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VISIT AND MONITORING REPORT

Medium and low secure forensic wards

AUGUST 2017

Contents

The Mental Welfare Commission

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Executive summary

The Mental Welfare Commission protects and promotes the human rights of people with mental ill health, learning disabilities, dementia and related conditions. One of the ways we do this is by checking if care and treatment of individuals are lawful and in line with good practice.

The Commission carries out themed visits where we visit similar services over a short period of time and ask key questions of patients, visitors and staff. In 2016 we visited all forensic medium and low secure wards across Scotland.

We reviewed the care of 165 patients and met with most, 85%, in person. We wanted to find out about the experience of patients and visitors and to check that their rights were being respected. This report shows our findings from these visits.

The Commission regularly visits medium and low secure wards but has not previously carried out a large scale themed visit. Patients in these wards are subject to some of the highest levels of restrictions and we wanted to hear about the experiences of people receiving care and treatment in these wards and if their rights were being respected.

Summary of findings

Mental health care and treatment

We found many areas of good practice, but also some areas which we felt could be improved. In general most patients we met with spoke well of their care and treatment and also of the staff caring for them. Understandably, some patients were not happy about being compulsorily detained in hospital and being required to take medication.

We found good attention was being paid to physical health needs, good access to independent advocacy and good provision of therapeutic and recreational activities.

We found the quality of the accommodation was generally good and well maintained, with access to outdoor space. There were a small number of wards for patients with learning disability that were less fit for purpose; this is an equalities issue that services need to actively review.

We found a level of attention to detail and good patient participation in care planning that we often find lacking in other wards that we visit. Most patients were managed using the Care Programme Approach (CPA) which gives enhanced coordination of care and support, particularly in relation to accessing other professions such as psychology and occupational therapy. Risk assessment and risk management are major factors in care planning for these patients and this was well evidenced.

Physical health

Around half the people we saw had chronic physical health problems. The majority considered they were receiving adequate support and advice in this regard, and we saw some good examples of engaging patients in their physical health care. We found that 88% of people had routine health checks, the remainder had ready access to GP services, and there was good follow up of health issues.

Health promotion

There was an emphasis in most units on healthy eating, and there were opportunities for exercise, but almost half the patients we interviewed had concerns about being overweight and nine per cent had concerns about getting access to opportunities for exercise.

Smoking remains prevalent with over 40% of patients reporting they were smokers. There was considerable variation in the restrictions in smoking between wards, particularly between independent and NHS hospitals, and it was a topic that evoked strong views from patients. It was clear that patients were offered support with smoking cessation on an ongoing basis.

It is important to see health promotion in the context of the high incidence of chronic physical health problems in this patient group.

Moving on

We were informed of difficulties for patients in medium secure wards who had made successful applications against their level of security and were awaiting moves to lower levels of security. It was evident that there were no places in low security readily available and these patients were on waiting lists.

In 24 low secure wards we were heard that there were 61 patients waiting to move to either a rehabilitation service or a community setting. We consider that this requires investigation as these delays are potentially resulting in patients remaining in environments in which they are living lives that are excessively restricted; it is also preventing other patients in higher security moving on.

We also heard of patients being frustrated on transition from a higher level of security to a lower level. Patients who had been able to achieve a considerable level of more independent leave and access to grounds and time in the community had to regain these ‘privileges’ when moved to a lower security setting. This was particularly evident when moving from medium to low security. In some cases this resulted in patients not being able to attend placements that they had been able to attend in higher levels of security. We heard that in some cases this frustration and lack of understanding of the situation had a detrimental effect on the patient’s mental health.

Restrictions

Often we did not think that restrictions were being applied in the least restrictive way. We found variance in practice across the country in relation to the application of restrictions; ranging from the number of personal belongings some patients were allowed to keep in their bedroom through to the use of seclusion.

We were not always clear why some wards seemed to keep the use of restrictions to a minimum and others did not; this also applied to the use of specified person provisions in low secure wards.

Each patient in a low secure unit should be individually assessed as to whether specified person measures are necessary and there should not simply be a blanket assessment of all patients in the ward.

Feeling safe

Around one in five patients said they felt unsafe at times in the ward or partially unsafe. For many it was related to incidents on the ward or perceived threats from other patients.

Patients have a right to feel safe and secure in hospital care, and should be able to approach staff where this is not the case and know that their issues will be addressed. Staff in turn need to feel they are able to provide a safe environment for patients with appropriate staffing levels.

Bearing in mind patients comments about feeling unsafe in wards following an incident, it is important that a post incident/restraint debrief is always carried out and that this extends to people who have witnessed incidents.

Women

Only two of the three medium security units accommodate women. In Rowanbank Clinic, though there are single sex wards, on the women's ward there is a mix of patients with learning disability and mental illness which is not the situation for men. In the Orchard Clinic there are only mixed wards, and women can be unsettled by sometimes being the only woman on a mainly male ward.

In low security, the main issue is that there are fewer female hospital options for women, and they are often in hospitals outside their home health board area. Often the only option for women is an independent hospital due to lack of local health board provision.

Patient mix

Many patients in the wards we visited have committed very serious offences. These patients are likely to have been detained by the criminal courts and may have spent many years receiving treatment in higher levels of security before being able to progress to lower levels of security.

It was evident from our visits that nearly half of the patients in low security wards were on mental health act orders, not criminal court orders. Some of these patients may have an offending history but others will not, and for those that do, offences are often less serious. Many of these patients are in medium or low security wards because they cannot be safely cared for in adult (non- forensic) services.

This indicates two very distinct groups of patients, mostly in low security, with potentially different needs to be considered. Many of the 'non-forensic' patients are in independent hospitals and away from their home areas; most of the women in low security are in this group of patients.

Advance statements

Forty two per cent of patients we met with said they had an advance statement. The Commission's recent report in relation to Adult Acute Services (April 2017)[1] reported only about 7% of patents interviewed had advance statements, so the situation on medium and low security wards is much better in relation to uptake of advance statements . There still, though, appears to be a level of uncertainty about advance statements amongst patients.

Peer support workers

Only one of the hospitals we visited employed peer support workers.

Staff and patients told us this has been very successful, particularly on the rehabilitation wards. These workers are able to work individually with patients, helping with recovery plans, general support and also helping in staff training.

Carers

Carers generally said they felt supported and kept informed by staff but a long distance to travel often made visiting difficult.

[1] Adult Acute Themed Visit Report (April 2017)

Promotion and maintaining life skills

There is concern regarding the lack of facilities (with some exceptions) to embrace this aspect of recovery, particularly given the number of years many patients spend on these wards.

Key points for ward managers

Managers of medium and low security wards should review this report with staff and patients to consider aspects of their current practice that can be improved, particularly in relation to these specific issues identified in the report:

Minimise unnecessary restrictions

- Examine the need to restrict patients' access to their bedrooms.
- Examine the need to restrict the number and types of items patients have in their rooms.
- In low secure wards each patient should be *individually* assessed as to whether being a specified person in terms of safety and security is necessary.
- Examine the need to restrict mobile phones and internet access, particularly for non-forensic patients.
- Ensure that a seclusion policy is in place that helps staff to determine if their interventions amount to seclusion.
- Ensure compliance with Secure Care Standards[2].

Ensure that all efforts are made to help patients feel safe

- There should be clear procedures for debriefing staff, patients and witnesses following incidents of restraint or seclusion. Details of the debriefing should be recorded in the patient's file.
- Ensure the right number of appropriately trained staff are available to maintain patient safety.
- Ensure the ward environment facilitates the management of distressed patients without the necessity of having to use patient bedrooms for isolation.

Promote physical health, wellbeing and recovery

- It is important to maintain a focus on healthy eating and ensuring access to some form of exercise for all patients, even where they are unable to leave the ward.
- Make sure staff are available where required to assist with exercise.
- Develop peer support opportunities.
- Continue promotion of advance statements.
- Improve opportunities to maintain and develop 'life skills'.

[2] Secure Care Standards - High and Low

- Develop patient opportunities for education, training and employment.
- Ensure alcohol and drug problems are sufficiently addressed.

Provide a ward environment to enhance recovery

- Have outside areas that are welcoming and enhance wellbeing.
- There should be facilities for patients to have privacy in seeing or phoning relatives and friends, unless there are assessed risks precluding this.
- Address improvements needed to the ward environments, particularly for learning disability wards.

Support families and carers

- Provide evidence of family and carer involvement; clearly documenting agreements around information sharing and how the specific difficulties for family contact are being addressed for each patient.

Recommendations

Scottish Government should:

1. Take forward and progress the work of the 'Forensic Mental Health Services Estate Review Group' to ensure appropriate medium secure provision, including for women and young people.

2. Require integrated joint boards / health boards to submit co-ordinated development plans for low secure and community forensic services.

3. Provide national support to assist in forensic service development.

4. Develop guidance, with advice from the Forensic Network, the Royal College of Psychiatrists in Scotland and the Mental Welfare Commission, to ensure consistent, rights-based practice in relation to restrictions on patients subject to enhanced levels of security.

5. Monitor delays for patients ready to move to less restrictive settings and address barriers to moving on.

6. Review processes in relation to granting permissions for restricted patients when moving to lower levels of security to ensure patients are not unnecessarily subjected to greater restrictions.

7. Work with the Mental Welfare Commission to update the regulations and guidance regarding use of mobile phones, technology and the internet.

Integrated joint boards / health boards (as appropriate) should:

8. Formally review the availability of low secure in-patient and community forensic provision to ensure there is adequate capacity to meet current and likely future need.

9. Minimise the use of out of area placements, except for highly specialised care.

10. Address issues of the inequalities in environment in their low secure wards (where they exist) for patients with learning disability.

Scottish Patient Safety Programme Mental Health (SPSP) should:

11. Consider the issues raised in this report regarding patients feeling safe, and promote the use of the patient safety climate tool in forensic wards.

12. Consider the issues raised in this report regarding the use of seclusion, and make recommendations regarding practice improvement.

13. Consider the issues raised in this report regarding the use of restraint, and make recommendations regarding practice improvements and debriefing for staff and patients.

14. Consider the extension of SPSP to include learning disability and independent hospitals. We appreciate that this would require additional resource.

What the Mental Welfare Commission will do next:

- We will write to all NHS health boards and independent hospitals to ask them to draw up an action plan for meeting our key recommendations.
- We will review how often we visit all low and medium secure forensic wards, particularly independent hospitals.
- We will use the information from these visits to inform future local visits to medium and low secure wards.
- We will review our guidance on the use of seclusion. We will do this in consultation with SPSP, the Forensic Network and the Royal College of Psychiatrists in Scotland.
- We will liaise with Healthcare Improvement Scotland(HIS) to determine how often we should visit independent low secure hospitals (HIS regulate and inspect independent hospitals in Scotland) and work closely with HIS inspectors in relation to monitoring of restraint and seclusion.
- We will update the Commission advice note on smoking.

Introduction and background

What this report is about

This report details what we found when we visited all medium and low security mental health inpatient wards across Scotland providing care for adults. It contains recommendations we have made to improve care, and highlights some good practice we found.

We reviewed the care of 165 patients and met with most, 85%, in person. We also had contact with 14 carers and we spoke to staff in all the wards.

Why we carried out these visits

The Commission has not previously carried out a large scale themed visit to medium and low security inpatient wards, though we visit them regularly on local visits.

Patients in these wards are subject to some of the highest levels of restrictions. We wanted to hear about the experiences of people receiving care and treatment in these wards, and if their rights were being respected.

Since 2006, patients in the State Hospital have been able to contest their level of security to the Mental Health Tribunal for an order declaring that they are being detained in conditions of excessive security. On 16 November 2015, the opportunity to contest their level of security[3] was extended to include patients detained in the three Scottish medium secure units; Rowanbank Clinic in Glasgow, the Orchard Clinic in Edinburgh and Rohallion Clinic in Perth. We wanted to see if this change in legislation was having an effect on services.

The Commission has also received concerns regarding the adequacy of provision in the forensic estate, particularly in relation to low security provision. This was identified in the Commission's Intensive Psychiatric Care in Scotland[4] (2015) report and from contacts with individual patients and hospitals.

The Scottish Government is aware of the issues of capacity within forensic mental health services, and recently commissioned a reference group the 'Forensic Mental Health Services Estate Review Group' to review capacity in the forensic estate, at which the Commission was represented. The findings of this group are still being considered by Scottish Government.

[3] Mental Health Legislation: Detention In Conditions Of Excessive Security
[4] Intensive Psychiatric Care in Scotland

Promoting a human rights approach to mental health services

Patients in secure mental health services are restricted in relation to freedoms that would be expected by individuals in other hospital or community settings. Given these restrictions, it is particularly important to ensure that their rights are protected, and any restrictions are applied lawfully and with good reason. It is also fundamentally important that these restrictions are applied for as short a period as can be rightfully justified.

The Commission has recently produced a patients' rights care pathway 'Rights in Mind[5]' developed in partnership with the Scottish Human Rights Commission, the NHS Scottish Patient Safety Programme (Mental Health) and the Royal College of Psychiatrists in Scotland and with input from patients and carers. Though developed for adult acute wards, this rights pathway is also very relevant for patients in medium and low secure wards.

A human rights based approach is about increasing the ability and accountability of all mental health care practitioners to respect, protect and fulfil human rights. It is also about empowering individuals to know and claim their rights.

This approach supports patients to gain a stronger role in participation so that they can help shape decision making around their own care and treatment. In addition, it helps staff to recognise and respect patients' rights, and to make sure that they are accountable when observing these in their day-to-day role.

The Human Rights Act provides an overarching framework within which the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Criminal Procedure (Scotland) Act 1995 must be applied.

This report has been written with these 'Rights in Mind' and all inserts:

Patients have the right to:

- **Relate to references from the Commission's good practice guide which accompanies Rights in Mind – Human Rights in Mental Health Services[6].**

[5] Rights in mind pathway
[6] Good practice guide - human rights in mental health services

Our visits

How we carried out these visits

We wrote to Scottish health board chief executive officers to request a list of all of the medium and low secure / forensic wards in their health board; we also asked for details of other out of area arrangements. In addition to this, we wrote to the managers of the two independent hospitals that provide low security mental health care in Scotland and the Forensic Network to advise them of our visits. We used the information gained from the replies to our letters to establish which wards should be included in our visit.

To help include issues raised by patients and carers in the questionnaires for our visits, the Commission's engagement and participation officers arranged a number of meetings with patients' groups and carers' groups. We would very much like to thank all the patients, families, carers, advocacy providers and groups involved for their time and help. We would also particularly like to acknowledge our appreciation to Circles Network advocacy and Support in Mind Scotland for their assistance in arranging these contacts.

From the information gathered we developed interview schedules for patients, carers and staff. We also used an audit tool to assess the physical environment of the wards.

Key information on the patient group we visited

Medium and low security inpatient facilities are primarily concerned with the assessment, treatment, rehabilitation and care of patients suffering from a mental disorder (or related conditions) who have been given mental health disposals by the criminal courts, or patients transferred from prison due to mental illness during their sentence. These wards are frequently referred to as forensic wards, and these patients as forensic patients, due to their links with the courts and legal system.

These wards however (particularly low secure) also provide care and treatment for some non-offending patients, including those whose care is difficult to safely manage in non-secure services.

There are three levels of enhanced security for inpatients in Scotland:

High Secure Services - provided at a national level	The State Hospital, Carstairs
Medium Secure Services - provided at a regional level - three units	North – Rohallion Clinic, Perth South East – Orchard Clinic, Edinburgh West – Rowanbank Clinic, Glasgow
Low Secure Services - provided at a local level by health boards	Most health boards have low secure services

The focus of this visit was to the medium and low security forensic wards, not the high security State Hospital. The Commission currently visits the State Hospital twice a year as part of the visit programme.

Medium and low secure services across Scotland: Facts and figures

Prior to our visits, we sent ward managers a form to provide us with details of their wards. This included details of numbers of patients, and some basic information about patients on their ward on the day of our visit.

Wards and bed numbers

From the information the Commission received from individual health boards, there are 14 medium secure and 32 low secure wards in Scotland - 46 wards in total.

This includes one medium secure ward and 11 low secure wards designated for people with learning disabilities, though there are some patients in other forensic wards who have a learning disability in addition to their mental illness.

It is evident that low security services have largely grown in response to local need, and there seems to be no consistency of provision across health boards. It is particularly noticeable that Lothian, one of the largest health boards, has no low secure provision for non-learning disability patients, meaning these patients require to be cared for away from their home area. They are, however, not alone in this.

Information received from the wards we visited showed that the total number of beds for the medium and low security wards was 439. Of these, 146 beds are in medium security wards with, 12 (8%) of these beds at Rowanbank designated for learning disability patients. Two hundred and ninety three beds are in low security wards, with 63 (21%) of these beds designated for people with learning disabilities.

We were informed that 54 of the 439 beds are designated for female patients, and 34 can be used as male or female beds, depending on what is required. The remainder are beds for male patients.

From information gathered from the ward mangers during the day of our visits.

There were:

- 400 inpatients across all the secure wards we visited – this was not a single day snapshot but a combination of data from the individual wards across the three month visit period. [This would not be the same figure as a one day snapshot, but given that there is not a high level of patient movement in these services, it is a reasonable reflection of total numbers].

- 56 (14%) of patients were women.
- Of 129 patients in medium secure wards, 12 (9%) were women.
- Of 271 patients in the low security wards, 44 (16%) were women.

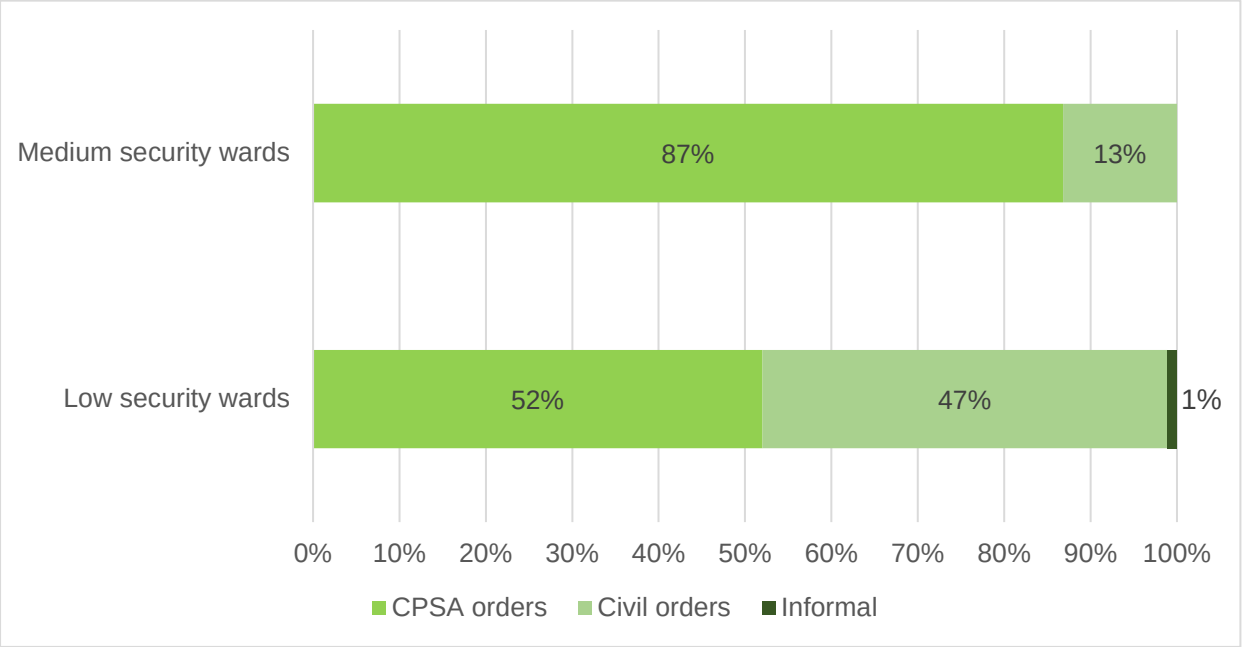
Patient Profile – all patients

Legal status

We looked at some of the details we had requested in relation to the type of orders that patients in the various wards were subject to. We wanted to gain an impression of the profile of patients in the two different levels of security. We had expected that the vast majority of patients in secure wards would be detained due to the restrictions imposed on patients in these wards, and this was indeed the case.

There was, however, a very noticeable difference between the levels of Criminal Court, Criminal Procedure (Scotland) Act 1995 (CPSA) orders - with 87% of patients in medium secure wards on CPSA orders - compared to only just over half of the patients in low security wards.

Figure 1: Medium and low security wards; Civil and CPSA orders



This potentially indicates that low security wards have two distinct groups of patients: one group of patients detained by the criminal courts who may have committed serious offences, and another group of patients on mental health act orders who were there because adult (non-forensic) services have been unable to safely manage their care.

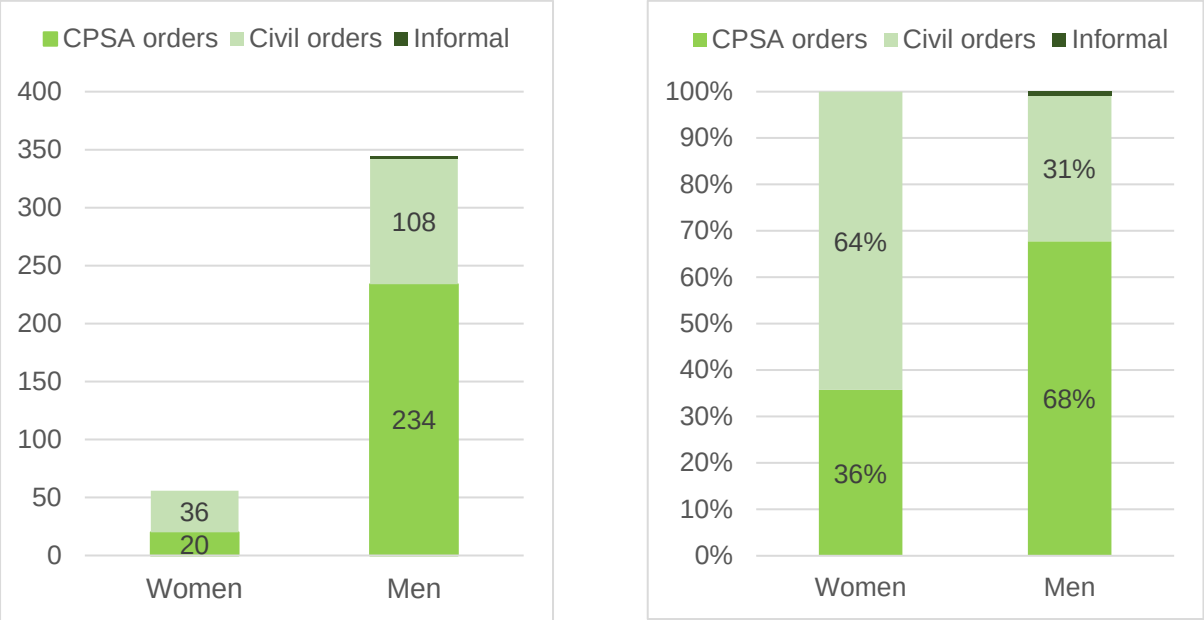
It is acknowledged that some of these mental health act patients may also have a forensic history, but many others will not.

There is a need to look closely at the two distinct patient groups in medium and low security wards and address how their needs and risks are best met and managed.

It is important that there is appropriate local provision for longer term patients with complex mental health needs who have not been convicted of serious offences.

The proportion of women on CPSA orders is very different from that of men. Men in secure care are mainly subject to CPSA court orders, with 68% being there on CPSA orders. This situation is reversed in the situation of women, with 64% being subject to civil orders.

Figure 2: Men and Women; Civil and CPSA orders



We noted that most of the women in low security - 33 (75%) - are patients in the independent sector hospitals. Twenty four (73%) of these women are on civil orders and only four (12%) are restricted patients. Many of these women have a history of severe self-harm and complex trauma; about half have diagnosis of a personality disorder.

Restricted patients (see Appendix 1)

These are patients on CPSA orders where Scottish Ministers have a specific statutory role in overseeing the decisions being made about leaving the hospital for any period of time. About half - 46% (183) - of the patients were restricted patients.

Table 1: Restricted patients by security and gender

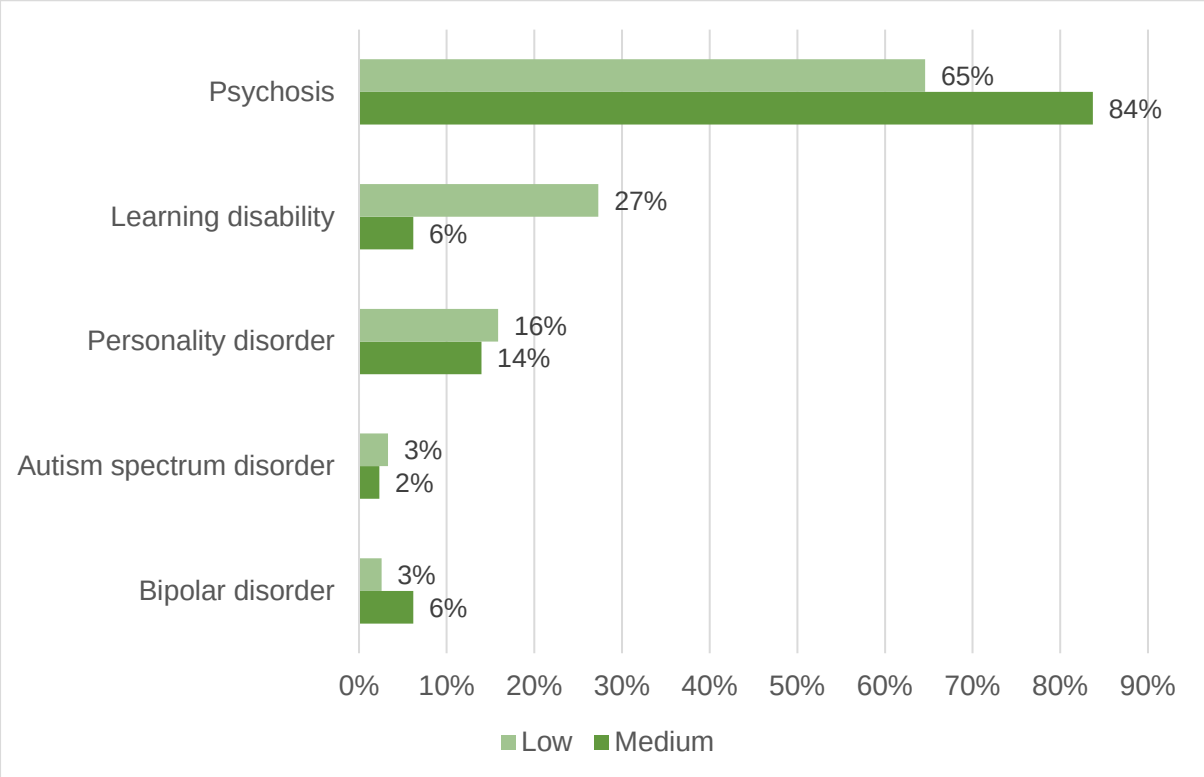
Restricted Patients			
	male	female	**Total**
Medium Security	86	4	**90**
Low security	84	9	**93**
Total	170	13	**183**

Diagnosis

We looked at patient diagnosis from the returns we received from ward managers (400 patients); the range of diagnosis was as below. Some patients were listed with more than one diagnosis.

In terms of mental disorder, psychosis was by far the most prevalent diagnosis in both medium and low security wards, and there were also notable levels of personality disorder diagnosis in both levels of security. Patients with a learning disability feature significantly in the low secure patient population; for some patients the learning disability was listed as mild. Diagnosis levels of depression, alcohol related brain damage (ARBD) and acquired brain injury (ABI) were all less than one percent.

Figure 4: Patients by diagnosis and security level



Some patients (14%) were listed with more than one diagnosis, which added to the complexity of their illness.

- 6% of patients with psychosis were also stated as having a personality disorder.
- 15% of patients with a learning disability were also listed as having a personality disorder.
- 17% of patients with a learning disability diagnosis also had a diagnosis of psychosis.

Who we saw

Prior to our visits, we provided information leaflets and posters to let patients know of our intention to visit, and to give them the opportunity to meet privately with us. On the day of our visits we met the patients who had agreed to speak with us. We also introduced ourselves to other patients on the wards to explain about our visits and managed to hear about many of their experiences; this particularly helped increase the number of patients we saw on learning disability wards.

Our initial target had been to meet with 100 patients as part of our visits, but during the visits we reviewed the care and treatment of 165 patients, and met with 140 of those patients directly to ask them about their care. This represented just over 41% of the total number of patients cared for in these medium and low security wards. Although our focus on the visit is to meet with as many patients as possible who want to meet with us, we also make sure we select some patients to interview who have not asked to speak to us in advance; particularly those who may be acutely unwell, have communication difficulties or for whom English is not their first language. We review the care and treatment of a wider range of patients to ensure their rights are being respected.

Almost all the patients we saw identified as White Scottish, with 6 (4%) identifying themselves as being from other ethnicity groupings. No patients mentioned cultural needs failing to be met.

Details of the wards visited, bed numbers for these wards and the number of patients Commission visitors saw / reviewed are listed in *Appendix 2 -Table 4*.

Table 2: Patients interviewed and / or reviewed by level of security and gender

Security Level	**Male**	**Female**	**Total seen**
Medium	36 (84%)	7 (16%)	**43**
Low	100 (82%)	22(18%)	**122**
Grand Total	**136 (82%)**	**29 (18%)**	**165**

Of these patients:

- 107 were on orders from the criminal courts
- 58 were on civil orders (not from the courts)

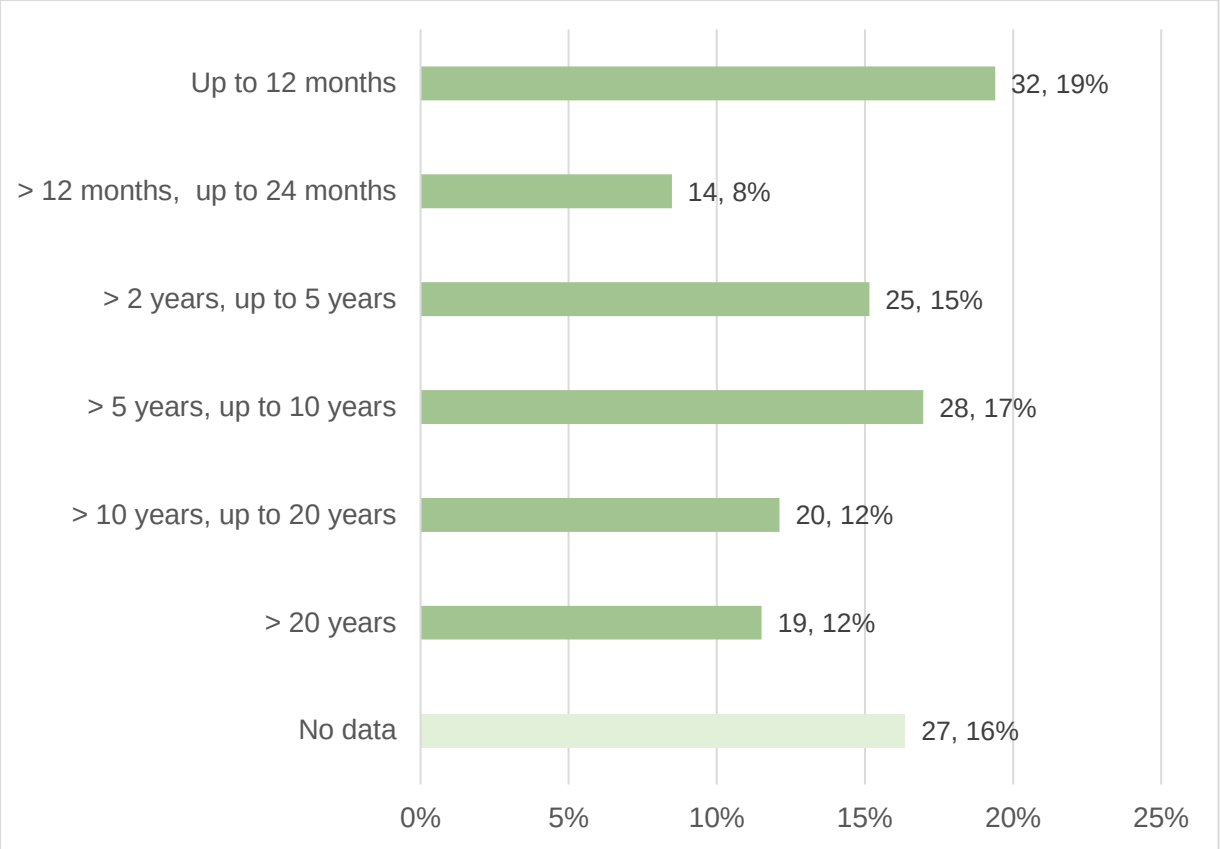
Details of orders (Appendix 2, Table 5)

We also looked at the age profile of these patients, with most of the patients (88%) being between the ages of 25-64. *(Appendix 2, Figure 11)*

Length of time in forensic services

When reviewing these 165 patients we looked at the dates they first entered the forensic system. Many patients have spent a very considerable number of years in these secure hospital wards. Twenty four per cent (39) of patients we met have spent more than 10 years in secure wards, and 23% (9) of these were patients in learning disability wards.

Figure 3: Length of time in forensic hospitals



Six of the patients we reviewed who have spent over 10 years in conditions of security are civil patients, so not all patients who have spent a long time in conditions of security have necessarily come from the criminal courts.

Admission criteria

We asked ward managers about the criteria used to admit patients to their wards.

What we expect to find

- That people in medium and low security wards will generally be detained patients under the Mental Health (Care and Treatment) Scotland Act 2003 or the Criminal Procedure Scotland Act (1995).
- That the decision to admit to a secure service will be based on a comprehensive risk assessment and detailed consideration of how the risks identified can be safely managed whilst in hospital.
- Many, but not all, of those admitted to secure services will have been in contact with the criminal justice system and will have either been charged with or convicted of a violent criminal offence.
- Patients would be eighteen years of age and above.

Medium security

The guidance 'Admission Criteria to Scottish High and Medium Secure Units' [7] separates out the three main sources of admission to determine criteria for both medium and high secure facilities.

- Admission from prison / court.
- Patients transferred from high secure care to medium secure care.
- Patients transferred from lower secure care.

It is clearly stated that it is expected that all patients admitted to medium secure care will be detained.

Low security

The guidance regarding admission criteria to low security services is less specific, but is largely based on patients who do not require the degree of security provided by medium or high secure care, but meet the criteria for detention under the Mental Health Act and/or:

- Have a definable clinical risk to others or a legal requirement to be in custody.
- Have a history of offending behaviour with low levels of violence for example assault.
- Have difficult to manage behaviour.
- Will benefit from a period of rehabilitation.
- Have moved from higher levels of security.

[7] Admission Criteria to Scottish High and Medium Secure Units

- Have co-morbid substance misuse issues (past or current).

Generally the criteria should exclude:

- People with complex needs who can be managed and treated in adult mental health services.
- People with a primary diagnosis of substance misuse without a secondary diagnosis of mental illness.

What we found

Medium security wards

There was no one specific definition emerging from our questionnaires, and there were slightly different responses from all the wards, even when in the same hospital.

In each of the three medium security hospitals, there was one ward used primarily for admissions and a period of assessment. Patients to these 14 wards come mainly from the courts, prison, State Hospital, low secure services or recalls from the community. Rowanbank has a separate assessment ward for women. The Orchard Clinic assessment ward is mixed sex; Rohallion is a male-only unit. There were other wards in these hospitals that patients can progress to.

Rowanbank Hospital has one ward specifically for patients with a diagnosed learning disability meeting the criteria for medium security.

Factors commonly referred to by ward managers as part of their assessment criteria were:

- Identified mental illness with a history of offending behaviour.
- Patients deemed to require care within a medium secure setting as evidenced by risk assessment.
- Patients present as a risk to others and have complex and varying needs.
- Challenging behaviour
- Patients aged between eighteen years and sixty-five years
- Patients detained under Mental Health (Care and Treatment) Scotland Act 2003 or the Criminal Procedure Scotland Act (1995).

Low security wards

Again, there was no common definition emerging from our ward manager questionnaires. At the time of our visits, services for patients with primarily for mental illness were distributed across eight NHS hospitals and two independent hospitals (21 wards/ units). Learning disability specific services were generally smaller units located in seven hospitals (11 wards/ units).

Factors commonly referred to by ward managers as part of their assessment criteria for the low security wards were generally similar to those stated by medium security ward managers, but included:

- Must require the level of security provided in a low level security unit.
- Patients coming from a medium security setting (moving to lower level of security).
- More mention of rehabilitation and preparation for a return to the community.
- Some patients coming from intensive psychiatric care units (IPCUs) or the community (moving to higher level of security).

We noted that the larger units had an admission unit, and other wards more directly focused on return to the community with a tiered progression through the wards and sometimes less environmental security.

In learning disability wards, forensic history was cited as factor for most wards, as was risk to self and others. Generally these wards had only a small number of beds.

Physical environment

Patients have the right to:

- **A positive therapeutic environment including sufficient living space; adequate lighting, heating and ventilation; a satisfactory state of repair and hospital hygiene; and adequate food and clothing.**

The physical environment of forensic medium and low security units is outlined in a matrix in the Definition of Security Levels in Psychiatric Inpatient Facilities in Scotland (2004)[8].

The main difference between the two levels of security in relation to the physical environment is that medium security units should be designed to a robust construction to deter and delay escape, whereas low security units should be specifically designed to deter escape.

The design and construction differences between the units primarily relate to the perimeter fencing, control of access to the site, and window/door security and furniture design.

Our main focus was on the experience of patients and visitors accommodated in or visiting the units, rather than their specific design.

[8] Definition of security levels in psychiatric inpatient facilities in Scotland

Our visitors had a ward environment questionnaire and completed this for each ward in relation to their own impressions, and were also informed by discussions with patients and staff.

What we expect to find

We expected to find a physical environment that provided a safe and secure environment for patients, staff and visitors that facilitates the appropriate treatment for patients and appropriately protects the wider community (as per the NHS HDL(2006) 48[9]). We expected this should be as homely as possible given the considerable length of stay most patients have in secure wards.

We expected to find a greater level of physical security in medium security units than in low security wards.

We also expected that there would be a consistency of physical security measures across the two levels of security of the units we were visiting.

What we found

Medium security wards

The three medium security units, though having the same security specification, have very different designs and layouts. All are relatively new purpose built units.

Entry and access

All three units have controlled access as appropriate to the level of medium security. There is a reception area checking and regulating authorised entry to the unit (some units have airport type electronic scanners), double air lock security doors, control regarding items taken into the unit and then also controlled access to the individual wards. The ward access in the medium security units is surrounded by a perimeter barrier made up of the buildings themselves and fencing.

The wards

The wards were generally clean, well maintained and overall had adequate heating and ventilation. We did get some comments from staff (in all three units) that it can be difficult to control the temperature and it can be too hot or too cold.

All the wards across the medium secure estate have single ensuite rooms providing adequate privacy.

[9] NHS HDL(2006) 48

Mostly the wards were rated by our visitors as a fairly pleasant place to be in relation to their general décor and environment.

Generally in the medium security wards the communal areas were open plan, and this could be noisy at times if lots of patients were in the area. We also had comments from the patients at Rowanbank "*that the communal areas were cramped if all the patients were there at the same time, as the communal areas in the wards are small, and the quiet room is often occupied".*

The nature of the wards and the heavy furniture can make these wards feel quite clinical. This was commented on in Rohallion where they were planning to involve patients in an art project to provide art work for the walls.

We asked staff and patients if they felt the wards could be improved, and in the main it was felt the units were fully fit for purpose. The only negative comments came from the Rowanbank wards which related mainly to the communal areas being too small. This had an impact on managing patients who are distressed, and there were suggestions of a need for a low stimulus room or an area to assist with de-escalation rather than using bedroom areas.

Outside space

Given the restrictions on patients in medium security settings, access to outside space is a particularly important factor in recovery, and we were pleased to see that this had been considered in relation to the design of these units. All units reported that patients could easily access outside space, though the nature of this space is different between the units. Rowanbank has a very large enclosed area within its perimeter with a football pitch, garden project and a recreation centre within the enclosed grounds. Rohallion and the Orchard Clinic also have enclosed garden and recreation facilities but some patients also have access to the hospital grounds (subject to appropriate safeguards).

Female patients in medium security

Female patients requiring medium security can be placed either in Rowanbank Clinic or the Orchard Clinic. There were only 12 women patients in medium security during the time of our visits, six in Rowanbank and six in the Orchard clinic. There are, however, specific issues for women in both units.

In Rowanbank Clinic there is a separate female-only assessment ward (Sycamore) and rehabilitation ward (Elder), but there can be a mix of patients with a learning disability along with non-learning disability patients; these patients can have very different needs.

In the Orchard Clinic, there is no separate female ward, and both male and female patients are treated on the same wards. This could create particular difficulties for women patients particularly in the assessment ward where they may be the only

female patient, however no female patients we spoke to seemed concerned about the situation.

Low security wards

The low security wards have developed in a very different way to the medium security units and are a mix of services developed by individual heath boards and also independent provision. These wards are also a mix of newer purpose built facilities and older wards modified for low security provision.

Entry and access

The entry and access to these wards was variable and is dependent on the size of the unit and the setting. Community units tended to be small units and often have a locked front door usually with a buzzer / intercom, with a second locked door inside a lobby area controlled by staff from inside the unit.

Larger low security hospital units such as Leverndale Wards 5 and 6, and the independent hospitals Surehaven and Ayr Clinic, have a single entrance to the wards with double doors and a specific reception area controlling access to the wards

Other ‘stand-alone’ wards on hospital sites generally had a locked outside door with a bell or buzzer, then a second locked door on to the ward. Doors were not locked in all units, however, Boulevard ward at Leverndale hospital acts as a step-down ward to wards 5 and 6, and is not locked during the day; this unit is used as part of preparation for moving on from hospital.

Double locked doors to these wards were generally not ‘air locked’ doors and it was often possible to have both sets of doors open if required which is consistent with this level of lower security.

The wards

It is much harder to draw comparisons between the low security wards. Nearly all (94%) of the wards in low security accommodation have single rooms, with only Royal Cornhill Hospital still having a mix of single rooms and dormitory accommodation. Most rooms (63%) have ensuite facilities, some wards (6%) have a mix of some ensuite rooms and non ensuite rooms, but 31% have no ensuite facilities. We noted that only 45% of the learning disability specific wards have ensuite facilities.

Overall, the wards were felt to be clean and generally well maintained. Five wards were reported to have maintenance issues and these issues were discussed with ward managers on the day of our visit. Four of these wards were learning disability wards and this reflects the importance of regular maintenance programmes especially for this client group. We again received some comments about difficulties relating to noise and temperature for a few wards that were addressed with managers during the visits.

Generally we found facilities for organised recreation to be less evident in low secure wards than those in medium security units. Wards typically had facilities similar to those in adult acute services. Most wards had day rooms and an activity room, frequently with arts and crafts materials. Generally games were available including games consoles, pool and table football.

The premise of low security is largely based on rehabilitation and moving back to the community, so the sort of provision provided in medium security units would generally be expected to be accessed in the community. Many patients we saw were able to access facilities in hospital grounds such as cafés, gyms and hospital shops and also facilities in the local area, but many were not. Some patients were not able to leave the wards and several units were not on hospital sites or near community facilities. Some of these patients felt low security wards were more restrictive than the conditions they experienced in medium or high security provision.

We expected to see more facilities in relation to promotion and maintaining of life skills than was evident from most of the wards we visited. Some units had therapeutic / rehabilitation kitchens, and some also had washing machines, but there was generally little apart from this. The Boulevard unit at Leverndale, however, was a ward that seemed to have embraced this aspect of recovery.

Our visitors rated eleven of the wards (34%) as being very pleasant. These included the five Leverndale wards that were described as bright, clean, and welcoming. The home-style model in operation on Boulevard and Campsie wards (where all patients are involved in helping out with cleaning and cooking) was also highlighted and provides a focus on rehabilitation and life skills. The new four bed Dalveen unit (Midpark Hospital) was well laid out with good inside and outside space. Bruar ward (New Craigs), Iona ward (Beckford Lodge), Daleview ward (Lynebank) and Lyon ward (Rohallion) were all felt to be pleasant, well maintained units with good facilities. The new female Gatehouse unit is a particularly welcome development as a low secure step-down unit for women. Being in the community, it is felt to be a very good environment for recovery.

Most of the other wards were rated as fairly pleasant (63%), with the others being rated as neither pleasant nor unpleasant.

There were particular issues with two learning disability wards, Fern Ward (Royal Cornhill) which requires major refurbishment and Ward One (Strathmartine) which was acknowledged as being no longer fit for purpose; there are plans for re-provision at Strathmartine.

In 10 out of the 12 (83%) learning disability wards, staff felt there could be improvements to the wards.

Improvements suggested were mainly in relation to the buildings -

Comments:

- *Staff feel building is usable but generally tired and in need of replacement.*
- *Ensuite rooms would be good but not feasible and we need more communal space.*
- *Staff feel building is dark and dingy - some parts of the ward have very limited natural light and in these areas lights have to be on all day.*

And the homeliness of the wards -

Comments:

- *The nature of the ward could be more homely.*
- *A washing machine and cooker would allow more work on life skills.*
- *Basic facilities - unit due to be moved to new hospital so there is no money to spend on current facilities unless they are urgent repairs.*
- *Staff feel that the furniture could be updated including lamps etc.*
- *There is not enough storage and the décor is dated.*

This compared to 24% of the non-learning disability specific wards where staff felt improvements were needed. Comments here were mainly regarding decoration and maintenance of the wards.

The disparity expressed by staff in the two client group provisions is concerning.

Outside space

All low security ward managers reported relatively easy access to outside space though there were specific issues in Belleisle at Ayr Clinic, where the garden was being redesigned and not being used at the time of our visit (staff were helping patients access alternative outside space).

Most garden areas were enclosed, relatively small outside gardens or courtyards. A few were larger and allowed for outdoor activities. Some spaces were very pleasant and well used areas; Campsie at Leverndale has a well-kept enclosed garden, seating areas and a fish pond, Kylepark has a garden area with garden furniture and raised plant beds which patients attend to, and Ayr Clinics Gatehouse unit has a very pleasant garden with decking leading off a conservatory.

Unfortunately, too many of the gardens were less pleasant, some untidy and unkempt and largely used as smoking areas, and others were kept locked and patients only had access when staff were available.

Female patients in low security

In low security, the main issue for women is that there are fewer female hospital options and for many women they are often in hospitals outside their home health board area. This makes maintaining contact with families, their communities and local health services more difficult, both during their time in hospital and in relation to preparation for leaving hospital.

Most of these women are in fact non-forensic patients whose care has not been able to be safely managed in their home areas. Many have often spent considerable lengths of time in adult intensive psychiatric care units (IPCUs).

Often the only option for women is an independent hospital due to lack of local health board provision.

Care and treatment

Patients have the right to:

- **Be treated in line with the principles of the Mental Health Act.**
- **Be treated with respect dignity and compassion.**
- **Adequate health care for their mental health needs.**

Professional input

What we expect to find

We expect care to be well managed, with good input and representation from a comprehensive multidisciplinary care team (MDT).

Services will have sufficient staff numbers and skills available to deliver effective treatment and maintain a safe environment. *[Care Standards for Forensic Mental Health Inpatient Facilities[10] Standard 3.1].*

What we found

All the medium and low security hospital ward managers reported they had input to their wards from medical, nursing, psychology, occupational therapy and pharmacy staff working in their units. There were generally weekly clinical team meetings where this core of the multidisciplinary team were able to discuss patients, and plan and review their care. At the time of our visits, there were a small number of staff changes, secondments or sickness issues causing short term difficulties in several wards.

[10] Care Standards for Forensic Mental Health Inpatient Facilities

Medical

All wards had a consultant psychiatrist or team of psychiatrists providing psychiatric care to the patients on the wards, and all patients had a named doctor specifically responsible for their care.

Nursing

Nursing staff are predominantly at the front line of patient care, and the main staff group on all wards nurses. The level of nursing participation with patients is vital in all aspects of patient care, and when discussing their care it is generally the help and support from nurses that patients speak about.

We asked about staffing levels and about ratios of registered and unregistered staff. Unregistered staff will primarily be healthcare assistants. We noted that the ratio of use of registered nurses to unregistered staff was about 58% on the NHS (non LD) medium and low secure wards, falling to 49% in the NHS LD hospitals, and about 40% in the independent hospitals, but there was some variation between individual wards and hospitals. We were told that staffing levels were generally increased if there were patients on the wards requiring enhanced observations.

Many ward managers (41%) spoke about difficulties in recruiting to nursing posts of all grades and of ward vacancies. Many were using ‘bank staff’ to maintain adequate levels of nursing cover.

Psychology

All ward managers reported that their patients had good access to input from clinical psychology; though there were several situations reported where staffing issues were resulting in temporary difficulties in accessing services. Psychology input was seen as vital in relation to work with patients in these wards. Medium security wards generally had a psychologist allocated to each ward, with psychologists attending ward meetings, reviews, undertaking risk assessments, involvement in 1:1 work and group work. Low secure wards often had a lesser level of direct psychologist provision, but there was still a very strong input from psychology, again attending ward meetings, 1:1 work and work relating to risk assessment. Psychologists also provided supervision support for nurses carrying out low intensity psychological interventions and reflective practice sessions.

Occupational Therapy (OT)

All wards reported access to OT services but with a higher level of provision in the medium secure wards, where most had an OT dedicated to the ward on a daily basis and who attended ward meetings. Low secure wards also reported good access to OT services with most reporting having dedicated OTs, but not always specifically for their wards. OTs were reported to be involved in 1:1 work both on and off the wards, ward-

based activity groups and rehabilitation programmes, and rehabilitation activities in relation to arranging off ward placements, discharge planning visits and contribution to risk management planning. Responses reported OTs to be fully included as part of the multidisciplinary team (MDT).

Pharmacy

Ward managers generally reported that there was good access to pharmacy support and advice on all the wards. Comments were mostly very positive, with pharmacy support being clearly valued by staff and patients alike.

Most of the wards managers said pharmacists regularly attend the ward MDT meetings and are available by phone for advice if required. The presence of pharmacy was felt to be very important in prompting regular reviews and discussions of patients' medication.

We also had comments that pharmacy will also give advice to patients on a one to one basis and support patients in self-managing their medication when preparing for discharge from the ward.

- *Rowanbank staff commented positively on the input from their pharmacist, saying the pharmacist is available to give advice and information to both staff and patients. They will meet with patients on a one to one basis to give information, support and feedback with regard to prescribed medications or changes to medication.*

Mental health officer (MHO) and social work input

All hospitals reported having good access to mental health officers (MHOs) and social work input which was often accessed via the MHOs. The Orchard Clinic and Rohallion Clinic have social workers as part of their staff team, which they reported as being useful. Other hospitals reported that they had regular input from MHOs and patients generally had an allocated MHO.

Mental Health Officer (MHO) *– a qualified and experienced social worker who has undertaken specialist accredited training in mental health and mental health law and is appointed to act as an MHO by their local authority employer. There is an expectation that MHOs for restricted patients should have also undertaken some level of forensic training. There is a requirement that a restricted patient[11] must have a designated MHO at all stages of their care.*

We heard that MHOs usually attend MDT meetings periodically according to patient need, attend care programme approach (CPA) meetings and are often more involved at the point of discharge or in relation to Mental Health Tribunals.

[11] The Scottish Government Memorandum of Procedure on Restricted Patients 2010

Physical health provision

The three medium security hospitals have visiting GP services, three times a week in Rowanbank and twice a week in the Orchard Clinic, though at Rohallion we were informed that the visiting GP has recently retired and the situation is under review.

In the low security hospitals the way patients accessed physical health care was less clearly reported and the picture more mixed. Most hospitals had access to GPs regularly visiting the hospital, with frequency of visits varying from one to three times each week. Patients were usually seen on a referral basis and also seen by the GP for annual health checks. Two ward managers mentioned that patients were registered with the local health centre, and in some cases patients were able to go to their local health centres. Two hospitals stated that hospital doctors were used to provide physical health care for their patients. Getting access to physical health care is very important given the restrictions on these patients being able to directly access services in the community.

We also heard about input from a wide range of other professions and agencies including dieticians, speech and language therapists, physiotherapists, dentists, optician, podiatrists, chaplain, art therapist, music therapist, and therapet. Overall it is clear that there is a very comprehensive range of input to these units.

Consent to treatment: Mental Health Act and Adults with Incapacity Act

We were pleased to see that nearly all consent to treatment documentation under the Mental Health Act (T2/T3 forms), for those who required it (144 people), was in place. However there were two people who were being given medication without proper authorisation and two where the documentation did not cover the medication that was being given. These instances were addressed at the time with staff.

General medical treatment for people who lack capacity to give informed consent is covered by the provisions of part 5 of the Adults with Incapacity Act. Fourteen people were assessed as lacking capacity to consent to their treatment. All but one of the people requiring s47 certificates were in learning disability units.

Two of these people did not have a valid section 47 certificate of incapacity as required by the Act. It is unlawful for staff to administer medication without proper legal authority. Where staff are not clear about the legal authority, they should discuss this with the appropriate member of medical staff as soon as possible. Any treatment should, however, be continued meantime. We discussed rectifying these issues with staff during our visits.

Care planning

What we expect to find

We expect that, given the level of complexity and risks involved with patients in the forensic setting, patients would be managed using the care programme approach (CPA).

That *Standard 1 - Care Standards for Forensic Mental Health Inpatient Facilities,*[12] in relation to assessment and care planning is met.

- *That services will have in place systems and processes, from the pre-admission stage through to aftercare, that ensure the multi-disciplinary assessment of the health and social care needs of patients, and the risk of harm posed by them to themselves and others. Assessments will then be used to inform the treatment plan and enhanced care programme approach.*

Care programme approach (CPA)

CPA was developed originally for use at local level in Scotland for people with severe and enduring mental illness in 1996 via Scottish Office Circular SWSG 16/9[13].

Following a review of CPA by the Forensic Network in 2006, the Scottish Government endorsed the use of CPA for restricted patients, and the Forensic Network produced updated CPA guidance (May 2010[14]). A prominent feature of this enhanced CPA for forensic patients is ensuring consistency across Scotland, and the updated guidance incorporates child protection, protection of adults at risk of harm, risk management traffic lights and good practice guidance.

The Commission continues to support the view that CPA should also be used, as was originally intended, for individuals with a mental illness and complex support needs, which will apply to non-forensic patients in medium and low secure accommodation.

What we found

Of the 161 patients where we had CPA information, we found 95% were managed using CPA. The eight patients not on CPA were those who had very recently been admitted and the process had not yet started. This was as we expected, but it was encouraging to see that patients on non-forensic orders and also patients with a learning disability were managed on CPA. This helps to ensure they are getting effective and co-ordinated ongoing care and support, it also makes sure that being in low security accommodation is regularly reviewed.

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[12] Care Standards for Forensic Mental Health Inpatient Facilities
[13] Scottish Office Circular SWSG 16/9
[14] CPA guidance

CPA Meetings

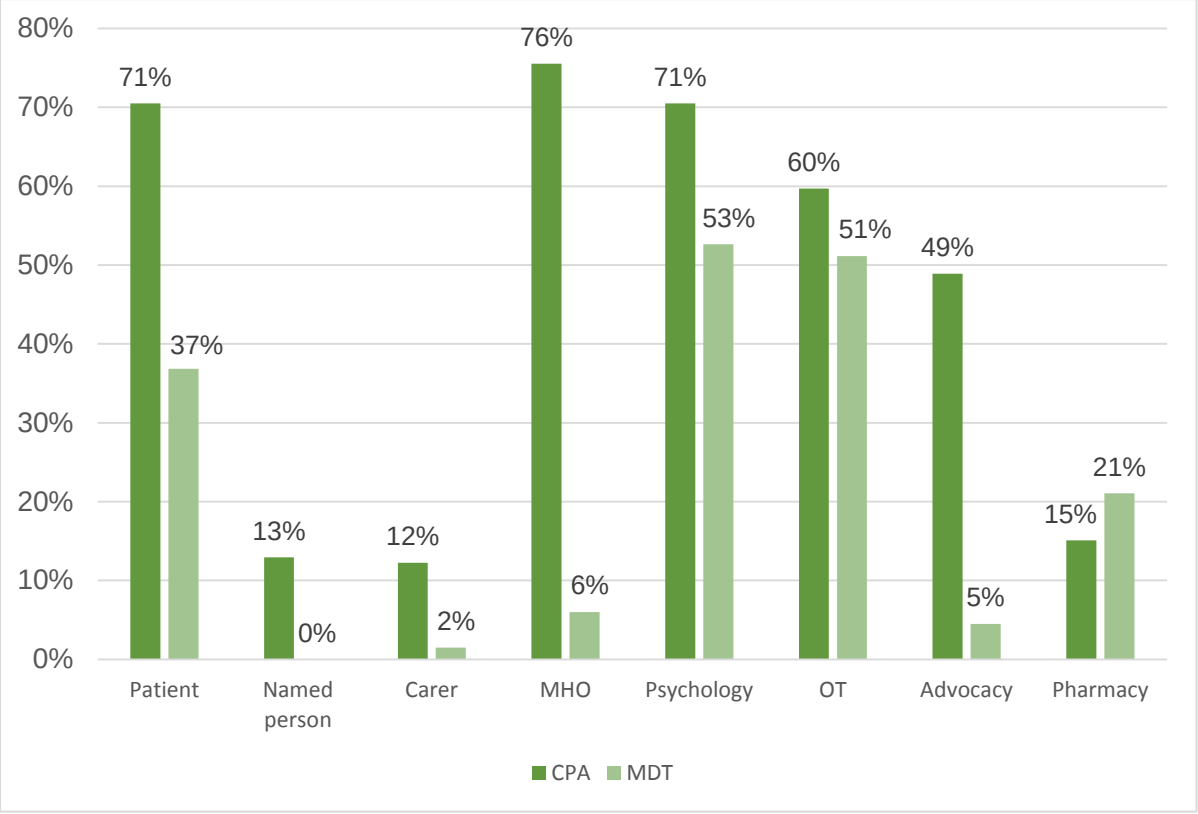
We found that CPA meetings were well attended, with MHOs present for most (76%) of the meetings. There was good input from psychology (71%) and OTs (60%); 71% of patients attended their CPA meetings, with advocacy input in about half of the meetings. There was carer / named person involvement in about 13% of the meetings but we noted efforts to involve their participation.

Multi-disciplinary team meeting (MDT) meetings

Ongoing treatment and care planning decisions generally take place at the MDT or ward meeting. We looked at the date of the last MDT (ward round) meeting prior to our visit, and over 50% of patients had been reviewed at a ward meeting within the last seven days and at least 75% within the last 21 days (we did not have this information for all patients). The overall situation appeared that patient care was regularly reviewed, with no differences between the level of security or patient group.

In terms of attendance at MDT meetings we found that medical staff and nursing staff were present at all reviews with a psychologist at 53% of meetings, OTs at 51% of meetings and patients themselves present at 37% of meetings. There was relatively low involvement of advocacy and carers in MDT meetings.

Figure 5: Attendance at CPA and MDT meetings



Care plans

Patients have the right to:

- **A care plan which is personal to them.**
- **Be involved in developing their care plan.**
- **Know what is in their care plan.**
- **Be involved in reviewing their care plan.**
- **A clear explanation of their medication and other treatment in a way they can understand.**

What we expect to find

Care plans should reflect the individual needs of the patient and be regularly reviewed.

We expect that individuals are engaged and involved as much as possible in their care and treatment.

What we found

The records we reviewed all had care plans for patients, and 80% were judged to fully address the person's needs, with the remaining 20% regarded as partially meeting the patient's needs.

For care plans not fully meeting the persons needs there were comments such as:

- *Lack of personalisation*
- *Care plan generic*
- *Recent admission – plan will be refined*

The overall picture however in relation to care plans across all medium and low security wards was very good with care plans generally being comprehensive, personalised, well evaluated and reviewed.

Patient involvement in care

In terms of patient involvement and participation, 88% of records indicated evidence of patient involvement in their care plans, with 58% of these showing good evidence of involvement. The remaining 12% showing little or no evidence of involvement were largely due to the patient being very unwell or lacking capacity for involvement. There were also a number of situations where patients were noted as refusing to engage or be involved with their care planning.

The Commission visitor comments in relation to patient engagement and involvement in care planning were very encouraging:

- *Her views were clearly sought and recorded. She has completed document on her views relating to her care and treatment. Rowanbank – Sycamore*
- *Staff compile and review care plan with the patient. Orchard Clinic - Redwood*
- *Good evidence of patient engagement with named nurse in order to review care plans and observation plans. Surehaven – Campsie*
- *Evidence in file of use of talking mat to engage patient in discussion about activities and participation. Royal Cornhill - Fern (LD)*
- *Easy read paperwork in place for Care plans evidenced – Strathmartine - Flat 1, Leverndale Campsie and Royal Edinburgh Glenlomond.*

There were also many other similar examples of good evidence of engagement and participation in most wards.

When we asked patients if they felt they had the opportunity to contribute to their care planning 84% (120 responses) of patients said they felt fully or partially involved; 64% of these saying they felt fully involved. This is a very similar response to the evidence from notes, and confirms a good level of patient participation and involvement across the secure wards, with no particular difference between services.

From our patient interviews, 81% said staff were always or mostly available to talk to.

“Sometimes staff are busy but they always make time to talk.”

“I get on well with staff and can talk when I need to.” (Orchard Clinic patient)

“I've got a good relationship with all the staff in here. If you want to have a wee chat with a member of staff it's no problem at all. If I've got a problem and want to chat for five minutes I can have half an hour, or an hour. To me the staff are really good.” (Beckford Lodge patient)

Some patients (13%) said staff were only sometimes available and comments mainly related to staff being busy; these comments were from a range of hospitals.

“The staff are so busy that nothing besides essential needs are met.”

“Staff seem to spend a lot of time in the office on written work..

There were five patients who said that staff were never available.

We asked patients to what extent they agreed with the statement – ‘The staff on the ward treat me with respect’. The vast majority, 84%, who responded felt they were respected, with nine per cent neither agreeing of disagreeing and only seven per cent

feeling they were not respected. In the context of all these patients being detained patients, and some being very unwell, this reflects well on these services.

Feeling safe

Twenty three per cent of people (30 of 131 responses) said they felt unsafe at times in the ward or partially unsafe. Some of those patients said it was due to their illness, but for many it was related to incidents on the ward or perceived threats from other patients. The comments below give some insight into the feelings of some patients.

“Sometimes other patients' shouting can be upsetting.”

“*I recently saw a patient restrained and another patient started to get involved. I was worried that this would escalate further. I think staff must feel overwhelmed.”*

“Sometimes I feel safe, sometimes not. Most of the time I feel anxious. Sometimes other patients make me feel unsafe.”

“Generally OK but I have been assaulted several times while resident on this ward by another patient.”

Patients have a right to feel safe and secure and should be able to approach staff where this is not the case and know that their issues will be addressed. Staff in turn need to feel they are able to provide a safe environment for patients, with appropriate staffing levels.

There was a concentration of comments from patients about feeling unsafe in a small number of hospitals. This was addressed on the day of our visit and will be followed up by the Commission on future visits to these hospitals.

Relative / family engagement

We looked at whether relatives and family were in contact and whether they were included in care planning. We found out of the 165 patients we reviewed, 42% (69) had ongoing family contact and family were generally involved in discussions with the ward and responsible medical officer (RMO) about progress and often attended planning meetings

Comments from notes:

- *Patient maintains regular contact with his mother and will keep her informed of progress and changes.*
- *His mother has always been involved but she is now quite elderly and less able to visit.*

For 13% of patients, there seemed to be occasional contact with family, but they were not generally involved in care discussions.

For some patients (41%) it was evident that there was no contact or very minimal contact with family. Often this was due to breakdown in family relationships or that relatives were elderly or had died. Previous lifestyle, long term illness and the nature of previous offending was a factor for many patients as well as length of stay in hospital.

From our interviews with patients, not all wanted their families involved and 12% (20) patients were very clear they did not want their families involved in their care.

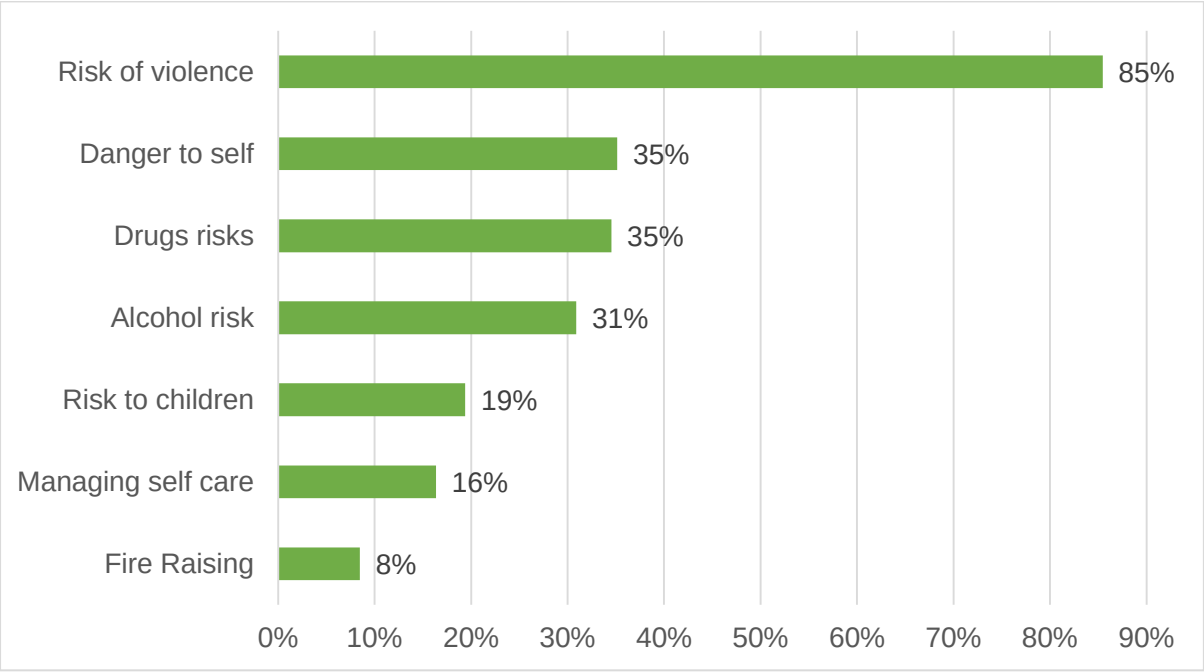
Fifty per cent of patients indicated that they felt their families were as involved as they wanted in decisions about their care and were happy with the situation. The other patients either did not respond or did not have a specific view.

Risk assessment

Risk is the primary reason for patients being in secure services, so we expected risk assessments to be a major component of care planning. This was found to be very much the case, with clear evidence of formal, up to date risk assessments in over 91% of the records we reviewed. Over half of these risk assessments included use of the HCR-20 (Version 3), a comprehensive set of professional guidelines for the assessment and management of violence risk, mainly used by psychologists. This tool was in fact mentioned as being used by over 90% of the wards in ward manager responses.

These managers also cite a comprehensive list of other structured risk assessments being used across the secure units, with the BEST index (mainly used by nursing staff) frequently mentioned, a number of local tools such as the Glasgow risk screening tool and Ayrshire risk assessment framework being used in these health boards. Reference was also made to the traffic light system included in CPA documentation. We were also encouraged to see that at least half of the LD units were using LD specific tools such as ARMADILLO-S (historical clinical risk sexual violence risk assessment of risk manageability for individuals with intellectual and developmental limitations who offend sexually).

Figure 6: Identified Risks



Our visitors looked at the main risks identified in relation to the risk assessments we reviewed and the profile of risks across the secure units is reflected in figure 6.

The highest risk was clearly risk of violence, but there were also many patients with significant self-harm risks and issues of risk associated with drug and alcohol use.

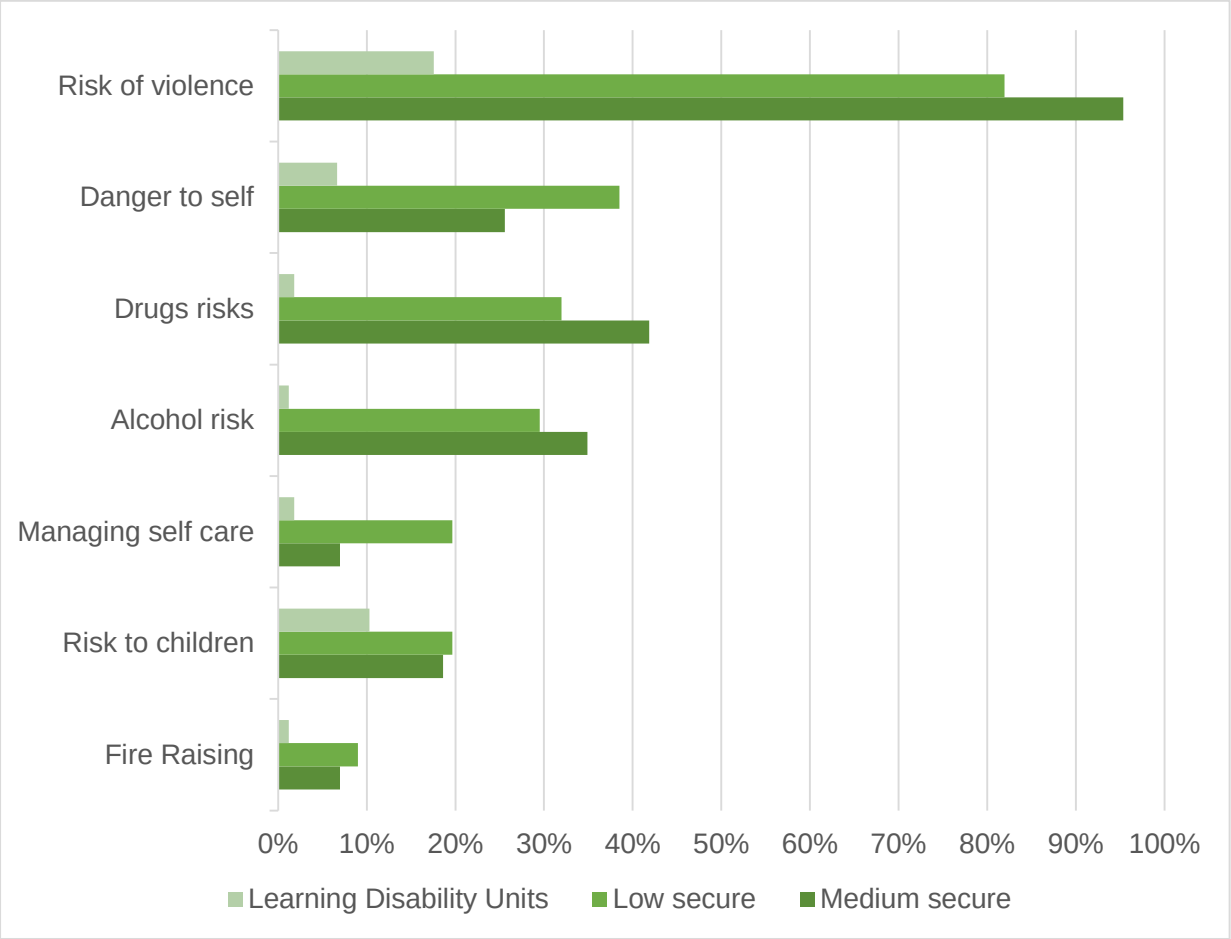
Many patients had more than one risk identified in relation to their assessment, but these multiple risks show no particular correlation to levels of security (from data on 160 patients).

Table 3: Multiple Risks

Number of risks identified (from above)	1 risk	2 risks	3 risks	4 risks	5 risks	6 risks
All wards	18%	41%	19%	16%	4%	1%
Medium Security (42 patients)	21%	38%	26%	10%	2%	2%
Low Security (118 patients)	17%	42%	17%	19%	4%	1%

When seen in relation to the respective levels of security, however, the profile of risks between the units is different. All wards have high levels of risk of violence, but levels of danger to self are higher in low security units, and risks to children is a significant factor in the LD patients in secure wards.

Figure 7: Profile of risk by security levels



From our visitors' comments (from 130 patients), patient risks were fully addressed in 83% of care plans. For the remaining 17% of patients it was identified that care plans only partially addressed the identified risks.

In these cases the main concerns were that alcohol and drug issues were not being fully addressed or there were no plans to address drug and alcohol issues. The other main concern raised was a lack of personalisation in care plans addressing aggression for the individual patient. Having highlighted these factors, it is important that services fully consider these aspects of risk when reviewing patient care plans.

Overall, we found that care planning and risk management for patients in medium and low security settings was good, particularly in comparison with other areas of mental health care.

Moving on

Ready to move on

We asked ward managers how many patients they felt were ready for discharge from their units. In total we were told there were 89 patients of the 400 ready to move on to other wards or to community placements.

This included 28 patients in medium secure wards (19 in Rowanbank, three in Rohallion and six in the Orchard Clinic). Some of these patients were waiting to move internally to rehabilitation wards, but most were potential moves to low secure wards.

Below are some comments from managers about the reason for delays:

- *There is a shortage of community accommodation placements.*
- *More community accommodation would allow faster throughput from low secure services thus allowing us a faster stream between medium and low secure services.*
- *Delays can result in disengagement from patients due to varying factors - deterioration in mental state, disgruntlement at pace of progression.*
- *Low secure female beds availability (though the opening of the five female beds at Leverndale has helped).*
- *Access to social work funding for supported accommodation.*
- *General delay in the availability of low secure beds.*
- *The processes associated with restricted patients, e.g. conditional discharge, tribunal delay, MAPPA[15] meetings and supported accommodation.*

In 24 low secure units we were informed that there were 61 patients waiting to move to either a rehabilitation service or a community setting. Most of the patients (49) ready to move on were in the non-LD wards and were patients across health boards and hospitals.

In one of these wards there were seven patients ready to move, in nine other units three or four patients were ready to move. The reasons given for the delays included the lack of 'step down' facilities, the lack of suitable accommodation, the location of the accommodation due to vulnerability or risk, the availability of money for support packages, restrictions with regard to victim issues and patient choice.

[15] Multi Agency Public Protection Arrangements (MAPPA) is the framework which joins up the agencies who manage offenders. The fundamental purpose of MAPPA is public safety and the reduction of serious harm.

Concerns were also raised by patients about feeling ‘stuck’ in hospital and not being able to move on.

“I’ve been here too long.”

“I am ready to move on.”

“He feels he has been in hospital for too long and that he is ready to move on, he has done everything he needs to do.”

These delays are concerning, and potentially result in patients remaining in environments in which they are living lives that are excessively restricted. There needs to be more exploration into these delays, and better monitoring of delays for individual patients. There are also differences between health boards in the use of more open forensic rehabilitation wards, a form of ‘low’ low security, creating different experiences and opportunities for patients in different areas.

Waiting list for units

We also asked ward managers if they had a waiting list. We were told there were 28 people on the waiting list for NHS low secure units. Fourteen of these were patients in Rowanbank waiting for places within the Greater Glasgow and Clyde low secure estate. There were other patients waiting to move from medium secure to other low secure units, some waiting for a move *within* low secure from assessment to rehabilitation beds and some in IPCUs, noticeably three women in one area where there is no female low secure provision.

Independent low secure hospitals informed us there were 15 people on their waiting lists. There may be some duplication in patient numbers with patients being on the waiting list for both an NHS bed and a bed in one of the independent hospitals.

Medium secure units also have patients awaiting moves to their units. Numbers were less clear, but we are aware that patients are awaiting moves from the State Hospital, IPCUs and prisons.

Rights and restrictions

Patients have the right to:

- **Be free of restrictions of their independence choice or control, unless restrictions are for clearly identified reasons and are the least necessary.**
- **Be involved as much as possible in agreeing any restrictions.**
- **Have restrictions reviewed to decide whether they are still necessary.**

Issues important to patients

We asked patients who spoke with us if they had issues that they would like to raise with us. Most spoke well of their care and treatment, and of staff caring for them, but there were many patients who were not happy about being detained in hospital and required to take medication. Issues and comments were varied and many related to their personal circumstances; specific issues of concern from patients were raised by staff on the day.

The issue of frustration related to moving on was a recurring theme.

The other main concerns were:

- About being unnecessarily restricted.

  "I am unhappy with being locked out of my bedroom in daytime hours."

  "There are too many restrictions, I am treated like a child."

- Not being able to smoke was also a contentious issue raised by many patients, as was the issue of not being able to use e-cigarettes.
- Several patients also raised being located away from the areas that they identified as home and being away from relatives and family.

Nearly all of these comments and issues came from patients who were in the low security wards.

What we expect to find

We expect that appropriate measures are taken to keep patients safe and their rights fully respected.

We expect that any restrictions are the least restrictive necessary in order to keep the patient and others safe.

Where rights are restricted, this should be in line with the law, good practice and the Care Standards for Forensic Mental Health Inpatient Facilities, [Standard 6;

Management of Violence, Standard 7; Excluded Items and Standard 8; Control of Restricted Items & Technology][16].

'*In low secure care most patients will be preparing for safe transfer to open wards, or care in the community. This requires increasing exposure to restricted items that may be freely available in the destination setting, with graduated increases in freedoms. This must be in the context of risk assessment of the individual patient.' Low Secure Care Standards S8.2* [17]

What we found

Access to rooms and possessions

From our consultation prior to the visits, patients told us to ask for information about access to bedrooms during the day and restrictions on what possessions could be kept in bedrooms.

We found considerable variation in the restrictions on people accessing their bedrooms. One medium secure hospital and two low secure hospitals (14 wards in all) reported that bedrooms were restricted for periods during the day. In other hospitals there were short periods where access was restricted to allow cleaning or at mealtimes.

In the wards of one of the medium secure hospitals patients could not access their rooms between 9am and 4pm weekdays and between 12 and 2pm at weekends, though they could get time there if they were anxious or distressed. There were no restrictions in the other two units other than for short period at mealtimes and to allow cleaning.

In low secure units, two hospitals restricted access 10am-4pm and 9am-4pm weekdays and for a shorter period at weekends. In all other units people could access their rooms, other than when they were being cleaned or sometimes at mealtimes. The reasons given for restricting access were about encouraging participation in activities, but some patients said they found this difficult if they were tired or frustrated with other people.

Similarly, some patients were also restricted in the number of items they could have in their rooms e.g. 20 items, 30 items, seven items in each category of item, whilst other units managed without such a restriction.

[16] Care Standards for Forensic Mental Health Inpatient Facilities
[17] Low Secure Standards

Money

No patients reported any difficulties in accessing their money. Most had an account in the hospital and withdrew money as required when going for shopping or on outings. Some patients had their money managed for them by the hospital, mainly due to lack of capacity to manage their money.

Phone calls

Patients have the right to:

- **Communication by phone and post unless it is necessary to restrict this for the individual.**

Privacy for phone calls

Twenty one per cent (29) of patients reported there was no privacy or only partial privacy to make phone calls. Nine of these were specified persons with regard to phone calls, so were having their calls monitored by staff (see below). The remainder reported that the phone was not in a private space but in a corridor or day room where they felt other people could overhear.

Where there is no restriction on making calls, provision should be afforded to patients to have privacy when speaking to relatives or friends.

Access to mobile phones

Policies on access to mobile phones vary between units. It seems in medium secure units, mobile phones without cameras or internet access can be generally be used when on unescorted leave, but not on the wards. In the majority of low secure units, access to mobile phones is similarly when on unescorted leave.

There are a few wards, particularly in one hospital, where mobiles, including smartphones, can be used on the ward, subject to risk assessment. There is also one ward where there is to be a pilot in the use of non-smart phones on the ward.

Access to the internet and computers

We asked patients if they had access to the internet and there was a huge variation in responses. Some people had no access to the internet. Some had limited supervised access to the internet and were able to listen to music and YouTube, make limited searches, do online shopping with the OT, or access the internet at the local library.

Some patients could access the internet on their smartphones in the grounds of the hospital but not in the ward. Some patients have access to laptop computers or have their own. Some patients wanted access to the internet and some, particularly older, patients said they had no interest in access to the internet.

One patient in medium security felt very strongly about this issue and made a written submission to the Commission regarding the inconsistencies that exist between hospitals regarding use of technology. This particular patient is concerned they will have less access to their laptop when they move to a lower level of security.

Advances in mobile phone technology, computers and other devices such as IPads, along with the wide spread use of social media, has resulted in the need for much clearer guidance and a consistent policy in this area.

Access to entertainment media

Access to entertainment media can include watching television through to accessing films or images, violent material or games. In 13 wards there is no formal policy with regard to this and matters are risk assessed on an individual basis by the MDT, guidance given, or specified persons measures put in place. The remaining units have policies in place e.g. Greater Glasgow and Clyde Directorate of Forensic Mental Health have a policy on entertainment media in the forensic directorate which aims to 'normalise patients' experiences as far as possible, whilst safely managing their risk'.

Specified persons

The 2003 Act introduced the concept of "specified persons" in respect of authorising restrictions of an individual's correspondence, use of telephones and in relation to safety and security in hospitals.

This means that where the RMO is considering applying such restrictions, the patient concerned must be designated as a specified person before:

- Restricting or withholding correspondence.
- Restricting or preventing the use of telephones.
- Taking other measures to ensure safety and security in hospitals (e.g. searching patients and their belongings, taking samples, searching their visitors, restricting access and carrying out surveillance during visits). Patients in medium secure units are automatically specified persons in terms of safety and security.

One hundred and thirty seven people in total were specified persons with appropriate authorisation in place under s281-286 of the Mental Health Scotland Act.

All the patients we reviewed (45) in medium security are routinely specified for safety and security but we also found 92 (77% of the low security patients we reviewed) were also specified for safety and security. The main intervention for these patients was regular urine screening for illicit drug taking and searching on return from outings.

We found 10 patients who were subject to restrictions on their correspondence, permitting interception of mail items being sent or received and six of these had had

these measures implemented. Seventeen people were specified for the use of telephones, and 13 had had the measures implemented.

Only three patients had requested a review of the restrictions they were subject to, and this had been carried out by the RMO.

We also asked ward managers in low security wards about patients being specified persons for safety and security reasons, and we found that in nine wards every patient was restricted in this. We were told that in four of the nine units the patients had been assessed individually and all required to be specified.

Each patient in a low secure unit should be individually assessed as to whether these measures are necessary and there should not simply be a blanket assessment of all patients in the ward. Some wards certainly expressed their view that it would be impossible for them to manage the ward safely without making all patients specified persons.

All units told us they assessed patients individually for restrictions on mail or telephones.

Searches

Nearly all - 40 of 46 - wards had a policy on searches. Two said they were considering this and the remainder felt this was unnecessary for their group of patients.

Search policies are applicable to patients whether they are detained or not and cover searches on admission and random searches of rooms, belongings and persons, with the patient's permission. They can also cover targeted searches where there is suspicion of an immediate danger to the health and safety of any person or the good order of the hospital. Where such a search was justified, this would be a reasonable trigger to consider making the individual a specified person.

We believe better guidance is needed to ensure a more consistent, rights based practice in relation to restrictions on patients subject to enhanced levels of security.

Enhanced Observation

All detained patients have the right to:

- **Only to be placed under constant or special observations if it is necessary for their own or others' safety and for the minimum time needed.**

Eleven patients were subject to enhanced observation on the day of our visits. Of those, 10 were under constant observation i.e. within sight or hearing of a member of staff, and one patient was subject to special observation i.e. within arm's reach of a staff member. Of these 11 patients, five were in medium secure units and five were in independent low secure units.

The main reasons given by staff for use of enhanced observation were risk of self-harm, risk to others due to impulsive or unpredictable behaviour or in some cases both.

Seclusion

All detained patients have the right to:

- **Not be secluded against their will unless it is the only way of managing risk to self or others**
- **Be subjected to seclusion for as little time as necessary**
- **Discussion and support (debrief) after seclusion**

Locking someone in a room alone because of their behaviour is usually referred to as seclusion. The use of seclusion can cause distress and psychological harm and can increase the potential risk of self-harm. It should not be regarded as a therapeutic intervention, but it may be necessary for managing extremely difficult situations.

Seclusion can be seen as a form of deprivation of liberty, albeit of relatively short duration. From this perspective, it may be useful to look at ways in which the principles of benefit, least restriction and best interests can be considered alongside a potential infringement of a basic human right.

The Commission's definition of seclusion is that it is 'the restriction of a person's freedom of association, without his or her consent, by locking him or her in a room. Seclusion can only be justified on the basis of a clearly identified and significant risk of serious harm to others that cannot be managed with greater safety by any other means (MWC, 2014)[18] .Although this definition of seclusion does not include situations where someone prevents a person from leaving a room, for example, by physically blocking the exit, the same principles should still apply in such a situation. This amounts to a form of 'de facto' seclusion. We are aware that the term seclusion is not always agreed and few wards have a dedicated room for this purpose.

We found that two patients had been subject to seclusion on a number of occasions in the last month, one six times and one seven times. For both the time in seclusion was on average around 30 minutes. It was being used to minimise the use of restraint which was felt to be more distressing for them.

A third patient lives in a situation of permanent seclusion due to high levels of violence to staff and issues of serious self-harm. A ward has been adapted to meet the particular needs of this patient and this situation is under regular review with the Commission.

[18] The use of seclusion

In addition to this secluded unit designed for this patient, there are three wards which have seclusion rooms, all in the same hospital. The two patients we saw who had been secluded were in this hospital. All the other hospitals do not have a specified seclusion room. One of the medium secure hospitals has a 'crisis area', a bedroom and small living room, in each ward to nurse patients when they are very unwell.

Other hospitals use quiet areas or bedrooms to de-escalate situations in addition to enhanced observation.

We asked patients about their experience of seclusion.

One person said "They *stay outside the room. I don't like it."*

Others who responded did not have recent experience of this but reflected on having spent time on special observation which they likened to seclusion.

One patient commented "*I was kept in my room against my will with 2:1 staffing and was not allowed to leave. They called it 'nursed in my room' but I called it seclusion."*

Eight of 34 wards who responded said they used seclusion, whilst 26 said they did not. Three of the units using seclusion were medium secure wards and two were wards for people with learning disabilities. Of 33 responses, 14 wards said they had policies on seclusion.

Restraint

All detained patients have the right:

- **Not be restrained unless it is the only way of managing risk to self or others.**
- **Restraint should be for as little time as necessary and with minimum force.**
- **Restraint should only be undertaken by appropriately trained staff.**
- **There should be discussion and support (debrief) afterwards.**

From examination of records we found that eight per cent of people (14) had been restrained in the last month. Often these patients experienced more than one incident of restraint and incidents of restraints ranged from one to seven.

Eight of the 14 people had a diagnosis that included a learning disability, though only three of these people were in units specifically for people with learning disabilities. Five of the 14 were in Independent hospitals units.

When we asked all ward managers about the use of restraint in their wards over the past three months, five units indicated they had had 20 or more incidents involving restraint in that period. Three of these wards were in independent hospitals (26, 33 and 83 incidents), one was a ward in a medium secure unit (52 incidents) and one was a ward for people with learning disabilities (23 incidents).

As the restraints were often of the same patient, it was hard to draw any inference about the overall management of aggression in the units. In all units staff had had training in the prevention and management of violence and aggression and received annual refresher training.

We noted that incidents were generally recorded in detail.

For example, one MWC visitor reported that "*there are incidents several times a week- the last being yesterday. Details recorded, oral meds given and evidence that support and debrief offered. Main difficulties have been attempts to harm self, ingest dangerous items etc."*

It was not always clear from documentation whether there had been some form of debrief with the patient following restraint or seclusion. Some units had more formal debriefing procedures, whilst others told us it was done as and when required, depending on the specific circumstances. We saw little written evidence of debriefing or support when we looked at incidents of restraint in patient care files. We think staff are usually holding a post-incident debrief after a period of restraint but this does not always extend to involving the patient, even at a later time when they are more able to discuss this.

Any episode of restraint will be distressing for the patient involved. They should be given the opportunity to discuss it honestly and openly with a member of staff and explore possible alternative strategies. Only in this way will it be possible to formulate a care plan to manage stressed and distressed behaviour which takes into account the views of the individual concerned. Best practice suggests that post-restraint/incident debrief should be conducted with the patient, and include a focus on triggers and psychological harm. An immediate debrief with staff and the patient involved should be held within three hours, and a formal incident debriefing within seven days, including family and the wider clinical team.[19] Bearing in mind patients comments about feeling unsafe in wards having seen episodes of restraint, it is important that this extends to people who have witnessed incidents.

Excessive security

Since 2006 the Mental Health Tribunal for Scotland (Tribunal) has been able to consider applications in respect of patients in the State Hospital for an order declaring that they are being detained in conditions of excessive security. From 16 November

[19] Te Po. o Te Whakaaro Nui. The National Centre of Mental Health Research, Information and Workforce Development, Auckland, New Zealand. (2014) Debriefing following seclusion and restraint. A summary of relevant literature. http://www.tepou.co.nz/uploads/files/resource-assets/debriefing-following-seclusion-and-restraint-281014.pdf

2015, the right to make an application to the Tribunal has been extended to include patients in the three medium security units, Orchard Clinic, Rowanbank Clinic and Rohallion clinic.

This is for patients whose detention is authorised by:

- a compulsory treatment order;
- a compulsion order (this includes patients subject to a compulsion order and restriction order);
- a hospital direction; or
- a transfer for treatment direction.

An application needs to be accompanied by supportive report from an approved medical practitioner. In addition the order needs to been authorised for more than six months. An application can also only be made once in a 12 month period[20].

The test is to establish whether the security at the medium secure hospital where the patient is detained is greater than necessary. This test is met if the security is greater than is necessary to manage the risk the patient may pose to the patient's own safety and the safety of any other person.

At the time of our visits, the right for patients in medium security hospitals to be able to challenge their security status was a relatively new provision. We wanted to find out if patients in medium secure hospital were aware of this new right, and how it was being used.

What we expect to find

We expect that patients would be aware of their right to make an application.

We expect to see evidence of patients considering and starting to challenge their security status.

What we found

We reviewed the cases of 43 patients who were in medium security wards and at the time of our visits we found that three patients had made successful applications to state they were being held in conditions of excessive security (one in the Orchard and two in Rowanbank). Another application was in process at Rowanbank. The patients who had made successful applications were awaiting moves to lower levels of security and there were no places in low security readily available, so these patients were on waiting lists.

[20] Excessive Security Guidance

We asked patients if they were aware of their rights in relation to being able to make an application to challenge their security status. Three said they were not, six reported not being sure, but fifteen said they were aware of their new rights. Several of the patients we spoke to had made successful challenges while at the State Hospital so the process was not unfamiliar. It seemed that generally patients were well informed and had support from advocacy and their legal representatives to discuss their situation regarding such a challenge if they wished to do so.

The Commission is notified by the Tribunal in relation to applications to challenge levels of security. These challenges to medium security provision were introduced by amendments to the 2003 Act by the Mental Health (Scotland) Act 2015 and applications in relation to excessive security are made under section 268 of the Act. If security is relaxed then the relevant health board has up to three months to identify a new appropriate hospital or accommodation.

If this is not done in the appropriate time period then the patient can return to the tribunal under section 269 where a further 28 days or a longer period up to three months (as the Tribunal thinks fit) can be given to the health board to find a new appropriate hospital or accommodation for the patient.

The Tribunal takes no formal proceedings after this stage and any further action in the event of non-compliance would be progressed using section 272 (in relation to failure to perform a statutory duty) and would progress to the Court of Session. The Commission is likely to be involved at this final stage.

We are aware (as of 12 April 2017) that there have been 25 applications from patients in medium security to challenge their level of security and 24 of these applications have been successful. Twenty one (91%) of the successful applications have been for patients in Rowanbank which is putting particular pressures on low security services in that area.

It is clear that the recent changes to legislation are having a significant impact for patients in relation to their ability to challenge their level of security, particularly in the west of Scotland. It will be important to try to look into these differences in the way patients have uses their new right to challenge being held in conditions of medium security as there may be reasons underlying these differences.

There is a lack of low security provision in Lothian Health Board, and patients may be concerned they will be moved away from their home areas. We also are aware that many patients would hope to be able to move directly to the community from medium security accommodation and feel a move to low security will make their stay in hospital longer.

Activity and recovery

Patients have the right to:

- **Activities for therapy and recreation**

Patients in medium and low security units are nearly always detained patients. This means that leaving these wards is subject to restrictions. For restricted patients this requires their doctor (RMO) to seek authorisation from Scottish Ministers for any time away from the ward or attend activities. For other patients who are detained, it is their RMO who can approve 'suspension of their detention' to allow them to leave the ward.

Time out of the ward is usually incremental, based on the assessment of patient risk and building up of trust and confidence that it is safe for them to do so.

What we expect to find

We expect that for patients in medium security that their risks will be considered to be higher and their leave is more likely to be escorted or within the hospital grounds, at least initially.

We expect for patients in low security there will be more focus on rehabilitation and returning to the community; we expect many activities will be in the community.

We also expect to see interventions with a specific therapeutic function to address some of the complex difficulties experienced by many of the patients in secure settings.

We expect to see activities for therapy and recreation for patients in all wards.

What we found

We asked about the opportunity to engage in activity and 127 patients responded to our questions; 79% of patients said they felt happy about opportunities to engage in activity (81% medium security 78% in low security), only six per cent of patients said there was nothing to do or said they prefer not to get involved in activities.

The other 15% of patients said there were only sometimes opportunities for activities. Some of these patients said that there is not really enough to do:

"I would like more activities but there are not enough nurses and OTs to do this."

"Not much in evening or weekends."

"I mainly play pool and watch videos."

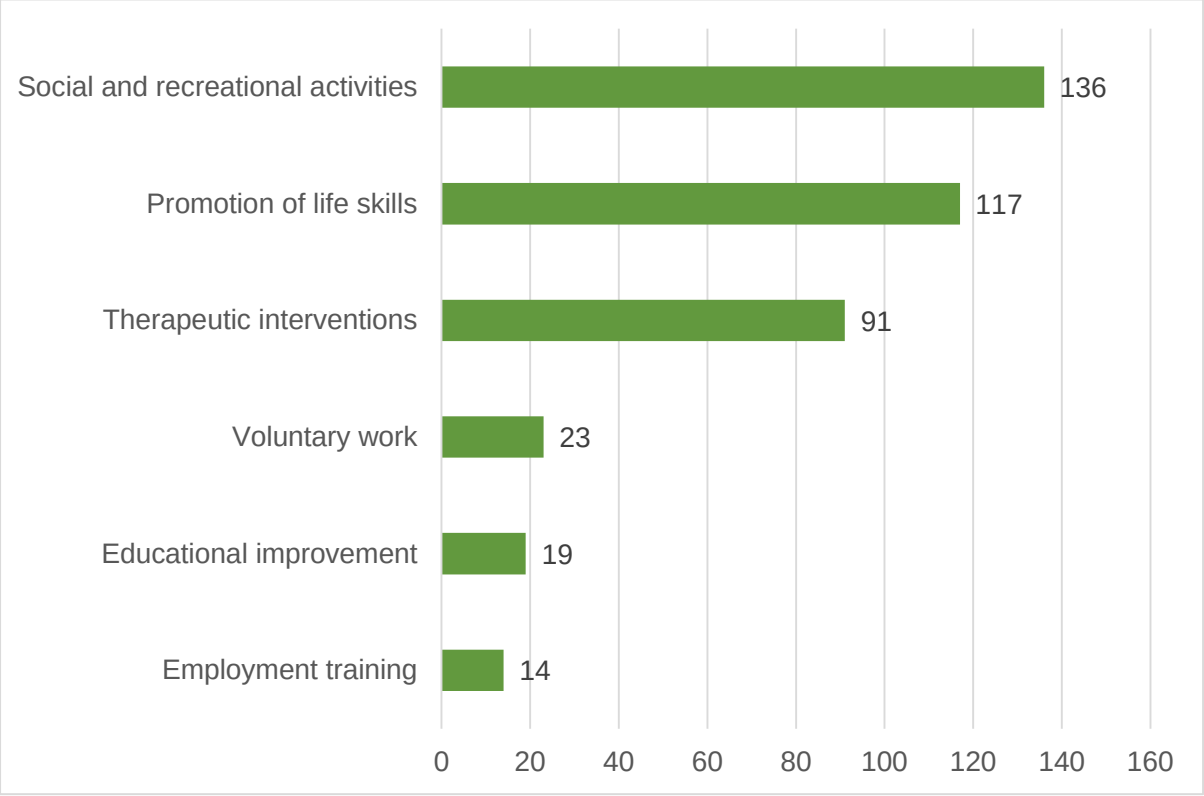
All three medium secure units had well developed facilities for providing activities and groups. The recreation centre at Rowanbank offers a broad range of educational activities, a café, library, gym, shop and IT facilities. The Cypress unit in the Orchard Clinic has a sports hall, art facilities, computer, library, games and a group room. Rohallion also has a day room, therapy kitchen, group room and games and activities.

Most patients agreed that there were opportunities for activities on weekdays during the day. About half of the patients we interviewed said that there was less to do in the evenings and at weekends. We did note however that many patients did have activity plans that covered evening and weekend activities.

We looked at plans for everyday activity and found (from 151 patients where we had information) that 94% had activity plans though we felt just over 10% of these plans should have been more detailed. A small number of patients (6%) did not have a plan for activity; these patients were either particularly unwell or unwilling to engage in activities.

Our visitors listed what was included in activity plans.

Figure 9: Components of activity plans



The main component of activity plans was very much focused on social and recreational activities such as going shopping, going for walks, arts, and cookery groups. In many situations activities achieved multiple benefits; activities such as cooking may have therapeutic and recreational benefits and also promote life skills.

Patients themselves tended to talk about the recreational activities they were involved in as the activities they enjoyed and valued.

In terms of recovery and moving on educational opportunities, work experience and employment training are particularly important and it was disappointing to see such low levels of these interventions.

We asked ward managers about activity opportunities for patients and it was evident that there were a good range of activities available across the units with lots of activity taking place using community resources.

Nature of activities

Activities were generally very individually focussed and specifically geared to the individual patient's stage of rehabilitation and leave status.

Recreation activities included - going to shops, outings to cinema, bowling, going out for meals to local restaurants, visits to cafes / coffee shops and visits to art galleries, parks, museums, football/rugby matches and theatre shows.

There were a wide range of projects and activity groups both on and off hospital sites, including art groups, community garden projects and allotment groups and even a barge project.

Sport and exercise also featured prominently with many wards having walking groups and access to gyms, swimming, football groups, badminton and bowling. We also heard of more adventurous activities including climbing, cycling, fishing and bird watching.

Volunteering in the community was well developed, with assignments in local charity shops and voluntary groups. Projects involving volunteering with animals seemed popular, with mentions of cat and dog homes, dog walking, dog rescue, owl rescue, community farms and work with horses.

There was specific mention of adult literacy opportunities by several wards and references to links with local colleges and opportunities for work experience.

We were also pleased to note in several responses that religious / cultural opportunities were being addressed, with Muslim patients supported to attend the local mosque and opportunities for patients to attend religious worship and church groups.

Patient responses seemed to very much reflect this wide range of activity, and patients also told us that if activities had to be cancelled they were generally rearranged quite quickly.

Visits and outings were generally a mix of being escorted and unescorted, mainly involving nursing staff, but some of the activities were facilitated by OTs. Many of the wards also had access to a minibus or transport to facilitate visits.

Barriers to activities

We asked if there were issues affecting the delivery of activity. It was acknowledged that there can be difficulty in providing escorted activity if there are staff absence issues or difficulties on the ward requiring increased observation levels. Wards were generally clear, however, that if activities were postponed they are rescheduled as soon as possible. It is important wards are able to monitor this situation.

We heard from some units that funding cuts in some voluntary organisations have resulted in a reduction in community placements offering vocational rehabilitation. If this is the case, then this is a situation the Commission would wish to be kept aware of on future visits.

We heard on several occasions of frustrations in relation to gaining government permissions for restricted patients. This can delay the opportunity to undertake rehabilitation activity and patients can find these delays very worrying.

We were also made aware of frustrations particularly on transition from a higher level of security to a lower level. This was particularly evident when moving from medium to low security. Patients who had been able to achieve a considerable level of more independent leave and access to grounds and the community, had to regain these ‘privileges’ which they struggled to understand having moved to a lower security setting. In some cases this resulted in them not being able to attend placements that they had been able to attend in higher levels of security. We heard that this frustration and lack of understanding of the situation in some cases had a detrimental effect on the patient’s mental health.

We asked patients specifically about therapeutic groups and interventions they were receiving as part of their treatment. Many of the patients we spoke to had undertaken significant input in relation to psychological interventions, particularly those who had previously been through the State Hospital. Many patients mentioned input on anger management, drugs and alcohol groups, sexual feelings and problem solving groups. They also spoke of therapy sessions; mindfulness; relaxation; recovery and talking groups and one to one sessions with psychologists.

Many patients were not involved in ongoing groups and some spoke of having done the groups and not wanting to repeat them. It seemed that for many patients, groups and programmes were something that had to be ‘ticked off’ on a list to progress through the system. Several patients also said they did not think the groups were much help.

What is most helpful?

We asked patients what they found most helpful to them while they were in hospital.

What patients seemed to appreciate most was support from hospital staff; 85% cited support from nursing staff. Many also said they appreciated the support from their doctor and psychology: peer support, advocacy and MHOs were as also mentioned by some patients.

Patient comments:

“Nurses and psychology input, people are listening and believing what I say, staff are excellent.”

“I think medication can only help so much. It is good to talk to staff.”

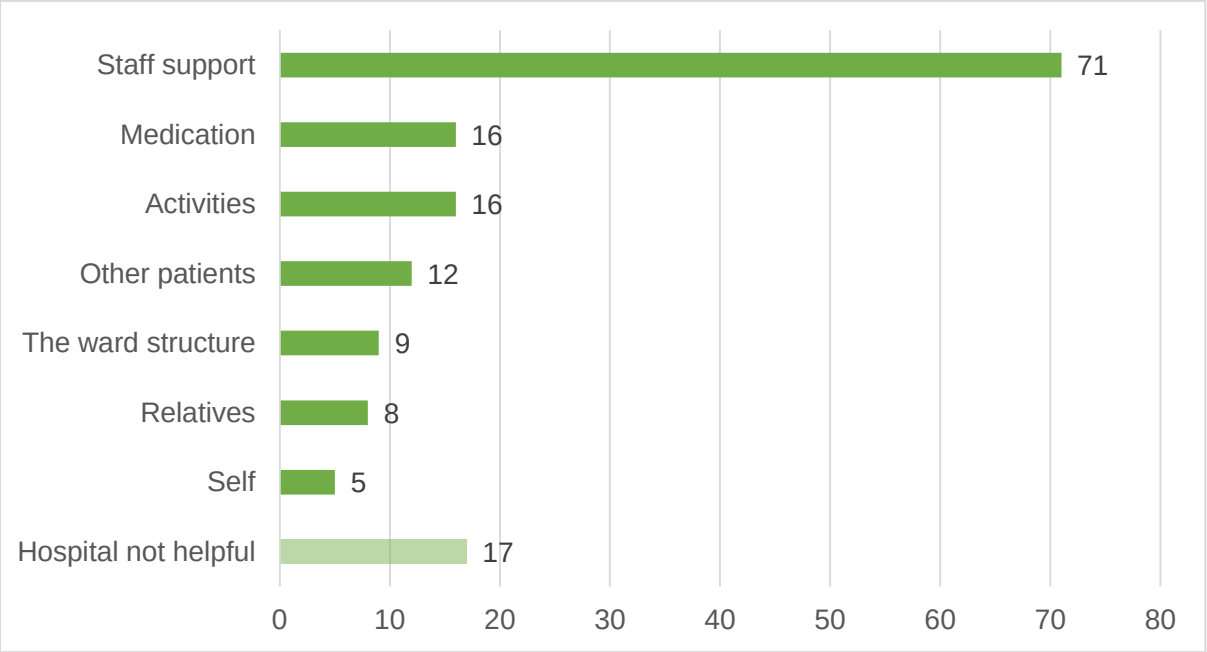
“Nursing staff input, and medication helps a lot but what helps most is getting out in the community."

“I enjoy the company of other patients this helps me especially the ones who have been here for a while.”

“Medication does help - both nurses and patients are also a help and can support you.”

The security of the ward structure and the ward environment was also mentioned as helpful by some patients who seemed to appreciate the availability of structure and routine in the day.

Figure 10: What patients find helpful



The importance of contact with relatives and family was also mentioned by some patients as being very important to them, and this is a factor to consider in relation to patients away from their home areas.

Other patients also spoke of the fact they now felt stronger and relied on their own strength for support. Prayer and faith was also stated as being important by several patients.

Not all patients were happy about their support or about being in hospital and the restrictions placed on them, and 17 said they did they did not need to be in hospital.

"I don't think I should be taking medication and I shouldn't be here as I haven't done anything wrong."

The mix of restricted patients and non-restricted patients can emphasise the feelings for some patients that they are in the wrong place as they have done nothing wrong.

Advance statements

The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act") sets out how people can be treated if they are unwell and need treatment for mental disorder.

The Act allows an individual to make a written statement, when they are well, which sets out how they would prefer to be treated (or not treated) if they were to become unwell in the future and their ability to make decisions about their treatment is significantly impaired. This is called an advance statement and is relevant only to treatment for mental disorder as defined by the Act.

The Commission has produced guidance to promote the use of advance statements[21].

Everyone has the right to:

- **Make an advance statement setting out the care and treatment they would prefer or dislike if they were to become mentally unwell in the future.**

Patients subject to detention have the right to:

- **Have their advance statement about care and treatment choices followed, unless there is a good reason not to, and that reason is explained in writing.**

[21] Advance statement guidance

What we expect to find

Given that many of the patients we spoke were detained patients and had been in hospital for a long time we expected that a significant number of them to have made advance statement or at least to be aware of their right to make one.

Where patients have made an advance statement we expect that the advance statement is taken into consideration by staff in relation to providing treatment and in care planning.

What we found

We asked ward managers and patients about advance statements.

Thirty six (78%) of the wards reported asking patients about advance statements as part of the admission process, though 10 wards reported not asking. Wards not asking on admission were all low security wards; there seemed to be an assumption this would have been discussed in previous wards or the discussion of advance statements was left to advocacy services.

Managers responded that 39% of the 400 patients in the units were reported to have an advance statement. They also reported that often patients declined making an advance statement, but the process had been discussed with them.

Of the 135 patients who responded to our questions about advance statements, 42% said they had an advance statement, with another four per cent stating that they were in the process of making one or considering doing so.

About an equal number of patients 45% said they had not heard of advance statements or were unsure if they had one and 9% said they had chosen not to make an advance statement.

Of those who had made advance statements just over half said they had done them with nursing staff, and just under half had completed their advance statements with an advocacy worker. A small number said posters on the wards had prompted them to make the advance statements. It was evident that in many cases there had in fact been discussions with both ward staff and advocacy, and some could not actually remember who had witnessed the statement.

We were also aware that many patients we spoke to were quite unwell or lacked capacity to understand about advance statements. We also heard from a number of patients that making an advance statement was something they had done a long time ago and could not remember what was in it; these statements need to be regularly reviewed and be a part of care planning.

The Commission's recent report in relation to Adult Acute Services (April 2017)[22] reported only about seven per cent of patents interviewed with advance statements. The situation on medium and low security wards is much better in relation to uptake of advance statements but there still appears to be a high level of uncertainty about the situation of advance statements amongst patients.

Advocacy

Patients have the right to:

- **Have independent advocacy services**

What we expect to find

We expected to find advocacy support available to patients in all the ward we visited and for advocacy services to be fully developed as an integral part of service provision. The availability of advocacy is particularly important for patients in secure settings due to their additional restrictions and detention status.

What we found

All the wards reported having advocacy services available to their patients. Contact was generally by means of a dedicated service from a range of third sector organisations contracted to provide advocacy services to the wards. The service generally comprised of a mixture of routine visits and drop in sessions accompanied by specific referrals and requests for one to one contacts from patients. All the comments we received from ward managers were very positive in speaking of regular contact, a good service and rapid responses. As well as individual contacts with patients, many managers spoke of advocacy running patient meetings and ward groups to raise collective issues. Some advocacy services such as 'Circles Advocacy' have focused particularly on working in forensic services and developed expertise in this area.

We asked patients about their experience of advocacy. All patients who responded (135) seemed aware of advocacy, and 80% of these said they had an advocacy worker.

Nearly all of these patients (96%) who made comments were very positive about support from advocacy.

"They help me at meetings. I will write down what I want to say."

"They are very supportive and helpful."

[22] Adult Acute Themed Visit Report (April 2017)

"'My advocate is here when needed."

Only four per cent made negative comments.

Fifteen per cent of patients said they had been offered advocacy but had refused. Of these, most who commented said they no longer needed advocacy as they were able to speak for themselves.

Only one patient said "*I have found that they are not always able to help me"*. Two patients said they would like advocacy as the result of us speaking to them, and three said they were unsure about whether they wanted advocacy.

Overall we were pleased to see the level of provision across these wards and to hear the very positive responses from patients.

Peer support

What we expect to find

We expect that wards will have developed the use of paid peer support work as part of their focus on promoting recovery and we expect an ongoing commitment to improving access to peer support workers.

Peer support is the help and support that people with lived experience of a mental illness or a learning disability are able to give to one another. It has been demonstrated that peer working is a powerful way to support and develop recovery-focused practice.

Peer workers are people who have personal experience of mental health problems who are trained and employed to work in a formalised role in support of others in recovery. They are willing and able to share their personal experiences on an equal level that validates, supports, empowers and brings hope to the individuals they partner with[23].

Recognition of the value of both formal and informal peer support was highlighted in Commitment 3 of Mental Health Strategy for Scotland 2012-2015, and this strategy indicated an intention to extend the use of the peer support model more widely.

What we found

We found that only one of the hospitals we visited (the Orchard Clinic) employed peer support workers; they have relatively recently employed two peer support workers. The view from staff and patients is that this has been very successful particularly on

[23] Scottish Recovery Network

the rehabilitation wards. These workers are able to work individually with patients helping with recovery plans, general support and also help in staff training.

"One comment from a patient in the Orchard Clinic said that they had weekly contact with a peer support worker and found it very helpful as they can they can relate with the hospital experience."

There were comments from several units of being interested in investigating the use of peer support further but no other forensic units were employing peer support workers.

We also received comments that 'there was no use of peer support due to the nature of being a secure provision'. This indicated that some managers did not see the appropriateness or possibility of peer support in a forensic setting, which is surprising given the Orchard Clinic experience.

Though there were no formal peer support workers in wards apart from the Orchard Clinic there was evidence of patients supporting each other and working together in their recovery. Tryst Park ward spoke of peers facilitating a problem solving group and in the Boulevard ward at Leverndale hospital patients work together in the unit using a 'home-style' model sharing tasks and responsibilities.

Health needs

Patients have the right to:

- **Adequate health care for their physical as well as their mental health needs.**
- **Have health care without which their life would be at risk.**
- **Have access to health promotion and prevention information.**

What we expect to find

We expect to find that the physical health of patients is looked after proactively, and that all care and treatment is lawfully provided.

Specifically we expect that:

- Each patient has routine health checks.
- Patients can access specialist input, where it is required.

What we found

Physical health care

People with mental illness have a much higher mortality than the general population, dying on average more than 10 years earlier[24].

That gap is widening as health gains have been made more quickly in the general population than for those with mental illness. A reason for this widening gap is the high prevalence of chronic diseases such as cardiovascular disease, cancer and diabetes, and the often poor access and quality of treatment for such conditions for people with mental illness[25].

Similarly, people with learning disabilities have higher than average rates of particular medical conditions such as respiratory disease, coronary heart disease, epilepsy, hypothyroidism and diabetes[26].

Fifty one per cent of the people we saw (83 of 164 responses) had chronic health problems. There was no variation between the people we saw who had a diagnosis of learning disability and those who did not. The most common chronic health problems were diabetes, obesity, asthma, epilepsy, cardio-vascular and renal problems.

We considered that in nearly all cases these were being managed proactively, though we had some difficulty accessing physical health information when no GP information was in the wards records. There were also concerns raised in one hospital due to the recent loss of their GP service.

When we asked patients about their health problems 45% (57 of 127 responses) considered they had issues with their physical health. Only two of these patients felt they had not received adequate support and advice (one was waiting for a physiotherapy referral and one felt his sore knee and back were not being treated properly).

Routine physical health checks

Eighty eight per cent of people (141 of 161 responses) had routine physical health checks along with good access to the GP for health problems that arose. The remainder, where we could access the records, had good GP attention as required.

We noted good practice in a number of areas. For example in Tayview Ward, we noted the use of the booklet 'All about My Health' to inform patients about their yearly health

[24] Chesney E., Goodwin GM., and Fazel S. (2014) Risks of all-cause and suicide mortality in mental disorders: a meta-review World Psychiatry Volume 13, Issue 2 June 2014 Pages 153–160
[25] The Scottish Government (2012) Mental Health Strategy for Scotland: 2012-2015
[26] Emerson E., Baines S. Health Inequalities in People with Learning Disabilities in the UK:2010, Improving Health and Lives: Learning Disability Observatory, 2012

check and the use of the OK learning disability specific health check. In Kyle Park 'My Health Check' leaflet was developed to help inform patients of the benefits of undertaking health checks. In Tryst Park, staff were discussing the timing of GP visits as these were early in the morning and not ideal to maximise the engagement of the patients. In most health boards there was good support from the dietician service and efforts by staff to promote a healthy diet and exercise.

In Rowanbank and Leverndale Hospitals we heard about their rolling programme of health clinics for specific chronic conditions such as a diabetes, renal conditions, asthma and cardiac review. Rowanbank also have nurse 'champions' in each ward responsible for coordinating psychotropic monitoring. They ensure results are up to date, interventions are arranged such as bloods, side effect scales and ECGs and review reports and sent to the responsible medical officer.

Smoking

A high proportion of patients continue to smoke. Forty one per cent of patients (14 of 34) in medium secure units who responded defined themselves as smokers. However the rules regarding smoking varied considerably. In one unit smoking was still allowed in the garden, though there was to be a ban in October 2017. In the other medium secure units, patients were not allowed to smoke in the hospital grounds or on escorted pass[27].

In low secure units, 55% (48 of 87 people who responded) said they were smokers. Again there was considerable variation in the restrictions in smoking in the low secure units. Independent hospitals are not subject to the same restrictions as NHS units and in one unit patients could smoke in the grounds and we were told there were five cigarette breaks in the day. In another hospital a ban was coming in at the end of January 2017. In others there was still smoking in the hospital grounds. It was a topic which evoked strong feelings. For instance one patient felt 'it was a violation of her rights' and was looking for legal means to challenge it. Another was particularly unhappy because of the inequality of patients on unescorted pass being able to smoke outside the hospital grounds whilst he was unable to do this as he had no unescorted time. A few patients stated the positive benefits to their health of having stopped smoking.

It was clear that patients in all units were offered support with smoking cessation on an ongoing basis.

There has been a legal challenge to the State Hospital smoking ban which went to a judgement by the UK Supreme Court[28]. The court judged that a smoking ban isn't in itself a breach of Article 8 of the ECHR but did raise issue regarding the way the ban was enforced, as regulations governing safety and security had not been properly

[27] MWC Guidance on smoking
[28] Supreme court smoking judgement

applied. At the time of writing we understand that these issues have been addressed and the ban is still in force.

Weight and exercise

Sixty patients of 125 responses were concerned about their weight. Except in one instance, their concerns were about being overweight. Forty five of these people felt they were supported by staff to eat healthily, take exercise or both. For instance one person said*, 'I play football, I like to walk and use the exercise bike and I am encouraged in these activities'.* Another commented*, "I find gardening helps and there is a gym."* Others felt that they managed this themselves e.g. *"I go for walks in the grounds. I am not interested in the gym though it is available."*

We asked patients in general whether they were able to get exercise. Ninety one per cent (100 of 110) of people who replied told us they got support to exercise and keep fit. Nine per cent (10) felt they were unable to do this. Four of these people told us they were not permitted to leave the ward; one person was not able to use the gym equipment, even though it was available in the ward, as staff could not facilitate this; and one person said there was not the kind of exercise available that he wanted to do.

All three medium security units reported that patients had access to exercise equipment. Rowanbank has some outside gym equipment in the grounds as well as a gym in the community centre. The Orchard Clinic has two exercise areas, one in the Cypress unit and one in the main hospital, Rohallion also has a gym. The gym equipment (not the outside equipment) requires trained staff to be available for patient supervision and we heard there can be difficulties in having trained staff available. This can be a barrier to patients getting exercise.

Overall, 87% of the wards said patients had access to exercise equipment; some wards said they did not feel their patients would be able to use the equipment but they encouraged walking. It seemed many patients have exercise activities as part of activity programmes, often using hospital gyms or community facilities, and when positively encouraged, exercise activity is popular. However, we also had comments that the exercise equipment is never or rarely used, and again we also heard of difficulties of having trained staff available to supervise activity.

Ward managers detailed various healthy lifestyle promotions in terms of healthy eating and access to regular exercise. For example, in Leverndale Hospital Boulevard, Campsie and Bute wards use a home-style model of care where patients plan, shop and prepare their meals in the ward. There is a traffic light system to encourage healthy eating choices supported by pictorial and written recipes, food choices and ideas. We also heard about the numerous activity groups in Ward 6 Leverndale including tennis, football and hula-hooping with awards for best efforts to show appreciation for positive involvement and charts to track activity levels. The hospital also has a mile walk laid out around the grounds which is well used by patients.

Support with drug and alcohol issues

Forty four per cent of patients who responded (55 of 125) said they had had problems with drugs or alcohol. Twenty six of these people said they were getting help with this.

A number were receiving psychological input-for instance "*I have had significant problems with drugs and drink in the past. I am currently attending a drug and alcohol group with psychology."*

One person was attending Alcoholics Anonymous (AA) three times a week. Several were prescribed methadone e.g. *"I was taking heroin in the past and I am now on methadone which helps. I feel a lot better physically since coming into the ward."*

Others who responded said they had previously attended groups to address these issues. For example one man commented "*I have attended groups for drug and alcohol in the State Hospital and have been told by the multi-disciplinary team that it will be readdressed in a low secure hospital"*.

Ward managers told of a variety of support available including referral to substance misuse services and AA groups in the local area, psychology-led individual and group work in the hospital, relapse and prevention awareness and coping strategies groups and harm reduction treatments.

Given the high numbers of patients with drug and alcohol problems, this issue requires to be fully addressed while in hospital as drug and alcohol issues are a significant factor in many recalls to hospital.

Family, carers and visiting

Patients have the right to:

- **Have their carer (family/ partner/ friend) involved in discussions about their care and have their views and caring role considered when determining the need for support and services for the patient.**
- **Support to maintain family relationships.**

The importance of involving family and carers to ensure the best outcomes in mental health treatment has been increasingly acknowledged in recent years. However, it has also been recognised that family and carer involvement has been less successful in forensic settings.

The Support in Mind Scotland (SiMS) and the Forensic Network report 'Exploring Family Carer Involvement in Forensic Mental Health Services - May 2014'[29]

[29] Exploring Family Carer Involvement in Forensic Mental Health Services - May 2014

highlighted inconsistencies in provision of support for this group of carers across the country.

The report identified that forensic carers particularly require additional support (generally) but particularly in relation to information provision, involvement in the care process and the reduction of stigma.

The report also recommended that the general principles of the 'Triangle of Care'[30] good practice guidance be applied.

Given these difficulties, we very much wanted to get carer feedback of their views of services during out visits.

Following on from that report, SiMS have set up "Caring Connections" which has a dedicated worker who is linking in with forensic services nationally. The Commission liaised with the SiMS forensic carers' worker to access their networks and held a range of meetings in the various wards with carers' representatives to gain carers' views. Despite these efforts we still only managed to get views from a relatively small number of families and carers.

A questionnaire was circulated for distribution to the wards and their carer groups.

What we expect to find

Under the principles of the Mental Health (Care and Treatment (Scotland) Act 2003 professionals who are treating someone under the Act must take into account the views of the service user's named person, carer, guardian or welfare attorney if they have them.

We expect to find that family and carers views are being respected.

We expect that family and carers are involved in their relative's care as much as is appropriate or wished for on the part of the patient or the carer.

We expect staff to take into account, if possible, the family and carer's needs and provide them with appropriate information that might help them care for their relative.

We expect staff to involve carers concerning past and present wishes of the patient regarding their care and treatment (sometimes this may only be available from the carer).

[30] The Triangle of Care: Carers Included: A Guide to Best Practice in Mental Health Care in Scotland

What we found

Overall we had contact with 14 carers over seven units who were either seen face to face or spoken to on the telephone.

We asked ward managers in all the wards how they kept family and carers involved and updated about care and treatment.

Every unit reported processes in place to keep family involved. Most cited invitations to CPA meetings and regular discussions with the named nurse. Many of the units mentioned they were using the Triangle of Care and some units also said they provided written information for families and carers. Some also had access to forensic carer support groups.

Despite this, when we asked the carers themselves about support, 57% (eight) reported having been offered none at all.

Medium secure wards

All three of the medium secure units were making significant efforts to try to address the issue of engaging carers.

Rowanbank spoke of a carers group that meets monthly and they have a 'behavioural family therapy' programme which they feel has been very successful in helping to maintain family relationships. They also have dedicated nursing staff who have been trained in carer engagement on each ward and 'meet the team days' which allow carers to meet the staff treating their relative. Rowanbank mentioned they have a section in the care plan designated for carers which is good practice and something we also observed in other units and wish to encourage.

The *Orchard Clinic* similarly has a carer support group and they have a carer feedback form that goes to carers after each CPA meeting. They also provide behavioural family therapy and mentioned that they benefit from having a social workers' service on site who are very active in engaging families and can arrange support and even breaks for carers.

Similarly *Rohallion* has dedicated 'carer champions' on the wards and they run open days and events for carers. They also said they send out a letter to families on admission, have a carers' newsletter and there is also a 'Meet the Charge Nurse' day each month.

All of the units indicated they helping maintain family contact by arranging home visits for individuals where appropriate. All the units also said they are now making use of new technology such as Skype to maintain contact with relatives who are too frail to visit or too far away.

Low secure wards

We saw evidence of good practice in engaging carers in many of the low secure units:

Ayr Clinic, an independent hospital, where many patients have family living in other areas uses Skype for communication and arranges home visits for patients. They have also on occasions made arrangements for an individual to meet his family half way. Carers are invited to Individual Care Review (ICR) meetings in addition to CPA meetings

Leverndale wards also use Skype and has a tablet that individuals can use under supervision.

Royal Cornhill wards run 'carer socials' and often arrange speakers, such as a pharmacist to give carers information.

Beckford Lodge have a monthly carer group and their carer coordinator helps with carer assessments.

Radernie have dedicated carer workers who can help make arrangements for carers to meet with the doctors and charge nurse. Carers commented on how welcome and approachable staff are in this unit.

Tryst Park has a drop in session once a month to meet with the consultant and charge nurse

In *Bruar ward* carers commented that staff were very helpful and supportive.

We also heard of many examples of staff providing a very person centred approach to linking with families and carers in many of the units, accompanying patients to funerals, care homes births and family events.

Information from families and carers

The majority of families and carers who spoke to us were generally satisfied with the visiting arrangements in the units.

We had comments such as:

"There have been no problems visiting my son and staff have been really good with me when visiting my son."

"There are no problems, the staff are very helpful. I was offered lots of support."

In terms of feeling welcome on the ward, the vast majority of carers gave a positive response.

“I have been made to feel very welcome when visiting my son and the staff are very approachable and easy to talk to, and there is always a member of staff at hand to talk to if needed which is very good.”

Some carers felt they could talk to staff easily but felt that they did not always listen.

The main issues raised were:

- *The long distances many carers have to travel*

Some patients are in areas a long way away from their home areas and families and many have parents who are elderly or have mobility issues. The majority of carers and family we had contact with were parents, and half of them were in the 65-84 age group, so this is a significant issue.

The cost of travel was also highlighted. Expenses are paid for CPA meetings but not for regular visiting, and some carers found this combined with the distances involved to be restrictive.

Others who had considerable distances to travel or where children are involved said they keep in touch by Skype or video link.

- *Lack of privacy and cancelled visits*

Another issue raised was the lack of privacy during visits as was the fact that visits can also be cancelled due to staff or transport difficulties.

Visiting often takes place in the dining room which many people feel is too public, although some units had a dedicated space.

“There is no privacy to visit there is often a staff member sitting or sometimes they are in the corridor but with door open. This gives a bad atmosphere.”

Another carer was upset that they could not visit their relative in their room.

Everyone seemed to accept that sometimes visits had to be cancelled due to their relative’s levels of distress.

Visitors were almost universally approved by staff before being allowed to visit and special arrangements were made for children, using off- ward sites if the environment was considered unsuitable for under 16s.

In terms of other comments carers and families said they felt were important:

Comments were made about:

- *The distance that can be involved if there are no secure facilities (which are more limited for women) in the local area.*

- *Concerns about the fact in the Orchard Clinic there is no dedicated female ward which can result in a female patient being the only woman on the assessment ward which can be isolating.*
- *There were also general concerns expressed that due to lack of provision for women in Scotland there was a risk for them being 'sent south of the border'.*
- *There was a concern mentioned by several carers who felt their relatives were becoming deskilled having spent a long time in secure wards and they were now lacking in confidence.*
- *Financial concerns were also a common issue with anxieties ranging from travel costs, the expense of caring for an individual's children and lawyer's fees.*

We had conflicting comments about activity. Some carers were concerned about lack of time outside and lack of activities, where others mentioned that they were impressed with the extensive activity programme provided. This is likely to reflect the variation in individual patient experience.

One family also stressed the importance to them of being kept informed about a deterioration in their relative's health, they had only found out about episodes of physical illness after the event.

Families also said that times of transition can be a very difficult time which services should be aware; they particularly need information and support at this time to alleviate uncertainties.

From our visits to patients, almost half of the individuals spoken to did not have any family contact, and many had only limited contact due to ongoing family conflict or frailty of relatives. The importance of contact with relatives and family was, however, also mentioned by a number of patients as being very important to them and their recovery. We would hope that patients are supported to maintain and or repair family relationships and that family are welcomed and supported on the ward.

Engaging with families and carers is not necessarily the same thing as supporting them, and it important for services to understand all of the factors involved if meaningful contact with patients family and carers is to be successful.

We would like to see that carers are provided with, or directed to, support for themselves and informed about their rights to a carer's assessment. It is also important that the good practice currently in place is shared.

Family and carers as named persons

We are aware that only four of the carers we communicated with said they were designated as named persons. For detained patients a named person has the right to receive specific information be notified about specific decisions and to make appeals and be involved in tribunals so this is an important role.

The small numbers of family members of carers we spoke to who were a named person would suggested that there is still a significant amount of work to be done to promote this.

It is important to note that changes related to named persons are about to come into force in the Mental Health (Scotland) Act 2015. Adult patients will only have a named person if they choose to have one, there will no longer be a default named person. The 2015 Act also introduces a limited right, where the patient has no named person, for listed persons (the carer, nearest relative, guardian or welfare attorney) to apply or appeal to the Mental Health Tribunal, if the patient does not have capacity to do so on their own behalf.

Conclusion and further action

Speaking with patients in the Scottish medium and low security wards gives a valuable insight into their experiences of being in secure care and of the particular issues faced by the services looking after them.

This report demonstrates that care and treatment for these patients in hospital is generally good. We found a level of attention to detail and patient participation in care planning that we often do not see in non-forensic wards; there was good access to other professionals such as psychology and occupational therapy. We also heard about a wide range of activities available and good physical health interventions. There is however a wide variation of restrictions that patients in different wards experience that does not always relate directly to their level of security.

We have particular concerns in relation to patients moving on from higher levels of security and what appears to be a lack of capacity in hospital and community provision.

We also feel there is a need to look more closely at the two distinct patient groups in medium and low security wards and how their needs are best met and risks best managed. It is important that there is appropriate local provision for longer term patients with complex mental health needs who have not been convicted of serious offences.

Our recommendations indicate that there needs to be a Scottish Government drive to ensure a consistent, rights based practice in relation to restrictions and for Integrated Joint Boards to be held accountable for delivery of low secure and community forensic services.

Appendix 1

Forensic Network

The Scottish Government (September 2003) established the Forensic Mental Health Services Managed Care Network (Forensic Network). The Forensic Network supports National, Regional and local services across Scotland to provide Forensic Mental Health & Learning Disabilities Services across the spectrum of levels of security. The aim was to bring a pan-Scotland approach to the planning of services, address fragmentation across the Forensic Mental Health Estate, determine the most effective care for mentally disordered offenders, consider wider issues surrounding patient pathways, align strategic planning across Scotland, and address teaching, training and research needs.

The Forensic Network commissioned report 'Definition of Security Levels[31] in Psychiatric Inpatient Facilities in Scotland' and has defined the levels of security as high, medium and low, broadly on the following basis if risk:[32]

- High security is the level of security necessary only for those patients who pose a grave and imminent danger to others if at large;
- Medium security is the level of security necessary for patients who represent a serious but less immediate danger to others.
- Low security is the level of security deemed necessary for patients who present a less serious physical danger to others. Security measures are intended to impede rather than completely prevent absconding.

This report defines the purpose of security as –

"The purpose of security in psychiatric care is to provide a safe and secure environment for patients, staff and visitors which facilitates appropriate treatment for patients and appropriately protects the wider community".

Restricted Patients

Restricted patients in hospital are patients who have been detained by the Criminal Courts either prior to their sentence under an Assessment Order (AO), Treatment Order (TO) or Interim Compulsion Order (ICO) or by way of sentence under a Compulsion Order and a Restriction Order (CORO), Hospital Direction (HD) or a Transfer for Treatment Direction (TFD). These orders all relate to sections of the Criminal Procedure Scotland Act (1995).

[31] http://www.forensicnetwork.scot.nhs.uk/documents/hdl/LevelsofSecurityReport.pdf
[32] http://www.mwcscot.org.uk/media/124446/s268_event_report.pdf

Scottish Ministers have a specific statutory role in respect of the management of restricted patients and oversee and make decisions about most aspects of transfer between hospitals, suspension of detention from hospital and return to the community for these patients. About 45% (75) of the patients we saw or reviewed in our visits were restricted patients.

Young people

The Commission has repeatedly raised the issue of the absence of any secure forensic mental health unit for young people in Scotland and also a lack of any similar facility for young people with learning difficulties. Young people requiring such a facility have generally been placed in specialist units in England and this continues to be the case.

We are pleased that Scottish Government has recently been given approval for a new 12 bedded medium security forensic unit as part of the new Mental Health in-patient facility at Woodland View Hospital (Ayrshire and Arran Health Board). This facility will fill a major gap in current forensic provision.

For the purposes of the Mental Health (Care and Treatment) Act 2003, a child is any person under the age of 18.

Appendix 2

Table 4 – Wards visited and number of patients seen / reviewed

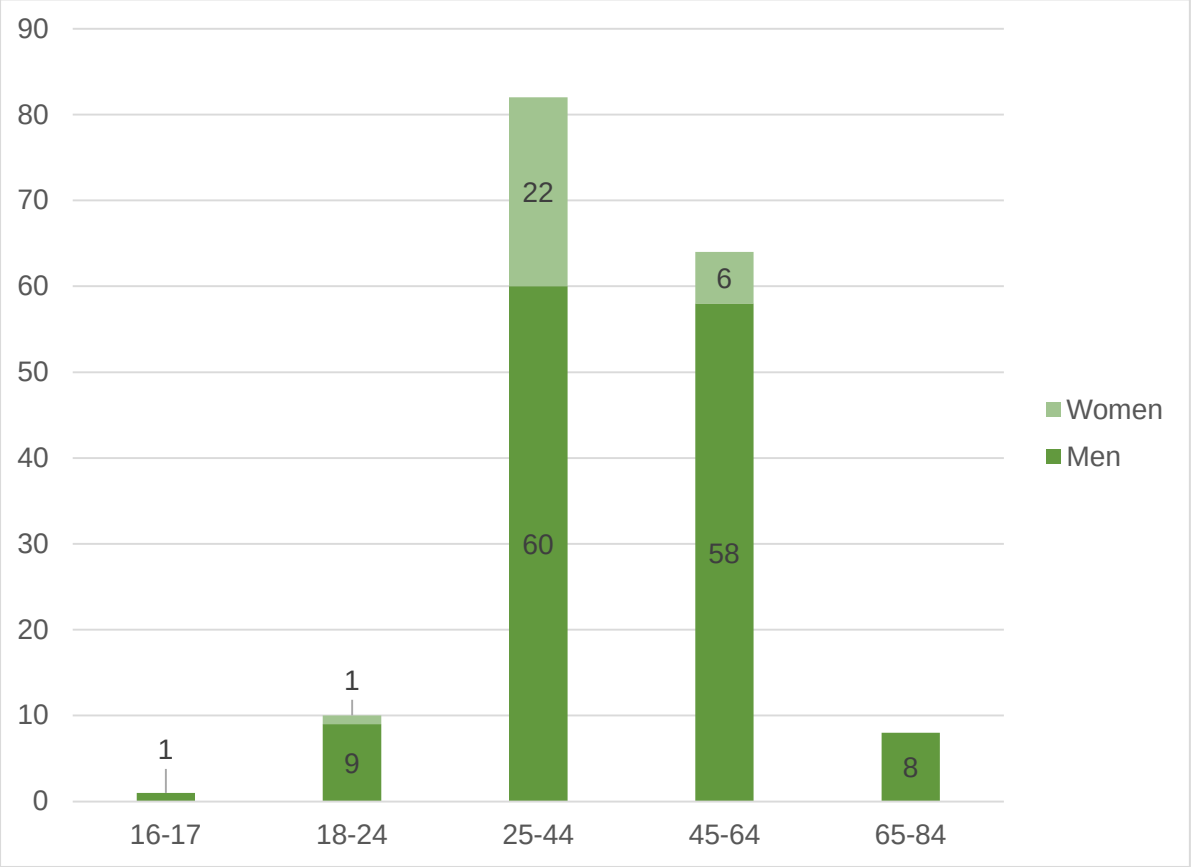
NHS Board	Hospital	Ward	Bed Numbers	Patients seen / reviewed by MWC
Medium Security - Regional Services				
Lothian	Orchard Clinic 3 Wards	Redwood Hawthorn Cedar	15 11 14	5 2 3
Tayside	Rohallion 3 Wards	Vaara Ythan Spey	12 12 8	4 3 3
Greater Glasgow and Clyde	Rowanbank Clinic 8 Wards	Elm Elder (female) Cedar Pine Sycamore (female) Larch Hazel Holly (LD)	12 4 12 12 6 10 10 8	2 1 3 2 3 5 5 2
Medium secure wards			**Total beds 146**	**Total seen 43**
Low Security - Health Board Services (Non LD)				
Lanarkshire	Beckford Lodge 1 Ward	Iona	15	7
Forth Valley	Bellsdyke 1 Ward	Tryst Park	18	7
Greater Glasgow and Clyde	Leverndale 4 Wards	Bute (female) Boulevard Ward 5 Ward 6	5 9 15 15	3 2 5 7
Dumfries And Galloway	Midpark 1 Ward	Dalveen	4	2
Highland	New Craigs 1 Ward	Bruar	8	3
Tayside	Rohallion-Low 3 Wards	Faskally Lyon Esk	10 12 13	2 3 3
Grampian	Royal Cornhill 3 Wards	Forensic Acute Forensic Rehab Great Western Lodge	7 16 8	6 4 6
Fife	Stratheden 1 Ward	Radernie	10	6
Low secure (Non LD) NHS			**Total beds 165**	**Total seen 66**

NHS Board	Hospital	Ward	Bed Numbers	Patients seen / reviewed by MWC
Low Security	**Independent Hospitals**			
Independent (based A&A)	Ayr Clinic 4 Wards	Low Green Gatehouse (female) Arran (female) Belleisle	12 8 12 12	5 5 4 2
Independent (based GG&C)	Surehaven 2 Wards	Kelvin Campsie (female)	11 10	3 5
Independent Hospitals			**Total beds 65**	**Total seen 24**
Low Security - Learning Disability Wards; NHS				
Ayrshire and Arran	Arrol Park 1 Ward	House 7	2	2
Lanarkshire	Kirklands (1)	Kyle Park	3	3
Greater Glasgow and Clyde	Leverndale 1 Ward	Campsie House	9	4
Fife	Lynebank 3 Wards	Tayview Levendale Daleview	1 8 10	1 4 3
Grampian	Royal Cornhill 1 Ward	Fern	8	4
Lothian	Royal Edinburgh 3 Wards	Glenlomond Strathaird Culzean (female)	6 4 4	2 2 3
Tayside	Strathmartine 1 Ward	Bridgefoot House	8	4
Low Security - Learning Disability Wards			**Total beds 63**	**Total seen 32**
All Low Security Wards			**Total beds 293**	**Total seen 122**
All Wards (Medium and Low Security)			**Total beds 439**	**Total seen 165**

Table 5: Patients interviewed and / or reviewed by detention status

Status	Number	%
Restricted Patients	(75)	
Assessment order (S52D 1995 Act)	2	1%
Treatment Order (S52M 1995 Act)	1	1%
Interim Compulsion Order (S53(2) 1995 Act)	1	1%
Hospital Direction (S59A 1995 Act)	1	1%
Transfer for Treatment (S136 2003 Act)	7	4%
Compulsion Order and Restriction Order (S59 & 57(2)(b) 1995 Act	63	38%
Non- restricted patients	(90)	
Compulsion Order (S200 1995 Act)	32	19%
Compulsory Treatment Order (2003 Act)	55	33%
Interim Compulsory Treatment Order (2003 Act)	1	1%
Short Term Detention Order (S44 2003 Act)	2	1%
Total	**165**	100%

Figure 11: Patients interviewed and / or reviewed by Age



Key

Most = more than 80%
A majority = 56-80%
About half = 45-55%

A minority = 20-44%
A few = less than 20%
Very few = less than 10%


npm
national
preventive
mechanism

mentalwelfare
commission for scotland

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk

Mental Welfare Commission (08/17)