mentalwelfare commission for scotland

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VISIT AND MONITORING REPORT

Specified Person monitoring

Contents

Our aim

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

Why we do this

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

Who we are

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

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

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

What we do

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

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

1. Why we carried out these visits

The Commission has found that there continues to be wide variation in the understanding and interpretation of those sections of the Mental Health (Care & Treatment) (Scotland) Act 2003 (the 2003 Act) that allow restrictions to be placed on people who are detained.

We have seen evidence of this during our visits to hospitals, in telephone calls made to the Commission by staff, patients and carers and also on written notifications sent to the Commission. Moreover, we have found restrictions have been placed on individuals not subject to compulsion under the 2003 Act, which may be in breach of their human rights.

The 2003 Act introduced the concept of "specified persons"[1] which authorises restrictions which may be imposed upon an individual's correspondence, use of telephones and also in relation to safety and security in hospitals.

In situations where the responsible medical officer (RMO) is considering applying such restrictions the individual concerned must first be designated as a specified person. This applies before:

- restricting or withholding correspondence;
- restricting or preventing the use of telephones; and
- taking other measures to ensure safety and security in hospitals (i.e. searching of belongings, taking samples, searching visitors, restricting access and carrying out surveillance during visits).

It is worth noting that restrictions placed on use of mobile phones will also have implications for access to social media, news, and many other forms of contact, information and entertainment for the individual. This would not have been the case at the time of the introduction of the 2003 Act.

[1] Mental Health (Care and Treatment)(Scotland) Act 2003 Part 18 Communications, security etc. Sections 282-289 http://www.legislation.gov.uk/asp/2003/13/part/18/crossheading/communications-security-etc

2. Background to specified persons

Sections 281 to 286 of the 2003 Act and their associated regulations provide the framework within which restrictions can be placed on people who are detained in hospital.

The following are the relevant Scottish Statutory Instruments[2] from October 2005 which contain the regulations in relation to:

- Sections 281-283: this regulates prohibition and restrictions of correspondence (SSI 408 and 466). This includes the conditions for implementation of the measures and the withholding of postal packets to and from an individual.

- Section 284: this regulates the prohibition and restrictions of the use of telephones (SSI 468). This includes conditions for implementation, review, exclusions, record keeping, notification and right of appeal.

- Section 286: this regulates safety and security in hospitals. This includes prohibition and restrictions in relation to searches, taking of samples, possession of certain items, visitors and surveillance (SSI 464).

All those in the State Hospital are automatically designated as specified persons in respect of all restrictions. For individuals who are in designated medium secure facilities[3], they are specified persons in respect of Section 286: Safety and Security. People in these settings need to be individually specified by the RMO (Responsible Medical Officer) for any other restrictions that are put in place. All others detained in hospital have to be individually specified if the RMO considers that restrictions are required.

Therefore, all low secure facilities, IPCUs, acute admission and any other wards should make decisions about specifying individuals who are detained in hospital under the 2003 Act, and implementing these regulations on an individual basis. This should only take place after the RMO has recorded a reasoned opinion that sets out the risk to the person or to others were these restrictions not put in place. In general, making a detained patient a specified person allows for the specific restrictions required to be in place for a period of up to six months.

It should be remembered that the principles of the 2003 Act apply in the application of all of its many parts and their associated regulations. Therefore, the principles of least restriction and of patient participation are of particular importance in the implementation of these regulations.

[2] Scottish Statutory Instruments http://www.legislation.gov.uk/ssi 2005 SSI 466, SSI 464
[3] At the time of these visits, the Orchard Clinic, Rowanbank and Rohallion units

Where restrictions are introduced, it is also important to consider human rights legislation. All actions must accord with the articles of the European Convention on Human Rights.

Relevant articles in use of Specified Persons include:

- Article 3: the right to be free from inhuman or degrading treatment, specifically where this is grossly humiliating or undignified and may cause psychological harm.

- Article 6: the right to a “fair trial”. This includes the right to a fair procedure in relation to civil rights and liberties. This would include the right to legal representation and an independent opinion.

- Article 8; the right to respect for private and family life. Any interference with Article 8 rights must be necessary, proportionate, pursue a legitimate aim and be in accordance with the law.

3. How we carried out Specified Person visits

From June 2013 to October 2013, we conducted a series of unannounced visits to psychiatric hospitals throughout Scotland. We identified hospitals where there was a likelihood of finding people who were specified persons. We did not inform these wards in advance that we were visiting. Visits were carried out by our medical, nursing and social work practitioners.

We asked the senior member of staff on duty to identify people who were designated as a Specified Person, under the 2003 Act. We also asked staff to identify individuals who were not specified but who nevertheless had restrictions placed upon them. We spoke with the nursing staff, examined the care file and met with the person where appropriate. Finally, we discussed those individuals' care and the operation of the legislation with key members of staff on the wards. We also checked that the care and treatment the individual was receiving was consistent with the documentation and that the restrictions were in keeping with the principles of the 2003 Act and with the individual's human rights.

Where we had concerns about treatment that appeared to us to be unlawful or out of keeping with the principles of the 2003 Act, we raised this immediately with staff on the day of our visit and wrote to the person's RMO. We also gave advice to the nursing/care staff and doctor if we considered that the documentation was not completed in line with best practice guidance. We then collated all of the information and examined the data in order to determine our findings and recommendations.

4. General findings

We visited134 individuals, in 65 wards in 27 hospitals across 10 health boards, and examined in detail their care files (15 women and 119 men). The smallest service we visited was an NHS learning disability unit with three beds. The largest service was a 28 bedded adult acute admission ward.

We visited several types of ward: adult acute admission; learning disability; rehabilitation; IPCU; and low secure forensic. We excluded visits to medium and high secure wards where individuals are automatically specified persons for certain things under the 2003 Act.

The majority of the individuals we saw were men (89%, 119) and just 11% (15) were women. More than half (54%, 73) of the individuals we saw were aged 25-44; 34% (45) were aged 45-64; just four were older than this and 8% (11) were aged under 24, including two individuals, both female, aged 16-17 years.

Specified persons were detained in hospital in roughly equal numbers under the Criminal Procedures (Scotland) Act 1995 (47% (63)) and under the Mental Health (Scotland) Act 2003 (43% (58)). Two people with restrictions were subject to the Adults with Incapacity (Scotland) Act 2000. That leaves 8% (11) who were in hospital on a voluntary basis with restrictions applied.

5. Safety and Security

This section involves the RMO taking measures to ensure safety and security in the hospital (i.e. searching patients and their belongings, taking samples, searching their visitors, restricting access and carrying out surveillance during visits).

Of the individuals visited, 75% (101) were specified persons for safety and security reasons. The identified risks ranged from: alcohol and substance misuse; use of weapons; self harm using sharp objects; fire risk; and being supplied with illicit substances by visitors. We found that there was a lack of knowledge about the reasons for implementation of Specified Persons measures.

One individual, who was unclear about what it meant, told us that as a specified person

"...you 'do what you're told' and 'every guy gets this'. He thought it was to do with those who take drugs. "

More worryingly, the nurse in charge of this ward thought all individuals in this low secure unit were automatically specified persons.

The measures employed included: room searches; rub down searches; removal of mobile phones, iPads and iPhones; and urine tests for alcohol/drugs.

Some searches were carried out when the individual returned from agreed time out of the hospital, others were carried out at regular times or often at random times. One visitor commented in one case involving random searches

"I was told by the ward manager that (the) room searches (were for) for drug screening. "

However, the visitor found nothing in the individual's notes to indicate when this happened and no reasoned opinion for it to continue.

Visitors also found someone with:

"....a history of using weapons and illicit drug misuse so is subject to searches."

And another person where

"the Care Programme Approach minutes indicate that he has restrictions "as per ward protocol" on telephone use, letters, room and personal searches, alcohol and drug testing, access to sharps and utensils and visitors."

We have concerns from these comments which indicate that there may be serious breaches of human rights occurring with no legislative authority to support the actions of staff.

6. Use of telephones

This section involves the restriction of making and receiving telephone calls. Where restrictions are deemed necessary, and where these cannot be implemented with the agreement of the person concerned, then the RMO has to have recorded a reasoned opinion which supports the restrictions imposed. The reasoned opinion has to have been made in the last six months.

The RMO must determine that "a telephone call made to or by the person detained may cause distress to the person detained or to any other person who is not on the staff of the hospital, or is a significant risk to the health, safety or welfare of the person detained or the safety of others".[4]

This restriction prohibits the person from using the telephone, or restricts the number, frequency or duration of calls made for a period not exceeding 3 months.

Around one in five individuals (26%, 29) specified had restrictions in the use of telephones. The following are some appropriate examples of how this occurred in practice.

We were told in one ward:

"Staff are always present in the room. The call is not on speaker but if necessary staff will dial the outgoing number and check the person is happy to receive the call".

We were told in another ward:

"Calls to his family are restricted and will be within agreed parameters regarding timing and frequency as stated in his care plan... to reduce the risk of him getting money and alcohol from others. "

One individual had restrictions as a result of

".....making sexually explicit phone calls."

[4] Scottish Statutory Instruments http://www.legislation.gov.uk/ssi 2005 SSI 468

7. Correspondence

Sections 281 to 283 of the Act make provision for the managers of a hospital to withhold the mail of patients who are specified persons in certain circumstances. The duration of a reasoned opinion is six months. The RMO is, however, expected to keep the necessity for designating the person as "specified" under review during this time.

Where mail is withheld, hospital managers are required to notify the Commission within seven days of the reasons for withholding the item and the nature of the contents. They must also notify the individual (in the case of mail sent to the individual, the person who sent the item must be informed) and must ensure that the individual is aware of their right to apply to the Commission to have the decision to withhold the item overturned.

Only 10% (11) of individuals had restrictions for correspondence. This normally resulted from a complaint made by an individual recipient of letters. One person had

" a history of sending sexually explicit mail to vulnerable persons. "

In another case, there was an

"entry in the notes that a member of the family telephoned to say (the individual) is phoning her all the time, threatening to kill her and she wants her to stop phoning. "

This form of restriction is dealt with in a number of ways, for example:

"(Individuals) are informed they will have correspondence restricted by the RMO who will then tell them how this will be carried out and why. If we receive correspondence for the person we usually open it in front of them in an interview room with 2 members of staff present."

8. Notification of Specified Persons

Where the RMO decides that restrictions should be applied, they must first designate the individual as a specified person.

Hospital managers are required to inform the Mental Welfare Commission of:

- *each specified person (using a RES 1 form);*

Only 81% (99) of files examined had the necessary RES1 forms in place indicating that the person was specified.

- *each review of the specified person's status (using a RES 2 form). The individual is entitled to a review of a reasoned opinion once during each six month period;*

The RMO has a duty to record a reasoned opinion that restrictions or prohibitions are required. 26% (32) of 121 files had the required RES2 form giving notification of a reasoned opinion.

- *any specific restrictions in respect of the use of telephones (using a RES 3 form);*

The only exceptions to notifying the individual of restrictions or prohibitions is where, in the opinion of the RMO, it would be prejudicial to the person's health or treatment. 15 files had RES3 forms notifying of restrictions in use of telephones. This accounts for only 50% of those who had legally authorised restrictions in place.

Visitors commented on examples of poor practice

"There were no RES1 forms held on the ward, only copies of reasoned opinions. There was no RES3 form for the individual for whom telephone calls had been restricted."

"I can see no mention of a reasoned opinion or reasons why he should be specified. Entry in CPA that he has harassed and stalked people, but that is not tied in with the reasons for being a specified person."

"I reviewed the care plan, MDT notes and medical records, there was no concise summary giving a reasoned opinion but there were various entries recording the ongoing areas of concern which would be attributable for him continuing to be specified. "

"There is an un-dated care plan for samples and searches, no RES 1 and no reasoned opinion."

9. Review of Specified Persons

The regulations state that the RMO, within the six months prior to any restriction being implemented, must have recorded a reasoned opinion that, without restrictions being in place, there would be a risk to the individual or to others.

Hospital managers are also required to inform the person specified and their named person that they are entitled to one review of the reasoned opinion in any six month period.

The specified person can request a review of the particular restrictions or prohibitions on use of telephones once every three months.[5] The specified person can also ask the Commission to review the restrictions placed. The MWC can review restrictions but does not have the power to review the specification of an individual patient. We can, however, direct hospital managers not to implement restrictions or prohibitions where we believe they are inconsistent with the principles of the Act.

Only two individuals we visited had requested a review of prohibitions and restrictions on use of telephones by the RMO (RES3A).

Three had asked for a review of restrictions of correspondence (RES6).

Nine individuals had requested a review of Specified Person status and in seven of those, there was evidence that the RMO had recorded that a review had been carried out.

In only 40% (30) of files was there a record of a reasoned opinion by the RMO in the previous six month period.

None of the individuals visited had requested a review by the Commission.

One visitor commented on a person's status

"He had no idea what I was talking about. He had not been told he was a Specified Person and had clearly never been informed of his status. There was no reasoned opinion in the notes, so I explained what it was about but could not tell him why (he had been specified). "

Of those 65 specified persons who were interviewed, 60% (39) of individuals reported that they knew they were specified. 28% (18) were unsure. Eight individuals who were specified said they weren't.

Around a half, 51% (33) said they knew why they had been specified. 17% (11) weren't sure and 28% (18) did not know why.

A majority, 65% (42) of individuals who were specified said that restrictions applied to them. Nine were unsure. Ten said restrictions did not apply.

[5] Scottish Statutory Instruments http://www.legislation.gov.uk/ssi 2005 SSI 468,

Visitors to wards found some discrepancies with regard to restrictions, for example.

“The Ward Manager thought three patients were specified person's but all their paperwork was out of date. These people had had routine drug screening and room searches”

“Mr A had no idea what I was talking about. He had not been told he was a SP and had clearly never been informed of his status. There was no reasoned opinion in the notes”

We followed up any instances of unlawful practice uncovered on visits.

One individual, who said he had a criminal past, was further confused stating

"I have prisoner status".

According to our visitor, another individual was

“unsure but understood it is mainly to ensure he does not have inappropriate images on his phone. “

In another ward, the visitor noted questionable practice. The specified person status

“had not been renewed, but (the individual) is showing staff letters sealed in addressed envelopes before he posts them, on a voluntary basis. “

Visitors found that 29% (19) of individuals knew they could ask for a review. 12% (8) were unsure. 58% (38) did not know about the review process. Only five had asked for a review. 25% (16) knew what to do if they still objected after review.

One visitor noted a

“letter in the file explaining he had been made a Specified Person but did not contain information on right of appeal“

A small percentage 18% (12) said they had received written information on right of appeal. 26% (17) were unsure whether they had received this. 56% (36) had not been given anything.

“Mr B had a letter on him that stated that his designation as a specified person had just been reviewed and would continue.”

“He quickly responded indicating he was specified and knew why so.”
“It has never been explained to me. “

Only 18% (12) had concerns about the restrictions. 72% (47) did not have concerns.

In 18% (12) of cases we felt restrictions were not being carried out lawfully. In 18% (12) of individuals visited, we raised issues on the day. Additional follow up was carried out on a further 12% (16). Here are some examples of action taken.

“Staff are under the impression that he is a specified person. However, notification to MWC is now more than 6 months old. A letter was sent to the RMO to seek clarification of status. “

“The Ward Manager thought all were specified persons but all their paperwork was out of date. These people had had routine drug screening and room searches. A letter was sent to the RMO to ask that these individuals are informed of their legal status.”

“Following discussion it transpired the nurse in charge thought everyone in the low secure unit was automatically subject to specified persons. I clarified our view that there should not be a blanket policy but applied individually.”

“Whilst the nurse in charge told me the patient was a specified person, the RES 1 was undated and unsigned by the doctor and there was no current reasoned opinion in the notes. I discussed my concerns with the deputy charge, service manager and consultant on the day and followed up with letter to RMO and service manager. “

10. Views of nursing staff

When asked, 33% (22) of staff interviewed stated that they did not have a ward policy on carrying out room searches.

Of the wards visited, 16% (24) did not have a policy on use of mobile phones with 61% (41) not having a policy on use of telephones.

Interestingly, 76 % (51) of wards stated they had access to the Mental Welfare Commission's guidance document on Specified Persons.

We found that 51% (34) of staff interviewed had never had training in use of specified persons with 36% (24) saying there were aspects of the legislation which were not clear to them when putting the restrictions into practice. In 60% (40) of visits, Commission staff provided information, clarified understanding of the legislation or offered comments on individual RES forms. Nurses were often unsure of how they were supposed to apply the measures, or how to respect the individual's rights.

One nurse said she was

"Not entirely clear on the process of appeal but the doctor is aware of these and visits regularly".

Only 28% of wards (19) said they had written information which they gave to individuals who had been made specified persons. We found examples of the leaflets in only 11 wards.

Between 57% (38) and 72% (48) of staff were aware that, if the individual opposed the restrictions, their RMO, a mental health advocate, a solicitor or the Commission could be contacted if they wanted to seek a review.

11. Actions taken by the Commission

We took various forms of action based on the findings from our visits. This was often carried out at the time of the visit. In other instances, we wrote to the relevant clinician or manager with our recommendations.

We wrote to the RMO regarding legal authorisation when we found restrictions in place but no mental health act documentation in support for people who had been detained. In most cases, the authority to carry out restrictions had expired without staff being aware of this.

Additionally, we wrote to seek clarification of the authority to place restrictions where this applied to individuals who were not detained under the 2003 Act. In some cases, staff stated that the restrictions were authorised by welfare guardianship powers. We do not believe that Adults with Incapacity powers authorise such restrictions.

We followed up on cases: where forms were either inaccurate or incomplete; where authority to restrict or prohibit may have been legally challengeable; and where it was unclear how the measures were being implemented.

12. Conclusions

Some individuals in hospital on a voluntary basis had restrictions or prohibitions imposed. In most cases, these restrictions placed on individuals were not legally authorised.

Searches of individuals and their belongings were not always legally authorised. In addition, a large number of wards had no local policy or procedure for such searches.

Where telephone calls were restricted, calls which are permitted under the 2003 Act e.g. to a solicitor were very often monitored by a member of staff sitting in the room with the individual, thereby affording little privacy. Nursing staff were frequently unable to locate a local policy either on use of telephones or use of mobile phones.

Nurses were generally unclear about the implementation of measures involved with specified persons and demonstrated the need for further training in this area of practice. In many wards, the measures are very seldom used and knowledge is, thereby, easily forgotten or lost.

A record of notification of specified persons could not always be located in the person's file. A record of a reasoned opinion was even less frequently found and often located amongst daily entries in the file continuation notes where it is difficult to locate. Therefore, it is no surprise that many nurses were sometimes unsure of a person's status as a specified person.

There was a general lack of knowledge of the right of appeal against restrictions, both from individuals and from staff. Very few individuals we visited had exercised their right of appeal. Many did not know their status and others denied they were specified persons when there was clear documentary evidence that they were. Nursing staff were equally unsure and in some cases incorrect when asked about certain individuals' status.

Very few individuals were given written information about specified persons, either at the outset or following a reasoned opinion. Little mention was made of mental health advocacy involvement in assisting individuals, especially those who lacked capacity, with issues in relation to restrictions and prohibitions.

13. Recommendations

1. Managers should carry out a training needs analysis amongst their staff to determine the level of training requirements in this area of mental health law.

2. The provisions of sections 281-286 of the 2003 Act, and the accompanying regulations, should be included in training programmes and Continuing Professional Development for staff working in mental health and learning disability hospital settings.

3. The current 2003 Act Code of Practice should be made available and staff should know how to access it in all hospital settings where specified persons restrictions or prohibitions may be in use.

4. Services should ensure that they have the necessary notification forms in place in the wards and that all reasoned opinions made by the RMO are available and easily accessible.

5. All individuals who have been designated as specified persons should receive written information about any restrictions, timescales involved and about their right of appeal. Mental health advocacy should be involved in helping individuals to understand the role and implications of specified person designation and in protecting their rights under the 2003 Act.

6. All mental health and learning disability hospitals should make available, for the guidance of their staff, policies and procedures in relation to: searching an individual and their belongings; restrictions on visitors; use of telephones; use of mobile phones and other electronic communication media; and the taking of samples.

7. Hospital managers should carry out a regular audit of compliance with sections 281-286 of the 2003 Act and with the implementation of the aforementioned recommendations.

14. Appendix 1

Number of individuals visited by hospital

Hospital	Individuals
AILSA	7
ARROL PARK RESOURCE CENTRE	1
AYR CLINIC	5
BECKFORD LODGE	15
BELLSDYKE	11
BLYTHSWOOD HOUSE	1
CARSEVIEW CENTRE	4
DYKEBAR	14
FORTH VALLEY ROYAL	1
GARTNAVEL ROYAL	2
LEVERNDALE	29
LOCHVIEW	1
LYNEBANK	7
MIDPARK	1
MURRAY ROYAL	2
NETHERTON UNIT	3
NEW CRAIGS	3
ROHALLION	2
ROYAL CORNHILL	8
ROYAL EDINBURGH	6
STOBHILL	1
STRATHEDEN	8
SUREHAVEN	1
WATERLOO CLOSE	1
Total	**134**


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