

GOOD PRACTICE GUIDE

Human Rights in Mental Health Services

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 is 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.

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A stylized landscape illustration in shades of pink and purple. It features a winding road with a dashed white center line that starts from the top left, curves down, then right, then down again, and finally right towards the bottom right. The background is filled with various rounded, hill-like shapes in different shades of pink and purple. The overall style is minimalist and modern.

INTRODUCTION

**EMBEDDING HUMAN
RIGHTS IN MENTAL
HEALTH CARE DELIVERY**

i. About this guide

This guide is written for staff in hospital and community teams. It aims to explain how and where human rights impact on mental health care delivery and how staff can best ensure that the key rights at each stage of the pathway through mental health care are respected and promoted.

The guide has been written in consultation with mental health care practitioners, users of services, patients, and patients' relatives who have direct experience of adult acute settings, but it may be useful for other areas of mental health care and other patient groups too. We hope it will also prove useful for service users themselves, and the carers and family members who support them.

Using this guide

This guide explains the background to human rights in mental health care and looks at each of the rights set out in the **Rights in Mind** pathway to patients' rights in mental health services. There is a section for each stage, from community through admission to hospital care, time on the ward and discharge. The guide also sets out overarching rights that apply across all of these stages.

The guide is designed to be used in two ways:

1. As a **reference guide** to which rights are most relevant at which stage and why, and to understanding human rights. The aim is to provide a useful resource with easily located information on particular rights and a straightforward explanation of where human rights come from.
2. As an **improvement resource** for services. We encourage staff to reflect on their policies and practice, and to use the guide and accompanying **Rights in Mind** booklet and videos as a resource for training and discussion, and to select areas to focus on for improvement. The Scottish Patient Safety Programme – Mental Health (SPSP)¹ can offer support to services in the design and implementation of small tests of change based on this guidance.

Any mental health care practitioner with concerns about human rights being abused, or not being upheld, should raise the issue with their own management team in the first instance. Advice on the practical application of a human rights-based approach is available from the Commission's advice line on 0131 313 8777.

What this guide does not do

The rights outlined in this guide apply to everyone. However, they have been selected as key rights based on our work with people using, and working in, adult acute services. For other groups, such as people with dementia or learning disabilities, or for children, there may be other rights that are equally important but which are not covered here. This guide focuses on a broad range of rights and does not cover the detail of rights relating to detention under the Mental Health Act. For more information on these rights, please see the Mental Health Act Code of Practice.²

1 Scottish Patient Safety Programme – Mental Health (SPSP) aims to systematically reduce harm experienced by people receiving care from mental health services in Scotland by supporting frontline staff to test, gather real-time data, and reliably implement interventions before spreading those across their NHS board area. <http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mental-health>

2 <http://www.gov.scot/Topics/Health/Services/Mental-Health/Law/Code-of-Practice>

ii. The origins of Rights in Mind: A Pathway to Patients' Rights in Mental Health Services

Public bodies and government officials are primarily accountable for ensuring that people's human rights are respected in society and this includes organisations such as the NHS and local authorities. But upholding these rights in the field of mental health care can often be challenging. How can we ensure that the human rights of people receiving treatment and care for mental health issues are applied sensitively, appropriately, and with due respect for dignity?

As the Mental Welfare Commission for Scotland (the Commission), we receive numerous queries from mental health care practitioners, carers and patients in relation to human rights, particularly around how and when to advise mental health service users of their rights and how to observe and apply those rights effectively within professional practice.

Establishing a clear pathway

Individuals accessing adult acute mental health services – whether in a community or hospital setting – may be less able than others to safeguard their own interests. This can raise many challenges, particularly as patients may experience a complex journey incorporating admission to hospital, staying in hospital, being discharged from hospital and/or being treated within a community health care setting. To address this, we developed **Rights in Mind: A Pathway to Patients' Rights in Mental Health Services**.³

Making human rights clear for all mental health care providers

We know that mental health care practitioners are keen to observe and uphold their patients' fundamental human rights but may not be familiar with them or understand their origins. We also know that human rights can sometimes be confused with simple examples of good practice. And we know that the language of human rights can sometimes be overly complex and packed with jargon. This good practice guide aims to make the challenging issues of human rights in a mental health care setting much more accessible and therefore more straightforward to understand and apply in practice.

Respect for human rights

We firmly believe that respect for human rights can and should:

- inform **decision-making**,
- develop better **participation** for patients,
- foster strong **working relationships**, and
- ensure that care is **personalised**.

Our long-term aim is that a robust and widely understood human rights-based approach, and the **Rights in Mind** pathway itself, influence and become embedded in mental health care delivery, ultimately contributing to a broad cultural change.

Embedding a human rights framework in policy making

Rights in Mind emerged from a demand for information from mental health care practitioners and from the Commission's findings from visits and casework. It is underpinned by important policy developments

³ http://www.mwscot.org.uk/media/367147/rights_in_mind.pdf

at a governmental level too. Human rights were a key theme of the Scottish Government's Mental Health Strategy 2012-2015 and Commitment 5 of the strategy stated:

"We will work with the Scottish Human Rights Commission and the Mental Welfare Commission for Scotland to develop and increase the focus on rights as a key component of mental health care in Scotland."

Other developments in relation to a human rights-based framework include the new National Care Standards,⁴ the Patient Rights (Scotland) Act 2011 (which introduced a Patient Charter)⁵ and the Rights for Life⁶ work developed in partnership between the Scottish Recovery Network, See Me and Voices of eXperience (VOX).

The Scottish Government published its Mental Health Strategy 2017-2027 in March 2017. It states:

"Our vision for the Mental Health Strategy is of a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma."

A human rights-based approach is intrinsic to actions in the Strategy.⁷

Informing and testing Rights in Mind

To inform **Rights in Mind**, we developed a project group with representatives from the Scottish Human Rights Commission, the NHS SPSP and the Royal College of Psychiatrists in Scotland. In March 2016, we undertook a consultation with individual patients and their carers, friends and family members, and mental health care practitioners.

Human rights in practice

We also asked two acute mental health admission wards to undertake test projects on improving practice around human rights and then report on impact. The methodology for this was drawn from SPSP's work in mental health settings and based on their mental health programme which aims to improve the safety of health care and reduce the level of harm experienced by patients using services. The SPSP mental health programme aims to cultivate learning for staff delivering care, as well as those receiving care and has five themes:

- communication at transition points such as admission and discharge;
- leadership;
- risk assessment and planning;
- safer aspects of medication; and
- a reduction in the number of instances of restraint, violence and seclusion.

SPSP has introduced a number of tools and techniques to support these principles and has adopted a human rights-based approach to this work.

4 <http://www.newcarestandards.scot/>

5 <http://www.gov.scot/Topics/Health/Policy/Patients-Rights>

6 <https://rightsforlife.org/>

7 <http://www.gov.scot/Publications/2017/03/1750>

We are grateful to the two mental health wards – Ward 1, Wishaw General Hospital and Ettrick Ward, Midpark Hospital, Dumfries & Galloway – who undertook the test projects. To help inform this work, senior charge nurses and other ward staff were present at the consultation event in March 2016. Prior to the test exercise beginning, ward staff met with members of the Commission to undertake a 'baseline session' on human rights. This involved working through a questionnaire on how human rights were currently being taken account of in a ward setting.

CASE STUDY 1: WARD 1, WISHAW GENERAL HOSPITAL

Improved information on advance statements

Ward staff decided to undertake work on advance statements as, in their experience, few patients were admitted with an advance statement in place and basic knowledge of this way of safeguarding rights was low among patients. The staff felt that giving patients the chance to express their wishes about treatment was helpful but that the best time to write the advance statement was post-discharge when patients had recovered and felt better informed in relation to their care. To address this, ward staff:

- carried out a questionnaire with patients about their knowledge and experience of advance statements; and
- incorporated discussion and information on advance statements into existing ward recovery group sessions (these run twice a week with an average of 10 patients per group) with the support of the local advocacy service, a patient on the ward who volunteered to help, and a peer support worker.

As a result, the groups devised a template for writing an advance statement and, having discussed the best times to complete this, ward staff then made follow-up phone calls to patients after their discharge from hospital to see if they had completed their statements. Staff now feel that discussion about advance statements is a clear part of ward policy. They also feel that having that discussion during recovery group sessions means that it takes place at a key point in each patient's recovery. Ward staff are also keen to embed the follow-up phone call as part of their practice.

CASE STUDY 2: ETRICK WARD, MIDPARK HOSPITAL, DUMFRIES & GALLOWAY

Improved information on informal rights

Ward staff felt that they were confident about informing detained patients about their rights, but less so with informal patients. In response to this, the following measures were put in place:

- a small working group was established to oversee the project and monitor progress;
- staff meetings and questionnaires were introduced to assess current staff knowledge of informal patients' rights; and
- feedback was taken from patients via meetings and a questionnaire.

As a result, a patient information leaflet on rights for informal patients (*Being an informal patient – what are my rights and what can I expect?*) was developed with input from key stakeholders. It is now used as part of the ward admission process with each admission nurse talking through the information with each patient. Ward staff can now deliver consistent information to patients at this key stage and have a useful resource that they can revisit. Feedback indicates that this has not only been beneficial for patients but has improved knowledge among ward staff. The ultimate aim is that this leaflet will be used in other wards in the hospital.

Resource materials

The outcomes of the consultation and ward test projects have helped the Commission to produce a series of videos relating to rights in practice, this good practice guide and a Rights in Mind tool for staff, which is also a useful resource for patients and carers. These three resources can be used alone or together to support staff to consider their practice, and to inform discussion and the practical application of a human rights framework as part of standard mental health care delivery. The pathway will be further tested through our programme of visits, where staff and patients will be asked how human rights are being respected and promoted in practice.

iii. Establishing a clear understanding of human rights

We all have human rights. These are basic rights and freedoms, based on our common humanity. Human rights are outlined in law and they set out a minimum standard for how we should all be treated by state organisations, including the NHS and local authorities. At an individual level, while we are all entitled to respect for our own human rights, we should also respect the rights of others.

Human rights apply to everyone, regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. They cannot be taken away except in specific, pre-determined situations and according to law. However, it's important to recognise that there are different types of rights, in particular there are **absolute rights** and **qualified rights**.

Absolute rights 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 can be restricted in certain circumstances and within limits – for example the right to respect for private and family life and the right to freedom of expression. Human rights legislation and international treaties establish whether public bodies (such as NHS Scotland) can legitimately interfere with a right, in order to protect the wider public interest.

Proportionate restriction of human rights

Within this guide, we explore a number of situations in which key human rights need to be restricted, usually to protect an individual with mental health issues or to protect others who may be affected by that individual's actions or behaviour.

Bear in mind, when thinking about restricting rights, that any action should be **proportionate**. This means that mental health care practitioners must be able to show that they have taken the individual's rights into account, and that any restriction is kept to the minimum possible and is never excessive – in other words, is in proportion to the circumstances. In a hospital setting, any restrictive policies should not adopt a blanket approach that affects all patients, but should be assessed and applied on an individual and proportionate basis.

How human rights are protected by law

In Scotland, human rights are protected by the European Convention on Human Rights (the 'ECHR'), the UK Human Rights Act 1998 and the Scotland Act 1998. The law applies to everyone equally and provides an important means of protection for the most vulnerable people in our communities, as well as a means of defining our individual and collective responsibility to uphold them.

1. The European Convention on Human Rights

The ECHR is made up of a series of articles, with each article being a short statement that defines a right or freedom, together with any permitted exceptions. These rights apply to everyone in the UK.

2. The UK Human Rights Act 1998

This Act brings most of the fundamental rights and freedoms contained in the European Convention on Human Rights into UK law. The rights included here affect the rights that everyone has in their day-to-day life including, for example, the right to family life, a fair trial, and what you can say or do. Most rights have limits to ensure that they do not unfairly infringe upon other people's rights. Others, such as the right not to be tortured, can never be limited by a court or anyone else. Cases based on the UK Human Rights Act 1998 can be argued in a UK court or tribunal and, in addition, all other legislation should be interpreted and applied in a way that is consistent with it.

3. The Scotland Act 1998

This Act ensures that the Scottish Parliament can only pass laws that are compatible with human rights and do not contravene the UK Human Rights Act 1998 or the ECHR. It means that these rights must be respected and realised at all levels in Scotland.

4. The UN Convention on the Rights of Persons with Disabilities

Although it is not part of domestic law in the Scotland, the UN Convention on the Rights of Persons with Disabilities (UNCRPD) can help us to understand and interpret the rights established in the UK Human Rights Act 1998, with respect to people with disabilities. It's one of the important international treaties that the UK, including Scotland, has signed up to. It details what should be done to break down the barriers which people with long-term physical, mental, intellectual or sensory impairments may face in realising their human rights.

The UNCRPD makes it clear that people with disabilities have the same rights as everyone else and sets out in some detail how to respect, protect and fulfil those rights. The UNCRPD has also highlighted the right of people with disabilities to legal capacity and calls for a fundamental move away from decisions being made on behalf of a person whose decision-making ability may be impaired (substituted decision-making)⁸ towards greater respect for their will and preference, with more emphasis on supporting them to make decisions themselves, even in complex situations.

Assignment of duties under the UK Human Rights Act 1998

Only public authorities and bodies exercising public functions have legal duties under this law. These include:

- NHS organisations and staff
- The police
- Local authorities and their employees
- NHS and private nursing and care homes, funded by public funds
- Prison staff
- Courts and tribunals including Mental Health Tribunals.

How duties under the UK Human Rights Act 1998 work

Duties are guided by three types of action – respecting, protecting and fulfilling human rights.

Respecting human rights

This means not doing something that restricts an individual's human rights or prevents their enjoyment of them. For example, being treated with dignity and respect and being free from inhuman and degrading treatment.

Protecting human rights

This means that public authorities must take action to prevent human rights abuses, which can mean taking positive action to ensure that rights are not infringed. For example, under the right to life, positive action should be taken to prevent danger, which would include protecting people from harm including, in some circumstances, self-harm.

Fulfilling human rights

This means that public authorities should take steps to strengthen access to human rights including having systems in place to prevent or investigate human rights abuses. Hospitals should have clear policies as to how patients can make complaints if they are not happy with their treatment.

8 Refer to the Commission's *Guidance on Supported Decision Making* [http://www.mwscot.org.uk/media/348023/mwc_sdm_draft_gp_guide_10_post_board_jw_final.pdf] which explains it in more detail.

iv. Identifying key human rights in mental health care settings

The EHCR, other treaties and the law in Scotland contain rights which are very specific to mental health settings, as well as overarching rights which should be enjoyed by everyone. The following articles from the ECHR express the key rights for individuals in mental health care settings.

In this good practice guide, we apply these articles to the patient journey, as set out in the **Rights in Mind** pathway, for individuals being treated in the community, being admitted to hospital, spending time on a ward and preparing for discharge. Some rights are more relevant than others at different points on the pathway and we highlight good practice or use case studies to demonstrate this.

The UK is a signatory to the ECHR, and this is independent of the European Union. Rights under the ECHR will not be affected by the UK leaving the European Union.

Article 2: The right to life

The right to life is an **absolute** right, which means that there is a duty not to take away anyone's life and a duty to take reasonable steps to protect life.

- » **Mental health care practitioners** have a duty to do all they reasonably can to prevent a patient from seriously harming themselves or attempting or completing suicide.

Article 3: The right not to be subjected to torture or to inhuman or degrading treatment or punishment

Inhuman treatment is that which causes severe mental or physical harm; degrading treatment means treatment that is grossly humiliating and undignified. Duties under this right not only include refraining from an action or omission that results in inhuman or degrading treatment but also taking positive steps to prevent ill treatment, to protect those at immediate risk of ill treatment, and to provide effective remedies wherever it occurs. The UK's National Preventive Mechanism (NPM) was established in March 2009 after the UK ratified the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)⁹ in December 2003. It is made up of 21 statutory bodies that independently monitor places of detention. The Commission is a member.

- » **Mental health care practitioners** have a duty to recognise abuse or neglect when it occurs and to carefully consider any use of force or restraint, which must be proportionate.

Article 5: The right to liberty and Article 6: The right to a fair trial

Under Article 5, everyone has the right to liberty; however, there are certain circumstances where it would be appropriate for this right to be limited. Being detained in a mental health ward is an example of this. However, detention cannot be arbitrary and should always be justified in law and the proper procedures followed, such as authorisation by a Mental Health Tribunal. Detention under mental health law does not in itself breach the right to liberty unless it is unlawful.

9 <http://www.nationalpreventivemechanism.org.uk/>

Under Article 6, everyone has the right to a fair trial by an independent and impartial tribunal established by law. Although it refers to a 'trial', this article includes other kinds of hearings, and means that people must have the opportunity to be supported and legally represented at Mental Health Tribunal for Scotland hearings. They have the right to an advocate and they have the right to a solicitor, with the cost covered by Legal Aid.

- » **Mental health care practitioners** have a duty to ensure that patients are not unlawfully detained and that when they are detained, they are aware of their right to legal representation and their right to advocacy is respected so that they can challenge any issue in relation to their own freedom.

Article 8: The right to private and family life

Everyone has the right to respect for their private and family life, including their correspondence. There can be no interference by a public body in the exercising of this right except for the protection of health, or the protection of the rights and freedoms of others. This right is very broad in its scope and can cover many situations. Importantly, it covers the right to physical, psychological and moral wellbeing, with the right to wellbeing upheld through retaining autonomy, choice and dignity. This means allowing access to information and participation in decisions that affect an individual's life.

- » **Mental health care practitioners** should recognise that **private life** means life inside and outside an individual's private home and so includes a hospital setting; **family life** covers all close and personal ties of a family kind (not just those of a formal, blood relationship) and therefore links with friends and the local community should be respected when patients are in hospital. Restrictions such as room searches, monitoring calls and contacts must be thought through and the law applied if necessary. Lastly, **correspondence** covers all forms of communication with others including phone calls, letters and e-mails. The Mental Health (Care and Treatment) (Scotland) Act 2003 ('the 2003 Act'), Sections 281 and 286, and the associated regulations, provide guidance on which restrictions can be made in these areas – there is often wide variation on how these are interpreted, so please refer to the Commission's *Specified Persons Guidance*.¹⁰

Article 9: The right to freedom of thought, conscience and religion

Everyone is free to hold a broad range of views, beliefs and thoughts, and to follow a religious faith. However the right to manifest this – that is, the right to practice a faith through, for example, prayer or diet; or the right to show a faith through, for example, dress – can be limited in certain circumstances. Such limitations are prescribed by law; they are necessary in the interests of public safety, the protection of public order, health or morals, or the protection of the rights and freedoms of others.

- » **Mental health care practitioners** should incorporate respect for cultural and religious requirements – for example, giving patients the opportunity to pray or supporting their dietary requirements – and detailing these observations in individual care plans.

¹⁰ http://www.mwscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

Article 14: The right not to be discriminated against

The enjoyment of rights and freedoms should be secured without discrimination on any ground including the nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) defined under the Equality Act 2011.

- » **Mental health care practitioners** must ensure that individuals are not denied treatment – for example, in relation to their age – and that treatment is appropriate to, and respectful of any protected characteristics – for example, providing non-English speakers with interpreters or acknowledging and respecting sexual orientation. Practitioners should aim to recognise those service users who are particularly marginalised or may face extra barriers – for example, refugees or asylum seekers or people with learning disabilities.

A further article, specific to mental health settings, comes from the UN Convention of the Rights of People with Disabilities and while it is not part of domestic law in Scotland, it still applies because the UK has ratified the Convention.

Article 25: The right to the highest attainable standard of physical and mental health

This concerns the right to a range of goods, services and information needed for health and includes both a right to healthy living conditions and a right to adequate health care. It covers a wide range of health areas, including mental health, and makes it clear that health care should be available, accessible and acceptable to those receiving treatment and, in terms of ethics, should be of good quality.

- » **Mental health care practitioners** must ensure that patients have good access to a range of evidence-based treatments for physical as well as mental health conditions, information on health care and services delivered in an appropriate way. NHS boards must ensure that hospitals are kept in good condition.

v. Defining the principles of a human rights-based approach

A human rights-based approach is about increasing the ability – and accountability – of all mental health care practitioners to respect, protect and fulfil human rights. It is also about empowering individuals to know and claim their rights. It means that patients gain a stronger role in participation so that they can help shape decision making around their own care and treatment. In addition, it helps staff to recognise and respect their patients' rights and to make sure that they are accountable when observing these in their day-to-day role.

The principles of a human rights-based approach have much in common with the 2003 Act principles, however, it is important to remember that the Human Rights Act provides the overarching framework within which the 2003 Act must be applied.

A human rights-based approach is about ensuring that both the standards and the principles of human rights are integrated into policymaking as well as the day-to-day running of organisations.

PANEL is a useful, shorthand way to make these rights understandable and memorable for mental health care practitioners:

- **P**articipation
- **A**ccountability
- **N**on-discrimination and equality
- **E**mpowerment
- **L**egality

How to embed PANEL principles in day-to-day care delivery

Participation

Everyone has the right to participate in decisions that affect them. Participation must be active, free and meaningful, and give due attention to issues of accessibility, including access to information in a form and language that can be understood.

- » **Mental health care practitioners** must both allow and encourage individuals with mental health issues to participate in every decision about their care and treatment, ranging from attendance at multi-agency meetings, to involvement in their own care planning.

Accountability

Accountability requires effective monitoring of human rights standards that, in turn, require appropriate laws, policies, administrative procedures and mechanisms of redress in order to secure them.

- » **Mental health care practitioners** must take responsibility for ensuring that the standards of accountability for human rights are as high as possible in their practices and procedures. For example, practitioners must ensure that they adhere to procedures designed to protect human rights such as using specified person's regulations when restricting a patient's communications. In Scotland, there are a number of bodies who promote accountability in different ways, including the Mental Welfare Commission, Health Care Improvement Scotland (HIS) and the SPSP.

Non-discrimination and equality

A human rights-based approach means that all forms of discrimination must be prohibited, prevented and eliminated. It requires prioritisation of those people in the most vulnerable situations, who face the biggest barriers to realise their rights.

- » **Mental health care practitioners** should adopt a human rights-based approach by paying attention to the protection and realisation of the rights of individuals with mental health issues who require care and treatment and can be among the most marginalised and vulnerable people in our society. They are often discriminated against and stigmatised when accessing and using services or expressing their views.

Empowerment

People should understand their rights, be able to claim them when necessary, and be fully supported to participate in the development of policies and practices that affect their lives.

- » **Mental health care practitioners** should provide suitable advocacy support and establish strong links to advocacy services to ensure that all patients are informed about, and helped to understand their rights and how to claim them.

Legality

The full range of legally protected human rights must be respected, protected and fulfilled. A human rights-based approach requires the recognition of rights as legally enforceable entitlements and is linked to national and international human rights law.

- » **Mental health care practitioners** including NHS staff and all other accountable bodies (including hospitals) must be sure that their practices and procedures are grounded in human rights law which must not be breached. Key mental health legislation in Scotland is laid out in the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000, both of which have principles reflecting human rights. However, a human rights-based approach means practitioners engaging fully with the overarching rights framework and all its implications.



CHAPTER 1

OVERARCHING RIGHTS

All patients receiving mental health care have a number of key human rights. These overarching rights are applicable to all patients, regardless of whether they are detained under the 2003 Act or are informal (not detained) and whether they are being treated in the community or in a hospital. Some rights are clearly defined by law while others are not – such rights are equally important but perhaps easier to forget.

Many daily decisions made by mental health care practitioners (such as observation levels, the use of medication and restraint) carry human rights implications and it is vital that everyone is aware of them. In this chapter, we explore these overarching rights along with key pieces of law and policy. A number of these overlap and interact.

i. The key rights of all patients in all mental health care settings

- 1. Mental Health (Care and Treatment) (Scotland) Act 2003 principles**
- 2. The Patient Rights (Scotland) Act 2011**
- 3. Respect, dignity and compassion**
- 4. Discrimination**
- 5. Advocacy services**
- 6. Patient-focused, participative NHS care**
- 7. Liberty and lawful detention**
- 8. Adequate health care and protection**
- 9. Family and friends' involvement**

i. The key rights of all patients in all mental health care settings

Every patient, whether they are receiving care and treatment in a community or hospital setting, has rights and should be encouraged to exercise them. For every member of staff, knowing when to advise, support and encourage patients to exercise their rights is fundamental.

Patients' rights can be as simple as being treated with dignity and respect or as complex as a detained patient's right to appeal. A good understanding of all rights is a critical part of staff knowledge and everyone working in mental health care should be able to apply this in practice.

1. Mental Health (Care and Treatment) (Scotland) Act 2003 principles

- » **All patients have the right to be treated in line with the principles of the 2003 Act**

The principles of the 2003 Act¹¹ are clearly set out and form a framework for best practice. All mental health care practitioners involved in making decisions about care and treatment should observe these principles and:

- take the past and present wishes of patients into account;
- make sure patients get the information and support they need to take part in decisions;

- take the views of the patient's carer, named person, guardian or welfare attorney into account;
- look at the full range of care and treatment options that a patient might need;
- give treatment that provides the maximum benefit to the patient;
- take account of the patient's background, beliefs and abilities;
- ensure that patients receiving care and treatment under the 2003 Act are not treated less favourably than other people;
- take the needs of carers into account and ensure they too get the information and support they need;
- take particular care of the patient's welfare if they are under 18 years of age when receiving care and treatment; and
- ensure safeguards are in place to protect the patient's rights.

Although these principles are clearly defined for patients *detained* under the 2003 Act, they should be used as a benchmark for *all* patients who come into contact with mental health services. The principles reflect rights from the European Convention on Human Rights.

In day-to-day practice, these principles can be applied to a number of straightforward situations – for example, patients and carers participating in meetings, patients developing their own care plans, encouraging decision-making and the use of advocacy. This may be more relevant when patients are less able to engage or communicate due to their illness, or when their care becomes more complex and challenging. It's important to remember that all patients have the same rights, regardless of their mental illness or capacity but that more support, or tailored responses, may be required in such circumstances. Staff should use these principles as a benchmark alongside their own knowledge of key human rights to assist in such situations.

CASE STUDY 3

Managing the difficult transition from community care to hospital ward

Liz has received treatment for depression for a number of years with her symptoms tending to come and go. She feels well supported at home by community staff, has a good relationship with the GP who oversees her medication and is in regular contact with a community psychiatric nurse who involves her in decision making and gives her clear information and a good understanding of her illness. The nurse has also educated Liz on self-guided help when her mood becomes low, giving Liz an element of responsibility and control.

However, when Liz becomes very unwell, she is admitted to hospital as a detained patient and finds herself miles away from friends and family. She feels anxious and isolated on the ward. She wants to go home and is upset to be told by the ward staff that she is not able to leave. Liz is aware that the ward staff are kind and caring, but at her first weekly ward meeting she feels too low to contribute. She feels powerless when decisions are being made about her treatment, not fully understanding the reasons.

Ward staff realise that although Liz was given information about her detained status when she was admitted, she has forgotten this and become confused and stressed. Over a number of days, they take her through her rights as a detained patient until they are confident that Liz fully understands her situation. They help her to access advocacy services and the advocate is also able to support Liz to understand her rights and make her views known. As a result, Liz feels more in control once again and able to focus on her recovery.

2. The Patient Rights (Scotland) Act 2011

- » **All patients have the right to be treated in line with the Patient Rights Act Charter of Patient Rights and Responsibilities**

The Patient Rights (Scotland) Act 2011 aims to improve a patient's experience of using all health services and to support their involvement in their own health and health care. It is human rights compliant as it has a series of underlying principles and has introduced a right for all patients to receive the care that is of optimum benefit to them. The 2011 Act also encourages patients to take part in decision making and provides them with the right to give feedback, raise concerns and make complaints.

The Patient Advice and Support Service (PASS)¹² has been developed to provide independent advice and support for patients in this regard. In addition, the Charter of Patient Rights and Responsibilities¹³ was developed under the 2011 Act and summarises what patients can expect from their health care and also outlines their own personal responsibilities for maintaining good health. The Charter details these rights and responsibilities under the following themes:

- Access
- Communication and participation

¹² <http://www.patientadvicescotland.org.uk/>

¹³ <http://www.gov.scot/Resource/0039/00390989.pdf>

- Confidentiality
- Respect
- Safety
- Feedback and complaints

From a mental health perspective, these rights and responsibilities are equally applicable to all patients. Mental health care practitioners should be aware of them and consider how they dovetail into the principles of the 2003 Act. They should also be able to signpost patients to appropriate services when they need to comment on their care and treatment, both positively and negatively.

3. Respect, dignity and compassion

» All patients have the right to be treated with respect, dignity and compassion

The right to be treated with respect, dignity and compassion comes from the right to respect for private and family life (Article 8 of the ECHR) and is also integral to the Patient Rights (Scotland) Act 2011. It relates to many different situations which involve people with mental health issues and it places a duty on mental health care practitioners to treat patients with respect at all times and ensure their dignity and privacy is protected. The more invasive aspects of care, such as periods of seclusion, constant or special observations and facilitating family contact, are all examples of situations where appropriate staffing response and intervention is critical.

It's important to understand that certain aspects of care *can* be restricted by law during care as not all rights are absolute. However, there has to be a legitimate reason for restriction and any action should be proportionate to the situation – for example, the stopping of mail, removal of personal possessions while in hospital and practices such as seclusion – and should only go as far as is necessary to achieve a legitimate aim. While some of these restrictions are permitted under the Mental Health Act 2003, they must also meet human rights obligations to be kept under review, be proportionate and be time limited. Wider aspects of dignity in relation to patient care include ensuring that any experience is considered, measured and personalised.

CASE STUDY 4

Respecting dignity in challenging situations

Elsa is admitted to hospital when her mental health condition deteriorates. The admission is upsetting enough but she finds it really hard when a nurse sits on her bed and starts counting through her underwear. For Elsa, it feels undignified and embarrassing. And although she realises later than the nurse was simply trying to ensure that her possessions were safe and accounted for, she would have been much happier if the nurse had taken the time to explain what she was doing and why – that way, Elsa would have felt she was being treated with more respect.

4. Discrimination

- » **All patients have the right not to be discriminated against on the grounds of protected characteristics: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation**

The right not to be discriminated against (Article 14 of the ECHR) and the Equality Act 2010 bring together a number of pieces of equality legislation to help tackle discrimination and equality. The 2010 Act applies to all organisations that provide a service to the public and makes provisions for these organisations to help people overcome their disadvantages or meet their needs. It also supports the realisation of the ECHR's articles in relation to individuals with protected characteristics.

Mental health care practitioners can uphold this right by ensuring that people are not denied services, facilities or treatment on the basis of their protected characteristics – for example, by ensuring that individuals from black and minority ethnic groups have parity of services; that non-English speakers are presented with their treatment options with an interpreter; that transgender patients are appropriately treated in line with their gender identity; and that lesbian, gay or bisexual patients are treated appropriately and are free from harassment or bullying by other patients. The Commission has produced good practice guidance on working with lesbian, gay, bisexual and transgender (LGBT) people, *LGBT inclusive mental health services: A guide for health and social care providers*, which is available on our website.¹⁴

CASE STUDY 5

The damaging impact of discrimination

Susan has been in a relationship with her partner Carol for five years. Although previously she was married to Derek, she is now divorced and has been through a difficult period of re-adjustment, facing criticism from family and friends.

On being admitted to a mental health ward for assessment, she is asked if she has a husband or a boyfriend. As Susan has struggled to come to terms with her sexuality and with the reaction of friends and family to her relationship with Carol, the question makes her feel anxious and uncomfortable and reopens feelings of guilt, worsening her mental health issues. Carol, her partner, feels offended that their same sex relationship is not recognised and this makes her unwilling to cooperate with the mental health care practitioners who are trying to help Susan.

5. Advocacy services

- » **All patients have the right to have independent advocacy services**

Advocacy is the process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities, and explore choices and options open to them. The right to independent advocacy is set out in Section 259 of the Mental Health Act 2003 and supports a patient's right to have their voice heard in decisions being made about

¹⁴ http://www.mwscot.org.uk/media/356012/lgbt_inclusive_mental_health_services.pdf

their health and wellbeing. While it is not the role of an independent advocate to make decisions for the patient, they are there to offer the necessary support to facilitate the patient's own decision-making. The right to private and family life (Article 8 of the ECHR) supports this, as it requires the participation of the individual in decision-making and the support they require to do so.

Mental health care practitioners should ensure that advocacy is explained to patients so that they understand what it is and how to access it. Be aware that while posters and leaflets may be available, they do not replace personal explanations. Advocacy services should be offered to patients at any stage of their treatment where they may benefit from it, but crucially at the point of being detained under the Mental Health Act 2003. Advocacy can be provided through an individual or peer relationship, or in a collective or group setting. Collective advocacy enables a wider peer group, with shared interests, to represent their views, preferences and experiences; it allows them to come together to work on specific issues.

6. Patient-focused, participative NHS care

- » **All patients have a right to NHS care which is patient-focused and encourages participation**

The Patient Rights (Scotland) Act 2011 and the Charter of Patient Rights and Responsibilities highlight communication and participation with patients as a key theme for the NHS in Scotland.

Mental health care practitioners should bear this in mind at all times, even when it may be difficult because of a patient's state of mind, and make every effort to ensure that patients are able to inform their care and treatment – for example, by involving the patient in care planning and ensuring that information relating to rights is reiterated at key points. This is particularly pertinent if patients are detained. Their perspectives should be incorporated as much as possible and having an advance statement in place is helpful here, particularly if the patient is very unwell and not able to express their wishes. The use of one-to-one nursing sessions is also helpful in establishing a rapport with the patient and being able to help them to understand their rights.

7. Liberty & lawful detention

- » **All patients have a right to liberty, unless detained lawfully**

The right to liberty (Article 5 of the ECHR) is fundamental for everyone working in mental health care. The right to liberty can be limited where necessary and this includes the detention of individuals with mental health issues. It can also apply to other settings such as care homes, or to situations where an individual is overly supervised. Under any circumstances, it must always be lawful. While detention in itself does not breach the right to liberty it must be *necessary* in the interests of health and safety for the patient being detained, or for the safety of others, and must be carried out in accordance with the law. Where a patient is detained, procedures must be followed to ensure this remains necessary.

The right to liberty also requires that a court or tribunal must have the power to review decisions on detention and that such decisions should be made speedily. Issues such as inappropriate or unlawful

periods of detention, significant delays or cancellations of tribunals, and long periods of restraint or seclusion pose potential difficulties as unlawful detention can occur inadvertently – for example (and most commonly) when an informal patient (a patient who hasn't been detained under the Mental Health Act 2003) is told that they can't leave the ward or when a nurse is positioned at a ward exit to discourage informal patients from leaving.

In both of these instances, either verbally or physically preventing a patient from leaving the ward without due cause is unlawful. In order to establish due cause, there must be a clear indication that the patient is making attempts to leave, that there are evident risks and that further clinical assessment is required before the patient can leave. Where the further clinical assessment shows that the patient does not meet the grounds for detention, then they cannot be prevented from leaving the ward.

If an informal patient wishes to leave, and staff believe this is unsafe, they should consider using the Nurse's Power to Detain¹⁵ (detailed under section 299 of the 2003 Act).¹⁶ The Act's Code of Practice says: "Where an informal patient wishes to leave hospital against medical advice, they should not be placed in the position of feeling they must agree to stay in hospital purely because of the possibility of being detained under the Act. Such 'de facto detention' places restrictions on an informal patient without according them the protection of the rights they would be accorded were they to be formally detained. It is important to remember that the patient's perception of whether or not they are likely to be detained if they do not comply with the medical practitioner's wishes is an important factor in deciding whether or not the patient is subject to de facto detention."

It's essential that patients are able to fully understand the difference between being detained (which brings certain restrictions) and being informal (which brings fewer restrictions and allows for refusal of medication and ability to leave the ward). If a previously informal patient is detained, a full explanation of their legal rights should be given, including their right to advocacy and legal representation.

CASE STUDY 6

Managing an informal patient's desire to leave the ward

Marek is 22 and has recently been advised by his community psychiatric nurse that he has a suspected psychotic illness and needs to be admitted to hospital, as an informal patient, for further assessment of his mental health.

Marek spends two days and nights in hospital but is unhappy about his diagnosis and the medication options he's been offered. He says he wants to go home and is able to cope on his own. The ward staff take time to explain that the complex thoughts he's been experiencing, and the voices he hears in his head, are symptoms of his illness and that if he can stay for longer they will be able to help him. Although he is not detained, ward staff try to discourage Marek from walking around the hospital grounds or going to the local shop and advise him that he will need to see a doctor first if he wants to leave. This is acceptable practice. However, one member of staff then tells Marek that he will be detained under mental health legislation if he tries to leave. This amounts to unlawful detention and breaches Marek's human rights.

15 See the Commission's Advice Note, *Nurses' Power to Detain*, section 299: http://www.mwscot.org.uk/media/140960/nurse_power_final.pdf

16 Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice, COP Vol 2, Ch7, para 18 <http://www.gov.scot/Publications/2005/08/30105347/53499>

8. Adequate health care and protection

- » **All patients have the right to:**
 - **adequate health care for their physical and mental health needs**
 - **have health care without which their life would be at risk**
 - **access to health promotion and preventative information**
 - **protection from inhuman or degrading conditions**

This right reflects the right to the highest possible attainable standard of health (Article 25, UN Convention on the Rights of Persons with Disabilities), which requires disabled people (including those with mental health issues) to be provided with the health services they need because of their disabilities. This includes early identification and intervention, as well as services designed to minimise and prevent further disabilities.

It also reflects the right to life and the right not to be subjected to torture or to inhuman or degrading treatment or punishment (Articles 2 and 3 of the ECHR). It means that patients have a right to appropriate treatment that prevents further distress or serious deterioration in their mental or physical wellbeing. This includes appropriate and proportionate response to risk to life – for example, if a patient is expressing suicidal ideas. In addition, the environment and conditions provided by services such as hospitals should be of a sufficient standard.

9. Family and friends' involvement

- » **All patients have a right to agree how much they want family and friends to be 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)**

The principles of the Mental Health Act 2003 make it very clear that the wishes of patients and their carers should be taken into consideration during treatment, so mental health care practitioners should include questions about family, friends and key personal contacts in any initial assessment. In addition, a full discussion should take place with the patient around the nature and level of contact and the patient's consent should be gained regarding the amount of information to be shared with family members. The role that family and friends plays in a patient's life, and how much support they can offer, is also worthy of discussion and can set a benchmark for the nature and frequency of contact.

The right to respect for private and family life (Article 8 of the ECHR) is crucial here. It makes it clear that on-going contact with the family is presumed and is important if patients are separated from them. Patients should be able to develop ordinary family relationships so hospital ward environments should provide good family private space and flexible visiting policies.

However, mental health care practitioners in a hospital setting should also bear in mind the need to restrict relationships should this be required – for example, due to safety issues for patients or family members, particularly if children are involved. The relationship between parents and children is also clearly highlighted in Section 278 of the Mental Health Act 2003, which states that any adverse effects, when patients are subject to compulsory measures, should be prevented.



CHAPTER 2

**RIGHTS IN
THE COMMUNITY**

In this chapter, we focus on mental health care services being delivered and accessed in the community and explain when specific rights become important. The onus is on community staff to afford individuals their rights, rather than on patients to claim them.

Patients who are subject to compulsory measures in the community as well as those staying at home on an informal (non-compulsory) basis are discussed in this stage of the pathway. The role of the community psychiatric nurse is key here as they should bring a wider perspective to a patient's care and be able to signpost them to other local services. We also include a subsection that explores the specific rights that only apply to patients who are subject to the Mental Health Act in the community.

i. The key rights of all patients in the community

- 10. Access to services**
- 11. Information, discussion, participation and explanation**
- 12. Crisis and out-of-hours services**
- 13. The role of the carer**
- 14. Advance statement choices**
- 15. Choosing a named person**
- 16. Care and support needs assessment and services**

ii. Specific rights of patients subject to the Mental Health Act 2003 in the community

- 17. Adherence to advance statement**
- 18. Compulsory treatment and appeal rights information**
- 19. Conditions of community living**

i. The key rights of all patients in the community

In this section, we explore the rights of all patients being supported in the community, when the key rights relate to access to the most appropriate services and informed participation in decision making.

10. Access to services

- » **All patients in the community have the right to:**
 - **access to mental health services when they need them, including early intervention**
 - **good support from primary care services, including GPs**

Community staff should ensure that all patients receiving mental health care at home are provided with appropriate support and know when to contact their GP and other primary care services. This also means ensuring patients understand how to access services and have clear information, including the contact details and roles of the services they are linked to. This is not simply good practice, it is underpinned by the right to the highest attainable standard of health (Article 25 of the United Nations Convention on the Rights of Persons with Disabilities) which requires disabled people (including those

with mental health issues) to be provided with the health services they need because of their disabilities. This includes early identification and intervention, as well as services designed to minimise and prevent further disabilities.

11. Information, discussion, participation and explanation

- » **All patients in the community have the right to:**
 - **information about their diagnosis, delivered in a way they understand and an opportunity to discuss this with the team providing their care**
 - **an explanation of their treatment, its benefits and side effects, in a way they understand**
 - **discuss any alternative treatment approaches, and benefits and risks**
 - **participate in putting together their own care plan and risk or safety plan**

Community staff should discuss diagnosis in a meaningful way and, importantly, discuss how it will impact on the patient on a daily basis. Treatment options (including the benefits, risks and alternatives) should also be discussed and, if possible, choices offered.

Explanations must be delivered in a way that patients will understand – face-to-face contact is often the best way of ensuring that information is shared and readily understood and community staff should bear in mind the difficulties or sensitive nature of some information and attempt to demystify this for patients. A helpful technique here is the ‘Teachback’ method, where staff ask individuals to repeat back the information they have just been given, in their own words. This can set a valuable benchmark, helping staff to recognise how much information a patient has retained. Some patients may need an explanation repeated several times and on different occasions.

Written information can be delivered through various mediums such as leaflets, websites or apps but should be straightforward and written in a way that patients will understand. Usually this should act as a back up to verbal information.

Staff should support patients to become involved in developing their care plan and risk or safety plan. This is important in terms of their right to participate in decision making and to give informed consent under the right to private and family life (Article 8 of the ECHR). It can also be influential in maintaining good mental health and the Wellness Recovery Action Plan (WRAP) promoted by the Scottish Recovery Network is a good example of effective patient involvement.¹⁷

¹⁷ <https://www.scottishrecovery.net/>

CASE STUDY 7

Putting good practice to good use in the community

Ruth has been diagnosed with severe depression and referred to the community mental health team by her GP. She's frightened by the sharp decline in her mood and has fleeting thoughts of suicide. Although she has a supportive husband and extended family, they don't really understand her diagnosis.

The community mental health team makes an appointment for Ruth with a consultant psychiatrist, who takes her through her diagnosis and fully explains both her symptoms and the benefits of different types of medication. Respecting Ruth's rights in this way means that she feels informed and in control – she also feels she has been given a choice about her treatment.

Ruth is also referred to a community psychiatric nurse, Jackie, with whom she builds up a good relationship. Jackie is empathetic, explaining Ruth's symptoms and offering useful interventions to help manage them. She also follows best practice by providing Ruth with written information as a back up and some workbooks that she can use to attempt to lift her mood. Jackie also suggests that Ruth's husband should be involved and she spends time with him to discuss how he can help to support his wife and how to recognise the triggers that result in Ruth's mood declining.

This regular support, provision of information and participation in care planning and treatment have made Ruth and her husband feel empowered, able to work through her condition together and better prepared to tackle the challenges of Ruth's depression as a family.

12. Crisis and out-of-hours services

- » **All patients in the community have the right to information about crisis and out-of-hours services**

It is vital that patients understand the process involved in contacting services after 5pm. Some areas will have crisis services and out-of-hours teams who respond after 5pm and at weekends, however, this may not be available in every area, leaving some patients to rely on more general NHS Scotland services (such as NHS24) which may not result in direct access to a mental health care practitioner. It's therefore crucial that all patients are given clear information about the different services available in their area and how they can make contact in a crisis or out-of-hours situation. This includes providing:

- appropriate contact details,
- clear explanations as to what different services offer, and
- a clear means of the patient ensuring their own welfare and protection.

This is particularly relevant in situations where a deterioration in an individual's mental health involves thoughts of suicide or self-harm. In such a situation, the individual should be able to seek and receive prompt assistance. Effective care and crisis planning can assist here and relates to the right to life and the

right not to be subjected to torture or to inhuman or degrading treatment or punishment (Articles 2 and 3 of the ECHR) as these cover the positive obligation to take reasonable steps to address risks to life and prevent suffering due to inhuman or degrading treatment.

13. The role of the carer

- » **All patients in the community have the right, with the patient's consent, to have their carer (family/partner/friend) involved and have their views and caring role considered when determining the need for support and services for the patient**
- » **The carer has the right to an Adult Carer Support Plan or Young Carer Statement, and to support if their needs meet local eligibility criteria**

Carer involvement can be central to aiding recovery, however, carers can only be involved with a patient's consent so it is important to discuss this with the patient (and their family) to ensure that privacy and confidentiality are protected. Gaining a carer's view can be really helpful when trying to build a picture of a patient's illness and how best to assist their recovery. The views of carers should also be taken into account when delivering care and treatment, in line with the principles of the Mental Health Act 2003. The right to private and family life (Article 8 of the ECHR) also helps to protect privacy and can assist with the involvement of families in decision making where a patient has given their consent.

Community staff should also remember that from April 2018¹⁸ carers have a new right to an assessment from the local authority and an Adult Carer Support Plan or Young Carer Statement, in addition to support if their needs meet local eligibility criteria under the Carers (Scotland) Act 2016.

14. Advance statement choices

- » **All patients in the community have the right to support to make an advance statement about their care and treatment choices if they become ill**

The Mental Health Act 2003 gives the right to make an advance statement, which must be taken into account when compulsory treatment is being considered. This is an important form of supported decision making when people become unwell and may be unable to make decisions. It's best to discuss drawing up an advance statement with a patient when they are well or recovering from an episode of illness and therefore able to make important decisions about their care and treatment. A personal statement can be added to this to highlight more general care details or issues that are important to the patient beyond their immediate care and treatment.

Advance statements are extremely helpful if a patient's mental health deteriorates so it's an important step to take and ensures that their wishes will be taken into account at a potentially stressful time. Supporting patients to complete their advance statement, and ensuring that it is part of their medical records, is key to maximising patient participation and to delivering good quality care. Reading the personal statement can also help community staff to get to know patients better.

Community staff should advise patients that their advance statement will be placed in their medical records and that its location will be noted on a register held by the Commission.¹⁹ Staff should explain that an advance statement will normally be followed and, if it is overridden, that this must be reported to the Commission who will review the rationale for this. There should be an ongoing discussion and review of a patient's advance statement and we have published information on this.²⁰

CASE STUDY 8

Promoting the benefits of an advance statement

Ryan has recently returned home following a long spell in hospital when he was very unwell. He is now settled, enjoying life once again and catching up with family and friends.

During his stay in hospital, Ryan went through three different medication trials before finding a drug that suited him and didn't cause troublesome side effects. His community psychiatric nurse is aware of this and helps Ryan to make an advance statement to protect his rights. In it, he writes that he does not want to take drug A because it made him put on weight, or drug B because it gave him muscle spasms, but he would be happy to be given drug C.

The nurse explains to Ryan that the advance statement guarantees that his wishes will be taken into account and, if for any reason it is not followed, that the situation will be reported to the Commission for further investigation. Ryan, who was previously worried about what might happen if he became ill again, feels less anxious about the future and more in control.

15. Choosing a named person

- » **All patients in the community have the right to support to choose a named person who will help to protect their interests if they become ill**

The Mental Health Act 2003 provides all patients with the right to have a named person at the point at which they become detained under the Act. Although it currently states that they must have a named person, under the new Mental Health (Scotland) 2015 Act this will change. From June 2017²¹ there will be no requirement to have a named person – it will become the personal choice of each patient. There is a role here for community staff to assist with this process by explaining the role of a named person, facilitating the choice of a named person and potentially witnessing the signing of any documentation.

16. Care and support needs assessment and services

- » **All patients in the community have the right to:**
 - **have their community care needs assessed and assessed needs met**
 - **care and support services through the local authority, if they are assessed as needing these, and help with travel to access them, if they need it**
 - **services to promote their wellbeing and social development through the local authority, and help with travel to access these, if they need it**

¹⁹ The register will be established on the implementation of the Mental Health (Scotland) Act 2015; expected to be June 2017

²⁰ <http://www.mwscot.org.uk/get-help/getting-treatment/advance-statements/>

²¹ This is the expected implementation date for the Mental Health (Scotland) Act 2015 at the time of publication

Local authorities have a legal duty to provide an assessment of patient need under the Social Work (Scotland) Act 1968 and to meet any assessed needs. In addition, section 25 of the Mental Health Act 2003 places a duty on local authorities to provide care and support to people with mental health issues, whether they have been in hospital or not. Under Section 26 of the 2003 Act, local authorities have a duty to provide or secure the provision of services to promote wellbeing and social development, including the provision of social, cultural and recreational activities; training; and assistance with obtaining and undertaking employment for those over school age. Under Section 27 of the 2003 Act, local authorities must also provide assistance with travel – for example, a concessionary travel card – which can be crucial for individuals to access services.

ii. Specific rights of patients subject to the Mental Health Act 2003 in the community

All patients have clearly defined rights under the Mental Health Act 2003 when they are subject to compulsory treatment under this Act. These rights are bound by the principles of the 2003 Act, which reflect some of the key articles of the European Convention on Human Rights.

17. Adherence to advance statement

- » **Patients subject to the Mental Health Act 2003 have the right to:**
 - **have their advance statement choices about care and treatment followed unless there is a good reason not to and that reason is explained in writing**
 - **have the Mental Welfare Commission for Scotland informed if they are treated against their advance statement choices**

All mental health care staff must ensure that they are aware of a patient's advance statement and follow it. If it is necessary to override an advance statement, then the reasons for this and the safeguards of the Mental Health Act 2003 should be clearly explained to the patient *and* put in writing to the patient, their named person, guardian or power of attorney. The Commission must also be notified.

Advance statements may be accompanied by personal statements and while these have no specific authority, they are an important way for patients to still participate in decision making when they are unwell and therefore to realise their right to autonomy. Named nurses in particular – that is, nurses specifically allocated to work with an individual patient in a personalised way, in either a community or ward setting – should be aware of, and discuss with the patient, the contents of their personal statement. Ideally, this conversation should take place when the patient feels well enough to discuss aspects of their treatment, but it's also worth repeating and reviewing the information over a period of time.

Sections 275 and 276 of the Mental Health Act 2003 outline these rights.²²

²² <http://www.legislation.gov.uk/asp/2003/13/contents>; and see information about advance statements at <http://www.mwscot.org.uk/get-help/getting-treatment/advance-statements/>

18. Compulsory treatment and appeal rights information

- » **Patients subject to the Mental Health Act 2003 have the right to be told how long they are detained for and why, and whether and how they can appeal**

Community staff should make sure that patients are clear as to which part of the law applies to them, how long they may be compulsorily treated for and why this is necessary. There will be a number of mental health care practitioners involved at this stage, some of whom (the consultant psychiatrist or MHO for example) have specific duties under the 2003 Act. Others – for example, community staff – should be clear that the information they share is consistent and in line with information already provided to patients.

Handing out leaflets and written information to patients is only useful as a back up to information given verbally, ideally face to face. Information in relation to advocacy, legal representation and rights of appeal *must* be provided at this stage. This protects the right to liberty, the right to a fair trial and the right to private and family life (Articles 5, 6 and 8 from the ECHR).

19. Conditions of community living

- » **Patients subject to the Mental Health Act 2003 have the right to an explanation of what the conditions are if they are on a community order or if their hospital order is suspended to allow them to be in the community**

When patients subject to the 2003 Act are living in the community or are on a period of suspension from hospital, the key conditions contained in each order should be fully explained to them. For example, a condition or power which states that a patient should advise if they change address should also make it very clear *who* they should advise. This information should be contained in a safety or crisis plan in case community circumstances change.

A stylized graphic of a road with a dashed white center line, winding through a landscape of rolling hills. The road starts at the top left, curves down and right, then turns left and curves down again. The hills are represented by simple, rounded shapes in various shades of pink and purple. The background is a solid dark pink color.

CHAPTER 3

**RIGHTS DURING
ADMISSION TO HOSPITAL**

Hospital admission can be distressing for patients, especially if they are detained under the Mental Health Act 2003. As highlighted in the Introduction to this guide, the 2003 Act is the legitimate means in Scotland by which freedom can be taken away from individuals with mental health issues in terms of the right to liberty (Article 5 of the ECHR). It is vital that all legal criteria are applied, along with the underlying principles of the 2003 Act which aim to reflect proportionality.

At this point, achieving a balance between freedom and autonomy for the patient being admitted on the one hand, and quality care, treatment and any resulting restrictions of their liberty on the other hand, should be carefully considered. The issues of safety planning, and the use of restrictive interventions, including seclusion, are particularly relevant here. All patients should be informed of all of their legal rights and given help to claim them. We explore these rights in this chapter, as well as providing explanations of further rights for both detained and informal patients during the process of hospital admission.

i. The key rights of all patients when being admitted to hospital

20. Explaining the need for admission

21. Voluntary admission

22. The admission process

23. Practical preparations

24. Information, introductions and explanations

25. Informal support

26. Religious and spiritual support

27. Visiting rights

28. Dietary requirements

ii. Specific rights of detained patients when being admitted to hospital

29. Explanation of detention, follow up and appeal rights

30. Access to a mental health officer

31. Representation by a solicitor

32. Named person informed

33. Minimum detention

34. Adherence to advance statement

iii. Specific rights of informal patients when being admitted to hospital

35. Ability to leave

36. Refusing treatment

37. Challenging unlawful detention

i. The key rights of all patients when being admitted to hospital

In this section, we explore the rights of all patients, detained or informal, when they are admitted to hospital. This can be a particularly distressing time with patients feeling vulnerable and isolated, even when fully supported.

It is important that hospital staff discuss patients' rights and how to exercise them, introducing topics such as legal representation or the use of advocacy as appropriate. This contributes to patients having more control over their care and treatment and feeling that their voice is heard.

20. Explaining the need for admission

- » **All patients have the right to an explanation of why they need to be admitted to hospital**

An explanation from a mental health care practitioner as to why they need to go into hospital should be available to all patients. This can be a distressing time so it is helpful to revisit this information over the first 72 hours of admission so that patients are clear about what is happening. Ensure information is relevant, clear and consistent and supported in writing. This right is underpinned by the right to private and family life (Article 8 of the EHCR) and by the Patient Rights Act principle of patient participation whereby patients should be encouraged to take part in decisions about their health and wellbeing and given any information or support that they need.

21. Voluntary admission

- » **All patients have the right to the opportunity to agree to go into hospital voluntarily for care and treatment, if they are able to make this decision**

Section 1 of the Mental Health Act 2003 lays out principles and is clear that these apply to *all* patients, whether informal or detained. All hospital staff should bear this in mind during voluntary admissions, ensuring they employ the least restrictive practices – where possible, giving a patient the opportunity to agree to informal admission as this reflects the least restrictive option. The right to liberty (Article 5 of the ECHR) recognises the need to avoid restriction if a voluntary agreement can be reached.

22. The admission process

- » **All patients have the right to an explanation, in a way they are able to understand, of what is happening now and what will happen during admission**

The process of being admitted to hospital can make patients, their family members and carers very anxious. Thinking about how information is provided is key and while written materials (such as leaflets) can provide a useful back up, face-to-face verbal contact is of primary importance. Any information given out at this point will need to be repeated throughout the period of admission to ensure it has been

understood. This is important in terms of the right to private and family life (Article 8 of the ECHR) as, even if some rights need to be restricted to an extent necessary to ensure treatment can take place in hospital, a patient's remaining autonomy should be preserved as much as possible within these bounds.

The process of admission is about more than filling out forms and providing information. When and how a patient arrives at the hospital, who accompanies them, when friends and family can visit and whether the patient can leave the hospital grounds for short periods are all factors that need to be considered and/or explained. There are a number of practical considerations too – smoking policy, diet, clothing and laundry guidance, bedtimes and mealtimes, and visiting by children. It is good practice to introduce patients to key members of staff and explain how shift patterns work so that patients know who's who and when they are likely to see different members of staff as part of their treatment.

It is also helpful to assign a member of the ward staff to help new patients find their way around the ward and go over rules such as visitor access or mealtimes again. Think about a written induction pack to assist the admission process or a peer support worker to help the patient settle into their new environment.

23. Practical preparations

- » **All patients have the right to the opportunity to make practical preparations for going into hospital, as much as is possible in the circumstances**

In line with of the right to private and family life (Article 8 of the ECHR), hospital staff should ensure that certain aspects of privacy and home life should not be compromised during the admission process. Patients should be afforded the opportunity to make practical arrangements *before* coming into hospital – for example, settling finances, securing property and arranging care for children or other dependents. This may not always be possible in a crisis situation of course, and it may then fall to community staff to ensure that good links are maintained between the hospital ward and family members for example.

24. Information, introductions and explanations

- » **All patients have the right to:**
 - **clear, accessible information**
 - **an introduction to the ward and key staff**
 - **have their questions answered**

Most wards now have an induction process in place to familiarise each patient with the ward setting. This tends to take place following the necessary admission assessment process. As patients often have difficulty remembering ward policies and procedures, staff should try to regularly reinforce basic details such as mealtimes, visiting arrangements, leaving the ward, storage of possessions and what can be brought onto the ward.

Review the ward induction policy regularly or produce a ward document which deals with frequently asked questions from patients to minimise confusion and, importantly, reduce any potential for conflict. Remember that admission can be a frightening experience and it helps if it is made as personal as possible.

25. Informal support

- » **All patients have the right to ask to have someone with them for support (but this may not always be possible or appropriate)**

Consideration should always be given to patients being accompanied by a partner, family member or friend during admission. It can be a useful additional support and helps to settle patients into the ward. This may not always be feasible, however, particularly if the supporting individuals are obstructive to proposed treatment or abusive to the patient or ward staff. In such instances, it is acceptable to limit their support. This fulfils the right to private and family life (Article 8 of the ECHR) and can be a form of supported decision making.

Rather than adopt a blanket policy in relation to allowing informal support or not, ward staff should assess the individual patient's situation.

26. Religious and spiritual support

- » **All patients have the right to have religious and spiritual needs respected and supported**

In line with the right to freedom of thought, conscience and religion (Article 9 of the ECHR), all individuals have the right to hold a broad range of views, beliefs and thoughts and to follow a religious faith. Within a ward setting, this could include opportunity for prayer or adherence to a specific diet. This should be clearly documented in a patient's care plan and ward staff should be prepared to encourage this as far as possible, providing the necessary support to enable patients to participate in their chosen religious practices.

27. Visiting rights

- » **All patients have the right to information about when family and friends can visit**

In line with the right to private and family life (Article 8 of the ECHR), contact with supportive family and friends should be made available and patients made aware of when they can receive visitors. From our own visiting programme, we are aware that many wards now operate flexible visiting times, particularly for those who have to travel long distances to see patients. This should be clearly explained at the point of admission (with back-up information provided in writing) and revisited to make sure the patient has taken in the information. With the patient's permission, it can be helpful if ward staff contact family and friends directly. It is also worth bearing in mind that it may be necessary, in some circumstances, to restrict patient contact in order to uphold family members' right – for example, to protect young children visiting wards.

CASE STUDY 9

A flexible approach to visiting works for the whole family

Helen is detained in an Intensive Psychiatric Care Unit (IPCU). She is very unwell, has made several attempts on her life and continues to self-harm. She misses her children, who are four and six and constantly asks to see them but there were concerns when she was first admitted that the children would be very distressed by their mother's condition and by the unit itself.

The nursing and medical staff discuss the situation at an inter-disciplinary ward meeting and consult Helen's husband to assess his concerns. Everyone agrees that it would benefit Helen to see the children. Her husband comments that they are upset and confused by her disappearance and so a visit may reassure them.

As the IPCU is a locked facility, visiting times are prescribed. There are also a number of other patients who are extremely unwell and whose behaviour may upset young children. The senior charge nurse (SCN) decides to adapt a small interview room located off the ward, providing comfortable seating, soft furnishings, and toys and games for Helen's children. When they come to visit, a member of the ward staff supervises their contact with their mother at all times.

Because the children are still at nursery and primary school, the SCN allows Helen's husband to bring them in around 4pm, even though this is outside the unit's prescribed visiting hours. Helen is encouraged by her renewed contact with the children and feels that their visits will help with her recovery. The children too are reassured by regular contact with their mother.

28. Dietary requirements

- » **All patients have the right to a special diet if they need it for health or religious reasons**

In line with the right to freedom of thought, conscience and religion (Article 9 of the ECHR), diets followed for health or religious reasons should be catered for if possible and hospital staff should establish any special dietary requirements as part of the admission process. If any requests are deemed unreasonable or unhealthy, it is worth considering providing basic education on a healthy diet or referral to a dietician, instead of restricting a patient's rights.

ii. Specific rights of detained patients when being admitted to hospital

The right to liberty (Article 5 of the ECHR) is a qualified right. This means it can be restricted for specific reasons but any restriction should always be proportionate and procedural safeguards must be followed.

In Scotland, the Mental Health Act 2003 is a legislative means by which the right to liberty can be restricted. The 2003 Act contains underlying principles that create a benchmark for the way in which the law can be implemented and attempt to incorporate and reflect the ECHR. If procedures set out in the 2003 Act are followed, this goes a long way towards protecting human rights but overarching human rights principles should always be applied to guide decision making.

29. Explanation of detention, follow up and appeal rights

- » **All patients being detained have the right to:**
 - **an explanation from the doctor of why they are being detained in a way they can understand**
 - **follow up from ward staff, as often as they need it, to make sure they have understood**
 - **information about how long they are detained for**
 - **information about whether and how they can appeal**

The responsibility for affording these rights is firstly down to the doctor who has undertaken the initial medical assessment in relation to detention. The doctor should provide a clear explanation of their decision to detain, and the likely length of the patient's stay in hospital, as well as their right to appeal. If this is impossible at the point of detention, for reasons of the doctor's own safety, this information must be provided as soon as possible afterwards. A MHO, who has specific duties under the law, should follow this recommendation up with the patient. Ward staff should follow up the doctor's decision and reassure the patient about this difficult information.

In our experience, patients will be confused or unclear about their rights or indeed why they are in hospital. Information should therefore be clear, in a format that is easily understood, and regularly followed up throughout the initial 72 hours of a hospital admission.

The involvement of advocacy services and legal representatives at this stage is essential with the Mental Health Act 2003 also placing a duty on the MHO to facilitate appeal services for patients. This can be difficult when a patient is very unwell or distressed so re-visiting the patient and reinforcing the information is helpful. It is best practice to ensure that patients are able to contact a lawyer and an advocacy representative should they want these services.

30. Access to a mental health officer

- » **All patients being detained have the right to a MHO to explain their rights (for short-term detentions, compulsory treatment orders and, where possible, for emergency detentions)**

The MHO has clearly defined duties under the Mental Health Act 2003 that include assessment, giving or withholding consent to detention, and advising on rights. MHOs have an important autonomous role in safeguarding the patient's rights with regard to determining if detention is required. They also have a sound knowledge of community services and are well placed to consider alternatives. Ward staff should have ready access to MHOs in their area.

Emergency detention certificates can be granted by any registered doctor (including GPs) without the MHO's consent, however, this should only happen in exceptional circumstances as it misses a key safeguard for patients' rights.

31. Representation by a solicitor

- » **All patients being detained have the right to a solicitor to represent them at the Mental Health Tribunal for Scotland, free with legal aid**

Patients have a clear right under the law to exercise their rights of appeal and having access to a solicitor who is experienced in this area is essential. This upholds the right to a fair trial (Article 6 of the ECHR). While hospital staff are not able to endorse specific legal firms, a list of appropriate companies can be given to patients. Staff should reassure patients that they will be entitled to legal aid for this and so will not have to pay, whatever their circumstances.

32. Named person informed

- » **All patients being detained have the right to have their named person informed of their detention**

If the patient has a named person, then they must be informed of the patient's detention. Named persons are identified by patients, sometimes at the point of detention, and have a distinct role, with their own rights, when the patient is being detained under the Mental Health Act 2003. The named person's rights include:

- being consulted when certain things happen – for example a short-term detention or an application for a compulsory treatment order (CTO) being considered;
- being notified of certain changes to the patient's circumstances;
- receiving certain records or information;
- appealing independently of the patient; and
- putting their own views to the tribunal.

It is important that hospital staff are aware of the named person's details and that these are clearly recorded in the patient's medical records. In addition, it is crucial that named persons have their role clearly explained to them and that they are confident about taking the role on.

33. Minimum detention

- » **All patients have the right not to be detained if they no longer need to be**

Patients have the right to have their detention status regularly reviewed and have the opportunity to be treated informally if the conditions for detention are no longer met. This review of human rights restrictions is essential to ensure that they remain proportionate. The Mental Health Act 2003 clearly sets out the duty for a doctor and MHO to keep a patient's detention status under review and, as part

of the ongoing ward assessment, hospital staff have a clear role here to apply legal criteria and ensure that changes in the patient's condition are acted upon if appropriate. Regular one-to-one sessions with individual patients and regular multi-disciplinary ward meetings endorse this good practice.

34. Adherence to advance statement

- » **Patients being detained have the right to:**
 - **have their advance statement choices about care and treatment followed unless there is a good reason not to and that reason is explained in writing**
 - **have the Commission informed if they are treated against their advance statement choices**

See [17. Adherence to advance statement](#)

iii. Specific rights of informal patients when being admitted to hospital

Informal patients (those who have not been detained under the Mental Health Act 2003) will experience some aspects of care that differ from those of detained patients.

At the Commission, we are aware, through our visiting programme, that informal patients are not always clear about the difference between their status and that of detained patients – for example, that there are no restrictions on their movements. There is a clear need for hospital staff to both ensure the care and protection of patients requiring treatment and advise them of their rights, making clear the distinctions between informal and detained status.

35. Ability to leave

- » **All informal patients have the right to leave the hospital at any time (but they should agree a plan with staff)**

Unless a patient is lawfully detained, they share the same right to liberty (Article 5 of the ECHR) without restriction as any other person. Unlawful detention – the process by which patients might be restricted by some form of prevention without being formally detained – can sometimes occur when ward staff are not absolutely sure of the patient's rights or have limited knowledge of legislation. It is important to gain a clear distinction between the rules around *ward policy* (when patients can and cannot leave) on the one hand, and a requirement to assess for *detention* on the other. For example, a nurse positioned at the door to the ward, preventing an informal patient from leaving, constitutes unlawful detention. It is important to identify that if a patient's liberty is restricted in such a way, it affords them rights to procedural safeguards.

Ward staff must make sure that informal patients are clear about their status, including the fact that they *can* leave the ward (but should let staff know that they are leaving). If, however, staff are concerned

about the patient's safety, they should discuss this with the patient and, if possible agree a plan (which includes risk assessment) for time away from the ward, either locally or at the patient's home.

Advising a patient that they will be detained if they try to leave the ward is unlawful detention. If an informal patient insists that they want to leave, and ward staff are concerned about potential risk – to the patient or others – then staff should discuss their concerns with the patient, clearly explaining the benefits of staying, and encouraging them to wait and speak to a doctor. The Nurses' Power to Detain, under Section 299 of the Mental Health Act 2003, allows time to obtain a doctor so that further assessment can be made and is useful if a patient is unwilling to wait for the doctor voluntarily.

Situations often arise where a patient ought not to leave the ward because of their poor mental health and associated risks, but is constantly trying to leave. This requires careful management by ward staff in particular as it is crucial that the principle of minimum restriction is balanced against the rights of the patient and appropriate application of the law.

CASE STUDY 10

A clear explanation of detained and informal status is critical for all patients

Jim has just been admitted to a psychiatric ward. He has been brought in by his family, who are concerned by his behaviour, but has yet to see a doctor. However, another patient has told him that he is not allowed to leave the ward or the hospital grounds, cannot smoke, cannot stay up late at night, will be forced to take medication against his will, and needs to get a lawyer urgently. Jim worries about this and ends up in a state of acute anxiety.

As part of the admission process, a nurse takes time to sit down with Jim and clearly explain the difference between being a detained patient and being an informal patient. The nurse goes over this several times with Jim to make sure he understands his informal status and the rights that this affords him. The nurse also reassures Jim that he is free to leave at any time but encourages him to discuss this with a doctor or member of the ward staff first.

Jim now understands his status as an informal patient with certain rights that cannot be denied. He feels much less anxious and willingly agrees to stay in hospital to discuss his condition and treatment options with a doctor.

36. Refusing treatment

- » **All informal patients have the right to refuse medication or other treatment, if they have capacity to do so**

When initially admitted to a ward, patients may or may not be receiving treatment. There is also the possibility that treatment options may change during the course of an admission. Treatment options should be fully discussed with the patient, side effects outlined and a rationale offered as to why this treatment could be effective. Although not always possible (depending on what is prescribed) a choice around medication can also be helpful.

The options of refusing treatment should be clearly outlined to patients (providing maximum support if they lack capacity to understand some or all of the options) and an unwise decision by the patient does not in itself mean that the patient lacks capacity. If the patient does refuse treatment, the ward staff should document this informed refusal in the patient's medical notes and also note that the need for treatment has been explained and a statement regarding the consequences of the refusal, including possible jeopardy to health or life, have been discussed. More detail on this subject can be found in our *Consent to Treatment* guidance.²³

If an informal patient does not have capacity to decide about treatments, safeguards in the Adults with Incapacity (Scotland) Act 2000 apply. Under the principles of this Act, all possible means to help the patient understand choices and communicate their wishes must be used, and evidence of their past wishes (such as an advance statement) must be taken into account.

37. Challenging unlawful detention

- » **All informal patients have the right to apply to the Mental Health Tribunal Scotland if they are detained without lawful authority**

Informal patients have the right to ensure that they are not being detained unlawfully in hospital. Under section 291 of the Mental Health Act 2003, a patient has the right to apply to the Mental Health Tribunal to review their need to be in hospital when not formally detained. The patient's named person, responsible parent or guardian, and welfare attorney – as well as a MHO, the Commission itself and anyone else having an interest in the welfare of the patient – also has the right to apply on their behalf. This may be particularly relevant if, for example, the patient has issues with capacity. The Tribunal must grant the application if it is satisfied that the patient is being unlawfully detained. Ward staff should ensure that the patient and/or their representative are aware of this right and have access to advocacy.

CASE STUDY 11

Challenging unlawful detention

Bill is 56 years old and has been in hospital for a number of days. He's been showing signs of acute anxiety, confusion and memory loss and is undergoing a full assessment of his mental health as he has a long history of drug and alcohol misuse.

Although Bill initially agreed with his GP that he would come into hospital on an informal basis, he can't remember doing this and doesn't know where he is. The door to the ward is locked and Bill paces the corridor continually, going back and forward to the door to try the handle. He repeatedly tells ward staff that he wants to go home but they simply tell him that he must wait for a doctor and stay in hospital for the time being.

This situation is observed by someone visiting another patient. Concerned, she telephones the Commission's Advice Line and our staff agree to pursue the situation on Bill's behalf. We advise the doctor to discharge Bill if appropriate or undertake an assessment for detention so that Bill can be afforded a right of appeal, and to inform Bill and his named person that he may have been unlawfully detained and may wish to consult a solicitor.

The doctor assesses Bill and decides to detain him which means that Bill and his named person have the right to appeal his detention. She writes to Bill and to his named person to explain their rights and arrange for Bill's advocate to discuss this with him.

The background features a stylized, abstract landscape in shades of pink and white. A winding road with a dashed white center line starts from the top left, curves down, then right, then down again, and finally right towards the bottom right. The road is flanked by several rounded, hill-like shapes in various shades of pink. The overall aesthetic is clean and modern.

CHAPTER 4

**RIGHTS ON THE
HOSPITAL WARD**

Time spent on a hospital ward can be a confusing, unsettling time for patients. The combination of poor mental health and separation from home, family and friends, can be a challenge, along with changes to routine and potential restrictions on freedom.

During this period there are a number of key rights and points of best practice that should be taken into consideration. For detained patients, this is particularly pertinent as the rights and protections afforded by the Mental Health Act 2003 are brought sharply into focus. Patients in this situation need to know what these rights are, when they need to be applied and how they should be applied. Ward staff have a key role here and can also assist in facilitating access to advocacy, legal representation and named persons. It is also important that staff are aware of, and facilitate, wider rights such as the right to vote or to access education.

i. The key rights of all patients on a hospital ward

38. Recovery and care plan involvement and review, explanation of treatment

39. Minimum restriction, safety and security

40. Therapy and recreational activities

41. A positive therapeutic environment

42. Access to education

43. Ability to vote

44. Access to medical records

45. Local authority responsibility for property

46. Family relationships

ii. Specific rights of detained patients on a hospital ward

47. Adherence to advance statement

48. Second opinion on compulsory treatment

49. Preparation for Mental Health Tribunal hearings

50. Minimum detention

51. Communication and safeguards

52. Minimum seclusion

53. Minimum restraint

54. Minimum level of observations

iii. Specific rights of informal patients on a hospital ward

55. Ability to leave

56. Refusing treatment

57. Seclusion

58. Communication restrictions

i. The key rights of all patients on a hospital ward

In this section, we look at the rights of all patients, detained or informal, during the time they spend on a hospital ward.

It is important that patients are afforded the right to be as fully engaged with their care and treatment as possible, that the ward environment and activities contribute positively to their care, and that their life outside the hospital is supported by ensuring that their property is cared for and that they are able to maintain family relationships.

38. Recovery and care plan involvement and explanation of treatment

- » **All patients have the right to:**
 - **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 clear explanation of their medication and other treatment in a way they can understand**

Patient involvement and participation are not just benchmarks of good practice, they are rights enshrined in the Patients Rights (Scotland) Act 2011, which reflects the right to respect for private and family life (Article 8 of the ECHR). Ensuring that restrictions remain proportionate requires efforts being made to work towards a position where the restrictions can be removed and a patient can regain their autonomy.

Active patient participation in care planning has become more prevalent in recent years but requires a concerted effort from ward staff, particularly if the patient's engagement is poor or they remain unwell. One-to-one sessions with patients to gain their views, draw up advance statements, and discuss their situation with family and friends are all crucial in establishing a particular perspective on care planning. Importantly, these actions are reflected in the principles of the Mental Health Act 2003 which highlight that these views should be taken into account. While it may not always be possible to uphold them, these should be heard and incorporated into recovery and care plans.

Tools such as Wellness Recovery Action Planning (WRAP)²⁴ (Scottish Recovery Network) can be used to encourage clearer expressions from patients. Patients should also be encouraged to attend ward meetings and care plan reviews to inform them of any changes. Assistance from advocacy services and peer support workers can also be beneficial.

Ward staff should always ensure that patients have their proposed treatment and medication fully explained to them and clearly detailed in a way they can understand.

39. Minimum restriction, safety and security

- » **All patients have the right to:**
 - **be free of restrictions of their independence, choice or control, unless restrictions are for clearly identified reasons and are the least necessary**
 - **be involved as much as possible in agreeing any restrictions**
 - **have any restrictions regularly reviewed to decide whether they are still 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 the internet, and to have these explained**

In line with the core principles of the ECHR, patients should, in general, be free of restrictions although some restrictions may relate to ward policy. All patients have the right to safety and security, and restrictions may be related to ensuring this – for example, there may be good reasons to lock the ward door and, if so, ward staff should explain these reasons and also explain how patients can leave, if they are entitled to. Similarly, staff must explain any policies on restricted access to the internet or social media and the reasons for them. All such policies must be proportionate.

If possible, encourage a personalised approach to safety as opposed to a blanket approach for the ward as a whole that could limit options for other patients. If ward staff believe that specific restrictions are necessary for an individual patient, they should always aim to involve the patient in agreeing to these. Again, any such restrictions should be proportionate and must be regularly reviewed.

CASE STUDY 12

Applying proportionate restrictions which are fair for everyone

Joe is an informal patient in a mental health admission ward. The ward opens onto a garden area and the patients are encouraged to go out and enjoy fresh air, however it is not a designated smoking area.

Although Joe does not smoke, a number of the other patients do and have been flouting the rules by smoking in the garden rather than the designated area, which is further away. To counteract this, the ward manager proposes closing access to the garden until further notice – a decision that will affect everyone, whether they flout the smoking rules or not. Joe feels that this is an unfair decision and challenges it. As a result, the ward staff and patients agree that the garden will be kept open for everyone, but any patient found smoking in it will have their right to use the garden removed.

40. Therapy and recreational activities

- » **All patients have the right to activities for therapy and recreation**

This right is in line with Article 26 of the UN Convention on the Rights of Persons with Disabilities which requires effective and appropriate measures to attain and maintain maximum independence; full

physical, mental, social and vocational ability; and full inclusion and participation in all aspects of life. To ensure it is afforded to patients, ward staff must ensure that activity planning is a meaningful part of any care plan and that activities are then provided. If possible, a patient's personal interests or preferences should be considered and, if appropriate, opportunities to complete some activities away from the ward in a community setting should be provided. Staff also have a responsibility to ensure that cancellations of structured activities are kept to a minimum.

41. A positive therapeutic environment

- » **All patients have the right to a positive therapeutic environment including sufficient living space; adequate lighting, heating and ventilation; a satisfactory state of repair and hospital hygiene; and adequate food and clothing**

The environment in which people are treated is important and, under the Standards of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, patients have a right to a suitable standard of environment. Hospital staff and managers have a responsibility to ensure that this is the case and the aim should be to offer material conditions that are conducive to the treatment and welfare of patients and provide a positive therapeutic environment.

42. Access to education

- » **All patients under the age of 18 have the right to access to education**

The Education (Scotland) Act 1980 provides for access to education for everyone under 18 and this continues to apply when the individual is a hospital patient. This is a local authority duty and the Mental Health Act 2003 imposes a duty on all NHS boards in Scotland to provide services and accommodation for patients under 18 years of age. Should a young person be admitted to an adult ward, appropriate arrangements for their education should be made. The Commission has a role to monitor this when an admission is expected to be long term, and the young person is well enough to carry out school work; there is an expectation that their school, college or university would provide this. Hospital staff have a duty to liaise with the education provider to ensure that this happens.

43. Ability to vote

- » **All patients have the right to vote in elections (apart from some people detained under criminal law)**

Individuals are entitled to vote even if they are in hospital. Guidance on voting rights is provided by the Electoral Commission and there is information on this on their website. Ward staff should access this prior to elections. In the main, there are no restrictions on detained patients being able to vote, unless they are detained under criminal law. Ward staff should ensure that patients are given help to apply for postal votes or to attend the polling station, as appropriate.

44. Access to medical records

- » **All patients have the right to ask to see their medical records (but the doctor can decide not to show information if it would risk their health)**

Access by a patient to their medical records is possible under the Access to Health Records Act 1990. A request for access is usually made in writing by the patient to the relevant NHS board but decisions can be made not to share all the information if it is considered detrimental to the patient's health. This can be a sensitive area and one that hospital staff need to consider carefully with patients, balancing the right to access with the patient's mental health. As such, this decision is best made through multi-disciplinary discussion, involving all members of the clinical team, to weigh up the factors.

45. Local authority responsibility for property

- » **All patients have the right to have arrangements made by the local authority, if necessary, to ensure that their property, including pets, is looked after while they are in hospital**

When a patient is admitted to hospital, this can sometimes be in a crisis situation and leaves their property, including their pets, unprotected. This is a duty on local authorities under Section 48 of the National Assistance Act 1948 to look after the property of people admitted to hospital but this can sometimes be overlooked at the point of admission. Ward staff should remember, and revisit as necessary, issues around keys, pets and other possessions and ensure that social work staff or family are made aware of the patient's situation, that the patient's property is being looked after, and the patient kept informed.

46. Family relationships

- » **All patients have the right to have support to maintain family relationships**

In line with the right to respect for private and family life (Article 8 of the ECHR), discussions around family contact, sharing information with relatives and how to meaningfully maintain relationships should be considered. This is particularly pertinent for patients who are in a hospital far from home.

Consider providing access to Skype or social media platforms if appropriate, and additional facilities for visiting such as a quiet room, space off the ward or toys for any visiting children. The use of home passes and phone calls to maintain family and community contact are also valuable ways to afford this right.

ii. Specific rights of detained patients on a hospital ward

Detained patients have specific rights under the Mental Health Act 2003 in addition to those already highlighted in this section. Ward staff should ensure these rights are respected and help patients to understand them.

47. Adherence to advance statement

- » All detained patients have the right to:
 - have their advance statement choices about care and treatment followed unless there is a good reason not to and that reason is explained in writing
 - have the Commission informed if they are treated against their advance statement choices

See [17. Adherence to advance statement](#)

48. Second opinion on compulsory treatment

- » All detained patients have the right to a second opinion from an independent doctor, if they are unable or unwilling to consent to treatment because of their mental disorder, after two months of treatment with medications or immediately for certain other treatments such as ECT or artificial nutrition

Part 16 of the Mental Health Act 2003 covers medical treatment. It explains when patients can be given treatment against their will and what safeguards should be put in place to protect their rights in such a situation.

The law states that a detained patient can be given medication to treat their mental illness for the first two months of their detention, without their consent, if it is in their best interests and where the patient is on a CTO and the giving of medical treatment authorised by the Tribunal. During this period, it is good practice for the doctor to discuss the treatment with the patient and involve them in decision making as much as possible. After this period, if a patient is able and willing to consent to the treatment, their doctor will ask for this in writing and complete a T2 form. The 2003 Act also states that some treatments, such as ECT or artificial nutrition, require safeguards to be put in place from the start of the treatment.

If a doctor wishes to give treatment without that patient's consent, then they must seek independent opinion from a Designated Medical Practitioner (DMP). The DMP service is provided by the Commission and the DMP will be an experienced psychiatrist, independent of the hospital. The DMP's role is to decide whether the treatment plan is in line with the law, and in the patient's best interests, by reviewing the plan and interviewing the patient, named person and others involved in the patient's treatment.

Patients who are unhappy with their diagnosis or treatment may request an informal second opinion, but this is not a right.

49. Preparation for Mental Health Tribunal hearings

- » **All detained patients have the right to support to understand and prepare for Mental Health Tribunal Scotland hearings**

Effective participation in tribunal hearings is necessary to realise the right to a fair trial (Article 6 of the ECHR) and the associated legal rights of advocacy. Access to a solicitor should be clearly explained and discussed at this stage of the patient's journey. If the patient is too unwell to instruct a solicitor, the Tribunal will appoint a 'curator ad litem' to safeguard their interests.

Detained patients should have the role and function of a Mental Health Tribunal clearly explained to them so that they understand their rights in this area. In addition, if they are able to visit a Tribunal suite, or if one is situated on the hospital grounds, patients could be allowed to familiarise themselves with the environment prior to a hearing.

50. Minimum detention

- » **All detained patients have the right to regular review and not to be detained if they no longer need to be**

All detained patients should have their detention status regularly reviewed by their RMO, as laid down in the Mental Health Act 2003 and the associated Code of Practice. This is fundamental to a patient's right to liberty. If a patient no longer meets the legal criteria for detention then compulsory measures should be revoked.

51. Communication and safeguards

- » **All detained patients have the right to:**
 - **communicate by phone and post unless it is necessary to restrict this for the individual**
 - **safeguards if their access to phones, letters, parcels, visitors or other things is restricted**

In itself, being detained does not change the usual rights that any individual has to communicate with others. However, at certain points during a hospital stay, a patient may need to be made subject to safeguards in relation to their access to phones, letters, parcels or visitors. These restrictions are known as 'specified persons' measures and are found in Sections 281 to 286 of the Mental Health Act 2003.

Restricting a patient's communications can have a knock-on effect with other rights – for example the right to family life or the right to access to a lawyer – safeguards are therefore essential here.

Sections 281 to 286 of the Mental Health Act 2003 and the associated regulations provide the framework within which restrictions can be placed on detained patients. Restrictions can only be placed

on patients if they have been made a 'specified person' by their Responsible Medical Officer (RMO), who must record a reasoned opinion that sets out the risk to the patient, 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 put in place for up to six months.

Restrictions could be in relation to the patient's own wellbeing or that of others and any restrictions should be proportionate and subject to regular review. The RMO must discuss any restrictions with the patient and explain the reasons clearly. They must also record this in writing and give the patient, their named person if there is one, and the Commission a copy.

Decisions to make a patient a 'specified person' must be made on an individual basis, with the exception of patients in some secure facilities. Patients in the State Hospital are automatically designated as 'specified persons' in respect of all restrictions; patients in designated medium secure facilities are 'specified persons' in respect of Section 286 of the 2003 Act which deals with safety and security, but need to be individually specified by the RMO for any other restrictions.

The patient has a right to ask the RMO for a review of all restrictions every three months. If calls are restricted, the patient has a right to ask the RMO for a review every seven days. Where mail is withheld, hospital managers must notify the Commission within seven days of the reasons for withholding the item and the nature of its contents, and must make sure the patient is made aware of their right to apply to the Commission to have the decision to withhold the item overturned.

Mental health care practitioners should always apply the principles of the 2003 Act. The principles of **least restriction**, **benefit to the patient** and **participation** are of particular importance in the implementation of these regulations. For further information please see our specified persons guidance.²⁵

52. Minimum seclusion

- » **All detained patients have the right to:**
 - **not be secluded against their will unless it is the only way of managing risk to their self or others**
 - **seclusion for as little time as necessary**
 - **discussion and support (debrief) afterwards**

The Commission's definition of seclusion is:

"The restriction of a person's freedom of association without his or her consent by locking her or him in a room. Seclusion can only be justified on the basis of a clearly identified and significant risk of serious harm to others that cannot be managed with greater safety by any other means. Although this definition does not include situations where someone prevents a person from leaving a room, the same principles should apply."

25 For staff: http://www.mwscot.org.uk/media/216057/specified_persons_guidance_2015.pdf and for patients: <http://www.mwscot.org.uk/media/307194/mhc-guides-specifiedpersons-revised.pdf>

Rights regarding minimum seclusion have strong links with the duty to protect individuals from risk to their life, namely the right to life and the right not to be subjected to torture or to inhuman or degrading treatment or punishment (Articles 2 and 3 of the ECHR). However, some situations of seclusion can also amount to inhuman and degrading treatment and pose significant restrictions on the right to liberty and the right to private and family life (Articles 5 and 8 of the ECHR).

We do not advocate the use of seclusion as a first-line response to aggressive behaviour in detained patients and it must only be used in the context of an approved policy on the management and prevention of violence, produced by the relevant NHS board for each hospital. We do, however, acknowledge its use and ensure that it is properly monitored within the aim of reducing risk. The principles of **least restriction** and **benefit to individuals** must be applied at all times and it is also important to support and debrief patients after an incident of seclusion. We would also advise that any patients who have observed distressing periods of seclusion are similarly debriefed. Our good practice guide, *The Use of Seclusion*²⁶ is helpful here.

The SPSP, which is part of Health Care Improvement Scotland (HIS), has a mental health team who have explored the issues around seclusion. The SPSP's overall aim is to improve the safety of health care and they work with staff to reduce the level of harm experienced by people using health care services. Reducing instances of seclusion is one of the outcomes of their work and, over the last four years, this has had impact. SPSP have consequently asked all NHS boards to consider their practices and look at staff training in the management of aggression, employ debriefing sessions and monitor the use of seclusion.²⁷

53. Minimum restraint

- » **All detained patients have the right to:**
 - **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**
 - **discussion and support (debrief) afterwards**

Any restraint on a detained patient's freedom should be proportionate to the risk posed. There should be a clear rationale for restraint and it should be time limited and reviewed. As with the use of seclusion, ward staff should apply the principles of the Mental Health Act 2003 at all times and, from a human rights perspective, bear in mind the right to life, the right to be free from inhuman or degrading treatment or punishment, the right to liberty and the right to respect for private and family life (Articles 2, 3, 5 and 8 of the ECHR).

Following an incident of restraint, ward staff and the patient involved should be offered the opportunity for debriefing; other patients who have witnessed the incident may also benefit from this. It is worth noting that restraint is not always confined to physical intervention but can be mechanical or pharmacological too – for example, strapping into a chair, restrictive clothing, locked doors or medication.

26 http://www.mwscot.org.uk/media/191573/final_use_of_seclusion.pdf

27 <http://www.scottishpatientsafetyprogramme.scot.nhs.uk/Media/Docs/Mental%20Health/End%20of%20Phase%20Report.pdf>

The SPSP has undertaken work in this area and has seen instances of restraint fall dramatically in some ward settings, and the Commission has published guidance, *Rights, risks and limits to freedom*.²⁸

CASE STUDY 13

Taking steps to reduce restraint incidents

David is a newly qualified staff nurse in a busy admission ward. Having worked on the ward for a number of months, he observes the high number of patient restraint incidents that occur during the early part of the evening. Following an incident in which a patient sustains an injury, a review of restraint practices is undertaken and David comments that many patients complain about being bored and frustrated at this time of day, leading to changes in their mental health.

The ward team develops a new approach and, with the assistance of an occupational therapist, develops and delivers a more structured programme of social activities and events in the early evening. Within just three months, ward staff record a significantly reduced number of restraints.

54. Minimum level of observations

- » **All detained patients have the right only to be placed under constant or special observations if it is necessary for their own or others' safety, and for the minimum time**

Constant or special observations are a recognised part of nursing practice and are used to monitor risk and protect individual patients. However, they are intrusive and impact on a patient's privacy with reference to the right to respect for private and family life (Article 8 of the ECHR). Ward staff need to balance this consideration with the importance of keeping an individual safe, reflected in the right to life (Article 2 of the ECHR), when constant or special levels of observation are required.

The current policy on the practice of nursing observation is contained in *Engaging People: Observation of People with Acute Mental Health Problems* CRAG (Clinical Resource and Audit Group) 2002.²⁹ This, however, is now somewhat out of date and the development of new guidance is currently being looked at by HIS. The aim is to review the existing guidance on observation policy in an attempt to improve the experience of patients requiring support for acute mental health issues. The emphasis is on adopting a more personalised approach to care at times of higher risk and to move away from observing patients in a contained environment such as their bedroom.

Patients have commented to the Commission (via our visiting programme) that they often find the process of constant or special observations helpful and supportive if the assigned nurse engages well and is able to develop a professional therapeutic relationship. In other instances however, we have heard of agency staff or new and inexperienced staff undertaking this role and the experience becoming intrusive and negative for the patient. Crucially, observations must be used for therapeutic purposes, not just as a way of managing behaviour.

28 <http://www.scottishpatientsafetyprogramme.scot.nhs.uk/my-account?ReturnUrl=%2fprogrammes%2fmental-health%2fsafety-principles%2fviolence-reduction>

29 <http://www.gov.scot/Publications/2002/08/15296/10454>

iii. Specific rights of informal patients on a hospital ward

Being admitted to a mental health ward will be a new and frightening experience for many patients – being detained can bring additional stresses and even being admitted informally can cause a lot of confusion. Every ward needs some level of structure and associated rules to aid its smooth running, but for new patients this can appear overly stringent and they will often not clearly understand their rights in this situation.

Hospital staff have told us that they are less confident about explaining informal rights than those clearly defined in mental health law. There is an anxiety, for nursing staff in particular, around being open about rights in relation to medication, staying in hospital and freedom of movement. The ability to offer accurate information to patients and to balance this with protecting their health and welfare is key.

55. Ability to leave

- » **All informal patients have the right to leave the hospital at any time (but they should agree a plan with staff)**

All informal patients remain free to leave the hospital ward at any time and the same guidance applies here as it does during their admission. Hospital staff should ensure they understand this right and do not unlawfully detain an informal patient.

56. Refusing treatment

- » **All informal patients have the right to refuse medication or other treatment, if they have capacity to do so**

Throughout their time on the ward, informal patients who have capacity have the right to refuse medication or other treatment. Hospital staff should respect this right and work with the patient to discuss the best treatment options and the potential consequences of refusal on their health. If an informal patient does not have capacity to decide about treatments, safeguards in the Adults with Incapacity (Scotland) Act 2000 apply.

57. Seclusion

- » **All informal patients have the right not to be put in seclusion against their will**

Seclusion is the restriction of a person's freedom. There is no legal authority for hospital staff to seclude an informal patient and to do so would be an unlawful deprivation of liberty. One option is to discuss with a patient whether they would agree to voluntary 'time out' – but this must not involve being locked in or confined to a room. If a situation arises where an informal patient's behaviour constitutes such a risk that seclusion is the only option, hospital staff will need to consider whether grounds for detaining the patient under the Mental Health Act 2003 are met and arrange for medical assessment to take place.

58. Communication restrictions

- » **All informal patients have the right not to have restrictions on communications by phone, post, email and social media (although there may be reasonable ward policies to help ensure the health, safety and welfare of patients, staff and visitors)**

There is no legal authority by which staff may restrict an informal patient's communications. However, there may be necessary ward policies in place – for example, smartphones may not be permitted on some wards because of the risk to confidentiality of other patients through the use of photography and social media – and so hospital staff must provide informal patients with an alternative means such as a landline, ideally in a quiet or private area in the ward. The use of any telephone may be difficult if a patient is unwell and consideration could be given to limiting its use while still ensuring that clear access is given. Our *Specified Persons Guidance*³⁰ is helpful here although do bear in mind that a patient can only be specified if they are detained.

A stylized illustration of a road winding through a landscape. The road is depicted with a dashed white line down the center and is set against a background of various shades of pink and purple. The landscape features several rounded, mountain-like shapes in different tones of pink and purple. The overall style is minimalist and modern.

CHAPTER 5

**RIGHTS ON DISCHARGE
FROM HOSPITAL**

The point of discharge is key for both hospital staff and patients and is a crucial transition point in the patient pathway. Discharge should be well planned in advance, with effective and meaningful community links made, and thought given as to how rights can be afforded and maintained.

Hospital staff and patients should feel confident that discharge from hospital will be able to achieve aspects of recovery for patients and that this can be maintained. This chapter focuses on patients' rights at the point of discharge from hospital. Transition points when moving between hospital and community settings call for good communication, clear forward planning and participation from patients and carers alike. Ward staff should be clear about their role in this process and how it dovetails with the role of community teams.

i. The key rights of all patients when being discharged from hospital

59. Discharge planning and participation

60. Scope of discharge plan

61. Community care needs

62. Carer involvement

63. Advance statement support

ii. Specific rights of informal patients who discharge themselves from hospital against advice

64. Information on care and treatment

i. The key rights of all patients when being discharged from hospital

Discharge planning is an important part of a patient's journey through hospital. It is essential that the route out of hospital is considered by the full clinical team and involves the participation of the patient and their family or friends.

Unplanned or poorly organised discharge can lead to increased risks for the patient and often inhibit a good recovery. Observing a patient's rights to contribute to their discharge plan will be beneficial and may ultimately decrease the need for future admission.

59. Discharge planning and participation

» **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**

Being discharged from hospital can hold anxieties for patients and their carers, and for hospital staff, so planning for this should start early. A patient's participation in their care is an important right in terms

of the right to respect for private and family life (Article 8 of the ECHR) and staff should explore their discharge plan with them well in advance, so that it is based on a full understanding of what is important to the patient in their recovery. Family members should also be involved (normally with the patient's consent) so that they can contribute to and assist with the transition from the hospital ward back to the patient's own home. The new Carers Act (expected to be implemented from April 2018) gives carers the right to be involved in discharge planning, with or without the patient's consent.

Hospital staff should ensure that patients are kept fully informed about their discharge plan, including how they are progressing towards discharge, the criteria for discharging them, and what arrangements are being made for their ongoing support and any other needs such as accommodation or crisis support.

60. Scope of discharge plan

- » **All patients have the right to**
 - **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**

A patient's discharge plan should have a clear emphasis on recovery and due consideration as to how this can be supported on their return to the community. Plans should therefore have good multi-disciplinary input and be personalised. They should include consideration of treatment, community services, informal support from family, friends and the community, and crisis support. Effective links and communication between hospital staff and community mental health teams help to ensure good continuity of care.

Plans should consider meaningful activities for patients such as employment, education and training. The right to habilitation and rehabilitation for those with a disability is a human right under Article 26 of the UN Convention on the Rights of Persons with Disabilities. It states that individuals with a disability have the same rights to those opportunities as others. Unfortunately, patients using mental health services often remain disadvantaged in terms of employment so the discharge plan should also consider how to link patients to employability services, employment support, volunteering opportunities, education and training as appropriate, and at the appropriate time in their recovery. Sections 25-27 of the Mental Health Act 2003 place a duty on local authorities to provide care and support services to people with mental health issues, as well as services to promote wellbeing and social development, including social, cultural and recreational activities; training; assistance with employment; and assistance with travel to access services.

61. Community care needs

- » **All patients have the right to have their community care needs assessed, and assessed needs met**

Local authority social work services have a duty under Section 12 of the Social Work Scotland Act 1968 to complete an assessment of needs and this includes individuals with mental health issues. As part of discharge planning, hospital staff should consider making the referral for this assessment prior to discharge so that a range of holistic needs are identified. In the case of patients with existing assessments, it may be worth requesting a review or update.

62. Carer involvement

- » **A patient's carer (family/friend/partner) has the right to be informed and involved in discharge planning**
- » **All patients have the right, with the patient's consent, to have their carer involved and have their views and caring role considered when determining the need for support and services for the patient**
- » **The carer has the right to an Adult Carer Support Plan or Young Carer Statement, and to support if their needs meet local eligibility criteria**

Under the new Carers Act (expected to be implemented from April 2018) carers will have new rights in relation to a hospital's discharge of the patient they care for. They will have a specific right to be involved in the planning prior to discharge and, if the patient is likely to require care after discharge, hospital staff must ensure that the carer is informed, as soon as is reasonably practicable, of the intention to discharge and invite the carer to give their views. This does not require the consent of the patient being discharged.

As far as is reasonable and practicable, the carer's views must be taken into account in planning the discharge and carers will also have the right to be involved, and have their views and caring role considered, when determining the need for support and services to be provided to the cared-for patient (with that patient's consent).

Carers can play a significant role in supporting and maintaining recovery and it is good practice, where the patient consents, for staff to encourage carers to participate in discharge planning meetings.

The new Carers Act gives carers themselves new rights, including having a plan for their own support needs prepared by the local authority. If their identified needs meet local eligibility criteria they will have a right to support but, if not, the local authority should provide access to other forms of support, information and advice and will still have a duty to provide support.

CASE STUDY 14

Respecting the rights of carers and benefitting from carer participation

Aneesa is the carer for her 25-year-old son, Syed, who was diagnosed with a psychotic illness when he was 18. He had had a number of hospital admissions and initially found it difficult for his mother to be party to confidential information. Over the years, he's recognised that she provides him with good support and can spot when he's becoming unwell so he's consented to Aneesa's involvement.

Syed is currently coming to the end of a long stay in hospital and since his last admission the ward has a new senior charge nurse (SCN) who has made various improvements to ward policy and, in particular, to contact with carers.

Aneesa and Syed both welcome this change – Aneesa is identified as Syed's carer early on in his admission and encouraged to share her views throughout his stay in hospital. She is regularly updated on his progress and given a full explanation of his treatment and medication. Previously, Aneesa felt that engagement was tokenistic and inconsistent – she now feels respected and valued by the ward staff.

Aneesa has financial worries as her care of Syed means that she can no longer work full time so arrangements are made for her to see a welfare rights advisor. The SCN also asks Aneesa to become involved in delivering a carer training programme for new staff on the ward.

By the time Syed is discharged, both he and his mother feel the benefit of the respect for carers' rights. Syed also feels that his confidentiality has been respected as there are some issues that he does not wish shared with his mother. They are confident about the discharge, about the support in place and the lines of communication in a crisis.

63. Advance statement support

- » **All patients have the right to support to make an advance statement about their care and treatment choices if they become ill**

Preparation for discharge is the ideal point to consider the completion of an advance statement. This could be incorporated into discharge planning and gives patients an opportunity to reflect on the period of admission and consider aspects of their care and treatment that could be approached differently. These are key starting points for discussions on care and treatment and will assist both the patient and community psychiatric nurses to complete the document at the point of recovery.³¹

See 14. [Advance statement choices](#).

31 <http://www.mwscot.org.uk/get-help/getting-treatment/advance-statements/>

ii. Specific rights of informal patients who discharge themselves from hospital against advice

Sometimes informal patients will suddenly decide that they want to leave the ward – they may miss their home, friends and family, feel alien in a ward setting, or lack insight into their illness. It's important to maintain a careful balance between respecting the rights and autonomy of the patient and protecting their health and welfare.

64. Information on care and treatment

- » **Informal patients have the right to information about how to get further care and treatment if they discharge themselves against advice**

There will be occasions when patients discharge themselves from hospital against the advice of the clinical team. These can be challenging circumstances for hospital staff, and often occur at difficult times of day and night when contact with community health services, social work or housing teams may be limited. On such occasions, it's important to reflect on the duty to protect individuals in terms of the right to life (Article 2 of the ECHR). Ideally, patients should be encouraged to remain on the ward until additional support can be organised. If this is not possible, having a clear ward policy on who to contact and where to signpost patients is helpful in ensuring their care and welfare.

Consideration should also be given to assessing whether the patient needs to be detained under the Mental Health Act 2003 with regard to their own safety and that of other people. This, however, should never be used as a threat – rather, discussion should take place around the patient's plans for support and keeping themselves safe at home. The involvement of the patient's family and friends can be helpful here.

These recommendations reflect the right to autonomy under the right to private and family life (Article 8 of the ECHR) and also the right to achieve the best possible health, free from discrimination (Article 25 of the UN Convention on the Rights of Persons with Disabilities). This requires services to be available, accessible, acceptable and of good quality and includes the provision of health-related information.



CONCLUSION

DEVELOPING THINKING
AND PRACTICE

The purpose of this good practice guide is to enable staff, working in both community and hospital mental health settings, to raise their awareness and knowledge of human rights and enable them to provide care that works better for everyone. More importantly, it aims to help all staff apply best practice in this area and encourage and promote these rights for the benefit of patients and carers.

Applying a human rights-based approach

Human rights range from the overarching rights contained in the European Convention on Human Rights to the established legal rights set out in the civil law of the Mental Health (Care and Treatment) (Scotland) Act 2003. As some of these rights are not immediately obvious, we hope that this guidance goes some way to helping staff know when and how to be aware of rights and ensure that they are afforded to patients. We have followed the patient's pathway from the community, through admission to hospital and back into the community to outline the key stages where knowledge in this area is critical for mental health care practitioners, and for patients and carers.

In compiling this good practice guide, we are aware that while many aspects of a human rights approach are already best practice for mental health care practitioners, some aspects may be more difficult to adopt. We encourage mental health care practitioners to use this guide and the additional resources that accompany it – the **Rights in Mind** pathway and video case studies – to assist them to reflect on, and further develop, their professional practice, service policies and procedures.



APPENDICES

1. References
2. Legislation and guidance
3. Acknowledgements

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Universal Declaration of Human Rights

UN Convention on the Rights of Persons with Disabilities

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The background features a stylized landscape in shades of pink and purple. A winding road with a dashed white center line curves across the scene. In the distance, there are rolling hills or mountains. The overall aesthetic is clean and modern.

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