mentalwelfare
commission for scotland

VISIT AND MONITORING REPORT

Adult acute ward visits 2012

Report on our themed visit to acute adult mental health admission wards in Scotland, 2012

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The Mental Welfare Commission for Scotland

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers' and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

Individuals with mental illness, learning disability and related conditions have the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment.

Why we visit

One of the ways in which the Commission monitors individuals care and treatment is through our visits programme. We visit individuals in a range of settings throughout Scotland: at home, in hospital or in any other setting where care and treatment is being delivered.

Visiting helps us to look at the care and treatment individuals are getting, to see the kind of places where care and treatment is provided and to hear how individuals feel about their care and treatment.

As part of this programme we carry out a number of national themed visits each year. The aim of national themed visits is to enable us to assess and compare care and treatment for particular groups of individuals across Scotland Our aim is to help services learn from good practice and to respond to any issues that we identify.

Through direct contact with those who use and provide services, we get a very good picture of whether services are being provided in line with the law, policy and best practice. We use this information to bring about immediate and longer term changes that improve the experience of those receiving care, treatment and supports now and in the future.

Why we visited acute adult mental health wards

We visited because we wanted to report on the views and experiences of individuals admitted to acute adult mental health wards and use their views to guide service providers to improve their service. Individuals receive mental health care in a variety of settings and from different organisations. A comprehensive mental health service will include a range of flexible community, inpatient and crisis mental health services that support people at different stages of recovery.

Admission to a mental health ward should only happen when it is no longer safe or appropriate for someone to receive care in a community setting. Care in hospital should be of the highest standard of quality and safety with the individual at the centre of all decisions.

In 2010 we visited all acute adult mental health wards across Scotland and we highlighted key areas where action was needed to change and improve particular aspects of care and treatment. (ref 1)

Since then, we have seen the increased availability of intensive home treatment services and crisis prevention approaches and a reduced number of admissions to psychiatric wards, a reduction in the number of acute psychiatric beds across Scotland and reduced number of readmissions. (ref 2)

The main purpose of this themed visit was to hear about the experiences of people receiving care and treatment in acute admission wards and intensive psychiatric care units (IPCUs). We wanted to hear about concerns they had about their admission and what they felt was, or was not, working well for them.

How we carried out the visits

Our aim was to see 500 individuals across all acute adult admission wards and IPCUs. We carried out our visits so that as many individuals as possible could contribute and we met with everyone who wanted to see us. We visited wards and IPCUs between June and September 2012.

An initial letter was sent out to all acute services managers in mid April 2012 telling them about our visit theme and when we hoped to visit. Six weeks before the visit date we sent a letter to the ward manager giving them more information and setting out the specific arrangements for the visit. A few days prior to the visit, the Commission visit coordinator telephoned the ward to make specific arrangements for the day, including identifying anyone who might need an interpreter. We also wrote out to local advocacy services to let them know about our visit and invited them to participate in individual interviews. Posters and leaflets were sent out to the wards in advance to advertise the day and time of our visit.

We visited some of the larger hospitals twice within the three month period. We met ten individuals twice though have only counted this as one visit.

As well as meeting with anyone who wanted to talk with us, we were particularly interested to meet with individuals where:

- They had been admitted three or more times in the last two years
- They were from an ethnic minority
- They had a dual mental health diagnosis
- They were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act) and had parental responsibilities for a child/children under 18 years of age
- They were homeless or in unsettled accommodation prior to admission
- They were deaf or deafened.

The reason for identifying these particular groups of individuals is explained further in the report.

We also asked about the physical environment of the ward and our visitors took the opportunity to look around the accommodation.

Our interviews

Our interview schedule was designed to gain an understanding of the individuals' own view of their mental health and experiences on the ward. We produced an interview schedule with a core section that was relevant to all and then additional questions applicable to the specific groups mentioned above.

The questions were informed by a number of sources including previous Commission visits, the Royal College of Psychiatrists and the Scottish Recovery Network. If during the interview we came across matters of concern we checked this out with staff and made further enquiries, including a review of the case file where indicated.

Not everyone we interviewed was able or wanted to answer all the questions.

Of the 476 people we met with, our visitors identified 24 individuals where what they told us led to us making formal inquiries. There were also many other cases where on the day we sought further information from or gave advice to ward staff.

Core questions

The core questions that we asked included

- What happens when you are admitted?
- What happens while you are on the ward?
- What is helping you?
- What is happening about your discharge from hospital?

We asked people what they thought about the way they were being treated and what was the best thing and worst thing about being on the ward. We asked about participation in care planning and identification and contact with a named nurse or key worker. We asked about the information that they had been given about the ward and what they had found helpful. We asked about particular worries that they had while they were on the ward and if they felt safe there.

Throughout the report we have used quotes from those who spoke with us as we feel these are powerful statements of first hand personal experience. Where these are positive, we have identified the service unless we feel this could identify the individual we spoke with.

We do not identify the service involved when we use quotes that can be viewed as negative (except in relation to some quotes about the physical environment). We have brought these to the attention of the service concerned as appropriate.

Summary of key messages

Admission and participation

People do not always understand the purpose of their admission and are often not given an adequate introduction to the ward.

People often do not feel involved or consulted in planning their care.

People worry about what is going on at home while they are in hospital and this can have a negative effect on their recovery. They particularly worry about money and housing.

Therapeutic activity

The provision of a range of therapeutic activities is of huge benefit and very much valued but needs to be available seven days a week.

Restriction and observation

People often find the restrictions placed on them difficult to understand and unnecessary. Staff need to recognise and address this.

Attitudes and availability of staff

The positive attitude of staff is highly valued and essential to providing a recovery focused service. Often though, people are hesitant to approach staff.

Feeling safe and secure

People often find the behaviour of others admitted to the ward makes them feel unsafe and staff need to recognise the effect this can have.

Recovery

There are many positive examples of recovery based practice in acute adult mental health wards in Scotland and all services should be striving to provide services of this standard.

Peer support

Peer support in acute adult admission wards is a valuable recovery tool and services should recognise the importance and value of informal peer support

Physical environment

We are seriously concerned about the poor physical environment in some acute admission wards and IPCUs.

Smoking in wards continues to be a concern for smokers and non smokers admitted to wards.

Discharge planning for individuals with multiple admissions

People admitted, particularly those who have had multiple admissions, need to be clear about their current discharge plan and plans to manage future periods of poor mental health.

Individuals from minority ethnic backgrounds

Mental health care should be provided in a way that does not discriminate against people from minority ethnic backgrounds. It must take into account the wider cultural needs of people, addressing any communication barriers, religious beliefs or special dietary needs appropriately.

Dual mental health diagnosis

A high number of those we met with were identified as having a dual diagnosis. The importance of building up a trusting therapeutic relationship with staff and having the chance to talk with someone and being listened to are highly valued by those with a dual diagnosis.

Parents and parental responsibilities

The majority of parents voiced concern in relation to their children and their own hospital stay. Children's understanding of mental illness, visiting arrangements and child care arrangements were common concerns. Staff must do more to identify concerns and address them. Visiting facilities for families must be improved.

Homelessness

Homelessness, or housing uncertainty, has an impact on the mental health of people admitted.It should not be considered simply a social work or housing department problem or only discussed or addressed at discharge.

General findings

We met 476 individuals on our visits. This is the largest series of interviews carried out with people admitted to adult acute admission wards in Scotland.

Of the 476 people we met, 46% were women and 54% men. Eighty seven percent were on an adult acute admission ward and 13% were on an Intensive Psychiatric Care Unit (IPCU) at the time of our visit. Of those on an IPCU, 78% were men and 22% were women. On acute admission wards, 50% were men and 50% women.

Of those we met on an adult acute admission ward, 60% were there on an informal basis and 40% were subject to compulsion under the 2003 Act.For those in IPCU,97%were detained under the 2003 Act.

An intensive psychiatric care unit is a ward that provides intensive treatment and interventions to those who present an increased level of clinical risk and require a higher level of observation. The ratio of nursing staff will be higher than in a general mental health ward. (ref 3)

We made further inquiries about those we met who were admitted informally to IPCU at the time of our visit and we were satisfied that they understood they were informal and able to leave if they chose to.

What individuals told us

We asked everyone a general question. What was the best thing about being on the ward and also the worst thing? We also asked general questions about admission and participation.

We had a large number of responses which fell into the following main categories.

- Admission and participation
- Therapeutic activity
- Restrictions and observation
- Attitudes and availability of staff
- Feeling safe and secure.

We discuss the responses in these categories later in the report.

Information about carers and caring

We did not make any specific arrangements to meet with carers at these visits or prepare an interview schedule for carers. We did meet on the visit day with any carers who wished to speak to us. Our aim was to meet with the individual who had been admitted and seek their views. We did though collect information about the number of people who had someone they identified as a carer or someone they cared for when at home.

Of those we met with, 24% identified someone they considered to be their carer and in the majority of cases this was a family member and the majority considered their carer’s involvement to be very helpful. Just over half lived at home with the person they identified as their carer. Around 78% said that the main thing they relied on their carer for was emotional support, followed by practical help in the home (58%). Most said they did not need any help with personal care such as washing and dressing.

Over half commented that they had a discussion with ward staff about their carer, about sharing information with them and their involvement at meetings. We think that this is still too low and will be addressing how we best make contact and seek information from carers at our future visits.

Twenty two people identified themselves as being the main carer for someone else. The majority (95%) cared for a family member and, similar to the group who identified themselves as a carer, this tended to be giving emotional support to someone. Less than a quarter gave help with personal care.

Admission and participation

People do not always understand the purpose of their admission and are often not given an adequate introduction to the ward.

People often do not feel involved or consulted in planning their care.

People worry about what is going on at home while they are in hospital and this can have a negative effect on their recovery. They particularly worry about money and housing.

Admission to hospital can be a distressing and disorientating experience for people. When we have visited, we have found they are often not given the information they need about the ward and their care and treatment. We expect they should be given information about the ward in a variety of formats.

We asked:

- Were you shown around the ward when you were first admitted?
- Were you introduced to staff on the ward?
- Were you given written information about the ward?

Overall, 80% of the people we met answered these questions (of those 84% were informal and 16% were detained).

For those answering this section, nineteen percent told us that when they were admitted they received a full introduction to the ward; they were shown around, given written information and introduced to their named nurse. A further 55% said they were shown around only and an additional 12% said they were introduced to the primary nurse or given written information. In total 86% therefore recalled some form of introduction on admission. Fourteen percent were clear they were neither shown around, introduced nor received written information.

More informal than detained people recalled some element of introduction with more informal than detained recalling the full introduction. Larger proportions of those detained who were first or multiple admissions said they were not shown around. Several for whom this was not their first admission, informal or detained, said they did not need to be shown around as they had been there before.

> *"I was moved to this ward from another ward. No one showed me around. I didn't know where anything was. I didn't eat for first few days as I felt so vulnerable and the ward felt huge. It was other patients who showed me around."*
>
> *"I was introduced to my two named nurses right away and I have been given lots of help to go to the bank and contact people. I was given a leaflet about mealtimes and all about the ward as well."* Ailsa Hospital.

On previous visits we found that people were often unaware of their care plan. We think it is important that they are actively involved in planning, developing and reviewing their care.

We asked:

- Were you involved in the development of your care plan? Of those who answered, more than half told us that they had been but the rest said they had not.
- Do staff listen to you about what does and doesn't help you? Of those who answered, the majority said staff did and a few said they did not.

We do not think it is acceptable that at least two fifths reported not being involved in the development of their care plan.

We asked:

- Are there particular things you are worried about because of being admitted to hospital? Fifty six percent told us that they were worried about something and the main things they were worried about were……

Housing 31% Money 23% Work/job 19% Children 18%

Others they were responsible for 15% What to tell friends 7% (Other 23%).

When we asked if they had been given help with any of these worries we received a mixed response. Many reported that Advocacy had been very helpful in sorting out many of these worries. This goes beyond the usual role of independent advocacy and many appeared to view them as having a traditional social work/welfare benefits advice role.

> *"I am signed off sick but I have not had any sick pay, I'm worried as I have no money and can't pay my rent. I told the doctor and she said would get the nurses to look into it but I haven't heard anything."*

> *"I am worried about my benefits. Money Matters have been helping but the benefits change after 28 days so I have asked to go home early. My Doctor wanted me to stay until next week but has agreed I can leave early."*

If someone receives payments of Disability Living Allowance and/or Attendance Allowance, this will stop when they have been in hospital for 28 days.

Recommendation

Service managers should ensure

- People admitted are given information about the ward in appropriate formats
- People are given information about and involved in planning their care
- In conjunction with Social Work departments, that admission assessment includes consideration of social factors and that

appropriate referral systems are in place. Staff and those admitted to hospital need to be able to access advice and support to address worries about finances and their housing situation.

Therapeutic activity

The provision of a range of therapeutic activities is of huge benefit and very much valued but needs to be available seven days a week.

Of those who spoke to us about activity within the ward, at least 38% made some very positive comments. We found that those who were detained were most likely to make negative comments about activity provision (60%) and this was often related to a lack of exercise and access to resources outwith the ward.

> *"There are groups every day which I find really helpful. The most helpful is the 10.30 goal setting group. The patients sit with the nurses around a table and everyone sets one goal for the day, no matter how small .It is really good to do this and plan to see it through. There is a meeting at the end of the day when everyone says how they got on. There is so much to do. Art class, aromatherapy (I have a massage booked in today), Tai Chi, a walking group. If you don't want to join a group then members of staff will approach you and make suggestions about what to do."* Huntlyburn House, Melrose
>
> *"I have been working with the OT's and they're really good, I get to use the gym when I'm not feeling lazy. I like the Hive as I can use the computers to keep in touch with family." Royal Edinburgh Hospital*

A common theme that emerged was that people reported that activity provision during the week can be good but is often inadequate at weekends.

> *"The best thing for me has been the groups. They give structure to the day and help me in understanding issues. No groups at the weekend and that's not good as it can mean too much time on your hands."*
>
> *"There are lots of activities and efforts to get us all involved. The only downside is weekends; there is no one from OT. The weekends are the most difficult time for us all."*
>
> *"I am bored most of the time. A lot of the stuff the OTs do is in groups and I don't like groups."*

Recommendation

Service managers should review in conjunction with Occupational Therapy departments

- their current activity provision and ensure that staff are able to provide a range of therapeutic activities both within and outwith normal working hours.

Restrictions and observation

People often find the restrictions placed on them difficult to understand and unnecessary. Staff need to recognise and address this.

Individuals told us about levels of nursing observation they were subject to and other restrictions. The majority of these comments were negative (80%) and we found little difference in the comments of those who were detained under the Act and those who were informal.

We also found little difference in the number of negative comments from those in acute wards and those in IPCUs*.*

> *"The worst thing about being here is that I'm here 24 hours a day and I can't get out. A nurse needs to take me out but they are too busy or short staffed*". (Commission visitor discussed this with staff who confirmed that until recently the ward had been full to capacity with a high number of individuals on constant observation and nurses did not have time to take him out).
>
> *"Observation levels can be hard at first because when you're ill you can't see the benefit."*
>
> *"When you're detained you feel the restraints. You feel the restrictions even though you know it's necessary. When you've been in three weeks like me, you're ready to open your wings and fly a bit but the restrictions stop you, it's not conducive to recovery."*
>
> *"I am bored and asked if my Mum could bring in a portable DVD player but was told they are not allowed because it might get stolen or thrown at someone. I hardly leave my room and I have never thrown anything at anyone in my life so I think these decisions should be made on an individual basis."*
>
> *"I hate it when the door is locked. It has only been locked for the last couple of days but it is a nuisance having to get a nurse to open the door."*
>
> *"Because I am on constant observations, there is always someone to talk to. I was really not sure about it at first but I actually find it quite reassuring."*

Recommendations

Service managers should:

- Review the potential restrictions that people admitted are subject to
- Ensure that any restrictions applied are individually assessed, proportionate and justifiable.

Scottish Government to

- Commission a review of Engaging People, Good Practice statement on the observation of people with acute mental health problems in

Scotland (ref 4).This review is required to ensure that the national good practice guidance reflects changing practice and that observation levels are the least restrictive and tailored to individual risk.

Attitudes and availability of staff

The positive attitude of staff is highly valued and essential to providing a recovery focused service. Often though, people are hesitant to approach staff.

When people spoke about the staff in the wards, the majority of comments (73%) were positive and this was only slightly less for those who were detained (66%).

Many of the positive responses we received are included in the section later in the report that looks at a recovery focused service. Where we did receive negative comments about availability and attitudes of staff, a key theme that emerged was about how difficult it can be to approach staff to ask for help.

> *"You have to knock on the duty room door and ask, even if it's your named nurse. It's more difficult than staff realise to do that when you're feeling bad."*
>
> "*Staff go all out to help anyone going through a bad patch; the staff speak to you as an individual. Within half an hour of speaking to them you feel better but I hate going to the duty room to catch their attention."*
>
> *"The key worker for the day does not always introduce themself, they just write their name on board. Sometimes a big group of staff are in a room at the back of nurse's station, laughing together. It can be really off putting if you want to approach to speak to someone."*
>
> *"Staff don't always speak to patients in the right way. Some can be quite rude and also staff rely on patients to approach them. They don't really make themselves available and I don't have the confidence to ask to talk."*

A common theme from individuals was how busy they thought the ward was with staff not having enough time to respond to requests for help.

> *"You are always having to ask for things. You are told to wait ten minutes then they never get back to you. You constantly have to go back to ask again."*
>
> *"You can't always get a member of staff to talk to you especially on Monday or Tuesday when the ward meetings are on and I'm anxious."*
>
> *"The worst thing is waiting about for psychiatrist to come. I don't know if it will be morning or afternoon and then sometimes it's a different day altogether. He could phone and make sure people know when he is coming, it's only civil."*

Recommendation

Service managers should:

- work with staff and individuals admitted to look at barriers locally to individuals approaching staff and consider adaptations that can be made to the physical environment to improve communication and visibility of staff.

Feeling safe and secure

People often find the behaviour of others admitted to the ward makes them feel unsafe and staff need to recognise the effect this can have.

All of the wards we visited, with the exception of Carseview IPCU (male only) and Meadows Ward, Royal Edinburgh Hospital(female only), were mixed sex.

Four hundred and thirty people answered this question about feeling safe and of those, 16% told us that they did not feel safe in the ward and just over half of them were women (55%).The middle age-groups were most likely to report feeling unsafe; 19% of women in the two middle age groups 25-44 and 45-64 and 20% for the male 25-44 age group.

About half (53%) told us that they would feel comfortable about speaking to a member of staff about this. Thirty three percent said they wouldn't feel comfortable and the rest were unsure.

Most of the comments we received about feeling unsafe related to the behaviours of others who had been admitted to the ward.

> *"There is one patient who is stealing other people's things. She is quite intimidating and swears a lot. She is quite ill but makes me nervous. Staff try to steer her away from others."*
>
> *"I don't feel safe. I had to approach staff to ask for help with another patient. The staff did not offer to help."*
>
> *"A new patient has been admitted today and she is assaulting people so I don't feel safe."*
>
> *"I want to be in a single sex ward. I don't feel safe with men about."*

Recommendation

Service mangers should:

- review the current accommodation within admission wards to ensure it affords maximum respect for privacy and dignity
- work with staff and people admitted to the ward to look at how best to manage distressing incidents.

Recovery

There are many positive examples of recovery based practice in acute adult mental health wards in Scotland and all services should be striving to provide services of this standard.

Recovery is often described as a journey and not simply the absence of symptoms.

Recovery involves enabling individuals to take charge of their own lives with the support they require. It is about empowering people to make real choices for themselves. (ref 5)

We believe it is essential for services to adopt recovery based approaches even in an acute admission ward when individuals are experiencing an acute episode of mental Illness. Many of the comments we received described such an approach.

To help us make sense of all the comments we collected, we decided to use the service user recovery indicators in the Scottish Recovery Indicator 2 (SRI 2) (ref 6). The SRI 2 is a tool that enables services to gauge their recovery focus in relation to a range of criteria. We did not carry out a formal SRI 2 exercise but used the indicators and reflective statements to help us categorise the comments received and make a judgement about whether this was evidence of recovery based practice.

Of course, not all the comments that we categorised about recovery were positive but around 80% of those we did receive were.

We looked at the comments that we felt demonstrated a recovery focus and linked these to the indicators and statements.

The indicators we thought the comments mainly related to were:

1. Indicator - Service encourages advance planning and self management.

Service user statement I'm encouraged to plan for the future including periods of poor mental health.

What we were told

"She spoke very positively about her prevention relapse plan that she developed with her CPN, her husband and son. She described feeling that her mental health was a shared responsibility and when she was becoming unwell it was an open topic of conversation." Written comment from Commission visitor to Parkhead hospital.

"I like the structure that is built into the day. One group that is particularly helpful is the one on identifying symptoms and coping mechanisms" Huntlyburn House

"I am fully involved through my staying well plan and I have an advance statement." Royal Edinburgh, Balcarres.

2. Indicator - Practice is recovery focused

Service user statement The staff are supportive, positive and approachable

What we were told

We commented earlier in this report about what we were told about the attitudes and availability of staff.

"Staff have taken time to get to know me and I feel they understand me. They tolerate my moods but help me see what I need to do to get over things too.**"**St. Johns hospital, ward 17

"Even if I don't feel like talking I can write down my thoughts and questions. I handed one of these letters to my named nurse and got a written response back" Huntlyburn House.

3. Indicator - Service promotes and acts on service user involvement

Service user statement Those who use the service have a say in how things are done.

What we were told

"Patients have a say in what is happening." Southern General Hospital.

"Positive Steps meeting with everyone to discuss what they are going to do for the week. Huntlyburn House.

4. Indicator - Goals are identified and addressed

Service user statement My goals are considered when planning my care

What we were told

"The good thing about being in hospital this time is that I am here voluntarily and making more decisions and setting goals, I've not been able to do that in the past." Wishaw General Hospital.

"My doctor is so good, always knows my care plan and there is good involvement from other professionals; I am working with the doctor and pharmacist about changes to my medication."

"I was involved in developing my care plan but not with my named nurse but two student nurses who spend a lot of time with me, very useful and helpful."

"Staff don't have time to give me a care plan; I feel I'm floundering in here without one." Service user.

General comments

"Things have come a long way. Staff treat you like an individual, really try to understand and support you. It's not just drugs; they listen and teach you techniques to manage how you feel." St John's Hospital, ward 17

"Best thing about being here is the staff. The staff are genuinely sincere, I think they really care."

The worst thing? "Not to do with being in the ward, just getting over being here, the realisation I've been in hospital"

"The staff are the best thing. I don't really remember the first four weeks here but I was fairly out of order, shouting at them etc and they put up with it all and looked after me. They are always around for you to talk to and always asking if you want a chat about things." Kyle ward, Ailsa Hospital.

Recommendation

Service managers should:

- ensure accomplishment of Scottish Recovery Indicator 2 and act on the areas for improvement identified.

Peer support

Peer support in acute adult admission wards is a valuable recovery tool and services should recognise the importance and value of informal peer support.

Peer support is a system of giving and receiving help founded on the key principles of respect, shared responsibility and a mutual agreement of what is helpful.

Although not identified specifically in the SRI 2, many people told us about the positive support they received from others who were admitted to the ward and the new social contacts they made.

> *"This is not the first time I have been on this ward and it was great to see familiar faces-some of the patients recognised me and I recognised them, that was great!"*
>
> *"Being in here has changed my life. Support from staff and fellow patients has been brilliant. I am able to look forward now."* Ward 3 Forth Valley Royal Hospital.
>
> *"I have learnt more about my illness and come to terms with it more from speaking to other patients, more so than staff. With staff it can be a bit hit or miss depending of dynamics of team on shift."*
>
> *"We are all in the same boat here, no one is any better than anyone else.We are all just folk who are unwell."*
>
> *"My experience is that patients are helpful to each other.There is a sense of community here that I found within a day or two of being here."* Huntlyburn House.

All comments here relate to the support received from others who were admitted to the ward .We are aware that five acute in patient services in Scotland have seen the introduction of paid peer support workers; this was taken forward under Delivering for Mental Health. We recognise the value of both informal and formal peer support approaches as highlighted in Commitment 3 of the Mental Health Strategy for Scotland (ref 2).

Recommendation

Service mangers should:

- ensure that staff recognise and understand the value and importance of informal peer support.

The physical environment

We are seriously concerned about the poor physical environment in some acute admission wards and IPCUs.

Smoking in wards continues to be a concern for smokers and non smokers admitted to wards.

From our previous visits to adult acute admission wards, the physical environment and in particular its effect on privacy and dignity has been a recurring concern. We highlighted this in our adult acute themed visit report in 2010 (ref 1) and our report on recommendations arising from our focussed visits in 2011(ref 7).

Those admitted in the acute phase of their illness are often temporarily unable to protect their own privacy and dignity and therefore staff need to take extra care to ensure this fundamental human right is protected.

Our visitors completed questionnaires about the environment and our observations were also supported by asking people what they thought about the cleanliness and the fabric of the building.

Bedrooms, dormitories and bathrooms

Many people admitted to hospital find themselves sharing sleeping and living accommodation. Most of the favourable comments we received came from wards with new or upgraded facilities where people had their own rooms and en-suite facilities.

> *"The best thing about being on the ward is having a single room where I can go and just be by myself if it all feels as if it's getting too much.It is absolutely great and really helps me"* *Dykebar North*

Older psychiatric hospitals and wards situated in general hospitals tended to have the least favourable comments.

> *"I wish the staff would check with new patients how they feel about being in a dormitory".* *Wishaw General Hospital.*

Not everyone described single, en-suite rooms as a positive experience.

> "You *can feel more isolated in the new unit because it is so big. Patients have their own rooms so you don't get the same chance to meet people and have the chance to speak to them."* *Gartnavel Royal Hospital*

Privacy in the bathrooms or showers was something that arose as an issue for most of those who were in shared accommodation. Several reported feeling uncomfortable or unsafe sharing a bathroom or shower.

> *"You can't lock the bathroom door so I just wash at the sink in my room" Ailsa IPCU*

> *"The worst thing is that the only bath is in the men's' bathroom"*
>
> Hermitage Ward, REH

One woman described sharing bathroom and shower areas as the worst part of her admission.

General comments

The majority of our visitors said that wards appeared to be clean on the day of our visit and comments from others supported this.

Being able to go somewhere quiet and peaceful was viewed as being very helpful particularly access to outside space.

> *"The garden area is good, it is enclosed and it is good to get out for fresh air because it is unhealthily warm in here."* Dykebar North

We also heard of the frustration at not being able to go somewhere quiet

> *"The noise level is horrendous, not just patients but staff too. They often slam doors without thinking. It's hard and the noise can be totally unacceptable at times."* Royal Edinburgh Hospital

> *"The constant noise means I can't rest or escape. Staff say it's an old building but the noise never stops."* Royal Edinburgh Hospital

Protecting property

On admission, many people will bring in their own devices to listen to music, their mobile phone etc and all these items, as well as day to day items like toiletries or perfumes that need to be stored and easily accessible.

Only half of all adult acute wards provided lockable drawers to store personal property.

We heard that bedroom doors and lockers were not routinely locked because keys had been lost and not replaced.

> *"There are drug users on the ward who keep coming into my room; Police are often in the ward. There is poor ward security. There are no locks on bedroom doors and no keys for bedside lockers."* Royal Edinburgh Hospital.

> *"I don't have a key to lock my door. Others have gone off with keys; it's not worth getting a nurse to come from the office to lock the door."* New Craigs Hospital

Locked doors

We asked whether or not the main entry/exit door to the door was normally locked. We found that doors to and from all IPCUs were always locked. Twenty nine percent of the main entry/exit doors in acute admission wards were locked.

Many hospitals controlled entry to the ward because of concerns about theft from the ward and to limit illicit drug use. We were told about a variety of systems that have been developed to control entry to and exit from the ward.

Keypads were in operation in one hospital. The number was displayed on the inside of the ward and individuals are able to leave when they wish, visitors ring the bell to come in and those inside can freely exit if appropriate to do so.

A minority of wards where the front doors were locked stated clinical activity as the reason for doing this (Stracathro Hospital, Murray Royal Hospital, Royal Edinburgh Hospital and Royal Cornhill Hospital). Some wards operated a system of having a nurse by the front door to monitor entry and exit, usually due to poor design layout which made observation difficult.

One ward also had a system in place where bedroom doors locked automatically. The visitor reported that the ward had a significant number of internal doors that were locked, many more than we would expect from an adult acute admission ward. People needed to ask staff to access their bedrooms as well as the kitchen and we asked for this to be reviewed as soon as possible. (Murray Royal Hospital)

Smoking

More than three quarters of wards were reported as being smoke free, 79% of admission wards and 64% of IPCUs.

The majority of wards reported not having facilities within the ward for smoking and that individuals go outside the ward to a designated area to smoke. This was reported as working well for facilities at ground level with secure gardens and offering smoke shelters.

This was more problematic for wards with no easy outside access. In a few of these wards it was reported by our visitors that there was evidence of a blatant disregard for the policy.

> *"It's a real issue for people to get off the ward for a cigarette if they need a staff escort due to staff levels and availability."* Commission visitor, Royal Edinburgh Hospital

> *"She said she is worried about smoking on the ward. She says people smoke in toilets and out of windows and is permitted by staff."* Commission visitor

> *"The garden is an ashtray with inch deep cigarette butts around the edge and on the flower beds."* Commission visitor, Stratheden Hospital

Eleven wards were identified as still providing a smoking room and many of the negative comments we received were from areas that still provided some indoor smoking areas.

> *"I have seen staff rolling cigarettes for patients. It's shocking."*

> *"Night staff are much more relaxed. They will come out and smoke with patients unlike day staff who don't do that."*

Recommendations

NHS Chief Executives and Boards should act to ensure improvements in areas where concerns about the physical environment have been identified.

Scottish Government should specify the environmental standards expected and in conjunction with Healthcare Improvement Scotland should monitor compliance with these standards.

Services need to be clear about their smoking policy within wards, IPCU's and within hospital gardens and grounds.

Individuals who are deaf/ deafened

The ‘Unheard Unseen’ report (ref 8) advises that deaf people are left feeling lonely and scared by the numerous barriers to accessing mental health services.

One of the recommendations from the ‘Unheard Unseen’ report was that the Mental Welfare Commission should investigate the treatment of those who are deaf or deaf/blind who are treated under a Compulsory Treatment Order (CTO). We met with the authors of the report at the time and advised them that we were not able do that because we are not informed about individuals who are on CTOs and are deaf.

There is currently no specialist inpatient provision in Scotland for people who are deaf or deaf blind with mental health problems.

We decided to look at this group of people as part of this series of visits to hear how they experienced the service they received. We compiled an interview schedule that addressed the main areas of concern for deaf people who are admitted to an acute adult admission ward.

Only one deaf person was identified during this visit and we met that individual. We are not able to make any general comments when we are able to elicit only one view and also it may be possible to identify the individual from their comments.

We were surprised though that there was only one person and on further investigation we were told that in the time period we visited, two deaf people had been admitted to the John Denmark Unit (a specialist mental health hospital facility in North Manchester which is commissioned to provide beds for deaf people from Scotland). One deaf person was also admitted to the Chapman Barker Unit, an addictions unit situated next to the John Denmark unit. This allowed them access to the addiction programme, while also having support from the signing staff and the chance to interact with fellow deaf people.

All three had been treated in local units previously but it was felt appropriate following assessment by the Scottish Mental Health Service for Deaf People that they were treated in a specialist unit.

Discharge planning for individuals with multiple admissions

People admitted, particularly those who have had multiple admissions, need to be clear about their current discharge plan and plans to manage future periods of poor mental health.

The Strategy for Mental Health 2012(ref 2), outlines 36 commitments to support improving services for people with mental health problems. This includes understanding the balance between community and inpatient services and how this can be improved.

Shifting the balance of care from hospital to the community was a key challenge within *Delivering for Health 2006. (ref 9)*

From our previous visits to mental health acute wards and from contact with service users via our telephone advice line, we have an awareness that readmission to hospital within short periods of time is still common. Of those we spoke with on this visit, 31% had been in hospital three or more times in the last two years.

We were keen to look at discharge planning arrangements for this group of people to see how they were supported to reintegrate into their communities.

We identified and spoke with those who had been admitted three or more times in the last two years. We asked about the plans that had been made for discharge on this admission and what had worked well, or not, in the past.

Over four fifths of this group were able to make some comments concerning planning for discharge but one in five of those felt it was 'too early' in their admission to address this or they were too ill currently to be asked the question.

> *"The Intensive home treatment team will be visiting on a regular basis for an unspecified time. They already introduced themselves at the ward meeting today."* Comment from Commission visitor, Dykebar Hospital)
>
> *"There is a clear plan in place, will see OT and psychologist after discharge and CPN."* Comment from Commission visitor. Wishaw General
>
> *"He has not been offered preparation for discharge support during previous admissions, but this is his first time detained. He wonders if that will lead to better support for discharge this time."* Comment from Commission visitor.

Of those commenting (123) over half (59%) were clear that discharge plans had been discussed with them but the rest were not clear that any discussion about discharge had taken place.

> *"I just need things clarified and need to stop getting mixed information from different staff."*

> *“There is proper planning between all the staff from health and social work involved in my care and they are meeting to discuss what can be put in place for my discharge”.* St John’s ward 17.

> *“The care in the ward has been exceptional but on discharge there is no ongoing support.”*

Sixty four percent felt they had been involved in planning for discharge and advised they had a plan in place while 26% said they were not aware of any plan being in place as yet.

> *“Consultants don’t turn up for discharge meetings and CPN appointments are cancelled. I believe she will be in and out of hospital forever unless they plan properly.”* Comment from a relative

> *“The problem is there is a big gap when you are discharged. When I’ve been discharged before maybe had a CPN once a month. I needed more than that. I felt I had no support, no incentive to get better.”*

The most common plan in place was to be in contact with a CPN (18%) followed by contact with day services & CMHT (11%).

> *“The introduction of the IHTT is so good. Before discharge I will have gone through my crisis plan with my CPN and nurse here.”* *(*Dykebar North)

> “I g*et a lot of support from my CPN – I see him once a week and I can phone him anytime – sometimes phones 3 or 4 times a day.” (*Parkhead 1*)*

This echoed what people said they had found most helpful in the past. Contact with the CPN service (36%) was most frequently mentioned as having been helpful followed by day services and family support (26%) However, 24% said nothing had helped in the past.

> *“Gym and physical activity worked. Self help group and support from friends.”*

> *“Nothing helps, Crisis Team and CPN are not enough. There needs to be a lot more support after discharge”*

> “*I always had CPN involvement when I get home, I know that works for me.”*

Seventy eight percent were clear about who they should contact at the first signs of being unwell.

> *“I go to my WRAP group, teaching me how to be responsible for my own mental health, but I get a lot of help from my husband.” (*Wishaw General 1)

Some clear examples were provided where individuals were being encouraged to take responsibility for their future and this is looked at further in the section relating to recovery.

Recommendation

Service managers should ensure that people admitted and their carers are actively involved in and know about discharge plans.

Individuals from minority ethnic backgrounds

Mental health care should be provided in a way that does not discriminate against individuals from minority ethnic backgrounds. It must take into account the wider cultural needs of individuals addressing any communication barriers, religious beliefs or special dietary needs appropriately.

1. Discrimination

The Commission's race and culture themed visit programme in 2003-04 produced "Respecting Diversity" (ref10). This report aimed to raise our profile among organisations with an interest in working with individuals from minority ethnic backgrounds. It also aimed to raise awareness of issues relating to race and culture within the Commission. It provided an overview of national and local concerns relating to the position of individuals from minority ethnic communities who experience mental illness or learning disability.

One of our recommendations was that inspection agencies should consider the care provided by mental health services and identify and act to correct any failures to provide an acceptable quality of service for those from black and minority ethnic backgrounds. In this themed visit we undertook to consider some of these needs again.

The Mental Health (Care and Treatment) (Scotland) 2003 Act specifically requires in the principles set out in section 1.3(h) that any individuals or organisation carrying out their role under the Act shall have regard to the "religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group".

On the basis of the 2001 census, the minority ethnic population comprised just over 2% of the Scottish population, although recent estimates put this at just over 3%. Findings from previous research carried out in England suggests that those from minority ethnic groups are proportionally more likely to be detained rather than treated informally in hospital, and once there, they are more likely to be "misunderstood and misdiagnosed", "prescribed drugs and ECT rather than talking treatments such as psychotherapy and counselling" and "their rights and health care needs are less likely to be taken seriously when compared to majority white patients." (Ref 11)

We routinely ask all those we see on visits about their ethnic origin and for people from non-white UK backgrounds we also ask how well their communication, cultural, religious and dietary needs are being met. In this visit programme we added a number of questions exploring whether they had experienced discrimination since admission to hospital as a result of their ethnic background, race, religion or colour.

"Fair for All" published by the then Scottish Executive in 2002 (ref12) highlighted that a "culturally-competent service" recognises and meets the diverse needs of individuals of different cultural backgrounds. A key part of cultural competence is ensuring that discrimination on the basis of culture, belief, race, nationality or colour has no role in the delivery of services.

The Report of the Ministerial task force on health inequalities completed alongside “Equally Well” found evidence of a significant impact on health as a result of one’s cultural background.(ref 13). It reported increased rates of ill health in some minority ethnic communities and many barriers to access, including “the impact of racism on mental health and wellbeing.”

However, one NHS Health Scotland group looking into the issue of mental health and ethnicity in 2009 found that there had been very little research undertaken to evaluate the appropriateness and effectiveness of current statutory mental health services for minority ethnic communities (ref 14). The Scottish Ethnicity and Health Research Strategy Working Group recommended the Scottish Government take steps to make it possible to link ethnicity and health-related databases and carry out qualitative research designed to provide “insights into perceptions, attitudes, behaviour and experience of health and social care services of relevance to major health issues in different ethnic minority groups”.

We asked to see as many people from minority ethnic backgrounds who would be willing to be interviewed so it is not surprising that they represented a larger proportion of those seen than one would expect from a census or a random sample. It is clearly not a scientific sample and it would be unfair to generalise too much from the 36 individuals from minority ethnic backgrounds that we interviewed. Even so, important themes emerged.

Fifty eight percent were detained under the Act as opposed to about half [47%] of the total group.Four of the 36 individuals told us that they believed they had faced discrimination since admission. Two of these had complained to staff about it and both were happy with the response by staff.

Of the four, one declined to give any information about the nature of the discrimination. One volunteered that they were currently acutely unwell and that their feelings may be influenced by the psychotic symptoms they were experiencing. One told us that it was to be expected that people from one country discriminated against those from another, but described health staff as being “very kind” and had no examples of how he had faced discrimination from staff or other people himself. In the remaining one case, he said that he had been verbally abused by another person admitted to the ward. He told us:

> *“I feel inspired by my consultant, and well supported by my primary key worker, and I would like that conveyed to them.”*

But he faced swearing, name calling and insults in anger from another person admitted to the ward. Staff spoke to the other person involved. His nurse key worker provided support and reassurance to him but, quite naturally, he continued to feel uncomfortable around the other person who was not transferred to another ward. He said that staff were limited in what they could do and he didn't know what else he was looking for from them. Advocacy declined assistance to address the racial abuse he experienced as they did not view this as being in their remit. We do not think this is acceptable.

Since it is not possible to set up advocacy services that serve BME communities throughout Scotland, it is important for joint working to be encouraged and for culturally sensitive advocacy services to be developed.

2 Principles of equality and diversity

As already stated, the Act specifically requires that any individual or organisation carrying out their role under the Act shall have regard to the principles of equality and diversity. They must take into proper account the religious persuasion, racial origin, cultural and linguistic background and ethnicity of the individuals.

Communication:

> *"An interpreter has been available for meetings/reviews with the doctor and arranged for our visit. The ward has frequent contact with the interpreter service."* Commission visitor

We saw five people who could not communicate in English and three others whose preferred communication was in a language other than spoken English. They all had an interpreter arranged on the day of our visit. In one case a family member had been involved with interpretation initially on admission, but this was only until an interpreter with the right language skills had been found.

> *"Mr A had only been in hospital for a week but the interpreter was used when he was assessed by the doctor and at subsequent reviews and meetings. The interpreter had also given an explanation of the short term detention certificate."*

Twenty-eight responded to the question of how satisfied they were with how staff are communicating with them on a day-to-day basis. It was very positive to find that half were very satisfied and nearly half were fairly satisfied. One person, admitted the night before, was not very satisfied and another was very keen to be discharged as soon as possible and was not at all satisfied.

Dietary Needs

> *"I was provided with a Halal diet, which is always good".* Ward 1, Wishaw General Hospital

> *"I am happy with the Halal diet provided"* Carseview Centre

We found a range of views about the food available with most who identified themselves as having a special diet being satisfied with what was on offer, whilst a few were unhappy with the general standard of food available. One was not aware she could ask for a Halal diet and had not been offered any information about this. We raised this with the nursing staff.

Spiritual Religious and other Cultural Requirements

> "I get a private room for prayer and can also use a prayer room; there are prayers on a Friday in hospital which I go to."

We asked all 36 about whether they felt their religious needs were being met. Five answered no, two were able to give an explanation. They both attended a mosque before admission to hospital. One couldn't keep Ramadan because of medication and diabetes. He felt that no help had been offered. He wanted contact with his spiritual leader. We followed up on this and found that meeting religious needs depended on people making a request and this person had not done this. We asked that this be addressed proactively and the visitor noted that meeting the cultural and religious needs of individuals is not high in the ward's awareness levels or priorities. This was followed up by us and will be again on further visits to this ward.

The other person could not attend his mosque because he was detained and no suspension had been approved yet. When it was suggested that someone from the mosque might come in to the ward to see him, he declined this saying he does not want anyone to visit him while he is in hospital.

Most of the issues raised by people from minority ethnic backgrounds were the same as those from others –

> *"I am getting good care, they let me do what I want but sometimes I feel I am expected to do it all for myself. I am left on my own a lot."*
>
> *"My main issue is access to doctors. I was admitted two weeks ago but I have been waiting for a week to speak to a doctor."*

Recommendations

Independent advocacy services, and commissioners of advocacy services, should ensure

- the service offers assistance to people who report to them an experience of racial abuse

Service mangers should ensure

- racially discriminatory behaviour is carefully recorded and reported and the police involved if appropriate.

NHS Boards, under their Public Sector Equality Duty, should ensure

- clear procedures are in place on how to manage situations where one individual is racially abusing another (or a member of staff)
- monitoring of the number and type of incidents of racial abuse and taking steps to eliminate it
- involvement of individuals from ethnic minority communities in their service development

Dual mental health diagnosis

A high number of individuals we met with were identified as having a dual diagnosis.

The importance of building up a trusting therapeutic relationship with staff and having the chance to talk with someone and being listened to are highly valued by those with a dual diagnosis.

Our recent investigations into the care and treatment of Mr O, Ms Z and Mr F (refs 15, 16, 17) involved individuals who had a diagnosed mental illness and a substance misuse problem. We are aware that working with people who have a dual diagnosis is highly complex and challenging.

A dual diagnosis means that someone who has a mental health problem also has problems with one or more drugs, including alcohol.

The interrelationship between mental health and substance misuse can present itself in several ways and psychiatric problems may result from substance misuse or may be triggered by substance misuse. (ref 18)

All psychoactive substances have an effect on thought and cognition to varying degrees and even a low level of substance misuse can lead to significant difficulties in those with a diagnosed mental health problem.

The consequences of this can be very serious and far reaching for the individuals and for their families. These include: poor prognosis, psychological problems, social isolation, loss of safe accommodation, financial difficulties, contact with criminal justice and physical health problems which may lead to an early death.

People with these difficulties often present to their GP, A&E, social work services or come to the attention of the police when they are in crisis. We know that they frequently abscond from acute wards, default from prescribed medication, take their own discharge against medical advice and fail to attend for follow up appointments made for them after discharge.

We met with as many individuals as we could who identified themselves as having a problem in this area.We were interested to see how many had solely drink or solely substance misuse issues, how many had both and whether this varied at all across age-groups or gender.

We asked about the types of drugs people were currently using. We were keen to hear their views on the care and treatment they were getting now and had received in the past. We wanted to know what had worked or not worked for them and to review this in light of the recommendations made in the report *Co Morbid mental health and substance misuse in Scotland 2006.* (ref 19)

Of the 476 we saw as part of this exercise, it was reported that 163 (34%) had a dual diagnosis.

We found that within our total visits, a larger proportion (42%) of the men interviewed than the women (25%) interviewed reported substance misuse.
Of the 163 reporting substance misuse:

68% used alcohol and, of those, 38% reported themselves to use alcohol only.

62% used drugs of which 32% reported using drugs only; including a smaller group of 10% reporting using cannabis only.

Twenty two in this category were also identified as homeless. We found that half of those identified as homeless (19 of 38) had a dual diagnosis of substance misuse. Homeless people represented 12% of our substance misuse group. This is a relatively high proportion but was what we expected to find.

We found a high proportion, 63%, of young people aged 18-24 years in our sample reported substance misuse. Thirty percent used a variety of drugs and alcohol; of these a sub-group said they used only alcohol and cannabis.

Early onset psychosis at a younger age is an indicator of poor prognosis. Early onset psychosis for a young person who also has a substance misuse problem has a poorer prognosis.

Of those reporting drug use, the substances reported to be used regularly included:

> Cannabinoids:(63%),Amphetamines/Stimulants/Hallucinogens:(27%), Opiates and related drugs including painkillers:(29%), Sedatives:(16%), Antipsychotics :(1%).

We know readmission rates for those with a diagnosis of schizophrenia and who use cannabis regularly is significantly higher than for those who have the same diagnosis but do not use cannabis. Of those using cannabis, three quarters reported being told that drinking and/ or taking drugs might affect their mental health.

Some recognised the ill-effects of cannabis themselves:

> *“I've used cannabis in the past; cannabis cake makes my paranoia and delusions worse.”*
>
> *"I stopped taking cannabis as it makes my mental health worse".*
>
> *“I took whatever drugs were available, except cannabis as this gives me psychosis.”*

We asked what help they have had during this admission and what has been helpful to them in the past.

They said they found the following helpful:

- A positive staff attitude; staff who listen and are able to build up relationships of trust
- Being in an alcohol and drug free environment
- Good food
- Being able to get physical health care needs taken care of

- After discharge, 1:1 sessions on a regular basis, peer group support (for some) and supportive relationships.

> *"I was going to the alcohol counsellor but I only saw her once a month and that probably wasn't enough. But that was what we agreed and I wouldn't go to groups."*

Other helpful strategies included; medication for depression and anxiety, talking about problems with counsellor or CPN, taking antabuse and access to a methadone programme.

> *"Having staff to talk to and encourage me to get involved with others helped. I had been living a very isolated life when I came in."*
>
> *"The chance to talk. I have had really bad thoughts and it really helps to talk to someone."*

Some people we interviewed did not want to or did not feel ready to get help to manage their drug or alcohol dependency. They felt that by resuming drug and alcohol use they exclude themselves or are excluded from helpful services. They felt the only time they then can next access help is when they become physically very ill, hit a crisis or are detained under The Act. Some commented on the isolation they felt once they were discharged.

> *"I got support from alcohol services and this helped in the past but I did not cooperate so they withdrew."*
>
> *"From other people's point of view I drink too much and I know I smoke too much cannabis but I like it."*

Recommendations

Service managers should ensure

- Staff are able to provide or refer to a service providing drug and alcohol education and counselling
- The Care Programme Approach is considered to help ensure consistency and continuity of services and that key workers follow up assertively when an individual misses an appointment.

Parents and parental responsibilities

The majority of parents voiced concern in relation to their children and their own hospital stay. Children's understanding of mental illness, visiting arrangements and child care arrangements were common concerns. Staff must do more to enquire, identify concerns and address them. Visiting facilities for families must be improved.

The nature of family life is complex. When parents are admitted to hospital, it is not only the parent who is affected. There is also impact on children and on those who may look after them in their parent's absence. Similarly, the presence of children can affect whether those admitted to hospital receive support. Fear of losing one's children is a frequent obstacle to parents seeking and accepting help.

This is the case for parents who are admitted either informally or detained under the Act so we wanted to take the opportunity on these visits to seek the views of those who had been admitted and who had children under the age of 18.

Under section 278 of the Act, service providers have a duty to mitigate the effects of compulsory measures on parental relations. The Commission has a responsibility to monitor use of the Act and we recently looked at how services were meeting this duty for parents who were detained under the Act. We found that although there were some areas of good practice, these duties were generally neglected. We have made recommendations to improve the experience of parents who are admitted and we feel these recommendations should be implemented for all parents admitted, not just those detained under the Act. (ref 20)

Parliament is currently considering a new children's bill which will ensure better planning and coordination of children's welfare. If we are to get it right for children and their parents, we must ensure the duties are well known and improve understanding of the importance of parent/child relations, especially at times of family crisis.

At this visit, we were seeking only the views of parents admitted to the ward, we did not routinely speak with staff other than when the Commission visitor had specific concerns which they felt needed to be brought to the attention of staff on the day.

We asked whether the parent had any concerns about the current care arrangements for their child/children and access to social work where relevant. We also asked for their views on arrangements and facilities for children visiting them in hospital and for planning for discharge.

Thirteen percent of our sample identified themselves as parents of a child/children aged under 18. Half were detained in hospital. Of these, seven parents did not have parental responsibilities, including three who were detained. We found no major differences in responses between detained or informal individuals who were parents. Therefore, our findings are reported for the whole group.

Of the 61 parents interviewed, 66% were mothers and 34% were fathers. The majority of parents identified were in the 25-44 age group. These parents gave us information about 98 children and young people; a quarter aged 0-5 years, about half aged 6-11 years (primary school age), a quarter aged twelve and over (secondary school age and including 7% aged 16-17 years). The children were fairly evenly represented by gender and by age group across parents of detained or informal status.

The children had a wide range of living arrangements. A third remained in their usual home with the other parent. A similar number were living with the ex-partner/parent of the child. The rest lived with other family members or friends, e.g. grandparents or older siblings, except for three who had been adopted or were in foster care.

Parents' concerns in relation to their children

The majority of parents voiced some issue or concern in relation to their children and their own hospital stay. In general, parents did not offer these concerns spontaneously. We only found their concerns by asking specific questions. In several cases, staff did not appear to have done so.

Concerns about care arrangements and impact on household

A few parents expressed concern about the other parent who was now taking on the main caring role (e.g. alcohol use). Child protection investigations or children being on the Child Protection Register were concerns for two parents. Three parents, all fathers, said separation or an ex-partner was posing a barrier to seeing their children.

Parents worried about the impact of their admission on their partner's work. One mother described her self-employed partner as being able to arrange his work around child care needs and with the help of friends care for the children. Another feared that her husband, a night shift worker, had been off work for some months caring for two young children; his initially supportive employer was now less sympathetic.

Concerns about child's understanding of parent's mental illness

Parents spoke of younger children's upset about separation, lack of understanding and fears about the parent's mental illness and hospital stay. Examples were:

> *"He misses me but does not understand' (5 year old)*

> *"Is it because of me that Mum is in hospital again?" (9 year old asking carer grandmother).*

With older teenagers, strain or breakdown in relationships was an issue:

> *"I must make no more false promises, I've let [child] down all along. Got to turn it around" (alcohol user)*

Several parents said that they did not know how to or did not want to explain their mental illness to their children; one chose to say she was 'not well', another 'my children think I am away working'.

> *'My six year old has only been in twice and both times we've gone out. She doesn't understand why I am here and I don't know what to say.'*

Only one parent described age-appropriate information about mental illness being made available to her son and herself. Forty parents(66%) were definite this had not been offered.

> *"CPN, social worker and staff on ward have given my child material to help with [child's] depression."*

Parents views about visiting arrangements for children

Most parents (65%) had concerns about visiting arrangements. We were told of inadequate and unsettling arrangements and facilities. Around a third felt they did not want their children to visit them in the ward. They felt the ward was unsuitable or frightening for children and some preferred to meet them elsewhere or go out. The main problems were:

- Lack of a designated space for children and families (dining rooms, interview rooms, the main ward area and individual rooms or dormitories were used but all had their problems);
- Lack of privacy and the presence of others or potential for interuptions;
- General loud noise or disturbance within the ward.

A good example was this comment from a parent:

> *"I don't like having kids in the ward as there are poor facilities. The ward is too busy, there is no privacy.I don't want them in the male ward area. Facilities aren't family friendly. It doesn't feel safe. I go to the cafe or outside to see them"*

The lack of child friendly provision, including toys, books, and age appropriate materials or 'snacks' meant parents had no 'distraction' for their child or activities to engage in with them. For example:

> *"We just meet in a side room. There are no games or anything to distract us so it seems a bit artificial to be just sitting chatting "*

Even where there was a family room there were perceived obstacles to use,such as it was locked, rarely used or had to be 'booked' for special occasions.

> *"There is meant to be a family room but it's just a room with 3 chairs and is always locked. I don't think it's safe for children and there should be much better facilities."*
>
> *"If there were a few toys in the family room it would be better." (Infection control specialists do not allow toys on the ward).*

The following example highlights the need for staff to be proactive in fulfilling their S278 responsibilities for parents who are under compulsory measures. This detained mother was not allowed off the ward at the start of her admission; this was her experience of a visit with her 6 year old son.

> *"My child came in with my husband to visit, when I could not leave the ward at the beginning. He had to see me in the dorm. He was scared as another patient was shouting and swearing. No one suggested seeing him somewhere else such as quiet room (locked) or interview room - I didn't think to ask myself. Now go down to the coffee shop, as can now leave the ward."*

Staff actions to support care arrangements for children of parents in hospital

We asked parents if staff had discussed how they might be supported to continue caring for their children and if any plans or actions had been identified by this discussion. Over a third of parents responded positively saying that ward staff had asked them about care arrangements for their children. Over a third were quite definite that they had not been asked.

Only 30% of parents felt staff had talked with them about how they might be supported to continue caring for their children. Fewer still, 25%, had been assisted by staff to identify any actions towards this. Even allowing for incomplete recall, this is a dismaying finding. Most parents will experience anguish at having to leave dependent children to go into hospital, far more so when the nature of the illness is likely to involve emotional disturbance and heightened anxiety.

The following examples illustrate how sensitive enquiry by staff can help, and lead to positive practical measures to minimise the detriment to families:

> *'They talk to my husband a lot and they got the background from him and knew the plans for family support."* (Carseview, NHS Tayside)

Staff helped to promote regular visits from partner/family members, if necessary supporting special arrangements. In some wards, staff clearly asked parents how they might be supported and took action as a result to accommodate children's visits whilst ensuring safety.

> *"Children visit every night at 6pm' partner encouraged to bring children in every night before main visiting time and at a suitable time for the children's routine".* Commission visitor, Carseview, NHS Tayside

> *"Staff facilitate informal access. They allowed her to bring in food to share and keep the dining room private during the visit. They offered a room off the ward for her daughter's visits."* (Commission visitor, Langhill Clinic, Inverclyde Royal

In the following case, good staff enquiry led to a helpful discussion about her child's need for help and information, and increased information and support for the sister who was supporting them:

> *"Staff had asked about arrangements for her son who was being cared for by aunt. They had identified a need for increased support for the whole family to help mum's recovery. As a result her sister was coming in to a meeting on the*

> *ward the following day; her son now had a social worker who had talked to him about his mother's illness and his own problems. Ward staff and mum's CPN had given him a leaflet about depression and talked it through with him and as a result he had gone to his GP and Mum felt relieved that he is now getting the help she thinks he needs".* Commission visitor

There were also positive examples of staff helping address concerns about important times in their children's lives, and of helping them find ways to be there for their children. This included appropriate spells of leave from hospital, e.g:

> *"I have discussed with them visits home and whether I feel able to go to my son's 4th birthday party which is next week. I am going to go for lunch but not stay for the party."*

> *"I am on 3 hour passes just now so have been home to my wife and my 3 year old child for visits. I don't feel ready to be at home."*

More often, we found situations where staff had not discussed arrangements for children. We found parents with deep anxieties. We found that failure on the part of staff to make specific enquiry about arrangements for children seemed to be associated with a tendency to simply assume that the parent has arrangements in place and is happy with them. There are missed opportunities to identify and address worries and aid recovery.

> *"Nothing was mentioned. I think they assume the children are with my mum. Staff sometimes ask how the kids are but that's it."*

Family circumstances change, and even when ward staff know someone well it is not reasonable to place the responsibility on the acutely unwell parent to report changes since last admission:

> *"They have not asked this time because they know mum and X look after him."*

We were very concerned about what we heard from one mother who was concerned about her children being cared for by another relative. Our visitor recorded:

> *"The nursing staff say they do not know or cannot help with arrangements for her children. They tell her to phone her social worker who does not attend the ward.I spoke to staff about this and they do not know what is happening regarding access, visiting etc. They could not tell me if the arrangement with her relative was voluntary or whether or not she still had parental responsibilities. They informed me they hadn't asked the social worker."*

It is hard to see how recovery can be helped if these issues remain unexplored by staff.

Social Work involvement and discharge planning

Almost a third of parents mentioned social work input to the family. This was either to the parent(s) or children, or both.This was more likely amongst detained than informal individuals and was seen as helpful. Comments from our visitors included.

> *"Detained parent with a toddler, said social work had helped her get a house and supported her in getting an injunction against a violent partner. They would also be putting extra support into the home when parent was discharged."* Commission visitor

> *"Mother, children living with ex-partner, had concerns about partner's drinking and ability to care properly for children. SW were involved and investigating whether there were child protection concerns or need for alternative arrangements and were liaising with ward staff and the parent."* Commission visitor

About 10% of parents identified a child/children as taking on carer responsibilities when they returned home. Clearly, this makes the inertia about providing age-appropriate information about mental illness all the more worrying.

Considering all of the above, we believe the challenges, and the solutions, must involve professionals from a range of agencies and disciplines. We also believe that those who commission services should commit more consideration to the resources required to support families where a parent is subject to compulsory measures.

We have already recommended to Scottish Government that mental health legislation should include duties on certain agencies to support parents in carrying out their parental roles. Our findings in this report strengthen the need for such a requirement.

Recommendations

Service managers should ensure that

- Staff ask at the earliest point possible in the admission about arrangements for children and determine whether the parent has concerns, whether other agencies need to be involved or included in care planning , review and discharge planning
- Staff are aware of the potentially wide range of support needs of parents. From those with healthy relationships with their children and supportive partners who appear to need or want little support, to those with complex family relationships where the needs of the child may be overlooked or only partially addressed
- Staff know how to access and share age-appropriate information about mental illness to support individuals who are parents in talking with their children
- Safe, welcoming, private and child-friendly facilities are provided for visits. Age-appropriate toys, games, snacks and drinks should be available. Concerns regarding infection risks to be addressed.

Homeless or in unsettled accommodation prior to admission

Homelessness or housing uncertainty has an impact on the mental health of people admitted. It should not be considered simply a social work or housing department problem or only discussed or addressed at discharge.

People with mental health problems are also more likely to become homeless (ref 21). Being homeless makes it harder for mental health services and others wanting to provide services to reach out and offer effective support.

They can often come into contact with a range of services, none of which singly takes responsibility for them, and none of which can on their own meet all their needs.

The Commission does not have a remit to look at all of the services provided to individuals facing homelessness. However, we have enquired about the care of some people with mental health problems who have had contact with homeless services, and found improvements necessary.

We have held discussions with a range of those working with mental health and homelessness and found a number of key areas where there could be improvement in practice.

We asked to speak to everyone in the acute admission wards we visited if they had been homeless or had unsettled accommodation in the six weeks prior to admission.

We asked what help they were receiving to sort out their accommodation difficulties whilst they were in hospital,and what they knew about where they would be living after discharge. Of the 38 individuals who were identified that met this criterion, 35 agreed to speak with us.

Prior to admission half of those we saw believed that their housing situation had negatively affected their health. Many had moved through a variety of accommodation types in the six weeks before admission and had a range of experiences which some found distressing.

> *"I came here from Europe a year ago. I worked at first but was not paid enough to keep a flat so I slept on scaffolding and the beach for two months. I had no benefits, no mental health support, no family and no support from friends."*
>
> *"I felt a burden to everyone. The offer of homeless accommodation was awful; it was frightening to me that I would end up there."*
>
> *"I was in a B&B with a curfew at 10pm. Temporary accommodation is usually disgusting - one stank of dog and had a mouldy bathroom. Sofa surfing is horrible. I relied on 4 friends and felt bad for them."*

Some reported that they were not registered with a GP because of their situation, whilst others travelled to a relative’s address to keep appointments with community psychiatric nurses. One said he lost contact with his Community Mental Health Team and was not sure if he was sent any appointments once he became homeless.

We are aware that in some Health Board areas there are health teams working closely alongside social work and housing colleagues. A half of those we spoke to told us they had no problems accessing health services.

A third of those we spoke to had received some help before admission from a housing or homelessness officer and most had found this helpful. But the majority [two-thirds] did not know where they would be living when it came to discharge.

> *“He told me he was leaving hospital tomorrow. He didn't know yet where his accommodation would be, he said, "the social worker will just tell me on the day”.* Commission visitor comment.

We interviewed a small number of those who identified themselves to us as having housing problems and nursing staff were unaware of this when we brought these to their attention. A few also told us that since mentioning their difficulties to the nursing staff they had received very little or no help.

However, half of those we spoke to said they were being offered help to sort out their housing problems whilst in hospital. Many were able to give good examples of how they had been helped, with meetings being arranged, free access to telephones given and key people being contacted.

> *“His Consultant has written to housing and the nursing staff and OT have helped him with internet searches and got him a bus pass.”*

Recommendations

Service managers should

- Ensure individuals are routinely asked on admission about their accommodation and know who to contact if housing issues are identified.

In conjunction with social work partners and housing departments

- review their current joint working arrangements to ensure they are meeting the needs of homeless individuals with mental health problems

- ensure consideration is given to using Care Programme Approach where multiple services are intervening.

Summary of recommendations

Admission and participation

Service managers should ensure:

- people admitted are given information about the ward in appropriate formats
- people are given information about and involved in planning their care
- in conjunction with Social Work departments, that admission assessment includes consideration of social factors and that appropriate referral systems are in place. Staff and those admitted to hospital need to be able to access advice and support to address worries about finances and their housing situation.

Therapeutic activity

Service managers should review in conjunction with Occupational Therapy departments

- Their current activity provision and ensure that staff are able to provide a range of therapeutic activities both within and outwith normal working hours.

Restriction and observation

Service managers should:

- Review the potential restrictions that people admitted are subject to
- Ensure that any restrictions applied are individually assessed, proportionate and justifiable.

Scottish Government to:

- Commission a review of Engaging People, Good Practice statement on the observation of people with acute mental health problems in Scotland This review is required to ensure that the national good practice guidance reflects changing practice and that observation levels are the least restrictive and tailored to individual risk.

Attitudes and availability of staff

Service managers should:

- Work with staff and individuals admitted to look at barriers locally to individuals approaching staff and consider adaptations that can be made to the physical environment to improve communication and visibility of staff.

Feeling safe and secure

Service managers should:

- Review the current accommodation within admission wards to ensure it affords maximum respect for privacy and dignity
- work with staff and people admitted to the ward to look at how best to manage distressing incidents

Recovery

Service managers should ensure:

- accomplishment of Scottish Recovery Indicator 2 and act on the areas for improvement identified

Peer support

Service managers should ensure:

- staff recognise and understand the value and importance of informal peer support

The physical environment

NHS Chief Executives and Boards should act to ensure improvements in areas where concerns about the physical environment have been identified.

Scottish Government should specify the environmental standards expected and in conjunction with Healthcare Improvement Scotland should monitor compliance with these standards.

Services need to be clear about the smoking policy within wards and IPCU's and within the hospital gardens and grounds.

Discharge planning for individuals with multiple admissions

Service managers should ensure:

- that people admitted and their carers are actively involved in and know about discharge plans.

Individuals from minority ethnic backgrounds

Independent advocacy services, and commissioners of advocacy services, should ensure

- the service offers assistance to people who report to them an experience of racial abuse

Service mangers should ensure

- racially discriminatory behaviour is carefully recorded and reported and the police involved if appropriate.

NHS Boards, under their Public Sector Equality Duty, should ensure

- clear procedures are in place on how to manage situations where one individual is racially abusing another (or a member of staff)
- monitoring of the number and type of incidents of racial abuse and taking steps to eliminate it
- involvement of individuals from ethnic minority communities in their service development

Individuals with a dual mental health diagnosis

Service managers should ensure:

- Staff are able to provide or refer to a service providing drug and alcohol education and counselling

- The Care Programme Approach is considered to help ensure consistency and continuity of services and that key workers follow up assertively when an individual misses an appointment.

Parents and parental responsibilities

Service managers should ensure:

- Staff ask at the earliest point possible in the admission about arrangements for children and determine whether the parent has concerns, whether other agencies need to be involved or included in care planning , review and discharge planning

- Staff are aware of the potentially wide range of support needs of parents. From those with healthy relationships with their children and supportive partners who appear to need or want little support, to those with complex family relationships where the needs of the child may be overlooked or only partially addressed

- Staff know how to access and share age-appropriate information about mental illness to support individuals who are parents in talking with their children

- Safe, welcoming, private and child-friendly facilities are provided for visits. Age-appropriate toys, games, snacks and drinks should be available. Concerns regarding infection risks to be addressed.

Homelessness

Service managers should ensure:

- individuals are routinely asked on admission about their accommodation and know who to contact if housing issues are identified.

In conjunction with social work partners and housing departments:

- review their current joint working arrangements to ensure they are meeting the needs of homeless individuals with mental health problems

- ensure consideration is given to using Care Programme Approach where multiple services are intervening.

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Definitions used

Most = more than 80%

Majority = 56-80%

About half = 45-55%

A minority= 20-44%

A few = less than 20%

Very few = less than 10%

APPENDIX: table of all wards visited

Table of wards visited by Health Board

HEALTH BOARD	HOSPITAL	WARD NAME	WARD TYPE	BED NUMBERS
Ayrshire & Arran	Ailsa	IPCU	IPCU	**7**
		Kyle	ADM	**22**
		Park	ADM	**22**
	Crosshouse	1D	ADM	**22**
		1E	ADM	**22**
Borders	Borders General	Huntlyburn House	ADM	**24**
Dumfries & Galloway	Midpark	Balcary	IPCU	**6**
		Ettrick	ADM	**17**
		Nithsdale	ADM	**17**
FIFE	Queen Margaret	2	ADM	**30**
	Stratheden	**IPCU**	**IPCU**	**10**
		Lomond	ADM	**30**
	Whytemans Brae	Ravenscraig	ADM	**29**
Forth Valley	Forth valley royal	2	ADM	**18**
		3	ADM	**24**
		IPCU	**IPCU**	**12**
Grampian	Dr Grays	4	ADM	**20**
	Royal Cornhill	Brodie	ADM	**28**
		Corgarff	ADM	**28**
		Crathes	ADM	**28**
		Drum	ADM	**28**
		IPCU	IPCU	**11**
Greater Glasgow & Clyde	Dykebar	East	ADM	**21**
		North	ADM	**21**
	Gartnavel Royal	Henderson	ADM	**20**
		IPCU	IPCU	**12**
		McNair	ADM	**20**
		Rutherford	ADM	**20**
	Inverclyde Royal	Langhill-IPCU	IPCU	**8**
		Langhill-Langhill Clinic	ADM	**20**
	Leverndale	3	ADM	**24**
		4	ADM	**24**

		Beith/31	ADM	**15**
		IPCU	IPCU	**12**
	Parkhead	1	ADM	**24**
		3	ADM	**24**
	Southern General	32	ADM	**15**
	Stobhill	Armadale	ADM	**20**
		Broadford	ADM	**20**
		Portree	IPCU	**12**
		Struan	ADM	**20**

HEALTH BOARD	ADM	WARD NAME	WARD TYPE*	BED NUMBERS**
Highland	Argyll and Bute	IPCU	IPCU	**7**
		Succoth	ADM	**23**
	Newcraigs	Affric	IPCU	**10**
		Maree	ADM	**12**
		Morar	ADM	**24**
		Ruthven	ADM	**24**
Lanarkshire	Hairmyres	19	ADM	**25**
		20	ADM	**25**
	Monklands	24	ADM	**24**
		25	ADM	**24**
	Wishaw general	1	ADM	**23**
		2	ADM	**23**
Lothian	Royal Edinburgh	Balcarres	ADM	**40**
		Hermitage	ADM	**20**
		IPCU	IPCU	**12**
		Meadows	ADM	**20(F)**
		Merchiston	ADM	**20(M)**
	St Johns	17	ADM	**24**
		1	IPCU	**12**
Tayside	Carseview Centre	1	ADM	**18**
		2	ADM	**22**
		IPCU	IPCU	**12(M)**
	Murray Royal	Moredun A & B	ADM	**30**
	Stracathro	Mulberry	ADM	**25**

*** All wards are mixed except where identified with a (F) or (M)**

**** Bed numbers given were given by the services prior to the visit and have not been verified as the actual bed state at that time and are as such indicative only**

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