mentalwelfare
commission for scotland

VISIT AND MONITORING REPORT

APRIL 2017

Contents

The Mental Welfare Commission

What we do

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

We do this by:

- Checking if individual care and treatment are lawful and in line with good practice.

- Empowering individuals and their carers through advice, guidance and information.

- Promoting best practice in applying mental health and incapacity law.

- Influencing legislation, policy and service development.

Introduction

What this report is about

A themed visit is when we visit people in similar services across a short period of time with key questions that we want to ask patients, visitors and staff.

This report details what we found when we visited all mental health admission wards across Scotland providing care for adults. It highlights areas of good practice we found, and contains recommendations for improving care and treatment.

We reviewed the care of 323 patients, most of whom (88%) we met in person. We also spoke to 41 carers, most often a member of the patient's family, and a number of hospital ward staff.

Why we visited

We wanted to hear about the experiences of people receiving care and treatment in acute admission wards and to find out whether or not their rights were being respected. Patients in hospital may be particularly vulnerable and, at times, less able than others to safeguard their own interests, but have important human rights which must be observed.

We wanted to find out whether or not key rights were being respected and make recommendations to improve practice where indicated.

We also wanted to identify areas of good practice to share locally and nationally, and were interested to see what had changed since our previous themed visit.

Previous visits

We visited all adult mental health admission wards as part of a themed visit in 2012.[1]

The key messages from that report were that patients did not always understand, feel involved in, or were not always consulted about their care and treatment. We found there was not enough therapeutic activity on offer for patients and many of the wards had very poor physical environments.

---

[1] The Mental Welfare Commission for Scotland, (2013). *Adult acute ward visits 2012.*
http://www.mwcscot.org.uk/media/126149/adult_acute_2012.pdf

Key findings from this visit

We found that while there were some improvements, for example, physical environments in some wards were better and some wards were taking a more recovery-focused approach, there was still much that needs to be done. This section of the report contains a summary of our main findings; there is more detail later in the report under the relevant headings.

The Good

Recovery focused care:

On this visit, we found a definite shift towards recovery-based care, which we welcome. Wards that had completed the Scottish Recovery Indicator 2 (SRI 2)[2], reported positive improvements to care planning, carer involvement and delivery of recovery focused group work.

Peer support workers:

Peer support workers (people with lived experience of mental illness and recovery), are increasingly recognised for their work in supporting patients. We were pleased to find an increased number of such workers since our last themed visit. Where peer support workers were employed we heard positive feedback, but more should be done to promote awareness of their role.

Physical environment:

There was general improvement to the physical environment since our last report was published, and we were pleased that where we had previously noted significant concerns, these were being addressed.

Patient experience:

Patients were generally positive about their time on the ward; most negative comments were about availability of staff.

Feeling respected:

The majority of patients said they felt respected by staff.

---

[2] Scottish Recovery Indicator 2 Scottish Recovery Network http://www.sri2.net/

Areas that still need to improve

Feeling safe:

Around one in five patients reported feeling unsafe in the ward, particularly at night.

Around one in four women expressed concerns about being on a mixed ward.

Care plans:

We found that the quality of care plans was inconsistent; in our view, three out of four care plans were not fully person-centred and focused on recovery. We found this disappointing.

Physical health:

We found that there was often not enough attention paid to physical health care and health promotion.

Patient rights:

We found that staff and patients had a mixed understanding of patients' rights, and not enough positive action was being taken to meet the rights of patients in hospital.

Mental Health Act:

Around one in 10 patients receiving medical treatment under the Mental Health Act were not covered by relevant safeguards.

Advance statements:

We found very few advance statements, and limited knowledge of these by patients and staff.

Carers:

Very few carers said they had received written information, although the vast majority of the units visited said they had written information available to give to carers.

Safety and security:

We found an inconsistent response to reviewing periods of unauthorised absence of patients.

Length of stay:

We had concerns that some patients, particularly those who had been diagnosed with alcohol-related brain damage, were spending too long in mental health admissions wards.

Occupancy levels:

On the days of our visits, occupancy levels were high, and in some hospitals there were also patients 'boarded out' to other wards.

Social work and discharge planning:

We found some good practice in relation to managing unplanned discharges, but we also heard about delays in accessing social work services quickly and the consequent effect this can have on discharge planning.

Delayed discharge:

Staff told us that they considered around one in 10 patient discharges to be delayed and this was usually in relation to accessing appropriate care and support out with hospital. We heard about some inconsistencies in recording of delayed discharges.

Access to psychologists:

Most wards did not have regular input from a psychologist; nurses are increasingly delivering psychological therapies. This is welcomed, but it does not replace the need for referral to a psychologist where indicated.

Activities for patients:

Patients told us that there continues to be a lack of activities at weekends.

Visiting:

One in four patients reported not being able to access a private space to meet with their visitors.

Facilities for children visiting their parents in hospital are not adequate in some areas.

Recommendations

Managers of adult acute mental health admission wards should review this report with staff and patients to consider aspects of their current practice that can be improved.

All NHS boards should:

- Review their current practice in relation to reviewing lengthy admissions and the boarding out of patients to other areas and delayed discharge.
- Ensure that staff have clear guidance and understanding of coding of delayed discharge.
- Ensure that there is adequate provision of activity at weekends.
- Ensure that if a patient who is engaged in constant observation leaves the area unobserved (whether or not harm has occurred) this should be reported under the organisation's adverse event policy and reviewed accordingly.
- Review care planning documentation and practice to ensure it is recovery focussed and promotes patient participation.
- Ensure SRI 2 action plans are implemented.
- Audit compliance with the consent to treatment safeguards of the Mental Health Act.
- Review the information that is currently available for carers to make sure this is helpful and is being distributed. Involve carers in this.
- Review the arrangements in place and take all necessary actions to ensure that patients feel safe, particularly at night and for women in mixed wards.

What the Commission will do next:

- We will write to all NHS boards and ask them to draw up an action plan for meeting our key recommendation in relation to lengthy admissions, boarding out of patients and delayed discharge.
- We will write to the head of The Scottish Patient Safety Programme (mental health) to share concerns raised by patients about feeling safe.
- We will visit all adult mental health admission wards every year and focus on specified aspects of patients' rights.
- In May 2017 we will publish "Rights in Mind" – a pathway to patients' rights in mental health services, with an accompanying good practice guide.
- We will raise with the Scottish Government, the importance of action to address physical healthcare within adult acute admission wards as part of their commitment to reducing health inequalities.
- We will liaise with key stakeholders to consider how to promote best practice in relation to care planning.

- We are currently holding engagement events with community psychiatric nurses across all NHS Board areas, focusing on promotion of advance statements. We are planning similar engagement events with medical staff in relation to advance statement and consent to treatment requirements.
- We will continue to develop and promote our materials on advance statements. These can be found at www.mwcscot.org.uk/get-help/getting-treatment/advance-statements

How we carried out these visits

We collected information on all the adult acute mental health admission wards in Scotland. An adult acute mental health admission ward admits adults who require hospital admission during an acute episode of mental illness. We visited 47 wards across 11 different health board areas. A full list of where we visited can be found in appendix one.

To help us decide what questions we wanted to ask, we consulted with organisations including the Scottish Recovery Network, HUG (action for mental health) and LGBT Health Scotland. We also consulted carer support organisations including Carers Trust, Glasgow Association for Mental Health (GAMH), Edinburgh Carers Council (ECC) and several other carer support groups. We thank them all for the time they took to help us.

They told us what they thought we should be looking for and asking about on our visits. The most common themes concerned involvement and participation: making sure patients feel involved in their care with particular focus on communication, information, recovery, care planning and discharge planning, peer support, access to collective and individual advocacy. Other issues were about feeling safe, being able to raise issues about care and treatment, access to activities, physical health care and the physical environment.

We developed interview schedules for patients, carers, staff and also a brief audit tool for the physical environment. We also developed a document for staff to record key information about unauthorised patient absences during the four-week period before our visit.

We carried out a pilot visit using these interview schedules to Broadford & Armadale wards at Stobhill Hospital, Glasgow. We would like to thank them for their co-operation in allowing us to do this.

We visited most wards between June and August 2016. Around six weeks before our visit we wrote to each ward manager to let them know that we were coming and details of the information that we wanted to collect on the day of our visit.

We provided leaflets and posters to let patients and visitors know that we planned to visit, and to give them the opportunity to meet privately with us either by making an advance appointment or by asking us if they could meet on the day of the visit.

On the day of the visit, we met with all patients, visitors and staff who wanted to speak with us. We also reviewed the case files, drug prescription and recording sheets of most patients we met with.

We often took follow-up action on the day of our visit or after the visit as a result of our findings. We did this on 140 occasions; most of these were resolved on the day of our visit and usually involved giving staff advice or clarifying an issue for a patient. We also wrote formally to senior managers or responsible medical officers (RMOs) on 13 occasions and to patients on five occasions in relation to more important matters.

Following the visit we sent a brief report to the unit manager highlighting any immediate concerns or good practice that we wanted to identify.

Key information on the patient group we visited

The Scottish Government has recently published the Inpatient Census 2016 Official Statistics Publication for Scotland (the 2016 census) as at midnight on 31st March 2016. We looked only at adult acute admission wards; the 2016 census looked at all mental health and learning disability inpatient beds.

For some key areas, we asked to be provided with a further breakdown of the census information to cover only adult acute mental health admission wards.

Patient profile

In total, we reviewed the care and treatment of 323 patients. We met 283 of them directly. Some patients were only able to engage for a short period of time with us and we were not able to ask them all the questions we had prepared.

Of patients reviewed, the largest group were aged 45-64 years (49%). About half were male (51%) and half female (49%). Four wards were single gender; the rest were able to use beds flexibly for male or female patients.

The youngest person we met with was aged 16 years and the oldest person was aged 86 years. The Commission routinely monitors the admission of young people (under 18) to non-specialist settings.

Our latest report can be found at http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf

Figure 1 Number of women and men by age range (Total=323)
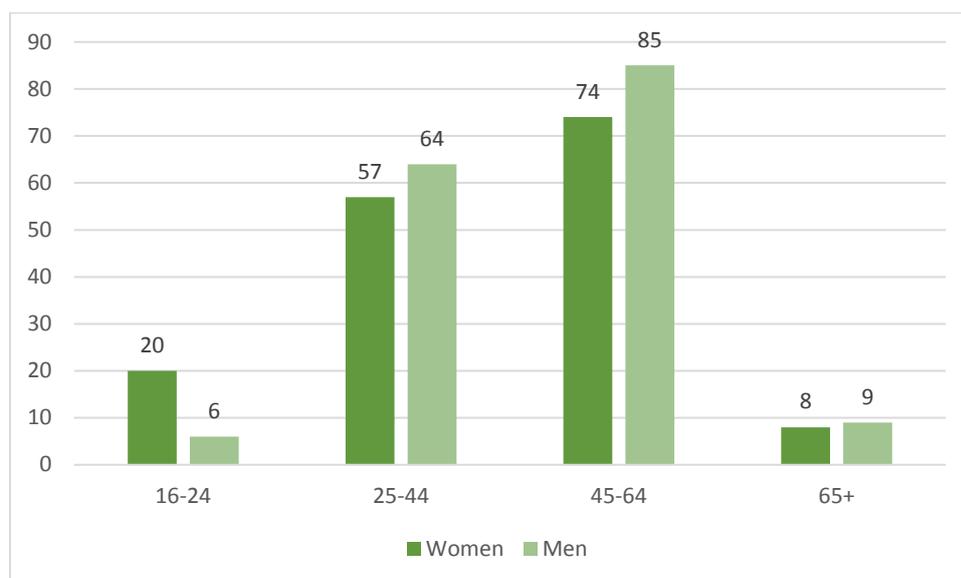
Detention status

Almost half the patients were informal (49%); half (50%) were on a Mental Health Act order and a small number were on a Criminal Procedure (Scotland) Act 1995 (CPSA) order.

Status	Number	%
Informal	159	49%
Emergency detention certificate (EDC)	2	1%
Short term detention certificate (STDC)	53	16%
Community compulsory treatment order (CCTO)	2	1%
Interim compulsory treatment order (ICTO)	1	0%
Compulsory treatment order (CTO)	104	32%
Criminal Procedure (Scotland Act) 1995 (CPSA)	2	1%
Grand Total	**323**	**100%**

Length of stay

Figure 2 Number of days in hospital (% of patients reviewed)
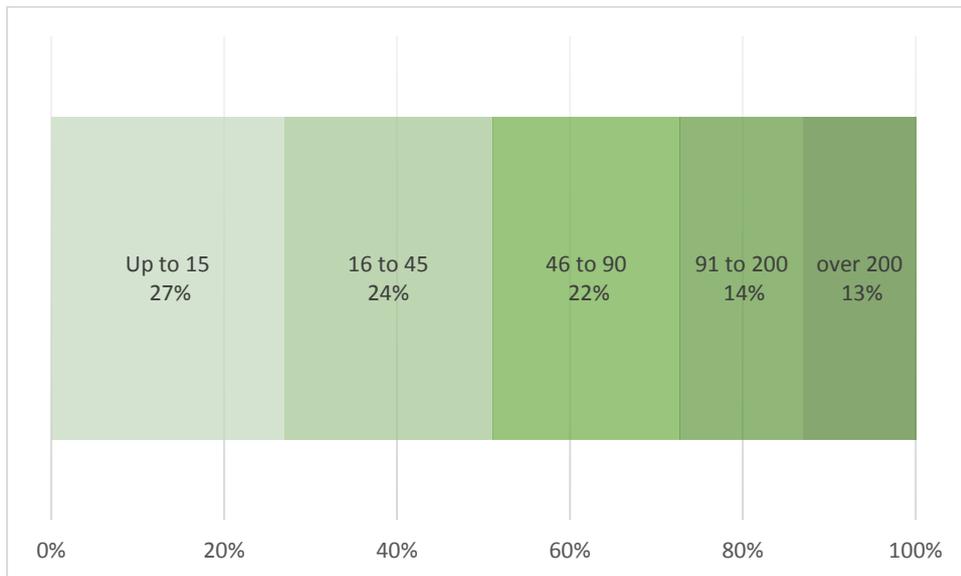
The majority (73%) of patients had been in hospital for 90 days or less. However, we were concerned to note that our sample showed 13% of patients had been in for 200 days or more. We looked at the 17 individual hospitals where these lengthy admissions were occurring and three of these accounted for just under half (43%) of these admissions.

Census information when applied only to adult acute mental health admission wards was broadly similar to our findings (11% over 200 days).

Diagnosis
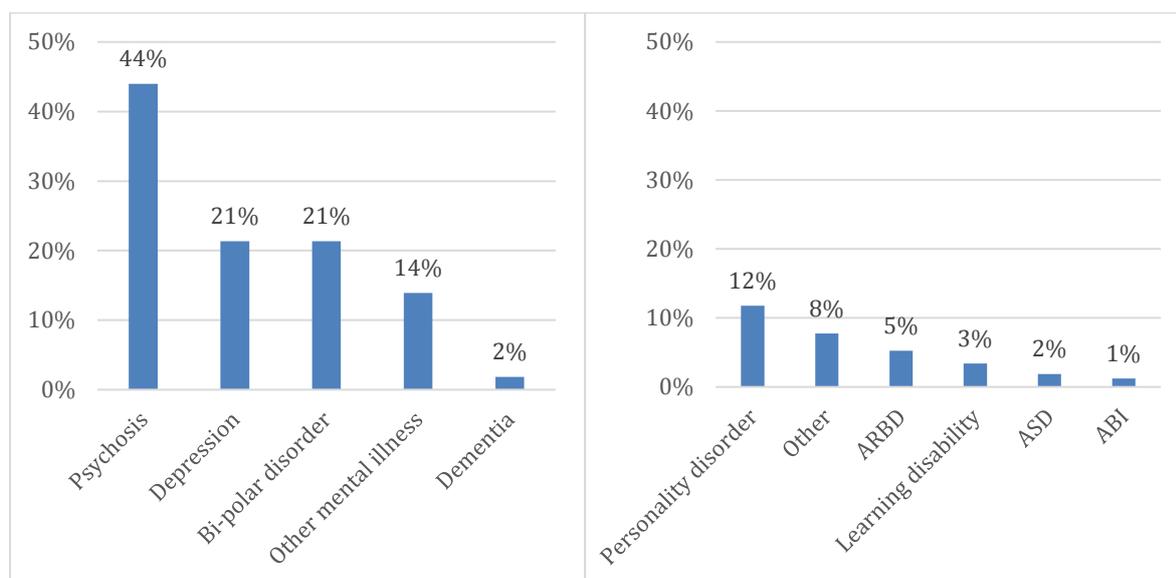
(Numbers add up to more than 100% as individuals may have more than one diagnosis).

The vast majority of patients (90%) had a diagnosis of mental illness.

While just 5% of patients reviewed had a diagnosis of alcohol related brain damage (ARBD), these accounted for 14% of cases where admission lasted more than 200 days. The 2016 census reported that 2.9% of patients in adult acute wards had a diagnosis of ARBD. [3]

The rest of those whose admission was for more than 200 days had a diagnosis of mental illness.

Ethnicity

In this visit, the majority of people were Scottish or Other British. At least 4% (14) of individuals identified themselves as belonging to other ethnic groups including Asian (6) Chinese (3), Bangladeshi (1), Pakistani (1) 1 other Asian (1), African (1), other ethnic group (4), or any mixed or multiple ethnic groups (3). The size of the minority ethnic population in the 2011 Census was 4% of the total population of Scotland (based on the 2011 ethnicity classification)[4], suggesting that the patient population is ethnically representative.

---

[3] Scottish Government, Health and Social Care Analysis (private communication 10/01/2017). Mental Health and Learning Disability Inpatient Bed Census. Proportion of inpatients in Acute wards with alcohol related brain injury: 3.1%, 2014; 2.9%, 2016.
[4] National Records for Scotland (2013)
Accessed 05/01/2017 at
http://www.scotlandscensus.gov.uk/documents/censusresults/release2a/StatsBulletin2A.pdf

The situation on the wards when we visited

Occupancy

We found that most wards were running at a high level of occupancy, although this in itself is not necessarily a concern. On the days that we visited, 94% of beds were occupied on average. The average occupancy of beds across all wards ranged from 86 to 100%.

The 2016 census for adult acute admission wards reported an overall occupancy rate of 85%, ranging from 60 to 100%.

There were approximately 68 vacant beds and 42 people on waiting lists to be admitted (17 male, 25 female).

Eighty six patients were 'boarded out' to another ward within the hospital; the vast majority (70) of these were from three large heath board areas: Tayside, Greater Glasgow & Clyde and Lothian. (Boarding out means that a patient is occupying a borrowed bed in another ward until a bed becomes available in their own ward. This can be within the same hospital or across hospitals/boards).

This was similar to census data which reported 78 patients boarded out to other wards within a hospital.

Boarding out to another area can potentially disrupt continuity of care and we would expect that this would only happen in exceptional circumstances and with clear guidance in place to minimise any disruption and address patient safety concerns.

What we found

During admission

Key point: All patients have the right to:

- Be treated with respect and dignity.

What we expect to find

We expect that patients will report that staff treat them with respect and are accessible and approachable.

What we found

For those we spoke to, we asked what it was like for them on the ward and how they felt they were treated. We asked about their experience of both staff availability and feeling respected by staff throughout their current episode of care.

The majority were positive about their time on the ward. The negative comments were mainly about lack of availability of staff.

About half (47%) of patients interviewed said they found staff were always available with 35% of patients feelings that staff were either sometimes or 'mostly' available.

"Very helpful staff – even during the night- very welcoming. I couldn't ask for better care." Huntlyburn House.

"Nursing staff are fantastic. Staff are busy and so I can't always comfortably approach them but I always feel they want to help in any way they can." Hermitage ward, Royal Edinburgh.

A few patients (12%) reported that staff were either rarely or never around. Patients thought that this lack of attention could be due to general busyness of nursing staff on the wards; others commented that staff were doing paperwork or chatting amongst themselves rather than spending time with patients

"The staff are too busy. My named nurse will seek me out, but staff are stressed and understaffed. The staff have taken me out on escorted pass sometimes, but not every day."

"You have to ask – all the time they are always busy – they say they will get back to me."

But others had a better experience:

"Staff have always made me feel welcome and have lots of time to spend with me. They've really supported and encouraged me to eat and get involved in things; they've given me hugs and time, even when I was nasty to them at first."
Ward 4a, Leverndale Hospital.

When asked whether or not they felt respected by staff on the ward, the majority of those who responded said that they did. About 5% of those who responded strongly disagreed that they felt respected, with some patients expressing the belief that their views are not truly valued.

Feeling safe

Key point: All patients have the right to:

- Feel safe and be protected from risks to their life.

In our last report in 2012, we commented that patients often found the behaviour of other patients admitted to the ward made them feel unsafe and staff needed to recognise the effect this can have.

What we expect to find

We expect that appropriate measures are taken to ensure patients feel safe, are protected from harm, and that their rights are fully respected.

What we found

The majority (74%) interviewed told us they felt safe always, or most of the time, but almost one in five (19%) reported feeling unsafe. This is higher than when we visited in 2012 and 16% reported feeling unsafe.

"I feel safe - I can lock my bedroom door if needed." Huntlyburn House.

There was no difference between men and women in their rating of how safe they felt. A common theme that emerged was feeling unsafe at night due to reduced staffing levels.

"One night I put a chair against my door because of the violence and the shortage of staff. When there is an emergency in another ward, staff run off leaving even fewer staff."

The patient mix was difficult for some people.

"Quite frightening, swearing, people on mobile phones in early hours. People with drug and alcohol problems."

In addition, we asked people if they minded being in a mixed sex ward and the majority had no concerns. Only four of the wards we visited were single sex (Royal Edinburgh Hospital). However, of those who did express concern, the majority (28) were female. One in four women who responded expressed concern about being in a mixed sex environment; this is clearly a significant issue for many women. Only two men expressed concerns.

The concerns expressed by the females related to feeling vulnerable in a mixed sex environment, again especially at night and finding the behaviours of some men upsetting. Some spoke of having experienced men making inappropriate sexual comments to them on the ward, which they found distressing.

We looked at whether patients felt able to report their concerns, and what response they had from staff. Of the 55 who reported not feeling safe, 16 had definitely not reported their concerns. The reasons given for not reporting included feeling that staff were too busy, not wanting to make trouble for others, fear of repercussions, or preferring to talk to their own family about their concerns.

Of the 23 who said they had definitely reported concerns, around half (12) felt concerns were dealt with and half (11) did not.

MWC visitor comments included:

> *"Feels staff could be more proactive in preventing unsafe incidents or be more vigilant in ensuring that particular males are not at risk of saying or doing something inappropriate."*

> *"She reported staff can be good and help with distraction other times dismissive, very inconsistent, night shift give a poor response."*

Care planning

Key point: All patients have the right to:

- NHS care which is patient focussed and encourages participation
- A recovery plan or care plan which is personal to them
- Be involved in developing their recovery plan or care plan
- Know what is in their recovery plan or care plan
- Be involved in reviewing their recovery plan or care plan

In our last report in 2012, we commented that often people did not feel involved or consulted in planning their care.

What we expect to find

We expect that patients are supported to be as engaged as possible in their care and treatment.

We expect that care plans reflect the individual needs of the patient and are regularly reviewed.

What we found

We asked patients about their care plans and if they had a chance to read them. We checked files to review their care plans. We wanted to know if the care plans were person-centred, addressing individual needs.

While almost all patients (98%) had some evidence of a care plan, these were only deemed appropriate – that is, individualised, person-centred and addressing the patient's needs – in around one in four cases. This was a cause for concern.

> *"The care plan has lots of detail of the patient's hopes and aspirations, aims, strengths and priorities, [contains] significant personal detail and refers to specific coping strategies such as using sensory box to reduce anxiety."* MWC visitor comment, Murray Royal Hospital, Moredun.

> *"Very person-centred care plans, many of which are outcome-focused and give staff clear guidance on how to best support the individual e.g. specifically promoting insight into his illness, and medication compliance. Very thorough care plans for physical health needs. Good evidence in care plan and chronological notes of discussion with the patient regarding his legal status and observation levels."* MWC visitor comment. Parkhead Hospital, Ward One.

"The recovery care plan clearly identifies hopes and aspirations, priorities and aims and areas that the patient specifically needs to develop. There is clear detail on how these areas can be developed, through the one to one session with keyworker, with a clear plan and focus for the one to one interventions." MWC visitor comment, Strathcathro Hospital, Mulberry Ward.

We felt that almost two thirds (65%) of care plans were partially appropriate, in that there were some areas of the care plans that were well addressed. However, the care plans were often generic and did not address the individual's specific care needs.

"'De-escalate the situation' was written in the care plan with no indication of what de-escalation or distractions techniques would be helpful to the patient." MWC visitor comment.

"The recovery plan identifies hopes and aspirations strategies, however some areas of the care plan were very generic, with no specific reference to using relapse signature and no information on the patient specific signs." MWC visitor comment.

The rest were considered to be inappropriate, with one described by an MWC visitor as *"simply a list of actions on a care plan with no supporting intervention."*

"The care plan is a standardised typed plan with spaces to enter patient's name; no meaningful personalisation." MWC visitor comment.

"Lots of problems identified, but no thought as to how to support the patient address those issues." MWC visitor comment.

In around four in 10 cases (41%) there was clear evidence of patient involvement within their care plan, but this was unclear in the remainder. Only 51 of the patients we interviewed told us they had read their care plans. Of those who had, the majority (75%) felt that their care plan had been written in collaboration with them and felt that their strengths and abilities were recognised in the care plan.

Recovery

What we expect to find

We expect to find care teams fully signed up to recovery-based practice. In particular, we recommend the use of the Scottish Recovery Indicator 2 (SRI 2) development tool.

What we found

A majority of wards had completed or were in the process of completing the SRI 2.

In our last report, we commented that there were many positive examples of recovery-based practice (care that supports a patient towards becoming well), and that all services should be striving to provide services of this standard. We also heard that peer support was a valuable recovery tool.

We recommend the use of SRI 2, a structured process centred around 10 recovery indicators. These are based on what works in recovery, for example, that the 'service is strength focused', and 'goals are identified and addressed'. Under this process, the service reflects its practice against those recovery indicators, seeking evidence from several sources, including documentary evidence from assessment, care planning and service information; and from conversations with people who provide the service, people who use the service, and carers.

The SRI 2 process has been shown to encourage, motivate and demonstrate examples of good practice and areas people can be proud of, as well as providing ideas for improvements.[5]

We asked all of the wards we visited whether the SRI 2 had been completed. The majority (37) said it had, and two were in the process of completion.

Of those that had not completed this particular process, some staff felt there was an overlap between the SR1 2 and the Patient Safety Climate Tool and also commented that the ward's focus was on the Scottish Patient Safety Programme.

For those wards where it had been completed, we asked what changes had taken place.

Responses fell into three main areas: care planning, carer involvement and delivery of recovery-focused group work.

The area that the SR1 2 seemed to have influenced the most was care planning, with staff commenting that the care plans had become more recovery-focused, documentation was improved and care plans had become more person-centred**.**

> *"Care planning has improved and is more recovery focused."* Stratheden Hospital Lomond Ward.

---

[5] Scottish Recovery Network (2016): How recovery focussed are we. Learning from four years of the Scottish Recovery Indicator.
http://www.sri2.net/images/files/Guidance/Documents/SRI2_Report_Final_Web.pdf

"From the review in 2013, the ward identified areas for improvement. The process raised awareness ensuring that the patient's view is the driver towards recovery, and the assessment highlighted the need to focus and improve on the patient's recovery and strengths. Our nursing assessments and care plans have now changed to reflect this." New Craig's Maree Ward.

We asked what kind of access patients had to recovery-focused groups.

The majority of wards said they provided recovery-focused groups, including discovery groups, anxiety management, mindfulness, relaxation, hearing voices, goal setting and relapse prevention. More information on therapeutic activity can be found on page 29.

Peer Support

What we expect to find

We expect that wards will have input to peer support workers, and we also expect an ongoing commitment to improving patients' access to peer support workers.

What we found

Level of input from peer support workers is improving, but more needs to be done to ensure all patients who could benefit have access to a peer support worker.

There is mixed awareness among patients of the availability of peer support workers.

In our last report in 2012, we identified five wards where they had introduced paid peer support workers.

The use of peer support can aid a patient's recovery.[6]

Formalised peer support exists in some inpatient settings, whereby a member of staff is "required to have a lived experience of a mental health problem/illness and/or be living in recovery. They draw on their lived experience to deliver a range of supports which assist individuals with their own process towards living in recovery".[7] The employment of paid support workers as part of a recovery-focused model within inpatient services is a recent development in Scotland.

---

[6]Insights: a series of evidence summaries - Peer support role in mental health services, May 2016, The Institute for Research and Innovation in social services.

[7] McLean J., Biggs H., Whitehead I., Pratt R., and Maxwell M., (2009) Evaluation of the delivering for mental health Peer Support Worker Pilot Scheme. http://www.gov.scot/resource/doc/291864/0089933.pdf (page 7) Edinburgh: Scottish Government Social Research

The value of both formal and informal peer support was highlighted in Commitment 3 of Mental Health Strategy for Scotland 2012-2015 and indicated an intention to extend its use more widely.

Four years on, we were advised that 21 of 47 wards had input from a paid peer support worker: of these, 13 have regular input (though three of these 13 were advertising to fill vacancies at the time of our visits); eight wards reported that formal peer support can be accessed on a referral basis only and in some instances the worker was linked to an advocacy service.

On one ward we visited, a paid peer support worker was taking the lead on assisting patients to complete their Wellness and Recovery Action Plans (WRAP).

However, of the people we directly interviewed (283), more than two thirds (71%), said that they were unsure or unaware of formal peer support on their ward, while 16 patients (6%) said that they were either aware of or were making use of formal peer support. There appears to be a mismatch between the existence of peer support workers and patient awareness.

While many patients did not have access to, or make use of, formal peer support, about half of those who provided some comment regarding formal or informal support spoke positively about the input from peers during their stay.

Comments included:

> "Some of us do support each other – I know a few of them and they keep an eye on me just as I will on them."

> "It's good to be able to talk to other patients; to share experiences and to help each other where we can."

> "I am aware of peer support from other patients. We are all aware of each other's limits: when to step in to offer help and when to get out of the way."

Several patients noted positive experiences in dormitory settings as they found this promoted positive peer support. Several others said that community meetings (patient forum) provided good opportunities to get support from others and to work collectively to make desired changes on the ward.

Some who expressed a lack of interest in engaging in peer support said that they preferred to keep to themselves, or didn't feel equipped to support others when they were going through a difficult period themselves. Others commented that the ward environment could lack privacy, and said it was difficult to avoid peers even when this is desired. One patient noted:

> "I don't find this [peer support] helpful; they are going through their own journey."

Physical health/health promotion

Key Point: All patients have the right to:

- All patients have the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health.
- Have their physical health needs supported.
- Access to health promotion and prevention.

What we expect to find

Anyone identified as having a chronic health condition will have an appropriate care plan and the patient will be given support to manage their condition.

Health promotion initiatives, such as smoking cessation support, dietary advice and support to exercise will be offered to patients.

What we found

Around four in 10 patients said they had a chronic condition, and almost two thirds said they were getting help to manage this.

Access to information and support to lead healthier lifestyles was mixed.

People with mental illness have a much higher mortality than the general population, dying on average more than 10 years earlier.[8]

This 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.[9]

Currently, 50% of adults in the general population have one or more chronic health conditions[10]. The 2016 census found 53% of mental health and learning disability patients aged 18+ had at least one long term physical health co-morbidity.

---

[8] 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
[9] The Scottish Government (2012) Mental Health Strategy for Scotland: 2012-2015 http://www.gov.scot/resource/0039/00398762.pdf p5
[10] In 2012-2015, half (50%) of adults aged 16 and over in Scotland had at least one long-term condition, as shown in Table 2.3, with a quarter (25%) having one condition and the remaining quarter (25%) reporting multiple (two or more) conditions.
The Scottish Government (2016) The Scottish Health Survey 2015 edition Volume 1 Main report Page 54
http://www.gov.scot/Resource/0050/00505798.pdf

We therefore wanted to look at how patients are being supported to manage chronic health conditions, and to make healthier choices in relation to smoking, diet and exercise.

We asked patients about their health and access to health promotion initiatives such as smoking cessation, dietary support, and access to exercise.

During our visits, 40% (114) of patients we interviewed self-identified that they had a chronic health condition. Of these, almost two thirds (64%) said they were getting help to manage this. Others felt they were not getting support or that they did not need help to manage their condition.

When we looked at the support patients were receiving to manage their chronic health conditions, we found that for a few there was no evidence of support being provided to manage their chronic health condition.

> *"A poor care plan with no evidence of patient involvement. No reference in the care plan to Type 2 diabetes which is very significant to his care. This is just documented in chronological notes."*

We also found evidence of good practice: almost a quarter of the files we reviewed, (77) had care plans to address the patient's chronic physical health needs.

> *"The patient only had one care plan, covering diagnosis and discussion with RMO. The patient had a complex presentation relating to both mental and physical health but did not have any supporting care plans."*

> *"The patient has epilepsy and had a seizure the day prior to our visit. There were no supporting care plans."*

> *"Good detailed care plan with emphasis on physical health and personal care given diagnosis of multiple sclerosis."*

Smoking, weight and exercise

Almost six in 10 (57%) of the patients we interviewed were smokers. This compares with 21% in the general adult population.[11] Of these who smoked, 66% said they had been offered help to stop smoking. In one ward, patients were openly using electronic cigarettes or vaping, despite this being against the ward rules.

---

[11] The Scottish Government (2016) The Scottish Health Survey 2015 edition Volume 1 Main report Page 118 http://www.gov.scot/Resource/0050/00505798.pdf

Surprisingly, only 26% of patients spoken to said they had concerns about their weight, (65% of the general adult population is overweight).[12] But our question was about whether patients were concerned about their weight, rather than whether they were overweight, so not directly comparable. More than half (55%) of the patients who said they were concerned had been offered support to manage this.

Less than half the patients we interviewed (48%) said they had the opportunity to exercise during their admission, yet many of the wards we visited said that patients have access to a gym, with others having walking groups and various activities such as football and badminton provided off the ward.

> *"The patient was participating in one to one therapeutic work that assisted the patient to understand and develop strategies regarding his physical and mental health. This work was vital due to the links between episodes of poor physical health and the deterioration of his mental health and increased risk."* Gartnavel Royal, McNair Ward

Three wards said that the multi-disciplinary team included input from physiotherapy. Exercise can have a positive impact on the physical and mental health of individuals. Given the correlation between mental illness and poor physical health, there are very real opportunities to have a positive impact on the general wellbeing of patients by providing a greater focus on support to exercise within inpatient settings.

Discharge Planning

Key Point: All patients have the right to:

- Participate in planning for discharge.
- Have their family and friends involved in planning for discharge, if they wish.
- Have discharge plans explained clearly.
- Not be discharged without a plan.
- Discharge plans which include support for recovery.
- Discharge plans prepared with multi-disciplinary input.
- Discharge plans which consider meaningful activity such as employment, education or training.
- Have their community care needs assessed, and assessed needs met.
- Discuss preparing an advance statement.

---

[12] The Scottish Government (2016) The Scottish Health Survey 2015 edition Volume 1 Main report Page 65 http://www.gov.scot/Resource/0050/00505798.pdf

What we expect to find

Patients are given opportunities to participate in planning for their discharge, including family and friends if they choose.

Planning for discharge should be evident in the patient's care file from an early stage and no patient should be discharged without a safe and effective plan.

Discharge plans should contain recovery support, inclusive of relevant community health and social care resources and timely post-discharge input; self-care; and a crisis management plan (where appropriate).[13][14]

What we found

We found concerning levels of delayed discharge.

Approaches to planned and unplanned discharge were inconsistent across Scotland.

Planned discharge

We believe it is good practice to show that a patient's readiness to be discharged from hospital is considered on a regular basis. We found little evidence of outcome-focused care plans linked to discharge readiness. Patients and others, where relevant (such as family members or carers), should be clear about what will show that a patient is ready for discharge, including their need for community resources, including housing, support for living, guardianship, employment, or access to community mental health services.

> *"We had a meeting with the doctor and pharmacist. They had no idea what we had said to social work about discharge; they had none of the notes. It made the meeting hard. The doctor was about to release patient X, not knowing that part of the reason he was first admitted was that he wasn't eating. There is no kitchen in his house, his door is damaged, and there is also no heating. There has been no help with this."* Comment from carer.

Within care files, we noted that discharge plans were often difficult to find, particularly where they were not part of a specific care plan or not highlighted as an explicit section of multi-disciplinary meeting notes or action plans.

---

[13] Care Services Improvement Partnership and National Institute for Mental health England (2007) A Positive Outlook: A good practice toolkit to improve discharge from inpatient mental health care http://www.wales.nhs.uk/sitesplus/documents/829/DoH%20-%20CSIP%20Good%20Practice%20Toolkit.PDF

[14] NICE guideline, transition between in patient mental health settings and community or care home settings, August 2016
http://www.nice.org.uk/guidance/ng53

We saw evidence of discharge planning in just over half of the files we reviewed. We did not necessarily see a detailed post-discharge plan, but it was noted that discharge and future plans for a patient were being considered.

The other half of cases either provided no mention of discharge, or there was mixed evidence or not enough information on which to base a decision. It was noted that in at least one-third of records, patients were noted to be either not ready for discharge, or undergoing further assessment.

In one ward (NHS Lanarkshire), they used a focused "Recovery Leading to Discharge" care plan, which detailed the support patients would need and what follow-up would be arranged from both mental health services and other agencies.

Outcome-focused discharge planning should articulate - to the benefit of the patient, staff, and relevant others - what it will mean for each patient to be ready for discharge, and what needs to be organised outside of hospital to promote successful, sustained discharge.

> *"I have completed a WRAP Recovery Plan. I will be involved with the crisis team, social work services, and the OT. Planned support is part of my follow-up and clinical psychology will also be involved post-discharge. My nurse is very good at making me feel comforted; he really listens and doesn't give personal views."*
> Moredun ward, Murray Royal.

NHS Scotland uses a system called EDISON to report on delayed discharge. EDISON is a real-time national information system which records and shares information on patients delayed, the care setting in which they are delayed, and the main reason for the delay. Monthly management reports are generated and published. These reports state the total number of hospital bed days associated with each delay.

We noted that health board areas do not appear to have a consistent approach to recording these delays. In some areas, ward staff told us that a patient is formally recorded as a delayed discharge as soon as they are assessed as no longer requiring inpatient support, regardless of the reason for any continued period in hospital. Others only appear to formally record a delayed discharge if it is felt that provision of community services (often social work-funded) is lacking.

Due to this inconsistency, it is difficult to accurately report on the number of delayed discharges within adult acute admission wards and the reasons for these delays.

> *"I have no discharge date. All the nurses said was that they could phone round the hostels on my discharge and that I had to declare myself homeless. It doesn't feel good to have to go to a hostel where there are drugs and crime."*

We were told by staff that more than one in 10 (11%) of beds were occupied by patients whose discharge was delayed. This is concerning, given the high occupancy levels and boarding out practices we came across.

The 2016 Census had provision to record the "ready for discharge date" on EDISON and multiple reasons for delayed discharge. Seven per cent of all patients in the 2016 census were identified as delayed discharge.

More than half of the charge nurses in the wards made reference to difficulties faced in patients accessing housing or supported accommodation (which also included residential settings). Ten wards said that social work allocation or delays to social work input have a detrimental impact on patient discharge, while a few others noted that a lack of (or loss of) crisis services in the community has had a negative impact on discharge. While only a few wards specifically mentioned that the guardianship process can delay discharge, this was noted to be a contributing factor for delay in eight per cent of patients we interviewed.

> *"It is very difficult to access social work. They will only see the patient when they are ready to go. They should be seeing them sooner. This isn't right for the patient."*

> *"Access to social work can be easier if the patient is detained, because they already have an MHO (mental health officer)."*

We heard several good examples of initiatives that are improving connections between inpatient and community services, assisting patients and staff with discharge planning and providing continuity for patients at a time of transition. These are supports that engage with patients while they are in hospital and provide time-limited post-discharge support.

Patients informed us that assistance includes preparing a tenancy; budgeting or benefits-application; signposting and supporting to community mental health resources; or being a consistent listening-ear during a time of change. Examples we heard included: Lanarkshire Links; Positive Steps (Lothian); and the link worker post within Woodland View (Ayrshire & Arran) working specifically with patients from the South Ayrshire area. These projects are examples of good partnership working and funding across health and social care, to the benefit of patients.

> *"Positive Steps are excellent. They come three times per week to the daily rapid rundown meeting with consultants. This organisation is run by the local authority and offers support and assessment for up to eight weeks. We are finding them very helpful. They are easy to contact and they come monthly to discuss how the service is going."* Lothian, Royal Edinburgh.

Unplanned Discharges

Nearly all wards had processes in place for safely and effectively managing unplanned discharges. This may occur when an informal patient discharges him/herself against medical advice or where discharge is arranged at short notice.

Some wards specifically noted that unplanned discharges are dealt with exactly as those done in a planned way, in that carers or relatives are informed with patient consent, and community resources - inclusive of GP and crisis services - are informed. Follow-up appointments are arranged, urgently if this is felt necessary.

A few wards across different boards referred to a pathway for unplanned discharges being in development, with the intent to manage unplanned discharges in a more robust and consistent way. Some wards spoke only of referrals being made to community mental health teams, or back to a community psychiatric nurse (CPN), if one had been involved at the point of admission.

> *"We have in place a Discharge Pause sticker, which prompts the discharging clinician to consider follow-up, medications, family involvement, and discussion with the community teams. In addition, we have a robust Discharge against Medical Advice policy. For all discharges – planned or otherwise – we do a transition of care document. A copy always goes to the patient. The document is electronically available to all staff involved in the care of the individual. All patients' GPs receive an immediate discharge letter at the point of discharge and there is a discharge checklist that prompts the nurse to contact all community services."* Forth Valley Royal Hospital.

Activities

Key Point: All patients have the right to:

- Activities for therapy and recreation.

What we expect to find:

- Staff should be able to provide a range of therapeutic activities both within and outside normal working hours.
- We would expect to see an activity programme that is person-centred, based on multidisciplinary assessment of a patient's needs and strengths and inclusive of the patient's opinion. Activity provision should include options on and off the ward and include both therapeutic and recreational activity.

What we found

- There was a good level of activities during working hours, but this was not the case in the evening and at the weekend.

In our last report in 2012, we commented that the provision of a range of therapeutic activity is of huge benefit and very much valued, but needs to be available seven days a week.

We recommended that service managers should review, in conjunction with occupational therapy departments, their current activity provision and ensure that staff are able to provide a range of therapeutic activities both within and out with normal working hours.

Most (83%) ward staff reported a satisfactory level of regular recreational activities in the day on weekdays, but this proportion dropped to 36% during evenings and weekends, when engagements were less frequent or structured.

> *"There are activities during the week like art, talking, cooking, crafts and chatting. There's not much on evenings or weekends. Time feels long particularly at weekends."*

We found that about a third (17 out of 47) of wards were clearly providing programmed activities on evenings and weekends; disappointingly, another third (18) reported that they do not have much on offer during evenings or weekends, and the remainder did not provide sufficient information for us to be able to comment.

Most (94%) patients interviewed responded to our questions about activities while they were in hospital. Less than half (46%) reported that there were general activities available on the ward or within hospital grounds on a regular basis.

Almost half (48%) told us that activities are predominantly available only during core hours, leaving evenings and weekends without planned or structured activity. Some patients reported that while activities were limited to core hours, they are able to keep active.

> *"There is a relaxation group, an advance statement group, a movie group and a gardening group. I can also have time off the ward with the peer support worker."*

The majority of patients who are aware of activities being available at times other than core hours (so opportunities inclusive of evenings and/or weekends) responded more favourably about activity provision on their wards than those patients who identified that activities are only available during core hours. About a third of patients reported to us that activities are available outside of core hours, including weekends and/or evening activity.

> *"There is a full activity programme from Monday to Friday, which changes every week and is individualised. The Patient Activity Coordinator nurse is very good at planning a whole week of activities. At night there are games on the ward. At weekends, there's nothing organised but staff will discuss games nights and film nights."* Ward 4b Leverndale Hospital.

"There are excellent facilities. There's a pool table, table tennis, aquarium, gardens, arts and crafts, and a gym group. I go for walks, help with the garden and greenhouse." Huntlyburn House

"The days merge into one but weekends are quieter. I would like to engage in drawing classes or pottery but there is nothing like that on the ward."

Around one in 10 patients felt that activities were very limited or non-existent. We heard from patients that:

"There are board games and jigsaws, but there are pieces missing. There is nothing on in the evenings or on weekends."'

"I would have thought there would be more to keep the mind active and stay fit. They've got badminton racquets and shuttlecocks but no net or anything. Hitting a shuttlecock backwards and forwards is not really keeping fit. The football ended up on the roof and that was it. I've been to the breakfast club a few times but I think they've stopped doing it. Nobody came back to me and said do you want to do it. I asked for puzzle books but they don't have any."

A further 12% of patients informed the Commission visitors that they were aware of either some or many activities available, but did not participate. Reasons given by patients for their lack of engagement included language barriers; physical health or mobility problems that restricted participation; a dislike of group activities or group interaction; or a feeling that activities on offer are 'infantile'.

"The activities coordinator has been off and it seems as though nothing is happening that Mum wants to take part in." Patient's relative.

Distinguishing recreational activities from those deemed 'therapeutic' is not a straightforward task. The distraction provided by a simple board game may be perceived as therapeutic by some patients, while engagement in a group psychology session may not be perceived as helpful.

For the purposes of this report, we asked patients and staff about their interpretation of 'therapeutic activity'; this was generally interpreted as group or individual work with an explicit recovery focus, including (but not limited to) stress management; anxiety management; wellness and recovery action planning (WRAP); mindfulness; or art therapy.

In almost a third (32%) of wards, we were happy to hear good examples of therapeutic activity that took place as part of a weekly programme.

"Hearing voices, creative writing, discovery, goal-setting groups and wide variety of activities group to support recovery and provide the patient with a variety of coping strategies." Queen Margaret Hospital Ward 2.

In half of the wards, we felt that activities were less imaginative and were not focused on promoting a therapeutic environment. Other ward staff commented that they were more limited in what was available on a group basis: the information we collated would suggest that recovery input to their patients was on an individual basis, as opposed to though group work.

Under half (46%) of those patients who discussed therapeutic activity provision with us said that there were at least some options for engaging in therapeutic activity.

Patients gave examples of attending relaxation groups; mindfulness sessions; art therapy; or one-to-one sessions with nursing staff on a regular basis. On the other hand, a similar number of respondents (39%) said that there was either no therapeutic activity offered, or that they were unaware of it being on offer within the ward. A further few patients (15%) told us that they did not attend any therapeutic activity; some of these felt that it was too soon in their recovery to attend such things, while others chose not to attend but did not specify a reason.

As noted above, in only one third of wards, was staff feedback satisfactory regarding the provision of therapeutic activity. This is consistent with feedback from patients, in that less than half were aware of and attending what they consider to be therapeutic activity.

> *"There are groups and musical bingo, which everyone enjoys. The cross trainer is broken. Activities depend on how many staff there are and varies from week to week. There are walking groups but this depends on staff."*

Consent to treatment

Key point: All patients have the right to:

- A clear explanation of their medication and other treatment, in a way they can understand.

Informal patients have the right to:

- Refuse medication, if they have capacity to do so.

Patients subject to detention have the right to:

- A second opinion from an independent doctor after two months, if they are being treated against their will under the Mental Health Act.
- The right to appeal their status to an independent tribunal and to receive legal support to do this.

What we expect to find

We would expect that informal patients are giving valid consent to their care and treatment in hospital including their medication.

We would expect that patients are giving valid consent to their medical treatment or are receiving care under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and/or part 5 of the Adults with Incapacity Scotland Act 2000 with the appropriate safeguards in place.

What we found

We found that in around one in 10 cases, patients were receiving medication not properly authorised under the Mental Health Act.

During our visits, we checked that medication being given under the Mental Health (Care and Treatment) (Scotland) Act was properly authorised. The usual situation is that either a T2 or T3 certificate must be in place for a detained patient once the patient has received medication for two months under the current episode authorised by the Act. A T2 certificate is a certificate of consent to treatment, used where the patient has the capacity to consent to treatment and does so. A T3 certificate is a certificate completed by a Designated Medical Practitioner (DMP) in circumstances where a T2 certificate is not appropriate.

We reviewed the care of 88 patients who had been subject to compulsory measures for two months or more continuously.

Eight of these patients did not have a T2 or T3 in place and a further two patients were receiving medication not included on their T2/3. Therefore, 10 (11%) of patients detained for two months or more were receiving medication not properly authorised under the Mental Health Scotland 2003 Act (mental health act).

For seven patients, we found no T3 copy on the ward, although we were later able to verify from the Mental Welfare Commission database that a T3 had been completed and was in date.

Advance statements

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.

What we expect to find

Where patients have made an advance statement, we expect to find a copy of this in their file, and to see that the advance statement is taken into consideration by staff in providing treatment.

We expect to find that hospitals have systems in place to ensure that staff are made aware of, and have access to a patient's advance statement on, or as soon as possible after, admission.

We expect to find that patients who have previous contact with services are aware of advance statements and the benefits of these.

What we found

Uptake and awareness of advance statements was disappointingly low.

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 their mental health condition. 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.

Advance statements are a powerful way of ensuring that people with mental illness are listened to, even when they become unwell. From summer 2017, health boards will require to keep a copy of an advance statement received within the patient's records, and to notify the Commission of the existence and location of the statement. We will then keep a register of this information. Boards are also required to publicise the support they provide for making advance statements.

We asked patients if they were aware of advance statements and if they had made one.

We checked the files of patients to see if they had an advance statement on file and we asked staff how they ensured that they knew if a patient had made an advance statement. We also asked staff what was done in their ward to promote advance statements.

We found advance statements in the files of 12 out of 323 patients. A further 10 patients said they had advance statements, but there was no record of these in their files on the ward.

When we asked people about whether they knew about advance statements, just over half (52%) had never heard of one. For 28% of them, it was their first admission to a psychiatric unit, so it may be reasonable to expect that they would be less likely to be aware of them.

However, for patients who have had previous contact with inpatient services, about half (105 out of 215) had not heard of advance statements; 52 were unsure about what they were, and 18 were choosing not to make one.

Given the important role that advance statements can play in ensuring the individual's right to participate in decisions about their own care, it was very disappointing that the uptake and awareness of advance statements was so low.

Overall, 14 people we discussed this with said they would like to make an advance statement, and we advised these individuals to discuss this with their care team and/or advocacy services.

Equally as concerning was that there were 10 patients who said they had made an advance statement, but there was no record of this in the individuals file. In one case where there was an advance statement on file, our practitioner made the following comment:

> *"It [the advance statement] doesn't appear to have been read. It is thorough and well thought out. This was pointed out to the charge nurse as being an error in their practice. The advance statement could have been the basis of good person centred care planning as it identified what was most important to that person."*

We then looked at how staff ensured that they were aware of the existence of a patients advance statement.

Twenty of the wards (43%) said that copies of advance statements were on the electronic system, which would mean that this information is available when the patient is admitted.

The remaining 27 wards relied on information in the case notes, from medical records, or from the community mental health team (CMHT) or patients themselves.

This can mean that if a patient is admitted outwith core hours, when medical records or CMHT is not available and the patient is too unwell to inform staff about their advance statement, there can be a delay in accessing this.

We then looked at what role the staff were taking in raising awareness about advance statements.

We found that almost a third (32%) of wards were actively promoting advance statements in some form, either through groups or individual interventions.

In a further third (36%) of wards, staff we spoke to said that the patients should be supported to make advance statements by their CPN or advocacy worker after they had been discharged rather than while they were in an acute admission ward, therefore, they were not actively promoting these.

In the remaining third (32%) of wards, staff told us that there were posters on display; some said information could be provided and it may be mentioned around discharge, but it was not actively promoted.

We would agree that advance statements should be made when someone is well enough to understand the implications of what they are including in their advance statement. Therefore, it may be more appropriate to make an advance statement whilst in the community.

However, we still feel that staff in acute admission units can play an important part in raising awareness about the benefits of advance statements and an initial discussion should form part of the discharge process.

> *"The care plan is highly personalised, e.g. patient can become easily irritated, nursing intervention should be short and focused". "Finds solace in religion, nursing staff to facilitate spiritual needs". "Has requested advocacy to be present at his reviews". These have been facilitated by a detailed advance statement on file."* Newcraigs Hospital Maree Ward.

Relationships

Carers

Key Point: All patients have the right:

- To support to maintain family relationships.
- Agree how much they want family and friends involved in their care and support (unless there is a legitimate reason to restrict this, in which case any restriction should be the least possible).

What we expect to find:

- The carer's role and knowledge are valued and acknowledged by staff, and carers continue to be involved in care as appropriate and provided with opportunities to share information with inpatient staff in a way that suits them.
- Carers are provided with information in relation to visiting arrangements, including arrangements for children visiting, and (when appropriate) are welcomed onto the ward.
- The carer's unique knowledge of their relative or friend is acknowledged and respected, and their views on care and treatment is taken into account.

- Carers are fully involved with care and treatment plans where appropriate and in discharge plans to ensure the best chance possible for a successful discharge and recovery.

What we found

- There was great variation in the ways that wards communicated with carers and in the type and amount of information shared with carers.
- Most carers said they felt welcome on the wards.

All patients have the right to support in helping them to maintain family relationships.

In this report we use the term 'carer' to mean partners, parents, other relatives or friends who provide unpaid care or support to someone. We recognise that some people see themselves as carers while others would not use this term to describe themselves.

The Triangle of Care[15] represents an alliance between carer, individual and staff that is hoped will aid the journey to sustainable and meaningful recovery. Its guidance highlights six key standards to which mental health services should aspire:

- Carers and the essential role they play are identified at first contact or as soon as possible afterwards;
- Staff are 'carer aware' and trained in carer engagement strategies;
- Policy and practice protocols regarding confidentiality and information sharing are in place;
- Defined post(s) responsible for carers are in place;
- A carer introduction to the service and staff is available, with a relevant range of information across the care pathway; and
- A range of carer support services are available.

We would expect the wards we visited to be aspiring to the Triangle of Care standards, even if they are not formally measuring their work against the assessment tools provided through this. The new Carers Act (Scotland)[16] will come into effect on 01 April 2018 and this also is focused on the positive aspects of involving carers while aiming to protect and support them.

---

[15] Carers Trust (2013) The Triangle of Care, Carers Included: A Guide to Best Practice in Mental Health Care in England Second Edition (
https://professionals.carers.org/sites/default/files/triangle_of_care_2016_latest_version.pdf
[16] http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/CarersBill

With this in mind, we contacted as many carers as we could to gather views and gain a carer perspective on the units we visited. We advertised our announced visit in advance and invited carers to make an appointment to meet us or to just come along on the day of the visit.

What carers told us

We spoke to 41 carers over 11 health boards either on a one to one basis, in groups, or by telephone conversation.

The majority (56%) of carers we spoke with came from three health boards: Lothian, Greater Glasgow and Clyde and Fife. Just over half had individual interviews with our visitors, and the rest were spoken to as a group or by telephone.

Just under half (46%) were looking after informal patients, while the rest cared for those who were detained under the Mental Health Act.

Most of the carers considered themselves to be the main carer or next of kin but only 34% were named persons.

If someone becomes unwell and they are detained in hospital under the Mental Health Act, they can nominate a "named person", who will look out for their interests. This is usually, but not always, their main carer if they have one.

Just under half (46%) were parent carers, with the rest being mainly a spouse or sibling. Only one individual was not a relative of the person they cared for.

Just under half (46%) of patients they cared for fell into the 45-64 age group, with 41% being between 25 and 44 years. Similarly, just over half of the carers (56%) were aged between 45 and 64.

We wanted to know how it felt to be a carer or visitor arriving on the ward, so we asked how welcome carers felt at visiting.

Most carers said they felt very or fairly welcome on the ward. No one described feeling unwelcome. Any negative comments tended to be around differing staff attitudes and several commented that a positive exchange depended on which staff member they approached.

> *"Every time I come, the nurses are very welcoming and supporting."* Royal Cornhill.

> *"There are some staff who are very friendly on arrival. Others don't seem to want you to speak to them because they have too much else to do."*

A few, however, raised concerns that speaking to staff did not always result in any action being taken:

> *"..Staff are always busy and anything I raise is not acted upon."*

> *"…they say they will pass it on (to Responsible Medical Officer - RMO) and that is the last I hear of it."*

All staff should be aware of the carer's needs and be active in approaching them to offer help and advice. Carers have a lot of vital information about the individual and for staff to form a good relationship with the carer benefits everyone in the long run.

Overall, the majority of units were aware of the Triangle of Care and most had some processes of carer engagement in place.

Few carers said they had received written information, although the vast majority of the units visited said they had written information available to give to carers.

> *"Was given info on diagnosis, meds, legal status verbally by his doctor, but no written info. Says has forgotten most of it."*

> *"I don't know anything about his rights - nothing about the ward - just the detention papers. I don't know what is available or what I could get."*

It is important to keep up communication with carers so they know what is happening with their loved one. Written information on the ward can help make them feel more welcome and when backed up with ongoing personal contact with staff can only improve the prospects for successful discharge and recovery.

The quantity and quality of information shared with carers varied considerably across units. For example, some wards have a carer link nurse on the ward, or one of the explicit roles of the patient's named nurse is to liaise with the nearest relative, where consent has been obtained.

Wards also varied in how they maintained contact with carers, including communicating by phone, e-mail, in person during visits, or during scheduled meetings. The majority of wards confirmed that carers are invited to ward rounds or to separate meetings with the psychiatrist. On the other hand, one ward stated explicitly that carers are not invited to weekly multi-disciplinary meetings. Several others noted that carers typically do not attend weekly meetings, but a member of nursing staff will make contact with them following the meeting to provide an update.

We asked carers if they had anything else to tell us and the comments were varied.

Some of the negative comments were on the difficulties of gaining admission for their loved one and the lack of support from community services.

One carer described a *"nightmare"* regarding the pre-admission period and thought *"How in God's name are we going to get him admitted and be in hospital and be safe."*

Two carers raised concerns about paperwork they had received from the Mental Health Tribunal Service Scotland (MHTS). We advised them to speak to MHTS directly.

Confidentiality is still an issue for many carers when interacting with staff:

> *"As hadn't been made named person initially, staff were reluctant to share information or discuss daughter's progress."*

However, confidentiality is improving in some areas:

> *"She said that when her daughter was first admitted she had told staff that she did not want her mother to be given information about her treatment. Her mother said she understood that staff had to respect her daughter's wishes at that point. Her daughter had then said she was happy for staff to share information, and she feels staff have been exemplary in the way they have involved her, as mother and carer, giving her all the information she could need and keeping her up to date with her daughter's progress."* Argyll and Bute.

One carer however described how her own confidentiality had been breached by a staff member:

> *"She had also handed in a letter for her daughter's RMO giving information about how her daughter was acutely unwell. She did not want her to know she had handed in this letter, but a nurse had mentioned the letter in front of her daughter when her mother was visiting."*

Carers should receive respect for their role and experience. All carers have the right to have their views listened to regarding how care and treatment is being provided to the person for whom they care. Carers' needs and circumstances should be taken into account and it is crucial for professionals to consider what information and advice carers need to help them care for the patient.[17]

---

[17] The Mental Welfare Commission for Scotland (2016) Carers and Confidentiality Guide
http://www.mwcscot.org.uk/media/307170/mhc-guides-carersandconfidentiality-_revised.pdf
The Mental Welfare Commission for Scotland (2013) Good Practice Guide: Carers and Confidentiality
http://www.mwcscot.org.uk/media/125263/carers_and_confidentiality_2013_web_version.pdf

What patients told us

We were also interested to know the extent that patients involve their family, and if the level of involvement was satisfactory to the patients being interviewed.

Two thirds of patients responding to this question felt carers were involved in their care. A few (18%) reported that their families were not involved as much as they would like.

In order to respect patient wishes and uphold patient rights regarding confidentiality, we would expect to find that patients' views have been sought, whenever possible, on information sharing with relatives or carers. Most wards (45) said they always recorded patient views in relation to information sharing. Most of the patients interviewed (98%) who stated a wish to have visitors were allowed visitors.

Visiting

We were surprised by how many patients with family/friend visitors reported that they either did not have a private place to meet visitors or were unaware if such a place existed. This was the case for almost a quarter (24%).

"It can be chaos finding a room to meet a visitor. You are not allowed in the dorms or your room, so there is nowhere really private to go."

"The only place to meet is the dining room, which is not very private."

"I am often told to see visitors in the dining room, which feels like prison and is not private. We're not allowed to have visitors in bedrooms. You need to ask staff specifically for a private space, but these are often reserved for disruptive patients."

Hospitals need to provide safe environments for patients but unless there are clear risks, it seems unreasonable to ask that visitors can only meet with a patient in a communal area, particularly if a private bedroom space is available.

Under Section 278 of the 2003 Act, service providers have a duty to mitigate the effects of compulsory measures on parental relations. Providing suitable visiting arrangements for children helps to meet this duty.

Forty nine patients reported that they have children under 18 years of age.

Most (45) wards reported access to a room in which children could visit, but relatively few of these could be described as child friendly, e.g. access to toys/games. Of the remaining two wards, one reports that they encourage patients with visiting children to go off the ward and another stated that they do not have a child-friendly visiting space.

We would expect that ward staff will promote family contact, when appropriate, and provide staff escort (when necessary) to accompany patients to family visits.

> *"Specific family friendly room with access to toys and books for children."*
> Inverclyde Hospital Langside Unit.

A staff team from Parkhead hospital applied to the National Lottery Fund for funding to refurbish the family visiting room. The room was well-decorated and bright, with a small soft play area and toys and books for the children to play with. The facility was shared between the two wards at Parkhead Hospital, Wards 1 and 3.

Restrictions, safety and security

Key Point: All patients have the right to:

- Be free of restrictions on their independence, choice or control, unless restrictions are for clearly identified reasons and are the least necessary.
- A proportionate approach to daily restrictions which may be needed on the ward for safety and security, such as ward policies on door locking, or restricting access to internet, and to have these explained.
- Be involved as much as possible in agreeing any restrictions and have any restrictions regularly reviewed to decide whether they are still necessary.

Patients who are detained have the right to:

- Information about how long they are detained for and why.
- Information about whether and how they can appeal, repeated as often as necessary, to make sure they understand.
- Not to be restrained unless it is the only way of managing risk to self or others.
- Restraint for as little time as necessary and with minimum force.
- A discussion afterwards about why they were restrained.
- Any restrictions in relation to use of telephones, correspondence and/or taking other measures to ensure safety and security in hospitals be carried out in accordance with Sections 281 to 286 of the 2003 Act (specified persons provisions).

What we expect to find

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

We expect action is taken to ensure the privacy and dignity of patients who may be subject to enhanced levels of observation, seclusion or restraint.

What we found

We found an inconsistent response to reviewing periods of unauthorised absence of patients

In our last report in 2012, we said that patients often find the restrictions placed on them difficult to understand and unnecessary and staff need to recognise and address this. On adult acute wards, common forms of restriction include locking the main exit door, restricting the use of mobile and camera phone and internet use. These are usually for the purpose of safeguarding the individual's or another's safety.

Enhanced level of observation

Enhanced observation provides a period of safety for patients during temporary periods of distress when they are at risk of harm to themselves and/or others. This will often involve a member of nursing staff being with a patient on a continuous basis for extended periods of time and often patients find this intrusive and restrictive.

Enhanced observation is a level of nurse observation to provide a period of safety for patients during periods of distress when they are at risk of harm to themselves and/or others.[18]

Constant observation is intended to meet the needs of those considered to pose a significant risk to self or others, and an allocated member of staff is to be aware of their precise whereabouts at all times through visual or hearing observation.

Special observation is used when a patient is clinically assessed as requiring intensive observation and should be within sight and arm's reach of a member of staff at all times.

On this visit, we found that on average 5% of patients were on an enhanced level of observation (4.5% on constant observation and 0.5% on special observation). The 2016 census showed that 7% of patients were receiving an enhanced level of observation.

There was variation across wards in the number of patients subject to enhanced observation at the time of our visits but we cannot comment with any validity on the reasons for this. At the time of writing, a new observation improvement framework is being developed by Healthcare Improvement Scotland with a move to advanced support rather than observation. This will provide a valuable opportunity for further work to analyse and improve practice.

---

[18] Reference clinical resource and audit group, CRAG, NHS Scotland 2002 engaging people: observation of people with acute mental health problems

Legal status/rights

Of the 268 patients who answered this question, most (85%) were aware of their legal status and understood this, but the remaining 15% of patients did not know or understand their legal status.

There is a difference in awareness between patients who were informal and those subject to the Mental Health Act.

Of the 268 patients who answered this question, 51% were informal.

Most (88%) informal patients understood their status. Twelve per cent did not know or understand their legal status; of these, two believed they were detained and 11 said they were not allowed to leave the ward.

Of the patients who were subject to the Mental Health Act, the majority (82%) understood their detention. Of those who did not understand their status, eight believed that they could leave at any time and a further three believed they could refuse medication.

> *"I asked staff to get an interpreter to go over his rights again and check if he remains willing to stay on ward."* MWC visitor.

We asked how people got information about their rights and 242 answered this question; of those a minority (22%) said they had not been given information about their rights.

> *"Knows he can come and go as he wishes, says he will alert staff when he is leaving as part of agreement with staff; just so they know when to expect him back and they don't worry."* MWC visitor.

The majority (78%) of people of people had received information. We were told this had come in a variety of ways, both in writing and verbally from staff and from advocacy. Some people felt that advocacy had an important role in helping them understand their rights

> *"He did not seem fully aware that he could refuse treatment and I discussed this with him. I asked if he had been told about his rights, he said he could not remember."* MWC visitor.

The Commission is currently working on developing a rights pathway for adult acute care. This is intended to assist staff to recognise the critical points when they need to ensure that patients are afforded their rights, rather than putting the responsibility onto individuals to claim their rights.

This will be available online, in print format and accompanying short videos will be published in May 2017. We hope these will assist staff to enhance their human rights approach.

Access to mobile phones

We did not come across any unnecessary restrictions on the use of mobile phones or received any comments from staff or patients that use of mobile phones was a problem. The use of camera and video facilities was discouraged in public areas, and if staff need to remove mobile phones from patients for clinical or security reasons without their consent, then this was usually managed by negotiation or under the specified person provisions of the Mental Health Act if required.

Not all wards had access to a wireless internet connection, but where this was in place, no problems were reported about allowing access or inappropriate use.

Preventing unauthorised absence

We are interested in how staff manage the balance between providing a therapeutic and minimally restrictive environment with ensuring protection at times of acute illness.

Following an MWC investigation of a suicide in 2014, the Commission wrote to all NHS Boards across Scotland asking them to review the safety and security systems in all acute psychiatric ward environments. We wanted to know how effective their systems were at monitoring the whereabouts of inpatients and preventing those, who were at risk from self-harm, from leaving acute psychiatric wards without staff knowledge

This visit to all adult acute admission wards across Scotland provided an opportunity to see how this was working in practice.

What we expect to find

There should be systems in place to prevent at risk patients leaving without the knowledge of staff. There should be a standard response and protocol for at risk patients who leave hospital without the permission of staff.

This is in keeping with the observation improvement framework being developed by Healthcare Improvement Scotland. This will state that staff on duty should have knowledge of the patients general whereabouts at all times, whether in or out of the ward; and that there is a system that ensures that the general whereabouts of any particular patient is known by a designated member of staff.

Controlling entry and exit

We asked ward staff how entry and exit from the ward was managed.

Sixteen wards were described as 'open'; no additional information was given.

The majority of inner city hospitals described free exit but entry to the ward being restricted to prevent uninvited visitors.

Seven were described as 'usually open' but staff would occasionally lock if required and locked door policies were in place. These policies describe under what circumstances the door can be locked and the process and review framework.

Six wards were described as being locked and only nursing staff could open the door on request. Other wards were described variously as locked but with a keypad inside the main door with the exit code and/or delayed exit doors.

Recording unplanned absence

Before our visits, we issued a template for staff to record unplanned absences as they occurred in the four weeks running up to the visit day. Unplanned absences were categorised by staff into:

- **A.** Patients on an enhanced (raised) level of observation who abscond/staff unable to keep on ward.
- **B.** Patients on general level of observation who leave the ward unobserved.
- **C.** Patients having escorted time off the ward who abscond.
- **D.** Patients having authorised time off the ward who fail to return at the expected time.

We asked for further details about the observation level of patients, brief details of any incidents, how staff addressed this and the outcome for the patient.

What we found

We relied on ward nursing staff to compete these forms; the quality of the information we received was variable, and sometimes not fully complete, and we cannot comment on its accuracy.

We received 41 completed templates from the 47 wards we visited.

Of these 41, five wards reported no unplanned absences during the previous four-week period. Of these, three were described as open and the other two (both sited in the same general hospital) were described as open but with a 'floor nurse'. (A floor nurse is a nurse who has been given the duty of observing the exit/entry to the ward for a specific period of time).

Of the wards that reported category A unplanned absences, one was described as usually locked but the patient managed to leave when someone was entering, one had a delayed exit system in place, and the others were described as open wards.

Findings

Thirty six wards informed us of 183 occasions of unplanned absence; certain patients were responsible for multiple occasions.

In the majority of occasions, the patient was detained (76%).

Returning to the ward

On many (38%) occasions, patients returned to the ward of their own volition. In a third (32%) of occasions, the police returned the patient; in an additional nine occasions the police were consulted and involved but did not actually return the patient.

Twenty eight per cent of patients were returned by family/friends/staff and two patients remained absent at the time of our visit.

On return

On return to the ward, 9% of patients had their observation level increased. One was discharged, three moved from informal to formal and one had their medication reviewed. Four had passes restricted or stopped.

Alcohol was a factor mentioned in four cases. One patient sustained a minor injury whilst out. One was admitted to a general hospital following an overdose and two were transferred to IPCU on return.

Review

A datix report (the incident and adverse event software reporting system used in NHS Scotland) was submitted in 63% of occasions for those in category A. There were various levels of review carried out, ranging from a nurse only review to a full multi-disciplinary discussion. Five of the wards involved submitted a datix report. There was no apparent correlation between the level of concern of the missing patient and the response to the incident.

A team review was mentioned in around half of category C and category D. However, information was not always provided about the type of review carried out, if any.

	Category A	Category B	Category C	Category D
	Patients on any enhanced (raised) level of observation who abscond/ staff unable to keep on ward	Patients on general level of observation who leave the ward unobserved	Patients having escorted time off the ward who abscond	Patients having authorised time off ward who fail to return at the expected time
Number of wards	7	21	8	28
Number of occasions (patients)	8 (7 patients – 1 had 2 episodes)	58	19	98 (9 patients accounted for 29 episodes)
Number informal	2	10	4	27
Number detained	6	48	15	71
Police accompanied to return	4	24	6	25
Family/friends/staff accompanied to return	4	27	5 returned by hospital staff	5
Self-returned/own volition		7	7	56
			1	1
Outcome where known				
Ward/unit	2 transferred to IPCU on return	1 admitted to general hospital following overdose		
Observation status	1 of 7 originally on constant obs. increased to special-	9 of 58 originally on general increased to constant	3 observation level increased to constant	4 increased to constant

Other	1 sustained a minor injury whilst absent	1 discharged	1 passes stopped 1 medication reviewed 2 alcohol use mentioned	3 passes restricted 3 moved from informal to formal 4 alcohol use mentioned
Datix report submitted	5	40	12	40
Team review	Range from nurse only to full multi-disciplinary discussion	13 team review mentioned	4 team review mentioned	50 team review (some no information provided)

*Not all columns total as often incomplete information submitted.

There are various practices across Scotland to maintain safety and security. The layout and design of some wards often makes it difficult for staff to observe unobtrusively. There appeared to be little correlation between a ward being 'locked' and the likelihood of a patient being able to leave unobserved.

Adult acute mental health admission wards are not secure units and it is unreasonable to suggest that patients will never be able to leave unobserved or safely prevented from leaving. Intensive psychiatric care units are appropriate when patients have an identified risk that cannot be managed safely on an adult acute mental health ward.

However, when patients are on an enhanced level of observation, the likelihood of unauthorised absence should be greatly reduced and should always be robustly reviewed if it occurs.

When a patient engaged in constant observation leaves the area unobserved (if harm has occurred or not), this should be reported under the organisation's adverse event policy and reviewed accordingly. The category of the event will support the decision-making process for the level of review required, however it must be stressed that a severe or tragic outcome is not the only determining factor. Near miss events with no adverse outcome and complex lower severity adverse events (Category III) can also warrant high level review if there is potential for learning.

Some wards completed a datix report for all periods of unauthorised absence and some did not report ever having completed a datix report for any type of unauthorised absence.

Wards should consider using tools available to think about and reduce risk. *Reducing Suicide Risk, Mental health team discussion framework*, May 2015[19] improvement area 1(unscheduled absence and time off the ward) and improvement area 8 (patient and staff engagement) are of particular relevance.

Wards could also benefit from the framework *Learning from adverse events through reporting and review: A national framework for Scotland April 2015* (2nd Edition)[20], which sets out clear guidance on reporting and reviewing near misses. (An adverse event is defined as an event that could have caused (a near miss), or did result in, harm to people or groups of people.)

Over a four week period, we were told about 61 occasions where police were involved in returning patients to acute admission wards and a further nine occasions where police were involved but did not actually return the patient. This shows the need for good liaison between mental health services and Police Scotland.

> *"[There is] liaison with local police to discuss how incidents are reported and responded to. As catchment area is directly adjacent to hospital, staff will use hospital cars to visit homes /local area and phone families before contacting police on many occasions. Positive risk taking, with expectation that when they do contact police they will get a very positive and proactive response. Also looking at completely electronic form for police rather than have two police turn up on ward to take a statement."* Leverndale Hospital, Ward 4a.

The physical environment

In our last report in 2012 we said that we were seriously concerned about the poor physical environment in some acute admission wards.

Key Point: All inpatients have the right to:

Positive therapeutic environment including sufficient living space, adequate lighting, heating and ventilation, a satisfactory state of repair, adequate food and clothing and meeting hospital hygiene requirements.

---

[19] *Reducing Suicide Risk, Mental health team discussion framework*, May 2015
[20] *Learning from adverse events through reporting and review: A national framework for Scotland April 2015* (2nd Edition)

What we expect to find

We expect to find conditions that are clean, comfortable, and free from unacceptable noise and odour and conducive to a positive therapeutic environment. There should be adequate space to uphold privacy and dignity.

What we found

There was general improvement to the physical environment since our last report was published and we were pleased that where we noted significant concerns, these were being addressed.

For the purposes of this visit, one visitor to each ward was given an environment questionnaire to complete, this looked at various aspects of the environment. The visitor also discussed their findings with the other visitors, patients and staff.

On the majority of the wards we visited, our visitors had no issues with overall cleanliness, odour, noise, heating temperature and ventilation, maintenance or decoration. We asked the visitor if overall the ward felt a pleasant place to be and the majority reported it was.

> *"Bright clean and pleasant environment."* Leverndale hospital Ward 4b.

> *"Spacious, pleasant nice décor alternative spaces accessible and lovely garden."* Woodland View Ward 9.

A very few (three) of the wards were rated as fairly unpleasant and issues identified were old dormitories, 1970s style wards and a lack of private space.

> *"Feels cramped with little individual space or private space."*

> *"Old tired furniture, the dormitory felt institutionalised, there was a lack of space."*

One of the wards we visited was rated as 'very unpleasant'. This was within the Royal Edinburgh hospital and the ward is due to close and transfer to new purpose built accommodation in summer 2017.

Most (98%) of the wards were described as clean by our visitors. One ward was described as dirty and this was raised with mangers on the day of the visit.

> *"The ward was not clean, it was noisy, and the maintenance and décor was also poor."*

The majority of the wards we visited were free from odour, but where there was an issue, this was about the smell of cigarette smoke.

"This is a no smoking ward but patients will smoke despite this, and it is a continuing problem."

"A patient commented that the "smell of smoke" is coming in from the garden."

Staff need to be clear about the smoking policy within wards and within the hospital garden and grounds.

Almost a third (32%) of the wards were in need of maintenance. The issues ranged from needing minor repair work to major refurbishment and renovation.

The majority (65%) of the wards we visited had clearly designated female spaces. Thirty five per cent did not.

Garden space inside and out

Most (83%) of the wards we visited had access to a garden space.

"Pleasant large garden with seating." Rutherford Ward, Gartnavel Royal Hospital.

"Clean, calming safe area, available to patients at any time." Woodland View, Ward 11.

A few wards had garden space but there were challenges with access, e.g. having to walk through the hospital or walk round the building or with the garden being downstairs. One ward had access locked due to building work.

For two of the wards we visited there was no garden or green space access.

Acknowledgements

Appendix

All patients have the right to:

- Be treated with respect and dignity.
- Feel safe and be protected from risks to their life. (Article 2 of the Human Rights Act 1998 states everyone's life should be protected by law. In the context of this report we took this to extend to the right to be free from harm or fear of harm).
- A recovery plan or care plan which is personal to them.
- Be involved in developing their recovery plan or care plan.
- Know what is in their recovery plan or care plan.
- Be involved in reviewing their recovery plan or care plan.
- A system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health.
- Participate in planning for discharge.
- Support to maintain family relationships and have their family and friends involved in planning for discharge, if they wish.
- Have discharge plans explained clearly.
- Not be discharged without a plan.
- Discharge plans which include support for recovery.
- Discharge plans prepared with multi-disciplinary input.
- Discharge plans which consider meaningful activity such as employment, education or training.
- Have their community care needs assessed, and assessed needs met.
- Activities for therapy and recreation.

All inpatients have the right to "a positive therapeutic environment including sufficient living space, adequate lighting, heating and ventilation, a satisfactory state of repair, adequate food and clothing and meeting hospital hygiene requirements."

Treatment

All patients have the right to:

- A clear explanation of their medication and other treatment, in a way they can understand and 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.

Informal patients have the right to refuse medication, if they have capacity to do so.

Patients subject to detention have the right to:

- A second opinion from an independent doctor after two months, if they are being treated against their will under the Mental Health Act and to appeal their status to an independent tribunal and receive legal support to do this.

Patients subject to detention also 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.

Restrictions

All patients have the right to:

- Be free of restrictions on their independence, choice or control, unless restrictions are for clearly identified reasons and are the least necessary.
- A proportionate approach to daily restrictions which may be needed on the ward for safety and security, such as ward policies on door locking, or restricting access to internet, and to have these explained.
- Be involved as much as possible in agreeing any restrictions and have any restrictions regularly reviewed to decide whether they are still necessary.

Patients subject to detention have the right to:

- Information about how long they are detained for and why.
- Information about whether and how they can appeal, repeated as often as necessary, to make sure they understand.
- Not be restrained unless it is the only way of managing risk to self or others.
- Restraint for as little time as necessary and with minimum force.
- A discussion afterwards about why they were restrained.

A note about where rights come from

We all have human rights. These are basic rights and freedoms, based on our common humanity. Human rights are outlined in law and set down a minimum standard for how we should be treated. At an individual level while we are all entitled to respect for our human rights, we should also respect the rights of others. Human rights should also apply regardless of nationality, place of residence, sex, national or ethnic origin, colour, religion, or language. They cannot be taken away except in specific, pre- determined situations and according to the law.

It is important to recognise that there are different types of rights - in particular there are absolute rights and qualified rights. Absolute rights mean that these cannot be restricted under any circumstances for example the right to life and the right not to be subjected to inhuman or degrading treatment.

Qualified rights means that these can be interfered with in certain circumstances and within limits. These rights establish whether public bodies can legitimately interfere with that right in order to protect the wider public interest. Examples are the right to respect for private and family life and the right to freedom of expression.

A human rights-based approach is about empowering individuals to know and claim their rights. It also increases the accountability and ability of staff working in health settings to respect, protect and fulfil human rights. This approach ensures that both the standards and the principles of human rights are integrated into policymaking as well as the day to day running of organisations.

This means patients gaining a stronger role in participation so that they can help shape decision-making around their care and treatment. In addition staff are able to recognise and respect rights and make sure that they are accountable when advising and applying these in their day to day role.

Some rights are set out in Scottish mental health law and other Scottish and UK legislation. Other rights come from international human rights conventions. The UK Human Rights Act put the rights in the European Convention on Human Rights into UK law.

Access to Health Records Act	Access to Health Records Act 1990
CRPD	The United Nations Convention on the Rights of Persons with Disabilities
Education Scotland Act	Education (Scotland) Act 1980
Equality Act	Equality Act 2010
Human Rights Act	Human Rights Act 1998
Mental Health Act	Mental Health (Care and Treatment) (Scotland) Act 2003
National Assistance Act	National Assistance Act 1948
Patient Rights Act	Patient Rights (Scotland) Act 2011
Representation of the People Act	Representation of the People Act 1983
Social Work Scotland Act	Social Work (Scotland) Act 1968
Carers Act	Carers (Scotland) Act 2016

The Mental Welfare Commission's good practice guidance on human rights in adult acute mental health services will be published summer 2017 and has more information about rights.

Where we visited

Adult acute themed visit locations – 2016/17

Health Board	Hospital	Ward / Unit	Bed numbers
Ayrshire and Arran	Woodland View	9	20
		10	20
		11	20
Borders	Borders General	Huntlyburn House	19
Dumfries and Galloway	Midpark	Ettrick	19
Fife (HB)	Queen Margaret	Ward 2	30
	Stratheden	Lomond	30
	Whytemans Brae	Ravenscraig	29
Forth Valley	Forth Valley Royal	Ward 2	18
		Ward 3	24
Grampian	Dr Grays	Ward 4	20
	Royal Cornhill	Brodie	28
		Corgarff	28
		Crathes	28
		Drum	28
Greater Glasgow and Clyde	Dykebar	South	15
	Gartnavel Royal	Henderson	20
		McNair	20
		Rutherford	20
	Inverclyde Royal	AAU	20
	Leverndale	Ward 3A	26

		Ward 3B	23
		Ward 4A	24
		Ward 4B	24
	Parkhead	Ward 1	24
		Ward 3	24
	Stobhill	Armadale	20
		Broadford	20
		Struan	20
Highland (HB)	Argyll and Bute	Succoth Ward	20
	New Craigs	Maree	24
		Morar	12
		Ruthven	24
Lanarkshire	Hairmyres	Ward 19	30
		Ward 20	25
	Monklands	Ward 24	24
	Wishaw General	Ward 1	23
Health Board	**Hospital**	**Ward / Unit**	**Bed numbers**
Lothian	Royal Edinburgh	Hermitage	20
		Balcarres male	20
		Balcarres female	20
		Meadows male	22
		Meadows female	20
	St Johns	Ward 17	24
Tayside	Carseview Centre	Ward 1	22
		Ward 2	22
	Murray Royal	Moredun	21

	Stracathro Hospital	Mulberry	25
Total	**25 hospitals**	**47 wards**	**1055**

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%

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