PERTH AND KINROSS INTEGRATION JOINT BOARD

Council Building
2 High Street
Perth
PH1 5PH

27 June 2017

With reference to the meeting of the **Perth and Kinross Integration Joint Board** to be held in **the Council Chamber, 2 High Street, Perth, PH1 5PH** on **Friday 30 June 2017** at **9.30am,** I now enclose papers relative to **Item 8.1** on the agenda.

If you have any queries, please contact Scott Hendry on 01738 475126 or e-mail committee@pkc.gov.uk.

Robert Packham
Chief Officer

Voting Members
Councillor C Reid, Perth and Kinross Council (Chair)
Councillor C Ahern, Perth and Kinross Council
Councillor X McDade, Perth and Kinross Council
Councillor E Drysdale, Perth and Kinross Council
L Dunion, Tayside NHS Board (Vice-Chair)
S Hay, Tayside NHS Board
J Golden, Tayside NHS Board
S Tunstall-James, Tayside NHS Board

Professional Advisers
J Pepper, Chief Social Work Officer, Perth and Kinross Council
R Packham, Chief Officer, Perth and Kinross Integration Joint Board
J Smith, Chief Financial Officer
Dr N McLeod, Independent Contractor
J Foulis, NHS Tayside
Dr N Prentice, NHS Tayside

Additional Members
Dr D Walker, NHS Tayside
Dr A Noble, External Advisor to Board

Stakeholder Members
F Fraser, Staff Representative, Perth and Kinross Council
A Drummond, Staff Representative, NHS Tayside
H MacKinnon, PKAVS (Third Sector Interface)
B Campbell, Carer Public Partner

PERTH AND KINROSS INTEGRATION JOINT BOARD

30 JUNE 2017

AGENDA

8.1 Mental Health Service Redesign Transformation Programme – Option Review Report and Consultation Plan – Report by Chief Officer (copy herewith G/17/93) ***(Pages 1 -1854)***

8.1
G/17/93

PERTH AND KINROSS INTEGRATION JOINT BOARD

30 JUNE 2017

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME – OPTION REVIEW REPORT AND CONSULTATION PLAN

REPORT BY CHIEF OFFICER

PURPOSE OF REPORT

Perth and Kinross IJB has hosting responsibility for in-Patient Mental Health (MH) and Learning Disability (LD) services. In line with the principles of Health and Social Care Integration, Mental Health and Learning Disability Strategy seeks to deliver an increasing proportion of care in local communities with greater emphasis on prevention and early intervention. The Mental Health Service Redesign Transformation Programme was initiated in 2012 to design safe and sustainable in-patient facilities for people with acute and complex needs. This redesign is the first step in a process intended to design safe and sustainable in-patient services for the future and to enable existing community services to meet the growth in population and the changing needs of the majority of people who live in Angus, Dundee, Perth and Kinross.

The report describes the option development, modelling and appraisal process. It presents a preferred option and the rationale for its selection. The proposal has been presented to NHS Tayside Board, Angus and Dundee Integration boards for noting and for comment before being presented to Perth and Kinross Integration Joint Board for approval. Perth and Kinross Integration Joint Board are asked to formally approve progression to a period of formal consultation on the preferred option from 3rd July 2017 to 3rd October 2017

1. RECOMMENDATION(S)

It is recommended that the Integration Joint Board:-

(i) Note the content of the Option Review Report and supporting Appendices (attached as Appendices 1, 2 & 3).
(ii) Note the process followed in undertaking the review and the level of engagement involved in the preparation and consideration of options for future General Adult Psychiatry and Learning Disability services.
(iii) Note the methodology used to identify the preferred option and justification for its choice over other options considered.
(iv) Note and comment on the consultation plan content (attached as Appendix 4)
(v) Approve the requirement to proceed to a three month period of formal consultation in line with Scottish Government guidance on major service change.

2. SITUATION/BACKGROUND / MAIN ISSUES

Mental Health Services in Tayside have undergone significant change following the Mental Health Review in 2005-06 which allowed for a shift in the balance of care and substantial reinvestment in community services through a reduction in General Adult Psychiatry inpatient bed numbers. However the decision to retain inpatient services within each locality of Tayside has meant the majority of mental health resources remain within Inpatient Services and the level of inpatient spend in Tayside is still substantially higher than the Scottish average when benchmarked against other Board areas.

In line with the optimum delivery of Mental Health service provision across Scotland, the balance of care must shift to community-based services. To achieve that we must ensure that people who need in-patient care have access to specialist, high quality care environments that support recovery. In particular, in conjunction with the three local Health and Social Care Partnerships with their focus on community-based services, we must re-model adult in-patient mental health services in a way that makes the best use of our skilled workforce to provide patients with the right care in the right place at the right time.

The Option Review Report attached presents and appraises the top four options identified in the August 2016 NHS Tayside Board report from the early Option Appraisal scoring exercises and recommends a preferred way forward, together with initial indicative costs, for further detailed analysis within subsequent Initial Agreement and Outline Business Case reports that will be presented for approval following a period of formal consultation in keeping with statutory requirements.

The initial plan outlining the approach to the period of formal consultation is included within the Option Review Report at section 14 and in the separate Consultation Plan Report attached. The consultation plan report describes the proposed methods of engagement and approach to be taken. The supporting consultation materials are currently being prepared and developed in partnership with key stakeholders and will be available for the consultation period starting on 3rd July 2017 following approval of this paper by Boards and Committees in June 2017.

It is only through the involvement of service users, carers, communities and those who work within the Mental Health and Learning Disability services that NHS Tayside and the three IJBs can ensure that services and the way in which they are delivered, have the best chance of being both fit for purpose and sustainable to meet the needs of the population of Tayside.

NHS Tayside and the three Integration Joint Boards must be assured that people with a mental disorder that require treatment can access this promptly and that the quality of care and treatment received is of a high standard.

Most people receive treatment while living at home or in residential care supported by a General Practitioner or community based services. Examples include community mental health teams, psychological services and substance misuse services. Third Sector, voluntary and self help organisations have an important role to play in this as well as social housing and supported accommodation.

Admission to hospital is required for only a small number of people when the nature and severity of the mental disorder cannot be managed safely or appropriately in the community. In these situations specialist care in an acute inpatient unit is necessary. In order to provide high quality care and treatment in these inpatient units it is fundamental that these are safe and therapeutic environments.

The options being considered for future inpatient services must address two key issues:

1. We are currently unable to safely maintain three General Psychiatry acute admission inpatient units in Tayside and two Learning Disability inpatient sites. This is because the current and predicted future availability of staff is insufficient to safely manage the services across multiple sites.

2. Strathmartine Centre does not meet the needs for patients who are in hospital for often years at a time. There is an urgent need to upgrade the physical environment for Learning Disability patients. This cannot be achieved in the current Strathmartine accommodation. However, these services could be re-located within the existing hospital estate offering potential to improve patient experience and make more efficient use of current resources.

The paper outlines the process by which options for change have been identified and evaluated, allowing recommendations to be made that can now be submitted for full public consultation. As services develop in conjunction with the community focus of Integration Joint Boards, we would seek to shift the balance of care to community based services and make best use of our workforce for the benefit of patients.

This paper seeks to provide an overview of the detailed information contained in the attached Mental Health Service Redesign Programme Option Review Report and supporting Appendix documents which provide Board members with a preferred way forward for Mental Health and Learning Disability inpatient services.

The attached Option Review Report outlines the current issues facing provision of Mental Health Inpatient services for both General Adult Psychiatry and Learning Disability services and examines in detail four potential options that seek to ensure provision of safe, sustainable and person centred services for the future which meet the needs of all our stakeholders across Tayside.

It is no longer possible to deliver safely the most specialist services for General Adult Psychiatry Acute inpatient admissions over three sites – overnight cover, weekends & public holidays are a particular challenge with the diverse geography and current spread of specialist Mental Health Services. NHS Tayside is experiencing the impact of a national shortage of Mental Health specialist clinical staff. Shortages of both Medical and Nursing workforce are particularly acute in Tayside though there are similar issues experienced across Scotland, particularly in more remote and rural areas. The workforce profile is ageing with early retirement opportunities for Mental Health employees affecting a large proportion of more experienced staff. The fixed single out-turn of Newly Qualified Practitioners every year is insufficient to match the numbers of people leaving the service. Tayside is competing with other Health Boards/Countries for a finite pool of staff. Like many areas in Scotland, National and Local Shortages of Junior and Senior Medical staff and Registered Mental Health Nurses are driving redesign. It is projected from staffing age profiles that within the next 5 years Mental Health and Learning Disability services will see retirements in current Nursing workforce of circa 35% and 24% of the substantive Consultant workforce (13 out of 54) are either at retirement age or expected to retire within the next 5 years. Ten locums are currently employed out of a total of 64 consultants across Tayside Mental Health and Learning Disability services.

In order to provide a safe service within current resource limits the option appraisal considered the deployment of these resources across the optimum number of sites. This assessment was done on the basis of safe staffing levels for the patient care needed for each option.

REPORT DETAIL

Drivers for Change

In addition to the workforce challenges noted above a number of policy drivers and specialist opinion demonstrate that a strategic shift is required. Services in all settings must be safe and effective; however national strategy and clinical evidence propose enhanced community based care and development of specialist centres for those people with the most complex needs. We need to redress the remaining imbalance of in-patient and community-based services across Tayside. The changing population profile means more people survive into older age with learning disabilities. While people with mental illness often suffer from inequality and are likely to live 10-20 years less than their more affluent, relatively more healthy counterparts, we anticipate the increasing requirements for services from a greater number of older people to conflict with static numbers of working people, low unemployment in the more rural areas of Tayside and therefore challenging circumstances in sustaining the current profile of the workforce.

Health and Social Care Integration brings with it the delegation of the greater part of Mental Health Services. Hosting arrangements in Tayside have delegated responsibility for the majority of inpatient services to Perth and Kinross and Psychology to Dundee. Integration Joint Boards are obliged to include a wide contribution to Mental Health Service provision. Fig 1 attached at Appendix Eleven of the Option Review Report highlights the range of Mental Health and Learning Disability services provided in Tayside and where responsibility for their delivery now sits.

Realistic Medicine (2016, is driving a conversation across the clinical professions about the redesign of services through reductions in variation and in considering how the most effective care can be delivered in future. Families, Carers, Service-Users, Health and Social Care Integration, Localities, Communities and the Third Sector all have a contribution

Tayside General Adult Psychiatry In-Patient Mental Health services are accommodated in three modern Not For Profit Distributing (NPD)/ Private Finance Initiative (PFI) buildings. The ageing property on the Strathmartine site requires significant refurbishment and the even with major refurbishment would not lend itself to provision of modern healthcare facilities with single bedroom en-suite accommodation.

Contingency Plan

The predicted workforce shortages have triggered development and implementation of a contingency plan which was approved by the NHS Tayside Board on the 27th October 2016 and by the Perth and Kinross Integration Joint Board on 4th November 2016. This contingency plan is providing temporary solutions for some of the drivers for change ahead of the conclusion of the MHSRT programme which will move services to a more structure approach to transformational change.

Option Appraisal

A series of Option Appraisal and Option Modelling workshops involving an equal number of service users and carers, third sector organisations and multi agency staff have been undertaken to support the production and consideration of the options being considered. Of the options developed, four were carried forward for clinical, technical, workforce and financial appraisal.

As the paper describes, the two options that scored highest from the two workshops held to facilitate the process, still have services for adult mental health being provided from three sites across Tayside, albeit the acute admissions wards are either on a single site or two sites; in addition the difference in scoring between the top four options was marginal; therefore the top four scored options have been presented in the Report to ensure the scope requested for a single site or two sites for adult inpatient services are presented. Board members are directed to the attached paper for the detailed description, content and outcome of the Option Review and the associated appendices.

It should be noted that it is the professional opinion that only options 3A and 5A described below would meet requirements for safety, sustainability and clinical continuity of services.

In summary the top four options which have been considered are:

Option 3A

Single site option for General Adult Psychiatry (GAP) acute admission beds which would relocate current inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit, Stracathro in Angus and Moredun Ward in Murray Royal in Perth to be provided from four refurbished wards in the Carseview Centre in Dundee and provide 84 beds for Tayside as per Table Two in section 9.3 below. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth. This option provides a single site option for Learning Disability services which would relocate current inpatient beds from Strathmartine and Carseview sites to a refurbished combined ward in Murray Royal. This ward will provide inpatient beds for Learning Disability assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area.. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.
The vacated Mulberry ward within the Susan Carnegie unit in Stracathro, Angus would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

Option 4A

Two site option for GAP acute admission inpatient beds with relocation of current inpatient beds provided in the Moredun Ward in Murray Royal in Perth to a refurbished ward in the Carseview Centre in Dundee. This option will continue to provide GAP acute admission inpatient beds in the Mulberry ward, Susan Carnegie Unit, Stracathro, Angus and from existing GAP acute admission inpatient beds in the Carseview Centre in Dundee and provide 87 beds for Tayside. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability services which would relocate current inpatient beds from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient

beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Moredun ward within the Murray Royal hospital site would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

Option 5A

Two site option for GAP acute admission inpatient beds which would relocate current inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit, Stracathro, Angus, to a refurbished ward in the Carseview Centre in Dundee. This option will continue to provide GAP acute admission inpatient beds in the Moredun Ward on Murray Royal site in Perth and from existing GAP acute admission inpatient beds in the Carseview Centre in Dundee. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability services which would relocate current inpatient beds from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Mulberry ward within the Susan Carnegie unit in Stracathro, Angus would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

Option 8

This option was a new option generated at the Option Appraisal events.

Single site option for General Adult Psychiatry (GAP) acute admission beds from a single inpatient ward for Tayside for acute assessment on the Carseview centre in Dundee. The inpatient beds provided from the Mulberry Ward in Susan Carnegie Unit, Stracathro in Angus and Moredun Ward in Murray Royal in Perth and in the Carseview Centre in Dundee would then change function to provide step down/treatment inpatient beds for each locality and provide a total of 89 beds (18/22 Acute Admission). This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability inpatient services which would relocate from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds in one ward and 8 open forensic inpatient beds in a second refurbished ward on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

Appendix Twelve of the full Option Appraisal Report (attached at Appendix Four) provides further descriptor of other NHS bed provision currently provided around each of these options.

Option Appraisal

A number of factors have been used to determine the preferred option. Key to any decision regarding the selection of the future inpatient models has to be the sustainability of the clinical and workforce models. Financial and Technical appraisals and initial costings have been undertaken and will continue to be refined though the process of approvals outlined in the Programme timetable in Section 17 below.

The detailed appraisal of each of the top four options is provided in the attached Option Review Report.

3. PROPOSALS

Preferred Option

Option 3A provides the safest most sustainable service for the future, ensuring sufficient medical cover, nursing, AHP and Psychology workforce who can share learning and experiences across speciality services. This option will allow maximum resource release for any potential reinvestment in community workforce to provide services to the majority of the population and prevent unnecessary admissions for both GAP and LD services. By shifting the balance of care and providing centralised specialist services this option reduces variation and provides ease of acute care pathway.

Option 3A would therefore be the recommended preferred option for NHST Board and the three Integration Joint Boards to progress to seek views on during the formal three month consultation phase.

A move from the status quo inevitably involves change. Almost the most controversial aspects of the Programme and strategic review is the possible centralisation of acute admission beds for both GAP and Learning Disability services. Each option outlined above and in the body of the Option Review report brings its own benefits and problems.

However the creation of a centralised service provides the opportunity for synergistic learning through close contact with professionals, service users and carers who would otherwise have been in separate services with different goals and potentially different quality standards.

Option 3A will allow for the above and creation of a “Centre of Excellence” for both GAP and Learning Disability services and the only future model of care which is both sustainable from a nursing and medical workforce availability, whilst improving patient environments and ensuring financial affordability.

By contrast travelling time for professionals, service users and carers will be significantly increased in some cases and the problems this can bring re escorts etc. Further exploration of the impacts on service users and their families need to be considered throughout the consultation period and planning for any option implementation. Through the use of the EQIA report and quantification of the potential impacts on the population the programme will continue to monitor and evaluate and take actions necessary to support access wherever possible.

While it is not ideal to be working under contingency plans in the short to medium term, it is essential to demonstrate the rigour of this planning process and the careful examination of all the options before agreeing a preferred option for presentation and public consultation. Although the arrangements for major service change under Health and Social Care Partnerships may vary from the processes used by NHS Boards in the past, this process is underway at a time when the policy landscape is still in development. The principles applied to implementation of the contingency plan will continue. Careful partnership working with patients, carers, staff and staff organisations will be ongoing and include communities, third sector organisations, independent contractors and care providers.

TIMETABLE FOR IMPLEMENTATION

Business Case Stages and Programme Timeline for Approval

Option Review Report Update and Consultation plan approval	June 2017 Committees/Boards
Consultation Period	3rd July 2017 to 3rdOctober 2017
Initial Agreement Report	December/January 2017/8 Committees/Boards then CIG in January/Feb 2018
Outline Business Case report	May/June 2018 Committees/Boards then CIG in May
Financial Close	November 2018
Full Business Case report	December 2018
Refurbishment timeline	January 2019 to December 2019

4. CONCLUSION

The Board are therefore asked to consider the information presented above and the process which had been followed to allow identification of the presented preferred option; that being Option 3A.

Following approval of the process leading to selection of the preferred option, the MHSRT Programme would then proceed to the period of formal consultation with wider stakeholder and public involvement. The draft consultation plan is attached. The consultation period will allow for the gathering of as much feedback, comment and opinion on the proposed preferred option to ensure further review and production of an Initial Agreement report which will then be presented to Boards for final approval.

The Programme reporting governance structure is attached in Appendix Eleven

Author(s)

Name	Designation	Contact Details
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Lesley McLay	Chief Executive NHST	l.mclay@nhs.net

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	**Yes / None**
HSCP Strategic Commissioning Plan	**Yes**
Transformation Programme	**Yes**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Assessments	
Equality Impact Assessment	**Yes**
Risk	**Yes**
Other assessments (enter here from para 3.3)	**Yes**
Consultation	
External	**Yes**
Internal	**Yes**
Legal & Governance	
Legal	**Yes**
Clinical/Care/Professional Governance	**Yes**
Corporate Governance	**Yes**
Communication	
Communications Plan	**Yes**

1. Strategic Implications

1.1 Strategic Commissioning Plan

CONTRIBUTION TO NHS TAYSIDE AND LOCAL INTEGRATION JOINT BOARD STRATEGIC AIMS

The Mental Health Clinical Services Strategy which is a component part of NHS Tayside Clinical Strategy was approved by NHS Tayside Board in December 2015. The proposed changes to the service delivery model are in keeping with the strategic aims nationally and locally, to continue to shift the balance of care to provide optimum care and treatment in community settings, promoting a model of recovery and enablement.

The detailed strategic aims are as highlighted within the detailed Option Review Report attached.

2. Resource Implications

2.1 Financial

The financial implications associated with the options being considered are captured in summary in Section 10 of the Option Review Report and detailed further in Appendices Six.

An appraisal of the financial benefits associated with each option has been reviewed by the management accounting team dealing with Mental Health and Capital resources to support the ranking of options. The detail of this is included in Appendix Seven.

Although the financial appraisal of the options is part of the identification of a preferred option, the primary focus of the programme is to ensure patient and staff safety through sustainable service models and high quality care as the priority. The Board can be assured that the preferred option at this stage does not place NHS Tayside in a position of any additional financial risk and will allow resource release and an associated reduction in current cost pressures in respect of supplementary staffing and premium locum agency costs.

Current high level estimates demonstrate that Option 3A allows for the greatest release of resources from current inpatient services to allow for any requirement for reinvestment in community and home treatment services, whilst maximising use of the current estate portfolio and allowing disposal of surplus assets which have significant backlog maintenance costs. Work will progress throughout the consultation period to identify any levels of reinvestment in community settings which may be required to support the preferred option. This work will review current activity data in line with the benchmarking data to ensure current community services are remodelled to make most effective and efficient use of resources available.

2.2 Workforce

The detailed workforce implications associated with each of the options are included in section 9 of the Option Review Report.

Option 3A is the only option which will provide sufficient safe inpatient staffing levels to provide services for the immediate future and next 5 years. This option also makes the most efficient use of the projected available workforce.

There are workforce implications associated with all options being considered and any proposed changes will be subject to NHS Tayside Organisational Change policies and procedures and implemented with full staff side and Human Resources support.

3. Assessments

3.1 Equality Impact Assessment

Under the Equality Act 2010, PKC and NHS Tayside is required to eliminate discrimination, advance equality of opportunity, and foster good relations between equality groups. Carrying out Equality Impact Assessments for plans and policies allows the HSCP to demonstrate that it is meeting these duties.

The Programme's Equality Impact Assessment is attached within Appendix One of the Option Review Report. Impact assessments have been undertaken to assess the potential impact of the options being considered in relation to both General Adult Psychiatry and Learning Disability proposals.

3.2 Risk

The current risk log for the programme captures all associated risks from the various work streams and work being undertaken and is reviewed at monthly Programme Team meetings. In addition to the risk assessment for the programme specifically, Mental Health service delivery is recorded as a strategic risk for NHS Tayside. The risk description presented here is specific to the risks of the sustainability of the current inpatient service delivery models that the programme is aimed at mitigating. Risk Description The current service configuration of the provision of General Adult Psychiatry inpatient services from three separate geographic localities across Tayside is not a sustainable service model for the current time and medium term future, due to the inability to provide optimal multidisciplinary staffing across all three sites. The consequences of lower than required medical and nursing staffing is a risk to patient and staff safety; risks to the quality of care and treatment provided; and continued risks of increasing financial imbalance.

Current Rating of Likelihood = 5
Current Rating of consequences = 4

- Crisis Resolution and Home Treatment services for Angus locality have been delivered from Dundee locality in the Out of Hours period since August 2015 as an emergency measure to address the continued vacancies on the junior doctor rotas.
- Business Continuity plans have now been evoked by the AMD, Lead Clinicians and Heads of Service to temporarily relocate Mulberry Ward and Perth locality Out of Hours assessments to Carseview Centre as a result of current Junior Doctor workforce shortages to ensure continued provision of safe services across Tayside.
- In times of nursing workforce shortages vs. clinical acuity on the inpatient wards, operational decisions are taken to temporarily divert admissions to other wards / localities in the interests of staff and patient safety. Target control level = 3
- The Mental Health Service Redesign Transformation Programme attached Option review Report recommended preferred option will reduce General Adult Psychiatry inpatient services from a three site to single site delivery model for Tayside.

3.3 Other assessments

3.3.1 Health Equity

One in four people will experience mental health problems and it's important to access the right support in the right place when it is needed. It is also important to remember that the majority of people recover or learn to manage their mental

health issue, lead meaningful lives and contribute positively to society.

94% of people who access secondary care mental health services each year do so in the community

The Mental Health Service Redesign Transformation Programme seeks to further promote health equity by ensuring a shift in the balance of care to meet the demands placed on both current and predicted population needs, whilst ensuring service users are cared for in as near to or in their own home as is possible. This will support equity of service provision across Tayside for the majority of the population accessing services.

3.3.2 Measures for Improvement

In keeping with the Keogh domains around patient improvement, we will measure the following:

- Continued quality improvement, evidenced through the outcome measures from the Institute for Healthcare Improvement pilot project on Safer Care
- Recruitment and retention of appropriately qualified and experienced staff
- Improved compliance with junior doctor rotas
- Improved medical trainee experience evidenced through a reduced incidence of 'red flags' in trainee placement evaluations
- Reduced use of supplementary staffing for nursing and medical staff
- Reduced cost pressures from junior doctor locums ; locum consultant agency costs; nursing agency costs totalling £1m in 2016/17

3.3.3 Patient Experience

The recommendations and preferred option being presented reflects an ambition to ensure patient experience is not adversely affected by the increasing challenges of further improving and sustaining the provision of high quality, safe, effective and efficient services. The transformation of the service includes a requirement to review and improve clinical pathways, revise service delivery models, and ensure most beneficial utilisation of hospital accommodation, aimed at improving patient experience, improving patient safety and providing sustainable, safe and effective, recovery focused services.

3.3.4 Information Technology Implications

No information technology implications have been identified at this stage and will be examined as part of the further review of community services and any investment requirements to support outreach working practices.

3.3.5 Health & Safety Implications

The programme is aimed at reducing current Health and Safety risks in respect of adequate, safe staffing levels and medical rota compliance. Any refurbishment works required will take cognisance of current work being

undertaken across all Mental Health sites to review ligature risks.

3.3.6 Healthcare Associate Infection (HAI)

No HAI implications identified

3.3.7 Delegation Level

Executive Sponsor - Dr Neil Prentice, Associate Medical Director
Operational Lead – Mr Robert Packham, Chief Officer, Perth & Kinross Integration Joint Board Programme Lead - Lynne Hamilton, Director Mental Health Programme Director and Finance Manager

4. Consultation – Patient/Service User first priority

Appendix Three details the programme of communications and engagement associated with the programme and work undertaken to date. The programme of engagement undertaken has sought to expand on initial involvement of key stakeholders in reviewing the options identified by that original group through a further Option Appraisal exercise and series of workshops, events, presentations etc. Staff side representatives have been members of the programme team and participated in associated work streams and workshops since inception of the programme. The contribution and support of staff side representatives throughout the process and at all events has ensured the implications for the workforce have been noted to date. The continued involvement of staff side representatives following the decision of the Boards will ensure the impact of the programme on individual staff will be considered in detail.

The consultation plan report is attached and outlines the proposed approach to be undertaken during the three month period identified, as noted in the report this has been reviewed with colleagues from the Scottish Health Council.

5. Legal and Governance

No legal implications identified. Any contractual issues associated with changes to existing PFI/NPD buildings will be reviewed with colleagues from the Central Legal Office (CLO)

6. Communication

6.1 Three month formal consultation period to be undertaken in line with Scottish Government guidance for major service change

7. BACKGROUND PAPERS/REFERENCES

As per references throughout the Option Review Report and supporting appendices.

8. APPENDICES

Option Review Report
Consultation Plan Report
Appendices 1 to 12 attached

Mental Health Service Redesign Transformation Programme

Option Review

June 2017

Document Control Information	
Control Status	MHSRT Programme Board –Scheduled 08/06/2017 Clinical Care Governance Committee – Scheduled 12/06/2017 Area Clinical Forum – Scheduled 15/06/2017 Area Partnership Forum – Scheduled 27/06/2017 P&K IJB Transformation Board – Scheduled 19/06/2017 Angus Integration Joint Board – Scheduled 28/06/2017 Dundee Integration Joint Board – Scheduled 27/06/2017 NHS Tayside Transformation Board – Scheduled 28/06/2017 Tayside NHS Board – Scheduled 29/06/2017 P&K Integration Joint Board – Scheduled 30/06/2017
Date Last Printed	15/06/2017
Version Number	1.28
Author(s)	L Hamilton, Mental Health Programme Director & Finance Manager, NHS Tayside

List of Contributors – Programme Board, Programme Team & Supporting Information

Full list of all stakeholders who contributed to Programme listed in Option appraisal report (Appendix Four)

Name	Designation
Mark Anderson	Head of Property
Allyson Angus	Public Involvement Manager
Karen Anderson	Director of Allied Health Professions
Robert Bain	Clinical Team Manager – Learning Disabilities
Lindsay Bedford	Director of Finance
Dave Bennett	Engineering Systems Lead – Property Department
Dave Berry	Chief Finance Officer – Dundee Health & Social Care Partnership
Sandy Berry	Chief Finance Officer – Angus Health & Social Care Partnership
Roger Blake	Consultant Psychiatrist – Angus
Jane Bray	Public Health Consultant
Eleanor Brewster	Consultant Psychiatrist – Learning Disabilities
Bernie Brophy-Arnott	LD Speech and Language Therapy Manager
Lesley Burnett	Learning Disability Health Team Leader – Dundee Health & Social Care Partnership
Elizabeth Caesar	Consultant Psychiatrist - Rehabilitation
Santosh Chima	Diversity & Inclusion Manager
David Cook	Senior Management Accountant
Andrew Cowie	General Practitioner
Shelagh Creeghan	Associate AHP Director for Mental Health & Learning Disabilities
Stuart Doig	Consultant Forensic Psychiatrist
Jane Duncan	Head of Corporate Communication
Margaret Dunning	Board Secretary
Diane Fraser	Perth & Kinross Health & Social Care Partnership
Alan Gall	Interim Performance Director
Judith Golden	Employee Director
Linda Graham	Consultant Clinical Psychologist – Deputy Head of service
Lynne Hamilton	Mental Health Programme Director & Finance Manager
Jodi Hassall	Management Accountant
Fabian Haut	Consultant Psychiatrist – Learning Disabilities
Val Johnson	Head of Inpatient Services Mental Health & Learning Disabilities
Peter Kingston	Gauldie Wright & Partners - Architects
Linda Kennedy	Service Manager - Learning Disability
Julie Kermack	Team Manager - Learning Disabilities
Diane McCulloch	Head of Service, Health and Community Care, Dundee Health & Social Care Partnership
Kate McDermott,	Staff Side Representative
Iain Mceachan	HR Business Lead
Angie McManus	Learning Disability Service Manager
Wilma Mason	Capital Accountant
Arlene Mitchell	Locality Manager – Dundee Health & Social Care Partnership
Andy Moir	Team Leader, Perth & Kinross Health & Social Care Partnership
Ross Muir	Contract manager - Bellrock
Gillian Munro	Head of Spiritual Care
Bill Nicoll	Director of Strategic Change
Neil Prentice	Associate Medical Director for Mental Health

Robert Packham	Chief Officer – Perth & Kinross Health & Social Care Partnership
Alan Pattinson	NHS Tayside Transformation Programme Lead
Kevin Power	Head of Psychology Service
Rowan Reffold	Consultant Clinical Psychologist – Lead Learning Disabilities
Keith Russell	Associate Nurse Director – Mental Health & Learning Disabilities
Irene Sharkie	Lead Principle Pharmacist – Mental Health
Aidan Shorrock	Contract manager - Robertsons FM
Christopher Smith	Associate Director of Human Resources - HR & OD
Jane Smith	Chief Finance Officer – Perth & Kinross Health & Social Care Partnership
Muriel Steven	MHSRT Programme Support Officer
Carole Sutherland	Speech & Language Therapy Manager
Lynne Swankie	Management Accountant
Bill Troup	Head of Mental Health Services – Angus Health & Social Care Partnership
Barbara Tucker	Staff Side Representative
Tracey Williams	Associate Director Improvement
Barbara Wilson	Head of Service – Forensic Services
Louise Wilson	Communication Manager
Sally Wilson	Locality Integration Improvement Manager

Title

The title of the programme described in this document is ""Mental Health Service Redesign Transformation Programme". This title will be used in all subsequent documentation.

Purpose of this Report

This Report sets out why NHS Tayside in partnership with the three locality Integration Joint Boards seeks to redesign its General Adult Psychiatry and Learning Disability inpatient service models and review the accommodation from where these services are provided.

The Option Review Report attached presents and appraises the top four options identified in the August 2016 NHS Tayside Board report from the early Option Appraisal scoring exercises and recommends a preferred way forward, together with initial indicative costs, for further detailed analysis within subsequent Initial Agreement and Outline Business Case reports that will be presented for approval following a period of formal consultation in keeping with statutory requirements..

The initial plan outlining the approach to the period of formal consultation is also included within the Option Review Report at section 14. A detailed consultation plan and supporting materials are being further developed and prepared in partnership with key stakeholders and will be available following approval of this paper in June 2017.

Mental Health Services in Tayside have undergone significant change following the Mental Health Review in 2005-06 which allowed for a shift in the balance of care and substantial investment in community based services through a reduction in inpatient bed numbers. However with the decision to retain inpatient services within each locality of Tayside has meant the majority of mental health resources remain within inpatient Services and the level of inpatient spend in Tayside is still substantially higher than the Scottish average when benchmarked against other Board areas.

In keeping with the optimum delivery of Mental Health provision across Scotland, the balance of care needs to move to predominately community-based services. In achieving this we must ensure that people who need in-patient care do so in environments where they can be provided with the specialist, high quality care that they need to support their recovery. In particular, in conjunction with the three local Health and Social Care Partnerships, with their focus on community-based services, we seek to re-model adult in-patient mental health and learning disability services in a way that makes the best use of our skilled workforce to provide patients with the right care in the right place at the right time. This document seeks to outline the process by which options for change have been indentified and evaluated; allowing recommendations to be made that can now be submitted for full public consultation.

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SEPARATE APPENDIX DOCUMENT -

1. INTRODUCTION

NHS Tayside in partnership with the Integration Joint Boards (IJBs) of the Angus, Dundee and Perth and Kinross Health and Social Care Partnerships is carrying out a strategic review of General Adult Psychiatry and Learning Disability inpatient services which is likely to lead to changes that will affect service users, their families, carers, voluntary organisations and staff. The extent of all of the changes required will not be fully known until the end of the review. The proposed changes (options) outlined in this paper have been developed by a group of key stakeholders who participated in an Options Appraisal process. The Option Appraisal is one part of the ongoing wider process of NHS Tayside's review of General Adult Psychiatry and Learning Disability Inpatient Services being undertaken by the Mental Health Service Redesign Transformation (MHSRT) Programme.

This paper seeks to outline:

- the mains reasons for the review
- the scope of the review
- the involvement process that has and continues to be followed during the review.
- the options that have been identified and considered
- the identification of a preferred option
- an initial plan outlining our approach to the consultation period

2. WHY IS A REVIEW BEING CARRIED OUT?

NHS Tayside and the three Integration Joint Boards must be assured that people with a mental disorder that require treatment can access this promptly and that the quality of care and treatment received is of a high standard.

Most people receive such treatment in a primary care setting and treatment occurs while living at home or in residential care and is supported by a General Practitioner.

Community services help people recover from the effects of their mental disorder and maintain their role in society as far as is possible. Examples include community mental health teams, psychological services and substance misuse services. Third Sector, voluntary and self help organisations have an important role to play in this as well as social housing and supported accommodation.

Admission to hospital however is required for a small number of people when the nature and severity of the mental disorder cannot be managed safely or appropriately in the community. In these situations specialist care in an acute inpatient unit is necessary.

Certain groups of patients also require specialist inpatient services such as eating disorder services, learning disability and forensic services.

In order to provide high quality care and treatment in these inpatient units it is fundamental that these are safe and therapeutic environments.

The reason this review is being carried out is to address two issues:

- Concern about the ability to safely maintain three General Psychiatry acute admission inpatient units in Tayside and two Learning Disability inpatient sites.

- Concern that the hospital environment at Strathmartine Centre does not meet the needs for patients who are in hospital for often years at a time.

As will be highlighted later in this report the main driver for the first of these issues is current and future availability of staff to safely manage the services across multiple sites.

For the second issue the main driver is the need to urgently upgrade the physical environment for Learning Disability patients which cannot be achieved in the current accommodation on the Strathmartine site. It is recognised however that the inpatient services provided on this site could be located in the existing hospital estate with the potential to improve patient experience and make more efficient use of current resources.

2.1 Strategic context

NHS Tayside's Mental Health Strategy (2015) supported the need to shift the balance of care from hospital based care to services that provide care and treatment in the community as near to home as possible. A review of Adult Mental Health services was undertaken in 2003/04. The earlier Adult Mental Health Review allowed for a shift in the balance of care through significant investment in community services to allow bed reductions at that time but agreed that general adult psychiatry acute admission inpatient beds would continue to be provided from three locations in Tayside.

When benchmarked against all other Scottish Health Boards, NHS Tayside continues to invest significantly more resources and whole time equivalent staffing in Mental Health inpatient services than all but one other Health Board area in Scotland. The cost per inpatient week for General Adult Psychiatry is £3,984 compared to Scottish average £3,283, approx £82 per head of population in comparison with the Scottish average of £57 per head of population. The cost per inpatient week for Learning Disabilities is £4,311 (2nd highest to NHS Fife) compared to Scottish average of £3,968, approx £18 per head of population in comparison with a Scottish average of almost half at £9 per head of population.

2015/16 figures for average GAP wte staffing levels demonstrate that NHS Tayside provides 1 wte nurse per 1181 members of population in comparison to Scottish average of 1 wte nurse per 1403 members of population. For Medical staffing the figures are 1 wte per 9,805 compared with 1 wte per 11,679 Scottish average so again this reflects a higher level of spend than other Boards. This position is also reflected in LD services where figures are 1 wte per 4,241 against

Scottish average of 1 wte per 5,993 in nursing, and 1 wte per 142,625 against Scottish average of 1 wte per 224,159 in medical staffing.

However on comparison, spend on community services, NHS Tayside is consistent with other Boards across Scotland and therefore there would appear to be an imbalance in how Tayside resources are currently being invested per head of population on its inpatient Mental Health services. Cost Book latest published figures for 2015/16 shows NHS Tayside spend £39 per head of population on Community Psychiatric Teams which is in line with the Scottish average of £39. Learning Disability community services are also on a par at £6 per head of population with the Scottish average spend of £7 per head of population. Detailed extracts from the cost book are attached in Appendix Nine – Supporting Information

As a result of this information, NHS Tayside requested a further review of the existing models of care to create proposals for redesign across Mental Health and Learning Disability services to prepare for the future needs of the population and look at the potential to further shift the balance of care in line with the strategic intentions of Health and Social Care Integration across Angus, Dundee, Perth and Kinross.

The MHSRT programme is also aligned with the work being progressed through the NHS Tayside Transformation Programme which has also given a commitment to review the Boards large Property portfolio and aging estate.

This section explains how the scope of the Programme fits with the national drivers for change.

These drivers for change include:

- Realistic Medicine – Chief Medical Officers Annual report (2014 -2015)
- A National Clinical Strategy for Scotland- Scottish Government (Feb 2016)
- Better Health, Better Care Action Plan (2007)
- Scottish Governments 2020 Vision (2011)
- NHS Scotland Quality Ambitions
- Delivering for Mental Health – Scottish Government 2006.
- Mental Health (Care and Treatment) (Scotland) Act 2003.
- National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) – DoH 2002.
- Safety Privacy and Dignity in Mental Health Units – DoH 2000.
- Royal College of Psychiatrists Guidance on Facilities for Junior Doctors Interviewing Patients.
- Mental Health Tribunal Standards.
- Admissions to Adult Mental Health Inpatient Services – Best Practice Statement NHSQIS April 2004.
- NHS QIS ICPs – Standards for Integrated Care Pathways for Mental Health (December 2007).

- NHS QIS Admissions to Adult Mental Health In-patient Services – April 2004.
- Delivering for Mental Health: National Standards for Crisis Services (2006).
- Same as you? (2000)
- Health and Social Work and Related services for Mentally Disordered Offenders in Scotland Mel 5 (1999)
- National Mental Health Strategy 2017-27
- The Keys to Life - Improving Quality of Life for People with Learning Disabilities (June 2013)
- Public Bodies (Joint Working) (Scotland) Act. 2014
- Angus Integration Joint Board Strategic Plan 2016
- Dundee Integration Joint Board Strategic Plan 2016
- Perth and Kinross Integration Joint Board Strategic Plan 2016

2.1.1 Organisational Overview

In 2014 the Chief Medical Officer of NHS Scotland produced the annual report entitled “Realistic Medicine”. This document challenges Medical Professionals and all NHS Boards to reduce unwarranted variation in clinical practice and services to achieve optimal outcomes for patients. NHS Tayside’s vision in line with this report requires us to ensure that by 2020 we will have established Mental Health and Learning Disability services that are able to not only respond to the changing population demographics described below, but deliver high quality, high value person-centred models of care, balancing capacity with demand, ensuring safety and sustainability while demonstrating the principles of best value for the public pound.

NHS Tayside and the three local Integration Joint Boards are responsible for meeting the health care needs of just under 500,000 people living in Tayside. Tayside covers 3000 square miles of Urban, Accessible Rural and Rural populations within catchment from four Local Authority areas; Angus, Dundee, Perth & Kinross and North East Fife. The Scottish Index of Multiple Deprivation (SIMD) identifies that three of the four local authority areas covered by NHS Tayside have areas within the 15% most deprived populations in Scotland, with the majority of these areas being in Dundee City.

The greatest proportion of Tayside’s population lie within the 50-54 (7.5%) and 20-24 (7.2%) age groups. This is consistent with the Scottish average creating future planning implications for Mental Health and Learning Disability service provision for 16 – 65 year olds.

Tayside’s population is also estimated to increase overall in the next 25 years with the greatest increase in Perth & Kinross (24.2% by 2037). Angus figures predict a decrease of 0.8% in growth, whilst Perth & Kinross under 16s population is set to increase by 26% and Dundee’s by 25% during the same period.

Locally Perth & Kinross is also projected to see a 27% increase in housing developments by 2037 and is set to be one of the fastest growing regions in Scotland.

These conditions co-exist with data that demonstrates the need to plan for the needs of an ageing population, Perth and Kinross for example is predicting a 70% increase in the older age bandings across the next 15 years.

These changes in population also signify the need for changes in the way future Mental Health and Learning Disability services are provided and reflected in the options put forward in the strategic case. NHS Tayside must create service resilience to manage the growing demands for Mental Health and Learning Disability services. We must plan for a shift in the balance of care that will see the majority of the service provision taking place within local communities and within the service users own home and a far greater interdependency with communities, third sector organisations, a wider range of care providers as well as families and carers themselves.

Since the Programme started there have been significant changes in the management structures for mental health services. Initially the inpatient and community services were largely locality based as part of Community Health Partnerships.

In 2012 it was agreed to develop the Directorate model to create a more unified approach to delivery of mental health services in Tayside. Whilst the majority of psychiatric subspecialties were under a Directorate of Mental Health and Learning Disabilities, other services such as Psychiatry of Old Age were managed separately to enable closer links with Medicine for the Elderly services and Child & Adolescent Mental Health Services were included as part of the Medicine Directorate.

In response to the integrating of health and social care as set out in The Public Bodies (Joint Working) Act 2014 the structure again changed in April 2016.

In keeping with most other part of Scotland Tayside adopted an integrated joint board model and the mental health services are organised as detailed in Figures 1 and 2 in Appendix Eleven attached.

2.1.2 Health Inequalities

Health inequalities arise from variations in a range of factors including access to services, quality of care provision and extrinsic factors such as lifestyle, economic, educational, genetic and environmental factors.

The MHSRT Programme will impact on all the protected characteristics ranging from individual patient to locality populations although there is no immediate reason to think the service changes (reconfiguration or changes to pathway) would have an adverse impact. The Equality Act 2010 introduced the term "protected characteristics" to refer to groups that are protected under the Act, examples of these are Age, Race, Disability, Sex, religion or belief, etc

Minority Ethnic - There is little evidence to demonstrate any link between racial background and prevalence of mental health or LD conditions however from the supporting data gathered from ISD submission it can be noted that few people from ethnic minority groups access mental health 2.4% and learning disability 1% support and services.

Women and Men – ISD information from inpatient admissions for GAP show more males are admitted to services than females (52% males 47% females), however in LD services this split shows admissions are predominately male dominated (66% male 33% females).

Perth & Kinross strategy for gypsies/travellers outlines a higher % of population in Perth & Kinross than elsewhere in Scotland – it highlights that the Scottish Census figures for 2011 included “Gypsy/Traveller” as a classification for the first time and the results were released in September 2013. Nationally 4,212 people were recorded as such with the highest individual local authority population being 415 in Perth and Kinross.

Current ISD information recorded 0.1% inpatient admissions in GAP were gypsy/travellers and none recorded in LD services

The MHSRT Programme team require to ensure the cultural and religious needs of service users are met. There is no link between religious belief and prevalence of Mental Health or Learning Disability

The options being considered will impact on people who have a learning disability and those with a learning disability and a major mental illness. In addition will also affect those who have a learning disability and are at a risk of offending behaviour (Forensic)

Evidence suggests that particular populations, for example those in areas of deprivation and remote rural communities have more difficulties gaining access to NHS Services. They often suffer multiple disadvantages (Appleby & Deeming 2001). NHS Tayside and the three Integration Joint Boards (IJBs) seek to understand the local reasons for inequalities and ensure the preferred option provides the best conditions to address these factors whilst building safe, effective and sustainable clinical and care services for the future.

There are fewer people living in poverty in rural areas. However their experience of deprivation may be different. It is important when planning future service provision to consider factors such as the infrequency and cost of public transport as a barrier for people seeking to access hospital sites. Such disadvantages are exacerbated if the person is disabled and/or requires to be accompanied by a carer when travelling, particularly if these challenges are encountered when a person is in a state of distress. These challenges already exist for patients in rural populations within Tayside. Consideration of transport issues will be reviewed following the feedback received during the consultation period; an initial evaluation of likely cost implications for volunteer drivers has been included within the draft financial framework.

A full Equality Impact Assessment (EQIA) has been undertaken as part of this process and as a “live” document will continue to be updated, monitored and evaluated throughout the duration of the programme to ensure full understanding of the impact of any changes approved. The draft EQIA is attached at Appendix One.

2.1.3 Mental Health Strategy

The Mental Health Services Clinical Services Strategic Framework, approved and endorsed by NHS Tayside Board in December 2015, reflects the strategic intent of both the NHS Tayside Clinical Services Strategy (NHS Tayside 2015 Reshaping Clinical Services for the Future) and the National Clinical Services Strategy. The Framework builds on a 12 year narrative and vision for adult mental health services across Tayside and further chimes with the Scottish Government’s 2020 Vision.

The guiding ambition within the recently published Mental Health Strategy 2017 – 2027 is to prevent and treat mental health problems with the same commitment, passion and drive as physical health problems.

Parity of esteem is central to the Strategy which sets out three key areas of improvement:

- Prevention, early intervention and physical wellbeing
- Access to treatment and joined up accessible services
- Rights information use and planning.

There is the intention to measure the following for mental health compared to physical health over the ten years of the policy -

- Equal access to the most effective and safest care and treatment
- Equal efforts to improve the quality of care
- Allocation of time, effort and resources on a basis commensurate with need
- Equal status within healthcare education and practice
- Equally high aspirations for service users
- Equal status in the measurement of health outcomes.

The Strategy sets out 40 actions which are underpinned by a human rights-based approach to the improvements needed by using the PANEL principles of Participation, Accountability, Non-Discrimination, Empowerment and Legality.

2.1.4 Learning Disability Strategy

Scotland’s first national Learning Disability Strategy “The same as you?” published in 2000 formed the original 10 year programme to meet the needs of people with learning disabilities. The strategy provided a range of recommendations to improve the lives of people with learning disabilities in terms of where and how they live and how they become more involved and included in their communities as neighbours, colleagues and social contacts. It was highly successful in shifting the balance of care to support more people to live in the

community. It also led to the closure of over 1000 long-stay beds, improved day opportunities, created employment and meaningful day activity and better protection from harm.

In 2010, a two-year evaluation involving detailed participation from people with learning disabilities and their carers began to assess what progress had been made and what needed to be achieved. From these findings, key themes were decided and debated by a national Learning Disability Strategy group who discussed key themes and agreed broader responses which have formed “The Keys to Life”.

The first Scottish Strategy for Autism was published by the Scottish Government in late 2011. The strategy set out a “vision that individuals on the autism spectrum are respected, accepted and valued by their communities and have confidence in services to treat them fairly so that they are able to have meaningful and satisfying lives”.

The six values that underpin the strategy are:

- Dignity
- Privacy
- Choice
- Safety
- Realising potential
- Equality and Diversity.

The expectation is that the strategy will achieve meaningful partnership between central and local government and the independent sector. Creative and collaborative use of service budgets is expected to meet individual need. Access to appropriate assessment of needs throughout life and access to consistent levels of appropriate support should be available across the lifespan into older age.

“The Keys to Life” - Improving Quality of Life for People with Learning Disabilities, was published in June 2013. This new ten year learning disability strategy acknowledges that progress in implementing ‘The Same as You?’ has resulted in people with learning disabilities reporting they are generally more accepted and valued in their communities. The Ministerial Foreword highlights the need for people with learning disabilities to be treated equally and fairly and having a health service which “recognises and addresses the stark fact that people with learning disabilities still die twenty years earlier than the general population”.

‘The Keys to Life’ contains 52 recommendations for local authorities, NHS Boards and the independent sector to progress in order to continue the promotion of equality of inclusion and access for people with learning disabilities across a range of community structures and systems.

The recommendations are grouped under 9 distinctive headings as follows:

(i) Human Rights – requiring public bodies to ensure equality impact assessments are completed where services are accessed by people with learning disabilities and including people with learning disabilities in service developments while ensuring accessible information is provided about their rights.

(ii) Commissioning of Public Services – community planning partners are required to develop joint commissioning plans by April 2015. In line with the implementation of the Social Care (Self-Directed Support) (Scotland) Act 2013 all stakeholders are advised to cooperate with the independent and voluntary sector to ensure there are varied options for people to access in order to meet personal outcomes.

(iii) Health – In total there are 18 recommendations associated with improving the health outcomes for people with learning disabilities that will require to be progressed within individual organisations and jointly as health and social care integration develops. A number of the recommendations within this heading are intended to promote equal access to mainstream healthcare and screening for people with learning disabilities. Examples include improved primary care liaison, improved support to people with learning disabilities admitted to general hospitals and improved palliative care pathways.

(iv) Independent Living – recommends that day opportunities for people with learning disabilities should be further developed. A review of Local Housing Strategies should be progressed to ensure the needs of people with learning disabilities are addressed.

(v) Shift the Culture – Keeping Safe – includes recommendations to develop befriending services for people with learning disabilities, improved availability of short break services and enhanced anticipatory care planning for carers of people with learning disabilities.

(vi) Break the Stereotypes – includes recommendations that transition pathways are improved for young people with learning disabilities, ensuring training and lifelong learning opportunities can be accessed. In addition, supported employment opportunities should be developed along with volunteering opportunities for people with learning disabilities.

(vii) People with Profound and Multiple Learning Disabilities – contains a variety of recommendations including development of shared commitment to the implementation of a developing Scottish Quality Framework for the delivery of invasive procedures such as gastrostomies, ventilation and responding to seizures.

(viii) Criminal Justice – it is well evidenced that there are significant numbers of people with learning disabilities in the criminal justice system and the recommendations require that accessible and easy to read versions of criminal justice related literature should be developed, along with the establishment of a National Criminal Justice Action Group to provide support for people with learning disabilities involved in the Criminal Justice system.

(ix) Complex Care – joint discharge agreement protocols are to be developed to minimise delays in discharging people with learning disabilities from hospital. A national group will consider how capacity is built in Scotland to

provide specialist services more locally with high cost support packages being considered nationally to enable exploration of alternative arrangements which would improve outcomes for the individuals.

Over the last decade there have been significant developments both locally and nationally that have changed the lives of many people with learning disabilities, their families and carers. The principles established by “The same as you?” continue to be valid. The ten year strategy ‘The keys to life’ reinforces these principles and has a strong emphasis on human rights, recognising that to be truly accepted in society means being treated fairly and equally in every way. ‘The keys to life’ sets out a vision for improved partnership working to deliver better outcomes for people with learning disabilities, their families and carers.

Autism is a national priority with the creation of the ‘The Scottish Autism Strategy’, launched by the Scottish Government in 2011, which identifies what services need to provide for people with autism across Scotland. Strategic action is required both nationally and locally. Children and adults on the autism spectrum each have a unique set of needs which will not necessarily fall within the areas of learning disabilities or mental ill health, although these conditions may be present. Autism is a pervasive disorder which impacts on the whole life experience of people. They need to be supported by a wide range of services such as social care, education, health, housing, employment and other community based services. The Scottish Autism Strategy (2011) directs local authorities and the NHS, as the joint commissioning bodies, to give high priority to redesigning services around the principles of prevention, early identification of problems, early intervention, assessment, diagnosis, support and management of transition throughout the lifespan of autism.

2.1.5 Health and Social Care Integration

In 2014, the Scottish Government published the Public Bodies (Joint Working) (Scotland) Act. This legislation set out the intentions for Health and Social Care Integration. It recognised the future benefits of a strategic shift towards greater interdependence between a wide range of agencies, stakeholder and professional groups. Health and Social Care Partnerships (HSCP) are now in place across Scotland. NHS Tayside has entered into formal partnership with Angus, Dundee, Perth and Kinross Councils for the Angus, Dundee, Perth and Kinross Health and Social Care Partnerships. Overseen by their respective IJB, the Partnerships have separate legal identity and specific duties set out in statute. Integration Authorities have responsibility for strategic planning and commissioning of a range of health and care services. NHS Tayside retains the responsibility for property and for the employment of health staff.

A set of governance arrangements underpin delegation of a range of services from the Partner Organisations to the IJB. In Tayside, this includes the vast majority of Mental Health and Learning Disability services with Child and Adolescent Mental Health Services and Regional Medium Secure Services remaining within the direct management of NHS Tayside. All community services are directly delegated to the IJB and are managed in an integrated way alongside a range of other services across defined localities. In patient Mental Health

Services are managed through a hosting arrangement. The hosting arrangement is an agreement between the Integration joint boards and the partner Agencies that allows services to be managed together across Tayside for reasons of safety, effectiveness and efficiency. A defined list of hosting arrangements is set out in the Schemes of Integration for each IJB. Perth and Kinross IJB is responsible for the hosting arrangements applicable to In-Patient Mental Health and Learning disability services. Dundee IJB is responsible for hosting Tayside-wide Psychology services. As noted in section 2.1.1 above Figures 1 and 2 attached at Appendix Eleven highlights the range of Mental Health and Learning Disability services provided in Tayside and where responsibility for their delivery now sits.

2.1.6 Community Mental Health Services

Community Mental Health Services are currently planned and commissioned by each of the three IJBs. The majority of community services are delivered by third and independent sector organisations with the statutory bodies of NHS Tayside and the three local authorities being responsible for providing services to those people in active treatment or in need of protection. A detailed breakdown of current community service provision is included in Appendix Two.

In planning for future community services we require to consider national drivers particularly The National Clinical Strategy for Scotland, the National Mental Health Strategy 2017-2027, Keys to Life and Health and Social Outcome Indicators, including:

- Being community focussed, supporting self-management and independence for everyone by supporting people to fully understand and manage their problems, promoting a focus on prevention, rehabilitation and independence.
- We must not provide an overall system that defaults to medical solutions (such as admission to hospital) when the needs are predominantly social.
- Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons and transform nursing roles to develop Advanced Nurse Practitioners.
- People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. An early intervention will reduce likelihood of a crisis and requirement for inpatient care.

The new IJB structures provide joint opportunities to create enhanced home treatment and support, bringing care for mental health and learning disabilities closer to people's homes thus creating less dependency on an inpatient admission to gain access to the right care and support.

The focus for the further development of community services will continue to progress with a more integrated model with all statutory, independent and third sector partners. People tell us the factors that they value most highly. These factors, which can include having a job or other meaningful occupation, somewhere to live, social relationships, and equality of participation as citizens, can lead to significant improvements in mental well-being. The role of medical

and therapeutic interventions: specialist services still have an important role to play in the recovery of a good quality of life and public protection. These specialist clinical services are nested within a broader framework of understanding of mental health and learning disabilities as influenced by personal, cultural and social experience. The integration of specialist clinical interventions within a wider framework of support is essential as those who experience mental health problems face many barriers to their full inclusion in the social and economic life of the community.

The Mental Health Strategy acknowledges that working to improve mental health care is not just the preserve of the NHS and requires a wide range of services to provide the broadest range of opportunities to help people improve their mental health and well being.

2.1.7 Shifting the Balance of Care

For many years, clinical practice has been moving away from hospital care towards community based care for the majority of people. There is still further work to be done to rationalise the delivery of hospital based care across Tayside and to remodel and strengthen the community services in Angus, Dundee, Perth and Kinross

IJBs have a specific responsibility to design services that are centred on the needs of patients and carers and to provide a range of services that are based in communities.

This obligation requires engagement with a wide range of stakeholders from service users through statutory and non statutory provider organisations, professions and the wider public. It is only through the involvement of service users, carers, communities and those who work within the Mental Health and Learning Disability services that the IJBs can ensure that services and the way in which they are delivered, have the best chance of being both fit for purpose and sustainable and meet the need of the population of Tayside.

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Integration bodies also have an obligation to wherever possible, move from traditional responsive services towards services that are designed to anticipate and prevent the avoidable consequences of ill health and inequalities and again input from stakeholders in designing future services is key to their success The most recent Health and Social Care Delivery plan (December 2016) places an expectation of a measurable decrease in emergency hospital admissions and has set a target of a 10% shift in the year 2017/18. It is in engagement with communities and the third sector that we see opportunity for early intervention that should reduce the root causes and manage the requirements of people for significant elements of the known root causes of acquired mental illness.

To successfully further shift the balance of care a process is required which engages and empowers staff as well as patients and their carers who are best placed to identify where services need to be improved, how these can be improved and where there are current waste and inefficiencies.

2.2 Case for change

- The current model of adult inpatient care is widely dispersed across Tayside. It is resource intensive with NHS Tayside having a far higher spend and higher staffing levels per head of population in inpatient services than all other Boards in Scotland. This inhibits our Mental Health and Learning Disability services to further develop and implement a 'whole system' approach in line with the national strategic objectives that focus greater emphasis on community based support for patients and carers.

- As a consequence of significant workforce challenges, the current configuration of clinical inpatient services is no longer sustainable. The current service model is introducing significant risks to the provision of safe effective patient care that must be addressed urgently. NHS Tayside is experiencing the impact of a national shortage of Mental Health specialist clinical staff. Shortages of both Medical and Nursing workforce are particularly acute in Tayside though there are similar issues experienced across Scotland, particularly in more remote and rural areas. The workforce profile is ageing with early retirement opportunities for Mental Health employees affecting a large proportion of more experienced staff. The twice yearly out-turn of Newly Qualified Practitioners is insufficient to match the projected numbers of people leaving the service. Tayside is competing with other Health Boards/Countries for a finite pool of staff. Like many areas in Scotland, National and Local Shortages of Junior and Senior Medical staff and Registered Mental Health Nurses are driving redesign. It is projected from staffing age profiles that within the next 5 years Mental Health and Learning Disability services will see retirements in current Nursing workforce of circa 35% and 24% of the substantive Consultant workforce (13 out of 54) are either at retirement age or expected to retire within the next 5 years. Ten locums are currently employed out of a total of 64 consultants across Tayside Mental Health and Learning Disability services.

- The current model for Learning Disability services is incapable of supporting person-centred care, rehabilitation and enablement. The poor quality of the environments from which services are provided are preventing delivery of services that meet the needs of some of our most complex patients.

2.2.1 In line with the Mental Health Service Redesign Transformation Programme's aims and objectives there is a need to provide:

- Models of care which support safe, effective and person-centred care and treatment across community and hospital mental health and learning disability services that focus on prevention of admission and timely supported discharge
- A shift in the balance to primary and community care and care at home.
- Hospital services that are designed to provide interventions and care that can only be delivered in an inpatient facility. (94% of people who access secondary care mental health services each year do so in the community)
- Models of care that ensure equity of access to services across Tayside

- Service models that support safe, effective and sustainable deployment of staff across Tayside
- Best Value and optimal use of resources to ensure that services are provided from flexible, fit for purpose, patient focussed facilities. Opportunities to disinvest in outdated estates and capital assets to reinvest in patient care.
- Effective recovery through close collaborative and co-productive relationships with family, carers and supporting community groups/organisations that complement statutory services.
- An environment that supports clinically effective and safe services
- A values based culture that promotes innovation in practice and enables staff to maximise their potential.
- A pleasant physical environment that promotes health and wellbeing
- Opportunities to redesign the patient pathway through care to improve patient experience, reduce length of stay and maximise use of scarce resources

To achieve this NHS Tayside and the IJBs must develop future service models for General Adult Mental Health and Learning Disability that will meet the requirements of patient safety and service sustainability, within the constraints of workforce availability and financial affordability.

As well as improving patient environments, NHS Tayside must make best use of existing PFI/NPD buildings and dispose of surplus property that is no longer fit for purpose or able to provide appropriate accommodation to deliver modern healthcare.

2.2.2 Current and future challenges to be addressed by the MHSR Transformation programme.

- Significant current and anticipated workforce shortages impacting on recruitment and retention of staff across all staffing groups
- Known age profile of current workforce across Mental Health and Learning disability services and anticipated retirements over the next 5 years
- Early retirement opportunities for Mental Health (staff can retire at 55)
- Requirement to optimise and balance available resources (staff, buildings and supplies are deployed as effectively, efficiently and fairly as possible)
- Redress the current weighting of resource envelope towards specialist inpatient services by shifting the balance of care to provide more community based services to reach the majority of population requiring services.
- Reduce variation in clinical practice across Mental Health and Learning Disability inpatient services in Tayside. (currently creates differences in service provision experienced by service users and their families)
- Providing safe services to as close to the service users home as possible, for communities living in both rural/remote and urban/deprived areas.

The Option Appraisal is a major step towards delivering this strategic vision to create sustainable, high quality safe, effective care and treatment through making best use of workforce skills and the resources at their disposal.

Although the Option Appraisal has focussed on inpatient service provision for adult mental health and learning disability, effective clinical services depend on a number of factors; effective prevention; support for recovery; timely return to living at home following hospital treatment, social inclusion and access to a range of supports in the wider community that maintain and promote health and well being.

Furthermore, effective treatment and recovery from mental ill health and optimum functioning and quality of life for people with learning disability is not solely determined by clinical interventions. The supports and opportunities required for people to regain and sustain mental well-being and fulfilling lives, lie within families, carer networks and local communities who are supported by a wide range of services and organisations.

To access and benefit from these services in future, care and treatment will be delivered through interagency collaboration. Individuals will move within communities through primary care, social care and housing services, voluntary organisations and a range of independent and private sector providers. The alignment of Mental Health and Learning Disability services with Health and Social Care Partnerships will improve the approach to service planning and delivery.

3. SCOPE OF THE STRATEGIC REVIEW

The Mental Health Service Redesign Transformation Programme was commissioned by NHS Tayside in partnership with the three local Integration Joint Boards to review Mental Health General Adult Psychiatry and Learning Disability services across Tayside.

This review includes inpatient services currently being provided from:

- Murray Royal Hospital in Perth
- Carseview Centre in Dundee
- Susan Carnegie Centre on Stracathro site near Brechin, Angus
- Strathmartine Centre in Dundee

The review will look at General Adult and Learning Disability service models for delivery of inpatient and community based care to the population of Tayside aged between 18 and 65 (circa 250,000).

4. WHAT DECISIONS HAVE ALREADY BEEN MADE?

NHS Tayside currently provides inpatient services for GAP acute admissions in three separate sites and Learning Disability services from two sites and across three Integration Joint Board structures and through hosting arrangements.

In 2014/15 an initial option appraisal was undertaken to review the sustainability of services, the provision of care in the community, and future inpatient provision. This informed a report presented to NHS Tayside Board on 10th March 2016. At this meeting, the Board approved a proposal to deliver general adult psychiatry acute inpatient services delivered from two sites in Tayside instead of three sites, as currently provided. In March 2016, NHS Tayside Board also requested that further

work was undertaken to consider services being delivered from one single site in Tayside.

The Programme team provided further information to the NHS Tayside Board in April 2016 to share plans for a further option appraisal exercise, describing the approach to be taken to ensure full stakeholder engagement in the process.

The initial finding of the option appraisal exercise and scoring were then presented to NHST Boards and the three Integration Joint Boards through August 2016 to endorse process followed and agree next steps for Programme.

Whilst the focus of the Programme and its review was on inpatient services it was apparent from the outset that this work was would be the first step towards a wider remodelling of mental health services.

An “acute care pathway” refers to the route that a person would take whilst being cared for from initial presentation with an acute mental health problem, to their ultimate discharge to care in the community or in their own home. This is as relevant to patients with a Learning Disability as it is for all other patients.

Such a pathway requires a range of different services and good links between them. Designing and implementing such a pathway is beyond the scope of this review.

However once the preferred options for inpatient units are defined, it will then be possible to look at options around creating acute care pathways which are more responsive to the needs of patients and their carers. During the public and staff engagement undertaken to date this was raised frequently as a key issue for discussion and had universal support.

5. PREVIOUS INVOLVEMENT AND ENGAGEMENT ACTIVITIES

The Mental Health Service Redesign Transformation Programme team recognises the strength of public opinion around our Mental Health services in Tayside which has been evident throughout the process and in all engagement activities. The programme has held two option appraisal workshops and two subsequent option modelling events which have included representation from a wider range of stakeholders which included service users, carers, third sector and voluntary organisations as well as staff and other statutory services. In addition several information sharing and presentations have been undertaken across Tayside over the last two years. The Programme’s communication and engagement team are committed to learning from early experiences and ensuring the process for the review involves as many of the above noted key stakeholders as possible in each stage of the process in an open and transparent way to ensure build of trust and more likelihood of meaningful engagement. The programme is committed to engaging and valuing the input received from all stakeholder groups. All engagement activity undertaken to date is recorded in the communication and engagement plan for the programme and is attached in Appendix Three and the plan for the consultation period is attached with this report as a separate paper.

6. DUTY TO INVOLVE AND MAJOR SERVICE CHANGE

NHS Boards in Scotland have a duty to involve people (health service users, patients, staff, member of the public, carers, volunteers and the voluntary organisations they represent) in designing, developing and delivering the health care services they provide for them*. NHS Tayside and the IJBs fully support this approach, and believe that co-production of solutions with service users, carers, the voluntary and third sectors, the wider public and all staff groups is an essential way of building consensus. The involvement process for the Mental Health Service Redesign Programme moving forward will be set out in the draft Consultation Plan discussed in Section 12 and detailed in Appendix Eleven, which will be further developed in partnership with these key stakeholders to agree how they wish to be consulted with and best approach for the particular stakeholder groups (ie, specific needs/ support etc). The Programme is committed to ensuring we engage with as many stakeholders as is possible throughout this process to ensure as many views and opinions can be captured to support NHS Tayside and IJBs make an informed decision on a preferred option. This process has been based on the Scottish Government guidance "Informing, Engaging and Consulting People in developing Health and Community Care Services.** The National Standards for Community Engagement will also be used to support the process.

*NHS Reform (Scotland) Act 2004
** www.sehd.scot.nhs.uk/mels/CEL2010_04.pdf

Although national guidance does not define major service change, the MHSRT Programme team have completed the Scottish Health Council (SHC) checklist/major service change template and has agreed that there is the potential for the options being considered in the review to lead to major service change and as such are following the associated principles of engagement and subsequent planning for consultation period as outlined in draft plan in section 12. The national guidance also states that in these cases the Board should continue to seek further advice from the Scottish Government Health Department (SGHD).

The MHSRT programme director and the communication and engagement team have regular contact and meetings with both representation from the SHC and SGHD.

7. PROCESS FOLLOWED

In the absence of National guidance for joint service planning across NHS Boards and Health and Social Care Integration Joint Boards, the updated Scottish Capital Investment Manual Guidance (2015) has been followed to establish the stages to be followed for service changes such as those being considered under this programme of work. In addition, guidance has been sought from the Scottish Government to ensure clarity of the expected process. The content and detail of the attached Option Appraisal report was noted by the Scottish Government to be of an extremely high standard. In addition the Scottish Health Council have been involved in the process and present at Option Appraisal events and have provided subsequent letter of support regarding process undertaken to date.

The Option Appraisal Report attached at Appendix Four describes in full the process that has been undertaken to identify and present options for the reconfiguration of GAP inpatient services to be provided from either a single site or two sites in Tayside and options for the future configuration of learning disability inpatient services.

Board members are directed to the attached paper for the detailed description, content and outcome of the Option Appraisal and the associated appendices.

8. DESCRIPTION OF CURRENT SERVICES

8.1 Bed Types

8.11 Acute Adult Inpatient Care

Acute psychiatric inpatient services are provided to deliver a high standard of treatment and care in a safe and therapeutic setting for patients in the most acute and vulnerable stage of mental illness, and whose circumstances or acute care needs are such that they cannot, at that time, be treated and supported appropriately at home or in an alternative, less restrictive setting (The Commission on Acute Psychiatric Inpatient Care, 2015)

An inpatient service is defined as a unit with 'hospital beds' that provides 24-hour nursing care (as opposed to residential care beds). Many patients are informal but the service must be able to care for patients detained under the Mental Health (Care & Treatment) (Scotland) Act, with Section 22 approved psychiatrist(s) appointed as Responsible Medical Officer for all patients admitted. The service must be able to offer same-day admission at any time of day or night.

All units / patients should have access to the full range of skills of the multi-professional team. In order to provide evidence-based care a full range of disciplines should be available including doctors, nurses, pharmacists, psychologists, occupational therapists, physiotherapists, dieticians, speech and language therapists, support staff, advocacy, mental health officers, spiritual care and social work and care colleagues. Not all patients will require all these disciplines to be involved in their care, but they do need to be available for those patients who have particular needs.

People should be treated in an inpatient setting only when their illness cannot be managed by either GPs in Primary Care or by mental health teams based in the community (including Crisis Resolution and Intensive Home Treatment Teams). At the point of needing to be treated in hospital, patients are often in crisis, afraid and vulnerable. In many cases they will be at risk of self- harm or suicide, and have significant needs which can only be met via the concentration of specialised resources that an inpatient setting will offer (Joint Commissioning Panel for Mental Health, 2013). Therapeutic activity and intervention is a key component of treatment and recovery.

Admission should be based on severity of the symptoms of illness and the associated risks that result due to those symptoms rather than the specific diagnosis itself.

Approximately **only 6%** of people who access secondary care mental health services each year, need to access care within inpatient services. 94% of the population access service in the community.

There needs to be a close relationship with Crisis Resolution and Home Treatment Service as this is the access route to Acute Adult Inpatient Services.

For those patients who are admitted to hospital for short term crisis alleviation, there needs to be active and early supported discharge facilitated through the CRHTT to ensure when safe to do so, these patients are supported to return to community living.

8.12 Intensive Psychiatric Care Unit (IPCU)

IPCU provides care for patients who cannot be managed safely on an acute ward. The ward is locked and entry and exit of patients and visitors is controlled. Staffing levels are of a higher patient: staff ratio than on an acute adult inpatient ward. Patients have access to the range of disciplines as they would in an acute adult inpatient admission ward.

The IPCU generally receives patients who cannot be managed on the acute inpatient wards due to the level of risk the patient poses to themselves or to others. Occasionally patients may also be referred from rehabilitation wards or from the courts. Admission to the IPCU is usually due to an acute or florid exacerbation of a patient's existing condition or it can be during a person's very first episode of illness. There is often a corresponding increase in risk to themselves or others, which does not enable their safe, therapeutic management and treatment in an acute ward.

The IPCU is a small unit with lower levels of stimulation that provides intensive care for patients across all localities and services. Patient's length of stay is normally short, ranging from a few days to a few weeks, depending on the patient's needs. Occasionally patients with very complex needs coupled with difficult behavioural aspects will be in IPCU for longer than a few weeks.

IPCU should not be located on an isolated site; it needs to be co-located with other psychiatric ward(s) due to occasional requirements for additional staffing support at very short notice. It must be able to accept patients any time of day or night. Patients in IPCU will usually be detained under mental health or criminal procedures legislation. There is therefore regular input from MHOs and Advocacy services required.

A patient would not normally have authorised time out from an IPCU. Low stimulus diversional activities are a key aspect of treatment. As the patients starts to respond to treatment they are usually returned to the acute inpatient ward or rehabilitation ward as soon as their risk has reduced and difficult behaviours settle, to enable them to engage in a mix of more psychological and therapeutic interventions to support recovery before discharge to community. In some complex cases they will require a period of Rehabilitation treatment and preparation before being discharged to community care.

8.13 Rehabilitation and Complex Care Services

Rehabilitation units are provided for adults with severe and enduring mental health problems who have ongoing symptoms and functional impairments and cannot manage independent community living, even with support. At any time, around 1 % of people with schizophrenia receive inpatient rehabilitation. Delayed recovery may be due to treatment resistance, cognitive impairment, severe negative symptoms, co-morbid physical long-term conditions (such as diabetes, pulmonary disease) substance misuse and challenging behaviours.

This service is required for a relatively small group of patients but, with such complex mental health needs and lengthy admissions, associated costs are high. There is good evidence that with suitable rehabilitation even those with the most complex needs can progress to supported community living.

The units accept referrals direct from acute admission wards and from forensic mental health services and are planned (i.e. they would not normally happen as an emergency OOHs). The aim of treatment is to develop skills for a successful return to community living with appropriate support. Community-based units provide a more homely environment than hospital-based units and usually support clients to carry out domestic tasks, whereas these tasks are performed for clients in hospital units. The expected usual length of stay should be one to two years, however in some cases length of stay can be longer.

It is essential that patients who need this type of hospital care can access it as soon as they are ready to ensure they can receive appropriate intervention to support their recovery. Access to rehabilitation is also essential to prevent acute admission wards from having ‘blocked beds’ thus preventing people with acute illness getting into hospital when they need to or having patients cared for in excessive levels of security in low secure services (this can be legally challenged by patients).

Time out of hospital to support ‘testing out’ of living skills, problem solving and resilience building is a component part of treatment therefore patients need to be able to be supported to access community based facilities and resources to support their recovery and rehabilitation. Most patients from this service will require robust packages of care in the community after discharge, either in supported accommodation (usually purchased through local authority commissioning and provided by third sector organisations) or in their own tenancy with ‘wrap around’ care.

8.14 Learning Disability

People with learning disabilities (LD) have a significant lifelong condition that begins before adulthood and affects their development. They need appropriate and additional support to access information, learn skills, and live as independently as possible. About 16,000 school-aged children and young people, and 26,000 adults in Scotland live with a learning disability that requires a range of support. There are more boys and men with LD than girls and women, although at older ages the gender distribution equalises, as women generally live longer. Population statistics suggest that 6 people in every 1,000 in Scotland have a Learning Disability. In

Tayside, this rate rises to 9.2/1,000 (1,132 adults) in Dundee, drops to 5.5/1,000 (525 adults) in Angus and 3.9/1,000 (479 adults) in Perth and Kinross.

As with adult mental health, it is important to consider all Learning Disability in-patient beds as a whole pathway. Although the aim is for all patients to move through to the community, it has to be recognised that not all will move at a predetermined pace all the way through the care pathway. For patients who stay in hospital for long periods, there should be demonstrable evidence of ongoing therapeutic input. This will include psychiatric input, nursing care, pharmacist, availability of psychological therapy, occupational therapy, physiotherapy, speech and language therapy, rehabilitation activities that include educational and vocational opportunities, and supervised or independent access to the community (Royal College of Psychiatrists, Faculty Report FR/ID/03 July 2013).

8.15 Learning Disability Assessment Unit

These are acute admission beds in specialist learning disability unit. This clinical service model is intended for the assessment and treatment of patients with Learning Disability and severe mental health and/or behavioural problems, of an intensity which poses a risk that cannot be safely managed in a community setting, while not meeting the risk threshold to be considered for a forensic bed.

Treatment is provided by specialist staff that have experience and skills in the mental health of people with learning disability. The unit should be particularly suitable for those with learning or developmental disadvantage allowing people with learning disability and mental health or behavioural difficulties to achieve the same equity of outcome as others with the same mental disorders.

Clinical presentations are usually a complex mix of learning disability, mental illnesses and other developmental disorders. The natural course of these mental disorders suggests that there may be both crisis situations and situations where symptoms or behavioural disturbance persist in spite of adequate treatment. During those times, they need a safe setting with professionally qualified staff who can treat them.

For some people who present with challenging behaviour, physical and mental health issues are intricately linked with each other and often it can be difficult to tease out whether the presentation is because of an underlying organic (physical) condition. In many of these complex presentations, continuous nursing observation, physical investigations, medical and psychiatric expertise may be needed within an in-patient setting for an accurate diagnosis and effective treatment.

8.16 Learning Disability Forensic Rehabilitation (Open LD Forensic)

This service is for people who have ‘stepped down’ from low secure forensic units with enduring issues of risky behaviours. Their legal status and current risk assessments still emphasise the need for ongoing therapeutic input and robust external supervision for the protection of the public. The availability of these hospital beds, often in locked or open community units, allows them to receive treatment in a less restrictive setting.

8.17 Learning Disability Complex Continuing Care and Rehabilitation (Behavioural Support & Intervention)

This service model is for people who have undergone the initial acute assessment and treatment but for a variety of reasons, including enduring mental illnesses or severe behavioural problems that have not responded adequately to treatment, ongoing risks arising from neglect or vulnerability or persisting risks to the safety of others, a safe transition into the community has not been possible. Persistent challenging behaviour, which poses a level of risk that is unmanageable in a community setting, may be the manifestation of some other underlying mental health difficulty that requires careful assessment and treatment in the safe setting of an in-patient resource.

The availability of these beds allows a process of rehabilitation and re-skilling in a safe, structured and therapeutic environment at a pace that patients can tolerate, and minimises the risk of 'revolving-door' patterns of hospital admissions to the Learning Disability Assessment Unit.

8.18 Forensic services

Forensic mental health services locally include North of Scotland Regional Medium Secure Unit (32 beds) and Tayside Low Secure Unit (35 beds) and a Tayside wide Forensic Community Mental Health Team. Forensic mental health services are provided for individuals with a mental disorder who because of their mental disorder present a risk of harm to others. This because of the need for specialist assessment of patients who may be awaiting trial or where the seriousness of the offence or risk of harm requires additional monitoring, supervision and treatment which is not provided by General Adult Psychiatry services.

Low secure units mainly form a rehabilitation function to plan and facilitate the safe discharge of patient into the community. The care and treatment for non LD and LD patient has the same aim but due to the differences in the nature of the mental disorders there is a significant difference in what care and treatment is delivered and how this is delivered.

Staff working in these settings are of the same disciplines as those required for adult inpatient services but they have knowledge, skills and experience specific to providing robust risk assessment, risk management which uniforms care and treatment in a secure environment.

8.2 Community Services

Community Services are delivered in clinics and people's homes across Tayside. IJB commission a number of third sector organisations to provide carer support, promote independent advocacy, empower service users in local and strategic planning and deliver employment services for people with mental health conditions.

Specialist supported accommodation is provided for people with severe and enduring mental health problems and to those with learning disabilities.

Adult Psychological Therapies Services assess and treat the following conditions: Mild to moderate depression, bulimia nervosa with no physical complications, panic disorder, generalised anxiety disorder, agoraphobia, specific phobia, social phobia, post-traumatic stress disorder, obsessive compulsive disorder and other psychological disorders where the presenting problem is likely to respond to brief psychological treatment

Multi-Disciplinary Community Mental Health Teams manage the following conditions: Severe and persistent mental disorders with significant effects on day to day functioning. This will predominately be people with psychotic illness such as schizophrenia, bipolar disorder and other types of psychosis, other long term non-psychotic disorders which require care and treatment that require a level of support and expertise that cannot be delivered by the primary care team alone, any disorder where there is also a significant risk of self harm, harm to others or risk of suicide and severe Personality Disorder where these can be shown to benefit from a care package involving secondary care.

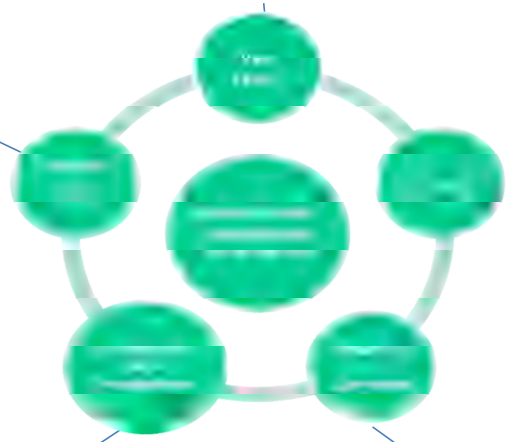
Learning disability resource centres, enablement, health & wellbeing and college support, employment schemes, befriending projects all support people to maximise their outcomes.

The Health and Wellbeing Poster attached below highlights an example of good practice and meets the outcomes outlined in the national Mental Health Strategy

Mental Health & Wellbeing Nurse in Primary Care

Time limited option with GP
Delayed assessment and early intervention
Delayed treatment
Lack of awareness of alternatives to meet individual needs
Inappropriate referrals
Referral to wrong service
Overprescribing of antidepressants
Increased unnecessary demand on statutory services
Over reliance on statutory services
Under use of self management and third sector services

Measures
Satisfaction feedback of service
CARE Questionnaire
% of referrals to statutory services
% of referrals to self management/third sector
Staff and patient narrative feedback
% of medication requests



Raised awareness of local population self management needs
Clear CMHT Pathway to meet early intervention to crisis management
Delivers on the national health and wellbeing outcomes
Spread to other GP Practices

Standard operating procedure in place
Appropriate referral to right agency at right time
Early intervention and preventions
No waiting list –pre-booked slots

Appropriate use of prescribed medication
Raised awareness to mental health and wellbeing within GP practices
Appropriate referrals to statutory services
Increased capacity and reduced demand on statutory services
Improved understanding of self management for individuals
Improved awareness of third sector services
Improved awareness of self help and self management options

Seen by same skilled Nurse every time
Timely signposting to meet individuals needs
Timely referrals to appropriate services

8.3 Current Service provision

NHS Tayside currently provides General Adult Psychiatry acute admission inpatient beds are provided from three sites in Tayside:

- Mulberry Ward in Susan Carnegie Centre, in Stracathro, Angus, (25 beds)
- Moredun Ward in Murray Royal Hospital, in Perth (24 beds)
- Ward One and Decant Ward in Carseview Centre in Dundee (40 beds plus 4 Advanced Intervention Service (AIS) Beds)

In addition to GAP acute admission, Tayside wide GAP services for Complex Continuing Care and Rehabilitation, Tayside wide Substance Misuse services, Tayside wide Low Secure Services and Regional Medium Secure Forensic services are provided from Murray Royal Hospital in Perth and Tayside Wide GAP IPCU beds in the Carseview Centre, Dundee.

The Carseview site requires refurbishment and improvements as set out in the original Adult Mental Health Review Outline Business Case approved in 2005/06. The refurbishment of the site was originally suspended when the building owner of the PFI site went into administration and then reinstated in 2011 to review potential movement of Psychiatry of Old Age services from Royal Dundee Liff site in Dundee. Further internal reviews regarding building utilisation of the site were then undertaken and a subsequent review of Tayside wide IPCU service models highlighted a requirement for a review of all GAP care pathways and future utilisation/refurbishment requirements. A resource previously earmarked for the refurbishment of the site has been discussed with Scottish Government and will now be subject to the SCIM approval process following option approval.

Tayside wide Learning Disability Assessment Unit inpatient beds are provided from the Carseview Centre, Dundee and Tayside wide open and locked forensic Learning Disability inpatient beds and Behavioural Support and Intervention inpatient beds are provided on the Strathmartine site, Dundee.

The Strathmartine site is an ageing estate with significant backlog maintenance requirements and is unable to be further refurbished/redesigned to provide modern single bedroom en-suite healthcare facilities. Whilst such environments do not stop Learning Disability services from providing high quality care, operating from these buildings continually force these services to make compromises. These can compromise on the dignity and respect of the service users looked after at incredibly vulnerable times in life. These compromises also can impact on the efficiency of services and compromise on the motivation of staff by demanding their very highest standards whilst asking them to work in an environment known to be difficult.

Services for Psychiatry of Old Age are also provided from Whitehills Community Care Centre and Susan Carnegie Centre in Angus, Murray Royal Hospital in Perth and Kingsway Care Centre in Dundee.

Current inpatient beds are supported by a range of varying levels of community support through community mental health teams, outpatient clinics, day services, assertive outreach, rehabilitation teams, crisis response and home treatment teams as well as interventions from multi disciplinary professionals such as Allied Health Professionals and Psychology services described above. The majority of service users are supported within the community through access to third sector and voluntary organisations and contact with General Practice.

8.4 Review of Current Medical Workforce Position

8.4.1 Consultants in General Psychiatry

14 General Adult Psychiatry consultants are employed on a regional basis to work in Angus, Dundee or Perth & Kinross. Inpatient consultant responsibility is organised differently in the three hospital sites

- Stracathro Hospital has one consultant working an inpatient only job plan with sessional input from a community based consultant. Cover for periods of leave for the inpatient only consultant is provided by colleagues working in the community
- Carseview Centre has five consultants covering the two inpatient wards. They have job plans which are split between inpatient and community work. Cross cover is provided by other consultants with inpatient responsibility.
- Moredun ward, Murray Royal Hospital is covered by a single consultant and cover for leave is provided by community consultants to their own sector patients
- Rehabilitation Psychiatry is based at Murray Royal Hospital and is covered by two consultants who cover each other.

There are Ten Locums currently employed across all Mental Health services. Seven locum consultants are currently employed within GAP services as follows

- In Angus two locums work in the Community Mental Health Teams (CMHTs) in Arbroath.
- In Dundee one locum works in both the Intensive Psychiatric Care Unit (IPCU) and instead of providing ward cover is now providing medical cover for the Crisis Response Home Treatment Team (CRHTT). The two other locum consultants work in CMHTs.
- In Perth & Kinross one locum works in the Moredun Ward, Murray Royal Hospital (MRH) and one in the North East Perthshire CMHT.

There are only three Higher Trainees in General Psychiatry at present in NHS Tayside which is not sufficient to meet this need even if all three wished to work in Tayside. The position nationally is similar with fewer trainees completing training than the number of vacant consultant posts.

Options of overseas recruitment have been explored in the past with no result but this option is again being looked at.

8.42 Consultants in Psychiatry of Learning Disability

There are three consultant psychiatrists working in the Learning Disability service. A long term full time vacancy exists and despite advertising it has not been possible to recruit to this post due to no applicants coming forward. This is filled with a long term locum by reconfiguring consultant job plans and having a SAS doctor work in the consultant role. This means the service is reduced in SAS provision as it has not been possible to fill that position with a locum most of the time.

It may be possible to recruit a local Higher Trainee to this post in the next couple of years but there are unfilled consultant posts nationally with insufficient number of trainees to meet this need.

8.43 Consultants in Forensic Psychiatry

Since 2012 the service has been able to recruit 4 new consultants to fill vacant posts which have arisen over that time due to retirement and resignation.

NHS Tayside funds three consultant posts to cover the low secure unit at Rohallion Clinic, Murray Royal Hospital, the Forensic CMHT and visiting psychiatrist sessions to HMP Perth and HMP Castle Huntly. These posts are all filled with substantive consultant appointments.

The North of Scotland consortium of health boards funds three consultant posts to cover the regional medium secure unit (MSU) at Rohallion Clinic. These posts involve significant amounts of travel across Scotland to other secure units and prisons. It has never been possible to recruit to one of these posts.

Over the past five years vacancies in consultant posts have been mitigated by various measures such as Higher Trainees employed on three month acting up positions, employing a long term locum for 12 months, a Service Level Agreement with the State Hospital for two years and most recently a retired consultant appointed on a part time basis to the MSU.

Sourcing locum consultants with the necessary knowledge and experience to work in the MSU is not easy. As a result the workload is being covered by the other consultants.

There are no Higher Trainees in Scotland who will be likely to apply for such a post until February 2018 at the earliest. It is planned to readvertise the post this summer but it is not encouraging that NHS Fife advertised a post working in a LSU within the past two months and received no applicants.

8.44 Future consultant numbers

Employing locum consultants does mitigate the impact on service delivery for services and provides safe patient care. However it can be unsettling to patients, carers and multidisciplinary teams because of problems with continuity of care. It is also a significant cost to NHS Tayside.

It should be highlighted that the locum consultants employed in Moredun ward and IPCU are both providing leadership in service development and a high level of patient care. Unfortunately both consultants, for personal reasons, will leave their posts in the next 6 to12 months. It is anticipated that other locum consultants will be employed and there are plans to reconfigure the post in IPCU and CRHTT to improve the chance of this.

Services are looking at their medical workforce plans to identify how they can maintain current level of service without the need for locum consultants and make vacant posts more attractive to potential applicants.

Reorganisation of consultant posts with inpatient responsibility could, in some of the options, release some consultant sessions. However these may be required to be invested in CMHTs and/or CRHTT to help prevent admission and support early discharge.

- This has already happened to an extent with the implementation of the contingency plan in February 2017 there was a move from 25 to 20 beds in Mulberry which freed up 2 DCC PA. These are being used to provide enhanced CMHT functions in Arbroath/Carnoustie and Monifieth.

- Also when medical cover to the Angus CRHTT made the service unsustainable in recent years 1 consultant PA was transferred to the Forfar and Montrose consultants to provide enhanced CMHT functions.

As described above there is no short term solution to consultant vacancies within the Higher Training schemes. Numbers of Higher Trainees are set nationally and recruitment is also national which makes it impossible for individual boards to have much influence over this.

The position is predicted to become worse with retirement rates greater than recruitment rates for the past couple of years. It will be some years until the cohort of consultants eligible for Mental Health Officer status have all retired.

24% of the substantive Consultant workforce (13 out of 54) are either at retirement age or expected to retire within the next 5 years.

8.45 Non consultant grade staff

NHS Tayside employs 11 SAS doctors. Two work in General Psychiatry, three in Learning Disability and three in Forensic Psychiatry. The other three work in Child and Adolescent Mental Health Services.

These doctors provide valuable service delivery but anecdotally it is very difficult to recruit to these posts. This may be due to the ready availability of higher paid locum work. In general SAS doctors are more likely to work less than full time.

In the medical workforce plan for Forensic Psychiatry there is an allocation for three whole time equivalent (wte) SAS doctors to cover the MSU. This recognised that no doctors in training would be allocated to the MSU to support

the consultants. It has only been possible to recruit to 2.0 wte. However the underspend has allowed the service to employ sessions from a General Practitioner to provide primary care across the inpatient service.

In 2016 the Forensic service offered part of its medical budget to employ an additional Physician Associate as part of NHS Tayside's Physician Associate Programme. Since September 2016 one Physician Associate has been working in the MSU. This has been a positive experience for all. Due to the limited training the Physician Associates get in psychiatry during their course their role appears mainly in providing primary care and physical health issues. There could be scope for other services to explore this option if NHS Tayside intends to employ an increased number of Physician Associates.

8.46 Doctors in training

The traditional model of doctors in training providing a substantial amount of planned care and service delivery out of hours appears unsustainable. This is largely due to insufficient numbers of doctors able to work out of hours rotas across three hospital sites but also because of the need to have a better balance of planned community experience compared to inpatient and emergency work.

Murray Royal Hospital is under scrutiny by the Deanery on behalf of the GMC because of persistent red flags about training and supervision in the National Trainee Survey. The next Deanery visit is in July 2017 to monitor progress on the action plan to remedy concerns. If the hospital is placed in Special Measures by the GMC after this visit and concerns about training remain then it is possible training status will be removed from the hospital This will risk service continuity for Moredun ward in particular but also have significant impact on all subspecialties in the hospital and potentially the out of hours medical cover to other hospital sites.

It requires 32 doctors to staff out of hours rotas across three hospital sites. There is funding for 28 training posts in psychiatry across Tayside. The numbers of trainees and funding is set nationally.

- Three of these posts are Foundation Year 1 doctors who provide limited service and cannot take part in out of hours emergency work.

- Six posts are Foundation Year 2 doctors. These doctors cannot be on a Stracathro Hospital rota because of concern about the support arrangements in the hospital out of hours.

- Nine Core Psychiatry Trainees. Since 2016 Stracathro Hospital has been assessed as an unsuitable training environment for Core Psychiatry Trainees because of the lack of emergency psychiatry experience.

- 10 GP Specialty Trainees. These doctors are organised on a local area basis and gaps in posts in one area are not covered by GP trainees from another area.

8.47 Current Medical Workforce position

NHS Tayside currently has 89 acute General Psychiatry inpatient beds and 10 Intensive Psychiatric Care Unit. There are 4 beds funded separately for the Advanced Intervention Service which are not included in this total or scope of the Review. The 10 IPCU beds are also not affected by any of the options in this appraisal.

The consultant Programmed Activities (PA) for Direct Clinical Care to the 89 inpatient beds (excluding IPCU) are allocated as follows

- Stracathro 10 PA
- Carseview 20 PA
- Moredun 12 PA

Currently the number of consultant PA allocated to cover the inpatient wards is consistent with guidance from the Royal College of Psychiatrist's contained in its report "Safe Patients and High Quality Services. A Guide to Job Descriptions and Job Plans for Consultant Psychiatrists"

Learning Disability:

The Learning Disability service has been unable to recruit following the retirement of a Consultant in 2014. This has been mitigated by reconfiguring consultant job plans and having an Associate Specialist work in a consultant role.

Forensic Psychiatry has also been unable to recruit to a full time consultant post in the regional medium secure unit. Since 2012 the service has been able to recruit 4 new consultants to fill vacant posts due to retirement and resignation. This post in the medium secure unit is funded from regional money but has never been filled since the unit became fully operational.

It is anticipated that over the next two to three years it will be hard to fill these vacancies with trainees who are currently working in Tayside.

These vacant posts reflect the position nationally with difficulty recruiting to substantive posts due to a lack of suitable applicants.

9. OPTIONS CONSIDERED

The full detail of the list of long and short of options is contained within the Option Appraisal report attached at Appendix Four.

The top four options which scored highest from the option appraisal events were:

9.1 Top Four Options

- **Option 3A**

  Single site option for General Adult Psychiatry (GAP) acute admission beds which would relocate current inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit, Stracathro in Angus and Moredun Ward in Murray Royal in Perth to be provided from four refurbished wards in the Carseview Centre in Dundee and provide 84 beds for Tayside as per Table Two in section 9.3 below. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

  This option provides a single site option for Learning Disability services which would relocate current inpatient beds from Strathmartine and Carseview sites to a refurbished combined ward in Murray Royal. This ward will provide inpatient beds for Learning Disability assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

  The vacated Mulberry ward within the Susan Carnegie unit in Stracathro, Angus would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

- **Option 4A**

  Two site option for GAP acute admission inpatient beds with relocation of current inpatient beds provided in the Moredun Ward in Murray Royal in Perth to a refurbished ward in the Carseview Centre in Dundee. This option will continue to provide GAP acute admission inpatient beds in the Mulberry ward, Susan Carnegie Unit, Stracathro, Angus and from existing

GAP acute admission inpatient beds in the Carseview Centre in Dundee and provide 87 beds for Tayside.. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability services which would relocate current inpatient beds from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Moredun ward within the Murray Royal hospital site would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

- **Option 5A**

Two site option for GAP acute admission inpatient beds which would relocate current inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit, Stracathro, Angus, to a refurbished ward in the Carseview Centre in Dundee. This option will continue to provide GAP acute admission inpatient beds in the Moredun Ward on Murray Royal site in Perth and from existing GAP acute admission inpatient beds in the Carseview Centre in Dundee. This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

This option provides a two site option for Learning Disability services which would relocate current inpatient beds from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds and also provide a separate open forensic inpatient bed area on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

The vacated Mulberry ward within the Susan Carnegie unit in Stracathro, Angus would then become available for alternative use and subject to further option appraisal. Potential alternative uses which could be considered could be Older Peoples services such as Psychiatry of Old Age or Medicine for Elderly Services.

- **Option 8**

  This option is a new option generated at the Option Appraisal events.

  Single site option for General Adult Psychiatry (GAP) acute admission beds from a single inpatient ward for Tayside for acute assessment on the Carseview centre in Dundee. The inpatient beds provided from the Mulberry Ward in Susan Carnegie Unit, Stracathro in Angus and Moredun Ward in Murray Royal in Perth and in the Carseview Centre in Dundee would then change function to provide step down/treatment inpatient beds for each locality and provide a total of 89 beds (18/22 Acute Admission). This option will also include continued provision of Intensive Psychiatric Care Unit (IPCU) inpatient beds for Tayside from Carseview Centre in Dundee. The Tayside wide Complex care and Rehabilitation inpatient beds will continue to be provided from Amulree and Rannoch Wards in Murray Royal Hospital in Perth.

  This option provides a two site option for Learning Disability inpatient services which would relocate from the Strathmartine site in Dundee to a refurbished combined ward for assessment and behavioural support and intervention beds in one ward and 8 open forensic inpatient beds in a second refurbished ward on the Carseview site in Dundee. Locked Forensic Learning Disability inpatient beds would relocate from Strathmartine site in Dundee to a Low Secure Forensic ward within the Rohallion Clinic on Murray Royal site in Perth.

  Appendix Twelve of the full Option Appraisal Report (attached at Appendix Four) provides further descriptor of other NHS bed provision currently provided around each of these options.

9.2 Option scoring

As the scoring results in Table One below demonstrates the four options scored extremely closely and therefore have been subject to further clinical appraisal, workforce review and financial appraisal of benefits.

Table One – Scoring of Short List option results

Option	Score	Rank
1 – Do Nothing	32811	7
3A	35349	4
3B	33223	6
4A	36146	2
5A	35496	3
5B	33528	5
8	36337	1

Option 8 which was the new model proposed at the workshops scored highest. The chart above demonstrates the proximity of the scores. Having reviewed each of the individual scoring sheets, generally the majority of participants adopted a similar approach to how they allocated the scores. This gives an indication that the general understanding of what each option would deliver was understood by participants.

Please note; due to the scoring system used to capture this information, it was found to be very subjective dependant on how strongly each individual felt about the specific question being posed to them. This threw up many outliers which in turn skewed several of the results up or down. There were a number of scoring sheets which were disproportionately scored. The full spread of tabular scores illustrates this and is provided for background information in Appendix Thirteen of the full Option Appraisal Report attached in Appendix Three.

The two options that scored highest, from the two workshops that were held to facilitate the process, still have services for adult mental health being provided from three sites across Tayside, albeit the acute admissions wards are either on a single site or two sites; and therefore met the criteria requested by NHST Board.

The difference in scoring between the top four options was marginal; therefore the top four scored options have been presented in this paper to ensure the scope requested for a single site or two sites for adult inpatient services is presented and the identification of a preferred option is clear.

10. OPTION COMPARISON

10.1 Option Modelling

Following the option appraisal events held in June 2016 and subsequent reporting of results to NHST Board and the three Integration Joint Boards in August 2016, it was agreed that further option modelling work would be required to support identification of a preferred option which was feasible in terms of clinical safety, sustainability, workforce availability and financial affordability. The Board requested the programme undertake the detailed modelling work with the involvement of key stakeholders to identify a single preferred option to progress an Initial Agreement report and move to period of consultation. Further guidance received from Scottish Government in mid December has advised that the Consultation Period will be required prior to the production of the Initial Agreement Report which is reflected in the revised timeline as shown in section 13.

An option modelling event to review the top four GAP options being considered was held on 29th September 2016. 61 nominations were received through the Integration Joint Boards however 55 were in attendance at event.

It was assumed that the detailed work for Learning Disabilities would be progressed through the Learning Disability work stream set up as part of the Programme. However work did not progress as timeline required or have sufficient representation of stakeholders involved in group. Following positive feedback of the option modelling event held for GAP services and recognition of the wider stakeholders involved in that process, the work stream leads requested a similar approach was required and a subsequent Learning Disability option modelling event was arranged and undertaken on 8th December 2016.

44 nominations were received for the Learning Disability option modelling event on the 8th December 2016 however only 29 attended.

The Option modelling events were facilitated by members of NHS Tayside Service Improvement team at Ninewells and hosted in the Improvement Academy. Both GAP and Learning Disability events followed the same format.

Service user and carer group representatives, clinicians, managers, AHPs, Psychologists, third sector, voluntary organisations and staff side representatives were initially presented with the background to programme and overview of process followed to date, detailed information highlighting the 5 year nursing workforce projection for services, a report on current junior and senior medical workforce issues and an outline of the next steps of the process to be followed

The participants were then separated into four pre-selected groups (membership ensured representation from all locations/clinical groups/third sector were in each group) and allocated an option to consider in the first of four sessions. The facilitators then took each group through discussion to provide identification of the patient pathway for the option and then a series of questions regarding the viability of the option. Each group then moved round to examine the next option and consider the comments of the previous group. This process was repeated four times to cover all options being considered.

As the Learning Disability options had three potential options (Option 4A and Option 5A same for Learning Disabilities) the opportunity was taken to use the fourth session to examine the option of whether the Locked Forensic Learning Disability services could be relocated from Strathmartine Flat One to a low secure ward in the Rohallion unit at Murray Royal in advance of the process as all four options had agreed this move in the option appraisal scoring exercise and would provide significant improvement to current environments for the 6 to 8 patients affected. NHST Board in August had approved in principle the suggestion to relocate these services but requested further information and therefore the fourth session sought to clarify the option, the ability to progress and issues this presented Feedback from the Learning Disability stakeholders who participated in the option modelling event did not feel it was viable to move services in advance of the options being considered, however this has been subject to further challenge and discussion and will continue to be explored with the preferred option.

The Low secure Forensic inpatient service will require to move from three wards to two wards in each of the top four options being considered. This will have implications of how this unit currently operates. The current model for Low Secure makes use of three wards to provide one ward for Assessment and Treatment and two wards for Rehabilitation. A re designation of one ward in the low secure unit will mean a reduction of 50% of rehabilitation beds if the same model of care is used. Other models which can be considered are to provide only rehabilitation with no admissions directly from prison, community or IPCU, or to develop a mixed function of assessment and rehabilitation in one ward which would still allow timely transfer of prisons in particular. This re- organisation could be done relatively quickly given the current patient numbers.

It was the view of senior clinicians and managers in the Forensic Service, that there is a benefit to both Learning Disability patients and staff if this element of the programme could be brought forward in advance of the current programme. Acceleration of the relocation of the locked LD forensic patients will have no impact on other parts of Low Secure Forensic services whichever option is

chosen but will greatly improve the environment for current Learning Disability locked forensic patients.

The patient pathways identified for each option have been demonstrated in flow charts in Appendix Five.

Full reports from these modelling events are included within Appendix Six.

10.2 Review of each option

Each option detailed below is compared to highlight changes from current models, what the option would require to work in practice and the pros and cons of each,

Table Two below highlights the proposed bed numbers for each option being considered:

Table Two – Bed Numbers by options

General Adult Psychiatry	**Current**	**Option 3A**	**Option 4A**	**Option 5A**	**Option 8**
Carseview					
Acute Admission	40	84	62	62	18
Advanced Intervention Service (AIS)	4	4	4	4	4
IPCU	10	10	10	10	10
Acute Step Down beds	-				22
Murray Royal					
Acute Admission	24			24	
Rehabilitation	16	16	16	16	16
Complex Care	10	10	10	10	10
Acute Step Down beds	-	-	-	-	24
Susan Carnegie Unit					
Acute Admission	25		25		
Acute Step Down beds	-				25
Total GAP Beds	**129**	**124**	**127**	**126**	**129**
Learning Disability and Low Secure Forensic	**Current**	**Option 3A**	**Option 4A**	**Option 5A**	**Option 8**
Carseview					
Learning Disability Assessment (LDAU)	10	-	-	-	-
Learning Disability LDAU/Behavioural support & Intervention (BSI)/Open Forensic combined in LDAU area	-	-	22	22	-
Learning Disability LDAU/Behavioural support & Intervention (BSI) combined in					16

LDAU area					
Separate Open Forensic LD					6
Murray Royal					
Learning Disability LDAU/BSI/Open Forensic combined in Acute ward	-	22	-	-	-
Low Secure Forensic	35	25	25	25	25
Locked Low Secure LD	-	10	10	10	10
Strathmartine					
BSI	6	-	-	-	-
Open Forensic	6	-	-	-	-
Locked LD Forensic	10	-	-	-	-
Total LD & Low Secure Forensic Beds	**67**	**57**	**57**	**57**	**57**

The Mental Health Transformation Programme impacts primarily on General Psychiatry, Psychiatry of Learning Disability and the Forensic Mental Health Service. However the consequences of reconfiguring the acute care pathway for General Psychiatry will undoubtedly have implications for other subspecialties medical cover out of hours.

In the options below there are scenarios where it is not guaranteed that safe medical cover can be provided with the current and predicted medical workforce. When balancing the pros and cons of each option it is suggested that this issue is the main priority.

Serious concern exists about the viability of delivering safe medical cover with two of the options below (4A and 8). This is because of problems in the number of doctors in the current and predicted medical workforce.

The subspecialties which are directly affected by the Mental Health Service Redesign Transformation Programme all currently have long term consultant vacancies which will be highly relevant to the implementation of whichever option is chosen.

Options which allow manageable job plans, which have ease of cross cover arrangements and offer the potential for career development will be more likely to be successful in retaining staff and improving the chance of future recruitment.

Options which make the best use of the existing consultant workforce and do not anticipate an increase in consultant numbers are more likely to be sustainable in the longer term.

There is also a persistent issue about insufficient number of doctors in training to deliver both planned and emergency care which is explained in greater detail above and below.

10.3 Option 3A

Option 3A provides a single site option for General Adult Acute Admission inpatient beds from the Carseview Centre in Dundee and a single site option for Learning Disability inpatient services from the Murray Royal site in Perth.

Tayside wide IPCU inpatient beds would continue to be provided from the Carseview Centre in Dundee and the Tayside wide Complex Care & Rehabilitation, Substance Misuse and Low and Medium secure Forensic Services would remain on the Murray Royal site in Perth.

10.3.1 What changes?

Current acute admission inpatient beds provided from both the Mulberry Ward in Susan Carnegie Unit in Angus (25beds) and Moredun Ward in Murray Royal Hospital, Perth (24beds) would relocate to Carseview Centre in Dundee to two refurbished 22 bed wards. Carseview site would therefore provide four acute admission wards (84 beds)

Learning Disability assessment unit inpatient beds on the Carseview Centre, Dundee and the Behavioural Support and Intervention beds on the Strathmartine Centre would relocate into a combined area within the vacated refurbished Moredun Ward at Murray Royal in Perth. Open Forensic Learning Disability beds on the Strathmartine site would also relocate to a separated area within the Moredun Ward at Murray Royal in Perth. Locked Forensic Learning Disability Services would relocate from Strathmartine Centre to a Low Secure Forensic ward on the Rohallion Unit in Murray Royal, Perth

Over the past two years there has been significant shift in how the forensic community patients have been managing dynamic risk factors. Instead of a first response of hospitalisation an approach of supporting and helping patients self manage their risk factors has been successful in reducing re admissions. Closer working with local authorities and housing in particular has brought benefit to patients in discharge planning which have been more successful in keeping patients living in the community. As a consequence 35 inpatient beds have not been required for over 12 months. It is anticipated that this is not a short term situation and there is a genuine reduced demand which brings NHS Tayside more in line with similar services across the country and would allow the accommodation of Learning Disability patients within the clinic.

Low secure Forensic beds for Tayside would therefore reduce current capacity by 10 beds to accommodate Learning Disability beds and provide services from two wards rather than three wards.

10.3.2 What would this model require to work in practice?

This model would require some remodelling and investment within community mental health and learning disability teams and home treatment services to support more care and treatment at home and prevention of admission. The workforce section of this report highlights potential levels of investment which

would be required for both an increase community services and recognition of estimated requirements for additional escort of patients etc.

Learning Disability day treatment services currently provided on Strathmartine site would require to be re-provided either/both from the Murray Royal site or in local community based settings. Current services benefit from workshops/gardens on the Strathmartine site and feedback has identified that these should be replicated. Detailed modelling of how (NHS/Local Authority/Social Enterprise models) and where (each locality/Centralised/beside inpatient beds) these services could be provided will be developed on selection of a preferred option.

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

10.3.3 What are the pros/ impact on service users/carers/staff?

A single site for GAP acute admission inpatient beds and a single site for Learning Disability services would provide the opportunity to reinvest some resources into community and home treatment services across Tayside. This remodelling and reinvestment of services would assist in further shifting the current balance of care towards provision of more treatment closer to or in the service users own home and meet the requirements of almost all strategic drivers. More intensive community services prevent admissions to hospital, improve service user experiences and streamline the pathway into and out of hospital on discharge when they are most acutely unwell. This reinvestment will help people get better closer to home. This will make a very real and lasting difference to the lives of all the people who use mental health and learning disability services

By accommodation of all GAP acute admission and IPCU inpatient wards on one site in Dundee and Learning Disability services on the Murray Royal site with other Tayside wide specialist services, NHS Tayside has the opportunity to create a “Centre of excellence” for both GAP and Learning Disability services on both campuses. The concentration of inpatient staffing resource allows for consistency of approach, improved patient safety, creation of a shared learning/teaching environment and an increase in provision of staffing cover across specialties.

Table Three below highlights a recent study undertaken on 46 Newly Qualified Practitioners (NPQs) geographical and specialty preferences.

Table Three – NQP preferences by location and speciality

Locality	Service	Number of Applicants	% of Total
Dundee	General Adult Psychiatry	18	39.1
	Community	5	10.9
	CAMHS	3	6.5
	Forensic	3	6.5
	Psychiatry of Old Age	2	4.3
	Total	**31**	**67.4**
Perth & Kinross	General Adult Psychiatry	3	6.5
	Forensic	5	10.9
	Psychiatry of Old Age	1	2.2
	TSMS	1 (HNC)	2.2
	Prison Health Service	1	2.2
	Total	**11**	**23.9**
Angus	Community	2	4.3
	Learning Disabilities	1	2.2
	Psychiatry of Old Age	1	2.2
	Total	**4**	**8.7**

As can be seen from the table above, of the 46 current NQPs 67% (31wte) have identified their preference is to work in the Dundee area and almost 40% in Dundee GAP services versus 7% in Perth and 4% in Angus GAP services. Therefore moving forward with a model where the majority of General Adult Psychiatry nurse staffing are required in Dundee area would fit with where NPQs are likely to seek employment when finish training.

As noted in Learning Disability comments below, it has traditionally been harder to recruit to LD nursing in Dundee. Perth is more accessible from the central belt and is more attractive to potential LD and Forensic applicants.

This model would also support improved medical responsiveness; improved training for junior doctors, concentration of on call would further free up trainees for training and other service related tasks and allow for a specialist model of impatient practice to develop.

Possible impact of the option on medical workforce

In this option the numbers of acute General Psychiatry beds reduce from 89 to 84.

Having all acute beds on one site allows for:

- Better consultant cross cover arrangements
- Greater peer support for consultants currently working single handed
- Reduction in variation of practice
- Greater resilience in dealing with vacancies in doctors in training posts through cross cover arrangements.
- The opportunity to look at developing primary care aimed at improving physical health of long term in patients with severe mental illness.
- The opportunity to innovate more non pharmacological approaches to treatment with greater patient numbers to sustain groups

The Royal College of Psychiatrists recommends an allocation of 7.5 DCC PA for 15 to 20 patients. The more complex the case load and higher turnover in patient numbers the more appropriate it is for the figure to be at the lower end of the range. More than 20 patients can be managed by a consultant provided there is additional senior medical support such as a Specialty Doctor or Higher Trainee.

It will be for the General Psychiatry service to develop a model for consultant inpatient work. This may be based on consultants working inpatient only jobs or split community / inpatient posts. Developing manageable job plans which make best use of consultant time may require considering greater flexibility in job plans and the consultant cover not strictly based on community team sectors.

The General Psychiatry acute inpatient wards currently have 42 PA allocated to cover inpatient wards, excluding the IPCU. Using a model of inpatient only post and using the midpoint of the College recommendation then consultant cover to four General Psychiatry wards could potentially be delivered with 36 PA. If the medical budget is used to recruit SAS doctors for the inpatient service rather than locum consultants then the number of consultant sessions could reduce to 32 PA.

All Learning Disability inpatient services are provided at MRH in this option. This allows for:

- Co located wards sharing medical staff and other resources to make better use of medical time.
- A smoother transition between locked secure wards and the open secure wards

There is no reduction in total LD beds from 32. Any savings in LD consultant PA will most likely come from transfer of the LD locked secure service to Forensic.

The model would also allow for a complimentary approach to treatment with more sharing between disciplines and make it easier to deliver the service.

The model would improve skill mix and consistency of care.

The Carseview site is also adjacent to Ninewells Accident and Emergency (A&E) department, which provides emergency medical response to the population of Dundee and Angus and the most complex emergency services to the population of P&K.

The assessment and crisis response services for the population of Dundee and Angus are currently based in Carseview Centre, Dundee from 3pm until 9am daily and 24 hours per day at weekends. Current contingency plans have seen the relocation of assessment and crisis response for Perth and Kinross provided on a temporary basis from Dundee due to current staffing shortages. The assessment and crisis response services provide a gate keeping role for admission to inpatient beds and therefore would be on site at Carseview and prevent service users having to transfer back to localities for admission following assessment during a period of where they are most acutely unwell.

GAP services would benefit from improved refurbished environments at Carseview.

LD services would benefit from significantly improved environments on the newly built Moredun ward and in the purpose built forensic building in the Rohallion Clinic at Murray Royal. The accommodation for these services currently on the Strathmartine site are not fit for purpose and often commented on during Mental Welfare Commission Audit Reviews.

Care and treatment for Learning Disabilities would be delivered in modern and fit for purpose accommodation improving both patient experience and journey whilst enabling staff to be part of specialist secure care services that would promote and facilitate ongoing and continual professional development. This proposal would also alleviate concerns from the mental welfare commission and would meet the standards required for the delivery of learning disability services and its low secure care. There are many benefits associated with this model and it would enable the service to address and meet some of the workforce planning challenges. There is a national shortage of learning disability nurses, most reside within the central belt geographical area, and historically it has been difficult to recruit to the location of Dundee. Perth is more accessible from the central belt and is more attractive to potential applicants. In addition being part of the wider secure care services would enhance recruitment opportunities based on forensic core competencies rather than just learning disability experience

This option, where all Learning Disability inpatient Services are placed in Perth, would enhance and support a step down model for Learning Disability forensic care by having a Learning Disability Open Forensic Ward on site for patients moving out of the Learning Disability Locked Forensic Ward. In addition the Forensic Community LD team could be co-located with the Forensic Community Mental Health Team in Birnam on the Murray Royal Hospital site. The other options being considered spit these services across sites.

This option is consistent with other Board areas across Scotland who have moved to a single site provision for GAP and LD services.

10.3.4 What are the cons/ impact on service users/carers/staff?

Access – the main area of concern raised throughout the process and when considering each of the options for both GAP and LD was the ability to access inpatient beds from the most rural areas within Tayside. Any reduction in the current site provision will mean that service users and their carers/families from north Angus and areas of Perthshire will have an increased distance to travel to access a General Adult Psychiatry acute admission inpatient bed. This option will also impact on Learning Disability service users and their carers/families in Dundee and Angus having an increased distance to travel to Perth for an inpatient stay.

Feedback throughout the process has highlighted the importance of family and carer support and their ability to visit service users when in an inpatient facility provides support and assists recovery.

Current links with Perth Royal Infirmary A&E department liaison may be reduced.

Re-provision of current day treatment was a major concern for LD stakeholders. Day treatment models would need to be developed in conjunction with the three local Integration Joint Boards to provide alternative integrated day treatments which do not necessarily require to be on a hospital site and may be provided in local communities through models such as social enterprises etc.

Links between Learning Disability Inpatient services and Angus and Dundee Learning Disability community services would require to be reviewed in this model.

Forensic Psychology services currently provide group therapy sessions on the Strathmartine site and use the workshop facilities. Due to the small numbers from each area, alternative ways of providing these valuable services will need to be further developed and appropriately resourced during the detailed review of a preferred option.

Increases in the need for rehabilitation beds in a reduced forensic low secure unit has the potential to create a problem in transfer of patients from prison or the medium secure unit. Prisoners would always be prioritised in this situation and it may be that the medium secure unit looks to adapt its model of care. Currently patients in the medium secure unit do not have regular unescorted community access. If the pathway to the low secure unit is slowed due to reduced capacity then it may mean patients remain in the medium secure unit longer than necessary. This could be offset however by adopting models used in the other two medium secure units of allowing regular unescorted community access as part of discharge planning for less complex patients and further mitigated by much improved patient pathways and joint working between Low secure, IPCU, Rehabilitation/Complex Care and GAP services.

The full impact on service users/carers/families will be assessed and monitored as part of the equality Impact assessment to ensure actions are taken to try and mitigate the impact any service change may have. This is an ongoing process

and during consultation on the preferred option, actions taken to reduce impacts will be monitored and evaluated to ensure equity of service provision across Tayside. Solutions required to address any access issues will be explored during this period

Other disadvantages of this option are:

- Disruption to medical staff in relocating their base
- Moving two General Psychiatry wards with accompanying medical and admin staff will place a strain on the already fully occupied accommodation and car parking arrangements.
- Input from consultants working in CMHTs to pre discharge meetings will mean increased travel for those based in Perth & Kinross and Angus. This could be reduced however with the use of video or tele conferencing.

Cross cover – Psychiatry of Old age services in Angus would no longer have the Mulberry Ward onsite to provide emergency cross cover. This would however be on a non recurring basis and require bridging resources to cover until a further option appraisal exercise could be undertaken by the Angus Integration Joint Board to agree utilisation of the vacated Mulberry ward.

10.4 Option 4A

Option 4A provides a two site option for all General Adult Acute Admissions from the Carseview Centre in Dundee and the Mulberry ward in Susan Carnegie Unit, Stracathro, Angus and a two site option for Learning Disability inpatient services from both the Carseview Cente in Dundee and from the Rohallion Clinic on the Murray Royal site in Perth. Carseview site would therefore provide three acute admission wards (62 beds) and one ward on Susan Carnegie Unit (25 beds)

Tayside wide IPCU inpatient beds would continue to be provided from the Carseview Centre in Dundee and the Tayside wide Complex Care & Rehabilitation, Substance Misuse and Low and Medium secure Forensic Services would remain on the Murray Royal site in Perth.

10.4.1 What changes?

Current acute admission inpatient beds provided from the Moredun Ward in Murray Royal Hospital, Perth (24beds) would relocate to a refurbished 22 bed ward in the Carseview Centre, Dundee.

Learning Disability Assessment Unit (LDAU) inpatient beds on the Carseview Centre, Dundee and the Behavioural Support and Intervention beds on the Strathmartine Centre would relocate into a combined area within the current LDAU ward on the Carseview site. Open Forensic Learning Disability beds on the Strathmartine site would also relocate to a separated area within the refurbished LDAU ward on the Carseview site. Locked Forensic Learning Disability Services would relocate from Strathmartine Centre to a Low Secure Forensic ward on the Rohallion Clinic in Murray Royal, Perth

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

10.4.2 What would this option require to work in practice?

This model would require some remodelling and investment within community mental health and learning disability teams and home treatment services to support more care and treatment at home and prevention of admission. The workforce section of this report highlights potential levels of investment required for an increase to community services in Perth to support relocation of beds and in recognition of requirements for escort etc.

Learning Disability day services currently provided on Strathmartine site would require to be re-provided either or both from the Carseview site or in local community based settings.

Low Secure Forensic services will need to provide services from two wards rather than current three ward model. This will mean combining admission and rehabilitation within these areas. A crisis suite will need to be included within one of the wards to ensure provision for crisis is available in both remaining environments.

This option will continue to require medical staffing cover across the three sites (Susan Carnegie, Carseview and Murray Royal).

10.4.3 What are the pros/ impact on service users/carers/staff?

Retention of local beds in Angus was seen as a preferred option for Angus service users/carers/families with reduced travel and access issues for rural North Angus residents.

Some reduction in nursing workforce requirements could be achieved through economies of scale with co-location of three GAP acute admission wards on the Carseview site.

Three GAP acute admission wards on Carseview site would increase ability to cross cover wards.

In this option the General Psychiatry beds at MRH transfer to Carseview Centre and the number of acute beds reduce from 89 to 87. The Mulberry Unit remains at Stracathro Hospital.

It is important to highlight that this option was considered as part of the contingency planning to deal with the reduced number of doctors in training in February 2017. It was not supported because of the inability to provide medical

cover to Stracathro Hospital with a reconfigured rota and the impact on the ability to safely provide medical cover to MRH.

This option however has the advantage of

- Better consultant cross cover arrangements than exist in MRH currently
- Reduction in variation of practice
- It is expected some of the current allocation of doctors in training will transfer to Carseview Centre with the inpatient unit from MRH. This could improve resilience at Carseview in dealing with vacancies in training posts but not Stracathro Hospital.

Retention of LDAU, BSI and Open Forensic Learning Disability services within Dundee provides easier access to services for Angus and Dundee LD service users and links with their current local community LD services.

LD services would benefit from improved environments on a refurbished Carseview site and LD Locked low secure inpatient services in the purpose built forensic building in the Rohallion Clinic at Murray Royal. The accommodation for these services currently on the Strathmartine site are not fit for purpose and often commented on during Mental Welfare Commission Audit Reviews.

10.4.4 What are the cons/ impact on service users/carers/staff?

The option will require continued GAP medical and nursing cover across three sites as although acute admission beds are on two sites (Susan Carnegie and Carseview), the Complex Care and Rehabilitation beds would still require to be provided from Murray Royal in Perth. This option is therefore unsustainable and unsafe given current workforce profiles and future projected staffing levels.

Disadvantages to this option are

- The minimum number of junior doctors to cover the out of hours rota in this option is 32. This is because it requires three sites to be staffed out of hours. It is not anticipated that the number of doctors in training will ever increase close to this number in the future
- Savings as a consequence of job plan review of General Psychiatry consultants in Moredun and Carseview are likely to be minimal as there is only a reduction of two inpatient beds.

This is a two site LD option which has an advantage of
One consultant who works in the LDAU could remain at Carseview Centre

However this model has an increase in bed capacity at Carseview Centre from 10 to 22 with a mixed function of the unit. It is likely this will require more consultant and supporting medical staff input. This will most likely come from staff working in the community or MRH. It is anticipated this will require additional travel and possibly additional consultant PA for this option.

This model was considered to have a negative impact on the patient pathway and would not significantly improve the patient environment; concerns were also noted regarding the ability to respond to patients with complex needs and in order to develop the model further would require a review of the workforce in relation to safe staffing levels.

The model does not fit for training of junior doctors and training status could be placed at risk.

Isolation of single acute admission ward in Angus would continue to require additional staffing levels to provide emergency cover and levels of observation due to environmental challenges in physical layout of ward.

The impact on the Forensic service is described above

This option would also reduce the ability to provide cross cover to the Complex Care and Rehabilitation wards on the Murray Royal site.

This option would mean a split of Learning Disability services for low secure inpatient beds for providing step down as open forensic beds would be on Carseview site and locked forensic beds in the Rohallion Unit in Perth.

Access – The ability to access inpatient beds from the most rural areas within Perth and Kinross is a concern with this option. The relocation of Moredun Ward from Murray Royal to Carseview will mean that service users and their carers/families from some areas within Perth and Kinross will have an additional distance to travel to access an inpatient bed.

Feedback throughout the process has highlighted the importance of family and carer support and ability to visit service users when in an inpatient facility provides support and assists recovery.

Re-provision of current day services was a concern for LD stakeholders. Again Day treatment models could be reviewed and developed in conjunction with the three local Integration Joint Boards to seek alternative day service/provision whether through local NHS/Local authority/Social enterprise models. Forensic Psychology services currently provide group therapy sessions on the Strathmartine site and use the workshop facilities. Due to small numbers from each area, alternative ways of providing these valuable services will need to be further developed and resourced during the detailed review of a preferred option.

Relocation of LD locked forensic services to Rohallion will mean Angus and Dundee LD service users/carers and families will have an excess distance to travel to access an inpatient bed.

10.5 Option 5A

Option 5A provides a two site option for all General Adult Acute Admissions from the Carseview Centre in Dundee and the Moredun ward in Murray Royal Hospital, Perth and a two site option for Learning Disability inpatient services

from both the Carseview Centre in Dundee and from the Rohallion Clinic on the Murray Royal site in Perth. Carseview site would therefore provide three acute admission wards (62 beds) and one ward on Murray Royal site (24 beds)

Tayside wide IPCU inpatient beds would continue to be provided from the Carseview Centre in Dundee and the Tayside wide Complex Care & Rehabilitation, Substance Misuse and Low and Medium secure Forensic Services would remain on the Murray Royal site in Perth.

10.5.1 What changes?

Current acute admission inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit in Angus (25beds) would relocate to a refurbished 22 bed ward in the Carseview Centre, Dundee.

Learning Disability Assessment Unit (LDAU) inpatient beds on the Carseview Centre, Dundee and the Behavioural Support and Intervention beds on the Strathmartine Centre would relocate into a combined area within the current LDAU ward on the Carseview site. Open Forensic Learning Disability beds on the Strathmartine site would also relocate to a separated area within the refurbished LDAU ward on the Carseview site. Locked Forensic Learning Disability Services would relocate from Strathmartine Centre to a Low Secure Forensic ward on the Rohallion Clinic in Murray Royal, Perth.

As noted in option 3A above, Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

10.5.2 What would this option require to work in practice?

This model would require some remodelling and investment within community mental health and learning disability teams and home treatment services to support more care and treatment at home and prevention of admission. The workforce section of this report highlights potential levels of investment which would be required for an increase to community services in Angus which would be required to support relocation of beds and in recognition of requirements for escort etc.

Learning Disability day treatment services currently provided on Strathmartine site would require to be reprovided either or both from the Carseview site or in local community based settings.

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within

one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

This option will require reduced junior medical staffing and nurse cover across two sites (Carseview and Murray Royal), which is more sustainable and safe given current workforce profiles and future projected staffing levels.

10.5.3 What are the pros/ impact on service users/carers/staff?

As above this option can be provided by the forecasted reduced junior medical staffing numbers and nurse staffing cover across two sites (Carseview and Murray Royal), which is more sustainable and safe given current workforce profiles and future projected staffing levels. However current Perth and Kinross GAP acute admission inpatient ward is covered by the use of Locum consultants and as highlighted in the workforce section there is significant risks around use of locums and future Consultant availability.

It was felt that this model was broadly clinically safe and could provide for easier cross cover and better training of junior doctors.

In this option the General Psychiatry beds at Stracathro Hospital transfer to Carseview Centre and the number of acute beds reduce from 89 to 86. This has the advantage of

- Better consultant cross cover arrangements than exist in Stracathro Hospital.
- Reduction in variation of practice
- It is expected some of the current allocation of doctors in training will transfer to Carseview. This could improve resilience at Carseview in dealing with vacancies in training posts but not Stracathro Hospital. This has not been realised however with the implementation of the contingency plan as is only an interim move and therefore Mulberry remains a separate operational unit from a medical perspective.

This is also is a two site LD option identical to 4A with the same implications on medical workforce
Retention of local beds in Perth was seen as a preferred option for Perth and Kinross service users/carers/families. This option would mean a reduction in travel time and improved access issues for rural Perthshire residents.

Some reduction in nursing workforce requirements could be achieved through economies of scale with co-location of three GAP acute admission wards on the Carseview site.

Three GAP acute admission wards on Carseview site would increase ability to cross cover wards.

Retention of LDAU, BSI and open forensic learning disability inpatient services within Dundee provides easier access to services for Angus and Dundee LD service users and links with their current local community LD services.

10.5.4 What are the cons/ impact on service users/carers/staff?

The option will require continued GAP consultant cover across two sites for acute admission beds which is currently sustained in Perth through use of locum Consultant staff. There is therefore a risk as to whether this option is therefore sustainable and safe given current workforce profiles and future projected staffing levels.

Disadvantages to this option appear to be that:

- Savings as a consequence of job plan review of General Psychiatry consultants in the Mulberry Unit and Carseview Centre are likely to be minimal as there is only a reduction of three inpatient beds.

This is also is a two site LD option identical to 4A with the same implications on medical workforce

The single acute admission ward in Perth would continue to require additional staffing levels to provide emergency cover and levels of observation due to environmental challenges in physical layout of Moredun ward.

This option would also reduce the ability to provide cross cover on an interim basis to Psychiatry of Old Age services on the Susan Carnegie site until a further option appraisal was undertaken to utilise the vacated Mulberry ward.

This option would mean a split of Learning Disability services for low secure inpatient beds for providing step down as open forensic beds would be on Carseview site and locked forensic beds in the Rohallion Unit in Perth.

Access – The ability to access inpatient beds from the most rural areas within North Angus is a concern with this option. The relocation of Mulberry Ward from Susan Carnegie to Carseview Centre in Dundee will mean that service users and their carers/families from North Angus will have an excess distance to travel to access an inpatient bed.

Feedback throughout the process has highlighted the importance of family and carer support and ability to visit service users when in an inpatient facility provides support and assists recovery.

Re-provision of current day services was a concern for LD stakeholders Again Day treatment models could be reviewed and developed in conjunction with the three local Integration Joint Boards to seek alternative day service/provision whether through local NHS/Local authority/Social enterprise models. Forensic Psychology services currently provide group therapy sessions on the Strathmartine site and use the workshop facilities. Due to small numbers from each area, alternative ways of providing these valuable services will need to be further developed and resourced during the detailed review of a preferred option.

Relocation of LD locked forensic services to Rohallion Clinic at Murray royal in Perth will mean Angus and Dundee LD service users/carers and families will have an excess distance to travel to access an inpatient bed.

The impact on the Forensic Service is described above

10.6 Option 8

Option 8 provides a single site option for all General Adult Acute Admissions from a single ward on the Carseview Centre in Dundee and a two site option for Learning Disability inpatient services from both the Carseview Cente in Dundee and from the Rohallion Clinic on the Murray Royal site in Perth. Three GAP step down/treatment wards will be provided from Susan Carnegie Centre, Angus, Carseview in Dundee and Murray Royal Hospital in Perth.

Tayside wide IPCU inpatient beds would continue to be provided from the Carseview Centre in Dundee and the Tayside wide Complex Care & Rehabilitation, Substance Misuse and Low and Medium secure Forensic Services would remain on the Murray Royal site in Perth.

10.6.1 What changes?

Current acute admission inpatient beds provided in the Mulberry Ward in Susan Carnegie Unit in Angus (25beds) and Moredun Ward would relocate to a single refurbished 22 bed ward in the Carseview Centre, Dundee. Three step down/treatment wards would be provided from the Mulberry Ward in Susan Carnegie Unit, Angus, Moredun Ward in Murray Royal in Perth and Ward One in Carseview Centre in Dundee.

Carseview would therefore provide one acute admission ward (20/22 beds) plus a step down/treatment ward (20/22beds), a step down/treatment ward on Susan Carnegie Unit (20/25 beds) and a step down/treatment ward on Murray Royal Hospital (26 beds)

Learning Disability assessment unit (LDAU) inpatient beds on the Carseview Centre, Dundee and the Behavioural Support and Intervention beds on the Strathmartine Centre would relocate into a combined area within the current refurbished LDAU ward on the Carseview site. Open Forensic Learning Disability beds on the Strathmartine site would relocate to a separate refurbished Ward Two on the Carseview site. Locked Forensic Learning Disability Services would relocate from Strathmartine Centre to a Low Secure Forensic ward in the Rohallion Clinic in Murray Royal, Perth

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

10.6.2 What would this option require to work in practice?

Acute / Sub-Acute Adult Inpatient Care (Model proposed in Option 8)

This type of service is one that combines Acute Inpatient Care services as described above, with a 'sub acute' service that provides care to people who are moderately less acutely ill, less florid in their presentation, less behaviourally disturbed and or not thought to be at high risk of suicide, but who still require treatment in hospital. There are descriptors from American, Australian and English literature.

In England a National survey of in-patient alternatives to traditional in-patient care (Lloyd-Evans; Johnson, Slade et al, 2010) identified sub acute care units as a variety of small residential units that provide care for patients in crisis and are usually closely geographically located to traditional inpatient care facilities. Australian models are similar to the English models, involving residential care provided in small units, usually by non statutory agencies. In both these models these are usually commissioned services and patients are classed as 'residential' therefore requiring funding allocations from local authority.

An Australian model described step-up step-down residential services for people requiring direct support during a time of crisis. They offer short-term residential support until symptoms have stabilized. Sub-acute, short-term residential mental health services have been developed to provide support and accommodation for people with mental illness in a less restrictive environment than inpatient units, often with a focus on development of skills necessary for successful community living, such as budgeting, domestic and interpersonal skills. These services are not hospitals and cannot care for detained patients; they are designed to provide an alternative to hospital treatment, taking some of the pressure off inpatient units, and comprising a more cost-effective delivery of services in a least restrictive environment (Lloyd-Evans et al., 2009). Step-up step-down units are increasingly being implemented in the Australian mental health system as part of system reforms to better meet the needs of mental health clients. Although the research evidence is limited, several studies have found sub-acute residential units to be effective in providing positive clinical outcomes and they appear to comprise a cost-effective alternative to hospitalization (Thomas & Rickwood, 2013).

In America there are sub acute adult inpatient services funded through healthcare insurance. Admission criteria includes clinical evidence that the patient has a diagnosis of mental illness that is amenable to active psychiatric treatment however they are not sufficiently stable to be treated outside of a highly structured 24- hour therapeutic environment. Patients require nursing supervision and intervention seven days per week, 24 hours per day to remain safe, manage symptoms and develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behaviour that will allow them to return to live in the community.

Patients would not be suitable for sub-acute care if they exhibit a risk to self or others or require enhanced observation and engagement due to disturbed behaviour.

Increased and remodelled home treatment and community services would be required in each locality to support service users for longer in their own home environments and to prevent admission.

Concerns were raised that with Option 8 staff will not be able to see acutely unwell patients getting better, concerns regarding changes of staff teams, and therapeutic relationships with potential for multiple transfers between teams. This also highlighted issues re potential burn out of staff and the ability to manage turnover of staff and skill mix required to sustain this model

The model has a high dependency on good communication.

The option described an optimal length of stay and raised further concerns as to how this was calculated and impact on patient experience in ward if patient where patient population was transient and everyone was acutely unwell

It was felt this model of care could not provide any advantage to the current model of care and could disadvantage patients in relation to continuity of inpatient care.

Option 8 also considers the use of crisis house models in each locality to support step down/treatment

Learning Disability day treatment services currently provided on Strathmartine site would require to be re-provided either or both from the Carseview site or in a community based setting.

Low Secure Forensic services will change to provide services from two wards rather than the current three ward model. There are 10 available beds most weeks but these are spread across the admission and rehabilitation wards. To implement this option it will mean combining admission and rehabilitation within one ward. An additional crisis suite will be required within one of the remaining low secure wards to ensure provision for crisis is available in both remaining environments.

10.6.3 What are the pros/ impact on service users/carers/staff?

Service users would have local bed provision during the step down/treatment phase of their admission.

Staff currently working in local areas could remain in situ.

Retention of LDAU, BSI and open forensic learning disability inpatient services within Dundee provides easier access to services for Angus and Dundee LD service users and links with their current local community LD services. The

provision of LD inpatient beds in two refurbished wards on Carseview site provides increased flexibility and space

The advantage of this model is that the majority of the patient care is delivered locally allowing easier visiting from family and carers. Discharge planning may also be easier and it increases the likelihood CMHT staff can be a practical source of help in this.

This model requires a robust system in place to manage not only capacity but flow through the system. With an acute admission ward and three separate step down units it is predicted there will be a higher turnover of patients and transition of care relatively early in the admission journey of a patient.

It will require a proactive discharge planning otherwise it risks the step down services not being able to take patients from the acute admission ward. As described above this type of model will probably require a higher number of consultant PA to manage the complexity and turnover of patients.

This is also is a two site LD option but with a different configuration of wards to accommodate the step down unit at Carseview Centre. It is anticipated this will have similar implications on the medical workforce as 4A and 5A.

10.6.4 What are the cons/ impact on service users/carers/staff?

There have been two tests of 'Assessment - Treatment' models of acute admission wards and step-down sub acute care wards in NHS Lanarkshire 2008-2009 and in NHS Forth Valley. There were similar experiences in both Board areas and the model was converted back to the Acute Adult Inpatient Care model after evaluation.

The Lanarkshire model was run for approximately 12 months and was ended due to demand for acute care beds being greater. Patients had to be transferred to the sub-acute wards whilst still very acutely unwell. Staff burn-out in the acute admission ward was a concern as all admissions were filtered through the single ward and staff felt their skills in therapeutic and psychological interventions were being lost as they were only involved with patients for the first 48-72 hours of admission.

The model describes acute admission for three days before transfer to step down/treatment ward. Clinical colleagues have raised concerns regarding the ability to fully assess a patient in three days and that this time period would only allow for medication of a patient.

Patients may not then become acutely unwell again whilst in the step down/treatment ward and require transfer back to the acute assessment ward. This could mean a patient may "yo-yo" back and forth between wards and staff dealing with them, this would impact on patient care, safety and experience.

Concerns were also expressed re the ability to maintain the patient pathway and flow of patients deliverable through this model and the likelihood that wards

would fill up quickly and lower number of acute admission beds would prevent ability to transfer patients when became more acutely unwell.

This option will continue to require medical staffing cover across the three sites (Susan Carnegie, Carseview and Murray Royal), which is unsustainable and unsafe given current workforce profiles and future projected staffing levels.

The ability to maintain safe medical cover at Stracathro Hospital is not possible as described above.

It is anticipated that there will at least be no reduction in consultant PA allocation in this option as there is neither a reduction in bed numbers or number of hospital sites to be covered.

The model does not fit for training of junior doctors and training status could be placed at risk.

This option would also impact on service user/carer travel and access as patient may be transferred back and forward from local bed to centralised admission ward on several occasions throughout episode of care.

Isolation of single GAP step down/treatment ward in Angus would continue to require additional staffing levels to provide emergency cover and levels of observation due to environmental challenges in physical layout of ward.

The provision of step-down/treatment beds across Tayside would lead to a clinical imbalance with 25 beds in Angus, 26 beds in Perth and Kinross and only 22 in Dundee. This is likely to lead to patients from Dundee being transferred out of their own geographical area for step down and lead to additional problems with transition to community services. It was also noted that the option provided a complex clinical pathway with no correlation between the proposed locality bed numbers and the population of Tayside.

Clinical colleagues also raised concerns that the model would build in complexity and potential pinch points to a system that already finds it difficult to manage current throughput. It was felt that the option would increase transitions between services/beds and therefore increase clinical risk

The option described also considered use of crisis house models in each locality to support step down/treatment. Modelling work reviewing crisis house provision reviewed current examples such as those provided in Edinburgh which identified services required larger centres of population to become viable, i.e. current Edinburgh crisis house provides 4 beds for the city (population of approx 500,000 equivalent to whole of Tayside – report attached in Supporting Document Appendix Nine)

The use of two wards on Carseview site for LD services would lead to under utilisation of Ward Two floor area for Low Secure Learning Disability services which would provide 8 beds in an area which could accommodate 22 beds.

This option would also mean a split of Learning Disability services for low secure inpatient beds for providing step down as open forensic beds would be on Carseview site and locked forensic beds in the Rohallion Unit in Perth.
The impact on the Forensic Service is described above and in detail below.

10.7 Forensic Low Secure and learning Disability Locked Forensic beds

Flat 1, Bridgefoot House, SMH, is currently an 8 bedded male low secure unit that is operationally, clinically and strategically part of Learning Disability In-Patient Services.

The accommodation for this service is not fit for purpose and is often commented on during Mental Welfare Commission Audit Reviews.

During the option appraisal process there was opportunity for staff, patients, carers and other key stakeholders to participate in a process to help shape and plan for future service provision. Each of the four option appraisal outcomes has recommended the transfer of the locked forensic LD service to the Low Secure forensic Unit at Rohallion Unit in Murray Royal Hospital, Perth. In addition there has been further engagement with this staff and patient group to determine whether a fast track to Rohallion would be an option worth considering and this was highlighted to the NHS Tayside Board meeting in August 2016.

Inpatient management have noted that there has been a positive response from within Flat 1 which notes that the general opinion is that accelerated transfer would be in the patients and service best interest. Care and treatment would be delivered in modern and fit for purpose accommodation improving both patient experience and patient journey whilst enabling staff to be part of specialist secure care services that would promote and facilitate ongoing and continual professional development. This proposal would also alleviate concerns from mental welfare commission and would meet the standards required for the delivery of low secure care.

There are many benefits associated with this proposal and it would enable the service to address and meet some of the workforce planning challenges. There is a national shortage of learning disability nurses, most reside within the central belt geographical area, and historically it has been difficult to recruit to the location of Dundee. Perth is more accessible from the central belt and is more attractive to potential applicants. In addition being part of the wider secure care services would enhance recruitment opportunities based on forensic core competencies rather than just learning disability experience

Based on these additional discussions with the service and management, it is estimated that an accelerated transfer to Rohallion Site would be realistically achievable within a 12 week period.

There are some risks associated with this such as provision of medical cover, psychology, therapy provision and available nursing resources. Recruitment into secure care is a far more attractive proposition for medics rather than the speciality of learning disabilities and there is a possible option of ongoing cover

from within the current LD medical staffing establishment (A medical review of this is noted in further section below).

Psychology provision into Flat 1 at present is limited to 4 x 1 hour sessions per week which includes participation in group work based at Strathmartine. There should be no disruption to this service provision as there would be sufficient resources to maintain links and attendance to these groups at Strathmartine. Patients within Flat 1 receive approx 70 therapy sessions per week at Strathmartine including, adult education, music therapy, art therapy and a variety of recreational and leisure activities ranging from 30 minutes to 2 hour sessions on both an individual and group basis.

Patients transferring to Rohallion should not experience a reduction in the level of service provision. Additional resources have already been put into therapy department at Strathmartine and these risks can be mitigated through the transfer of resources to Rohallion for the purpose of delivering therapy sessions.

In addition certain activities could be replicated at Rohallion or existing links could be maintained for attendance at group sessions within Strathartine on interim basis until final decision is made re future sighting of remaining LD inpatient services.

At present management are reporting that a large percentage of the workforce within Flat 1 are, keen, motivated and willing to transfer to Rohallion. This would however require to be discussed with all staff on a one to one basis and supported by Human Resources and staff side representatives through organisational change policies. It is envisaged that any staffing shortfalls could be covered by existing staffing resources within Rohallion and any staff member wishing to remain within Learning Disability Services in Dundee would be accommodated into existing vacancies.

Part of the proposal to relocate these services in advance of decision regarding other options would also require consideration of the transfer of the Community Forensic Learning Disability Team including MAPPA resource. Some discussion and engagement has already begun with this team. This proposal would continue to allow the interface between this team and the impatient ward to continue and it would support the transition from one site to another whilst maintaining existing links with the Strathmartine site.

The potential accelerated transfer of Flat 1 to Rohallion would free up accommodation on the Strathmartine site which could be used to allow for the LDAU on Carseview to decant into Flat 1 and allow Learning Disability Services to consolidate service delivery on a single site prior to any potential future service move. This would assist with the logistics of planning for the refurbishment works to be undertaken on the Carseview site and provide an empty ward for decant. In addition this would mitigate the risk of moving a service off site to ensure there were appropriate and suitable staffing resources at hand to deliver safe and effective service delivery. The unintended consequence would be a reduction in supplementary staffing costs as it would be easier to redeploy staff on a single site as opposed to multiple sites. This model would support any potential

recommendation for Learning Disability Services to be placed in Perth and would enhance and support a step down model for forensic care by having a Learning Disability Open Forensic Ward also on the Murray Royal site in the future under option 3A. This option would also allow for income generation potential from three of the ten beds available as this service is in demand nationally and other Boards have already noted an interest in purchasing LD locked secure beds.

A medical workforce review of the above has noted the following key issues.

All the options have the same reconfiguration for LD Locked forensic beds and the reduction in Forensic Low Secure beds. The key decision to be made for these services is what the operational management structure will be. It is recommended this is made as early as possible to allow the two services to enter detailed discussion well in advance of any moves

The Medium Secure Unit is funded by a consortium of North of Scotland health boards and hosted by NHS Tayside. The Forensic Low Secure Unit is managed by NHS Tayside. The current LD Locked forensic unit is based at Strathmartine Centre and hosted by Perth & Kinross Integration Joint Board.

This raises a number of questions about co locating a service managed by an IJB with a service which is not and to what extent they share resources such as staff and facilities.

If the LD Locked forensic service remains under the LD service

- Due to the reduction in forensic beds there will be a reduction in 5 PA for Forensic Psychiatry consultants. This will mean that consultant sessions to HMP Perth and HMP Castle Huntly which are currently allocated as Extra Programmed Activities (EPAs) will be regularised into job plans
- Medical cross cover arrangements for LD patients could be a challenge unless the other LD services relocate to MRH and not Carseview
- LD patients will not have access to the care and treatment to patients in the Low Secure Unit which is currently funded from the Medium Secure Unit medical budget e.g. primary healthcare from a GP.
- LD staff will not be able to use the support for nursing and Allied Health Professional staff which is funded from the Medium Secure Unit medical budget e.g reflective practice.
- LD Locked forensic unit will be covered by the general on call medical rota unlike the rest of Rohallion Clinic which has a separate Consultant Forensic Psychiatrist on call.

If the LD Locked forensic service comes within the Forensic Service

- The Forensic service will assume consultant cover without a need for additional PA
- Savings of about 2.5 PA in consultant LD sessions but this allocation is considered an under allocation for what the work involves.
- Consultant cross cover would be from the Forensic Service including out of hours.

- Access to all services funded from the forensic medical budget
- The removal of LD locked forensic service from the LD service creates a barrier in the pathway from secure care for LD patients
- This option limits the current access of patients to specialist LD care and treatment including specialist LD consultants
- Access to LD group therapies may be limited particularly if the LD service is split between Dundee and Perth

The issue of deciding on operational management goes beyond the medical workforce. It is anticipated that the current Allied Health Professional and Psychology workforce at Rohallion Clinic will need to be reviewed. This is to ensure appropriate mix of professionals e.g. increased need for a Speech and Language Therapist. It is also anticipated there will need to be a greater resource allocation of Psychologist and AHP time to ensure treatment interventions are delivered. The levels of reinvestment will require further review of requirements for these specialties.

Some of this could be achieved by transfer of the existing staff but as described above there will be a need for robust planning around this in line with organisational change policies and support from human resources and staff side representatives.

11. Workforce

11.1 Medical

One of the most compelling and linked drivers for the reconfiguration of services in many health boards is their capacity to provide appropriate medical cover 24/7(King's Fund, Briefing 2011).

In-patients in Mental Health Hospitals need to have access to medical assessment 24 hours per day, 7 days per week. Doctors must be available to patients in the community who are experiencing current mental health problems and give advice on their management. The population of Tayside require reliable access to urgent medical assessment 24 hours per day, 7 days per week.

Normally this cover is provided by doctors in their first 4 years of training. To do this safely across all sites, NHS Tayside and the three IJBs require 31 junior doctors to sustain current rotas. These doctors are in training for general experience or specific experience for a career in General Practice or Psychiatry. The doctors in training are allocated centrally by the Deanery (the responsible training organisation). Mental Health Services have no influence in relation to who is placed in services and how many posts are filled. National shortages of doctors in training over the last few years have resulted in significant numbers of vacant posts across a number of specialties including Mental Health. Under these circumstances, NHS Tayside has filled vacant posts, wherever possible, with additional locum doctors. The shortage of junior doctors nationally has also had an effect on the numbers of locum doctors currently available which has led to some unfilled posts in Mental Health Services.

The reduction in working hours for trainees has led to a decrease in their level of experience and this also now impacts on the consultant workload and service provision. It is vital that NHS Boards and IJBs recognise that these challenges may mean the requirement for more senior input earlier in the patient pathway in order to maximise patient outcome. As such it must be acknowledged that appropriately supervised doctors in training remain a valued and integral part of our sustainable workforce and their needs have to be addressed. An important facet for doctors in training within Tayside is the opportunities they have for education and learning, which must run parallel with service provision. The General Medical Council regulates all stages of medical training and professional development, both undergraduate and postgraduate. An annual training survey by the regulator assesses the quality of training programmes to ensure a safe learning environment for patients and trainee staff. Currently NHS Tayside mental health service is at risk of failing to meet the required standards due to the current shortages and workloads.

From February 2017, there have been significant gaps in junior doctor availability. Only 18.6 of the 31 posts required to maintain Mental Health and Learning Disability services have been filled. NHS Education Scotland currently funds 29 core training posts in mental health services in Tayside. This is made up between Core Psychiatry Trainees, General Practice Specialty Trainees and Foundation Programme Doctors. There are also gaps in the numbers of Higher Trainees who also deliver routine and emergency services across the psychiatric subspecialties. This again is a national issue with under recruitment and NHS Tayside has little ability to influence this as allocation of trainees is on a national basis. The reconfigured Out of Hours rota working across two sites can be operated with the 18.6 wte numbers available however it has still been necessary to employ locum doctors to fill unfilled posts and cover for maternity leave in the services.

It is anticipated that NHS Tayside will not be able to find enough locum doctors of sufficient knowledge or experience in the future to fill all the vacant posts which will have an impact on provision of both emergency and non emergency services. This will leave NHS Tayside with insufficient doctors to provide safe cover across all of the current inpatient and assessment units.

National figures for the next 5 years remain at low levels and reflect these reduced numbers for a prolonged period. As most of Tayside's in-patient services (including services for younger people, people with a learning disability, long term rehabilitation care and forensic services), are based either in Dundee or Perth and Kinross, it is therefore deemed clinically appropriate to consolidate services within these geographical areas.

All subspecialties within the scope of the MHSRT Programme have Consultant Psychiatry vacancies. NHS Tayside currently employs 7 locum consultants and 6 locum junior doctors to fill long term vacancies and to maintain service provision across the current configuration of services. These locums are at a premium cost (current annual cost pressure of approx £1M).

The current Consultant workforce levels required are currently sustained through use of 10 Locum Consultant Psychiatrists across all Mental Health and Learning Disability Services.

In Angus locums cover the Community Mental Health Teams in Arbroath, in Dundee one locum covers the IPCU and Crisis response Home Treatment Team, in Perth one locum cover the Inpatient unit and a second covers the Community Mental Health Team in North East Perthshire. Learning Disabilities have been unable to recruit following a retirement and cover is currently provided by reconfiguration of job plans and Associate Specialist providing cover to a Consultant role. Forensic services have also been unable to recruit to a full time post in the Regional Medium Secure unit since became operational. It is anticipated that over the next two to three years it will be hard to fill these vacancies with trainees who are currently working in Tayside. These vacant posts reflect the position nationally where difficulties are being experienced recruiting to substantive posts due to lack of suitable applicants.

An analysis of the senior medical workforce in Mental Health and Learning Disability services shows that at least 8 will reach the retirement age of 55 within the next 5 years at a time where there is a national shortage in Consultant Psychiatrists and the recruitment climate is extremely difficult. Consultants who are eligible for Mental Health Officer status prior to 1995 can retire at age 55. Due to recent changes in Pension rules around earnings and tax it is now no longer financially viable for Consultant staff who have Mental Health Officer status to stay on after 55 and can only return to work on part time basis. The continued reliance on the use of locum medical staff to manage workforce gaps places pressure on the commitment to deliver safe care, with a sustainable workforce and delivery of financial balance. The use of locum Consultants also impacts on the quality of care received by service users and their experience if having constant change of Consultants they are being assessed and treated by.

Consultant and Junior Medical figures - Table Four

Mental Health & LD	Consultant staffing levels	Junior Medical staffing levels
Current	64	34
Option 3A	62	24
Option 4A	64	34
Option 5A	64	24
Option 8	65	34

11.2 Nursing

NHS Tayside currently recruits the majority of their Mental Health and Learning Disability nursing workforce from university graduates once per year. Last year of the 92 students who qualified NHS Tayside managed to successfully recruit 42. Therefore less than 50% of those trained in Tayside were successfully retained in NHS Tayside. This low recruitment is due to the number of students from Northern Ireland and England who come to Tayside to train then return to their home localities on completion of training. The colleges are unable to assist

us in addressing this as are required to support equal opportunities and access to placements and therefore this is out with NHS Tayside's ability to address. This low intake of young staff, coupled with an aging profile of current nursing workforce and similar issues regarding Mental Health Officer status retirement at 55, presents Mental Health and Learning Disability services significant workforce challenges to sustain current and future services. On examination of current staff profile it is estimated that over 30% of staff are eligible to retire in next 5 years. In some teams this figure rises to almost 50% which means the most experienced staff in current GAP and LD services are likely to retire over this period.

The nursing workforce implications for each model have been prepared in correlation with the Associate Nurse Director for Mental Health and Learning Disability Services, the Senior Nurse, Workforce Development and Planning and reviewed with the Senior Nurses within Operational Managers posts who have responsibility for Nursing Care Governance for each service.

These workforce estimates will be subject to review as more detail regarding the preferred option becomes available.

The staffing models presented have been developed by utilising national nursing & midwifery workforce planning methodology acknowledging the current evidence base and incorporating the following key rationale:

- Ratio of Registered nurse (60-65%) to Healthcare Support Worker (35-40%)
- Senior Charge Nurse in a non-case holding leadership role
- Ward Assistant/Housekeeper role for each Ward environment
- Minimum of 2 Registered Nurses on Night Duty per Ward environment
- Equity of staffing resources across speciality wards
- Secure Care Wards remaining on a 12hr shift pattern
- All remaining Wards utilising a standardised shift pattern

Inpatient Ward	**Current Wte**	**Option 3A**	**Option 4A**	**Option 5A**	**Option 8**
Nursing Workforce					
Combined LDAU/BSI	56.62	43.16	43.16	43.16	43.16
LD Locked Forensic	25.87	24.30	24.30	24.30	24.30
LD Open Forensic	25.67	24.30	24.30	24.30	24.30
Amulree Complex Care & rehab (16 beds)	31.76	31.76	31.76	31.76	31.76
Rannoch Female Complex care	21.50	22.58	22.58	22.58	22.58
GAP Acute admission Ward One Carseview 22 Beds	27.80	28.30	28.30	28.30	45.45
GAP Acute admission Decant ward Carseview 18 plus 4 AIS Beds	29.50	28.30	28.30	28.30	28.30

GAP Acute admission Ward Two Carseview 22 Beds	-	28.30	28.30	28.30	-
GAP Acute admission into LDAU ward at Carseview 22 Beds	-	28.30	-	-	-
Moredun Ward Murray Royal	39.80	-		39.80	34.01
Mulberry Ward SCC	38.39	-	38.39	-	34.01
IPCU 10 Beds	28.20	28.30	28.30	28.30	28.30
Liaison/Patient Escort		10.29	6.86	6.86	13.72
Total	**325.11**	**297.86**	**304.53**	**305.94**	**329.88**

All of the above options contain an allowance for Liaison and patient transportation shown under the calculations for each ward. These figures do not reflect any potential economies of scale from ECT and nurse management workforce that will be subject to review following identification of the preferred option.

11.3 Allied Health Professionals

The availability of multidisciplinary therapeutic input distinguishes good in-patient facilities from those that are no more than settings of containment (*RC Psychiatrists Faculty report FR/ID/03 July 2013).* The Allied Health Professionals are a key part of the Mental Health and Learning Disability workforce and have knowledge, skills and approaches that are highly valued by service users and carers as they help individuals to maximise their potential and enable productive and independent living.
AHPs are a diverse group of professions, who as members of the multiagency/ multidisciplinary teams provide a wide range of interventions and contributions to promote good mental health, independence and recovery from illness. They constitute a very important resource for people accessing mental health services, but this also provides a challenge in ensuring that the AHPs skills are profiled and deployed to the maximum benefit of service users. There are core Allied Health Professions working in MH/LD services; Art Therapists, Dieticians, Occupational Therapists, Physiotherapists and Speech and Language Therapists with other professional services inputting as part of an individual's pathway of care such as Podiatry.

Rehabilitation skills are core to the services provided by all AHPs, this can be considered the main contribution of AHPs to MH/LD services. Their rehabilitation orientation enables them to focus beyond symptoms to:

- Promote psychosocial function and social inclusion
- Support emotional, spiritual and physical wellbeing
- Respect diversity and choice and the absolute right of the person to self determine
- Focus on what a person can do, rather than what he or she cannot do (a strengths based approach)

- Work collaboratively with service users and carers (*Realising Potential, Scottish Government, 2010*).

The numbers and skill mix of AHPs employed across Tayside (in-patient units, community teams for partnerships and pan Tayside) varies considerably with a significant percentage of the workforce working across 2 or more settings. This flexible (and person focussed) approach to service delivery works in the patient's favour. However this makes the financial calculation (as to the discrete and accurate identification of AHP staff attached to the in-patient units identified within the options) extremely challenging. It has therefore been difficult to identify, at this stage, the specific workforce implications for the range of AHP services providing service to the patients in an inpatients setting.

The table below provides a high level workforce snapshot of the total Tayside AHP resource funded across Tayside for all adults requiring access to services for conditions of a mental health and learning disability origin (extract Feb 2016).

Professional background	**Resource wte**
Arts Therapies	2.40
Nutrition and Dietetics	3.54
Occupational Therapy	44.31
Physiotherapy	8.22
Podiatry	0.20
Speech and Language Therapy	6.26
AHP Support workers (often work across 2+ disciplines)	30.87
Total	95.80

This totals an AHP workforce of 95.8 wte for all inpatient and community settings.

The critical challenge for the Allied Health Professions is the absence of validated workforce and workload tools available nationally or internationally. Ideally using the 6 steps methodological approach, workforce planning requires the active involvement of the lead staff AHP in the redesign of the clinical pathways to enable capacity building and succession planning to be robustly taken forward, optimising the unique skills and skill mix opportunities of a flexible highly skilled workforce.

For the options detailed within the paper, it should be clear that any adjustment to a bed base does not in the first instance affect the AHP resources as, in the main; these resources are directed to meet patient need and are not modelled on a bed complement. The requirements for AHP input and therefore the workforce model should be determined by population need, direct outcome and impact and contribution to community based/coproduced models with a focus on self management.

There will be no reduction in the AHP resources required and in some instances, through the further work conducted on the clinical and patient focussed pathways and population profile, there be an increased understanding of future need and investment.

There will be a direct impact on existing staff clinical interface time and capacity in terms of travel and caseload capacity as they conduct their business across a larger geographical area dependant on the option finally selected if single or dual sited. A key determinant for where AHP services are delivered will be informed by the availability of areas fit for service user need and subsequent AHP related activity (access to gyms/therapy kitchens/outdoor space /workshops/etc)

Recruitment to a range of the professions is recognised as a challenge e.g. Nutrition and Dietetics and Physiotherapy. This challenge increases significantly when trying to recruit to specialist areas of practice such as Forensic particularly when posts are part time in nature and the opportunities for gaining experience is limited.

There are a number of HEIs providing undergraduate AHP education in Scotland (note Tayside is not one of the areas). Tayside provide a significant number of undergraduate placements across all the professions; continued investment in delivering robust, high quality education from experienced, highly skilled and motivated clinicians is pivotal in maintaining ability to recruit post qualification.

Further detailed analysis of current AHP workforce division between inpatient and community based settings has been undertaken but further work is required to enable a full analysis of future AHP requirements to support models which will progress following identification of the preferred option. The initial work undertaken to map existing AHP workforce and a projection of future manpower requirements has highlighted a requirement for some reinvestment to address historic shortfalls in services. This work will continue to be refined throughout the consultation period and the work to progress in the remodelling of existing community services.

11.4 Psychology

Psychology services in Tayside had historically struggled to recruit to vacancies within GAP and LD services due to national shortages in Psychology trainees. More recent work around recruitment of trainees has supported filing of vacancies. An initial review of psychology workforce levels required to sustain inpatient models has highlighted requirements to invest in Psychology workforce and skill mix to meet the predicted demand on these services to support enhanced inpatient care. The Psychological Therapies review undertaken in 2005/06 secured resources to fund posts to provide Level 2 and Level 3 community psychology services. The Review did not address requirements for inpatient interventions which were later presented in a Level 4 report which was supported but not resourced. LD psychology services have also been historically underfunded. A review of community psychology requirements will be undertaken with all other staffing specialities for the preferred option moving forward to support prevention of inpatient admissions.

Psychology Staffing Workforce –

Inpatient and Community	Current Wte
Psychology Workforce	
GAP	
8A Clinical Psychologist – Dundee CMHT	4.8
8A Clinical Psychologist – Angus CMHT	2.8
8A Clinical Psychologist - Perth CMHT	1.8
8D Clinical Psychologist – Dundee CMHT	0.4
8C Clinical Psychologist – Angus Lead	0.3
8D Clinical Psychologist - Perth Lead	0.2
8A Clinical Psychologist - Tayside Rehab Service	1.5
Total	**11.8**
	Current Wte
Psychology Workforce	
LD	
8D Consultant Clinical Psychologist LD and Tayside wide	0.8
8B Clinical/Forensic Psychologist - Forensic Tayside	1.0
Band7 Applied Clinical Associate - Dundee	0.4
8B Psychology Services - Dundee Community	1.0
8A Psychology Services - P&K Community	0.6
8A Clinical Psychologist - Community Angus	0.6
Band 4 Assistant Psychologist - Dundee & P&K	1.0
Band 4 Assistant Psychologist - Forensic	1.0
Band 4 Assistant Psychologist - Angus & BSI	1.0
Total	**7.4**

11.5 Pharmacy

An initial analysis of Pharmacy requirements have been undertaken and based on the needs assessment carried out by NHS Tayside pharmacy and NHS Fife. Pharmacists work in an integrated way on each site across all sub-specialties to

deliver the same standard of service to patients irrespective of whether they are in GAP, POA, forensic or Substance misuse beds.

The figures being reviewed currently highlight historic shortfalls in pharmacy resources to cover the community mental health and learning disability services. There is currently no dedicated learning disability resource.

These current shortfalls are managed by using staff funded to cover other in-patient areas and specialities. If there are no GAP inpatient services in a locality then there will be a requirement to review the need for increased pharmacist expertise within the community mental health teams. This would mean higher requirements for options without local beds as the community service is currently unmet need.

It should also be noted that there are significant medicine cost pressures in Mental Health services and more patients on high risk/ high cost medicines within the community mental health service will require a dedicated pharmacy resource to manage this.

As such the Pharmacy workforce requirements will be further progressed from the initial assessment work undertaken as part of the review of community investments in each locality through the local Integration Joint Board Strategic Planning groups for the preferred option.

Staff Grade	**Current Wte**
Band 8b	0.8
Band 8a	1.3
Band 7	1.3
Band 6	1
Band 5	2.7
Band 2	2.3
Total Pharmacy	**9.4**

Admin and clerical and support services staffing levels will also be subject to detailed review following selection of the preferred option and are currently being reviewed.

Key to the delivery of sustainable services is ensuring a highly skilled workforce and a strong approach to workforce planning, recruitment and retention of staff. As can be seen from the above nursing and medical workforce figures, Option 3A will enable NHS Tayside to respond to the current and future workforce challenges particularly facing Medical and Nursing specialties, to deliver safe, sustainable services into the longer term for the benefit of the population and allow for a greater shift in the balance of care and subsequent remodelling and reinvestment in home treatment and community services to allow patients to be cared for in their own homes for as much of the time as is possible.

12. ESTIMATED COST OF OPTIONS

The NHS as a whole and NHS Tayside as a Board are facing unprecedented financial challenges which mean that all services require to look to ensure best value for the financial resources allocated. NHS Tayside is one of the highest spenders in Scotland on their Mental Health services and has been in the top three for best part of last two decades. NHS Tayside tasked the MHSRT programme to review how GAP and Learning Disability services can be delivered within this resource envelope to ensure delivery of the best service models for the population of Tayside whilst minimising variation, assuring high quality, safe, and sustainable person centred care. Better care does not always require additional resources and conversely improving care has the potential to reduce costs. It is clear that other areas in Scotland have made significant changes in their investment profile in Mental Health and Learning Disability services and longer travelling distances to access inpatient services are not uncommon.

12.1 Mains Points

- One of the Option Appraisal parameters required that any proposals brought forward must cost no more than current services in terms of recurring revenue funding.
- The estimated costs of the proposals require to remain within the current budget
- The estimated costs require to identify any bridging funding which may be necessary on a non recurring basis to cover any additional temporary double running or cross cover issues
- The proposals would include initial estimates for any refurbishment capital/cash prepayment costs. These are at very early design stage and will require further detailed design work with stakeholders before considered as part of the IA and OBC documentation required for presentation to the Capital Investment Group at Scottish Government for approval of any additional funding requirements

12.2 Financial Case – Overall Affordability

This section explains and provides summarised detail of:

1. Recurring revenue costs
2. Potential non recurring (bridging) costs
3. Estimated capex cost of options
4. Financial appraisal of options

12.2.1 Recurring revenue costs

The initial estimated recurring revenue implications for each option are summarised in Table Five below, the detailed breakdown to these estimated costs are provided in Appendix Six of the report.

These costing will require further detailed analysis once a preferred option is identified and will require to include implications for all potential staffing groups

affected (administration and clerical staff, support services, day services, third sector, advocacy, Mental Health Officers). Full analysis of all potential building running cost implications and savings are required, this has the potential to increase with identification of other site retraction savings which may be achievable from further property disposals which may arise if other services relocate to the vacated areas available in Options 3A, 4A and 5A

Figures below reflect comparisons of estimated costs versus current recurring budgets, however there are significant cost pressures currently within GAP and Learning Disability services.

Further detailed analysis of estimated cost pressure reduction will be undertaken once identification of a preferred option.

Table Five – Recurring Revenue Implications

Inpatient Ward	**Current Budget £000**	**Option 3A £000**	**Option 4A £000**	**Option 5A £000**	**Option 8 £000**
Nursing Workforce					
Combined LDAU/BSI	2,108	1,546	1,546	1,546	1,546
LD Locked Forensic	932	906	906	906	906
LD Open Forensic	927	906	906	906	906
Amulree Complex Care & rehab (16 beds)	1,121	1,121	1,121	1,121	1,121
Rannoch Female Complex care	730	838	838	838	838
GAP Acute admission Ward One Carseview 22 Beds	1,025	1,045	1,045	1,045	1,637
GAP Acute admission Decant ward Carseview 18 plus 4 AIS Beds	1,096	1,045	1,045	1,045	1,020
GAP Acute admission Ward Two Carseview 22 Beds	-	1,045	1,045	1,045	-
GAP Acute admission into LDAU ward at Carseview 22 Beds	-	1,045	-	-	-
Moredun Ward Murray Royal	1,374	-	-	1,374	1,228
Mulberry Ward SCC	1,358	-	1,358	-	1,228
IPCU 10 Beds	1,034	1,045	1,045	1,045	1,045
Liaison/Nurse Escort		298	199	199	397
Total Nursing Costs	**11,704**	**10,841**	**11,054**	**11,070**	**11,870**
Variance – investment/(budget release)		**(863)**	**(650)**	**(634)**	**166**
Low Secure ward	-	(883)	(883)	(883)	(883)

resource release					
Low Secure ward Nursing reinvestment		195	195	195	195
Total Variance – investment/(Budget release)		**(1,551)**	**(1,338)**	**(1,322)**	**(522)**
Medical Workforce					
Senior Medical Staffing	4,067	3,867	4,067	4,067	4,187
Junior Medical Staffing	774	546	774	546	774
Total Medical Costs	4,841	4,413	4,841	4,613	4,961
Variance – investment/(Budget release)	-	**(428)**	**0**	**(228)**	**120**
Estimated changes to building running costs					
Additional Unitary Charge for Carseview	-	291	308	308	120
Strathmartine running costs	**-**	(288)	(288)	(288)	(288)
Variance – investment/(budget release)		**3**	**20**	**20**	**(168)**
Assumed potential income generation available from 2 beds in Low secure LD Forensic beds	**-**	**(442)**	**(442)**	**(442)**	**(442)**
Total Projected Variance – Investment/(Budget Release)		**(2,418)**	**(1,760)**	**(1,972)**	**(1,012)**

Current Medical cost pressures of approx £1M per annum exist through use of Locum Medical staffing. Continued requirement to provide medical cover across three sites in options 4A and Option 8 will therefore not allow for any potential reduction in the use of locums and therefore require to be offset against any savings identified above. Locum costs will continue to be incurred for all options considered until Consultant vacancies are able to be filled on a permanent basis, this will be reviewed on an ongoing basis to try and further reduce locum costs.

Building costs for current sites at Murray Royal and Susan Carnegie will remain regardless of option considered and therefore have been excluded from this analysis. It is NHS Tayside's continued intention to fully utilise these new facilities for the life of the building contracts and therefore no saving or additional cost for these sites are assumed as part of this Programme. It is recognised that options 3A, 4A and 5A may release additional site savings as noted above from relocation of other services into vacated areas within these two buildings.

Further detailed planning for the remodelling and reinvestment in community based services will now be progressed through each of the three Local Integration Board strategic planning groups through partnership with NHS Tayside Board, Local Authority and third sector organisations. It will be through this local planning and evaluation of current community service provision that further detail regarding the resources required can be identified.

It has therefore prudent at this stage not to attempt to quantify any potential reinvestment required in community services for any relocation of inpatient beds until further detailed mapping work of community services is undertaken.

This work cannot be progressed in detail to date until a preferred option for inpatient services could be identified and through the support of the three Health and Social Care Partnerships. The formal planned consultation period will support the gathering of information/feedback on the preferred option to assist IJB Strategic planning groups in planning of remodelled future community services and evaluation of the level of resources required within each area. Resources must be remodelled and invested to meet the needs of the varying local populations/demographics and improve current community provision further shifting the balance of care across both GAP and LD services

As highlighted in Table Five above Option 3A provides the most efficiency in terms of economies of scale from inpatient services to release resources which may then be utilised to invest into community based services, whilst still achieving a saving on recurring resource envelope and reducing current % spend on impatient services.

12.2.2 Potential non recurring (bridging) costs

There are a number of areas within each option which will require an element of non recurring bridging resources. The resources are required in the short term to support potential double running cost when services are initially being implemented, short term impacts or issues which may arise as a knock on effect from a change or for time limited costs such as excess travel (4 years).

The quantification of these at this stage in the process is extremely difficult and subjective as will not be known until detailed implementation planning is undertaken on a preferred option.

Double running costs may arise where numbers of staff are unable to relocate through organisational change policies and retained within services as displaced staff. The quantification of any potential impact would only be able to be

quantified accurately following agreement of a preferred option and subsequent one to ones with any staff impacted by change.

Each of the options in turn will have a potential bridging implication as noted below and scored within the financial appraisal exercise.

Potential bridging implications will require to be met from savings achieved on a non recurring basis.

Option 3A

Potential bridging implications may arise from:

Potential additional staffing cover required to support temporary isolation of remaining POA wards on Susan Carnegie site on non recurring basis until a further Option Appraisal undertaken to utilise vacated Mulberry ward.

Excess Travel costs for GAP staff relocated to Dundee from Mulberry ward in Susan Carnegie unit in Angus and from Moredun ward in Murray Royal in Perth.

Excess Travel costs for Learning Disability staff relocated from Strathmartine site and Carseview sites in Dundee to Murray Royal site in Perth.

% of GAP staff in Angus and Perth who may not be able to transfer to Carseview Centre in Dundee. (subject to organisational change)

% of Learning Disability staff in Dundee who may not be able to transfer to Murray Royal site in Perth (subject to organisational change)

Non recurring allocation to allow refurbishment of NPD (Not Profit Distribution) building at Murray Royal and Susan Carnegie Unit for environmental changes required as part of HSE review and for Learning Disability services relocation to combined Moredun ward at Murray Royal and changes required to Rohallion Clinic for Forensic Services.

Removal expenses and patient transfer costs

Option 4A

Potential bridging implications may arise from:

Excess Travel costs for GAP staff relocated to Dundee from Moredun ward in Murray Royal in Perth.

Excess Travel costs for Learning Disability staff relocated from Strathmartine site to Carseview site in Dundee and for locked forensic services relocated to Rohallion Clinic at Murray Royal site in Perth.

% of GAP staff in Perth who may not be able to transfer to Carseview Centre in Dundee. (subject to organisational change)

% of Learning Disability locked forensic staff in Dundee who may not be able to transfer to Murray Royal site in Perth (subject to organisational change)

Non recurring allocation to allow refurbishment of NPD (Not Profit Distribution) building at Murray Royal and Susan Carnegie Unit for environmental changes required as part of HSE review and changes required to Rohallion unit for relocation of Forensic Learning Disability services.

Option 5A

Potential bridging implications may arise from:

Potential additional staffing cover required to support temporary isolation of remaining POA wards on Susan Carnegie site on non recurring basis until a further Option Appraisal undertaken to utilise vacated Mulberry ward.

Excess Travel costs for GAP staff relocated to Dundee from Mulberry ward in Susan Carnegie unit in Angus

Excess Travel costs for Learning Disability staff relocated from Strathmartine site to Carseview site in Dundee and for locked forensic services relocated to Rohallion Clinic at Murray Royal site in Perth.

% of GAP staff in Angus who may not be able to transfer to Carseview Centre in Dundee (subject to organisational change)

% of Learning Disability locked forensic staff in Dundee who may not be able to transfer to Murray Royal site in Perth (subject to organisational change)

Non recurring allocation to allow refurbishment of NPD (Not Profit Distribution) building at Murray Royal and Susan Carnegie Unit for environmental changes required as part of HSE review and changes required to Rohallion Clinic for relocation of Forensic Learning Disability services.

Removal expenses and patient transfer costs

Option 8

Potential bridging implications may arise from:

Excess Travel costs for Learning Disability staff relocated from Strathmartine site to Carseview site in Dundee and for locked forensic services relocated to Rohallion Clinic at Murray Royal site in Perth.

% of Learning Disability locked forensic staff in Dundee who may not be able to transfer to Murray Royal site in Perth (subject to organisational change)

Non recurring allocation to allow refurbishment of NPD (Not Profit Distribution) building at Murray Royal and Susan Carnegie Unit for environmental changes

required as part of HSE review and changes required to Rohallion Clinic for relocation of Forensic Learning Disability services.

Removal expenses and patient transfer costs

12.2.3 Estimated capex cost of options

Given the availability of capital funding at a local and national level, a revenue based finance solution is required to deliver any building works associated with this programme. Initial modelling undertaken as part of the original Adult Mental Health review OBC in 2005/06 considered the use of a cash prepayment option to progress refurbishment of Carseview Centre which is an existing PFI site. This work was updated in 2011 but again placed on hold pending review of strategic vision for site. The original resource earmarked for this work has not been utilised to date but would require to be approved by SG given the time period which has elapsed and the change in economic climate since original approval granted.

Initial modelling work undertaken indicated the Programme would be affordable in revenue terms if this cash prepayment resource is made available to buy out the capex implications associated with any refurbishment/development of Carseview site.

Initial capex high level costing estimates have been undertaken by NHST property department with support from Gauldie Wright & Partner Architects, are detailed in Table Four below which note building inflation of 34% on previous capex estimates provided for Carseview. These will be revised and refined once identification of a preferred option and further more detailed design work can be undertaken.

Public sector capital allocation will be required on completion of scheme to meet current outstanding planning consent commitments to provide external cladding to the modular decant building at Carseview. The ward was originally constructed following approval in 05/06 on a temporary planning approval application (originally intention was to relocate on completion of requirement as decant) however subsequent discussions with Dundee City Council Planners have indicated a requirement to ensure exterior of building matches the finish of the main building if NHS Tayside wishes to retain in situ on a permanent basis. Initial estimates identified an associated cost of £250k this will be subject to review and detailed costing on progression of a preferred option but will be required regardless of option approved. This is not currently contained within NHS Tayside capital plan and will require to be progressed through the Capital Scrutiny Group approval process. Timing for the works will be agreed following further discussion and clarification of preferred option plans with the planning department during the consultation period. It is not envisaged this will be a requirement until the end of any Programme of refurbishment work.

Capital receipt from disposal of surplus assets would be available from the proposed closure of the Strathmartine site. Any capital receipts received from sale of property are not retained by NHS Tayside and are returned to Scottish

Government. Current estimated receipt is noted in table below and is reflective of actual receipt envisaged; this has been reduced from previous estimates of £1M to reflect current market position, recent NHS capital receipts for similar sites such as Little Cairnie, planning restrictions and expected conditions placed on sale. Any preferred option which identifies vacant areas of buildings at Murray Royal or Susan Carnegie sites will be subject to a further option appraisal exercise to agree which alternative services could occupy empty ward. These alternative services may relocate from NHS sites/areas which could then become available for disposal and generate further capital receipt.

Any amendments required to the NPD buildings at Murray Royal and Susan Carnegie sites can be made as variation to contract and either funded through the traditional PFI/NPD route (increase in annual payment) or through buy out of the additional cost from revenue. It is proposed that as the amendments for each of the options relate to refurbishment of the Murray Royal site that these could be met by a combination of revenue funding then offset against potential SG DEL funding allocation and also through negotiation with the NPD/PFI providers to meet costs from their existing life cycle funds i.e. for decoration etc if area is due to be repainted every 3 years then they would undertake as part of the planned maintenance of site.

Initial estimated capex costs in Table Six below are based on a first review of likely accommodation requirements. These requirements will further identified through detailed design works undertaken with key stakeholders for the preferred option. Estimates below have been based on original 2011 costing work undertaken for the Carseview site Phase 2 refurbishment and have been uplifted to include building inflation uplift of 34%. This uplift for inflation increases costs beyond the original estimated £5M cash prepayment required and will be subject to further review. These estimates have not been reduced to reflect work which has already been undertaken under lifecycle programme on site, the recent Ward Two refurbishment under the contingency plan and ongoing refurbishment in relation to Health & Safety improvements across all Mental Health sites. These will be refined with progress of a preferred option.

Table Six – Capex estimated costs

Site/Ward	**Option 3A £000**	**Option 4A £000**	**Option 5A £000**	**Option 8 £000**
Capital				
Cladding of Decant	250	250	250	250
Total Capital	**250**	**250**	**250**	**250**
Capital Receipts				
Strathmartine Site Disposal	**(600)**	**(600)**	**(600)**	**(600)**
Other	Subject to further Option appraisal	Subject to further Option appraisal	Subject to further Option appraisal	0

Total capital receipts	**(600) may increase following further OA**	**(600) may increase following further OA**	**(600) may increase following further OA**	**(600)**
Cash Prepayment				
IPCU ward upgrade	2,102	2,102	2,102	2,102
Ward One upgrade to decant ward standard	247	247	247	247
Ward Two upgrade a GAP ward	2,076	2,076	2,076	
LDAU upgrade as GAP ward	2,550	-	-	-
LDAU upgrade as combined ward (LDAU,BSI and Open forensic)	-	2,985	2,985	-
LDAU upgrade as combined LDAU & BSI ward only	-	-	-	2,313
Ward Two upgrade as Open Forensic Ward	-	-	-	1,218
Total Cash Prepayment	**6,975**	**7,410**	**7,410**	**5,880**
Revenue – refurbishment (DEL funding)				
Moredun ward refurbishment to combined LD ward	58	-	-	-
Amendments to Rohallion for additional crisis suite	12	12	12	12
Total Potential revenue/(DEL funding)	**70**	**12**	**12**	**12**

Detailed breakdown of financial costs are included in Appendix Seven and design drawings included in Appendix Nine.

12.2.4 Financial Appraisal of options

In order to compare each of the options in terms of affordability not purely on revenue or capex costs but across the spectrum of financial implications, a financial appraisal has been undertaken by the Finance representatives on the MHSRT Programme team and Operational Finance team colleagues who manage Mental Health and Learning Disability and Capital resources within the Integration Joint Boards and NHS Tayside.

The detailed scoring of the appraisal is attached in Appendix Eight

The appraisal highlights that Option 3A provides the greater recurring resource release from site closure running costs, increase opportunities for capital receipts from disposal of surplus properties, increased opportunity to remodel and reinvest in community services to further shift the balance of care through associated economies of scale and reduce current cost pressures associated with Medical and supplementary staffing costs across both GAP and Learning Disability services. This option would require additional non recurring bridging funding to progress and the continued availability of previously agreed Scottish Government cash prepayment to allow full refurbishments of the sites identified to be undertaken.

13. IDENTIFICATION OF PREFERRED OPTION

As can be concluded from the information provided above in terms of the criteria used to consider options:

Safety and Sustainability: Option 3A provides the safest most sustainable service for the future, ensuring sufficient medical cover, nursing, AHP and Psychology workforce who can share learning and experiences across speciality services. This option will allow remodelling and reinvestment in community workforce to provide services to the majority of the population and prevent unnecessary admissions for both GAP and LD services. By shifting the balance of care and providing centralised specialist services it reduces variation and provides ease of acute care pathway.

Workforce Availability: Option 3A is the only option which will provide sufficient safe inpatient staffing levels to provide services for the immediate future and next 5 years. This option also makes the most efficient use of workforce and would maximise the number of posts available for transfer to local community services.
Financial Affordability: Option 3A allows for the greatest release of resources from current inpatient services to allow for a remodelling and reinvestment in local community and home treatment services, whilst maximising use of the current estate portfolio and allowing disposal of properties which have significant backlog maintenance costs.

Criteria/Ranking	Option 3A	Option 4A	Option 5A	Option 8
Option Appraisal ranking	4	2	3	1

Safety/Sustainability ranking	1	3	2	4
Workforce Availability	1	3	2	4
Financial Affordability & Analysis	1	3	2	4
Overall ranking if criteria weighted equally	**1**	**3**	**2**	**4**

Option 3A would therefore be the recommended preferred option for NHST Board and the three Integration Joint Boards to progress to Consultation phase.

A move from the status quo inevitably involves change. Almost the most controversial aspects of the Programme and strategic review is the possible centralisation of acute admission beds for both GAP and Learning Disability services. Each option outlined above brings its own benefits and problems.

However the creation of a centralised service provides the opportunity for synergistic learning through close contact with professionals, service users and carers who would otherwise have been in separate services with different goals and potentially different quality standards.

Option 3A will allow for the above and creation of a "Centre of Excellence" for both GAP and Learning Disability services and a future model of care which is both sustainable from a workforce availability, environment and financial affordability.

By contrast travelling time for professionals, service users and carers will be significantly increased in some cases and the problems this can bring re escorts etc. Further exploration of the impacts on service users and their families will require to be considered throughout the consultation period and planning for any option implementation. Through the use of the EQIA report (appendix One) and quantification of the potential impacts on the population the programme will continue to monitor and evaluate and take actions necessary to support access wherever possible.

Bed Numbers

Whilst the Royal College of Psychiatrists have traditionally provided guidelines on bed provision for GAP, as has the Scottish Needs Assessment Programme, the National Services framework in England have moved away from this using this detail. This reflects an understanding that inpatient care is only one element of overall service provision with usage potentially regulated by explicit care pathways and arrangements into and out of inpatient care. On discussion throughout the MHSRT Programme a key message emerged repeatedly in response to question "Have we got the bed numbers right?", the message and answer has continuously been that in themselves the bed numbers are less important than how patient pathways are developed and facilities are going to be used. Changes in the numbers of beds and people providing community services need to be reflected in a progressive self-examining, modern and evidence based culture associated with the care, treatment and recovery of people with

mental health problems. As such the number of beds required for the future provision of the preferred option will be further questioned and examined in relation to provision of community based services as the preferred option is further progressed and developed during the subsequent detailed business case stages in line with the strategic plans of the three IJBs and the National MH strategy to shift the balance of care

14. CONSULTATION PLAN

The MHSRT Programme communications and engagement work stream in partnership with the three local Integration Joint Boards strategic planning groups are developing a robust consultation plan and programme for the three month formal consultation period, building on the engagement work undertaken to date.

Scottish Government and Scottish Health Council have provided guidance and support to the MHSRT Programme team throughout the option appraisal and engagement process and in preparation of the consultation plan. The programme team will continue to seek their support, guidance and assurance that the correct processes and procedures are followed for this next stage in the Programme.

Stakeholders must be part of the consultation planning process and advise on best practice, methods of communication, approach to take and format they require to be consulted with, particularly within Learning Disability services where service users may require additional support to fully participate.

There are a range of ways which can be used to raise awareness of the consultation, including media releases; targeted distribution of consultation paper and feedback questionnaires; wide distribution of a consultation flyer (which would be required in English and other languages); information on NHST website and MHSRT Programme links, Facebook page, a Twitter profile: as well as using the internal communication tools to raise awareness amongst all staff. (Staffnet, bulletins, Spectra etc): face to face meetings, public meetings, events, one to ones with staff and patients and their families who may be directly affected by any proposed change: focus groups of stakeholders; open responses (letter and email); staff briefings: presentations to groups and committees

The consultation plan is attached as a separate summary report. Supporting website and materials are being prepared with support of the NHS Tayside communications team. This team will assist in the presentation the above information in a format which is easily presented and understood by the range of stakeholders and general public likely to be impacted upon by the proposed preferred option. A soft start approach is planned during June 2017 where posters, flyers, newsletters and press releases will inform of the Programme and the forth coming consultation and provide details of how people can become involved and points of contact to note interest in being involved in the process. The formal consultation period is planned to commence on the 3rd July 2017 and continue through to the 3rd October 2017.

15.CONCLUSION AND NEXT STEPS

The Boards are therefore asked to consider the information presented above and the process which had been followed to allow identification of the presented preferred option; that being Option 3A.

On approval of the process which has been followed regarding the selection of the preferred option, the MHSRT Programme would then proceed to the period of formal consultation with wider stakeholder and public involvement. The draft consultation plan is attached and outlined above. The consultation period will allow for the gathering of as much feedback, comment and opinion on the proposed preferred option to ensure further review and production of an Initial Agreement report which will then be presented to Boards for final approval.

The Programme reporting governance structure is attached in Appendix Eleven.

Business Case Stages and Programme Timeline for Approval

Option Review Report Update and Consultation plan approval	June 2017 Committees/Boards
Consultation Period	3rd July 2017 to 3rdOctober 2017
Initial Agreement Report	December/January 2017/8 Committees/Boards then CIG in January/Feb 2018
OBC report	May/June 2018 Committees/Boards then CIG in May
Financial Close	November 2018
FBC report	December 2018
Refurbishment timeline	January 2019 to December 2019

Mental Health Service Redesign Transformation Programme

Option Review

Appendices One – Six

Document Control Information	
Control Status	Draft
Date Last Printed	02/06/2017
Version Number	2.0
Author(s)	L Hamilton, Mental Health Programme Director & Finance Manager NHS Tayside

Appendices to Options Review Report

Table of Contents – Appendices One to Six

Appendix One

Equality Impact Assessment

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME

EQUALITY IMPACT ASSESSMENT

February 2017

Document Control Information - ***LIVE DOCUMENT***	
Control Status	MHSRT Programme Board – Approved/Scheduled MHSRT Programme Team – Approved/Scheduled Clinical Care Governance Committee – Approved/Scheduled Area Clinical Forum – Approved/Scheduled Area Partnership Forum – Approved/Scheduled P&K IJB Transformation Board – Approved/Scheduled Angus Integration Joint Board – Approved/Scheduled Dundee Integration Joint Board – approved Scheduled NHS Tayside Transformation Board – Approved/Scheduled Tayside NHS Board – Approved P&K Integration Joint Board – Approved/Scheduled
Date Last Printed	23/05/2017
Version Number	1.8
Author(s)	L Hamilton, Mental Health Programme Director & Finance Manager, NHS Tayside M Steven, Mental Health Programme Support Officer, NHS Tayside Reviewed – S Chima, Diversity and Inclusion Manager, NHS Tayside

EQUALITY IMPACT ASSESSMENT

Name of Policy, Service Improvement, Redesign or Strategy:

Mental Health Service Redesign Transformation (MHSRT) Programme

Lead Director or Manager:

Neil Prentice – Executive Lead - Associate Medical Director for Mental Health

Robert Packham – Operational Lead – Chief Officer, Perth & Kinross IJB

Lynne Hamilton – Programme Lead - Mental Health Programme Director & Finance Manager

What are the main aims of the Policy, Service Improvement, Redesign or Strategy?

The main aims of the MHSRT Programme are to review the clinical models of how we sustain and deliver good quality care and to optimise the use of the current facilities from where we deliver that care.

In line with these Programme aims and objectives there is a need to provide:

- Models of care which support safe, effective and person-centred care
- Improved care and treatment across hospital and community mental health services that focus on prevention of admission and timely supported discharge
- Hospital services are designed to provide interventions and care that can only be delivered in an inpatient facility. (only 6% of people who access secondary care mental health services each year, need to access care within inpatient services.)
- A shift in the balance to primary and community care and care at home.
- Models of care that ensure equity of access to services across Tayside
- Service models that support safe, effective and sustainable deployment of staff across Tayside

- Best Value and optimal use of resources to ensure that services are provided from flexible, fit for purpose, patient focussed facilities. Opportunities to disinvest in outdated estates and capital assets to reinvest in patient care.
- Effective recovery through close collaborative and co-productive relationships with family, carers and supporting community groups/organisations that complement statutory services.
- An environment that supports clinically effective and safe services
- A pleasant physical environment that promotes health and wellbeing
- Opportunities to redesign the patient pathway through care to improve patient experience, reduce length of stay and maximise use of scarce resources

To achieve this NHS Tayside therefore requires to develop future General Adult Mental Health and Learning Disability service models which will deliver these in terms of clinical service sustainability, workforce availability and financial affordability.

As well as improving patient environments NHS Tayside aims to make most efficient use of its asset base, maximise utilisation of existing PFI/NPD buildings and look to dispose of surplus assets which are no longer able to provide modern healthcare and fit for purpose accommodation.

Description of the Policy, Service Improvement, Redesign or Strategy –

What is it? What does it do? Who does it? And who is it for?

The MHSRT Programme was commissioned by NHS Tayside in partnership with the three local Integration Joint Boards to review Mental Health General Adult Psychiatry and Learning Disability services across Tayside.

This would include inpatient services currently being provided from:

- Murray Royal Hospital in Perth
- Carseview Centre in Dundee
- Susan Carnegie Centre on Stracthro site near Brechin, Angus
- Strathmartine Centre in Dundee

The review will look at General Adult Psychiatry (GAP) services for those aged between 18 and 65 (circa 250,000) and Learning Disability (LD) service models (no upper age limit) for delivery of care to the population of Tayside to provide Improved pathways and access to psychiatric care both through inpatient and community care.

What are the intended outcomes from the proposed Policy, Service Improvement, Redesign or strategy? – What will happen as a result of it?- Who benefits from it and how?

The main intended outcome of the MHSRT Programme is to provide safe, sustainable person centred GAP and LD service models for the future.

Through improved access to services in a sustainable way and improved community access/home treatments more people can be cared for as close to home or in own homes as is possible.

The proposed changes will review service user care pathways, workforce availability, service models sustainability, financial affordability and a review of the accommodation from where we provide these models.

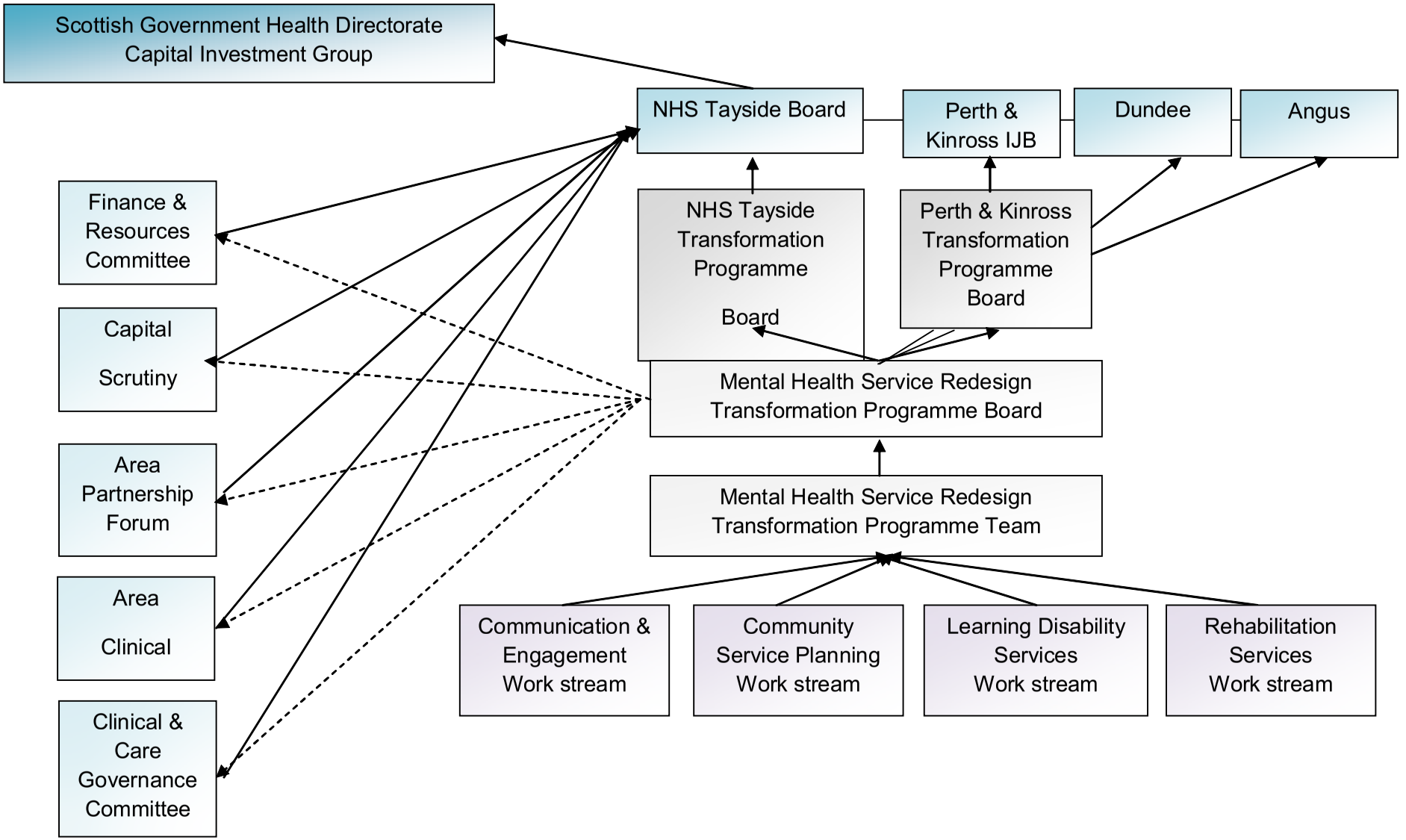
94% of the Mental Health population access MH and LD services in the community and only 6% access specialist inpatient services yet almost 60% of current resources are tied up in inpatient services. The MHSRT Programme seeks to shift the balance of care and investment of resources to more community based services to meet the needs of the population of Tayside.

Name of the group responsible for assessing or considering the equality impact assessment? This should be the Policy Working Group or the Project team for Service Improvement, Redesign or Strategy.

Mental Health Service Redesign Transformation Programme Team and Programme Board will assess and provide draft for approval at committees noted in table below – also see attached supporting reporting structure for MHSRT Programme

Name of meeting	Date of Meeting
Clinical Care Governance Committee	12th June 2017
Dundee IJB	27th June 2017
Angus IJB	28th June 2017
Perth & Kinross IJB	30th June 2017
Perth & Kinross Transformation Board	xxx
NHS Tayside Board	29th June 2017
NHS Transformation Board	xxx
Area Partnership Forum	27th June 2017
Area Clinical Forum	xxx
MHSRT Programme Board	June 2017
MHSRT Programme Team	1st June 2017

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME GOVERNANCE/REPORTING STRUCTURE



Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
1.1	Will it impact on the whole population? Yes or No. If yes will it have a differential impact on any of the groups identified in 1.2. If no go to 1.2 to identify which groups	No. The MHSRT Programme will not impact on the whole population. Any proposed changes to services will impact on the current % of population accessing NHS Tayside Adult Mental Health and Learning Disability services. Potential changes to service provision will impact on the population with all of the protected characteristics noted in section 1.2 Options being considered for both General Adult Psychiatry (GAP) and Learning Disability (LD) services have the potential to improve services for the majority of the mental health and learning disability population through a shift in balance of resources to the	Population/demographic statistics – detail attached in population report % of population affected by mental health in Tayside – A major study of psychiatric morbidity in Britain reported that, in 2000, one in six people had a neurotic illness, including anxiety and depression, while one in 200 had a psychotic disorder such as schizophrenia (Singleton et al., 2001; Cooper and Bebbington, 2006). One in seven people in the same survey had considered suicide at some point in their lives (Cooper and Bebbington, 2006) Approximately only 6% of people who access secondary care mental health services each year, need to access care	The MHSRT Programme team in partnership with the three local Integration Joint Board Strategic Planning groups will need to continually review all GAP and LD inpatient and community based services within localities and consider how these can be accessed more widely. Ensure services can be accessed by everyone regardless of age, race, gender and other equality factors. Enhance signposting of mental health services within local communities. Provision of Spiritual

		community. NHS Tayside is responsible for meeting the health care needs of just under 500,000 people living in Tayside. Tayside covers 3000 square miles of Urban, Accessible Rural and Rural populations within catchment from four Local Authority areas; Angus, Dundee, Perth & Kinross and North East Fife The largest populations in Tayside sit within the 50-54 year olds (7.5%) and 20-24 year olds (7.2%) bandings which is consistent with the Scottish average and has implications for Mental Health and Learning Disability service provision for 18 to 65 year olds moving forward. NHS Tayside and the three Integration Joint Boards need to provide the resilience to manage the growing demands for Mental Health and Learning	within inpatient services with 94% of activity taking place within a community based setting or service users own home. The changes proposed will provide greater care in the community and allow patients across Tayside to be cared for longer in their local communities and own home environments. For the residents of South Angus from areas such as Carnoustie, Monifieth, Tealing, Forfar and Monikie the relocation of the GAP acute admission inpatient services to Carseview site in Dundee will mean a reduction in travel time and improved transport links for GAP service users requiring acute admission and for their visiting families and carers and NHS staff. Those service users, visitors, staff and carers from North Angus will have increased travel as they are currently closer to current services	care rooms on all sites. Working with partners to look at possibility of provision of any demand responsive transport solutions where applicable Raise awareness of services available and how to access them in a variety of ways utilising existing networks, newsletters, sign-posting, closer working with general practice, etc. The Integration Joint Board (IJB) as a separate legal entity will operate independently from the Health Board. An annual performance report required by statute will be provided by the IJB

		Disability services especially for the majority of the activity which takes place within our local communities and within the service users own home. People with learning disabilities (LD) have a significant lifelong condition that begins before adulthood and affects their development so they need help to understand information, learn skills, and cope independently. About 16 000 school-aged children and young people, and 26 000 adults in Scotland have LD and require support. Population statistics suggest that 6 people in every 1 000 in Scotland have a LD. This rate increases to 9.2/1,000 (1,132 adults) in Dundee, drops to 5.5/1,000 (525 adults) in Angus and 3.9/1,000 (479 adults) in Perth and Kinross.	provided in Susan Carnegie Centre on Stracathro site near Brechin. Approx only 20% of the total current population of Angus live in North Angus. i.e Brechin and Montrose areas which equates to approx 4 to 5 patients of the current 25 acute inpatient admissions Currently 39% of Angus GAP Acute patient admissions have to be admitted out with Angus to inpatient beds within the Carseview Centre in Dundee and Murray Royal site in Perth due to varying bed demands. For the residents of North/East Perthshire from areas such as Invergowrie, Longforgan, Errol/Carse of Gowrie, Alyth and Blairgowrie the relocation of the GAP acute admission inpatient services to Carseview site in Dundee will mean a reduction or equivalent travel time and improved transport links for GAP service users requiring acute admission and for their	The MHSRT Programme team will continue to liaise with equalities team and local identified minority support groups. Cultural aspects/population and geographical trends will be monitored throughout process. Liaise with interpretation and translation and speech and language services to ensure appropriate service provision available for people who require support (particularly within LD service) The MHSRT Programme Team

			visiting families and carers and NHS staff. Those service users, visitors, staff and carers from South/West and more rural Perthshire will have increased travel as they are currently closer to current services provided in Murray Royal Hospital in Perth (furthest additional travel is 21 miles) Approx 27% of the total current population of Perth & Kinross live in South West and more rural areas of Perth & Kinross. i.e which equates to approx 7 patients of the current 26 acute inpatient admissions. Approx 45% of the total current population of Perth & Kinross live in city centre area of Perth i.e which equates to approx 11 patients of the current 26 acute inpatient admissions Approx 28% of the total current population of Perth & Kinross live in the North East area of Perth & Kinross and would	require to monitor and evaluate the ability to deliver service after any proposed change. As below in section 8 benefits realisation will support evaluation against agreed set of deliverables and benefits criteria

			therefore be nearer to Carseview Centre i.e which equates to approx 8 patients of the current 26 acute inpatient admissions Currently 21% of Perth GAP Acute patient admissions have to be admitted out with Perth & Kinross to inpatient beds within the Carseview Centre in Dundee and Susan Carnegie Centre in Angus due to varying bed demands. Tayside populations are split across three localities as 36% Perth & Kinross, 28% Angus and 36% Dundee. The relocation of Learning Disability inpatients beds currently provided in Strathmartine and Carseview sites in Dundee to Murray Royal hospital in Perth will mean greater travelling distances for the population of Angus and Dundee (64% of Tayside population) to access services	

			on the Murray Royal site in Perth (of 30 inpatient beds using this % would be approx 19 service users). However in turn this would mean reduced travelling distances for the residents of Perth & Kinross (34% of Tayside population) approx 11 service users.	

SECTION 1 Part B – Equality and Diversity Impacts

Which equality group or Protected Characteristics do you think will be affected?

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
1.2	Which of the protected characteristic(s) or groups will be affected? • Minority ethnic population (including refugees, asylum seekers & gypsies/travellers) • Women and men	The MHSRT Programme will impact on all the protected characteristics ranging from individual patient to locality populations although there is no immediate reason to think the service changes (reconfiguration or changes to pathway) would have an adverse impact Minority Ethnic - There is little	Ethnicity Figures for Tayside is attached: **ATTACHED AT THE END OF APPENDIX** ISD data : **ATTACHED AT THE END OF APPENDIX**	Review services within localities and consider how these can be accessed more widely. Ensure services can be accessed by everyone regardless of age, race, gender and other equality factors.

	• People in religious/faith groups • Disabled people (refer to 2.2, 2.3) • Older people, children and young people • Lesbian, gay, bisexual and transgender people • People with mental health problems • Homeless people • People involved in criminal justice system (refer to 2.2) • Staff	evidence to demonstrate any link between racial background and prevalence of mental health or LD conditions however from the supporting data gathered from ISD submission it can be noted that few people from ethnic minority groups access mental health 2.4% and learning disability 1% support and services Women and Men – ISD information from inpatient admissions for GAP show more males are admitted to services than females (52% males 47% females), however in LD services this split shows admissions are predominately male dominated (66% male 33% females) Perth & Kinross strategy for gypsies/travellers outlines a higher % of population in Perth & Kinross than elsewhere in Scotland – it highlights that the	Supporting research used to review impact: Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) **DOCUMENT ATTACHED AT THE END OF APPENDIX.** The Same as You a Review of Services for People with Learning Disabilities May 2000 **DOCUMENT ATTACHED AT THE END OF APPENDIX.** The Key to Life: Improving the Quality of Life for Patients with a Learning Disability June 2013 **DOCUMENT ATTACHED AT THE END OF APPENDIX.** Gypsy/Traveller Strategy for Perth and Kinross 2013 – 2018 **DOCUMENT ATTACHED AT THE END OF APPENDIX.** Health & Social Care Partnerships	Enhance signposting of mental health services within local communities. Provision of Spiritual care rooms on all inpatient sites. Working with partners to look at viability of any demand responsive transport solutions. Raise awareness of services available and how to access them in a variety of ways utilising existing networks, newsletters, sign-posting. Providing appropriate equality and diversity awareness training for staff and other service providers in line with NHST policy on

	• Socio- economically deprived groups	Scottish Census figures for 2011 included “Gypsy/Traveller” as a classification for the first time and the results were released in September 2013. Nationally 4,212 people were recorded as such with the highest individual local authority population being 415 in Perth and Kinross. Current ISD information recorded 0.1% inpatient admissions in GAP were gypsy/travellers and none recorded in LD services The MHSRT Programme team require to ensure the cultural and religious needs of service users are met. There is no link between religious belief and prevalence of Mental Health or Learning Disability The options being considered will impact on people who have a learning disability and those with a learning disability and a major mental illness. In addition will also affect those who have a	host mental health services Lesbian, Gay, Bisexual &/ Transgender (LGB&/T) ….A 2012 survey carried out by LGB&/T Youth Scotland of 273 people aged 13-25 found that 40% of LGBT youth consider themselves to have a mental health condition (compared to 25% of the population overall), with higher levels of poor mental health reported by transgender individuals (66.7%) and bisexual women (63%). Homophobic and transphobic bullying was reported as a significant contributing factor to mental health problems – Extract from the Mental Health in Scotland Fundamental Facts report – Mental Health Foundation report 2016 NHS Tayside Family friendly policies are in place alongside organisational change policies to support staff.	equality Continue to undertake analysis of any potential impacts identified and continually evaluate throughout life of programme The Integration Joint Board (IJB) as a separate legal entity will operate independently from the Health Board. An annual performance report required by statute will be provided by the IJB. Liaise with equalities team. Cultural aspects/population and geographical trends. Liaison with interpretation and translation and speech and language

		learning disability and are at a risk of offending behaviour (Forensic) There is the possibility of travelling further to the location/needing different travel / transport issues / arrangements depending on the location of inpatient beds compared to the current nearest inpatient bed. This could have a negative impact where age groups of service users/carers are disproportionally affected by transport issues (e.g less likely to have own transport if older/additional cost of transport) or where service users require assistance to travel or escort Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in		therapy services are available to ensure appropriate support for those who require and for people with LD and their families. Information is readily available and provided in other languages where requested/required. All programme consultation documentation will be provided in multiple languages. Written information for LD service users may also be required to be in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists within the service

		more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population		External review of LD day treatments to be undertaken and alternative models considered
Item	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
1.3	Will the development of the policy, strategy or service improvement/redesign lead to • Discrimination • Unequal opportunities • Poor relations between equality groups and other groups	Changes in service provision may have direct or indirect impacts on the Learning disability inpatient population through potential relocation of beds where current environment may be deemed by some	Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) **DOCUMENT ATTACHED AT THE END OF APPENDIX.** No Through Road: Mental Welfare Commission Report	The MHSRT Programme will continue to maintain and record all comment and views regarding the options considered within the programme communication and engagement plan which

	• Other	service users as their home. Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population	(Feb 2016) **DOCUMENT ATTACHED AT THE END OF APPENDIX.** A National Clinical Strategy for Scotland (Feb 2016) **DOCUMENT ATTACHED AT THE END OF APPENDIX.** NHS Tayside Clinical Services Strategy for Mental Health (2015) **DOCUMENT ATTACHED AT THE END OF APPENDIX.** NHS Tayside Health Equity Strategy – Communities in Control (2010) **DOCUMENT ATTACHED AT THE END OF APPENDIX** IJB Strategic Plans NHS Tayside LDP 2015 **DOCUMENT ATTACHED AT THE END OF APPENDIX.**	records all engagement activity undertaken to date. Feedback on preferred option will need to be obtained / considered during consultation period of the planned changes and appropriate solutions/support put in place to allow all key stakeholders to participate in the process. Various methods of communication and engagement such as evaluation through carer & patient groups/patient feedback questionnaires, focus groups, public events etc will support evaluation of options. Participation must be active, free and meaningful and give attention to issues of

		In order to reduce the risk of discrimination the following needs to be considered: Working with partners re demand responsive transport solutions. Ensure that services can be accessed by everyone regardless of age, race, gender and other equality factors. GAP options being considered will impact on access however it should be noted that current GAP beds are Tayside beds regardless of location and patients have been required to travel to other localities for admission when no bed in local area was available. Dundee GAP Patients will not be impacted upon by any of the options being considered. No change to relations between equality groups and other groups is foreseen. All options being considered for	Patients Rights (Scotland)Act 2011 **DOCUMENT ATTACHED AT THE END OF APPENDIX.** Convention on the Rights of Persons with Disabilities (UN 2006). **DOCUMENT ATTACHED AT THE END OF APPENDIX.**	accessibility, including access to information in a form and a language that can be understood. Working with partners re demand responsive transport solutions. Ensure that services can be accessed by everyone regardless of age, race, gender and other equality factors.

		both GAP and LD services impact on current service provision as options are purely considering change to the location of the service provision Learning Disability options look at the relocation of inpatient services from accommodation that is poor/ageing to brand new purpose built or refurbished accommodation which will greatly improve patient experience and impact on individual.		

SECTION 2 – Human Rights and Health Impact.

Which Human Rights could be affected in relation to article 2, 3, 5, 6, 9 and 11. (ECHR: European Convention on Human Rights)

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
2.1	**On Life (Article 2, ECHR)** • Basic necessities such as adequate nutrition, and safe drinking water	No impact – It is not envisaged that there will be any impact on basic necessities from any of the options being considered for GAP or LD	Adult Support and Protection (Scotland) 2007 **DOCUMENT ATTACHED AT THE END OF APPENDIX.** Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) Patients Rights (Scotland)Act 2011 MEL 5 (1999) Health Social	The MHSRT Programme will require to monitor/evaluate outcomes in relation to these factors– this can be supported by regular review of suicide rates, datix reporting, ligature incidents Specific views will need to be obtained /considered during consultation on the planned changes and appropriate solutions/support put in place.
	• Suicide	There is no evidence to suggest that prevalence of suicide rates would be impacted upon by any of the changes proposed for GAP or LD		
	• Risk to life of / from others	There is no evidence to suggest that prevalence of risk to life of self or others would be impacted upon by any of the changes proposed for GAP or LD		

	• Duties to protect life from risks by self / others	There is no evidence to suggest that duties to protect life from risk by self/others would be impacted upon by any of the changes proposed for GAP or LD	Work and Related Services for Mentally Disordered Offenders in Scotland, **DOCUMENT ATTACHED AT THE END OF APPENDIX.** Mental Health Strategy for Scotland: 2012-2015 **DOCUMENT ATTACHED AT THE END OF APPENDIX.** The Key to Life: Improving the Quality of Life for Patients with a Learning Disability June 2013	Risk Assessments which include risk of suicide to be carried out on all patients. Within inpatients, these would be completed on admission and reviewed at least daily by the multidisciplinary team. Patients' will engage in therapeutic activities to manage their thoughts and actions associated with risk of suicide. If required patients would be placed on higher level of observations which mean having a dedicated nurse with them 24/7.Ward doors to the unit can also be locked to mitigate risk and access to areas of
	• End of life questions	No impact - It is not envisaged that there will be any impact on End of Life questions from any of the options being considered for GAP or LD		

				known environmental risks removed.
2.2	**On Freedom from ill-treatment** **(Article 3, ECHR)** • Fear, humiliation • Intense physical or mental suffering or anguish • Prevention of ill-treatment, • Investigation of reasonably substantiated allegations of serious ill-treatment • Dignified living conditions • Standards of care	There is no immediate reason to think the service changes proposed in the options through reconfiguration or changes to pathway would have an adverse impact. A well designed service and accommodation should improve living conditions and the prevention of ill-treatment. Access to gardens/grounds/fit for purpose buildings/ safe environments Significant delay in transfer from prison can lead to mentally ill prisoners being managed for lengthy periods segregated from others and locked in a cell for almost 24h a day. This can exacerbate mental suffering. Manage separation of client groups regardless of option considered e.g. separate	Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) Patients Rights (Scotland)Act 2011	Specific views will need to be obtained /considered during consultation on the planned changes and appropriate solutions/support put in place. Participation must be active, free and meaningful and give attention to issues of accessibility, including access to information in a form and a language that can be understood MHSRT Programme team will require to assess and monitor impacts throughout process Review of Advocacy/peer support workers to support options

		entrances, separation of severity of illness/challenging behaviours etc Some of the options proposed look to improve standards of care through provision of "centres of Excellence" which can enhance ability to train staff and encourage shared learning and experiences		
Item	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
2.3	**On Liberty (Article 5, ECHR)** • Detention under mental health law • Review of continued justification of detention • Informing reasons for detention	Some potential impact on patients in criminal justice system, however options being considered are not changing the level of detention or right to be detained in the right environment only the potential distance to travel to for service users/carers and families. Levels of security will remain	Mental Health (Scotland) Act 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report	Monitored consistently through tribunals/MHCTA etc Review of requirement for Advocacy services/peer support workers

		appropriate and consistent with those set out in the MHCTA documentation. People who have a learning disability. People who have a learning disability and a major mental illness.	(Feb 2016) Adult Support and Protection (Scotland) 2007 Patients Rights (Scotland)Act 2011	
2.4	**On a Fair Hearing (Article 6, ECHR)** • Staff disciplinary proceedings • Malpractice • Right to be heard • Procedural fairness • Effective participation in proceedings that determine rights such as employment, damages / compensation	Within NHS Tayside any proposed changes to service delivery are the subject of full consultation with employees and staff side representatives. Any changes for employees in relation to their employment would be dealt with in accordance with NHS Tayside policy and practice following consultation with staff, human resources and staff side representatives	Adult Support and Protection (Scotland) 2007 Patients Rights (Scotland)Act 2011 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) NHS Tayside policies/procedures	Any potential impact will be dealt with in accordance with NHS Tayside organisational change policies supported through Human Resources team and staff side representatives. Right to be heard 1:1 meetings Communications and engagement through staff bulletins, Spectra, staffnet, social media, staff events etc

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
2.5	**On Private and family life** **(Article 6, ECHR)** • Private and Family life • Physical and moral integrity (e.g. freedom from non-consensual treatment, harassment or abuse • Personal data, privacy and confidentiality • Sexual identity • Autonomy and self-determination • Relations with family, community • Participation in decisions that affect rights • Legal capacity in decision making supported participation and decision making, accessible information and communication to support decision making • Clean and healthy environment	The options being considered as part of the MHSRT Programme will allow for the shift in balance of care for both GAP and LD services with an increased focus on community services this should mean fewer patients separated from their carers/ families/children. Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report Adult Support and Protection (Scotland) 2007 Patients Rights (Scotland)Act 2011 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in	Gain views from service users impacted upon any proposed changes re their wider family and community life Review requirements for Advocacy/peer support workers Ongoing communication engagement and monitoring Specific views will need to be obtained /considered during consultation on the planned changes and appropriate solutions/support put in place. Access to information in a form and a language

		around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population Impact on family life Family and community Through improved clean and healthy environments for inpatient services in GAP and LD Focus on community services should mean fewer patients separated from their carers/families/children.	Control (2010) Appleby and Deeming (2001)	that can be understood. Liaison with interpretation and translation services to ensure appropriate for people with LD and their families. Information is provided in other languages where required, requested, in relation to LD written information may also be required to be in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists within the service External review of LD day treatments to be undertaken and alternative models considered

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
2.6	**On Freedom of thought, conscience and religion (Article 9, ECHR)** • To express opinions and receive and impart information and ideas without interference	It is not envisaged there will be any impact from the service changes being considered	Patients Rights (Scotland)Act 2011	Spirituality services/accommodation provided on all sites to ensure consistency. Ongoing communication and engagement and monitoring of any complaints.
2.7	**On Freedom of assembly and association (Article 11, ECHR)** • Choosing whether to belong to a trade union	No impact		Monitored and appropriate solutions/support put in place if required.
2.8	**On Marriage and founding a family** • Capacity • Age	Increased access to normalised opportunities within a risk management framework (Forensic) No Impact envisaged for other services	Patients Rights (Scotland)Act 2011 No Through Road: Mental Welfare Commission Report (Feb 2016)	Monitored and appropriate solutions/support put in place if required.
2.9	**Protocol 1 (Article 1, 2, 3 ECHR)**	No change to enjoyment of possessions is envisaged as	Patients Rights (Scotland)Act 2011	Monitored and appropriate

	• Peaceful enjoyment of possessions	current restrictions implemented for safety will remain for all options being considered for GAP and LD.		solutions/support put in place if required.

SECTION 3 – Health Inequalities Impact

Which health and lifestyle changes will be affected?

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
3.1	What impact will the function, policy/strategy or service change have on lifestyles? For example will the changes affect: • Diet & nutrition • Exercise & physical activity • Substance use: tobacco, alcohol or drugs • Risk taking behaviours • Education & learning or skills • Other	Positive impact through improving pathways and access to psychiatric care through inpatient care with a focus on community care. Improvements in capacity and flow in our rehabilitation services which captures our learning education and skills. Promotes autonomy to make lifestyle choices through increased ability to be looked after in the community. Current provision will be matched/re-provided regardless of option selected Staff education – improvements through options	Evidence re repatriation of patients from out of areas – change in rehabilitation model and Tayside crisis response and Home Treatment pathway which signposts people towards healthy behaviours and reduction of risk. Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services	MHSRT Programme will continue to monitor and evaluate Liaison with interpretation and transaltion services to ensure appropriate for people with LD and their families Information is provided in other languages where required, requested, in relation to LD written information may also be required to be in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists

		which consider centralisation of workforce will allow for creation of “centres of excellence” which will increase training opportunities and promote shared learning and experiences. Greater equality and consistency of service provision	Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	within the service
3.2.	Does your function, policy or service change consider the impact on the communities? Things that might be affected include: • Social status • Employment (paid/unpaid) • Social/family support • Stress • Income	Positive impact in options considering centralisation of services where it is proposed that more patients will be cared for in the community/at home and be able to maintain their usual activities/family relationships. Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015)	Evaluate and monitor impact. Work with Police to minimise impact/risk Liaise with Scottish ambulance services, local authority with regard to options for transport/other services Look at identifying resource requirement for volunteer divers etc External review of LD day treatments to be undertaken and alternative models

		escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population There is a risk of a reduction in social/ family/carer support because of the distance between all inpatient units and their area of residence, particularly for some rural areas of Tayside and where carers may require support to access. This is particularly relevant to those patients with Learning	No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	considered

		Disabilities as they are more likely to have more contact with family and in particular elderly parents/relatives They also tend to be in hospital for longer. For both sets of patients it is extremely important that any rehabilitation in preparation for discharge is carried out as near the patients home area as possible.		
Item	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
3.3	Will the function, policy or service change have an impact on the physical environment? For example will there be impacts on: • Living conditions • Working conditions • Pollution or climate change • Accidental injuries/public safety • Transmission of infectious	The options being considered for both GAP and LD will increase ability to recruit and retain staff this can also be supported through staff engagement, imatter, Options considering a single or two site solution will support ability to provide more safe and sustainable medical rotas, consultant cover and staffing	Will be managed and mitigated through NHS Tayside organisational policies. Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission	Continue to monitor patient experience and evaluate impact Monitoring of benefits realisation Liaise with Scottish ambulance services, local authority with regard to options for transport/other services

	diseases • Other •	levels within inpatient services. Options which look at centralisation of services encourage provision of Centres of excellence, which will in turn assist in up-skilling of workforce, training and shared learning and experiences. Improved local links with colleges Options being considered will provide far improved working conditions for staff and living environments for patients. Some options being considered for patients within current LD environments will benefit from significantly improved environments within fit for purpose single bed room en-suite accommodation., football pitches, gyms, activity space, hub shop, café etc Could potentially lead to	Sept 2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	Look at identifying resource requirement for volunteer divers etc External review of LD day treatments to be undertaken and alternative models considered Improve links with colleges

		unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse media reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population		

3.4	Will the function, policy or service change affect access to and experience of services? For example • Healthcare • Social services • Education • Transport • Housing	Yes the proposed service change will improve access to services in a sustainable way and improve community access for GAP Mental Health services through redesigned community models and enhanced home treatment services. The options which allow for a shift in the balance of care to provide more support in the community will benefit the majority of the population who come in contact with services (94%) who will receive improved care and support as close to or in own home as is possible. This will also be case for Learning Disability service users through improvements in both service provision and physical environments. There is a risk of a reduction in social/ family support because of the distance between all	Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015) No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	Communication and engagement plan will continue to capture all comment and feedback received re experiences and stakeholder views Qualitative data gathered highlighting Patient experience. Liaise with Scottish ambulance services, local authority with regard to options for transport/other services Liaise with equalities team re cultural aspects and any supported minority groups. Liaison with interpreter services to ensure appropriate for people with LD and their families Information is provided in other languages where required, requested, in relation to LD written information

		inpatient units and their area of residence. This is particularly relevant to those patients with Learning Disabilities as they are more likely to have more contact with family and in particular elderly parents/relatives They also tend to be in hospital for longer. Could potentially lead to unequal opportunities due to: 1. Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2. Public perception around perceived loss of inpatient services rather than relocation of beds 3. Potential negative impact on community relations due to adverse		may also be required to be in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists within the service Look at identifying resource requirement for volunteer divers etc External review of LD day treatments to be undertaken and alternative models considered

		media reports and delays in taking elements of work forward. 4. Potential impacts on access to day service and psychology services for LD population		
tem	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
3.5	In relation to the protected characteristics and groups identified: • What are the potential impacts on health? • Will the function, policy or service change impact on access to health care? If yes - in what way? • Will the function or policy or service change impact on the experience of health care? If yes – in what way?	A potential reduction in 30% of the planned low secure rehabilitation beds will mean less availability for treatment of patients in a therapeutic secure environment. However current activity has remained below these levels since the opening of the unit in 2012. This could increase the likelihood individuals will continue to engage in harmful behaviour to themselves and others with an impact on their mental health if demand increased beyond envisaged capacity and therefore subsequent places	See Supporting Data Appendix Patients Rights (Scotland)Act 2011 Adult Support and Protection (Scotland) 2007 Hidden in Plain Sight (Equality & Human Rights Commission Sept 2015) A National Clinical Strategy for Scotland (Feb 2016) NHS Tayside Clinical Services Strategy for Mental Health (2015)	Communication and engagement plan will continue to be updated and include all feedback received Qualitative data gathered re Patient experience Liaise with equalities team re cultural aspects. Liaison with interpreter services to ensure appropriate for people with LD and their families Information is

		may then have to be secured out of area. We anticipate the proposed changes will rebalance care towards community treatment and widen access to healthcare at a local level. Access and Travel impacts as per previous sections	No Through Road: Mental Welfare Commission Report (Feb 2016) NHS Tayside Health Equity Strategy – Communities in Control (2010)	provided in other languages where required, requested, in relation to LD written information may also be required to be in an alternative style such as pictorial or graphically illustrated, this is developed when need arises by LD Speech and language Therapists within the service

SECTION 4 – Financial Decisions Impact

How will it affect the financial decision or proposal?

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
4.1	• Is the purpose of the financial decision for service improvement/redesign clearly set out • Has the impact of your financial proposals on equality groups been thoroughly considered before any decisions are arrived at	Yes. The MHSRT Programme Option Review Report provides detailed financial plans and potential estimated impact of both GAP and LD options being considered. These costings include initial high level estimates of recurring revenue, non recurring bridging plans, potential capital implications and any capital receipts available from the options being considered. The MHSRT Programme aims are to make more effective efficient use of current revenue resources within the existing resource envelope for both	MHSRT Programme Option Review Report – Financial section 10 and Appendix 6 & 7 Patients Rights (Scotland)Act 2011	MHSRT Programme Team will continue to review and work up more detailed costing information as progress through formal business cases stages to production of an Initial Agreement report through to Outline and Full business Case stages. Continued review of required workforce and safe staffing levels for the preferred option once identified.

		GAP and LD services. The options being considered present no reduction of current services but look at options to potentially relocate services which could allow for investment in more local based community services, enhancing provision of services for the majority of GAP and LD services whilst sustaining inpatient services and increasing safety and staff training opportunities. Economies of scale through relocation of workforce in some of the options being considered will mean a reduction in current inpatient workforce but additional community services		Requirement to work closely with Human Resources and staff side to ensure adherence to organisational change policies.
4.2	• Is there sufficient information to show that "due regard" has been paid to the equality duties in the financial decision making • Have you identified methods for mitigating or	Due regard has been paid and no disadvantage has been paid to any individuals	MHSRT Programme Option Review Report – Financial section 10 and Appendix 6 & 7 Patients Rights (Scotland)Act 2011	MHSRT Programme Team will continue to review and work up more detailed costing information as progress through formal business

	avoiding any adverse impacts on equality groups • Have those likely to be affected by the financial proposal been consulted and involved	See item 1.3 in terms of duties Options which consider relocation of services in Angus may need support in interim basis to provide cost cover for remaining Psychiatry of Old age wards on short term basis until a further OA would be conducted and alternative service could occupy.	EHRC: Making Fair Financial Decisons, A guide for decision-makers in Scottish Public Authorities (January 2015) EHRC: Assessing Impact and the Public Sector Equa;lity Duty, a guide for public authorities in Scotland	cases stages to production of an Initial Agreement report through to Outline and Full business Case stages.
Item	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
5.	Involvement, Consultation and Engagement (IEC) 1) What existing IEC data do we have? • Existing IEC sources • Original IEC • Key learning 2) What further IEC, if any, do	The MHSRT programme has a detailed communications and engagement plan which has included staff events, reference forums, information sharing events, stakeholder bulletins, website updates, press releases etc of all activity undertaken with GAP and LD service users/carers/voluntary organisations. The document also records all presentations	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report Attached MHRST Programme Communication and Engagement plan Patients Rights (Scotland)Act 2011	MHSRT Programme team and Board through the Communications and Engagement work stream will continue to follow SG and SHC guidance in relation to IEC in the preparation of the consultation plan and proposed formal consultation process.

	you need to undertake?	to relevant committees and organisations and feedback and comment received to date. Option Appraisal events and Option modelling events have been undertaken for both GAP and LD services and a further period of formal consultation of 3 months will be undertaken following identification of preferred option. Formal CEL04 guidance has been followed and support and advice received from the Scottish Health Council (SHC) and SG throughout the process to date.	Accessibility Information Policy NHS Health Scotland (May 2015) **DOCUMENT ATTACHED AT THE END OF APPENDIX.**	Ensure key stakeholder support in planning for consultation period for advise re best approach and any additional support requirements (i.e speech & language support, interpreter services, communication methods, use of technology/social media) Continue to review best practice and other examples undertaken by other NHS Boards i.e NHS Grampian Maternity services consultation report/web site

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
6.	Have any potential negative impacts been identified? • If so, what action has been proposed to counteract the negative impacts? (if yes state how) For example: • Is there any unlawful discrimination? • Could any community get an adverse outcome? • Could any group be excluded from the benefits of the function/policy? (consider groups outlined in 1.2) • Does it reinforce negative stereotypes? (For example, are any of the groups identified in 1.2 being disadvantaged due to perception	MHSRT Programme service model options being considered could potentially lead to unequal opportunities for both GAP and LD populations through: 1.Access Issues – primarily transport issues/ financial burden of travel costs/access to private or public transport/poor public transport links in more rural areas/ability to drive/requirement for escort/vulnerability of individually having to travel or be transported. 2.Public perception around perceived loss of inpatient services rather than relocation of beds	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report Patients Rights (Scotland)Act 2011 As per previous sections above	Programme Team and Programme Board will continue to monitor and evaluate any potential negative impacts identified throughout the process. Programme Team will look to work with partners to look at viability of any demand responsive transport solutions. Programme leads will continue to share information and provide updates regarding options and progress to formal consultation on preferred option to gather further stakeholder information and more detailed understanding of

	rather than factual information?)	3.Potential negative impact on community relations due to adverse media reports and delays in taking elements of work forward. 4.Potential impacts on access to day service and psychology services for LD population Yes. Negative comment/ feedback has been received from a number of staff/ service users/carers/vol orgs whom may be impacted upon by changes to service models being proposed. No unlawful discrimination. Reduced bed capacity to admit prisoners transferred to hospital for treatment and to admit accused persons in custody requiring assessment in hospital. No negative stereotypes reinforced		impact of change. Use of positive media coverage regarding proposed improvements to service provision and increased community supports to be made available Further detailed modelling of day service models for LD and LD Forensic psychology group work required once preferred option identified. Look at identifying resource requirement for volunteer divers etc External review of LD day treatments to be undertaken and alternative models considered

Item	Considerations of impact	Explain the answer and if applicable detail the Impact	Document any Evidence/Research/Data to support the consideration of impact	Further Actions required
7.	Data & Research • Is there need to gather further evidence/data? • Are there any apparent gaps in knowledge/skills?	We will continue to follow the Scottish Capital Investment Manual re Scottish Government approved process of option appraisal and CEL 04 guidance and advise from Scottish Health Council to support with relevant demographic/population information.	See Supporting Data Appendix Nine of the MHSRT Programme Option Review Report	Programme Team/Board will continue to review data/evidence requirement regarding impacts throughout process.
8.	Monitoring of outcomes • How will the outcomes be monitored? • Who will monitor? • What criteria will you use to measure progress towards the outcomes?	Benefits realisation process will be used to record the potential impact and improvements to services throughout the programme The programme will consider and monitor outcomes against the agreed benefits criteria used to score the options being considered as part of the option appraisal process.	Benefits realisation pro-forma used by the MHSRT - Programme Whiteboard example **DOCUMENT ATTACHED AT THE END OF APPENDIX.** Benefits Criteria used to score options in OA – 1. Supports safe, effective and person-centred care 2. Improved care and treatment across hospital and community mental health services with a	Programme team and Programme board will monitor and evaluate benefit realisation documentation against benefit criteria

			focus on prevention of admission and timely supported discharge 3. Ensures equity of access to services across Tayside 4. Supports effective and sustainable deployment of staff across Tayside 5. Makes best use of resources to ensure that services are provided from flexible, fit for purpose, patient focussed facilities. 6. Emphasis on maintaining effective recovery through close relationships with family, carers and supporting community groups and organisations that compliment NHS services.	
9..	Recommendations State the conclusion of the Impact Assessment	EQIA identifies clear actions within this live document which will be updated as part of ongoing communication and engagement with relevant stakeholders and throughout the business case process into implementation. Highlights	Benefits realisation report updated throughout process an implementation phase.	Continuously monitor and evaluate and provide update as required.

		requirement to review the effect of indirect/direct impacts on certain groups including those with noted protected characteristics.		
Item	**Considerations of impact**	**Explain the answer and if applicable detail the Impact**	**Document any Evidence/Research/Data to support the consideration of impact**	**Further Actions required**
10.	Completed function/policy • Who will sign this off? • When?	Tayside NHS Board and Dundee, Angus and Perth & Kinross IJB Boards February Board meetings	Board minutes	Continue to update as live document and present at each stage of business case approval process
11.	Publication	NHST and Dundee, Angus and Perth & Kinross Integration Joint Board minute from June 2017 Ongoing document reviewed and revised through Programme Team and Programme Board	Option Review Report & Supporting Appendices Board and Committee minutes	As 10. above

Conclusion Sheet for Equality Impact Assessment	
Positive Impacts (Note the groups affected) Ability to invest more resources in community to provide enhanced services for the majority of population. Centralisation of services allows for creation of centres of excellence, support training and support shared learning and experiences for both GAP and LD services	Negative Impacts (Note the groups affected) Potential additional travel for some service users, carers and families particularly coming from rural areas of Tayside.
What if any additional information and evidence is required User/Carer/third sector/staff/voluntary organisation feedback will be collated and provided within final Board paper	
From the outcome of the Equality Impact Assessment what are your recommendations? (refer to questions 5 - 10) NHS Tayside and three local Integration Joint Boards to give consideration to the proposed preferred service model option for approval to progress to formal consultation at Board meeting in June 2017	

This conclusion sheet should be attached to the relevant committee report.

MUST BE COMPLETED IN ALL CASES

Manager's Signature Date 23/05/2017

Table 1. Summary of Mid-year Population Estimates 2015-
NHS Tayside and Tayside's Local Authority Areas

AREA of RESIDENCE	GENDER	AGE GROUP (YRS)							AGE BANDS				All Ages
		0-4	5-14	15-44	45-64	65-74	75-84	85+	00-64yrs	65+yrs	00-74yrs	75+yrs	
Scotland	Males	149,284	288,053	1,017,346	720,105	259,409	137,723	38,549	2,174,788	435,681	2,434,197	176,272	***2,610,469***
	Females	141,890	276,445	1,036,055	760,824	285,872	184,187	77,258	2,215,214	547,317	2,501,086	261,445	***2,762,531***
	Both	***291,174***	***564,498***	***2,053,401***	***1,480,929***	***545,281***	***321,910***	***115,807***	***4,390,002***	***982,998***	***4,935,283***	***437,717***	***5,373,000***
NHS Tayside	Males	11,011	21,582	76,087	55,189	21,757	12,436	3,724	163,869	37,917	185,626	16,160	***201,786***
	Females	10,348	20,643	76,957	58,032	23,990	15,925	7,359	165,980	47,274	189,970	23,284	***213,254***
	Both	***21,359***	***42,225***	***153,044***	***113,221***	***45,747***	***28,361***	***11,083***	***329,849***	***85,191***	***375,596***	***39,444***	***415,040***
Angus	Males	3,075	6,288	19,366	16,474	6,952	3,717	1,078	45,203	11,747	52,155	4,795	***56,950***
	Females	2,861	6,126	19,467	17,166	7,460	4,711	2,159	45,620	14,330	53,080	6,870	***59,950***
	Both	***5,936***	***12,414***	***38,833***	***33,640***	***14,412***	***8,428***	***3,237***	***90,823***	***26,077***	***105,235***	***11,665***	***116,900***
Dundee City	Males	4,160	7,321	31,322	17,482	6,235	3,746	1,161	60285	11142	66520	4,907	***71,427***
	Females	3,991	6,912	32,562	18,602	7,175	5,210	2,331	62,067	14,716	69,242	7,541	***76,783***
	Both	***8,151***	***14,233***	***63,884***	***36,084***	***13,410***	***8,956***	***3,492***	***122,352***	***25,858***	***135,762***	***12,448***	***148,210***
Perth & Kinross	Males	3,776	7,973	25,399	21,233	8,570	4,973	1,485	58381	15028	66951	6,458	***73,409***
	Females	3,496	7,605	24,928	22,264	9,355	6,004	2,869	58,293	18,228	67,648	8,873	***76,521***
	Both	***7,272***	***15,578***	***50,327***	***43,497***	***17,925***	***10,977***	***4,354***	***116,674***	***33,256***	***134,599***	***15,331***	***149,930***

Source: NRS Mid Year Populations Estimates (MYPE), June 30th 2015 (Released April 28th, 2016)

Notes: NHS Tayside figures differs slightly from the sum of the 3 Tayside Local Authorities as a small proportion of these are encompassed within the population of Fife. Full details can be found on the "National Records of Scotland -NRS" (formally GRO(S)) website http://www.gro-scotland.gov.uk
Based on April 2014 NHS Board areas.

Chart 1. NHS Tayside: Mid-Year Population Estimates by Gender & Age Band, 2015

NHS Tayide_2015

- NHS Tayside covers an area of 7,527 square kilometres (population density 55 persons per sq km), providing health services to a population of approximately 415,040 people living throughout Angus (28.2% Tayside *population = 116,900]*, Dundee *(35.7% of Tayside population = 148,210)* and Perth and Kinross *(36.1% of Tayside population = 149,930)*, based on the 2015 mid-year population estimate.

- Taking into consideration the population estimates from 1981 onwards, 2014 was the first year where the population figure for Perth & Kinross exceeded that of Dundee City. In 2015, Perth & Kinross again held the highest proportion of the Tayside population. However, even with this change in proportions, the population desnity does vary considerably between the two local authority areas, while Perth & Kinross displays 28 persons per square kilometre, Dundee City's density was recorded as 2,477 persons per square kilometre[1] in 2015.

- The 2015 population estimate is a slight increase from the previous year's figure, an increase of 0.3% within NHS Tayide. Across the three Tayside local authority areas, Angus increased by 0.14%; Dundee City by 0.05% and Perth & Kinross recorded the largest increase of 0.67% between 2014 and 2015 population estimates[2].

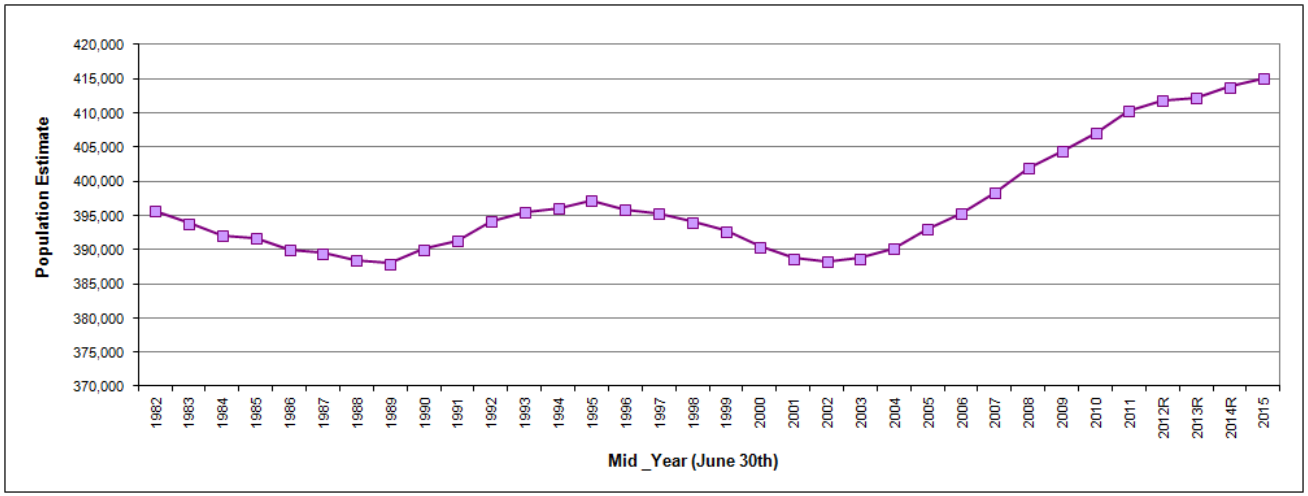
- In 2015, there were 49% males and 51% females (all ages). As the population ages, the male to female ratio becomes more apparent, esepcially within the elderly population, with more females surviving in the older age groups. In 2015, for those 65+ years, there were 45% males and 55% females, these proportions become 41% and 59% respectively for those aged 75+ years.

- Although a smaller proportion of population is found at the lower and higher age ends of the range across NHS Tayside, it is these people who generally have a higher level of health needs.

Note 1: Area (sq km) - Angus = 2,182; Dundee = 60; P&K = 5,286. Angus populatin density = 54 persons per sq km
Note 2: Population Estimates 2014 (Revised): Angus - 116,900; Dundee - 148,210; P&K - 149,930 & Tayside - 415,040

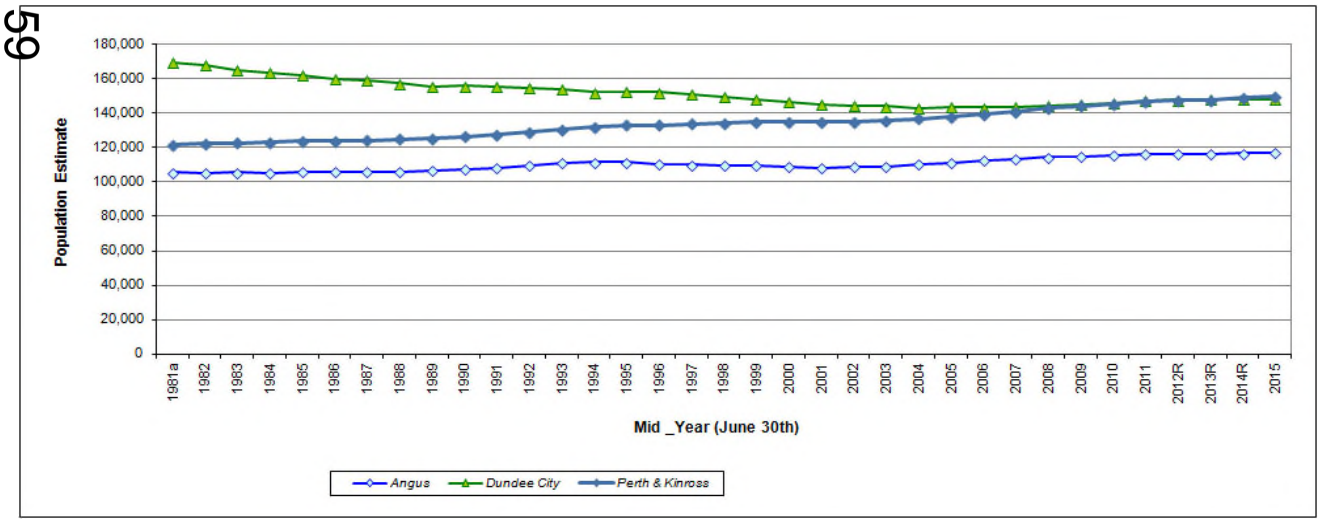
NHS Tayside 1981-2015

Chart 2. Tayside Health Board: Mid-year Population Estimates (All Persons / All Ages), 1981 - 2015



Source: NRS (formally GRO(S)) Mid Year Populations Estimates, as at June 30th each year

Chart 3. Tayside's Council Areas: Mid-year Population Estimates (All Persons / All Ages), 1981 - 2015



Source: NRS (formally GRO(S)) Mid Year Populations Estimates, as at June 30th each year

R= Revised

In October 2015 National Records of Scotland (NRS) acknowledged cumulative errors in the mid-year population estimates (MYPE) for 2012-2014. In April 2016 NRS released the revised (corrected) MYPEs for council and NHS boards in conjunction with the 2015 mid-year population estimates.

2015

Table 2. 2015 Mid-year population estimates by gender and 'single year of age' and 'five year-bands of age'.

 Note:April 2016 NHS Board areas.

Source: NRS Mid Year Populations Estimates (MYPE), June 30th 2015 (Released April 28th, 2016)

2.1 Scotland & Tayside by Gender and Single Year of Age

Persons	All Ages	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Scotland	*5,373,000*	*56,001*	*56,678*	*57,813*	*59,341*	*61,341*	*58,497*	*60,030*	*59,905*	*57,571*	*56,353*	*55,960*	*54,864*	*53,191*	*52,935*	*55,192*	*56,590*	*58,760*	*60,074*	*62,576*	*65,983*	*68,431*	*71,367*
Tayside	**415,040**	**4,141**	**4,085**	**4,284**	**4,412**	**4,437**	**4,255**	**4,411**	**4,365**	**4,200**	**4,024**	**4,290**	**4,148**	**4,104**	**4,068**	**4,360**	**4,486**	**4,493**	**4,888**	**5,106**	**5,246**	**5,299**	**5,922**

Males	All Ages	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Scotland	*2,610,469*	*28,765*	*29,135*	*29,527*	*30,503*	*31,354*	*29,801*	*30,513*	*30,453*	*29,438*	*28,689*	*28,779*	*28,216*	*27,119*	*26,995*	*28,050*	*29,133*	*30,163*	*30,796*	*32,041*	*33,634*	*34,514*	*35,638*
Tayside	**201,786**	**2,171**	**2,155**	**2,159**	**2,237**	**2,289**	**2,150**	**2,270**	**2,179**	**2,141**	**2,026**	**2,209**	**2,130**	**2,127**	**2,094**	**2,256**	**2,335**	**2,302**	**2,481**	**2,582**	**2,578**	**2,605**	**2,983**

Females	All Ages	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Scotland	*2,762,531*	*27,236*	*27,543*	*28,286*	*28,838*	*29,987*	*28,696*	*29,517*	*29,452*	*28,133*	*27,664*	*27,181*	*26,648*	*26,072*	*25,940*	*27,142*	*27,457*	*28,597*	*29,278*	*30,535*	*32,349*	*33,917*	*35,729*
Tayside	**213,254**	**1,970**	**1,930**	**2,125**	**2,175**	**2,148**	**2,105**	**2,141**	**2,186**	**2,059**	**1,998**	**2,081**	**2,018**	**1,977**	**1,974**	**2,104**	**2,151**	**2,191**	**2,407**	**2,524**	**2,668**	**2,694**	**2,939**

2.2 Tayside's Local Authority Areas by Gender and Single Year of Age

Persons	All Ages	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Angus	116,900	1,123	1,185	1,209	1,202	1,217	1,248	1,230	1,304	1,192	1,199	1,242	1,261	1,220	1,203	1,315	1,303	1,310	1,376	1,382	1,278	1,253	1,358
Dundee City	148,210	1,607	1,535	1,637	1,724	1,648	1,501	1,577	1,498	1,450	1,391	1,465	1,351	1,333	1,328	1,339	1,414	1,415	1,659	2,042	2,463	2,542	2,885
Perth & Kinross	149,930	1,411	1,365	1,438	1,486	1,572	1,506	1,604	1,563	1,558	1,434	1,583	1,536	1,551	1,537	1,706	1,769	1,768	1,853	1,682	1,505	1,504	1,679

Males	All Ages	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Angus	56,950	630	623	595	612	615	586	627	648	603	622	636	646	618	615	687	719	683	704	728	656	648	722
Dundee City	71,427	806	786	844	862	862	778	828	734	736	707	753	704	702	678	701	703	713	834	972	1,096	1,158	1,342
Perth & Kinross	73,409	735	746	720	763	812	786	815	797	802	697	820	780	807	801	868	913	906	943	882	826	799	919

Females	All Ages	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Angus	59,950	493	562	614	590	602	662	603	656	589	577	606	615	602	588	628	584	627	672	654	622	605	636
Dundee City	76,783	801	749	793	862	786	723	749	764	714	684	712	647	631	650	638	711	702	825	1,070	1,367	1,384	1,543
Perth & Kinross	76,521	676	619	718	723	760	720	789	766	756	737	763	756	744	736	838	856	862	910	800	679	705	760

2.3 Scotland & Tayside by Gender and Five Year Age Band

Persons	All Ages	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90+
Scotland	*5,373,000*	*291,174*	*292,356*	*272,142*	*303,983*	*367,670*	*363,886*	*347,900*	*320,137*	*349,825*	*395,818*	*405,293*	*362,820*	*316,998*	*312,955*	*232,326*	*187,569*	*134,341*	*76,012*	*39,795*
Tayside	**415,040**	**21,359**	**21,255**	**20,970**	**24,219**	**29,874**	**26,883**	**25,473**	**22,130**	**24,465**	**28,895**	**30,952**	**28,036**	**25,338**	**26,358**	**19,389**	**16,259**	**12,102**	**7,188**	**3,895**

Males	All Ages	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90+
Scotland	*2,610,469*	*149,284*	*148,894*	*139,159*	*155,767*	*183,161*	*180,793*	*170,000*	*157,465*	*170,160*	*191,565*	*197,222*	*177,071*	*154,247*	*151,487*	*107,922*	*82,703*	*55,020*	*27,126*	*11,423*
Tayside	**201,786**	**11,011**	**10,766**	**10,816**	**12,278**	**15,162**	**13,536**	**12,516**	**10,871**	**11,724**	**14,051**	**15,049**	**13,685**	**12,404**	**12,755**	**9,002**	**7,324**	**5,112**	**2,591**	**1,133**

Females	All Ages	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90+
Scotland	*2,762,531*	*141,890*	*143,462*	*132,983*	*148,216*	*184,509*	*183,093*	*177,900*	*162,672*	*179,665*	*204,253*	*208,071*	*185,749*	*162,751*	*161,468*	*124,404*	*104,866*	*79,321*	*48,886*	*28,372*
Tayside	**213,254**	**10,348**	**10,489**	**10,154**	**11,941**	**14,712**	**13,347**	**12,957**	**11,259**	**12,741**	**14,844**	**15,903**	**14,351**	**12,934**	**13,603**	**10,387**	**8,935**	**6,990**	**4,597**	**2,762**

2.4 Tayside's Local Authority Areas by Gender and Five Year Age Band

Persons	All Ages	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90+
Angus	116,900	5,936	6,173	6,241	6,649	6,359	5,968	6,288	6,240	7,329	8,505	9,062	8,271	7,802	8,287	6,125	4,882	3,546	2,071	1,166
Dundee City	148,210	8,151	7,417	6,816	8,993	15,106	13,149	10,589	8,060	7,987	9,198	10,094	9,261	7,531	7,805	5,605	5,060	3,896	2,292	1,200
Perth & Kinross	149,930	7,272	7,665	7,913	8,577	8,409	7,766	8,596	7,830	9,149	11,192	11,796	10,504	10,005	10,266	7,659	6,317	4,660	2,825	1,529

Males	All Ages	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90+
Angus	56,950	3,075	3,086	3,202	3,490	3,323	2,989	3,037	3,018	3,509	4,173	4,486	4,005	3,810	4,046	2,906	2,222	1,495	742	336
Dundee City	71,427	4,160	3,783	3,538	4,318	7,302	6,683	5,211	3,902	3,906	4,507	4,746	4,551	3,678	3,686	2,549	2,227	1,519	806	355
Perth & Kinross	73,409	3,776	3,897	4,076	4,470	4,537	3,864	4,268	3,951	4,309	5,371	5,817	5,129	4,916	5,023	3,547	2,875	2,098	1,043	442

Females	All Ages	0 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80 - 84	85 - 89	90+
Angus	59,950	2,861	3,087	3,039	3,159	3,036	2,979	3,251	3,222	3,820	4,332	4,576	4,266	3,992	4,241	3,219	2,660	2,051	1,329	830
Dundee City	76,783	3,991	3,634	3,278	4,675	7,804	6,466	5,378	4,158	4,081	4,691	5,348	4,710	3,853	4,119	3,056	2,833	2,377	1,486	845
Perth & Kinross	76,521	3,496	3,768	3,837	4,107	3,872	3,902	4,328	3,879	4,840	5,821	5,979	5,375	5,089	5,243	4,112	3,442	2,562	1,782	1,087

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22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
73,141	*77,485*	*77,246*	*74,147*	*73,527*	*73,839*	*71,408*	*70,965*	*70,533*	*68,276*	*69,258*	*70,132*	*69,701*	*68,314*	*66,079*	*61,363*	*60,428*	*63,953*	*64,459*	*65,347*	*69,421*	*73,863*	*76,735*	*75,732*	*78,720*	*80,228*	*80,816*	*80,322*	*83,200*
6,152	**6,284**	**6,217**	**5,569**	**5,419**	**5,485**	**5,285**	**5,125**	**5,280**	**5,114**	**4,961**	**5,124**	**4,994**	**4,654**	**4,522**	**4,264**	**4,258**	**4,432**	**4,357**	**4,513**	**4,837**	**5,278**	**5,480**	**5,405**	**5,757**	**5,799**	**5,866**	**6,068**	**6,366**

22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
36,142	*38,305*	*38,562*	*37,083*	*36,676*	*36,683*	*35,205*	*35,146*	*34,548*	*33,488*	*33,813*	*34,009*	*34,142*	*33,487*	*32,708*	*29,894*	*29,942*	*31,434*	*31,390*	*32,144*	*33,994*	*35,763*	*36,869*	*36,546*	*37,963*	*38,692*	*39,457*	*38,907*	*40,490*
3,111	**3,218**	**3,245**	**2,799**	**2,785**	**2,751**	**2,656**	**2,545**	**2,622**	**2,483**	**2,492**	**2,490**	**2,429**	**2,286**	**2,281**	**2,090**	**2,058**	**2,156**	**2,096**	**2,119**	**2,310**	**2,541**	**2,658**	**2,645**	**2,801**	**2,766**	**2,835**	**3,004**	**3,071**

22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
36,999	*39,180*	*38,684*	*37,064*	*36,851*	*37,156*	*36,203*	*35,819*	*35,985*	*34,788*	*35,445*	*36,123*	*35,559*	*34,827*	*33,371*	*31,469*	*30,486*	*32,519*	*33,069*	*33,203*	*35,427*	*38,100*	*39,866*	*39,186*	*40,757*	*41,536*	*41,359*	*41,415*	*42,710*
3,041	**3,066**	**2,972**	**2,770**	**2,634**	**2,734**	**2,629**	**2,580**	**2,658**	**2,631**	**2,469**	**2,634**	**2,565**	**2,368**	**2,241**	**2,174**	**2,200**	**2,276**	**2,261**	**2,394**	**2,527**	**2,737**	**2,822**	**2,760**	**2,956**	**3,033**	**3,031**	**3,064**	**3,295**

22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
1,289	1,231	1,228	1,129	1,174	1,216	1,183	1,266	1,188	1,202	1,251	1,381	1,266	1,277	1,241	1,220	1,212	1,290	1,293	1,389	1,506	1,573	1,568	1,618	1,737	1,641	1,735	1,774	1,839
3,062	3,373	3,244	3,018	2,752	2,652	2,515	2,212	2,403	2,162	2,030	2,040	1,954	1,752	1,677	1,536	1,535	1,560	1,489	1,432	1,553	1,661	1,852	1,731	1,852	1,859	1,822	1,934	2,055
1,801	1,680	1,745	1,422	1,493	1,617	1,587	1,647	1,689	1,750	1,680	1,703	1,774	1,625	1,604	1,508	1,511	1,582	1,575	1,692	1,778	2,044	2,060	2,056	2,168	2,299	2,309	2,360	2,472

22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
671	625	657	613	598	606	550	622	595	552	627	677	586	622	639	569	559	629	619	662	730	762	736	815	848	791	836	883	909
1,497	1,672	1,633	1,468	1,463	1,319	1,308	1,125	1,225	1,070	1,014	982	920	845	799	755	750	753	714	693	751	804	944	852	928	902	896	929	956
943	921	955	718	724	826	798	798	802	861	851	831	923	819	843	766	749	774	763	764	829	975	978	978	1,025	1,073	1,103	1,192	1,206

22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
618	606	571	516	576	610	633	644	593	650	624	704	680	655	602	651	653	661	674	727	776	811	832	803	889	850	899	891	930
1,565	1,701	1,611	1,550	1,289	1,333	1,207	1,087	1,178	1,092	1,016	1,058	1,034	907	878	781	785	807	775	739	802	857	908	879	924	957	926	1,005	1,099
858	759	790	704	769	791	789	849	887	889	829	872	851	806	761	742	762	808	812	928	949	1,069	1,082	1,078	1,143	1,226	1,206	1,168	1,266

51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79
82,142	*81,807*	*79,957*	*78,187*	*75,506*	*74,932*	*72,849*	*70,878*	*68,655*	*65,720*	*64,782*	*63,577*	*61,183*	*61,736*	*61,768*	*63,190*	*65,005*	*70,181*	*52,811*	*49,594*	*50,402*	*48,067*	*43,865*	*40,398*	*40,800*	*39,510*	*37,998*	*35,493*	*33,768*
6,183	**6,271**	**6,155**	**5,977**	**5,775**	**5,740**	**5,689**	**5,587**	**5,245**	**5,133**	**5,015**	**5,306**	**4,877**	**5,007**	**5,104**	**5,203**	**5,521**	**6,080**	**4,450**	**4,179**	**4,112**	**3,994**	**3,732**	**3,372**	**3,552**	**3,418**	**3,303**	**3,057**	**2,929**

51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79
39,635	*39,711*	*39,209*	*38,177*	*37,015*	*36,388*	*35,448*	*34,653*	*33,567*	*31,963*	*31,625*	*30,952*	*29,767*	*29,940*	*30,116*	*30,668*	*31,496*	*33,786*	*25,421*	*23,449*	*23,965*	*22,259*	*20,048*	*18,201*	*18,333*	*17,682*	*16,944*	*15,270*	*14,474*
3,094	**3,052**	**3,002**	**2,830**	**2,810**	**2,801**	**2,815**	**2,722**	**2,537**	**2,523**	**2,469**	**2,588**	**2,374**	**2,450**	**2,497**	**2,507**	**2,681**	**2,903**	**2,167**	**1,948**	**2,000**	**1,816**	**1,680**	**1,558**	**1,683**	**1,564**	**1,451**	**1,355**	**1,271**

51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79
42,507	*42,096*	*40,748*	*40,010*	*38,491*	*38,544*	*37,401*	*36,225*	*35,088*	*33,757*	*33,157*	*32,625*	*31,416*	*31,796*	*31,652*	*32,522*	*33,509*	*36,395*	*27,390*	*26,145*	*26,437*	*25,808*	*23,817*	*22,197*	*22,467*	*21,828*	*21,054*	*20,223*	*19,294*
3,089	**3,219**	**3,153**	**3,147**	**2,965**	**2,939**	**2,874**	**2,865**	**2,708**	**2,610**	**2,546**	**2,718**	**2,503**	**2,557**	**2,607**	**2,696**	**2,840**	**3,177**	**2,283**	**2,231**	**2,112**	**2,178**	**2,052**	**1,814**	**1,869**	**1,854**	**1,852**	**1,702**	**1,658**

51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79
1,804	1,829	1,901	1,689	1,790	1,677	1,626	1,610	1,568	1,524	1,541	1,666	1,473	1,598	1,582	1,656	1,769	1,919	1,361	1,311	1,343	1,248	1,165	1,058	1,092	973	1,007	947	863
1,943	2,049	1,999	2,048	1,947	1,872	1,908	1,882	1,652	1,588	1,503	1,537	1,449	1,454	1,521	1,532	1,637	1,823	1,292	1,225	1,157	1,118	1,079	1,026	1,067	1,060	1,067	918	948
2,436	2,393	2,255	2,240	2,038	2,191	2,155	2,095	2,025	2,021	1,971	2,103	1,955	1,955	2,001	2,015	2,115	2,338	1,797	1,643	1,612	1,628	1,488	1,288	1,393	1,385	1,229	1,192	1,118

51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79
940	896	960	781	871	814	795	768	757	742	742	823	702	801	820	776	878	907	665	622	649	580	544	511	506	439	446	442	389
925	977	935	953	932	922	944	941	812	786	751	713	715	713	695	754	752	870	615	557	563	514	468	447	501	485	450	384	407
1,229	1,179	1,107	1,096	1,007	1,065	1,076	1,013	968	995	976	1,052	957	936	982	977	1,051	1,126	887	769	788	722	668	600	676	640	555	529	475

51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79
864	933	941	908	919	863	831	842	811	782	799	843	771	797	762	880	891	1,012	696	689	694	668	621	547	586	534	561	505	474
1,018	1,072	1,064	1,095	1,015	950	964	941	840	802	752	824	734	741	826	778	885	953	677	668	594	604	611	579	566	575	617	534	541
1,207	1,214	1,148	1,144	1,031	1,126	1,079	1,082	1,057	1,026	995	1,051	998	1,019	1,019	1,038	1,064	1,212	910	874	824	906	820	688	717	745	674	663	643

80	81	82	83	84	85	86	87	88	89	90+
31,477	*28,857*	*26,397*	*25,116*	*22,494*	*19,821*	*17,425*	*14,672*	*12,855*	*11,239*	*39,795*
2,772	**2,621**	**2,273**	**2,317**	**2,119**	**1,843**	**1,612**	**1,391**	**1,265**	**1,077**	**3,895**

80	81	82	83	84	85	86	87	88	89	90+
13,378	*11,995*	*10,877*	*10,003*	*8,767*	*7,412*	*6,435*	*5,175*	*4,389*	*3,715*	*11,423*
1,174	**1,113**	**976**	**949**	**900**	**721**	**596**	**503**	**417**	**354**	**1,133**

80	81	82	83	84	85	86	87	88	89	90+
18,099	*16,862*	*15,520*	*15,113*	*13,727*	*12,409*	*10,990*	*9,497*	*8,466*	*7,524*	*28,372*
1,598	**1,508**	**1,297**	**1,368**	**1,219**	**1,122**	**1,016**	**888**	**848**	**723**	**2,762**

80	81	82	83	84	85	86	87	88	89	90+
811	754	661	687	633	551	452	398	337	333	1,166
871	897	729	717	682	588	557	452	384	311	1,200
1,090	970	883	913	804	704	603	541	544	433	1,529

80	81	82	83	84	85	86	87	88	89	90+
338	331	278	277	271	232	162	145	109	94	336
348	339	294	262	276	204	211	156	130	105	355
488	443	404	410	353	285	223	202	178	155	442

80	81	82	83	84	85	86	87	88	89	90+
473	423	383	410	362	319	290	253	228	239	830
523	558	435	455	406	384	346	296	254	206	845
602	527	479	503	451	419	380	339	366	278	1,087

1. Tayside's Ethnic Group Populations - Census 2001

Between the census of 1991 and that taken a decade later in 2001, the non-white ethnic population within Tayside was shown to have increased by over 3,000 indivduals to 7,495. The proportion accounted for by this population group, in terms of the total Tayside population, increased from 1.2% to 1.9% during this period.

Table 1.1 summarises the 2001 census figures for Tayside's ethnic groups, showing that Pakistani recorded the largest non-white ethnic population group within Tayside *(0.5% of the Tayside population)*, followed in proportion by both Indian and Chinese communities *(0.3% of the Tayside population each)* at the time of the census.

Table 1.1 Tayside's Ethnic Group Populations (Census 2001)

Administrative Area	Ethnic Group Populations (Census 2001)								
	White[1]	Indian	Pakistani	Other South Asian[2]	Chinese	Black[3]	Any Mixed Background	Other ethnic group	All Non-White Ethnic Groups
Tayside	381,517	1,244	1,998	*818*	1,243	582	882	728	**7,495**
(Pop = 389,012)	98.0%	0.3%	0.5%	0.2%	0.3%	0.1%	0.2%	0.2%	**1.9%**
Angus	107,546	90	142	*66*	229	62	181	84	**854**
(Pop = 108,400)	99.2%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	**0.8%**
Dundee	140,330	1,023	1,723	*649*	699	383	395	461	**5,333**
(Pop = 145,663)	96.3%	0.7%	1.2%	0.4%	0.5%	0.3%	0.3%	0.3%	**3.7%**
Perth & Kinross	133,641	131	133	*103*	315	137	306	183	**1,308**
(Pop = 134,949)	99.0%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	**1.0%**

Source: Census 2001 - "Sex and Age by Ethnic Group"

Table 1.1 Notes:
1. Encompasses the 2001 Census categories of White Scottish, Other White British, White Irish and Other White
2. Encompasses the 2001 Census categories of Bangladeshi and Other South Asian
3. Encompasses the 2001 Census categories of Caribbean, African, Black Scottish or Other Black

Of Tayside's three local council areas, as recorded at the time of the 2001 Census, Dundee City held the highest proportion of ethnic groups within it's own population (3.7% of the Dundee population). In addition, Dundee City's ethnic population accounted for 71.1% of Tayside's total ethnic population.

The non-white ethnic population across Tayside's three council areas in 2001 numbered:

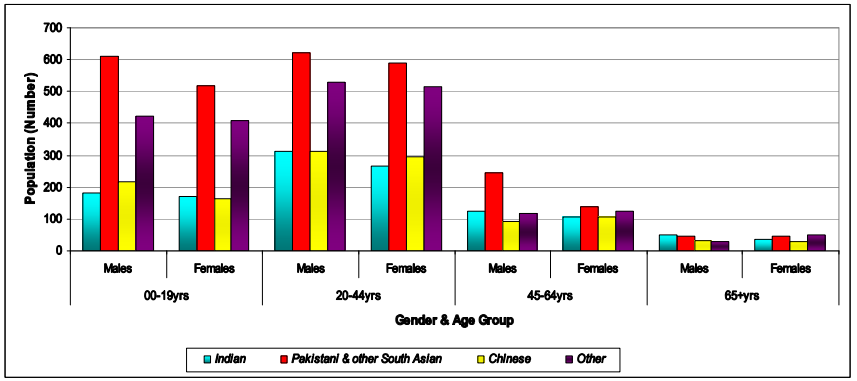
Angus
- 854 individuals *(11.4% of the Tayside ethnic population)*
- Both "Any Mixed Background" and Chinese population groups formed the largest minority ethnic population *(each representing 0.2% of the Angus population).*

Dundee City
- 5,333 individuals *(71.1% of Tayside ethnic population)*
- The Pakistani community formed the largest minority ethnic group *(1.2% of the Dundee population)*

Perth & Kinross
- 1,308 individuals *(17.5% of Tayside ethnic population)*
- Both the "Any Mixed Background" and Chinese population groups formed the largest minority ethnic group *(each representing 0.2% of the Perth & Kinross population).*

The age and gender distribution of the Tayside's ethnic population, as recorded in the 2001 Census, is displayed in Figure 1. The age distribution of the Tayside ethnic population differs from the collective population of Tayside, having a higher proportion of individuals in the younger age groups, a common age distribution recorded throughout the UK.

Figure 1. Tayside's Ethnic Population Groups by Gender and Age (Census 2001)



Source: Census 2001 - "Sex and Age by Ethnic Group"

Table 1.2 summarises Tayside's ethnic population across the three council areas at the time of the census by age and gender, displaying the same age distribution recorded at the Tayside level, of having a higher proportion of individuals in the younger age groups across the three local council areas.

Table 1.2 Tayside's Council Area Ethnic Population Groups by Gender and Age Group (Census 2001)

Administrative Area	Indian		Pakistani & other South Asian		Chinese		Other	
	Male	Female	Males	Female	Males	Female	Males	Female
Tayside (7,495 individuals)								
00-19yrs	2.4%	2.3%	8.1%	6.9%	2.9%	2.2%	5.6%	5.5%
20-44yrs	4.1%	3.5%	8.3%	7.9%	4.1%	3.9%	7.1%	6.9%
45-64yrs	1.6%	1.4%	3.3%	1.8%	1.2%	1.4%	1.6%	1.6%
65+yrs	0.7%	0.5%	0.6%	0.6%	0.4%	0.4%	0.4%	0.6%
Angus (854 individuals)								
00-19yrs	1.9%	0.6%	6.2%	4.3%	4.7%	4.8%	9.7%	6.9%
20-44yrs	2.1%	1.9%	4.2%	5.5%	5.0%	4.9%	6.0%	6.4%
45-64yrs	1.5%	1.2%	2.0%	1.1%	2.9%	3.6%	2.8%	3.7%
65+yrs	1.3%	0.1%	0.5%	0.6%	0.6%	0.2%	0.7%	2.0%
Dundee (5,333 individuals)								
00-19yrs	2.8%	2.7%	9.5%	8.5%	1.7%	1.5%	4.0%	3.7%
20-44yrs	4.8%	4.1%	9.8%	9.4%	4.2%	4.0%	6.7%	6.3%
45-64yrs	1.8%	1.6%	3.7%	2.2%	0.6%	0.6%	1.0%	0.8%
65+yrs	0.7%	0.6%	0.7%	0.7%	0.3%	0.3%	0.3%	0.4%
Perth & Kinross (1,308 individuals)								
00-19yrs	1.1%	1.5%	3.7%	2.4%	6.7%	3.2%	9.6%	11.5%
20-44yrs	2.7%	2.2%	5.1%	3.1%	3.4%	3.1%	9.3%	9.3%
45-64yrs	1.1%	0.8%	2.3%	1.0%	2.7%	3.3%	3.1%	3.8%
65+yrs	0.2%	0.4%	0.3%	0.1%	0.7%	0.9%	0.5%	0.8%

Source: Census 2001 - "Sex and Age by Ethnic Group"

2. Tayside's Ethnic Group Populations - Census 2011

More 2011 Census ethnic population data will be summarised here following any future national releases by the Scotland Census.

◆ Over the last decade between the 2001 Census and 2011 Census, the non-white ethnic population within Tayside has increased by over 5,500 individuals to 13,294 (7,495 in 2001). The proportion of the total Tayside population, accounted for by this non-white ethnic population group, increased from 1.9% to 3.2% over the last decade.

◆ Table 2.1 summarises the 2011 census figures for Tayside's ethnic groups, showing that at the time of the census, 'Asian' (inc. Scottish & British) recorded the largest non-white ethnic population group within Tayside *(2.1% of the Tayside population; N = 8,611)*, followed in proportion by the 'African' *(0.4% of the Tayside population; N = 1,527)*, and then both the 'Other -' and 'Mixed/Multiple -' ethnic population groups *(0.3% of the Tayside population each; N = 1,241 & 1,420 respectively).*

Table 2.1 Tayside's Ethnic Population Groups (Census 2011)

Administrative Area	All People	Ethnic Groups (Census 2011)						
		White[a]	Scottish or Asian British[b]	African[c]	Caribbean or Black[d]	Other Ethnic Groups[e]	Mixed or Multiple Ethnic Groups	**All Non-White Ethnic Groups**
Tayside	409,709	396,415	8,611	1,527	495	1,241	1,420	**13,294**
		96.8%	2.1%	0.4%	0.1%	0.3%	0.3%	**3.2%**
Angus	115,978	114,468	921	125	75	125	264	**1,510**
		98.7%	0.8%	0.1%	0.1%	0.1%	0.2%	**1.3%**
Dundee	147,268	138,460	5,838	1,170	269	846	685	**8,808**
		94.0%	4.0%	0.8%	0.2%	0.6%	0.5%	**6.0%**
Perth & Kinross	146,652	143,676	1,852	232	151	270	471	**2,976**
		98.0%	1.3%	0.2%	0.1%	0.2%	0.3%	**2.0%**

Source: Census 2011 (www.scotlandscensus.gov.uk) Release 2A, Table KS201SC "Ethnic Group by Health Board and Council Area"

Table 2.1 Notes:
a. Encompasses: White: Scottish; White: Other British; White: Irish; White: Gypsy/Traveller; White: Polish; White: Other White
b. Encompasses: Pakistani, Pakistani Scottish or Pakistani British; Indian, Indian Scottish or Indian British; Bangladeshi, Bangladeshi Scottish or Bangladeshi British; Chinese, Chinese Scottish or Chinese British; Other Asian
c. Encompasses: African, African Scottish or African British; Other African
d. Encompasses: Caribbean, Caribbean Scottish or Caribbean British; Black, Black Scottish or Black British; Other Caribbean or Black
e. Encompasses: Arab, Arab Scottish or Arab British; Other ethnic group

◆ All three of Tayside's council areas have recorded increases in their non-white ethnic population groups between the 2011 and previous census. As displayed in Table 2.1, of Tayside's three council areas, Dundee City recorded the highest proportion of non-white ethnic groups within it's own council area population *(6.0% of the Dundee population; N = 8,808)*. Dundee City's non-white ethnic population accounted for 66.3% of Tayside's total non-white ethnic population, the largest contribution of Tayside's three council areas.

◆ Tables 2.2.1 - 2.2.4 summarise the 2011 census figures for Tayside's ethnic population sub-groups (or communities). Of the recorded 'White' ethnic population (Table 2.2.1) within Tayside, following the communities of 'Scottish' and 'Other British', which account for the majority of this population group, 'Other White' and 'Polish' account for the next largest proportions within the Tayside population *(2.0%; N = 8,051 & 1.3%; N = 5,486 respectively)* at the time of the census.

◆ Of the 'Asian' ethnic population (Table 2.2.2), the 'Pakistani' community represented the largest proportion of the Asian population within Tayside *(0.6% of the Tayside population; N = 2,644)*, followed closely by both the 'Indian' and 'Chinese' communities, each representing 0.5% of the Tayside population *(N = 2,165 & 1,999 respectively)*.

◆ Table 2.2.4 shows that of those recorded as 'Other' ethnic populations residing within Tayside at the time of the 2011 Census, the 'Arab' community represented the largest proportion of this population *(0.2% of the Tayside population, N = 982).*

Table 2.2.1 Tayside's 'White' Ethnic Population Communities (Census 2011)

Administrative Area	All Persons	Ethnic Group: White						
		Scottish	Other British	Irish	Gypsy / Traveller	Polish	Other White	White [i] Total
Tayside	409,709	345,923	33,221	3,032	702	5,486	8,051	**396,415**
		84.4%	8.1%	0.7%	0.2%	1.3%	2.0%	**96.8%**
Angus	115,978	102,316	8,884	530	189	1,014	1,535	**114,468**
		88.2%	7.7%	0.5%	0.2%	0.9%	1.3%	**98.7%**
Dundee City	147,268	123,827	7,783	1,369	98	1,990	3,393	**138,460**
		84.1%	5.3%	0.9%	0.1%	1.4%	2.3%	**94.0%**
Perth & Kinross	146,652	119,916	16,597	1136	415	2,482	3,130	**143,676**
		81.8%	11.3%	0.8%	0.3%	1.7%	2.1%	**98.0%**

Source: Census 2011 (www.scotlandscensus.gov.uk) Release 2A, Table KS201SC "Ethnic Group by Health Board and Council Area"

Table 2.2.2 Tayside's 'Asian' Ethnic Population Communities (Census 2011)

Administrative Area	All Persons	Ethnic Group: Asian, Asian Scottish or Asian British					
		Pakistani, Pakistani Scottish or Pakistani British	Indian, Indian Scottish or Indian British	Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Chinese, Chinese Scottish or Chinese British	Other Asian	Asian [ii] Total
Tayside	409,709	2,644	2,165	400	1,999	1,403	**8,611**
		0.6%	0.5%	0.1%	0.5%	0.3%	**2.1%**
Angus	115,978	266	163	17	264	211	**921**
		0.2%	0.1%	0.0%	0.2%	0.2%	**0.8%**
Dundee City	147,268	2,047	1,417	310	1,274	790	**5,838**
		1.4%	1.0%	0.2%	0.9%	0.5%	**4.0%**
Perth & Kinross	146,652	331	585	73	461	402	**1,852**
		0.2%	0.4%	0.0%	0.3%	0.3%	**1.3%**

Source: Census 2011 (www.scotlandscensus.gov.uk) Release 2A, Table KS201SC "Ethnic Group by Health Board and Council Area"

Table 2.2.3 Tayside's 'Caribbean or Black' Ethnic Population Communities (Census 2011)

Administrative Area	All Persons	Ethnic Group: Caribbean or Black			
		Caribbean, Caribbean Scottish or Caribbean British	Black, Black Scottish or Black British	Other Caribbean or Black	Caribbean or Black [iii] Total
Tayside	409,709	315	127	53	**495**
		0.1%	0.0%	0.0%	**0.1%**
Angus	115,978	52	18	5	**75**
		0.0%	0.0%	0.0%	**0.1%**
Dundee City	147,268	167	66	36	**269**
		0.1%	0.0%	0.0%	**0.2%**
Perth & Kinross	146,652	96	43	12	**151**
		0.1%	0.0%	0.0%	**0.1%**

Source: Census 2011 (www.scotlandscensus.gov.uk) Release 2A, Table KS201SC "Ethnic Group by Health Board and Council Area"

Table 2.2.4 Tayside's 'African' and 'Other' Ethnic Population Communities (Census 2011)

Administrative Area	All Persons	Ethnic Group: African			Other Ethnic Groups			*Mixed or Multiple Ethnic Groups*
		African, African Scottish or African British	Other African	African [iv] Total	Arab, Arab Scottish or Arab British	Other ethnic group	Other Ethnic [v] Group Total	
Tayside	409,709	1,515	12	**1,527**	982	259	**1,241**	*1,420*
		0.4%	0.0%	**0.4%**	0.2%	0.1%	**0.3%**	*0.3%*
Angus	115,978	124	1	**125**	96	29	**125**	*264*
		0.1%	0.1%	**0.1%**	0.1%	0.0%	**0.1%**	*0.2%*
Dundee City	147,268	1,163	7	**1,170**	693	153	**846**	*685*
		0.8%	0.0%	**0.8%**	0.5%	0.1%	**0.6%**	*0.5%*
Perth & Kinross	146,652	228	4	**232**	193	77	**270**	*471*
		0.2%	0.0%	**0.2%**	0.1%	0.1%	**0.2%**	*0.3%*

Source: Census 2011 (www.scotlandscensus.gov.uk) Release 2A, Table KS201SC "Ethnic Group by Health Board and Council Area"

Table 2.2.1 - 2.2.4 Notes:
i. White Total encompasses: White: Scottish; White: Other British; White: Irish; White: Gypsy/Traveller; White: Polish; White: Other White
ii. Asian Total: "Asian, Asian Scottish or Asian British" encompasses Pakistani, Pakistani Scottish or Pakistani British; Indian, Indian Scottish or Indian British; Bangladeshi, Bangladeshi Scottish or Bangladeshi British; Chinese, Chinese Scottish or Chinese British; Other Asian
iii. Caribbean/Black Total encompasses: Caribbean, Caribbean Scottish or Caribbean British; Black, Black Scottish or Black British; Other Caribbean/Black
iv. African Total encompasses: African, African Scottish or African British; Other African
v. Other Ethnic Group Total encompasses: Arab, Arab Scottish or Arab British; Other ethnic group

- With regards to Tayside's white ethnic population communities recorded by the 2011 Census at council area level (Table 2.2.1), Perth & Kinross recorded the largest[1] proportion of 'Polish' residents, 1.7% of the Perth & Kinross population (N = 2,482), compared with Dundee City *(1.4%; N = 1,990)* and Angus *(0.9%; N = 1,014)* council area populations.

- The non-white ethnic communities across Tayside's three council area populations recorded within the 2011 Census included:

Angus

- There were 1,510 non-white ethnic residents, representing 1.3% of the total Angus population. This represented an increase in proportion from 0.8% recorded in the 2001 Census.
- These 1,510 Angus residents accounted for 11.4% of the total Tayside non-white ethnic population on Census day.

- Those recorded as belonging to the Asian population accounted for the highest proportion of the total Angus population *(0.8%; N = 921)*. Within this Asian population, the 'Pakistani', 'Chinese' and 'Other Asian' communities, each accounted for 0.2% of the total Angus population. *(Refer to Table 2.2.2)*

Dundee City

- There were 8,808 non-white ethnic residents, representing 6.0% of the total Dundee City population. This represented an increase in proportion from 3.7% recorded in the 2001 Census.
- These 8,808 Dundee residents accounted for 66.3% of Tayside non-white ethnic population on Census day.

- Those recorded as belonging to the Asian population accounted for the highest proportion of the total Dundee City population *(4.0%; N = 5,838).*

- Within Dundee City's Asian population, the 'Pakistani' community accounted for the largest proportion of this population *(1.4%; N = 2,047)*, with the 'Indian' *(1.0%; N = 1,417)* and 'Chinese' *(0.9%; N = 1,274)* communities representing the subsequent largest proportions within this council area. *(Refer to Table 2.2.2)*

- Dundee City recorded the highest proportion of 'African', 'Caribbean or Black' and 'Arab' (Other Ethnic Groups) communities, compared with it's Tayside counterparts. *(Refer to Table 2.2.3 & 2.2.4)*

Perth & Kinross

- There were 2,976 non-white ethnic residents, representing 2.0% of the total Perth & Kinross population. This represented an increase in proportion from 1.0% recorded in the 2001 Census.
- These 2,976 Perth & Kinross residents accounted for 22.4% of Tayside non-white ethnic population on Census day.

- Those recorded as belonging to the Asian population accounted for the highest proportion of the Perth & Kinross population *(1.3%; N = 1,852)*.

- Within Perth & Kinross's Asian population, the 'Indian' community accounted for the largest proportion of this population *(0.4%; N = 585)*, with both the 'Chinese' and 'Other Asian' communities, each accounting for a further 0.3% of the total Perth & Kinross population. *(Refer to Table 2.2.2)*

Notes:
1. As was recorded across Tayside as a Health Board, within each council area of Tayside, 'Scottish White', 'Other British' and 'Other White' accounted for the majority (in descending order) of each council areas collective 'White' ethnic population group.

3.1 Tayside's Ethnic Group Populations by Age - Census 2011

Scotland's Census 2011 - National Records of Scotland

Table DC2101SC - Ethnic group by sex by age

National Records of Scotland

Tayside

Ethnicity (Flat)		All people	White: Total	White: Scottish	White: Other British	White: Irish	White: Gypsy/Traveller	White: Polish	White: Other White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British: Total	Asian, Asian Scottish or Asian British: Pakistani, Pakistani Scottish or Pakistani British	Asian, Asian Scottish or Asian British: Indian, Indian Scottish or Indian British	Asian, Asian Scottish or Asian British: Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Asian, Asian Scottish or Asian British: Chinese, Chinese Scottish or Chinese British	Asian, Asian Scottish or Asian British: Other Asian	African: Total	African: African, African Scottish or African British	African: Other African	Caribbean or Black: Total	Caribbean or Black: Caribbean, Caribbean Scottish or Caribbean British	Caribbean or Black: Black, Black Scottish or Black British	Caribbean or Black: Other Caribbean or Black	Other ethnic groups: Total	Other ethnic groups: Arab, Arab Scottish or Arab British	Other ethnic groups: Other ethnic group
	Total	409,898	396,604	346,059	33,264	3,035	702	5,486	8,058	1,420	8,611	2,644	2,165	400	1,999	1,403	1,527	1,515	12	495	315	127	53	1,241	982	259
	0 to 4	21,075	19,850	18,257	619	25	49	591	309	285	659	263	176	32	89	99	126	126	0	35	17	14	4	120	108	12
	5 to 9	20,258	19,360	17,853	914	50	38	274	231	190	524	250	116	22	61	75	81	81	0	19	12	3	4	84	74	10
	10 to 14	22,896	22,170	20,311	1,233	52	38	261	275	135	440	188	88	25	70	69	68	68	0	23	17	3	3	60	54	6
	15	4,908	4,757	4,350	275	9	18	34	71	27	93	34	7	7	23	22	16	16	0	2	1	1	0	13	12	1
	16 to 17	9,603	9,305	8,515	508	21	25	82	154	52	190	63	38	8	58	23	16	16	0	9	7	1	1	31	28	3
	18 to 19	11,856	11,318	9,838	937	141	27	95	280	71	332	105	84	7	104	32	48	48	0	14	9	4	1	73	61	12
	20 to 24	28,835	26,834	21,829	2,353	488	45	674	1,445	175	1,406	295	346	47	532	186	183	181	2	74	48	11	15	163	134	29
	25 to 29	25,836	24,006	19,372	1,752	253	76	1,224	1,329	117	1,173	313	350	65	291	154	319	316	3	59	37	12	10	162	123	39
All people:	30 to 34	22,430	20,912	17,049	1,701	206	42	952	962	86	963	266	301	54	139	203	270	268	2	53	30	21	2	146	115	31
	35 to 39	23,335	22,358	18,850	2,222	180	55	423	628	44	658	168	172	27	99	192	146	144	2	38	27	9	2	91	63	28
	40 to 44	28,253	27,418	23,653	2,738	195	54	240	538	78	529	180	109	25	101	114	103	103	0	44	30	13	1	81	53	28
	45 to 49	30,976	30,339	26,390	3,022	214	51	211	451	47	415	118	90	12	116	79	69	69	0	40	18	18	4	66	50	16
	50 to 54	28,743	28,239	24,745	2,691	185	43	184	391	22	362	124	56	20	109	53	37	37	0	26	16	9	1	57	42	15
	55 to 59	25,784	25,391	22,241	2,567	212	32	89	250	26	286	101	54	16	72	43	17	15	2	24	19	3	2	40	27	13
	60 to 64	27,889	27,635	24,260	2,864	203	41	45	222	23	190	46	51	17	51	25	13	12	1	11	9	0	2	17	14	3
	65 to 69	21,513	21,342	18,804	2,138	185	29	28	158	15	131	32	47	10	23	19	7	7	0	6	5	0	1	12	7	5
	70 to 74	18,752	18,607	16,666	1,663	141	18	12	107	15	101	39	27	1	28	6	4	4	0	12	10	2	0	13	10	3
	75 to 79	15,610	15,505	14,067	1,207	123	8	11	89	5	93	34	31	2	21	5	2	2	0	0	0	0	0	5	2	3
	80 to 84	11,458	11,409	10,327	904	75	5	15	83	4	35	12	12	2	5	4	1	1	0	4	1	3	0	5	4	1
	85 and over	9,888	9,849	8,682	956	77	8	41	85	3	31	13	10	1	7	0	1	1	0	2	2	0	0	2	1	1
	Total	198,355	191,242	166,532	16,305	1,438	328	2,766	3,873	705	4,510	1,415	1,223	212	1,069	591	874	866	8	262	166	66	30	762	596	166
	0 to 4	10,738	10,095	9,268	314	16	20	294	183	145	344	145	84	10	52	53	75	75	0	13	7	5	1	66	57	9
	5 to 9	10,370	9,911	9,150	473	18	21	129	120	98	258	137	52	7	29	33	47	47	0	13	8	1	4	43	37	6
	10 to 14	11,720	11,362	10,437	624	27	16	125	133	65	212	91	45	8	38	30	39	39	0	8	5	1	2	34	29	5
	15	2,484	2,393	2,195	127	3	9	15	44	13	58	21	4	5	15	13	10	10	0	0	0	0	0	10	10	0
	16 to 17	4,934	4,790	4,387	261	10	12	37	83	34	82	25	13	4	28	12	6	6	0	3	2	0	1	19	17	2
	18 to 19	5,907	5,583	4,895	438	55	13	43	139	37	199	60	51	1	61	16	22	22	0	5	3	2	0	61	51	10
	20 to 24	14,453	13,335	10,929	1,166	232	21	302	685	92	813	146	236	26	321	84	84	82	2	33	23	4	6	96	75	21
	25 to 29	12,878	11,879	9,577	891	134	33	577	667	59	604	176	186	38	143	61	199	198	1	45	33	6	6	92	71	21
	30 to 34	11,035	10,195	8,146	901	105	24	526	493	43	527	136	190	30	84	87	158	156	2	33	19	12	2	79	65	14
Males:	35 to 39	11,187	10,667	8,915	1,084	93	28	241	306	16	336	96	91	17	50	82	94	93	1	20	14	4	2	54	36	18
	40 to 44	13,674	13,246	11,428	1,331	87	20	127	253	34	261	103	67	15	40	36	53	53	0	27	18	8	1	53	34	19
	45 to 49	15,240	14,897	12,965	1,450	124	22	130	206	19	209	69	42	7	56	35	41	41	0	27	9	16	2	47	36	11
	50 to 54	14,023	13,786	12,098	1,320	87	23	95	163	9	152	48	33	6	51	14	23	23	0	11	6	4	1	42	32	10
	55 to 59	12,641	12,442	10,849	1,308	96	14	60	115	9	146	62	32	9	32	11	10	8	2	5	4	1	0	29	21	8
	60 to 64	13,620	13,488	11,808	1,445	108	21	19	87	14	97	23	23	15	26	10	5	5	0	4	3	0	1	12	9	3
	65 to 69	10,203	10,117	8,839	1,091	84	18	10	75	6	65	17	19	10	11	8	3	3	0	3	2	0	1	9	5	4
	70 to 74	8,639	8,552	7,624	808	67	6	4	43	8	62	27	17	1	13	4	1	1	0	10	8	2	0	6	6	0
	75 to 79	6,888	6,821	6,186	552	44	3	2	34	3	57	22	19	1	13	2	2	2	0	0	0	0	0	5	2	3
	80 to 84	4,588	4,567	4,098	419	29	2	5	14	0	16	5	6	1	4	0	1	1	0	1	1	0	0	3	2	1
	85 and over	3,133	3,116	2,738	302	19	2	25	30	1	12	6	3	1	2	0	1	1	0	1	1	0	0	2	1	1
	Total	211,543	205,362	179,527	16,959	1,597	374	2,720	4,185	715	4,101	1,229	942	188	930	812	653	649	4	233	149	61	23	479	386	93
	0 to 4	10,337	9,755	8,989	305	9	29	297	126	140	315	118	92	22	37	46	51	51	0	22	10	9	3	54	51	3
	5 to 9	9,888	9,449	8,703	441	32	17	145	111	92	266	113	64	15	32	42	34	34	0	6	4	2	0	41	37	4
	10 to 14	11,176	10,808	9,874	609	25	22	136	142	70	228	97	43	17	32	39	29	29	0	15	12	2	1	26	25	1
	15	2,424	2,364	2,155	148	6	9	19	27	14	35	13	3	2	8	9	6	6	0	2	1	1	0	3	2	1
	16 to 17	4,669	4,515	4,128	247	11	13	45	71	18	108	38	25	4	30	11	10	10	0	6	5	1	0	12	11	1
	18 to 19	5,949	5,735	4,943	499	86	14	52	141	34	133	45	23	6	43	16	26	26	0	9	6	2	1	12	10	2
	20 to 24	14,382	13,499	10,900	1,187	256	24	372	760	83	593	149	110	21	211	102	99	99	0	41	25	7	9	67	59	8
	25 to 29	12,958	12,127	9,795	861	119	43	647	662	58	569	137	164	27	148	93	120	118	2	14	4	6	4	70	52	18
	30 to 34	11,395	10,717	8,903	800	101	18	426	469	43	436	130	111	24	55	116	112	112	0	20	11	9	0	67	50	17
Females:	35 to 39	12,148	11,691	9,935	1,138	87	27	182	322	28	322	72	81	10	49	110	52	51	1	18	13	5	0	37	27	10
	40 to 44	14,579	14,172	12,225	1,407	108	34	113	285	44	268	77	42	10	61	78	50	50	0	17	12	5	0	28	19	9
	45 to 49	15,736	15,442	13,425	1,572	90	29	81	245	28	206	49	48	5	60	44	28	28	0	13	9	2	2	19	14	5
	50 to 54	14,720	14,453	12,647	1,371	98	20	89	228	13	210	76	23	14	58	39	14	14	0	15	10	5	0	15	10	5
	55 to 59	13,143	12,949	11,392	1,259	116	18	29	135	17	140	39	22	7	40	32	7	7	0	19	15	2	2	11	6	5
	60 to 64	14,269	14,147	12,452	1,419	95	20	26	135	9	93	23	28	2	25	15	8	7	1	7	6	0	1	5	5	0
	65 to 69	11,310	11,225	9,965	1,047	101	11	18	83	9	66	15	28	0	12	11	4	4	0	3	3	0	0	3	2	1
	70 to 74	10,113	10,055	9,042	855	74	12	8	64	7	39	12	10	0	15	2	3	3	0	2	2	0	0	7	4	3
	75 to 79	8,722	8,684	7,881	655	79	5	9	55	2	36	12	12	1	8	3	0	0	0	0	0	0	0	0	0	0
	80 to 84	6,870	6,842	6,229	485	46	3	10	69	4	19	7	6	1	1	4	0	0	0	3	0	3	0	2	2	0
	85 and over	6,755	6,733	5,944	654	58	6	16	55	2	19	7	7	0	5	0	0	0	0	1	1	0	0	0	0	0

3.2 Angus CHP Ethnic Group Populations by Age - Census 2011

Scotland's Census 2011 - National Records of Scotland

Table DC2101SC - Ethnic group by sex by age

Angus Community	Ethnicity (Flat)		All people	White: Total	White: Scottish	White: Other British	White: Irish	White: Gypsy/Traveller	White: Polish	White: Other White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British: Total	Asian, Asian Scottish or Asian British: Pakistani, Pakistani Scottish or Pakistani British	Asian, Asian Scottish or Asian British: Indian, Indian Scottish or Indian British	Asian, Asian Scottish or Asian British: Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Asian, Asian Scottish or Asian British: Chinese, Chinese Scottish or Chinese British	Asian, Asian Scottish or Asian British: Other Asian	African: Total	African: African, African Scottish or African British	African: Other African	Caribbean or Black: Total	Caribbean or Black: Caribbean, Caribbean Scottish or Caribbean British	Caribbean or Black: Black, Black Scottish or Black British	Caribbean or Black: Other Caribbean or Black	Other ethnic groups: Total	Other ethnic groups: Arab, Arab Scottish or Arab British	Other ethnic groups: Other ethnic group
	All people:	Total	115,978	114,468	102,316	8,884	530	189	1,014	1,535	264	921	266	163	17	264	211	125	124	1	75	52	18	5	125	96	29
		0 to 4	5,967	5,805	5,394	182	8	18	112	91	64	64	20	12	2	12	18	17	17	0	5	4	1	0	12	10	2
		5 to 9	6,096	5,973	5,569	273	14	8	58	51	34	61	24	10	1	14	12	12	12	0	5	5	0	0	11	10	1
		10 to 14	6,802	6,682	6,215	336	12	3	52	64	27	66	29	6	1	16	14	10	10	0	7	6	0	1	10	7	3
		15	1,393	1,377	1,275	71	4	4	9	14	3	10	3	0	0	4	3	0	0	0	0	0	0	0	3	3	0
		16 to 17	2,930	2,879	2,704	130	2	4	18	21	16	25	9	4	0	8	4	1	1	0	2	2	0	0	7	7	0
		18 to 19	2,567	2,536	2,380	125	3	4	9	15	10	20	12	1	0	4	3	1	1	0	0	0	0	0	0	0	0
		20 to 24	5,983	5,879	5,244	347	22	7	97	162	22	65	22	5	0	29	9	10	10	0	1	1	0	0	6	5	1
		25 to 29	6,040	5,924	5,015	409	27	26	193	254	16	76	29	9	4	22	12	7	7	0	6	3	3	0	11	5	6
		30 to 34	5,983	5,831	4,992	422	33	13	171	200	21	96	27	17	3	18	31	26	25	1	5	1	2	2	4	3	1
		35 to 39	6,911	6,776	5,867	631	47	12	100	119	6	91	9	23	2	18	39	17	17	0	13	11	2	0	8	8	0
		40 to 44	8,306	8,208	7,216	755	48	11	44	134	9	64	24	10	1	19	10	6	6	0	7	3	4	0	12	8	4
		45 to 49	9,089	8,987	7,879	874	53	18	46	117	8	74	9	20	0	25	20	6	6	0	6	3	3	0	8	5	3
		50 to 54	8,324	8,227	7,226	813	40	16	46	86	6	65	15	13	0	24	13	4	4	0	5	2	2	1	17	14	3
		55 to 59	7,790	7,725	6,819	763	60	9	28	46	3	48	12	7	0	22	7	3	3	0	2	2	0	0	9	5	4
		60 to 64	8,736	8,690	7,716	846	46	12	6	64	6	31	3	6	1	16	5	2	2	0	5	4	0	1	2	2	0
		65 to 69	6,694	6,666	5,926	641	39	15	6	39	6	18	3	3	0	4	8	1	1	0	2	2	0	0	1	0	1
		70 to 74	5,587	5,565	5,068	439	29	3	5	21	5	13	5	4	0	4	0	0	0	0	2	1	1	0	2	2	0
		75 to 79	4,582	4,562	4,190	332	22	0	3	15	0	17	6	6	0	5	0	2	2	0	0	0	0	0	1	1	0
		80 to 84	3,293	3,280	3,026	227	10	1	3	13	1	11	3	4	1	0	3	0	0	0	1	1	0	0	0	0	0
		85 and over	2,905	2,896	2,595	268	11	5	8	9	1	6	2	3	1	0	0	0	0	0	1	1	0	0	1	1	0
	Males:	Total	56,206	55,448	49,407	4,435	237	91	510	768	128	450	145	85	10	135	75	72	71	1	37	20	14	3	71	52	19
		0 to 4	2,958	2,872	2,659	91	4	6	55	57	35	29	9	4	0	8	8	14	14	0	3	2	1	0	5	4	1
		5 to 9	3,114	3,044	2,840	135	4	4	25	36	16	38	13	7	0	11	7	8	8	0	2	2	0	0	6	6	0
		10 to 14	3,534	3,476	3,252	165	6	2	17	34	12	35	17	5	0	8	5	5	5	0	1	1	0	0	5	3	2
		15	709	696	646	31	1	3	4	11	2	8	2	0	0	3	3	0	0	0	0	0	0	3	3	0
		16 to 17	1,493	1,468	1,381	65	0	2	9	11	12	9	3	2	0	2	2	0	0	0	1	1	0	0	3	3	0
		18 to 19	1,345	1,327	1,244	65	1	2	5	10	4	13	8	2	0	2	2	1	1	0	0	0	0	0	0	0	0
		20 to 24	3,084	3,022	2,694	191	12	3	35	87	10	40	13	2	0	20	5	9	9	0	1	1	0	0	2	1	1
		25 to 29	3,021	2,959	2,531	199	11	7	89	122	10	39	19	5	3	8	4	2	2	0	6	3	3	0	5	0	5
		30 to 34	2,867	2,801	2,363	217	18	11	91	101	6	41	14	9	2	10	6	12	11	1	4	1	1	2	3	3	0
		35 to 39	3,311	3,243	2,762	326	25	6	67	57	4	44	7	10	2	10	15	9	9	0	6	5	1	0	5	5	0
		40 to 44	3,978	3,933	3,477	354	17	4	23	58	3	28	10	7	0	10	1	3	3	0	5	1	4	0	6	3	3
		45 to 49	4,552	4,505	3,978	403	28	11	28	57	4	34	7	9	0	10	8	2	2	0	2	0	2	0	5	4	1
		50 to 54	4,009	3,971	3,469	418	16	9	27	32	1	20	3	7	0	8	2	2	2	0	3	1	1	1	12	9	3
		55 to 59	3,826	3,793	3,314	414	23	2	18	22	1	25	9	3	0	12	1	1	1	0	0	0	0	0	6	4	2
		60 to 64	4,305	4,286	3,767	459	24	5	4	27	2	15	1	3	1	8	2	1	1	0	0	0	0	0	1	1	0
		65 to 69	3,216	3,204	2,810	336	21	11	4	22	3	6	1	0	0	1	4	1	1	0	1	1	0	0	1	0	1
		70 to 74	2,632	2,621	2,382	215	14	2	1	7	3	6	3	3	0	0	0	0	0	0	1	0	1	0	1	1	0
		75 to 79	2,023	2,006	1,832	157	8	0	1	8	0	14	5	5	0	4	0	2	2	0	0	0	0	0	1	1	0
		80 to 84	1,319	1,314	1,195	112	3	0	0	4	0	4	0	3	1	0	0	0	0	0	1	1	0	0	0	0	0
		85 and over	910	907	811	82	1	1	7	5	0	2	1	0	1	0	0	0	0	0	0	0	0	0	1	1	0
	Females:	Total	59,772	59,020	52,909	4,449	293	98	504	767	136	471	121	78	7	129	136	53	53	0	38	32	4	2	54	44	10
		0 to 4	3,009	2,933	2,735	91	4	12	57	34	29	35	11	8	2	4	10	3	3	0	2	2	0	0	7	6	1
		5 to 9	2,982	2,929	2,729	138	10	4	33	15	18	23	11	3	1	3	5	4	4	0	3	3	0	0	5	4	1
		10 to 14	3,268	3,206	2,963	171	8	1	35	30	15	31	12	4	1	8	9	5	5	0	6	5	0	1	5	4	1
		15	684	681	629	40	3	1	5	3	1	2	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
		16 to 17	1,437	1,411	1,323	65	2	2	9	10	4	16	6	2	0	6	2	1	1	0	1	1	0	0	4	4	0
		18 to 19	1,222	1,209	1,136	60	2	2	4	5	6	7	4	0	0	2	1	0	0	0	0	0	0	0	0	0	0
		20 to 24	2,899	2,857	2,550	156	10	4	62	75	12	25	9	3	0	9	4	1	1	0	0	0	0	0	4	4	0
		25 to 29	3,019	2,965	2,484	210	16	19	104	132	6	37	10	4	1	14	8	5	5	0	0	0	0	0	6	5	1
		30 to 34	3,116	3,030	2,629	205	15	2	80	99	15	55	13	8	1	8	25	14	14	0	1	0	1	0	1	0	1
		35 to 39	3,600	3,533	3,105	305	22	6	33	62	2	47	2	13	0	8	24	8	8	0	7	6	1	0	3	3	0
		40 to 44	4,328	4,275	3,739	401	31	7	21	76	6	36	14	3	1	9	9	3	3	0	2	2	0	0	6	5	1
		45 to 49	4,537	4,482	3,901	471	25	7	18	60	4	40	2	11	0	15	12	4	4	0	4	3	1	0	3	1	2
		50 to 54	4,315	4,256	3,757	395	24	7	19	54	5	45	12	6	0	16	11	2	2	0	2	1	1	0	5	5	0
		55 to 59	3,964	3,932	3,505	349	37	7	10	24	2	23	3	4	0	10	6	2	2	0	2	2	0	0	3	1	2
		60 to 64	4,431	4,404	3,949	387	22	7	2	37	4	16	2	3	0	8	3	1	1	0	5	4	0	1	1	1	0
		65 to 69	3,478	3,462	3,116	305	18	4	2	17	3	12	2	3	0	3	4	0	0	0	1	1	0	0	0	0	0
		70 to 74	2,955	2,944	2,686	224	15	1	4	14	2	7	2	1	0	4	0	0	0	0	1	1	0	0	1	1	0
		75 to 79	2,559	2,556	2,358	175	14	0	2	7	0	3	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0
		80 to 84	1,974	1,966	1,831	115	7	1	3	9	1	7	3	1	0	0	3	0	0	0	0	0	0	0	0	0	0
		85 and over	1,995	1,989	1,784	186	10	4	1	4	1	4	1	3	0	0	0	0	0	0	1	1	0	0	0	0	0

For further information on variables, see www.scotlandscensus.gov.uk/variables

In order to protect against disclosure of personal information, some records have been swapped between different geographic areas. Some cell values will be affected, particularly small values at the most detailed geographies.

3.3 Dundee CHP Ethnic Group Populations by Age - Census 2011

Scotland's Census 2011 - National Records of Scotland

Table DC2101SC - Ethnic group by sex by age

Dundee Community

Ethnicity (Flat)		All people	White: Total	White: Scottish	White: Other British	White: Irish	White: Gypsy/Traveller	White: Polish	White: Other White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British: Total	Asian, Asian Scottish or Asian British: Pakistani, Pakistani Scottish or Pakistani British	Asian, Asian Scottish or Asian British: Indian, Indian Scottish or Indian British	Asian, Asian Scottish or Asian British: Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Asian, Asian Scottish or Asian British: Chinese, Chinese Scottish or Chinese British	Asian, Asian Scottish or Asian British: Other Asian	African: Total	African: African, African Scottish or African British	African: Other African	Caribbean or Black: Total	Caribbean or Black: Caribbean, Caribbean Scottish or Caribbean British	Caribbean or Black: Black, Black Scottish or Black British	Caribbean or Black: Other Caribbean or Black	Other ethnic groups: Total	Other ethnic groups: Arab, Arab Scottish or Arab British	Other ethnic groups: Other ethnic group
	Total	147,268	138,460	123,827	7,783	1,369	98	1,990	3,393	685	5,838	2,047	1,417	310	1,274	790	1,170	1,163	7	269	167	66	36	846	693	153
	0 to 4	7,791	7,007	6,541	127	7	4	217	111	130	439	207	114	22	47	49	95	95	0	18	5	10	3	102	93	9
	5 to 9	6,855	6,305	5,944	158	18	6	91	88	79	340	184	70	14	29	43	54	54	0	9	2	3	4	68	59	9
	10 to 14	7,390	6,967	6,577	193	15	3	90	89	51	269	134	60	16	28	31	51	51	0	11	6	3	2	41	41	0
	15	1,668	1,570	1,488	48	1	2	15	16	17	58	28	4	6	9	11	12	12	0	2	1	1	0	9	9	0
	16 to 17	3,044	2,894	2,742	94	7	1	21	29	17	105	44	33	8	13	7	10	10	0	4	4	0	0	14	14	0
	18 to 19	6,084	5,751	4,790	580	131	4	48	198	50	210	80	38	7	64	21	40	40	0	12	9	3	0	21	17	4
	20 to 24	15,337	13,775	10,613	1,502	444	15	273	928	120	1,146	250	234	38	475	149	148	147	1	57	40	5	12	91	75	16
	25 to 29	11,733	10,337	8,375	713	168	16	458	607	57	897	248	256	50	236	107	263	261	2	49	32	8	9	130	104	26
	30 to 34	8,877	7,817	6,456	524	104	8	342	383	47	650	217	193	40	84	116	213	212	1	26	13	13	0	124	103	21
All people:	35 to 39	8,042	7,425	6,487	507	48	7	135	241	21	404	136	106	18	54	90	106	105	1	18	10	6	2	68	50	18
	40 to 44	9,255	8,732	7,895	537	47	6	91	156	34	327	130	71	18	52	56	81	81	0	20	15	4	1	61	42	19
	45 to 49	10,196	9,841	9,079	504	44	5	75	134	17	235	81	51	10	58	35	46	46	0	17	11	5	1	40	31	9
	50 to 54	9,873	9,573	8,897	444	55	5	51	121	10	228	101	36	19	46	26	26	26	0	12	8	4	0	24	17	7
	55 to 59	7,994	7,778	7,258	388	40	3	25	64	9	164	73	36	16	18	21	11	10	1	7	5	0	2	25	18	7
	60 to 64	8,532	8,399	7,833	422	57	8	17	62	5	110	37	33	14	14	12	7	6	1	2	2	0	0	9	7	2
	65 to 69	6,367	6,263	5,862	299	56	3	12	31	4	91	27	37	10	11	6	3	3	0	1	1	0	0	5	3	2
	70 to 74	5,985	5,891	5,552	242	58	2	4	33	8	74	32	19	1	17	5	2	2	0	4	3	1	0	6	5	1
	75 to 79	5,229	5,167	4,912	191	27	0	1	36	4	55	23	15	2	11	4	0	0	0	0	0	0	0	3	1	2
	80 to 84	3,790	3,762	3,546	158	19	0	5	34	3	19	8	5	1	4	1	1	1	0	0	0	0	0	5	4	1
	85 and over	3,226	3,206	2,980	152	23	0	19	32	2	17	7	6	0	4	0	1	1	0	0	0	0	0	0	0	0
	Total	70,706	65,991	58,752	3,916	647	49	986	1,641	343	3,080	1,092	764	165	694	365	660	656	4	146	97	29	20	486	398	90
	0 to 4	4,039	3,632	3,391	59	8	1	110	65	62	229	116	51	6	30	26	53	53	0	6	3	2	1	57	50	7
	5 to 9	3,526	3,242	3,071	89	2	4	42	34	38	175	106	34	5	11	19	30	30	0	7	2	1	4	34	28	6
	10 to 14	3,764	3,551	3,359	100	7	0	47	38	24	131	65	31	7	15	13	31	31	0	5	2	1	2	22	22	0
	15	854	799	761	21	1	1	7	8	7	34	16	2	4	5	7	7	7	0	0	0	0	0	7	7	0
	16 to 17	1,573	1,505	1,433	45	3	0	9	15	12	40	17	11	4	6	2	5	5	0	1	1	0	0	10	10	0
	18 to 19	2,816	2,645	2,226	247	49	3	16	104	28	111	45	19	1	39	7	16	16	0	5	3	2	0	11	8	3
	20 to 24	7,430	6,610	5,128	731	207	9	117	418	60	637	121	142	19	284	71	62	61	1	22	17	0	5	39	29	10
	25 to 29	5,819	5,056	4,045	377	92	11	214	317	31	469	138	136	30	116	49	151	150	1	35	28	2	5	77	66	11
	30 to 34	4,329	3,727	2,980	301	58	5	181	202	26	365	110	123	23	49	60	129	128	1	17	8	9	0	65	57	8
Males:	35 to 39	3,891	3,555	3,063	269	24	4	75	120	8	210	76	55	10	29	40	70	70	0	9	4	3	2	39	28	11
	40 to 44	4,611	4,319	3,869	296	25	3	46	80	19	176	78	41	11	20	26	43	43	0	13	10	2	1	41	29	12
	45 to 49	4,874	4,678	4,285	253	28	0	51	61	7	114	43	21	6	28	16	33	33	0	10	6	4	0	32	26	6
	50 to 54	4,834	4,687	4,340	229	27	2	32	57	5	102	42	21	5	24	10	18	18	0	6	4	2	0	16	12	4
	55 to 59	3,935	3,815	3,538	212	18	1	15	31	3	87	42	21	9	7	8	7	6	1	4	4	0	0	19	13	6
	60 to 64	4,082	4,011	3,721	217	34	4	7	28	4	58	20	14	13	7	4	2	2	0	1	1	0	0	6	4	2
	65 to 69	2,976	2,922	2,727	152	23	1	3	16	1	48	15	16	10	4	3	1	1	0	1	1	0	0	3	2	1
	70 to 74	2,669	2,613	2,457	114	25	0	2	15	4	46	22	10	1	10	3	0	0	0	4	3	1	0	2	2	0
	75 to 79	2,200	2,162	2,071	72	7	0	0	12	3	32	13	11	1	6	1	0	0	0	0	0	0	0	3	1	2
	80 to 84	1,467	1,454	1,358	85	6	0	1	4	0	9	4	2	0	3	0	1	1	0	0	0	0	0	3	2	1
	85 and over	1,017	1,008	929	47	5	0	11	16	1	7	3	3	0	1	0	1	1	0	0	0	0	0	0	0	0
	Total	76,562	72,469	65,075	3,867	722	49	1,004	1,752	342	2,758	955	653	145	580	425	510	507	3	123	70	37	16	360	297	63
	0 to 4	3,752	3,375	3,150	68	1	3	107	46	68	210	91	63	16	17	23	42	42	0	12	2	8	2	45	43	2
	5 to 9	3,329	3,063	2,873	69	16	2	49	54	41	165	78	36	9	18	24	24	24	0	2	0	2	0	34	31	3
	10 to 14	3,626	3,416	3,218	93	8	3	43	51	27	138	69	29	9	13	18	20	20	0	6	4	2	0	19	19	0
	15	814	771	727	27	0	1	8	8	10	24	12	2	2	4	4	5	5	0	2	1	1	0	2	2	0
	16 to 17	1,471	1,389	1,309	49	4	1	12	14	5	65	27	22	4	7	5	5	5	0	3	3	0	0	4	4	0
	18 to 19	3,268	3,106	2,564	333	82	1	32	94	22	99	35	19	6	25	14	24	24	0	7	6	1	0	10	9	1
	20 to 24	7,907	7,165	5,485	771	237	6	156	510	60	509	129	92	19	191	78	86	86	0	35	23	5	7	52	46	6
	25 to 29	5,914	5,281	4,330	336	76	5	244	290	26	428	110	120	20	120	58	112	111	1	14	4	6	4	53	38	15
	30 to 34	4,548	4,090	3,476	223	46	3	161	181	21	285	107	70	17	35	56	84	84	0	9	5	4	0	59	46	13
Females:	35 to 39	4,151	3,870	3,424	238	24	3	60	121	13	194	60	51	8	25	50	36	35	1	9	6	3	0	29	22	7
	40 to 44	4,644	4,413	4,026	241	22	3	45	76	15	151	52	30	7	32	30	38	38	0	7	5	2	0	20	13	7
	45 to 49	5,322	5,163	4,794	251	16	5	24	73	10	121	38	30	4	30	19	13	13	0	7	5	1	1	8	5	3
	50 to 54	5,039	4,886	4,557	215	28	3	19	64	5	126	59	15	14	22	16	8	8	0	6	4	2	0	8	5	3
	55 to 59	4,059	3,963	3,720	176	22	2	10	33	6	77	31	15	7	11	13	4	4	0	3	1	0	2	6	5	1
	60 to 64	4,450	4,388	4,112	205	23	4	10	34	1	52	17	19	1	7	8	5	4	1	1	1	0	0	3	3	0
	65 to 69	3,391	3,341	3,135	147	33	2	9	15	3	43	12	21	0	7	3	2	2	0	0	0	0	0	2	1	1
	70 to 74	3,316	3,278	3,095	128	33	2	2	18	4	28	10	9	0	7	2	2	2	0	0	0	0	0	4	3	1
	75 to 79	3,029	3,005	2,841	119	20	0	1	24	1	23	10	4	1	5	3	0	0	0	0	0	0	0	0	0	0
	80 to 84	2,323	2,308	2,188	73	13	0	4	30	3	10	4	3	1	1	1	0	0	0	0	0	0	0	2	2	0
	85 and over	2,209	2,198	2,051	105	18	0	8	16	1	10	4	3	0	3	0	0	0	0	0	0	0	0	0	0	0

For further information on variables, see www.scotlandscensus.gov.uk/variables

In order to protect against disclosure of personal information, some records have been swapped between different geographic areas. Some cell values will be affected, particularly small values at the most detailed geographies.

3.4 Perth & Kinross CHP Ethnic Group Populations by Age - Census 2011

Scotland's Census 2011 - National Records of Scotland

Table DC2101SC - Ethnic group by sex by age

Perth and Kinross																												
Ethnicity (Flat)			All people	White: Total	White: Scottish	White: Other British	White: Irish	White: Gypsy/Traveller	White: Polish	White: Other White	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British: Total	Asian, Asian Scottish or Asian British: Pakistani, Pakistani Scottish or Pakistani British	Asian, Asian Scottish or Asian British: Indian, Indian Scottish or Indian British	Asian, Asian Scottish or Asian British: Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Asian, Asian Scottish or Asian British: Chinese, Chinese Scottish or Chinese British	Asian, Asian Scottish or Asian British: Other Asian	African: Total	African: African, African Scottish or African British	African: Other African	Caribbean or Black: Total	Caribbean or Black: Caribbean, Caribbean Scottish or Caribbean British	Caribbean or Black: Black, Black Scottish or Black British	Caribbean or Black: Other Caribbean or Black	Other ethnic groups: Total	Other ethnic groups: Arab, Arab Scottish or Arab British	Other ethnic groups: Other ethnic group
	All people:	Total	146,652	143,676	119,916	16,597	1,136	415	2,482	3,130	471	1,852	331	585	73	461	402	232	228	4	151	96	43	12	270	193	77
		0 to 4	7,317	7,038	6,322	310	10	27	262	107	91	156	36	50	8	30	32	14	14	0	12	8	3	1	6	5	1
		5 to 9	7,307	7,082	6,340	483	18	24	125	92	77	123	42	36	7	18	20	15	15	0	5	5	0	0	5	5	0
		10 to 14	8,704	8,521	7,519	704	25	32	119	122	57	105	25	22	8	26	24	7	7	0	5	5	0	0	9	6	3
		15	1,847	1,810	1,587	156	4	12	10	41	7	25	3	3	1	10	8	4	4	0	0	0	0	0	1	0	1
		16 to 17	3,629	3,532	3,069	284	12	20	43	104	19	60	10	11	0	37	12	5	5	0	3	1	1	1	10	7	3
		18 to 19	3,205	3,031	2,668	232	7	19	38	67	11	102	13	45	0	36	8	7	7	0	2	0	1	1	52	44	8
		20 to 24	7,515	7,180	5,972	504	22	23	304	355	33	195	23	107	9	28	28	25	24	1	16	7	6	3	66	54	12
		25 to 29	8,063	7,745	5,982	630	58	34	573	468	44	200	36	85	11	33	35	49	48	1	4	2	1	1	21	14	7
		30 to 34	7,570	7,264	5,601	755	69	21	439	379	18	217	22	91	11	37	56	31	31	0	22	16	6	0	18	9	9
		35 to 39	8,382	8,157	6,496	1,084	85	36	188	268	17	163	23	43	7	27	63	23	22	1	7	6	1	0	15	5	10
		40 to 44	10,692	10,478	8,542	1,446	100	37	105	248	35	138	26	28	6	30	48	16	16	0	17	12	5	0	8	3	5
		45 to 49	11,691	11,511	9,432	1,644	117	28	90	200	22	106	28	19	2	33	24	17	17	0	17	4	10	3	18	14	4
		50 to 54	10,546	10,439	8,622	1,434	90	22	87	184	6	69	8	7	1	39	14	7	7	0	9	6	3	0	16	11	5
		55 to 59	10,000	9,888	8,164	1,416	112	20	36	140	14	74	16	11	0	32	15	3	2	1	15	12	3	0	6	4	2
		60 to 64	10,621	10,546	8,711	1,596	100	21	22	96	12	49	6	12	2	21	8	4	4	0	4	3	0	1	6	5	1
		65 to 69	8,452	8,413	7,016	1,198	90	11	10	88	5	22	2	7	0	8	5	3	3	0	3	2	0	1	6	4	2
		70 to 74	7,180	7,151	6,046	982	54	13	3	53	2	14	2	4	0	7	1	2	2	0	6	6	0	0	5	3	2
		75 to 79	5,799	5,776	4,965	684	74	8	7	38	1	21	5	10	0	5	1	0	0	0	0	0	0	0	1	0	1
		80 to 84	4,375	4,367	3,755	519	46	4	7	36	0	5	1	3	0	1	0	0	0	0	3	0	3	0	0	0	0
		85 and over	3,757	3,747	3,107	536	43	3	14	44	0	8	4	1	0	3	0	0	0	0	1	1	0	0	1	0	1
	Males:	Total	71,443	69,803	58,373	7,954	554	188	1,270	1,464	234	980	178	374	37	240	151	142	139	3	79	49	23	7	205	148	57
		0 to 4	3,741	3,591	3,218	164	6	13	129	61	48	86	20	29	4	14	19	8	8	0	4	2	2	0	4	3	1
		5 to 9	3,730	3,625	3,239	249	12	13	62	50	44	45	18	11	2	7	7	9	9	0	4	4	0	0	3	3	0
		10 to 14	4,422	4,335	3,826	359	14	14	61	61	29	46	9	9	1	15	12	3	3	0	2	2	0	0	7	4	3
		15	921	898	788	75	1	5	4	25	4	16	3	2	1	7	3	3	3	0	0	0	0	0	0	0	0
		16 to 17	1,868	1,817	1,573	151	7	10	19	57	10	33	5	0	0	20	8	1	1	0	1	0	0	1	6	4	2
		18 to 19	1,746	1,611	1,425	126	5	8	22	25	5	75	7	11	0	20	7	5	5	0	0	0	0	0	50	43	7
		20 to 24	3,939	3,703	3,107	244	13	9	150	180	22	136	12	92	7	17	8	13	12	1	10	5	4	1	55	45	10
		25 to 29	4,038	3,864	3,001	315	31	15	274	228	18	96	19	45	5	19	8	46	46	0	4	2	1	1	10	5	5
		30 to 34	3,839	3,667	2,803	383	29	8	254	190	11	121	12	58	5	25	21	17	17	0	12	10	2	0	11	5	6
		35 to 39	3,985	3,869	3,090	489	44	18	99	129	4	82	13	26	5	11	27	15	14	1	5	5	0	0	10	3	7
		40 to 44	5,085	4,994	4,082	681	45	13	58	115	12	57	15	19	4	10	9	7	7	0	9	7	2	0	6	2	4
		45 to 49	5,814	5,714	4,702	794	68	11	51	88	8	61	19	12	1	18	11	6	6	0	15	3	10	2	10	6	4
		50 to 54	5,180	5,128	4,289	673	44	12	36	74	3	30	3	5	1	19	2	3	3	0	2	1	1	0	14	11	3
		55 to 59	4,880	4,834	3,997	682	55	11	27	62	5	34	11	8	0	13	2	2	1	1	1	0	1	0	4	4	0
		60 to 64	5,233	5,191	4,320	769	50	12	8	32	8	24	2	6	1	11	4	2	2	0	3	2	0	1	5	4	1
		65 to 69	4,011	3,991	3,302	603	40	6	3	37	2	11	1	3	0	6	1	1	1	0	1	0	0	1	5	3	2
		70 to 74	3,338	3,318	2,785	479	28	4	1	21	1	10	2	4	0	3	1	1	1	0	5	5	0	0	3	3	0
		75 to 79	2,665	2,653	2,283	323	29	3	1	14	0	11	4	3	0	3	1	0	0	0	0	0	0	0	1	0	1
		80 to 84	1,802	1,799	1,545	222	20	2	4	6	0	3	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0
		85 and over	1,206	1,201	998	173	13	1	7	9	0	3	2	0	0	1	0	0	0	0	1	1	0	0	1	0	1
	Females:	Total	75,209	73,873	61,543	8,643	582	227	1,212	1,666	237	872	153	211	36	221	251	90	89	1	72	47	20	5	65	45	20
		0 to 4	3,576	3,447	3,104	146	4	14	133	46	43	70	16	21	4	16	13	6	6	0	8	6	1	1	2	2	0
		5 to 9	3,577	3,457	3,101	234	6	11	63	42	33	78	24	25	5	11	13	6	6	0	1	1	0	0	2	2	0
		10 to 14	4,282	4,186	3,693	345	11	18	58	61	28	59	16	13	7	11	12	4	4	0	3	3	0	0	2	2	0
		15	926	912	799	81	3	7	6	16	3	9	0	1	0	3	5	1	1	0	0	0	0	0	1	0	1
		16 to 17	1,761	1,715	1,496	133	5	10	24	47	9	27	5	1	0	17	4	4	4	0	2	1	1	0	4	3	1
		18 to 19	1,459	1,420	1,243	106	2	11	16	42	6	27	6	4	0	16	1	2	2	0	2	0	1	1	2	1	1
		20 to 24	3,576	3,477	2,865	260	9	14	154	175	11	59	11	15	2	11	20	12	12	0	6	2	2	2	11	9	2
		25 to 29	4,025	3,881	2,981	315	27	19	299	240	26	104	17	40	6	14	27	3	2	1	0	0	0	0	11	9	2
		30 to 34	3,731	3,597	2,798	372	40	13	185	189	7	96	10	33	6	12	35	14	14	0	10	6	4	0	7	4	3
		35 to 39	4,397	4,288	3,406	595	41	18	89	139	13	81	10	17	2	16	36	8	8	0	2	1	1	0	5	2	3
		40 to 44	5,607	5,484	4,460	765	55	24	47	133	23	81	11	9	2	20	39	9	9	0	8	5	3	0	2	1	1
		45 to 49	5,877	5,797	4,730	850	49	17	39	112	14	45	9	7	1	15	13	11	11	0	2	1	0	1	8	8	0
		50 to 54	5,366	5,311	4,333	761	46	10	51	110	3	39	5	2	0	20	12	4	4	0	7	5	2	0	2	0	2
		55 to 59	5,120	5,054	4,167	734	57	9	9	78	9	40	5	3	0	19	13	1	1	0	14	12	2	0	2	0	2
		60 to 64	5,388	5,355	4,391	827	50	9	14	64	4	25	4	6	1	10	4	2	2	0	1	1	0	0	1	1	0
		65 to 69	4,441	4,422	3,714	595	50	5	7	51	3	11	1	4	0	2	4	2	2	0	2	2	0	0	1	1	0
		70 to 74	3,842	3,833	3,261	503	26	9	2	32	1	4	0	0	0	4	0	1	1	0	1	1	0	0	2	0	2
		75 to 79	3,134	3,123	2,682	361	45	5	6	24	1	10	1	7	0	2	0	0	0	0	0	0	0	0	0	0	0
		80 to 84	2,573	2,568	2,210	297	26	2	3	30	0	2	0	2	0	0	0	0	0	0	3	0	3	0	0	0	0
		85 and over	2,551	2,548	2,109	363	30	2	7	35	0	5	2	1	0	2	0	0	0	0	0	0	0	0	0	0	0

4.1 Tayside's Older Population Ethnic Group Populations - Census 2011

Scotland's Census 2011 - National Records of Scotland
Source: Table DC2101SC - Ethnic group by sex by age

Tayside

		All people	White: Total	White: Scottish	White: Other British	White: Irish	White: Gypsy/Traveller	White: Polish	White: Other White	TOTAL NON_WHITE	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British: Total	Asian, Asian Scottish or Asian British: Pakistani, Pakistani Scottish or Pakistani British	Asian, Asian Scottish or Asian British: Indian, Indian Scottish or Indian British	Asian, Asian Scottish or Asian British: Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Asian, Asian Scottish or Asian British: Chinese, Chinese Scottish or Chinese British	Asian, Asian Scottish or Asian British: Other Asian	African: Total	African: African, African Scottish or African British	African: Other African	Caribbean or Black: Total	Caribbean or Black: Caribbean, Caribbean Scottish or Caribbean British	Caribbean or Black: Black, Black Scottish or Black British	Caribbean or Black: Other Caribbean or Black	Other ethnic groups: Total	Other ethnic groups: Arab, Arab Scottish or Arab British	Other ethnic groups: Other ethnic group
All people:	Total	409,898	**396,604**	*346,059*	*33,264*	*3,035*	*702*	*5,486*	*8,058*		**1,420**	**8,611**	2,644	2,165	400	1,999	1,403	1,527	1,515	12	495	315	127	53	1,241	982	259
	65+ YEARS	77,221	**76,712**	*68,546*	*6,868*	*601*	*68*	*107*	*522*	509	**42**	**391**	130	127	16	84	34	15	15	0	24	18	5	1	37	24	13
	65 to 69	21,513	**21,342**	*18,804*	*2,138*	*185*	*29*	*28*	*158*	171	**15**	**131**	32	47	10	23	19	7	7	0	6	5	0	1	12	7	5
	70 to 74	18,752	**18,607**	*16,666*	*1,663*	*141*	*18*	*12*	*107*	145	**15**	**101**	39	27	1	28	6	4	4	0	12	10	2	0	13	10	3
	75 to 79	15,610	**15,505**	*14,067*	*1,207*	*123*	*8*	*11*	*89*	105	**5**	**93**	34	31	2	21	5	2	2	0	0	0	0	0	5	2	3
	80 to 84	11,458	**11,409**	*10,327*	*904*	*75*	*5*	*15*	*83*	49	**4**	**35**	12	12	2	5	4	1	1	0	4	1	3	0	5	4	1
	85 and over	9,888	**9,849**	*8,682*	*956*	*77*	*8*	*41*	*85*	39	**3**	31	13	10	1	7	0	1	1	0	2	2	0	0	2	1	1

Angus Community Health Partnership

		All people	White: Total	White: Scottish	White: Other British	White: Irish	White: Gypsy/Traveller	White: Polish	White: Other White	TOTAL NON_WHITE	Mixed or multiple ethnic groups	Asian, Asian Scottish or Asian British: Total	Asian, Asian Scottish or Asian British: Pakistani, Pakistani Scottish or Pakistani British	Asian, Asian Scottish or Asian British: Indian, Indian Scottish or Indian British	Asian, Asian Scottish or Asian British: Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Asian, Asian Scottish or Asian British: Chinese, Chinese Scottish or Chinese British	Asian, Asian Scottish or Asian British: Other Asian	African: Total	African: African, African Scottish or African British	African: Other African	Caribbean or Black: Total	Caribbean or Black: Caribbean, Caribbean Scottish or Caribbean British	Caribbean or Black: Black, Black Scottish or Black British	Caribbean or Black: Other Caribbean or Black	Other ethnic groups: Total	Other ethnic groups: Arab, Arab Scottish or Arab British	Other ethnic groups: Other ethnic group
All people:	Total	115,978	**114,468**	*102,316*	*8,884*	*530*	*189*	*1,014*	*1,535*		**264**	**921**	266	163	17	264	211	125	124	1	75	52	18	5	125	96	29
	65+ YEARS	23,061	**22,969**	*20,805*	*1,907*	*111*	*24*	*25*	*97*	92	**13**	**65**	19	20	2	13	11	3	3	0	6	5	1	0	5	4	1
	65 to 69	6,694	**6,666**	*5,926*	*641*	*39*	*15*	*6*	*39*	28	**6**	**18**	3	3	0	4	8	1	1	0	2	2	0	0	1	0	1

All people:	70 to 74	5,587	**5,565**	*5,068*	*439*	*29*	*3*	*5*	*21*	22	**5**	**13**	5	4	0	4	0	0	0	0	2	1	1	0	2	2	0
	75 to 79	4,582	**4,562**	*4,190*	*332*	*22*	*0*	*3*	*15*	20	**0**	**17**	6	6	0	5	0	2	2	0	0	0	0	0	1	1	0
	80 to 84	3,293	**3,280**	*3,026*	*227*	*10*	*1*	*3*	*13*	13	**1**	**11**	3	4	1	0	3	0	0	0	1	1	0	0	0	0	0
	85 and over	2,905	**2,896**	*2,595*	*268*	*11*	*5*	*8*	*9*	9	**1**	6	2	3	1	0	0	0	0	0	1	1	0	0	1	1	0

Dundee Community Health Partnership

		All people	**White: Total**	*White: Scottish*	*White: Other British*	*White: Irish*	*White: Gypsy/Traveller*	*White: Polish*	*White: Other White*	**TOTAL NON_WHITE**	**Mixed or multiple ethnic groups**	**Asian, Asian Scottish or Asian British: Total**	Asian, Asian Scottish or Asian British: Pakistani, Pakistani Scottish or Pakistani British	Asian, Asian Scottish or Asian British: Indian, Indian Scottish or Indian British	Asian, Asian Scottish or Asian British: Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Asian, Asian Scottish or Asian British: Chinese, Chinese Scottish or Chinese British	Asian, Asian Scottish or Asian British: Other Asian	**African: Total**	African: African, African Scottish or African British	African: Other African	**Caribbean or Black: Total**	Caribbean or Black: Caribbean, Caribbean Scottish or Caribbean British	Caribbean or Black: Black, Black Scottish or Black British	Caribbean or Black: Other Caribbean or Black	**Other ethnic groups: Total**	Other ethnic groups: Arab, Arab Scottish or Arab British	Other ethnic groups: Other ethnic group
All people:	Total	147,268	**138,460**	*123,827*	*7,783*	*1,369*	*98*	*1,990*	*3,393*		**685**	**5,838**	2,047	1,417	310	1,274	790	1,170	1,163	7	269	167	66	36	846	693	153
	65+ YEARS	24,597	**24,289**	*22,852*	*1,042*	*183*	*5*	*41*	*166*	308	**21**	**256**	97	82	14	47	16	7	7	0	5	4	1	0	19	13	6
	65 to 69	6,367	**6,263**	*5,862*	*299*	*56*	*3*	*12*	*31*	104	**4**	**91**	27	37	10	11	6	3	3	0	1	1	0	0	5	3	2
	70 to 74	5,985	**5,891**	*5,552*	*242*	*58*	*2*	*4*	*33*	94	**8**	**74**	32	19	1	17	5	2	2	0	4	3	1	0	6	5	1
	75 to 79	5,229	**5,167**	*4,912*	*191*	*27*	*0*	*1*	*36*	62	**4**	**55**	23	15	2	11	4	0	0	0	0	0	0	0	3	1	2
	80 to 84	3,790	**3,762**	*3,546*	*158*	*19*	*0*	*5*	*34*	28	**3**	**19**	8	5	1	4	1	1	1	0	0	0	0	0	5	4	1
	85 and over	3,226	**3,206**	*2,980*	*152*	*23*	*0*	*19*	*32*	20	**2**	17	7	6	0	4	0	1	1	0	0	0	0	0	0	0	0

Perth and Kinross Community Health Partnership

		All people	**White: Total**	*White: Scottish*	*White: Other British*	*White: Irish*	*White: Gypsy/Traveller*	*White: Polish*	*White: Other White*	**TOTAL NON_WHITE**	**Mixed or multiple ethnic groups**	**Asian, Asian Scottish or Asian British: Total**	Asian, Asian Scottish or Asian British: Pakistani, Pakistani Scottish or Pakistani British	Asian, Asian Scottish or Asian British: Indian, Indian Scottish or Indian British	Asian, Asian Scottish or Asian British: Bangladeshi, Bangladeshi Scottish or Bangladeshi British	Asian, Asian Scottish or Asian British: Chinese, Chinese Scottish or Chinese British	Asian, Asian Scottish or Asian British: Other Asian	**African: Total**	African: African, African Scottish or African British	African: Other African	**Caribbean or Black: Total**	Caribbean or Black: Caribbean, Caribbean Scottish or Caribbean British	Caribbean or Black: Black, Black Scottish or Black British	Caribbean or Black: Other Caribbean or Black	**Other ethnic groups: Total**	Other ethnic groups: Arab, Arab Scottish or Arab British	Other ethnic groups: Other ethnic group
	Total	146,652	**143,676**	*119,916*	*16,597*	*1,136*	*415*	*2,482*	*3,130*		**471**	**1,852**	331	585	73	461	402	232	228	4	151	96	43	12	270	193	77
	65+ YEARS	29,563	**29,454**	*24,889*	*3,919*	*307*	*39*	*41*	*259*	109	**8**	**70**	14	25	0	24	7	5	5	0	13	9	3	1	13	7	6

All people:	65 to 69	8,452	**8,413**	*7,016*	*1,198*	*90*	*11*	*10*	*88*	39	**5**	**22**	2	7	0	8	5	3	3	0	3	2	0	1	6	4	2
	70 to 74	7,180	**7,151**	*6,046*	*982*	*54*	*13*	*3*	*53*	29	**2**	**14**	2	4	0	7	1	2	2	0	6	6	0	0	5	3	2
	75 to 79	5,799	**5,776**	*4,965*	*684*	*74*	*8*	*7*	*38*	23	**1**	**21**	5	10	0	5	1	0	0	0	0	0	0	0	1	0	1
	80 to 84	4,375	**4,367**	*3,755*	*519*	*46*	*4*	*7*	*36*	8	**0**	**5**	1	3	0	1	0	0	0	0	3	0	3	0	0	0	0
	85 and over	3,757	**3,747**	*3,107*	*536*	*43*	*3*	*14*	*44*	10	**0**	8	4	1	0	3	0	0	0	0	1	1	0	0	1	0	1

For further information on variables, see www.scotlandscensus.gov.uk/variables
In order to protect against disclosure of personal information, some records have been swapped between different geographic areas. Some cell values will be affected, particularly small values at the most detailed geographies.

4.2 Tayside's Older Population Ethnic Group Populations - Census 2011

Administrative Area	No. People Aged 65+ Years	65+ Years - Ethnic Groups (Census 2011)						
		White[a]	Asian, Asian Scottish or Asian British[b]	African[c]	Caribbean or Black[d]	Other Ethnic Groups[e]	Mixed or Multiple Ethnic Groups	All Non-White Ethnic Groups
Tayside	77,221	76,712	391	15	24	37	42	**509**
Health Board		99.3%	0.5%	0.0%	0.0%	0.0%	0.1%	**0.7%**
Angus	23,061	22,969	65	3	6	5	13	**92**
CHP		99.6%	0.3%	0.0%	0.0%	0.0%	0.1%	**0.4%**
Dundee CHP	24,597	24,289	256	7	5	19	21	**308**
		98.7%	1.0%	0.0%	0.0%	0.1%	0.1%	**1.3%**
Perth & Kinross	29,563	29,454	70	5	13	13	8	**109**
CHP		99.6%	0.2%	0.0%	0.0%	0.0%	0.0%	**0.4%**

Source: Census 2011 (www.scotlandscensus.gov.uk) Table DC2101SC - "Ethnic group by sex by age"

Table 2.1 Notes:

a. Encompasses: White: Scottish; White: Other British; White: Irish; White: Gypsy/Traveller; White: Polish; White: Other White

b. Encompasses: Pakistani, Pakistani Scottish or Pakistani British; Indian, Indian Scottish or Indian British; Bangladeshi, Bangladeshi Scottish or Bangladeshi British; Chinese, Chinese Scottish or Chinese British; Other Asian

c. Encompasses: African, African Scottish or African British; Other African

d. Encompasses: Caribbean, Caribbean Scottish or Caribbean British; Black, Black Scottish or Black British; Other Caribbean or Black

e. Encompasses: Arab, Arab Scottish or Arab British; Other ethnic group

2565 MH activity Dec14-Nov16

admissions by month

Last refreshed: 18/01/2017 by L Pennycook

checked by NH

Notes:
Admission dates are based on admission to hospital, not first admission from community, to capture all ward admissions.
Age on *first* admission is restricted to age 16 to age 65 years.
Analysis is based on number of stays, one patient may have more than one stay included.
Age breakdown is in 5 year bands, so 15-20 is equivalent to 16-19y, 20-25 is equivalent to 20-24y, 60-65 is equivalent to 60-64y, 65-70 is equivalent to 65y, etc.
TSMS and IPCU are reported separately from GAP, but the total of these 3 sections can be used to give an absolute total for GAP for overall admissions.

Click links to access relevant pages:

2565 MH activity Dec14-Nov15

admissions by month

Last refreshed: 18/01/2017

Total admissions per month

		2014-12	2015-01	2015-02	2015-03	2015-04	2015-05	2015-06	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11
General Psychiatry	Carseview Centre	37	56	50	60	54	47	39	43	41	58	47	40	39	43	39	55	48	52	52	36	47	56	50	58
	Murray Royal Hospital	35	35	30	49	39	37	33	27	36	38	39	44	67	78	63	66	54	67	57	66	66	49	48	55
	Stracathro Hospital	21	21	24	16	18	21	28	26	22	22	18	24	20	18	18	27	22	21	21	18	22	27	17	19
General Psychiatry		**93**	**112**	**104**	**125**	**111**	**105**	**100**	**96**	**99**	**118**	**104**	**108**	**126**	**139**	**120**	**148**	**124**	**140**	**130**	**120**	**135**	**132**	**115**	**132**
General Adult Psychiatry; IPCU	Carseview Centre	6	2	1	4	1	2	4	1	5	5	4	2	4	3	2	2	5	2	7	2	5	7	5	2
General Adult Psychiatry; IPCU		**6**	**2**	**1**	**4**	**1**	**2**	**4**	**1**	**5**	**5**	**4**	**2**	**4**	**3**	**2**	**2**	**5**	**2**	**7**	**2**	**5**	**7**	**5**	**2**
Forensic Psychiatry	Murray Royal Hospital	2	4	6	5	2	4	3	4	4	3	5	4	3	3	1	19	2	5	6	5	1	3	4	4
Forensic Psychiatry		**2**	**4**	**6**	**5**	**2**	**4**	**3**	**4**	**4**	**3**	**5**	**4**	**3**	**3**	**1**	**19**	**2**	**5**	**6**	**5**	**1**	**3**	**4**	**4**
Learning Disability	Carseview Centre	5	2	3	6	1	1		1	3	3			4	1	5		3	2	5	5		6	2	4
	Strathmartine Hospital	1	2	2	2	2	5	2	3	1	2	2	2	1	2		4	1	2	2	2	2	3	3	
Learning Disability		**6**	**4**	**5**	**8**	**3**	**6**	**2**	**4**	**4**	**5**	**2**	**2**	**5**	**3**	**5**	**4**	**4**	**4**	**7**	**7**	**2**	**9**	**5**	**4**
TSMS	Murray Royal Hospital	10	19	19	20	22	19	23	19	13	29	20	17	1	1		1				1		1		
TSMS		**10**	**19**	**19**	**20**	**22**	**19**	**23**	**19**	**13**	**29**	**20**	**17**	**1**	**1**		**1**				**1**		**1**		
Grand total		**117**	**141**	**135**	**162**	**139**	**136**	**132**	**124**	**125**	**160**	**135**	**133**	**139**	**149**	**128**	**174**	**135**	**151**	**150**	**135**	**143**	**152**	**129**	**142**

Count of unique patients

		2014-12	2015-01	2015-02	2015-03	2015-04	2015-05	2015-06	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11
General Psychiatry	Carseview Centre	35	56	49	54	53	46	35	39	39	57	43	40	39	42	38	54	47	51	50	36	47	53	48	52
	Murray Royal Hospital	30	26	21	38	26	27	27	24	33	28	31	30	50	53	57	62	48	57	53	58	61	44	48	44
	Stracathro Hospital	21	21	22	15	18	21	25	24	21	20	18	23	20	18	18	26	21	20	21	18	21	25	17	19
General Psychiatry		**81**	**93**	**86**	**102**	**89**	**87**	**81**	**82**	**85**	**102**	**87**	**81**	**107**	**105**	**107**	**137**	**106**	**116**	**113**	**107**	**115**	**109**	**109**	**107**
General Adult Psychiatry; IPCU	Carseview Centre	6	2	1	3	1	2	4	1	5	5	4	2	4	3	2	2	5	2	7	2	5	7	5	2
General Adult Psychiatry; IPCU		**6**	**2**	**1**	**3**	**1**	**2**	**4**	**1**	**5**	**5**	**4**	**2**	**4**	**3**	**2**	**2**	**5**	**2**	**7**	**2**	**5**	**7**	**5**	**2**
Forensic Psychiatry	Murray Royal Hospital	2	4	5	5	2	4	3	4	4	3	5	4	2	3	1	7	2	5	4	4	1	3	4	4
Forensic Psychiatry		**2**	**4**	**5**	**5**	**2**	**4**	**3**	**4**	**4**	**3**	**5**	**4**	**2**	**3**	**1**	**7**	**2**	**5**	**4**	**4**	**1**	**3**	**4**	**4**
Learning Disability	Carseview Centre	5	2	3	6	1	1		1	3	3			3	1	5		3	2	5	5		6	2	3
	Strathmartine Hospital	1	2	2	2	2	5	2	3	1	2	2	2	1	2		4	1	2	2	2	2	3	2	
Learning Disability		**6**	**4**	**4**	**8**	**3**	**6**	**2**	**4**	**4**	**5**	**2**	**2**	**4**	**3**	**5**	**4**	**4**	**4**	**7**	**7**	**2**	**9**	**4**	**3**
TSMS	Murray Royal Hospital	10	19	18	20	22	19	23	17	13	27	20	16	1	1		1				1		1		
TSMS		**10**	**19**	**18**	**20**	**22**	**19**	**23**	**17**	**13**	**27**	**20**	**16**	**1**	**1**		**1**				**1**		**1**		
Grand total		**103**	**122**	**113**	**137**	**116**	**117**	**112**	**107**	**109**	**142**	**115**	**105**	**117**	**115**	**114**	**149**	**114**	**126**	**129**	**119**	**122**	**127**	**120**	**115**

2565 MH activity Dec14-Nov15

admissions breakdown

Last refreshed: 18/01/2017

Total admissions per month

Specialty	Location	Ethnicity	Age band	Totals F	Totals M	Total:
General Psychiatry	Carseview Centre	African, African Scottish or African British	05: 25-30		2	2
			06: 30-35		1	1
			09: 45-50	3		3
General Psychiatry	Carseview Centre	African, African Scottish or African British		3	3	6
		Asian/Asian Scottish/Asian British - Other	06: 30-35	1		1
General Psychiatry	Carseview Centre	Asian/Asian Scottish/Asian British - Other		1		1
		Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	06: 30-35		3	3
General Psychiatry	Carseview Centre	Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British			3	3
		Asian - Chinese, Chinese Scottish or Chinese British	03: 15-20	1		1
			04: 20-25		1	1
General Psychiatry	Carseview Centre	Asian - Chinese, Chinese Scottish or Chinese British		1	1	2
		Asian - Indian, Indian Scottish or Indian British	04: 20-25		2	2
			11: 55-60		1	1
General Psychiatry	Carseview Centre	Asian - Indian, Indian Scottish or Indian British			3	3
		Asian - Pakistani, Pakistani Scottish or Pakistani British	05: 25-30	1	1	2
			06: 30-35		1	1
			07: 35-40	1		1
			08: 40-45	3	2	5
			10: 50-55		1	1
General Psychiatry	Carseview Centre	Asian - Pakistani, Pakistani Scottish or Pakistani British		5	5	10
		Not Known	03: 15-20	4	5	9
			04: 20-25	4	16	20
			05: 25-30	6	10	16
			06: 30-35	1	6	7
			07: 35-40	8	14	22
			08: 40-45	3	2	5
			09: 45-50	9	3	12
			10: 50-55	5	3	8
			11: 55-60	1	2	3
			12: 60-65	1	1	2
General Psychiatry	Carseview Centre	Not Known		42	62	104
		Other African	09: 45-50		2	2
General Psychiatry	Carseview Centre	Other African			2	2
		Other Ethnic Group	06: 30-35	1		1
			07: 35-40	1		1
General Psychiatry	Carseview Centre	Other Ethnic Group		2		2
		Refused/Not provided by patient	03: 15-20	1	3	4
			05: 25-30	1	3	4
			06: 30-35	1		1
			07: 35-40	2	2	4
			08: 40-45	2	1	3
			11: 55-60		3	3
General Psychiatry	Carseview Centre	Refused/Not provided by patient		7	12	19

		White - Gypsy/Traveller	07: 35-40		2	2
General Psychiatry	Carseview Centre	White - Gypsy/Traveller			2	2
		White - Irish	04: 20-25	2	2	4
			05: 25-30		1	1
			06: 30-35	1		1
			07: 35-40	1		1
			08: 40-45	1		1
General Psychiatry	Carseview Centre	White - Irish		5	3	8
		White - Other British	03: 15-20		3	3
			04: 20-25	18	9	27
			05: 25-30	17	15	32
			06: 30-35	3	6	9
			07: 35-40	11	13	24
			08: 40-45	12	9	21
			09: 45-50	6	9	15
			10: 50-55	5	6	11
			11: 55-60	10	8	18
			12: 60-65	3	6	9
General Psychiatry	Carseview Centre	White - Other British		85	84	169
		White - Other Ethnic Group	03: 15-20	1		1
			07: 35-40	2	3	5
			08: 40-45		1	1
General Psychiatry	Carseview Centre	White - Other Ethnic Group		3	4	7
		White - Polish	04: 20-25		1	1
			05: 25-30		1	1
			06: 30-35		2	2
			07: 35-40	1	3	4
			08: 40-45		1	1
General Psychiatry	Carseview Centre	White - Polish		1	8	9
		White - Scottish	03: 15-20	23	11	34
			04: 20-25	36	42	78
			05: 25-30	51	38	89
			06: 30-35	37	64	101
			07: 35-40	36	49	85
			08: 40-45	54	63	117
			09: 45-50	52	42	94
			10: 50-55	42	49	91
			11: 55-60	33	30	63
			12: 60-65	18	23	41
			13: 65-70	4	3	7
General Psychiatry	Carseview Centre	White - Scottish		386	414	800
General Psychiatry	Carseview Centre	Ethnicity Total:		541	606	1147
	Murray Royal Hospital	African, African Scottish or African British	06: 30-35	1	1	2
General Psychiatry	Murray Royal Hospital	African, African Scottish or African British		1	1	2
		Asian/Asian Scottish/Asian British - Other	04: 20-25	2		2
General Psychiatry	Murray Royal Hospital	Asian/Asian Scottish/Asian British - Other		2		2
		Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	06: 30-35	1		1
General Psychiatry	Murray Royal Hospital	Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British		1		1
		Asian - Pakistani, Pakistani Scottish or Pakistani British	04: 20-25		1	1
			08: 40-45	1		1
General Psychiatry	Murray Royal Hospital	Asian - Pakistani, Pakistani Scottish or Pakistani British		1	1	2
		Mixed/Multiple Ethnic Groups	09: 45-50		1	1

General Psychiatry	Murray Royal Hospital	Mixed/Multiple Ethnic Groups			1	1
		Not Known	03: 15-20	1	5	6
			04: 20-25	3	9	12
			05: 25-30	3	12	15
			06: 30-35	6	11	17
			07: 35-40	4	11	15
			08: 40-45	11	11	22
			09: 45-50	25	19	44
			10: 50-55	5	12	17
			11: 55-60	2	2	4
			12: 60-65		4	4
General Psychiatry	Murray Royal Hospital	Not Known		60	96	156
		Other Ethnic Group	04: 20-25	1		1
			06: 30-35	1		1
General Psychiatry	Murray Royal Hospital	Other Ethnic Group		2		2
		Refused/Not provided by patient	06: 30-35		1	1
			08: 40-45	1	3	4
			09: 45-50		1	1
			10: 50-55	2	1	3
			11: 55-60		2	2
General Psychiatry	Murray Royal Hospital	Refused/Not provided by patient		3	8	11
		White - Gypsy/Traveller	03: 15-20	1		1
General Psychiatry	Murray Royal Hospital	White - Gypsy/Traveller		1		1
		White - Irish	04: 20-25	1	1	2
			05: 25-30	1		1
			06: 30-35		1	1
			09: 45-50		1	1
			11: 55-60		2	2
			12: 60-65	2		2
General Psychiatry	Murray Royal Hospital	White - Irish		4	5	9
		White - Other British	03: 15-20		1	1
			04: 20-25	8	1	9
			05: 25-30	2	3	5
			06: 30-35	11	3	14
			07: 35-40	15	5	20
			08: 40-45	3	4	7
			09: 45-50	21	10	31
			10: 50-55	31	5	36
			11: 55-60	4	13	17
			12: 60-65	22	6	28
General Psychiatry	Murray Royal Hospital	White - Other British		117	51	168
		White - Other Ethnic Group	06: 30-35		1	1
			07: 35-40	1		1
			08: 40-45		3	3
			09: 45-50	2	1	3
			11: 55-60	1	4	5
			12: 60-65	1		1
			13: 65-70	36		36
General Psychiatry	Murray Royal Hospital	White - Other Ethnic Group		41	9	50
		White - Polish	05: 25-30	2	2	4
			06: 30-35		7	7
			07: 35-40		2	2
			09: 45-50		4	4

			10: 50-55		1	1
			11: 55-60	2		2
General Psychiatry	Murray Royal Hospital	White - Polish		4	16	20
		White - Scottish	03: 15-20	16	7	23
			04: 20-25	22	18	40
			05: 25-30	27	31	58
			06: 30-35	45	36	81
			07: 35-40	26	55	81
			08: 40-45	30	48	78
			09: 45-50	47	59	106
			10: 50-55	51	61	112
			11: 55-60	50	26	76
			12: 60-65	14	54	68
			13: 65-70	9	21	30
General Psychiatry	Murray Royal Hospital	White - Scottish		337	416	753
General Psychiatry	Murray Royal Hospital	Ethnicity Total:		574	604	1178
	Stracathro Hospital	Asian - Pakistani, Pakistani Scottish or Pakistani British	07: 35-40		2	2
			08: 40-45		1	1
General Psychiatry	Stracathro Hospital	Asian - Pakistani, Pakistani Scottish or Pakistani British			3	3
		Not Known	03: 15-20	2		2
			04: 20-25	1	7	8
			05: 25-30	1	2	3
			06: 30-35	1	3	4
			07: 35-40	1	3	4
			08: 40-45	4	3	7
			09: 45-50	1		1
			10: 50-55	1	4	5
			12: 60-65		1	1
			13: 65-70		1	1
General Psychiatry	Stracathro Hospital	Not Known		12	24	36
		Refused/Not provided by patient	03: 15-20		4	4
			04: 20-25	1	2	3
			05: 25-30	1	6	7
			06: 30-35		1	1
			07: 35-40	3	2	5
			08: 40-45	2	4	6
			09: 45-50	1	1	2
			10: 50-55	1	6	7
			11: 55-60		2	2
			12: 60-65	3		3
General Psychiatry	Stracathro Hospital	Refused/Not provided by patient		12	28	40
		White - Irish	06: 30-35	1		1
General Psychiatry	Stracathro Hospital	White - Irish		1		1
		White - Other British	03: 15-20	2		2
			04: 20-25	15	4	19
			05: 25-30	4	3	7
			06: 30-35	3	2	5
			07: 35-40	3	4	7
			08: 40-45	3	1	4
			09: 45-50	1	6	7
			10: 50-55	2	11	13
			11: 55-60	4	4	8

			12: 60-65		6	6
General Psychiatry	Stracathro Hospital	White - Other British		37	41	78
		White - Polish	04: 20-25		1	1
			06: 30-35		1	1
General Psychiatry	Stracathro Hospital	White - Polish			2	2
		White - Scottish	03: 15-20	10	7	17
			04: 20-25	15	11	26
			05: 25-30	30	16	46
			06: 30-35	18	29	47
			07: 35-40	21	18	39
			08: 40-45	22	11	33
			09: 45-50	25	14	39
			10: 50-55	26	24	50
			11: 55-60	19	8	27
			12: 60-65	8	11	19
			13: 65-70	2	6	8
General Psychiatry	Stracathro Hospital	White - Scottish		196	155	351
General Psychiatry	Stracathro Hospital	Ethnicity Total:		258	253	511
General Psychiatry		Specialty Total:		1373	1463	2836
General Adult Psychiatry; IPCU	Carseview Centre	Asian/Asian Scottish/Asian British - Other	04: 20-25	1		1
General Adult Psychiatry; IPCU	Carseview Centre	Asian/Asian Scottish/Asian British - Other		1		1
		Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	06: 30-35		2	2
General Adult Psychiatry; IPCU	Carseview Centre	Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British			2	2
		Not Known	03: 15-20		2	2
			04: 20-25		5	5
			05: 25-30	1	2	3
			06: 30-35		3	3
			07: 35-40	2	2	4
			08: 40-45		3	3
			09: 45-50		4	4
			10: 50-55		1	1
			11: 55-60		1	1
General Adult Psychiatry; IPCU	Carseview Centre	Not Known		3	23	26
		Other Ethnic Group	06: 30-35	1		1
General Adult Psychiatry; IPCU	Carseview Centre	Other Ethnic Group		1		1
		Refused/Not provided by patient	03: 15-20		2	2
			10: 50-55		1	1
General Adult Psychiatry; IPCU	Carseview Centre	Refused/Not provided by patient			3	3
		White - Other British	03: 15-20	1		1
			04: 20-25		2	2
			05: 25-30	1		1
			06: 30-35	2		2
			07: 35-40		2	2
			08: 40-45		3	3
			09: 45-50	1		1
			10: 50-55		1	1
			11: 55-60	1		1
General Adult Psychiatry; IPCU	Carseview Centre	White - Other British		6	8	14
		White - Other Ethnic Group	10: 50-55		1	1
General Adult Psychiatry; IPCU	Carseview Centre	White - Other Ethnic Group			1	1

		White - Polish	06: 30-35		1	1
General Adult Psychiatry; IPCU	Carseview Centre	White - Polish			1	1
		White - Scottish	04: 20-25		2	2
			05: 25-30		7	7
			06: 30-35	3	5	8
			07: 35-40		4	4
			08: 40-45		2	2
			09: 45-50	1	2	3
			10: 50-55	1	3	4
			11: 55-60	1	1	2
			12: 60-65	1	1	2
General Adult Psychiatry; IPCU	Carseview Centre	White - Scottish		7	27	34
General Adult Psychiatry; IPCU	Carseview Centre	Ethnicity Total:		18	65	83
General Adult Psychiatry; IPCU		Specialty Total:		18	65	83

Forensic Psychiatry	Murray Royal Hospital	Asian/Asian Scottish/Asian British - Other	10: 50-55		1	1
Forensic Psychiatry	Murray Royal Hospital	Asian/Asian Scottish/Asian British - Other			1	1
		Black, Black Scottish or Black British	06: 30-35		1	1
Forensic Psychiatry	Murray Royal Hospital	Black, Black Scottish or Black British			1	1
		Mixed/Multiple Ethnic Groups	06: 30-35		1	1
Forensic Psychiatry	Murray Royal Hospital	Mixed/Multiple Ethnic Groups			1	1
		Not Known	04: 20-25		2	2
			05: 25-30		5	5
			06: 30-35		1	1
			07: 35-40		4	4
			08: 40-45		4	4
			09: 45-50		4	4
			10: 50-55		2	2
			12: 60-65		1	1
Forensic Psychiatry	Murray Royal Hospital	Not Known			23	23
		Refused/Not provided by patient	03: 15-20		1	1
Forensic Psychiatry	Murray Royal Hospital	Refused/Not provided by patient			1	1
		White - Other British	04: 20-25		1	1
			06: 30-35		1	1
			07: 35-40		4	4
			08: 40-45		1	1
			11: 55-60		1	1
Forensic Psychiatry	Murray Royal Hospital	White - Other British			8	8
		White - Other Ethnic Group	06: 30-35		1	1
			09: 45-50		2	2
Forensic Psychiatry	Murray Royal Hospital	White - Other Ethnic Group			3	3
		White - Polish	05: 25-30		2	2
			08: 40-45		1	1
Forensic Psychiatry	Murray Royal Hospital	White - Polish			3	3
		White - Scottish	04: 20-25		4	4
			05: 25-30		1	1
			06: 30-35		13	13
			07: 35-40		20	20
			08: 40-45		13	13
			09: 45-50		2	2
			10: 50-55		3	3
			11: 55-60		3	3
			12: 60-65		2	2

Forensic Psychiatry	Murray Royal Hospital	White - Scottish			61	61
Forensic Psychiatry	Murray Royal Hospital	Ethnicity Total:			102	102
Forensic Psychiatry		Specialty Total:			102	102
Learning Disability	Carseview Centre	Asian - Pakistani, Pakistani Scottish or Pakistani British	05: 25-30	1		1
Learning Disability	Carseview Centre	Asian - Pakistani, Pakistani Scottish or Pakistani British		1		1
		Not Known	03: 15-20	1		1
			04: 20-25	1	5	6
			05: 25-30		1	1
			07: 35-40	1	1	2
			08: 40-45		1	1
			09: 45-50		1	1
			10: 50-55	1		1
			11: 55-60		1	1
Learning Disability	Carseview Centre	Not Known		4	10	14
		Refused/Not provided by patient	04: 20-25		2	2
			05: 25-30		1	1
			12: 60-65	1		1
Learning Disability	Carseview Centre	Refused/Not provided by patient		1	3	4
		White - Other British	03: 15-20	2		2
			04: 20-25	1		1
			08: 40-45	1		1
			11: 55-60		1	1
Learning Disability	Carseview Centre	White - Other British		4	1	5
		White - Scottish	03: 15-20	1	1	2
			04: 20-25	1	1	2
			05: 25-30	5	2	7
			06: 30-35	7	2	9
			07: 35-40	2	2	4
			08: 40-45	1	1	2
			09: 45-50	2	1	3
			10: 50-55		4	4
			11: 55-60	1	1	2
			12: 60-65	2		2
			13: 65-70	1		1
Learning Disability	Carseview Centre	White - Scottish		23	15	38
Learning Disability	Carseview Centre	Ethnicity Total:		33	29	62
	Strathmartine Hospital	Not Known	03: 15-20		1	1
			07: 35-40		6	6
			10: 50-55		1	1
			11: 55-60		2	2
			12: 60-65		3	3
Learning Disability	Strathmartine Hospital	Not Known			13	13
		Refused/Not provided by patient	04: 20-25		2	2
			07: 35-40		1	1
			11: 55-60		2	2
Learning Disability	Strathmartine Hospital	Refused/Not provided by patient			5	5
		White - Other British	04: 20-25		2	2
			05: 25-30		1	1
Learning Disability	Strathmartine Hospital	White - Other British			3	3
		White - Scottish	04: 20-25		5	5
			05: 25-30	1	5	6
			06: 30-35	3	3	6

			07: 35-40		3	3
			08: 40-45		1	1
			09: 45-50		4	4
			10: 50-55		1	1
			11: 55-60		1	1
Learning Disability	Strathmartine Hospital	White - Scottish		4	23	27
Learning Disability	Strathmartine Hospital	Ethnicity Total:		4	44	48
Learning Disability		Specialty Total:		37	73	110
TSMS	Murray Royal Hospital	Asian - Pakistani, Pakistani Scottish or Pakistani British	08: 40-45	1		1
TSMS	Murray Royal Hospital	Asian - Pakistani, Pakistani Scottish or Pakistani British		1		1
		Not Known	06: 30-35	1		1
			07: 35-40		5	5
			08: 40-45	1	5	6
			09: 45-50		9	9
			10: 50-55		5	5
			11: 55-60	1	6	7
			12: 60-65		2	2
TSMS	Murray Royal Hospital	Not Known		3	32	35
		Refused/Not provided by patient	04: 20-25	1		1
			07: 35-40	1		1
			09: 45-50		1	1
TSMS	Murray Royal Hospital	Refused/Not provided by patient		2	1	3
		White - Irish	09: 45-50		1	1
			11: 55-60		1	1
TSMS	Murray Royal Hospital	White - Irish			2	2
		White - Other British	05: 25-30		1	1
			06: 30-35		1	1
			07: 35-40	1	5	6
			08: 40-45	4	1	5
			09: 45-50	1	3	4
			10: 50-55	1	2	3
			11: 55-60	3	2	5
			12: 60-65	1	1	2
			13: 65-70		1	1
TSMS	Murray Royal Hospital	White - Other British		11	17	28
		White - Other Ethnic Group	07: 35-40		1	1
			08: 40-45		1	1
			09: 45-50		2	2
TSMS	Murray Royal Hospital	White - Other Ethnic Group			4	4
		White - Scottish	03: 15-20	1		1
			04: 20-25	2	2	4
			05: 25-30	6	4	10
			06: 30-35	6	9	15
			07: 35-40	3	12	15
			08: 40-45	8	24	32
			09: 45-50	8	13	21
			10: 50-55	7	30	37
			11: 55-60	3	8	11
			12: 60-65	6	9	15
			13: 65-70		1	1
TSMS	Murray Royal Hospital	White - Scottish		50	112	162
TSMS	Murray Royal Hospital	Ethnicity Total:		67	168	235

TSMS		Specialty Total:		67	168	235
		Overall total:		1495	1871	3366

2565 MH activity Dec14-Nov15

admissions breakdown (by age)

Last refreshed: 18/01/2017

Total admissions per month

Specialty	Location	Age band	Totals F	Totals M	Total:
General Psychiatry	Carseview Centre	03: 15-20	30	22	52
		04: 20-25	60	73	133
		05: 25-30	76	71	147
		06: 30-35	45	83	128
		07: 35-40	63	86	149
		08: 40-45	75	79	154
		09: 45-50	70	56	126
		10: 50-55	52	59	111
		11: 55-60	44	44	88
		12: 60-65	22	30	52
		13: 65-70	4	3	7
General Psychiatry	Carseview Centre		541	606	1147
	Murray Royal Hospital	03: 15-20	18	13	31
		04: 20-25	37	30	67
		05: 25-30	35	48	83
		06: 30-35	65	61	126
		07: 35-40	46	73	119
		08: 40-45	46	69	115
		09: 45-50	95	96	191
		10: 50-55	89	80	169
		11: 55-60	59	49	108
		12: 60-65	39	64	103
		13: 65-70	45	21	66
General Psychiatry	Murray Royal Hospital		574	604	1178
	Stracathro Hospital	03: 15-20	14	11	25
		04: 20-25	32	25	57
		05: 25-30	36	27	63
		06: 30-35	23	36	59
		07: 35-40	28	29	57
		08: 40-45	31	20	51
		09: 45-50	28	21	49
		10: 50-55	30	45	75
		11: 55-60	23	14	37
		12: 60-65	11	18	29
		13: 65-70	2	7	9
General Psychiatry	Stracathro Hospital		258	253	511
General Psychiatry			1373	1463	2836

General Adult Psychiatry; IPCU	Carseview Centre	03: 15-20	1	4	5					
		04: 20-25	1	9	10					
		05: 25-30	2	9	11					
		06: 30-35	6	11	17					
		07: 35-40	2	8	10					
		08: 40-45		8	8					
		09: 45-50	2	6	8					
		10: 50-55	1	7	8					
		11: 55-60	2	2	4					
		12: 60-65	1	1	2					
General Adult Psychiatry; IPCU	Carseview Centre		18	65	83					
General Adult Psychiatry; IPCU			18	65	83	1391	1528	2919	47.653306	52.346694
Forensic Psychiatry	Murray Royal Hospital	03: 15-20		1	1					
		04: 20-25		7	7					
		05: 25-30		8	8					
		06: 30-35		18	18					
		07: 35-40		28	28					
		08: 40-45		19	19					
		09: 45-50		8	8					
		10: 50-55		6	6					
		11: 55-60		4	4					
		12: 60-65		3	3					
Forensic Psychiatry	Murray Royal Hospital			102	102					
Forensic Psychiatry				102	102					
Learning Disability	Carseview Centre	03: 15-20	4	1	5					
		04: 20-25	3	8	11					
		05: 25-30	6	4	10					
		06: 30-35	7	2	9					
		07: 35-40	3	3	6					
		08: 40-45	2	2	4					
		09: 45-50	2	2	4					
		10: 50-55	1	4	5					
		11: 55-60	1	3	4					
		12: 60-65	3		3					
		13: 65-70	1		1					
Learning Disability	Carseview Centre		33	29	62					
	Strathmartine Hospital	03: 15-20		1	1					
		04: 20-25		9	9					
		05: 25-30	1	6	7					
		06: 30-35	3	3	6					
		07: 35-40		10	10					
		08: 40-45		1	1					
		09: 45-50		4	4					
		10: 50-55		2	2					
		11: 55-60		5	5					
		12: 60-65		3	3					
Learning Disability	Strathmartine Hospital		4	44	48					
Learning Disability			37	73	110	33.6	66.363636			
TSMS	Murray Royal Hospital	03: 15-20	1		1					
		04: 20-25	3	2	5					
		05: 25-30	6	5	11					
		06: 30-35	7	10	17					
		07: 35-40	5	23	28					
		08: 40-45	14	31	45					

		09: 45-50	9	29	**38**
		10: 50-55	8	37	**45**
		11: 55-60	7	17	**24**
		12: 60-65	7	12	**19**
		13: 65-70		2	**2**
TSMS	**Murray Royal Hospital**		**67**	**168**	**235**
TSMS			**67**	**168**	**235**
			1495	**1871**	**3366**

2565 MH activity Dec14-Nov15

admissions data

Last refreshed: 18/01/2017

Total admissions per month

Admission date yyyy	Location name	Specialty	Ethnicity description	Sex (M/F)	First Admission age	Age band	Total stays
2014-12	Carseview Centre	General Psychia	African, African Scottish or African British	M	33	06: 30-35	1
2014-12	Carseview Centre	General Psychia	Asian - Bangladeshi, Bangladeshi Scottish or E	M	30	06: 30-35	2
2014-12	Carseview Centre	General Psychia	Asian - Indian, Indian Scottish or Indian British	M	59	11: 55-60	1
2014-12	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	F	40	08: 40-45	1
2014-12	Carseview Centre	General Psychia	White - Other British	F	39	07: 35-40	1
2014-12	Carseview Centre	General Psychia	White - Other British	F	41	08: 40-45	1
2014-12	Carseview Centre	General Psychia	White - Other British	F	59	11: 55-60	1
2014-12	Carseview Centre	General Psychia	White - Other British	M	20	04: 20-25	1
2014-12	Carseview Centre	General Psychia	White - Other British	M	45	09: 45-50	2
2014-12	Carseview Centre	General Psychia	White - Other British	M	54	10: 50-55	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	21	04: 20-25	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	22	04: 20-25	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	25	05: 25-30	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	31	06: 30-35	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	32	06: 30-35	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	33	06: 30-35	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	45	09: 45-50	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	49	09: 45-50	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	51	10: 50-55	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	57	11: 55-60	1
2014-12	Carseview Centre	General Psychia	White - Scottish	F	60	12: 60-65	1
2014-12	Carseview Centre	General Psychia	White - Scottish	M	19	03: 15-20	1
2014-12	Carseview Centre	General Psychia	White - Scottish	M	22	04: 20-25	1
2014-12	Carseview Centre	General Psychia	White - Scottish	M	26	05: 25-30	1
2014-12	Carseview Centre	General Psychia	White - Scottish	M	28	05: 25-30	1
2014-12	Carseview Centre	General Psychia	White - Scottish	M	29	05: 25-30	1
2014-12	Carseview Centre	General Psychia	White - Scottish	M	37	07: 35-40	2
2014-12	Carseview Centre	General Psychia	White - Scottish	M	47	09: 45-50	1
2014-12	Carseview Centre	General Psychia	White - Scottish	M	51	10: 50-55	1
2014-12	Carseview Centre	General Psychia	White - Scottish	M	58	11: 55-60	1
2014-12	Carseview Centre	General Psychia	White - Scottish	M	59	11: 55-60	1
2014-12	Murray Royal Hospit	General Psychia	Not Known	F	24	04: 20-25	1
2014-12	Murray Royal Hospit	General Psychia	Not Known	F	46	09: 45-50	1
2014-12	Murray Royal Hospit	General Psychia	Not Known	M	27	05: 25-30	1
2014-12	Murray Royal Hospit	General Psychia	Not Known	M	29	05: 25-30	1
2014-12	Murray Royal Hospit	General Psychia	White - Other British	M	22	04: 20-25	1
2014-12	Murray Royal Hospit	General Psychia	White - Other British	M	44	08: 40-45	1

2014-12	Murray Royal Hospit	General Psychia	White - Polish	F	29	05: 25-30	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	17	03: 15-20	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	19	03: 15-20	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	31	06: 30-35	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	32	06: 30-35	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	38	07: 35-40	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	42	08: 40-45	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	47	09: 45-50	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	53	10: 50-55	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	F	62	12: 60-65	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	16	03: 15-20	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	24	04: 20-25	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	25	05: 25-30	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	38	07: 35-40	2
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	49	09: 45-50	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	53	10: 50-55	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	54	10: 50-55	4
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	58	11: 55-60	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	61	12: 60-65	1
2014-12	Murray Royal Hospit	General Psychia	White - Scottish	M	65	13: 65-70	3
2014-12	Stracathro Hospital	General Psychia	Not Known	F	17	03: 15-20	1
2014-12	Stracathro Hospital	General Psychia	Not Known	M	29	05: 25-30	1
2014-12	Stracathro Hospital	General Psychia	Not Known	M	41	08: 40-45	1
2014-12	Stracathro Hospital	General Psychia	White - Other British	F	23	04: 20-25	1
2014-12	Stracathro Hospital	General Psychia	White - Other British	M	22	04: 20-25	1
2014-12	Stracathro Hospital	General Psychia	White - Other British	M	23	04: 20-25	1
2014-12	Stracathro Hospital	General Psychia	White - Other British	M	46	09: 45-50	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	F	29	05: 25-30	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	F	39	07: 35-40	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	F	45	09: 45-50	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	F	46	09: 45-50	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	F	50	10: 50-55	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	F	52	10: 50-55	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	M	21	04: 20-25	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	M	25	05: 25-30	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	M	46	09: 45-50	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	M	50	10: 50-55	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	M	51	10: 50-55	1
2014-12	Stracathro Hospital	General Psychia	White - Scottish	M	54	10: 50-55	2
2014-12	Stracathro Hospital	General Psychia	White - Scottish	M	59	11: 55-60	1
2015-01	Carseview Centre	General Psychia	African, African Scottish or African British	M	25	05: 25-30	1
2015-01	Carseview Centre	General Psychia	Asian - Indian, Indian Scottish or Indian British	M	22	04: 20-25	1
2015-01	Carseview Centre	General Psychia	Not Known	M	21	04: 20-25	1
2015-01	Carseview Centre	General Psychia	Not Known	M	28	05: 25-30	1
2015-01	Carseview Centre	General Psychia	Not Known	M	36	07: 35-40	1
2015-01	Carseview Centre	General Psychia	Not Known	M	48	09: 45-50	1
2015-01	Carseview Centre	General Psychia	Not Known	M	50	10: 50-55	1

2015-01	Carseview Centre	General Psychia	White - Other British	F	22	04: 20-25	1
2015-01	Carseview Centre	General Psychia	White - Other British	F	24	04: 20-25	1
2015-01	Carseview Centre	General Psychia	White - Other British	F	42	08: 40-45	1
2015-01	Carseview Centre	General Psychia	White - Other British	M	36	07: 35-40	1
2015-01	Carseview Centre	General Psychia	White - Other British	M	42	08: 40-45	1
2015-01	Carseview Centre	General Psychia	White - Other British	M	49	09: 45-50	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	2
2015-01	Carseview Centre	General Psychia	White - Scottish	F	24	04: 20-25	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	27	05: 25-30	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	36	07: 35-40	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	40	08: 40-45	2
2015-01	Carseview Centre	General Psychia	White - Scottish	F	42	08: 40-45	2
2015-01	Carseview Centre	General Psychia	White - Scottish	F	43	08: 40-45	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	49	09: 45-50	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	56	11: 55-60	2
2015-01	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	62	12: 60-65	1
2015-01	Carseview Centre	General Psychia	White - Scottish	F	65	13: 65-70	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	21	04: 20-25	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	26	05: 25-30	2
2015-01	Carseview Centre	General Psychia	White - Scottish	M	28	05: 25-30	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	31	06: 30-35	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	2
2015-01	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	42	08: 40-45	2
2015-01	Carseview Centre	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	48	09: 45-50	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	49	09: 45-50	2
2015-01	Carseview Centre	General Psychia	White - Scottish	M	50	10: 50-55	2
2015-01	Carseview Centre	General Psychia	White - Scottish	M	51	10: 50-55	2
2015-01	Carseview Centre	General Psychia	White - Scottish	M	56	11: 55-60	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	60	12: 60-65	1
2015-01	Carseview Centre	General Psychia	White - Scottish	M	63	12: 60-65	1
2015-01	Murray Royal Hospit	General Psychia	Not Known	M	31	06: 30-35	1
2015-01	Murray Royal Hospit	General Psychia	White - Other British	M	32	06: 30-35	1
2015-01	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	35	07: 35-40	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	24	04: 20-25	2
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	26	05: 25-30	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	31	06: 30-35	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	38	07: 35-40	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	42	08: 40-45	2
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	49	09: 45-50	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	51	10: 50-55	2

2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	F	60	12: 60-65	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	21	04: 20-25	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	23	04: 20-25	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	30	06: 30-35	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	31	06: 30-35	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	40	08: 40-45	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	54	10: 50-55	7
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	60	12: 60-65	2
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	1
2015-01	Murray Royal Hospit	General Psychia	White - Scottish	M	65	13: 65-70	2
2015-01	Stracathro Hospital	General Psychia	Not Known	M	41	08: 40-45	1
2015-01	Stracathro Hospital	General Psychia	White - Other British	F	22	04: 20-25	1
2015-01	Stracathro Hospital	General Psychia	White - Other British	F	43	08: 40-45	1
2015-01	Stracathro Hospital	General Psychia	White - Other British	M	35	07: 35-40	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	29	05: 25-30	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	36	07: 35-40	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	42	08: 40-45	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	50	10: 50-55	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	56	11: 55-60	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	58	11: 55-60	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	62	12: 60-65	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	64	12: 60-65	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	F	65	13: 65-70	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	M	26	05: 25-30	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	M	34	06: 30-35	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	M	41	08: 40-45	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	M	54	10: 50-55	1
2015-01	Stracathro Hospital	General Psychia	White - Scottish	M	65	13: 65-70	1
2015-02	Carseview Centre	General Psychia	Asian - Indian, Indian Scottish or Indian British	M	22	04: 20-25	1
2015-02	Carseview Centre	General Psychia	Not Known	F	46	09: 45-50	1
2015-02	Carseview Centre	General Psychia	Not Known	F	52	10: 50-55	1
2015-02	Carseview Centre	General Psychia	Not Known	M	23	04: 20-25	2
2015-02	Carseview Centre	General Psychia	Not Known	M	51	10: 50-55	1
2015-02	Carseview Centre	General Psychia	Refused/Not provided by patient	F	31	06: 30-35	1
2015-02	Carseview Centre	General Psychia	White - Other British	F	20	04: 20-25	1
2015-02	Carseview Centre	General Psychia	White - Other British	F	21	04: 20-25	1
2015-02	Carseview Centre	General Psychia	White - Other British	F	47	09: 45-50	1
2015-02	Carseview Centre	General Psychia	White - Other British	M	27	05: 25-30	1
2015-02	Carseview Centre	General Psychia	White - Other British	M	54	10: 50-55	1
2015-02	Carseview Centre	General Psychia	White - Other British	M	56	11: 55-60	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	20	04: 20-25	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	23	04: 20-25	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	24	04: 20-25	2

2015-02	Carseview Centre	General Psychia	White - Scottish	F	25	05: 25-30	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	32	06: 30-35	2
2015-02	Carseview Centre	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	37	07: 35-40	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	38	07: 35-40	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	40	08: 40-45	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-02	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	28	05: 25-30	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	30	06: 30-35	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	32	06: 30-35	3
2015-02	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	35	07: 35-40	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	38	07: 35-40	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	2
2015-02	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	42	08: 40-45	3
2015-02	Carseview Centre	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	50	10: 50-55	2
2015-02	Carseview Centre	General Psychia	White - Scottish	M	54	10: 50-55	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	59	11: 55-60	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	61	12: 60-65	1
2015-02	Carseview Centre	General Psychia	White - Scottish	M	64	12: 60-65	1
2015-02	Murray Royal Hospit	General Psychia	Not Known	M	23	04: 20-25	1
2015-02	Murray Royal Hospit	General Psychia	White - Other British	F	32	06: 30-35	1
2015-02	Murray Royal Hospit	General Psychia	White - Other British	F	36	07: 35-40	1
2015-02	Murray Royal Hospit	General Psychia	White - Other British	F	62	12: 60-65	1
2015-02	Murray Royal Hospit	General Psychia	White - Other British	M	35	07: 35-40	1
2015-02	Murray Royal Hospit	General Psychia	White - Other British	M	56	11: 55-60	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	F	23	04: 20-25	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	F	27	05: 25-30	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	M	36	07: 35-40	2
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	M	37	07: 35-40	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	M	42	08: 40-45	8
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	M	45	09: 45-50	2
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	M	50	10: 50-55	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	1
2015-02	Murray Royal Hospit	General Psychia	White - Scottish	M	65	13: 65-70	2
2015-02	Stracathro Hospital	General Psychia	Not Known	F	51	10: 50-55	1
2015-02	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	38	07: 35-40	1
2015-02	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	25	05: 25-30	2
2015-02	Stracathro Hospital	General Psychia	White - Other British	F	22	04: 20-25	1
2015-02	Stracathro Hospital	General Psychia	White - Other British	M	27	05: 25-30	1

2015-02	Stracathro Hospital	General Psychia	White - Other British	M	54	10: 50-55	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	F	22	04: 20-25	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	F	29	05: 25-30	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	F	44	08: 40-45	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	F	50	10: 50-55	2
2015-02	Stracathro Hospital	General Psychia	White - Scottish	F	51	10: 50-55	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	F	57	11: 55-60	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	M	32	06: 30-35	2
2015-02	Stracathro Hospital	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	M	50	10: 50-55	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	M	54	10: 50-55	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	M	55	11: 55-60	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	M	64	12: 60-65	1
2015-02	Stracathro Hospital	General Psychia	White - Scottish	M	65	13: 65-70	1
2015-03	Carseview Centre	General Psychia	Not Known	F	24	04: 20-25	1
2015-03	Carseview Centre	General Psychia	Not Known	F	28	05: 25-30	1
2015-03	Carseview Centre	General Psychia	Not Known	F	29	05: 25-30	1
2015-03	Carseview Centre	General Psychia	Not Known	F	47	09: 45-50	1
2015-03	Carseview Centre	General Psychia	Not Known	M	16	03: 15-20	1
2015-03	Carseview Centre	General Psychia	Not Known	M	22	04: 20-25	1
2015-03	Carseview Centre	General Psychia	Not Known	M	23	04: 20-25	1
2015-03	Carseview Centre	General Psychia	Not Known	M	57	11: 55-60	1
2015-03	Carseview Centre	General Psychia	White - Other British	F	20	04: 20-25	1
2015-03	Carseview Centre	General Psychia	White - Other British	F	22	04: 20-25	1
2015-03	Carseview Centre	General Psychia	White - Other British	F	41	08: 40-45	1
2015-03	Carseview Centre	General Psychia	White - Other British	F	50	10: 50-55	1
2015-03	Carseview Centre	General Psychia	White - Other British	F	57	11: 55-60	1
2015-03	Carseview Centre	General Psychia	White - Other British	M	27	05: 25-30	1
2015-03	Carseview Centre	General Psychia	White - Other British	M	28	05: 25-30	1
2015-03	Carseview Centre	General Psychia	White - Other British	M	38	07: 35-40	1
2015-03	Carseview Centre	General Psychia	White - Other British	M	42	08: 40-45	1
2015-03	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	2
2015-03	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	1
2015-03	Carseview Centre	General Psychia	White - Scottish	F	27	05: 25-30	3
2015-03	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	2
2015-03	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	1
2015-03	Carseview Centre	General Psychia	White - Scottish	F	51	10: 50-55	3
2015-03	Carseview Centre	General Psychia	White - Scottish	F	52	10: 50-55	1
2015-03	Carseview Centre	General Psychia	White - Scottish	F	54	10: 50-55	2
2015-03	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	2
2015-03	Carseview Centre	General Psychia	White - Scottish	F	59	11: 55-60	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	21	04: 20-25	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	23	04: 20-25	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	27	05: 25-30	2
2015-03	Carseview Centre	General Psychia	White - Scottish	M	29	05: 25-30	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	31	06: 30-35	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1

2015-03	Carseview Centre	General Psychia	White - Scottish	M	36	07: 35-40	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	5
2015-03	Carseview Centre	General Psychia	White - Scottish	M	42	08: 40-45	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	48	09: 45-50	2
2015-03	Carseview Centre	General Psychia	White - Scottish	M	51	10: 50-55	1
2015-03	Carseview Centre	General Psychia	White - Scottish	M	54	10: 50-55	2
2015-03	Carseview Centre	General Psychia	White - Scottish	M	56	11: 55-60	2
2015-03	Carseview Centre	General Psychia	White - Scottish	M	59	11: 55-60	1
2015-03	Murray Royal Hospit	General Psychia	Not Known	F	44	08: 40-45	1
2015-03	Murray Royal Hospit	General Psychia	Not Known	M	25	05: 25-30	1
2015-03	Murray Royal Hospit	General Psychia	Not Known	M	45	09: 45-50	1
2015-03	Murray Royal Hospit	General Psychia	White - Other British	F	32	06: 30-35	1
2015-03	Murray Royal Hospit	General Psychia	White - Other British	F	36	07: 35-40	1
2015-03	Murray Royal Hospit	General Psychia	White - Other British	F	57	11: 55-60	1
2015-03	Murray Royal Hospit	General Psychia	White - Other British	M	51	10: 50-55	1
2015-03	Murray Royal Hospit	General Psychia	White - Other British	M	59	11: 55-60	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	24	04: 20-25	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	26	05: 25-30	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	29	05: 25-30	2
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	32	06: 30-35	3
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	33	06: 30-35	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	51	10: 50-55	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	52	10: 50-55	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	53	10: 50-55	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	56	11: 55-60	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	21	04: 20-25	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	22	04: 20-25	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	26	05: 25-30	2
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	27	05: 25-30	2
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	33	06: 30-35	2
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	42	08: 40-45	4
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	51	10: 50-55	4
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	61	12: 60-65	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	1
2015-03	Murray Royal Hospit	General Psychia	White - Scottish	M	65	13: 65-70	2
2015-03	Stracathro Hospital	General Psychia	Not Known	M	61	12: 60-65	1
2015-03	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	62	12: 60-65	1
2015-03	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	31	06: 30-35	1
2015-03	Stracathro Hospital	General Psychia	White - Other British	M	45	09: 45-50	1

2015-03	Stracathro Hospital	General Psychia	White - Other British	M	50	10: 50-55	1
2015-03	Stracathro Hospital	General Psychia	White - Other British	M	54	10: 50-55	1
2015-03	Stracathro Hospital	General Psychia	White - Scottish	F	18	03: 15-20	1
2015-03	Stracathro Hospital	General Psychia	White - Scottish	F	27	05: 25-30	1
2015-03	Stracathro Hospital	General Psychia	White - Scottish	F	38	07: 35-40	1
2015-03	Stracathro Hospital	General Psychia	White - Scottish	F	40	08: 40-45	1
2015-03	Stracathro Hospital	General Psychia	White - Scottish	F	44	08: 40-45	1
2015-03	Stracathro Hospital	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-03	Stracathro Hospital	General Psychia	White - Scottish	M	26	05: 25-30	1
2015-03	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	2
2015-03	Stracathro Hospital	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-04	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	F	35	07: 35-40	1
2015-04	Carseview Centre	General Psychia	Not Known	F	19	03: 15-20	1
2015-04	Carseview Centre	General Psychia	Not Known	F	23	04: 20-25	1
2015-04	Carseview Centre	General Psychia	Not Known	F	31	06: 30-35	1
2015-04	Carseview Centre	General Psychia	Not Known	M	41	08: 40-45	1
2015-04	Carseview Centre	General Psychia	Other Ethnic Group	F	31	06: 30-35	1
2015-04	Carseview Centre	General Psychia	Refused/Not provided by patient	F	39	07: 35-40	1
2015-04	Carseview Centre	General Psychia	White - Irish	F	42	08: 40-45	1
2015-04	Carseview Centre	General Psychia	White - Other British	F	21	04: 20-25	1
2015-04	Carseview Centre	General Psychia	White - Other British	F	35	07: 35-40	1
2015-04	Carseview Centre	General Psychia	White - Other British	F	56	11: 55-60	1
2015-04	Carseview Centre	General Psychia	White - Other British	F	59	11: 55-60	2
2015-04	Carseview Centre	General Psychia	White - Other British	M	41	08: 40-45	1
2015-04	Carseview Centre	General Psychia	White - Other British	M	42	08: 40-45	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	17	03: 15-20	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	18	03: 15-20	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	27	05: 25-30	2
2015-04	Carseview Centre	General Psychia	White - Scottish	F	29	05: 25-30	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	30	06: 30-35	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	2
2015-04	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	49	09: 45-50	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	52	10: 50-55	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	53	10: 50-55	2
2015-04	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	1
2015-04	Carseview Centre	General Psychia	White - Scottish	F	63	12: 60-65	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	19	03: 15-20	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	22	04: 20-25	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	24	04: 20-25	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	30	06: 30-35	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	2
2015-04	Carseview Centre	General Psychia	White - Scottish	M	36	07: 35-40	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	37	07: 35-40	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	42	08: 40-45	1

2015-04	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	50	10: 50-55	2
2015-04	Carseview Centre	General Psychia	White - Scottish	M	52	10: 50-55	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	53	10: 50-55	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	57	11: 55-60	1
2015-04	Carseview Centre	General Psychia	White - Scottish	M	65	13: 65-70	1
2015-04	Murray Royal Hospit	General Psychia	Asian - Bangladeshi, Bangladeshi Scottish or E	F	31	06: 30-35	1
2015-04	Murray Royal Hospit	General Psychia	Not Known	F	46	09: 45-50	1
2015-04	Murray Royal Hospit	General Psychia	Not Known	M	24	04: 20-25	1
2015-04	Murray Royal Hospit	General Psychia	Not Known	M	26	05: 25-30	2
2015-04	Murray Royal Hospit	General Psychia	Not Known	M	29	05: 25-30	1
2015-04	Murray Royal Hospit	General Psychia	White - Other British	F	44	08: 40-45	1
2015-04	Murray Royal Hospit	General Psychia	White - Other British	F	49	09: 45-50	1
2015-04	Murray Royal Hospit	General Psychia	White - Other British	F	58	11: 55-60	1
2015-04	Murray Royal Hospit	General Psychia	White - Other British	M	60	12: 60-65	1
2015-04	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	M	57	11: 55-60	1
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	F	27	05: 25-30	1
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	F	39	07: 35-40	2
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	F	49	09: 45-50	2
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	F	57	11: 55-60	1
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	6
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	M	34	06: 30-35	1
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	1
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	M	51	10: 50-55	7
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	M	52	10: 50-55	2
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	M	55	11: 55-60	1
2015-04	Murray Royal Hospit	General Psychia	White - Scottish	M	65	13: 65-70	2
2015-04	Stracathro Hospital	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	M	36	07: 35-40	1
2015-04	Stracathro Hospital	General Psychia	Not Known	F	31	06: 30-35	1
2015-04	Stracathro Hospital	General Psychia	White - Other British	F	32	06: 30-35	1
2015-04	Stracathro Hospital	General Psychia	White - Other British	F	55	11: 55-60	1
2015-04	Stracathro Hospital	General Psychia	White - Other British	M	51	10: 50-55	1
2015-04	Stracathro Hospital	General Psychia	White - Other British	M	53	10: 50-55	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	F	27	05: 25-30	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	F	41	08: 40-45	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	F	51	10: 50-55	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	F	53	10: 50-55	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	F	58	11: 55-60	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	M	42	08: 40-45	2
2015-04	Stracathro Hospital	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-04	Stracathro Hospital	General Psychia	White - Scottish	M	59	11: 55-60	1
2015-05	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	M	43	08: 40-45	1

2015-05	Carseview Centre	General Psychia	Not Known	F	18	03: 15-20	1
2015-05	Carseview Centre	General Psychia	Not Known	F	28	05: 25-30	1
2015-05	Carseview Centre	General Psychia	Not Known	F	47	09: 45-50	1
2015-05	Carseview Centre	General Psychia	Not Known	F	48	09: 45-50	1
2015-05	Carseview Centre	General Psychia	Not Known	F	52	10: 50-55	1
2015-05	Carseview Centre	General Psychia	Not Known	F	53	10: 50-55	1
2015-05	Carseview Centre	General Psychia	Not Known	M	35	07: 35-40	1
2015-05	Carseview Centre	General Psychia	Not Known	M	49	09: 45-50	1
2015-05	Carseview Centre	General Psychia	Refused/Not provided by patient	F	19	03: 15-20	1
2015-05	Carseview Centre	General Psychia	Refused/Not provided by patient	F	41	08: 40-45	1
2015-05	Carseview Centre	General Psychia	White - Other British	F	20	04: 20-25	1
2015-05	Carseview Centre	General Psychia	White - Other British	F	22	04: 20-25	1
2015-05	Carseview Centre	General Psychia	White - Other British	F	25	05: 25-30	1
2015-05	Carseview Centre	General Psychia	White - Other British	F	39	07: 35-40	1
2015-05	Carseview Centre	General Psychia	White - Other British	F	42	08: 40-45	2
2015-05	Carseview Centre	General Psychia	White - Other British	M	25	05: 25-30	1
2015-05	Carseview Centre	General Psychia	White - Other British	M	27	05: 25-30	1
2015-05	Carseview Centre	General Psychia	White - Other British	M	29	05: 25-30	1
2015-05	Carseview Centre	General Psychia	White - Other British	M	41	08: 40-45	1
2015-05	Carseview Centre	General Psychia	White - Scottish	F	17	03: 15-20	1
2015-05	Carseview Centre	General Psychia	White - Scottish	F	25	05: 25-30	1
2015-05	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-05	Carseview Centre	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-05	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	1
2015-05	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	2
2015-05	Carseview Centre	General Psychia	White - Scottish	F	50	10: 50-55	2
2015-05	Carseview Centre	General Psychia	White - Scottish	F	55	11: 55-60	2
2015-05	Carseview Centre	General Psychia	White - Scottish	F	56	11: 55-60	1
2015-05	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	1
2015-05	Carseview Centre	General Psychia	White - Scottish	F	59	11: 55-60	2
2015-05	Carseview Centre	General Psychia	White - Scottish	F	65	13: 65-70	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	27	05: 25-30	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	49	09: 45-50	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	53	10: 50-55	1
2015-05	Carseview Centre	General Psychia	White - Scottish	M	65	13: 65-70	1
2015-05	Murray Royal Hospit	General Psychia	Not Known	F	49	09: 45-50	1
2015-05	Murray Royal Hospit	General Psychia	Not Known	M	24	04: 20-25	1
2015-05	Murray Royal Hospit	General Psychia	Not Known	M	36	07: 35-40	1
2015-05	Murray Royal Hospit	General Psychia	Other Ethnic Group	F	32	06: 30-35	1
2015-05	Murray Royal Hospit	General Psychia	White - Irish	F	62	12: 60-65	2
2015-05	Murray Royal Hospit	General Psychia	White - Other British	F	60	12: 60-65	1
2015-05	Murray Royal Hospit	General Psychia	White - Other British	M	35	07: 35-40	1
2015-05	Murray Royal Hospit	General Psychia	White - Other British	M	42	08: 40-45	1
2015-05	Murray Royal Hospit	General Psychia	White - Other British	M	58	11: 55-60	1

2015-05	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	M	57	11: 55-60	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	F	26	05: 25-30	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	F	30	06: 30-35	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	6
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	F	60	12: 60-65	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	M	21	04: 20-25	2
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	M	28	05: 25-30	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	M	31	06: 30-35	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	M	34	06: 30-35	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	1
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	3
2015-05	Murray Royal Hospit	General Psychia	White - Scottish	M	65	13: 65-70	3
2015-05	Stracathro Hospital	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	M	43	08: 40-45	1
2015-05	Stracathro Hospital	General Psychia	Not Known	M	24	04: 20-25	1
2015-05	Stracathro Hospital	General Psychia	Not Known	M	30	06: 30-35	1
2015-05	Stracathro Hospital	General Psychia	Not Known	M	50	10: 50-55	1
2015-05	Stracathro Hospital	General Psychia	Not Known	M	65	13: 65-70	1
2015-05	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	41	08: 40-45	1
2015-05	Stracathro Hospital	General Psychia	White - Other British	F	19	03: 15-20	1
2015-05	Stracathro Hospital	General Psychia	White - Other British	F	42	08: 40-45	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	F	16	03: 15-20	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	F	29	05: 25-30	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	F	41	08: 40-45	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	F	51	10: 50-55	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	F	52	10: 50-55	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	F	55	11: 55-60	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	F	65	13: 65-70	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	M	29	05: 25-30	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	M	30	06: 30-35	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	M	51	10: 50-55	1
2015-05	Stracathro Hospital	General Psychia	White - Scottish	M	53	10: 50-55	2
2015-06	Carseview Centre	General Psychia	African, African Scottish or African British	F	45	09: 45-50	1
2015-06	Carseview Centre	General Psychia	African, African Scottish or African British	M	25	05: 25-30	1
2015-06	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	F	40	08: 40-45	1
2015-06	Carseview Centre	General Psychia	Not Known	F	35	07: 35-40	2
2015-06	Carseview Centre	General Psychia	Not Known	F	47	09: 45-50	1
2015-06	Carseview Centre	General Psychia	Not Known	M	19	03: 15-20	1
2015-06	Carseview Centre	General Psychia	Not Known	M	24	04: 20-25	1
2015-06	Carseview Centre	General Psychia	Not Known	M	28	05: 25-30	1
2015-06	Carseview Centre	General Psychia	Refused/Not provided by patient	F	38	07: 35-40	1
2015-06	Carseview Centre	General Psychia	White - Irish	M	29	05: 25-30	1
2015-06	Carseview Centre	General Psychia	White - Other British	F	21	04: 20-25	1
2015-06	Carseview Centre	General Psychia	White - Other British	F	35	07: 35-40	1
2015-06	Carseview Centre	General Psychia	White - Other British	F	51	10: 50-55	1

2015-06	Carseview Centre	General Psychia	White - Other British	F	55	11: 55-60	1
2015-06	Carseview Centre	General Psychia	White - Other British	M	37	07: 35-40	1
2015-06	Carseview Centre	General Psychia	White - Other British	M	46	09: 45-50	1
2015-06	Carseview Centre	General Psychia	White - Other British	M	56	11: 55-60	1
2015-06	Carseview Centre	General Psychia	White - Other British	M	58	11: 55-60	1
2015-06	Carseview Centre	General Psychia	White - Polish	M	41	08: 40-45	1
2015-06	Carseview Centre	General Psychia	White - Scottish	F	17	03: 15-20	2
2015-06	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	1
2015-06	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	2
2015-06	Carseview Centre	General Psychia	White - Scottish	F	29	05: 25-30	1
2015-06	Carseview Centre	General Psychia	White - Scottish	F	30	06: 30-35	1
2015-06	Carseview Centre	General Psychia	White - Scottish	F	42	08: 40-45	1
2015-06	Carseview Centre	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-06	Carseview Centre	General Psychia	White - Scottish	F	61	12: 60-65	1
2015-06	Carseview Centre	General Psychia	White - Scottish	M	19	03: 15-20	2
2015-06	Carseview Centre	General Psychia	White - Scottish	M	23	04: 20-25	1
2015-06	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2015-06	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-06	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-06	Carseview Centre	General Psychia	White - Scottish	M	53	10: 50-55	2
2015-06	Carseview Centre	General Psychia	White - Scottish	M	54	10: 50-55	1
2015-06	Murray Royal Hospit	General Psychia	Not Known	F	18	03: 15-20	1
2015-06	Murray Royal Hospit	General Psychia	Not Known	F	46	09: 45-50	1
2015-06	Murray Royal Hospit	General Psychia	Not Known	M	29	05: 25-30	1
2015-06	Murray Royal Hospit	General Psychia	Not Known	M	39	07: 35-40	1
2015-06	Murray Royal Hospit	General Psychia	Not Known	M	45	09: 45-50	1
2015-06	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	F	42	08: 40-45	1
2015-06	Murray Royal Hospit	General Psychia	White - Other British	F	21	04: 20-25	1
2015-06	Murray Royal Hospit	General Psychia	White - Other British	F	40	08: 40-45	1
2015-06	Murray Royal Hospit	General Psychia	White - Other British	M	46	09: 45-50	2
2015-06	Murray Royal Hospit	General Psychia	White - Other British	M	54	10: 50-55	1
2015-06	Murray Royal Hospit	General Psychia	White - Polish	M	29	05: 25-30	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	F	22	04: 20-25	2
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	F	30	06: 30-35	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	F	35	07: 35-40	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	F	57	11: 55-60	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	3
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	F	62	12: 60-65	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	M	22	04: 20-25	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	M	29	05: 25-30	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	M	30	06: 30-35	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	M	53	10: 50-55	1
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	2
2015-06	Murray Royal Hospit	General Psychia	White - Scottish	M	65	13: 65-70	4
2015-06	Stracathro Hospital	General Psychia	Not Known	M	21	04: 20-25	1
2015-06	Stracathro Hospital	General Psychia	Not Known	M	33	06: 30-35	1
2015-06	Stracathro Hospital	General Psychia	Not Known	M	37	07: 35-40	1
2015-06	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	21	04: 20-25	1

2015-06	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	40	08: 40-45	2
2015-06	Stracathro Hospital	General Psychia	White - Other British	F	22	04: 20-25	3
2015-06	Stracathro Hospital	General Psychia	White - Other British	M	45	09: 45-50	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	F	17	03: 15-20	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	F	25	05: 25-30	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	F	28	05: 25-30	2
2015-06	Stracathro Hospital	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	F	37	07: 35-40	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	F	51	10: 50-55	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	F	57	11: 55-60	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	F	64	12: 60-65	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	M	19	03: 15-20	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	M	38	07: 35-40	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	M	41	08: 40-45	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	M	50	10: 50-55	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	M	59	11: 55-60	1
2015-06	Stracathro Hospital	General Psychia	White - Scottish	M	62	12: 60-65	1
2015-07	Carseview Centre	General Psychia	Asian/Asian Scottish/Asian British - Other	F	30	06: 30-35	1
2015-07	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	M	30	06: 30-35	1
2015-07	Carseview Centre	General Psychia	Not Known	F	19	03: 15-20	1
2015-07	Carseview Centre	General Psychia	Not Known	F	29	05: 25-30	1
2015-07	Carseview Centre	General Psychia	Not Known	F	38	07: 35-40	1
2015-07	Carseview Centre	General Psychia	Refused/Not provided by patient	M	18	03: 15-20	1
2015-07	Carseview Centre	General Psychia	White - Irish	F	38	07: 35-40	1
2015-07	Carseview Centre	General Psychia	White - Other British	F	42	08: 40-45	1
2015-07	Carseview Centre	General Psychia	White - Other British	F	48	09: 45-50	1
2015-07	Carseview Centre	General Psychia	White - Other British	F	55	11: 55-60	1
2015-07	Carseview Centre	General Psychia	White - Other British	M	28	05: 25-30	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	23	04: 20-25	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	31	06: 30-35	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	35	07: 35-40	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	49	09: 45-50	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	52	10: 50-55	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	59	11: 55-60	2
2015-07	Carseview Centre	General Psychia	White - Scottish	F	60	12: 60-65	1
2015-07	Carseview Centre	General Psychia	White - Scottish	F	63	12: 60-65	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	20	04: 20-25	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	21	04: 20-25	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	2
2015-07	Carseview Centre	General Psychia	White - Scottish	M	36	07: 35-40	2

2015-07	Carseview Centre	General Psychia	White - Scottish	M	37	07: 35-40	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	48	09: 45-50	2
2015-07	Carseview Centre	General Psychia	White - Scottish	M	50	10: 50-55	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	52	10: 50-55	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	54	10: 50-55	1
2015-07	Carseview Centre	General Psychia	White - Scottish	M	59	11: 55-60	1
2015-07	Murray Royal Hospit	General Psychia	Not Known	M	48	09: 45-50	2
2015-07	Murray Royal Hospit	General Psychia	Not Known	M	63	12: 60-65	1
2015-07	Murray Royal Hospit	General Psychia	White - Gypsy/Traveller	F	17	03: 15-20	1
2015-07	Murray Royal Hospit	General Psychia	White - Other British	F	45	09: 45-50	1
2015-07	Murray Royal Hospit	General Psychia	White - Polish	M	30	06: 30-35	1
2015-07	Murray Royal Hospit	General Psychia	White - Polish	M	34	06: 30-35	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	F	18	03: 15-20	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	F	28	05: 25-30	2
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	F	37	07: 35-40	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	F	50	10: 50-55	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	F	53	10: 50-55	3
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	2
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	M	22	04: 20-25	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	M	23	04: 20-25	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	M	29	05: 25-30	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	M	60	12: 60-65	1
2015-07	Murray Royal Hospit	General Psychia	White - Scottish	M	65	13: 65-70	2
2015-07	Stracathro Hospital	General Psychia	Not Known	F	24	04: 20-25	1
2015-07	Stracathro Hospital	General Psychia	Not Known	M	25	05: 25-30	1
2015-07	Stracathro Hospital	General Psychia	Not Known	M	33	06: 30-35	1
2015-07	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	18	03: 15-20	1
2015-07	Stracathro Hospital	General Psychia	White - Other British	M	51	10: 50-55	1
2015-07	Stracathro Hospital	General Psychia	White - Other British	M	54	10: 50-55	1
2015-07	Stracathro Hospital	General Psychia	White - Other British	M	61	12: 60-65	1
2015-07	Stracathro Hospital	General Psychia	White - Other British	M	63	12: 60-65	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	F	34	06: 30-35	2
2015-07	Stracathro Hospital	General Psychia	White - Scottish	F	37	07: 35-40	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	F	55	11: 55-60	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	F	56	11: 55-60	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	M	35	07: 35-40	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	M	36	07: 35-40	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	M	48	09: 45-50	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	M	50	10: 50-55	1

2015-07	Stracathro Hospital	General Psychia	White - Scottish	M	55	11: 55-60	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	M	64	12: 60-65	1
2015-07	Stracathro Hospital	General Psychia	White - Scottish	M	65	13: 65-70	3
2015-08	Carseview Centre	General Psychia	Not Known	F	24	04: 20-25	1
2015-08	Carseview Centre	General Psychia	Not Known	F	36	07: 35-40	1
2015-08	Carseview Centre	General Psychia	Not Known	M	21	04: 20-25	1
2015-08	Carseview Centre	General Psychia	Not Known	M	24	04: 20-25	1
2015-08	Carseview Centre	General Psychia	Refused/Not provided by patient	M	58	11: 55-60	1
2015-08	Carseview Centre	General Psychia	White - Other British	F	22	04: 20-25	1
2015-08	Carseview Centre	General Psychia	White - Other British	M	28	05: 25-30	1
2015-08	Carseview Centre	General Psychia	White - Other British	M	45	09: 45-50	1
2015-08	Carseview Centre	General Psychia	White - Other British	M	57	11: 55-60	1
2015-08	Carseview Centre	General Psychia	White - Other British	M	61	12: 60-65	1
2015-08	Carseview Centre	General Psychia	White - Other Ethnic Group	F	38	07: 35-40	1
2015-08	Carseview Centre	General Psychia	White - Polish	M	31	06: 30-35	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	22	04: 20-25	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	24	04: 20-25	2
2015-08	Carseview Centre	General Psychia	White - Scottish	F	27	05: 25-30	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	29	05: 25-30	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	35	07: 35-40	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	37	07: 35-40	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	38	07: 35-40	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	45	09: 45-50	2
2015-08	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	51	10: 50-55	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	53	10: 50-55	1
2015-08	Carseview Centre	General Psychia	White - Scottish	F	59	11: 55-60	2
2015-08	Carseview Centre	General Psychia	White - Scottish	F	63	12: 60-65	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	19	03: 15-20	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	20	04: 20-25	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	31	06: 30-35	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	38	07: 35-40	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	47	09: 45-50	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	55	11: 55-60	2
2015-08	Carseview Centre	General Psychia	White - Scottish	M	59	11: 55-60	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	62	12: 60-65	1
2015-08	Carseview Centre	General Psychia	White - Scottish	M	64	12: 60-65	1
2015-08	Murray Royal Hospit	General Psychia	Not Known	M	24	04: 20-25	1
2015-08	Murray Royal Hospit	General Psychia	Not Known	M	41	08: 40-45	1
2015-08	Murray Royal Hospit	General Psychia	Not Known	M	48	09: 45-50	1
2015-08	Murray Royal Hospit	General Psychia	Other Ethnic Group	F	24	04: 20-25	1
2015-08	Murray Royal Hospit	General Psychia	White - Other British	F	21	04: 20-25	1
2015-08	Murray Royal Hospit	General Psychia	White - Other British	F	28	05: 25-30	1
2015-08	Murray Royal Hospit	General Psychia	White - Other British	F	49	09: 45-50	2
2015-08	Murray Royal Hospit	General Psychia	White - Polish	F	56	11: 55-60	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	18	03: 15-20	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	22	04: 20-25	1

2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	29	05: 25-30	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	31	06: 30-35	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	41	08: 40-45	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	2
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	51	10: 50-55	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	57	11: 55-60	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	4
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	F	62	12: 60-65	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	M	22	04: 20-25	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	M	26	05: 25-30	3
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	2
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	M	38	07: 35-40	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	M	41	08: 40-45	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	1
2015-08	Murray Royal Hospit	General Psychia	White - Scottish	M	63	12: 60-65	1
2015-08	Stracathro Hospital	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	M	36	07: 35-40	1
2015-08	Stracathro Hospital	General Psychia	Not Known	M	21	04: 20-25	1
2015-08	Stracathro Hospital	General Psychia	Not Known	M	50	10: 50-55	1
2015-08	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	61	12: 60-65	1
2015-08	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	18	03: 15-20	1
2015-08	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	24	04: 20-25	1
2015-08	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	35	07: 35-40	1
2015-08	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	40	08: 40-45	1
2015-08	Stracathro Hospital	General Psychia	White - Irish	F	31	06: 30-35	1
2015-08	Stracathro Hospital	General Psychia	White - Other British	F	22	04: 20-25	1
2015-08	Stracathro Hospital	General Psychia	White - Other British	M	54	10: 50-55	2
2015-08	Stracathro Hospital	General Psychia	White - Polish	M	31	06: 30-35	1
2015-08	Stracathro Hospital	General Psychia	White - Scottish	F	37	07: 35-40	1
2015-08	Stracathro Hospital	General Psychia	White - Scottish	F	38	07: 35-40	1
2015-08	Stracathro Hospital	General Psychia	White - Scottish	F	42	08: 40-45	1
2015-08	Stracathro Hospital	General Psychia	White - Scottish	F	52	10: 50-55	2
2015-08	Stracathro Hospital	General Psychia	White - Scottish	F	57	11: 55-60	1
2015-08	Stracathro Hospital	General Psychia	White - Scottish	M	19	03: 15-20	1
2015-08	Stracathro Hospital	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-08	Stracathro Hospital	General Psychia	White - Scottish	M	65	13: 65-70	1
2015-09	Carseview Centre	General Psychia	Not Known	F	57	11: 55-60	1
2015-09	Carseview Centre	General Psychia	Not Known	M	28	05: 25-30	1
2015-09	Carseview Centre	General Psychia	Not Known	M	32	06: 30-35	1
2015-09	Carseview Centre	General Psychia	Not Known	M	33	06: 30-35	1
2015-09	Carseview Centre	General Psychia	Not Known	M	35	07: 35-40	1
2015-09	Carseview Centre	General Psychia	Not Known	M	37	07: 35-40	1
2015-09	Carseview Centre	General Psychia	Not Known	M	43	08: 40-45	1
2015-09	Carseview Centre	General Psychia	Refused/Not provided by patient	M	42	08: 40-45	1
2015-09	Carseview Centre	General Psychia	White - Irish	M	20	04: 20-25	1
2015-09	Carseview Centre	General Psychia	White - Other British	F	35	07: 35-40	1
2015-09	Carseview Centre	General Psychia	White - Other British	M	37	07: 35-40	1
2015-09	Carseview Centre	General Psychia	White - Other British	M	43	08: 40-45	1

2015-09	Carseview Centre	General Psychia	White - Other British	M	47	09: 45-50	2
2015-09	Carseview Centre	General Psychia	White - Other British	M	57	11: 55-60	1
2015-09	Carseview Centre	General Psychia	White - Other Ethnic Group	F	19	03: 15-20	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	21	04: 20-25	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	23	04: 20-25	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	30	06: 30-35	2
2015-09	Carseview Centre	General Psychia	White - Scottish	F	36	07: 35-40	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	42	08: 40-45	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	43	08: 40-45	3
2015-09	Carseview Centre	General Psychia	White - Scottish	F	54	10: 50-55	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	61	12: 60-65	1
2015-09	Carseview Centre	General Psychia	White - Scottish	F	63	12: 60-65	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	16	03: 15-20	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	18	03: 15-20	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	27	05: 25-30	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	29	05: 25-30	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	30	06: 30-35	2
2015-09	Carseview Centre	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	3
2015-09	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	38	07: 35-40	2
2015-09	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	2
2015-09	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	51	10: 50-55	2
2015-09	Carseview Centre	General Psychia	White - Scottish	M	54	10: 50-55	2
2015-09	Carseview Centre	General Psychia	White - Scottish	M	55	11: 55-60	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	60	12: 60-65	1
2015-09	Carseview Centre	General Psychia	White - Scottish	M	64	12: 60-65	1
2015-09	Murray Royal Hospit	General Psychia	Mixed/Multiple Ethnic Groups	M	45	09: 45-50	1
2015-09	Murray Royal Hospit	General Psychia	Not Known	F	44	08: 40-45	1
2015-09	Murray Royal Hospit	General Psychia	Not Known	F	48	09: 45-50	1
2015-09	Murray Royal Hospit	General Psychia	Not Known	M	20	04: 20-25	1
2015-09	Murray Royal Hospit	General Psychia	Not Known	M	52	10: 50-55	1
2015-09	Murray Royal Hospit	General Psychia	White - Other British	F	49	09: 45-50	9
2015-09	Murray Royal Hospit	General Psychia	White - Other British	F	62	12: 60-65	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	17	03: 15-20	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	18	03: 15-20	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	19	03: 15-20	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	22	04: 20-25	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	30	06: 30-35	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	31	06: 30-35	2
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	33	06: 30-35	1

2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	35	07: 35-40	2
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	58	11: 55-60	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	M	27	05: 25-30	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	M	29	05: 25-30	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	M	36	07: 35-40	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	M	50	10: 50-55	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	1
2015-09	Murray Royal Hospit	General Psychia	White - Scottish	M	63	12: 60-65	1
2015-09	Stracathro Hospital	General Psychia	Not Known	F	41	08: 40-45	1
2015-09	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	42	08: 40-45	1
2015-09	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	58	11: 55-60	1
2015-09	Stracathro Hospital	General Psychia	White - Other British	F	54	10: 50-55	1
2015-09	Stracathro Hospital	General Psychia	White - Other British	M	60	12: 60-65	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	F	20	04: 20-25	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	F	27	05: 25-30	2
2015-09	Stracathro Hospital	General Psychia	White - Scottish	F	29	05: 25-30	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	F	31	06: 30-35	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	F	42	08: 40-45	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	F	57	11: 55-60	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	F	59	11: 55-60	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	M	17	03: 15-20	2
2015-09	Stracathro Hospital	General Psychia	White - Scottish	M	20	04: 20-25	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	M	27	05: 25-30	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	M	35	07: 35-40	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	M	47	09: 45-50	1
2015-09	Stracathro Hospital	General Psychia	White - Scottish	M	49	09: 45-50	1
2015-10	Carseview Centre	General Psychia	Asian - Chinese, Chinese Scottish or Chinese I	M	23	04: 20-25	1
2015-10	Carseview Centre	General Psychia	Not Known	M	18	03: 15-20	1
2015-10	Carseview Centre	General Psychia	Not Known	M	19	03: 15-20	1
2015-10	Carseview Centre	General Psychia	Not Known	M	21	04: 20-25	1
2015-10	Carseview Centre	General Psychia	Not Known	M	30	06: 30-35	1
2015-10	Carseview Centre	General Psychia	Refused/Not provided by patient	M	18	03: 15-20	1
2015-10	Carseview Centre	General Psychia	White - Other British	F	23	04: 20-25	1
2015-10	Carseview Centre	General Psychia	White - Other British	F	43	08: 40-45	1
2015-10	Carseview Centre	General Psychia	White - Other British	M	38	07: 35-40	1
2015-10	Carseview Centre	General Psychia	White - Other British	M	51	10: 50-55	1
2015-10	Carseview Centre	General Psychia	White - Other British	M	56	11: 55-60	1
2015-10	Carseview Centre	General Psychia	White - Other British	M	62	12: 60-65	2
2015-10	Carseview Centre	General Psychia	White - Other Ethnic Group	F	37	07: 35-40	1
2015-10	Carseview Centre	General Psychia	White - Scottish	F	16	03: 15-20	1
2015-10	Carseview Centre	General Psychia	White - Scottish	F	23	04: 20-25	3
2015-10	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	1
2015-10	Carseview Centre	General Psychia	White - Scottish	F	29	05: 25-30	3

2015-10	Carseview Centre	General Psychia	White - Scottish	F	35	07: 35-40	1
2015-10	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2015-10	Carseview Centre	General Psychia	White - Scottish	F	42	08: 40-45	1
2015-10	Carseview Centre	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-10	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	2
2015-10	Carseview Centre	General Psychia	White - Scottish	F	60	12: 60-65	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	18	03: 15-20	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	20	04: 20-25	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	23	04: 20-25	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	25	05: 25-30	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	26	05: 25-30	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	27	05: 25-30	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	32	06: 30-35	2
2015-10	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	2
2015-10	Carseview Centre	General Psychia	White - Scottish	M	35	07: 35-40	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	36	07: 35-40	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	38	07: 35-40	2
2015-10	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	48	09: 45-50	1
2015-10	Carseview Centre	General Psychia	White - Scottish	M	52	10: 50-55	1
2015-10	Murray Royal Hospit	General Psychia	Not Known	F	44	08: 40-45	1
2015-10	Murray Royal Hospit	General Psychia	Not Known	M	50	10: 50-55	1
2015-10	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	M	40	08: 40-45	1
2015-10	Murray Royal Hospit	General Psychia	White - Other British	F	31	06: 30-35	2
2015-10	Murray Royal Hospit	General Psychia	White - Other British	F	37	07: 35-40	1
2015-10	Murray Royal Hospit	General Psychia	White - Other British	F	38	07: 35-40	1
2015-10	Murray Royal Hospit	General Psychia	White - Other British	F	50	10: 50-55	4
2015-10	Murray Royal Hospit	General Psychia	White - Other British	F	62	12: 60-65	3
2015-10	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	M	58	11: 55-60	1
2015-10	Murray Royal Hospit	General Psychia	White - Polish	M	46	09: 45-50	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	F	19	03: 15-20	2
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	F	23	04: 20-25	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	F	29	05: 25-30	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	F	32	06: 30-35	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	F	33	06: 30-35	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	F	54	10: 50-55	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	F	59	11: 55-60	2
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	19	03: 15-20	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	23	04: 20-25	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	24	04: 20-25	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	27	05: 25-30	3
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	29	05: 25-30	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	50	10: 50-55	1
2015-10	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	1

2015-10	Stracathro Hospital	General Psychia	Not Known	F	27	05: 25-30	1
2015-10	Stracathro Hospital	General Psychia	Not Known	F	42	08: 40-45	1
2015-10	Stracathro Hospital	General Psychia	Not Known	M	21	04: 20-25	1
2015-10	Stracathro Hospital	General Psychia	Not Known	M	53	10: 50-55	1
2015-10	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	63	12: 60-65	1
2015-10	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	18	03: 15-20	1
2015-10	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	36	07: 35-40	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	F	16	03: 15-20	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	F	38	07: 35-40	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	F	42	08: 40-45	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	F	44	08: 40-45	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	F	48	09: 45-50	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	M	20	04: 20-25	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	M	27	05: 25-30	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	M	31	06: 30-35	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	1
2015-10	Stracathro Hospital	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-11	Carseview Centre	General Psychia	African, African Scottish or African British	F	46	09: 45-50	1
2015-11	Carseview Centre	General Psychia	Not Known	F	38	07: 35-40	1
2015-11	Carseview Centre	General Psychia	Not Known	M	27	05: 25-30	1
2015-11	Carseview Centre	General Psychia	Other Ethnic Group	F	37	07: 35-40	1
2015-11	Carseview Centre	General Psychia	White - Irish	F	31	06: 30-35	1
2015-11	Carseview Centre	General Psychia	White - Other British	F	39	07: 35-40	1
2015-11	Carseview Centre	General Psychia	White - Other British	M	30	06: 30-35	1
2015-11	Carseview Centre	General Psychia	White - Other British	M	51	10: 50-55	1
2015-11	Carseview Centre	General Psychia	White - Other British	M	62	12: 60-65	1
2015-11	Carseview Centre	General Psychia	White - Other Ethnic Group	M	41	08: 40-45	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	20	04: 20-25	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	27	05: 25-30	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	32	06: 30-35	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	52	10: 50-55	2
2015-11	Carseview Centre	General Psychia	White - Scottish	F	54	10: 50-55	2
2015-11	Carseview Centre	General Psychia	White - Scottish	F	64	12: 60-65	1
2015-11	Carseview Centre	General Psychia	White - Scottish	F	65	13: 65-70	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	20	04: 20-25	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	25	05: 25-30	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	29	05: 25-30	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	2
2015-11	Carseview Centre	General Psychia	White - Scottish	M	36	07: 35-40	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	46	09: 45-50	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	47	09: 45-50	1

2015-11	Carseview Centre	General Psychia	White - Scottish	M	48	09: 45-50	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	52	10: 50-55	1
2015-11	Carseview Centre	General Psychia	White - Scottish	M	54	10: 50-55	2
2015-11	Carseview Centre	General Psychia	White - Scottish	M	62	12: 60-65	1
2015-11	Murray Royal Hospit	General Psychia	Not Known	F	44	08: 40-45	2
2015-11	Murray Royal Hospit	General Psychia	Not Known	F	45	09: 45-50	4
2015-11	Murray Royal Hospit	General Psychia	Not Known	M	48	09: 45-50	1
2015-11	Murray Royal Hospit	General Psychia	White - Other British	F	24	04: 20-25	1
2015-11	Murray Royal Hospit	General Psychia	White - Other British	F	37	07: 35-40	3
2015-11	Murray Royal Hospit	General Psychia	White - Other British	F	50	10: 50-55	1
2015-11	Murray Royal Hospit	General Psychia	White - Other British	F	62	12: 60-65	8
2015-11	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	47	09: 45-50	1
2015-11	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	M	41	08: 40-45	1
2015-11	Murray Royal Hospit	General Psychia	White - Polish	M	30	06: 30-35	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	F	30	06: 30-35	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	F	52	10: 50-55	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	F	54	10: 50-55	2
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	17	03: 15-20	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	27	05: 25-30	3
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	34	06: 30-35	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	45	09: 45-50	2
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	48	09: 45-50	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	51	10: 50-55	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	52	10: 50-55	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	61	12: 60-65	1
2015-11	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	2
2015-11	Stracathro Hospital	General Psychia	Not Known	F	47	09: 45-50	1
2015-11	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	25	05: 25-30	1
2015-11	Stracathro Hospital	General Psychia	White - Other British	F	19	03: 15-20	1
2015-11	Stracathro Hospital	General Psychia	White - Other British	F	23	04: 20-25	1
2015-11	Stracathro Hospital	General Psychia	White - Other British	F	24	04: 20-25	2
2015-11	Stracathro Hospital	General Psychia	White - Other British	F	27	05: 25-30	1
2015-11	Stracathro Hospital	General Psychia	White - Other British	M	35	07: 35-40	1
2015-11	Stracathro Hospital	General Psychia	White - Other British	M	51	10: 50-55	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	F	22	04: 20-25	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	F	27	05: 25-30	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	F	44	08: 40-45	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	F	47	09: 45-50	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	F	52	10: 50-55	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	F	56	11: 55-60	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	M	19	03: 15-20	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	M	27	05: 25-30	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	M	35	07: 35-40	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	M	46	09: 45-50	1

2015-11	Stracathro Hospital	General Psychia	White - Scottish	M	49	09: 45-50	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	M	54	10: 50-55	1
2015-11	Stracathro Hospital	General Psychia	White - Scottish	M	60	12: 60-65	1
2015-12	Carseview Centre	General Psychia	Not Known	F	26	05: 25-30	1
2015-12	Carseview Centre	General Psychia	Not Known	M	24	04: 20-25	1
2015-12	Carseview Centre	General Psychia	Not Known	M	27	05: 25-30	1
2015-12	Carseview Centre	General Psychia	Not Known	M	31	06: 30-35	1
2015-12	Carseview Centre	General Psychia	Not Known	M	55	11: 55-60	1
2015-12	Carseview Centre	General Psychia	White - Other British	F	20	04: 20-25	1
2015-12	Carseview Centre	General Psychia	White - Other British	F	26	05: 25-30	1
2015-12	Carseview Centre	General Psychia	White - Other British	F	27	05: 25-30	1
2015-12	Carseview Centre	General Psychia	White - Other British	F	43	08: 40-45	1
2015-12	Carseview Centre	General Psychia	White - Other British	M	18	03: 15-20	1
2015-12	Carseview Centre	General Psychia	White - Other British	M	22	04: 20-25	1
2015-12	Carseview Centre	General Psychia	White - Other British	M	30	06: 30-35	1
2015-12	Carseview Centre	General Psychia	White - Other British	M	37	07: 35-40	1
2015-12	Carseview Centre	General Psychia	White - Other British	M	38	07: 35-40	1
2015-12	Carseview Centre	General Psychia	White - Other British	M	43	08: 40-45	1
2015-12	Carseview Centre	General Psychia	White - Polish	M	37	07: 35-40	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	16	03: 15-20	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	18	03: 15-20	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	20	04: 20-25	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	21	04: 20-25	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	32	06: 30-35	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	33	06: 30-35	2
2015-12	Carseview Centre	General Psychia	White - Scottish	F	34	06: 30-35	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	38	07: 35-40	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	43	08: 40-45	2
2015-12	Carseview Centre	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	57	11: 55-60	1
2015-12	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	1
2015-12	Carseview Centre	General Psychia	White - Scottish	M	24	04: 20-25	1
2015-12	Carseview Centre	General Psychia	White - Scottish	M	31	06: 30-35	1
2015-12	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2015-12	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	1
2015-12	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2015-12	Carseview Centre	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-12	Carseview Centre	General Psychia	White - Scottish	M	47	09: 45-50	1
2015-12	Carseview Centre	General Psychia	White - Scottish	M	53	10: 50-55	2
2015-12	Murray Royal Hospit	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	F	41	08: 40-45	1
2015-12	Murray Royal Hospit	General Psychia	Not Known	F	45	09: 45-50	8
2015-12	Murray Royal Hospit	General Psychia	Not Known	F	54	10: 50-55	1
2015-12	Murray Royal Hospit	General Psychia	Not Known	F	58	11: 55-60	1
2015-12	Murray Royal Hospit	General Psychia	Not Known	M	19	03: 15-20	1
2015-12	Murray Royal Hospit	General Psychia	Not Known	M	24	04: 20-25	1
2015-12	Murray Royal Hospit	General Psychia	Not Known	M	27	05: 25-30	1
2015-12	Murray Royal Hospit	General Psychia	Not Known	M	33	06: 30-35	2
2015-12	Murray Royal Hospit	General Psychia	Not Known	M	39	07: 35-40	1
2015-12	Murray Royal Hospit	General Psychia	Not Known	M	41	08: 40-45	1
2015-12	Murray Royal Hospit	General Psychia	Not Known	M	49	09: 45-50	1

2015-12	Murray Royal Hospit	General Psychia	Not Known	M	54	10: 50-55	1
2015-12	Murray Royal Hospit	General Psychia	Not Known	M	58	11: 55-60	1
2015-12	Murray Royal Hospit	General Psychia	White - Other British	F	37	07: 35-40	4
2015-12	Murray Royal Hospit	General Psychia	White - Other British	F	40	08: 40-45	1
2015-12	Murray Royal Hospit	General Psychia	White - Other British	F	50	10: 50-55	2
2015-12	Murray Royal Hospit	General Psychia	White - Other British	M	57	11: 55-60	1
2015-12	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	5
2015-12	Murray Royal Hospit	General Psychia	White - Polish	M	29	05: 25-30	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	19	03: 15-20	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	24	04: 20-25	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	32	06: 30-35	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	39	07: 35-40	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	40	08: 40-45	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	48	09: 45-50	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	50	10: 50-55	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	52	10: 50-55	2
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	53	10: 50-55	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	54	10: 50-55	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	F	60	12: 60-65	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	18	03: 15-20	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	22	04: 20-25	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	30	06: 30-35	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	34	06: 30-35	3
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	36	07: 35-40	2
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	38	07: 35-40	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	40	08: 40-45	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	45	09: 45-50	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	46	09: 45-50	2
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	2
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	57	11: 55-60	1
2015-12	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	3
2015-12	Stracathro Hospital	General Psychia	Not Known	M	52	10: 50-55	1
2015-12	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	18	03: 15-20	1
2015-12	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	51	10: 50-55	1
2015-12	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	58	11: 55-60	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	F	28	05: 25-30	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	F	30	06: 30-35	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	F	31	06: 30-35	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	F	35	07: 35-40	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	F	45	09: 45-50	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	F	56	11: 55-60	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	F	61	12: 60-65	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	M	29	05: 25-30	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	M	32	06: 30-35	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	2
2015-12	Stracathro Hospital	General Psychia	White - Scottish	M	35	07: 35-40	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	M	38	07: 35-40	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	M	50	10: 50-55	1
2015-12	Stracathro Hospital	General Psychia	White - Scottish	M	51	10: 50-55	1

2015-12	Stracathro Hospital	General Psychia	White - Scottish	M	62	12: 60-65	1
2016-01	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	F	26	05: 25-30	1
2016-01	Carseview Centre	General Psychia	Not Known	F	53	10: 50-55	1
2016-01	Carseview Centre	General Psychia	Not Known	M	21	04: 20-25	1
2016-01	Carseview Centre	General Psychia	Not Known	M	22	04: 20-25	1
2016-01	Carseview Centre	General Psychia	Not Known	M	30	06: 30-35	1
2016-01	Carseview Centre	General Psychia	Not Known	M	36	07: 35-40	1
2016-01	Carseview Centre	General Psychia	Not Known	M	37	07: 35-40	1
2016-01	Carseview Centre	General Psychia	Not Known	M	39	07: 35-40	1
2016-01	Carseview Centre	General Psychia	Refused/Not provided by patient	F	40	08: 40-45	1
2016-01	Carseview Centre	General Psychia	Refused/Not provided by patient	M	27	05: 25-30	1
2016-01	Carseview Centre	General Psychia	White - Other British	F	26	05: 25-30	2
2016-01	Carseview Centre	General Psychia	White - Other British	M	18	03: 15-20	1
2016-01	Carseview Centre	General Psychia	White - Other British	M	29	05: 25-30	1
2016-01	Carseview Centre	General Psychia	White - Other British	M	61	12: 60-65	1
2016-01	Carseview Centre	General Psychia	White - Scottish	F	24	04: 20-25	1
2016-01	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	1
2016-01	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-01	Carseview Centre	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-01	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	2
2016-01	Carseview Centre	General Psychia	White - Scottish	F	46	09: 45-50	2
2016-01	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-01	Carseview Centre	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-01	Carseview Centre	General Psychia	White - Scottish	F	53	10: 50-55	1
2016-01	Carseview Centre	General Psychia	White - Scottish	F	61	12: 60-65	1
2016-01	Carseview Centre	General Psychia	White - Scottish	M	22	04: 20-25	1
2016-01	Carseview Centre	General Psychia	White - Scottish	M	27	05: 25-30	2
2016-01	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-01	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-01	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	2
2016-01	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-01	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	2
2016-01	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	2
2016-01	Carseview Centre	General Psychia	White - Scottish	M	50	10: 50-55	2
2016-01	Carseview Centre	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-01	Carseview Centre	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-01	Murray Royal Hospit	General Psychia	Not Known	F	37	07: 35-40	1
2016-01	Murray Royal Hospit	General Psychia	Not Known	F	45	09: 45-50	6
2016-01	Murray Royal Hospit	General Psychia	Not Known	F	53	10: 50-55	1
2016-01	Murray Royal Hospit	General Psychia	Not Known	M	20	04: 20-25	1
2016-01	Murray Royal Hospit	General Psychia	Not Known	M	41	08: 40-45	1
2016-01	Murray Royal Hospit	General Psychia	Not Known	M	53	10: 50-55	1
2016-01	Murray Royal Hospit	General Psychia	White - Irish	M	59	11: 55-60	1
2016-01	Murray Royal Hospit	General Psychia	White - Other British	F	29	05: 25-30	1
2016-01	Murray Royal Hospit	General Psychia	White - Other British	F	33	06: 30-35	1
2016-01	Murray Royal Hospit	General Psychia	White - Other British	F	35	07: 35-40	1
2016-01	Murray Royal Hospit	General Psychia	White - Other British	F	37	07: 35-40	1
2016-01	Murray Royal Hospit	General Psychia	White - Other British	F	50	10: 50-55	8
2016-01	Murray Royal Hospit	General Psychia	White - Other British	M	29	05: 25-30	1
2016-01	Murray Royal Hospit	General Psychia	White - Other British	M	47	09: 45-50	1

2016-01	Murray Royal Hospit	General Psychia	White - Other British	M	51	10: 50-55	1
2016-01	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	5
2016-01	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	M	58	11: 55-60	1
2016-01	Murray Royal Hospit	General Psychia	White - Polish	M	51	10: 50-55	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	29	05: 25-30	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	31	06: 30-35	2
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	34	06: 30-35	3
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	48	09: 45-50	2
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	49	09: 45-50	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	50	10: 50-55	2
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	52	10: 50-55	2
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	54	10: 50-55	2
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	55	11: 55-60	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	F	62	12: 60-65	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	34	06: 30-35	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	40	08: 40-45	2
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	41	08: 40-45	2
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	46	09: 45-50	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	48	09: 45-50	2
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	50	10: 50-55	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	54	10: 50-55	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	61	12: 60-65	1
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	8
2016-01	Murray Royal Hospit	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-01	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	27	05: 25-30	1
2016-01	Stracathro Hospital	General Psychia	White - Other British	F	55	11: 55-60	1
2016-01	Stracathro Hospital	General Psychia	White - Other British	M	61	12: 60-65	1
2016-01	Stracathro Hospital	General Psychia	White - Scottish	F	20	04: 20-25	2
2016-01	Stracathro Hospital	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-01	Stracathro Hospital	General Psychia	White - Scottish	F	46	09: 45-50	2
2016-01	Stracathro Hospital	General Psychia	White - Scottish	F	56	11: 55-60	1
2016-01	Stracathro Hospital	General Psychia	White - Scottish	M	22	04: 20-25	1
2016-01	Stracathro Hospital	General Psychia	White - Scottish	M	27	05: 25-30	2
2016-01	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	2
2016-01	Stracathro Hospital	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-01	Stracathro Hospital	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-01	Stracathro Hospital	General Psychia	White - Scottish	M	40	08: 40-45	1
2016-01	Stracathro Hospital	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-02	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	F	41	08: 40-45	1
2016-02	Carseview Centre	General Psychia	Not Known	M	24	04: 20-25	1
2016-02	Carseview Centre	General Psychia	Not Known	M	28	05: 25-30	1
2016-02	Carseview Centre	General Psychia	Not Known	M	36	07: 35-40	1
2016-02	Carseview Centre	General Psychia	Not Known	M	37	07: 35-40	1

2016-02	Carseview Centre	General Psychia	Refused/Not provided by patient	M	57	11: 55-60	1
2016-02	Carseview Centre	General Psychia	White - Gypsy/Traveller	M	38	07: 35-40	1
2016-02	Carseview Centre	General Psychia	White - Other British	F	25	05: 25-30	1
2016-02	Carseview Centre	General Psychia	White - Other British	F	26	05: 25-30	1
2016-02	Carseview Centre	General Psychia	White - Other British	F	37	07: 35-40	1
2016-02	Carseview Centre	General Psychia	White - Other British	F	56	11: 55-60	2
2016-02	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	1
2016-02	Carseview Centre	General Psychia	White - Scottish	F	21	04: 20-25	2
2016-02	Carseview Centre	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-02	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	1
2016-02	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	1
2016-02	Carseview Centre	General Psychia	White - Scottish	F	29	05: 25-30	1
2016-02	Carseview Centre	General Psychia	White - Scottish	F	37	07: 35-40	3
2016-02	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-02	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	2
2016-02	Carseview Centre	General Psychia	White - Scottish	F	56	11: 55-60	1
2016-02	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	1
2016-02	Carseview Centre	General Psychia	White - Scottish	M	22	04: 20-25	1
2016-02	Carseview Centre	General Psychia	White - Scottish	M	24	04: 20-25	1
2016-02	Carseview Centre	General Psychia	White - Scottish	M	27	05: 25-30	2
2016-02	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-02	Carseview Centre	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-02	Carseview Centre	General Psychia	White - Scottish	M	47	09: 45-50	1
2016-02	Carseview Centre	General Psychia	White - Scottish	M	48	09: 45-50	3
2016-02	Carseview Centre	General Psychia	White - Scottish	M	60	12: 60-65	1
2016-02	Carseview Centre	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-02	Murray Royal Hospit	General Psychia	African, African Scottish or African British	F	32	06: 30-35	1
2016-02	Murray Royal Hospit	General Psychia	Not Known	F	23	04: 20-25	1
2016-02	Murray Royal Hospit	General Psychia	Not Known	F	41	08: 40-45	1
2016-02	Murray Royal Hospit	General Psychia	Not Known	M	17	03: 15-20	3
2016-02	Murray Royal Hospit	General Psychia	Not Known	M	21	04: 20-25	1
2016-02	Murray Royal Hospit	General Psychia	Not Known	M	35	07: 35-40	1
2016-02	Murray Royal Hospit	General Psychia	Not Known	M	38	07: 35-40	1
2016-02	Murray Royal Hospit	General Psychia	Not Known	M	44	08: 40-45	1
2016-02	Murray Royal Hospit	General Psychia	Not Known	M	48	09: 45-50	1
2016-02	Murray Royal Hospit	General Psychia	Not Known	M	49	09: 45-50	1
2016-02	Murray Royal Hospit	General Psychia	White - Other British	F	50	10: 50-55	3
2016-02	Murray Royal Hospit	General Psychia	White - Other British	F	53	10: 50-55	1
2016-02	Murray Royal Hospit	General Psychia	White - Other British	M	30	06: 30-35	1
2016-02	Murray Royal Hospit	General Psychia	White - Other British	M	43	08: 40-45	1
2016-02	Murray Royal Hospit	General Psychia	White - Other British	M	45	09: 45-50	1
2016-02	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	3
2016-02	Murray Royal Hospit	General Psychia	White - Polish	F	25	05: 25-30	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	18	03: 15-20	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	28	05: 25-30	2
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	29	05: 25-30	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	30	06: 30-35	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	35	07: 35-40	2
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	37	07: 35-40	1

2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	40	08: 40-45	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	2
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	50	10: 50-55	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	53	10: 50-55	2
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	54	10: 50-55	2
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	57	11: 55-60	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	F	58	11: 55-60	2
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	18	03: 15-20	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	28	05: 25-30	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	31	06: 30-35	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	36	07: 35-40	3
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	52	10: 50-55	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	53	10: 50-55	2
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	54	10: 50-55	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	56	11: 55-60	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	58	11: 55-60	1
2016-02	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	2
2016-02	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	40	08: 40-45	1
2016-02	Stracathro Hospital	General Psychia	White - Other British	F	37	07: 35-40	1
2016-02	Stracathro Hospital	General Psychia	White - Other British	M	34	06: 30-35	1
2016-02	Stracathro Hospital	General Psychia	White - Other British	M	44	08: 40-45	1
2016-02	Stracathro Hospital	General Psychia	White - Other British	M	55	11: 55-60	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	F	21	04: 20-25	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	F	38	07: 35-40	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	F	61	12: 60-65	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	M	26	05: 25-30	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	M	35	07: 35-40	2
2016-02	Stracathro Hospital	General Psychia	White - Scottish	M	47	09: 45-50	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	M	50	10: 50-55	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	M	51	10: 50-55	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-02	Stracathro Hospital	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-03	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	M	44	08: 40-45	1
2016-03	Carseview Centre	General Psychia	Not Known	F	36	07: 35-40	1
2016-03	Carseview Centre	General Psychia	Not Known	F	45	09: 45-50	1
2016-03	Carseview Centre	General Psychia	Not Known	F	54	10: 50-55	1
2016-03	Carseview Centre	General Psychia	Not Known	M	17	03: 15-20	1
2016-03	Carseview Centre	General Psychia	Not Known	M	61	12: 60-65	1
2016-03	Carseview Centre	General Psychia	White - Other British	F	27	05: 25-30	2
2016-03	Carseview Centre	General Psychia	White - Other British	F	32	06: 30-35	1
2016-03	Carseview Centre	General Psychia	White - Other British	F	49	09: 45-50	1
2016-03	Carseview Centre	General Psychia	White - Other British	M	28	05: 25-30	1

2016-03	Carseview Centre	General Psychia	White - Other British	M	32	06: 30-35	1
2016-03	Carseview Centre	General Psychia	White - Other British	M	44	08: 40-45	1
2016-03	Carseview Centre	General Psychia	White - Other Ethnic Group	M	35	07: 35-40	1
2016-03	Carseview Centre	General Psychia	White - Polish	M	30	06: 30-35	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	18	03: 15-20	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	29	05: 25-30	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	32	06: 30-35	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	39	07: 35-40	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	40	08: 40-45	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	45	09: 45-50	2
2016-03	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	50	10: 50-55	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	53	10: 50-55	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	54	10: 50-55	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	57	11: 55-60	1
2016-03	Carseview Centre	General Psychia	White - Scottish	F	64	12: 60-65	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	20	04: 20-25	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	23	04: 20-25	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	24	04: 20-25	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	25	05: 25-30	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	27	05: 25-30	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	28	05: 25-30	2
2016-03	Carseview Centre	General Psychia	White - Scottish	M	30	06: 30-35	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	35	07: 35-40	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	47	09: 45-50	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	51	10: 50-55	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	52	10: 50-55	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	53	10: 50-55	1
2016-03	Carseview Centre	General Psychia	White - Scottish	M	55	11: 55-60	2
2016-03	Carseview Centre	General Psychia	White - Scottish	M	60	12: 60-65	2
2016-03	Carseview Centre	General Psychia	White - Scottish	M	62	12: 60-65	2
2016-03	Murray Royal Hospit	General Psychia	African, African Scottish or African British	M	32	06: 30-35	1
2016-03	Murray Royal Hospit	General Psychia	Asian/Asian Scottish/Asian British - Other	F	21	04: 20-25	1
2016-03	Murray Royal Hospit	General Psychia	Not Known	F	30	06: 30-35	1
2016-03	Murray Royal Hospit	General Psychia	Not Known	F	49	09: 45-50	1
2016-03	Murray Royal Hospit	General Psychia	Not Known	M	36	07: 35-40	1
2016-03	Murray Royal Hospit	General Psychia	Not Known	M	42	08: 40-45	1
2016-03	Murray Royal Hospit	General Psychia	Not Known	M	46	09: 45-50	1
2016-03	Murray Royal Hospit	General Psychia	Not Known	M	64	12: 60-65	1
2016-03	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	F	53	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	M	54	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	White - Other British	F	35	07: 35-40	1

2016-03	Murray Royal Hospit	General Psychia	White - Other British	F	45	09: 45-50	1
2016-03	Murray Royal Hospit	General Psychia	White - Other British	F	46	09: 45-50	1
2016-03	Murray Royal Hospit	General Psychia	White - Other British	F	48	09: 45-50	1
2016-03	Murray Royal Hospit	General Psychia	White - Other British	F	50	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	White - Other British	F	62	12: 60-65	1
2016-03	Murray Royal Hospit	General Psychia	White - Other British	M	57	11: 55-60	1
2016-03	Murray Royal Hospit	General Psychia	White - Other British	M	58	11: 55-60	1
2016-03	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	3
2016-03	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	M	40	08: 40-45	1
2016-03	Murray Royal Hospit	General Psychia	White - Polish	M	31	06: 30-35	1
2016-03	Murray Royal Hospit	General Psychia	White - Polish	M	37	07: 35-40	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	18	03: 15-20	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	22	04: 20-25	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	26	05: 25-30	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	28	05: 25-30	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	33	06: 30-35	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	2
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	49	09: 45-50	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	53	10: 50-55	2
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	54	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	58	11: 55-60	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	F	60	12: 60-65	2
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	34	06: 30-35	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	42	08: 40-45	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	43	08: 40-45	4
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	3
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	48	09: 45-50	3
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	49	09: 45-50	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	51	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	52	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	53	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	54	10: 50-55	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	58	11: 55-60	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	60	12: 60-65	1
2016-03	Murray Royal Hospit	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-03	Stracathro Hospital	General Psychia	Not Known	M	20	04: 20-25	1
2016-03	Stracathro Hospital	General Psychia	Not Known	M	36	07: 35-40	1
2016-03	Stracathro Hospital	General Psychia	White - Other British	F	26	05: 25-30	1
2016-03	Stracathro Hospital	General Psychia	White - Other British	F	37	07: 35-40	1
2016-03	Stracathro Hospital	General Psychia	White - Other British	M	48	09: 45-50	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	18	03: 15-20	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	20	04: 20-25	1

2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	28	05: 25-30	3
2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	29	05: 25-30	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	37	07: 35-40	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	38	07: 35-40	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	41	08: 40-45	2
2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	52	10: 50-55	2
2016-03	Stracathro Hospital	General Psychia	White - Scottish	F	62	12: 60-65	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	M	26	05: 25-30	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	M	28	05: 25-30	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	M	32	06: 30-35	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	2
2016-03	Stracathro Hospital	General Psychia	White - Scottish	M	43	08: 40-45	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-03	Stracathro Hospital	General Psychia	White - Scottish	M	52	10: 50-55	1
2016-04	Carseview Centre	General Psychia	Asian - Chinese, Chinese Scottish or Chinese I	F	17	03: 15-20	1
2016-04	Carseview Centre	General Psychia	Not Known	F	36	07: 35-40	1
2016-04	Carseview Centre	General Psychia	Not Known	F	42	08: 40-45	1
2016-04	Carseview Centre	General Psychia	Not Known	M	27	05: 25-30	1
2016-04	Carseview Centre	General Psychia	Not Known	M	28	05: 25-30	2
2016-04	Carseview Centre	General Psychia	Not Known	M	36	07: 35-40	1
2016-04	Carseview Centre	General Psychia	Refused/Not provided by patient	M	19	03: 15-20	1
2016-04	Carseview Centre	General Psychia	White - Other British	F	22	04: 20-25	1
2016-04	Carseview Centre	General Psychia	White - Other British	F	26	05: 25-30	1
2016-04	Carseview Centre	General Psychia	White - Other British	F	27	05: 25-30	1
2016-04	Carseview Centre	General Psychia	White - Other British	F	28	05: 25-30	1
2016-04	Carseview Centre	General Psychia	White - Other British	F	40	08: 40-45	1
2016-04	Carseview Centre	General Psychia	White - Other British	F	49	09: 45-50	1
2016-04	Carseview Centre	General Psychia	White - Other British	F	52	10: 50-55	1
2016-04	Carseview Centre	General Psychia	White - Other British	M	18	03: 15-20	1
2016-04	Carseview Centre	General Psychia	White - Other British	M	21	04: 20-25	1
2016-04	Carseview Centre	General Psychia	White - Other British	M	24	04: 20-25	1
2016-04	Carseview Centre	General Psychia	White - Other British	M	51	10: 50-55	1
2016-04	Carseview Centre	General Psychia	White - Other Ethnic Group	M	36	07: 35-40	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	2
2016-04	Carseview Centre	General Psychia	White - Scottish	F	20	04: 20-25	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	24	04: 20-25	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	33	06: 30-35	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	38	07: 35-40	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	39	07: 35-40	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	50	10: 50-55	2
2016-04	Carseview Centre	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-04	Carseview Centre	General Psychia	White - Scottish	F	65	13: 65-70	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	25	05: 25-30	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	28	05: 25-30	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1

2016-04	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	42	08: 40-45	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	47	09: 45-50	2
2016-04	Carseview Centre	General Psychia	White - Scottish	M	51	10: 50-55	1
2016-04	Carseview Centre	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-04	Murray Royal Hospit	General Psychia	Not Known	F	40	08: 40-45	1
2016-04	Murray Royal Hospit	General Psychia	Not Known	M	28	05: 25-30	1
2016-04	Murray Royal Hospit	General Psychia	Not Known	M	29	05: 25-30	1
2016-04	Murray Royal Hospit	General Psychia	Not Known	M	31	06: 30-35	1
2016-04	Murray Royal Hospit	General Psychia	Not Known	M	36	07: 35-40	1
2016-04	Murray Royal Hospit	General Psychia	White - Irish	M	34	06: 30-35	1
2016-04	Murray Royal Hospit	General Psychia	White - Irish	M	47	09: 45-50	1
2016-04	Murray Royal Hospit	General Psychia	White - Irish	M	57	11: 55-60	1
2016-04	Murray Royal Hospit	General Psychia	White - Other British	F	30	06: 30-35	1
2016-04	Murray Royal Hospit	General Psychia	White - Other British	F	33	06: 30-35	2
2016-04	Murray Royal Hospit	General Psychia	White - Other British	F	50	10: 50-55	1
2016-04	Murray Royal Hospit	General Psychia	White - Other British	M	29	05: 25-30	1
2016-04	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	3
2016-04	Murray Royal Hospit	General Psychia	White - Polish	M	31	06: 30-35	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	20	04: 20-25	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	29	05: 25-30	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	33	06: 30-35	3
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	34	06: 30-35	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	38	07: 35-40	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	49	09: 45-50	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	50	10: 50-55	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	58	11: 55-60	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	F	65	13: 65-70	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	24	04: 20-25	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	33	06: 30-35	2
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	38	07: 35-40	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	39	07: 35-40	3
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	43	08: 40-45	2
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	3
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	50	10: 50-55	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	51	10: 50-55	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	53	10: 50-55	2
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	54	10: 50-55	2
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	59	11: 55-60	1
2016-04	Murray Royal Hospit	General Psychia	White - Scottish	M	61	12: 60-65	2
2016-04	Stracathro Hospital	General Psychia	Not Known	F	40	08: 40-45	1

2016-04	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	52	10: 50-55	1
2016-04	Stracathro Hospital	General Psychia	White - Other British	F	23	04: 20-25	1
2016-04	Stracathro Hospital	General Psychia	White - Other British	F	26	05: 25-30	1
2016-04	Stracathro Hospital	General Psychia	White - Other British	M	46	09: 45-50	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	24	04: 20-25	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	29	05: 25-30	2
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	31	06: 30-35	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	38	07: 35-40	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	39	07: 35-40	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	42	08: 40-45	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	50	10: 50-55	2
2016-04	Stracathro Hospital	General Psychia	White - Scottish	F	63	12: 60-65	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	M	30	06: 30-35	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	M	51	10: 50-55	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	M	54	10: 50-55	1
2016-04	Stracathro Hospital	General Psychia	White - Scottish	M	62	12: 60-65	1
2016-05	Carseview Centre	General Psychia	Asian - Bangladeshi, Bangladeshi Scottish or E	M	31	06: 30-35	1
2016-05	Carseview Centre	General Psychia	Not Known	F	27	05: 25-30	1
2016-05	Carseview Centre	General Psychia	Not Known	F	49	09: 45-50	2
2016-05	Carseview Centre	General Psychia	Not Known	M	27	05: 25-30	1
2016-05	Carseview Centre	General Psychia	Refused/Not provided by patient	M	58	11: 55-60	1
2016-05	Carseview Centre	General Psychia	White - Gypsy/Traveller	M	39	07: 35-40	1
2016-05	Carseview Centre	General Psychia	White - Irish	F	22	04: 20-25	2
2016-05	Carseview Centre	General Psychia	White - Irish	M	21	04: 20-25	1
2016-05	Carseview Centre	General Psychia	White - Other British	F	23	04: 20-25	1
2016-05	Carseview Centre	General Psychia	White - Other British	F	27	05: 25-30	1
2016-05	Carseview Centre	General Psychia	White - Other British	F	32	06: 30-35	1
2016-05	Carseview Centre	General Psychia	White - Other British	F	36	07: 35-40	1
2016-05	Carseview Centre	General Psychia	White - Other British	F	39	07: 35-40	1
2016-05	Carseview Centre	General Psychia	White - Other British	F	43	08: 40-45	1
2016-05	Carseview Centre	General Psychia	White - Other British	F	54	10: 50-55	1
2016-05	Carseview Centre	General Psychia	White - Other British	M	22	04: 20-25	2
2016-05	Carseview Centre	General Psychia	White - Other British	M	28	05: 25-30	1
2016-05	Carseview Centre	General Psychia	White - Other British	M	29	05: 25-30	1
2016-05	Carseview Centre	General Psychia	White - Other British	M	32	06: 30-35	1
2016-05	Carseview Centre	General Psychia	White - Other British	M	37	07: 35-40	1
2016-05	Carseview Centre	General Psychia	White - Other British	M	38	07: 35-40	1
2016-05	Carseview Centre	General Psychia	White - Other British	M	63	12: 60-65	1
2016-05	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	1
2016-05	Carseview Centre	General Psychia	White - Scottish	F	25	05: 25-30	1
2016-05	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	1
2016-05	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	2
2016-05	Carseview Centre	General Psychia	White - Scottish	F	31	06: 30-35	1
2016-05	Carseview Centre	General Psychia	White - Scottish	F	32	06: 30-35	1
2016-05	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-05	Carseview Centre	General Psychia	White - Scottish	F	42	08: 40-45	2
2016-05	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	1

2016-05	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	2
2016-05	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-05	Carseview Centre	General Psychia	White - Scottish	F	50	10: 50-55	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	22	04: 20-25	2
2016-05	Carseview Centre	General Psychia	White - Scottish	M	26	05: 25-30	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	38	07: 35-40	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	42	08: 40-45	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	53	10: 50-55	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	56	11: 55-60	1
2016-05	Carseview Centre	General Psychia	White - Scottish	M	61	12: 60-65	1
2016-05	Murray Royal Hospit	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	M	20	04: 20-25	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	F	32	06: 30-35	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	F	34	06: 30-35	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	F	35	07: 35-40	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	F	36	07: 35-40	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	M	32	06: 30-35	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	M	34	06: 30-35	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	M	40	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	M	41	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	M	42	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	M	47	09: 45-50	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	M	48	09: 45-50	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	M	51	10: 50-55	1
2016-05	Murray Royal Hospit	General Psychia	Not Known	M	57	11: 55-60	1
2016-05	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	M	43	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	White - Irish	F	26	05: 25-30	1
2016-05	Murray Royal Hospit	General Psychia	White - Irish	M	21	04: 20-25	1
2016-05	Murray Royal Hospit	General Psychia	White - Other British	F	30	06: 30-35	1
2016-05	Murray Royal Hospit	General Psychia	White - Other British	F	32	06: 30-35	1
2016-05	Murray Royal Hospit	General Psychia	White - Other British	F	50	10: 50-55	7
2016-05	Murray Royal Hospit	General Psychia	White - Other British	F	52	10: 50-55	1
2016-05	Murray Royal Hospit	General Psychia	White - Other British	F	63	12: 60-65	1
2016-05	Murray Royal Hospit	General Psychia	White - Other British	M	46	09: 45-50	1
2016-05	Murray Royal Hospit	General Psychia	White - Other British	M	60	12: 60-65	2
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	18	03: 15-20	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	20	04: 20-25	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	32	06: 30-35	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	34	06: 30-35	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	36	07: 35-40	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	37	07: 35-40	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	40	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	47	09: 45-50	1

2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	50	10: 50-55	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	54	10: 50-55	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	F	55	11: 55-60	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	18	03: 15-20	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	28	05: 25-30	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	2
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	38	07: 35-40	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	46	09: 45-50	2
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	48	09: 45-50	2
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	49	09: 45-50	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	54	10: 50-55	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	58	11: 55-60	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	59	11: 55-60	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	60	12: 60-65	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	61	12: 60-65	1
2016-05	Murray Royal Hospit	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-05	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	26	05: 25-30	1
2016-05	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	50	10: 50-55	1
2016-05	Stracathro Hospital	General Psychia	White - Other British	F	23	04: 20-25	1
2016-05	Stracathro Hospital	General Psychia	White - Other British	F	24	04: 20-25	1
2016-05	Stracathro Hospital	General Psychia	White - Other British	M	28	05: 25-30	2
2016-05	Stracathro Hospital	General Psychia	White - Other British	M	63	12: 60-65	1
2016-05	Stracathro Hospital	General Psychia	White - Polish	M	22	04: 20-25	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	17	03: 15-20	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	20	04: 20-25	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	26	05: 25-30	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	28	05: 25-30	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	37	07: 35-40	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	38	07: 35-40	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	47	09: 45-50	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	50	10: 50-55	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	F	63	12: 60-65	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-05	Stracathro Hospital	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-06	Carseview Centre	General Psychia	Not Known	F	43	08: 40-45	1
2016-06	Carseview Centre	General Psychia	Not Known	F	61	12: 60-65	1
2016-06	Carseview Centre	General Psychia	Not Known	M	31	06: 30-35	1
2016-06	Carseview Centre	General Psychia	Not Known	M	36	07: 35-40	1
2016-06	Carseview Centre	General Psychia	Refused/Not provided by patient	F	28	05: 25-30	1
2016-06	Carseview Centre	General Psychia	White - Other British	F	22	04: 20-25	1
2016-06	Carseview Centre	General Psychia	White - Other British	F	27	05: 25-30	1
2016-06	Carseview Centre	General Psychia	White - Other British	F	49	09: 45-50	1
2016-06	Carseview Centre	General Psychia	White - Other British	M	22	04: 20-25	2

2016-06	Carseview Centre	General Psychia	White - Other British	M	28	05: 25-30	1
2016-06	Carseview Centre	General Psychia	White - Other British	M	30	06: 30-35	1
2016-06	Carseview Centre	General Psychia	White - Other British	M	39	07: 35-40	1
2016-06	Carseview Centre	General Psychia	White - Other British	M	43	08: 40-45	1
2016-06	Carseview Centre	General Psychia	White - Other British	M	47	09: 45-50	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	21	04: 20-25	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	22	04: 20-25	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	24	04: 20-25	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	25	05: 25-30	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	27	05: 25-30	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	34	06: 30-35	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	36	07: 35-40	2
2016-06	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	2
2016-06	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	2
2016-06	Carseview Centre	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	56	11: 55-60	1
2016-06	Carseview Centre	General Psychia	White - Scottish	F	59	11: 55-60	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	23	04: 20-25	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	24	04: 20-25	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	25	05: 25-30	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	26	05: 25-30	2
2016-06	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	2
2016-06	Carseview Centre	General Psychia	White - Scottish	M	35	07: 35-40	2
2016-06	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	54	10: 50-55	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	56	11: 55-60	2
2016-06	Carseview Centre	General Psychia	White - Scottish	M	59	11: 55-60	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	62	12: 60-65	1
2016-06	Carseview Centre	General Psychia	White - Scottish	M	65	13: 65-70	1
2016-06	Murray Royal Hospit	General Psychia	Asian/Asian Scottish/Asian British - Other	F	21	04: 20-25	1
2016-06	Murray Royal Hospit	General Psychia	Not Known	F	28	05: 25-30	1
2016-06	Murray Royal Hospit	General Psychia	Not Known	M	29	05: 25-30	1
2016-06	Murray Royal Hospit	General Psychia	Not Known	M	34	06: 30-35	1
2016-06	Murray Royal Hospit	General Psychia	Not Known	M	41	08: 40-45	1
2016-06	Murray Royal Hospit	General Psychia	Not Known	M	46	09: 45-50	1
2016-06	Murray Royal Hospit	General Psychia	Not Known	M	52	10: 50-55	1
2016-06	Murray Royal Hospit	General Psychia	Not Known	M	53	10: 50-55	1
2016-06	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	F	53	10: 50-55	1
2016-06	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	M	49	09: 45-50	1
2016-06	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	M	56	11: 55-60	1
2016-06	Murray Royal Hospit	General Psychia	White - Irish	F	22	04: 20-25	1
2016-06	Murray Royal Hospit	General Psychia	White - Other British	F	22	04: 20-25	1
2016-06	Murray Royal Hospit	General Psychia	White - Other British	F	36	07: 35-40	1
2016-06	Murray Royal Hospit	General Psychia	White - Other British	F	46	09: 45-50	1

2016-06	Murray Royal Hospit	General Psychia	White - Other British	F	49	09: 45-50	1
2016-06	Murray Royal Hospit	General Psychia	White - Other British	F	50	10: 50-55	2
2016-06	Murray Royal Hospit	General Psychia	White - Other British	M	18	03: 15-20	1
2016-06	Murray Royal Hospit	General Psychia	White - Other British	M	35	07: 35-40	1
2016-06	Murray Royal Hospit	General Psychia	White - Other British	M	47	09: 45-50	1
2016-06	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	M	49	09: 45-50	1
2016-06	Murray Royal Hospit	General Psychia	White - Polish	M	31	06: 30-35	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	F	22	04: 20-25	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	F	32	06: 30-35	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	F	36	07: 35-40	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	F	37	07: 35-40	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	F	44	08: 40-45	2
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	F	58	11: 55-60	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	F	61	12: 60-65	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	26	05: 25-30	2
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	31	06: 30-35	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	34	06: 30-35	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	37	07: 35-40	2
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	39	07: 35-40	2
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	41	08: 40-45	2
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	43	08: 40-45	3
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	46	09: 45-50	2
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	48	09: 45-50	2
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	54	10: 50-55	2
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	56	11: 55-60	1
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	59	11: 55-60	2
2016-06	Murray Royal Hospit	General Psychia	White - Scottish	M	62	12: 60-65	1
2016-06	Stracathro Hospital	General Psychia	Not Known	F	17	03: 15-20	1
2016-06	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	28	05: 25-30	1
2016-06	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	46	09: 45-50	1
2016-06	Stracathro Hospital	General Psychia	White - Other British	F	29	05: 25-30	1
2016-06	Stracathro Hospital	General Psychia	White - Other British	F	56	11: 55-60	1
2016-06	Stracathro Hospital	General Psychia	White - Other British	M	30	06: 30-35	1
2016-06	Stracathro Hospital	General Psychia	White - Other British	M	47	09: 45-50	1
2016-06	Stracathro Hospital	General Psychia	White - Other British	M	51	10: 50-55	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	F	19	03: 15-20	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	F	25	05: 25-30	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	F	31	06: 30-35	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	F	42	08: 40-45	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	M	19	03: 15-20	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	M	26	05: 25-30	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	M	28	05: 25-30	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	M	51	10: 50-55	1
2016-06	Stracathro Hospital	General Psychia	White - Scottish	M	54	10: 50-55	1

2016-06	Stracathro Hospital	General Psychia	White - Scottish	M	62	12: 60-65	1
2016-07	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	M	27	05: 25-30	1
2016-07	Carseview Centre	General Psychia	Not Known	M	35	07: 35-40	1
2016-07	Carseview Centre	General Psychia	Refused/Not provided by patient	M	27	05: 25-30	1
2016-07	Carseview Centre	General Psychia	White - Other British	F	22	04: 20-25	1
2016-07	Carseview Centre	General Psychia	White - Other British	F	28	05: 25-30	1
2016-07	Carseview Centre	General Psychia	White - Other British	M	20	04: 20-25	1
2016-07	Carseview Centre	General Psychia	White - Other British	M	38	07: 35-40	1
2016-07	Carseview Centre	General Psychia	White - Other British	M	54	10: 50-55	1
2016-07	Carseview Centre	General Psychia	White - Polish	M	29	05: 25-30	1
2016-07	Carseview Centre	General Psychia	White - Scottish	F	32	06: 30-35	1
2016-07	Carseview Centre	General Psychia	White - Scottish	F	36	07: 35-40	1
2016-07	Carseview Centre	General Psychia	White - Scottish	F	39	07: 35-40	1
2016-07	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-07	Carseview Centre	General Psychia	White - Scottish	F	42	08: 40-45	2
2016-07	Carseview Centre	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-07	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	1
2016-07	Carseview Centre	General Psychia	White - Scottish	F	61	12: 60-65	1
2016-07	Carseview Centre	General Psychia	White - Scottish	F	64	12: 60-65	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	20	04: 20-25	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	21	04: 20-25	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	22	04: 20-25	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	27	05: 25-30	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	38	07: 35-40	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	42	08: 40-45	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	50	10: 50-55	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	52	10: 50-55	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	54	10: 50-55	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-07	Carseview Centre	General Psychia	White - Scottish	M	57	11: 55-60	2
2016-07	Murray Royal Hospit	General Psychia	Not Known	F	34	06: 30-35	1
2016-07	Murray Royal Hospit	General Psychia	Not Known	F	40	08: 40-45	1
2016-07	Murray Royal Hospit	General Psychia	Not Known	F	44	08: 40-45	1
2016-07	Murray Royal Hospit	General Psychia	Not Known	F	59	11: 55-60	1
2016-07	Murray Royal Hospit	General Psychia	Not Known	M	32	06: 30-35	1
2016-07	Murray Royal Hospit	General Psychia	Not Known	M	33	06: 30-35	1
2016-07	Murray Royal Hospit	General Psychia	Not Known	M	38	07: 35-40	1
2016-07	Murray Royal Hospit	General Psychia	Not Known	M	43	08: 40-45	1
2016-07	Murray Royal Hospit	General Psychia	Not Known	M	54	10: 50-55	2
2016-07	Murray Royal Hospit	General Psychia	Not Known	M	62	12: 60-65	1
2016-07	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	M	31	06: 30-35	1
2016-07	Murray Royal Hospit	General Psychia	White - Other British	F	20	04: 20-25	1
2016-07	Murray Royal Hospit	General Psychia	White - Other British	F	22	04: 20-25	1
2016-07	Murray Royal Hospit	General Psychia	White - Other British	F	47	09: 45-50	1
2016-07	Murray Royal Hospit	General Psychia	White - Other British	F	49	09: 45-50	1

2016-07	Murray Royal Hospit	General Psychia	White - Other British	M	29	05: 25-30	1
2016-07	Murray Royal Hospit	General Psychia	White - Other British	M	44	08: 40-45	1
2016-07	Murray Royal Hospit	General Psychia	White - Other British	M	48	09: 45-50	1
2016-07	Murray Royal Hospit	General Psychia	White - Other British	M	51	10: 50-55	1
2016-07	Murray Royal Hospit	General Psychia	White - Other British	M	55	11: 55-60	3
2016-07	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	4
2016-07	Murray Royal Hospit	General Psychia	White - Polish	M	45	09: 45-50	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	18	03: 15-20	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	20	04: 20-25	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	24	04: 20-25	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	26	05: 25-30	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	28	05: 25-30	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	29	05: 25-30	2
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	30	06: 30-35	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	32	06: 30-35	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	33	06: 30-35	3
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	53	10: 50-55	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	56	11: 55-60	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	62	12: 60-65	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	63	12: 60-65	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	F	65	13: 65-70	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	29	05: 25-30	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	30	06: 30-35	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	34	06: 30-35	2
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	36	07: 35-40	4
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	37	07: 35-40	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	42	08: 40-45	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	48	09: 45-50	1
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	52	10: 50-55	3
2016-07	Murray Royal Hospit	General Psychia	White - Scottish	M	59	11: 55-60	1
2016-07	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	38	07: 35-40	1
2016-07	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	49	09: 45-50	1
2016-07	Stracathro Hospital	General Psychia	White - Other British	F	23	04: 20-25	1
2016-07	Stracathro Hospital	General Psychia	White - Other British	F	34	06: 30-35	1
2016-07	Stracathro Hospital	General Psychia	White - Other British	F	56	11: 55-60	1
2016-07	Stracathro Hospital	General Psychia	White - Other British	M	55	11: 55-60	1
2016-07	Stracathro Hospital	General Psychia	White - Scottish	F	20	04: 20-25	1
2016-07	Stracathro Hospital	General Psychia	White - Scottish	F	24	04: 20-25	1
2016-07	Stracathro Hospital	General Psychia	White - Scottish	F	29	05: 25-30	1
2016-07	Stracathro Hospital	General Psychia	White - Scottish	F	33	06: 30-35	2
2016-07	Stracathro Hospital	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-07	Stracathro Hospital	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-07	Stracathro Hospital	General Psychia	White - Scottish	M	22	04: 20-25	1
2016-07	Stracathro Hospital	General Psychia	White - Scottish	M	34	06: 30-35	1

2016-07	Stracathro Hospital	General Psychia	White - Scottish	M	43	08: 40-45	1
2016-07	Stracathro Hospital	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-07	Stracathro Hospital	General Psychia	White - Scottish	M	48	09: 45-50	1
2016-08	Carseview Centre	General Psychia	African, African Scottish or African British	F	46	09: 45-50	1
2016-08	Carseview Centre	General Psychia	Not Known	M	46	09: 45-50	1
2016-08	Carseview Centre	General Psychia	Other African	M	46	09: 45-50	1
2016-08	Carseview Centre	General Psychia	White - Other British	M	36	07: 35-40	1
2016-08	Carseview Centre	General Psychia	White - Other British	M	55	11: 55-60	1
2016-08	Carseview Centre	General Psychia	White - Other British	M	59	11: 55-60	1
2016-08	Carseview Centre	General Psychia	White - Polish	M	38	07: 35-40	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	27	05: 25-30	3
2016-08	Carseview Centre	General Psychia	White - Scottish	F	33	06: 30-35	2
2016-08	Carseview Centre	General Psychia	White - Scottish	F	36	07: 35-40	2
2016-08	Carseview Centre	General Psychia	White - Scottish	F	37	07: 35-40	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	40	08: 40-45	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	42	08: 40-45	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	44	08: 40-45	2
2016-08	Carseview Centre	General Psychia	White - Scottish	F	45	09: 45-50	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	46	09: 45-50	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	2
2016-08	Carseview Centre	General Psychia	White - Scottish	F	49	09: 45-50	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	57	11: 55-60	1
2016-08	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	20	04: 20-25	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	21	04: 20-25	2
2016-08	Carseview Centre	General Psychia	White - Scottish	M	24	04: 20-25	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	25	05: 25-30	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	28	05: 25-30	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	31	06: 30-35	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	43	08: 40-45	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	47	09: 45-50	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	50	10: 50-55	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	51	10: 50-55	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	58	11: 55-60	1
2016-08	Carseview Centre	General Psychia	White - Scottish	M	61	12: 60-65	1
2016-08	Murray Royal Hospit	General Psychia	Not Known	F	33	06: 30-35	1
2016-08	Murray Royal Hospit	General Psychia	Not Known	F	42	08: 40-45	1
2016-08	Murray Royal Hospit	General Psychia	Not Known	F	53	10: 50-55	1
2016-08	Murray Royal Hospit	General Psychia	Not Known	M	19	03: 15-20	1
2016-08	Murray Royal Hospit	General Psychia	Not Known	M	48	09: 45-50	3
2016-08	Murray Royal Hospit	General Psychia	Not Known	M	62	12: 60-65	1
2016-08	Murray Royal Hospit	General Psychia	White - Other British	F	58	11: 55-60	1

2016-08	Murray Royal Hospit	General Psychia	White - Other British	F	64	12: 60-65	1
2016-08	Murray Royal Hospit	General Psychia	White - Other British	M	48	09: 45-50	1
2016-08	Murray Royal Hospit	General Psychia	White - Other British	M	52	10: 50-55	1
2016-08	Murray Royal Hospit	General Psychia	White - Other British	M	55	11: 55-60	2
2016-08	Murray Royal Hospit	General Psychia	White - Other British	M	59	11: 55-60	1
2016-08	Murray Royal Hospit	General Psychia	White - Other British	M	63	12: 60-65	1
2016-08	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	49	09: 45-50	1
2016-08	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	59	11: 55-60	1
2016-08	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	4
2016-08	Murray Royal Hospit	General Psychia	White - Polish	M	45	09: 45-50	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	29	05: 25-30	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	30	06: 30-35	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	32	06: 30-35	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	34	06: 30-35	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	38	07: 35-40	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	39	07: 35-40	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	2
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	2
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	47	09: 45-50	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	56	11: 55-60	3
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	F	57	11: 55-60	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	23	04: 20-25	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	24	04: 20-25	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	26	05: 25-30	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	27	05: 25-30	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	28	05: 25-30	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	31	06: 30-35	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	2
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	37	07: 35-40	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	38	07: 35-40	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	43	08: 40-45	2
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	47	09: 45-50	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	48	09: 45-50	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	49	09: 45-50	2
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	50	10: 50-55	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	51	10: 50-55	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	53	10: 50-55	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	59	11: 55-60	1
2016-08	Murray Royal Hospit	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-08	Stracathro Hospital	General Psychia	Not Known	M	20	04: 20-25	1
2016-08	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	50	10: 50-55	1
2016-08	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	53	10: 50-55	1
2016-08	Stracathro Hospital	General Psychia	White - Other British	M	39	07: 35-40	1

2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	19	03: 15-20	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	27	05: 25-30	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	30	06: 30-35	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	33	06: 30-35	2
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	35	07: 35-40	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	45	09: 45-50	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	47	09: 45-50	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	50	10: 50-55	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	57	11: 55-60	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	F	58	11: 55-60	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	M	20	04: 20-25	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	M	24	04: 20-25	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	M	50	10: 50-55	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-08	Stracathro Hospital	General Psychia	White - Scottish	M	61	12: 60-65	1
2016-09	Carseview Centre	General Psychia	Not Known	F	49	09: 45-50	1
2016-09	Carseview Centre	General Psychia	Not Known	M	36	07: 35-40	1
2016-09	Carseview Centre	General Psychia	Other African	M	46	09: 45-50	1
2016-09	Carseview Centre	General Psychia	Refused/Not provided by patient	M	26	05: 25-30	1
2016-09	Carseview Centre	General Psychia	White - Other British	F	21	04: 20-25	1
2016-09	Carseview Centre	General Psychia	White - Other British	F	27	05: 25-30	1
2016-09	Carseview Centre	General Psychia	White - Other British	F	31	06: 30-35	1
2016-09	Carseview Centre	General Psychia	White - Other British	F	35	07: 35-40	1
2016-09	Carseview Centre	General Psychia	White - Other British	F	37	07: 35-40	1
2016-09	Carseview Centre	General Psychia	White - Other British	F	43	08: 40-45	1
2016-09	Carseview Centre	General Psychia	White - Other British	F	48	09: 45-50	1
2016-09	Carseview Centre	General Psychia	White - Other British	F	57	11: 55-60	1
2016-09	Carseview Centre	General Psychia	White - Other British	M	32	06: 30-35	1
2016-09	Carseview Centre	General Psychia	White - Other British	M	39	07: 35-40	1
2016-09	Carseview Centre	General Psychia	White - Polish	F	35	07: 35-40	1
2016-09	Carseview Centre	General Psychia	White - Polish	M	23	04: 20-25	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	20	04: 20-25	3
2016-09	Carseview Centre	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	2
2016-09	Carseview Centre	General Psychia	White - Scottish	F	31	06: 30-35	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	35	07: 35-40	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	42	08: 40-45	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	49	09: 45-50	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	53	10: 50-55	2
2016-09	Carseview Centre	General Psychia	White - Scottish	F	56	11: 55-60	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	57	11: 55-60	1
2016-09	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	17	03: 15-20	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	20	04: 20-25	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	21	04: 20-25	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	23	04: 20-25	1

2016-09	Carseview Centre	General Psychia	White - Scottish	M	24	04: 20-25	2
2016-09	Carseview Centre	General Psychia	White - Scottish	M	26	05: 25-30	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	28	05: 25-30	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	30	06: 30-35	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	35	07: 35-40	3
2016-09	Carseview Centre	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	37	07: 35-40	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	38	07: 35-40	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	2
2016-09	Carseview Centre	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	46	09: 45-50	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	48	09: 45-50	1
2016-09	Carseview Centre	General Psychia	White - Scottish	M	53	10: 50-55	2
2016-09	Murray Royal Hospit	General Psychia	Not Known	F	24	04: 20-25	1
2016-09	Murray Royal Hospit	General Psychia	Not Known	F	33	06: 30-35	1
2016-09	Murray Royal Hospit	General Psychia	Not Known	F	36	07: 35-40	1
2016-09	Murray Royal Hospit	General Psychia	Not Known	F	51	10: 50-55	1
2016-09	Murray Royal Hospit	General Psychia	Not Known	M	31	06: 30-35	1
2016-09	Murray Royal Hospit	General Psychia	Not Known	M	32	06: 30-35	1
2016-09	Murray Royal Hospit	General Psychia	Not Known	M	49	09: 45-50	1
2016-09	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	M	59	11: 55-60	1
2016-09	Murray Royal Hospit	General Psychia	White - Other British	F	20	04: 20-25	1
2016-09	Murray Royal Hospit	General Psychia	White - Other British	F	64	12: 60-65	3
2016-09	Murray Royal Hospit	General Psychia	White - Other British	M	32	06: 30-35	1
2016-09	Murray Royal Hospit	General Psychia	White - Other British	M	37	07: 35-40	1
2016-09	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	4
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	F	19	03: 15-20	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	F	35	07: 35-40	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	F	42	08: 40-45	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	2
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	F	49	09: 45-50	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	F	50	10: 50-55	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	F	53	10: 50-55	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	F	63	12: 60-65	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	21	04: 20-25	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	26	05: 25-30	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	29	05: 25-30	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	30	06: 30-35	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	31	06: 30-35	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	37	07: 35-40	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	40	08: 40-45	2
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	46	09: 45-50	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	50	10: 50-55	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	52	10: 50-55	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	53	10: 50-55	1

2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	56	11: 55-60	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	58	11: 55-60	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	60	12: 60-65	1
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	63	12: 60-65	2
2016-09	Murray Royal Hospit	General Psychia	White - Scottish	M	65	13: 65-70	1
2016-09	Stracathro Hospital	General Psychia	Not Known	M	43	08: 40-45	1
2016-09	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	38	07: 35-40	1
2016-09	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	26	05: 25-30	1
2016-09	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	53	10: 50-55	1
2016-09	Stracathro Hospital	General Psychia	White - Other British	F	34	06: 30-35	1
2016-09	Stracathro Hospital	General Psychia	White - Other British	F	35	07: 35-40	1
2016-09	Stracathro Hospital	General Psychia	White - Other British	M	57	11: 55-60	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	18	03: 15-20	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	19	03: 15-20	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	24	04: 20-25	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	29	05: 25-30	2
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	31	06: 30-35	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	34	06: 30-35	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	43	08: 40-45	2
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	45	09: 45-50	2
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	F	56	11: 55-60	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	M	17	03: 15-20	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	M	21	04: 20-25	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	M	23	04: 20-25	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	M	28	05: 25-30	1
2016-09	Stracathro Hospital	General Psychia	White - Scottish	M	49	09: 45-50	1
2016-10	Carseview Centre	General Psychia	Asian - Pakistani, Pakistani Scottish or Pakista	M	51	10: 50-55	1
2016-10	Carseview Centre	General Psychia	Not Known	F	19	03: 15-20	1
2016-10	Carseview Centre	General Psychia	Not Known	F	38	07: 35-40	1
2016-10	Carseview Centre	General Psychia	Not Known	M	21	04: 20-25	2
2016-10	Carseview Centre	General Psychia	Not Known	M	37	07: 35-40	1
2016-10	Carseview Centre	General Psychia	Refused/Not provided by patient	M	36	07: 35-40	1
2016-10	Carseview Centre	General Psychia	White - Other British	F	27	05: 25-30	1
2016-10	Carseview Centre	General Psychia	White - Other British	M	29	05: 25-30	1
2016-10	Carseview Centre	General Psychia	White - Other British	M	45	09: 45-50	1
2016-10	Carseview Centre	General Psychia	White - Polish	M	38	07: 35-40	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	22	04: 20-25	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	26	05: 25-30	2
2016-10	Carseview Centre	General Psychia	White - Scottish	F	30	06: 30-35	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	31	06: 30-35	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	36	07: 35-40	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	37	07: 35-40	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	38	07: 35-40	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	39	07: 35-40	2
2016-10	Carseview Centre	General Psychia	White - Scottish	F	40	08: 40-45	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	46	09: 45-50	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	1

2016-10	Carseview Centre	General Psychia	White - Scottish	F	51	10: 50-55	3
2016-10	Carseview Centre	General Psychia	White - Scottish	F	53	10: 50-55	2
2016-10	Carseview Centre	General Psychia	White - Scottish	F	56	11: 55-60	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	58	11: 55-60	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	61	12: 60-65	1
2016-10	Carseview Centre	General Psychia	White - Scottish	F	63	12: 60-65	1
2016-10	Carseview Centre	General Psychia	White - Scottish	M	21	04: 20-25	1
2016-10	Carseview Centre	General Psychia	White - Scottish	M	22	04: 20-25	2
2016-10	Carseview Centre	General Psychia	White - Scottish	M	31	06: 30-35	2
2016-10	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	3
2016-10	Carseview Centre	General Psychia	White - Scottish	M	36	07: 35-40	2
2016-10	Carseview Centre	General Psychia	White - Scottish	M	38	07: 35-40	2
2016-10	Carseview Centre	General Psychia	White - Scottish	M	40	08: 40-45	1
2016-10	Carseview Centre	General Psychia	White - Scottish	M	58	11: 55-60	1
2016-10	Carseview Centre	General Psychia	White - Scottish	M	60	12: 60-65	1
2016-10	Carseview Centre	General Psychia	White - Scottish	M	61	12: 60-65	1
2016-10	Carseview Centre	General Psychia	White - Scottish	M	62	12: 60-65	1
2016-10	Murray Royal Hospit	General Psychia	Not Known	F	28	05: 25-30	1
2016-10	Murray Royal Hospit	General Psychia	Not Known	M	20	04: 20-25	1
2016-10	Murray Royal Hospit	General Psychia	Not Known	M	25	05: 25-30	1
2016-10	Murray Royal Hospit	General Psychia	Not Known	M	38	07: 35-40	1
2016-10	Murray Royal Hospit	General Psychia	Not Known	M	46	09: 45-50	1
2016-10	Murray Royal Hospit	General Psychia	Not Known	M	48	09: 45-50	1
2016-10	Murray Royal Hospit	General Psychia	Not Known	M	53	10: 50-55	1
2016-10	Murray Royal Hospit	General Psychia	White - Other British	F	30	06: 30-35	1
2016-10	Murray Royal Hospit	General Psychia	White - Other British	F	46	09: 45-50	1
2016-10	Murray Royal Hospit	General Psychia	White - Other British	F	55	11: 55-60	1
2016-10	Murray Royal Hospit	General Psychia	White - Other British	M	45	09: 45-50	1
2016-10	Murray Royal Hospit	General Psychia	White - Other British	M	48	09: 45-50	1
2016-10	Murray Royal Hospit	General Psychia	White - Other British	M	56	11: 55-60	1
2016-10	Murray Royal Hospit	General Psychia	White - Other British	M	62	12: 60-65	1
2016-10	Murray Royal Hospit	General Psychia	White - Other British	M	63	12: 60-65	1
2016-10	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	63	12: 60-65	1
2016-10	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	1
2016-10	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	M	41	08: 40-45	1
2016-10	Murray Royal Hospit	General Psychia	White - Polish	M	49	09: 45-50	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	18	03: 15-20	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	31	06: 30-35	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	36	07: 35-40	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	39	07: 35-40	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	50	10: 50-55	2
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	51	10: 50-55	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	56	11: 55-60	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	F	64	12: 60-65	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	31	06: 30-35	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	32	06: 30-35	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	37	07: 35-40	1

2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	38	07: 35-40	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	48	09: 45-50	3
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	50	10: 50-55	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	60	12: 60-65	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	61	12: 60-65	3
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-10	Murray Royal Hospit	General Psychia	White - Scottish	M	64	12: 60-65	1
2016-10	Stracathro Hospital	General Psychia	Not Known	F	38	07: 35-40	1
2016-10	Stracathro Hospital	General Psychia	Not Known	M	24	04: 20-25	1
2016-10	Stracathro Hospital	General Psychia	Not Known	M	37	07: 35-40	1
2016-10	Stracathro Hospital	General Psychia	White - Other British	F	20	04: 20-25	1
2016-10	Stracathro Hospital	General Psychia	White - Other British	F	45	09: 45-50	1
2016-10	Stracathro Hospital	General Psychia	White - Other British	M	20	04: 20-25	1
2016-10	Stracathro Hospital	General Psychia	White - Other British	M	35	07: 35-40	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	F	30	06: 30-35	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	F	31	06: 30-35	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	F	32	06: 30-35	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	F	39	07: 35-40	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	F	45	09: 45-50	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	F	53	10: 50-55	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	F	57	11: 55-60	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	M	46	09: 45-50	1
2016-10	Stracathro Hospital	General Psychia	White - Scottish	M	52	10: 50-55	1
2016-11	Carseview Centre	General Psychia	Not Known	F	20	04: 20-25	1
2016-11	Carseview Centre	General Psychia	Not Known	F	42	08: 40-45	1
2016-11	Carseview Centre	General Psychia	Not Known	M	20	04: 20-25	1
2016-11	Carseview Centre	General Psychia	Not Known	M	52	10: 50-55	1
2016-11	Carseview Centre	General Psychia	Refused/Not provided by patient	M	38	07: 35-40	1
2016-11	Carseview Centre	General Psychia	White - Other British	F	41	08: 40-45	1
2016-11	Carseview Centre	General Psychia	White - Other British	F	51	10: 50-55	1
2016-11	Carseview Centre	General Psychia	White - Other British	F	64	12: 60-65	3
2016-11	Carseview Centre	General Psychia	White - Other British	M	29	05: 25-30	1
2016-11	Carseview Centre	General Psychia	White - Other Ethnic Group	M	37	07: 35-40	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	19	03: 15-20	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	20	04: 20-25	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	21	04: 20-25	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	23	04: 20-25	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	28	05: 25-30	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	30	06: 30-35	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	32	06: 30-35	2
2016-11	Carseview Centre	General Psychia	White - Scottish	F	34	06: 30-35	3
2016-11	Carseview Centre	General Psychia	White - Scottish	F	35	07: 35-40	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	36	07: 35-40	2
2016-11	Carseview Centre	General Psychia	White - Scottish	F	42	08: 40-45	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	43	08: 40-45	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	45	09: 45-50	1

2016-11	Carseview Centre	General Psychia	White - Scottish	F	47	09: 45-50	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	49	09: 45-50	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	50	10: 50-55	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-11	Carseview Centre	General Psychia	White - Scottish	F	62	12: 60-65	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	17	03: 15-20	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	18	03: 15-20	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	21	04: 20-25	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	23	04: 20-25	2
2016-11	Carseview Centre	General Psychia	White - Scottish	M	27	05: 25-30	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	30	06: 30-35	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	31	06: 30-35	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	33	06: 30-35	2
2016-11	Carseview Centre	General Psychia	White - Scottish	M	34	06: 30-35	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	41	08: 40-45	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	42	08: 40-45	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	44	08: 40-45	2
2016-11	Carseview Centre	General Psychia	White - Scottish	M	48	09: 45-50	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	49	09: 45-50	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	52	10: 50-55	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	53	10: 50-55	1
2016-11	Carseview Centre	General Psychia	White - Scottish	M	55	11: 55-60	2
2016-11	Carseview Centre	General Psychia	White - Scottish	M	63	12: 60-65	1
2016-11	Murray Royal Hospit	General Psychia	Not Known	F	28	05: 25-30	1
2016-11	Murray Royal Hospit	General Psychia	Not Known	F	42	08: 40-45	1
2016-11	Murray Royal Hospit	General Psychia	Not Known	F	45	09: 45-50	1
2016-11	Murray Royal Hospit	General Psychia	Not Known	F	54	10: 50-55	1
2016-11	Murray Royal Hospit	General Psychia	Not Known	M	35	07: 35-40	1
2016-11	Murray Royal Hospit	General Psychia	Not Known	M	38	07: 35-40	1
2016-11	Murray Royal Hospit	General Psychia	Not Known	M	44	08: 40-45	1
2016-11	Murray Royal Hospit	General Psychia	Not Known	M	51	10: 50-55	2
2016-11	Murray Royal Hospit	General Psychia	Refused/Not provided by patient	M	43	08: 40-45	1
2016-11	Murray Royal Hospit	General Psychia	White - Other British	F	20	04: 20-25	1
2016-11	Murray Royal Hospit	General Psychia	White - Other British	F	64	12: 60-65	2
2016-11	Murray Royal Hospit	General Psychia	White - Other British	M	37	07: 35-40	1
2016-11	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	F	65	13: 65-70	4
2016-11	Murray Royal Hospit	General Psychia	White - Other Ethnic Group	M	34	06: 30-35	1
2016-11	Murray Royal Hospit	General Psychia	White - Polish	F	55	11: 55-60	1
2016-11	Murray Royal Hospit	General Psychia	White - Polish	M	30	06: 30-35	1
2016-11	Murray Royal Hospit	General Psychia	White - Polish	M	36	07: 35-40	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	F	32	06: 30-35	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	F	41	08: 40-45	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	F	44	08: 40-45	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	F	45	09: 45-50	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	F	46	09: 45-50	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	F	48	09: 45-50	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	F	53	10: 50-55	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	F	55	11: 55-60	3

2016-11	Murray Royal Hospit	General Psychia	White - Scottish	F	65	13: 65-70	7
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	19	03: 15-20	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	25	05: 25-30	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	31	06: 30-35	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	33	06: 30-35	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	35	07: 35-40	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	39	07: 35-40	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	44	08: 40-45	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	45	09: 45-50	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	46	09: 45-50	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	52	10: 50-55	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	55	11: 55-60	1
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	56	11: 55-60	2
2016-11	Murray Royal Hospit	General Psychia	White - Scottish	M	57	11: 55-60	2
2016-11	Stracathro Hospital	General Psychia	Not Known	F	43	08: 40-45	1
2016-11	Stracathro Hospital	General Psychia	Refused/Not provided by patient	F	23	04: 20-25	1
2016-11	Stracathro Hospital	General Psychia	Refused/Not provided by patient	M	50	10: 50-55	1
2016-11	Stracathro Hospital	General Psychia	White - Other British	F	43	08: 40-45	1
2016-11	Stracathro Hospital	General Psychia	White - Other British	F	51	10: 50-55	1
2016-11	Stracathro Hospital	General Psychia	White - Other British	M	20	04: 20-25	1
2016-11	Stracathro Hospital	General Psychia	White - Other British	M	55	11: 55-60	1
2016-11	Stracathro Hospital	General Psychia	White - Other British	M	60	12: 60-65	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	F	21	04: 20-25	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	F	26	05: 25-30	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	F	27	05: 25-30	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	F	39	07: 35-40	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	F	52	10: 50-55	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	F	56	11: 55-60	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	M	21	04: 20-25	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	M	23	04: 20-25	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	M	31	06: 30-35	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	M	36	07: 35-40	1
2016-11	Stracathro Hospital	General Psychia	White - Scottish	M	63	12: 60-65	1
2014-12	Carseview Centre	General Adult Ps	Not Known	M	27	05: 25-30	1
2014-12	Carseview Centre	General Adult Ps	Not Known	M	41	08: 40-45	1
2014-12	Carseview Centre	General Adult Ps	White - Other British	M	24	04: 20-25	1
2014-12	Carseview Centre	General Adult Ps	White - Scottish	M	25	05: 25-30	1
2014-12	Carseview Centre	General Adult Ps	White - Scottish	M	26	05: 25-30	1
2014-12	Carseview Centre	General Adult Ps	White - Scottish	M	33	06: 30-35	1
2015-01	Carseview Centre	General Adult Ps	White - Other British	F	49	09: 45-50	1
2015-01	Carseview Centre	General Adult Ps	White - Scottish	M	27	05: 25-30	1
2015-02	Carseview Centre	General Adult Ps	Not Known	M	20	04: 20-25	1
2015-03	Carseview Centre	General Adult Ps	Asian - Bangladeshi, Bangladeshi Scottish or E	M	34	06: 30-35	2
2015-03	Carseview Centre	General Adult Ps	Not Known	M	48	09: 45-50	1
2015-03	Carseview Centre	General Adult Ps	White - Other British	M	35	07: 35-40	1
2015-04	Carseview Centre	General Adult Ps	White - Other British	M	42	08: 40-45	1
2015-05	Carseview Centre	General Adult Ps	White - Scottish	M	23	04: 20-25	1
2015-05	Carseview Centre	General Adult Ps	White - Scottish	M	33	06: 30-35	1
2015-06	Carseview Centre	General Adult Ps	Not Known	M	47	09: 45-50	1

2015-06	Carseview Centre	General Adult Ps	White - Scottish	M	25	05: 25-30	1
2015-06	Carseview Centre	General Adult Ps	White - Scottish	M	33	06: 30-35	1
2015-06	Carseview Centre	General Adult Ps	White - Scottish	M	38	07: 35-40	1
2015-07	Carseview Centre	General Adult Ps	White - Scottish	M	59	11: 55-60	1
2015-08	Carseview Centre	General Adult Ps	Not Known	M	19	03: 15-20	1
2015-08	Carseview Centre	General Adult Ps	Refused/Not provided by patient	M	18	03: 15-20	1
2015-08	Carseview Centre	General Adult Ps	White - Other British	M	42	08: 40-45	1
2015-08	Carseview Centre	General Adult Ps	White - Scottish	M	26	05: 25-30	1
2015-08	Carseview Centre	General Adult Ps	White - Scottish	M	33	06: 30-35	1
2015-09	Carseview Centre	General Adult Ps	Not Known	M	47	09: 45-50	1
2015-09	Carseview Centre	General Adult Ps	Not Known	M	51	10: 50-55	1
2015-09	Carseview Centre	General Adult Ps	Not Known	M	55	11: 55-60	1
2015-09	Carseview Centre	General Adult Ps	Other Ethnic Group	F	32	06: 30-35	1
2015-09	Carseview Centre	General Adult Ps	White - Other British	M	52	10: 50-55	1
2015-10	Carseview Centre	General Adult Ps	Not Known	F	36	07: 35-40	1
2015-10	Carseview Centre	General Adult Ps	Refused/Not provided by patient	M	18	03: 15-20	1
2015-10	Carseview Centre	General Adult Ps	White - Other Ethnic Group	M	51	10: 50-55	1
2015-10	Carseview Centre	General Adult Ps	White - Scottish	M	50	10: 50-55	1
2015-11	Carseview Centre	General Adult Ps	Not Known	M	23	04: 20-25	1
2015-11	Carseview Centre	General Adult Ps	Not Known	M	32	06: 30-35	1
2015-12	Carseview Centre	General Adult Ps	White - Scottish	F	54	10: 50-55	1
2015-12	Carseview Centre	General Adult Ps	White - Scottish	M	41	08: 40-45	1
2015-12	Carseview Centre	General Adult Ps	White - Scottish	M	48	09: 45-50	1
2015-12	Carseview Centre	General Adult Ps	White - Scottish	M	61	12: 60-65	1
2016-01	Carseview Centre	General Adult Ps	Not Known	F	35	07: 35-40	1
2016-01	Carseview Centre	General Adult Ps	Not Known	M	22	04: 20-25	1
2016-01	Carseview Centre	General Adult Ps	Not Known	M	40	08: 40-45	1
2016-02	Carseview Centre	General Adult Ps	White - Other British	M	44	08: 40-45	1
2016-02	Carseview Centre	General Adult Ps	White - Scottish	M	54	10: 50-55	1
2016-03	Carseview Centre	General Adult Ps	White - Polish	M	31	06: 30-35	1
2016-03	Carseview Centre	General Adult Ps	White - Scottish	F	46	09: 45-50	1
2016-04	Carseview Centre	General Adult Ps	White - Other British	F	26	05: 25-30	1
2016-04	Carseview Centre	General Adult Ps	White - Scottish	M	29	05: 25-30	1
2016-04	Carseview Centre	General Adult Ps	White - Scottish	M	33	06: 30-35	1
2016-04	Carseview Centre	General Adult Ps	White - Scottish	M	40	08: 40-45	1
2016-04	Carseview Centre	General Adult Ps	White - Scottish	M	47	09: 45-50	1
2016-05	Carseview Centre	General Adult Ps	Not Known	M	34	06: 30-35	1
2016-05	Carseview Centre	General Adult Ps	White - Scottish	M	35	07: 35-40	1
2016-06	Carseview Centre	General Adult Ps	Not Known	M	18	03: 15-20	1
2016-06	Carseview Centre	General Adult Ps	Not Known	M	33	06: 30-35	1
2016-06	Carseview Centre	General Adult Ps	Not Known	M	35	07: 35-40	1
2016-06	Carseview Centre	General Adult Ps	Not Known	M	40	08: 40-45	1
2016-06	Carseview Centre	General Adult Ps	White - Other British	F	34	06: 30-35	1
2016-06	Carseview Centre	General Adult Ps	White - Other British	F	56	11: 55-60	1
2016-06	Carseview Centre	General Adult Ps	White - Scottish	M	39	07: 35-40	1
2016-07	Carseview Centre	General Adult Ps	Refused/Not provided by patient	M	50	10: 50-55	1
2016-07	Carseview Centre	General Adult Ps	White - Scottish	F	33	06: 30-35	1
2016-08	Carseview Centre	General Adult Ps	Not Known	M	23	04: 20-25	1
2016-08	Carseview Centre	General Adult Ps	Not Known	M	49	09: 45-50	1
2016-08	Carseview Centre	General Adult Ps	White - Other British	F	34	06: 30-35	1

2016-08	Carseview Centre	General Adult Ps	White - Scottish	F	32	06: 30-35	1
2016-08	Carseview Centre	General Adult Ps	White - Scottish	M	39	07: 35-40	1
2016-09	Carseview Centre	General Adult Ps	Asian/Asian Scottish/Asian British - Other	F	21	04: 20-25	1
2016-09	Carseview Centre	General Adult Ps	Not Known	F	28	05: 25-30	1
2016-09	Carseview Centre	General Adult Ps	Not Known	M	28	05: 25-30	1
2016-09	Carseview Centre	General Adult Ps	White - Scottish	F	30	06: 30-35	1
2016-09	Carseview Centre	General Adult Ps	White - Scottish	F	63	12: 60-65	1
2016-09	Carseview Centre	General Adult Ps	White - Scottish	M	23	04: 20-25	1
2016-09	Carseview Centre	General Adult Ps	White - Scottish	M	53	10: 50-55	1
2016-10	Carseview Centre	General Adult Ps	Not Known	M	35	07: 35-40	1
2016-10	Carseview Centre	General Adult Ps	White - Other British	F	18	03: 15-20	1
2016-10	Carseview Centre	General Adult Ps	White - Other British	M	20	04: 20-25	1
2016-10	Carseview Centre	General Adult Ps	White - Scottish	F	55	11: 55-60	1
2016-10	Carseview Centre	General Adult Ps	White - Scottish	M	28	05: 25-30	1
2016-11	Carseview Centre	General Adult Ps	Not Known	M	24	04: 20-25	1
2016-11	Carseview Centre	General Adult Ps	White - Other British	M	35	07: 35-40	1
2014-12	Murray Royal Hospit	Forensic Psychia	Not Known	M	44	08: 40-45	1
2014-12	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	61	12: 60-65	1
2015-01	Murray Royal Hospit	Forensic Psychia	White - Other British	M	36	07: 35-40	1
2015-01	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	38	07: 35-40	1
2015-01	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	42	08: 40-45	1
2015-01	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	44	08: 40-45	1
2015-02	Murray Royal Hospit	Forensic Psychia	Not Known	M	27	05: 25-30	1
2015-02	Murray Royal Hospit	Forensic Psychia	White - Other British	M	35	07: 35-40	1
2015-02	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	40	08: 40-45	1
2015-02	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	50	10: 50-55	2
2015-02	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	55	11: 55-60	1
2015-03	Murray Royal Hospit	Forensic Psychia	White - Other British	M	36	07: 35-40	1
2015-03	Murray Royal Hospit	Forensic Psychia	White - Other Ethnic Group	M	34	06: 30-35	1
2015-03	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	32	06: 30-35	1
2015-03	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	38	07: 35-40	1
2015-03	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	42	08: 40-45	1
2015-04	Murray Royal Hospit	Forensic Psychia	Not Known	M	60	12: 60-65	1
2015-04	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	42	08: 40-45	1
2015-05	Murray Royal Hospit	Forensic Psychia	Mixed/Multiple Ethnic Groups	M	30	06: 30-35	1
2015-05	Murray Royal Hospit	Forensic Psychia	Not Known	M	24	04: 20-25	1
2015-05	Murray Royal Hospit	Forensic Psychia	White - Other British	M	33	06: 30-35	1
2015-05	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	47	09: 45-50	1
2015-06	Murray Royal Hospit	Forensic Psychia	White - Polish	M	41	08: 40-45	1
2015-06	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	22	04: 20-25	1
2015-06	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	43	08: 40-45	1
2015-07	Murray Royal Hospit	Forensic Psychia	White - Other British	M	35	07: 35-40	1
2015-07	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	41	08: 40-45	1
2015-07	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	43	08: 40-45	1
2015-07	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	59	11: 55-60	1
2015-08	Murray Royal Hospit	Forensic Psychia	Not Known	M	25	05: 25-30	1
2015-08	Murray Royal Hospit	Forensic Psychia	Not Known	M	37	07: 35-40	1
2015-08	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	34	06: 30-35	1
2015-08	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	42	08: 40-45	1
2015-09	Murray Royal Hospit	Forensic Psychia	Black, Black Scottish or Black British	M	34	06: 30-35	1

2015-09	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	31	06: 30-35	1
2015-09	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	41	08: 40-45	1
2015-10	Murray Royal Hospit	Forensic Psychia	Not Known	M	27	05: 25-30	1
2015-10	Murray Royal Hospit	Forensic Psychia	Not Known	M	49	09: 45-50	1
2015-10	Murray Royal Hospit	Forensic Psychia	White - Other Ethnic Group	M	46	09: 45-50	1
2015-10	Murray Royal Hospit	Forensic Psychia	White - Polish	M	28	05: 25-30	1
2015-10	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	45	09: 45-50	1
2015-11	Murray Royal Hospit	Forensic Psychia	Not Known	M	40	08: 40-45	1
2015-11	Murray Royal Hospit	Forensic Psychia	White - Other Ethnic Group	M	46	09: 45-50	1
2015-11	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	22	04: 20-25	2
2015-12	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	31	06: 30-35	2
2015-12	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	34	06: 30-35	1
2016-01	Murray Royal Hospit	Forensic Psychia	Not Known	M	35	07: 35-40	1
2016-01	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	30	06: 30-35	1
2016-01	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	43	08: 40-45	1
2016-02	Murray Royal Hospit	Forensic Psychia	Not Known	M	41	08: 40-45	1
2016-03	Murray Royal Hospit	Forensic Psychia	Asian/Asian Scottish/Asian British - Other	M	51	10: 50-55	1
2016-03	Murray Royal Hospit	Forensic Psychia	Not Known	M	37	07: 35-40	1
2016-03	Murray Royal Hospit	Forensic Psychia	White - Polish	M	28	05: 25-30	1
2016-03	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	32	06: 30-35	1
2016-03	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	35	07: 35-40	12
2016-03	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	37	07: 35-40	2
2016-03	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	43	08: 40-45	1
2016-04	Murray Royal Hospit	Forensic Psychia	Not Known	M	22	04: 20-25	1
2016-04	Murray Royal Hospit	Forensic Psychia	Not Known	M	37	07: 35-40	1
2016-05	Murray Royal Hospit	Forensic Psychia	Not Known	M	30	06: 30-35	1
2016-05	Murray Royal Hospit	Forensic Psychia	Not Known	M	41	08: 40-45	1
2016-05	Murray Royal Hospit	Forensic Psychia	Not Known	M	48	09: 45-50	2
2016-05	Murray Royal Hospit	Forensic Psychia	Not Known	M	53	10: 50-55	1
2016-06	Murray Royal Hospit	Forensic Psychia	Not Known	M	52	10: 50-55	1
2016-06	Murray Royal Hospit	Forensic Psychia	White - Other British	M	43	08: 40-45	1
2016-06	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	34	06: 30-35	1
2016-06	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	37	07: 35-40	3
2016-07	Murray Royal Hospit	Forensic Psychia	Refused/Not provided by patient	M	19	03: 15-20	1
2016-07	Murray Royal Hospit	Forensic Psychia	White - Other British	M	20	04: 20-25	1
2016-07	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	34	06: 30-35	2
2016-07	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	37	07: 35-40	1
2016-08	Murray Royal Hospit	Forensic Psychia	Not Known	M	28	05: 25-30	1
2016-09	Murray Royal Hospit	Forensic Psychia	Not Known	M	28	05: 25-30	1
2016-09	Murray Royal Hospit	Forensic Psychia	Not Known	M	48	09: 45-50	1
2016-09	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	34	06: 30-35	1
2016-10	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	20	04: 20-25	1
2016-10	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	28	05: 25-30	1
2016-10	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	56	11: 55-60	1
2016-10	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	63	12: 60-65	1
2016-11	Murray Royal Hospit	Forensic Psychia	White - Other British	M	58	11: 55-60	1
2016-11	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	31	06: 30-35	1
2016-11	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	44	08: 40-45	1
2016-11	Murray Royal Hospit	Forensic Psychia	White - Scottish	M	54	10: 50-55	1
2014-12	Carseview Centre	Learning Disabili	White - Scottish	F	34	06: 30-35	1

2014-12	Carseview Centre	Learning Disabili	White - Scottish	F	48	09: 45-50	1
2014-12	Carseview Centre	Learning Disabili	White - Scottish	F	62	12: 60-65	1
2014-12	Carseview Centre	Learning Disabili	White - Scottish	M	23	04: 20-25	1
2014-12	Carseview Centre	Learning Disabili	White - Scottish	M	50	10: 50-55	1
2014-12	Strathmartine Hospit	Learning Disabili	White - Other British	M	25	05: 25-30	1
2015-01	Carseview Centre	Learning Disabili	Not Known	M	23	04: 20-25	1
2015-01	Carseview Centre	Learning Disabili	White - Scottish	M	53	10: 50-55	1
2015-01	Strathmartine Hospit	Learning Disabili	Not Known	M	51	10: 50-55	1
2015-01	Strathmartine Hospit	Learning Disabili	White - Scottish	M	23	04: 20-25	1
2015-02	Carseview Centre	Learning Disabili	Not Known	M	24	04: 20-25	1
2015-02	Carseview Centre	Learning Disabili	Refused/Not provided by patient	M	24	04: 20-25	1
2015-02	Carseview Centre	Learning Disabili	White - Scottish	F	62	12: 60-65	1
2015-02	Strathmartine Hospit	Learning Disabili	Not Known	M	19	03: 15-20	1
2015-02	Strathmartine Hospit	Learning Disabili	Refused/Not provided by patient	M	24	04: 20-25	1
2015-03	Carseview Centre	Learning Disabili	Not Known	M	45	09: 45-50	1
2015-03	Carseview Centre	Learning Disabili	White - Scottish	F	27	05: 25-30	1
2015-03	Carseview Centre	Learning Disabili	White - Scottish	F	32	06: 30-35	1
2015-03	Carseview Centre	Learning Disabili	White - Scottish	F	33	06: 30-35	1
2015-03	Carseview Centre	Learning Disabili	White - Scottish	M	35	07: 35-40	1
2015-03	Carseview Centre	Learning Disabili	White - Scottish	M	51	10: 50-55	1
2015-03	Strathmartine Hospit	Learning Disabili	White - Scottish	M	21	04: 20-25	1
2015-03	Strathmartine Hospit	Learning Disabili	White - Scottish	M	31	06: 30-35	1
2015-04	Carseview Centre	Learning Disabili	Refused/Not provided by patient	F	61	12: 60-65	1
2015-04	Strathmartine Hospit	Learning Disabili	Not Known	M	35	07: 35-40	1
2015-04	Strathmartine Hospit	Learning Disabili	White - Other British	M	20	04: 20-25	1
2015-05	Carseview Centre	Learning Disabili	White - Scottish	M	57	11: 55-60	1
2015-05	Strathmartine Hospit	Learning Disabili	White - Scottish	F	33	06: 30-35	1
2015-05	Strathmartine Hospit	Learning Disabili	White - Scottish	M	24	04: 20-25	1
2015-05	Strathmartine Hospit	Learning Disabili	White - Scottish	M	35	07: 35-40	1
2015-05	Strathmartine Hospit	Learning Disabili	White - Scottish	M	38	07: 35-40	1
2015-05	Strathmartine Hospit	Learning Disabili	White - Scottish	M	45	09: 45-50	1
2015-06	Strathmartine Hospit	Learning Disabili	Not Known	M	63	12: 60-65	1
2015-06	Strathmartine Hospit	Learning Disabili	Refused/Not provided by patient	M	58	11: 55-60	1
2015-07	Carseview Centre	Learning Disabili	White - Scottish	F	17	03: 15-20	1
2015-07	Strathmartine Hospit	Learning Disabili	Not Known	M	58	11: 55-60	1
2015-07	Strathmartine Hospit	Learning Disabili	Refused/Not provided by patient	M	58	11: 55-60	1
2015-07	Strathmartine Hospit	Learning Disabili	White - Scottish	M	23	04: 20-25	1
2015-08	Carseview Centre	Learning Disabili	Refused/Not provided by patient	M	24	04: 20-25	1
2015-08	Carseview Centre	Learning Disabili	White - Scottish	M	29	05: 25-30	1
2015-08	Carseview Centre	Learning Disabili	White - Scottish	M	54	10: 50-55	1
2015-08	Strathmartine Hospit	Learning Disabili	White - Scottish	M	23	04: 20-25	1
2015-09	Carseview Centre	Learning Disabili	Not Known	F	18	03: 15-20	1
2015-09	Carseview Centre	Learning Disabili	Not Known	M	23	04: 20-25	1
2015-09	Carseview Centre	Learning Disabili	White - Scottish	F	33	06: 30-35	1
2015-09	Strathmartine Hospit	Learning Disabili	Refused/Not provided by patient	M	24	04: 20-25	1
2015-09	Strathmartine Hospit	Learning Disabili	White - Scottish	M	26	05: 25-30	1
2015-10	Strathmartine Hospit	Learning Disabili	White - Scottish	F	25	05: 25-30	1
2015-10	Strathmartine Hospit	Learning Disabili	White - Scottish	M	27	05: 25-30	1
2015-11	Strathmartine Hospit	Learning Disabili	White - Scottish	M	32	06: 30-35	1
2015-11	Strathmartine Hospit	Learning Disabili	White - Scottish	M	39	07: 35-40	1

2015-12	Carseview Centre	Learning Disabili	White - Scottish	F	26	05: 25-30	2
2015-12	Carseview Centre	Learning Disabili	White - Scottish	F	34	06: 30-35	1
2015-12	Carseview Centre	Learning Disabili	White - Scottish	F	43	08: 40-45	1
2015-12	Strathmartine Hospit	Learning Disabili	White - Scottish	M	28	05: 25-30	1
2016-01	Carseview Centre	Learning Disabili	White - Other British	F	18	03: 15-20	1
2016-01	Strathmartine Hospit	Learning Disabili	Not Known	M	35	07: 35-40	1
2016-01	Strathmartine Hospit	Learning Disabili	White - Other British	M	21	04: 20-25	1
2016-02	Carseview Centre	Learning Disabili	Not Known	F	20	04: 20-25	1
2016-02	Carseview Centre	Learning Disabili	Not Known	F	51	10: 50-55	1
2016-02	Carseview Centre	Learning Disabili	Not Known	M	23	04: 20-25	1
2016-02	Carseview Centre	Learning Disabili	White - Scottish	F	25	05: 25-30	1
2016-02	Carseview Centre	Learning Disabili	White - Scottish	F	49	09: 45-50	1
2016-03	Strathmartine Hospit	Learning Disabili	Not Known	M	64	12: 60-65	1
2016-03	Strathmartine Hospit	Learning Disabili	White - Scottish	M	28	05: 25-30	1
2016-03	Strathmartine Hospit	Learning Disabili	White - Scottish	M	32	06: 30-35	1
2016-03	Strathmartine Hospit	Learning Disabili	White - Scottish	M	45	09: 45-50	1
2016-04	Carseview Centre	Learning Disabili	Asian - Pakistani, Pakistani Scottish or Pakista	F	28	05: 25-30	1
2016-04	Carseview Centre	Learning Disabili	White - Scottish	F	55	11: 55-60	1
2016-04	Carseview Centre	Learning Disabili	White - Scottish	M	40	08: 40-45	1
2016-04	Strathmartine Hospit	Learning Disabili	White - Scottish	M	46	09: 45-50	1
2016-05	Carseview Centre	Learning Disabili	White - Other British	M	55	11: 55-60	1
2016-05	Carseview Centre	Learning Disabili	White - Scottish	F	65	13: 65-70	1
2016-05	Strathmartine Hospit	Learning Disabili	Not Known	M	35	07: 35-40	1
2016-05	Strathmartine Hospit	Learning Disabili	White - Scottish	F	33	06: 30-35	1
2016-06	Carseview Centre	Learning Disabili	Not Known	F	35	07: 35-40	1
2016-06	Carseview Centre	Learning Disabili	White - Other British	F	23	04: 20-25	1
2016-06	Carseview Centre	Learning Disabili	White - Other British	F	42	08: 40-45	1
2016-06	Carseview Centre	Learning Disabili	White - Scottish	F	21	04: 20-25	1
2016-06	Carseview Centre	Learning Disabili	White - Scottish	F	26	05: 25-30	1
2016-06	Strathmartine Hospit	Learning Disabili	Not Known	M	57	11: 55-60	1
2016-06	Strathmartine Hospit	Learning Disabili	White - Scottish	M	47	09: 45-50	1
2016-07	Carseview Centre	Learning Disabili	White - Other British	F	18	03: 15-20	1
2016-07	Carseview Centre	Learning Disabili	White - Scottish	F	33	06: 30-35	1
2016-07	Carseview Centre	Learning Disabili	White - Scottish	F	34	06: 30-35	1
2016-07	Carseview Centre	Learning Disabili	White - Scottish	M	32	06: 30-35	1
2016-07	Carseview Centre	Learning Disabili	White - Scottish	M	38	07: 35-40	1
2016-07	Strathmartine Hospit	Learning Disabili	Not Known	M	35	07: 35-40	1
2016-07	Strathmartine Hospit	Learning Disabili	White - Scottish	M	40	08: 40-45	1
2016-08	Strathmartine Hospit	Learning Disabili	Refused/Not provided by patient	M	35	07: 35-40	1
2016-08	Strathmartine Hospit	Learning Disabili	White - Scottish	M	53	10: 50-55	1
2016-09	Carseview Centre	Learning Disabili	Not Known	M	20	04: 20-25	1
2016-09	Carseview Centre	Learning Disabili	Not Known	M	28	05: 25-30	1
2016-09	Carseview Centre	Learning Disabili	Not Known	M	35	07: 35-40	1
2016-09	Carseview Centre	Learning Disabili	Not Known	M	57	11: 55-60	1
2016-09	Carseview Centre	Learning Disabili	White - Scottish	M	26	05: 25-30	1
2016-09	Carseview Centre	Learning Disabili	White - Scottish	M	46	09: 45-50	1
2016-09	Strathmartine Hospit	Learning Disabili	Not Known	M	64	12: 60-65	1
2016-09	Strathmartine Hospit	Learning Disabili	White - Scottish	F	34	06: 30-35	1
2016-09	Strathmartine Hospit	Learning Disabili	White - Scottish	M	59	11: 55-60	1
2016-10	Carseview Centre	Learning Disabili	Not Known	M	43	08: 40-45	1

2016-10	Carseview Centre	Learning Disabili	Refused/Not provided by patient	M	28	05: 25-30	1
2016-10	Strathmartine Hospit	Learning Disabili	Not Known	M	36	07: 35-40	2
2016-10	Strathmartine Hospit	Learning Disabili	White - Scottish	M	26	05: 25-30	1
2016-11	Carseview Centre	Learning Disabili	White - Scottish	F	37	07: 35-40	2
2016-11	Carseview Centre	Learning Disabili	White - Scottish	M	18	03: 15-20	1
2016-11	Carseview Centre	Learning Disabili	White - Scottish	M	33	06: 30-35	1
2014-12	Murray Royal Hospit	TSMS	Not Known	M	49	09: 45-50	1
2014-12	Murray Royal Hospit	TSMS	Not Known	M	52	10: 50-55	1
2014-12	Murray Royal Hospit	TSMS	Not Known	M	55	11: 55-60	1
2014-12	Murray Royal Hospit	TSMS	White - Irish	M	56	11: 55-60	1
2014-12	Murray Royal Hospit	TSMS	White - Scottish	F	45	09: 45-50	1
2014-12	Murray Royal Hospit	TSMS	White - Scottish	F	58	11: 55-60	1
2014-12	Murray Royal Hospit	TSMS	White - Scottish	M	37	07: 35-40	1
2014-12	Murray Royal Hospit	TSMS	White - Scottish	M	50	10: 50-55	1
2014-12	Murray Royal Hospit	TSMS	White - Scottish	M	52	10: 50-55	1
2014-12	Murray Royal Hospit	TSMS	White - Scottish	M	53	10: 50-55	1
2015-01	Murray Royal Hospit	TSMS	Not Known	M	37	07: 35-40	1
2015-01	Murray Royal Hospit	TSMS	Not Known	M	38	07: 35-40	1
2015-01	Murray Royal Hospit	TSMS	Not Known	M	42	08: 40-45	1
2015-01	Murray Royal Hospit	TSMS	Not Known	M	56	11: 55-60	1
2015-01	Murray Royal Hospit	TSMS	White - Other British	F	43	08: 40-45	1
2015-01	Murray Royal Hospit	TSMS	White - Other British	F	64	12: 60-65	1
2015-01	Murray Royal Hospit	TSMS	White - Other British	M	35	07: 35-40	1
2015-01	Murray Royal Hospit	TSMS	White - Other British	M	36	07: 35-40	1
2015-01	Murray Royal Hospit	TSMS	White - Other British	M	37	07: 35-40	1
2015-01	Murray Royal Hospit	TSMS	White - Other British	M	48	09: 45-50	1
2015-01	Murray Royal Hospit	TSMS	White - Other British	M	57	11: 55-60	1
2015-01	Murray Royal Hospit	TSMS	White - Scottish	F	41	08: 40-45	1
2015-01	Murray Royal Hospit	TSMS	White - Scottish	F	51	10: 50-55	1
2015-01	Murray Royal Hospit	TSMS	White - Scottish	M	35	07: 35-40	1
2015-01	Murray Royal Hospit	TSMS	White - Scottish	M	37	07: 35-40	1
2015-01	Murray Royal Hospit	TSMS	White - Scottish	M	44	08: 40-45	1
2015-01	Murray Royal Hospit	TSMS	White - Scottish	M	54	10: 50-55	2
2015-01	Murray Royal Hospit	TSMS	White - Scottish	M	62	12: 60-65	1
2015-02	Murray Royal Hospit	TSMS	Not Known	M	37	07: 35-40	1
2015-02	Murray Royal Hospit	TSMS	Not Known	M	41	08: 40-45	1
2015-02	Murray Royal Hospit	TSMS	Not Known	M	49	09: 45-50	1
2015-02	Murray Royal Hospit	TSMS	White - Other British	M	34	06: 30-35	1
2015-02	Murray Royal Hospit	TSMS	White - Other British	M	53	10: 50-55	2
2015-02	Murray Royal Hospit	TSMS	White - Scottish	F	24	04: 20-25	1
2015-02	Murray Royal Hospit	TSMS	White - Scottish	F	49	09: 45-50	1
2015-02	Murray Royal Hospit	TSMS	White - Scottish	F	52	10: 50-55	1
2015-02	Murray Royal Hospit	TSMS	White - Scottish	M	33	06: 30-35	1
2015-02	Murray Royal Hospit	TSMS	White - Scottish	M	34	06: 30-35	1
2015-02	Murray Royal Hospit	TSMS	White - Scottish	M	39	07: 35-40	1
2015-02	Murray Royal Hospit	TSMS	White - Scottish	M	41	08: 40-45	1
2015-02	Murray Royal Hospit	TSMS	White - Scottish	M	43	08: 40-45	1
2015-02	Murray Royal Hospit	TSMS	White - Scottish	M	47	09: 45-50	1
2015-02	Murray Royal Hospit	TSMS	White - Scottish	M	54	10: 50-55	2
2015-02	Murray Royal Hospit	TSMS	White - Scottish	M	56	11: 55-60	1

2015-02	Murray Royal Hospita	TSMS	White - Scottish	M	57	11: 55-60	1
2015-03	Murray Royal Hospita	TSMS	Not Known	F	56	11: 55-60	1
2015-03	Murray Royal Hospita	TSMS	Not Known	M	52	10: 50-55	1
2015-03	Murray Royal Hospita	TSMS	Not Known	M	60	12: 60-65	1
2015-03	Murray Royal Hospita	TSMS	White - Other British	M	48	09: 45-50	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	F	27	05: 25-30	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	F	31	06: 30-35	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	F	43	08: 40-45	3
2015-03	Murray Royal Hospita	TSMS	White - Scottish	F	55	11: 55-60	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	F	63	12: 60-65	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	M	24	04: 20-25	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	M	32	06: 30-35	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	M	33	06: 30-35	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	M	34	06: 30-35	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	M	36	07: 35-40	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	M	37	07: 35-40	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	M	43	08: 40-45	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	M	44	08: 40-45	1
2015-03	Murray Royal Hospita	TSMS	White - Scottish	M	61	12: 60-65	1
2015-04	Murray Royal Hospita	TSMS	Not Known	F	31	06: 30-35	1
2015-04	Murray Royal Hospita	TSMS	White - Other British	F	42	08: 40-45	1
2015-04	Murray Royal Hospita	TSMS	White - Other British	F	59	11: 55-60	1
2015-04	Murray Royal Hospita	TSMS	White - Other British	M	62	12: 60-65	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	F	28	05: 25-30	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	F	29	05: 25-30	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	F	42	08: 40-45	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	24	04: 20-25	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	42	08: 40-45	2
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	43	08: 40-45	2
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	45	09: 45-50	2
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	46	09: 45-50	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	51	10: 50-55	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	52	10: 50-55	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	54	10: 50-55	2
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	55	11: 55-60	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	62	12: 60-65	1
2015-04	Murray Royal Hospita	TSMS	White - Scottish	M	63	12: 60-65	1
2015-05	Murray Royal Hospita	TSMS	Not Known	M	37	07: 35-40	1
2015-05	Murray Royal Hospita	TSMS	Not Known	M	40	08: 40-45	1
2015-05	Murray Royal Hospita	TSMS	Not Known	M	46	09: 45-50	1
2015-05	Murray Royal Hospita	TSMS	Not Known	M	47	09: 45-50	1
2015-05	Murray Royal Hospita	TSMS	White - Other British	F	49	09: 45-50	1
2015-05	Murray Royal Hospita	TSMS	White - Other Ethnic Group	M	48	09: 45-50	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	F	31	06: 30-35	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	F	35	07: 35-40	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	F	49	09: 45-50	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	M	30	06: 30-35	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	M	37	07: 35-40	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	M	38	07: 35-40	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	M	40	08: 40-45	2

2015-05	Murray Royal Hospita	TSMS	White - Scottish	M	44	08: 40-45	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	M	49	09: 45-50	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	M	54	10: 50-55	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	M	57	11: 55-60	1
2015-05	Murray Royal Hospita	TSMS	White - Scottish	M	61	12: 60-65	1
2015-06	Murray Royal Hospita	TSMS	Not Known	F	44	08: 40-45	1
2015-06	Murray Royal Hospita	TSMS	Not Known	M	48	09: 45-50	1
2015-06	Murray Royal Hospita	TSMS	White - Irish	M	47	09: 45-50	1
2015-06	Murray Royal Hospita	TSMS	White - Other British	M	36	07: 35-40	1
2015-06	Murray Royal Hospita	TSMS	White - Other British	M	59	11: 55-60	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	F	24	04: 20-25	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	F	26	05: 25-30	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	F	34	06: 30-35	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	F	37	07: 35-40	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	F	52	10: 50-55	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	F	53	10: 50-55	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	F	60	12: 60-65	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	27	05: 25-30	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	29	05: 25-30	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	30	06: 30-35	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	44	08: 40-45	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	46	09: 45-50	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	49	09: 45-50	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	50	10: 50-55	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	52	10: 50-55	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	53	10: 50-55	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	54	10: 50-55	1
2015-06	Murray Royal Hospita	TSMS	White - Scottish	M	65	13: 65-70	1
2015-07	Murray Royal Hospita	TSMS	Not Known	M	45	09: 45-50	2
2015-07	Murray Royal Hospita	TSMS	Not Known	M	56	11: 55-60	1
2015-07	Murray Royal Hospita	TSMS	Not Known	M	58	11: 55-60	1
2015-07	Murray Royal Hospita	TSMS	White - Other British	F	43	08: 40-45	1
2015-07	Murray Royal Hospita	TSMS	White - Other British	F	55	11: 55-60	1
2015-07	Murray Royal Hospita	TSMS	White - Other British	M	35	07: 35-40	1
2015-07	Murray Royal Hospita	TSMS	White - Other British	M	47	09: 45-50	1
2015-07	Murray Royal Hospita	TSMS	White - Scottish	F	32	06: 30-35	1
2015-07	Murray Royal Hospita	TSMS	White - Scottish	F	46	09: 45-50	1
2015-07	Murray Royal Hospita	TSMS	White - Scottish	F	60	12: 60-65	1
2015-07	Murray Royal Hospita	TSMS	White - Scottish	M	31	06: 30-35	1
2015-07	Murray Royal Hospita	TSMS	White - Scottish	M	38	07: 35-40	1
2015-07	Murray Royal Hospita	TSMS	White - Scottish	M	41	08: 40-45	1
2015-07	Murray Royal Hospita	TSMS	White - Scottish	M	44	08: 40-45	1
2015-07	Murray Royal Hospita	TSMS	White - Scottish	M	52	10: 50-55	2
2015-07	Murray Royal Hospita	TSMS	White - Scottish	M	55	11: 55-60	1
2015-07	Murray Royal Hospita	TSMS	White - Scottish	M	59	11: 55-60	1
2015-08	Murray Royal Hospita	TSMS	Not Known	M	44	08: 40-45	1
2015-08	Murray Royal Hospita	TSMS	Refused/Not provided by patient	F	36	07: 35-40	1
2015-08	Murray Royal Hospita	TSMS	White - Other Ethnic Group	M	48	09: 45-50	1
2015-08	Murray Royal Hospita	TSMS	White - Scottish	F	28	05: 25-30	1
2015-08	Murray Royal Hospita	TSMS	White - Scottish	F	34	06: 30-35	1

2015-08	Murray Royal Hospita	TSMS	White - Scottish	F	36	07: 35-40	1
2015-08	Murray Royal Hospita	TSMS	White - Scottish	F	48	09: 45-50	1
2015-08	Murray Royal Hospita	TSMS	White - Scottish	F	49	09: 45-50	1
2015-08	Murray Royal Hospita	TSMS	White - Scottish	F	64	12: 60-65	1
2015-08	Murray Royal Hospita	TSMS	White - Scottish	M	35	07: 35-40	1
2015-08	Murray Royal Hospita	TSMS	White - Scottish	M	51	10: 50-55	1
2015-08	Murray Royal Hospita	TSMS	White - Scottish	M	52	10: 50-55	1
2015-08	Murray Royal Hospita	TSMS	White - Scottish	M	64	12: 60-65	1
2015-09	Murray Royal Hospita	TSMS	Not Known	M	41	08: 40-45	1
2015-09	Murray Royal Hospita	TSMS	Not Known	M	49	09: 45-50	1
2015-09	Murray Royal Hospita	TSMS	Not Known	M	50	10: 50-55	1
2015-09	Murray Royal Hospita	TSMS	Not Known	M	52	10: 50-55	2
2015-09	Murray Royal Hospita	TSMS	Not Known	M	59	11: 55-60	1
2015-09	Murray Royal Hospita	TSMS	White - Other Ethnic Group	M	39	07: 35-40	1
2015-09	Murray Royal Hospita	TSMS	White - Other Ethnic Group	M	40	08: 40-45	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	F	18	03: 15-20	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	F	29	05: 25-30	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	F	32	06: 30-35	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	F	40	08: 40-45	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	F	50	10: 50-55	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	42	08: 40-45	2
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	43	08: 40-45	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	44	08: 40-45	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	45	09: 45-50	2
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	46	09: 45-50	2
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	48	09: 45-50	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	50	10: 50-55	2
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	51	10: 50-55	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	52	10: 50-55	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	53	10: 50-55	1
2015-09	Murray Royal Hospita	TSMS	White - Scottish	M	55	11: 55-60	2
2015-10	Murray Royal Hospita	TSMS	Not Known	M	37	07: 35-40	1
2015-10	Murray Royal Hospita	TSMS	Not Known	M	48	09: 45-50	1
2015-10	Murray Royal Hospita	TSMS	Not Known	M	56	11: 55-60	1
2015-10	Murray Royal Hospita	TSMS	Not Known	M	62	12: 60-65	1
2015-10	Murray Royal Hospita	TSMS	Refused/Not provided by patient	M	47	09: 45-50	1
2015-10	Murray Royal Hospita	TSMS	White - Other British	M	28	05: 25-30	1
2015-10	Murray Royal Hospita	TSMS	White - Other British	M	41	08: 40-45	1
2015-10	Murray Royal Hospita	TSMS	White - Other British	M	65	13: 65-70	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	F	44	08: 40-45	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	F	45	09: 45-50	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	F	48	09: 45-50	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	F	53	10: 50-55	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	F	59	11: 55-60	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	F	60	12: 60-65	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	M	34	06: 30-35	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	M	35	07: 35-40	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	M	41	08: 40-45	2
2015-10	Murray Royal Hospita	TSMS	White - Scottish	M	42	08: 40-45	1
2015-10	Murray Royal Hospita	TSMS	White - Scottish	M	53	10: 50-55	1

2015-11	Murray Royal Hospit	TSMS	White - Other British	F	39	07: 35-40	1
2015-11	Murray Royal Hospit	TSMS	White - Other British	F	57	11: 55-60	1
2015-11	Murray Royal Hospit	TSMS	White - Scottish	F	40	08: 40-45	1
2015-11	Murray Royal Hospit	TSMS	White - Scottish	F	60	12: 60-65	1
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	25	05: 25-30	1
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	29	05: 25-30	1
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	37	07: 35-40	1
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	41	08: 40-45	1
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	44	08: 40-45	1
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	46	09: 45-50	1
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	51	10: 50-55	2
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	52	10: 50-55	2
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	60	12: 60-65	2
2015-11	Murray Royal Hospit	TSMS	White - Scottish	M	64	12: 60-65	1
2015-12	Murray Royal Hospit	TSMS	Asian - Pakistani, Pakistani Scottish or Pakista	F	41	08: 40-45	1
2016-01	Murray Royal Hospit	TSMS	Refused/Not provided by patient	F	23	04: 20-25	1
2016-03	Murray Royal Hospit	TSMS	White - Other British	F	50	10: 50-55	1
2016-07	Murray Royal Hospit	TSMS	White - Scottish	F	52	10: 50-55	1
2016-09	Murray Royal Hospit	TSMS	White - Other British	F	42	08: 40-45	1
	3366	**3366**	**3366**	**3366**		**3366**	**3366**

Breakdown by age

Specialty	Location	Ethnicity	Totals F	Totals M	Total:
General Psychiatry	**Carseview Centre**	**African, African Scottish or African British**	3	3	**6**
		Asian/Asian Scottish/Asian British - Other	1		**1**
		Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British		3	**3**
		Asian - Chinese, Chinese Scottish or Chinese British	1	1	**2**
		Asian - Indian, Indian Scottish or Indian British		3	**3**
		Asian - Pakistani, Pakistani Scottish or Pakistani British	5	5	**10**
		Not Known	42	62	**104**
		Other African		2	**2**
		Other Ethnic Group	2		**2**
		Refused/Not provided by patient	7	12	**19**
		White - Gypsy/Traveller		2	**2**
		White - Irish	5	3	**8**
		White - Other British	85	84	**169**
		White - Other Ethnic Group	3	4	**7**
		White - Polish	1	8	**9**
		White - Scottish	386	414	**800**
General Psychiatry	**Carseview Centre**	**Site Total:**	**541**	**606**	**1147**
	Murray Royal Hospital	**African, African Scottish or African British**	1	1	**2**
		Asian/Asian Scottish/Asian British - Other	2		**2**
		Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British	1		**1**
		Asian - Pakistani, Pakistani Scottish or Pakistani British	1	1	**2**
		Mixed/Multiple Ethnic Groups		1	**1**
		Not Known	60	96	**156**
		Other Ethnic Group	2		**2**
		Refused/Not provided by patient	3	8	**11**

		White - Gypsy/Traveller	1		1
		White - Irish	4	5	9
		White - Other British	117	51	168
		White - Other Ethnic Group	41	9	50
		White - Polish	4	16	20
		White - Scottish	337	416	753
General Psychiatry	Murray Royal Hospital	Site Total:	574	604	1178
	Stracathro Hospital	Asian - Pakistani, Pakistani Scottish or Pakistani British		3	3
		Not Known	12	24	36
		Refused/Not provided by patient	12	28	40
		White - Irish	1		1
		White - Other British	37	41	78
		White - Polish		2	2
		White - Scottish	196	155	351
General Psychiatry	Stracathro Hospital	Site Total:	258	253	511
General Psychiatry		Specialty Total:	1373	1463	2836
General Adult Psychiatry; IPCU	Carseview Centre	Asian/Asian Scottish/Asian British - Other	1		1
		Asian - Bangladeshi, Bangladeshi Scottish or Bangladeshi British		2	2
		Not Known	3	23	26
		Other Ethnic Group	1		1
		Refused/Not provided by patient		3	3
		White - Other British	6	8	14
		White - Other Ethnic Group		1	1
		White - Polish		1	1
		White - Scottish	7	27	34
General Adult Psychiatry; IPCU	Carseview Centre	Site Total:	18	65	83
General Adult Psychiatry; IPCU		Specialty Total:	18	65	83
Forensic Psychiatry	Murray Royal Hospital	Asian/Asian Scottish/Asian British - Other		1	1
		Black, Black Scottish or Black British		1	1
		Mixed/Multiple Ethnic Groups		1	1
		Not Known		23	23
		Refused/Not provided by patient		1	1
		White - Other British		8	8
		White - Other Ethnic Group		3	3
		White - Polish		3	3
		White - Scottish		61	61
Forensic Psychiatry	Murray Royal Hospital	Site Total:		102	102
Forensic Psychiatry		Specialty Total:		102	102
Learning Disability	Carseview Centre	Asian - Pakistani, Pakistani Scottish or Pakistani British	1		1
		Not Known	4	10	14
		Refused/Not provided by patient	1	3	4
		White - Other British	4	1	5
		White - Scottish	23	15	38
Learning Disability	Carseview Centre	Site Total:	33	29	62
	Strathmartine Hospital	Not Known		13	13
		Refused/Not provided by patient		5	5
		White - Other British		3	3
		White - Scottish	4	23	27

Learning Disability	Strathmartine Hospital	Site Total:	4	44	48
Learning Disability		Specialty Total:	37	73	110
TSMS	Murray Royal Hospital	Asian - Pakistani, Pakistani Scottish or Pakistani British	1		1
		Not Known	3	32	35
		Refused/Not provided by patient	2	1	3
		White - Irish		2	2
		White - Other British	11	17	28
		White - Other Ethnic Group		4	4
		White - Scottish	50	112	162
TSMS	Murray Royal Hospital	Site Total:	67	168	235
TSMS		Specialty Total:	67	168	235
		Overall total:	1495	1871	3366

Hidden in plain sight

Inquiry into disability-related harassment

Equality and Human Rights Commission

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This inquiry has benefited from the generous contributions of many individuals. The Equality and Human Rights Commission is grateful to all those individuals, disabled people's organisations, voluntary organisations, inspectorate bodies, permanent secretaries, government departments and public and private authorities who have given evidence to the inquiry.

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Particular thanks goes to the friends, families and survivors of disability harassment who were generous enough to share their experiences with us.

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Foreword

by Mike Smith
Lead Commissioner for the inquiry, Equality and Human Rights Commission

Having grown up as a disabled person myself, I am used to my fair share of discriminatory behaviour: people treating you as though you are stupid; talking to the person with you instead of to you; overtly treating you less favourably. All of this can be unpleasant, but is it harassment? Probably not, but there have been other times in my life when I most definitely have been subject to harassment.

The most serious case was a period over about three months in the 1990s, when I lived alone in a block of flats on a smart, tree-lined avenue. I regularly had 'NF', 'cripple' and swastikas painted on my front door. I had wooden stakes pushed under my front door at night, and the ramp for my wheelchair moved. I had offensive graffiti painted on my bedroom window while I slept.

I called the police several times, and each time they just told me to ignore it and paint my front door again. It was only after about the fourth or fifth time that I was lucky enough to get someone who took the situation seriously. For the next two nights officers sat in my hallway, waiting to catch the perpetrator. They installed security TV and panic alarms. When he finally struck again, including torching the garages, half a dozen officers surrounded the place and caught him.

I didn't acknowledge that I had been targeted because of my disability until several years later. And despite the perpetrator being caught red-handed by police, the case never went to court.

Despite all of my personal and national experience of disability issues, nothing could have prepared me for the journey that we have travelled during the 18 months of this inquiry, and the horrendous things some disabled people have experienced. In the worst cases, people were tortured. And apparently just for fun. It's as though the perpetrators didn't think of their victims as human beings. It's hard to see the difference between what they did, and baiting dogs.

The really serious cases catch the headlines. But what about the constant drip, drip, nag, nag of the so-called 'low-level' harassment that many disabled people face on a daily basis. It ruins their lives. They don't have the confidence to go out. It undermines their ability to be part of society. It makes them behave differently.

For me, two things come out of this inquiry that are far more shocking than the 10 cases that we cover in more detail, awful as they are. The first is just how much harassment seems to be going on. It's not just some extreme things happening to a handful of people: it's an awful lot of unpleasant things happening to a great many people, almost certainly in the hundreds of thousands each year.

The second is that no one knows about it. Schools don't know how many disabled pupils are bullied; local authorities and registered social landlords don't know how many antisocial behaviour victims are disabled; health services don't know how many assault victims are disabled; police don't know how many victims of crime are disabled; the courts don't know how many disabled victims have access to special measures, what proportion of offences

against disabled victims result in conviction or how many of these offences result in a sentence uplift; and the prisons don't know how many offenders are serving sentences for crimes motivated by hostility to disabled people.

And why? How can we have created a society where no one appears to be seeing what's happening. As one of my colleagues on the inquiry said, when were young we were told not to stare at the disabled person. So no one is.

OK, that's not strictly fair. Over the last couple of years the number of people being convicted of 'disability hate crime' offences has gone up. Some parts of the system are making a real effort. But last year the police only recorded 1,567 cases of disability hate crime. It's probably a drop in the ocean, compared with the high proportion of disabled people reporting experiencing disability-related harassment. We need a step change in reporting and recognition.

Over the last 30 years disability activists have developed the social model of disability. It says, put simply, the thing that's 'wrong with you' should be referred to as your impairment. This might be a physical condition, a sensory one, a mental health issue, etc. But it is not your impairment, in itself, that disables you. Instead it is society's response to you and your impairment: the way we build the environment; the way we construct our attitudes to what is 'normal'; the way we think people should behave.

A wider understanding of this model will, I believe, help us understand why some of this harassment happens in the first place, and why we also don't deal with it well.

As human beings, we are not very good at dealing with difference. We're also pretty concerned about good health. Most people, if they are honest with themselves, are pretty uncomfortable about disability. Every day, people say things like 'I hear you are having a baby, do you want a boy or girl?', the response being, 'I don't mind, as long as it's healthy'. Or if some accident or health misfortune happens to someone, others indicate they would rather be dead than have that happen to them.

On top of that, there are societal attitudes and laws that tell people to treat disabled people differently: you can be excluded from being a company director, you can be prevented from doing jury service; you can be aborted much later – in 2010 the total number of abortions due to suspected disability was up 10 per cent on the previous year; you're not allowed to sit on certain seats in aeroplanes, or go to certain public places, because you will be a health and safety risk to others. People with mental health issues can be forced to take medication to keep everyone else 'safe', or if they refuse, be locked up. As disabled people, we even have different toilets. Something as fundamental as going to the loo, and we are separated rather than make regular toilets accessible.

Some people say they don't know how to act because they've never come across a disabled person. How can that be, when 21 per cent of the population are disabled in some way, according to government figures? Well, they probably will have done. But many of the people they know who are disabled will not choose to identify as such, or even if they do, keep it to themselves.

As a society we exclude disabled people from the mainstream – making them live in special homes, educating them in special schools, shut away from the rest of us. It's done under the pretext of 'we think it's best for them'. But is it really? If you educate disabled children in separate settings, how are they to know how to integrate into society properly when they reach

adulthood? And if non-disabled children don't grow up alongside disabled children, surely they're going to perceive them as different. If you have never come across someone with autism, how are you expected to know how they communicate or how you communicate with them? It seems to me that educating disabled children separately just stores up problems for the future for all of us.

So we don't really feel comfortable about disability, we are taught to think of disabled people as different, and are told to feel sorry for them. I personally think this is a significant part of the reason why, as a society, we have failed to recognise the nature and scale of the problem of disability-related harassment. Throughout the inquiry there seemed to be a collective denial that this sort of thing could be happening. It's as though people are thinking 'we are supposed to feel sorry for these people, so why would anyone be deliberately horrible to them?' Maybe it just makes us too uncomfortable, thinking that might be the society in which we live.

Despite the above, I did not think it is all doom and gloom. We came across some great examples of good practice. Throughout the report we highlight many of them. Appendix 17 includes many examples of areas where good practice has been developed where previously things have gone wrong. It is often said that disabled people know best what works for them. Good public authorities know this is true, and work effectively with disabled people and their organisations to achieve better outcomes.

This inquiry has already started the process of change. In many evidence sessions, I asked what would help drive the process of change. Many said they didn't need to wait for our recommendations, and just talking to us had already motivated them to take action. Others have promised new or revised guidance once this report is published.

The sheer depth and breadth of evidence that we've taken has given us a unique perspective. It was only by taking such a broad view that we were able to see the full extent of the issue and come to our conclusions.

It enabled us to see how the impact of decisions in one policy area affect another. Social services often award care and support based on quite limited criteria around an individual's 'vulnerability', and whether or not someone needs physical assistance to bathe or get dressed. Many local authorities allow support for 'one significant social encounter a week'. They say they can't afford more, but think how socially isolated that will leave many people – a common thread of our inquiry was that people were socially excluded. The design of transport and housing often prevents some disabled people from getting out and about, including getting to a place of employment. So then the disabled person has no choice but to live on benefits, and is then labelled a scrounger and a burden on the rest of society. People think of choice of school as parental choice, but it is only when you step back that you can consider the wider impact on our society of segregated education. There are many, overlapping, vicious circles.

We also found that some of the measures that are meant to help might inadvertently be making things worse. The 'No Secrets' guidance in England has resulted in criminal offences such as theft or fraud not being dealt with as crimes, and professionals focusing on vulnerability and protecting the disabled person (perhaps by moving them), rather than dealing with the perpetrators. The impact on the human rights of disabled people does not appear to have been considered.

Equally the language of 'hate crime' has been useful up until now, to get the issues on the radar, but it probably now acts as a barrier to effective reporting and recognition. Many people think they have just been taken advantage of, rather than hated. Who wants to think of themselves as hated? This terminology also probably contributes to the culture of disbelief. Language may not be the most important thing in the world – action counts for more – but it's probably time to use a new terminology.

Dealing with disability-related harassment is not going to be solved just by better policing. It's going to take concerted, joined up effort by a significant number of public authorities, with proper leadership, and joint working at all levels.

It won't just be public authorities that have to act differently. It's all of us. In the way that we think of and treat disabled people. I want the person at the bus stop who sees something happening, or the plumber repairing a tap who comes across something untoward, to know that they too should take action. I don't want everyone to think that all disabled people are vulnerable and need protecting – far from it – but some people do need help and support.

Ultimately, it will only be when disabled people are supported to be and recognised as equal members of our society, and we accept disability as normal and part of the natural variation in the human condition, that we will feel comfortable in recognising and addressing the shame on our society that is disability-related harassment.

There are many people who I would like to thank for helping make this inquiry so successful. First of all, the brilliant staff within the Equality and Human Rights Commission for your many hours of hard work, dedication and commitment to this project. It's been a joy to work with you. Also, the members of our external reference group and the Disability Committee: collectively you have provided many excellent insights and guiding words along this journey and have helped us make sure that all critical stones have been upturned. I would like to thank the many people who gave us evidence in the call for evidence, in key-informant interviews, in focus groups, and in formal evidence sessions. Together you have given us tens of thousands of pages of evidence, which has significantly influenced the course of this inquiry and will give us a valuable information resource going forward.

But finally, I would like to thank all the disabled people who have told us their story: of the things that happened to you; of how you were supported, or not; of how you coped afterwards, or didn't. Without your voices, this report would not have the impact I believe it will. Please, continue using those voices, all across our nations, and make change happen.

Part 1: About the inquiry

Why this inquiry?

> 'We can do anything we like and you can't do anything about it.'
>
> One of the gang of young people involved in harassing Fiona Pilkington and her children[1]

On 23 October 2007, the charred remains of Fiona Pilkington and her daughter Francecca Hardwick were found in the family's burnt-out blue car in a lay-by not far from their home. The inquest into their deaths concluded that Fiona had killed herself and her daughter 'due to the stress and anxiety regarding her daughter's future, and ongoing antisocial behaviour'.

Fiona Pilkington and her two disabled children – Francecca, who had a learning disability and Anthony, who has severe dyslexia – had endured seven years of harassment. Eggs and stones had been aimed at their house, bottles thrown into their garden. Their hedge was repeatedly jumped on, the 'for sale' sign outside their house was damaged and their gates and fences were set on fire. Their windows were broken on a number of occasions. They were taunted, insulted and verbally abused.

Stones were thrown at Francecca's bedroom window as she went to bed, accompanied by demands that she lift up her nightdress. Her way of walking was imitated and mocked. Anthony was bullied at school and received death threats. He was punched in the mouth, chipping a tooth, and pushed into a car, injuring his hand. He was locked in a shed at knifepoint and had to smash a window to escape. He was hit by stones while out cycling and was attacked with an iron bar.

As shocking as the abuse itself was the failure of any interventions by organisations to protect the family. Leicestershire Constabulary had been contacted on 33 separate occasions by Fiona herself, her mother Pam Cassell and her neighbours on Bardon Road in Barwell, Leicestershire. Often police attended days later, if at all. In a suicide note to her family, among other concerns, Fiona said that she was disillusioned with the police response to the family's ordeal. At the inquest into the deaths of Fiona and Francecca, the jury decided that both Leicestershire Constabulary and Hinckley & Bosworth Borough Council bore some responsibility for their deaths. Leicestershire County Council social services department was also criticised for failing to refer Fiona for professional help after she told a social worker she felt suicidal, although the inquest decided that the County Council's actions did not contribute to Fiona's death.

The case deeply concerned us at the Commission, as did a number of similar incidents of serious harassment and abuse

1 Quoted by Fiona Pilkington's mother, Pam Cassell, during the inquest into her death.

of disabled people which had been reported in the media over the last few years. We started to see a pattern emerging: our previous research[2] indicated that violence and hostility towards disabled people was widespread in Britain. Intelligence gathered through our helpline and stakeholder network convinced us that there was a serious problem regarding the harassment of disabled people that needed to be better understood.

An important finding to emerge from this inquiry is that the most severe cases – like that of the Pilkington-Hardwick family – which come to the courts and receive coverage in the media, are only the tip of the iceberg. They are the most public face of a more profound social problem. Our evidence indicates that, for many disabled people, harassment is a commonplace experience. Many come to accept it as inevitable, and focus on living with it as best they can.

Disabled people often do not report harassment, for a number of reasons: it may be unclear who to report it to; they may fear the consequences of reporting; or they may fear that the police or other authorities will not believe them. Indeed, we have found that a culture of disbelief exists around this issue. Even when it is reported or uncovered it is often not recognised for what it is. For this reason, we describe it as a problem which is 'hidden in plain sight'.

About the Commission

The Equality and Human Rights Commission (the Commission) was founded in 2006. It has a statutory remit to promote and monitor human rights; and to protect, enforce and promote equality across seven 'protected' grounds including disability.[3] Under section 3 of the Equality Act 2006, the Commission is required to encourage and support the development of a society in which:

- people's ability to achieve their potential is not limited by prejudice or discrimination
- there is respect for, and protection of, each individual's human rights
- there is respect for the dignity and worth of each individual
- each individual has an equal opportunity to participate in society
- there is mutual respect between groups based on understanding and valuing of diversity, and on shared respect for equality and human rights.

Under section 16 of the Equality Act 2006, the Commission may conduct inquiries into issues or sectors where there are concerns relating to human rights and/or equality (see Appendix 1 for more information on the Commission and its inquiry powers). Through our inquiry powers, the Commission can require organisations to provide evidence, both in writing and in person. We then publish

2 Equality and Human Rights Commission, 2009, *Promoting the Safety and Security of Disabled People*.

3 The other protected grounds are age, gender, gender reassignment, race, religion and belief, and sexual orientation.

authoritative, evidence-based reports and make recommendations against which we expect action to follow.

The remit of this inquiry

The definition of disability-related harassment

For the purposes of this inquiry, the Commission defined disability-related harassment as unwanted, exploitative or abusive conduct against disabled people which has the purpose or effect of either:

- violating the dignity, safety, security or autonomy of the person experiencing it, or
- creating an intimidating, hostile, degrading or offensive environment.

It includes harassment of the friends and family of disabled people and of people perceived to be disabled.

It should be noted that our definition of disability-related harassment goes wider than the definition currently used by the criminal justice system.[4]

Terms of reference

The Commission is required to set terms of reference for its formal inquiries. Appendices 2 and 3 explain the draft terms of reference and how they were changed in response to our consultation process.

The final terms of reference are attached in full as Appendix 4. They set out that the inquiry investigates:

- the causes of disability-related harassment
- the actions of public authorities and public transport operators to prevent and eliminate it.

The scope of the inquiry covers:

- England, Scotland and Wales
- disability-related harassment carried out by individuals or groups of people, including strangers, neighbours, acquaintances, friends, family, relatives and partners
- harassment in public places such as streets, parks, schools and leisure facilities and/or in private such as the home.

It does not cover harassment in the workplace, which is covered by a separate legislative framework.

The number of people who are disabled

The Office for Disability Issues have issued figures which show that there are 10.1 million adults in Great Britain who are disabled.[5] The total number of people aged 16 and over was 49 million (using mid-2009 estimates).[6] So the percentage of adults in Britain who are disabled is 21 per cent. This estimate covers the number of people with a longstanding illness, disability or infirmity, and who have a significant difficulty with day-to-day activities.

4 See http://www.cps.gov.uk/legal/s_to_u/stalking_and_harassment/#a02a

5 See http://odi.dwp.gov.uk/docs/res/factsheets/disability-prevalence.pdf

6 See http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14060

The legislative framework

There are several pieces of legislation relevant to disability-related harassment.

The Disability Discrimination Act (DDA) 1995

Gave disabled people rights in the areas of: employment, education, access to goods, facilities and services, buying or renting land or property and access to public transport. Introduced protection from harassment within employment (see Appendix 5).

The Disability Discrimination Act 2005

Extended the protections offered by the DDA 1995 and introduced a requirement for public authorities to promote equality of opportunity for disabled people and to eliminate harassment against them (the Disability Equality Duty) (see Appendix 6).

The Equality Act 2010

Consolidated and expanded existing equalities legislation, including introducing a new public sector equality duty (see Appendix 7).

Public sector equality duty

Since December 2006, public authorities have had a responsibility to have due regard to eliminating harassment related to disability, initially under the Disability Equality Duty (DED) and more recently under the new public sector equality duty (PSED).

Until April 2011, the DED applied to 45,000 public authorities across Britain – such as central or local government, schools, health trusts and emergency services. It required them to actively consider how to promote equality for disabled people and ensure that they were treated fairly. The DED specifically highlighted the need for public authorities to eliminate harassment of disabled people that was related to their disabilities and to promote positive attitudes towards them.

The DED has now been superseded by the PSED, which also requires public authorities to pay due regard to eliminating harassment of disabled people, alongside a number of other protected characteristics.

Equality duties in Wales

In Wales the Welsh Government has introduced specific duties that apply to devolved public authorities in Wales. These duties require authorities, among other things, to set equality objectives, assess the impact of their policies and practices, and promote knowledge and understanding of the specific and general duties among its staff. Tackling disability harassment could well feature as an objective of a Welsh Public Authority.

Criminal law

A wide range of criminal offences may be committed during the harassment of a disabled person such as assaults, criminal damage, public order offences, sexual offences and murder. There are no specific aggravated offences related to disability and no offence of incitement to disability hatred.

Judges may impose increased sentences for offences proven to be motivated by hostility[7] or prejudice[8] to disability.

The European Convention on Human Rights

All public authorities (such as courts, police, councils, hospitals, publicly funded schools) and other bodies carrying out public functions have to comply with the Convention which includes:

- the right to life
- the right to respect for private and family life
- freedom from torture and inhuman or degrading treatment or punishment.

In its consideration of two British cases (*Z. and Others v. the United Kingdom*[9] and *A. v. the United Kingdom*) the European Court of Human Rights confirmed that the State is obliged to 'take measures to protect individuals... from ill-treatment and to take reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge'.[10]

The Human Rights Act 1998

The Human Rights Act 1998 made the rights and freedoms guaranteed under the European Convention on Human Rights enforceable in British courts. As a result, individuals can take human rights cases in domestic courts rather than having to go to the European Court of Human Rights.

All public authorities must ensure that everything they do is compatible with European Convention rights unless an Act of Parliament prevents them from doing so.

The United Nations Convention on the Rights of Persons with Disabilities

A number of the Convention's articles are of relevance to harassment (see Appendix 9), particularly article 16, freedom from exploitation, violence and abuse. Under article 16, the UK Government is required to take a wide range of measures to prevent all forms of exploitation, violence and abuse of disabled people, both within and outside the home, and to investigate and prosecute those responsible.

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7 In England and Wales through section 146 of the Criminal Justice Act 2003, see Appendix 8.

8 In Scotland through the Offences (Aggravation by Prejudice) (Scotland) Act 2009, see Appendix 8.

9 See *Z. and Others v. the United Kingdom*, application No. 29392/95, judgment of 10 May 2001, paras. 73 and 74 and *A. v. the United Kingdom*, application No. 25599/94, judgment of 23 September 1998, para. 22.

10 United Nations General Assembly, 2008, *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, p17. Sixty-third session: Promotion and protection of human rights: implementation of human rights instruments. A/63/175. Available from: http://www.unhcr.org/refworld/docid/48db99e82.html

These obligations extend from government through to other public authorities in Britain.

The Autism Act 2009

During the course of running this inquiry, the Autism Act has been implemented. Although not part of the terms of reference of the inquiry, we recognised that when developing their strategies and plans, local authorities and health services can use these plans to ensure they are addressing the specific requirements of adults with autism when preventing disability-related harassment.

The Autism Act is the first ever impairment specific law in England. The Act did two key things. The first was to put a duty on the Government to produce a strategy for adults with autism (March 2010). The second was a duty on the Government to produce statutory guidance for local councils and local health bodies on implementing the adult autism strategy by the end of 2010 (December 2010). The Act, strategy and the statutory guidance relates only to adults with autism living in England.

The policy framework

Antisocial behaviour

Harassment of disabled people may be dealt with as antisocial behaviour, particularly by the police, housing providers and local authorities. Antisocial behaviour is defined by the Home Office as 'any aggressive, intimidating or destructive activity that damages or destroys another person's quality of life'. It includes both non-criminal and criminal behaviours.

The previous Government introduced a range of initiatives to tackle antisocial behaviour in England and Wales through the Anti-social Behaviour Act 2003 including antisocial behaviour orders, child safety orders, parenting orders, child curfews and fixed penalty notices.[11] In February 2011, the current Government launched a consultation on improving responses to antisocial behaviour.[12] The outcome is not yet known.

The Anti-social Behaviour (Scotland) Act 2004 says that a person is involved in antisocial behaviour if they:

- act in a way that causes or is likely to cause alarm or distress to anyone; or

11 Home Office, 2008, *A guide to Anti-social Behaviour Tools and Powers*, p1. Available from: http://webarchive.nationalarchives.gov.uk/20100405140447/http://asb.homeoffice.gov.uk/uploadedfiles/Members_site/Documents_and_images/Enforcement_tools_and_powers/ToolsPowersGuideMay08_0145.pdf

12 Home Office, 2011, *More effective responses to anti-social behaviour – a consultation*. Available from: http://www.homeoffice.gov.uk/publications/consultations/asb-consultation/

- behave in a way that causes or is likely to cause alarm and distress to at least one person not of the same household as them.

The Scottish Government also introduced a range of measures for tackling antisocial behaviour similar to those in England and Wales. In March 2009, the Scottish Government and the Convention of Scottish Local Authorities (COSLA) jointly published their framework for tackling antisocial behaviour, 'Promoting Positive Outcomes'.[13] The four pillars of the framework are prevention, integration, engagement and communication.[14]

Hate crime

Harassment may also be dealt with as hate crime or hate incidents. There is no definition of disability hate crime in law;[15] however, the following definition has been agreed by the Association of Chief Officers and the Crown Prosecution Service in England and Wales in order to effectively tackle incidents:

- Any criminal offence, which is perceived, by the victim or any other person, to be motivated by hostility or prejudice based on a person's disability or perceived disability.

A disability hate incident is:

- Any non-crime incident which is perceived, by the victim or any other person, to be motivated by a hostility or prejudice based on a person's disability or perceived disability.

13 See http://www.scotland.gov.uk/Topics/Justice/public-safety/asb/ASBframework

14 **Prevention:** People are deterred from behaving in an antisocial way and have better educational, employment and social opportunities in their communities.

Integration: Services share staff, finances and other resources more effectively to improve their impact, services focus on clear shared priorities and outcomes, and information and intelligence are shared effectively.

Engagement: Local communities feel empowered and take an active and meaningful role in planning and delivering work to tackle antisocial behaviour.

Communication: There are consistent messages at a national and local level about what antisocial behaviour is and what it is not and partners and members of the public understand those messages.

15 The agreed definition of 'monitored hate crimes and incidents' was first developed in 2007 by the Race for Justice programme and adopted by criminal justices agencies, commencing with ACPO who adopted it in November that year. The agreed definition came about after consultation with criminal justice sector (CJS) agencies after it became apparent that different CJS agencies were using different definitions. The agreed definition of hate crime is not defined in law as such but there is a general agreement among CJS agencies that this is what hate crime is and they have signed up to this agreed definition which builds on the findings of the Stephen Lawrence Inquiry of 1999 and considers the 'enhanced sentencing' legislation of sections 145 and 146 of the Criminal Justice Act 2003.

In Scotland a hate crime is a crime motivated by malice and ill-will towards a social group.[16]

Adult protection

'No Secrets'[17] and 'In Safe Hands'[18] are the policy frameworks for adult protection in England and Wales respectively. Launched in 2000, the two frameworks were developed in parallel and contain broadly similar provisions, based around the protection of 'vulnerable adults'. They use the following definition of a vulnerable adult as someone over the age of 18 who:

- is or may be in need of community care services by reason of mental or other disability, age or illness, and
- is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.[19]

In England and Wales, local councils, working with other agencies, have a responsibility to investigate and take action to prevent abuse. Both frameworks are guidance rather than legislative requirements. They have each been recently reviewed and changes are anticipated.

The Adult Support and Protection (Scotland) Act 2007[20] introduced a rights based framework to adult protection in Scotland. The Act defines 'adults at risk' as individuals, aged 16 years or over, who:

- are unable to safeguard themselves, their property, rights or other interests, and
- are at risk of harm, and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than others who are not so affected.

If a safeguarding referral is made, Scottish councils have a duty to investigate whether or not further action is required to stop or prevent harm occurring. Other organisations have a duty to co-operate in investigating suspected or actual harm. A range of protection orders including

16 Scottish Executive, Working Group on Hate Crime, 2004. Available from: http://www.scotland.gov.uk/Topics/Justice/crimes/8978/17915/10744

17 Department of Health, 2000, *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

18 Welsh Government, 2000, *In Safe Hands: Implementing Adult Protection Procedures In Wales*. Available from: http://wales.gov.uk/topics/health/publications/socialcare/reports/insafehands?lang=en

19 Department of Health, 2000, *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, pp8-9. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

20 Scottish Government website, Adult Support and Protection (Scotland) Act 2007. Available from: http://www.legislation.gov.uk/asp/2007/10/contents

assessment orders, removal orders and banning orders are available within the legislation. Authorities covered by the Act have a duty in all cases to make the least restrictive intervention.

Bullying

Harassment in the context of schools and other settings involving young people is often called bullying.[21] National guidance for schools in England, Scotland and Wales recognises that people may be bullied because of prejudice including on the grounds of special educational needs.

How we conducted the inquiry

Methodology

We used a number of evidence-gathering approaches. These included:

- reviewing existing research and reports
- key informant interviews with disabled people's organisations (DPOs), other targeted violence organisations, academics, public bodies and public transport operators
- a questionnaire aimed at capturing individual experiences[22]
- a proforma for organisations and interested parties
- regional events for disabled people's organisations, public authorities and public transport operators
- a questionnaire on the Disability Equality Duty for public authorities
- focus groups, supplemented by individual interviews with disabled people, to explore disabled people's experiences of harassment and their views about the way this is currently addressed by public authorities
- formal evidence hearings in London, Manchester, Glasgow, Cardiff and north Wales, primarily aimed at national and local public authorities and public transport operators, and government departments
- roundtable events on specific themes including:
  - for friends and family of people killed as a result of disability-related harassment and for survivors of serious violence and abuse
  - the role of media regulators and intermediary bodies which represent parts of the media sector in influencing the portrayal of disabled people and disability-related harassment
  - cyber-bullying and cyber-harassment with a number of experts from the public, private and voluntary sectors.

More information about each of these approaches is set out at Appendix 10.

21 See https://www.education.gov.uk/publications/eOrderingDownload/Bullying-SEN.pdf

22 The questionnaire was available to individuals in various ways including through the Commission's website, via regional roundtable events and through disabled people's organisations.

The evidence

The evidence base for the inquiry included:

- more than 90 research and policy papers
- transcripts of 85 key informant interviews. Interviewees included: 46 experts from the disability sector and eight from other third sector organisations; 17 from the public sector; 13 academics
- 287 disabled people's questionnaires
- 161 submissions to the call for evidence from organisations and interested parties (see Appendix 11 for breakdown)
- 13 regional events for disabled people's organisations, public authorities and public transport operators
- 272 questionnaires from public authorities on the DED
- report of qualitative research conducted for this inquiry, based on 12 focus groups and 16 in-depth interviews. In this report, we draw on both the evidence provided by disabled people in this research, and on the researchers' analysis of their findings.[23] We are grateful to Independent Social Research for carrying out this work for the inquiry[24]
- transcripts of 76 formal evidence hearings (including three themed roundtables) held in London, Manchester, Glasgow, Cardiff and north Wales, involving 234 witnesses and 132 organisations (a full list of organisations is given in Appendix 12). Witnesses included:
  - 11 local authority chief executives, one local authority leader and nine directors of adult social care
  - seven chief constables, three deputy chief constables and five assistant chief constables
  - the following inspectorates: Ofsted, Care Quality Commission, Her Majesty's Inspectorate of Constabulary, Audit Commission, Ofcom, Her Majesty's Crown Prosecution Service Inspectorate, Press Complaints Commission, Her Majesty's Inspectorate of Education Scotland, Her Majesty's Inspectorate of Constabulary for Scotland, Audit Scotland, Inspectorate of Prosecution Scotland, Her Majesty's Inspector of Education Scotland, Scottish Commission for Regulation of Care, Scottish Housing Regulator, Estyn, Care and Social Services Inspectorate Wales, Wales Audit Office
  - six NHS chief executives and three housing chief executives
  - four permanent secretaries and 11 directors of government departments (England, Scotland and Wales)
  - two headteachers, one deputy head and a principal of a Further Education college

23 Sykes, Groom and Desai, 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*, Equality and Human Rights Commission.

24 Ibid.

  - the Victims' Commissioner, Information Commissioner and the chief executives of the National Offenders Management Service and Her Majesty's Court Service, respectively
  - the Director of Public Prosecutions, Solicitor General (Scotland) and two judges
- written evidence from 59 organisations in advance of formal inquiry hearings sessions and from 55 organisations following hearings.

The evidence was analysed using a qualitative data analysis software package.

External advisory group

An external advisory group was established to provide feedback on issues arising from the inquiry and on the inquiry itself. It met four times. A list of members is provided in Appendix 13.

Internal advisory group

During the course of the inquiry the Commission's Disability Committee considered, at each of its bi-monthly meetings, progress, issues and preliminary findings, and gave useful guidance to the Lead Commissioner and staff.

Part 2: Ten cases

As part of this inquiry we examined 10 very serious cases in which disabled people have died or been seriously injured. These cases show beyond doubt that the experiences of Fiona Pilkington and her children were not a one-off. In many other locations and circumstances, the appalling abuse of disabled people has been greeted with disbelief, ignored or mishandled by the authorities, with tragic consequences.

We could not investigate every case in which a disabled person has been seriously harmed as the result of harassment. Our intention in looking at this selection of cases is to illustrate some of the key features of disability-related harassment. They give us some clues as to how and why such behaviour happens, and how, even when it is of a very extreme nature, it can go unchallenged. They show that a failure to tackle harassment can have dreadful results, both for the victims and also for society as a whole.

We wanted to examine each case in sufficient detail to learn lessons for the future. In each case we called the public authorities that were involved to give evidence at a formal inquiry hearing and/or in writing.[25] At the hearings, we asked them about:

- their awareness of the harassment
- their handling of the case
- what, if anything, they could have done differently
- whether they had put into practice any measures to help them avoid similar tragedies in the future.

Authorities were asked to supply various documents (such as any serious case review, their disability equality scheme, data on harassment cases) in advance of attending the formal hearing and were often requested to provide further information as follow up. Where available, we considered serious case reviews, Independent Police Complaints Commission (IPCC) investigations[26] and inspectorate investigations into the case. In some cases we also spoke to family members and friends and to local disabled people's organisations.

25 The authorities are listed at Appendix 16.

26 IPCC reports or findings on three cases investigated by this inquiry (David Askew, Michael Gilbert and Fiona Pilkington and her children) became available in the period following the hearings. They were considered as part of the analysis of evidence. Both the IPCC and individual inspectorate investigations are able to consider individual cases in more depth than was possible within this inquiry, which was set up to investigate the responses of authorities to harassment overall and make recommendations for improvement. IPCC and inspectorate investigations often take many months and even years to review an individual case, interviewing frontline staff involved and other witnesses in order to provide a detailed analysis of what went wrong within that case. This was not appropriate within this inquiry's wider focus.

The cases contain lessons for health services, councils, police and other agencies about how to encourage disabled people, their families or neighbours to report incidents of harassment and how to respond when they do. We learnt most from authorities who had taken the opportunity to reflect on what went wrong, either because they had undertaken a thorough serious case review themselves or an in-depth review had been conducted by an independent agency such as an inspectorate.

We found some encouraging examples of these agencies learning from their mistakes, particularly where they had shown senior level commitment to implementing changes as a result of the review. However, the learning was often only applied in the area where the case had happened and had not been shared effectively across the country.

Most cases had not been subject to either a serious case review or other external review prior to the Commission's interest in the case. There was generally less evidence that these authorities had made significant changes to their practice, although some improvements had been put in place. In Appendix 17 we have shown some of the improvements made by agencies in the cases highlighted in the rest of this section.

The key findings from this chapter are:

- Public authorities were often aware of earlier, less serious incidents but had taken little action to bring harassment to an end. In some cases, no effective action was taken to protect the disabled person even when public authorities were aware of allegations of very serious assaults. This left the disabled person at risk of further harm.
- Social isolation is a factor in many of the cases we reviewed. The harassment often took place in the context of exploitative relationships.
- Left unmanaged, non-criminal behaviour and 'petty' crime has the potential to escalate into more extreme behaviour. Several of the deaths in this chapter were preceded by relentless non-criminal and minor criminal behaviour, which gradually increased in frequency and intensity.
- Public authorities sometimes focused on the victim's behaviour and suggested uncalled for restrictions to their lives to avoid harassment rather than dealing with the perpetrators.
- The failure of public agencies to share intelligence, co-ordinate their responses and treat harassment as a priority meant that opportunities to bring harassment to an end were missed. In a number of cases, the violence subsequently escalated resulting in serious harm or death.
- Disability was rarely considered as a possible motivating factor in crime and antisocial behaviour. As a result, the incidents are given low priority and appropriate hate incident policy and legislative frameworks are not applied.
- Extreme violence was a frequent feature in the murders of disabled people, often accompanied by degrading treatment and torture. Most of the murders that we investigated were not prosecuted as disability hate crimes even though this type of dehumanising treatment appears to be more common in the murders of disabled people than in other murders.

- Reports of violence may be treated by public authorities with disbelief and disregard, resulting in inaction and leaving the disabled person at risk of further harm.

1. David Askew

What happened

David Askew died of a heart attack in the rear garden of his home in March 2010. He collapsed minutes after local youths had reportedly thrown a wheelie bin around and tampered with his mother's mobility scooter.

David was a 64-year-old man with learning disabilities who lived with his older brother and their mother in Hattersley, Greater Manchester. He had been subjected to harassment by at least 26 different people over a period of more than 12 years. Some of those involved in later incidents were the children of people thought to have been involved in earlier harassment. Incidents happened both at his home and in the nearby Kingston Arcade of shops and included verbal abuse, taking money and cigarettes off him and throwing stones at his windows. Many incidents had been reported to public authorities, particularly the police.

Following David's death, one man, Kial Cottingham, 19, was prosecuted for harassment.

The response

The police were aware of sporadic incidents of harassment as far back as 1998. In the period 2004-07 the police recorded 10 incidents involving the family. During the first spate of incidents from May to August 2004, the police spoke to social services regarding David and his mother. A CCTV camera was installed at the rear of the address.

In 2004, David's address was given a computer marker on the police incident management system as a repeat address with 'vulnerable victims'. That marker remained on the address throughout the period up to and including David's death. However, a number of the police officers responding to the reports appear not to have been aware of it, often dealing with incidents in isolation rather than as part of a pattern of persistent harassment.

There was a gap in reported incidents after August 2004 but they started again in January 2006. The police acknowledged that throughout the period up to December 2006 there were often delays in attending the scene following reports and a lack of recognition of the risks the family faced. Communication between the neighbourhood police team and other police staff was inadequate.[27]

However, the neighbourhood police had instigated some support by raising the family's situation at the Police and Community Together (PACT) meeting in

27 The issue of communication on antisocial behaviour between neighbourhood police and other police staff is also raised by the HMIC inspection of Greater Manchester Police. Available from: http://www.hmic.gov.uk/SiteCollectionDocuments/Greater%20Manchester/GMP_ASB_20100923.pdf

December 2006. At that meeting of PACT, 'issues of offenders, removal of low wall and David's mental health issues' were identified for action. PACT did not act with sufficient urgency in relation to these matters. However the Neighbourhood Office did start to keep a written record of incidents of harassment which led to a more accurate picture of the amount of harassment being suffered by David and his family.

From 1 January 2007 to David's death on 10 March 2010 there were 78 incidents reported to the police, nearly all committed at or close to the home address. On only one occasion was hate crime considered by the police in relation to the case. That was on 27 June 2007 when a sergeant reviewing the incident report made the comment that the matter appeared to be a hate incident. The officer attending mentioned David's 'mental problems' and the fact that youths had called him a 'paedo' but then went on to state that no mention was made by the youths of David's mental health issues and therefore it was not a hate incident. None of the 31 crimes recorded from the 78 incidents had been identified as hate-related. Recognition of incidents as hate-related would have raised the profile of the problem regarding the family at least to neighbourhood supervision if not to the senior leadership team.

Giving evidence to this inquiry, Greater Manchester Police said 'It was very, very difficult to get any credible evidence. David did get very stressed and agitated when he was called upon to talk about what happened. They also thought the experience of giving evidence would be distressing for him. This put the emphasis on getting evidence from other sources such as the CCTV but the recording system that was installed produced images of poor quality which could not be used to support prosecutions.'

Other agencies, including social services, the council community safety team and the Askew family's landlord, Peak Valley Housing Association, were also aware of the harassment. From around July 2008 referrals of many of the 26 youths involved in the harassment were made to the community safety team. A gradually escalating policy was adopted starting with sending letters to the parents of the young people involved in the harassment and then arranging meetings with them. Antisocial behaviour orders were obtained but they were frequently breached without any sanctions.

On some occasions, the authorities put the onus on the Askew family to avoid their abusers rather than tackling the perpetrators themselves. For example, the housing association tried to get the family to move. Similarly, the council's solution seems to have focused on giving David things to do, such as attending a snooker club and doing voluntary work in order to reduce his contact with the harassers, rather than tackling the perpetrators more effectively.

In conclusion, this inquiry found that although various agencies took some action, it was neither joined up nor effective in dealing with the harassment, there was often a lack of urgency and no overall plan for resolving the issues. There was no tracking of repeat victimisation so

the police tended to deal with incidents in isolation, rather than as part of a pattern. There were few consequences for the perpetrators. The presumption that David would not be a good witness and the poor quality of the CCTV images influenced the decision not to take criminal proceedings. The hate crime framework was not applied.[28]

Prosecution

Following David's death, one man, Kial Cottingham, 19, was prosecuted. The case was not dealt with as a hate crime. He pleaded guilty to harassment on 20 September 2010 and was sentenced to 16 weeks prison. As he had been on remand he was released. He was also given a restraint order not to enter a defined area of Hattersley or to contact David's family. The case was not prosecuted as a disability hate crime.

Review process

The Independent Police Complaints Commission conducted a review of the police's role.[29]

A serious case review was also conducted.[30] It focused primarily on the Askew family although some consideration was given to preventing the children of perpetrators going on to become perpetrators. The main recommendations include the following:

- improve training to enable identification of disability hate crime
- improve data collection and sharing of information in this regard
- establish the purpose, benefits and drawbacks of CCTV and fencing solutions, identifying effectiveness and unintended consequences
- help health services to meet the needs of vulnerable adults

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28 The Independent Police Complaints Commission's investigation into how Greater Manchester Police dealt with the alleged harassment of David Askew reached similar conclusions, although their remit was solely the police response. IPCC found there had been: 'a lack of consistent identification of, and response to, the vulnerability factors affecting the Askew family; a total failure to recognise and respond to the incidents as "hate crime"; an apparent lack of coordination and cohesive action between partner agencies; a lack of robust offender management'. Independent Police Complaints Commission (IPCC) website, *IPCC publishes findings from investigation into GMP contact with David Askew*, 21/03/11. Available from: http://www.ipcc.gov.uk/news/Pages/pr_210311_gmpaskew.aspx

29 Independent Police Complaints Commission (IPCC) website, *IPCC publishes findings from investigation into GMP contact with David Askew*, 21/03/11/. Available from: http://www.ipcc.gov.uk/news/Pages/pr_210311_gmpaskew.aspx

30 Tameside Adult Safeguarding Partnership, *Executive Summary of the Serious Case Review in respect of Adult A*. Available from: http://www.tameside.gov.uk/socialcare/adultabuse/seriouscasereview

- ensure Fair Access to Care Services (FACS) guidance addresses safeguarding responsibilities
- place a lead professional in charge of action to tackle persistent abuse where there are multi-agency responsibilities
- establish common risk identification and management processes among different organisations
- share learning from the serious case review with residents and professionals to prevent future problems and explore restorative justice opportunities
- clarify the purpose of advocacy and communication support from the outset to enable justice to be achieved in each case.

It also recommended that 'the findings of this serious case review should be reported to the Equality and Human Rights Commission review, noting the difficulties that experienced and committed staff have in using the concept of hate crime in their everyday work and when prosecuting an offence of harassment against a learning disabled person'.[31]

2. 'The case of the vulnerable adult'[32]

What happened

In March 2002, a 30-year-old woman with learning disabilities was admitted to Borders General Hospital in Scotland with multiple injuries as a result of sustained physical and sexual assaults. The abuse had been carried out at home and was perpetrated by three men, one of whom was her carer.

The woman had made allegations against one of the perpetrators as a child but agencies decided her mother could protect her. When her mother died, he was allowed to become her carer, making her sleep on a carpet in the hall at his home. He began taking the woman's benefit money, deprived her of food and liquid and made her sit in the dark for long periods. Together with two friends he forced her to strip, shaved her head, sexually assaulted her and repeatedly stamped on her face and body. They also threw the woman over a fence, handcuffed her to a door and set fire to her clothing.

The police, health and social services had been aware of allegations of abuse dating back to the woman's childhood. These had been investigated and reported to the Procurator Fiscal but she was considered an unreliable witness due to her learning disability.

31 Tameside Adult Safeguarding Partnership, *Executive Summary of the Serious Case Review in respect of Adult A*, p53. Available from: http://www.tameside.gov.uk/socialcare/adultabuse/seriouscasereview

32 This is the term that the individual involved has asked to be used. Her identity is protected under rules giving anonymity to victims of rape.

The response

The woman had been known to police, social work services and the health board from her early childhood. As a subsequent investigation into the case found, 'Over many years, there were events and statements in records held by social work, health services and the police that raised serious concerns about this person's [the primary carer following the mother's death] behaviour toward this woman'.[33] In the period leading up to the 'vulnerable adult's' hospital admission in 2002, the abuse had clearly escalated to extreme levels.

A police investigation into the circumstances of the 'vulnerable adult' was triggered when a neighbour reported his concerns. This coincided with the admission of the 'vulnerable adult' to Borders General Hospital. As the 'vulnerable adult' had experienced disbelief previously at the hands of the police,[34] it was important for the officer leading the investigation to be able to build sufficient trust with her for the investigation to make progress.

During the investigation it emerged that another person with learning disabilities was also experiencing sexual abuse and another was experiencing severe physical neglect within the same network. One had previously disclosed abuse but had been dismissed as unreliable. One had been receiving services from both the Council and Health Board and had suffered severe forms of neglect and abuse over many years. The professionals involved included: social workers, GPs, district nurses, the learning disability specialist team, general hospital services, dieticians and the police.

Prosecution

Numerous allegations over a period of 20 years did not result in criminal proceedings being taken until the intervention of a neighbour resulted in decisive action in 2002. The criminal case against the three men focused on the three month period leading up to the 'vulnerable adult's' hospitalisation. In September 2002, the carer received a sentence of 10 years' imprisonment and the other two men sentences of seven years.

The Offences (Aggravation by Prejudice) (Scotland) Act (2009) was not introduced until some time after this case and so the offences could not have been prosecuted as hate crime.

Review process

There have been a number of investigations and reports in relation to this case, both internal and external. The most significant was a report by the Social

33 Scottish Government, 2004, *Investigations into Scottish Borders Council and NHS Borders Services for People with Learning Disabilities: Joint Statement from the Mental Welfare Commission and the Social Work Services Inspectorate*. Available from: http://www.scotland.gov.uk/Publications/2004/05/19333/36719

34 In part due to having been inaccurately assessed in the past as having only a mild learning disability; officers acting on this assessment therefore took her prevarication as deliberate evasion and a refusal to co-operate.

Work Services Inspectorate (SWSI) which was commissioned by the Minister for Education and Young People into the social work services provided to people with learning disabilities by the Scottish Borders Council, and a parallel investigation by the Mental Welfare Commission into the involvement of health services. The findings of these two investigations included:[35]

- failure to investigate appropriately very serious allegations of abuse
- poor assessment of need and engagement with service users
- unco-ordinated approach to assessment, service provision and monitoring
- lack of information-sharing and multi-agency working
- poor record keeping and poor supervision of frontline staff
- inability and/or unwillingness to confront aggression and staff's consequent collusion with aggressors to the detriment of victims
- lack of senior management and leadership
- no means to resolve disputes between agencies as to appropriate course of action.

The reports were published in 2004 and made recommendations both for the agencies in the Borders area and more widely for the adult protection system in Scotland. This resulted in a number of changes, most significantly the development of the Adult Support and Protection (Scotland) Act 2007, which introduced a rights-based framework to adult protection. A follow-up inspection[36] in the Borders area was published in 2005 and showed that real progress had been made.

Overall the inspection found:

- that agencies were more likely to be aware of abuse of disabled people and take action to stop it
- that people with learning disabilities knew who to contact if they were being abused
- improvements in training, information sharing, record keeping, leadership and management.

The inquiry found a number of ways in which public authorities had improved practice in areas such as governance, information sharing and guidance, notably including:

- Co-operation and multi-agency working which benefited from the creation of a 'Critical Services Oversight Group'.

35 Scottish Government, 2004, *Investigations into Scottish Borders Council and NHS Borders Services for People with Learning Disabilities: Joint Statement from the Mental Welfare Commission and the Social Work Services Inspectorate*. Available from: http://www.scotland.gov.uk/Publications/2004/05/19333/36719

36 Scottish Government, 2005, *"No fears as long as we work together" – Follow Up Joint Inspection of Scottish Borders Council and NHS Borders: Verifying implementation of their action plan for services for people with learning disabilities*. Available from: http://www.scotland.gov.uk/Publications/2005/10/1394351/43512

This brings together the senior leaders of all agencies in the Borders to review progress on protecting vulnerable adults. These authorities are also part of the Edinburgh, Lothian and Borders Executive Group (ELBEG) which again involves the most senior officers and officials providing oversight of arrangements for protecting vulnerable persons. All ELBEG partners have signed up to the group's 'Adult Support and Protection: Ensuring rights and preventing harm' Multi-agency Guidelines, published in January 2010.

- The Director of Social Work working in partnership with the Scottish Government to lead a programme of work on practice governance. This has led to publication of guidance on the role of the chief social work officer and the registered social worker and a framework for practice governance.[37]

Further details of a range of sustained improvements which have been made are covered in Appendix 17.

3. Keith Philpott

What happened

In March 2005, Keith Philpott, a 36-year-old man with learning disabilities, was found dead at his home by the police. Keith lived on his own at Billingham, Stockton-on-Tees, but was in daily contact with his family who lived nearby and provided support. They had alerted the police when Keith did not arrive for dinner as expected.

Keith was murdered at some time on the 23 or 24 March 2005. He had been tied and gagged and repeatedly beaten around the body and head. He had been stabbed or slashed with a knife so severely that he was disembowelled. The post-mortem report found a considerable amount of blood in the cavity of Keith's abdomen, indicating that he was alive when the stomach injuries were inflicted.

Two men, Sean Swindon and Michael Peart, were subsequently convicted of his murder. The background to the murder became clear through the admissions the men made when questioned. They linked it to disapproval of Keith's relationship with Sean Swindon's sister Gemma Swindon, as discussed below.

The response

Keith was not known to social services or other council services. He was registered with a GP and attended infrequently. He was not on a GP learning disability register. His contact with public authorities in relation to harassment was with the police.

In July 2004, eight months before he was murdered, Keith told the police that members of the Swindon family had threatened him and that he was scared to go out for fear of being attacked by Sean Swindon. Gemma Swindon was friendly with Keith and regularly visited his home with one of her friends. She had known Keith for six years, since she was 13 years old. Her family thought the relationship between she and Keith had become sexual and disapproved, allegedly because of the disparity in age. (Keith's family have said

37 See http://scotland.gov.uk/Publications/2011/03/14093805/0

that the relationship was never sexual and police officers investigating the murder concluded that it had not been a sexual relationship.) Keith's family was also concerned about his relationship with Gemma but for different reasons – they believed she was taking advantage of him including running up his phone bills.

The police spoke to the Swindons and cautioned them about their future behaviour. No arrests were made. The police also advised Keith to stay away from Gemma. Keith did not have the support of an appropriate adult when he was interviewed, even though the police had considered this to be necessary when he reported an unrelated assault to them nine months earlier.

Gemma continued to visit Keith in the months following the July 2004 threats. Closer to the time of the murder, she allegedly sent him threatening text messages.[38] There are claims that Keith sent her sexually suggestive texts but the police found no evidence of a sexual relationship. The police were not aware of these texts until after the murder. It is not clear that the police gave Keith advice about reporting any further threats to them when they spoke to him in July 2004. The police do not appear to have been aware that Keith was (falsely) accused of having an inappropriate sexual relationship with a young woman.

On the night of the murder, Sean Swindon and his friend Michael Peart went to Keith's house. Sean Swindon warned Keith to stay away from his sister. According to Peart, Keith refused to stop seeing Gemma. He was tied up and tortured for around three hours. Swindon then stabbed him in the stomach and (according to Peart) 'started cutting him until his insides came out'.

Prosecution

Both men admitted murder. Both received life sentences, with Swindon having to serve a minimum of 20 years and Peart 15. These sentences were later appealed by the Attorney General, Lord Goldsmith, who felt that the sentences were 'unduly lenient'. The Court of Appeal increased them to 28 years and 22 years respectively.

The murder was not prosecuted as disability hate crime. Sean Price, Chief Constable of Cleveland Police, explained this: 'It was very clear from our investigation that this was not hate crime. We would not define it as hate crime.'

Disability was not included in Cleveland Constabulary Hate Crime Policy until 2006, despite the introduction of legislation three years earlier which put the onus on the police to investigate whether a crime is linked to hostility to disability and, if so, gather evidence to support an enhanced sentence (see Appendix 8 for more information on section 146 of the Criminal Justice Act 2003).

38 One of the witnesses during the murder investigation told the police that he had seen a text message allegedly sent by Gemma to Keith which read 'You perv', 'we are going to break your legs', 'watch your back', 'watch your flat', and 'what was that?'.

Figures supplied to the inquiry by Cleveland police, suggest that they recorded 34 disability hate crimes/ incidents in 2009.[39] Nine of these were recorded and investigated as crimes. Cleveland police also provided the inquiry with details of a number of disability-related harassment incidents that they had recorded in 2010. They are undertaking a number of initiatives to improve both reporting and recognition of disability-related harassment.

Prior to the threats made by the Swindon family to Keith in July 2004, he had made three reports to the police in the period between April and October 2003:

- on 12 April 2003, unidentified youths had 'banged' on his door and had shouted abuse
- on 30 August 2003, he reported criminal damage to a window, but he did not see who did it
- on 5 October 2003, he reported having been assaulted by a man called Geoff which resulted in a minor eye injury.

None of the incidents reported by Keith in 2003 or the threats against him in 2004 were recorded as motivated by hostility to disability. No-one was prosecuted.

At the inquiry hearing we explored the police's reasoning for not treating Keith's murder as motivated, at least in part, by hostility to disability. For a sentence enhancement under section 146 to be applied to an offence against a disabled person, the Crown Prosecution Service has to prove evidence of hostility not hatred. Crown Prosecution Service guidance advises that 'in the absence of a precise legal definition of hostility, consideration should be given to ordinary dictionary definitions, which include ill-will, ill-feeling, spite, contempt, prejudice, unfriendliness, antagonism, resentment, and dislike'.[40] Hostility is not always explicit. It does not need to be the sole motivation and can be present alongside other factors.

At the start of our inquiry hearing, the police said that they considered the motivation for the attack to be Sean Swindon's concerns about the nature of the relationship between his sister and Keith. The police told us that they and the CPS did consider whether the case should be pursued as one to which a sentence uplift may be applied. However, Sean Price, Chief Constable of Cleveland Police, subsequently acknowledged in the inquiry hearing that: 'we may have had a number of feelings... but what we didn't have was evidence that suggested disability had been a factor'.

According to Price, the police were also aware that 'some people in the area thought there might have been a

39 See http://www.acpo.police.uk/asp/policies/Data/084a_Recorded_Hate_Crime_-_January_to_December_2009.pdf

40 Crown Prosecution Service, 2010, *Disability Hate Crime – Guidance on the distinction between vulnerability and hostility in the context of crimes committed against disabled people*. Available from: http://www.cps.gov.uk/legal/d_to_g/disability_hate_crime_/#a04

paedophile ring being involved with a very limited number of members. Absolutely no evidence for that at all, but those sort of rumours can resound in a community.' Although no concerns were raised about the nature of Gemma's relationship with Keith until she was an adult, the application of the label 'paedophile' to Keith was used to dehumanise him. According to Price: 'putting a label of paedophile on certain sections of the community almost means anything goes'.

There is evidence that the victims of at least two other murders considered by this inquiry (Steven Hoskin and Michael Gilbert) were labelled as 'paedophiles' by the perpetrators. Both cases involved extreme violence and degrading treatment of the victims. 'Paedo' was also used as a term of abuse against David Askew on at least one occasion.

Although most sexual abuse of children is carried out by adults that they know, often within their family or friendship network, the popular stereotype of a 'paedophile' suggests that they are very different to other members of society. It may be that perceptions of both disabled people and 'paedophiles' as 'different', leads to disabled people being falsely labelled as sexual offenders.

It also seems that some people in the community may maliciously accuse a disabled person of being a 'paedophile' to excuse their hostility to them and justify violence. There is a need for further research on the perpetrators of disability harassment, their motivations and offending patterns. This issue could be usefully explored in that context.

While it is not the only possible motivation, the extreme level of violence used in Keith's murder is also potentially suggestive of hostility to disability being part of the motivation. As Sir Ken MacDonald, former Director of Public Prosecutions, has said: 'Some exceptionally grave cases have shown disabled people treated like animals… Each case looked at in isolation may seem like senseless and unprovoked violence… It seems to me that when we're examining these cases, we must ask a simple and obvious question: If the victim were not disabled would they have been subjected to this sort of treatment?'[41]

Review process

No serious case review was conducted in this case. Agencies involved did re-examine the case at a day conference held in 2008 in the wake of the death of Brent Martin and the publication of the serious case review into the death of Steven Hoskin.

41 Speech to Bar Council and the Equality and Diversity Forum 06/10/08.

4. Shaowei He

What happened

Shaowei He's body was found in the yard at the back of the Kings Chef Chinese takeaway in Rotherham on the morning of 23 March 2006. The ambulance service had been called by her husband Lun Xi Tan who said there was a body in the garden. When they arrived, the ambulance service staff found that rigor mortis had already set in. They also found Su Hua Liu, Tan's pregnant girlfriend, upstairs with a superficial and self-inflicted knife wound to her wrist.

Shaowei He was around 25-years-old at the time of her death. Acquaintances described her as 'childlike'. From the evidence of those who knew her, she appears to have had a learning difficulty although the level of her impairment was never formally assessed. She came to this country from China in March 2005 having been given leave to enter the UK as Tan's spouse in January 2005.

A post-mortem established that Shaowei He had extensive bruising all over her body; old knife wounds to her hands which were probably defensive injuries; and a deep stab wound to her right elbow which had clearly never received medical attention and showed signs of infection. Police found evidence that she was being made to sleep in an outside store. They also found copper piping, a broken broom and a piece of wood with nails embedded into it which had all been used to beat Shaowei He. According to the police case summary, 'her injuries can only be described as horrific and clearly this woman had been tortured'. The cause of death was haemorrhage and shock due to multiple blunt traumas.

Lun Xi Tan pleaded guilty to causing or allowing the death of a vulnerable adult and was sentenced to six years. Su Hua Liu was charged with murder but pleaded guilty to manslaughter and grievous bodily harm. She was sentenced to 14 years.

The response

Shaowei He had limited contact with public authorities following her arrival from China on 21 February 2006. Two environmental health officers paid a routine visit to the takeaway and noticed that Shaowei He had burns on her hands and a badly bruised eye. The injuries were 'severe enough that both discussed the matter after they left the premises' but did not raise the matter with anyone. This suggests that they lacked a clear understanding of what action they could or should take, for example making a safeguarding referral.

Lun Xi Tan's former wife, who left him in April 2005, said that that he had been violent towards her from time to time. She had met Shaowei He at the takeaway but was not allowed to speak to her other than to show her how to help in the kitchen. On the day she moved out, the girlfriend Su Hua Liu moved in.

Other employees at the takeaway said that on her arrival in the UK Shaowei He had been happy and had taken pride in her appearance. However, from February 2006 onwards they began to notice bruising and other injuries. Her hands and face were swollen (probably as a result of bleeding into the tissue). On one occasion

she had her head wrapped in a tea towel and was bleeding but her husband said that she had fallen over and hit her head on the toilet. Employees raised concerns with her husband on a number of occasions but did not contact the police or social services.

Following Shaowei He's death, a number of neighbours also reported that they had witnessed her being treated badly and having black eyes and other injuries.

Prosecution

When arrested, Lun Xi Tan claimed that he had married Shaowei He in China but that when they arrived in England she said she wanted a divorce. He said it had cost him £10,000 to bring Shaowei He to England and she agreed to work for two years with no wages to pay him back. He said that his girlfriend, Su Hua Liu, was the aggressor and when asked why he hadn't intervened to stop severe beatings which he'd witnessed, he said that she had a crazy temper and that he didn't want to physically intervene because he didn't want to harm his unborn child.

When Su Hua Liu was interviewed she confirmed hitting Shaowei He on a number of occasions with various implements. She claims that she only did so after Shaowei He had hit her in the stomach after finding out about her pregnancy. However the midwives and doctors treating Su Hua Liu during her pregnancy said that she had made no reference to being assaulted until after she was arrested in connection with Shaowei He's death.

Su Hua Liu was charged with murder but pleaded guilty to manslaughter and also guilty to a charge of inflicting grievous bodily harm. She was sentenced to nine years for manslaughter and a concurrent five years for Grievous Bodily Harm. Lun Xi Tan pleaded guilty to causing or allowing the death of a vulnerable person (an offence created by the Domestic Violence, Crime and Victims Act 2004). A 'not guilty' verdict was entered against the charge of manslaughter against Lun Xi Tan on the direction of the judge. He was sentenced to six years.

They appealed against the sentences. The Court of Appeal said the applications to appeal 'lack any scintilla of merit and are refused'. The Court of Appeal judgment said the sentences were 'richly deserved' and 'the facts of the case must turn the stomach of any humane person'. The case was not prosecuted as a disability hate crime.

There has been a general lack of recognition and recording of disability-related harassment by South Yorkshire police. In 2009, only four disability-related hate crimes were recorded by South Yorkshire police. The Chief constable, Meredydd Hughes, acknowledged that many incidents could be going unrecorded. He said that disability-related crime had traditionally not been considered a priority, although this was beginning to change: 'within the police in South Yorkshire, the single biggest diversity issue is about racially motivated crime. Against that, disability-related crime is virtually invisible.'

Review process

No serious case review was undertaken in this case so the agencies involved did not take the opportunity to identify what lessons could be learned from Shaowei He's death.

5. Christopher Foulkes

What happened

On 8 March 2007, Christopher Foulkes was found dead in his flat in Rhyl, Wales, by his care worker. He was lying on the floor on a blanket with blood around him. The flat was not as it had been when the care worker had left the previous day. Paperwork was strewn around, the commode was out of position and the door from the kitchen to the back yard was open. The police initially thought Christopher had fallen and assessed the death as non-suspicious.

Christopher was 39 and had a physical impairment, using a Zimmer frame or wheelchair to get around, and a mental health issue. Carers attended his flat three times a day.

It later emerged that Christopher had died following an assault by X,[42] a 15-year-old boy who he had previously accused of stealing from him. On the night of 7 March 2007, X broke into Christopher's flat, beat him about the head and body and stole various items including a mobile phone, £9 in loose change, a carton of apple juice and an A4 folder containing Christopher's record of achievement. Between 10pm and 10.05pm, Christopher's upstairs neighbour heard two loud bangs from the flat followed by the sound of someone laughing and then the back gate slamming.

X was originally charged with murder, but the charge was reduced as the medical evidence was inconclusive as to the cause of Christopher's death. He pleaded guilty to wounding with intent.

The response

Christopher had been in contact with the council's social services department for several years as a result of his long history of drug and alcohol abuse. On a number of occasions he was offered a residential placement which he chose not to accept. He was identified in August 2006 as being at risk of self-neglect; at risk due to physical impairment and at risk of falls. He was considered to have mental capacity and so a referral to the protection of vulnerable adults' team was considered to be inappropriate.

X had been visiting Christopher for some months, helping him around the flat and running errands for him in return for payment. Social care agencies had been aware of these visits since at least November 2006 and had been informed by Christopher that the boy was Christopher's son. They knew that X was buying alcohol on Christopher's behalf.

Christopher began to suspect X of stealing from him and told a friend he didn't want him at his home. In December 2006 he

42 He cannot be named for legal reasons, and will be referred to as X throughout this chapter.

reported his concerns to social care saying he was 'almost positive' that the boy had stolen £140 from his pocket. A risk assessment completed on 28 December 2006 noted that X might be at risk of 'physical abuse' as a consequence of the alleged thefts (which were termed financial exploitation). The potential risk X posed to Christopher does not appear to have been considered. It appears that the risks around Christopher's ongoing health issues crowded out proper consideration of other risks.

Further incidents of theft and break-ins were reported by Christopher to social care in February 2007, indicating X as the perpetrator. He also complained that X had been having sex in the flat with a girlfriend. Christopher told X to stop visiting. A social care worker was present when X tried to smash in Christopher's door after he was refused entry to the flat.

At no point did social care agencies make a referral to Children's Services. As a result they remained unaware of X's extensive involvement with Children's Services and his history of theft and violence. He had two previous convictions: for actual bodily harm of a 'friend' and for burglary of a school. He was permanently excluded from school for violent behaviour and assault on a member of staff. Children's Services had closed the teenager's case in December 2005 and were unaware of the escalating allegations of criminal behaviour against him. Children's Services acknowledge that had the full circumstances been known by them he clearly should have been an open case.

The police were called following the attempted forced entry and as a result of some of the thefts. Some incidents were 'no-crimed' and another person was identified as a potential suspect in others. Ian Shannon, Deputy Chief Constable of North Wales Police, told us that X 'wasn't on our radar at all' in relation to Christopher, not having been identified to the police as a suspect for the thefts. There was an acknowledgement from the police that Christopher was disbelieved on at least one occasion and that there were residual cultural issues among some staff who, according to Shannon, considered some groups (based on lifestyle rather than whether the person is disabled) 'of not being worthy of the same level of service as some other groups'. (Ian Shannon, Deputy Chief Constable of North Wales Police). The Deputy Chief Constable also said that North Wales Police have a cultural change programme to seek to address these attitudes and that on a number of indicators they were moving in the right direction.

In conclusion, there was a great deal of contact between Christopher and various health and social care agencies. Social care workers were aware that the teenager was visiting Christopher and that he might be stealing from him. While there is evidence of multi-agency working in relation to his health and social care needs, there was no link up with Children's Services. The risk that X posed to Christopher was never assessed. Communication between social care and the police was limited and intelligence about earlier allegations of theft from Christopher by X were not shared.

Prosecution

None of the thefts or break-ins in the six months prior to Christopher's

death resulted in anyone being cautioned or prosecuted.

The police attended Christopher's flat after the care worker found him dead. They assessed the death as non-suspicious in spite of the blood, open back door and disarray. They only launched a murder investigation six days later after a witness contacted them. It is possible that without this fresh evidence, the death would have remained categorised as 'non-suspicious' and X would not have been prosecuted.

When arrested, X denied the assault. He was initially charged with murder but this charge was dropped as the forensic evidence was inconclusive as to whether it was the assault or other factors which had been the direct cause of death. X was convicted of Actual Bodily Harm. The charge of Grievous Bodily Harm with intent was left on the file. He was sentenced to an 18 months training and detention order. He has already been released.

The assault was not prosecuted as a disability hate crime. According to Sian Beck, detective inspector for North Wales Police, the police considered the motivation to be 'the need for money'. As discussed in relation to Keith Philpott, hostility to disability need not be the sole motivation for sentence uplift to be applied. The police should have considered whether there was also evidence of hostility to disability.

Review process

A serious incident investigation was carried out in September 2007 and included contributions from Denbighshire County Council, mental health liaison, North Wales Police and the risk co-ordinator from Conwy & Denbighshire NHS Trust. It considered contact with both the victim and the perpetrator. Key findings included that:

- staff considered the risk of self-harm to be the greater risk in the case
- there were examples of good practice in Christopher's care such as close working between some of the agencies
- links between adult and children's services needed to be improved.

In evidence to the inquiry hearing, Denbighshire County Council told us about a number of steps taken to address these issues including training for adult services staff on assessment systems within children's services.

6. Colin Greenwood

What happened

On Friday 13 April 2007, Colin Greenwood was assaulted by two teenagers – Lewis Barlow, 14, and Leon Gray, 15 – on the way from his partner's home to the nearby tram stop. Colin lived in another part of Sheffield but was a regular visitor to his partner, with whom he had four children. He was a 45-year-old partially-sighted man who was frequently taunted on the estate because of his alcoholism. On this occasion, the teenagers punched him, pulled him to the ground and kicked and stamped on him so that his head bounced off the concrete. The assault lasted between four and five minutes.

Colin subsequently got up but staggered and fell, hitting his head on the ground. Witnesses offered him help but he refused to get an ambulance. He made it to the tram but collapsed later that evening and was taken to hospital where he died early the next morning. His death was due to a head injury which could have occurred by the head being struck a blow or blows, or when he fell to the ground.

Both the assailants had verbally abused Colin on numerous occasions and Barlow had targeted his partner's house for other antisocial behaviour including throwing a dirty nappy at their window.

Colin had stopped carrying a white cane as he had been attacked before and he felt the cane drew attention to his disability, making him a greater target for harassment.

Witnesses reported that prior to the assault Colin had been confronted by Barlow, who had threatened to stab him. Colin kicked out at him, which may have triggered the later assault. After the assault, the perpetrators were heard boasting about beating up 'Colin the drunk'.

Both Barlow and Gray were initially found guilty of murder but this was quashed on appeal and they pleaded guilty to manslaughter.

The response

The Greenwoods had been in close contact with a number of different public agencies. Colin was in touch with health services in relation to his deteriorating eyesight and his alcoholism was well known. Lee Adams, deputy chief executive of Sheffield City Council, highlighted that Colin's partner had made several complaints about being harassed at home but had not related this to disability. 'They seemed to feel it was related to the alcoholism and other discriminatory issues… so it was a very complex situation.'

According to the chief constable of South Yorkshire Police, Meredydd Hughes, Colin was 'very well known to his local policeman' and had reported 15 crimes against him over a 10 year period. He also had a criminal record himself.

His assailants had come to the attention of the police for committing antisocial behaviour but it was not considered serious enough to warrant specific attention.

Prosecution

Both the perpetrators were heard boasting of their attack on Colin before their arrest. They were found guilty of murder in September 2007 and jailed for at least 12-and-a-half years for Colin's murder. The case was not prosecuted as a disability hate crime although the perpetrators had told friends they expected to get long sentences for the attack. The police believed that Colin's alcoholism, rather than his visual impairment, was the key motivation for the assault. The judge described them as 'out of control, amoral and prepared to use gratuitous and mindless violence on vulnerable people'.

Their convictions were subsequently quashed at the Court of Appeal. They admitted manslaughter and were jailed for four years each and released after two.

Review process

No serious case review was carried out.

7. Steven Hoskin

What happened

In July 2006, Steven Hoskin was found dead at the bottom of a 100-foot railway viaduct in St Austell, Cornwall. He had been tortured for hours before his death, suffering various injuries inflicted upon him by a number of perpetrators. He had been tied up, dragged round by a lead, imprisoned, burnt with cigarettes, humiliated and repeatedly violently abused in his own home over a period of time. He had been forced to make a false confession that he was a paedophile and coerced into taking a lethal dose of paracetamol tablets. Finally he was taken to the viaduct and forced over the railings before one of the perpetrators stamped on his fingers until he let go.

Steven was a 38-year-old man with learning disabilities. His murder was the culmination of ongoing abuse. Five people were involved on the night of his death. The ringleader was Darren Stewart, 29, who had moved into Steven's flat along with his girlfriend. The other perpetrators were Martin Pollard, 21, Stewart's girlfriend Sarah Bullock, 16, and two male teenagers, who cannot be named for legal reasons. The two male teenagers took part in the torture and humiliation of Steven but left before he was forced to take the tablets and taken to the viaduct.

Stewart and his girlfriend were convicted of murder; Pollard of manslaughter; the teenage boys of false imprisonment and assault.

The response

Steven's death followed a series of abusive incidents occurring over a period of months that a number of agencies, including police, health services, housing and social services, had been alerted to at some stage. Opportunities to intervene to halt the abuse were missed.

Steven had been identified as having learning disabilities as a child and numerous agencies and organisations came into contact with him throughout his lifetime. He attended an NHS Assessment and Treatment Unit for persons with learning disabilities and mental health issues. He was assessed by Adult Social Care as having 'substantial need' and allotted weekly visits. Social services did not conduct a risk assessment when agreeing to stop these weekly visits at Steven's request, after he was befriended by Stewart.

Various healthcare visits, including an emergency ambulance call after Steven had been assaulted, were not reported to the police or adult protection. Once the Adult Care support ceased, Steven contacted the police on a number of occasions, without ongoing follow up taking place. There were numerous 999 calls to the property but these were treated as individual events and not linked.

His greatly increased contact with police and health services in the period following the cessation of weekly visits did not trigger a safeguarding referral.

Steven's landlord, Ocean Housing Group, was aware that he was a 'vulnerable adult', that young people were always hanging around his bedsit and that he had a lodger who was 'dangerous' and officials should not visit the accommodation alone. They did not intervene to address why Steven became the subject of frequent neighbour complaints after Stewart moved in with him or contact adult protection to alert them to their concerns.

Stewart had serious ongoing mental health issues and was in contact with a number of agencies as a result. He was recognised as 'dangerous' by both Ocean Housing and the ambulance service, who would not visit the property unaccompanied. Agencies did not consider how Stewart's presence in the flat impacted on Steven's freedom to make choices.

Agencies failed to record what was happening properly, to share information and undertake proper risk assessment. Co-ordinated action and an effective flagging up system could have prevented the abuse and subsequent events leading to Steven's death. His murder raised serious questions regarding multi-agency actions concerning both Steven and the perpetrators of the crimes.

Prosecution

Five people were prosecuted for their part in Steven's death. Stewart was jailed for life with a minimum term of 25 years. Bullock was also convicted of murder and sentenced to a minimum term of 10 years. Pollard was convicted of the lesser charge of manslaughter and jailed for eight years. Two male teenagers were convicted of false imprisonment and assault occasioning actual bodily harm.

The case was not prosecuted as disability hate crime. The combination of 'paedophile' labelling and extreme violence are suggestive of disability hate crime, as explained in more detail in the Keith Philpott case. The 'paedophile' labelling seems to have been used to justify the perpetrators inhumane treatment of Steven. There is no evidence that there was any basis for their accusation, but as the serious case review noted: 'A rumour-dynamic of this order is impossible to suppress and, as the final hours of Steven's life testify, it had chilling consequences.'

Review process

Cornwall Safeguarding Adults Board commissioned an independent serious case review[43] of the events leading up to Steven Hoskin's death which addressed agency contact with both Steven and the perpetrators. Agencies in Cornwall have shown considerable commitment to learning from their mistakes and have taken time and effort to make improvements.

A follow-up review a year after the serious case review found that 'the progress in Cornwall is considerable and goes far

43 Flynn, 2007, for Cornwall Adult Protection Committee, *The Murder of Steven Hoskin: A Serious Case Review*. Available from: http://www.cornwall.gov.uk/Default.aspx?page=5609

beyond minimalist adjustment'.[44] Actions from the serious case review had been implemented, and improvements included:

- better information sharing
- a more proactive approach to safeguarding across agencies
- better systems for flagging concerns and triggering referrals
- better risk assessment processes and training
- effective leadership
- a spirit of collaboration between agencies.

The police have established a 'neighbourhood harm reduction' process. Systems are in place to identify addresses of persons at risk and reason for contact, and this is being monitored.

We took evidence from both Margaret Flynn, the independent chair of the Steven Hoskin serious case review and separately from the key agencies in Cornwall.
It was clear that the commitment to implementing a proactive approach to safeguarding was still strong and that all agencies have made significant efforts to continue improving their responses to disability-related harassment including:

- further work to develop and refine the triggers protocol
- greater emphasis on training all staff who may have contact with members of the public in how to recognise and refer safeguarding issues
- risk matrix to assist in assessment
- better engagement around sub-criminal as well as criminal matters
- strong relationships with Cornwall People First (a learning disability organisation)
- joining up safeguarding, human rights, equality and diversity training
- a greater focus on entitlement to safety and independence, not just protection
- clear engagement with the complexities of balancing safeguarding and independence
- neighbourhood harm reduction register for the police working with other agencies.

Much of the learning in Cornwall is applicable to other areas across Britain, but is not necessarily being applied. Flynn told us that there are currently no mechanisms for effectively sharing lessons. She said: 'Hand on heart, I couldn't say that the lessons have been abstracted for other localities. If anything, I think the typical response is "thank God it didn't happen here".'

8. Laura Milne

What happened

On 12 December 2007 Laura Milne, a young woman with learning disabilities, was at a flat in Aberdeen with three people, Stuart Jack, Debbie Buchan and

44 Flynn, 2009, for Cornwall Safeguarding Adults Board, *The successes achieved and barriers encountered in delivering the Steven Hoskin Serious Case Review action plans*, p16. Available from: http://www.cornwall.gov.uk/Default.aspx?page=5609

Leigh Mackinnon. Buchan had previously bullied Laura when they were at school together. She had also been present on another occasion in 2006 when Laura had been assaulted with a golf club.

That night all four had been drinking alcohol when an argument ensued. Laura was punched, kicked and stamped on and forced to drink a glass of urine. Mackinnon and Buchan are said to have demanded that Jack 'Finish her off'. Jack repeatedly slashed Laura's throat with a kitchen knife. He later said that he enjoyed cutting her throat and that he had murdered her because she was 'worthless'.

On 16 December Jack and Buchan returned to the flat and attempted unsuccessfully to dismember Laura's body by hacking at her neck and legs. They then hid her body in a cupboard beneath the kitchen sink. The following day Laura was reported as a missing person to Grampian Police by staff at the Stopover project, where she lived. Her body was found at the flat two days later.

The response

Laura lived an unsettled life, drinking heavily and living at various supported accommodation projects. She had few long-term friends.

Laura had a long history of contact with the police and criminal justice system, much of it related to her heavy drinking and misuse of the 999 number. Laura was charged by the police for misuse of 999. They also completed an 'adult at risk' (OPS 12/1) form following her silent 999 calls and forwarded it to social services. Aberdeen City Council could not confirm whether that form was received or whether any action was taken as a result.

At the time of her murder, Laura was subject to a three year probation order. She had a criminal justice social worker who tried to keep contact weekly due to Laura's high level of need, but her attendance was erratic. Laura also had a social worker, but Aberdeenshire Council social services closed her case in November 2007 due to 'lack of engagement'.

Two of the three perpetrators also had contact with the police and social services. Buchan was subject to a probation order at the time of Laura's murder. She had a social worker, who was concerned that Buchan was at risk of harm. MacKinnon was also subject to court orders and family therapy had been recommended.

Prosecution

All three people involved in Laura's murder were convicted. Jack admitted murder and was sentenced to 18 years. Buchan and Mackinnon admitted attempted murder and were sentenced to nine years and nine years and four months respectively.

The Offences (Aggravation by Prejudice) (Scotland) Act (2009) was not introduced until some time after this case and so the offences could not have been prosecuted as hate crime. At the hearing we discussed whether Laura's murder would now be recognised as a disability hate crime. Fred McBride, director of social care and wellbeing at Aberdeen City Council, said: 'There is some debate as to whether Stuart Jack, who made some derogatory comments about Laura… whether he saw

her as worthless because she had some level of disability... only he knows that, I suppose.'[45]

Review process

No formal review of Laura's death was conducted by the agencies involved.

Laura's death took place just over a year after a very serious sexual and physical assault in similar circumstances in the same area on another young woman with learning difficulties. Although the young woman survived the attack, she was permanently disfigured.

A review was conducted in the earlier case. The perpetrators were all known to criminal justice services and all were subject to social work input at the time of the offence. The review was undertaken in the months leading up to Laura's death and was published just two days after Laura's murder, before her body had been found. It made recommendations about how to handle those within the criminal justice system who also had needs of a social or medical nature. However the review seems to have been conducted on a single agency (social services) rather than multi-agency basis. As a result, other agencies were not engaged in considering how to protect other young women with learning disabilities at risk of harm. When agencies were asked about it at an inquiry hearing, only social services were aware of the report or the case.

Agencies suggested that their response to the risks faced by someone like Laura would be much better now as a result of the Adult Support and Protection (Scotland) Act (2007), which was passed by the Scottish Government in February 2007 but not implemented until October 2008. For example, the police have better procedures for informing the council when an adult at risk comes to their attention and the council maintain a 'vulnerable persons' database. Adult support and protection plans are put in place for adults at risk of harm.

9. Michael Gilbert

What happened

On 10 May 2009, Michael Gilbert's headless, dismembered body was found in the Blue Lagoon at Arlesey, near Luton. He was 26 years old and there is evidence that he had an undiagnosed mental health issue.

Almost a year later, in April 2010, six people were jailed for involvement in his murder – three of murder and three of familial homicide. The ringleader was James Watt, who had met Michael when they were both in care as teenagers.

Michael had lived with the Watt family for much of the seven years prior to his murder. He was kept as a domestic slave and tortured over much of that period. He was beaten on many occasions, punched and stamped on, stabbed with a knife, shot with an air pellet gun and had snooker balls dropped on his testicles. In the weeks before his death a piece of wood was put in his mouth on which James Watt would do push ups and his stomach was repeatedly jumped on.

45 Inquiry hearings, 22/02/11.

Michael attempted to escape the Watt family on a number of occasions, trying to find safety both within Luton and further afield in Norfolk, Cambridge and Lancashire. On each occasion he was tracked down by the Watt family, taken back to their home and beaten. A number of these abductions were reported to the police but none of them resulted in effective action to protect Michael.

The response

Some information is taken from the serious case review, other information is extracted from confidential sources.

Michael met James Watt when he was 14, while they were both in care in a children's home. Michael's early years had been characterised by instability. He came into care following an allegation that he had sexually abused a young boy. After meeting James Watt, he became involved in petty crime. On leaving care his life was unsettled and he had periods of homelessness.

Michael first went to live with the Watt family in 2001 after a period sleeping rough. Within months he was experiencing violence at their hands. As early as October 2001, more than seven years before he was murdered, Michael told Luton social services that he wanted protection after a dispute with James Watt and Watt's mother. This was one of many missed opportunities to help him find safety away from the Watts.

In January 2002, Michael's family told Bedfordshire Police that he had been abducted and seriously assaulted by the Watt family. There was considerable delay in conducting an investigation into the allegations. Basic intelligence checks that would have supported Michael's account were not done. Michael was regarded as blatantly lying, in order to try and cause others considerable inconvenience. Michael's physical height and build compared to that of his alleged kidnappers were thought to make the scenario he stated had happened farcical.

The incidents were subsequently no-crimed (i.e. the police decided that no crime had occurred) on the basis that Michael had 'a very long history of making false, malicious complaints about his family… it is clear that this is also a false allegation and therefore should be reported as a no crime'. The history of false allegations was, in fact, a case of mistaken identity and related to a different Michael Gilbert, who was a different age and ethnicity and from a different area. There was also misinformation from health and social care services.

The pattern of Michael escaping the Watt family but being hunted down and brought back recurred over the following six years. On a number of occasions, the Watt family contacted the Department for Work and Pensions and quoted Michael's national insurance number to discover where he was signing on before snatching him back. The police were made aware of several of these abductions but either did not believe the accounts of violence and abduction reported by Michael and his family or decided that Michael was free to make his own decisions without considering the duress he was living under. As with the first reported abduction, there was often a delay in properly investigating a number

of the abductions and assaults reported to the police.

Following one abduction, from Cambridge, Michael was arrested in connection with a separate offence in a shopping centre in Luton in the company of James Watt. He was interviewed in the presence of an appropriate adult, a legal protection that must be made available to 'young people under the age of 17 and adults who are mentally vulnerable'.[46] After the police had satisfied themselves that Michael was not a suspect in the offence they were investigating, they asked him about the abduction. He confirmed that he had been taken against his will from outside the job centre in Cambridge by James Watt and two women (the three people subsequently convicted of his murder). He had been driven back to a house in Luton, where he had been assaulted. He refused to make a complaint saying: 'it will only make it worse for me in the long run. I just wish to return to Cambridge without fear of them following. I do not wish anymore to do with them. At the moment I will not support a police prosecution and will refuse to attend court.'

While Michael was being interviewed, James Watt and others were waiting for him outside the police station. The police arranged a rail warrant for Michael to return to Cambridge and took him to the railway station via the back entrance to avoid the Watt family. Michael moved to Blackburn later in 2007. On 28 January 2008, while on his way to sign on, he was again taken away in a car by the Watt family. This was the last time he would escape.

Towards the end of 2008 the violence intensified. On 12 January 2009 a 999 call was made using Richard Watt's mobile phone. It appears that Michael made this call, giving the false name of Aaron and claiming his younger brother was being threatened. The police attended at the house but there is no record of what action they took. They were called back to the address soon after regarding another matter not involving Michael but did not see him. This incident was 10 days before his death.

Four days later, on Friday 16 January 2009, Michael was seen badly injured when signing on at Luton Job Centre. The clerk noticed that he was 'not moving freely and didn't look right' and had 'a myriad of cuts and bruises and grazes around his face'. The clerk asked about the injuries and Michael replied that he'd been in a fight. He declined the clerk's offer of medical assistance.

Assaults continued over the next few days including jumping on Michael's stomach. Afterwards Michael, in extreme pain, lost control of his bowels and was barely able to walk. He died soon afterwards, between 21 and 22 January 2009.

James Watt, the ringleader of the abuse, had 14 previous convictions for 22 different offences. There were also a number of unprosecuted allegations of violent sexual assaults on teenage girls and physical assaults on members of his family including: his disabled uncle (with the first assault being reported to police in 1997), his mother (who he was alleged to have threatened with a knife), and his brothers.

46 Website, National Appropriate Adult Network, www.appropriateadult.org.uk

Opportunities for agencies to intervene to protect Michael were not taken. Evidence given at the inquiry hearing suggested this was at least in part because agencies did not consider that he met the definition of a 'vulnerable person' within the terms of the No Secrets[47] guidance. Michael was not considered to be disabled, even though he had sought medical help for anxiety, depression and auditory hallucinations suggesting that he had a mental health issue. He was also interviewed by the police with an appropriate adult on a number of occasions. The absence of a formal medical diagnosis of his mental health issue appears to have led to agencies not regarding him as disabled. As a result, he was not referred to adult safeguarding and agencies did not share information so the wider picture of the risk that he faced was not considered.

In evidence to the inquiry, the independent chair of Luton Safeguarding Adults Board, Professor Michael Preston-Shoot, said there were problems with the definition of a vulnerable adult, and that agencies did not intervene to protect Michael because it was not clear that he met the criteria: 'even on those occasions where it was obvious to individuals that he had a degree of vulnerability it was by no means obvious that he was not a competent, autonomous, self-determining, decision-making adult'. Michael's fear of the Watt family and the impact of coercion on his decision-making do not appear to have been taken into account.

We believe there was scope for agencies to act, not only under the terms of No Secrets but also having regard to their positive obligations as public authorities under the Human Rights Act 1998 to protect the rights to life and to freedom from torture and inhuman or degrading treatment or punishment.

Prosecution

None of the assaults or abductions of Michael Gilbert that were reported to the police prior to his death resulted in anyone being charged or prosecuted.

Six people were jailed for involvement in his murder. James Watt was convicted of murder and sentenced to life with a minimum term of 36 years. His girlfriend Natasha Oldfield and his brother's girlfriend Nichola Roberts were also convicted of murder and given minimum terms of 18 years and 15 years respectively. An appeal against their sentences was rejected.

James Watt's mother Jennifer Smith Dennis and brother Robert were convicted of familial homicide, an offence that only applies to the death of a child or

47 No Secrets is the policy framework for adult protection in England and Wales. It defines a vulnerable adult as someone over the age of 18 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. Department of Health, 2000, *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

'vulnerable adult', and sentenced to 10 and eight years respectively. James Watt's brother Richard Watt pleaded guilty to familial homicide. He was sentenced to six years, reduced to four on appeal.

Although the case was not prosecuted as a disability hate crime, three people were convicted of familial homicide, an offence which only applies to the death of a child or vulnerable adult.[48]

Review process

Luton safeguarding vulnerable adults board conducted a serious case review into Michael's death.[49] The terms of reference focused on Michael although his contact with James Watt's family was also included within the serious case review report along with a summary of reported offending by James Watt.

It is clear that the Watt family had extensive contact with a number of public authorities,[50] including police, probation and social services, and the review might have benefited from wider terms of reference, looking at interventions with the perpetrators. The report concludes that: 'neither Adult B [James Watt] nor his family benefitted from accepted wisdom in child welfare and youth justice which holds that early intervention is crucial to achieving good outcomes (see, for example, Home Office, 1997; and Department for Education and Skills, 2004)'. Nevertheless, the recommendations do not address these issues.[51]

Michael Gilbert was widely described as 'disabled' in press reporting at the time of the murder trial. However, at an inquiry hearing the chair of Luton safeguarding vulnerable adults board, Professor Michael Preston-Shoot, asserted that Michael did not meet the definition of a disabled person contained within either the NHS and Community Care Act or the Disability Discrimination Act. However, other evidence that had been sent to the inquiry by agencies involved in the serious case review suggested that Michael had an undiagnosed mental health issue:

- He was interviewed by the police with an appropriate adult on a number of occasions, a protection usually only afforded to adults considered 'mentally vulnerable'.

48 Familial homicide was introduced as an offence in England and Wales by the Domestic Violence, Crime and Victims Act 2004 (no equivalent is currently in place in Scotland). According to the Crown Prosecution Service, 'for the purposes of this offence a vulnerable adult is defined as a person aged 16 or over whose ability to protect themselves from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, old age or otherwise (s. 5(6))'. Available from: http://www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/#a19

49 See http://www.luton.gov.uk/0xc0a80123_0x110468ec

50 For example, according to the serious case review report, pp4-5, the police visited the Watt family home on 35 occasions in 2001 alone.

51 Flynn, M., 2011, *The Murder of Adult A (Michael Gilbert): A Serious Case Review*, p14, Luton Safeguarding Vulnerable Adults Board.

- Sometimes the appropriate adult was requested by Michael himself, suggesting he regarded himself as being disabled.
- On other occasions the presence of an appropriate adult was instigated by the police, suggesting that they recognised that Michael may have had a mental health issue or learning disability.
- Michael visited GPs on a number of occasions regarding anxiety and depression and was prescribed anti-anxiety drugs.
- He was referred to a psychiatrist regarding auditory hallucinations, although he failed to attend.
- The offence of familial homicide only applies to the death of a child or vulnerable adult.[52] Three people were found guilty of this offence in relation to Michael's death. The court, at least, was satisfied that Michael Gilbert was a 'vulnerable adult', a term linked in law in England and Wales with disability.

The final report of the serious case review recognises that Michael may have had 'undiagnosed mental health problems', that a diagnosis of depression 'may have been appropriate' and that 'it is questionable whether or not the across the board assumption that Adult A [Michael] had capacity was reasonable'.

The serious case review report found:

- As early as his time in the children's home, Michael had asked for help to keep away from James Watt.
- Little evidence of attempts to address his sexualised behaviour in his childhood and teenage years which included allegations of abuse against both his sister and another child.
- No evidence of effective inter-agency work during his childhood and teenage years, as implied by the Children Act.
- Insufficient support when he was in care and leaving care.
- Lack of co-ordination resulted in agencies making decisions within their own terms rather than on the basis of the overall picture.
- Michael was assumed to have mental capacity without formal assessment, even when he was making decisions not in his own interest. The impact of coercion was not considered.

Independent Police Complaints Commission findings have been published in relation to this case.[53]

10. Brent Martin

What happened

Brent Martin was beaten to death on the evening of 23 August 2007 by three young people who he had previously considered to be his friends. He was 23. Brent had learning difficulties and a mental health issue. He had been detained under the Mental Health Act from the age of 16 until May 2007. He died just three months after his release.

On the evening of the attack, Brent had been subjected to a series of brutal assaults as he was chased across two

52 See note 48.

53 See http://www.ipcc.gov.uk/news/Pages/pr_070711_michaelgilbert.aspx

estates in Sunderland. His assailants had a bet on who could inflict the most damage. finally he was left in a pool of blood next to a parked car. He died on 25 August 2007. A post-mortem examination revealed he died from a massive head injury and had suffered at least 18 separate blows to his head and neck.

William Hughes, 21, and Marcus Miller, 16, pleaded guilty to murder and were sentenced to a minimum term of 22 years and 15 years respectively. Stephen Bonallie, 17, denied murder but was found guilty by a jury. He was sentenced to a minimum of 18 years. All three men had their sentences reduced on appeal – Hughes to 19 years, Miller to 13 years and Bonallie to 15.

The response

Brent was detained under section 3 of the Mental Health Act 1983 on 13 October 2000 until 24 May 2007. Discharge planning appears to have been curtailed, with his release happening quickly once a decision was made that he should no longer be sectioned.

Tim Docking, of the Northumberland and Tyne and Wear Trust, said that: 'There had been a lot of discharge planning with Brent to try and prepare him to go back into a community setting, but because his section was closed very quickly... the tail end of his discharge plan was truncated.'

It was agreed that he would stay with his sister and he was assigned a care co-ordinator. However he soon moved to a more deprived area in Sunderland to live with his mother.

Brent left hospital with between £2,000 and £3,000 of accumulated benefits money, of which he had total control. Having spent his young adulthood in an institution, Brent was desperate to make friends and used his money to socialise with a group of young men. He was assessed as being at low risk of self-harm, self-neglect/exploitation and violence[54] but it seems that he lacked the life skills to recognise those who meant him harm and was in danger of being preyed on.[55] The men who went on to murder him appear to have turned against him when his money ran out.

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54 Letter from Brent Martin's Consultant Psychiatrist to his GP, dated 28 August 2007: Bundle A, Div 7.

55 There is no detail in the documents about his discharge plan, save for a brief written note. This occurred before the introduction of community treatment orders (CTO). Under such an Order, which may have been appropriate for Brent Martin, conditions can be attached to the patient's discharge – including where he is to reside, that he must comply with medication, attend regular medical reviews, and screening for illicit substances, as well as general monitoring of his mental health. The detaining authority through the responsible clinician retains a power to recall the patient to hospital if the conditions are breached or if there is a deterioration in his mental health. It is not clear from the documentation how the various agencies have accommodated the CTO into their practices – everyone on a CTO will be a 'vulnerable adult' by definition.

There were several indications that Brent was at risk. On 22 August 2007 a review of his case found that he was failing to co-operate in taking his prescribed medication and continued to take illicit drugs and excessive alcohol. It was proposed that a 'robust package' would be applied and if Brent did not comply he would be re-sectioned. He was murdered the next day.

Prosecution

The case was not prosecuted as disability hate crime, despite one of the murderers telling friends 'I am not going down for a muppet' – a reference to Brent's impairments. Although this remark was not made at the time of the offence, it suggests an underlying attitude of hostility towards disability. The Crown Prosecution Service guidance[56] indicates that sentence uplift applies to offences committed in either of the following circumstances:

- At the time of committing the offence or immediately before or after doing so, the offender demonstrated towards the victim of the offence hostility based on a disability or presumed disability of the victim.

or

- The offence was motivated (wholly or partly) by hostility towards persons who have a disability or a particular disability.

The investigating police officer had told the media at the time of the murder that there was 'no motive for the assault'.[57]

Review process

The Sunderland Safeguarding Adults Partnership Board failed to commission a serious case review after Brent's death. This was because the case did not meet their criteria at the time. The reason given was that there was no evidence to suggest that abuse or neglect was known or suspected to be a factor in his death. The board did however decide that the existing protocol for serious case reviews needed to be amended.

Neil Revely, executive director of health, housing and adult services for Sunderland City Council, acknowledged that with hindsight the decision not to do a serious case review 'wasn't correct... the common-sense approach might have been to say, we will undertake a serious case review'.

The new protocol incorporates a number of lessons learned from Brent's death and expands the criteria for when a serious case review is needed.

56 Crown Prosecution Service, 2007, *Policy for Prosecuting Cases of Disability Hate Crime*, p8. Available from: http://www.cps.gov.uk/publications/docs/disability_hate_crime_policy.pdf

57 See http://www.thetimes.co.uk/tto/news/uk/crime/article1873131.ece

Lessons learnt

In this chapter we have profiled 10 cases that we believe illustrate lessons for authorities across Britain.[58]

1. David Askew
2. The case of the 'vulnerable adult'
3. Keith Philpott
4. Shaowei He
5. Christopher Foulkes
6. Colin Greenwood
7. Steven Hoskin
8. Laura Milne
9. Michael Gilbert
10. Brent Martin

We have drawn lessons from each case, some of those lessons will apply across different circumstances, others to particular circumstances. All are valuable insights which could make a difference to preventing and addressing harassment more effectively in the future.

We urge all public authorities to consider how to apply the learning from these cases in their own areas and to incorporate the following core lessons into their practice:

Practice[59]

- Always consider whether a victim of antisocial behaviour or crime is disabled, and whether their disability is part of the motivation for the harassment. (1,2,3,4,5,6,7,8,9,10)
- Agencies involved in responding to antisocial behaviour and crime against disabled people (particularly the police, local authorities and housing providers) should consider whether such harassment is disability-related from the outset. (1,2,3,4,5,6,7,8,9,10)
- Where the behaviour is identified as disability-motivated, agencies should apply the relevant legal and policy frameworks. (1,2,3,4,5,6,7,8,9,10)
- Where crimes have been committed, police should investigate them thoroughly and gather evidence to identify and prosecute perpetrators. This should include consideration of how to support disabled people to give credible evidence and how to identify other corroborating sources of evidence. (1,2,5,9)
- All allegations of crimes against disabled children and adults should be investigated thoroughly by the police. Adult/child protection processes should not be used as an alternative to criminal investigation. (2)
- The police should review their rates of 'no-criming' where the victim is disabled across all crime types and address any issues re disbelief that may emerge as a result. The police should

58 Although there are some differences in policy and legal frameworks the core lessons apply across jurisdictions.

59 Numbers indicate the cases where similar issues arose. In some cases, the lessons were learnt from authorities' own findings, in others we draw out the lessons.

not dismiss allegations of rape and sexual assault made by disabled people as 'no crime' unless they have strong evidence to prove that the allegation is untrue. All allegations should be investigated thoroughly. (2,5,9)

- Disabled people should not be placed into the care of people against whom they have made serious allegations of abuse. (2)
- Where a disabled person has died unexpectedly, if there is any evidence of injuries that could have resulted from an assault, police should properly investigate the scene and circumstances to ensure that a death which may have resulted from an assault is not mistakenly classified as 'non-suspicious'. (5)
- The language of 'financial exploitation' used in social care rather than 'theft' or 'fraud' can mask crimes committed against disabled people. Where service users have experienced crimes the police should investigate thoroughly. (5)
- Risk assessment processes should consider the risk of further victimisation for a disabled person who has already been targeted within their social/family network and identify means to reduce the risk. This should include clear actions, the people responsible and timeframe for it to be carried out effectively. (1,2,3,5,6,9)

Training and guidance

- Ensure that systems are in place and applied to identify repeat victims. Urgent action should be taken to bring repeat harassment to an end rather than dealing with incidents as isolated events. (1,2,5,6,9)
- Implement a corporate approach to adult protection, with training for all public-facing staff and their managers on identifying and referring people at risk of harm. (1,2,3,4,7,8,9,10)
- The police should develop robust training and guidance on investigating hostility to disability as a motive in incidents and crimes, recognising that evidence may be less explicit than for other 'hate crimes'. (1,3,8,10)
- The Crown Prosecution Service (and Procurator Fiscal in Scotland) should ensure that guidance on prosecuting offences motivated by hostility/prejudice to disability is applied. (1,2,3,4,5,6,7,8,9,10)
- Police should receive training in recognising and investigating disability-related crime so sentence enhancements can be applied where relevant. (1,2,3,4,5,6,7,8,9,10)

Changing attitudes

- Provide information for the public about reporting harassment that they are experiencing themselves or concerns that they may have about the safety of a disabled person. (2,3,4)
- Recognise the high level of risk faced by disabled people who have been labelled as 'paedophiles'. These accusations are usually without foundation and are made by adults as part of a smear campaign rather than as a result of genuine cases where children have come forward to report abuse. This term is used as an excuse for targeting a disabled person, sometimes with extreme violence. (1,3,7)
- Police, health and social services should take steps to challenge cultures of disbelief of disabled people who make allegations of serious assault. (2,9)

Investigation

- Where a disabled person has died as a result of harassment, always conduct a serious case review to learn lessons. Serious case reviews should also be considered where a disabled person has suffered serious harm as a result of harassment. The serious case review should consider both the perpetrator and the victim and whether there were opportunities for earlier interventions. Use professional networks to share lessons that might be of relevance to other localities. (1,2,3,4,5,6,7,8,9,10)

Partnership working

- Develop and implement partnership approaches to preventing harassment and safeguarding adults at risk of harm. (1,2,4,5,7,8,9,10)
- Community safety partnerships should review their systems for sharing information between local agencies to ensure critical information is shared effectively and used to trigger action. (1,2,5,7)
- Local authorities should review the operation of referral mechanisms between children's and adult's services to ensure that appropriate referrals are made when there may be issues relating to adult or child protection. Protocols for discussing cases where there are clients in common across children's and adults services should be put in place. (5)

Outcomes

- Agencies should ensure that perpetrators face consequences for their actions. (1,2,3,5,6,9)
- While the inspectorate reports and subsequent changes in legislation ensured that agencies in Scotland were aware of the lessons of the Borders case, they have had little impact in England and Wales. The Department of Health, Scottish Government, Welsh Government, Association of Directors of Social Services, Association of Directors of Social Work and Association of Directors of Social Services Wales should consider how to promote learning across Britain. (1,2,5,7,9)

- Enhanced sentencing can send out important messages in society about acceptable behaviour and help deter future offences. In order to do so, crimes motivated in part or in whole by hostility/prejudice to disability need to be recognised and prosecuted as such. (1,2,3,4,5,6,7,8,9,10)
- Public authorities need to ensure that recent immigrants understand British systems and sources of help when they are experiencing harassment. This should be incorporated into the 'British citizenship test' and backed up by local information. (4)

Recognising risk

- Agencies, particularly adult social care and housing, should be aware that some disabled people, particularly those who are socially isolated, can be at risk of being befriended by people wishing to take advantage of and exploit them. Exploitative relationships should be challenged while putting in place measures to reduce the victim's social isolation. This may involve helping people to build their social networks through groups or voluntary activity. (7,8,10)
- If agencies are concerned about the safety of their own staff – as they were when dealing with Darren Stewart – they should consider and address as a matter of course the impact of that individual on the other people around them, such as families and flat mates. (7)
- Persistent 999 phone calls should trigger concerns about an individual's ability to cope and an adult protection referral should be made. (7,8)
- Experiences of bullying at school can have long-term implications. Schools need to adequately address the needs of victims and deal effectively with perpetrators in order to reduce the risk of escalation and tackle the social attitudes that lead to the harassment of disabled people. (8)
- Agencies should assess the impact of coercion on decision-making and ensure that they intervene to secure the safety of a disabled person living in a situation of duress. (7,9)
- An appropriate care package should be provided for any individual leaving institutional care. This needs to consider the risks they may face in the community and how best to support them during the transition including how to reduce social isolation and encourage the development of positive relationships. (10)
- If an individual leaving institutional care has a substantial amount of savings on release, agencies should consider how to reduce the risk of others preying on that individual for financial gain. This may include support to manage the funds. (10)


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Part 3: The wider problem

'We take it so often that we don't think it is abuse, but it is.'

Focus group participant, woman with a mobility impairment, age 31-59

Introduction

The shocking cases of abuse and murder described in the previous chapter clearly show the potential consequences of a failure to tackle disability-related harassment. The most important finding of this inquiry, however, is that disability-related harassment is experienced by many disabled people each year and is not confined to just a few extreme cases. The incidents which reach the courts and receive media attention are just the most public manifestation of a profound social problem.

For many disabled people, harassment is a part of everyday life. Many come to accept it as inevitable, and focus on living with it as best they can. Harassment can take many forms. It ranges from name calling in the street to bullying at school; petty violence to full-on physical assault; theft and fraud; sexual assault; domestic violence and damage to property. It can be perpetrated by strangers, but equally it can happen in the context of the family, friendships or relationships.

Furthermore, harassment can take place in full view of other people and the authorities without being recognised for what it is. A culture of disbelief exists around this issue. We find it difficult to face up to the fact that disabled people are the recipients of much spite, brutality and exploitation.

In our society we are used to thinking about disabled people as the recipients of our pity, sympathy or help as a result of a 'medical model', approach to disability. In order to tackle the issues raised in this report effectively, there will need to be an understanding and application of what is referred to as the 'social model[60] of disability'. The social model of disability identifies the barriers, negative attitudes and exclusion by society (purposely or inadvertently) that mean society is the main factor why people are 'disabled'. While disabled people have different types of impairments, these do not have to lead to disability unless society fails to take account of and include people regardless of their individual differences.

The culture of disbelief operates at many different levels. Authorities do not take the complaints of disabled people seriously and respond with sufficient urgency. Witnesses in the wider community do not tackle or challenge behaviour such as name-calling, teasing and bullying, seeing it as a normal or inevitable part of life. If a disabled person has become socially isolated, it can be difficult for other people to recognise when a friendship or relationship is in fact exploitative and damaging.

60 See http://odi.dwp.gov.uk/about-the-odi/the-social-model.php

Even disabled people themselves, perhaps in response to being ignored or disbelieved, can play down the impact of harassment. They often don't report it, sometimes because they don't know who they could report it to, sometimes because they fear that reporting could make the harassment worse. As a result, this behaviour is not investigated, recorded, or addressed. It passes under the radar without a trace. The perpetrators never have to face any consequences of their actions, and their victims continue to live in fear.

This is why we describe disability-related harassment as hidden in plain sight.

Because this problem is hidden, it is difficult to know what the true scale of it is. This chapter will look at some indicators of prevalence, though they cannot give us the whole picture. It also draws on the submissions made by people who have experienced disability-related harassment themselves and the organisations that support them, and qualitative research conducted for the inquiry with disabled people.[61] We also refer to our previous research, *Promoting the safety and security of disabled people*.[62]

The key findings of this chapter are:

- The cases which reach the courts and media are just the tip of the iceberg, and represent the public face of a deeper social problem.
- The harassment of disabled people can take many different forms, including bullying, cyber-bullying, physical violence, sexual harassment and assault, domestic violence, financial exploitation and institutional abuse.
- The percentages of disabled adults who were victims of crime in the previous 12 months, were 19 per cent in England and Wales[63] and 17 per cent in Scotland.[64] Combined with an estimated 10.1 million disabled adults in Britain,[65] this suggests that approximately 1.9 million disabled people were victims of crime in the previous 12 months.
- Harassment takes place in many different settings, including close to home, in the home, on public transport and in public places and at school or college.
- Harassment can be perpetrated by strangers, but also by neighbours, friends, partners and family members.
- Disabled people often do not report harassment when it occurs, for a range

61 Sykes, W., Groom, C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*, Equality and Human Rights Commission.

62 Equality and Human Rights Commission, 2009, *Promoting the Safety and Security of Disabled People*.

63 Unpublished analysis of the British Crime Survey 2009/10, provided by the Home Office Crime Surveys Programme and reproduced with permission.

64 Unpublished analysis of the Scottish Crime and Justice Survey 2009/10, provided by the Scottish Government and reproduced with permission.

65 ODI, Disability prevalence estimates 2008/09. Accessed 2 August 2011.

of reasons including fear of consequences, concerns that they won't be believed and lack of information about who to report it to.

- Disabled people have told us not just about attacks on themselves, but also attacks on their families, friends, support workers, assistance dogs, equipment and adaptations.

The context of harassment

Disabled people have told us that harassment in all its forms makes their daily lives unpleasant; that it makes them fearful and restricts their movements, undermines their confidence and prevents them from participating fully in society.

Using data on various areas of life it is possible to build up a picture of how harassment interacts with a pattern of discrimination, underachievement, poverty, poor mental health and poor life outcomes for disabled people. Clearly, there are many factors at play in the course of a person's lifetime and it is impossible to attribute a direct causation. Nevertheless, it is important to note that harassment takes place in the context of a society in which many things are already loaded against disabled people achieving their full potential.

More than four-fifths of young people with a statement of special educational needs or disability that affected their schooling report being bullied.[66] Disabled people in the UK have poorer educational outcomes: the proportion of those who have no qualifications is three times higher than non-disabled people.[67] Only 11 per cent of working age disabled people have degree level qualifications, compared to 22 per cent of working age non-disabled people.[68]

This discrepancy is then played out in employment. The proportion of disabled people who experience discrimination in the workplace is nearly twice as high as non-disabled people, and the proportion of disabled people who report experiencing bullying or harassment in the workplace is more than twice as high.[69] This is in a context in which disabled people have a lower employment rate than non-disabled people.[70]

66 DCSF, 2008, *Youth Cohort Study and Longitudinal Study of Young People in England: The Activities and Experiences of 16 year olds: England 2007*. Available from: http://www.dcsf.gov.uk/rsgateway/DB/SBU/b000795/YCS_LSYPE_Bulletin_final.pdf

67 Hills, J. et al., 2010, *An Anatomy of Economic Inequality in the UK*. London: Government Equalities Office.

68 ODI, Key facts and figures. Analysis of Labour Force Survey, Quarter 2, 2008. http://odi.dwp.gov.uk/disability-statistics-and-research/disability-facts-and-figures.php

69 Fevre, R., Nichols, T,. Prior, G. and Rutherford, I., 2009, *Fair Treatment at Work*

70 *Report 2009: Findings from the 2008 Survey*. Employment Relations Research Series 103. London: Department for Business, Innovation and Skills. Available from: http://www.berr.gov.uk/files/file52809.pdf

A disability pay gap in earnings of 11 per cent existed between disabled men and non-disabled men in the years 2004-07.[71] Although the gap remains, data for 2010 show that it is no longer statistically significant.[72] In 2009/10, 21 per cent of individuals in families with a disabled person lived below 60 per cent median income (before household costs), compared to 16 per cent of individuals in families where there were no disabled adults or children.[73]

The available evidence demonstrates that proportionately more disabled people report mental health issues than do non-disabled people.[74] In England, four times as many disabled people or those with long-term illnesses report poor mental health compared with non-disabled people. In Scotland, three times as many do. In Wales, more than twice as many disabled people or those with a long-term illness report symptoms of poor mental health as compared with non-disabled people, but as this is measured differently it is not possible to directly compare with the results from England and Scotland.

While the evidence demonstrates that a larger proportion of disabled people report 'poor' mental health, this may be in part due to their impairment (such as a mental health condition), but without impairment-specific data it is difficult to explore this further. According to the Health Survey for England, poverty is associated with an increased risk of mental health issues.[75] That people who are disabled or have long-term illnesses are overly represented in lower socio-economic quintiles highlights that these compound issues may explain the high levels of poor mental health in these groups.

First reactions

First reactions to harassment tended to be to keep a low profile and escape the situation, but some people were more assertive. Later, many told someone what had happened – usually a friend or trusted confidant – but often to 'unload' rather than in expectation of anything further being done.

The first time one person went out in her wheelchair she was at the supermarket checkout and the person in front swung around and hit her in the face with their shopping bags. Although the incident was not deliberate, the perpetrator was

71 Longhi, S. and Platt, L., 2008, *Pay gaps across equalities areas*. Research report 9. Equality and Human Rights Commission.

72 ODI, Disability Equality Indicators. Hourly wage rates. Labour Force Survey, quarter 2, 2010.

73 ODI, Disability Equality Indicators. Individuals living in low income. Family Resources Survey 2009/10. Available from: http://odi.dwp.gov.uk/roadmap-to-disability-equality/indicators.php

74 Allmark, P. et al., 2010, *Life and Health: An evidence review and synthesis for the Equality and Human Rights Commission*, Equality and Human Rights Commission.

75 The Poverty Site, Mental Health. Available from: http://www.poverty.org.uk/62/index.shtml

unapologetic and reacted as if it was her fault. After that incident, she spent a whole year without going out. 'I just felt I don't want to go through this again. I'd rather stay at home where I'm safe... I just wouldn't go out.'[76]

Some said they managed to laugh off the harassment and ignore it but it clearly cost them some effort. Some had adjusted over time:[77]

> 'When I was younger I was more angry, wanted to go and bop them. Now I tend to think oh you're just stupid, you're not worth it.'
>
> Focus group participant, woman with visual impairment, age 31-59

Targeted incidents were often very shocking for respondents, especially where they felt no provocation had been offered, and they sometimes searched for rational explanations: 'Did I hurt somebody and not realise it?' wondered a member of the long-term health conditions group.[78]

Many respondents said that being harassed made them feel more vulnerable. This could be very undermining, especially for those who normally tried hard to maintain an attitude of not being stopped or held back by their health condition or impairment.[79]

> 'I hate the word victim – it's not me, I don't identify as a victim... I don't want to be afraid. I want to live my life.'
>
> Focus group participant, woman with visual impairment, age 31-59

Being harassed made people feel generally less safe, and often very fearful. As mentioned earlier many respondents had curtailed their lives to avoid situations where they felt they were likely to be harassed; for example, avoiding public transport at certain times of day or not going out at night:[80]

> 'You avoid it, there are lots of places where I would avoid going. I wouldn't go to the town centre after eight at night. I have been travelling on the bus and I feel threatened. I avoid the situation, if I get called [names] I walk off.'
>
> Focus group participant, man with mobility impairment, age 31-59

Incidents sometimes left respondents embarrassed or ashamed of being harassed, even if there were no witnesses. Being harassed in public was humiliating for many because of the attention they attracted. They were exposed, made to stand out from the crowd, made to feel different, pitiful and isolated.

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76 Sykes, W., Groom, C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*, Equality and Human Rights Commission, p13.

77 Ibid., p25.

78 Ibid.

79 Ibid.

80 Ibid.

One respondent with multiple long-term health conditions was berated by a passerby for being slow and getting in the way:[81]

> 'It was horrible, horrible. I got very flushed and red and embarrassed, more really worried in case anybody else had heard the language and (seen) that it was directed at me. People looking at you because she'd pointed you out and said those things... I was so taken aback and upset, I don't think I said sorry which normally I do you know... Even if you're not in the wrong.'
>
> Focus group participant, woman with long-term health condition, age 31-59

Incidents where respondents were duped, exploited or preyed upon, especially by people they knew, were hurtful and embarrassing in equal measure. They reported feelings of betrayal, of being 'ripped off' and also of feeling foolish, gullible and weak. Many had found in any case that on becoming ill or disabled, previous friendships melted away. They felt especially dependent on existing or new friends and found it hard to accept that they had been exploited by them.[82]

Many respondents were angry and resentful about being harassed, although these feelings were not necessarily at the forefront of their mind. Interviews and focus groups often provided a chance for such emotions to surface:[83]

> 'You just get so sick of it... You don't think about it at the time because it happens so often, but of course it is harassment because other people don't have to put up with that. They are left to get on with their business, whereas we are not.'
>
> Focus group participant, woman with mobility impairment, age 31-59

It was also common for people to feel some measure of guilt about an incident: to wonder what they had done to invite the situation:[84]

> 'I guess it is hard to tell what degree of responsibility you should take in those situations, but yes I guess I do always tend to think that it is my fault.'
>
> Focus group participant, man with mental health issue, age 18-30

Respondents who had experienced harassment over the internet often found it distressing because of the direct trauma of being abused, fear generated by threats and the backlash or follow-on consequences, such as losing former friends caught up in the 'mob mentality', or feeling forced to withdraw from certain internet sites which may have played an important role for them previously.[85]

Some respondents however reacted more assertively; one wheelchair user for

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81 Ibid., p26.
82 Ibid.
83 Ibid.
84 Ibid.
85 Ibid.

example described the following incident:[86]

> 'I was sitting outside a shop one day and this elderly man came up – I was eating a bag of chips at the time – and he put his face right up to me and said "Are you enjoying them pet"? And I just looked at him and said "Yeah I wouldn't eat them if I wasn't". And he didn't know what to say. But to me that was just stupid. Why would you talk to someone as if they are a child when they clearly are not?'
>
> Focus group participant, woman with mobility impairment, age 31-59

A visually impaired respondent said that she thought perpetrators did not expect retaliation from disabled people and that she had got into the habit of being very vocal if she was harassed in public places where passers-by were likely to come to her aid:[87]

> 'One day I was on the street with my guide dog and a man shouted "Get off the ****ing street". I stood up to him and he then came up and pushed me, actually on my breasts. The fact that he actually grabbed my breasts! It was totally deliberate. I should come off the street and if I don't he is going to grope me! It was frightening but my mouth is big. I told him about himself loud enough so people heard and came to my rescue. People came to my rescue, which I was very grateful for.'
>
> Focus group participant, woman with visual impairment and long-term health condition, age 31-59

Another respondent said that in terms of how to react she had found counselling helpful:[88]

> 'I have become stronger, and I have become thick-skinned... I have put my foot down.'
>
> Focus group participant, woman with long-term health condition, age 31-59

Telling someone

Immediately following an incident, it was normal for many respondents simply to absorb the impact without telling anyone about it. If they did tell it was most likely to be someone they knew well and trusted; family, close friends and/or perhaps carers or other familiar professionals. Some respondents said they didn't have anyone they felt they could talk to about being harassed. Telling other people was seen mainly as an opportunity 'safely' to unload the emotional impact of an incident. They did not want necessarily to do more than this:[89]

> 'There's only so much fighting you can do. You get very tired. Emotionally tired. I have had enough.'
>
> Focus group participant, woman with mobility impairment, age 60-74

86 Ibid.

87 Ibid., p27.

88 Ibid.

89 Ibid.

In a focus group of people with learning disabilities, respondents said that the 'good' people to talk to are friends and family, people who can keep things to themselves and someone who is responsive, who knows and understands you, and has time for you:[90]

> 'They know your background. You don't have to explain too much.'
>
> Focus group participant, man with learning disability, age 18-30

Disability support groups and organisations had played an important part for some respondents in providing them with an understanding and safe forum for talking about disability-related harassment. They were keen to emphasise the significant role such organisations had played in helping them to unburden and feel less isolated. Importantly, some had been helped to be more assertive about dealing with harassment where they encountered it. One said that attending a local group had turned her from 'a gobshite into a bigger gobshite'. Another described the emotional need not to simply withdraw in the face of harassment.[91]

> 'Victim is about you giving in to their power in a way, they want you to be their victim, and you want to fight back.'
>
> Focus group participant, woman with visual impairment, age 31-59

Everyday life

A 46-year-old woman who has a long-term health condition, a wheelchair user, told us about her experiences of harassment.

She says these have left her reluctant to leave her home on her own. She rarely socialises in pubs, restaurants, or other public places. 'I avoid going into the centre [of town] as I feel vulnerable – it's not a pleasure any more.

'I tend not to go out socially. When I'm out I seem to spend my time apologising or slowing people down. It has knocked my confidence – it makes me feel worthless.

'I used to go to the cinema on my own, but I don't anymore – it's simply not worth the hassle.

'I still have some good friends, but it means my social circle has shrunk.'

She says that, although some people are very helpful, others make thoughtless comments on a day-to-day basis. 'It can be little things, like rolling of eyes. You get groups of youths and sometimes one will make a comment and the rest will laugh.

'I've had someone pat me on the head and say "she's put make-up on, how sweet". People assume that because I'm in a wheelchair I don't have a brain.' She is a qualified occupational health nurse with a science degree and an MSc. She is also a published author.

90 Ibid.

91 Ibid.

In addition to this day-to-day bullying, she has experienced several more serious incidents over the years. One involved a dispute over a supermarket parking bay. As all the accessible bays were occupied, she parked her adapted car in a standard bay. As it was not wide enough to fit her scooter and wheelchair, its tyres extended into the next bay. As she was disembarking a man shouted at her, calling her a 'stupid f****** spastic' for taking up the extra space.

'When I came out of the shop I was really worried he would still be there. Instead I found a note written on what looked like the inside of a toilet roll. It was left under the windscreen wiper directly above my blue badge. It said in capital letters: "YOU STUPID BITCH"

'I'm not a tearful person, but if someone had put their arm around me then I would have turned into Mrs Waterworks. I will never go to [that supermarket] again – I don't want to risk being shouted at.'

She now usually relies on getting home deliveries and going to smaller local shops. On the rare occasion she ventures to the supermarket she drives three miles to a different one rather than going to the nearby superstore where she was abused.

By contrast, she feels very confident when she is performing one of the voluntary roles she has taken on, such as advising health authorities, and speaking at conferences representing a public body at a senior level.

'Within my professional remit I'm very confident, but as a person I get judged by my disability – this tends to make me feel worthless and hide myself away.

'I think a lot of it is ignorance. I don't think people know how to respond to someone in a wheelchair.'

Many disabled people who contributed to our research did not necessarily distinguish between harassment and other experiences they found upsetting or difficult, such as the ways their lives were affected or restricted by inadequate provision of services for disabled people.[92] Many respondents said that low-level harassment, especially insensitivity and verbal harassment, formed a backdrop to their everyday lives.[93]

> 'Every day there's some little thing that sort of reminds you what you are, puts you back in your place.'
>
> Woman with visual impairment, age 31-59

> 'From the day your disability arrives you have to fight. Everything you get and everything you need you have to fight for. You have no idea of what disabled people go through.'
>
> Woman with mobility impairment, age 31-59

92 Ibid., p6.

93 Ibid.

Respondents felt that few non-disabled people know about the extent and ways in which disabled people are harassed on a regular basis. They often claimed to have 'learned to live with it', or tried to 'rise above it', and they had often found ways of thinking about it to minimise its impact. They didn't think that so-called low level incidents were of interest to public authorities or the outside world. They thought it pointless to report because no one would or could do anything, or worried about being seen to be overreacting or making a fuss.[94]

Forms of harassment

Types of harassment described by disabled people during research conducted for this inquiry included being ignored or overlooked; stared at; called names; asked intrusive questions, offered offensive advice, patronising comments or jokes; threatened or actual physical harassment including invasion of personal space, touching, pushing, being spat at or hit or being the target of thrown objects; sexual harassment and assault; damage to property; and actual or attempted theft or fraud. We explore some of the most frequently mentioned types of harassment below.

Damage to property

A common type of harassment reported by disabled people who contributed to our research was damage to property, especially damage to homes, gardens and vehicles. Incidents included bricks, sticks and stones being thrown at windows of homes and into gardens; cars being scratched, their windows broken and tyres deflated or slashed.[95]

One respondent with a mobility impairment uses a wheelchair. He reported that people throw eggs into his back garden, as well as stones, sticks, beer cans and potatoes. He does not want to go and look while it is happening because he feels vulnerable. He has only recently moved in and the neighbours' homes are not accessible so it is hard for him to get to know people. He thinks the perpetrators may be local 'kids' but he can't ask because he doesn't have local friends. He has reported it to the housing association, but they won't do anything until they know who the perpetrators are. He thinks it is just kids – just a laugh. But he can't clear his garden up. He has asked neighbours on either side if they have been targeted but they haven't. It is just him.[96]

Exploitation, theft and fraud

Disabled people also told us about theft, fraud and other financial exploitation such as being 'encouraged' to spend all their money on people who befriend them in order to exploit them. Some felt that they were seen as an easy target for such behaviour.[97] Often this kind of exploitation happens in the context of friendships or relationships.

94 Ibid.
95 Ibid., p16.
96 Ibid.
97 Ibid.

One respondent who is bipolar felt friends had taken advantage of her vulnerability to borrow money. In one incident she re-mortgaged her flat in order to lend money for a business venture to a woman who was a former therapist but who had become her friend. The friend had looked after her when she had a breakdown and helped her to stay out of hospital, so she felt indebted to her. At the time she had signed over Power of Attorney to this friend, though she said 'I have no recollection of it.' When her own financial position became less secure, she asked her friend to pay back the money she had loaned without any formal agreement being signed. Since then, the friend has been 'markedly less available to me'. She has paid back some of the money she was loaned, but only under pressure.

Other friends of the respondent believe she has been exploited. She is still not sure, but she says 'If I am honest I did feel compromised (when she asked me for the loan). This was someone who I had lived with when I had my breakdown. If I hadn't I would have been hospitalised, which I am terrified of. Part of me felt pressured to keep this friend. I don't have any family at all, and this was the nearest thing I had. I felt I couldn't say no.'[98]

'Cuckooing' was a term used by some people we talked to. This describes a situation where someone moves in to a disabled person's home, perhaps ostensibly to help, but in reality to get access to food, clothes, drugs or benefits.[99]

The Association for Real Change[100] has coined the term 'mate crime' to refer to 'the exploitation, abuse or theft from people with a learning disability, by those they consider as their friends'.

A participant in one focus group asked: 'Have you ever heard the term cuckooing?' All the others in the group nodded in recognition. He made a friend – or he thought it was a friend, really just an acquaintance of a couple of weeks. He invited him to stay temporarily in the flat 'to give me a bit of support'. The other person quickly 'took over' – keeping at least three quarters of his benefit, some of his medications, wearing his clothes and taking his watch: 'I hadn't got the strength to do something about that situation. I was aware that I was being exploited.'

He felt he could not go to the police or the council because he was terrified of either of them investigating him, because having someone else in the flat affected his benefit and housing status. He said that perpetrators who do this to vulnerable people understand this very well: 'You are always anxious and worried about upsetting your situation. The one thing I need to be able to function is stability. Anything that rocks the boat, even by a few pounds a week, makes a mess of my life and I go to pieces... The first thing the council will say [if you report someone staying even against your will and exploiting you] is that you are breaking your tenancy agreement.'[101]

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98 Ibid., p35.

99 Ibid., p16.

100 See http://arcuk.org.uk/

101 Sykes, W., Groom C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report.* Equality and Human Rights Commission, p35.

> 'For somebody with autism for example, we had a case one of our volunteers who worked on both projects with us who has autism, has learning disabilities and brain injury and epilepsy, so he has a quite chaotic lifestyle, and is trying to live independently and succeeding well until a group of drug users got into his flat, decided to make out they were friends of his so they could get free accommodation used the place as a drug den.'
>
> Interview submission

> 'People that you think are friends, aren't, they are just using you in one way or another. For somewhere to live or for the reason that you have that extra bit of benefit. They think you are rich.'
>
> Interview, woman with mobility and long-term health condition, age 31-59

'Cuckooing' was also a factor in a number of cases we looked at, including that of Steven Hoskin (see Part 2).

Cyber-bullying and cyber harassment

This is the use of technology, such as internet chat rooms, mobile phones and social media to harass a person. Such harassment can include threats, offensive remarks and defamatory comments. There are essentially two categories of cyber-bullying/harassment – one is targeted specifically against an individual in a digital arena where the perpetrator is often known. The second is more general, often anonymous, abuse of a group of people in a digital arena.

Cyber-bullying and harassment can occur in the digital arena alone, or accompany abuse or harassment experienced face-to-face. For example, disabled people being physically or sexually assaulted and that being recorded on phones and loaded onto the internet.

Richard Piggin, Deputy Chief Executive of Beat Bullying told us from the research they conducted in 2009, 'Virtual Violence' that disabled young people (and children with special educational needs statements) experience more persistent cyber-bullying than non-disabled people over a longer period of time.[102]

The Restricted Growth Association has received several complaints from its members about being filmed in the street and the images are then uploaded onto social networking sites, such as Facebook, and YouTube where abusive comments are made.

102 See http://www2.beatbullying.org/pdfs/Virtual%20Violence%20-%20Protecting%20Children%20from%20Cyberbullying.pdf

Inquiry submission, Restricted Growth Association

Some respondents in focus groups felt that harassment conducted 'remotely' is attractive to perpetrators because it offers:

- potential anonymity
- less risk of being caught
- fewer social controls and more licence to express 'socially unacceptable' views and use extreme and highly offensive language
- a potentially wide audience, for example everyone that a perpetrator can access directly through their own address book or mobile directory and virtually unlimited reach if messages can be easily relayed on, and
- rewards for the perpetrator, who may be simply seeking to provoke reaction through stating extreme views deliberately to draw attention to themselves, known as 'trolling'.[103]

Regular users of the internet were obviously more likely to have experienced cyber harassment than those respondents who were not. Younger respondents in particular tended to regard the internet and the mobile phone as natural arenas for harassment, especially for attempting to isolate someone socially, humiliate them publicly or 'stalk' them. Disability-related cyber harassment reported by young disabled respondents was not necessarily seen in a different light to cyber harassment generally.[104]

One respondent said that when he was younger he had anorexia, and was using a lot of websites at the time to talk about it. He received some very nasty comments, and people wrote nasty things about him publicly. It really upset him, and made him more unwell: 'Online I think it is much easier for people to be nasty, because they can't see the consequences... The things that they write – if it was in a letter it would be hate mail, but because it's an email it doesn't seem to count. A lot of people see it just as an inevitable part of being on the internet.'

He was seeing a psychiatrist at the time and having group therapy. When he mentioned the incidents he was simply advised to stay off the internet. No-one seemed to have any idea how else it could be tackled.[105]

One of our evidence hearings focused on cyber-bullying and harassment. The following problems were identified:

- There is generally a lack of understanding of the offence and not enough prevalence data.
- Chat rooms are unregulated.
- With electronic communications people are usually living in different locations, e.g. victim lives in one location and the offender another. So if an incident of harassment is occurring this can involve several different police forces across the country and indeed

103 Sykes, W., Groom, C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*. Equality and Human Rights Commission, p20.

104 Ibid.

105 Ibid.

internationally, and there is a reliance on collaboration between forces.

- Cost of conducting an investigation can be a big factor, and working with an internet service provider to get a subscriber address can be difficult and costly.
- Having the necessary expertise to investigate cyber-crime is also key.
- Dealing with different jurisdictions if harassment is occurring internationally.
- Once information is uploaded it is almost impossible to capture and withdraw because of the sheer numbers of people copying it, passing it on etc.

If disabled people did report this online harassment, a common response was that they should avoid it by not remaining online. However, this misses the point about why they were online in the first place. For many disabled people, communication via the internet is often their only significant contact with others if they are unable to get out and about much or face significant communication barriers. In addition, many were sharing their problems or concerns on discussion boards set up specifically for raising such issues, and so to be targeted within those forums seemed particularly unfair to them.

Potential solutions may be:

- to reaffirm the importance of school bullying policies to include cyber-bullying, and
- to increase pressure on industry to protect their users in line with their corporate responsibility.

Sexual violence and harassment

Previous analysis of the experience of intimate violence[106] using the British Crime Survey has shown that having a limiting illness or disability was associated with all types of intimate violence except with stalking among men. Women with limiting disabilities were more likely than average to have experienced non-sexual partner abuse and stalking.[107]

In evidence to the inquiry, disabled men and women described incidents of sexual harassment, including unwanted touching, strangers' knees inserted between their legs while on public transport, being asked if 'disabled people like sex', and being followed.[108] At its worst, this harassment included rape and sexual assault.

106 Intimate violence includes: non-sexual partner and family abuse, sexual assault and stalking.

107 Jansson, K., 2007, Domestic violence, sexual assault and stalking – 2005/06 British Crime Survey. Chapter 3 in Homicides, Firearm Offences and Intimate Violence 2005/2006. Home Office Statistical Bulletin 02/07. London: Home Office.

108 Sykes, W., Groom, C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*. Equality and Human Rights Commission, p15.

> 'I was raped by a nasty bloke... I met him on a train, at the train station, and he asked us round to his house. I went to his house and he started doing nasty things to us, and he got me on the settee and started doing rude things, and he started to touch me below, down below... And then I had a flat and he came around to my flat and he did – he raped us and that, and I asked him would he stop doing that and he said no, and he carried on attacking us.'
>
> Friends, family and survivors event, male with learning disabilities, age 31-59

One focus group participant with mental health issues who identified as transgender said the impact of his mental health issue fluctuates, which had occasionally impaired his judgement and behaviour, leading to risky situations, particularly sexual.

He said that people had taken advantage of his mental health issue when he was in a vulnerable state. On one occasion, the perpetrators were two ex-partners. He went to collect some things from their house. They pinned him down and raped him; one had a hand over his mouth so he couldn't scream. He was making it clear he was not consenting: 'A couple of times when I did say stop, tried to remove myself from the situation, I was forced upon... If I wasn't in that awful mental state I just don't think it would have happened.'[109]

In our hearings with public authorities, we looked into the case of a 16-year-old woman with learning disabilities. She was taken to a house undergoing renovation where she was raped by a group of 10 or more men and boys and then had a chemical substance poured over her body causing over 50 per cent burns. She has burns to her face, neck, chest, torso, back, upper arms and upper legs, and her genitalia. Some of these burns were full thickness burns, i.e. burns that went through all layers of her skin. The Court of Appeal judgment in 2009 noted that she was subsequently unable to live an independent life as a result of the injuries.

At trial, it was noted that although she had consented to have sex with the boy she first met, she did not want to have sex with anybody else. When she was alone, naked, with between 6-11 boys and men present she was too scared to refuse. Three of the perpetrators were eventually convicted, the cases against the others having been dismissed at various stages of the criminal proceedings for lack of evidence.

All three were convicted of rape and sentenced (after a successful appeal against the leniency of two of the sentences) to eleven, nine and three years respectively. The young man who threw the chemical substance was convicted of Grievous Bodily Harm (GBH) but not of GBH with intent. This was because the jury accepted his evidence that he did not know what the chemical was or what its effect would be.

109 Ibid.

Bullying

More than four-fifths of 16-year-olds with a statement of special educational needs or disability that affected their schooling have reported being bullied. This contrasts with under two-thirds of non-disabled young people who report being bullied.[110]

Bullying may continue outside school on the journey home and beyond. In some cases bullying that started in childhood at school persists into adulthood and can escalate into extreme physical and sexual assaults.

> 'I was bullied on a daily basis from getting on the school bus... it started from being called "spacca"... I was punched, kicked, spat at.'
>
> Interview with man with learning difficulties, age 31-59

> 'When walking [with my stick] in public areas I have had the word "cripple" shouted at me far too many times. When returning to school (after time off for treatment) ...people have shouted at me "what the f*** are you doing here, so you've stopped skiving then", and many others to the same effect.
>
> Submission to the inquiry, woman with physical impairment, age 16-24

For respondents in a young people's focus group, being bullied by fellow pupils had a major impact on their wellbeing at school and was the main type of harassment reported. Incidents involved name calling, teasing, playing tricks, and various forms of assault.[111]

One person had significantly impaired brain and body functions and used a wheelchair. A gang picked on him at college; he was teased, bullied and his money and phone were stolen. Eventually someone at college tried to strangle him, which left marks on his neck. Until then, he had kept the bullying to himself.[112]

Some older respondents said they were still emotionally raw from bullying that had happened a long time ago.

> 'I have a learning disability and ever since I was a child I have been called names like "spastic" and taunted because I can't read and write.'
>
> Submission to the inquiry, person with a learning disability

One person was over 60 and had a long-term health condition. He said he had been badly bullied at school because he was Jewish, because he was fat and because he was disabled: 'it could have been a combination of all three'. He was called names not only by fellow pupils but

110 DCSF, 2008, *Youth Cohort Study & Longitudinal Study of Young People in England: The activities and experiences of 16 year olds: England 2007*. Statistical Bulletin. DCSF.

111 Sykes, W., Groom, C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*. Equality and Human Rights Commission, p18.

112 Ibid., p15.

also by teachers. His experiences at school still have the power to upset him.[113]

Antisocial behaviour

> 'You can call it neighbourhood crime; you can call it antisocial behaviour; frankly, you can call it whatever you want. For the victim on the receiving end it makes their lives an absolute misery.'
>
> Louise Casey, Victims Commissioner

Antisocial behaviour may include insulting and inconsiderate behaviour, verbal taunts, threats, graffiti, being spat at, having windows broken and car tyres slashed and being pushed and shoved. Some behaviours are criminal offences.

In one study, 29 per cent of a random sample of 5,699 people who had reported antisocial behaviour were disabled.[114] Although the results of this study are not nationally representative, it found that a larger proportion of disabled than non-disabled people had experienced intimidation or repercussions as a result of reporting antisocial behaviour.

Victims of antisocial behaviour are not routinely asked whether they are disabled by the police, housing or local authority community safety teams and the victim's disability is usually not investigated as a motivation for the antisocial behaviour.

Domestic violence

In situations of domestic violence, it can be particularly difficult for disabled victims to end the relationship and build a new safe life. All the respondents in Women's Aid Federation England's (WAFE) research into the needs of disabled victims of domestic violence[115] said that 'being disabled made the abuse worse, and also severely limited their capacity to escape or take other preventative measures'.

> 'I think definitely for disabled women that there is this issue of like 'Oh you're so lucky that you've got somebody' that you think I'm not going to get somebody again. I'd rather put up with this... because there are some nice times and you know he is sorry. So this is better than being on my own.'
>
> Quoted in *Making the Links*[116]

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113 Ibid., p17.

114 Ipsos MORI for Her Majesty's Inspectorate of Constabulary (HMIC), 2010, *Policing anti-social behaviour: the public perspective*. Available from: http://www.hmic.gov.uk/SiteCollectionDocuments/Anti-social_behaviour_2010/ASB_IPS_20100923.pdf

115 Hague et al., 2008, *Making the Links: Disabled women and domestic violence*. Available from: http://www.womensaid.org.uk/domestic-violence-articles.asp?itemid=1722&itemTitle=Making+the+links%3A+disabled+women+and+domestic+violence&section=00010001002200080001&sectionTitle=Articles%3A+disabled+women

116 Ibid., p39.

Disabled people who are reliant on the person who is abusing them (often their partner or carer) are often trapped – especially if their home has been adjusted to accommodate their physical, communication or psychological/mental health needs. This can leave them at risk of further sexual violence and emotional or financial abuse.[117] Information about available help may not be readily available in accessible formats, and many refuges are ill-equipped to meet the needs of disabled women. Those who leave their registered address risk losing their access to welfare entitlements, personal assistants and so on (i.e. their 'care' package).

We were told about a young disabled woman who was being sexually abused by her uncle and wanted to move out of the family home. When she reported it to her mother, her mother said 'you are disabled, why would he want you'. Because her benefits as a disabled person paid a tenants allowance for her mother and provided a family car, family members refused to support her leaving. It was very easy for the family to isolate her and continue perpetrating. Her experiences eventually came to light when she was able to access independent voluntary sector support from a disabled people's organisation.

Perpetrators of domestic violence may reinforce their control by exploiting someone's impairment such as moving aids out of their reach or not providing care.

> 'I can't feed myself and he would go out in the evenings deliberately and I wouldn't have eaten anything for a 24-hour period or more.'
>
> Quoted in *Making the Links*[118]

Physical violence

The disabled people who responded to our inquiry referred to a range of physical behaviour that they felt was threatening or intimidating, including being pushed and shoved and having objects thrown at them.

Offences against the person are the most common offences prosecuted as disability hate crime by the Crown Prosecution Service.[119]

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117 Women's Aid, 2008, *Making the Links: Disabled women and domestic violence.* Available from: http://www.womensaid.org.uk/core/core_picker/download.asp?id=1481 [Accessed 25/08/2010].

118 Hague et al., 2008, *Making the Links: Disabled women and domestic violence*, p36. Available from: http://www.womensaid.org.uk/domestic-violence-articles.asp?itemid=1722&itemTitle=Making+the+links%3A+disabled+women+and+domestic+violence&section=00010001002200080001&sectionTitle=Articles%3A+disabled+women

119 Crown Prosecution Service, 2010, *Hate crime and crimes against older people report*, 2009-2010, p4. Available from: http://www.cps.gov.uk/publications/docs/CPS_hate_crime_report_2010.pdf

'I have been hit by a stranger and beaten up by young people. They tried to push me through a chip shop window. When someone tried to help me by putting me in their car, they started rocking the car.'

Submission to the inquiry, woman with learning disability, age 55-64

'About five years ago a local youth approached me at a bus stop and hit me in the head, I was knocked unconscious, smashed my glasses and got a black eye.'

Submission to the inquiry, Man with long-standing illness, age 35-44

'My partner and I were walking along in London going for a night out. I had to hold his arm as I cannot see at night at all. A gang of chaps came along verbally abused us, called us queers and bum boys. One of them attacked us and I fell to the floor injuring my ankle. My partner screamed at them saying that I was blind but this had little effect until a couple intervened and chased the gang away. I did not know it, but my partner suffered head and back injuries and had to be taken to hospital. The police were called but did very little once they knew we were a gay couple. They did not even ask the couple who helped us for descriptions of the gang that attacked us.'

Submission to the inquiry, man with visual impairment

Institutional abuse

Although the area of institutional abuse was not covered in the terms of reference for the inquiry, we did receive a number of examples in the call for evidence. These will remain logged with the Commission.

To date, the experiences of those disabled people living in institutions is an under-researched area. In 2001 the Census counted 858,098 people in England and Wales living in communal establishments,[120] of these, 91 per cent (362,343) of those living in a medical care establishment were disabled and 12 per cent (56,577) of people living in other types of communal establishment were disabled.[121]

This accounts for 2 per cent of the England and Wales population that are never given the opportunity to voice their experiences, as ad hoc and national statistics do not collect information from this non-household population. Unfortunately, this statistical gap is further compounded by problems in accessing this community for qualitative type research as ethical approval to work in these medical establishments is hard to gain.

The important point to note here is that sometimes disabled people are moved from living in the community to institutions because other people feel they will be safer. In light of previous Commission research,[122] where

120 A communal establishment is defined as managed residential accommodation where there is full-time or part-time supervision of the accommodation.

121 See http://www.statistics.gov.uk/STATBASE/ssdataset.asp?vlnk=8944

122 See http://www.equalityhumanrights.com/uploaded_files/research/disabled_people_s_experiences_of_targeted_violence_and_hostility.pdf

victimisation by caregivers and peers has been recorded, institutionalisation should not necessarily be seen as a way of protecting disabled people from others.

We hope that the findings of the inquiry and subsequent recommendations can be transferred and made relevant to work to prevent and eliminate instances of institutional abuse. The Commission's Homecare Inquiry covers a different but related area, which will be reporting in November 2011.

Prevalence

Our research suggests that disability-related harassment is widespread. However, comprehensive statistics on the magnitude of the problem are not currently available. This is a gap that needs to be addressed if organisations are to set their priorities and monitor the impact of efforts to tackle the problem. It will also be essential if local people are to be able to make informed choices when prioritising how resources should be spent as part of the government's 'localism agenda'.

In an environment where there is reduced regulatory scrutiny of public authorities in England, following the abolition of the Audit Commission and the changed role of the Care Quality Commission in respect of local authorities, these authorities will need good, comparable data in order to benchmark their own performance against that of others.

Collecting such statistics will not be an easy task considering the barriers around reporting which we will discuss later in this chapter.

Data gaps

We found major gaps in evidence gathering by public authorities relating to disability harassment across all sectors. Schools don't know how many disabled pupils are bullied; local authorities and registered social landlords don't know how many antisocial behaviour victims are disabled; health services don't know how many assault victims are disabled; police don't know how many victims of crime are disabled; the courts don't know how many disabled victims have access to special measures, what proportion of offences against disabled victims result in conviction or how many of these offences result in a sentence uplift;[123] and the prisons don't know how many offenders are serving sentences for crimes motivated by hostility to disabled people.

This lack of data compounds public authorities' lack of understanding of disability-related harassment. Without such data it is impossible for authorities to understand disability-related harassment in their area, assess the effectiveness of their responses to it and develop interventions to prevent it.

> 'Of the 1.5 million offences we have on our system, we can't pull those that involve a disabled victim or witness and

123 There is provision in England and Wales under section 146 of the Criminal Justice Act 2003 and in Scotland under Articles 1 of the Offences (Aggravation by Prejudice) (Scotland) Act 2009 to increase the sentence if the crime is proven to be motivated by hostility (England and Wales) or malice and ill-will (Scotland) towards a victim because of his or her actual or presumed disability (see Appendix 8 for further information).

> we can't identify them by disability, by impairment.'
>
> Joanna Perry, Crown Prosecution Service, 17/11/10

Although robust data are not available on harassment as such, the available data show the percentages of disabled adults who were victims of crime in the previous 12 months were 19 per cent in England and Wales[124] and 17 per cent in Scotland.[125] Combined with an estimated 10.1 million disabled adults in Britain,[126] this suggests that approximately 1.9 million disabled people were victims of crime in the previous 12 months. Of course, not all the crime experienced by disabled people is related to their disability. Equally, however, much disability-related harassment does not involve criminal behaviour, so the numbers experiencing harassment may be much higher. More than half (56 per cent) of the disabled people in one small online poll said they had experienced hostility, aggression or violence from a stranger because they were a disabled person (Scope, 2011).

In order to obtain a more detailed picture of the crimes experienced by disabled people, we commissioned some analysis of the British Crime Survey.[127]

Likelihood of becoming a crime victim

We found that disabled people in all age groups are more likely than non-disabled people to have experienced a crime in the past 12 months.

- Among disabled young people aged 16-24, for instance, 42 per cent have been victims of crime in the previous 12 months, compared to 33 per cent of non-disabled people of the same age.
- Breakdowns by impairment groups show that, in 2009-10, 32 per cent of people with a mental health issue had experienced a crime. This group had proportionately more such experiences than non-disabled people (22 per cent).
- Among people aged 16-64, those with a mobility impairment were more likely than non-disabled people to have experienced a crime (27 and 24 per cent respectively).

Fear of crime

- Disabled women and men were more likely than non-disabled women and men to report feeling either 'a bit unsafe' or 'very unsafe' when walking alone after dark. Among disabled women, 57 per cent felt a bit or very

124 Unpublished analysis of the British Crime Survey 2009/10, provided by the Home Office Crime Surveys Programme and reproduced with permission.

125 Ibid.

126 ODI, Disability prevalence estimates 2008/09 [Accessed 2 August 2011].

127 Equality and Human Rights Commission, 2011, *Disabled people's experiences and concerns about crime: Analysis of the British Crime Survey*, 2007-08, 2008-09 and 2009-10. Equality and Human Rights Commission Research Briefing.

unsafe, compared to 38 per cent of non-disabled women. For men, the figures were 30 per cent for disabled men and 14 per cent for non-disabled men.

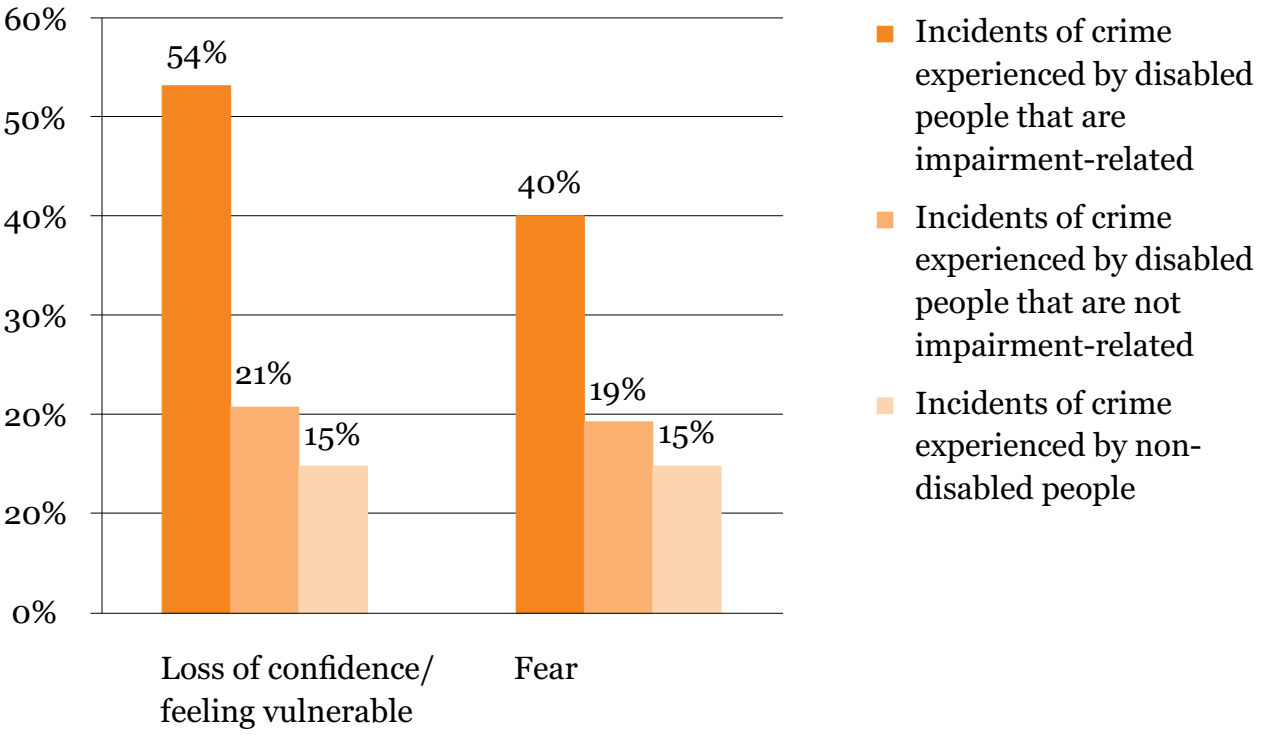
- Disabled women and men were more likely than non-disabled women and men to report being either 'very' or 'fairly' worried about being physically attacked by strangers. Among disabled women, 43 per cent felt very or fairly worried, compared to 39 per cent of non-disabled women. For men, the figures were 30 per cent for disabled men and 25 per cent for non-disabled men.
- Disabled women and men were more likely than non-disabled women and men to report being 'very or fairly' worried about being insulted or pestered by anybody. Among disabled women, 37 per cent felt very or fairly worried, compared to 35 per cent of non-disabled women. For men, the figures were 26 per cent for disabled men and 22 per cent for non-disabled men.
- Disabled women and men were more likely than non-disabled women and men to report being either 'very' or 'fairly' worried about being a victim of crime. Among disabled women, 46 per cent felt very or fairly worried, compared to 39 per cent of non-disabled women. For men, the figures were 37 per cent for disabled men and 30 per cent for non-disabled men.

Impact of crime

The extent to which disabled people were adversely affected by incidents of crime differed from the experiences of non-disabled people. The impact was also greater if the crime was considered to be related to them being disabled.

- Disabled people were more likely to be affected 'very much' or 'quite a lot' by 81 per cent of incidents that were thought to be motivated by their impairment, compared with 62 per cent of other incidents that they had experienced. In the case of non-disabled people, 49 per cent of incidents of crime had such an emotional effect.

Figure 1: Emotional impact of crimes (percentage of incidents)



Source: Equality and Human Rights Commission, 2011, D*isabled people's experiences and concerns about crime: Analysis of the British Crime Survey 2007-08, 2008-09* and 2009-10. Equality and Human Rights Commission Research Briefing.

Experiences of harassment

Many research studies are exploratory in nature or intend to give an indication of issues, rather than being designed to provide authoritative statistics that would be relevant at a national level. Two reports that are based on robust statistical methodology show that:

- a significantly higher proportion of disabled women in England and Wales experience non-sexual abuse from partners, as compared with non-disabled women[128]
- a larger proportion of young disabled people in England report being victims of all types of bullying, as compared with other young people.[129]

128 Jansson, K., 2007, Domestic violence, sexual assault and stalking – 2005/06 British Crime Survey. Chapter 3 in Homicides, Firearm Offences and Intimate Violence 2005/2006. Home Office Statistical Bulletin 02/07. London: Home Office.

129 Green, R. et al., 2010 C*haracteristics of bullying victims in schools*. Research report DFE-RR001. Available from: https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR001.pdf

Other sources of evidence on disability-related harassment are frequently based on self-selecting rather than representative samples:

- 29 per cent of a sample of people who had reported antisocial behaviour to the police identified themselves as having a long-standing illness, disability or infirmity[130]
- as mentioned earlier, more than half (56 per cent) of the disabled people in Scope's online sample said they had experienced hostility, aggression or violence from a stranger because of their condition or impairment (Scope, 2011)
- in Scotland, 47 per cent of a sample of disabled people had experienced hate crimes due to their disability (DRC and Capability Scotland, 2004)
- 16 per cent of almost 2,000 people with learning disabilities who responded to a Community Care survey in 2007 said they had been bullied on the street in the previous year (Gillen, 2007)
- research by the mental health charity Mind in 2007 showed that 71 per cent of respondents had been victimised in the community at least once in the past two years and felt this to be related to their mental health history.[131]

Although these sources provide useful indications of the scale of disability-related harassment, more systematic data collection is urgently needed.

Where harassment takes place

Incidents reported by respondents took place in a very wide range of settings and situations.

Out and about

On the streets or in parks and other public places in the neighbourhood or further afield provided the setting for much incidental harassment that was described by respondents; people calling disabled people names, following them, ignoring or overlooking them, making them feel out of place and in the way, pushing them and throwing things at them. Some respondents said they were reluctant to go out as a consequence, or were careful to avoid certain routes, places or times of day or night:[132]

> 'I am registered blind, use a guide dog as my mobility aid, and at night only have light perception. I live in a lane which has no footways. I was walking home ... being guided by my dog on the near side of the road, in the lane where I live.

130 Ipsos MORI, 2010, *Policing anti-social behaviour: the public perspective*. Her Majesty's Inspectorate of Constabulary (HMIC). Available from: http://www.hmic.gov.uk/SiteCollectionDocuments/Anti-social_behaviour_2010/ASB_IPS_20100923.pdf

131 Mind, 2007, *Another Assault*.

132 Sykes, W., Groom, C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*. Equality and Human Rights Commission, p16.

> … a vehicle came towards me and stopped about 5 ft in front of me with the headlights on. I tried to speak to the driver, the response was a female voice, I am not scratching my vehicle driving round you. You can see, I have seen you walking round the building site and I am going to report you for fraud. I asked "would you tell me who you are". The vehicle was then driven at me and it struck me on the right shoulder, and then proceeded without stopping. Another motorist came to my assistance and obtained the reg. no. of the vehicle that had struck me.
>
> 'I reported the incident via a 999 call to the police… The police interviewed me the following day… It has left me frightened to go out alone, as the police have refused to take the matter further.'
>
> Submission to inquiry call for evidence

Close to home

This was the setting for several reported incidents where the key perpetrators were neighbours and other local – especially young – people. One visually impaired respondent said the same people near where he lives 'bump' into him in a way that seems deliberate. He feels they want to provoke him and in turn he feels he mustn't respond or things will escalate; if he knows they are likely to be around, he does not go out.[133]

Some respondents were living in social housing that had become a local focus for repeated antisocial behaviour:

One person lives in an area where her house is the only one with a ramp for wheelchair access. The local children use it for skateboarding – they do it more and 'make a nuisance of themselves' when they know her husband is not in. They knock on her windows and look in, or knock on the door. They disappear when they see her husband's car.[134]

Some reported problems involved neighbours persistently and deliberately parking in reserved bays and in front of dropped kerbs.

The homes of disabled people can become targets, particularly if they have obviously been adapted for mobility aids. We have been told about incidents being triggered because of adapted parking spaces and vehicles outside homes, ramps and other adaptations to the outside of properties being used for targeting disabled people and resentment related to size and location of social housing allocations.

In the home

We have also been told about incidents that have taken place within the home where the perpetrators are family members or other people in the household, including: the withholding of food, water, communication and travel aids, money, medication and sanitary aids by placing out of reach; bullying; sexual assault and rape; violence; torture and murder.

133 Ibid., p17.

134 Ibid.

Some of the issues that exacerbate disability-related harassment in and around the home relate to poor or inadequate social housing and public space design and social and health care provision of housing adaptations that result in a 'bolt on' afterthought rather than an integrated approach to living in the community for disabled people. We share our recommendations later in the report in respect of addressing these issues.

School or college

School or college was the setting for a lot of reports of harassment, including from adult respondents who in many cases said they were still emotionally raw from experiences that happened to them a long time ago,[135] as discussed in the previous section.

Public transport

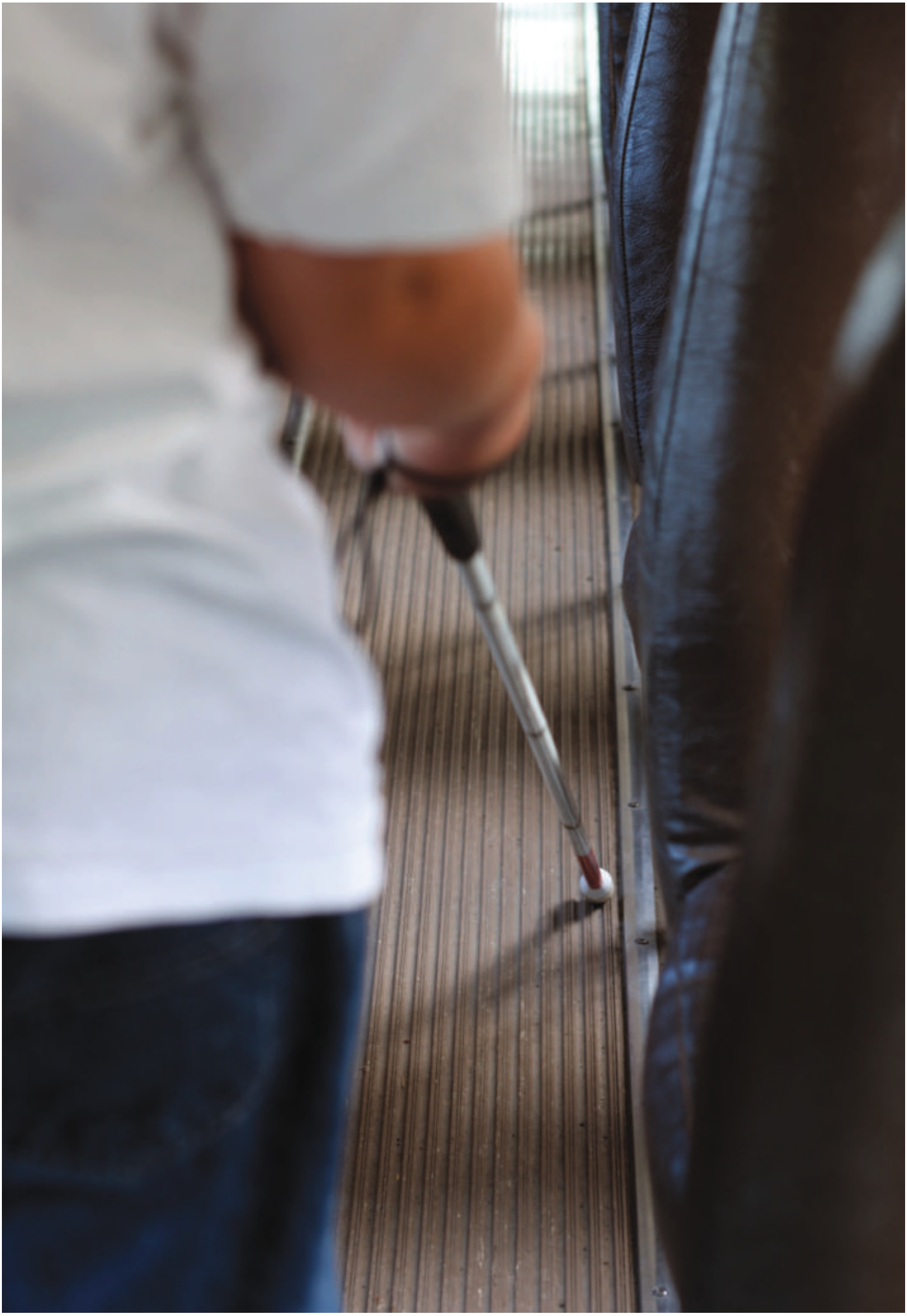
On and around public transport, including stations, stops, ticket offices and waiting areas were settings for harassment incidents cited in almost every focus group and interview. These affected respondents' lives not only because of the intrinsic features of the incidents themselves but also because many disabled people rely on public transport.[136]

Respondents mentioned being stared or laughed at, avoided and commented on by other passengers. They also talked about other passengers showing impatience or annoyance, for example if they were slow or took up a lot of space with aids such as assistance dogs, sticks, frames and wheelchairs.[137]

One visually impaired person recalled an example of such resentment, although it did happen some years ago. On a crowded tube train she had pulled her assistance dog onto her lap and when someone else put a case on top of the dog she pushed it slightly away. The other passenger slapped her, saying, 'Who do you think you are?'[138]

Respondents also complained about bus companies that did not maintain their wheelchair ramps in working order and about individual bus drivers who were inconsiderate or ignorant of their needs. One respondent with a mobility impairment said she often could not board buses because the drivers did not pull in close enough or refused to lower the step. Bus drivers were often seen to be overly concerned with their timetables, to the detriment of disabled passengers' convenience and safety. Respondents said that drivers in a hurry sometimes didn't stop for them or moved off from the bus stop before they were safely seated or – when getting off – before they were safely on the pavement.[139]

135 Ibid.
136 Ibid., p18.
137 Ibid.
138 Ibid.
139 Ibid.



Seating reserved for disabled people and wheelchair spaces on public transport were reported to be a major cause of harassment, especially where designed to be shared with groups such as pregnant women or people with young children. The main cause of the problem was perceived by respondents to be the 'competition' for the relatively small number of places:[140]

A blind person stopped using public transport and was living a much more restricted life because the driver on her route had on more than one occasion made her give up her seat for a woman with a child in a pram. Disoriented and offered no help by any of the other passengers, she found it difficult to balance on the moving bus and she was unable to see where to hold on. She was too traumatised by these incidents to keep on using the bus.[141]

One person with a mobility impairment gets stiff, is often in a lot of pain and needs to use a stick when walking. Recently, on a bus, there were children in the disabled seats, with their mother. It was crowded. She desperately needed to sit down. She stood near to them but no-one got up. She asked if they were disabled. The woman/mother was talking on her phone and said in a very loud voice: 'She is asking children to get up so she can sit on the seat.' Eventually one of the children stood for her in spite of the mother's attitude.[142]

Some academics told us that the 'bottleneck' effect of many people generally in a hurry to get to wherever they are going and the potential for someone who needs to do something a little differently, or slower, is evidenced as triggering anger or resentment or impatience. Public authorities and transport operators have a duty to pro-actively consider how they are going to effectively reduce this tension in their preventative work, for example, by designing out tension hot spots such as shared spaces that cause conflict, but we received little evidence of where this is being addressed.

One common theme that was reported by people who experienced harassment on public transport was that the operators' employees, especially bus drivers, did little to prevent the harassment from occurring, or were even the perpetrators of it. Disabled people stopped using public transport as a result, which left them more isolated and socially excluded.

Accessible facilities

The right to use accessible facilities was described as the basis for harassment incidents in a range of settings. One woman said she was so upset by constantly being challenged – mainly by other disabled people – about her right to use reserved parking, that she had returned her badge. Other respondents said they avoided disabled parking if at all possible because of the stress associated with being challenged or even with being looked at suspiciously. Some respondents felt that to be regarded as 'deserving' of

140 Ibid.

141 Ibid.

142 Ibid., p19.

certain services and facilities they are expected to fit some stereotype of how disabled people 'look' and 'behave'. A man who uses a wheelchair said people sometimes tell him that he should not use the buses, because 'you have your own buses'.[143]

Shops, cinemas, restaurants, clubs and other leisure venues

Respondents did not confine their accounts of harassment to settings in which public authorities have an obvious remit. Verbal and physical harassment incidents involving accessible facilities were also reported as having occurred in shops, cinemas, restaurants, clubs and other leisure venues. Some of the incidents involving accessible facilities (e.g. toilets) took place in these settings.

> 'Football is quite territorial in that it's really important to be with your own fans and unfortunately in a lot of football clubs at the moment disabled fans are put together in one group, and they are not with their own fans so it's quite common to be an away disabled fan in the home section of the stadium and most of the incidents of abuse we see start from that very point... it's happened to me personally we have experienced abuse when we have been spat on had coins thrown at us or cigarette lighters... and certainly stewards have been notified and sadly in almost every case the result has been to ask the disabled person to leave for their own safety.'
>
> Joyce Cooke, National Association of Disabled Supporters

Workplace harassment

Harassment in the workplace was outside of the terms of the reference of this inquiry, because we were focusing on the actions of other public authorities to eliminate harassment, and there is not an obligation in relation to employment that is specific to public authorities. However, we did receive evidence in respect of disability-related harassment in the workplace. We recognise that this is a significant barrier to the life chances of disabled people, and have collated evidence elsewhere in respect of the damage and harm it is doing.[144] For example, we know that disabled employees are over twice as likely as other employees to report experiencing discrimination, bullying or harassment in the workplace, while disabled women are four times more likely to report being bullied than other employees. While this report has not focused on the workplace, we do recognise that these experiences will exacerbate and compound experiences of disability-related harassment outside the workplace.

Perpetrators

Incidents of harassment recounted by disabled people involved a wide range of perpetrators: complete strangers as well as family, friends and acquaintances; men and women; younger and older people; and people from all social classes and cultures. In general, no one group was

143 Ibid.

144 See http://www.equalityhumanrights.com/key-projects/how-fair-is-britain/

singled out as more or less likely to be involved in disability-related harassment, although there was some perceived correlation between certain groups and harassment situations.

There is however, a distinct lack of evidence on both the motivation and the profile of perpetrators.

Harassment from family members and partners

A range of harassment and related problems were reported as occurring within families, or perpetrated by people with whom respondents were in relationships of some kind (although many respondents did report highly supportive relationships with family, partners and friends). Discussing this category of harassment exposed or touched on a complex array of issues.[145]

Some respondents thought family members were embarrassed or 'in denial' about having a disabled relative:[146]

> 'It comes back to the old thing, lock them up and make sure they are not seen around.'
>
> Man with a mobility impairment and long-term health condition, age 60-74

Respondents with mental health issues were particularly likely to mention difficulties with family members coming to terms with their condition ('the elephant in the room'). But respondents with a range of other impairments and health conditions also referred to the same issue:[147]

> 'My mother hasn't spoken to me for two years because she didn't like that I was epileptic. The last time I seen her, she wouldn't even stand next to us to speak to us. She stood at the other end of the mall and shouted across the mall, "I am not coming over there because you have got a bit of a cold and I am going to the hospital to see your auntie"... But I am used to this, it is normal... And what everyone has talked about here [in the focus group] is just normal practice and you had better get used to it because it is never ever going to end.'
>
> Focus group participant, man with mobility impairment, age 60-74

Individuals affected said that support from their family when they really needed it was not available.[148]

One person with an inherited condition said his family was ashamed of the genetic 'defect' and told others that he had had 'an accident' – to keep secret the 'family condition'.[149]

145 Sykes, W., Groom, C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*. Equality and Human Rights Commission, p21.

146 Ibid., p22.

147 Ibid.

148 Ibid.

149 Ibid.

Overt, direct and offensive verbal harassment from family members was also particularly reported by respondents in the mental health issues group, who sometimes regarded their condition as a special case in terms of the fear and prejudice aroused and the disruption to normal family relationships. Other examples include a man with learning disabilities who was harassed by his wife; a man with mobility impairment and long-term health conditions who said that his violent stepfather had picked on him when he lived at home as an adult (this example is discussed more fully later); and a woman with long-term health conditions who said her older relatives repeatedly called her 'a burden':[150]

> 'I'm absolutely still considered to be a burden at home, I'm being taunted at home, but I ignore it.'
>
> Focus group participant, woman with a long-term health condition, age 31-59

Some respondents said that harassment by people with whom they were in a relationship was complicated by emotional and physical dependency and the need to believe a relationship is genuine, however dysfunctional.[151]

Social deprivation

Harassment of disabled people occurs across the social spectrum. Respondents were from a wide range of social classes, and so were perpetrators. Examples of harassment were provided that took place in all kinds of areas and settings.[152]

However, disabled people are more likely to live in lower income households[153] and in more deprived areas,[154] so harassment is more likely to be concentrated in these locations. Moreover, evidence from our research suggests that social deprivation is an important contributing factor in some disability-related harassment. For example, in areas where unemployment is high and poverty an issue, antisocial behaviour targeted at disabled people may be more prevalent and resentment may build where disabled people are perceived to be getting special treatment, such as extensions and adaptations to their homes, special transport, and extra benefits. When it came to reporting disability-related harassment to public authorities, respondents sometimes felt that living in an area of social deprivation could 'fog' the issue, with the authorities likely to regard reported behaviour as typical of the area rather than dealing with it as disability-related.[155]

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150 Ibid.

151 Ibid.

152 Ibid., p48.

153 Palmer, G., MacInnes, T. and Kenway, P., 2007, *Monitoring poverty and social exclusion 2007*. York: Joseph Rowntree Foundation and New Policy Institute.

154 Scottish Public Health Observatory Disability: long-standing illness, health problem or disability. Available from: http://www.scotpho.org.uk/home/Healthwell-beinganddisease/Disability/Disability_Data/disability_LLI.asp.

155 Sykes, W., Groom, C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*. Equality and Human Rights Commission, p48.

Although harassment did appear to be a bigger problem in areas of social deprivation, it must be remembered that it occurs throughout all parts of society and all geographies, and is therefore relevant to public authorities throughout the country.

Perceived motivations for harassment

There is no definitive research or evidence to indicate motivation of disability-related harassment perpetrators. However, respondents suggested they felt there were a number of factors for the disability-related harassment that they experienced. One respondent outlined a spectrum of attitudes to disability:[156]

> 'There's a small percentage who are just – nasty – bastards I would say. There's a slightly larger percentage who are just ignorant, and if they had some sort of enlightenment they might be a bit better. A large percentage of people I think don't really understand but kind of are all right. Then there are a few people that think they know. Those who are really nasty are the ones I really don't like.'
>
> Focus group participant, woman with visual impairment, age 31-59

Ignorance about disability generally and certain types of disability in particular was thought by respondents to be pervasive, and a fertile breeding ground for disability-related harassment. Many respondents thought that there was widespread lack of genuine empathy for disabled people. One participant with impaired mobility said that people assumed her husband 'could not be her husband, must be her carer… because someone disabled could not have a personal life'. Another wheelchair user said people spoke to him as if his understanding was affected, and a woman with visual impairment said people behaved towards her as if they assumed that 'if you can't see you're also daft'.[157]

Some respondents said they felt non-disabled people were 'frightened' of them, of what they represented and perhaps of the possibility of being disabled themselves:[158]

> 'I hate people's attitudes – I suppose it's about learning difficulties as well as mental health – when they say things like, "Oh, don't get too close to them, you might turn out like them, or end up talking like them" that sort of thing. Like it's some contagious disease or something. It's not contagious! You just want to live your life and be a person".'
>
> Focus group participant, woman with mental health issue, age 18-30
>
> 'I think we bring out fear in people. "If you spot it you've got it"… I think it brings out a lot of fear in ignorant people. They go into attack and bully us in that way because it's actually touching on their insecurities. They are frightened of what is going on with them.'

156 Ibid., p23.

157 Ibid.

158 Ibid.

> Focus group participant, woman with mental health issue, age 31-59

Some respondents felt that people were sometimes embarrassed by them and uncomfortable about how to interact.[159]

> 'They don't want to help you.'
>
> 'It spoils their day basically.'
>
> Focus group participants, people with visual impairments, age 31-59

Some respondents saw harassment simply as an unthinking emotional response to being seen as 'different' and vulnerable:[160]

> 'In general I think that if people are vulnerable, if they are ill, in general people are cruel to them. ... We are animals... it is part of human nature... they are like feral rats. If you are in a vulnerable state, they look out for your body language and so on, and they pick on you, they attack, they are like hyenas. They look for the ones that are weak and torment them.'
>
> Focus group participant, man with long-term health condition, age 31-59

Some said they were seen as 'fair game' by people (especially young people) who were bored and had nothing better to do. They often took care to avoid adding excitement to this process, for example they refrained from reporting incidents to the police as this might only make the situation worse.[161]

Many respondents thought that their perceived vulnerability made them an easy target for criminal and/or predatory individuals seeking profit, power or sexual gratification.[162]

One said that last year someone came to the door saying he wanted to read the meter. Her lodger looked out of the window, and when the caller saw someone else was there he covered his head and left quickly. More recently there was another knock when she was in alone with her young daughter – she could tell from the intercom that he was breathing heavily, and standing close to the window. Her daughter looked out, and again he covered his head and left. She believes it is the same person. Both times the lodger's car happened not to be there, so she concludes someone nearby is checking out when she might be alone. From the voice she thinks it might be a taxi driver who used to pick her up. She has not reported her suspicions, 'the police might think I was crackers!' But she is very worried about it escalating, especially as her lodger is moving out soon. She is thinking of getting CCTV and another dog who will bark if someone is round the house outside – a guide dog is trained not to bark.[163]

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159 Ibid.
160 Ibid.
161 Ibid.
162 Ibid., p24.
163 Ibid.


POLICE LINE DO NOT CROSS
POLICE LINE DO NOT CROSS

While some respondents felt they were targeted because their impairment was visible (making them a more obvious easy target for prejudice, cruelty or opportunistic crime) others said they were sometimes harassed because their impairment was not visible. For example, Some Deaf respondents said people simply got impatient with their 'slowness' in understanding; one woman with a long-term health condition thought that most people attributed her breathlessness and frequent need to stop and rest in public places to her being overweight; another with multiple sclerosis found that if she was not using a stick people would comment that she was 'drunk' because of the way she walked. One respondent with a mental health issue said:[164]

> 'My mental health problems are not visible. I might seem to be a bit grumpy or a bit hyperactive ... and if people only see me in that moment they might think that's just my personality. It's only if people know me over a longer duration, and get to see the swings – and changes – and the variability that you can work out there is anything amiss.'
>
> Focus group participant, man with mental health issue, age 18-30

As already indicated, in some neighbourhood settings respondents identified envy and jealousy as a prime motivation for harassment of disabled people; not envy of their disability per se but of the perceived 'special treatment' they received as a consequence, be it disability benefits, housing adaptations, mobility aids and cars or reserved parking spaces, seats and toilets.[165]

One person with a mobility impairment and long-term health condition has an adapted car and a Blue Badge, and also mentioned that he has had a lot of new heating put in for free under a special scheme. He believes in taking advantage of anything that makes his life 'just a bit' easier. He feels, especially in relation to the Blue Badge, that: 'People get a bit jealous, which is weird. They just make comments, "You're lucky to have that". But anything that makes my life easier is just great.'[166]

One person's 19-year-old son with cerebral palsy had just had an extension built to meet his access requirements. The neighbours objected to the work on the grounds of noise but the respondent thought the real cause was jealousy; the neighbours also allegedly deliberately park across the dropped kerb outside the house designed to provide wheelchair access.[167]

Although there is a considerable literature on attitudes in relation to gender, ethnicity and sexual orientation, there is little on attitudes towards disabled people, especially in Britain. Analysis by the Office for Disability Issues (ODI) of the last two

164 Ibid.
165 Ibid.
166 Ibid., p25.
167 Ibid., p24.

British Social Attitudes Surveys (2005 and 2009) suggests that attitudes to disabled people may be improving.[168] In 2009:

- 7 per cent of those surveyed thought of disabled people as getting in the way compared with 9 per cent in 2005
- 17 per cent thought of disabled people with discomfort and awkwardness compared with 22 per cent in 2005
- 85 per cent thought disabled people were the same as everybody else, compared with 77 per cent in 2005.

However ODI also found that 'whilst few people reported openly negative views, many respondents expressed views that suggest they see disabled people as less capable than non-disabled people'. The 2009 survey shows that:

- Less than half of people would be comfortable if their MP had a learning disability or mental health issue
- Nearly four in 10 people thought of disabled people as less productive than non-disabled people
- Three-quarters thought of disabled people as needing to be cared for some or most of the time.

Impact

> 'It's completely unacceptable for anyone in this day and age and this country, or any other country, to live their life around a certain timetable, because there is a timetable based on fear of attack.'
>
> Home Office evidence session,
> Paul Daly, Hate Crime Policy Adviser,
> Home Office

Reactions to harassment vary. Few disabled people who participated in our research claimed to be emotionally unaffected, and some incidents left respondents profoundly shocked. Low-level harassment could have a major impact on a 'bad day' and its cumulative effect on individuals could be significant.

Reporting harassment

Our research for this inquiry supports previous findings[169] that suggest there is significant under-reporting of disability-related harassment to public authorities.

Fiona[170] was sitting in her car sharing a joke with her boss when their conversation came to an abrupt, and violent, end. In an apparent road rage outburst another woman driver strode up to Fiona and punched her in the mouth. Several witnesses immediately volunteered to give evidence against the attacker. Fiona's boss also said he would testify to the

168 Office for Disability Issues, 2010, *Public perceptions of disabled people*. Available from:http://odi.dwp.gov.uk/docs/res/ppdp/ppdp.pdf

169 Equality and Human Rights Commission, 2009, *Promoting the Safety and Security of Disabled People*.

170 Not her real name.

unprovoked assault, which took place in a city in the north of England.

But when Fiona, who has cerebral palsy, went to report the incident to the police, their reaction had possibly a more detrimental long-term effect on her than the attack. 'The first thing they asked me when I went to the police station was "what had I done to provoke the assault?" It felt like there was an automatic assumption that it had to be all my fault, because they would not believe a non-disabled person would attack a disabled person.'

The police refused to take the case further, says Fiona, who at the time of the assault was a project officer for a disability organisation. The police said that her assailant had been going through a difficult divorce at the time of the incident. 'The inference I drew from this report was that her own personal trauma made it OK for her to punch me', says Fiona. 'So she got away with it, and I was too scared to drive past the place where it happened for another six months.'

This incident, which happened in the mid-1990s, was not an isolated one for Fiona. Previous reports of sexual harassment and a break-in were also ignored by the police. Now aged in her late 40s, she no longer believes it worthwhile to report a crime for fear of being blamed or ignored due to her disability. 'I have learnt the hard way that I am absolutely on my own when it comes to being the victim of crime. I will never report any future incidents of crime to the police, because their refusal to take my reports seriously has previously left me feeling even more scared and alone than I was by the incidents themselves.'

A relatively small number of the total incidents mentioned by respondents in our focus groups had been formally reported to anyone, rather than simply talked about informally with friends or family. While deciding formally to report an incident is a deliberate and considered act, not reporting an incident was often the outcome of much less conscious decision-making. Factors that inhibited respondents from reporting disability-related harassment to public authorities included the following:[171]

Not recognising harassment incidents

Respondents didn't necessarily recognise what had happened to them as disability-related harassment, or were sometimes not sure. Incidents might be seen purely as unpleasant events that had occurred, independent of their impairment or health condition. One visually impaired woman who was sexually harassed at a bus stop wondered:[172]

171 Sykes, W., Groom, C. and Desai, P., 2011, *Disability-related harassment: the role of public bodies. A qualitative research report*. Equality and Human Rights Commission, p.30.

172 Ibid.

> 'Is it because he's seen my cane, or because he always does this with women?'
>
> Focus group participant, woman with visual impairment, age 31-59

A few respondents with neuro-diverse conditions said they hadn't recognised treatment – for instance by teachers or employers – as disability-related harassment until long after the event.[173]

Embarrassment or shame

Some respondents said that they felt embarrassed or ashamed of being taken advantage of or abused. Some group and interview sessions were highly emotionally charged for respondents who were talking publicly about harassment for the first time:[174]

One person with a learning disability and other health conditions has very weak eyesight. He says that he is harassed on a daily basis by his wife, 'everyday telling me you are bad, you are blind'. She restricts his movements, takes his money and passport, and controls his mail. His GP has advised him to have counselling, but his wife has kept his appointments from him. He has told family members, but no-one else. He does not want to involve the police or social services because he doesn't want his family life or his relationship with his wife to be disrupted, 'I am truly loving her.' He also said that he thought if he told people what was happening to him they would laugh at him, because he is a man being harassed by his wife.[175]

Low self-esteem

Some respondents said they had low self-esteem and lacked the personal confidence to report incidents of harassment. For example, one respondent with a learning disability said he was very nervous as a result of having been bullied most of his life. He said that people stare at him and he is constantly wondering if he is dressed wrongly, or whether he is in a place where he isn't 'allowed'. He keeps his problems to himself and broods on them. He will open up if someone invites him to, but he says he needs them to be sensitive enough to know that something is wrong and to ask him about it.[176]

Concern about the process being stressful

Many respondents were put off reporting because they thought it would be physically, mentally or emotionally stressful:[177]

> 'It is a hassle and I don't want to go through all that. You know, I'm 70. It's just too much…'
>
> Focus group participant, woman with mobility impairment, age 60-74

173 Ibid.
174 Ibid.
175 Ibid.
176 Ibid., p31.
177 Ibid.

'When you are feeling a bit better it's hard to remember how you felt when you were really ill, that is the problem... If you have any kind of illness, you haven't got any fight in you to fight it; you are fighting to get better. You just can't. The rest of the time you feel it is futile, a waste of time. That time would be better spent trying to look after myself and my mental health.'

Focus group participant, woman with mental health issue, age 31-59

'I think part of the reason you don't get into this reporting is that for everything you want, you have to fight for it. If something happens you think, "I can't be doing with all this stress". You have had to go through it all just for the simple things, like going shopping. So you just get home and think, you know, I don't have the energy. It takes its toll.'

Focus group participant, woman with visual impairment, age 31-59

Reporting harassment to public authorities

Many respondents knew very little about the duty of public authorities in respect of disability-related harassment. As suggested earlier, the idea of reporting harassment to a public authority seemed to be something of a new thought to some respondents; they hadn't really considered the possibility before, especially in relation to some more common, low-level incidents. Nor was it clear to them which public authority it would be appropriate to report individual incidents to or whose remit it was.[178]

No confidence that public authorities will take you seriously

Respondents often said they did not feel they would be taken seriously if they reported an incident, and doubted that anything would be done, especially if the perpetrator couldn't be identified or the incident was a 'one-off'.[179]

One person has a mobility impairment and uses a stick. Coming out of a pub with his girlfriend a few young people in their twenties started calling him names, like 'spastic'. He told them to 'f*** off' and one punched him in the face, knocking him to the ground. He thinks that for the perpetrators this was 'a bit of fun – especially if they're with their mates. It's much funnier.' He managed to get away and back to his car and drove off. He

178 Ibid.

179 Ibid.

thinks he was hit because the perpetrator 'had to look hard' in front of the others.

He did not think of reporting. He didn't think there was any point because the police wouldn't want to know. If he had been really hurt he might have thought differently, and fear of reprisal wouldn't have stopped him. If the person had been caught he does not think anything much would have happened to them. He is influenced by media reports which he thinks demonstrate that even rapists and murderers get very short sentences; they are let out early and 'nearly always' kill or rape again.[180]

Some respondents were sceptical of how much public authorities **could** do to prevent or take action against disability-related harassment even if they were willing to listen. This was partly about the powers available to public authorities, as one man said about being harassed by local children:[181]

> 'What can they do, ban kids?'
>
> Man with mobility impairment and long-term health condition, age 31-59

Public authorities were also sometimes criticised for a 'box ticking' mentality and an overriding concern with targets and appearances at the expense of genuine action, which respondents said undermined their confidence in reporting harassment.[182]

Low expectation of a sympathetic hearing from public authorities

Some respondents worried about reporting incidents to an unsympathetic ear; for example someone who couldn't empathise with their situation as a disabled person or see an incident from their point of view:[183]

> 'You tend to think that the police aren't people like me. You are not going to get disabled people in the police force... Perhaps they should employ people that have sensitivity to those issues if they don't themselves.'
>
> Woman with visual impairment, age 31-59

> 'I find even from medical professionals I don't always get great reactions if I disclose [that he is bipolar]. These are people who are being trained to help you. Other authorities, I would feel even less confident about disclosing to unless I absolutely had to.'
>
> Man with mental health issue, age 18-30

Low expectation of having access needs met

On the whole, respondents had low expectations that public authorities would have good knowledge or understanding of the needs of disabled people, or provide

180 Ibid., p32.
181 Ibid.
182 Ibid.
183 Ibid.

the right access, communication and psychological support, even at the reporting stage. For some, form-filling was itself a deterrent:[184]

> 'As soon as I have forms, I get that terrible creeping feeling of not wanting to be there at all. Forms are my sort of nemesis. Face-to-face oral reporting would be a minimum requirement.'
>
> Focus group participant, man with neuro-diverse condition, age 18-30

One participant with some experience of campaigning on disability matters other than harassment commented that, if it came to seeking redress, courts and the court system were 'among the worst' for meeting access needs – for parking, physical access, documents in accessible formats and so on.[185]

Negative past experiences of dealing with public authorities

Some respondents said they had had negative dealings in the past with public authorities that would put them off reporting harassment incidents. For example, a number of those with mental health issues or learning disabilities had 'been in trouble' with the police and found it hard to see them as potential allies:[186]

> 'I have had a few experiences with the police before when they have just called me a liar to my face. So I don't like the police very much because they are never there when you need them, just when they are getting you into trouble and stuff like that... I remember this one time I was in a fight with this guy who started winding me up because of my ADHD, and the police broke it up and asked who started it. And I said it was the boy who was winding me up because of my ADHD and the policeman said "stop making up ADHD, there is no such thing". So I started going nuts with him and he didn't believe me.'
>
> Focus group participant, man with learning disability, age 18-30

One person with a visual impairment mentioned many incidents. But there was only one she ever reported to the police and it happened many years previously when she lived in London and used the tube. A man kept touching her legs in spite of her protests and tried to follow her off the train – she only got away because two other passengers stopped him from alighting. She knew many visually impaired people used the network and for that reason decided she should report it to the police. She remembers, 'They said there's nothing we can do. You don't know what he looks like – [laughs].' In fact she had some sight at that time and had given a partial description. She felt also they thought it was pretty trivial. 'There was nothing [in the police response] that encouraged me, clearly, because I never have again [reported incidents]...I thought they would just say the same, you can't give us any information.'[187]

184 Ibid.
185 Ibid.
186 Ibid., p33.
187 Ibid.

Other respondents said they had found public authorities such as local authorities or transport providers difficult to communicate with or to access in the past, and overly rigid or process bound in their dealings with disabled people.[188]

Some respondents who lived in areas where antisocial behaviour was common said they were accustomed to the seemingly automatic response when complaining that 'everybody gets that'. One person in the mobility group said how having the tyres on her mobility vehicle let down frequently means she is stranded:[189]

> 'Any of those things to a policeman is sort of "oh, lots of people have their tyres let down", but they don't see what effect that has on a disabled person which is why they are reporting it.'
>
> Focus group participant, woman with mobility impairment, age 31-59

Anxiety about reprisals or other unwelcome consequences

Respondents sometimes said they were anxious about possible reprisals and of making matters worse if they reported incidents. A common fear was that situations would be only half dealt with at best, leaving them to face the consequences:[190]

> 'I'm not going to walk into the police station. When you're that frightened, you can be paranoid about making a phone call – it might sound crazy but if you are that scared you think of anything that could increase the danger. People don't feel safe to report... These are serious issues that affect people's lives. Once you say to people come and report, they really need to know that that's solid, not just something that's got to be done so your chief officer gets a pat on the back.'
>
> Focus group participant, woman with visual impairment, age 31-59
>
> 'The trouble is reporting individuals you'd be frightened.'
>
> Focus group participant, man with long-term health condition, age 60-74

Where incidents had been perpetrated by friends, family or acquaintances, respondents said they could be anxious about damaging or losing the relationship:[191]

> 'There is an emotional investment – it's called Stockholm Syndrome where you put an emotional investment into somebody because you are needy, then even if they are running riot with you and using you because in some way you are completely emotionally dependent on them – you wouldn't do the obvious thing that would seem so straightforward to someone who wasn't vulnerable or had a problem. You are emotionally reliant on someone that

188 Ibid.
189 Ibid.
190 Ibid., p34.
191 Ibid.

treats you badly. There is a need being met but there is a huge price to pay.'

Focus group participant, woman with mental health issue, age 31-59

Self blame

Respondents often blamed themselves or said they thought they might have contributed in some way to incidents that had happened to them. This was another potential barrier to reporting; making it harder for respondents to tell someone about the event and increasing the concern that their side of the story might not be believed.[192]

Uncertain outcomes

To set against the barriers, doubts and concerns such as those already outlined, the potential positive **gains** from reporting or making a complaint often seemed uncertain to respondents – for example in terms of identifying and punishing the perpetrators and/or stopping further incidents.[193]

Experiences of reporting to public authorities

Our research indicated that disabled people are more likely to report harassment incidents if:

- The incident was undeniably serious, for example was a criminal or potentially criminal act, or carried some future threat. This is one reason why a high proportion of the examples of experiences of reporting to a public body provided later in this section involve incidents that were reported to the police.
- They were able to identify an organisation with a clear remit to address the kind of problem presented by the incident.
- They knew where and how to contact the relevant authority and did not feel worried or intimidated by the prospect.
- They felt there was a realistic chance of achieving a desired outcome, such as catching and punishing perpetrators, or better training for staff in an organisation.[194]
- The reporting mechanisms were known to be accessible.

Good experiences of reporting

Good experiences from the respondents' viewpoint were those where, for example:[195]

- It was clear who to report to.
- The process was accessible to the complainant.
- They were met with a sympathetic and understanding reception.
- The authorities responded swiftly, where it was called for.
- Staff concerned were disability aware

192 Ibid., p35.
193 Ibid., p36.
194 Ibid., p37.
195 Ibid., p39.

and sensitive to the needs of the person reporting harassment.

- They were given the opportunity to describe the incident in full.
- Something happened in response to the report, that satisfied them to some degree.
- They were kept informed of what was being done.
- A resolution was sought that reduced the risk of reprisals or escalation of the problem.
- Intermediary support was offered.

It should be noted that positive experiences of reporting increased the likelihood of reporting future incidents, and that sometimes this could be irrespective of whether the incident itself was satisfactorily resolved. For example, one respondent in the Lesbian, Gay, Bisexual and Transgender group had reported several incidents to the police, even without being able to identify the perpetrators and with hardly any success in terms of tangible outcomes. His reporting behaviour was reinforced because he felt that each of his reports had met with an appropriate, sensitive and sympathetic response.[196]

One person with a mobility impairment and long-term health conditions was going to the hospital alone about three months previously. She was crossing a road when a complete stranger came up to her, spat at her and called her a 'crippled bitch'. She reported the incident to the police without hesitation, though it 'could not be followed up' because she could not say who it was or where they lived. She found their response very frustrating: 'The police are under this illusion. If a disabled person reports an incident against them, the police don't always log it as a hate crime even though the person is disabled and this could be an ongoing thing with them... A lot of this is still under a blanket and we need to bring it out, and bring awareness.' She has since taken steps to set up a reporting centre to help the police build a profile of incidents in a particular area, and also 'educate police' about the kinds of things going on. She says the police at local and regional level are backing the initiative, though it is independent of them. The centre will offer support and take details of incidents without rushing people and 'where they can moan and cry if necessary'. She is keen to encourage reporting, ideally through a 24 hour helpline. She thinks the centre should be funded as a public service but is prepared if necessary to continue to obtain funding for it herself.

Some respondents chose an indirect route for reporting incidents, preferring to be represented rather than reporting themselves. This could be, for example, because they lacked confidence to tackle reporting procedures, did not think that they would be listened to or taken seriously or were worried about reprisals and therefore wanted to remain in the background. Representatives in these instances were often disability groups or organisations that the respondent knew and trusted.[197]

196 Ibid.

197 Ibid.

One person with learning disabilities has had a lot of harassment from kids near where he lives; throwing stones at the windows and other missiles to get him to come out and chase them. Also every time he went out he got taunted and followed. He told staff in charge of the shared house. Cameras were installed which cut down on the harassment around the house, for example damage to the property, but didn't prevent the kids from harassing him on the street. The police were involved, a community officer came to talk to the kids, and so did the ordinary police, though the kids would disappear when the police were there. The 'person in charge of the house' dealt with the police rather than him. He feels they wouldn't pay him much attention, but they do listen to the person in charge of the house.[198]

A person with mobility impairment who lives in housing for disabled people said that children living in the neighbourhood targeted her home and damaged her garden, pulling up plants and stealing ornaments. She reported these incidents to the local estate officer who came to her house and took photos of the children, whom she recognised. She (the estate officer) was able to talk to the children's parents who agreed to put a stop to the problem. One of the parents brought her daughter round with a bunch of flowers to apologise. This was felt to be a satisfactory outcome resulting from having 'good people' in the right posts to listen to and deal with reports and complaints. The estate officer was locally based, knew the neighbourhood, was able to take the time to investigate the case thoroughly and sensitively and sought a resolution that reduced the risk of escalation.[199]

The following case, though it achieved an outcome eventually that was what the respondent wanted, shows the enormous amount of effort and commitment from disabled people themselves that is sometimes required before a situation is addressed by a public authority:[200]

Case study

One person has a long-term health condition that affects her in various ways when it flares up, including her mobility. Her teenage daughter also has a long-term health condition. The family lives in one of a group of five houses for disabled people on the edge of a housing estate which has a lot of deep-seated social and economic problems. For years the five families were regularly targeted by local children (ages estimated from six to 14 years). They would climb on the roofs, damage and destroy their cars, destroy their bins. 'They were ruthless.' She was in her garden at the front of the house one day when a little girl stopped and said, 'Oh, your flowers are very nice!' before adding: 'Are you going to use them on your grave?' The respondent said it was very clear in context that all these incidents were related to the neighbours' resentment and hostility towards those in the housing set aside for disabled people. The respondent

198 Ibid.

199 Ibid., p40.

200 Ibid., p42.

found these incidents very stressful and frightening. On more than one occasion her car, which she relies on for work and to transport her daughter, was damaged. Another respondent in this group commented: 'Unfortunately, if they group you together you then become a prime target.'

The police – including the community police – were called on many occasions, but with little result and with some escalation of the problem: 'It was a mistake involving the police actually. Because that was making them (the children) more upset. And the police were like, "oh, there's nothing we can do any more".' In the end, the respondent and one other resident organised a petition to the local council to make the properties more secure. The matter went to consultation for more than a year during which they thought that nothing was going to happen. The respondent was very persistent, kept logs of incidents and of all correspondence about the matter. She had to become very organised and evidence-based. 'My bedroom is full of files!' Finally new measures were installed including security gates round the small complex. There are still incidents but both the frequency and the intensity are much less. However the residents still have to be sure not to leave their cars outside the gates.[201]

Bad experiences of reporting

Bad experiences of reporting from the respondents' standpoint were those where:

- The reporting process was difficult, impossible or unclear.
- The organisation and individual staff concerned were unreceptive and/or insensitive to the respondent's impairment-related needs.
- Nothing happened following the complaint.
- They were not informed of any action that had been taken.
- There was escalation of incidents as a result of reporting:[202]
- The report was not believed.
- The disabled person was not seen as a credible witness.
- The incident was dismissed.
- The issue was not taken seriously.
- The issue was not understood.
- The matter was passed onto other authorities.

In some cases, attempts to report harassment were unsatisfactory because no one would accept that the incidents were part of their remit or that there was anything they should do in response to them.[203] Below are some examples.

201 Ibid.
202 Ibid., p43.
203 Ibid.

Case study

One person has been visually impaired since birth. After losing her remaining sight, she took some time to regain her confidence enough to use the familiar bus that she relied on to get to town, using the seat set aside for disabled people. One day the driver advised a woman with a young child to 'Get that girl to move.' 'He couldn't talk to me, had to get them to do it.' This experience was repeated on a number of occasions with the same bus driver involved each time. She felt that he was targeting her personally. She was upset and more than once reduced to tears. Her confidence was undermined and she eventually stopped using the bus on her own, so can only travel to town if she goes with friends. 'I have not been able to travel on my own now for two years.'

She did not complain directly to the bus company because she knew that the driver would be able to identify her as the complainant and she was afraid that matters would be made worse. She discussed the case with the Guide Dogs Association who took it up in a general way with the bus company concerned, but there is no evidence that any action has been taken. For example, she has not heard if the driver has been offered disability awareness training. She would have liked the driver to receive some education about how to speak to a person with visual impairment and how to help them.[204]

Case study

One story was told by the representative of the person concerned who was too frightened to attend a focus group herself, or have her name mentioned in the group. She has cerebral palsy and is the single parent of five children, separated from her ex-partner because of assault and abuse. The police had her re-housed in disabled accommodation in a different area so she would be safe from him, but in her new home windows were broken even before she had moved in. Her windows were broken more than 20 times and stones and other things were thrown at the house, which she was frightened to leave. On one occasion she was at her kitchen window washing her dishes when the window was broken.

She contacted the police and the housing company on several occasions and was told by the housing officer 'everyone gets this'. The police told her they have higher priority crime to deal with. Her children were at the same school as the main perpetrators, so they had no respite from the harassment either at home or school. In the end the house was being bombarded by snowballs or eggs for hours at a time, but because there was no injury or damage, the police said there was nothing that could be done; even though the incident was reported. She says that the police implied that she was being paranoid. The final outcome was that the family was eventually re-housed again which was what they wanted.[205]

204 Ibid., p44.

205 Ibid., p45.

Reporting issues and respondent subgroups

The preceding sections cover reporting issues common to many respondents irrespective of the type of impairment or health condition. However there was also some evidence of important differences between impairment subgroups. For example some respondents with mental health issues said they had uneasy relationships with certain public authorities such as the police (who may have been involved in complaints made against them, or in helping forcibly to section them), and/or with health personnel (who may have imposed compulsory forms of treatment, or whose treatment may have been experienced as inadequate or unsatisfactory). They also sometimes said they were accustomed to not being believed, on the grounds of their mental health issue.[206]

Similarly some respondents with neuro-diverse conditions lacked confidence that their condition (or any report of harassment) would be taken seriously by public authorities.

People with HIV or AIDS told us about disparities in the law:

> 'With HIV there is another complication around the police. Because you can be prosecuted for reckless HIV transmission.
>
> 'We see it in other situations like we work very closely with... they work with young people with HIV. There are some young people (who were born) with HIV who are now in their teens, and becoming sexually active. And some of them are in care or in contact with the care system. And I can tell you about one case where a 15-year-old girl began having sexual relationships with men somehow or other her social worker found out that she had had sex with two older men and that they had (subsequently) raped her and instead of the police... dealing with those men, they and the social worker were all down on that young girl, for having underage sex and putting them at risk. We are very wary, of encouraging people to go to the police.'
>
> Individual submission to the inquiry[207]

Important variations between and within impairment groups mean that public authorities need a sophisticated model of disability awareness that extends well beyond enabling access for wheelchair users and communication for people with sensory impairments.

206 Ibid., p46.

207 Ibid., p47.

Initiatives to make reporting easier

It was encouraging that over half of the police and criminal justice agencies who responded to the inquiry's call for evidence considered it important to make it easier for disabled people to report disability-related harassment. A number referred to various innovative approaches they were adopting to enhance reporting, although most are very recent and it has not yet been possible to gauge their effectiveness. They included:

- Sponsoring the production of information booklets
- Supporting a local organisation to develop a DVD on improving the reporting of crime
- Making disabled people aware of all the different methods of reporting an incident, for example phone, textphone, email, text messaging, remote or third party reporting.

Suffolk Hate Crime Service[208] is a partnership between Suffolk Constabulary and Suffolk County Council. It deals with hate crime across all the diversity strands and has been widely advertised. The service has produced a DVD on the impact of hate crime and is providing training for a group of adults with learning disabilities, the 'Respect Champions', who will support hate crime officers in delivering awareness sessions to their peers. The team is also training councillors and front line staff to help them identify hate crime among the clients they come into daily contact with.

Reporting rates have increased in Suffolk.

Third party reporting schemes have been introduced by many police forces. They can offer victims and witnesses of harassment a safe environment for reporting harassment without contacting the police directly. They provide information and advice and can support people to report to the police and pursue an investigation. Police will only investigate the crime with the victim's consent. A number of police forces referred to increases in hate crime reporting as a result of third party reporting initiatives.

To be effective, a third party reporting scheme needs to be well advertised and fully accessible. It should be seen as only part of the solution, and not a replacement for public bodies addressing barriers to disabled people accessing their own services.

> 'I went into my local police station... I remember there was a poster on the wall about hate crime against disabled people and I thought how fantastic... I said to the guy behind the desk, 'so does that mean if I were to come in and report a hate crime, there'd be proper support for me?' He said, "Oh no, we just got it from head office".'
>
> Key informant interview, Tara Flood, 28/07/10

To be successful, reporting initiatives need to be backed up by training and guidance for staff and properly evaluated.

208 See www.suffolkhatecrime.org.uk/

Beyond the criminal justice system, only a handful of other public authorities (four local councils[209] and one transport provider)[210] commented on reporting systems within their responses to the call for evidence. This suggests that community based agencies such as local authorities, housing providers and health services may not recognise the role that they should play in encouraging reporting of harassment to them.

Some disabled people's organisations have started to develop advocacy and casework services specifically for victims of disability-related harassment which can encourage reporting, help with safety planning and support disabled people through any ongoing investigation.

There is scope for further development of specialist advocacy services, potentially using the national approach to the provision of independent sexual violence advisors (ISVAs)[211] and independent domestic violence advisers (IDVAs)[212] as models.

There is also scope for increasing reporting of harassment by both members of the public and public officials.

Recognising and recording harassment

Increasing reporting is a crucial aspect of improving responses to disability-related harassment but it is of limited value if it does not trigger action to end it.

The lack of urgency in responding to harassment of disabled people is linked in part to the lack of recognition of disability as a potential motivation for bullying, antisocial behaviour and hate crime. This lack of recognition leads to a lack of recording of bullying, antisocial behaviour and crime as linked to disability. Not all agencies have adequate systems to enable harassment to be recorded as disability related, especially for victims who may also be members of other groups who are targeted for harassment such as black and ethnic minority communities.

The Commission's thematic review of public authority responses to identity-based violence found the following barriers to recording:

- Lack of a decent database/software limitations
- Data protection issues

209 Leicester City Council, Essex County Council, Norfolk County Council and Rotherham MBC.

210 Greater Manchester Passenger Transport Executive.

211 ISVAs provide advocacy to help victims of sexual assaults to access the services they need including advice on reporting, the criminal justice system and availability of counselling/other support. In England and Wales they are funded by the Home Office.

212 IDVAs provide support to victims who are at high risk of harm from intimate partners, ex-partners or family members. They act as the main point of contact for the victim and provide information, help with safety planning and practical support in navigating criminal and civil courts, housing services and other agencies. In England and Wales they are funded by the Home Office.

- Lack of staff knowledge (e.g. sometimes the decision to flag a case is left to administrative staff without sufficient knowledge), and
- Lack of resources.

Multi-identity issues

> 'Five youths jostled my chair and laughing at me, called me a n***er in a wheelchair. I felt scared, shocked and deeply humiliated. Call the Police? It never occurred to me. What would they do?'[213]

The Commission's previous research found that disabled people may be targeted because of 'intersectional' aspects of their identity (or multi-identity) – age, race, religion, gender, sexual orientation, sexual identity – as well as disability. It suggested that women and younger people may be more at risk of experiencing harassment and that those with learning disabilities and/or mental health issues are particularly at risk and suffer higher levels of actual victimisation.[214]

We sought to explore how public authorities respond to victims with multiple protected characteristics. There appears to be little understanding of how a victim may be targeted as a result of more than one aspect of their identity and how to meet the needs of diverse victims. For example, rape and sexual assault against disabled women tends to be dealt with only as a 'violence against women' issue rather than potentially both a violence against women and disability-related harassment issue. A report by the Crown Prosecution Service Inspectorate examined 151 cases of rape cases and found that mental health and learning difficulties were 'frequently identified vulnerabilities'[215] yet this does not appear to be on the radar of people managing 'violence against women' programmes.[216]

The Commission's thematic review of targeted violence across strands found that agencies tended to have a silo mentality when responding to people with multiple protected characteristics and would focus on only one aspect of a person's identity. When the Metropolitan police reanalysed its data on victims of racist and homophobic hate crime, they found that a disproportionate number of them were also disabled.

Some respondents in the focus groups commissioned for this inquiry felt that they could be at a 'double disadvantage' in relation to harassment, with harassment within their own community based on their disability and in wider society based on their disability and/or other characteristics such as race. The focus groups also found that the nature of

213 Quoted in submission to the Inquiry by Metropolitan Police Authority (MPA), from a report commissioned by MPA, *Disabled People and the Police: A New relationship*.

214 Sin, C. H. et al., 2009, *Disabled people's experiences of targeted violence and hostility*, Research Report 21. Equality and Human Rights Commission, p14.

215 See http://www.hmcpsi.gov.uk/index.php?id=47&docID=258

216 Ibid.

someone's impairment could affect experiences of harassment and responses to it, for example people with mental health issues had less confidence that they would be believed if they reported.

Just under a third of individuals who responded to this inquiry's call for evidence told us why they thought they'd been targeted. While most thought it was because of their disability around a third mentioned other factors in addition including age, gender, race and sexual orientation.

The Crown Prosecution Service told us that there have been no recorded cases of double aggravation on record despite evidence that indicates some disabled people are being targeted on other grounds as well as disability. The Association of Chief Police Officers also told us that their current electronic recording systems prevent flagging more than one personal characteristic for motivation purposes.

The evidence submitted to the inquiry indicates that hostility based on multiple personal characteristics is an area that requires more understanding and research to ensure that public authorities and transport operators are adequately addressing the issues faced by those with significantly enhanced chances of multiple harassment.

Part 4: Responses to harassment

Introduction

A central aim of this inquiry was to investigate how disability-related harassment is dealt with by public authorities, public transport operators and others. It was clear to us, having identified the scale of the problem, that the collective response to this issue was far from sufficient. The current system is not succeeding in preventing harassment occurring in the first place; neither is it ensuring that perpetrators face consequences for their actions.

This is a problem which needs to be better dealt with by the criminal justice system. However, organisations such as local councils, housing associations and health agencies also play a key role. Crucially, such community-based organisations are well placed to recognise and deal with harassment before it escalates to a level where the criminal justice system is involved.

In this chapter we considered evidence from organisations including the police, local authorities, the courts, schools, housing providers and public transport operators. We asked them to tell us how they work to prevent disability-related harassment and to deal with it when it is reported. Although we identified some pockets of good practice, we found a number of common problems. These were:

- Incidents are often dealt with in isolation rather than as a pattern of behaviour.
- There is a lack of consideration by agencies of disability as a possible motivating factor in bullying, antisocial behaviour and crime. As a result, the response to harassment is given low priority and appropriate hate incident policy and legislative frameworks are not applied.
- Left unmanaged, low level behaviour has the potential to escalate into more extreme behaviour. Opportunities to bring harassment to an end are being missed.
- There is often a focus on the victim, questioning their behaviour and 'vulnerability', rather than dealing with the perpetrators.
- Agencies do not tend to work effectively together to bring ongoing disability-related harassment to an end.
- There has been little investment in understanding the causes of harassment and preventing it happening in the first place.
- There are barriers to reporting and recording harassment across all sectors.
- There are barriers to accessing justice, redress and support so most perpetrators face few consequences for their actions and many victims receive inadequate support.

- There is a lack of shared learning from the most severe cases, so the same mistakes are repeated again and again.

Taken together, this amounts to systemic institutional failure to protect disabled people and their families from harassment.

Why should agencies take action?

As we have shown in Parts 2 and 3 of this report, disability-related harassment has a significantly detrimental impact on the lives of disabled people. Agencies discussed in this chapter should act to prevent, recognise, record and tackle disability-related harassment, simply because it is the right thing to do.

However, they do also have a responsibility to have 'due regard' to eliminating harassment related to disability, initially under the Disability Equality Duty (DED) and more recently under the new public sector equality duty (PSED) (for more information on the equality duties, see the section on 'The legislative framework' in Part 1). They also have a duty to have due regard to the need to foster good relations. The Equality Act 2010 describes fostering good relations as tackling prejudice and promoting understanding between people from different groups.

We recognise that agencies are operating in an environment where resources are constrained, and that every decision has to be justified. But it is worth pointing out in this context that public authorities have a statutory obligation to act on this issue.

The public sector equality duty

The public sector equality duty (PSED) should be a helpful tool for public authorities to demonstrate that they are engaging with their equality obligations and implementing policies accordingly.

A DED questionnaire (see Appendix 14) was emailed to all public authorities in England, Scotland and Wales:

- police forces
- local authorities
- NHS primary care trusts, foundation trusts, health boards, hospitals and ambulance services
- higher and further education institutions.

Although response rates were low, the questionnaires that were returned suggest that public authorities are not meeting their obligations. Of those authorities that responded,[217] just over half (52 per cent)[218] said that they had included disability-related harassment as a priority within their disability equality scheme or single equality scheme and were undertaking a range of actions to address it including awareness-raising and encouraging reporting. However, there was little evidence of well-developed

217 The questionnaire was deliberately short, in recognition of the time constraints on many authorities, but fewer than one in six responded.

218 A greater proportion of authorities in Scotland (83 per cent) and Wales (68 per cent) said they had included harassment as a priority than in England (48 per cent).

prevention strategies, without which public authorities have little chance of eliminating harassment.

Alongside this inquiry, the Commission has been undertaking a review of the responses of public authorities to targeted violence[219] across all protected strands. Most of the authorities surveyed said that they had policies in place relating to harassment but almost half had no action plan to turn policy into reality. Preventing harassment was not a priority for most authorities.

A key part of complying with the previous Disability Equality Duty and the new public sector equality duty is for public authorities to gather and use evidence to understand the major challenges that they need to address and set goals for improvement. Public authorities are only able to have 'due regard', and meet their legal requirements under the duties, if they understand the impact on protected groups of how they carry out their functions. They will not be able to do this unless they have gathered and used sufficient evidence in making decisions about how they exercise their functions.

Schools

> 'You're right to identify [a] pivotal role for education in shaping attitudes and values.'
>
> David Bell, Permanent Secretary, Department for Education, inquiry hearing, 27/01/11

The inquiry held a special hearing session on the role of schools in addressing disability-related harassment involving schools, bullying charities, academics and the Department for Education. Schools also contributed to a special hearing on cyber-bullying. We held formal inquiry hearings with Ofsted, Estyn, Her Majesty's Inspector of Education and the Department for Education. A number of key informants and submissions to the call for evidence referred to the role of schools.

Schools have a significant role to play in changing attitudes to disabled people through:

- increasing integration and inclusion of disabled pupils into society on an equal basis with non-disabled pupils
- reducing fear of difference and encouraging understanding of diversity
- dealing effectively with bullying of disabled pupils, both at school and outside it
- dealing effectively with pupils harassing disabled people in public places and on public transport.

219 The Commission has used the terms 'targeted violence' and 'identity-based violence' to describe 'unwanted conduct, violence, harassment or abuse that is targeted against a person because of their age, disability, gender, transgender status, race, religion or belief, sexual orientation or a combination of these characteristics'.

Integration and inclusion

> 'Without inclusive education you will not get an inclusive society.'
>
> Key informant interview, Professor Colin Barnes, Professor of disability studies, University of Leeds, 29/06/10

Increasing the degree to which disabled children are educated alongside non-disabled children is an important element of developing a more inclusive society. Many schools are still struggling to support full integration of disabled pupils. Ofsted's review of special educational needs and disability (SEN)[220] found that additional provision for pupils with SEN in England was often not of good quality. It was rare for schools to take positive action to ensure that disabled pupils and those with special educational needs participated in activities and events outside the usual curriculum. The inquiry received evidence from a number of parents who felt that their disabled children had been left feeling marginalised at school, unsupported and often the focus of bullying.

> 'There have been several instances when we have either been made to feel, or it has been actually said to us, when we have encountered problems that "this is what happens when you choose a mainstream school".'
>
> Individual submission to the inquiry call for evidence

Some schools have been more effective at integrating disabled pupils and providing an inclusive environment where all flourish and where positive attitudes and behaviours around disability and difference generally are developed.

Case study

At Marlborough School in Oxfordshire it is perfectly normal to see students with a wide range of impairments, mixing in class, at play and in extra curricular activities with their fellow youngsters.

This distinctive approach to integrate disabled children into mainstream education has made the school popular with children, parents and carers.

A key part of the integration is having a unit with specialist facilities, such as physiotherapy rooms, at the very centre of the school. Known as the Ormerod Centre it is the hub of the school and has all of the school's children walking through it all the time.

Most of the disabled children, who have a wide range of impairments and educational needs join in with everyday classes and playtime alongside non-disabled children.

Julie Fenn, headteacher at Marlborough, observes: 'If you come here at break time you will probably find a child in a wheelchair being whizzed around by another child, or you might find a child rather dangerously whizzing themselves

220 Ofsted, 2010, The special educational needs and disability review. Available from: http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Thematic-reports/The-special-educational-needs-and-disability-review


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around. These are the kind of risks a mainstream child may take so it's important that we allow children with disabilities to take the same kind of risks.

'Our first premise is that they [disabled children] are going to go to every lesson and be fully integrated – then we work back from that point', explains Fenn. This includes having classrooms that are larger than normal so that they can accommodate wheelchairs and other specialist equipment.

One of the initiatives to aid integration and combat bullying is to set up a 'circle of friends' for every disabled child. When a disabled child first comes to Marlborough the school selects a small group of children in their form to act as their friendship circle. The children also work together to develop a rights and responsibilities charter which includes anti-bullying initiatives.

Fenn explains that the school is very open about a youngster's impairments with the friendship circle and other form members to help dispel any fear or misunderstandings.

'What's really important is the children whose form they are going into really understand what particular needs a child has – and the response is amazing.'

The headteacher says that name calling or staring at disabled children is very rare because everyone is just a normal part of the school. On the few occasions this has happened then the school usually holds a 'restorative meeting' with the children and adults involved. Fenn says the cause of a problem is usually lack of understanding or fear on the part of a child.

Fenn believes that integration has profound long-term benefits for everyone. 'It's about educating other people in society to understand that having a disability isn't necessarily a barrier to achievement, and it's about people with disabilities having a right to have the same opportunities as everybody else does.'

Bullying

The Commission's research on identity-based bullying in England and Wales[221] found major gaps in collecting data on bullying of disabled and pupils with special educational needs. Without adequate monitoring schools are unable to understand the problem that they are dealing with or evaluate the effectiveness of their responses.

Proportionately more disabled children report being bullied, as compared with non-disabled children.[222] In 2006, 81 per

221 Tippett, N. et al., 2011, *Prevention and response to identity-based bullying among local authorities in England, Scotland and Wales. Research Report 64,* Equality and Human Rights Commission. Available from: http://www.equalityhumanrights.com/publications/our-research/research-reports/research-reports-61-70/

222 Chamberlain, T. et al., 2010, Tellus4 National Report. Research Report DCSF-RR218. DCSF.

cent of 16-year-olds with a statement of educational need or a disability that affected their schooling were bullied, compared with 65 per cent of other young people.[223]

Young disabled people have said:

> 'I told my teachers at school and they said that I had special needs so I should get used to it as I would be bullied all my life. They also told me to stop playing out at break times then I would not get bullied.'[224]

> 'When I was at primary school, these kids that bullied found out how to put my chair onto manual and one day they went behind me and put it onto manual and wheeled me into a bush and the teachers knew about it and none of them did anything about it, they said it would have to have been an accident. One of them said "oh it can't have happened". I told my teacher and my headteacher and they didn't believe me and the only one that did believe me said that it must have been an accident.'[225]

> 'I want schools to take bullying more seriously – disabled children are more vulnerable to bullying. Teachers could teach classes about disabilities... disabled kids could help if they wanted to. A bit like a new lesson!'[226]

Bispham High School and Arts College in Blackpool has introduced the 'sharp system' for reporting bullying anonymously via email to a senior member of staff. They respond to all emails and try to resolve issues quickly. The Deputy Head, John Topping, gave an example of how they dealt with a bullying clip that had been posted on Facebook:

> 'Very quickly we got the behaviour managers together in school. We interviewed the student, the parent was in within half an hour, and within half an hour, also, that material, after the mother had seen it, was taken off Facebook. The child was punished, and the boy who brought it to our attention, who had been making nasty text messages to this girl, because they were boyfriend/girlfriend, he was punished as well, so within a day that was – a line was drawn under it. You need staff in

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223 Department For Children, Schools And Families, *Youth cohort study and longitudinal study of young people in England: the activities and experiences of 16 year olds,* England 2007, 2008.

224 Mencap (undated) *Bullying wrecks lives: the experiences of children and people with a learning disability.*

225 Disabled Children's Manifesto for Change. Quoted in Anti-Bullying Alliance, 2010, Responding to bullying among children and young people with SEN and/or disabilities: the views and experiences of children and young people with SEN and/or disabilities. Available from: http://www.anti-bullyingalliance.org.uk/PDF/SEND_bullying_CDC_Briefing_final.pdf

226 Anti-Bullying Alliance, 2010, Responding to bullying among children and young people with SEN and/or disabilities: the views and experiences of children and young people with SEN and/or disabilities.

school, behaviour managers, for each year group who are particularly sensitive to and can deal with it.'

John Topping, Deputy Headteacher, Bispham High School, Blackpool, inquiry hearings, 11/02/2011.

Some disabled people and their organisations raised concerns about the harassment of disabled people by schoolchildren on public transport. Schools should be involved in resolving these problems, alongside transport providers themselves.

'Greater Manchester Passenger Transport Executive (GMPTE) identified that harassment of disabled people on public transport is a problem. They commissioned research which indicated that schoolchildren are often the main instigators for harassing disabled people, especially people with learning disabilities, particularly on buses and trains and when waiting at bus stops. In response to this, GMPTE have undertaken various projects to enhance the travel opportunities of people with learning disabilities and improve access, enabling them to make better use of mainstream public transport services and increase confidence when using public transport.'

Submission to the inquiry by Greater Manchester Passenger Transport Executive (GMPTE)

'Andrew was on his way home from college using the bus. A group of schoolchildren in uniform spoke to him as they were all getting on the bus. The schoolchildren sat at the back of the bus while Andrew sat at the front. When the schoolchildren got off the bus, one of them smacked Andrew over the back of his head. When Andrew got home, he reported it to his support workers. After discussing it with his support workers Andrew didn't want to report the incident to the police. Andrew often asked "Why me?" Andrew continues to travel independently on public transport and has community members he often sees when travelling which bring him security. Now Andrew is wary of groups of young adults/children when he is out in the community and goes out of his way to avoid them.'

Submission to the inquiry by United Response

'Dave has learning disabilities and is partially sighted so when out in the community he has a white stick to support him with his bearings. Dave got on a bus and school children in uniform started sniggering at him and calling him names such as "Blind *******". Dave decided it was best not to say anything to the children or the bus driver but was determined to stay on the bus until he reached his destination.'

Submission to the inquiry by United Response

'Use of public transport can be in itself isolating on two counts. Firstly, a person who is waiting for public transport is there for a reason and should bullying take place at this point, the individual would not have the same opportunity to vacate this environment in the same way that they would, for example, leave a shop if they felt threatened. Secondly, once on the public transport, the journey itself can

be quite isolating as once underway, the individual may not have the opportunity to simply get up and exit the transport for a range of reasons.'

Submission to the inquiry by Greater Manchester Passenger Transport Executive (GMPTE)

Local government

Twenty-seven local authorities responded directly to our call for evidence. Local government was also represented at the regional roundtables and the Local Government Association, the Convention of Scottish Local Authorities and the Welsh Local Government Association gave evidence at formal inquiry hearings. A further 15 individual authorities gave evidence at formal hearings that were investigating particular harassment cases. We also held formal inquiry hearings with the Department for Communities and Local Government, the Audit Commission, Audit Scotland, the Wales Audit Office and the Welsh Government.

Local councils play a key role in delivering and commissioning services to meet the needs of their communities, leading partnerships with other agencies and planning a better future for their locality. Local authorities can improve responses to harassment through promoting positive attitudes to disabled people, tackling antisocial behaviour and promoting community safety, safeguarding adults at risk of harm and child protection.

The Westminster Government is committed to the decentralisation and devolving power from government directly to individuals and local communities. Local authorities will be at the heart of this new localism agenda.

The Localism Bill intends to create several new rights for communities including the right to challenge, the right to buy assets of community value, influence neighbourhood planning and hold local referendums. In London, the Localism Bill will also pass greater powers over housing and regeneration to local democratically elected representatives. In order for disabled people to play an active role in this new local democracy, and ensure issues like disability-related harassment are seen as priorities to be tackled in their areas, local authorities will have to address the methods by which disabled people are engaged and involved, including strengthening their accessible voting mechanisms, engagement strategies and representation of disabled people in all areas including in public office.

Positive attitudes

There was little evidence of evaluated initiatives aimed at promoting positive attitudes across the public sector including within local government. Although some public authorities submitted evidence regarding programmes promoting positive attitudes, many did not. This is disappointing, given that it is now over five years since the DED required evidence of this.

The new PSED requires those subject to the duty to have due regard to the need to foster good relations between people who share a protected characteristic and those who do not. Fostering good relations is described as tackling prejudice and promoting understanding.

We wish to see greater progress made by public authorities to foster good relations. Examples of this work could include public authorities in the same locality working together to tackle the prejudice and hostility that disabled people can experience when using public transport. It could also include schools incorporating topics around disability, inclusion and challenging negative attitudes into relevant lessons and generating opportunities for positive interaction between students and local disabled people.

Undertaking activities such as these will help public authorities to demonstrate how they are fostering good relations between disabled people and non-disabled people. For more information on the new PSED please see the Commission's website.

Antisocial behaviour

The Local Government Association survey of community safety partnerships found that antisocial behaviour was among the top three community safety priorities for 80 per cent of partnerships in England and Wales.[227] There is no equivalent survey in Scotland but discussions with local councils suggest that antisocial behaviour is also a priority there.

Disabled people are disproportionately affected by antisocial behaviour – they are more likely to experience it than non-disabled people and more likely to be harmed by it.[228] Failure to recognise disability-related motivation can result in antisocial behaviour being dealt with inappropriately, negating the impact of hostility based on prejudice. Antisocial behaviour and crime may be dismissed by both local authorities and criminal justice agencies as 'motiveless' rather than investigated as potentially disability-related.

> 'It is pretty clear that some incidents are dismissed as motiveless... that can't be the case, there must be something that drives it.'
>
> Steve Atkinson, Chief Executive of Hinckley & Bosworth Borough Council, inquiry hearings, 17/11/10

We have strong evidence that ineffective responses to antisocial behaviour can have tragic circumstances, for example in the case of David Askew (see Part 2). The lack of understanding and address of authorities and service providers towards disability-related harassment means that much of it gets re-classified as antisocial behaviour. This is unhelpful as it can take an inquiry down a sometimes inappropriate route, and negates the impact of hostility based on prejudice.

A new mandatory power of possession for antisocial behaviour

We welcome the recent proposal[229] which seeks to create a new mandatory power of

227 Local Government Association, 2009, *Crime and disorder reduction partnership survey 2009*, p15. Available from: http://www.lga.gov.uk/lga/aio/4856365

228 Ipsos MORI for Her Majesty's Inspectorate of Constabulary (HMIC), 2010, Policing anti-social behaviour: the public perspective. Available from: http://www.hmic.gov.uk/SiteCollectionDocuments/Anti-social_behaviour_2010/ASB_IPS_20100923.pdf

229 See http://www.communities.gov.uk/publications/housing/antisocialbehaviourconsult

possession to enable social landlords and other agencies to take swifter action to evict their most antisocial tenants. It chimes with the inquiry findings that prevention and early intervention should be at the heart of all landlords' approaches to tackling antisocial behaviour.

The evidence that suggests that social landlords use possession proceedings for antisocial behaviour sparingly is compelling. There are nearly 4 million social households in England but it is estimated that there are only approximately 3,000 eviction orders made by the Courts annually against social tenants for antisocial behaviour.[230]

Evidence also suggests that over 75 per cent of antisocial behaviour cases are resolved through early intervention without resorting to formal tools.[231] But where antisocial behaviour persists then landlords need to take more formal steps to resolve the problem.

It is clearly right that eviction for antisocial behaviour should remain exceptional: the loss of one's home is a serious sanction and eviction may simply displace the problem elsewhere rather than providing a long-term solution. It is important that landlords work with other local agencies to provide support or interventions at the earliest opportunity when difficult or disruptive behaviour is identified.

We know that this type of joined-up working effectively addresses these problems and helps remove the need for evictions. Effective interventions, such as Family Intervention Projects for example, delivered through partnerships between social housing providers and children's services, have been shown to be successful at reducing housing-related antisocial behaviour, as well as the number of possession notices issued by landlords.

The simplifying and streamlining of the process will be a valuable tool for social housing providers to better tackle antisocial behaviour and disability-related harassment and have a positive impact on bringing to an end the suffering of victims earlier than is currently possible.

Safeguarding

Local authorities have been given particular responsibilities for leading both adult and child protection. The issue of adult safeguarding, which was considered in some depth during the inquiry, is explored in more detail below.

Disabled people are not responsible for being harassed or victimised and a focus on their behaviour rather than that of the (potential) perpetrators is generally unhelpful. However, as harassment is a reflection of the lack of power of disabled people in society, initiatives which empower disabled people can help to

230 No data is available for local authority landlords or private registered providers with less than 1,000 units of stock but Regulatory and Statistical Return data shows that private registered providers with 1,000 units of stock or more evicted 1,523 tenants for reasons including antisocial behaviour in 2009-10. Assuming local authority landlords evict tenants for antisocial behaviour in roughly the same proportion to their total stock, that gives a figure of about 3,000 pa.

231 HouseMark anti-social behaviour benchmarking service: analysis of results 2010-11.

reduce their risk of being victimised and help them to access support to bring harassment to an end.

Greater personalisation of social care offers not only greater choice, control and independence for disabled people, but potential benefits in terms of safety.

> 'Empowering people through the personalisation agenda also helps mitigate risks of abuse or harassment.'
>
> Dr Adi Cooper, Joint Chair, Association of Directors of Adult Social Services Safeguarding Network, inquiry hearings, 11/01/11

To realise these benefits, disabled people need to be properly supported to understand and manage risks and to report abuse if it does occur, and professionals need to understand how to balance safety with choice and control.[232] Good quality accessible independent advocacy is key to making personalisation work for many disabled people, enabling them to get the support that they need. There are gaps in the availability of advocacy services[233] which need to be plugged to deliver on both the personalisation and safeguarding agendas.

Safeguarding is not the sole responsibility of adult social care. Agencies need to be more effective in sharing information and co-ordinating their responses in order to safeguard adults at risk of harm. Referral mechanisms need to be in place, not only to ensure that adults for whom there are safeguarding concerns are referred to the adult safeguarding team for assessment, but also to ensure that where there are allegations of criminal acts, that these are referred promptly to the police for criminal investigation.

Housing providers

The inquiry received five submissions from the housing sector, although some local authority responses also referred to their housing role. We held formal inquiry hearings with the Department for Communities and Local Government, the Homes and Communities Agency, Chartered Institute for Housing, Chartered Institute for Housing (Wales), Welsh Government (Housing), Scottish Housing Regulator, National Housing Federation, Community Housing Cymru and Tai Pawb. A number of housing associations and arms length management organisations were represented at hearings investigating specific cases of harassment.

As set out in the previous chapter, harassment often occurs at or near people's homes.[234] Local authorities and housing providers can help reduce

232 See, for example, Social Care Institute for Excellence, *At a glance 31: Enabling risk, ensuring safety: Self-directed support and personal budgets*. Available from: http://www.scie.org.uk/publications/ataglance/ataglance31.asp

233 Equality and Human Rights Commission, 2011, *Personalisation in the reform of social care: key messages*. Available from: http://www.equalityhumanrights.com/key-projects/care-and-support/access-to-advocacy-and-personalisation/

234 Equality and Human Rights Commission, 2009, *Promoting the Safety and Security of Disabled People*.

disability-related harassment by including safety and security measures in the design of social housing estates and facilities, strengthening responses to antisocial behaviour, ensuring that the needs of disabled victims are addressed within their responses to domestic violence, and strengthening their role in safeguarding.

Conflict over, and poor design of, what might be termed 'shared space' such as walkways and parking on housing estates, can act as a trigger for harassment. Anticipating problems before they occur and designing them out is important in relation to housing. A number of disabled people's organisations highlighted problems if disabled people's homes are easily identifiable as 'different' to other homes in the area or if landlords make inadequate provision for the storage of disabled people's equipment.

Tackling antisocial behaviour is a priority for housing providers but, as with other sectors, there is often a lack of reporting and lack of recognition of disability as a potential motivation.

> 'I think services and responsiveness to the needs and requirements and aspirations and expectations of disabled people is one of the areas that has been weaker (with social housing providers).'

> 'The messages that are out there around antisocial behaviour in particular are very strong. It is very much about a zero-based tolerance level to ASB [Antisocial behaviour]. That message, I think, has gone out very clearly. The question is how you pick up on something that might be seen as ASB and actually dig into that to see what the origins of that might be and if you are picking up on something which is, for example, harassment based on disability, how you understand that is something that is distinct from ASB and is treated as such.'
>
> Richard Capie, Director of Policy and Practice at the Chartered Institute of Housing (4/11/10)

Many housing providers include antisocial behaviour within tenancy agreements but eviction of perpetrators for breaching these clauses is rare. David Carrigan from the Homes and Communities Agency told us that: 'it is not just an option to evict the perpetrators because you will be pushing them somewhere else where the same situation may occur... There is always that view that eviction is the last resort because it does not necessarily serve any party in an effective way and does not remove the issue.' Housing providers need to work in partnership with other agencies to ensure that perpetrators face consequences to prevent behaviour escalating. In a number of cases investigated by the inquiry, for example in the case of David Askew, agencies suggested that the victims rather than the perpetrators should be the ones to move. We think that often this is not the right approach.

However, we do recognise that some victims do want to move to get away from harassment. There is a risk that proposed changes to security of tenure may act as a barrier to doing so. The Localism Bill will give social landlords in England and Wales the option to offer shorter fixed term tenancies for new tenancies, as well as the current lifetime tenancies. While the tenancies of existing tenants will not be affected if they remain in their current accommodation, it is unclear whether they

will be able take these terms with them if they move to a new property. Giving up a secure lifetime tenancy for a potentially less secure two-year one is likely to act as a barrier for victims who need to move because of harassment or crime.

The Chartered Institute for Housing recommend two considerations on preventative work. One is around the nature of the tenancy agreement in the first place, putting good behaviour clauses in them. Obviously a risk with that is that if you end up using the ultimate sanction against somebody who is a tenant who is breaching that clause or creating a nuisance or major problem, then the risk is to displace them into the private rented sector potentially in the same community where actually the tenancy sanctions that exist are a lot lighter.

The other consideration is around good neighbour agreements. Not simply the tenancy itself, but what tenants responsibilities are in the community. This is not just about your own behaviour as a tenant but it is also about the support that people can provide to each other.

Almost all of the deaths investigated within this inquiry were preceded by harassment at or near their home and a number of the murders investigated by this inquiry took place in the victim's home. There were opportunities for housing personnel to intervene to prevent escalation (in the case of David Askew) and to alert other agencies to safeguarding concerns (in the case of Steven Hoskin).

Ocean Housing made changes to its policies following the serious case review into Steven Hoskin's death. It committed to:

- inform care managers in writing of extensions to probationary tenancies
- inform the police and care managers of damage to the tenancies of vulnerable tenants
- review vulnerable tenants' rent arrears and complaints policy and procedures
- ensure that tenants who cannot read are not sent letters and notices
- review staff training
- introduce a new safeguarding vulnerable tenants policy.

Following the serious case review into the death of Steven Hoskin in Cornwall, David Renwick, Chief Executive of the Ocean Housing Group, Steven's landlord, told us:

> 'I think for everyone who had been involved in that, we really put our hands up and said, "Well, communications and other failures were really just not good enough." I think crucially we could have reacted in a number of ways, and I think you can almost go into denial. Some people might do that. I think straight away we were on that very day, I can remember the conversations, leaving the press conference was regarding the recommendations... and we all agreed then, and it wasn't just the Chief Executive or director level, that we weren't going to hide, we were going to try and make improvements, that we would not be complacent.
>
> 'The joint working has improved very, very significantly... they all know and could tell you about the triggers for safeguarding. They could have not done that a number of years ago... and we

then embarked, from that, to train every single member of staff at different levels on safeguarding... down to the joiner and the plumber, when they go out, and I think that commitment is as strong now as it was, without being complacent. I think that's evolved; we've tried to do that in different ways and shared those experiences.

'Our information base has improved dramatically over the last four to five years. We carry out a census ourselves of everyone who lives in our properties. And we collect a whole range of information about the individuals and the families. We've used that information to do a range of profiling into the type of service and how we need to respond to make sure that people don't miss out on communications or accessing the service. We have a system which, in essence, if somebody was to ring up our switchboard, for example, and we knew that they had literacy problems, we wouldn't be writing them a letter back, there would be a home visit done. So that's just one of the illustrations of how we've moved on.'

Healthcare providers

Out of 192 health providers across England, Scotland and Wales we received three responses to our call for evidence. We also received one response to our call for evidence from a Strategic Health Authority. The Department of Health and Scottish Government Health and Social Care department gave evidence at formal inquiry hearings. A further 15 health organisations gave evidence at formal hearings, mainly those that were investigating particular harassment cases.

Disability-related harassment can have short- and long-term impacts on both physical and mental health. The NHS is often involved in dealing with these impacts, tending to injuries and treating anxiety and depression. Health professionals can be the first or only contact that a disabled victim of harassment has with a public authority. As such they can play a significant role in supporting the victim to find a route to ending the harassment and finding safety.

Health services have done much to improve their responses to domestic violence in recent years. As well as benefiting disabled victims of domestic violence, this approach could benefit victims of other forms of disability-related harassment.

In a number of cases of particularly severe harassment (for example the case of the 'vulnerable adult', Michael Gilbert, Christopher Foulkes, Colin Greenwood, Brent Martin and Steven Hoskin in Part 2) health agencies have missed opportunities to intervene to protect the disabled person. The number of safeguarding/adult protection referrals from the sector varies across Britain from 18 per cent in England to 14.5 per cent in Wales to 4 per cent in Scotland. Concerns were raised in several inquiry hearings about the rates of safeguarding referrals from health agencies. Some concerns were expressed at evidence sessions that the terminology is not helping healthcare providers to identify those they need to help.

'I think most people would say there is a dissatisfaction with the terminology about vulnerable adults because, as you say, people aren't inherently able to be labelled as "vulnerable" or "not

vulnerable", and you're not able to draw a neat line about this category of person. People can be in a situation of vulnerability according to the position they're in; they all differ according to time.'

Sean Gallagher, Director, Social Care Policy, Department of Health

In the first years since the implementation of the Adult Support and Protection Act in Scotland, health agencies have instigated only a small percentage of referrals to adult protection committees, although the Scottish Government expects this proportion to increase in the coming years as awareness grows within the NHS.

'There's been a fairly substantial training and awareness programme rolling out, and hopefully as that becomes more and more embedded then people will begin to use the legislation more to refer people on.'

Graeme Dickson, Director of Health and Social Care Integration at the Scottish Government, inquiry hearings, 20/01/11

There are examples of good local initiatives developing in Scotland such as enabling reporting of harassment through GP surgeries and clinics.

Both local and national health representatives at the hearings recognised the need for health services to work with other agencies to promote the safety of disabled people. Agencies in Cornwall cited the involvement of very senior health champions in partnership work as an important aspect of their response to the murder of Steven Hoskin (see Part 2). They had increased the likelihood of early preventative action through the development of a triggers protocol used by staff across health services as well as other agencies. There has been extensive training of health staff, including GPs, on what to look out for and do if abuse or harassment is suspected.

Some health initiatives have sought to challenge a perceived lack of understanding and awareness of the wider health needs of disabled people.

'One of the things we identified through "No Secrets" is people's attitudes and behaviours to people with learning disabilities in hospital, their ignorance – not to put too fine a point on it – meant that they were behaving in a particular way, which discriminated against the needs of people with learning disabilities.'

David Behan, Director General of Social Care, Local Government and Care Partnerships, inquiry hearings, 25/01/11

The Valuing People Now initiative has raised awareness and expertise among clinicians and staff about the health needs of people with a learning disability. The Department of Health's 'No Health Without Mental Health' has the potential to have a positive impact on disability-related harassment by tackling stigma and discriminatory attitudes.

There is an increasing emphasis on local rather than centralised decision-making within health across Britain. There is a risk that health's contribution to dealing with disability-related harassment may not be prioritised in this context.


AMBULANCE

> '[This is] the biggest organisational change ever witnessed since the NHS was founded; I think there is a huge risk of some of these issues just completely disappearing in that change.'
>
> Andy Buck, Chief Executive NHS Rotherham

Health priorities in Scotland are increasingly being determined locally by NHS boards with reference to the Scottish Government's 15 National Outcomes and 45 National Indicators.[235] The framework for health commissioning in England is still under discussion.

We welcome the Department of Health and British Medical Association's recently launched guidance[236] to help doctors protect adults at risk of harm. Doctors are obliged to take action if they believe adults at risk of harm are being abused or neglected. However, we feel the use of the term 'vulnerable adults' in the guidance is unhelpful in tackling the wider attitudinal barriers many disabled people face, and suggest a change of terminology to 'adults at risk of harm'.

While the guidance is principally aimed at GPs, any professional working in healthcare settings with adults at risk of harm will find it useful.

The guidance highlights the obligation doctors have to protect adults at risk of harm and that legislation is in place to protect doctors who wish to speak out. This includes identifying abusers, identifying systemic healthcare failures and reporting poor performance by health professionals.

The toolkit also stresses that safeguarding adults at risk of harm is not the same as child protection. Adults 'at risk at harm' covers an extremely wide range of individuals, some of whom may be incapable of looking after any aspect of their lives and others who may be experiencing short periods of illness or disability with an associated reduction in their ability to make decisions.

It is essential, according to the British Medical Association's guidance, 'that doctors support the independence and the quality of life of vulnerable adults. Doctors should also involve this group of individuals in decisions about their treatment and care as far as possible.'

Safeguarding and adult protection services

Two adult safeguarding boards submitted responses to the call for evidence. A number of submissions by local authorities, police and health services also referred to their role in safeguarding. The Department of Health, Scottish Government Health and Social Care department, Information Commissioner's Office, Care and Social Services

235 The key National Outcomes for the inquiry are numbers 7 ('We have tackled the significant inequalities in Scottish society'), 9 ('We live our lives safe from crime, disorder and danger') and 11 ('We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others').

236 See http://www.bma.org.uk/images/safeguardingvulnerableadultsjuly2011_tcm41-208050.pdf

Inspectorate Wales, Care Quality Commission, Scottish Commission for Regulation of Care, Association of Directors of Adult Social Services, Association of Directors of Social Work and Association of Directors of Social Services Wales gave evidence at formal inquiry hearings in relation to adult protection. Safeguarding was also discussed in the hearings investigating particular harassment cases.

There are differences in the policy and legal frameworks governing adult protection/ safeguarding across England, Wales and Scotland. We will start with England and Wales, where the frameworks are broadly similar before going on to look at Scotland.

'No Secrets' and 'In Safe Hands'

The safeguarding agenda in England and Wales has been governed by the Department of Health's 'No Secrets' guidance,[237] and the Welsh Government's 'In Safe Hands'[238] respectively, both published in 2000. Both documents set out broadly similar national frameworks that required local council social services departments to act as lead agencies in the development of local multi-agency codes of practice for the protection of vulnerable adults. A vulnerable adult was defined as someone over the age of 18:

- who is or may be in need of community care services by reason of mental or other disability, age or illness, and
- who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.[239]

'Vulnerable adult'

The Commission has previously set out its concerns[240] that the framing of No Secrets (and In Safe Hands) suggests that disabled people are inherently vulnerable rather than recognising that they may experience vulnerable situations. It tends to encourage a protectionist response from social care agencies rather than a multi-agency response which aims to secure both safety

237 Department of Health, 2000, *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

238 Welsh Government, 2000, *In Safe Hands: Implementing Adult Protection Procedures In Wales*. Available from: http://wales.gov.uk/topics/health/publications/socialcare/reports/insafehands?lang=en

239 Department of Health, 2000, *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, pp8-9. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

240 See, for example, Equality and Human Rights Commission, 2009, *Promoting the Safety and Security of Disabled People*. Available from: http://www.equalityhumanrights.com/uploaded_files/research/promoting_safety_and_security_of_disabled_people.pdf and Equality and Human Rights Commission, 2009, *Response to consultation on review of 'No Secrets' guidance*.

and freedom. Many disabled people resist being labelled vulnerable and may be concerned about reporting harassment if they feel it will remove their choices.

> 'I was talking to a woman who basically said that she wouldn't report something like that to the police again because it ended up with teams of safeguarding people and social workers... questioning whether she was able to live independently. And she said "I'm never going to do that again" and "I felt that the process was completely taken out of my control and essentially somebody had just nicked some money from me, and if that happened to anybody else their capacity to live in their own home would not have been the first question everybody asked".'
>
> Key informant interview, Ruth Scott, Scope, 09/09/10

The Commission's previous report,[241] suggested that the term situational vulnerability was more appropriate, recognising that the risk of experiencing harassment is influenced by the circumstances in which someone lives their life including wider social, economic and community conditions. The concept of 'situational' rather than 'individual' vulnerability was referred to in some of the evidence received by the inquiry. The term 'transient vulnerability' was also used, which recognises that risk of harm can vary over an individual's life course, for example someone may be more at risk if they've been recently bereaved.

The 'vulnerable' label has presented difficulties for agencies. The terms of reference for the serious case review into the death of Michael Gilbert, who was murdered by a family who had tortured him for years and kept him as a domestic slave (see Part 2), included:

> 'All agencies to scrutinise their own and other organisations' definition of "vulnerable adult" and analyse the impact in this case. Additionally an analysis should be undertaken of eligibility criteria relating to services and access to support.'

At the hearing examining this case, agencies suggested that the definition was too narrow and had impeded their ability to intervene to protect Michael Gilbert from escalating violence.

The serious case review into the deaths of Fiona Pilkington and Francecca Hardwick recommended that agencies in Leicestershire should review the definition of 'vulnerability' 'to ensure it was inclusive enough'.[242] This resulted in the development of a local definition of

241 Equality and Human Rights Commission, 2009, *Promoting the Safety and Security of Disabled People*. Available from: http://www.equalityhumanrights.com/uploaded_files/research/promoting_safety_and_security_of_disabled_people.pdf

242 Leicester, Leicestershire and Rutland Safeguarding Adults Board, 2008, *Executive Summary of Serious Case Review* in relation to A and B, p14. Available from: http://www.leics.gov.uk/index/social_services/protect_children_adults/adult_protection_procedures/safeguarding_adults_partnership/seriouscasereview.htm

vulnerability, namely 'a person is vulnerable/at risk if as a result of their situation or circumstances they are unable to protect themselves from harm'.[243]

Agencies in Leicestershire have developed a vulnerability factor checklist and an antisocial behaviour vulnerability risk assessment tool to help frontline staff to identify wider vulnerability. Factors which may be considered in the Leicestershire context include health and disability; equalities/discrimination factors (e.g. age, gender); personal circumstances (including being affected by antisocial behaviour); and economic circumstances (such as deprivation/financial concerns). The risk matrix allocates a score of 0-3 (or 0-5 for some factors), with high scores given for antisocial behaviour that is:

- assessed as a hate crime
- happening daily
- targeted by specific individuals.

Environment can play an important role in relation to risk of harassment but this is often overlooked by agencies.[244] Deprived areas, where disabled people are more likely to live than non-disabled people, are linked to a greater risk of harassment. Although agencies may have an awareness of the impact of environment this does not tend to be included in formal risk assessment. The recognition of environmental factors such as economic circumstances within Leicestershire's approach is a welcome step although we continue to have concerns about the value of the term 'vulnerable' as a label to be applied to individual disabled people.

A review of 'In Safe Hands' in 2010[245] made a number of recommendations which would deliver a more rights-based approach to safeguarding in Wales and would replace the vulnerable adult definition with a definition of adults at risk from abuse who cannot protect their own interests. In March 2011, the Deputy Minister for Children and Social Services in Wales announced the publication of Sustainable Social Services in Wales: A Framework for Action which set out the Welsh Government's intention to establish a National Safeguarding Board for adults and children. The First Minister has announced that there will be a Social Services Bill which is expected to include safeguarding.

In 2010 the Law Commission provisionally proposed to replace the definition of 'vulnerable person' in No

243 Leicester, Leicestershire and Rutland Community Safety Partnership ASB/vulnerability task and finish working group document, 15 June 2010.

244 Sin et al. for Equality and Human Rights Commission, 2009, *Disabled people's experiences of targeted violence and hostility*, p82. Available from: http://www.equalityhumanrights.com/uploaded_files/research/disabled_people_s_experiences_of_targeted_violence_and_hostility.pdf

245 Welsh Institute for Health and Social Care, University of Glamorgan, 2010, *Review of In Safe Hands: A Review of the Welsh Government's Guidance on the Protection of Vulnerable Adults in Wales*. Available from: http://www.nmc-uk.org/Documents/Safeguarding/Wales/Review%20of%20In%20Safe%20Hands.pdf

Secrets with 'adult at risk',[246] defined as 'anyone with social care needs who is or may be at risk of significant harm'.[247] In evidence to the inquiry, the Association of Adult Directors of Social Services highlighted their support for the Law Commission's proposals.

The Law Commission published its final report on reform of adult social care law, including adult protection, in May 2011.[248] We welcome the Law Commission's proposal to replace the term 'vulnerable adult' with 'adult at risk', although we believe that 'adult at risk of harm' would provide greater clarity. We also welcome the proposed statutory footing for adult protection and safeguarding boards. We hope changes to the safeguarding framework will deliver a more rights-based approach in England and Wales. Ideally we would move away completely from the concept of vulnerability, and instead recognise that people may need support if they are less able to realise their human rights compared to others. Not only would this positively promote human rights, but also recognise that the people that need support need it to put them on equal footing with all others, rather than focus on what is 'wrong' with them.

We are also encouraged by the Government's recognition of the danger of over-protectiveness and the need to balance risk and freedom in safeguarding.[249] The Government's consultation document on social care sets out how personalisation of support and more effective safeguarding can be mutually supportive and recognises that balancing choice and risk is an integral part of personalisation.

> 'People should be protected when they are unable to protect themselves. This should not be at the cost of people's right to make decisions about how they live their lives.'[250]

The Government's vision also recognises that 'choice and control can only be meaningful if people can make informed choices, in an environment where they can make decisions freely and safely'. Ongoing harassment, especially by someone living with or near the victim, reduces the victim's freedom to make informed choices. The degree of duress victims were experiencing, and its impact on their decision-making, was not recognised by the authorities dealing with a number of harassment cases investigated by this inquiry (for example Steven Hoskin and

246 The Law Commission, 2010, Consultation Paper No 192: Adult Social Care - A Consultation Paper, p145. Available from: http://www.justice.gov.uk/lawcommission/docs/cp192_Adult_Social_Care_consultation.pdf

247 Ibid., p46.

248 The Law Commission, 2011, *Adult Social Care* (LAW COM No 326). Available from: http://www.justice.gov.uk/lawcommission/adult-social-care.htm

249 Department of Health, 2010, Vision for Adult Social Care: Capable Communities and Active Citizens, pp25-6. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

250 Ibid.

Michael Gilbert, see Part 2). A number of respondents highlighted parallels between domestic violence and ongoing harassment of disabled people.

Adult Support and Protection (Scotland) Act 2007

Scotland already has a rights based framework for adult safeguarding under the Adult Support and Protection (Scotland) Act. This was introduced following the inspectorate investigations commissioned by the Scottish Government into the 'case of the vulnerable adult' (see Part 2). The Act:

- provides greater protection to those thought or known to be at risk of harm through new powers to investigate and intervene in situations where concern exists
- places a duty on specified organisations to co-operate in investigating suspected or actual harm
- places a duty on councils to make inquiries and investigations to establish whether or not further action is required to stop or prevent harm occurring
- introduces a range of protection orders including assessment orders, removal orders and banning orders
- requires that any intervention must provide benefit to the adult; and should be the least restrictive to the adult's freedom of the range of options available to meet the object of the intervention
- provides a legislative framework for the establishment of Adult Protection Committees across Scotland.

The Act defines 'adults at risk' as individuals, aged 16 years or over, who:

- are unable to safeguard themselves, their property, rights or other interests
- are at risk of harm, and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than others who are not so affected.

All three conditions have to be met before public authorities can take steps under the Act.

A summary of the duties and powers included in the Adult Support and Protection (Scotland) Act is set out at Appendix 15 and more information is available on the Scottish Parliament website.[251]

The Adult Support and Protection (Scotland) Act has led to significant changes across Scotland in the approach to protecting adults at risk of harm. The first biennial reports from the 29 Adult Protection Committees established under the Act were produced in October 2010 covering the first two years since the commencement of the Act. The sources of safeguarding referrals were:

police (73 per cent)
various social work services[252] (11 per cent)

251 Scottish Government website, *Adult Support and Protection (Scotland) Act 2007.* Available from: http://www.legislation.gov.uk/asp/2007/10/contents

252 For example, referrals to adult protection services from other parts of social work.

health sources (4 per cent)
family members (3 per cent).

The remaining referrals came from a variety of other sources with no single other source accounting for more than 1 per cent.

There has been limited use of the protection orders under the Act, particularly removal orders (three applied for, two granted in 2010/11). This would seem to reflect the requirement of identifying the least restrictive option within the Act. However, there is marked regional variation, with one relatively small rural authority accounting for roughly 50 per cent of the approved banning orders for the whole country. This may suggest that different thresholds for the use of protection orders may exist in different places, potentially meaning markedly different outcomes depending on where you live in Scotland. A number of committees have also indicated that there are challenges in ensuring adequate user, carer and advocacy engagement.

Safeguarding and justice

The Commission has found that the focus on help and protection within the adult safeguarding system can be at the expense of ensuring justice and redress.[253] Agencies may encourage disabled people to change their behaviour or may move them away from the perceived risk rather than taking action against the perpetrator (see for example the case of David Askew in Part 2). Although no national data is available, it appears that only a small proportion of safeguarding referrals in England and Wales result in a criminal prosecution of the alleged perpetrator of the abuse which had triggered the safeguarding referral. Several sources of evidence indicated that police sometimes referred incidents to social services to deal with, even though the underlying issue was actually criminal behaviour.

Calling a crime a crime is an important part of getting it right. For example, we have come across agencies using the term 'abuse' rather than 'physical assault' or 'rape', and 'financial exploitation' in place of 'theft' when referring to disabled people's experiences. The impact of this, whether or not intentional, is at its best unhelpful and misleading and at its worse prevents appropriate legal redress. Changing language is often part of the solution to changing attitudes, and as we have highlighted, attitudinal barriers are some of the most pervasive barriers that need to be tackled if we are to address this issue effectively.

Serious case reviews

Unlike child deaths in Britain and domestic violence homicides in England and Wales, there is no statutory requirement to conduct a serious case review into the murder of a disabled person. In situations where a disabled person dies or is seriously injured as a result of disability-related harassment, the local safeguarding board makes the decision on whether or not to conduct a serious case review.

253 Sin et al., 2009, *Disabled people's experiences of targeted violence and hostility*, p79. Available from: http://www.equalityhumanrights.com/uploaded_files/research/disabled_people_s_experiences_of_targeted_violence_and_hostility.pdf

In Scotland, Adult Protection Committees (APCs) – all the key agencies who have a statutory duty to co-operate – can decide to conduct a significant case review where a disabled person has been killed or has been the victim of a non-fatal serious incident (or series of incidents). An initial case review can then be used to determine the need for a serious case review, and the committees will consider what other processes are underway (e.g. those conducted by the police, Procurators Fiscal or inspection agencies). Most committees now have protocols in place on when and how to conduct significant case reviews following the implementation of the Adult Support and Protection (Scotland) Act 2007 three years ago.

Serious case reviews were conducted in only four out of the 10 murders of disabled people investigated by this inquiry. No serious case reviews were conducted in the cases of Brent Martin, Colin Greenwood, Keith Philpott, Laura Milne or Shaowei He (for more details of these cases, see Part 2).

In addition to these murders, no serious case review was conducted in another case investigated by this inquiry, the gang rape and chemical burning of a 16-year-old woman with learning disabilities, even though her age and the severity and consequences of the assault would suggest it should have been considered under the statutory framework for serious case reviews relating to children.

The purpose of serious case reviews is to identify any lessons to be learned and improve practice as a result. Serious case reviews are particularly important where victims and/or perpetrators were in contact with public authorities or where authorities should have been aware that individuals were being abused or at risk of serious harm. Without the rigour of a detailed review, agencies are less likely to identify and learn from mistakes.

A serious case review might not necessarily have been appropriate in all of the cases we have considered. However, in the context of a widespread lack of recognition of the extent of the hostility towards disabled people, and the low rates of prosecution of crimes as disability hate crimes, serious case reviews are particularly important. The failure to undertake them has contributed to the widespread ignorance of the extent and impact of disability-related harassment and the inadequate responses to it.

The quality of the serious case reviews that had been conducted was patchy and they often focus only on the victim and don't consider what contact there had been between the authorities and the perpetrators. The better ones, such as that into the murder of Steven Hoskin (see Part 2), have a real value in improving agencies' awareness and understanding of disability-related harassment. Much of this learning applies across areas and is not specific to the localities in which it was developed. The response of the Scottish Government to the case of the 'vulnerable adult' (see Part 2) and the introduction of the Adult Support and Protection (Scotland) Act has helped share some of the learning from Borders with other authorities in Scotland. There is currently no mechanism, however, for sharing lessons from Scotland with agencies in England and Wales and vice versa.

The evidence suggests a change of approach to serious case reviews, with learning from the approach taken in sectors such as aviation and healthcare. The Munro Review's 15 recommendations in respect of transforming child protection represents the opportunity to deliver holistic reform of the child protection system. These recommendations could be used as a basis for a review of the adult safeguarding systems and its perceived shortcomings. There should be a stronger focus on understanding the underlying issues that made professionals behave the way they did and what prevented them from being able to properly help and protect children. The current system is too focused on what happened, not why.

Public transport operators

> 'A lot of conflict between disabled people and other service users can be traced back to the infrastructure and how transport systems are designed. If... spaces that may be allocated for wheelchair users or people who have other mobility impairments [are] not well signed... then conflict between people who may be standing or sitting in these places and a disabled person who needs them is almost inevitable.'
>
> Stephen Golden, Head of Equality and Inclusion at Transport for London

As discussed in Part 3, public transport was identified in almost all the focus groups and in-depth interviews conducted for the inquiry as a hotspot for disability-related harassment. There was a limited response to the call for evidence from transport providers, with only two providers making submissions. However, through the hearings and key informant interviews we took evidence from the Association of Transport Operating Companies, Welsh Government Department for Economy and Transport Equality Support Unit, Arriva Trains Wales, Bus Users UK, Confederation of Passenger Transport, Passenger Focus Wales, Strathclyde Passenger Transport, Transport for London and the British Transport Police.

Reporting levels

Despite anecdotal evidence that disability-related harassment is a major problem on public transport, reporting levels appear low. The British Transport Police recorded a total of only 60 disability-related crimes in the three years 2007-09. The Association of Transport Operating Companies were aware of only 19 recorded incidents which were classified as hate crimes against disabled people on the entire rail network in the previous year, out of a total of 61,000 incidents.

The low reporting levels may be because disabled people think that behaviours are non-criminal so no-one will be interested in them. They may also be unclear who to complain to. For example if someone is harassed on a train and then gets off at a station, they may not encounter anyone from the company running the train service.

Understanding the problem

The evidence we gathered suggested some differences in opinion and understanding on the extent and nature of the problem

between different public transport organisations and providers. For example, Transport for London had a good understanding that harassment takes place and what needs to be done. Other organisations had less of an understanding and tended to perceive the relatively low numbers of complaints as indicative that this is not a major problem.

> 'Most of our members don't actually have a harassment categorisation in their complaints systems, so even if harassment is going on it's not generally resulting in complaints by disabled people to bus operators.'
>
> Stephen Salmon, Director of Policy Development from the Confederation of Passenger Transport

Many operators still see physical access in relation to disabled people as their main issue. They did not always understand the links between access or disabled provision with incidents of harassment.

Generally, there was a good understanding of conflict over shared space between wheelchair users and people with buggies, for instance, and this leading to incidences of harassment. There was also a broad awareness that many users of public transport, including disabled people, choose not to travel at certain times (e.g. school leaving times) for fear of harassment.

Nevertheless, the impression remained of a mismatch between the viewpoint of transport operators on this issue and what disabled people have told us about their experiences. Generally, transport operators need help in understanding the scale of the problem, some more than others.

Some transport operators talked about their responsibilities under the Disability Discrimination Act in terms of ensuring discrimination does not occur in the delivery of services and focus wholly on access issues. They had less of a sense of their responsibility in terms of preventing disability-related harassment. For many, this is understandable, given that as private sector organisations they were not subject to the DED (now replaced by the PSED). Notwithstanding that there is no legal obligation to prevent harassment, we do feel that there is a moral and corporate social responsibility obligation to. And of course it makes good business sense, attracting more customers.

Good practice

Most public transport is provided by the private sector. In providing services, private companies must comply with relevant equalities legislation – the Disability Discrimination Act until October 2010, the Equality Act 2010 since then. They must not discriminate themselves and if a crime occurs on public transport they must take action to stop it, such as stopping the bus and calling the police. Some public transport operators are public authorities and have responsibilities for eliminating harassment under the PSED, both within services they deliver and those that they procure from other providers.

We found several examples of good practice in the public transport sector. For example:

- 995 rail stations on the network have achieved 'Safer Stations' Status, which means CCTV installed and improvements in security.
- For bus services in London, the bus companies are contractors to Transport for London. As part of the contract, there is an obligation on the bus operators to record and report all incidents that happen on buses to Transport for London. Incidents of harassment would come under that obligation. But this obligation is not something that is widely used across the country. In fact, Stephen Salmon, director of policy development from the Confederation of Passenger Transport, described it as 'extremely rare' and 'virtually unknown' outside London.
- Transport for London has its own travel mentoring programme helping people make their journeys. It runs a quarterly meeting with young people with learning disabilities around what they can do to make themselves safer when they are travelling on the network.

The police and the prosecution services

The police have a key role to play in responding to harassment and were mentioned in more than 80 per cent of submissions by disabled people to the inquiry. We received written evidence from 14 police authorities and 32 police forces. We held formal inquiry hearings with representatives from the Association of Chief Police Officers (ACPO), the Association of Chief Police Officers Scotland (ACPOS), the Association of Police Authorities, Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Constabulary Scotland and the government departments with responsibility for policing in England and Wales (the Home Office) and Scotland (Safer Communities). The police were represented at the regional roundtables and 11 police forces gave evidence to formal inquiry hearings investigating specific cases of harassment.

Prosecution services have a key role in ensuring justice is afforded to all citizens equally and that crimes are sanctioned with appropriate measures. We received responses from the Crown Prosecution Service covering England and Wales and Procurator Fiscal Service in Scotland. We also held formal inquiry hearings with representatives from these services and their inspectorate bodies.

Reporting and recording

There is a substantial gap between the amount of harassment that disabled people experience, the amount that they report to the police and the amount that is recorded as disability motivated. ACPO first published data on disability hate crime in November 2010,[254] for the calendar year 2009. Out of a total of 51,920 reported

254 ACPO, 2010, *Total of recorded hate crime from regional forces in England, Wales and Northern Ireland during the calendar year 2009*, p2. Available from: http://www.report-it.org.uk/files/acpo_-_recorded_hate_crime_-_january_to_december_2009_revised_data_july_2011.pdf

hate crimes across protected characteristics, only 1,294 related to disability. The relatively low numbers overall are at odds with other evidence received by this inquiry indicating the widespread nature of harassment of disabled people.

For 2010/11 the figures have changed. Out of 47,977 recorded hate crimes, 1,567 were recorded as disability-related hate crimes.

Overall hate crime in England and Wales, as recorded by the police, has decreased by 7 per cent between 2009/10 and 2010/11. Zero or a low rate of recorded incidents should not be interpreted as evidence that disabled people are not targeted because of hostility. Rather it suggests that the systems for encouraging disabled people to report antisocial behaviour and crime and/or for recognising and recording whether such behaviour is linked to hostility to disability are inadequate. However, some types of hate crime have seen an increase, including a 25 per cent increase in recorded disability hate crime. It is not possible to say from statistics on recorded crime whether incidence of these types of hate crime has increased or whether this is the result of increased awareness and reporting. The Police Force areas with the highest recorded disability hate crime are Metropolitan and Norfolk (both 116), although the largest increases were in South Wales (from 22 to 103) and Leicestershire (from 35 to 87).[255]

This is clearly an improvement, and we commend the work that ACPO have done to improve reporting. Notwithstanding that, it is clear to see that these numbers are still a drop in the ocean.

One major 'problem' in relation to the police seems to be identifying disability when it is not immediately obvious. A participant in one of the evidence sessions referred to a 'nervousness' or 'fear of offending' about asking people whether they have a disability. This may be similar in relation to other protected characteristics but perhaps not in relation to race. It was reported that officers used to be uncomfortable but now that it was 'business as usual' officers were comfortable asking questions in relation to ethnicity. This nervousness or fear of offending is probably a reflection of wider societal discomfort and attitudes towards disability.

As well as this nervousness to ask about disability there appears to be limited action by the police to encourage someone to declare they have a disability.

> 'In relation to the training of new officers I am not aware that there is a specific amount of encouragement to invite people to identify whether or not they have a disability.'
>
> Richard Crompton, ACPO

Disabled people do not go to the police for a variety of reasons including concerns that they won't be believed, previous negative contact with the police, fear that it will make their situation worse and lack of confidence that the police will do anything to help (see Reporting harassment, Part 3). Under-reporting was acknowledged as a problem by many police respondents and a number of forces have started to take action to address it including through better community engagement, third party reporting

255 See www.acpo.police.uk

schemes and improving public awareness through leaflets and DVDs.

> 'The police service is committed to reducing the under-reporting of hate crime and would view increases in this data as a positive indicator, so long as it reflects an increase in reporting and not an increase in the actual incidence of crime which we strive to reduce.'[256]

At a time when the Government has said that police forces should be judged by their reported crime rates, some forces may be reluctant to actively encourage disabled people to come forward in case this increases their overall level of reported crime and they are judged negatively as a result. By encouraging disabled people to come forward, particularly those who have been reluctant to do so in the past, police have the opportunity to prevent harassment escalating into more serious crime and to bring offenders to justice.

There are large variations in recorded figures of disability hate crimes across forces, from none in Durham and City of London to 102 in Thames Valley. These variations appear to reflect differences in police practice rather than in incidence of hate crime. Comparatively, we see figures ranging from 48 race hate crimes reported in the City of London, 203 in Cheshire, 205 in Cleveland to 9,395 race hate crime reports in the Metropolitan Police force, indicating how much more well embedded dealing with reports of race hate has become over the past few years. Cleveland Police submitted evidence to the inquiry that they had recorded 34 disability hate crimes/incidents in 2009. Nine of these were recorded and investigated as crimes.[257]

In 2007, Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI) and Her Majesty's Inspectorate of Constabulary (HMIC) published, Without Consent,[258] a report on the joint review of the investigation and prosecution of rape offences. It highlighted that mental health conditions and learning difficulties were 'frequently identified vulnerabilities' and that outcomes are particularly poor for women with these impairments.

> 'In 2009, Cambridgeshire Police made an out of court compensation payment of £3,500 to a woman with a mental health issue who had accused them of failing to properly investigate a rape that she had reported to them in 2005. The woman began legal proceedings

256 ACPO, 2010, *Total of recorded hate crime from regional forces in England, Wales and Northern Ireland during the calendar year 2009*, p1. Available from: http://www.acpo.police.uk/asp/policies/Data/084a_Recorded_Hate_Crime_-_January_to_December_2009.pdf

257 See http://www.acpo.police.uk/asp/policies/Data/084a_Recorded_Hate_Crime_-_January_to_December_2009.pdf http://www.acpo.police.uk/asp/policies/Data/084a_Recorded_Hate_Crime_-_January_to_December_2009.pdf

258 HMIC and HMCPSI, 2007, *Without Consent: A report on the joint review of the investigation and prosecution of rape offences*. Available from: http://www.hmcpsi.gov.uk/index.php?id=47&docID=258

under the Human Rights Act after she discovered that the attack had not been recorded as a crime and CCTV footage of her attacker had been destroyed because the police failed to obtain it in time. Although Cambridgeshire Police made no admission of liability they did issue an apology to the woman. The victim said, "I should have been getting over a crime but because of what they did, I have never had the time or the space to do it. I walked around feeling like a dirty dishcloth".'[259]

Some disabled people may need support to be able to give best evidence to the police. In Britain, someone who is alleged to have committed an offence who is under the age of 17 or a 'vulnerable adult' must be interviewed by police in the presence of an appropriate adult. In Scotland this provision is also made for victims of crime. This is not a requirement in England and Wales, although some police forces do offer it on occasion.

Preventing escalation

Police responses to reported disability-related harassment are framed by overlapping policies on antisocial behaviour and hate crime. Disability-related harassment is often non-criminal antisocial behaviour and minor/'petty' crime, at least initially. Where harassment happens at or near someone's home, it is often repeated. Unchecked, repeated harassment can escalate in frequency and severity. By contrast, prompt action by the police, often working in partnership with other agencies, can bring it to an end.

The report of HMIC on antisocial behaviour[260] found that only half (22 out of 43) of police forces in England and Wales are able to identify and prioritise repeat callers at the time when the call is made and less than a third (13 out of 43) can effectively identify the most at risk callers. In January 2011, the Government announced a number of pilots of a new computer system to help identify repeat and vulnerable victims of antisocial behaviour.[261]

Police call-handling systems use a number of criteria to decide the priority of the call and control room operators may not be aware of the history or impact of harassment when grading the call. As a result the police may not visit at all or may take some days to respond. Individual officers may also de-prioritise low level harassment in order to focus on 'criminal behaviour'.

Few police forces monitor calls for service in terms of whether the victim is disabled. Some forces, such as Leicestershire, have started to screen calls in terms of the 'vulnerability' of the victim. This has inherent problems in terms of equating disability with vulnerability.

259 Quoted on BBC News Website, 01/12/09, *Rape complaint woman reaches settlement with police*. Available from: http://news.bbc.co.uk/1/hi/uk/8387622.stm

260 HMIC, 2010, *Anti-social Behaviour: Stop the rot*, p11. Available from: http://www.hmic.gov.uk/SiteCollectionDocuments/Anti-social_behaviour_2010/ASB_SPE_20100923.pdf

261 The pilots are currently underway in Avon and Somerset, Cambridgeshire, Leicestershire, Lincolnshire, London, South Wales, Sussex and West Mercia.

Recognition

The low rates of recorded disability hate crimes suggest a lack of recognition of hostility/prejudice to disability as a potential motivating factor for either antisocial behaviour or crime.[262] As highlighted in the introduction, Leicestershire police did not investigate hostility or prejudice to disability as a motivation for the antisocial behaviour experienced by Fiona Pilkington and her children. In our formal evidence sessions, we often spoke to police forces who reported repeat incidents against particular individuals or families, but repeatedly disability was ruled not to be a factor in why the incidents occurred.

The inquiry investigated the response of Greater Manchester Police to the antisocial behaviour experienced by David Askew prior to his death. The police received reports of 78 incidents regarding the Askew family in three years yet on only one occasion was hostility to disability considered as a motivation. Even on that occasion it was dismissed. The Independent Police Complaints Commission undertook detailed investigations of each of these cases and criticised the responses of both forces, including their failure to recognise the antisocial behaviour as motivated by hostility to disability.[263] A similar issue was identified in many of the other cases we considered (see Part 2).

Although prosecution decisions are a matter for the Crown Prosecution Service (England and Wales) and the Crown Office and Procurator Fiscal Service (COPFS) (Scotland) they depend on the evidence gathered by the police. If the police do not adequately consider the possibility that a crime against a disabled person was motivated by hostility to disability, then they are unlikely to investigate it as such and gather evidence of any such motivation that can be used by the prosecutors to support an argument for a sentence uplift.

Representatives from the Crown Prosecution Service said that often they do not even know that the person for whom they are preparing a case is disabled until the last moment. This might affect the way they are to prepare the case, and can make it harder to request 'special measures', which is perceived by many as an overly bureaucratic system to apply (see below).

Hostility/prejudice to disability does not have to be the sole motivation for a case to be prosecuted as hate crime. However these cases seem to suggest that where another motive is evident, it will be put forward as the sole motive, rather than considering disability alongside it. Where another motive is not evident, the crime might be considered to be motiveless, as was the case with the murder of Brent Martin (see Part 2). There is no data available about the numbers of murders

262 Part 1 explains the legislative framework including sentence uplift and policy framework including antisocial behaviour and hate crime within which the police operate in responding to disability-related harassment.

263 Independent Police Complaints Commission, 2011. Available from: http://www.ipcc.gov.uk/news/Pages/pr_240511_pilkington.aspx andhttp://www.ipcc.gov.uk/news/Pages/pr_210311_gmpaskew.aspx

where the victim is a disabled person so it is not possible to consider this against a wider base of cases.

The inquiry also considered the circumstances surrounding the death of Christine Lakinski, a woman with a learning disability and curvature of the spine, who was urinated on, covered in shaving foam by a neighbour and filmed on a mobile phone as she lay dying in the street of pancreatic failure. The abuse of Christine Lakinski in her dying moments reveals shameful attitudes towards another human being, but it did not cause her death. The perpetrator was prosecuted for a public order offence. It was not prosecuted as disability hate crime, although a relatively high sentence of three years imprisonment was awarded.

The inquiry did not come across a single case of sexual violence against a disabled person that has been recorded and prosecuted as hate crime, despite some evidence disabled women are at greater risk of being targeted for these offences than non-disabled women.

Elsewhere in this report we have said that frontline police and antisocial behaviour officers should have a duty to establish whether the victim is disabled, and if they are, consider whether or not it may have been a factor in why the incident occurred. This should occur not just at the beginning of an investigation, but should also be re-evaluated at various points. Similarly, the same should apply when a case is first taken on by the Crown Prosecution Service (England and Wales) and the COPFS (Scotland), in case investigating officers have overlooked a possible alternative or additional motive.

Charging framework

The inquiry considered whether the charging framework influenced police evidence-gathering. In the wake of the Lawrence Inquiry, new specific offences for racially motivated attacks were introduced in England, Wales and Scotland. These were recognised by a number of respondents as having helped to change the culture by raising the profile and focusing the attention of the police on racial harassment and encouraging them to gather evidence to establish racist motivation.

There are no similar specific offences linked to disability. We asked police representatives what impact the absence of specific offences has on police practice in relation to evidence-gathering. Although some respondents did not consider this to be a problem, others suggested that the charging offence directs police evidence-gathering and the lack of a specific offence means that consideration of disability hostility is not at the forefront of the investigator's mind. Others suggested that there was an implied hierarchy of offences, because of the existence of specific offences for other types of identity motivated crime.

Positive response

Many of the police submissions to the inquiry acknowledged their historic lack of understanding of harassment of disabled people. The inquiry was encouraged that the police appear to recognise that their responses to antisocial behaviour and crime need to improve. A range of initiatives are being developed. A number of forces have undertaken training and seminars/workshops to improve understanding, some successfully involving disabled people's organisations

in conducting training programmes. Others are planning similar initiatives.

HYDRA[264]

'HYDRA' is a unique training system, which enables real-time decision-making to be monitored and assessed. The system was originally developed as a training tool for police officers managing critical incidents, however more recent exercises have also included professionals from the fields of education, health, and social services.

The training system offers an innovative means of capturing complex decision-making in dealing with critical incidents. The video footage, decision logs, and communication records obtained during the training exercise also provide a novel way of studying decisions as they are made during real-world situations, as well as the leadership and group dynamics of the individual teams. Among other skills, the training is developed to test biases, behaviours, working under pressure and multi-agency inertia.

Greater Manchester and South Wales Police forces are using basic version of HYDRA for training on tackling disability hate crimes and the Metropolitan Police are currently using a disability hate crime incident as part of force-wide training on the full HYDRA system.

Parallel justice

The model of parallel justice, developed by the Parallel Justice project,[265] makes support for victims to rebuild their lives a key part of justice. This system is being trialled in police forces across the USA. While restorative justice offers much of value it can still fall short for victims in critical ways. Hence, a parallel justice framework in which there would be two separate responses to crime: one focused on offenders, the other focused on victims, would offer a more comprehensive response than some of the current restorative justice practices that focus specifically on offenders.

Guiding principles include:

- all victims deserve justice and support to rebuild their lives
- all victims should be presumed credible unless there is reason to believe otherwise
- victims' safety should be a top priority and they should experience no further harm
- victims' rights should be implemented and enforced
- victims' needs should be addressed through a comprehensive, co-ordinated communal response.

The National Center for Victims of Crime (which established the Parallel Justice project) has developed guiding principles for implementing justice[266] including:

264 See http://www.hydra-minerva.com/history/history.htm

265 See http://www.paralleljustice.org/

266 National Center for Justice, *Parallel Justice Guiding Principles*. Available from: http://www.ncvc.org/ncvc/AGP.Net/Components/documentViewer/Download.aspxnz?DocumentID=41484

- create a planning and implementation infrastructure that will foster joint working and systemic change
- develop data-driven responses that build on local assets and meet local needs
- make safety of victims a high priority
- offer victims appropriate support and assistance
- provide victims with an opportunity to be heard
- co-ordinate services and resources
- Government plays a key role
- services and support should also extend beyond a government response.

Parallel justice provides a potentially useful framework for considering how to improve access to justice and redevelop the criminal justice system's response to disability-related harassment.

Woolwich Model[267]

The Woolwich Model, developed by Ben Rogers (associate of the Institute of Public Policy Research (IPPR) and DEMOS) in 2010 is aimed specifically at addressing lower level incidents and antisocial behaviour. It is based on the model developed in Woolwich in 1878 which established the principle of first aid.

A skills-based approach to co-production in delivering public services, it creates a 'fit' with current policy agendas of central government. The principles are a high level skills-based training programme provided to frontline public servants, park wardens, street cleaners, and transport staff, shopkeepers, local neighbourhood watch officers and other community based agents, to enable them to effectively and appropriately intervene and tackle low level incidents and antisocial behaviour as they come across it.

The approach recognises that the cumulative effect of low level incidents such as name calling and vandalism can be devastating and destroy lives and function as 'signal crimes' – read as indicators to communities of interest about what and where to avoid. The engagement of local people on a voluntary basis has the effect of, in part, tackling the 'bystander' impact and providing locally agreed solutions for regulating antisocial behaviour. The incentive for training is based on the same model as the incentive for first aid or other voluntary activity, rewarded with skills-based training and a civic recognition.

The courts

'Even if we, the police and others, are clear and better in our approach, we will still see people dropping off [rather than going through a case in the courts] once they realise what the adversarial system has in for them... for disabled people, as well as other people in vulnerable situations, there is a question mark over whether the old

267 See http://www.thersa.org/events/audio-and-past-events/2010/the-woolwich-model-how-citizens-can-tackle-anti-social-behaviour

> fight that was the adversarial system is the right way.'
>
> Keir Starmer, Director of Public Prosecutions, inquiry hearings, 17/11/10

The concept of a 'fair trial' lies at the heart of the court system but it is not always afforded to disabled victims of crime. The Youth Justice and Criminal Evidence Act 1999 introduced the system of 'special measures' in England and Wales to enable witnesses who are young, or who have a mental health issue, learning disability, sensory or physical disability, or who may be in fear or intimidated to give best evidence in court. Special measures are also available in Scotland through the Vulnerable Witnesses Scotland Act 2004.

Both HMCPSI annual report of 2009-10[268] and the Ministry of Justice's report on the court experiences of adults with mental health issues or learning disabilities[269] found failings in the provision of special measures in England and Wales, including a lack of co-ordination in the service provided to victims and witnesses, inadequate communication and availability of information and late applications to court. A Scottish Government review[270] of the implementation of special measures in Scotland also found problems with late applications and inadequate identification of those who would qualify for the measures and would benefit from them.

As a result, victims do not always get the appropriate support to give best evidence although prosecutors often display good standards of witness care in court. Giving evidence to this inquiry, the Director of Public Prosecutions, Keir Starmer, criticised the system of special measures as 'just too complicated. Applying for special measures is almost like a series of tripwires for a prosecutor which you are quite unlikely to get through without falling over.'

> 'The primary rule that we teach is that special measures applications should be dealt with well before the trial. And by that we mean at the plea and case management hearing which is generally the first hearing before the Crown Court after the case comes up from the magistrates because it's clearly in the complainant's interest or the witness's interest that they know well in advance whether they are in fact going to have the benefits of special measures or not. And what we try to avoid is the last minute application made.'
>
> Judge Phillips, Director of Studies for the Judicial College

Concerns were also expressed about the terminology, with some arguing that the name 'equalising measures' would be more appropriate.

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268 HM Crown Prosecution Service Inspectorate, *Promoting Improvement: HM Chief Inspector of the Crown Prosecution Service, Annual Report 2009-2010*. Available from: http://www.hmcpsi.gov.uk/index.php?id=47&docID=1028

269 Ministry of Justice, 2010, *Court experiences of adults with mental health conditions or learning disabilities*. Available from: http://www.justice.gov.uk/publications/research-and-analysis/moj/court-experiences-adults-mental-health.htm

270 Scottish Government, 2008, Turning Up The Volume: The Vulnerable Witnesses (Scotland) Act 2004. Available from: http://www.scotland.gov.uk/Resource/Doc/233342/0063950.pdf

> 'They're not special measures; they're making my ability to give evidence the same as yours. That's what it's about, and the system doesn't see it that way.'
>
> Louise Casey, Victims Commissioner

Neither Her Majesty's Courts Service, who manage the courts system in England and Wales, nor the Scottish Courts Service, record how many applications for special measures are made nor how many are granted.

In the prosecution of James Watts, a care worker who was convicted of sexually assaulting four women with severe physical and communication impairments, innovative techniques were used to allow disabled people to give evidence. One of the victims gave evidence by blinking her eyes and the jury also watched a video of a police interview with one of the women who used a pointer on a computer screen to describe what happened to her.

In another serious case, a key witness had agoraphobia and multiple medical issues. Agencies worked together to ensure the appropriate equipment and personnel were in place for the witness to effectively give their evidence over a remote link set up in their home.

Disabled victims may not report the crime in the first place or may withdraw their allegations if they fear that they, rather than the defendant, may be put on trial. This is particularly the case for people with learning disabilities or mental health issues, the groups most likely to experience disability-related harassment, who have historically not been seen as credible witnesses. Defence lawyers can exploit negative stereotypes and assumptions about disabled witnesses to undermine their credibility with the jury. Concerns about this risk have sometimes led the Crown Prosecution Service to drop cases where the key witness is disabled.

In 2008, the Crown Prosecution Service dropped a prosecution where the victim of an assault (FB) had a history of mental illness. FB had suffered a serious assault on Boxing Day 2005. The police investigated and the Crown Prosecution Service initially decided to prosecute but on the morning of the trial the Senior Prosecutor decided not to proceed.

The prosecution had concluded that FB would not be a credible witness because he had a history of mental health issues. FB applied for a judicial review of the decision by the High Court. The Equality and Human Rights Commission intervened in the case to offer expert advice to the Court. The High Court ruled that the Crown Prosecution Service were wrong to drop the prosecution and that FB's human rights had been breached as dropping the prosecution had amounted to a failure in provision of legal protection to FB.

The Crown Prosecution Service subsequently reviewed its policies on prosecuting crimes involving victims and witnesses with mental health issues and learning disabilities, and issued new guidance for prosecutors[271] and a leaflet

271 Crown Prosecution Service, 2010, Victims and Witnesses Who Have Mental Health Issues and/or Learning Disabilities – Prosecution Guidance. Available from: http://www.cps.gov.uk/legal/v_to_z/victims_and_witnesses_who_have_mental_health_issues_and_or_learning_disabilities_-_prosecution_guidance/index.html

for disabled people.[272] These are welcome steps, which demonstrate the commitment of the Crown Prosecution Service in recent years to pursue cases of harassment of disabled people that might previously have been dropped. The Crown Prosecution Service is also undertaking a number of initiatives to improve staff awareness including the appointment of hate crime co-ordinators in each region and better guidance and training for staff, although the Director of Public Prosecutions acknowledged that there is room for further improvement in the criminal justice system.

> 'There's undoubtedly an awareness issue within the police and the prosecuting service. We get people who miss the signs until later or the signs haven't been picked up at all. There is an awareness problem.'
>
> Keir Starmer, Director of Public Prosecutions, inquiry hearings, 17/11/10

Both the Director of Public Prosecutions, Keir Starmer, and the then Solicitor General in Scotland, Frank Mulholland,[273] spoke of their commitment to increasing access to justice for victims of disability-related harassment. In Scotland, there is 'a strong presumption in favour of prosecution, where there's sufficient, admissible, credible and reliable evidence'.[274] Where the offence is being prosecuted as a hate crime under the Offences Aggravated by Prejudice Act 2009 it 'should not be plea bargained out unless there's a specific authorisation given at a very high level'.

Both jurisdictions have improved their policies and recognise the need to ensure that they are implemented and to continue to raise staff awareness and understanding. However Keir Starmer suggested that these improvements, and equivalent steps by other agencies such as the police, might be insufficient because of the continuing risk that someone's impairment may be used to discredit them in court. As well as resulting in acquittals, the fear of such an ordeal can lead disabled victims to withdraw their complaints or not come forward in the first place.

> 'I would be interested in exploring a system that was much clearer in narrowing the real issues between the parties... isolating those issues and only determining those issues. So when it came to disclosure, for example, unless somebody's mental health was really part of the issue to be determined in the case, then we wouldn't have to even think about disclosing the details... We could then confidently say [to the victim]: We don't need to disclose this, that will not be an issue for you or, if it is an issue – in the cases where we know it's an issue – this is going to come up in your case and this is how we're going to handle it.'
>
> Keir Starmer, Director of Public Prosecutions, inquiry hearings, 17/11/10

272 Crown Prosecution Service, 2010, *Policy for Prosecuting Cases of Disability Hate Crime*. Available from: http://www.cps.gov.uk/publications/prosecution/disability_hate_crime_leaflet.pdf

273 At the time of the hearing in January 2011, Frank Mulholland was Solicitor General in Scotland. In May 2011, he was appointed as Lord Advocate. The new Solicitor General is Lesley Thomson.

274 Frank Mulholland, Solicitor General, inquiry hearing, 18/01/11.

The law

Unlike for racial harassment, there are no specific offences linked to disability-related harassment. However sentences can be increased, or varied in other ways in Scotland,[275] where there is evidence that offences were motivated by hostility (England and Wales) or prejudice (Scotland) towards disability (see Appendix 8).

These approaches to sentencing have the potential to be a useful tool in raising the profile of disability-related harassment and the prejudice/hostility underlying it. They signal that these offences should be taken particularly seriously. But to act as a deterrent, they need to be known about, and applied.

It is too early to assess the operation of sentence variation in Scotland as the Offences (Aggravation by Prejudice) (Scotland) Act 2009 has only been in force since March 2010. However, relatively few cases have been taken forward in relation to disability in the first year of operation (50 disability-related out of 5,370 hate crime offences, less than 1 per cent).[276]

The Crown Office does not hold data on the application of the Act so it is difficult to get a picture of how many prosecutions have been successful and which offences the aggravations have been applied to.

The proportion of prosecuted hate crimes that are disability-related is also relatively small in England and Wales at 4.6 per cent in 2009/10, but the trend is upward from only 1.3 per cent in 2007/08.[277] This is encouraging and reflects the efforts of the Crown Prosecution Service in recent years to improve their response to disability hate crime, although conviction rates remain lower for disability hate crime than for hate crime overall.[278]

The Crown Prosecution Service collect but do not publish how often they have sought to prove that an offence was motivated by hostility to disability as required for sentence uplift to be applied. Although Her Majesty's Court Service, who manage the courts system in England and Wales, record information about the outcome of criminal trials in England and Wales, including the verdict and sentence, they do not systematically collect any information on the application of the

275 In England and Wales, application of section 146 automatically increases the sentence. In Scotland, the Offences (Aggravation by Prejudice) (Scotland) Act allows for a 'variation in sentence' approach. The judge must take the motivation into account when sentencing which could result in a sentence increase but could also lead to a different type of sentence.

276 Crown Office and Procurator Fiscal Service, 2011, *Hate Crime in Scotland 2010-11*. Available from: http://www.copfs.gov.uk/sites/default/files/Hate%20Crime%20-%20publication%20-%20final%20version.pdf

277 Crown Prosecution Service, 2010, p9. Available from: http://www.cps.gov.uk/publications/docs/CPS_hate_crime_report_2010.pdf

278 Ibid., pp3-4.

sentence uplift. As a result there is no official data on this in England and Wales. Other evidence suggests that its application is patchy, linked to widespread failings in the system to recognise a victim's disability as motivation for crime.

> 'One of the great problems of the system that we have is that there is very little evidence of why judges specifically pass sentence as they do in any particular case. The judge will have said what he's doing but those remarks are not then collected for statistical purposes. They're relevant to the particular offender but not collected so that we can see ... What we are trying to do at the moment is to get to grips with why judges pass sentence. The better to understand how their sentences fit in to our guidelines and so from last October we started a data collection exercise. We ask all judges to fill in a form about the sentences they've passed... and what we're trying to do is find out what the aggravating and mitigating factors are.'
>
> Lord Justice Levenson, evidence session

As far as we have been able to establish from the information published by the Crown Prosecution Service, sentence uplift has never been applied to any prosecution of rape or sexual assault where the victim is a disabled person.

Improving application of the sentence uplift legislation depends in part on the police being more effective in recognising disability hate crime, as discussed previously. It also requires prosecutors to actively consider whether an offence against a disabled person is motivated by hostility (England and Wales) or prejudice (Scotland), even if it has not been flagged as such by the police.

Not all offences against disabled people are motivated by hostility or prejudice. Criminal justice respondents considered that disabled people were often seen by offenders as 'easy targets' or 'vulnerable' and that such cases should not be considered as disability hate crimes. However, we came across incidents that we thought were disability hate crimes, that the authorities involved had described as motiveless, and so particular care should be taken when there is no apparent motive for a crime.

> 'You would expect the prosecutor to say... to remind the judge, one hopes the judge already knows about 146, but to remind the judge of section 146 and to say that the following factors bring the case within section 146, at which point the defense counsel might say, "Yes, I agree, it's aggravated by section 146, but there were the following mitigating factors, it wasn't that much aggravated", or defense counsel might say, "I disagree, this is not a section 146 case and you judge should not aggravate the sentence on that account." But the extent to which it's being applied I really can't comment on.'
>
> Judge Phillips, Director of Studies for the Judicial College

New sentencing guidelines on assault came into effect on 13 June 2011 and are applicable in both magistrates' and crown courts. Their aim is to ensure a 'consistent and proportionate approach to sentencing' with sentences reflecting both the harm caused to the victim and the offender's

culpability. The new guidelines should mean that offenders who cause serious harm are punished with substantial prison sentences, but that courts make more use of community sentences for offenders who cause no or very minor injury.

Chairman of the Sentencing Council, Lord Justice Leveson, said: 'This guideline will increase consistency in sentencing and help ensure offenders receive sentences that accurately reflect the harm they have caused their victim and their culpability. Where serious injuries are inflicted, offenders can rightly expect to go to jail, but where very minor or no injuries are caused, sentencers need to apply a proportionate response.'

Incitement

The legal framework for both England and Wales and for Scotland contain offences for incitement on the basis of racial or religious hatred, but there are no similar incitement offences linked to disability. Only incitement to racial hatred applies in Scotland.

Some have said that there is no basis for creating such an offence in relation to disability, because it does not happen. Some of our evidence, for example in relation to cyber-bullying, appears to contradict this. We think that government should conduct a review to establish if a similar incitement offence should be introduced. This would be to create parity with other identity-based crime and also to address actual occurrences. In particular this would benefit situations where it is hard to give an adequate response to disability-related hate incidents under the current legal framework, such as within cyber-bullying and also persistent non-crime incidents.

Schedule 21

There are inherent problems with the sentencing framework for disability-related murders in England and Wales. Under Schedule 21, which sets out the basic starting points for sentencing of murder, the minimum starting point for racist or homophobic murders is 30 years. Murders motivated by hostility to disability are not included in Schedule 21 resulting in a much lower starting point of 15 years.

Philip Holmes was beaten and kicked to death in his flat in April 2010 by Martin Mather. The prosecutors and North Wales Police had flagged the case as a disability hate crime.[279] Prosecuting counsel drew the court's attention to the fact that Mather was aware of and exploited Philip's vulnerable situation and had displayed hostility to Philip's disability in interviews with police after his arrest. The court accepted that the murder was motivated by hostility to disability and Mather was sentenced to a minimum of 17 years in prison. However, if the court had found that a similar murder had been motivated by racism or homophobia, the minimum sentence would have been at least 30 years.

279 See CPS press release: http://www.cps.gov.uk/wales/news_and_views/martin_mather_jailed_for_murder_of_disabled_man_in_rhyl/

Schedule 21 is, of course, not the only driver that affects how a judge will arrive at a sentence. There are also sentencing guidelines, and a range of factors that an individual judge could and should take into account. But it is evident to many that this disparity on the face of this guidance inadvertently sends out a message that a disabled person's life can be considered only half as valuable as that of others. We believe this is wrong, and we urge the Government to take steps to address this imbalance.

Justice for victims

> 'Victims overall are the poor relation in the criminal justice system. There's no doubt in my mind at all. Less than one penny in the pound is spent on services for victims as opposed to what's spent on everything else in the criminal justice system. It doesn't look very fair.'
>
> Louise Casey, Victims Commissioner

Throughout our evidence-gathering, we considered the responses of agencies to victims, in terms of bringing the harassment to an end, achieving justice and redress and supporting recovery from the impact of the harassment. We also held a hearing specifically on victims' issues with the Victims Commissioner, Louise Casey.

We found that the systems available to help disabled victims give evidence to the best of their abilities do not always work effectively. We also found that victims often have limited access to the support that they need to achieve safety and rebuild their lives. Agencies have limited understanding of how other aspects of identity such as age, race, religion, gender, sexual orientation and sexual identity interact with disability to affect victimisation.

There is little specialist provision for disabled people who have experienced harassment. Disabled people's organisations have started to address this, but there has been little evaluation of the effectiveness of specialist advocacy to date. There is also a distinct lack of funding available for disabled people's organisations to sustain any kind of support. Support for families where a victim has been murdered has been patchy historically, although this appears to be improving.

The National Center for Victims of Crime in America has developed the concept of parallel justice. It recognises that 'justice not only requires a fair and appropriate response to people who commit crimes; it also requires helping victims of crime rebuild their lives'.[280]

Understanding perpetrators

There is very little research specifically about perpetrators of harassment of disabled people, though there is a more general body of work exploring hate crimes against people, based on different equalities characteristics. We have also drawn from the experiences of disabled people as part of this inquiry.

The lack of recording and recognition of disability hate incidents and crimes impacts upon our knowledge of and

280 See http://www.paralleljustice.org/


ror and do a
behaviour. How do
"What's the matter wit
do anything right? I'm
you and your *%@#!"
Do our kids with
shouting matches?
acceptable in the famil
violence seen a
ving? Kids beli

response to perpetrators. As non-criminal and minor criminal harassment is often ignored, models for how harassment escalates are wholly undeveloped. Those who are convicted may not be representative of those who commit harassment. The way disability harassment interacts with other motivating factors such as financial gain has also received little attention. This is exacerbated by an assumption that disabled people are 'easy targets'.

The criminal justice system does not have any data on the number of offenders that they are dealing with through either custodial or community sentencing who were convicted for offences recognised by the court as motivated by hostility to disability, or more broadly for a crime where the victim was disabled. The National Offender Management Service (NOMS) do not have any tailored programmes specifically aimed at offenders who were motivated by disability.[281]

There is a lack of consequences for many perpetrators either through the criminal justice system or outside it through community-based initiatives.

Representations and understanding of disability

> 'There are no really genuinely positive and real images around disabled people and the lives that we lead.'
>
> Key informant interview with Tara Flood, ALFIE, 28/07/10

Earlier in this report we have discussed the impact of wider societal attitudes towards disability in relation to the incidence of disability-related harassment. We have looked at the role of educators in tackling negative attitudes and promoting positive attitudes. Other agencies central to being able to influence attitudes include those in the media industry.

Many submissions to the inquiry from disabled people and their organisations mentioned the media as influencing attitudes to harassment as well as to disabled people more generally. We held a roundtable with representatives from the media including representatives from the Society of Editors, the National Union of Journalists, the Press Complaints Commission and OFCOM. The meeting focused on the role of the media in respect of the portrayal of disabled people and the power of the media to positively or negatively impact on disabled people's lives.

Coverage of changes to the welfare benefit system in the media was raised with the inquiry by disabled people who complained that it implied that they were 'scroungers'. The roundtable considered that current codes of practice in the industry should be sufficient to address the concerns.

There was some recognition of improved use of terminology to describe disabled people (as a result of a voluntary code of conduct applied by the majority of journalists), and involvement of the media in some campaigns to change attitudes, in particular around the portrayal of people with mental health issues.

281 Although NOMS stated to the inquiry that there are interventions that treat the risk factors that hate crime offenders present generally.

We recommend that government departments make efforts to persuade the press to act responsibly when reporting benefit statistics and messages to help deal with the impact disabled people have told us about. We also recommend that public authorities assess their own representation of disabled people and promote positive attitudes towards disabled people.

Although members of the viewing public generally support greater representation of disabled people on screen in a wider variety of roles,[282] professionals in the television industry tend to underestimate the number of disabled people in Britain and the degree of support for greater representation. Some described disabled people as 'untelevisual'.[283]

In 2010, Ofcom, which regulates television, upheld complaints against both the BBC and E4 for use of offensive language to describe disabled people. However there are also examples of positive portrayals of disabled people in the media, and we recommend that the press and broadcast industries consider the impact of overtly negative portrayals of disabled people.

The BBC recruited six new disabled presenters for the recent coverage of the Paralympics World Cup and work is underway to address proportionate representation of disabled people for the Olympics in 2012.

The planned disability legacy for the London 2012 Olympic and Paralympic games also includes a commitment to improve public perceptions of disabled people.

Case study

The BAFTA nominated documentary *Katie: My Beautiful Face* was first shown on Channel 4 in October 2009 and highlighted the impact of facial disfigurement on former model and television presenter, Katie Piper. The follow-up series *Katie: My Beautiful Friends* received extensive media coverage when it was shown in 2011 and included stories of harassment of people with disfigurements.

Case study

The Panorama programme, *Undercover Care: The Abuse Exposed*, first shown on BBC1 in 2011, uncovered the abuse of disabled adults by staff in a Bristol care home. The programme led to the suspension of 13 members of staff, including two managers, and four people have been arrested. The Government has asked the regulator, Care Quality Commission (CQC), to make unannounced inspections of similar services and has announced an investigation into the roles of the CQC and local authorities in the home featured in the programme.

282 Sancho, J., 2003, *Disabling Prejudice: Attitudes towards disability and its portrayal on television*, undertaken by the British Broadcasting Corporation, the Broadcasting Standards Commission and the Independent Television Commission.

283 Ibid.

Partnership responses

We considered the role of inter-agency responses in dealing with disability-related harassment. We held formal hearings with senior representatives from 12 inter-agency partnerships. These included local authorities, police forces, housing, education and health bodies. We also discussed the role of partnerships in other formal sessions such as with inspectorates.

Some examples of good inter-agency working, particularly from areas who have actively sought to change following a serious case review, were apparent. Agencies' working together before an issue becomes 'critical' is seen as important.

Examples of ineffective partnership work included:

- referrals not being made appropriately between agencies. This included agencies not referring adults at risk of harm to adult safeguarding, and adult safeguarding teams not referring criminal allegations to the police for investigation
- inadequate data gathering and information sharing across agencies. As a result agencies responded to a partial picture of the harassment and found it difficult to track cases
- a lack of consideration given to the wider environment in which a person may be living and potential risk factors involved
- a lack of co-ordination so the different parts of the system did not act together to bring the harassment to an end
- the majority of the partnership working being at senior level only – more effective partnership working included cross-agency working at multiple levels, and especially among frontline staff
- a lack of recognition of the role of disabled people's organisations in responding to harassment.

Many public authorities told us they were good at partnership working, even when we were investigating them under the 10 cases in Part 2. There does seem to be considerable variation between different areas. We would like to see better understanding and promulgation of good practice across different areas.

Inspectorates and regulators

We held formal evidence sessions with 15 inspectorates and regulators including Audit Commission, Audit Scotland, Care and Social Services Inspectorate Wales, Care Quality Commission, Estyn, Her Majesty's Crown Prosecution Service Inspectorate, Her Majesty's Inspector of Education, Her Majesty's Inspectorate Constabulary, Her Majesty's Inspectorate Constabulary Scotland, OFCOM, Ofsted, Press Complaints Commission, Scottish Commission for Regulation of Care, Scottish Housing Regulator and Wales Audit office.

Although all the inspectorates/regulators provided insights into the operation of the sectors that they work within, they varied in the degree to which they were addressing disability-related harassment themselves. Most of these bodies are

public authorities, subject to the public sector equality duty, including the duty to pay due regard to eliminating disability-related harassment. They have a key role to play as part of the impetus for creating change and improving the response to disability-related harassment. The Commission is itself a regulator and will also have an important role to play going forward.

Ofsted have placed equalities and human rights at the heart of their approach to regulation and inspection. They train their inspectors on how to integrate effective inspection in these areas into the overall inspection process. The inspection framework for schools includes specific questions about:

- how schools are meeting their equalities duties
- whether there are different outcomes for different groups of children
- how schools are dealing with bullying.

Ofsted has introduced a 'limiting judgement' on equalities performance which means that schools cannot be judged as excellent if their equalities performance is inadequate.

Part 5: Conclusions

Our inquiry learnt much from both its investigation into 10 cases and the evidence that disability-related harassment is a widespread problem which has a significant impact on the day to day lives of disabled people.

We found that the extent of harassment remains largely hidden, its seriousness rarely acknowledged, its link to the victim's disability not investigated.

While we have presented new data from the British Crime Survey, which shows that disabled people are more likely to experience crime than non-disabled people, we rely on the strong indications from other, less comprehensive surveys from IPSOS Mori and Scope, to give us a sense of the scale of the problem. Personal testimony from our witnesses and our own qualitative research supports our view of the likely level of prevalence.

This data and our own evidence leads us to believe that the 1,567 cases of disability hate crime recorded in the ACPO data for 2009/10 significantly under-represent the scale of the problem.

Filling this data gap and getting comprehensive information on the scale, severity and nature of disability-related harassment therefore features highly in our recommendations in the next section.

There is also much we do not know about the causes of harassment or indeed the motivations of perpetrators, and understanding these will be key to tackling the root causes of the hostility we have evidenced in this report. Disability-related harassment incidents and crimes are not motiveless – they often stem from deep-seated animosity and prejudice which feeds off the wider cultural devaluation and social exclusion of disabled people.

Evidence to the inquiry suggested a number of possibilities for causation, which do require further investigation. These include overall negative attitudes towards disabled people, power differences between non-disabled people and disabled people and a general inaction, based on lack of recognition by public authorities.

The inquiry evidenced that disabled people's marginalisation and disempowerment contributes significantly to becoming a victim of crime and disability-related harassment flourishes in a climate of social exclusion.

Many of the witnesses who gave evidence thought harassment was linked to prejudice against disabled people. Some suggested that the historical representation of disabled people as in need of charity ('handicapped') is still embedded in the stereotype of disabled people as objects of pity rather than as equal members of society. This was seen by some as being exacerbated by the differences in power – disability-related harassment as a manifestation of a much wider power dynamic that socially excludes, marginalises and discriminates against disabled people.

In the recent past, some legislation has also reinforced the idea of disabled people as 'different'. For example, until the Sexual Offences Act 2003, the maximum sentence that could be awarded for raping a person with learning difficulties[284] was two years, compared with up to life for raping a non-disabled person. Disabled people continue to be treated differently in parts of the law – people who are receiving treatment for a mental health issue cannot serve on a jury; the time limit for abortion is usually 24 weeks but a pregnancy can be terminated up to full term where the foetus is likely to be born 'seriously handicapped' under the Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act (HFEA) 1990.[285]

The Commission's work on school bullying has found that 'real or perceived differences between children are a cause of bullying'.[286]

Fear of difference can be exacerbated by the lack of contact that non-disabled people may have with disabled people, reflecting the history of institutionalisation and the lack of integration of disabled people in many aspects of society.

Until relatively recently, many disabled people lived in institutions, were educated in segregated schools and worked in segregated employment, cut off from contact with mainstream society, and literally in many cases, 'hidden away' from society. Over the last 20 years there have been welcome steps to enable more disabled people to live independent lives within the community. There have also been moves to reduce the level of segregation of disabled children within the education system, with fewer children educated in 'special' schools.

Despite this progress, barriers to integration and acceptance remain in these and other aspects of life, such as lower rates of participation of disabled people in cultural, leisure and sporting activities than non-disabled people.[287] Underlying prejudice has not been fully addressed, which can manifest in harassment and exploitation of disabled people.

If we accept evidence that disability-related harassment is linked to wider attitudes to disabled people, then public awareness campaigns have a role to play to help address both negative attitudes generally and to raise the public's

284 Referred to as 'a defective' in Section 7 of the Sexual Offences Act 1956.

285 Scientific Developments Relating to the Abortion Act 1967, House of Commons Science and Technology Committee. Available from: http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf

286 Tippet et al., 2011, *Prevention and response to identity-based bullying among local authorities in England, Scotland and Wales*, page iv, for the Equality and Human Rights Commission.

287 Department of Culture, Media and Sport, 2010, *Taking Part – The National Survey of Culture, Leisure and Sport: Adult and Child Report* 2009/10.

understanding of disability-related harassment. We should also remove or amend laws that unnecessarily reinforce disabled people's exclusion or disparity.

While we found a number of awareness campaigns aimed at improving reporting, we did not identify examples of evaluated campaigns aimed at either raising the awareness of the general public about harassment or deterring perpetrators from carrying out harassment.

The failure of public authorities and public transport operators to take effective action to prevent harassment and deal effectively with it when it does occur also contributes to harassment. In most of the cases highlighted in Part 2, agencies were aware of previous harassment but did not take action to bring it to an end. We found little evidence of public authorities discharging their equality duties effectively in respect of the remit of this inquiry.

Disabled people also face barriers to accessing justice, redress and support and have few guarantees about how they should be treated. Little is done to stop most perpetrators continuing their behaviour and they face few consequences for their actions. An unhelpful emphasis on vulnerability can lead to a focus on the disabled person's behaviour rather than on that of the perpetrators. Most authorities are, at best, putting in place systems to respond to harassment that is reported to them with little investment in prevention.

This begs the questions: what is stopping schools, councils, the police, and other agencies doing more to prevent disability harassment? What could they do better?

Our recommendations in the next chapter are addressed at the main agencies, groups and policy-makers involved in dealing with disability-related harassment. These include schools, local government, housing providers, healthcare providers, social services, the police, the courts and public transport operators.

Taken together they aim to deal with three critical aspects of harassment.

- **Recognition**

  One of the principal findings of this inquiry is that the scale of the problem is not adequately recognised. Addressing this will involve raising public awareness of disability-related harassment; training staff in relevant agencies to recognise it and record it; encouraging staff at senior level in these agencies to show leadership in addressing it; and all agencies collecting data to improve our understanding of why and how harassment happens and what can be done to tackle it effectively.

- **Prevention**

  The second key issue is how disability-related harassment can be prevented. It is essential that agencies are proactive in preventing harassment; it is not enough to simply deal with it once it has already happened. Prevention will largely fall to community-based agencies, such as local government, schools, housing providers and public transport operators. All of these organisations must consider the preventative measures they can take – from discouraging bullying, to the design of housing and the layout and accessibility of public transport. Of

course, the criminal justice system also plays an important role in deterring potential perpetrators.

- **Redress**

  Once an incident of disability-related harassment has occurred, it needs to be dealt with swiftly and fairly. This may, again, involve community-based agencies such as schools taking prompt action on bullying, for example. However in more serious cases it will involve the police recognising, recording and investigating disability-related harassment; the Crown Prosecution Service and the Courts ensuring that victims have access to justice; and all agencies working to ensure that victims are supported, and that perpetrators face consequences for their actions and rehabilitation where necessary.

Manifesto for change

Our inquiry uncovered evidence that there is much which all agencies involved could do to improve their performance in preventing and dealing with disability-related harassment.

Over the next six months we will consult widely with stakeholders on whether these are the right steps, how they might work and whether there are any other measures which might be more effective. We want to find out how these recommendations can be embedded in planned initiatives, to be cost-effective. Most importantly, we recognise that we will only succeed in effecting change when others take responsibility and ownership for these recommendations.

We will then publish the manifesto for change in the Spring of 2012 which will outline the commitments others have made and the outcomes which we expect to see over the next five years and how we propose to evaluate and regulate the outcomes.

At this stage, it is clear that there are seven overall outcomes which will show to us that society is achieving real progress in tackling harassment. Later in this section we set out specific measures for each relevant sector which our evidence suggests could make a major difference.

They require multi-agency co-operation in most instances and a real commitment to effective partnership working if we are to see results. We understand that, in some areas, they may require additional resources and extra cost and are conscious of the financial and operational constraints which public authorities are under. For this reason we are keen to engage with all parties to find out how the improvement can be achieved for the most reasonable cost.

Seven core recommendations

- There is real ownership of the issue in organisations critical to dealing with harassment. Leaders show strong personal commitment and determination to deliver change.
- Definitive data is available which spells out the scale, severity and nature of disability harassment and enables better monitoring of the performance of those responsible for dealing with it.

- The criminal justice system is more accessible and responsive to victims and disabled people and provides effective support to them.
- We have a better understanding of the motivations and circumstances of perpetrators and are able to more effectively design interventions.
- The wider community has a more positive attitude towards disabled people and better understands the nature of the problem.
- Promising approaches to preventing and responding to harassment and support systems for those who require them have been evaluated and disseminated.
- All frontline staff who may be required to recognise and respond to issues of disability-related harassment have received effective guidance and training.

There is real ownership of the issue in organisations critical to dealing with harassment. Leaders show strong personal commitment and determination to deliver change

Our evidence shows the most critical factor in organisations improving their performance is the level of commitment and determination to address the issue shown by their leaders. It is, after all, senior officers and executives who set the priorities for organisations. If there is a real and visible commitment to change at the most senior level then it is likely that this will drive real change throughout the organisations which they lead.

In addition to showing leadership within their organisations, we would expect leaders to embrace public accountability. Transparency over performance is one aspect to this – which involves a real commitment to share data which shows how their organisation is performing. Another aspect is the display of a personal willingness to be publicly accountable for any serious instances which occur in their area. Finally, we would expect this personal commitment to be formally recognised within public authorities core objectives, either within their governance structures or otherwise.

Definitive data is available which spells out the scale, severity and nature of disability harassment and enables better monitoring of the performance of those responsible for dealing with it

While our inquiry has uncovered a great deal about disability-related harassment, there remains much which we don't know. Without comprehensive data, across all agencies, it will be impossible for our society to properly respond. In the interests of transparency, we also need public authorities to publish their performance so that the public can assess how they are performing.

We recommend that all data systems in these agencies:

- are able to record whether the victim is a disabled person (and/or has another type of protected characteristic)
- are able to determine:
  - whether the incident was motivated by the victim's disability and/or any

other form of protected characteristic

- the clearly identified lead officer who will take the issue forward
- whether or not this is a first instance of harassment or part of a more general, or escalating, pattern
- the priority status accorded to each incident in relation to risk to the victim or, if known, motives and circumstances of the perpetrator
- where harassment of offending persists, whether and to what extent priority status should be given to a situation
- which other local agencies have been alerted to the problem or, if this has not occurred, why not and under what circumstances should such agencies become involved. Also what appropriate partnership arrangements should be in place

- enable identification of all ongoing or repeat instances to avoid the risk that such instances of behaviour will become progressively more serious
- share data across agencies and identify solutions to effective data sharing, particularly where lives may be at risk, to ensure that all involved have a comprehensive picture.

The criminal justice system is more accessible and responsive to victims and disabled people and provides effective support to them

Another major requirement of the general response to disability-related harassment, and other forms of crime and antisocial behaviour, is that victims feel adequately supported by all the agencies involved and that these agencies, more generally, respond to their concerns effectively.

Wherever a disabled person first reports an incident, the route to reporting, including ultimately the criminal justice system, needs to be clear and unhindered.

We recommend the following:

- all agencies involved with dealing with the issue should review, and, where necessary, remove all obstacles to the reporting of disability-related harassment. This will, in particular, involve seeking the views of disabled people and their representatives
- the police and prosecution services should always establish whether a victim is disabled, and if they are, should consider themselves whether that may be a factor in why the crime/incident occurred. They should not rely solely on the victim's perception. They should reconsider this at several stages throughout the investigation. Crimes against disabled people should rarely be considered motiveless.

We have a better understanding of the motivations and circumstances of perpetrators and are able to more effectively design interventions

One fundamental issue in dealing with the problem of disability-related harassment, and other forms of abuse, is to understand why it occurs.

The most urgent issue is getting a better understanding of the characteristics and motivations of those who commit acts of disability-related harassment.

In addition, there needs to be more awareness of the general structures and attitudes (and the interactions between them) which give rise to the problem in the first place.

To address these issues, we recommend that:

- targeted research is undertaken in collaboration with the National Offender Management Service and local authorities in Scotland to build a clearer picture of perpetrator profiles, motivations and circumstances and, in particular, to inform prevention and rehabilitation.
- criminal justice agencies support bodies that commission research to stimulate and support studies that look into why harassment occurs in the first place and broader attitudes towards disabled people.

The wider community has a more positive attitude towards disabled people and better understands the nature of the problem

With the possible exception of some of the cases which are given a high profile by the media, disability-related harassment does not seem to be perceived as serious or widespread by the public. It is, as we describe, hidden in plain sight. Changing wider public attitudes towards the seriousness of such harassment, and more general social attitudes towards disabled people, forms an important part of a wider solution.

In order to initiate change in this area, we recommend that public authorities:

- review the effectiveness of current awareness raising activities concerning disability-related harassment where they exist and assess where gaps in their campaigns could usefully be filled
- use the public sector equality duty as a framework for helping promote positive images of disabled people and redress disproportionate representation of disabled people across all areas of public life
- encourage all individuals and organisations to recognise, report and respond to any incidences of disability-related harassment they may encounter.

All frontline staff who may be required to recognise and respond to issues of disability-related harassment have received proper training

It is clear from our evidence that reporting of and responses to harassment would both be improved substantially with better training for frontline staff providing public services. The cases show that even staff such as environmental health officers may come across instances of harassment and the ability to make appropriate safeguarding referrals could make a significant difference to people's lives.

To address these issues, we recommend that:

- all frontline staff working in all agencies, whether public authorities or voluntary and private sector, where disability-related harassment, antisocial behaviour or other similar forms of activity are likely to be an issue, are trained in how to recognise and ensure appropriate safeguarding
- more generally all agencies should consider whether their wider staff training and development processes and appraisal and promotion systems should be amended to ensure such knowledge becomes embedded and an incentive for better job performance
- staff gain an understanding of disability equality matters and appropriate engagement with disabled service users.

Promising approaches to preventing and responding to harassment have been evaluated and disseminated

There is much in what many public bodies are doing which might emerge as good practice and create vital learning which other bodies can follow to help reduce the problem. However, many of these promising approaches are in their infancy and as yet we do not know conclusively what works and what doesn't.

Therefore, we recommend that public bodies conduct rigorous evaluation of their response and prevention projects, some of which are outlined in Appendix 17, over a three year time frame so that we can build a shared knowledge of the most effective routes to take to deal with harassment and reduce its occurrence. All evaluations should then be widely and openly shared so that all bodies can learn from them.

Targeted recommendations

We believe that there are also a number of steps which specific agencies should take to improve their performance and a number of suggested changes to policy and practice are outlined below. We will also consult closely over the next six months to develop a final set of recommendations.

For ease of reference, we have grouped the specific recommendations by sector:

National Governments

Overall, government departments have an important part to play in setting the policy framework within which responses to harassment sit. They also set the service priorities which drive the performance and practice of the agencies which they sponsor.

In addition to the specific measures which we would like to see certain departments consider, national policy makers in government could usefully encourage greater innovation in responses. For example, is there a role to be played for the use of service guarantees to provide greater confidence to disabled people of the expected levels of response from individual public bodies? Also, what other non-criminal sanctions might be effective, perhaps including modifications to the social housing tenancy agreements of known perpetrators?

The Office for Disability Issues should, with other departments and disabled people's organisations, conduct a review of all statutory and common law restrictions on the public participation of disabled people, and other laws which unnecessarily and inappropriately treat disabled people differently to others.

The Home Office, Ministry of Justice and devolved administrations in Scotland and Wales should:

- Commission primary research on disability-related harassment to help fill the knowledge and data gaps. This should include:
    1. The economic and social costs of disability-related harassment
    2. How the criminal justice system treats victims of harassment to improve the chance of a successful prosecution
    3. Whether any specific groups of disabled people are more prone to particular forms of harassment and targeted crime
    4. Improving the understanding of how people with multiple identities are targeted and subsequently responded to.
- Take the lead in working with other departments to clarify the ambiguity between statutory agencies over who has lead responsibility for dealing with harassment.
- Amend Schedule 21 guidance to give parity in sentencing guidelines for all types of identity-based hate crime murders.
- Conduct a review to consider the potential benefits of specific offences motivated by hostility towards disability.
- Conduct a review to consider the benefits of an 'incitement' offence, particularly as a potential measure to address cyber-bullying.
- Consider the introduction of national reports and plans on disability related harassment to ensure joined up national approaches are built into the planning procedures of all government agencies.

The Department of Health and devolved administrations in Scotland and Wales should:

- Review the guidelines for serious case reviews to ensure that such harassment is always acted upon in prevention campaigns and in future police investigations. Serious case reviews should also be mandatory for cases involving adults at risk (as already applies to cases involving children).
- Revise the 'No Secrets' guidelines in England as suggested by the Law Commission. In the longer-term, 'No

Secrets' should be replaced by a rights-based approach (such as the provisions in the Adult Support and Protection (Scotland) Act (2007), replacing a perception of individual vulnerability with one which sees disabled people as being 'at risk of harm'.

- Review eligibility criteria for social services to better include support for social inclusion. Ideally, eligibility criteria should not be focused on vulnerability or risk of harm, but instead focus on an individual's circumstances preventing them from fully achieving their human rights, and targeting resources to enable them to do so.

The Welsh Assembly Government should:

- explore how the Welsh public sector general and specific equality duties could assist towards eliminating disability-related harassment.

The Department for Education and devolved administrations in Scotland and Wales should:

- Commission primary research on the extent to which segregated education, or inadequately supported integrated education, affects not just the learning outcomes of both disabled and non-disabled children, but also the ability of disabled children to subsequently re-integrate into wider society, and the extent to which segregation adversely impacts on non-disabled children's views of disability and disabled people.
- Keep OFSTED's ability to make limiting judgements where schools underperform in equalities-related areas, and especially in identity-based bullying.
- Ensure schools with strong citizenship and human rights agendas which promote an understanding of disability share good practice with other schools as a matter of course.

The criminal justice sector

Although we have specific recommendations for each part of this sector, we highlight some critical considerations here for the whole sector:

- 'Special measures', a procedure that we have mentioned throughout this report aimed at ensuring disabled people can access the justice system, is an unhelpful term, and is currently failing to be embedded effectively in criminal justice systems. We recommend a change of language to focus on providing an equitable service. We are open to those services considering the most appropriate language themselves, but suggest the following options for consideration:
  - 'equalising' measures
  - 'fair trial' measures
  - we also recommend that the procedure for 'special measures' be turned on its head. If you need special measures, there should be a rebuttable presumption that you will receive them rather than the current 'bolt on' approach which is also overly complicated to process. These systems need to be simplified and streamlined, which will also take unnecessary costs out of the system.

- Likewise the term 'hate crime' is unhelpful. Many of the acts of hostility and harassment we have highlighted in this report are not recognised as 'hate' crimes by either victims or service providers and failure to recognise is resulting in a failure to act effectively. We believe that a single new terminology should be adopted, and suggest the following alternatives are considered:
  - 'disability motivated' crimes and incidents
  - 'identity-targeted' crimes and incidents
  - 'hostility' crimes and incidents.

The police

- Police forces should develop an in-depth understanding of the characteristics and motivations of perpetrators, design local prevention strategies accordingly and evidence their effectiveness.
- Police forces need to review their 'no-criming' and 'motiveless' procedures, to give warning triggers when the victim is disabled, to ensure they fully capture the true incidence of harassment.
- The police must always take a prompt lead in investigating all repeat cases of disability-related harassment that come to their attention and should not use responses such as safeguarding as a substitute. When doing so, they should be able to identify earlier interventions, including notification of pre-criminal incidents. Police call response priorities should be based on this data.
- Where the police identify suspected repeat victimisation or a suspected repeat disability-related harassment perpetrator, the investigation should automatically receive a higher-priority status for resolution.
- A named officer should provide victims and witnesses with acknowledgement of their incident in an accessible format, including incident reference numbers, contact details and advice on both what to do if further incidents occur and accessible support services available. The named officer should also provide regular feedback and progress updates.
- All incidents and crimes should be investigated for potential aggravated offences where disability may be a factor, both at the beginning of a report and throughout the case. This will require officers and prosecutors to develop intelligence around perpetrator motivation, the personal characteristics of the victims and the situational vulnerability, and assess likelihood of disability-related harassment being either primary motivation or secondary motivation and act accordingly.
- The seriousness of the offence, rather than the capacity of the victim (and especially any concerns about their potential reliability as a witness), should form the basis for any police investigation.
- The police should identify where 'special measures' may be required as soon as possible in any investigation. They should also ensure that prosecutors are made aware of the need for such equalising measures in any court proceedings, and ensure they are notified to the Courts at the earliest possible opportunity. They should also

ensure that, where required, 'responsible adult' provisions are both understood and fully implemented.

Prosecution services

- Comprehensive monitoring systems should be introduced to identify whether victims of crime are disabled and the outcome of interventions to assist them.
- Recording systems should be:
  - able to record whether the victim was disabled (along with other protected characteristics)
  - able to record whether hostility/ prejudice to disability was a motivation.
- Clear training, guidance and procedures on recognising and recording disability-related harassment should be provided. Hate crime and hate incident levels should be separately identified within crime figures.
- Information on how many reported incidents in a local authority area were recorded as crimes and how many have resulted in prosecution should be published.
- Good quality accessible and independent advocacy should be available to disabled people throughout a case, enabling them to get the support that they need.
- Access audits of the support services offered to victims should be undertaken to establish where disabled people are receiving inadequate support and remedies to providing equitable services provided.
- Where there is evidence of hostility/ prejudice, police should gather evidence to support a prosecution under section 146 of the Criminal Justice Act 2003 (England and Wales) or the Offences (Aggravation by Prejudice) (Scotland) Act 2009 and prosecutors should prosecute as an aggravated offence. The courts should be clearer about when and how sentence uplifts are applied, and what the different sentencing outcomes were as a result.
- Police should alert prosecutors at an early stage that the victim is disabled so that the need for 'special measures' can be considered and applied for in good time.
- Applications for and availability of 'special measures' should be monitored.

The Courts, National Offender Management Service (NOMS) and local authorities in Scotland

- Disabled people should have access to the court system and their experiences should form part of any system for evaluating the courts and criminal justice system. Courts should ensure that they are fully accessible to disabled people. All unnecessary barriers, whether legal (such as restrictions on jury service), attitudinal or physical (such as provision of advocacy or interpreter services or access to court buildings), should be removed.
- We would like to see the courts service do more to proactively find ways in which disabled people can participate in improving the administration of justice in their areas.
- Current arrangements for 'special measures' to support victims should be

reviewed and revised at the earliest opportunity (including an examination of whether the term itself is appropriate). In particular, their application should not impede or unnecessarily delay access to justice by using them in a 'bolt on' way. They should be mainstreamed into the provision of criminal justice services in such a way that they provide parity for disabled and non-disabled people in accessing the services.

- Appropriate and accessible independent advocacy and support services, which should be drawn to the victim's attention by the police and/or prosecuting authorities, should be available to the victim throughout and, where necessary, beyond the prosecution process.
- Courts need to take proactive steps to support victims appropriately within an adversarial court system. For example, attention should be paid to ensure that a victim's impairment is never used inappropriately during court proceedings, for example to cast doubt on their reliability as a witness.
- Appropriate sanctions should always be applied to convicted offenders at the earliest stage and should take account of their previous convictions. All perpetrators should be made aware of the full consequences of any repeat offending during sentencing and through all their contacts with NOMS and other agencies.
- Prosecutors and those responsible for sentencing should recognise the full impact of harassment in their decisions and this should be clearly documented. This includes the wider impacts on the friends, relatives and carers of victims.
- The new sentencing guidelines in England and Wales provide opportunity to re-assess and monitor consistency of sentencing for disability-related harassment offences. We recommend those opportunities are taken up to help provide an overview of the scale of the issue and how it is addressed.

Local agencies and partnerships

In addition to the police and criminal justice system, there are many other local agencies which have an important part to play in dealing with disability-related harassment. These can include the education and health systems, housing organisations, and partnership bodies which incorporate a number of these agencies.

Working together to prevent and tackle harassment and hate crimes will inevitably have greater economic benefits for all agencies concerned so we urge local partnerships to raise the issue of disability-related harassment on their agendas in order to effectively tackle it together.

Local agencies and partnerships need to ensure that staff are fully aware of how to identify harassment and are able to communicate their concerns within, and to other, local agencies. They must also ensure that they put in place effective mechanisms to both prevent and recognise harassment and, in instances where it does occur, are able to communicate and act together in ways that produce a swift resolution.

It is worth noting that all public bodies have had a statutory responsibility to promote positive attitudes towards disabled people and yet our inquiry has

found little evidence that they are currently working together effectively to do so.

Senior managers in private sector bodies who supply the public sector also need to ensure the services they provide meet appropriate standards. The transfer of obligations for managing and dealing with services from public to other providers should reflect, in service level agreements, the duties to prevent and tackle harassment and promote good relations.

- Local agencies and partnerships should review the priority they give to dealing with harassment and work together to eliminate it. If appropriate, this should be formalised in a joint action plan.
- All agencies and partnerships dealing with crime and disorder should appoint a local harassment co-ordinator (unless they can evidence properly there is no requirement) and such co-ordinators should meet on a regular basis to identify issues of joint concern.
- Statistics on the performance of local agencies and partnerships in addressing harassment, and any service guarantees, should be published annually in a uniform format using accessible media. These should include surveys which measure community satisfaction with their work.
- Local partnership boards should be fully accessible for disabled people to join, which may include providing additional support to them to participate on an equal basis.
- Local agencies and partnerships should ensure support and advocacy services in their area are adequate, accessible and that the victims of disability-related harassment, and potential victims, know their rights and the options available to them with regard to all forms of harassment. Those experiencing high-impact disability-related harassment should be referred to specialist services while the families of murder victims should also be offered counselling services.
- Whenever repeat perpetrators or repeat victims are identified, the priority given to solving the case should always be increased to urgent. Local partnerships and agencies should ensure that the police are immediately notified of this information and act on the basis of this.
- Adult Safeguarding Boards should be put on a Statutory basis.
- All local agencies should ensure that their needs assessment and service provision arrangements minimise the risk of harassment. For example, housing and social care providers should ensure any accommodation provided to disabled people is not capable of being identified as such.
- Standards, and any associated terminology, for identifying 'at risk' individuals should be consistent and agreed across agencies and relevant information should be shared at officer level on a regular basis as 'case conferencing'. However, all agencies and partnerships must avoid an overly intrusive approach to identifying at risk individuals so as to ensure the privacy and independence of those whom they seek to protect and to encourage full reporting.

Local authorities

- Local authorities should play a lead role in driving local partnerships to deliver on preventing and tackling disability-related harassment.
- They should invest in awareness campaigns aimed at encouraging victims of disability-related harassment to come forward.
- They should ensure that good quality accessible, independent advocacy is available to disabled people, enabling them to get the support that they need.
- They should undertake access audits of the support services offered to victims to establish where disabled people are receiving inadequate support and action remedies to providing equitable services.

Transport providers

- Transport providers should identify ways to design out potential for conflict in new fleet and transport infrastructure design. For example, they should review their vehicles and waiting areas to ensure that conflicts between disabled passengers and those with pushchairs are minimised. They should also ensure that disabled access provisions are clearly identified and enforced and promptly resolve any disputes regarding these.
- Public transport operators should develop reciprocal reporting arrangements between providers so that people can report harassment experienced at stops, stations and on transport to whichever operator they encounter. They should also develop systems to allow repeat perpetrators to be refused entry to each other's vehicles (similar to those already used by licensed premises).
- Regular disability equality training should be provided for frontline staff on handling disability-related harassment and clear guidance to staff on routes to take when reporting an incident. This should be included as part of core training, before transport staff work with the public.
- Disabled people should be involved in public transport policy development and transport providers should work in partnership with criminal justice agencies to reduce risk on and around transport provision.
- Data on high risk areas and subsequent actions to reduce risk should be collated. Based on this data they should provide adequate protection where known high risks exist, in the same way as other provision is made, for example, around football matches.

Housing providers

- Regeneration and social housing design and planning should involve disabled people at planning stages in order to help 'design out crime' from future developments.
- Housing providers should identify and implement interventions to prevent harassment occurring in the first place and develop responses to prevent escalation.
- They should consider appointing a harassment co-ordinator to support improvement of responses and should support third party reporting systems. They should also invest in awareness campaigns aimed at encouraging victims of disability-related harassment to come forward.

- They should include provisions against disability harassment within tenancy agreements and take action against breaches.
- If a disabled person is forced to move in order to avoid disability-related harassment, their security of tenure should not be adversely affected.

Health and social care

- Health and social care providers should put robust and accessible systems in place so that residents living in institutions can be confident of reporting harassment by staff or other residents.
- Health and social care providers should review eligibility criteria to increase social interaction and reduce social isolation for disabled people.
- Adult Protection Committees and Community Safety Partnerships should ensure that accessible information and advocacy services are available to enable disabled people to understand and exercise their rights.
- Health services (especially GPs, accident and emergency and ambulance services) should ensure that their safeguarding alerts process is sufficiently robust and staff are adequately trained.

Education

- Schools and colleges should actively develop material for helping students understand disabled people and the social model of disability, and the prejudice that disabled people face within society. The training should encourage a better understanding and respect for diversity and difference. The training should also help students know what to do when they see others perpetrating bullying and harassment, both in school and outside (on public transport, in public places, etc).
- Schools and colleges should ensure that their procedures for identifying the bullying of disabled students and students with special educational needs are fully operative, effective, and understood by all staff and students. These procedures should be based on a zero tolerance approach with early stage incidents, such as name calling, dealt with appropriately and firmly. It should not be assumed that harassment is committed only by, or to, other students but, potentially, by all those who work within educational establishments.
- The growing threat posed by 'cyber-bullying' should be recognised and dealt with on the same basis as face to face bullying. This is particularly important for schools to address as many perpetrators are young people.
- Schools and colleges should identify and implement interventions to prevent harassment occurring in the first place and develop responses to prevent escalation and invest in awareness campaigns aimed at encouraging victims of disability-related harassment to come forward.

- Schools and colleges should ensure disabled pupils and those with special educational needs are able to participate in all school/ college and after school/college activities on an equal basis with non-disabled pupils.

Regulators and inspectorate bodies

While combating harassment is all of our responsibility, certain groups and individuals have a particular responsibility to deal with its causes and consequences. In addition to elected officials and the senior leaders of agencies, regulators and inspectors need to be aware that they have an important role in improving the performance of those organisations which they regulate.

They have responsibility for changing the culture, behaviour and performance of the organisations over which they exercise control both in terms of their statutory functions and the more informal advice and support that they give the bodies under their supervision

- The appropriate regulator should always intervene when a serious case of repeat disability-related harassment, such as one which leads to death or serious injury of a victim, emerges in the sector under their supervision.
- Measures for how all public bodies deal with the issue of disability-related harassment, and other forms of hate crime, should be built into all of the appropriate regulatory and inspection regimes.
- Regulators and Inspectorates, along with senior representatives of those service providers and their clients, should work together to devise and disseminate procedures and standards which seek to minimise further the risk of harassment. Lessons should be learnt from previous serious cases, regularly embedded in training and practice and lessons from all areas shared effectively across other areas.
- Regulators should ensure their responses to harassment are joined-up and use common standards and criteria for its identification. Poor performers should be identified and sanctioned if no improvement is apparent within a reasonable period of time.

In summary

Taken together, we believe that the above recommendations constitute a comprehensive approach to the problems described in earlier parts of this report. The Commission will seek to progress them in partnership with the various groups and agencies identified above in the coming months. But everyone should be aware that disability-related harassment is predominantly a social problem and one that, in the final analysis, also requires an individual response and commitment to change.

Appendices

Appendix 1: The Equality and Human Rights Commission and our inquiry powers

The Equality and Human Rights Commission (the Commission) was founded in 2006. It has a statutory remit to promote and monitor human rights; and to protect, enforce and promote equality across seven 'protected' grounds including age, disability, gender, gender identity, race, religion and belief, and sexual orientation. Under section 3 of the Equality Act 2006, the Commission is required to encourage and support the development of a society in which:

- people's ability to achieve their potential is not limited by prejudice or discrimination
- there is respect for, and protection of, each individual's human rights
- there is respect for the dignity and worth of each individual
- each individual has an equal opportunity to participate in society, and
- there is mutual respect between groups based on understanding and valuing of diversity, and on shared respect for equality and human rights.

Under section 16 of the Equality Act 2006, the Commission may conduct inquiries into issues or sectors where there are concerns relating to human rights and/or equality. Through our inquiry powers, the Commission can require organisations to provide evidence, both in writing and in person. We then publish authoritative, evidence-based reports and make recommendations against which we expect action to follow.

Appendix 2: Draft Terms of Reference for our inquiry into the elimination of disability-related harassment

Definitions

Although public authorities have a responsibility under the Disability Equality Duty to have due regard to eliminating disability-related harassment, the term is not defined for the purposes of the Duty.

We propose to use the following definition of disability-related harassment within this inquiry

Unwanted, exploitative or abusive conduct on the grounds of disability which has the purpose or effect of either:

- violating the dignity, safety, security or autonomy of the person experiencing it, or
- creating an intimidating, hostile, degrading or offensive environment.

Harassment may involve repeated forms of unwanted and unwarranted behaviour but a one-off incident can also amount to harassment.

The Inquiry will include disability-related harassment of both disabled people themselves and of their family, friends and associates. However in order for there to be a clear focus for the inquiry, the Commission proposes to exclude both harassment in the workplace and domestic violence.

For the purposes of the inquiry, the Commission proposes to use the Disability Discrimination Act (DDA) definition of a disabled person, which is someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. The inquiry will also investigate harassment against people perceived to be disabled.

Geographical scope

The inquiry will cover England, Scotland and Wales.

Draft Terms of Reference

1. To inquire into steps taken by public authorities, singly and jointly to eliminate disability-related harassment.

2. To inquire into steps taken by public authorities, singly and jointly, to address the causes of disability-related harassment including prejudice and negative attitudes.

3. To inquire into the effectiveness of the steps taken by public authorities, singly or jointly, to eliminate disability-related harassment and address its causes.

4. To inquire into how public authorities, singly and jointly, have ensured the involvement of disabled people in eliminating disability-related harassment and addressing its causes, including steps taken to enable disabled people to effectively report disability-related harassment.

5. To identify examples of good practice in eliminating disability-related harassment and addressing its causes

and effective means of disseminating such good practice.

6. To make such recommendations as are appropriate.

7. In carrying out the inquiry the Commission will, where relevant, have regard to the extent to which the public authorities concerned have:

   a) complied with their duties in relation to the Disability Equality Duty set out in s.49A and s.49D of the Disability Discrimination Act 1995, including in particular those elements of the duty relating to the elimination of disability-related harassment and its causes, the promotion of positive attitudes towards disabled people and the duty to encourage the participation of disabled people in public life

   b) complied with any obligations arising under the Human Rights Act 1998, and

   c) are aware of their obligations under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), in particular Article 16 of that Convention, and the degree to which they have taken action to fulfil them.

8. The inquiry will consider steps carried out directly by public authorities; those carried out through private and voluntary sector organisations; and issues relating to procurement relevant to the inquiry's Terms of Reference.

Appendix 3: Responses to consultation on the Draft Terms of Reference

What did individuals and organisations tell us?

The Terms of Reference were broadly supported by most people. There were a number of issues raised that the Commission needed to address, either through changes to the Terms of Reference or in other ways. The main findings were:

- Most respondents agreed with the definition of disability-related harassment. Some people suggested changes to make it clearer what is covered, who might experience it and where.
- Some respondents wanted a more 'social model' definition of disability to be used as the basis for the inquiry.
- Other respondents wanted recognition that some groups may not see themselves as disabled, such as Deaf people and people with mental health conditions.
- Many respondents wanted the inquiry to address issues of domestic violence, including that experienced by disabled men, either in the inquiry or in other work by the Commission.
- Many respondents wanted the inquiry to address issues of workplace harassment, either in the inquiry or in other work by the Commission.
- Most respondents wanted the focus to be on the public sector. Many people thought that the role of the voluntary sector and, to a lesser extent, the private sector should be looked at too.

- Some respondents wanted the terms of reference to be made clearer and more understandable using plain English.

What is different as a result of your input, and why?

Explanatory notes and examples have been provided to support the definition of disability-related harassment. The Terms of Reference now state that the scope of the Inquiry covers harassment by strangers, neighbours, acquaintances, friends, family, relatives and partners. Harassment may occur in public places, such as streets, parks, schools and leisure facilities. It also happens in private, such as in the home. Examples have been provided of the kind of incidents that would constitute disability-related harassment. This might be verbal abuse, such as derogatory, demeaning or humiliating remarks and name-calling, or physical assaults and murder. The Commission recognises that different groups of people will often use different language to describe an incident, including 'bullying' and 'hate crime'. The Terms of Reference now explicitly state that bullying and hate crime come within the scope of the inquiry.

There was overwhelming support for including the harassment of **family, friends and associates** of disabled people as well as conduct against a person who is **perceived to be disabled**. This will be included but disabled people's experiences will be the main focus of the Inquiry's attention.

Harassment by relatives, family and partners will be considered within the Inquiry. Many respondents to the consultation disagreed with the proposed exclusion of domestic violence from the scope of the inquiry and pointed to the high incidence of violence experienced in the home by both disabled women and men. The Commission will now cover this (see explanatory notes and examples above). In addition, the Commission's strategy on tackling violence against women and girls may also address domestic violence against disabled women.

The **diverse experiences and needs** of disabled people related to their age, race or ethnicity, gender, religion or belief, gender identity, sexual orientation and impairment type will also be looked at within the inquiry. This is now covered in an additional Term of Reference.

The inquiry's **focus on public authorities** remains in place. The Commission will also look at private and voluntary sector organisations operating in the public sphere, for example a charity or business that runs services for a local authority. It will inquire into the steps taken by public authorities to prevent as well as eliminate disability-related harassment, and look at whether public authorities work together to do this. Police, schools, local councils, social housing providers and health providers were seen as some of the most important public bodies to focus on, though many thought that all public authorities were equally important.

Public transport was identified as a 'hot spot' for disability-related harassment. An additional term of reference will look at the steps taken by public transport operators to prevent and eliminate disability-related harassment on or around public transport.

Plain English, as far as possible, has been and will be used throughout. Examples are also provided where helpful.

What has not changed and why?

The Disability Discrimination Act and its **definition of disability** remains the basis for the inquiry. We understand the importance of the social model of disability, but we are using the DDA definition to ensure we can hold public bodies to account in relation to their legal responsibilities. The law was changed in 2005 so that the legal definition of disability includes people with recurring or fluctuating conditions such as HIV, cancer and multiple sclerosis from the point of diagnosis. It also includes people who may not define themselves as disabled, including deaf people and people with mental health conditions.

The Commission recognises that workplace harassment is an important issue and it is one that we take very seriously. We have taken the very difficult decision to **exclude workplace harassment** from the inquiry. This is most certainly NOT because we do not think it is important. We know it is, not least because stakeholders told us so. But the decision was taken ultimately for the following reasons:

- the original purpose of the inquiry is to find out what public authorities are doing to eliminate prevent harassment. Different laws apply to public authorities in respect of this general responsibility
- the Commission has limited resources and that means that this formal inquiry has a fixed budget. We want to make sure that this inquiry delivers meaningful results, and makes a real impact, on the issues it is trying to address. If we included employment as well, that would significantly extend the scope of the inquiry and increase the risk that we could not deliver properly
- people experiencing harassment in the workplace already have special laws and protections against such treatment, and clear avenues for redress if they are not treated fairly. We would be happy to work with others to promote understanding and awareness of these rights, and
- ultimately employment is just one specific place where disability-related harassment can occur. The purpose of this inquiry is to help identify some of the fundamental reasons why disability-related harassment happens in the first place, and seek to eliminate it. If we can change society's attitudes generally, that will help disabled people in all settings.

In addition, during 2010/11 the Working Better programme has been reviewing the evidence around workplace harassment of disabled people. On the basis of the Working Better review and emerging lessons from the Disability Harassment Inquiry, the Commission will scope what further action to take to address workplace harassment.

Discrimination by public bodies, such as a refusal to provide services or inadequate service provision, will not be covered in this Inquiry. It will be dealt with by the Commission's work on the UNCRPD.

Appendix 4: Final Terms of Reference

Terms of Reference

1. To inquire into steps taken by public authorities, singly and jointly with others, to prevent and eliminate disability-related harassment.

2. To inquire into steps taken by public authorities, singly and jointly with others, to address the causes of disability-related harassment including prejudice and negative attitudes.

3. To inquire into steps taken by public transport operators, singly or jointly with others (including public authorities), to prevent and eliminate disability-related harassment on or around public transport.

4. To inquire into how public authorities and public transport operators, singly and jointly with others, have ensured the involvement of disabled people in the prevention and elimination of disability-related harassment and addressing its causes, including steps taken to enable disabled people to effectively report disability-related harassment.

5. To inquire into the effectiveness of the steps referred to in paragraphs 1-4 above in preventing and eliminating disability-related harassment and its causes.

6. To inquire into how, in deciding on and carrying out the steps in 1-4 above, public authorities and public transport operators have taken into account the diverse experiences and needs of disabled people related to their impairment type, age, gender, gender identity, race or ethnicity, religion or belief, and sexual orientation.

7. To inquire into the causes of disability-related harassment and identify effective approaches to preventing and eliminating disability-related harassment and disseminating good practice.

8. To make such recommendations as are appropriate.

9. In carrying out the inquiry the Commission will, where relevant, have regard to the extent to which the public authorities concerned:
   - have complied with their duties in relation to the Disability Equality Duty set out in s.49A and s.49D of the Disability Discrimination Act 1995, including in particular those elements of the duty relating to the elimination of disability-related harassment and its causes, the promotion of positive attitudes towards disabled people and the duty to encourage the participation of disabled people in public life
   - have complied with any obligations arising under the Human Rights Act 1998, and
   - are aware of their obligations under the UNCRPD, in particular Article 16 of that Convention, and the degree to which they have taken action to fulfil them.

10. The inquiry will consider steps carried out directly by public authorities, steps carried out through private and voluntary sector organisations and

issues relating to procurement relevant to the inquiry's Terms of Reference. For the avoidance of doubt, the inquiry will consider those steps taken by registered social landlords and Arm's Length Management Organisations (ALMOs).

Scope of the inquiry

Scope of disability-related harassment to be considered by the Inquiry
The inquiry will investigate disability-related harassment carried out by individuals or groups of people, including strangers, neighbours, acquaintances, friends, family, relatives and partners. Such harassment may occur in public places such as streets, parks, schools and leisure facilities and/or in private such as the home. The inquiry will not investigate harassment in the workplace, which is covered by a separate legislative framework.

Geographical scope

The inquiry will cover England, Scotland and Wales.

Definitions

Disabled person
For the purposes of the inquiry, the Commission will use the definition of a disabled person in the Disability Discrimination Act 1995, as amended by the Disability Discrimination Act 2005:

- someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities, including people with recurring or fluctuating conditions such as depression, HIV, cancer and multiple sclerosis.

The inquiry will investigate harassment against people who satisfy this definition but may not define themselves as disabled, including Deaf people and people with mental health conditions.

Disability-related harassment
Although public authorities have a responsibility under the Disability Equality Duty to have due regard to eliminating disability-related harassment, the term is not defined for the purposes of the Duty. The Commission will use the following definition of disability-related harassment within this inquiry.

- Disability-related harassment is unwanted, exploitative or abusive conduct against disabled people which has the purpose or effect of either:
  - violating the dignity, safety, security or autonomy of the person experiencing it, or
  - creating an intimidating, hostile, degrading or offensive environment.
- Disability-related harassment is also such conduct against the family, friends and associates of disabled people because of their connection with a disabled person.
- Disability-related harassment is also such conduct against a person perceived to be a disabled person.
- Disability-related harassment encompasses bullying and hate crime against disabled people.
- Disability-related harassment may involve repeated or one-off incidents.

Public authority
A public authority for the purposes of s.49B of the Disability Discrimination Act 1995.

Public transport
Trains (overground and underground), trams, buses and other public service vehicles as defined by s.40(5) Disability Discrimination Act.

Public transport operators
Any company or organisation (including those in the private sector) involved in the provision of public transport including, for the avoidance of doubt, those involved in owning, operating and maintaining transport infrastructure such as rail and bus stations.

Examples of disability-related harassment, including bullying and hate crime

The following are some examples of disability-related harassment, bullying and hate crime. This is not an exhaustive list and there may be other examples.

- derogatory, demeaning or humiliating remarks
- name-calling or ridicule
- offensive or patronising language
- insults
- threats and intimidation
- invasion of personal space
- unnecessary touching
- unwanted comments about appearance or disability
- intrusive questioning about disability
- offensive jokes, banter
- abusive verbal or written comments related to disability
- offensive emails
- cyberbullying, using the internet, interactive and digital technologies or mobile phones to threaten, bully or intimidate
- offensive graffiti
- financial exploitation of a disabled person including taking their benefits money
- deliberately putting aids and adaptations out of reach
- damage to a disabled person's property, including aids and adaptations
- sexual abuse, rape and sexual assault, and
- physical assault, ranging from lower level assaults up to murder.

Appendix 5: Definition of harassment within the context of employment in the Disability Discrimination Act 1995

(1) A person subjects a disabled person to harassment where, for a reason which relates to the disabled person's disability, he engages in unwanted conduct which has the purpose or effect of:
  (a) violating the disabled person's dignity, or
  (b) creating an intimidating, hostile, degrading, humiliating or offensive environment for him.

(2) Conduct shall be regarded as having the effect referred to in paragraph (a) or (b) of subsection (1) only if, having regard to all the circumstances, including in particular the perception of the disabled person, it should reasonably be considered as having that effect.

Appendix 6: Disability Equality Duty, Disability Discrimination Act 2005

The Disability Discrimination Act 2005 set out a general duty requiring public authorities to have due regard to the need to:

a) eliminate discrimination that is unlawful under the Act
b) eliminate harassment of disabled persons that is related to their disability
c) promote equality of opportunity between disabled persons and other persons
d) take steps to take account of disabled persons' disabilities, even where that involves treating disabled people more favourably than other persons
e) promote positive attitudes towards disabled persons, and
f) encourage participation by disabled persons in public life.

Appendix 7: Public Sector Equality Duty, Equality Act 2010

Those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The new duty covers the following eight protected characteristics: age, disability, gender identity, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The general duty, set out above, applies to public authorities across Britain but there are different specific duties in England, Scotland and Wales. Further information is available on the Commission's website at:

http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/guidance-on-the-equality-duty/

Appendix 8: Sentence uplifts

England and Wales

Under section 146 of the Criminal Justice Act 2003 the sentence can be increased if the crime was proven to be motivated by hostility on the basis of sexual orientation or disability. In relation to disability, section 146 applies if:

(a) at the time of committing the offence, or immediately before or after doing so, the offender demonstrated towards the victim of the offence hostility based on:
(ii) a disability (or presumed disability) of the victim, or
(b) the offence is motivated (wholly or partly):
(ii) by hostility towards persons who have a disability or a particular disability.

Scotland

Under Articles 1 and 2 of the Offences (Aggravation by Prejudice) (Scotland) Act 2009 (**http://www.legislation.gov.uk/asp/2009/8/pdfs/asp_20090008_en.pdf**) the sentence can be increased if the crime is proven to be motivated by malice and ill-will towards a victim because of his or her actual or presumed disability, sexual orientation or transgender identity. Where an offence has been found to be 'aggravated by prejudice', the court must:

(a) state on conviction that the offence is aggravated by prejudice relating to disability, sexual orientation or transgender identity

(b) record the conviction in a way that shows that the offence is so aggravated
(c) take the aggravation into account in determining the appropriate sentence, and
(d) state (i) where the sentence in respect of the offence is different from that which the court would have imposed if the offence were not so aggravated, the extent of and the reasons for that difference, or (ii) the reasons for there being no such difference.

Appendix 9: Relevant Articles of the United Nations Convention on the Rights of Persons with Disabilities

Article 10: Right to life

States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

Article 13: Access to justice

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

Article 15: Freedom from torture or cruel, inhuman or degrading treatment or punishment

1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular,

no one shall be subjected without his or her free consent to medical or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

Article 16: Freedom from exploitation, violence and abuse

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.

2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognise and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.

3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Appendix 10: Methodology

- **Reviewing existing research and reports** – in excess of 90 research and policy reports including in the related areas of bullying, cross-strand targeted violence responses, attitudes, safeguarding and rehabilitation of hate crime offenders were considered.
- **Questionnaire for individual experiences** – the testimony of people who have experienced disability-related harassment, either directly or through friends, family and advocates, was gathered using the questionnaire. It focused on their experiences of reporting harassment and what happened as a result. It also addressed the barriers to reporting for those who did not report. It was available in hard copy and on the website in both English and Welsh and in a range of accessible formats.
- **Proforma for organisations and interested parties** – this encouraged disabled people's organisations, other voluntary organisations, public bodies, public transport operators, inspectorates, academics and other interested parties to give evidence against some or all of the terms of reference. It was available on the website in English and Welsh and in a range of accessible formats. Hard copies were also available.
- **Key informant interviews** – more than 80 individual (and some group) interviews were carried out with DPOs, other targeted violence organisations, academics, public bodies and public transport operators. Those identified for interview were 'key informants' – experts in the field of disability-related harassment and/or other forms of targeted violence.
- **Regional events** – these brought together disabled people and their organisations, other voluntary organisations, public bodies and public transport operators to consider the key issues for the inquiry, with an emphasis on the local and regional picture. Thirteen events took place – nine in England, two in Scotland and two in Wales.
- **Questionnaire on Disability Equality Duty for public authorities** – a short questionnaire was circulated to public authorities seeking information on how they had addressed their Disability Equality Duty responsibilities regarding disability-related harassment.
- **Focus groups and individual interviews** – focus groups, supplemented by individual interviews with disabled people, were used to explore disabled people's experiences of harassment and their views about the way this is currently addressed by public bodies. They explored factors such as impairment type and other protected characteristics to help ensure that disabled people whose voices were less likely to be heard through other evidence gathering processes were able to contribute to the inquiry.
- **In-house research** – we reviewed existing evidence regarding attitudes to disabled people and prevalence of harassment.
- **Formal hearings** – the hearings were aimed primarily at public bodies, public transport operators and civil servants and included intermediary bodies;

inspectorates; individual frontline authorities; government departments. Hearings were led by Mike Smith, as the lead Commissioner, or a senior Commission staff member. All sessions were recorded and transcribed.

- **Focused evidence sessions** – these sessions were led by Mike Smith, as the lead Commissioner, supported by other Commission staff members. All sessions were recorded and transcribed. Three focused sessions were held:
  - A friends, family and survivors event was held to take evidence from families and friends of people killed as a result of disability-related harassment and from survivors of serious violence and abuse.
  - An event was also held to focus on the role of media regulators and intermediary bodies in influencing the portrayal of disabled people and disability-related harassment.
  - An event was held specifically on cyber-bullying.

Appendix 11: Breakdown of responses to the call for evidence

The call for evidence resulted in 448 submissions from:

- 287 individual disabled people
- 50 criminal justice agencies including 32 police forces, 14 police authorities
- 46 voluntary and community sector organisations including 36 disabled people's organisations
- 27 local authorities
- seven education and training bodies
- six partnership bodies including three adult protection committees, two hate crime partnerships and one learning disability partnership
- five government departments
- five housing providers
- four health services
- three representative bodies
- three trade unions
- two religious organisations
- two transport operators, and
- one fire and rescue service.

Appendix 12: Organisations giving evidence to the formal hearings sessions

Organisation	Category
Glyndwr University	Academic
University of Bedfordshire	Academic
University of Cambridge	Academic
Judicial training	Courts
Sentencing Council	Courts
Dept. Communities and Local Government	Government
Dept. for Economy and Transport Equality support unit (Welsh Government)	Government
Dept. for Education	Government
Dept. of Health	Government
Her Majesty's Courts Service	Government
Home Office	Government
Ministry of Justice	Government
Scottish Government (Health and Social Care)	Government
Scottish Government (Safer Communities)	Government
Solicitor General (Scotland)	Government
Victims Commissioner	Government
Welsh Government – Social Justice and Local Government	Government
Welsh Government Housing	Government
Information Commissioner's Office	Government agency
Aneurin Bevan Local Health Board	Health
Betsi Cadwaladr University Local Health Board	Health
Cornwall and Isles of Scilly Primary Care Trust	Health
NHS Borders	Health
NHS Grampian	Health
NHS Haringey	Health
NHS Hartlepool	Health
NHS Hounslow	Health
NHS Luton	Health

Organisation	Category
NHS Rotterham	Health
NHS Sunderland	Health
NHS Tameside and Glossop	Health
NHS Tyne and Wear	Health
Sheffield Primary Care Trust	Health
Welsh Ambulance Service	Health
Chartered Institute for Housing (CIH)	Housing
Chartered Institute for Housing Wales	Housing
Community Housing Crymu	Housing
Contour Housing	Housing
Homes and Communities Agency	Housing
Hounslow Homes	Housing
National Housing Federation	Housing
Ocean Housing Group	Housing
Peak Valley Housing Association	Housing
Tai Pawb	Housing
Society of Editors	Independent body
Law Commission	Independent body
Katharine Quarmby	Independent expert
Margaret Flynn	Independent expert
Peter Smith	Independent expert
Audit Commission	Inspectorate/regulator
Audit Scotland	Inspectorate/regulator
Care and Social Services Inspectorate Wales	Inspectorate/regulator
Care Quality Commission	Inspectorate/regulator
Estyn	Inspectorate/regulator
Her Majesty's Crown Prosecution Service Inspectorate	Inspectorate/regulator
Her Majesty's Inspectorate of Prosecution Scotland	Inspectorate/regulator
Her Majesty's Inspector of Education Scotland	Inspectorate/regulator
Her Majesty's Inspectorate of Constabulary	Inspectorate/regulator
Her Majesty's Inspectorate of Constabulary Scotland	Inspectorate/regulator

Organisation	Category
OFCOM	Inspectorate/regulator
Ofsted	Inspectorate/regulator
Press Complaints Commission	Inspectorate/regulator
Scottish Commission for Regulation of Care	Inspectorate/regulator
Scottish Housing Regulator	Inspectorate/regulator
Wales Audit Office	Inspectorate/regulator
Aberdeen City Council	Local government
Convention of Scottish Local Authorities	Local government
Conway County Council	Local government
Cornwall Council	Local government
Denbighshire Council	Local government
Flintshire County Council	Local government
Hartlepool Borough Council	Local government
Hinckley and Bosworth Council	Local government
Leicestershire County Council	Local government
Local Government Association	Local government
London Borough of Haringey	Local government
London Borough of Hounslow	Local government
Luton Borough Council	Local government
Rotherham Metropolitan Borough Council	Local government
Scottish Borders Council	Local government
Sheffield City Council	Local government
Stockton on Tees Council	Local government
Sunderland City council	Local government
Tameside Metropolitan Borough Council	Local government
Welsh Local Government Association	Local government
Wrexham Borough Council	Local government
National Offender Management Service	Offender management
Association of Chief Police Officers	Police
Association of Chief Police Officers Scotland	Police
Association of Police Authorities	Police

Organisation	Category
Bedfordshire Police	Police
British Transport Police	Police
Child Exploitation and Online Protection Centre	Police
Cleveland Police	Police
Devon and Cornwall Police	Police
Dyfed Powys Police	Police
Grampian Police	Police
Greater Manchester Police	Police
Gwent Police	Police
Haringey Police	Police
Hounslow Police	Police
Leicestershire Police	Police
Lothian and Borders Police	Police
North Wales Police	Police
Northumbria Police	Police
South Wales Police	Police
South Wales Police Authority	Police
Surrey Police	Police
West Yorkshire Police	Police
BT	Private sector
Crown Prosecution Service	Prosecutor
Procurator Fiscal Service	Prosecutor
Bispham High School	School/college
Coleg Llandrillo	School/college
Marlborough School	School/college
Oakfield School and Sports College	School/college
Stanmore College	School/college
Association of Directors of Adult Social Services	Social care
Association of Directors of Social Work	Social care
Association of Directors of Social Services Wales	Social care
National Union of Journalists	Trade union

Organisation	Category
National Council for the Training of Journalists	Training body
Arriva Trains Wales	Transport
Association of Transport Operating Companies	Transport
Bus users UK	Transport
Confederation of Passenger transport	Transport
Passenger Focus Wales	Transport
Strathclyde Passenger Transport	Transport
Transport for London	Transport
Beat Bullying	Voluntary and Community Sector
Leeds Access Committee	Voluntary and Community Sector
Network for Surviving Stalking	Voluntary and Community Sector
Voice UK	Voluntary and Community Sector

Appendix 13: Membership of the External Advisory Group

Name	Organisation (where applicable)
Anne Novis	UK Disabled People's Coalition
James Pool	Office for Disability Issues
Joanna Perry	Crown Prosecution Service
John Marr	Local Government Group
Julie Jaye Charles	Equalities National Council
Juliet Simmons	Association of Chief Police Officers
Karen Warner	Learning Disability Wales
Katharine Quarmby	Author of Scapegoat – why are we failing disabled people and joint co-ordinator of the Disability Hate Crime Network
Kathryn Stone	Voice UK
Kim Wright	Association of Directors of Adult Social Services
Liz Robinson	Office for Disability Issues
Mick Conboy	Crown Prosecution Service
Mike Adams	Essex Coalition of Disabled People
Nigel Thomspon	Care Quality Commission
Paul Giannasi	Association of Chief Police Officers
Paul Iganski	Academic
Paula Coppell	Merseytravel
Rachel Perkins	Individual
Rose Doran	Local Government Improvement and Development
Ruth Bashall	Disability Action Waltham Forest
Stephen Brookes	Disability Hate Crime Network
Susie Balderston	Vision Sense
Will Bee	Individual

Appendix 14: Disability-related harassment questionnaire sent to public authorities

Name of Organisation

_____

_____

1. Was the organisation's Single or Disability Equality Scheme revised in December 2009? **Yes / No**

2. Did staff responsible for revising the scheme read guidance produced by the Commission on revising Disability Equality Schemes? **Yes / No**

3. Are actions to prevent and eliminate disability-related harassment included within the revised scheme? **Yes / No**

If yes, please answer question 3a. If no, please answer question 3b.

3a. Does your action plan include any of the following? Please mark **Yes** or **No** and provide additional information.

- Awareness raising amongst disabled people
- Awareness raising with young people
- Awareness raising with general public
- Measures to encourage direct reporting to your organisation
- Measures to encourage third party reporting
- Better recording of disability-related harassment
- Measures to improve investigation / prosecution
- Anti-bullying initiatives in schools
- Sanctions for perpetrators
- Better support for victims
- Other primary prevention initiatives (please provide info)

3b. Please outline the reasons why disability-related harassment was not included within the revised scheme.

4. Have disabled people been involved in agreeing actions around preventing and eliminating disability-related harassment? **Yes / No**

Additional information

_____

_____

_____

5. Are actions to promote positive attitudes towards disabled people included within the revised scheme? **Yes / No**

Additional information

_____

_____

_____

6. Are actions to encourage the participation of disabled people in public life included within the revised scheme? **Yes / No**

Additional information

_____

_____

7. Is your organisation working jointly with other public authorities in the local area to prevent and eliminate disability-related harassment? **Yes / No**

Additional information

_____

_____

_____

8. Is your organisation working jointly with disabled people's organisations in the local area to prevent and eliminate disability-related harassment? **Yes / No**

Additional information

_____

_____

_____

Appendix 15: Duties and powers under the Adult Support and Protection (Scotland) Act 2007

Duties

The Act requires councils to:

- make inquiries to establish whether action is required, where it is known or believed that an adult is at risk of harm and that intervention may be necessary to protect the adult. (Section 4). 'Harm' can be physical or psychological harm, neglect, sexual abuse or financial exploitation, and is defined in the Act as including all harmful conduct and, in particular, including:
  - conduct which causes physical or psychological harm (for example by causing fear, alarm or distress)
  - unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion), and
  - conduct which causes self-harm.
- cooperate with other councils and other listed bodies[288] (Section 5)
- have regard to the importance of the provision of appropriate services (including, in particular, independent advocacy services), where the council considers that it needs to intervene in order to protect an adult at risk of harm (Section 6)

288 The Mental Welfare Commission for Scotland, the Care Commission, the Public Guardian, all councils, chief constables of police forces, the relevant Health Board, and any other public body or office holder that Scottish Ministers specify.

inform any adult interviewed that they may refuse to answer any question put to them (Section 8)

inform any adult believed to be at risk that they may refuse to consent to a medical examination (Section 9)

protect property owned or controlled by an adult who is removed from a place under a removal order. This may include moving property belonging to the adult from that place, where this is considered reasonably necessary in order to prevent the property from being lost or damaged. The council must ensure the property is returned to the adult concerned as soon as reasonably practicable after the relevant removal order ceases to have effect (Section 18)

- visit a place at reasonable times only, to state the object of the visit and produce evidence of authorisation to visit. Council officers may not use force to facilitate, or during, a visit. However, a sheriff or justice of the peace may authorise the police to use force (Sections 36 to 40), and
- set up an Adult Protection Committee to carry out various functions in relation to adult protection in its area, and to review procedures under the Act (Section 42). The Adult Protection Committee may cover more than one council area.

Powers

The Act enables a council to:

- visit any place necessary to assist inquiries under Section 4 (see below). Council officers may interview, in private, any adult found at the place being visited, and may arrange for a medical examination of an adult known or believed to be at risk to be carried out by a health professional. Health, financial and other records relating to an adult at risk may be requested and examined. Only a health professional may inspect health records (Sections 7-10), and
- apply to the sheriff for the grant of a protection order. This may be an assessment order, a removal order, a banning order or temporary banning order (Sections 11-22):
  - an **assessment order**; which allows the adult to be taken to a place to be interviewed or medically examined in private. This should be undertaken in the quickest time available. The order does not allow the adult to be detained against their will
  - a **removal order**; which allows the adult to be removed to a place for up to seven days, but again does not allow the adult to be kept there unless they choose, or
  - a **banning or temporary banning order**; which bans someone from a place or vicinity.

Inquiries

Councils have a duty under the Act to make inquiries into an adult's wellbeing, property or financial affairs, where they know or believe an adult may be at risk of harm. When certain public bodies become aware that an adult is, or is suspected to be, at risk of harm the Act obliges those public bodies to report this to their local council. Concerns may also be raised by a family relation or carer, or could result from the care assessment review process.

Inquiries are undertaken to ascertain if an adult is at risk of harm and to establish if further action is required to stop or prevent harm from occurring.

The Act provides for a number of actions that a council can take where it is found necessary to intervene to support or protect an adult at risk of harm. This could mean using other legislation to ensure that the adult or any other person, such as a family carer, is provided with appropriate support.

Independent advocacy

There is no mandatory access to advocacy in the Act. The Act applies to all adults at risk of harm, including those who have mental capacity. It recognises that not all persons will either need or choose to access independent advocacy as they may be well able to represent their own views, either on their own or with existing forms of support.

Where an adult has a mental disorder, including those adults with a learning disability, then that adult is already entitled to access independent advocacy services by way of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Adult Protection Committees (APCs)

APCs are designed to oversee adult protection activities at a strategic level. Their functions include encouraging and evaluating inter-agency working, developing and reviewing policies, monitoring and reviewing activities and raising awareness.

The Act requires APC conveners to prepare a biennial report on their committee's work. The convenor must be independent of the council. While not mandatory, it is considered good practice to ensure that the convener is independent of all statutory bodies on the committee. Early evidence suggest that there may be a need for greater clarity as to the role of APC chairs, and a need to see greater consistency in the composition of APCs across Scotland.

Appendix 16: Organisations providing evidence to hearings investigation specific cases

Name of organisation (those marked * gave evidence in writing only)	**Case**
NHS Sunderland	Brent Martin
Northumbria Police	Brent Martin
Sunderland City council	Brent Martin
Lothian and Borders Police	Case of the Vulnerable Adult
NHS Borders	Case of the Vulnerable Adult
Scottish Borders Council	Case of the Vulnerable Adult
Betsi Cadwalder University Hospital Trust	Christopher Foulkes/ Philip Holmes
Denbighshire Council	Christopher Foulkes/ Philip Holmes
North Wales police	Christopher Foulkes/ Philip Holmes
Surrey Police	Cyber-bullying case
West Yorkshire Police	Cyber-bullying case
Greater Manchester Police	David Askew
NHS Tameside and Glossop	David Askew
Peak Valley Housing Association	David Askew
Tameside Metropolitan Borough Council	David Askew
Hinckley and Bosworth Council	Fiona Pilkington and Francecca Hardwick
Leicestershire County Council	Fiona Pilkington and Francecca Hardwick
Leicestershire Police	Fiona Pilkington and Francecca Hardwick
Cleveland Police	Keith Philpott/ Christine Lakinski
Hartlepool Borough Council	Keith Philpott/ Christine Lakinski
NHS Hartlepool/ Stockton on Tees	Keith Philpott/ Christine Lakinski
Stockton on Tees Council	Keith Philpott/ Christine Lakinski
Aberdeen City Council	Laura Milne
Aberdeenshire Council *	Laura Milne
Grampian Police	Laura Milne
NHS Grampian	Laura Milne

Name of organisation (those marked * gave evidence in writing only)	**Case**
Bedfordshire Police	Michael Gilbert
Cambridgeshire Police *	Michael Gilbert
Lancashire Police *	Michael Gilbert
Luton Borough Council	Michael Gilbert
NHS Luton	Michael Gilbert
Haringey Police	Rape case
London Borough of Haringey	Rape case
NHS Haringey	Rape case
Stanmore College	Rape case
NHS Rotherham	Shaowei He
Rotherham Metropolitan Borough Council	Shaowei He
Sheffield City Council	Colin Greenwood
Sheffield Primary Care Trust	Colin Greenwood
South Yorkshire Police	Shaowei He/ Colin Greenwood
Cornwall and Isles of Scilly Primary Care Trust	Steven Hoskin
Cornwall Council	Steven Hoskin
Devon and Cornwall Police	Steven Hoskin
Ocean Housing Group	Steven Hoskin
Hounslow Homes	X and Y
Hounslow Police	X and Y
London Borough of Hounslow	X and Y
NHS Hounslow	X and Y

Appendix 17: Improvements made by agencies

During the course of the evidence-gathering, many of the authorities which responded to the inquiry told us about the ongoing work they were doing to address disability-related harassment, perhaps as a result of a serious case review, an inspection, investigation or recognised lack of performance in the area.

In this appendix, we have highlighted some of the measures that agencies involved in the cases highlighted in the report have taken to improve practice. This is not an appendix of good practice – it is appendix of recognised continuing improvement measures.

Many examples of continuing improvement are common to many authorities. These include disability awareness and equality training, Single and Disability Equality Schemes, the use of SMS texting service as a method of contact for deaf and speech-impaired people, help card systems to assist particular disabled people identify where they might face communication barriers in an emergency situation, speed dial emergency contact number (101) for reporting hate crimes, autism awareness cards for alerting emergency services to communication issues and arrangements with a range of private, public and voluntary sector providers to develop 'safe spaces' for disabled people to go to when they are concerned about harassment.

Others also told us about their partnership work with agencies and disabled peoples organisations, their work to improve access to buildings and services, their encouragement to wider participation in public life of disabled people, their workforce training on equality and diversity, and their recognition of improvement through national schemes such as the two ticks scheme for employment of disabled people, and sector inspection reports.

The inquiry itself recognises that initiatives to address disability-related harassment are still in their infancy. There is no set right or wrong way to tackle this issue – it will depend on context, locality, issue, demographics and a whole range of other factors. What we do know is that responses are best shaped by those with a responsibility to address harassment and in conjunction with those to whom it happens, they need to be monitored and evaluated and change with changing contexts over time.

Authorities provided us with a range of documents prior to and post formal hearings in respect of recent actions taken to eliminate disability-related harassment. The following lists some of the more recent initiatives taken by those authorities as a result of those cases or more generally carried out in the past few years.

The Crown Prosecution Service (CPS)

The call for evidence information from the CPS includes:

- The action plan and lessons learned from the breach of Article 3 of the European Convention on Human Rights in the case of FB which was handled by CPS London. The area

commissioned an independent review of how it handled the case and published an action plan setting out the steps to be taken to ensure that the lessons are learned. All the actions have been addressed. Training on mental health and learning disability was delivered to Borough Community Prosecution Coordinators, and a multi-agency training day focusing on safeguarding adults and special measures.

- The refresh of the CPS disability hate crime policy which will also seek to raise the level of awareness of obligations in respect of the UN Convention on the rights of persons with disabilities (2011).
- Special measures:

New provisions under Coroners and Justice Act 2009 (April 2011)

- **S98** – changes the relevant age for child witnesses from under 17 to under 18.
- **S99** – creates a stronger presumption in favour of special measures for intimidated witnesses to offences against the person and offences involving weapons.
- **S100** – allows the court to give more consideration to the child's views as to whether special measures are required – and whether they are likely to maximise the quality of the evidence.
- **S101** – creates a stronger presumption that courts will play video recorded evidence as evidence in chief for adult victims of sexual offences.

Following the judgment in *R v R* [2008] EWCA CRIM 678 the Court of Appeal held that special measures were available across the whole of England and Wales and have been since commencement orders were issued in 2002 and 2004.

Witness Intermediary Scheme data
This scheme received an average of 100 requests for intermediaries each month (2010). The largest single group of victims receiving the intermediary service were people with learning disabilities. The number of requests for intermediaries has increased consistently each year since implementation, suggesting to CPS that awareness across the criminal justice system about the scheme and its benefits is growing. Most requests were made for victims.

CPS Wales

- The number and quality of disability hate crime prosecutions. From 2008-09 to 2009-10 there was an 84 per cent increase in the volume of prosecutions and a 6 per cent increase in the conviction rate.
- The CPS Policies for Victims and Witnesses who have Learning Disabilities and/or Mental Health Issues have been promoted extensively to staff.[289] There has been considerable

289 www.cps.gov.uk/publications/docs/supporting_victims_and_witnesses_with_a_learning_disability.pdf and http://www.cps.gov.uk/publications/docs/supporting_victims_and_witnesses_with_mental_health_issues.pdf

involvement of disabled people in the work of the CPS across the Wales Group (examples provided).

- Hate Crime Co-ordinators are members of the All Wales Adult & Abuse Prosecutions Task and Finish Group. This group was established by the Welsh Assembly because of concerns about low prosecution rates of abuse of vulnerable adults. It adopts a multi-agency approach to ensuring safety of vulnerable adults in Wales. Production of a Wales Adult Protection Policy has been a priority for the group.
- The Group delivers hate crime training to third-party reporting centres and local authority housing officers to increase awareness of hate crime incidents.

National Offender Management Service (NOMS)

The call for evidence information from NOMS includes:

a) Approach to rehabilitating perpetrators of disability-related harassment/ violence:

- Generic work undertaken to prevent reoffending, including attitudes and behaviours work.
- Following the Corston Review in 2006, additional measures were put in place supporting women prisoners who have experienced domestic violence, abuse, rape or been exposed to prostitution.
- Some work is undertaken on mediation around bullying.
- The West Yorkshire Probation Trust has also developed a community-based intervention to address hate crime.

b) Evidence base for the success/ appropriateness of approaches

- A review of existing Offending Behaviour Programmes and the way in which they are delivered is taking place and an adapted version of the Sex Offenders Treatment Programme for prisoners with low IQs is already available.
- Interim sentence planning guidance for staff working with prisoners with a learning disability or difficulty has been issued to Probation Chief Executives and relevant Offender Management leads.

NOMS were invited to provide some examples of good practice as well as details of when they expect to conclude the Hate Crime Framework.

a) London Probation Trust developed the London Diversity Awareness and Prejudice Package (DAPP) which is a toolkit to respond to offending behaviour related to prejudice and hatred. The aim is to assess and engage effectively with hate crime offenders in order to reduce their risk of reoffending including one-to-one work with offenders to focus on their individual risk factors, triggers and pattern of offending. Other areas including Surrey, Nottinghamshire and Thames Valley are now also using DAPP.

b) Merseyside Probation Trust use programmes called Against Human Dignity for one-to-one work and Promoting Human Dignity for group work. Each programme contains 14 modules and covers attitudes, discriminatory thinking, victims and empathy. As with DAPP, other areas have also taken on these programmes.

- The use of the Priestley One-to-One accredited programme with a specific additional element to deal with Racially Motivated Offenders began in 2004. The programme consists of 21 weekly sessions, each lasting either an hour and a half, or an hour. The offender's needs are identified at the beginning before moving on to exercises which are designed to teach and improve social skills, problem-solving, empathy, self-management, goal-setting and attitudes; with a particular emphasis upon characteristics associated with racially motivated offending. Current research in relation to all types of hate crime suggests that perpetrators have similar underlying characteristics, regardless of what type of hate crime they commit. There would seem to be potential therefore to use this type of approach with other hate crime perpetrators.
- NOMS has reviewed its suite of programmes, including the One-to-One programme, in the light of recent research, feedback from facilitators and users, and theoretical developments in the area. Following this review, NOMS is in the process of developing a new One-to-One programme which will eventually replace the Priestly One-to-One programme. NOMS will ensure that this programme caters for all the groups of offenders that currently participate in the One-to-One programme. One of these groups will be hate crime perpetrators.

c) Hate Crime Framework. NOMS Rehabilitation Services Group are working collectively with various stakeholders including the MoJ, ACPO, the Crown Prosecution Service, the Hate Crime Independent Advisory Group and others as part of a Hate Crime Strategy Board. NOMS will work with these agencies to ensure that the framework tackles and responds to disability hate crime effectively.

Wales NOMS

The Wales Probation Trust is currently developing its practice in relation to the safeguarding of vulnerable adults.

East Midlands

The deaths of Fiona Pilkington and Francesca Hardwick were investigated in a hearing for this inquiry. As a result, Leicestershire Constabulary in conjunction with Hinckley and Bosworth Borough Council and Leicestershire County Council have told us about some of their improved practices:

- Action to increase reporting of disability hate crime, including provision of a Stamp It Out website which tackles disability hate crime.
- Project regarding lessons learned from Pilkington/Hardwick case.
- Assessed the feasibility of a possible single system which would allow joint case management of ASB across the partnership.
- Tackled bullying in schools and developed a Beyond Bullying website.
- Locality meetings of key agencies to discuss issues and individual cases of vulnerable people, for example Hinckley Forum supported by Hinckley and Bosworth Borough Council.

- Leicestershire Constabulary have a timeline from June 2008–July 2011 outlining improved practice, including new processes for grading vulnerability of victims (2009), launch of Stamp It Out (2010), a Home Office Anti Social Behaviour pilot (2011), introduction of Steria STORM (2011, aimed at linking incidents by victim) and second phase of Protecting Vulnerable People training (2011).
- Hinckley and Bosworth Borough Council has undertaken a range of approaches to tackling disability-related harassment which include:
  - The Safety Crew project aimed at tackling bullying in schools with inclusive youth games and football project.
  - Circles of Need project identifying needs of victims.
  - The Stop and Tell video including three disabled people providing a victim perspective in partnership with Leicestershire County Council.
  - Examples of leadership work across surrounding authorities led by Hinckley and Bosworth Borough Council by way of lessons learned workshop.
- Leicestershire County Council has developed:
  - Employment of inclusion development workers within adult social care.
  - Involvement in multi-agency hate incident monitoring project, including work with schools and youth projects.
  - Stronger risk prevention measures in respect of escorted travel in transport for schools.

North West

The death of David Askew was examined in a hearing for this inquiry. As a result, Greater Manchester Police (GMP), Tameside Metropolitan Borough Council and Peak Valley Housing Association have told us about some of their improved practices:

- Jointly developed Local Hate Crime Scrutiny Panels

Greater Manchester Police (GMP) has developed:

- A 'vulnerability' matrix in order to further enhance their service to people experiencing Anti-Social Behaviour in their community. GMP has recently implemented new corporate processes, which are a means by which staff can identify people in the community with an enhanced level of vulnerability to anti-social behaviour.
- A strategic Service Level Agreement (SLA) jointly between the Crown Prosecution Service, Probation Service, Court Service and Youth Offending Service (this SLA outlines the interventions that the Probation Service and Youth Offending Service will undertake in relation to work with Hate Crime Offenders) and a separate SLA with Victim Support.
- School-based police officers.
- Events and conferences, including a consultation event hosted by the Greater Manchester Passenger Transport Authority.
- Working with Breakthrough UK, a local disabled people's organisation that promotes the rights of disabled people, on a project called Working It Through

Together, aimed at tackling disability hate crime.

- Independent advisory groups – involvement with disabled people.
- Disability Partnership Boards.
- Involvement in the I'm Not Laughing campaign, which aims to put a stop to disability hate crime across Bolton by raising awareness of it and the impact it has upon victims.

Tameside Metropolitan Borough Council has developed:

- Schools and youth work. All staff in their Disability Unit have undertaken training in relation to hate crime awareness.

Peak Valley Housing has developed:

- Their Anti-Social behaviour Policy to include hate crime, which is defined as medium risk.
- Policy in relation to not transferring complainants or perpetrators as a means of resolving nuisance or anti-social behaviour (except in exceptional circumstances); instead they will deal with the nuisance.
- Policy in relation to housing staff offering support to victims including keeping in regular contact and referral to specialist support agencies. In extreme situations this may include the provision of additional security measures, rehousing or injunctions.

East of England

The death of Michael Gilbert was examined in a hearing for this inquiry. As a result, Cambridgeshire Police Force, Luton Borough Council, Bedfordshire Police, Lancashire Police, and NHS Luton told us about some of their improved practices.

Cambridgeshire Police Force has developed:

- A Hate Crime Co-ordinator and a draft Hate Crime Manual of Standards.
- The crime recording system CrimeFile, which can record and be searched for different types of hate crime. There is currently a list of qualifying markers available on CrimeFile relating to hate/prejudice crime.
- A CrimeFile Policy which gives clear guidance on flagging repeat victims; these can be quickly and easily accessed by the investigating officer so they have a history of previous reported crimes.
- Two action plans have been produced as a result of the deliverables within the Local Policing Plan – Reducing Repeat Anti-Social Behaviour (ASB) and improving overall satisfaction for victims of ASB.
- Force website, a section on hate crime went live in November 2009 which refers to disability hate crime. In June 2010 a section on reporting online was included.
- The Open Out scheme, which has produced posters that raise awareness of hate crime; also a book called Supporting Victims of Hate Crime has been distributed to local organisations of disabled people.

- Police enhanced access line (PEAL), a dedicated phone number for people with communication difficulties. The PEAL is available 24 hours a day for non-emergency calls for anyone who has difficulty communicating.
- A process map depicting the complete journey of hate crime and hate incidents from the point they are first reported to the constabulary through to their conclusion with recommendations.
- A new process to highlight/discuss repeat victims of violent crime at daily management meetings.

Luton Borough Council has developed:

- Evidence of a Tell Us poster campaign aimed at encouraging reports of disability hate crime.
- Being Safe in Luton young people's strategy on bullying 2006/7.
- Anti-Bullying Strategy launched in 2008 and an electronic survey carried out of young people experiences of bullying inside and outside of school.

Bedfordshire Police has developed:

- A new performance management IT system, which provides improved performance information to supervisors in the organisation capturing ASB trend behaviour.
- At a local division level, supervising officers with daily ASB incidents including repeat locations. One division is piloting an approach where the data feeds the Safer Neighbourhood Team.
- Recording of hate incidents. From January 2009 it records all incidents on the crime system, rather than the incident system. This enables full capture of victims and suspect details for hate incidents, showing an accurate record of hate incidents and hate crimes.
- A hate crime partnership forum that has strategic responsibility for delivering performance improvements and partnerships for hate crime/ incidents.
- Three Independent Advisory Groups which include disabled people.
- A close partnership with Advocacy Alliance, a charity that provides a service for adults with disabilities in Bedfordshire.
- As a way of increasing home security and reassurance, officers have carried out SmartWater installation, with the aim to reduce ASB for repeat victims.

Lancashire Police has developed:

- Citizen focus –with a view to understanding and being visible and accessible to communities and delivering a high-quality service to them. Lancashire Constabulary delivers this primarily through neighbourhood policing and have been graded 'excellent' in neighbourhood policing by Her Majesty's Inspectorate of Constabulary (HMIC).
- A dedicated headquarters-based Public Protection Compliance and Development Unit (PPU).
- Specialist police and communities together (PACT) meetings held monthly. Examples include Disability PACT, Visual Impairment PACT, Deaf PACT, Mental Health and Learning Disability PACT.

- Programmes in schools about bullying and hate crime.
- IT systems behind their communication centres which recognise and highlight repeat callers and repeat locations.
- Minimum standards of investigation for ASB incidents to ensure robustness around identifying vulnerability at an early stage before escalation. Implemented in 2010 the standards include a risk assessment process, generating far higher referrals from non-crime incidents than previously.
- Advice and guidance on release from custody with a view to how 'vulnerable' people may feel in terms of depression and suicidal thoughts, particularly addressing people with learning difficulties or mental health issues. All detainees are subject to a risk assessment before leaving custody.
- Links into the City of London Police intelligence hub around financial exploitation with a view to identifying the perpetrators of mass marketing financial exploitation fraud.
- A unique dedicated Disability Liaison and Deaf Link officer to raise awareness around deaf/disability issues, identifying and taking actions to remove barriers for this community when accessing policing services. Lancashire Unite Against Hate: a partnership project about the consequences of leaving hate crime unchallenged.
- A new third-party reporting scheme in partnership with Disability Equality North West launched in the Preston area in July 2010.
- A project where on appointment all new Lancashire police recruits complete a baseline diversity knowledge assessment. Should disability awareness be identified as a developmental need, the individual can receive a week's placement at a disability resource centre or organisation.
- The E Card (The Emergency Information Card) is a Lancashire initiative and has been adopted by Lancashire Fire and Rescue Service (LFRS), Greater Manchester and Merseyside Police and has recently featured in the National Mind publication: The Police and Mental Health – how to get it right locally. The National Police Improvement Agency (NPIA) quote the E card as an example of best practice.

South West

The death of Steven Hoskin was examined in a hearing for this inquiry. As a result, Devon and Cornwall Police, Cornwall and Isles Of Scilly Primary Care Trust, Ocean Housing Group and Cornwall Council told us about some of their improved practices.

Devon and Cornwall Police has developed:

- A pilot to identify the vulnerability of callers, through analysis of repeat telephone numbers, as well as the more established Neighbourhood Harm Reduction Register of repeat calls to locations.
- A shared understanding with mental health practitioners and the police using shared language and definitions around risk in mental health care cases, who work together to review risk levels regularly.

- Indicative data in relation to disabled victims of crime. An increase can be seen in year to date reporting of disability-related hate crime. Although it is too early to know if this is improving trend, it may indicate a greater sense of confidence to report to the police.

Cornwall and Isles of Scilly Primary Care Trust developed:

- A safeguarding adults conference – lessons learned from Steven Hoskin case.
- Home safe scheme – locks to properties made available to adults at risk of harm in their home.
- Sanctuary scheme (2004) for victims of domestic violence.
- Independent domestic violence advocacy scheme.
- Bogus callers scheme.
- Third-party reporting centres.
- Street pastors scheme.
- Multi-agency information sharing protocol and triggers.
- Multi-agency action plans.

Ocean Housing Group has developed:

- An Equality and Diversity strategy – including lessons from the Steven Hoskins case and what to implement.
- A review of policies and procedures in relation to the support of vulnerable adults.
- A review of policies and training programme.
- A Safeguarding Adult Policy.
- A Safeguarding Adults Housing Providers Group (chaired by Cornwall Council's Head of Housing in partnership with Cornwall Council).

Cornwall Council has developed:

- A multi agency progress action plan with lessons learnt from the death of Steven Hoskin in 2008 including shared trigger protocols.
- A single agency action plan progress report in 2009.
- Various reviews of the triggers protocols.
- A Safeguarding Adults data monitoring information system.
- A disability hate crime strategic assessment tool.
- Say No to Abuse leaflet.
- Safe Places Scheme project progress report.

London/South East

The report also looked at what we might learn from the case of a high-profile rape in the London area. As a result of the hearing to examine this case, the London Borough of Haringey, NHS Haringey, and the Metropolitan Police told us about some of their improved practice.

NHS Haringey has developed:

- A lead nurse for safeguarding (first in the UK) and a lead nurse for learning disability. These work closely together to ensure full compliance with expected safeguarding protocol and procedure from all stakeholders, including GPs.

- Safeguarding arrangements to oversee the transition of GP commissioning.
- A transition arrangements sub-group links the adult and children's safeguarding boards to address the challenges posed as young people move between these services.

Haringey Police have piloted, with the local authority, a Public Protection Desk arrangement where police officers and social workers work side by side to improve the free flow of information and subsequently the response procedures and times to serious incidents involving vulnerable people. These Multi-Agency Safeguarding hubs are being developed across London with Haringey taking a lead role in this work

North East

The deaths of Christine Lakinski and Keith Philpott were examined in a hearing for this inquiry. As a result, Hartlepool Borough Council , Stockton on Tees Borough Council, Cleveland Police and NHS Hartlepool and Stockton on Tees told us about their improved practices.

In partnership they have developed:

- A Changing People's Lives event involving statutory agencies, private and voluntary sector agencies, people using services and their carers (2009).
- A hate crime reporting system, ARCH, including disability-related incidents, promoted at community events.
- The Repeat Victims Case Group (RVCG) a multi-agency group which meets on a monthly basis to discuss repeat victims of antisocial behaviour.
- Close links between Cleveland Police and local authorities on the IIP (Intensive Intervention Project) which works with individuals some with ASBOs and others close to receiving an order. All juveniles in Middlesbrough issued with an Acceptable Behaviour Contract are referred to Challenge and Support project.
- Operation Stay Safe (police, local authority) – hot spot areas of anti-social behaviour targeted and children found in these areas who are deemed vulnerable are taken to a place of safety.
- Police Anti Social Behaviour teams programme visiting schools to talk to young people about the impact of antisocial behaviour in the community and school environment.
- A Pilot Safer Schools Partnership Model, looking at improving the profile of young people and getting them involved in shaping local services. A schools officer working with young people in relation to modifying behaviour and antisocial behaviour. Facebook and Twitter is used to communicate and engage young people.
- A newly established Teeswide Adult Safeguarding Board in 2010. NHS Hartlepool and NHS Stockton have led the review process of the Adult Safeguarding policy.
- Review of the Teeswide Serious Case Review protocol to ensure that it remains 'fit for purpose'.
- In NHS Hartlepool and NHS Stockton a proforma to encourage reporting by staff, professionals and those involved in the voluntary sector and frontline services in relation to hate crime incidents involving vulnerable adults.

Cleveland Police Force has developed:

- A hate crime and hate incidents policy review 2010 broken down into what to do in the case of hate crimes for recording, evidence-gathering, investigation, search, witness statements, support, repeat victimisation.
- A disability awareness handbook for officers.
- A community impact assessments policy.
- Putting People First – a vision statement and strategy for Cleveland police.
- A repeat locations/incidents system to record hate incidents.
- Crime Vulnerability Units – these provide a specialist investigation and safety planning service to the most vulnerable individuals.
- Developed and introduced Autism Alert Cards as a means of aiding communication with this group.
- A force wide mental health policy and procedures to ensure that people with mental health issues are treated fairly and equitably.
- A procedural internal communications to ensure that relevant Liaison Officers share information to ensure joined-up practices.
- The Acceptable Behaviour Campaign (2001) to intervene at an early stage to stop anti-social behaviour from escalating and to prevent young people from entering the criminal justice system unnecessarily.
- Officers conducted Operation Ride 'n' Hide, travelling on buses used by pupils to travel to and from school. The aim of the operation is to reduce the fear of crime and incidents of anti-social behaviour.
- Emergency Signs for Deaf People – A tripartite (police, fire and ambulance) initiative as a result of consultation with the deaf community called Z cards.

Hartlepool Borough Council has developed:

- A Protecting Vulnerable Adults from Abuse Easy Read leaflet No Secrets (2007).
- A presentation on Safeguarding Adults with Learning Disabilities (2008).
- A 'Keep Safe' booklet and 'Keeping Safe Rap' (Roaring Mouse and SYMO) marketing tools in partnership with people with learning disabilities (2009)
- Visioning event Housing, Health, Employment and Carers: Promoting Good Practice (2010).
- A booklet Staying Safe (via the Learning Disability Partnership Board) to prevent discrimination.
- Communication with the deaf community was raised as a particular issue during consultation so Hartlepool NOW website is to be populated with a range of signed videos.
- Joined the Leisurewatch scheme – a scheme endorsed by ACPO to train staff in leisure services on safeguarding.

Stockton on Tees Borough Council has developed:

- An Offensive Incident scheme a third-party reporting scheme which is subject to ongoing publicity and promotion – for example local taxi operators.

- A diversity and cohesion communication strategy with disabled people.

Following the death of Brent Martin, we interviewed Northumbria police, Sunderland City Council, NHS Tyne and Wear and Northumberland and NHS South of Tyne of Wear.

Northumbria Police Force has developed:

- Work with local disability organisation Vision Sense in 2006 to identify barriers to disabled people, and consulted widely (over 350 disabled people's groups, and 845 individual disabled people).
- The consultation resulted in five key priorities:
  - Improving frontline staff attitudes towards disabled people.
  - Taking steps to address disability hate crime.
  - Improving communications and access to information for disabled people.
  - Involving disabled people in decision-making and problem-solving.
  - Improving the accessibility of force premises.
- A procedure on reporting and monitoring hate incidents.
- Operation Strongbow – March 2009, a high-profile multi-agency approach to tackling doorstep crime, including the media, private, public and voluntary sectors.
- Operation Bombay – a regional response to distraction burglary offences targeting vulnerable people in 2010.
- A Grant Pool to support vulnerable victims and offenders (2010).
- Funding to help local communities engage with the police agendas National Police Association participatory budgeting.
- Blue Card Scheme – emergency contact scheme for adults with learning disabilities – for use with emergency services to speed up communication
- Third-party reporting centres.
- Conflict management training to young people in the area.
- Campaigns to tackle domestic violence at recognised peak times such as Christmas and during FIFA World Cup.
- Rape awareness campaign at Christmas 2009/10.
- Safer schools partnership.
- A harm reduction unit.
- Ebeat force website for parents, children and teachers includes lesson plans on anti-social behaviour and cyber bullying 2011.
- Special measures improvements – to agree with courts for late application in order to get special measures in place – rather than deeming a case 'late' because of getting requirements met.
- A conference Prevention and Protection on disability hate crime.

Sunderland City Council has developed:

- An Independent Disability Advisory Group.
- Safeguarding Champions.
- A Home Support Agency Monitoring Tool.

- A Guide to Adult Placements in Sunderland.
- A Learning Disability Service Charter Guide.
- The Protect Yourself and Others Training Pack – course in Adult Safeguarding.
- Sunderland Learning Disability Partnership – Customer Charter.
- Shared Ownership – a new scheme to help people with disabilities own their own home.
- The Staying Up Late three promises – a project to ensure people with learning disabilities are able to attend evening meetings.

NHS Tyne and Wear Northumberland has developed:

- A mental health model of care programme, a whole system 'model' of mental health care in 2010 in conjunction with NHS South of Tyne and Wear.
- Tyne and Wear PCT Assessment of Services Dashboard indicating where services are failing.
- A hate crime reporting system from across all three local authorities to provide to PCT staff. A pro-forma was developed for use by staff to report incidents involving vulnerable adults.
- A relaunch of the anti-bullying charter mark run by the local authority.
- A serious untoward incident process briefing.

Yorkshire and Humberside

The deaths of Colin Greenwood and Shaowei He were examined in a hearing for this inquiry. As a result NHS Sheffield, South Yorkshire Police, Rotherham Council and Sheffield Council told us about some of their improved practices.

In partnership they have developed:

- Partners for Inclusion, a partnership board for people with physical, sensory and cognitive impairment, which identified hate crime as one of the concerns and priorities in 2010. Actions are being implemented in partnership between NHS Sheffield and South Yorkshire Police.
- A Safe Place Scheme in partnership with the Learning Disability Partnership Board.
- Joint conferences between the police, council, housing and social care staff to improve information sharing and joint working.
- An awareness raising event Let's Talk about Being Safe!, organised by the Learning Disability Partnership Board in April 2010 as part of the Speak Up campaign in Rotherham.

NHS Sheffield has developed:

- Actions to revise their Single Equality Scheme (2011), following disabled people identifying hate crime and harassment as a local priority over the last nine months.
- Expert Patient Programme course presentations to both local and national conferences.

A conference to explore implementing the learning resulting from the Fiona Pilkington case in April 2011.

South Yorkshire Police Force developed:

- All mainstream local authority and independent schools in Barnsley with Year 6 pupils are invited by Community Safety to attend Crucial Crew which includes an anti-social behaviour scenario training for schools through interactive media. Special Needs schools and Pupil Referral Units are also invited.

Sheffield Council has developed:

- An action plan to increase awareness, reporting and recording of hate crime incidents.
- VARMM, a risk management tool used for identifying vulnerable adults. This model can also be used to manage high risk safeguarding adults cases.

Rotherham Council has developed:

- Environmental Health Officers adult safeguarding training.
- A new database for recording all types of hate incident.
- An electronic reporting system for staff.
- A hate crime officer post in the performance division (2011).
- Anti Social Behaviour Champions project (2010 Rotherham Ltd).
- Every Contact Counts initiative, which enhances ability to deliver on a preventative/early intervention agenda. Visiting officers who identify issues or concerns about a customer which is not part of their day to day role are asked to complete a form and send it to Adult Social Care who then make contact.
- A new Hate Incident/Crime Strategy and Policy (2011) to be followed by the development of an e-learning module on the new policy and training workshops for Rotherham Metropolitan Borough Council staff.

North Wales

The deaths of Christopher Foulkes and Philip Holmes were examined in a hearing for this inquiry. As a result, we interviewed North Wales Police Force, Betsi Cadwaladr University Health Board and Denbighshire Council who told us about their improved practices.

North Wales Police has developed:

- Alternative ways of reporting hate crime (including print and text based methods) so that victims, witnesses and others do not have to visit a police station or have direct contact with the police.
- Use of the 101 scheme for non-emergency calls to the police.
- An autism awareness card that people with autism can show to the police to make officers aware of their condition.
- Victim Panels, where victims of hate crimes are given the opportunity to discuss how their case was handled, and how they feel about the way North Wales Police have dealt with them, leading to changes in the way the Police relate to hate crime victims.

Betsi Cadwaladr University Health Board has developed:

- All serious incidents or no surprises (sensitive issues) electronic reporting mechanisms to the Improving Patient Safety Team Mailbox at the Assembly Government (2011).
- Updates and action planning sharing with the Welsh Government on any serious incident where an investigation has been held.
- Issues and learning arising from incidents and complaints are considered at the Assembly Government Patient Safety Committee to determine any action required, particularly at a national level.
- Introduction of a single integrated risk management system (Datix) which captures disability-related harassment issues among other risks.
- Joint working between the Health Board and Denbighshire Local Authority in all aspects of adult protection, including interface meetings between children and adult services.
- Flintshire Keeping Safe course for people with learning disabilities.

Denbighshire County Council has developed:

- An Adult and Child Protection Awareness Course.
- A protocol for parents with severe mental health problems and/or substance misuse.
- A framework for safeguarding children in partnership with Betsi Cadwaladr University Health Board.

Scotland

The 'case of the vulnerable adult' was examined in a hearing for this inquiry. As a result, we interviewed Scottish Borders Council, NHS Borders and Lothian and Borders Police.

Among the steps taken by agencies in the Scottish Borders are:

- an action plan as a response to the Social Work Inspectorate and Mental Welfare Committee Report 2004 into the abuse of vulnerable adults with learning disabilities.
- Developed good practice guidelines for GPs in working with parents with learning disabilities.
- A Critical Services Oversight Group (CSOG) was set up in 2004, comprising of the chief executives of Scottish Borders Council and NHS Borders, and the Borders divisional commander for Lothian and Borders Police, with the aim of ensuring that both the Child and Adult Protection Committees have a senior management forum which can be quickly appraised of critical issues. The group is designed to complement the oversight provided by the two independent chairs of the adult and child protection committees, and meets quarterly.
- Both the Child Protection Committee and Adult Protection Committee have been led by independent Chairs since 2005. These key personnel are appointed by the local authority and remunerated on a sessional basis.

- The Director of Social Work was invited by Scottish Government to lead a programme of work on practice governance which led to publication of guidance on the role of the chief social work officer and the registered social worker and a framework for practice governance.[290]
- The Scottish Borders sits within the ELBEG (Edinburgh, Lothian and Borders Executive Group) Partnership. ELBEG comprises the chief executives of NHS Lothian and NHS Borders, the five local authorities and the Chief Constable of Lothian and Borders police. ELBEG is designed to provide multi-agency leadership and oversight of arrangements for protecting vulnerable persons. It was established in March 2004 in response to Scottish Executive guidance regarding the Child Protection Reform Programme, and at that time was unique in Scotland. All local Child and Adult Protection Committees report to their CSOG which in turn reports to ELBEG, and a data sharing protocol has been agreed.
- All ELBEG partners have signed up to the group's Adult Support and Protection: Ensuring Rights and Preventing Harm multi-agency guidelines, published in January 2010. The guidelines reflect the legislation and replace the previous ELBEG multi-agency guidelines Protecting Vulnerable Adults: Ensuring Rights and Preventing Abuse, which were published in 2003. Significant training has been undertaken across all partners to support the implementation of these guidelines.
- Scottish Borders and partners developed a range of communication methods to raise the profile of adult support and protection. The ELBEG Partnership produced explanatory leaflets which can be accessed by the public. The 2010 guidelines and leaflets have been distributed locally and are available on the Scottish Borders Council and NHS Borders websites. In addition to this ELBEG has published wallet-sized cards that contain information about the Lothian & Borders Multi Agency Public Protection Arrangements (MAPPA) and phone numbers that people may need if they have concerns about adults or children. In addition, the Chief Social Work Officer produces an annual report to Council including commentary on adult support and protection activity to keep councillors fully informed of progress and changes.

We also looked at what we might learn from the death of Laura Milne in a hearing for the inquiry. We interviewed Grampian Police Force, Aberdeen City Council and NHS Grampian. As a result, they told us about improved practice.

In partnership they have developed:

- A Carewatch scheme. This scheme allows Grampian Officers to call on staff from a local care provider to provide assistance to anyone with personal needs who has been taken into police custody (2008).
- A hate crime campaign (2010), supported by the local Licensing Boards and the three local authorities in the area.

290 See http://scotland.gov.uk/Publications/2011/03/14093805/0

- Guidance for police staff on incidents involving adults at risk of harm.
- Grampian Interagency Guidelines: Supporting and Protecting Adults at Risk of Harm.

Grampian Police Force has developed:

- Mental health and place of safety standard operating procedures.
- Hate crime reporting and recording standard operating procedures.
- A Disability Advisory Group.
- A force Diversity Group.
- ACPOS Disability and Mental Health Reference Groups.

Appendix 18: Article 16 of the United Nations Convention on the Rights of Persons with Disabilities

Freedom from exploitation, violence and abuse

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.

2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognise and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.

3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Appendix 19: Disability Facts and Figures from the Office of Disability Issues

Living standards

- A substantially higher proportion of individuals who live in families with disabled members live in poverty, compared to individuals who live in families where no one is disabled.
- Twenty-three per cent of individuals in families with at least one disabled member live in relative income poverty, on a Before Housing Costs basis, compared to 16 per cent of individuals in families with no disabled member.[291]
- Twenty-nine per cent of children in families with at least one disabled member are in poverty, a significantly higher proportion than the 20 per cent of children in families with no disabled member.[292]

Employment

- The employment-rate gap between disabled and non-disabled people has decreased from around 36 per cent in 2002 to around 29 per cent in 2010.[293]
- However, disabled people are far less likely to be in employment. Although there have been significant improvements in the employment rates of disabled people in the last decade, the employment rates of disabled

291 Households Below Average Income 2008/09.

292 Households Below Average Income 2008/09.

293 Labour Force Survey, Quarter 2, 2002 and Quarter 2, 2010.

people are around 48 per cent, compared with around 78 per cent of non-disabled people.[294]

Education

Between 2005/06 and 2008/09, the percentage of pupils at the end of Key Stage 4 achieving five or more GCSEs at grades A*-C has:

- increased from 66 per cent to 80 per cent for students without Special Educational Needs (SEN)
- increased from 20 per cent to 40 per cent for students with SEN without a statement, and
- increased from nine per cent to 15 per cent for students with SEN with a statement.[295]

Post-19 education

- Disabled people are around twice as likely not to hold any qualifications compared to non-disabled people, and around half as likely to hold a degree-level qualification.[296]
- Twenty-four per cent of working age disabled people do not hold any formal qualification, compared to 10 per cent of working age non-disabled people.[297]
- Eleven per cent of working age disabled people hold degree-level qualifications compared to 22 per cent of working age non-disabled people.[298]

Independent living

- Over a fifth of disabled people say that they do not frequently have choice and control over their daily lives.[299]

Discrimination

- Disabled people are significantly more likely to experience unfair treatment at work than non-disabled people. In 2008, 19 per cent of disabled people experienced unfair treatment at work compared to 13 per cent of non-disabled people.[300]
- Around a third of disabled people experience difficulties related to their impairment in accessing public, commercial and leisure goods and services.[301]

Leisure, social and cultural activities

- Disabled people remain significantly less likely to participate in cultural, leisure and sporting activities than non-

294 Labour Force Survey, Quarter 2, 2010.
295 National Pupil Database 2005/06-2008/09.
296 Labour Force Survey, Quarter 2, 2008.
297 Labour Force Survey, Quarter 2, 2008.
298 Labour Force Survey, Quarter 2, 2008.
299 ONS Opinions Survey 2009.
300 Fair Treatment at Work Survey 2008.
301 ONS Opinions Survey 2009.

disabled people. Latest data shows disabled people are more likely to have attended a cinema, museum or gallery than in 2005/06. However disabled people are less likely to have participated in sporting activities, attended historic environment sites or the library over the same period.[302]

Civic involvement and volunteering

- Disabled people are less likely to have engaged in civic involvement than non-disabled people. In 2009/10, 55 per cent of disabled people undertook at least one activity of civic involvement in the last 12 months compared to 60 per cent of non-disabled people.[303]
- Disabled people are significantly less likely to engage in formal volunteering. In 2009/10, 22 per cent of disabled people engaged in formal volunteering at least once a month, compared with 26 per cent of non-disabled people.[304]

Transport

- Around a fifth of disabled people report having difficulties related to their impairment or disability in accessing transport.[305]
- Between 2005/06 and 2007/08, the percentage of buses with low-floor wheelchair access increased from 50 per cent to 62 per cent.[306]

Communications

- Around half of households with a disabled member have access to the internet, compared to over two-thirds of households with no disabled members.[307]

Justice system

- Disabled people are significantly more likely to be victims of crime than non-disabled people. This gap is largest among 16-34 year-olds where 38 per cent of disabled people reported having been a victim of crime compared to 30 per cent of non-disabled people.[308]
- Disabled people are less likely than their non-disabled peers to think the Criminal Justice System (CJS) is fair. This gap is largest among 16-34 year-olds, where 49 per cent of disabled people think that the CJS is fair compared to 65 per cent of non-disabled people.[309]

302 Taking Part Survey 2009/10.
303 Citizenship Survey 2009/10.
304 Citizenship Survey 2009/10.
305 ONS Opinions Survey 2009.
306 Department for Transport's Annual Sample Survey of Bus Operators.
307 British Social Attitudes Survey 2006.
308 British Crime Survey 2009/10.
309 British Crime Survey 2009/10.

Housing

- Although the gap in non-decent accommodation has closed over recent years, one in three households with a disabled person still live in non-decent accommodation.[310]
- One in five disabled people requiring adaptations to their home believe that their accommodation is not suitable.[311]

310 English House Condition Survey 2007.

311 Survey of English Housing 2007/08.

Glossary

adults 'at risk of harm'	Individuals who may be at risk of harm or abuse. Proposed alternative wording to 'vulnerable adult'.
advocacy	Advocacy means supporting an individual to say/communicate what they want, secure their rights and/or services.
aggravated offences	A criminal offence made more serious (aggravated) by factors such as the conduct or motivation of the person committing the offence. In Great Britain, offences can be aggravated by 'hostility' (England and Wales) or 'malice or ill-will' (Scotland) towards disabled people.
antisocial behaviour	Any aggressive, intimidating or destructive activity that damages or destroys another person's quality of life.[312]
appropriate adult	A family member, friend or volunteer present when a young person under the age of 17 or, in some cases, an adult at risk of harm, is supported in their engagement with public authorities. For example, being interviewed by the police.
Community Safety Partnerships	Partnerships that bring agencies in local areas together to tackle crime in their local community.

312 Home Office Definition.

cuckooing	A situation where someone, often a recent 'acquaintance', moves into a disabled person's home to take advantage of their facilities (such as their telephone, living accommodation) and get access to food, clothes, money, drugs or benefits.
cyber-bullying/harassment	The use of technology, such as internet chat rooms, mobile phones and social media to harass a person.
disability-related harassment	Unwanted, exploitative or abusive conduct on the grounds of disability which has the purpose or effect of either: • violating the dignity, safety, security or autonomy of the person experiencing it, or • creating an intimidating, hostile, degrading or offensive environment.
financial exploitation	Theft, fraud or other abuse of a person's money or benefits.
hate crime	Any criminal offence, which is perceived, by the victim or any other person, to be motivated by hostility or prejudice based on a person's disability or perceived disability, race, religion or sexual orientation.[313]
hate incident	Any non-crime incident which is perceived, by the victim or any other person, to be motivated by a hostility or prejudice based on a person's disability or perceived disability, race, religion or sexual orientation.[314]
hostility	Unfriendliness, ill will, animosity, aggression.

313 Agreed definition of monitored hate crimes and incidents.

314 Agreed definition of monitored hate crimes and incidents.

'In Safe Hands'	Welsh Government guidance on adult safeguarding.
incitement to hatred	An offence whereby a person uses threatening, abusive or insulting words or behaviour, or displays written material which is threatening, abusive or insulting, with the intention of stirring up hatred. Currently only incitement on the grounds of race, religion and sexual orientation exists and not in all GB jurisdictions.
inquiry	A close examination of a matter in search of information.
learning disability register	A register held by a GP of individuals living in their area with a learning disability for the purpose of ensuring better access to health services, including annual health checks.
localism	A shift in power away from central government towards local communities.
mate crime	The exploitation, abuse or theft from people with learning disabilities, by those they consider as their friends.[315]
medical model of disability	Model of disability which focuses on 'fixing' an individual's health condition or impairment. It is generally not supported by disabled people or their organisations.
'No Secrets'	Westminster Government guidance on adult safeguarding
personalisation	Giving greater choice and control to individuals in respect of the support they receive.

315 Association for Real Change definition.

risk assessment	A consideration of the dangers/risks associated with a particular action or situation and how to lessen or eliminate them.
safeguarding	Keeping individuals safe who may be at risk of harm, including intervention in a particular situation and prevention before a situation develops.
Schedule 21	Schedule 21 of the Criminal Justice Act 2003 sets out the basic starting points for sentencing of murder in England and Wales.
sentence uplift/enhanced sentence	An increase in a sentence where a crime is proven to be motivated by hostility. See Appendix 8.
serious case review	An investigation into the death or serious harm of a child or 'vulnerable adult' to determine what happened and what lessons can be learnt. Also known as a significant case review in Scotland and serious incident investigation in Wales.
situational vulnerability	Recognition that the risk of experiencing harassment is influenced by the circumstances in which someone lives their life including wider social, economic and community conditions.
social model of disability	Model of disability which looks at the barriers, negative attitudes and exclusion by society that can, purposefully or not, 'disable' those with impairments.
special measures	Steps that can be taken, provisions or adjustments to ensure equal access in court for giving evidence. This includes screens in the court room to prevent the witness seeing the defendant or live links from another location.

targeted violence	Unwanted conduct, violence, harassment or abuse that is targeted against a person because of their age, disability, gender, transgender status, race, religion or belief, sexual orientation or a combination of these characteristics.
Terms of Reference	Outline of what an inquiry will cover and not cover including definitions and examples.
third party reporting	A means by which victims and witnesses can report harassment without going directly to the police. Third party reporting sites are often operated by charities and voluntary organisations.
transient vulnerability	Recognition that the risk of harm can vary from time to time, over an individual's life.
Triggers Protocol	A series of events or warning signs that together can initiate an intervention.
'trolling'	Writing inflammatory or contentious remarks in an online setting, such as a chat room, to provoke a response among other users.
'vulnerable adult'	Someone over the age of 18 who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.[316] The inquiry proposes that the term 'adults at risk of harm' replaces this as a better descriptor of the transient and situational nature of vulnerability.

316 Department of Health, 'No Secrets' definition.

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The same as you?

A review of services for people with learning disabilities

ii The same as you?

Ministerial foreword

It is over 20 years since the last policy initiative on learning disability services in Scotland. Although there has been progress in many areas since then, it has not been consistent. Overall, the pattern of services in Scotland is not as advanced as in many countries in Europe. So, I very much welcome this wide-ranging review, and the way it has been carried out. In it we meet the commitment in our Programme for Government 'Making It Work Together' to publish in 2000 our proposals for services for people with learning disabilities.

The Learning Disability Review has succeeded in involving many of those with an interest, especially those who use services and their carers, at different points in the journey. I know from meeting people how much that has been welcomed and valued. I was involved in the review-visiting projects, at one of the seminars and answering questions in a live internet session. I was very impressed by the desire for change, the reasonableness and responsibility of those pressing for it and the willingness of agencies to respond.

This review began by looking at services, especially in social and healthcare, and their relationship with education, housing, employment and other areas. However, its focus changed to include people's lifestyles. That is what matters. Services are there to support people in their daily lives.

We are committed to improving the quality of life for people with disabilities. The review reflects our wider policies including **social inclusion**, equality and fairness, and the opportunity for people to improve themselves through continuous learning. These are just as important and just as relevant to people with learning disabilities as they are to all of us.

The focus of the report is consistent with our existing policies on community care. 'Modernising Community Care' wants better results for people through quicker and better decision-making, greater emphasis on care at home and agencies working more closely together. Our desire to improve the general health of people with learning disabilities is also directly related to our aims

in 'Towards a Healthier Scotland'. The responsibility of the Joint Future Group, which I chair, is to build on both these documents and identify and promote good practice in working with others.

People with learning disabilities should be able to lead normal lives. We want them to:

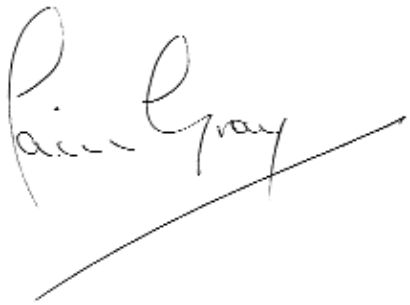
- be included, better understood and supported by the communities in which they live;
- have information about their needs and the services available, so that they can take part, more fully, in decisions about them;
- be at the centre of decision-making and have more control over their care;
- have the same opportunities as others to get a job, develop as individuals, spend time with family and friends, enjoy life and get the extra support they need to do this; and
- be able to use local services wherever possible and special services if they need them.

People with learning disabilities want to make a positive contribution to society. Communities and individuals must learn to recognise their needs and respond more positively to them. A programme to improve public awareness is part of helping them to have a better quality of life.

I particularly welcome the opportunities for people to have more say and more control over their lives. Professionals need to acknowledge their limits and the rights of others. Using **direct payments**, **brokerage** and advocacy services more will help people have more influence.

Lastly, the review recommends that for all but a few people, health and social care should be provided in their own homes or in community settings alongside the rest of the population. I know that many people will welcome this idea. However, we must put in place the appropriate services and support to allow people to live properly in the community, to allow the rest of the long-stay institutions to close.

In welcoming the vision for the future, we have to be realistic and recognise the many pressures there are for resources both nationally and locally. We want and need to make the lives of people with learning disabilities better. Over time that will need more resources but now we can make better use of the considerable funds that are available in all sectors. The review gives agencies very clear signals about the level of change needed. People with learning disabilities and their carers must see early evidence of that beginning to take shape.



Iain Gray MSP

Deputy Minister for Community Care

How the review was done

1 We formed four main groups (see appendix 7 for details):

- an interdepartmental steering group;
- a multidisciplinary working group;
- a users' and carers' group; and
- a stakeholders' group made up of experts in the field.

2 We set up six smaller task groups with specific responsibilities to discuss **complex needs**, best practice, training, the **mapping of services**, best-value, and children's services.

3 We carried out a major consultation to get a good understanding of:

- learning disabilities;
- the experiences people have of services;
- the demand for services; and
- what the solutions to service shortfalls might be.

4 We used a range of methods including the following.

Written views

We wrote to over 600 people and agencies inviting their views on current services and on the shape of future services.

Website (http://www.scotland.gov.uk/ldsr/)

We set up an interactive website to give and receive information about the review and to generate on-going debate. Iain Gray, Deputy Minister for Community Care, held a live session on the web to hear the concerns and hopes people have. The website contains most of the material we used.

User and carer roadshows

The user and carer group held 11 roadshows across Scotland to get a national view on what people with learning disabilities and their carers need and want.

Site visits

We visited sites across Scotland to see, at first hand, good and new, creative projects.

Meetings

We met people who used services, carers, staff and representatives from professional organisations to listen to what they felt was important now and in the future.

Conferences

We held four national conferences across the country:

- explaining the reason for and scope of the review;
- examining the best use of resources;
- discussing good practice; and
- looking at the shape of future services.

Workshops

We held four smaller workshops on:

- children's issues;
- people with **complex needs**;
- staff development; and
- a brainstorming day for all the groups involved in the review.

Research, surveys and analysis

We carried out the following research and surveys.

- A survey of people with learning disabilities and their families about social and healthcare services.
- A survey of housing solutions and a review of international literature on housing options for those with learning disabilities.
- Research on the general health needs of people with learning disabilities.

- Research on the needs of people with **profound** and **multiple disabilities**.
- Research on the needs of those with **challenging behaviour**.
- An analysis of those with learning disabilities who are held under the Mental Health (Scotland) Act 1984.
- A policy paper on public education about people with learning disabilities.
- Analysis of community care plans, health improvement plans, trust implementation plans, children's plans, Scottish Health Advisory Service reports, and relevant Social Work Services Inspectorate reports.

Adults and children

5 Our evidence and recommendations relate to services for both adults and children unless we say they are for a particular group such as older people or adolescents. Where we make recommendations relating to local authority services these should be considered by those dealing with adults ***and*** those dealing with children.

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