mentalwelfare
commission for scotland

Greater expectations revisited

Findings from our visits to people with severe and enduring mental illness who are receiving care and treatment in hospital

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.

Themed visits

One of the ways in which the Commission monitors individual care and treatment is through our visits programme.

This year the Mental Welfare Commission is conducting a series of themed visits to psychiatric hospitals. The aim of themed visits is to enable us to compare care and treatment for particular groups of service user. Our aim is to help services learn from good practice and to respond to any issues that are identified. This report provides an overview of our findings from a series of visits to rehabilitation and continuing care wards in psychiatric hospitals throughout Scotland. These wards typically provide care and treatment to people with severe and enduring mental illnesses.

In June, July and August 2008 we visited a total of 159 people, in 45 rehabilitation and continuing care wards, across 21 hospital sites. Our visits were announced in advance so that individuals who had particular concerns could arrange to meet us. We also asked people we met on the

day if they would be willing to share their experiences with us by answering prepared questions.

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.

Our questionnaire was designed to capture their 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

As well as meeting individuals, during visits we also scrutinised patient records, looking in particular at care planning and activities. We looked for evidence of involvement in care planning. We talked to a staff member in each ward, using a questionnaire to focus discussion on the same areas that we had discussed with individuals.

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

Why we carried out these visits

In 2003, the Mental Welfare Commission carried out unannounced visits to 18 facilities defined as rehabilitation or continued care wards. During those visits, we used a questionnaire format to build up a picture of the quality of life for people living in these wards. The format of the questionnaire was similar to the one we used for our themed visits in 2008. We wanted to know if any concerns had arisen for people who may have spent long periods of their lives in this kind of setting.

'Greater Expectations', the report published at that time referred to concerns about:

- The apparent low level of therapeutic, rehabilitative and recreational activities;
- The drabness of many of the wards and units we visited; and
- How little individuals knew about the treatment they were receiving.

Many individuals were still living in large institutional settings, with dormitory type sleeping arrangements and with limited personal possessions and personal space. Our 2003 report expressed concerns about arrangements for the review of care and treatment; the ability to access community facilities; and the clearly stated boredom associated with the lack of occupation that many people experience.

Five years on and following the introduction of new mental health legislation, we felt it was time to revisit these continued care and rehabilitation wards in order to evaluate the progress made since 2003.

Wards visited during the visits in June-August 2008

NHS Board	Hospital	Ward	Type	Individual Interviews	Formal	Informal
Ayrshire & Arran	Ailsa	Glenapp	Rehabilitation	1	3	3
		Crossraguel	Adult CC			
		Ballantrae	Rehabilitation	1		
		Killochan	Adult CC	2		
		Albany	Adult CC	2		
Borders	Galashiels	East Brig	Rehabilitation	4	5	5
		West Brig	Rehabilitation	1		
		Galavale	Rehabilitation	5		
Dumfries & Galloway	Crichton Royal	Lahraig	Rehabilitation	4	2	2
Fife	Stratheden	Dunino	Rehabilitation	7	10	11
		Falkland	Rehabilitation	5		
		Lindores	Adult CC	5		
		Kinnaird	Adult CC	4		
Forth Valley	Bellsdyke	Russell Park	Adult CC	8	12	14
		Tryst Park	Adult CC	7		
		Tryst View	Adult CC	6		
	Craigenhall		Rehabilitation	3		
	Forthbay		Adult CC	2		
Glasgow & Clyde	Dykebar	Ward 9	Rehabilitation	2	5	
		Ward 15	Adult CC	3		
	Gartnavel	Ward 8	Adult CC	8	11	2
		Ward 10	Rehabilitation	1		
		Tate	Adult CC	4		

Wards visited during the visits in June-August 2008 continued

NHS Board	Hospital	Ward	Type	Individual Interviews	Formal	Informal
	Leverndale	Ward 2	Adult CC	2	2	2
		Rehab	Rehabilitation	2		
	Parkhead	Phoenix House	Rehabilitation	3	3	
Glasgow & Clyde	Ravenscraig	Corlic C	Rehabilitation	5	1	4
	Stobhill	Orchards 1	Adult CC	1	4	3
		Orchards 2	Adult CC	4		
		Orchards 3	Adult CC	2		
Grampian	Royal Cornhill	Dunottar	Adult CC	3	6	3
		Fyvie	Adult CC	6		
Highland	New Craigs	Aonach Mor	Rehabilitation	2	6	
		Bruar	Rehabilitation	3		
		Morlich	Rehabilitation	1		
	Argyle & Bute	Tigh na Linne	Rehabilitation	2	2	4
		Arran	Adult CC	4		
Lanarkshire	Hartwoodhill	Gigha	Adult CC	2	1	1
Lothian	Royal Edinburgh	Craiglea	Rehabilitation	2	9	6
		Ettrick	Rehabilitation	2		
		North Wing	Rehabilitation	2		
		Swanston	Rehabilitation	4		
	St John's	Ward 2	Adult CC	5		
Tayside	Murray Royal	Glenelg	Rehabilitation	8	14	2
	Royal Dundee Liff	Gourdie House	Adult CC	8		
Total				**159**	**97**	**62**

What people told us and what we found

Privacy, dignity and identity

It is important for individuals who have to spend a long period in hospital that the effects of institutionalisation are kept to a minimum. It is therefore essential that people are treated with appropriate dignity and respect and are able to exercise some degree of freedom of choice.

Two-fifths of the people we interviewed during the visits told us that they have to share a room – some still in dormitory type accommodation. In some hospitals everyone said they had a single room and in many there was a mix of provision. It was more common for people in rehabilitation wards to have single rooms and for people in continuing care wards to share. Nearly everyone we spoke to in the following hospitals had to share accommodation:

- Hartwoodhill (Gigha)
- Gartnavel Royal (ward 8 and Tate)
- Murray Royal (Glenelg),
- Ravenscraig (Corlic C & D),
- Royal Cornhill (Dunnottar and Fyvie)
- Stratheden (Dunino, Falkland, Kinnaird and Lindores)

Almost a quarter of the people we spoke to said they did not feel confident that their possessions were kept safe. Some people had no access to secure lockers, or had to rely on staff locking things away. Hospitals where a high proportion of respondents felt their possessions were not safe were:

- Hartwoodhill
- Murray Royal
- Bellsdyke

Responses from people in the other hospitals were mixed, but the majority of people reported feeling confident their possessions were secure. Perceived safety of personal possessions did not seem to be affected by whether a person had a single or a shared room.

Privacy in bathroom and toilet areas identified more concerns. More than one in five of the people we spoke to said their privacy is not respected. This does mean that in most hospitals there is no significant problem. However, twice as many people in Gartnavel (ward 8 and Tate) answered ‘no’ to the question *“is your privacy respected?”* than answered ‘yes’. Responses from individuals in Stratheden hospital were half and half. There were single negative comments from people in a number of other hospitals.

The main issue for individuals on wards appears to be intrusion from staff – one person recalled a member of staff walking in without prior announcement or explanation, and when challenged said *“I’ve seen it all before”*. This lack of courtesy was reflected in some other comments reportedly made by staff, e.g. *“you don’t have anything I don’t have”*.

The ability to exercise choice in as many areas of daily living as possible is important for the individual’s rehabilitation as well as sense of self. Yet almost half of those interviewed did not have the opportunity to make snacks or hot drinks when they wished. The priority given to smooth running

of the daily routines and the risks to a few appears to limit the experiences of all, in these wards. In this respect, there has been little progress since the 2003 unannounced visit report where we said that locking the door to the kitchen for safety reasons was not good enough.

On a positive note, nearly everyone has access to a garden and almost all of the respondents were actively keeping in touch with family or friends outside the hospital. Moreover, two-thirds did not think anything needed to be changed. For some, this may reflect the reduction in aspirations over the time they had been in hospital, but we believe that many people came to a positive conclusion about their overall experience, after careful consideration.

Although we did not ask about the accommodation that was available when they were ready to be discharged, a number of people made unsolicited comments on this subject. These indicated a lack of choice in supported accommodation in some areas, which limited people's opportunities of moving on to a place in the community.

Safety

In comparison to our 2003 unannounced visit, there is an increase in the number of people who do not feel safe in their ward. Some of those interviewed acknowledged that their symptoms cause a sense of insecurity, but for many the fears are external.

Almost half of the people we asked said that they had felt threatened or been subject to aggression in hospital. Of those who answered yes, more than half were men. In some cases, the protagonist was perceived to have been unwell at the time.

Only three out of five people who have been subject to threats or aggression reported an incident to staff – slightly more men than women. One person, who had been subjected to verbal threats reported it to staff and felt that this prevented further escalation. Other positive comments we received included; *"he (member of staff) reassured me"*, *"things have improved"* and *"staff are more ready to listen"*. Another said that *"there is a patient who threatened me [in the past] and another who hits staff. It makes me feel scared to use the smoke room alone. Staff will come to the smoke room with me if I ask"*.

However, other comments suggested that for some, even if incidents are reported, *"staff don't bother"*, and *"staff just laughed and joked about it when I told them"* or *"staff just say behave yourself and don't worry"*. Alarmingly, less than two out of five of those who felt threatened said they had received help to deal with threats or aggression. Lack of staff support was reported in Dundee Liff, Gartnavel Royal, Leverndale, Russell Park and Murray Royal. Positive staff support was identified in comments about Craigenhall Unit, Ailsa, Galavale, Argyll & Bute, and The Orchards.

Care planning

Participation in care and treatment is one of the principles of the 2003 mental health act and a key element in individual recovery. Good information is a foundation stone in participation. Almost two-thirds of the people we interviewed said they were offered information about their illness and more than two-thirds said they had attended review meetings. About two-thirds felt that they had been able to have a say in their care and treatment. Less than half stated that their family or friends had been involved in their care planning.

That still means that about a third of people were not offered information and were not involved in review meetings. This is reflected in some of the comments we received:

"I haven't been to a review meeting… I don't know when they happen."

"I've never had a meeting with doctors and nurses. I've only seen the consultant once in the past year."

More than two-thirds of those asked said they had a key worker who they could talk to about their care and treatment. The frequency of meetings with key workers varied from daily to monthly, many people reported being able to meet on request. The most frequent response was a weekly meeting.

More than a third were unsure, or were unaware of any plans being considered for their future.

We asked staff if they thought anyone was inappropriately placed in their ward and what effect this was having. In one ward, we heard of a *"volatile mix of patients",* where elderly frail individuals were placed alongside younger, fitter people with widely varying mental and physical health needs. One person still needed periods in an Intensive Psychiatric Care Unit in the management of his care.

A mix of older and younger adults was described in:

- Ailsa
- Argyll & Bute
- Bellsdyke
- Borders General
- Royal Cornhill
- Gartnavel
- Larbert
- The Orchards
- Gourdie House
- Stratheden

In some cases, inappropriate placements in wards may have arisen from closures elsewhere. This is noted in:

- Ailsa
- Crichton
- Dykebar
- Gartnavel
- Leverndale
- New Craigs
- The Orchards

Some staff interviewed felt that they had to balance the needs of individuals preparing for discharge, with those of individuals with complex needs who required 24 hour care.

Individuals requiring more intensive care were often placed in their service when other services had closed. While staff wanted to work with individuals towards discharge, competing demands made it difficult to maintain focus on rehabilitation. Delayed discharges were identified in:

- Argyll & Bute
- Craigenhall
- Crichton
- Phoenix House

Involvement

Around two-thirds of interviewees said they had been offered advocacy services; these included 73 people subject to detention and 56 who were being treated informally.

More than three-quarters of the former group, but less than two-thirds of the latter, said they had been offered advocacy. Some who said they had not been offered advocacy may have forgotten that they actually had at some point.

All people with mental disorder have a right of access to advocacy under Section 259 of Mental Health (Care & Treatment) (Scotland) Act 2003). The requirement for mental health officers to inform detained individuals of availability of advocacy services, may account for this improvement for people who are detained. It is important to ensure that all others are periodically advised of their right to access advocacy.

"Do you think that I could see one of them?" was a question we received from a person who said they had never heard of advocacy before our interview.

Quality of the environment

The vast majority of those interviewed felt that their ward was kept clean and our visitors' comments reflected this. Although clean, however, wards were not always described as welcoming environments.

Comments from Commission visitors varied from one ward being:

"clean, homely, individualised … a benchmark of how existing older wards can be made service user friendly and inviting",

Another where:

"furniture is shabby, the carpet is worn and dirty… (with) infestation of ants/beetles in the living area".

Almost a third of wards visited had the door to the ward locked during the day, or for parts of the day. On the day of our visit, locked doors were found in:

- Ailsa
- Bellsdyke
- Borders General
- Royal Cornhill
- Gartnavel
- Leverndale
- New Craigs
- The Orchards
- Dundee Liff
- St John's
- Stratheden

The main reasons given were related to security or due to the number of detained people in the ward.

More than one in five people we interviewed told us that their bedrooms were locked during the day, without ease of access. Bedroom doors were locked in:

- Ailsa
- Bellsdyke
- New Craigs
- The Orchards
- St John's
- Dykebar

One person said that he could always get access to his room, but this invariably involved having to wait until the nurse was available. A number of people had a single room with their own key, so that they could determine whether their room was locked or not. In one area where we had previously commented on bedrooms being locked, it was noted that, following a change in practice to open bedrooms, the incidence of aggression on the ward had decreased.

The majority of wards we visited had a quiet area available. Many wards had converted what had previously been a smoking room for this purpose. One person, however, stated that there was no access to a quiet area and that if he wanted somewhere quiet to sit, he would just have to sit in the corridor.

Almost three-quarters of wards we visited had a room for visitors. In some wards visits took place in bedrooms, but these were often described as too cramped for this purpose. In others, there was a flexible use of activity/quiet/dining rooms for visiting. In many wards, staff identified the areas available for this purpose to be inadequate. We also found little evidence of facilities for visiting children, or policies on younger visitors.

Only three-quarters of wards had drinking water available at all times. This varied from having water coolants, having the kitchen or pantry open, or making jugs of water available. Restricted access to water occurred in:

- Ailsa
- Royal Cornhill
- Crichton
- The Orchards
- Stratheden
- St John's
- Galavale
- Bellsdyke

Management of funds

During our visits we focused our attention on how an individual's funds are managed.

Perhaps surprisingly, three-quarters of the people we interviewed said they could spend their money the way they wanted. Those who said they could not were evenly scattered throughout the hospitals. Almost half of the people we spoke to said they managed their own money and just under two-thirds said they get help with budgeting.

We found a wide variety of ways in which people were supported with their finances. Support comes from ward staff, care managers and family members – both formally and informally.

The following comments from individuals illustrate the wide range of views and needs, as well as the diversity of arrangements to meet them:

Some comments about arrangements were fairly positive:

"Staff do all the money management… I recently bought a new chair… no problems with money".

"I agree the budget plan… with my key worker".

"My sister manages my money, brings food etc".

"I have just been made 'incapax'. I would like to go and buy a guitar, get new clothes, go swimming".

Some not so positive:

"Don't know how I'm fixed financially".

"I only get £2 per day and would rather have £5-£10 per day. I can't buy things I want like sweeties. I need to get trainers, pyjamas, new jacket and jeans and a haircut. Don't know when this is going to happen".

"I hate it, wish I could manage own money".

Comments from staff illustrate varied approaches to support offered:

"I was told he goes drinking, so he is restricted to £1.00 per day".

"He has a history of gambling and needs help with finances".

"He recently had 'incapax' status revoked. His key worker is helping with budgeting".

We met a small number of individuals who have a positive opportunity to budget for food to cook their meals. This provides a good rehabilitative learning experience. Unfortunately, this is an opportunity that is not available to many.

It is reassuring that most people felt that they have enough money for their personal needs; even those who smoked did not complain. However, we spoke to one mother who found she could not afford to buy her children clothes and presents. This undermined her self-confidence to act in her role as a mother. It also demonstrates some of the difficulties encountered by people with severe mental illness in trying to maintain positive parental relationships.

Activities

In around three-quarters of the wards we visited there was a staff member identified to take responsibility for arranging activities. This responsibility is shared by occupational therapists and nurses. All but four wards had space dedicated for activities and – in all but two – activities were also organised off the ward. Staff in all the wards said they tried to encourage those who are poorly motivated to engage in activities. However, staff in a third of wards acknowledged they had no process for evaluating the activities offered.

The following responses from staff illustrate the range of activities made available:

"Physio group, men's group, women's group, community meeting, Artlink, creative working, yoga, music & movement, baking, Stepping Stones, healthy lifestyle group, daily lunch groups, exercise group, knitting group, etc."

"In the recreation hall there is a full monthly programme of activities which include bands, evening meals, and celebratory events. Off the ward there are cinema trips, walking trips, shopping. People are constantly asked what ideas they have and what they would like to do."

"there are arts and crafts in the ward; recreational therapy off the ward, pool, bowling etc. We aim to get into town as much as possible in the mini-bus. People usually go out 2 or 3 times per week. We have Nintendo Wii in TV room."

"Lunch groups, reading groups, quizzes, outings, dedicated room in ward and occupational therapy department nearby – There is easy access to garden and café – there is a minibus available for trips."

"No programme as such. We advertise what's on offer and react to patients' interests. Tuesdays and Fridays there is a ladies group in ward."

The following comments represent individual's comments on activities:

"I am… hoping to go to college in September to study 'mind, body and soul' and crafts. The nurse will accompany me discreetly".

"I go to the arts group, walking group and supper group".

"I attend OT. We have outings, shopping, theatre, pub trips".

"I'm starting college course (FT design and media) in September. I go to the 'Music Bus' (Wednesdays), go to the library to use the computer frequently and go to the gym 5 days per week".

"I enjoy going to the bookies. I was down at the coast for a pub lunch with other people from the ward last week. We go out in the people carrier".

"The OT sometimes comes up to the ward – about once a week – and you make stupid wee dolls and things like that".

"I get out 5 hours a day. It takes 2/3 hours to travel so I only see my children for a short time".

One person described feeling like a *"known woman"* in her town and feels she cannot go out as a result.

It can be seen, therefore, that activity programmes are very varied; some will be enriching and beneficial, others limited. Few people were directly critical of the activities available, perhaps showing

the value of any kind of diversion while on the ward.

We asked each person if they had their own activity programme, something which indicates an awareness of his or her individual needs and preferences. Disappointingly, around half said they did not. This is a similar proportion to the results in our 2003 survey.

No one we spoke to in the units in Argyll and Bute, nor in Crichton, knew about an individual activity plan. Responses were about half and half in the Bellsdyke, Leverndale, New Craigs and Stratheden units. Nearly everyone we spoke to in the following wards were able to talk to us about their own activity plans:

- Orchards
- Ravenscraig
- Dunnottar ward

Nearly everyone said they were able to go out of the hospital, although a quarter knew of reasons limiting their comings and goings from the ward.

Activities which individuals said they had done 'yesterday' ranged from going for coffee in the hospital, to a trip to one of the day centres. Some people described their opportunities as very limited and others talked about enjoying trips out.

Some accounts also capture the sense of loss experienced by individuals who are seriously affected by long term illness. One person told us *"I used to be an interesting person"*.

Physical healthcare

Around three-quarter of interviewees said they had a health check. Of those, we were able to record dates of the health check for most. All but three of the dates were within the past year.

We were pleased to see that a large proportion of the individuals receiving care and treatment for a severe and enduring mental illness are receiving physical health checks at least annually. However, a significant number of these occurred in the context of medical treatment provided for identified need, rather than routine scheduled health checks. Given the additional risks and health inequalities experienced by this group of individuals, we think more attention needs to be paid to this aspect of care. All of the wards we visited received medical input from a hospital doctor, GP or both.

When asked whether there was a policy on physical health checks, around a half of staff answered positively, but, disappointingly, almost half did not have a policy. Where there is a policy on health checks, around a half specified annual checks. Some were more frequent and some did not state the frequency with which they occurred.

In some wards, where staff said there is no policy for routine health checks, it was clear that despite the absence of policy there is still good medical input. In several wards there were also plans to introduce a policy.

"This person was receiving hospital treatment for an eye injury, but there were no regular physical health checks on the ward, there was no GP input and junior doctors provided a responsive service but did not attend the ward regularly." (MWC visitor to Gartnavel Royal)

"The GP attends every day and responds to nurses requests to see individuals. Nurses run a 'health care clinic' every Monday morning and perform bloods, BP and ECGs, but there are no overall regular GP health checks." (MWC visitor to Bellsdyke)

The Scottish Government's *'Delivering for Mental Health'* (2006) requires, where possible and appropriate, that every person with severe and enduring mental illness has a physical health assessment at least once every fifteen months.

Local hospital policies should be in place to ensure regular physical health checks are done for these individuals, whether or not they have an identified illness requiring medical attention. This is especially important in view of their increased risk of physical health problems and potential side effects of medication.

"I was recently diagnosed with diabetes after a routine health check."

"This man's bloods are checked regularly for Lithium levels. He claims not to have had a full physical examination for 15 years." (MWC visitor)

Smoking

Three in four of the individuals we interviewed said they were currently a smoker. Of those, half said they had been offered smoking cessation advice but half said they had not. While some people said clearly that they did not want to stop smoking, some smokers who said they had not been offered cessation advice expressed a wish to stop.

"A total ban will help me to stop smoking."

"I would love to give up smoking, it makes me sick."

Several people reported that they had given up smoking with the help of staff or smoking cessation advisers.

The 56 people who said they had not been offered smoking cessation advice were spread over 28 wards. Staff interviewed in 25 of those wards said smoking cessation advice was available. It may be that, in some wards, if people cannot recall when asked, it may not be offered on a regular basis.

Staff on three of the wards housing smokers said that they were unaware of the availability of smoking cessation advice:

- Glenelg, Murray Royal Hospital
- East Brig, Borders General
- Gourdie, Royal Dundee Liff Hospital

There are smoking rooms or designated smoking areas in around two-thirds of wards. In two wards these were particularly inappropriate – the front reception area in one and a conservatory off the dining room in another.

Smokers have to go outside in 10 wards. In one of these wards, we were told this

was a matter of individual preference. Only three of these wards had smoking shelters. We were told it was planned to erect shelters in three more.

Substance misuse

We asked staff whether substance misuse is an issue on their ward. In more than a third of wards, staff said it is. We asked how this is addressed. Five of the staff referred to specialist services outwith the ward team. Three of the staff mentioned involving the police.

Weight, diet and exercise

Staff interviewed on four out of every five wards told us that dietary advice, or access to a dietician, is available for individuals.

Records were kept of individual weights in nearly all wards, but regular monitoring of weight only occurred in three-quarters of those. Because of the correlation between weight gain and certain medications, we believe that monitoring should be in place for all those with severe and enduring mental illness.

Almost a third of the individuals we interviewed expressed concerns about their weight. However, only just over half said they had been offered dietary advice. This is potentially concerning. We would urge services to reflect on this locally.

We asked those we interviewed whether there was an exercise programme available. Less than half answered positively. Staff on nearly a quarter of wards said there was no exercise programme available.

Health promotion should include availability of an exercise programme for all in-patients and encouragement to engage with this.

Consent to treatment/capacity

More than two-thirds of those individuals we interviewed said that someone had given them information about their treatment. Three-quarters said they had agreed to all the treatment they were getting. Of those who said they had not agreed to all their treatment, one quarter were informal. Concerns that people expressed in relation to consent related mostly to lack of information about the treatment they were receiving.

Staff in 41 wards answered questions on consent to treatment issues. T2 and T3 forms were in evidence in 37 of the 38 wards, where one or more individual was subject to detention under the 2003 Act. In one ward, Form 9 and 10s were still in place. These are outdated forms from the Mental Health (Scotland) Act 1984 that require to be replaced with T2s or T3s as appropriate.

Evidence of consent to treatment for individuals who are not subject to detention was only present in half of wards where this was sought.

“I recently became informal and am happy to continue receiving treatment as a voluntary patient. My consultant keeps me informed of what is happening, as do all the staff.”

In 25 wards we identified people who lacked capacity to consent to treatment and for whom, Adults with Incapacity Act S47 consent to treatment certificates should have been in place. Section 47 certificates were present in four out of every five of these wards.

Where applicable, we sought evidence that capacity in respect of decisions about treatment was kept under review. Evidence of this was present in nearly all wards for which this information was recorded.

One or more person was receiving covert medication in three of the wards visited. These were located in Dykebar and Royal Cornhill hospitals. Our guidance on the use of covert medication was being comprehensively followed in one of these wards. Procedures fell short of best practice in the other two wards. For one individual, the use of covert medication was reviewed less frequently than weekly, as is recommended by the Royal College of Psychiatrists.

Conclusions and key recommendations

Areas of good practice

- It is evident from these visits that, since our visits to rehabilitation and continued care wards five years ago, there have been improvements in some areas. It would appear that expectations of staff and people receiving care and treatment have increased during this period, as recommended in the '*Greater Expectations'* report. Where this has brought about change for the better, people have benefited. Where raised expectations are not met, however, there was evidence of discontent and disappointment.
- From the responses to our questionnaires, it seems that the ability to keep in touch with family and friends, the opportunity to spend time out of hospital, and access to a garden area have all improved. More people are now given information about their care and treatment, are able to attend review meetings and feel involved in decisions about their care. Advocacy services are made more widely available both to those subject to the Mental Health (Care and Treatment) (Scotland) Act 2003, but also to others.
- The environment of care remains unfit for purpose in many older buildings which are unsuitable for further modification. Nevertheless, fewer concerns about cleanliness were reported than in 2003. The removal of smoke rooms from many wards may have contributed to this perception.

Areas for improvement

- For many, it is still common to have to negotiate locked doors in wards, while people are unable to the lock door to their bedroom or bathroom themselves. People in hospital should be afforded the same courtesy and right to privacy and dignity as anyone else. Staff should knock and seek permission before entering someone's private space. To be constantly seeking staff assistance to unlock doors is also a barrier to gaining a sense of autonomy, especially in relation to internal ward doors.

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

- A feeling of safety and security is a fundamental human need. That a majority of the individuals we saw had been threatened or been subject to aggression may be related to the length of time they have spent in hospital. However, people in such a vulnerable position should feel confident that they can ask for help and receive support following such incidents. Furthermore, they should be informed of action taken and how this will help them to feel safer in future.

  Policies on dealing with incidents in hospital should describe how someone is to be supported following threats or aggression and what feedback is to be given to the individual after the event.

- Clinical need, not service expediency, should determine who is placed in rehabilitation and continuing care wards. A wide age difference alone presents enormous difficulties for staff and is not supportive of individual progress and recovery.

  There is a need for NHS boards to set admission criteria for wards in order to prevent the emergence of resident groups with widely disparate mental and physical health care needs.

- There is increasing evidence of staff being employed to promote activity and recreation within wards and in the wider community. Opportunities for activity and recreation are far greater than existed five years ago. However, for some there is little evidence that this is being translated into meaningful programmes of activity and this is confirmed in the individual records.

  People should be offered and actively encouraged to participate in appropriate, individualised programmes of activity and recreation.

- 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.

  Smoking cessation, dietary advice and physical exercise programmes should be actively – and repeatedly – promoted in rehabilitation and continuing care wards, employing appropriately qualified staff to support this hospital population.

- Although nursing staff are generally aware of matters of consent in relation to those subject to compulsion, for others issues remain in upholding rights and evaluating capacity to consent to all forms of treatment. In this regard, awareness of Adults with Incapacity Scotland Act 2000 may be just as important for this patient group as the Mental Health (Care and Treatment) (Scotland) Act 2003.

  The Mental Welfare Commission publications on 'Consent to Treatment' and 'Covert Medication' should be made widely available in all wards and appropriate training in these areas put in place.

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