mentalwelfare
commission for scotland

Rights, recovery and restriction

Report from our visits to people receiving care and treatment in forensic mental health services across Scotland

Contents

Who we are

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect;
- Have the right to treatment that is allowed by law and fully meets professional standards;
- Have the right to live free from abuse, neglect or discrimination;
- Get the care and treatment that best suits her or his needs; and
- Be enabled to lead as fulfilling a life as possible.

What we do

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice information and guidance to people who use or provide mental health and learning disability services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

About this report

This report presents our findings from visits to people receiving care and treatment in low and medium secure mental health wards across Scotland in 2008. We visited people in these services as part of our duty to monitor the care and treatment of people receiving treatment under the Mental Health (Care & Treatment) (Scotland) Act 2003. People who receive care and treatment in low and medium secure wards have usually been admitted to psychiatric care following a conviction for a criminal offence, where the presence of a mental disorder has played a significant part in a person's behaviour; or have developed a serious mental disorder while serving a prison sentence and been transferred to hospital. These 'forensic mental health services' are also provided for people who have a learning disability and are convicted of an offence. Some people who receive care and treatment in forensic settings have not been convicted of an offence, but are placed there because they need particular care and treatment that is not available in other mental health facilities.

About our visits

Our visits took place from September to November 2008. During this period, there were approximately 177 individuals receiving inpatient treatment, care and support within the hospitals we visited. We spoke to 68 people in 26 wards across nine hospital sites. This represents just under 40% of the total number of people in these wards. Our visits were announced in advance so that individuals could ask to meet us and discuss any issues they had with their care and treatment. We also asked people on wards if they would be willing to share their experiences with us by answering prepared questions.

As well as talking to individuals, relatives and staff, we reviewed individual care records. The visits and surveys gave us an opportunity to gather information in a structured way. This approach helps us to compare and contrast the care and treatment individuals receive from similar services across the country.

During our visits we met people who asked to see us to discuss specific concerns. Where necessary, we followed up on these issues with the services concerned and made recommendations for change. Where possible, we met someone in each ward who had no friends or family to support them and someone whose money was being managed by the service. As well as discussing individual matters, we used a questionnaire to gather people's views and experiences in the following areas:

- Privacy, dignity and identity
- Safety
- Care planning
- Involvement
- Quality of the environment
- Management of funds
- Activities
- Physical healthcare
- Consent to treatment/capacity

We talked to a staff member in each ward using a questionnaire to focus discussion on these same topics.

Our observations and the recorded responses to the questionnaires form the basis of the findings in this report.

Why we carried out these visits

Over the past five years, there have been significant developments in services for people receiving care in forensic mental health services. There are well developed plans to reduce bed numbers at the State Hospital. Additional medium secure services have also been developed, with the opening of Rowanbank in Glasgow adding to the existing medium secure facilities at the Orchard Clinic, Edinburgh. The Care Programme Approach has been revised and Multi Agency Public Protection Arrangements (MAPPA) are well established across Scotland. In addition, a Forensic Network was established in September 2003. The Network is multi-agency, with strong links with Scottish Prison Service, social work services, police and criminal justice agencies, the Scottish Government and carers.

Many individuals whose admission to hospital has been through the criminal justice system, or who are subject to civil powers but who have had contact with the criminal justice service, have found themselves in forensic services largely on the basis of risk. The Commission is particularly interested to see how the principles are being applied to this group of service users.

The overall purpose of forensic mental health services is to co-ordinate care and support for the benefit of the individual, while ensuring public safety. The key to achieving this is good needs assessment backed by effective multi-disciplinary working. Quality care requires proper attention to the needs of the individual and planning that promotes recovery and enhances the person's chance for an independent life. Where possible the emphasis should be on providing care in the community rather than in institutional settings in accordance with the principle of least restriction of freedom.

Working within the principles of mental health law will lead to a patient-centred service, which delivers care at the lowest appropriate level of security, as close to the patient's home as their medical condition and personal circumstances allow. That said, we are aware that,

(a) the geography of Scotland is such that for some individuals from rural communities the appropriate specialist treatment has to be provided at a distance from their homes; and

(b) treatment considerations must be viewed in tandem with the need to protect the public.

Of the 68 individuals we interviewed, 51 had appeared in court for offending behaviour and 43 of these had spent some time in prison. In addition, 34 had formal contact with a mental health or learning disability service before admission. For 10 of the people interviewed there had been no previous contact with mental health services

For people in low and medium secure services we would expect greater emphasis to be placed on risk assessment. We were particularly interested to see how this affected the principle of least restriction and how it impacts on individual assessed need. Care and treatment needs should be related to the individual's mental disorder and associated assessment of risk. There should be no discrimination because of offending behaviour.

In planning our visiting programme, we took a conscious decision not to include services provided at the State Hospital. The State Hospital is Scotland's only high security hospital and provides services for offenders with mental health problems, as well as those who have not been through the criminal justice system, but who need care under conditions of special security.

Because everyone at the State Hospital is subject to formal measures the Commission visits on at least six occasions each year. As the only provider of its type, we would not have had other services to compare it with. Instead we have concentrated on these low and medium secure facilities across the country which provide, in some circumstances, step down facilities for people moving on from the State Hospital. Most people who use medium and low security services, however, have never required the services provided by the State Hospital.

The scope of our visits

Wards visited

Health Board	Hospital	Ward
Ayrshire & Arran	Ayr Clinic	Roselle
		Low Green
Glasgow & Clyde	Dykebar	Bute
	Leverndale	Ward 6
		Boulevard
		Campsie
		White House
		Ward 5
Glasgow & Clyde	Rowanbank	Pine
		Elm
		Sycamore
		Larch
Lanarkshire	Hartwoodhill	Iona
Lothian	Orchard Clinic	Redwood
		Hawthorn
		Cedar

Health Board	Hospital	Ward
Tayside	Murray Royal	Kinnoull
		Blair
		Birnam
	Strathmartine	Bridgefoot House
		Bridgefoot 2
		Craigowl
Grampian	Royal Cornhill	Forensic Acute
		Forensic Rehab
		IPCU
	Community rehabilitation	Great Western Lodge
Total		26

Our findings and what people told us

Environment

We visited 26 wards and a day unit. All catered to some extent for service users with a forensic history. Four of the wards visited were not exclusively for people who had offended but had a mixed client group. All other wards told us they were specialist forensic care services.

Most of the wards are locked at all times, but two of the 26 wards said they did not lock the ward during the day (Leverndale, Boulevard and Strathmartine, Craigowl). One unit claimed that it was the only in-patient forensic unit placed in the community in Scotland and although the front door is locked, individuals have a key (Great Western Lodge, Aberdeen).

Fifteen of the wards did not lock bedroom areas or (in four cases) they were locked but a key was provided. We think enabling free access to bedroom areas is good practice and in line with the principle of least restriction.

In the other wards we visited, restrictions were in place that limited access to bedroom areas during the day. Restrictions applied to everyone regardless of their individual need. Some nursing staff felt that this encouraged people to participate in activities; others said they would give access on request. It is our view that access to bedrooms during the day should, as far as possible, be determined on each individual's care plan. A universal policy restricting access to bedrooms does not meet the principle of least restriction.

Many services had difficulty locating copies of their door locking policy. These policies should be easily available on the ward for everyone, including relatives and carers, to refer to.

Mental illness can be very distressing and many service users tell us that sometimes they need to have a quiet area for reflection, away from the daily hustle and bustle of an acute ward. Five of the wards we visited did not have a specific quiet room, away from TVs and other activity areas, that people could use. Of these five, some said interview rooms could be used if available. Staff in one ward commented that:

"the ward was designed for older peoples' services and is not suitable for forensic patients"

Access to fresh drinking water is a right that most people would take for granted. In wards where bedrooms and kitchen areas are locked we found that this was not always provided. This can be a big problem in environments which are kept very warm, especially when many individuals are on medication which might make them more thirsty than normal. We found two wards where there was no open access to drinking water when we visited (Hartwoodhill, Iona; Strathmartine, Bridgefoot 2)

"Staff have to take people to the kitchen to access drinking water – cold drinks used to be accessible in a fridge which patients could use, but this has been condemned as unsafe and removed and not replaced."

Arrangements for visitors

Most wards could point to a room that could be used for visits from family and friends. It was clear, however, that in some hospitals these rooms had a multiple function, doubling up as the meeting, interview, or even dining room – and these other uses would be given priority. This is not ideal and we suggest more should be done to provide visitors with welcoming areas to encourage the maintenance of contact with families and friends. This is particularly true where the patient is also a parent.

There is a general duty for hospitals to take steps to mitigate any adverse effects on the personal relations or contacts between parents subject to any measure under the 2003 Act and their children.

All wards had some arrangements in place for children visiting, though some said this never happened. While some wards had special facilities and seemed well organised for visits from children, others said they did not permit child visitors under 16 but may allow supervised visits outside the ward. We believe that it would be more in line with the requirements of the 2003 Act if, following careful assessments, contact between parents in forensic units and their children were facilitated and where appropriate, encouraged.

Access to garden areas

Out of 23 wards we visited that have a locked door, only one did not provide a secure garden area. All others provided some level of outside area, which people could access; although some were small and basic, others could enhance well-being.

Care planning

Care plans are the accepted means by which individual care and treatment can be planned, documented and shared. Care plans and care planning provide a framework for agreeing and reviewing the benefits of a given programme of care, support and treatment to assist in a person's recovery. Good care planning is essential in supporting recovery. Information sharing and participation is a key factor in ensuring individuals and their carers/named persons feel involved in the care pathway process.

People receiving care and treatment in forensic services have a right to the same recovery focussed care planning as other mental health service users. There should be no discrimination because of offending behaviour. Care and treatment needs should be related to the individual's mental disorder and based on a clear assessment of risk. We would therefore expect greater emphasis to be placed on risk assessment for people within forensic services. During our reviews of care plans we were particularly interested to see how risk interacts with the principle of least restriction and the assessment of individual care and treatment needs.

While most people we interviewed told us they were offered information about their illness and said they attended reviews, only half felt that they had a say in their treatment

There were mixed views from people across services:

"There are no plans for the future. I am never going to get out of here"

"Can't get any better treatment than I have had here, best in my life"

"There are clear plans in place to support people to move on"

"The staff are really nice here, they're understanding it is a good hostel"

Individual participation and family involvement

With regard to family involvement, encouragingly two-thirds of people felt that family and friends had been involved in the planning of care. However, people from the following hospitals expressed particular concern over lack of involvement for both themselves and their families:

- Rowanbank
- Leverndale
- Dykebar

We understand that for some people, involvement of family and friends may not be appropriate. Being involved in planning your own care however is an integral part of recovery. We are concerned that a high proportion of individuals do not feel involved in this aspect of their care and treatment.

It is clear that good named nurse arrangements and access to advocacy are important to improving people's sense of involvement in their care. Five out six people who felt positive about their experience, said they knew who their named nurse was and were very positive about having time to talk about their care, treatment and support. In addition almost all individuals we spoke to were aware of the advocacy service and had made use of it at sometime during their period of illness.

Delayed discharges

Some staff we spoke to said that moving people on from secure services can be difficult. Staff can feel hampered by having to understand and negotiate a number of different local authority procedures. In discussion with staff, 1 in 3 felt that some people were not appropriately placed and 2 out of 3 said that there were obstacles, which slowed down the discharge process and impacted on patient care.

"It's difficult to get services to take on care packages for people with forensic issues"

Privacy, dignity and identity

The 2003 Act spells out the principles that should be taken into account by anyone carrying out functions under the Act. Not least of these is the principle of non-discrimination. Services need to ensure, unless it can be shown that it is justified in all the circumstances, that a patient is not treated in a way that discriminates against them on the basis of their mental illness. Individuals should be treated with dignity at all times and allowed as much privacy as is safe and conducive to their recovery. They should be able to express themselves and their individual identity, background and characteristics, including sexual orientation, religious persuasion, cultural, ethnic or racial origin, without fear of prejudice or less favourable treatment. Our visitors asked a range of questions to find out how service users felt these principles were being applied to their care and treatment.

We asked people whether they had a single bedroom. The majority (86%), did and exactly the same number of people told us they had a safe place to keep possessions. It is hard to understand why services cannot manage to provide a safe place in which to leave personal possessions. Many people (58%) told us their rooms had been searched, some on a periodic basis. Half of these people told us they had not been given a reason for the searches; although we recognise that a significant number of people would be subject to regulations which permit the searching of rooms and possessions under certain circumstances. (We discuss this further on pages 11-12.)

“He said he felt “singled out” for search and urine tests after visits, but these stopped when he spoke with the ward manager”

Nearly everyone we spoke to agreed that there was sufficient privacy in the bathroom and toilet areas, but 3 of the 5 people who disagreed were from Rowanbank, a new purpose built hospital.

Most individuals also agreed that they were able to keep in touch with people outside the hospital, although for a variety of reasons ten people expressed some difficulties with this. Over a third of all individuals interviewed told us there was no access to a private telephone.

Forty of the people we interviewed told us there was a limit in their ward on the number of personal items they are allowed to keep in their room. Some had a limit of 10 DVDs and 10 CDs; others told us they were allowed no more than 7 changes of clothes. Yet in other similar wards, individuals told us they were not aware of any restrictions. While available space may dictate a limit, it seems odd that some hospitals set blanket policies based on arbitrary limits, while others take into account differences in personality and identity.

Feeling safe

When we asked if people felt safe, 14 people told us they did not feel safe in the ward environment. Women were three times more likely to say they did not feel safe.

“I feel safe, only sometimes”

“I get bullied sometimes”

“There was an attitude on the ward, but I spoke to the team leader and things improved”

Risk assessment/management

With regard to assessment and risk management plans, the majority of staff we spoke to told us there was a process to ensure each patient had a plan in place. For many wards, risk assessment is incorporated into the care planning process and more than half of individuals we spoke to are subject to the care programme approach.

Plans are regularly reviewed in all wards. Where a multidisciplinary system is in place, there is regular input from social work and psychology and staff in 18 of the wards reported that family members regularly attend reviews.

Implementation of 'specified persons' Regulations; restrictions on correspondence and use of telephones

The regulations of the 2003 Act provide for a compulsory patient to be designated as a "specified person' in relation to the protection of the safety and security of themselves and others, their use of the telephone and for the withholding of correspondence.

All individuals in medium secure units, are 'specified persons' in relation to safety and security. In all other facilities the use of the regulations should be determined on an individual basis and by the Responsible Medical Officer (RMO) making a 'reasoned opinion' as to the necessity of designating an individual as a 'specified person'. The regulations cover matters such as searching of individuals, their rooms and belongings, and visitors, restrictions on the use of telephones and on the sending and receiving of correspondence. Individuals can be a specified person in respect of any, or all, of the regulations.

We asked the nursing staff five questions under this heading. The answers were varied and demonstrated different understanding and interpretation of Sections 281-286 of the 2003 Act and its associated regulations. It is clear from the data that many staff are unclear about the regulations and their implementation and that searches of individuals and restrictions on the use of telephones in particular, are being carried out without appropriate authority. It is also clear that where specified persons regulations are implemented in relation to safety and security, they are often applied in a blanket fashion and not on an individual basis. Some staff within the medium secure facilities reported that they had no patients who were 'specified'.

Room searches

Room searches were being carried out in a variety of ways. Some wards carried out random, weekly, or monthly searches, while others carried out searches in response to incidents. In at least five wards it would appear that these searches are being carried out in the absence of any designation of specified persons, whether by blanket regulation, or individual reasoned opinion. Two units reported that they did not carry out room searches unless there was an incident to suggest the need for it. We thought this was a positive approach and an example of minimum restriction of freedom that other units could learn from.

Use of phones

Again the interpretation of what was offered in respect of phone use varied. Of the 26 wards visited, 20 said they had no policy on the use of phones, and some of these had restrictive practices in place with no evidence of proper use of legislation.

We also found very different practices in units of similar type. For example, we were advised that in one medium secure unit private calls were allowed, while in another similar unit people told us that they were observed during calls. This may reflect the differing levels of security within the units, or the lack of understanding on the part of individuals and staff of the restrictions authorised by 'specified person' status. In one hospital the number of calls made by individuals in a day, and the length of calls are restricted.

Mobile phones

In terms of telephone use (S284-285), the use of mobile phones is not currently covered by the regulations. However, we thought it useful to include our findings.

In all medium secure units mobile phones were not allowed because of concerns regarding misuse of phones with cameras. In most low secure units, mobile phones were not allowed on the ward for the same reason, but very few wards or units had a written policy for this. Some units allowed mobile phones to be used when out of the unit, but not all followed this practice.

Internet use

No unit that we visited allowed internet use. However, some people could access the internet when out of the unit. A number of units are reviewing whether access is possible while maintaining IT security.

Restriction of correspondence

The implementation of regulations around written correspondence is much more clearly understood, perhaps because the ability to restrict people correspondence has formed part of previous mental health acts. However, it is concerning to note that in one setting (not a medium secure setting) all patients have to open their letters in front of staff.

Management of peoples' finances

We asked individuals and staff about the management of people's finances. We wanted to know if people needed help with this, and if so what help was given. The answers we received showed that many people did not know if there were arrangements in place for the management of their money and benefits. Some people whose money was managed by staff objected strongly to their funds being restricted, others indicated that they could spend their money as they wished.

Staff reported that 46 people were unable to manage their own money. Only seven individuals felt they could not manage their own money. Most people felt that they could spend their money as they wished, this includes many people whom the staff indicated needed help with budgeting.

"I only get £3 per day to spend. I am not allowed to carry my own money and I don't know how much I've got"

Many wards had procedures in place to assist in the proper management of peoples' funds when it was required. Ten wards did not have procedures in place, some because there was no one on the ward who could not manage their own money.

For one person, their status as a prisoner meant that they had access to very little money for personal use.

"For those whose funds are managed by the hospital, there are 6 and 12 monthly meetings with the cashier, support services, advocacy worker, next of kin or named person and the multidisciplinary team to work out a financial plan".

“Such restricted environment and most have very limited funds so need doesn’t arise but system is in place”

“Staff member not sure of formal roles of Part 4 AWI management. Not sure how it works.”

The Code of Practice for Part 4 of the Adults with Incapacity (Scotland) Act 2000, which covers the management of individuals’ funds, provides useful guidance for staff. The principles of benefit and minimum intervention, which are set out in the 2000 Act, should be applied by staff to the management of individual funds. We would also expect individuals to be informed and aware of how their funds are being managed.

Activities

Providing a programme of activity for individuals in this client group, who may be in hospital for very long periods of time, is essential. Activities should reflect all areas of an individual’s life – self-care, productivity, education and leisure. Activity may be generally therapeutic in nature and provide occupation; it may be physical in nature and help to maintain health, or it can be designed specifically to address identified psychological or behavioural needs. All these are essential components on the pathway to recovery.

Availability of all types of activity, with involvement of staff from different disciplines, is an indicator of a well run service. A service cannot fulfill its potential or responsibility to aid recovery if it provides the majority of activity in just one of these areas, or where acting provision is left solely to nursing staff or an occupational therapist (OT) to provide.

“When the OT is off no activities occur on the ward”

“Would not say activities were organised. It seems to be up to the nurse. “Too busy” is often the response”

Individuals’ views

We asked a range of questions about people’s experience of activities on offer to them. Over two thirds told us that activities were arranged on the ward. Others were either unaware that activities were arranged, or believed that no activities had been offered since admission. Some of those who were aware that activities are arranged, told us that they chose not to engage with them, whilst others were currently too unwell to participate. Well over half of the people we spoke to told us they participated in a programme of activities.

From what people told us, it appears that most ward activity focuses on cookery and gardening, walking in the grounds or into town, playing games such as pool, or using gym equipment. However, a third of people told us that they also engaged in educational or work based activities.

“College course, shopping, library, OT session weekly approximately, also outing with physio (fitness instructor) e.g. golf range, badminton, and other outings with nursing staff”

“Activities include: keep fit, walking group, art classes, problem solving and anger management, IT at college, voluntary work”

We also asked people if they had the opportunity to take part in activities outside the ward and over half agreed that they had. Half told us they were allowed off the ward almost daily, although this might just involve a short time in the hospital grounds. However, it appeared from notes and interviews that six people had not been off their ward for over a month. Half of these individuals had not been out of the ward for much longer periods. One person told us that he had not been off the ward for over a year.

Staffing issues were occasionally blamed for limits put on time off the ward. Nevertheless, some individuals acknowledged that there were clinical reasons why their time off the ward was restricted.

Staff views

In five of the wards we visited, staff told us that organisation of activities was left to the occupational therapy (OT) department. Ten wards reported that a combination of nursing and OT staff organised activities, and in seven it was a combination of nursing, OT, and other members of the multi-disciplinary team. One hospital reported having a designated activity nurse.

Two wards (Boulevard, Leverndale and Great Western Lodge, Aberdeen) had an ethos that all activities take place off the ward. These wards were designated as “forensic rehabilitation” wards. Most others have a mixture, with some activities taking place on the ward and some in other areas – both in and out of the hospital. Some wards have dedicated space for activities such as multi-gyms which encourage fitness. In six wards there was no dedicated space for activities. The range of activity available varied but on the whole seemed appropriate:

“Within the unit activities occur in the kitchen, the recreational hall nearby (badminton and soft ball), on the football pitch outside the hospital. The gym and fitness centre run classes, there are technical college courses, sports courses at the community hall and staff take the patients out when time permits for cycling, walking, hill walking and swimming”.

Staff felt that motivating individuals was sometimes difficult and some were exercising their choice not to engage in activities, but only 4 wards reported that one or more people refused entirely to engage with the activities available.

Occupational therapy is a core part of a multidisciplinary approach to care and should be available to all those who require it.

Two wards were unable to provide any evidence on the day of the visit that the programme of activities were reviewed. It is clear that not all services have access to specialist OT input.

Access to physical healthcare

The majority of individuals we interviewed believed they were receiving physical health checks, but most had difficulty knowing how often these took place. We found it difficult to see from the notes when checks occurred and there were no policies or procedures governing physical health care in place. Of the 26 staff members that we spoke to, half said health checks were carried out annually. It was difficult to determine how extensive the checks were, and who carried them out. Nevertheless, one patient stated:

"I'm Hep C positive – I probably get better treatment in here than I would outside"

Access to a dentist varied and in some units was not readily available. One person told us that he had been waiting for months, but many did not regard dental needs as a priority for them.

Local hospital policies should be in place to ensure regular physical health checks are undertaken as a matter of routine. This is especially important in view of the increased risk of physical health problems and potential side effects of medication in this group of people. The minimum scope of the health check should be clearly stated in the policy.

Smoking

The majority of individuals we spoke to told us that they smoked, this gives rise to problems for staff who have to work within the provisions of the Smoking, Health and Social Care (Scotland) Act 2005. Further consultation on "Achieving smoke free Mental Health Services" is currently underway and it is already apparent that there are diverse opinions about this. Some health boards already have policies which restrict smoking, even in the grounds of the hospital and this can cause problems for people.

From the 26 wards visited, seven still have smoking rooms while individuals from the remaining 18 wards smoke outside. One ward stated that there were restrictions in place regarding how often people can go out for a cigarette and all those who smoke have to go out together. This appears to be an institutionalised response to implementing policy and removes any element of choice for the individual.

Weight, diet and exercise

The impact on the general health of the population of obesity, lack of exercise and poor diet is well recognised and there are many initiatives in place to address this. There is an even greater need for these issues to be prioritised for individuals who find themselves in hospital, often for lengthy periods of time.

Of the 68 people interviewed, 34 said they were concerned about their weight but only 18 said they had received dietary advice. However, another six individuals said they had been offered advice but did not believe they had weight problems.

We also asked about activities in relation to the availability of exercise. It is considered beneficial to introduce more activities in your daily routine, such as using the stairs, taking a brisk walk every day. However, people in forensic services have a number of restrictions placed on their ability to freely come and go. Even simple exercise such as walking, may need risk assessments and other complicated organisational and safety hurdles to overcome, before the person is able to take part.

Most individuals we interviewed mentioned the difficulty in accessing the simplest of exercise.

Only one unit had exercise as an integral part of the assessment process and care plan. This unit had a physiotherapist working with people who all benefitted from one form of exercise or another.

Most people told us they could access a gym but chose not to. One unit was actively engaging people in activities such as badminton, cycling and walking.

Interviews with staff revealed that the majority are trying to promote a healthier lifestyle as part of their daily work routine, without specialist advice and support. Individuals would benefit greatly from greater public health investment and support for in-patient mental health services.

Substance misuse

We asked individuals if they had previous or current problems with drugs and alcohol and if they had input from specialised services. Half of the people we spoke to said drugs and/or alcohol had been, or were still a problem for them. Only 15 reported that they had been offered specialist services or interventions.

In three units staff reported that psychology provided a service for drug and alcohol work with individuals. In all other units (22), it was expected that nursing staff would provide it. None had input from substance misuse services.

It is worrying that specialist drug and alcohol services, which are available within every health board area, are not being utilised or accessed by this patient group. We are concerned at this situation. The impact of co-morbidity, in the form of drug or alcohol misuse, is now well recognised and it is clear that this is a significant issue for this group of people. Lack of specialist input may have a detrimental effect on an individual's recovery and prolong their stay in hospital unnecessarily.

Consent to treatment/capacity

In each of the wards, people were asked about their understanding of the treatment they were receiving and whether or not they had given consent. The majority said they had been given information about their treatment (48 out of 68) but only one said they had received written information about the medication being administered.

Forty-three out of 68 people had given consent to the treatment they were receiving, with appropriate paperwork in place (T2 forms). No-one was receiving covert medication at the time of our visits.

While most wards had appropriate paperwork in place to make sure treatment was in line with the 2003 Act (T2/T3 forms), the situation for those incapable of consenting was less clear. In four wards, it appeared that paperwork was not in place for people who lacked capacity and whose treatment came under the Adults with Incapacity Act 2000. Six wards had the appropriate certificates in place. In 17 wards there was evidence in the case notes – and from staff interviews – that capacity issues were properly reviewed. These wards also had evidence that welfare proxies – people authorised to consent to medical treatment on behalf of the individual – would be consulted. However, staff in other settings commented that they “did not know who is thought incapable of consenting to treatment” and clearly had very little understanding of the importance of these matters.

This lack of understanding and knowledge of the 2000 Act and the concepts of capacity to consent to treatment is of concern, given that many people in this population will have impaired decision making ability. Proper assessment of capacity is essential to ensure that treatment is lawful and is also appropriate for the individual.

Key findings and recommendations

Areas of good practice

Activities

In over two thirds of wards there was evidence that activities were being arranged. Over half of the people we spoke to said that they participated in planned activities. We welcome the fact that a third of patients we spoke to told us they engaged in a fuller range of educational or work based activities. There is clearly still room for further improvement in those wards that have limited activities available.

Room searches

We understand there is a need, at times, for searches to be undertaken. We welcome the policy in two wards that searches are only undertaken in response to an incident that suggests it is required. This is consistent with the principles of the 2003 Act and is an approach that could be adopted in other facilities.

Management of funds

In almost two thirds of the wards we visited, staff advised us that they were providing care and treatment for at least one person who could not manage their own financial affairs. There was evidence of good practice in supporting this process through formal, regular multi-disciplinary financial planning.

Involvement in care and treatment

Many people are now given information about their care and treatment, are able to attend review meetings and feel involved in decisions about their care. We believe that this could be a universal approach.

Advocacy services are widely available with almost all of people we spoke to reporting that they had been offered advocacy support.

Access to drinking water

Of the patients we interviewed, only two reported that they had no free access to drinking water. We expect all individuals to have access to drinking water, especially because medication can affect thirst.

Areas for improvement

Individualised care

We are concerned that the blanket implementation of the 'specified persons' regulations in some low-secure areas reveals a lack of understanding both of the intention of the regulations and of the relevance of a person centred approach to recovery and care. The 2003 Act and the Code of Practice are clear that the regulations should be applied on an individual basis, with the exception of the State Hospital and the existing two medium secure facilities. We found much more restrictive practices in some low secure areas and, in some cases, without the appropriate legal authority.

Consent to treatment

The lack of understanding in a third of wards about general consent to treatment and the role of the Adults with Incapacity Act in facilitating lawful treatment needs to be addressed through appropriate staff training.

Physical health care

The majority of people we spoke to said that their physical health care was regularly reviewed, however, only half of staff said that health checks were carried out routinely.

As outlined in “Delivering for Mental Health”, we would expect to see a greater emphasis being placed on reducing health inequalities by improving general health care of individuals in psychiatric hospital settings.

Smoking, diet and exercise were highlighted as areas of concern. Many recognised the problems associated with their lifestyles but did not feel they were receiving the necessary support to make the changes needed to improve their health. We were concerned to find that half of the people we interviewed were worried about their weight, while only around half of them received dietary advice.

Smoking cessation, dietary advice and physical exercise programmes should be actively promoted in these settings.

Locked doors

People in hospital should be afforded the same courtesy and right to privacy and dignity as anyone else. Accepting that in some environments, there is a need to have a locked door policy, having to constantly seek staff assistance to unlock internal doors such as kitchen and bedroom doors can be a barrier to recovery.

Services should review the need for restrictions to freedom of choice, especially in relation to locking internal doors during the day.

Access to specialist drug and alcohol services

Only 15 people interviewed indicated that they had received specialist help in respect of their drug or alcohol problems, yet there were 34 who indicated that this was a significant factor for in their mental illness.

Access to specialist drug and alcohol services should be available for people in forensic services.

Key Recommendations

1. All services should review their implementation of the ‘specified persons’ regulations. The regulations should be used only in those circumstances where it is clear that the individual, following a reasoned medical opinion, meets the criteria for ‘specification’ and that the actions or restrictions are appropriate and proportionate. The principle that searches should only take place in response to an incident is one which we would commend.
2. Services should ensure that all staff are fully aware of the requirements of the Adults with Incapacity Act 2000 in relation to consent to treatment issues and the management of peoples finances.
3. All services should ensure that the physical health of patients is given the appropriate priority and that the commitments of the Mental Health Delivery Plan are met. This includes smoking cessation advice and diet and exercise advice as appropriate. Access to complementary specialist services such as substance misuse services should be available where appropriate.
4. Policies in relation to locked doors, both internal and external, should be reviewed to ensure that unnecessary restrictions are not put in place. Unless clinically necessary, no patients should have their access to fresh drinking water restricted or their access to bedrooms and kitchens limited.

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