

Research on the Implementation of the “Rights in Mind” Resources

REID-HOWIE ASSOCIATES LTD.

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SUMMARY

A research study was carried out for the Mental Welfare Commission for Scotland¹ by Reid-Howie Associates (RHA) between January and April 2018, to examine the implementation of “Rights in Mind” materials produced by the Commission. The study was funded by a grant from the Legal Education Foundation.

The main strand of the study involved the completion of eight case studies to examine staff awareness and use of the Rights in Mind materials in ward and community settings. An analysis was also carried out of information gathered by the Commission in 2016 and 2017-18 relating to the general promotion of patients’ rights in a mental healthcare setting.

Key points

The full report presents the detailed findings of the research. The key points are summarised below.

Awareness and use of the Rights in Mind materials in a mental healthcare setting

In terms of awareness and use of the Rights in Mind materials in a mental healthcare setting, the research found that the majority of services are aware of the existence of the Rights in Mind materials (particularly in the case study locations), but that some are not, and that awareness of the Good Practice Guide is low even among the case study locations.

The Pathway document is used most often, with lower levels of usage of the guide and videos. In some locations, awareness of the initiative has been limited to those staff directly involved in the local projects.

Where the Rights in Mind materials are used, they are well-regarded by the staff, and seen as helpful, informative and effective. There is also a general view that management are positive and supportive of rights-based work.

The Rights in Mind materials have been used in the case study areas as a tool to assist in reviewing practice, and as a resource to inform the development of specific local rights-based projects.

Such specific local rights-based projects have been developed and implemented in a number of areas, to enhance existing practice and to promote work on advance statements and on improving the information provided to voluntary patients (and, in one case, their carers).

There have been a number of outputs and developments from these projects including, for example: staff training; guidance and protocols for staff; awareness raising materials for patients and carers; rights-related discussions with patients;

¹ Referred to throughout as the Commission.

amendments to processes; changes to recording and documentation; and monitoring work.

The research found evidence of a number of positive benefits from the projects, for staff, for the operation of the ward or service, and for patients and for carers. Some lessons have also been learned from these experiences, including the importance of: ownership by all relevant staff, and a team approach; review; communication; and embedding any changes in ward procedures, staff induction and training.

There has been some dissemination and sharing of good practice information from the projects to date, and a number of them intend to continue to develop their work in the future.

The research also found, however, that not all wards are aware, and there is little general evidence of the Rights in Mind materials being used outwith the case study areas.

Staff can also face a number of barriers to using the Rights in Mind materials. These generally relate to practical and operational issues (e.g. time pressures and competing priorities) but can also, in some cases, relate to a perception by individual staff members of a lack of a need for additional information.

General promotion of patients' rights in a mental healthcare setting

In terms of the general promotion of patients' rights in a mental healthcare setting, the analysis of the Commission's data showed that wards take a number of steps to ensure that individual patients understand their rights. The most common method is discussion between staff and patients, although this can also be done by support organisations and / or other workers, and the provision of written information. The same methods are used to promote advance statements.

Most patients are aware of having received information about their rights, and most are aware of their legal status. Some patients, however, are not aware of having been given information about their rights and / or lack understanding of these. Some do not know or understand their legal status, and some have not heard of advocacy services (or do not have an advocate).

Most wards have an approach in place for accessing advance statements. However, there is a low level of take-up of advance statements, and limited knowledge of these. There is limited work being undertaken to promote them, and some wards do not recognise this as part of their responsibility

The research also found that there is mixed understanding among staff of patients' rights and advance statements. Additionally, variations were identified in practice between wards in promoting and enabling these rights. There is no standard, consistent approach, nor procedure for action to ensure that: the promotion and provision of rights is undertaken in a systematic way; patients have all the information they require; and that they understand and can exercise their rights.

Suggestions for consideration

On the basis of these research findings, a number of suggestions for consideration can be made relating to awareness and use of the Rights in Mind materials and to the general promotion of patients' rights in a mental healthcare setting.

The Commission could:

- Identify ways to increase overall awareness of the initiative and further means of disseminating the materials and encouraging their use.
- Consider providing alternative formats of the existing materials.
- Widely disseminate the online learning resource currently in development.
- Consider developing new and additional materials for specific groups.

Healthcare Improvement Scotland and the Scottish Patient Safety Programme - Mental Health could:

- Continue to promote an overall NHS focus on rights and emphasise its priority.
- Consider promoting further work on patients' rights.

Health boards could:

- Encourage further local improvement projects in wards and community teams, using the Rights in Mind materials.
- Encourage wards and community teams to work together on key projects.
- Identify successful rights-based improvement projects and roll these out to enhance consistency of practice.
- Consider promoting further work on patients' rights, for example by appointing "rights champions".
- Promote advance statements, to increase take-up.

Ward managers and team leaders could:

- Enable and encourage staff to consider the Rights in Mind materials and rights-related work, promoting discussion and further learning such as the forthcoming Commission LearnPro module.
- Use the Rights in Mind materials for auditing and action planning to identify progress and potential improvements and develop plans.
- Involve staff team in the specification, development and implementation of improvement projects, to enhance ownership and impact.
- Undertake improvement projects using the Rights in Mind materials.
- Ensure that changes are properly embedded in ward procedures, and that all staff (including new and temporary staff) are implementing them.
- Encourage staff to subscribe to the Commission's mailing list.
- Consider developing rights-based projects for student nurses on placement.

SECTION 1: BACKGROUND AND CONTEXT

- 1.1 This report presents the findings of a research study carried out by Reid Howie Associates (RHA) to examine the implementation of “Rights in Mind” materials produced by the Mental Welfare Commission (MWC)². The study was part-funded by a grant from the Legal Education Foundation.
- 1.2 The fieldwork was undertaken between January and April 2018, and the case study findings presented in this report were current at that time. The report also draws on the findings of an analysis of data collected by the Commission from 2016-2018.
- 1.3 The report is in 5 sections:
 - This section provides the background to, and context for the research.
 - Section 2 presents the findings from 8 case studies carried out by RHA on awareness and use of the Rights in Mind materials in ward and community settings.
 - Section 3 summarises some key findings from the data collected by the Commission on approaches to the promotion of rights and advance statements in mental healthcare settings (with further details provided in Annex 1).
 - Section 4 summarises suggestions made by participants in the case studies about the future use of the Rights in Mind materials.
 - Section 5 presents a small number of conclusions and suggestions.
- 1.4 The remainder of this section provides brief background information about: human rights issues in a mental healthcare setting; the development of the Rights in Mind materials by the Commission; and the nature and purpose of this research.

Background

- 1.5 The protection of human rights is fundamental to all mental health services. Human rights apply equally to everyone, including those who are unwell, or who, for whatever reason, may be unable to exercise them.
- 1.6 All patients receiving mental health care have a number of overarching human rights which are applicable to all patients, whether or not they are detained or compulsorily treated under the Mental Health (Scotland) Act 2003. Individuals have human rights regardless of whether they are detained in hospital, in hospital voluntarily or receiving treatment in the community.
- 1.7 Some rights are important throughout the patient’s “journey”, while there are some key rights at specific stages. There are also some rights which are specific to those who are detained in hospital under the Mental Health (Care

² Referred to in the remainder of this report as “the Commission”.

and Treatment) Act 2003, and some rights which are specific to informal patients (i.e. those who are being treated voluntarily).

- 1.8 All public bodies, including the NHS, have a duty to ensure these rights are respected and promoted. Healthcare Improvement Scotland has made human rights integral to the Scottish Patient Safety Programme in the area of mental health³. Human rights were a key theme of the Scottish Government's Mental Health Strategy 2012-2015⁴ and the new Strategy for 2017-2027 states that "a human rights based approach is intrinsic to actions to improve mental health"⁵.

The nature of rights in mental healthcare

- 1.9 Patients accessing mental health services in hospital or in the community have a range of interlocking human rights which are underpinned by legislation. The key legislation relating to human rights in a mental health setting includes the:

- European Convention on Human Rights.
- Human Rights Act 1998.
- Scotland Act 1998.
- UN Convention of the Rights of Persons with Disabilities.
- Equality Act 2010.

- 1.10 There are also specific rights contained within the:

- Social Work (Scotland) Act 1968.
- Mental Health (Care and Treatment) (Scotland) Act 2003.
- Patient Rights (Scotland) Act 2011.
- Carers (Scotland) Act 2016.

- 1.11 The Rights in Mind pathway sets out overarching rights, and rights which apply at key stages during a patient's journey. All patients, whether in hospital or the community have the right to:

- Be treated in line with the principles of the 2003 Mental Health Act.
- Be treated in line with the Patient Rights Act Charter of Patient Rights and Responsibilities.
- Be treated with respect, dignity and compassion.
- Not be discriminated against on the ground of protected characteristics.
- Have independent advocacy services.
- NHS care which is patient-focused and encourages participation.
- Liberty, unless detained lawfully.
- Adequate healthcare for their physical and mental health needs.

³ Health Improvement Scotland (2016). *SPSP Mental Health: End of Phase Report*. Edinburgh: Health Improvement Scotland.

⁴ Scottish Government (2012) "*Mental Health Strategy for Scotland*" Edinburgh: Scottish Government.

⁵ Scottish Government (2017) *Mental Health Strategy 2017-2027* Edinburgh: Scottish Government.

- Agree how much they want family and friends to be involved in their care and support (unless there is a legitimate reason to restrict this, in which case any restriction should be the least possible).
- 1.12 The Rights in Mind pathway also sets out a number of key rights for patients at specific stages. Although these will not be presented in full in this report, the nature of these is summarised below⁶.
 - 1.13 Rights for all patients in the community include rights relating to: access to, and information about, mental health services and support; information and explanation of their diagnosis and treatment; involvement of others in their care; support to make an advance statement (discussed later) and to make choices about their care; assessment of their community care needs and services to address these.
 - 1.14 There are also a number of rights for patients in the community who are subject to the Mental Health Act 2003, and these relate to issues such as: having their advance statement choices about care and treatment followed unless there is a good reason not to; explanation of their circumstances, and explanation of appeals and conditions.
 - 1.15 When patients are being admitted to hospital, all patients have rights relating to: explanation of the reasons and what is happening; opportunity for voluntary admission; opportunity for practical preparations; clear and accessible information; access to support; and provision to meet their religious, spiritual and special dietary needs.
 - 1.16 There are also specific rights for patients being detained, and these relate to: explanation of the reasons for detention and related information; a mental health officer (MHO) to explain and safeguard their rights; a solicitor to represent them; information to their “named person”; not to be detained longer than needed; and having their advance statement choices about care and treatment followed unless there is a good reason not to.
 - 1.17 Informal hospital patients have rights relating to: being able to leave the hospital at any time; refuse medication; and apply to the Mental Health Tribunal for Scotland, if they are detained without lawful authority.
 - 1.18 When on the ward, all patients have rights relating to: the development and review of individual care plans; explanation of their treatment; freedom from unnecessary restrictions; access to activities and education; a positive therapeutic environment; voting; requesting their medical records; and support with practical and family arrangements.
 - 1.19 Detained patients have rights while on a ward which relate to: having their advance statement choices about care and treatment followed unless there is a good reason not to; accessing a second opinion; support to understand and

⁶ For further information, see “Rights in Mind: A pathway to patients’ rights in mental health services” and “Human Rights in Mental Health Services” (The Mental Welfare Commission for Scotland, 2017).

prepare for Mental Health Tribunal hearings; not to be detained, restrained, secluded or put under constant or special observations unless necessary, and not for any longer than is needed; and having access to communication, with safeguards.

- 1.20 Informal patients' rights when on the ward relate to: being able to leave the hospital at any time; refuse medication or other treatment; not to be put in seclusion against their will or to have restrictions on their communications.
- 1.21 On discharge, all patients have rights relating to: participation and involvement in discharge planning; discharge plans; assessment and meeting of their community care needs; involvement of, and support to their carer; support to make an advance statement. Informal patients, on discharge, have a right to information about how to get further care and treatment if they discharge themselves against advice.

Respecting and promoting rights in mental healthcare

- 1.22 Given the nature of these rights, it is clear that they should be central to the care and treatment of people in mental health care settings, whether in hospital or in the community. In order to ensure that rights are met, it is essential that they are understood by patients and staff, and are promoted by those involved in patient care and support.
- 1.23 The Commission has also stated, however, that it can be challenging to uphold these rights in the field of mental health care. Individuals who are accessing acute mental health services may also be less able than others to safeguard their own interests. Patients may experience a complex journey, with stages that can include hospital admission, a stay in a hospital, discharge and treatment in a community health setting.
- 1.24 Central to the focus of the Commission is a recognition of the need to ensure that the human rights of people receiving treatment and care for mental health issues are applied sensitively, appropriately and with due respect for dignity. There is a firm belief that respect for human rights can, and should:
 - Inform decision making.
 - Develop better participation for patients.
 - Foster strong working relationships.
 - Ensure that care is personalised.
- 1.25 In 2012, the Commission carried out a series of visits to all adult mental health admission wards across Scotland, during which they explored a number of human rights related issues with patients and staff⁷.
- 1.26 The findings of this work identified that patients did not always understand, feel involved in their care and treatment and were not always consulted about

⁷ The Mental Welfare Commission for Scotland (2013). *Adult acute ward visits 2012*. Edinburgh: MWC.

this. Consultation work carried out on behalf of the Commission had found that individuals did not always understand their rights (and this was true even where participants had been detained)⁸.

- 1.27 The Commission also identified inconsistencies in levels of awareness across Scotland.
- 1.28 Where information was provided, the positive impact of this was also noted, with some participants, for example, citing the importance of individual mental health practitioners on their level of knowledge, or giving examples of circumstances in which a particular positive experience had enhanced their understanding.
- 1.29 The Commission concluded from the visits that, while mental healthcare practitioners may be keen to observe and uphold patients' rights, staff and patients had a mixed understanding of patients' rights, and not enough positive action was being taken to meet the rights of patients in hospital.
- 1.30 Some staff were also unsure of what they could do to ensure that patients were aware of, and able to exercise their rights, and of how best to protect and enhance these.
- 1.31 The Commission also observed some confusion between promoting and upholding rights, and good practice, with lack of recognition of the mandatory nature of promoting and upholding rights.
- 1.32 These findings were seen to highlight the need for better information to be made available, on a more consistent basis, as well as for education for patients and carers.

The development of the Rights in Mind materials

- 1.33 Following from these findings, the Commission identified the importance of developing good practice guidance on human rights in mental health services.
- 1.34 A project group was created, which included the Mental Welfare Commission, the Scottish Human Rights Commission, the Scottish Patient Safety Programme (Mental Health) and the Royal College of Psychiatrists. The group developed a set of materials, packaged as "Rights in Mind", and designed to improve understanding of human rights issues and promote good practice.
- 1.35 These materials were published in May 2017, shortly after the publication of a report summarising the findings of the 2016 themed visits⁹.
- 1.36 The Rights in Mind resources were launched by the Minister for Mental Health, at an event in Edinburgh on 24th May 2017. The event was attended

⁸ Griesbach, D. and Gordon, J. (2013). *Individuals' Rights in Mental Health Care*. Edinburgh: MWC.

⁹ The Mental Welfare Commission for Scotland (2017a). *Adult acute themed visit report*. Edinburgh: MWC.

by 80 people, mainly staff in mental health services and mental health organisations, as well as people who use services and carers. The launch attracted good media and social media attention.

1.37 The materials were disseminated widely, including an initial distribution of 3,500 hard copies to all adult acute mental health wards and to a wide distribution list, and the creation of a new dedicated section of the Commission's website.

1.38 Commission practitioners encourage take-up of the resources during their visits to local services.

The materials

1.39 The Rights in Mind materials consist of:

- A good practice guide: "Human Rights in Mental Health Services"¹⁰.
- A summary document: "Rights in Mind: A Pathway to Patients' Rights in Mental Health Services"¹¹.
- A set of 5 videos¹².

1.40 These resources set out to empower staff to act wherever they can, and to seek further advice (from managers or the Commission) where they are unsure.

1.41 Each of the resources is described briefly below.

Good practice guide: "Human Rights in Mental Health Services"

1.42 The Good Practice Guide "Human Rights in Mental Health Services"¹³ was published in May 2017 and was made available in print and on-line versions.

1.43 The Guide was targeted at mental health professionals in both hospital and community settings, although it was recognised that it could also be used by other professionals, as well as by patients, family members or carers.

1.44 It aimed to explain how and where human rights impact on mental healthcare delivery, and how staff can best ensure that the key rights are respected and promoted at each stage of the pathway through mental healthcare.

1.45 It explains the background to human rights in mental healthcare and looks at each of the rights: from community; through admission to hospital care; time on the ward; and discharge.

¹⁰ The Mental Welfare Commission for Scotland (2017b). *Human Rights in Mental Health Services*. Edinburgh: MWC.

¹¹ The Mental Welfare Commission for Scotland (2017c). *Rights in Mind: A Pathway to Patients' Rights in Mental Health Services*. Edinburgh: MWC.

¹² Accessed from <http://www.mwscot.org.uk/rights-in-mind/> (October 2017).

¹³ Referred to as "the Guide".

1.46 The Guide was designed to be used in two complementary ways:

- As a reference guide, highlighting which rights are most relevant at which stage, and why.
- As an improvement resource for services, to help to encourage staff to reflect on their policies and practice.

1.47 It was designed to be used either as a stand-alone resource, or in conjunction with the “Pathway to Patients’ Rights in Mental Health Services” document (see below).

“Rights in Mind: A Pathway to Patients’ Rights in Mental Health Services”

1.48 The “Rights in Mind: A Pathway to Patients’ Rights in Mental Health Services”¹⁴ document was also published in May 2017, primarily as a print-based resource (although it was also made available as a PDF file for downloading from the Commission’s web site, to facilitate distribution across health board areas).

1.49 The Pathway document was designed to be used by staff at all levels, regardless of specialisation. It was intended to provide a practical, pathway-based reference, to allow them to identify quickly and accurately patients’ rights at any point on their journey through mental health services. It was also anticipated that it would help patients and their families and carers to understand their rights.

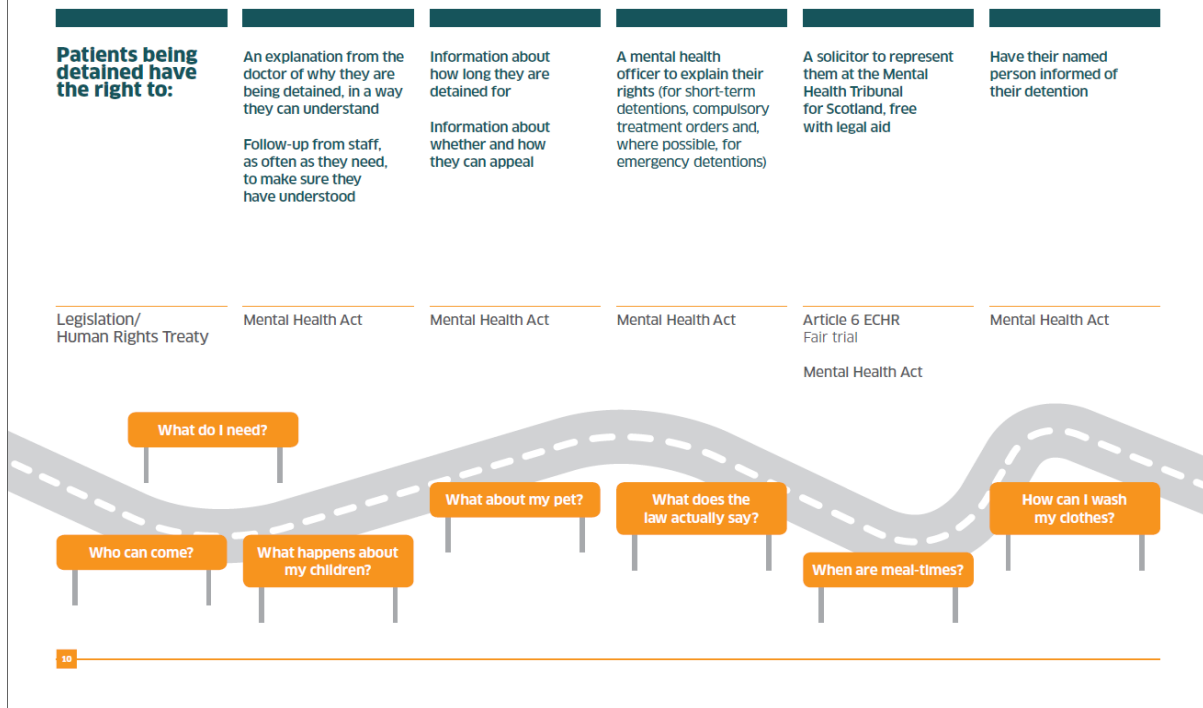
1.50 The Pathway document sets out the key human rights and legal rights which are important throughout the patient’s “journey”, as well as highlighting key rights at particular points.

1.51 The booklet was written from the perspective that staff need to know that a right exists and what it means in practice, but do not need to know its legislative basis in detail. For these reasons, the Pathway document was written in an accessible style, with a minimum of jargon.

1.52 Whereas the Guide was presented in a traditional format, the Pathway document was designed to be more visual, by adopting a visual “pathway” metaphor. For illustrative purposes, a sample page of the Pathway document is set out below:

¹⁴ Referred to as “the Pathway document”.

3. Key patients' rights when being admitted to hospital



1.53 The Pathway document was designed to be used as a stand-alone resource, although it could be used alongside the Guide (see above), or as the basis of an internet-search, should further detail be required. References were provided for each right described.

Videos

1.54 Five videos were also produced, including:

- Two describing work carried out in wards undertaking pilot work on the promotion of rights, as part of the implementation of the Rights in Mind materials.
- Two interviews with patients.
- A presentation by the Commission.

1.55 It was intended that these videos would provide a further illustration of human rights issues, and some examples of the means and impact of promoting human rights in a mental health setting.

This research

1.56 Following a pilot period in two locations, the materials were published formally in May 2017, with the intention of rolling these out across Scotland. These were distributed by the Commission to all adult acute mental health wards and to a wide distribution list including advocacy services and patient and carer organisations.

- 1.57 In late 2017, the Commission sought to undertake a research study to summarise the key issues relating to the promotion of rights, and to examine the ways in which the Rights in Mind materials were being implemented in practice.
- 1.58 As such, this research was commissioned in late 2017, and carried out by RHA, to bring together the relevant information from the Commission's previous visits to adult acute wards, and to explore early staff experiences of the implementation and use of the new Rights in Mind materials.
- 1.59 The research took place alongside a further series of visits by the Commission in 2017-18 to adult mental health admission wards. Part of the visits' remit was to examine progress across a range of human rights issues, in the light of the publication of the resources.

Methodology

- 1.60 The research had two distinct, but linked strands:
- Case study visits (8) to explore staff experiences of the implementation of the "Rights in Mind" materials in more detail.
 - Analysis of baseline and follow-up data collected by the Mental Welfare Commission as part of its visits programme from 2016-2018.

Case study visits

- 1.61 The main strand of the research was the completion of eight case study visits, carried out by RHA from January - April 2018. These included two community-based mental health teams, and six ward-based mental health teams.
- 1.62 The Commission initially asked health boards to identify wards which were carrying out specific Rights in Mind-related work. Due to a limited response, the Commission then approached individual wards to explain the purpose of the research, and to request their participation in the study. Participants self-selected and opted in to the work.
- 1.63 Visits were made to the following wards:
- Midpark Hospital, Dumfries, Ettrick Ward.
 - Midpark Hospital, Dumfries, Nithsdale Ward.
 - Woodland View Hospital, Irvine, Ward 11.
 - Wishaw General Hospital, Wishaw, Ward 1.
 - Whyteman's Brae Hospital, Kirkcaldy, Ravenscraig Ward.
 - Borders General Hospital, Melrose, Huntlyburn Ward.
- 1.64 Visits were made to the following community-based mental health teams:
- Ythan Community Mental Health Team, Aberdeenshire.
 - North Lanarkshire Community Mental Health Team, Airdrie.

- 1.65 These involved a good mix of NHS Boards, area types and patient populations. It also included both early adopters and teams which had only recently introduced the resources, with participants in various stages of implementation (as will be clear in Section 2).
- 1.66 In each case, discussions were held with those staff identified by the team as being the most relevant to the work. A total of 35 staff participated in the research. These included (with variations in number and combination between areas):
- Consultant Psychiatrists.
 - Senior Charge Nurses / Senior Nurses.
 - Staff nurses.
 - Nursing assistants.
 - Occupational therapists.
 - Psychologists.
 - Mental Health Officers / social work staff.
 - Administrative staff.
- 1.67 Participants were informed that the research was intended to explore the use of the materials to promote patients' rights, and that the material collected would be used in a publication to share good practice across the NHS and to help inform the further development of Rights in Mind and related work.
- 1.68 A large amount of detailed qualitative data was gathered from these visits, which is summarised in Sections 2 and 4.

Analysis of baseline and follow-up data

- 1.69 Alongside the case studies, data gathered by the Commission during visits to wards in 2016 and 2017-18 was analysed and summarised.
- 1.70 Baseline data was gathered by the Commission in 2016, as part of visits to 47 wards across 11 different health board areas in Scotland. The Commission gathered information from the ward staff and reviewed the care of 323 patients, most of whom (88%) were spoken with in person.
- 1.71 This dataset (and the specific questions relating to enabling patients to understand their rights; and advance statements) was analysed in detail to provide contextual information about the promotion of rights in a ward setting. It also helped inform the case studies.
- 1.72 Further data gathered by the Commission in 2017-18 was also analysed in detail. This involved ward information from 10 visits, as well as information from 67 individuals in 19 hospitals (26 wards).
- 1.73 RHA analysed the information from the ward staff, while the Commission analysed the information from individuals and passed the key findings to RHA for inclusion in this report.

- 1.74 Emergent themes were identified from both datasets (2016 and 2017-18). It was not possible to compare the two directly, as the follow-up visits involved a small subset (7) of the 2016 wards and 3 new wards; and different individual patients. The combined data, however, provided valuable information which can be used to assist the Commission in identifying developments to rights-based work in the future.
- 1.75 Section 3 summarises the findings from this strand of the research, with further details given in Annex 1.

Analysis and presentation of the findings

- 1.76 The case study findings were analysed qualitatively, exploring and comparing experiences in relation to each of the following themes:
- Awareness of the materials.
 - Views of the materials.
 - Use of the materials.
 - Benefits of the materials.
 - Key lessons arising from local projects.
- 1.77 The visits data provided by the Commission was also analysed qualitatively by individual question. This involved, for each question:
- Creation of a document from the data provided at each stage, showing: the ward code and identifier number; and the response to the question, with a separate row for each respondent.
 - Working systematically through the detailed comments made by staff at each question to identify themes and sub-themes and detailed points made within these themes.
 - Summarising the qualitative information to provide an indication of the range and depth of views.
- 1.78 The qualitative nature of the analysis is reflected in the presentation of the findings. Although numbers and proportions are given in relation to some of the data, this is with the proviso that these are indicative rather than definitive, for the following reasons:
- Some of the points made overlapped more than one theme.
 - The focus of the analysis was on the identification of the range and detail of views, rather than a “weighing” of responses.
 - There was a need for subjective judgement about where to include some of the material.
- 1.79 In the presentation of the findings in Sections 2-4, the terms “Rights in Mind initiative”, “Rights in Mind materials” or “the initiative” are taken to encompass all of the Rights in Mind materials. Where reference is made to “local projects” this relates to work undertaken by ward or community teams as part of the Rights in Mind initiative. The “location” refers to the ward or community-based team which participated in the fieldwork.

- 1.80 The general term “participant” refers to anyone who took part in the research. Patients who took part in the Commission’s visits are referred to as “patients” or “individuals” as distinct from “wards” or “ward respondents” (i.e. the staff involved).
- 1.81 In presenting the findings of some of the case studies, a job title has been used, in order to further illuminate a point, where appropriate.
- 1.82 The remainder of the report presents the findings and suggestions arising from the research. Section 2 focuses on the findings from the case studies.

SECTION 2: AWARENESS AND USE OF THE RIGHTS IN MIND MATERIALS

- 2.1 This section presents the findings relating to eight case studies which were carried out in ward and community settings to examine staff awareness and use of the Research in Mind materials. Each case study involved a local project¹⁵ which had been developed to promote patients' rights.
- 2.2 Each case study explored: participants' overall awareness of the materials; views of the materials; the ways in which the materials were used; the benefits arising from their use; the ways in which good practice was disseminated; and the key lessons to date from the experiences of the case study participants.

Awareness of the Rights in Mind materials

- 2.3 Overall, the case studies identified a high level of awareness of the Rights in Mind initiative in these locations. In more than half of the case study areas (5), Senior Charge Nurses (SCN) or team leader indicated that all staff were likely to be aware of the initiative.
- 2.4 It was also found that, in four of these locations, SCNs or team leader had included consideration of the initiative (either as a one-off or standing item) in team meetings, mostly through a focus on a specific local project.
- 2.5 In the remaining locations (3), it was suggested that only those staff working on the local project would be likely to be aware of the initiative. In each of these locations, it was planned that, once the local project had become embedded, other staff would be made aware of the initiative.
- 2.6 While overall awareness of the Rights in Mind initiative was relatively high, however, awareness of the individual resources was found to be more variable.
- 2.7 At each study location, at least some of the staff involved were aware of the Pathway document (and, as will be set out later, the Pathway document was being used in all bar one of the local projects).
- 2.8 Only three participants, however, had read some (or all) of the Good Practice Guide, and two had used it while reviewing aspects of their practice. In half of the locations (4), staff were unaware of the Guide. Staff were aware of the videos in just over half (5) of the locations, and staff in three had viewed them.
- 2.9 One participant suggested that it was disappointing that more of the staff in their setting were not aware of the Rights in Mind initiative and the resources available, given their strong commitment to patients' rights.

¹⁵ In the case of one ward (in Whyteman's Brae Hospital), there were two strands to the project, but these are described as one project overall.

Finding out about the Rights in Mind materials

- 2.10 The research found that staff had found out about the Rights in Mind initiative in a variety of ways.
- 2.11 In two of the locations, staff had been invited by the Mental Welfare Commission to design and run pilot projects. In two further locations, staff had attended the launch of the Rights in Mind initiative.
- 2.12 In the remaining locations, the SCN or team leader had been given the Pathway document by senior management (and although supplies of the pathway document and a copy of the Good Practice Guide were posted to every adult acute ward at the time of the launch in May 2017, none of these staff had been aware of the initiative, nor its launch, previously).
- 2.13 In all locations, it was found that the staff had access to at least one paper copy of the Pathway document. In two locations, it was available in multiple copies and displayed on the ward. Staff in two further locations had downloaded a PDF file of the Pathway document from the Commission's website and had printed this for colleagues.
- 2.14 Among the staff who reported having access to the Guide (4 locations), all had a paper copy. In one location, staff also noted that they had accessed the Guide on-line (and, in another location, the SCN "assumed" that other staff would have accessed the Guide on-line, but could not confirm this).
- 2.15 Where staff reported having viewed at least one of the videos (3 locations) they had accessed these via the Commission website. More generally, staff in all but one of the locations reported that they were aware of the Commission website and the existence of on-line resources.

Views of the Rights in Mind materials

- 2.16 Among those who had used the Pathway document, views were generally positive. There was a consensus that it was well-written and easy to use. One participant noted that staff in their location had been "very positive" about the approach. Several noted that the visual metaphor of a "pathway" and the overall layout had been effective. Another indicated that the "snapshots" were useful, and provided an appropriate level of information.
- 2.17 A small number of participants indicated that they had subsequently carried out an internet search to obtain further information, but this had been to supplement the material in the document. None expressed a view that the document itself should have contained additional information.
- 2.18 In relation to the Guide, as noted earlier, while few participants had seen or used this, those who had were very positive about it, describing it as well-written and helpful. It was also suggested that it enabled staff to obtain information about specific issues of relevance to their particular requirements. As one noted, for example:

“... the document is structured to follow a typical patient’s journey – that’s helpful. It makes ‘dipping-in’ easier.”

2.19 Among the small number of staff who had seen the videos, there was again a consensus that they had been helpful and informative.

Accessibility and potential barriers

2.20 All of the participants were content that the materials themselves (where they had used them) were accessible and easy to understand.

2.21 Staff in all locations indicated that their management were positive about the promotion of rights issues, and both senior and operational managers were considered likely to be supportive of staff who wished to explore the Rights in Mind materials and their relevance to professional practice.

2.22 Participants in most locations, however, acknowledged that there were some practical, perceptual and operational barriers to using the materials. The main barriers identified were:

- Time pressures.
- Competing demands on staff.
- Limited opportunities for training and personal development.
- Limited time for reflective practice.

2.23 One participant said that an email about the Rights in Mind materials had been in a “to do” section of their inbox for nearly a year, but had not reached a sufficiently high level of priority to be actioned.

2.24 In addition to these time pressures, participants in two locations suggested there could be some perceptual barriers to using the materials. A few stated that some staff may not feel they needed this, as they already considered their rights-related practice to be sound, and to conform to the standards set out in the Guide. It was suggested that such staff may see no “added value” in the materials.

2.25 Another participant suggested that more could have been done to emphasise the modular nature of the Guide, noting that:

“I was initially put off by it. I think a lot of hard-pressed staff wouldn’t read any of it because they would assume it wasn’t relevant to them.”

2.26 A small number of participants reported a perceived lack of current focus on rights-related issues (either directly or indirectly) within the NHS, and said that this may make it less likely that staff would choose to use the Rights in Mind materials. One noted that staff tended to focus on aspects of practice for which they were held accountable, or which formed part of performance measures.

Use of the Rights in Mind materials

2.27 The research found that the staff involved in the case studies had used the Rights in Mind materials in two main ways: to review practice; and to inform a series of specific local projects.

Reviewing practice using the Rights in Mind materials

- 2.28 Staff in just over half of the case study locations (5) indicated that the Rights in mind materials had been used as a means of reviewing practice. In most of these locations (4), the Pathway document had been used, while in the other location, both the Guide and Pathway documents had been used.
- 2.29 In three of the locations where the materials had been used in this way (i.e. to review aspects of practice), all the staff in these locations had been encouraged to do so. In the other two locations, individual staff had been delegated to review aspects of practice, in each case with a view to helping to identify and define a local rights-based project (and these projects are described in more detail below).
- 2.30 Respondents in two of the locations where the materials were used also indicated that the Pathway document had been made available to be used as an ongoing reference tool. In both these cases, staff indicated that the document had been used by patients, as well as staff. In two further locations, participants suggested that the materials had been circulated as a means of drawing attention to rights issues.
- 2.31 In two locations, participants suggested that it was intended that, in the future, staff would be encouraged to use the materials to review practice.
- 2.32 Respondents in one location indicated that, while they had reviewed rights-based practice, they had not used the Rights in Mind materials at the start, as the development of their local project had pre-dated the Rights in Mind launch.

Developing local rights-based projects

- 2.33 In seven of the eight case study locations, participants provided details of specific local rights-based projects which were ongoing, or at an advanced stage of preparation.
- 2.34 In the other location (Ythan Community Mental Health Team), participants reported that it was intended that a local project would be undertaken in the future, but that its development had not yet started. They did, however, comment on the ways in which the Rights in Mind initiative might inform this, as well as providing suggestions about how the materials might be used to support such a rights-based project (see Section 4).
- 2.35 Among the projects identified, two focused on advance statements, and the work undertaken, at the time of the research, was found to have been as follows:
- Ward 1 at Wishaw General Hospital had taken a number of actions to raise awareness of advance statements.
 - North Lanarkshire CMHT was carrying out an information gathering exercise on awareness and take-up of advance statements, with a view to developing new material for staff and patients.

2.36 Four of the projects focused on improving the information provided to men and women on their admission to hospital as voluntary patients. The work undertaken, at the time of the research, was found to have been as follows:

- Ettrick Ward at Midpark Hospital had developed a new protocol to stimulate conversations between staff and patients on rights issues.
- Nithsdale Ward at Midpark Hospital had adapted the same protocol (developed in Ettrick Ward) for use with older, vulnerable patients.
- Ward 11 at Woodland View Hospital had implemented an admission and information-giving protocol for informal patients (different to the approaches taken by the wards at Midpark Hospital).
- Ravenscraig Ward at Whyteman's Brae Hospital was in the process of implementing a new admission protocol for informal patients.

2.37 One project (Huntlyburn Ward at Borders General Hospital) had reviewed information given to patients and carers on admission, and had revised this to strengthen coverage of both rights issues and advance statements.

Identifying the need for the projects

2.38 In all locations, it was noted that the wards and community teams involved in the projects had been made aware of the potential for carrying out development work relating to patients' rights by others.

2.39 In two cases (Wishaw Ward 1 and Midpark Ettrick Ward), the initial stimulus had come from the Mental Welfare Commission. In the other cases, the stimulus for the work had come from local health board managers who had been alerted by the Commission to the materials, and the potential for carrying out development projects.

2.40 Participants in two locations noted that they had been influenced in their decision to carry out a local project by the presentations made at the launch of the Rights in Mind materials in 2017.

2.41 Participants in all locations reported that the final decision about whether or not to undertake a local project had rested with the relevant SCN or team leader.

2.42 In all cases, the specific nature of the project had been decided by the ward or community team, taking account of local requirements and circumstances. In one location, for example, participants reported that they had initially considered carrying out a project on advance statements, but had decided against this, as there had been on-going discussions within the health board about wider policy issues. As a result, they had changed the focus of the project.

2.43 Participants in all locations stressed that none of the local projects had been developed in response to any concern about the ways in which they promoted or enabled patients' rights. Instead, they had been undertaken as a means of developing and enhancing existing practice.

2.44 The Commission played no direct role in the development or implementation of any of the projects, other than through the provision of materials on request, or through responding to a small number of queries.

Delivery arrangements

2.45 Each location was found to have taken a slightly different approach to the delivery of the local projects.

2.46 The project undertaken in Ward 1 at Wishaw General Hospital was led by the SCN, but much of the information gathering and implementation work was delegated to a small group of staff. A Patients' Information Group, developed as part of the project (and described further below), was led by a voluntary sector worker, supported by a nursing assistant.

2.47 The project undertaken in Etrick Ward at Midpark Hospital was led by the SCN and involved a variety of staff. For example, the information gathering with patients was undertaken by a senior mental health support worker, and the design of the process and paperwork was taken forward by a group of nursing staff at various grades.

2.48 The project undertaken in Ward 11 at Woodland View Hospital was led by the Deputy Charge Nurse and was designed and rolled out via weekly team meetings, in order to ensure that all of the staff were aware of the work and able to contribute to it as it progressed. This approach was also taken when reviewing the implementation of the project.

2.49 The project undertaken in Nithsdale Ward at Midpark Hospital was overseen by the SCN and taken forward by an implementation group of nursing staff at various levels as a development project. This group then engaged with all staff and patients on the ward.

2.50 The projects in Ravenscraig Ward at Whyteman's Brae Hospital were undertaken by the SCN, with the involvement of all of the other staff on the ward.

2.51 The project undertaken in Huntlyburn Ward at Borders General Hospital was taken forward by a Charge Nurse, with input from other staff.

2.52 The project undertaken in the North Lanarkshire Airdrie CMHT was overseen by the team leader, while the scoping element (which is expected to be a precursor to developing a local project on advance statements) was being taken forward by a community psychiatric nurse.

2.53 As noted earlier, at the time of the research, the Ythan CMHT was at an early stage in considering how to take forward a local project, and no decisions had been taken on the means of delivering this.

Information gathering to underpin the projects

- 2.54 Five locations reported undertaking specific information gathering, either before embarking on their local project, or as part of its implementation. The nature of this is described below.
- 2.55 In Ward 1 at Wishaw General Hospital, a staff member was asked to have conversations with patients, to determine their level of awareness of advance statements. They were also asked to examine patients' files to identify how many had advance statements in place.
- 2.56 These conversations identified that awareness of advance statements was mixed, with patients who had had several spells as an in-patient found to be more likely to be aware of these statements than other patients. The conversations also identified that take-up of advance statements was low (a finding consistent with issues raised in the findings of the Commission's visits, as will be described in Section 3).
- 2.57 Staff from the Ettrick Ward at Midpark Hospital carried out a scoping exercise on patients' rights. This was undertaken in two phases:
- A facilitated discussion with staff, to identify the key rights they felt should be included within the local project.
 - A series of interviews and group discussions with patients, to determine their level of awareness of their own rights.
- 2.58 The scoping exercise also found variations in patients' awareness of their rights, although this was not directly correlated with the number of times they had been admitted as an in-patient. It was also found that, for some patients, their information was not obtained from the staff and, as one staff member stated, this could lead to inaccuracies. For example:
- "It's other patients, not staff, who are sometimes the main source of information about rights. We can't know if the information patients are being given is right or not."*
- 2.59 At the same time, staff carried out a review of the availability of information for voluntary patients. This research identified that, although the ward had a welcome pack, there was little rights-related information provided.
- 2.60 It was also noted that staff had not been given any specific guidance about how to respect and promote patients' rights, and there was a lack of documentation to allow any check to be made of whether staff had discussed rights-related issues with patients.
- 2.61 Staff in the Nithsdale Ward at Midpark Hospital were given the materials prepared by Ettrick Ward, and, rather than use these directly, chose to carry out their own initial scoping exercise with their client group (vulnerable elderly patients).
- 2.62 A small sub-group of staff used a standard pro-forma to explore patients' awareness of their rights. Overall, the research found a higher level than expected, although there were some individuals with a low level of

awareness. The sub-group also met individually with other members of the staff group to discuss the best means of implementing a local project, and, at a later stage, all the staff were invited to contribute to, and comment on, all of the materials prepared for the project.

- 2.63 Staff in the Ravenscraig Ward at Whyteman's Brae Hospital reviewed admission materials from throughout the NHS (including those developed in the Ettrick Ward, as mentioned above) and incorporated these into the design of a new process (which it was anticipated would be implemented from Spring 2018).
- 2.64 In the final example of information gathering to inform a local project, the team leader of the North Lanarkshire Airdrie CMHT had become aware of a low level of take-up of advance statements among its client group. A member of staff was tasked with using the Rights in Mind Guide, as well as other material on advance statements, to develop a questionnaire for circulation to all members of the team.
- 2.65 The questionnaire explored issues including: levels of awareness, levels of use and barriers to use of advance statements. At the time of the case study fieldwork, the questionnaire had been circulated to team members, with a high level of response expected. It was intended that the analysis of the findings would inform the project in the future.

Outputs of the local projects

- 2.66 At the time of the case studies, six of the local projects were found to be sufficiently far advanced to allow the identification of outputs to address key objectives (described below).
- 2.67 In Ward 1 at Wishaw General Hospital, the following actions had been taken to increase the take up of advance statements:
- Provision of awareness training for staff about advance statements.
 - Development of an information leaflet for patients.
 - Development and display of a poster in the ward and public areas of the hospital.
 - Set up of a stall in the hospital atrium to promote advance statements.
 - Establishment of a 40-minute weekly group, where patients were given: a presentation on advance statements; a copy of the information leaflet; and the opportunity to raise any questions.
 - Addition of the consideration of developing an advance statement to the protocol which guides discharge planning.
- 2.68 In the Ettrick ward at Midpark Hospital, the following actions had been taken to improve the transmission of patients' rights-related information on admission and at a change of status to informal:
- Preparation and dissemination of guidance to staff on ensuring that all voluntary patients are made aware of their rights within a few days of admission.

- Development of a list of rights seen to be essential on admission (following consultation with staff and patients).
- Creation of a guide to support staff in engaging with patients, and to encourage them to cover each of the key rights in conversation (rather than, for example, by providing a leaflet).
- Introduction of a requirement, in the conversation guide, for staff to note whether, in their view, the patient has understood the conversation (and, if not, the provision of encouragement to revisit this until this is the case).
- Development of a protocol to ensure that the conversation guide would be completed should a patient's status change to informal at any point.

2.69 In Ward 11 at Woodland View Hospital, the following actions had been taken to improve the transmission of patients' rights-related information in the period immediately following admission:

- Preparation of guidance to staff to encourage them to engage with patients on a face-to-face basis to ensure that they understand their rights.
- Provision of the Pathway document to all staff, with encouragement to familiarise themselves with its contents (although staff noted that they had been familiar with the underlying issues prior to this).
- Introduction of a requirement to document any instances where staff had any concern that a patient did not, or could not understand any of their rights, and to return to the conversation once they considered the patient to be sufficiently well.
- Use of text fields within the patients' records system to allow staff to document conversations with patients about rights issues.
- Development of a protocol to allow all staff to input to the same record, to ensure consistency (e.g. across shifts, specialisms, or in the event of sickness or holidays) and to ensure that all information about a patient was up to date, and visible to all of those who need to access it.
- Provision to patients of a summary of rights-based information (which is kept in their room).
- Implementation of changes to increase the visibility of information about who is responsible for a patient's care at a given time (e.g. when their named nurse is not on the ward).
- Encouragement to staff to review information recorded by patients on their "what's important to me" boards regularly.
- Updating of a range of rights-based information contained in folders in each room, and displayed on TV screens in communal areas (which had originally been prepared when Woodland View opened in 2013).
- Preparation of a basic information pack for carers, setting out the rights of the patient and the carer, and describing some of the issues which would be addressed by staff in the period following admission.

2.70 In the Nithsdale Ward at Midpark Hospital, the following actions had been taken to improve the transmission of patients' rights-related information on admission:

- Assessment and adaptation of the conversation guide developed in Etrick Ward for use with a vulnerable elderly client group (some of whom had significant cognitive impairments) while covering the same basic rights.
- Provision of guidance to staff in the use of the conversation guide and how to ensure that patients understand their rights, with encouragement to go back to patients “as often as necessary” until this is clear.
- Roll-out and monitoring (by the SCN) of the new process for all new admissions, and communication of the findings to staff via the implementation group at team meetings. At the time of the case study, the process had been in place for around three months.

2.71 In the Ravenscraig Ward at Whyteman’s Brae Hospital, actions had been taken through two strands of a local project to improve the consistency of information provided to patients being admitted to the ward on a voluntary basis. The key actions that had been taken in the first strand were:

- Preparation of a “welcome” pack for all patients, with specific information for voluntary patients (including relevant domestic information such as visiting times, how to get to meals etc. and also information on rights).
- Provision of guidance to staff on going through the pack with new admissions on a face to face basis, before leaving it in the patient’s room (with this process put in place for all admissions, but having a particular emphasis on emergency out-of-hours admissions, and men or women who were unwell or disorientated).

2.72 The key actions that had been taken in the second strand were:

- Review of the procedures in the ward relating to voluntary admissions (again, with a particular focus on out-of-hours or emergency admissions) while recognising that that the welcome pack had improved the flow of information to patients.
- Design of a new process, incorporating a new checklist for informal patients, including elements gleaned from other examples across the NHS and with a section on patients’ rights relating to time out.
- Amendment of a health-board wide form, as well as small changes to recording systems, to make the new checklist compatible with an existing checklist used to monitor admission procedures for detained patients. (At the time of the fieldwork, the changes were being actioned centrally by Fife Health Board.)
- Development of guidance to staff on the need for face to face engagement with staff to take patients through the checklist, and to return to any issues the patient does not appear to have understood.
- Provision of space in the adapted checklist for staff to record any concerns about whether a patient has understood their rights, and to update this in the light of additional conversations.

2.73 In the Huntlyburn Ward at Borders General Hospital, the following actions had been taken to improve information for patients and carers:

- Review of existing materials for patients and carers in the light of the Pathway document.
- Changes to the Patient Information booklet to include a section on advance statements.
- Creation of a booklet entitled “Your Rights as an Informal Patient”, with information from the Pathway document.
- Changes to the booklet “Information for Carers and Relatives”.

Future plans

- 2.74 Participants in each of the six locations where the local projects were at the stage of identifying outputs (above) were also able to identify further actions they intended to take in relation to their local project in the future.
- 2.75 In Ward 1 at Wishaw General Hospital, for example, participants indicated that they intended to monitor the impact of the project over a period of 6 months to a year. It was suggested that this would enable them to identify whether the introduction of the group had had any impact in raising the number of advance statements created, either in the ward, or in the community. Staff also indicated that they would work with CMHTs to try to bring standardisation to the process of developing advance statements, and, potentially, undertake joint promotion of these.
- 2.76 In both the Ettrick and Nithsdale Wards at Midpark Hospital, as well as in Ward 11 at Woodland View Hospital, participants noted that the SCNs would continue to monitor the implementation of their local projects, and make any amendments necessary in the light of this. Staff at the two wards at Midpark Hospital noted that they were looking at ways of providing patients with some record of the rights-based conversations, to encourage them either to refer back to this, or to ask further questions.
- 2.77 Participants at Ravenscraig Ward at Whyteman's Brae Hospital noted that their second local project would be monitored as it was implemented, with any amendments being made, as necessary.
- 2.78 In the Huntlyburn Ward at Borders General Hospital, participants stated that they would continue to use the materials to review practice, and to engage other staff in the review processes.

Benefits of the Rights in Mind initiative and local projects

- 2.79 It was clear from the information gathered and the views expressed in the case studies that there were a number of benefits from the Rights in Mind initiative and the implementation of the local rights-based projects. The projects were seen to have brought benefits for four main areas: the staff; the operation of the ward; patients; and carers.

Benefits to staff

- 2.80 Participants in most of the case study locations indicated that staff now had a better understanding either of patients' rights in general, or about specific rights.
- 2.81 Several specific examples of increased understanding were given, including that:
- In Ward 1 at Wishaw General Hospital, nursing staff (who had been aware of advance statements before the project) reported that they were now better able to provide information and advice to patients about, for

example, the difference between an advance statement and a Personal Statement. Non-nursing staff were also seen to have an increased awareness of advance statements.

- In Ettrick Ward at Midpark Hospital, the project led staff to challenge their assumption that informal patients would have a clear idea of what their status meant in practice. They noted that they had a much clearer understanding of the information required by informal patients.
- In Nithsdale Ward at Midpark Hospital, staff reported feeling “empowered” by the focus on rights, and noted that they had identified other areas in which patients could exercise rights, if made aware of them. (Suggestions about these areas have been included in Section 4.)

2.82 In one location, while the SCN did not identify any specific changes as a result of the project per se, the nurses themselves believed that their awareness had improved, and one stated, for example, that:

“I think my awareness of patients’ rights has increased, and I know my practice has benefitted from the standardised procedures we’ve introduced.”

2.83 It was also suggested, in a few locations, that the process of documenting conversations on rights was providing an auditable record that patients had been informed of their rights. This was seen to give staff increased protection in the event of a legal challenge. Several participants stressed the importance of this, and the danger of a lack of recorded information, stating, for example, that:

“If it’s not written down, it didn’t happen”.

2.84 In a number of locations, participants also identified that the staff were now more confident in using rights-related terminology.

Benefits to the operation of the ward

2.85 Participants in a number of locations suggested that the main benefit to the operation of the ward had been the standardisation of processes. One participant described the improvement in the following terms:

“Now we’re really well-organised. In the past, we were a bit haphazard in comparison.”

2.86 Some participants identified that the implementation of standard documentation had made it easier for care teams to ensure that all the necessary issues had been dealt with.

2.87 One noted that patients, in their first 72 hours, would be likely to interact with several staff (across different specialisations and at different grades), in addition to their named nurse. It was suggested that having shared documentation meant that all of those involved had a simple way of knowing at any time which issues had been covered, and which were outstanding.

2.88 It was also noted that this was likely to be helpful to the patient's named nurse. One noted, for example, that:

"When I come back on shift, even if I've been away for 24 hours, I only need to look in one place and I can see everything that's happened."

2.89 It was also suggested that, where a ward may have as many as 30 staff, the single approach, supported by uniform documentation, made information sharing easier and improved consistency. A number of participants also highlighted the fact (mentioned previously) that it made the processes auditable.

2.90 One participant suggested that the introduction of common processes had changed staff practice, placing a requirement on them to talk with patients about rights, and to frame conversations in these terms.

2.91 Participants in two areas also suggested that the focus on rights had led to increased interest in the issue among both patients and staff. Although no specific examples were offered, staff believed that patients had been more proactive in raising rights-based issues, or in bringing these to patients' forums.

Benefits to patients

2.92 Participants in all of the case studies suggested that it was too soon to say definitively that the patients had experienced tangible benefits from any of the projects. Some also mentioned that these projects were small scale, and that this should be borne in mind in assessing any potential patient benefits. With these provisos in mind, however, there were a number of areas in which perceived benefits to patients were identified.

2.93 Overall, the most common benefit identified was that patients should be more aware of their rights than before. Clear examples of this were seen to be the introduction of new processes (in 4 wards) to improve information to patients who were admitted (particularly if someone was admitted when particularly unwell, or out of hours, or if they had had some form of cognitive impairment). It was suggested that, although their rights would have been respected in the past, they may not have been explained fully, and the projects had made this more likely to happen.

2.94 Some staff noted that patients may now understand better that some staff actions were based on implementing the patient's actual rights, rather than simply reflecting good practice. Additionally, some expressed the view that the way in which staff now spoke about rights-based issues had impacted on this. As one stated, for example:

"In the past, I might've said 'if you want to, you can ...', whereas now, I would say 'it is your right to ...'"

2.95 Staff in two locations suggested that they had the impression (without statistical evidence) that patients were raising more right-based issues, either

with their care team / named nurse, or through patients' forums (mentioned above).

2.96 Participants in one location noted that the local project, although nominally addressing the rights of voluntary patients, also appeared to be benefiting detained patients. Staff noted that the ways in which detained patients were provided with information on admission had also been revised to make the information more visible, and to encourage more interaction about rights between named nurses and patients.

Benefits to carers

2.97 Participants also identified some benefits to carers arising from the Rights in Mind initiative and the local projects, including that:

- Direct information provided to carers had been improved and could be used to explain to carers the steps that had been taken to inform their family member of their rights.
- The focus on patients' rights relating to the involvement of family members in their care would help to clarify a number of potential areas of misunderstanding.
- Family members would now be much more familiar with the fact of advance statements, and how these could be created.

2.98 Participants also suggested that a local project had helped to highlight to staff that there were variations in carers' awareness of patients' rights. As one noted, for example:

"Their [carers'] knowledge of patients' rights goes from encyclopaedic to zero. If we focus on ensuring patients understand their rights, it could take pressure off carers to deliver this information."

2.99 As will be set out in Section 4, a number of suggestions were also made about ways to enhance the benefits to carers in the future.

Review, dissemination and sharing of good practice

2.100 The research found that local projects were at varying stages in their development, and that there was also variation in the extent to which there had been review, dissemination or sharing of good practice.

2.101 The two sites initially encouraged by the Mental Welfare Commission to undertake projects (Wishaw Ward 1 and Midpark Ettrick Ward) had undertaken the most dissemination and sharing of good practice. Staff in other locations were seen to have undertaken this to a level broadly commensurate with the maturity of their local project.

2.102 Among the different means identified for disseminating and sharing good practice information were:

- Presentations at the national launch of Rights in Mind.

- Provision of case studies for inclusion in the Rights in Mind materials.
- Presentations to local quality-focused groups.
- Presentations to SCN/Band 7 forums.
- Presentations to patient group-related forums.

2.103 The research also found that there had been a significant amount of information sharing between the different locations which had undertaken, or which were considering undertaking right-related projects. The clearest example of this (set out earlier) was the adaptation of procedures developed at Midpark Ettrick Ward by Midpark Nithsdale Ward. Evidence was also found, however, of informal contacts between staff carrying out local projects in a number of other locations.

2.104 A small number of participants suggested that their local projects were, in effect, “pilot projects” which, if successful, would be adopted in similar settings throughout their health board area.

Key lessons

2.105 A number of participants identified specific lessons which, in their view, had been learned from the planning and implementation of the local improvement projects.

Ownership

2.106 Participants in a number of locations suggested that a key lesson in implementing their local project had been the importance of developing a sense of ownership among staff at all levels (reflecting the fact that any staff member could interact with a patient at any time).

2.107 A further, related lesson identified was the value of taking a team approach to specifying and developing a project. It was suggested that this was more likely to make project implementation trouble-free, and to be more effective in bringing about sustained change in the longer term.

2.108 One participant also suggested that, by involving staff in the specification, development and implementation of the project, they had become, in effect, “project champions”. This was seen to be beneficial in terms, for example, of maintaining the momentum of the project in the future.

2.109 Staff also suggested that the involvement of, and engagement with a wide range of staff had made the projects more effective and comprehensive (e.g. in identifying the rights issues to be included in information packs, or in identifying potential barriers to the take-up of advance statements).

Review

2.110 A further key lesson identified was the importance of the review of projects as they were developed and implemented.

2.111 A number of SCN / team leader participants noted, for example, that a key element of their role had been to ensure that the changes were being actioned consistently by all staff. A number provided examples of having undertaken weekly, fortnightly or monthly checks of compliance with new systems. This was seen to have provided oversight of the effectiveness of the implementation process.

2.112 Participants also identified the benefits of implementing change for a designated period, then carrying out a specific review. One example was provided of such a review having identified small changes to paperwork which could remove blockages in relation to the overall process.

Communications

2.113 Another key lesson, highlighted in a number of locations, was the importance of communication about rights issues, or specifically about the implementation of a local project.

2.114 One example was provided in which making this a standing item for ward meetings was seen to have maintained a focus on the project, as well as encouraging staff to speak informally about any issues they may be facing.

2.115 Participants in some locations also stressed the need to inform patients about the local project, and the reasons for its implementation, in order to increase their understanding of the work and maximise the benefits to them.

2.116 More generally, participants in one location stated that the key lesson from their own local project had been the need to ensure dialogue between patients and staff on rights issues.

Embedding the changes

2.117 A further lesson, identified by participants in two locations, was the importance of ensuring that all of the changes were properly embedded in ward procedures, and that all new staff (including temporary staff) were provided with appropriate induction and, if necessary, training.

2.118 It was suggested that this was vital to ensure continuity of the work in the longer term, and to make it more likely that the positive outcomes would be sustained.

Overview

2.119 It is clear that there have been a number of positive developments to rights-based work in the case study areas, with the Rights in Mind materials having helped to inform the development of a range of local projects.

2.120 A number of suggestions were also made by participants in the course of the case studies about further work that could be undertaken in relation to the Rights in Mind materials.

2.121 These will be presented Section 4, along with more general suggestions about the promotion of patients' rights in a mental healthcare setting, following a brief summary of the findings from the Commission's visits in 2016 and 2017-18 in Section 3.

SECTION 3: THE PROMOTION OF RIGHTS

- 3.1 This section presents a summary of the findings relating to the ways in which rights are respected and promoted in a ward setting, and some issues and problems with ensuring that rights are met, as identified through the Commission's 2016 and 2017-18 visits. Further details are provided in Annex 1.

Ensuring that patients understand their rights

- 3.2 One of the key aspects of respecting and promoting patients' rights involves ensuring that patients are aware of, and that they understand these rights. Approaches to this were explored specifically in the Commission's visits.

Methods used

- 3.3 The Commission found three main methods used to ensure that patients were aware of and understood their rights. These were through: discussion with staff; the involvement of support organisations and / or other workers; and the provision of written information.
- 3.4 The most common way was through discussion with staff (usually between nursing staff and individual patients, but sometimes involving the Responsible Medical Officer [RMO], doctor or both). Discussion with staff was mentioned by almost all of the wards involved in the 2016 visits (91%)¹⁶ and in the 2017/18 visits (90%).
- 3.5 Just under half of the wards visited in 2016 (45%), and half of those visited in 2017-18, mentioned specific procedures or stages at which rights would be explained to patients, and the most common was on admission. Just under a fifth of wards visited in 2016 identified that they would review or revisit the explanation and discussion of rights with patients (e.g. as part of ongoing discussions, or as part of assessment and review).
- 3.6 A further common means of ensuring that patients understood their rights, mentioned by just under two thirds (64%) of wards visited in 2016, just under two thirds (70%) of wards visited in 2017-18, and by individual patients, was through the involvement of support organisations or workers.
- 3.7 The most common type of other organisation or worker, identified by just over half (57%) of all wards visited in 2016 and a similar proportion (60%) in 2017-18, was the involvement of advocacy support. Just over a third (38%) of individuals who participated in the Commission's 2016 visits, and 42% of those in 2017-18, had an independent advocate and, where this was the case, a number of positive comments were made about this support.

¹⁶ As mentioned in Section 1, the percentages should be taken to be "around" the figure given in each case, rather than fixed numbers.

- 3.8 Other organisations or workers were also involved. Just under a fifth (19%) of the wards visited in 2016 mentioned the involvement of legal organisations and services; and a similar proportion mentioned the involvement of the Mental Health Officer (MHO). A small number of other organisations or workers were also highlighted (e.g. the Mental Welfare Commission; the Citizens Advice Bureaux (CABx); peer supporters; and family members or others).
- 3.9 The third main method of ensuring that patients could understand their rights, was through written information. Among wards visited in 2016, 43% identified using this method, as well as two of those visited in 2017-18. Some individuals also spoke of having been given written information. This generally took the form of a leaflet or booklet (although a few wards identified other written materials).
- 3.10 A small number of wards involved in the 2016 visits (15%) stated that they used other methods to ensure that patients could understand their rights, including: providing the information in other languages; embedding this in their overall approach; and providing information to family members or other carers which refer to patients' rights (and take account of the Carers [Scotland] Act 2016).

Overall awareness of rights and issues raised

- 3.11 Overall, in 2016 and in 2017-18, the Commission found a mixed understanding of patients' rights. While the majority of patients (over 70% in both cases) stated that they had been given information about their rights, the remainder appeared not to have a clear (or, in some cases, any) understanding of their rights.
- 3.12 The majority of patients in the 2016 visits (85%) were also found to have been aware of their legal status and to have understood this, and the Commission practitioners in 2017-18 gave examples of particular patients who had a good understanding of their rights and restrictions. The 2016 visits also found, however, that around 15% did not know, or did not understand their legal status.
- 3.13 It was also clear from the Commission's findings that, although there were some common methods being used to ensure that patients were able to understand their rights, there was no consistent overall approach to this, with variations in the nature and balance of methods and processes to promote and review rights issues; the locus of responsibility; the stage at which this was done; the nature and level of involvement of other organisations; the extent of proactive work carried out to promote patients' rights; and the extent to which this was "embedded" in the operation of the ward.
- 3.14 The Commission concluded from the 2016 visits that not enough positive action was being taken to meet the rights of patients in hospital, and some wards identified the need for further developments to this.

Advance statements

- 3.15 Advance statements are a further, specific, element of respecting and promoting patients' rights, and these have an important role in ensuring the individual's right to participate in decisions about their own care.
- 3.16 An advance statement is a written statement, made by an individual when they are well, setting out the care and treatment they would prefer (or would not wish to be given), should they become mentally unwell in the future. Everyone has a right to make an advance statement, and this allows a person's choices and preferences to be taken into account if they are so unwell that their ability to make decisions about their treatment, or make their views clear, has become significantly impaired.
- 3.17 The Commission's visits explored how advance statements were being accessed and promoted.

Accessing advance statements

- 3.18 There were found to be three main ways of accessing advance statements, through: patients' notes and medical records (electronic and manual); discussion with patients and / or their families / carers; and the involvement of other organisations or workers.
- 3.19 The most common means was through a patient's notes or medical records, sometimes in conjunction with other methods. Almost all of the wards visited in 2016 (94%) and 2017 / 18 (90%) stated that they would access advance statements in this way. While most did not give further details of the source of the records, just under half of the wards visited in 2016 (43%) and just under a third in 2017-18 mentioned specifically that they used a shared electronic system. Just over a quarter (28%) of those visited in 2016, and one of those visited in 2017-18, mentioned that they used manual record systems.
- 3.20 Just under half of the wards visited in 2016 (47%) and just under a third of those visited in 2017-18 stated that they would identify whether an advance statement was in place and / or access this through discussion with patients and / or their families. There was some evidence of differences in whether wards would rely on the patient or family to highlight this, or ask specifically about it.
- 3.21 Just under half of the wards visited in 2016 (47%), and just under a third of those visited in 2017-18, mentioned the involvement of other organisations or workers in facilitating access to advance statements, particularly community staff. Those mentioned most frequently were the Community Psychiatric Nurse (CPN) or Community Mental Health Team (CMHT), although others were also highlighted.

Promoting advance statements

- 3.22 Three main ways of promoting advance statements were identified. These were found to be the same as those used to ensure that patients understood their rights: discussion with staff; involvement of support organisations or workers; and written information.

- 3.23 The means of promoting advance statements identified most frequently was through discussion. Around two thirds of wards visited in 2016 (66%), and a similar proportion (60%) of those visited in 2017-18, mentioned this (e.g. providing information to patients; talking with them about creating an advance statement; and encouraging their development). This generally involved discussion between individuals and ward staff.
- 3.24 Just over a fifth in 2016 (21%), and a similar proportion (20%) in 2017-18, mentioned that advance statements were also promoted through groups or meetings.
- 3.25 Just under a fifth of wards visited in 2016 (19%), and just under a third (30%) of those visited in 2017-18, mentioned promoting advance statements at specific stages or as part of other procedures (e.g. on admission; approaching discharge; during an assessment).
- 3.26 Support organisations or workers were also found to be involved in promoting advance statements, and just under half of the wards visited in 2016, and just under a third (30%) of those visited in 2017-18, identified using this means.
- 3.27 Among these, the most common (mentioned by just under a fifth of all wards visited in 2016 and a similar proportion in 2017-18) was the involvement of advocacy support. Around 11% of the wards visited in 2016 mentioned the specific involvement of the CMHT, and a similar proportion mentioned CPNs. A small number of others were mentioned by a small number of wards.
- 3.28 The third method of promoting advance statements was through the use of written information, and just over a quarter of wards visited in 2016 mentioned this, with the most common forms being leaflets or booklets (although other types of written information were also highlighted). A small number of wards stated that written information was their only means of promoting advance statements.
- 3.29 In terms of other methods used, one ward mentioned its involvement in a recent initiative to promote advance statements through a regular group (described in Section 2) and one mentioned doing so through the review of their observation policy.

Overall access to and promotion of advance statements and issues raised

- 3.30 As with ensuring that patients were able to understand their rights, the Commission data suggested that there appeared to be no standard or consistent processes in place across wards to access and promote advance statements.
- 3.31 The 2016 visits found very few advance statements in place, and awareness low. Advance statements were found in the files of 12 out of 323 patients (4%), and just over half of the individuals (52%), had never heard of these. In the 2017-18 research, Commission practitioners found that over three quarters (76%) of individuals had not heard of advance statements, or were

unsure of what they were. Only a minority of individuals had made an advance statement of their own.

3.32 Both the 2016 and 2017-18 information suggested considerable variation in practice between different wards (e.g. in the means of undertaking this work; and the extent of proactive work to promote advance statements).

3.33 Some more specific problems were also identified with both accessing and promoting advance statements, including:

- Practical difficulties in accessing advance statements outwith the opening hours of the medical records department.
- Difficulties in finding advance statements in practice, or identifying that they are in place¹⁷.
- A lack of specific work to promote advance statements.
- Difficulties in promoting these in an acute setting.
- Limited uptake.
- Perception of the promotion of advance statements as being the role of community organisations / workers.

Awareness and use of the Rights in Mind material

3.34 During the 2017-18 visits, ward respondents were asked whether they were aware of the Rights in Mind materials. The majority (70%) stated that they were¹⁸. When asked to give examples of how they had used the Rights in Mind materials to improve ward practice or systems, however, most were unable to do so.

3.35 Two of the wards visited by the Commission in 2017-18 gave specific examples of having used the Rights in Mind materials. In one case, this involved giving the Pathway document to an individual patient; advising them of their rights and support; and taking steps to ensure that appropriate documentation was in place. In the other case, the ward was involved in a pilot scheme, linking with other hospitals to help promote and discuss rights at different stages of the patient journey.

3.36 The case studies described in the previous section clearly provided further examples of early work to implement the Rights in Mind materials.

Overview

3.37 The findings described in this section suggest that, while there are some examples of work taking place to ensure that patients understand their rights

¹⁷ Since June 2017, health boards must now ensure a copy is placed in medical records, and inform the Commission of its existence and location, and the Commission keeps a register of this information, so that it should be straightforward in future to check whether a patient has an advance statement, even where they are being treated in a different area.

¹⁸This group of visits involved only 10 wards, and it is impossible to generalise from the data. Additionally, the implementation of the Rights in Mind materials was at a relatively early stage.

and to access and promote advance statements, the nature and extent of this work appears to be varied.

3.38 The next section presents suggestions about further actions to respect and promote patients' rights.

SECTION 4: SUGGESTIONS FOR FUTURE ACTION

- 4.1 This section presents suggestions made by participants in the case studies described in Section 2 about future actions to respect and promote patients' rights, particularly using the Rights in Mind materials.
- 4.2 The suggestions were in four broad areas, relating to:
- The nature and dissemination of the Rights in Mind materials.
 - The development of new and additional materials for particular audiences.
 - The identification of further uses of the Rights in Mind materials.
 - Other linked suggestions.

The nature and dissemination of the Rights in Mind materials

- 4.3 Participants made a number of suggestions relating to the dissemination of the Rights in Mind materials. These focused on: use of the materials with patients; developing the Pathway format; and the general dissemination of materials.

The nature of the materials

- 4.4 As set out in Section 2, participants were generally very positive about the overall format of the Pathway document (i.e. working through the different stages on the "journey"), and no suggestions were offered about ways to improve this.
- 4.5 A small number of suggestions were made about the format of the Guide, all of which focused on making it more accessible (and, by extension, more likely, in their view, to be used by staff). It was suggested that:
- A brief section could be added (before the current content) containing the key reasons why staff should use the Guide, and why it is directly relevant to their practice.
 - Two versions of the Guide could be created, one specifically for community-based teams (who, in the participant's view, would be least likely to consider the materials relevant to them) and one for hospital-based staff. These documents could cross refer, but provide a specific reference point for each group.
 - The material in the Guide could be made more accessible by making it available as a series of linked web pages, thus allowing staff to identify more easily the sections relevant to their needs at that time.
 - A mono "laser printer" version of the Pathway document could also be created and made available on the Commission website.

Dissemination of the Rights in Mind materials

- 4.6 Participants made a small number of suggestions about the dissemination of the Rights in Mind materials, including the dissemination of the Pathway document (or a version of this) to patients themselves.

- 4.7 The Commission recognised from the outset that the Pathway document may be helpful to patients and their families / carers, and participants in two of the case study locations noted that patients had open access to this (as copies had been placed within the ward). Some suggested, however, that a specific version of the Pathway document could be created, aimed particularly at patients, with some simplification of the language used and the use of the first person in the text (e.g. “what are my rights” etc.).
- 4.8 One participant suggested that there could be two different versions for patients in different circumstances (i.e. detained patients and informal patients), to reduce the risk of misunderstanding. They acknowledged that there would be likely to be some level of overlap between versions, but believed that this could provide a straightforward explanation for both groups, containing specific information relevant to each.
- 4.9 It was also suggested that more videos describing patients’ experiences (including those of patients of different types) could also be produced.
- 4.10 Some suggestions were also made about additional ways in which the Commission could develop the dissemination of the materials further including to:
- Share findings from individual projects as these develop.
 - Encourage networking between practitioners.
 - Encourage staff in wards and community teams to subscribe to the email-based mailing list maintained by the Commission.
 - Make more use of the mailing list to make subscribers aware of new developments.

Development of new / additional materials for particular audiences

- 4.11 A further group of suggestions related to developing new and additional materials to supplement the Rights in Mind Pathway document and Guide.
- 4.12 All of the suggestions focused on the production of additional materials (pathways or guides) for specific groups, including: vulnerable elderly patients; adults with learning difficulties; carers; patients in rural areas; and young people aged 16 and under.

Vulnerable older patients

- 4.13 It was suggested that, as a supplement to the existing materials, the Commission (or others) could provide additional guides, or learning materials, about the specific issues relating to vulnerable older patients.
- 4.14 Staff in one location, for example, described some difficulties they had experienced in helping vulnerable older people to understand, or to exercise their rights. They stated that there could be a number of barriers to this, including that older people could often be reluctant to express their own views, or may be unwilling to appear to disagree with the nursing staff and doctors.

4.15 It was suggested that the preparation of specific guidance for them would help staff to better understand the issues facing this group of patients, and to recognise how these might impact on them in relation to understanding or exercising particular rights at different stages (e.g. giving consent or agreeing to their Care Plan).

Patients with learning difficulties

4.16 It was also suggested that a Pathway and guide could be prepared in relation to promoting rights for patients with learning difficulties.

4.17 Staff in a number of locations described difficulties which they had faced in ensuring that a patient had understood their rights where they had limited capacity to exercise these in a meaningful way. Participants in one area highlighted particular difficulties in being sure that they had secured meaningful consent.

4.18 It was acknowledged that staff had a number of routes available to them to seek further guidance (or a second opinion) on these issues, but it was suggested that having specific guidance for them, to provide further clarity, may assist them in working to promote the rights of this group.

Carers

4.19 Suggestions were also made about developing a version of the Pathway document and Guide aimed specifically at carers or family members, detailing their rights, as well as those of the patients (or including a carer-specific annex).

4.20 It was suggested that the Pathway document could be used as the basis of an audit of information for carers to help ensure that the content presents an appropriate balance between carers' and patients' rights.

4.21 Participants in a number of locations highlighted ways in which the existing Rights in Mind materials raised issues relating to carers and their rights, most often pertaining to issues such as the provision of information, and carers' participation in care planning and review.

4.22 Staff in one location identified that carers may have misconceptions about their own rights in relation to the care provided to their family member, suggesting that a guide to carers' rights could be beneficial both to carers and staff.

4.23 Staff in another location suggested that more information on carers' rights per se would be useful in the light of the implementation of provisions within the Carers (Scotland) Act 2016 from April 2018.

Patients in rural areas

4.24 A further suggestion was that the development of specific materials for CMHTs and wards serving large rural areas could be helpful in ensuring that these services could do as much as possible to ensure patients' rights in

these settings. It was suggested that people in these circumstances may face specific issues which would impact on exercising and promoting their rights.

- 4.25 Participants in two locations, for example, identified that the fact of living in a rural area may have consequences for issues such as: accessing appointments and services; travelling for treatment and visiting (for individuals, and for their carers and relatives); and obtaining possessions from patients' homes.
- 4.26 Staff also highlighted potential problems where, for example, there was a conflict between a client and worker, and where effecting a change of worker in a rural area may create practical difficulties, or have a detrimental effect on another client's care.
- 4.27 It was suggested that these, and other relevant issues could be highlighted in specific guidance, to help ensure that any potential barriers for this group were identified and addressed.

Young people

- 4.28 It was also suggested that the basic Pathway format could be used to develop information specific to the circumstances of young people aged 16 and under.
- 4.29 Some participants stated, for example, that this group can also face specific age-related issues, and would benefit from material tailored to their needs and presented using age-appropriate language and in an appropriate format.

Further uses of the Rights in Mind materials

- 4.30 In addition to the development of existing and new materials, participants made a number of suggestions about further ways in which the Rights in Mind materials could be used to develop both national and local projects with a rights focus.
- 4.31 These included: auditing and action planning; informing the use of resources; developing support in the community; improving transitions between community and hospital; developing practice on admission to hospital; promoting rights in hospital and general education and awareness raising.

Auditing and action planning

- 4.32 Several suggestions were made about the potential to use the Rights in Mind materials to promote and support strategic developments in rights-based work.
- 4.33 A common suggestion was that they could be used to help audit current practice in a ward or community setting. This could include, for example: identifying the nature of rights-based work done; assessing progress on rights-based work; and identifying improvements that could be made.

- 4.34 It was suggested that the findings from such an audit could then be used to develop new and additional tools to enhance practice, such as action plans; checklists; and protocols.
- 4.35 One participant suggested, for example, that the Guide could be used to support the creation of a “rolling” Rights Development Action Plan at a ward or community team level. It was suggested that the first step in this would be an audit of current practice to identify any issues or gaps (as noted above).
- 4.36 This could then be followed by the development of an action plan, to address any shortcomings in the first instance, and, over time, to provide a framework for on-going review and further development of rights-related work.
- 4.37 Participants also suggested using the Rights in Mind materials to help inform and support other aspects of strategic work.

Informing the use of resources

- 4.38 Suggestions were also made about using the Rights in Mind materials to help inform the use of resources and contribute to relevant decision-making.
- 4.39 For example, participants in one area highlighted three potential conflicts which, it was suggested, could benefit from new protocols, developed from the Rights in Mind materials. These were where an individual:
- Wished to exercise their right to seek a diagnosis, but the Health Board did not have the expertise (or funding) necessary to enable this.
 - Having received a diagnosis could not access treatment as their Health Board did not have the skills or resources, or had chosen to de-prioritise this area of work.
 - Wished to seek a second opinion.

Developing support in the community

- 4.40 A number of suggestions were also made about potential uses of the Rights in Mind materials at particular stages, some of which focused on ways of developing support in the community.

Developing a protocol for changes to treatment

- 4.41 Participants in two locations suggested, for example, that the Guide could be used as the basis for developing a protocol for medical staff and CMHTs to ensure that, if a diagnosis was to be given, or any key change to treatment was being considered (e.g. to medication), a patient’s named CPN should be alerted.
- 4.42 It was suggested that this might tackle some of the current difficulties experienced, whereby some of the processes in place in a hospital setting were seen to be sometimes absent (or less well-developed) in a community setting.

- 4.43 These related particularly to ensuring that a staff member was present when key information was given to a patient, in order to enable them to provide support immediately, and to answer questions at that time, or soon afterwards. It was suggested that, in a community setting, a patient might receive a diagnosis during an appointment at which no other staff might be present.
- 4.44 Participants expressed the view that the development of a protocol for this would allow the CPN either to be present at the appointment, or to make themselves available to the patient immediately afterwards.

Developing information for staff relating to patients' risk-taking

- 4.45 A further suggestion relating to work in the community made by participants in one location was that the materials could be used to develop useful specific information for community staff on the options they would have if a patient chose not to take medical advice, or where they engaged in risk-taking behaviours (potentially to the detriment of their mental health).
- 4.46 Staff indicated that a good example of this would be a patient who, although otherwise conforming to their care plan, continued to abuse alcohol or drugs.
- 4.47 It was suggested that providing clear information about the actions they could take, based on the Rights in Mind materials, would enhance their response to these circumstances.

Improving transitions between community and hospital

- 4.48 Participants in a number of locations identified that the Rights in Mind materials could also be used to help inform and develop projects designed to improve transitions between community and hospital.
- 4.49 Suggestions were made about the potential for specific projects to: develop consistent information across CMHTs about a stay in hospital; and promote a consistent approach to developing and using advance statements across wards and community teams.

Developing consistent information across CMHTs about a stay in hospital

- 4.50 There was seen to be potential for a project to develop consistent information across CMHTs about a stay in hospital.
- 4.51 Participants in one location, for example, expressed concerns that patients received different information, depending on which community team managed their case. Participants in a second location identified concerns that patients may reach the ward with "misconceptions" about what to expect.
- 4.52 Participants in both locations suggested that a project involving ward and community staff could for example, review: information leaflets for patients and carers; and any checklists and guidance given to staff. On the basis of the findings, the project could then develop new material, as necessary, and

to ensure that it clearly set out the patients' (and carers') rights, and that it was consistent.

Promoting a consistent approach to advance statements across wards and community teams

- 4.53 Participants in three locations identified the potential for a project to develop a consistent approach to advance statements across wards and community teams, using the Rights in Mind materials.
- 4.54 As set out in Section 2, staff in a number of locations have already developed local projects focussing on advance statements and, in each case, these projects have involved either a ward or a community team (but not, as yet, both).
- 4.55 Participants suggested that there could be benefits for patients and for staff in the development of a consistent approach to the promotion and development of advance statements across wards and community teams (focusing on those wards most likely to accept patients from a particular community team).
- 4.56 It was suggested that SCNs and Team Leaders could use the Rights in Mind materials to review current practice and, if necessary, to develop and agree a consistent approach to:
- How advance statements should be promoted in wards and by community teams.
 - When advance statements should ideally be developed (i.e. in the ward or in the community), although clearly patients can choose to do this at any time.
 - Involving named staff in both the ward and community teams in supporting the patients in developing their advance statement.
 - Using a single, consistent template to ensure that patients have the option of addressing issues relating to their care in the community and as an in-patient.

Developing practice on admission to hospital

- 4.57 Participants also made a number of suggestions relating to using the Rights in Mind materials to develop practice relating specifically to admission to hospital.

Developing a checklist or procedure for detained patients

- 4.58 A number of approaches to developing a checklist / procedure for admitting informal patients to hospital in some of the case study locations were described in Section 2.
- 4.59 Participants in one location suggested that this type of approach could also be used to develop a checklist / procedure for detained patients. It was suggested that this would be similar to that for informal patients, and would

provide staff with a simple approach to ensuring that all relevant patients' rights were maintained.

Developing a shared checklist for ward and community teams on "practical" issues

- 4.60 It was also suggested that the Guide could be used by SCNs / Team Leaders to develop a standard checklist of "practical" issues which needed to be addressed when a patient was admitted to hospital.
- 4.61 Participants in two locations which had developed admissions checklists noted that these did not cover matters such as: housing; personal possessions; benefits; ensuring the safety of pets; or arranging access to bank accounts etc.
- 4.62 It was noted that staff admitting patients usually identified whether the patient had any concerns in relation to such issues, but it was suggested that they were unlikely to take a comprehensive approach to this. One participant suggested that this was due, at least in part, to an assumption that these matters would have been addressed by community teams prior to admission.
- 4.63 It was suggested that a checklist could help to ensure that all of these issues were addressed in a timely way. It was also noted that it could be shared between the ward and CMHT, with each ensuring that all aspects were covered (e.g. within the first 72 hours after admission).

Promoting rights in hospital

- 4.64 A number of suggestions were also made about using the Rights in Mind materials to develop practice relating to promoting informal patients' rights while receiving treatment in hospital.
- 4.65 These included work to: review patients' rights; review time out; access to pets; patients' preparation for ward rounds; and visits by children and families.

Reviewing patients' rights

- 4.66 It was suggested that the materials could be used to develop different methods of reviewing patients' rights. For example, participants in one location suggested that the Guide could be used to inform a benchmarking exercise to assess how various views (consultants, doctors, nurses, patients and carers) were taken into account, and how decisions were reached.
- 4.67 Participants in another location suggested that the materials could be used to identify key patients' rights during a stay in hospital as a voluntary patient. It was suggested that this could then inform the development of a checklist of rights-based issues to be reviewed periodically by the patient and their named nurse.
- 4.68 Participants in three locations mentioned that they were already reviewing consents, and one suggested that it would be straightforward to extend this to review other key rights issues at the same time.

Reviewing time out

- 4.69 Participants in four locations identified time out as an area which could potentially benefit from a right-based review.
- 4.70 It was noted that, when a patient was admitted on a voluntary basis, wards generally implemented a 72-hour review process designed to: assess the issues facing an individual; provide them with all necessary induction information; and develop a short-term care plan. Participants noted that, from a management and clinical perspective, staff generally preferred patients to remain on the ward for the whole of the 72-hour period.
- 4.71 It was also noted, however, that patients could choose to leave the ward at any time and staff identified a wide variety of reasons why this might be the case, including to: collect items from home; visit relatives or pets; or purchase items not available in hospital (e.g. cigarettes or items of clothing).
- 4.72 Staff in all locations noted that requests for “time out” may lead to tensions, and could create administrative difficulties. Participants in one location suggested that they had to work together with patients on this issue (acknowledging that staff had no power to dictate the parameters of a voluntary patient’s time out).
- 4.73 Participants suggested using the Guide to support a comprehensive review of the 72-hour assessment period, and to identify how best to manage time out, could help clarify the issues. It was suggested that the development of a protocol, following this, might make the management of these situations easier for staff, and less stressful for patients.

Summarising rights relating to access to pets

- 4.74 it was suggested that the Guide could be used to develop a clear summary of the variety of rights involved in enabling patients’ access to pets, and could help set this in the context of management and safety issues.
- 4.75 Participants in two areas identified that patients’ access to pets could be an area of tension, and could involve potentially competing rights (as well as creating management and practical problems). Staff noted, for example, that allowing patients to leave the ward to visit a pet may not be in their best interests, while allowing pets onto the ward may cause distress to other patients. Staff also identified potential health and safety issues relating to, for example, the potential for staff to be injured by dogs.
- 4.76 While it was noted that an acceptable compromise could usually be reached, it was suggested that a summary of the rights issues involved could assist wards to create a sustainable policy in relation to this issue

Helping patients prepare for ward rounds

- 4.77 Staff suggested that the Guide could be used as the basis of work to prepare an information sheet for patients about their rights as these relate to ward

rounds (e.g. the right not to have medical students present, the right to speak to a doctor privately, the right to refuse specific medication etc).

- 4.78 Staff in one location reported that they usually helped patients to prepare for ward rounds, often explaining or reminding them of their rights particularly in relation to medication. Some expressed the view, however, that an information sheet would enhance patients' ability to exercise their rights in this area.

Developing information on visits by children and families

- 4.79 A further area in which it was suggested that the Guide could underpin the development of information was in relation to the considerations which needed to be taken into account in determining the nature and frequency of visits by children and families.

- 4.80 It was suggested, for example, that there could be differences of view between clinicians, nursing staff, patients and families about who could visit, and how best to manage this. Some participants considered that the development of such information would assist in reaching an acceptable solution.

Benchmarking discharge planning

- 4.81 Participants in two locations (in slightly different ways) suggested that the Guide could also be used to benchmark discharge planning. One suggested, for example, using it to assess how views were currently taken into account throughout the discharge planning process, and to identify any developments required.

- 4.82 Another suggested that the Guide could inform the development of a key rights checklist to guide this process.

General education and awareness raising

- 4.83 In addition to developing particular aspects of work at the different stages mentioned above, some participants suggested that there was further potential to use the Rights in Mind materials for more general education and awareness raising relating to patients' rights, both for those using and those delivering mental health services.

- 4.84 As noted above, some of these suggestions related to ensuring wider dissemination and promotion of the materials, using a range of means.

- 4.85 It was also suggested that individual staff members should be encouraged to use the Guide as a tool to help them to evaluate their own current practice, and to address any areas of concern.

- 4.86 The information within the documents was also seen to provide a basis for discussion of rights-related issues between staff, to prompt and promote

further awareness raising and mutual learning. One participant suggested that the materials could be developed into an e-learning package for staff¹⁹.

Other linked suggestions

4.87 A small number of additional suggestions were made which could be seen to link and relate to rights issues, but which did not relate directly to the materials.

Creating a national “resource” for standard materials

4.88 One participant, acknowledging the number of local projects being undertaken, suggested that a national resource could be helpful, bringing together materials which had been proven to be effective.

4.89 It was suggested that these could include, for example:

- Admission protocols, checklists or documentation.
- Patient information leaflets (which would have to be adapted for local circumstances).
- Promotional material (e.g. on advance statements).
- “Standard” wordings which could be used in local materials.

4.90 This would enable staff to build on previous work, and links to earlier suggestions about developing consistent information and ensuring that good practice information was disseminated.

Appointing “rights champions”

4.91 One participant suggested that each health board should designate a “Rights Champion” at a senior level, who would be responsible for promoting patients’ rights, and who could act as a conduit for information flowing from (and to) the Commission.

4.92 The participant suggested that, had such a post been in place, this would, for example, have helped enable a wider distribution, and potentially a higher profile, for the Rights in Mind initiative.

Developing placement projects for student nurses

4.93 One participant (who had been responsible for the design and implementation of a local project) suggested that SCNs and universities could work together to identify right-based projects which could be developed and implemented by students as part of an in-ward placement.

Overview

¹⁹ It should be noted that the Commission was, at the time of the research developing an e-learning resource.

- 4.94 It is clear that the staff in the case study locations have identified a range of potential additional uses of the Rights in Mind material, and have suggested a range of new projects which could be underpinned by these resources.
- 4.95 All of these additional suggestions can help to inform the future development of rights-related work in hospital and community settings.
- 4.96 The final section of the report identifies a small number of key conclusions that can be drawn from the information gathered, and makes a small number of suggestions for consideration.

SECTION 5: CONCLUSIONS AND SUGGESTIONS

5.1 This final section presents a small number of conclusions and suggestions for consideration which can be drawn from the research findings. These are in two areas: awareness and use of the Rights in Mind materials; and the general promotion of patients' rights in a mental healthcare setting.

Awareness and use of the Rights in Mind materials

5.2 A number of conclusions and suggestions can be drawn from the case study data (presented in Sections 2 and 4) relating to awareness and use of the Rights in Mind materials.

Positive developments and strengths

5.3 A number of positive developments and strengths can be identified relating to the awareness and use of the Rights in Mind materials.

5.4 The research found that the majority of staff are generally aware of the existence of the Rights in Mind materials. There is a particularly high level of awareness of these materials in the case study locations, as would be expected.

5.5 Where the Rights in Mind materials are used, they are well-regarded by the staff, and are seen to be helpful, informative and effective. There is also a general view that management are positive and supportive of rights-based work.

5.6 The Rights in Mind materials have been used in the case study areas as a tool to assist in reviewing practice, and as a resource to inform the development of specific local rights-based projects.

5.7 Such specific local rights-based projects have been developed and implemented in a number of areas, to enhance existing practice and to promote work on: advance statements; and on improving the information provided to voluntary patients (and, in one case, their carers).

5.8 There have been a number of outputs and developments from these projects including, for example:

- Staff training.
- Guides and protocols for use by staff.
- Awareness-raising materials for patients and carers.
- Rights-related discussions (group and individual) with patients.
- Amendments to processes (including review).
- Changes to recording and documentation.
- Monitoring of the impact of the changes.

5.9 There is also evidence of a number of positive benefits arising from the local projects. These include benefits for:

- Staff (in terms, for example, of: improved understanding and awareness of rights issues; and the opportunity to review practice).
- The operation of the ward (in terms, for example of: standardisation of processes; and improved information sharing).
- Patients (in terms, for example, of: their improved understanding and awareness of rights issues; and increased likelihood of their taking action to raise rights issues).
- Carers (in terms, for example, of: improved information; greater clarity and understanding of rights issues; and decreased pressure on them).

5.10 A number of lessons have been learned from the experiences of the local projects, including the importance of:

- Ownership by all relevant staff and a team approach from the outset.
- Embedding any changes in ward procedures, staff induction and training.
- Communication, including discussion of a project with staff and patients, and ongoing dialogue.
- Review, in order to ensure consistency; and identify any amendments required.

5.11 There has been some dissemination and sharing of good practice information and lessons arising from the projects to date, including between the different local projects.

5.12 A number of projects intend to continue to develop their work in the future, to monitor, build on (and amend where necessary) their practice in enabling and promoting patients' rights.

Issues and concerns

5.13 Alongside these positive developments, however, the research also identified some issues and concerns relating to awareness and use of the Rights in Mind materials in ward and community settings.

5.14 It was found, for example, that not all wards are aware of the Rights in Mind materials, and there is little general evidence of these being used outwith the case study areas (even where wards are aware of them).

5.15 Even in the case study areas, where participants are generally aware of the Rights in Mind initiative, there is more varied awareness of some of the specific materials. The Pathway document appears to be used most often, with lower levels of usage of the Guide and videos.

5.16 In some of the case study areas, awareness of the Rights in Mind initiative has been limited to those staff directly involved in the implementation of the projects.

5.17 Staff can also face a number of barriers to using the Rights in Mind materials. These generally relate to practical and operational issues (e.g. time pressures and competing priorities) but can also, in some cases relate to a perception by individual staff members of a lack of a need for additional information.

General promotion of patients' rights in a mental healthcare setting

5.18 A number of conclusions and suggestions can also be drawn from the Commission data (presented in Section 3 and detailed in Annex 1) relating to the general promotion of patients' rights in a mental healthcare setting.

Positive developments and strengths

5.19 A number of positive developments and strengths can be identified relating to the general promotion of patients' rights in a mental healthcare setting.

5.20 It is clear that wards take a number of steps to ensure that individual patients understand their rights. This is done in three main ways, through: discussion between staff and patients; the involvement of support organisations and / or other workers; and the provision of written information. Most patients are aware of having received information about their rights and most are aware of their legal status.

5.21 Similar methods are used to promote advance statements. In both cases, the most common method used is discussion between ward staff and individual patients (but not generally the named nurse). Group discussions on these issues also take place in some wards.

5.22 A variety of people (in addition to nursing staff) may also be involved in ensuring that patients understand their rights, and in promoting advance statements. Among these, the most common are advocacy services, with positive views of this form of support. A range of others can also be involved (e.g. legal services; social work / MHOs; RMOs; CABx; the Mental Welfare Commission; peer supporters; family members; and others).

5.23 Written materials are also used to promote patients' rights and advance statements, including: posters; leaflets, booklets and letters (with some examples of information being provided in other languages). A number of wards and community teams also provide information for carers and family members which refers to patients' rights (and takes account of the Carers (Scotland) Act 2016).

5.24 Most wards have an approach in place for accessing advance statements. This can include: through patients' notes and medical records (electronic or manual); discussion with patients and / or their families / carers; and the involvement of other organisations or workers.

Issues and concerns

5.25 Alongside these actions, however, a number of issues and concerns can be identified from the findings in relation to the general promotion of patients' rights in a mental healthcare setting.

5.26 There is, for example, a mixed understanding of patients' rights and of advance statements, and there are variations in practice between wards in promoting and enabling patients' rights, and in identifying and promoting advance statements. A significant proportion of patients remain unaware of

advance statements and only a minority have made an advance statement of their own.

5.27 There is no standard, consistent approach, nor standard procedure for action to ensure that: the promotion and provision of rights is undertaken in a systematic way; patients have all the information they require; and that they understand, and can exercise their rights.

5.28 There are specific differences in approaches to issues such as:

- The methods and processes to promote and review rights issues, and the relative emphasis on different means of undertaking this.
- The locus of responsibility for ensuring that rights and advance statements are promoted and enabled.
- The stage at which rights-related work is undertaken.
- The nature and level of involvement of other organisations.
- The nature of written material provided, and the approach to this.
- The level of proactivity in the approach taken by the ward to rights-related issues.
- The extent to which this work is “embedded” in the operation of the ward.

5.29 Some patients are not aware of having been given information about their rights and some lack understanding of these rights. Some do not know or understand their legal status, and some have not heard of advocacy services (or do not have an advocate).

5.30 There is a low level of take-up of advance statements, and limited knowledge of these. Most patients have never heard of them, or are unsure what they are, and there are few available in patients’ files. A number of wards recognise that they are doing little work to promote advance statements, or do not recognise this work as part of their responsibility.

Suggestions for consideration

5.31 On the basis of these research findings, a number of suggestions for consideration can be made, relating to awareness and use of the Rights in Mind materials in ward and community settings and to the general promotion of patients’ rights in a mental healthcare setting.

5.32 The Commission could:

- Identify ways to increase overall awareness of the Rights in Mind initiative and further means of disseminating the associated materials and encouraging their use, including through dissemination of this report.
- Consider providing alternative formats of the existing materials, such as a mono laser printer pdf version of the pathway document, or presentation of the good practice guide as a series of linked web pages.
- Widely disseminate the online Rights in Mind learning resource currently in development.
- Consider developing new and additional materials relating to particular groups, such as:

- Vulnerable elderly patients.
- Patients with learning difficulties.
- Carers.
- Patients in rural areas.
- Young people.

5.33 Healthcare Improvement Scotland and the Scottish Patient Safety Programme
- Mental Health could:

- Continue to promote an overall NHS focus on rights and emphasise its priority, with a clear emphasis on the relevance of the work to individual staff and teams.
- Consider promoting further work on patients' rights, for example by creating a national resource for standard materials (e.g. protocols, checklists or documentation; patient information and promotional materials).

5.34 Health boards could:

- Encourage further local improvement projects in wards and community teams, using the Rights in Mind materials.
- Encourage wards and community teams to work together on key projects.
- Identify successful rights-based improvement projects and roll these out to enhance consistency of practice (e.g. developing consistent processes and procedures for wards and CMHTs at the point of a patient's admission to hospital or addition to a caseload; consistent information across CMHTs about a stay in hospital; promoting a consistent approach to advance statements across wards and community teams)
- Consider promoting further work on patients' rights, for example by appointing "rights champions".
- Promote advance statements, to increase take-up²⁰.

5.35 Ward managers and team leaders could:

- Enable and encourage staff to consider the Rights in Mind materials and rights-related work, promoting discussion and further learning, including e-learning such as the forthcoming Commission LearnPro module, and review this in supervision / team meetings.
- Use the Rights in Mind materials for auditing and action planning to identify progress and potential improvements and develop plans.
- Involve staff teams in the specification, development and implementation of improvement projects, to enhance ownership and impact.
- Undertake improvement projects using the Rights in Mind materials, such as:

²⁰ The Commission has produced a set of materials to assist in the promotion of advance statements: <https://www.mwscot.org.uk/get-help/getting-treatment/advance-statements/>

- Developing protocols and information to guide staff for example, relating to changes to treatment, or patients' risk-taking.
 - Improving transitions between community and hospital
 - Developing practice on admission to hospital (e.g. developing a checklist or procedure for detained patients; developing a shared checklist for ward and community teams on "practical" issues).
 - Promoting rights in hospital (e.g. reviewing patients' rights; reviewing time out; summarising rights relating to access to pets; helping patients prepare for ward rounds; developing information on visits by children and families; and benchmarking discharge planning).
- Ensure that changes are properly embedded in ward procedures, and that all staff (including new and temporary staff) are implementing them.
 - Encourage staff to subscribe to the Commission's email-based mailing list.
 - Consider developing rights-based projects for student nurses on placement.

5.36 All of these findings and suggestions can help to inform the future development of rights-related work in hospital and community settings, and can enable staff to continue to sustain and promote a rights-based approach to their work with patients in the future.