work the same shift pattern as my mentor. On arrival at the ward I was shown around, introduced to the staff and patients and instructed on all health and safety matters including fire exits and my role within the clinical area. None of the patients are to be resuscitated if they have a cardiac arrest which I have found quite distressing. I have discussed this with my mentor and have found him to be a great support.

At the commencement of each shift we receive a report from the staff who have been on duty. I find this to be a very interesting report and I have to concentrate to make sure I listen to everything that is being said. I am not allocated any patients of my own to look after as I am too inexperienced and will always accompany my mentor and am supervised regarding all care practice. If I am unsure of anything that has been said in the report I will ask my mentor and he will explain things to me. He will also ask me questions and this has involved me researching the different types of dementia and treatment options.

I am involved in assisting the ladies in the ward with all aspects of their personal hygiene and this morning assisted a lady with her bathing. This involved using a hoist as the lady had mobility problems. She became very upset in the bath and started to scream when she was asked if she would like her hair washed. My mentor was able to calm the lady down and I would use the techniques I observed in the future if I were ever to find myself in this situation again.

When assisting the lady to dress herself she was adamant about what she wanted to wear and thoroughly enjoyed having her hair and make up done. We communicated throughout this activity of dressing and she was able to describe her job as a nurse in the 1950s and told me all about her family when they were young. The photographs beside her bed allowed me to discuss her family more fully with her and she responded very well to this interaction.

At mealtimes the ladies are encouraged to choose what they would like to have for lunch and some of them require gentle encouragement to make a choice. I am asked to assist a lady with her meal as she has motor neurone disease and finds it very difficult to hold the cutlery to eat. I enjoyed assisting this lady with her meal and everything I had been taught in College assisted me to make this as positive an experience as I possibly could.

In the afternoon some of the ladies had a sleep before the activities coordinator arrived in the ward. She was carrying out a baking activity with three ladies and I was to assist. The ladies were to

be icing biscuits and decorating them. I had not appreciated how challenging such a simple activity could actually be for someone who had dementia and the level of support that was required. One of the ladies had great difficulty identifying the knife to spread the icing on the biscuit but once she got started she thoroughly enjoyed herself and was telling us all about how she was a cook in a school when she was younger.

Later in the afternoon my mentor and I had to update each of the patients care plans who we had been looking after. I found this to be very rewarding as my mentor spent time going through the different aspects of the plan and assisting me with all aspects of the documentation. Prior to going off duty my mentor gave the report to the staff who had just come on duty for a back shift.

8. Scottish Educational System

◆ Scotland's education system is quite different to that of the rest of the United Kingdom as well as to the system in your own country.

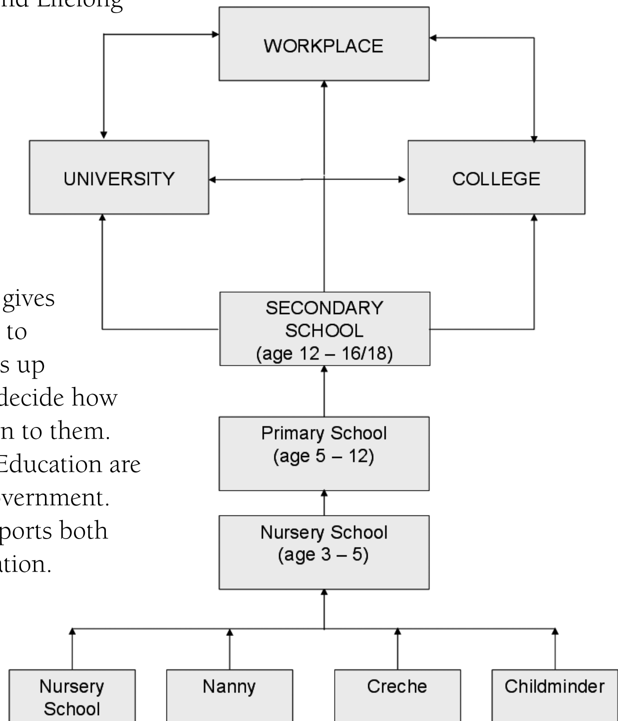
When Scotland got its own parliament in 1999, as a result of devolution, the responsibility for education became that of the new Scottish Parliament.

The education and training policy in Scotland is overseen and administered by the Scottish Governments Education Department and the Scottish Governments Enterprise and Lifelong learning Department.

At a local level it is the responsibility of one of the 32 councils to deliver the education services in preschool, primary and secondary education. The Scottish Government gives a sum of money each year to support education and it is up to each local authority to decide how to allocate the money given to them. Both Further and Higher Education are funded by the Scottish Government. The Funding Council supports both Further and Higher Education.

Scottish Qualifications Authority (SQA)

The SQA is a very important body in Scotland and has responsibility for the vast majority of qualifications which are completed in school and college environments. They **are not** responsible for developing, accrediting, assessing or certification of University qualifications. The SQA can best be described as a 'national body' for qualifications in Scotland. There are many different



The Education System in Scotland

types of qualifications which people can undertake and which allow for progression to take place.

SQA is responsible for different qualifications which can be described as: Units, Courses and Group Awards.

Each Unit taught to a student must be assessed and this is marked by the teacher/lecturer and is the cross marked by SQA to ensure consistency and standardisation of the award.

Scottish Credit Qualifications Framework

Each unit is allocated a number of points in relation to how much learning has had to be done to achieve it. This is known as the Scottish Credit Qualifications Framework (SCQF). There are a number of different levels ranging from 1 to 12 with 1 being the least difficult up to 12 which is the most challenging. Each qualification that a student undertakes is allocated a level and a number of credit points.

Nursing Studies at University

For students to progress to study at University many of them will attend College first and undertake the necessary qualifications. Different Universities require different qualifications to study nursing. At present it is usually 2 or 3 Highers for students who progress directly from school. The minimum age is 16 years to begin nursing at University.

Many students who attend Colleges in Scotland will undertake a Higher National Certificate (HNC) in Health Care. An HNC is usually studied by students in a College environment. An HNC qualification is composed of a number of Higher National Units, usually 12 in total to achieve the award. Many of the students who study an HNC qualification in Health Care will progress to University to study for example Nursing, Physiotherapy, Speech and Language Therapy, Occupational Therapy or Behavioural Science.

We do not have an equivalent to the Practical Nurse Training course which you undertake in your own country in Scotland, the nearest qualification to this is the HNC Health Care course.

Scottish Vocational Qualification (SVQ) Units/Courses

Scottish Vocational Qualification (SVQ) units are undertaken by many individuals in care work and are an excellent way for a worker to gain a qualification which is specific to their work role. SVQ's are often described as 'gaining a qualification on the job'. This means that people can continue to work and achieve a recognised qualification at the same time. These qualifications recognise the many skills, experience and knowledge which an individual has already in the work place.

All SVQ units are based on National Occupational standards. This applies

to the Care sector as well as any other industry. These standards are drawn up by a 'sector skills council' and each of the units which the student studies will assess their level of competency. Each student must produce a portfolio of written evidence as well as being assessed actually demonstrating the particular skill they are being assessed on.

Each SVQ unit which the student achieves will be built up into a SVQ qualification which is transferable qualification in the work place. By law care establishments have to have their staff trained and this has led to an increase in the number of staff undertaking this type of qualification in the work place. Staff who work in the Social Care and Health Care sectors can complete an SVQ qualification.

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10. Glossary

Advance Statement – allows the service user to write down, when they are well, how they would like to be treated when they are ill (Mental Health (Care and Treatment) (Scotland) Act 2003

Alcohol and Drug Action Teams (ADATs) – is a multi agency strategic planning group which co-ordinates actions around alcohol and drug related problems

Compulsory Treatment Order (CTO) – Under the Mental Health (Care and Treatment) (Scotland) Act 2003 a CTO authorises the detention in hospital and/or treatment of a person for 6 months.

Devolution – on the first of July 1999 powers in devolved matters were transferred from Ministers in London to Scottish Ministers in Edinburgh.

Drug Action Team – they are the partnerships responsible for delivering the drug strategy at local level.

General Practitioner (GP): Family Doctor

Multidisciplinary Team: A number of professionals who are involved in the care of an individual

National Health Service (NHS): the NHS is the health service provided in the UK

Nursing and Midwifery Council (NMC) – Governing body for nursing. The NMC maintains a register of all nurses eligible to practice in the UK. The NMC ensures standards of education, training, conduct and performance for nursing and midwifery are maintained.

Scottish Executive – following the passage of the Scotland Act 1998 the Scottish Executive and Scottish Parliament were convened on July 1st 1999.

Scottish Government – the Scottish Executive has been known as the Scottish Government since July 2007

Scottish Qualifications Authority – National body in Scotland responsible for the development, accreditation, assessment and certification of qualifications (not degrees).

Scottish Social Services Council (SSSC) – the SSSC are responsible for registering people who work in social services in Scotland and for regulating their education and training.

Notes

Notes