Scottish Human Rights Commission

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Human Rights in a Health Care Setting: Making it Work

An Evaluation of a human rights-based approach at The State Hospital

SHRC
10th December 2009

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Acknowledgements

The Commission would like to thank the lead researcher on this evaluation, David Bolger, and all of those who contributed to this project, especially staff, patients and carers from The State Hospital; all external agencies who participated in interviews; and the Project Advisory Group who supported the work of this evaluation: Prof. Jim McManus, Dr. Janice McLaughlin, Ms. Louise Arthurs, Mr. Oliver Lewis and Ms. Judith Bueno de Mesquita.

Full report reference: SHRC, 2009, *Human Rights in a Health Care Setting: Making it Work for Everyone: an evaluation of a human rights-based approach at The State Hospital.* Glasgow: SHRC.

Executive Summary:

Human Rights in a Health Care Setting: Making it Work for Everyone

An evaluation of a human rights-based approach at The State Hospital

Introduction

Eleven years on from the introduction of the Human Rights Act 1998 many public authorities are faced with the challenge of putting human rights at the heart of their day-to-day operations. This year the Scottish Human Rights Commission (the Commission) undertook an independent evaluation of the experience of a Special NHS Health Board which has sought to adopt a human rights culture. The results provide practical lessons for other public authorities.

The State Hospital, located in Lanarkshire, is the high security forensic mental health hospital for Scotland and Northern Ireland. It provides psychiatric care in conditions of high security, for persons with mental illness who are compulsorily detained under mental health or criminal law.

In 2000, a critical report by the Mental Welfare Commission into the treatment and care of a particular patient, allied with The State Hospital Board's drive to build on the changing culture throughout the 90s, prompted The State Hospital to conduct a fundamental examination of its human rights practice. A decision was taken to use the Human Rights Act as a vehicle for cultural change, to put the human rights of everyone – staff, patients, carers and family members – at the heart of The State Hospital's services.

What is a human rights-based approach?

A human rights-based approach (HRBA) means putting human rights considerations at the centre of all policies and practices. In this way human rights are seen as both a means (a way of doing things), driven by human rights standards and principles, as well as an end to be achieved. The Commission promotes a HRBA which emphasises the following principles:

Participation: everyone has the right to participate in decisions which affect their human rights

Accountability of duty-bearers to rights-holders: this requires both effective monitoring and effective remedies.

Non-discrimination and equality: all forms of discrimination in the realisation of rights must be prohibited, prevented and eliminated.

Empowerment of rights holders: everyone should know their rights and be supported to participate in decision making, and to claim their rights where necessary.

Legality – public authorities should expressly apply the Human Rights Act and link to international and regional rights standards.

What The State Hospital did to adopt a HRBA

Following a decision by the Board to adopt a HRBA, The State Hospital established a Human Rights Working Group led by senior management and involving clinical and non-clinical members of staff. The Group underwent training in human rights with a human rights expert who helped them to identify specific human rights which were relevant to The State Hospital. Through discussions with around 100 staff and patients, the Group assessed all policies and practices using a Traffic Light assessment tool:

Red = policy/ practice is not human rights compliant

Amber = policy/ practice has significant risk of non-compliance

Green = policy/ practice is human rights compliant.

No policy was given the red light and many were given a green light. However, some policies and practices, such as those related to seclusion and restraint, were given an amber light and further policy development and training needs were identified accordingly.

The Group worked with a human rights expert to develop human rights training for staff and tools for the assessment of future policy and practice. Other steps taken included the creation of a forum for staff, patient, and carer involvement in

decisions, and ultimately the creation of an Equality, Diversity and Human Rights Group to ensure a human rights approach to the delivery of equality duties.

Why we undertook this evaluation

The Commission's general duty is to promote human rights and best practice in relation to human rights in Scotland. To deliver on this duty we have made the promotion and protection of human dignity in care through a HRBA our main priority for 2008-2012. This independent evaluation of one of the most advanced efforts to put human rights into the day-to-day practice of a Scottish public authority is part of that work.

We wanted to know: did the human rights-based approach work? Why? What benefits did it bring? What challenges remain?

With these lessons we hope to work with other public authorities in the health and social care sectors as well as others to support them to take a human rights approach.

How we undertook the evaluation

Following approval from The State Hospital research committee the Commission worked with national and international experts on mental health, human rights and research methodology, as well as a research consultant, to develop a methodology for the evaluation which was based on human rights law. The research included a review of documents related to the adoption of a human rights-based approach including internal policies; one to one interviews and focus groups with staff, patients and carers and a comparison with other human rights-based approach projects and evaluations.

What we found

A human rights-based approach is better for everyone

The adoption of a HRBA was successful in supporting a cultural change from an institution where rights were largely "*left at the door*", and with a "*them and us*" culture, towards an organisation with a more positive and constructive atmosphere with mutual respect between staff and patients. This had led to increased staff and patient engagement, increased work-related satisfaction

amongst staff and increased satisfaction among patients over their care and treatment.

The adoption of a HRBA coincided with staff reporting a reduction in stress and anxiety. Staff told us that the explicit, proactive adoption of a human rights-based approach reduced their "*fear*" of human rights, increased their understanding of how to make choices and take decisions in a rights respecting manner as well as understanding the meaning and benefit of their own human rights.

The HRBA saw a reduction in "*blanket*" policies and an increased focus on individual patient's risks. It also saw an increased focus on the rights of every member of staff, patient and carer. Applying this in all decisions, related to treatment and care, restrictions of freedoms, employment practice and other areas had led to a fairer environment and better relations between staff and patients. As one member of staff said, "*Patients have increasingly recognised their responsibilities as well as their rights*".

Patients too generally noted significant and sustained improvements in their care and treatment and in the overall culture at The State Hospital. Procedures to manage violence and aggression were now seen as proportionate, seclusion was not routinely used as a punishment and patients actively engaged in decisions that affect them.

Taking a rights-based approach reduces risks

By proactively adopting a human rights-based approach an organisation can reduce its risks of having to react to critical media comment, negative public perceptions or legal proceedings, when its policy and practice is shown to breach human rights. Prior to the adoption of a rights-based approach The State Hospital was concerned about the potential for negative publicity and the expense associated with individual cases. Clarity and predictability on limitations of rights through use of simple tests introduced by the HRBA *("Is it legal? Is it necessary? Is it proportionate?"*) can lead to a greater understanding amongst everyone.

Starting with the support of tailored human rights expertise to audit policy and practice and using a 'traffic light' warning system linked to these simple tests makes human rights user friendly, and reduces human and organisational risks.

Human rights are the foundation for other duties

Since the Human Rights Act all relevant legislation has to be read through the lens of human rights. Taking a human rights-based approach at The State Hospital made delivering on other duties a less daunting process. It laid the foundations for the integration of new equality, freedom of information and mental health duties. In particular The State Hospital experience demonstrates that human rights can provide a bedrock for implementing equality duties. The evaluation also shows the importance of maintaining a clear link to the Human Rights Act in practice.

Why it worked

The experience of The State Hospital provides clear lessons for the integration of human rights into other public authorities in the health and social care sectors as well as others. The following elements were seen as crucial to its success:

- Top level buy-in and vision from the Board, Chief Executive and senior management;
- Clear executive leadership in implementation by a senior management team;
- Involvement from an early stage of human rights expertise to support the development and tailoring of a HRBA;
- A participatory diagnostic process, 'the human rights audit', involving staff and stakeholders of an organisation;
- Investment of appropriate time and resources;
- A proportionate approach, consistent with human rights principles itself, so that the HRBA effort reflects the significance of the issues;
- An approach which focuses on the rights of everyone affected: staff as well as patients and their carers.

The HRBA promoted understanding of everybody's rights, and how to balance one person's rights against those of another, as well as how to justify limitations of rights.

There is no room for complacency

Crucial to the success of The State Hospital HRBA was the involvement of staff, and the reflection of their rights throughout the process. There is a need to regularly refresh the HRBA to respond to changes in personnel and in circumstances for example through periodic training, as well as continual assessment and evaluation of policy and practice. Likewise whilst taking the HRBA allowed for the straightforward incorporation of specific equality duties, there is a need to ensure that a focus on equality duties does not result in a shift of focus in some cases away from human rights. Explicit linking of human rights and the Human Rights Act to other duties such as those under equality or mental health laws will help to ensure the sustainability of a HRBA.

Next steps

We would like to work with the Scottish Government and Scottish Public Authorities to:

Promote the experience and lessons from the evaluation of The State Hospital HRBA to see how the human rights-based approach can be applied elsewhere;

Support the lessons from this being taken forward in other key health initiatives including the Patients' Rights Bill and the review of the Mental Health (Care and Treatment) (Scotland) Act 2003;

Develop clear guidance on how all Scottish public authorities should take human rights into account in delivering equality duties, including in the context of the new specific duties under the forthcoming Equality Act;

Develop human rights impact assessment tools, and other mechanisms for integrating human rights into the culture of health and social care institutions.

Introduction

Origins of the evaluation

On 10 December 2008, the 60th anniversary of the Universal Declaration of Human Rights, the Scottish Human Rights Commission (the Commission) became operational, launching a nationwide consultation into the development of its first Strategic Plan. One of the most consistent messages during the consultation was that the Commission should support public authorities to put human rights at the heart of their day to day work, something that was not happening consistently over a decade after the entry into force of the Human Rights Act 1998. Taking this on board, the Commission's first Strategic Plan aims to promote and protect human dignity in Scotland through the promotion of a human rights-based approach which empowers people to know and claim their rights, and fosters the ability and accountability of public authorities to fulfil rights (SHRC 2008).

This evaluation of the experience of a Special NHS Health Board (The State Hospital, from here TSH) which has sought to adopt a human rights culture is a key step in our strategy to support Scottish public authorities to adopt a human rights-based approach.

In May 2009, following approval from TSH research committee, the Commission began an independent evaluation of the experience, perceived benefits and outcomes of using a human rights-based approach at TSH to draw out any transferable lessons for other public authorities.

A human rights-based approach

A human rights-based approach integrates the legal norms, standards and principles of the international human rights system into policymaking as well as day-to-day practice. It can be applied to all areas of public life that affect human rights, including housing, education, policing, social care and in this case, health.

A human rights-based approach means putting the human being and human rights at the centre of all policies and practices. Internationally, the United Nations system has adopted a common understanding on a human rights-based approach, including a commitment to build the capacity of duty-bearers to meet their

obligations and of rights-holders to claim their rights[1]. The commission has outlined in its Strategic Plan for 2008-12 that a human rights-based approach means:

> *"giving people greater opportunity to participate in shaping the laws, policies and practices that impact on their human rights; increasing the ability of those with responsibility for fulfilling rights to recognise and respect those rights; and making sure they can be held to account. It also means ensuring non-discrimination, equality and the prioritisation of the most marginalised."*

Building on a common understanding of a human rights-based approach, the Commission promotes the *PANEL* approach which emphasises the following five elements, founded directly upon human rights law:

Participation: everyone has the right to participate in decisions which affect their human rights

Accountability of duty-bearers to rights-holders: this requires both effective monitoring and effective remedies.

Non-discrimination and equality: all forms of discrimination in the realisation of rights must be prohibited, prevented and eliminated.

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[1] The "human rights-based approach" has emerged primarily from those working on human rights and international development, although it is now increasingly applied to a wide range of settings, including in the developed world. The High Commissioner for Human Rights has promoted the PANEL approach since at least 2001, see Craig Mokhiber, "Toward a measure of dignity: Indicators for rights-based development", Statistical Journal of the United Nations Economic Commission for Europe, vol. 18, nos. 2-3, 2001, pp 155-162. More recently, see UN Office of the High Commissioner for Human Rights, *Principles and Guidelines for a Human Rights-based Approach to Poverty Reduction Strategies*, UNOG, Geneva, 2006, UN Doc. HR/PUB/06/12 (based on *Draft Guidelines on a Human Rights Approach to Poverty Reduction Strategies* (2002) and *Human Rights and Poverty Reduction: A Conceptual Framework* (2004), drafted by Professors Paul Hunt, Manfred Nowak and Siddiq Osmani). Also, *The Human Rights-based Approach to Development Cooperation Towards a Common Understanding among UN*, UN, New York, 2003, which is broadly similar to PANEL, http://www.undg.org/archive_docs/6959-The_Human_Rights_Based_Approach_to_Development_Cooperation_Towards_a_Common_Understanding_among_UN.pdf. For an example of applying human rights-based approaches in a developed country context, see Amnesty International Irish Section and International Human Rights Network, *Our Rights, Our Future – Human rights-based approaches in Ireland: principles, policies and practice*, Dublin, 2005, http://www.amnesty.ie/amnesty/upload/images/amnesty_ie/campaigns/HRBA/PDF%20HRBA%20REPORTsmall.pdf

Empowerment of rights holders: everyone should know their rights and be supported to participate in decision making, and to claim their rights where necessary.

Legality – public authorities should expressly apply the Human Rights Act and link to international and regional rights standards.

Evaluation aim & objectives

The core aim of this evaluation was to undertake an evaluation of the procedural steps and the outcomes of a human rights-based approach to facilitate cultural change at TSH. In order to achieve this, six key objectives were set. The first of which was to understand the process of developing and implementing an effective human rights-based approach and to draw out key learning for replicating this process successfully in other settings both within and beyond health and social care settings.

The second and third objectives were focused on assessing the perceived impact of implementing a human rights-based approach, including benefits for patients, staff and carers from the perspectives of all involved and identifying the extent to which human rights outcomes were perceived to have changed as a result of the adoption of a human rights-based approach.

The fourth objective was to evaluate the extent to which the human rights-based approach is now applied in practice and the degree to which human rights have genuinely been embedded within the culture and are now respected in practice at TSH.

The final two objectives relate to the development of effective human rights-based approach tools and materials that could be used by other public authorities to bring about positive cultural change and the development of an effective human rights-based approach evaluation methodology which could be replicated by those introducing a human rights-based approach.

Evaluation Framework and Methods

In order to assess the perceived impact and benefits of the human rights-based approach and the degree to which human rights are embedded within the current

practice at TSH, the evaluation drew on the *PANEL* framework to identify the indicators and survey, focus group and interview questions for the evaluation. The Commission developed this framework of indicators and questions in conjunction with an independent consultant who undertook the research and a project advisory group made up of five national and international experts in the field of mental health, human rights law and/or research methods. The advisers were: Prof. Jim McManus, Dr. Janice McLaughlin, Mr. Oliver Lewis, Ms. Louise Aurthurs and Ms. Judith Bueno de Mesquita.

In order to obtain the required evidence a range of data was collected throughout this evaluation using a number of different methods. Set out below are the various methods[2] used in order to achieve each of the set objectives.

Review of documentary process and implementation evidence from TSH	(Objectives 1, 3, 4 & 5)
Review of other HRBAs/ evaluations	(Objectives 1, 5 & 6)
Review of other legislative obligations with potential impact on development of policy and day-to-day practice at TSH	(Objectives 1, 3, 4 & 5)
Survey of existence of key policies and indicators of effective practice (developed by the Commission and its Project Advisory Group)	(Objectives 1, 3, 4 & 5)
Semi-structured Interviews with key stakeholders at TSH	(Objectives 1, 2, 3, 4 & 5)
Semi-structured Interview with Prof. Alan Miller	(Objectives 1, 2, 3 & 5)
Semi-structured Interviews with external commentators including: SAMH, Mental Welfare Commission, Scottish Police College, Scottish Recovery Network, Scottish Government, Mental Health Division and TSH Advocacy.	(Objectives 1, 2, 3 & 5)

[22] Limitations to the methods used can be found in Appendix i.

Focus Groups with Staff: members of the initial Human Rights Working Group	(Objectives 1, 2, 3 & 5)
Focus Groups with Staff: cross section of front-line clinical & non-clinical staff	(Objectives 2, 3 & 5)
Focus Groups with Patients	(Objectives 2, 3 & 5)
Focus Groups with Carers	(Objectives 2, 3 & 5)

In total semi-structured face to face interviews were conducted with six key stakeholders at TSH (including the Chief Executive; Director of Nursing (repeat interviews); PFPI Co-ordinator; Carer Co-ordinator; Risk Management; Complaints Officer); the human rights expert who originally worked with TSH to develop the human rights-based approach (Prof. Alan Miller); the Mental Welfare Commission for Scotland (whose initial investigation into the care and treatment of an individual patient was one of the key triggers for TSH to adopt a human rights-based approach); and a range of external commentators including representatives of the Scottish Association for Mental Health (SAMH), Scottish Police College and the Scottish Recovery Network. Telephone interviews were also conducted with a retired member of the Human Rights Working Group; TSH Advocacy Service and the Scottish Government Mental Health Division. The face to face interviews typically lasted an hour to 90 minutes and the telephone interviews lasted 20 to 30 minutes.

A total of 93 individuals contributed to the study through their involvement in focus groups. This included 56 staff, 26 who has worked at TSH for more than ten years and eight of whom were members of the original Human Rights Working Group; 25 patients, five of whom had been cared for at TSH for more than ten years; and twelve carers[3] (including some who were caring for long-standing

[3] A carer at TSH is someone who without payment provides help and support to a friend or relative. The 2007 carer survey (http://www.tsh.scot.nhs.uk/Carers/docs/Newsletters/Carers%20Newsletter%20No%202%20-%20May%2008.pdf) revealed that almost 85% of carers were relatives, with friends and independent advocates making up the remaining 15%.

patients of up to 30 years and others who were relatively recent admissions within the last two years).

Eight focus groups with staff took place, this included: two groups with members of the Human Rights Working Group (6-7 staff); one small group of psychiatrists (5 staff) and five groups containing a mixture of clinical and non-clinical staff (6-7 staff) and lasted on average 90 minutes (although the smaller psychiatrists group lasted 30 minutes).

Five focus groups took place with patients. Two of the sessions were at Patient Partnership Group meetings and one session was in the garden centre (8-11 patients). These three sessions lasted around 60-75 minutes. Two further sessions took place on Wards (3-4 patients) and lasted approximately 30 minutes each. Everything possible was done to provide patients with the opportunity to talk freely, however it was necessary, given the secure nature of the hospital, to have some staff present at a distance whilst the focus groups were taking place.

Finally, two focus groups were run with carers, each lasting about 30 minutes. The first included ten carers and the second included two.

TSH also provided answers to the survey of key indicators through the involvement of a range of staff, including representatives from Senior Management, Human Resources, Policy Development, Patient Focus Public Involvement team, Risk Management Team, and Administrative Support.

In addition to the interviews, focus groups, survey and documentary evidence collected, the researcher was also able to observe day-to-day practice as it unfolded at the hospital.

Research began in May 2009 with the collection of documentary evidence. The majority of interviews and focus groups took place from July to November 2009 and survey information was collected throughout the whole process.

An interim report of emerging findings was presented in October to a group of national and international experts who advised SHRC throughout the implementation of the project, highlighting what further information was required to be collected through a small number of follow-up interviews at TSH in November.

Chapter 1: The Human Rights-based Approach Process at The State Hospital

TSH in Context

TSH is located in Lanarkshire, midway between Glasgow and Edinburgh. It is one of four high security forensic mental health hospitals in the UK and the only such hospital for Scotland and Northern Ireland. Currently, just under 740 staff[4] provide psychiatric care in conditions of high security, to approximately 140 persons with mental illness who are compulsorily detained under mental health or criminal law.

Patients can be compulsorily detained at TSH under the provisions of: The Criminal Procedure (Scotland) Act 1995 and The Mental Health (Care and Treatment) (Scotland) Act). Patients are generally admitted from and discharged to other NHS hospitals, prisons or the courts. Since 2008 TSH has only cared for male patients and this will remain the situation after the current hospital rebuild is completed (due for completion 2011/12).

The majority of patients being cared for at TSH have a primary diagnosis of schizophrenia and a quarter have another primary diagnosis. Significant numbers have a secondary diagnosis relating to substance abuse (drugs/alcohol) and personality disorder. One third of patients in TSH have not committed an offence, but have been admitted due to the risk they pose to themselves or others.

Patients at TSH are more likely to have complex needs, including treatment resistant psychosis, and more than one substance abuse problem, compared with the patient population of general adult mental health services. They are also more likely to be living with the consequences of previous institutional care. Patients spend on average around seven years in TSH, ranging from around four weeks to over 40 years.

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[4] Data valid as of 1st June 2009, SHRC personal correspondence with The State Hospital 12th June 2009. Just over 50% of those staff are nursing staff, the remainder are found in support services (21%), administrative services (14%), allied health professions (6%), other therapeutic services, medical and dental services (3%) senior management (0.01%) and health science services (<0.01%).

In recent years TSH has been considered overcrowded, a view shared by TSH Board which views current facilities as unfit for modern service delivery.[5] As a consequence TSH is currently being rebuilt on the existing site.[6] The new hospital will have 140 high-secure beds for male patients requiring maximum secure care, including 12 specifically for patients with a learning disability. Patients not requiring the high security of TSH will be transferred to more appropriate and planned medium and low secure services.

The drivers for a rights-based approach at TSH (1990s – 2001)

During the 1990s TSH was going through a period of significant change. A new management team at the hospital aimed to shift the ethos of the hospital from an essentially custodial one to one which emphasised the care and treatment of its patients. This process of change was not without its difficulties, as was noted by some staff who experienced this. Some felt that changes often appeared draconian and threatening. However, the majority of staff with whom we spoke readily acknowledged that there was a need for change.

Part of this recognition came about as a result of the report of an inquiry by the Mental Welfare Commission for Scotland[7] in March 2000 over the treatment of an individual patient at TSH. The inquiry began in August 1999 following a request by the then Scottish Minister for Health and Community Care. The impact of this inquiry was not limited to TSH. It was also instrumental in bringing about the changes to legislation that were to come in 2003 with the introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003.

The inquiry concluded that many improvements were made to the general treatment and care provided to patients at TSH during the relevant time. However, the first recommendation in the report was that "*the human rights of individual patients must be recognised*" (MWC 2000:8). Recommendations in the

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[5] Whilst other care and treatment was commended, the issue of overcrowding and unsuitable facilities was highlighted in a visit by the Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment in May 2003.

[6] See the Business Case for the rebuild here: http://www.tsh.scot.nhs.uk/New_State_Hospital/docs/OBC%20-%20Updated%20Submission%20-%20Public%20Domain%20-%20June%2020061.pdf

[7] See for example http://www.polfest.org/business/bills/billsPassed/rudr-01.htm

inquiry report included that TSH should: review the communication between security staff and clinical teams; examine the management systems and how they worked within the hospital; put in place (where they did not exist) more open, accountable and effective corporate management systems and methods of monitoring those systems.

In summary, the investigation highlighted that a number of systemic problems existed within the working culture at TSH at that time. A series of initiatives were put in place to respond to the totality of the Mental Welfare Commission's report of its inquiry (MWC 2000). Considering how to address the overall recommendation on human rights, TSH Board made a crucial decision in determining how to proceed. Senior management described during this evaluation how an emerging interest in human rights was growing within the hospital prior to the inquiry. However, this interest primarily came from within rather than out with TSH. Since the adoption of the Human Rights Act in 1998 and later in October 2000 when it came into force, very little advice had been provided by government on how to take the implications of the HRA into consideration. Those interviewed during this evaluation could not recall significant promotion of the Human Rights Act from government or any other external body.

The Mental Welfare Commission inquiry report gave the Board the impetus to look at human rights within the hospital in a systematic manner. Moving forward, The Board took the decision to use the Human Rights Act as the vehicle for culture change in the hospital to move towards a culture where the rights of everyone - staff, patients and carers – are respected, protected and fulfilled. They wanted to make human rights work for them.

Development and implementation of the rights-based approach at TSH (2002-2004)

The process of developing a human rights culture within TSH began in early 2002 when a multi-disciplinary Human Rights Working Group was established, chaired by the Nursing Director. One of the first actions of this Working Group was to commission an expert human rights consultant to undertake research and produce a report on human rights issues at TSH. His findings indicated that the

following articles of the European Convention on Human Rights[8] had particular and acute relevance for TSH:

> Article 3: Prohibition of torture, inhuman and degrading treatment or punishment
>
> Article 5: Right to liberty
>
> Article 6: Right to a fair trial and a fair hearing
>
> Article 8: Right to respect for privacy and family life

Building on this analysis, the members of the Working Group developed their own knowledge and expertise in human rights. They then embarked on an extensive consultation with members of staff and patients from every ward in the hospital. The purpose of this consultation was to encourage those involved to identify real life scenarios which may have human rights dimensions. This appears to have been an important part of the process in that staff and patients themselves were enabled to flag up potential human rights issues.

Based on the findings of this consultation, the Working Group together with the human rights consultant developed an audit tool, which addressed three key questions in relation to all policy and practice at TSH: *"Is the policy/practice legal?, Is there a legitimate aim?, Is the practice proportional?"*

Using this tool the Working Group conducted an audit of all policy and practice at TSH using a simple traffic light method:

Red: policy/practice not human rights compliant

Amber: policy/practice has significant risk of non-compliance

Green: policy/practice is human rights compliant

The audit was conducted over the summer of 2002 and the results were communicated to the Board and to staff at the end of that year. No outright 'red lights' in policy or practice were identified and there were a reasonable number of

[8] The majority of rights in the European Convention on Human Rights and Fundamental Freedoms have been part of the law of Scotland since the Scotland Act 1998 and the Human Rights Act 1998.

'green lights'. There were, however a significant number of 'amber lights' and the audit concluded that:

> *"It is in this area [practice, knowledge and awareness] that most human rights breaches would appear to be most likely to occur – potential failure to achieve proportionality in interfering with a patient's rights"*[9]

Whilst the audit did reveal some areas where policy was lacking, the biggest 'amber' concern was in relation to policy awareness. The audit revealed that there was significant lack of awareness of policies which existed and practice was recognised to be very different from the policy. As one member of senior management stated:

> *"There is no point in having shiny nice compliant policies on the shelf if the practice on the shop-floor doesn't reflect the policy".*

Therefore, the major areas for further work that were identified as priority issues were to develop policy where none existed and to make sure that practice reflected policy and that staff were fully aware of all policies. In particular the following policy areas were highlight for immediate attention: prevention and management of violence and aggression (PMVA, which at the time of the audit was known as control/restraint); staff restrictions; employment practices; mail vetting; searching; grounds access; and entrapped patients.

The programme of work flowing from the findings of the audit comprised of these four main elements:

Development of a Human Rights Best Practice Guide for staff;

Development of education and awareness-raising programmes for all staff;

Further review of key 'at risk' policies and procedures highlighted as 'amber lights' during the audit process; and

Development and a Human Rights Charter for everyone (staff, patients and carers).

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[9] Quoted from a 2004 State Hospital Presentation.

Best Practice Guide

First to be developed was the Best practice Guide, which contained the process that staff should follow if faced with a situation that they believe may result in a breach of human rights, followed by an A to Z of hospital policies and practices summarising where and how human rights breaches may arise and how to prevent this from occurring. The Guide[10] presents a clear statement of the basic principle for a move towards a human rights culture:

> *"The starting point now of a patient's journey through the Hospital is the recognition of the patient's human rights. Forfeiting all rights on admission and winning back privileges is no longer sustainable".*

Human rights training workshops

From 2003 until 2005 a series of training workshops for staff were delivered to approximately 200 staff[11]. The workshops explored the motivations behind the human rights-based approach and made use of realistic case studies to bring human rights issues to life for staff.

Review of 'amber light' policy and practice

During this time a systematic review of the key policies identified as 'amber lights' in the audit also took place. During this review human rights issues were generally reflected explicitly. One of the most significant shifts in policy presentation can be seen in relation to Prevention and Management of Violence and Aggression (PMVA). This policy[12] makes extensive reference to TSH's human rights obligations and approach and highlights the need to ask three key questions of legality, necessity and proportionality:

> *"In the case of procedures for the prevention and management of violence and aggression, especially those that potentially may involve greater infringement of patients' rights, the staff response must be justified, appropriate and proportionate*[13] *to the assessed actual or potential risk."*

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10 TSH Best Practice Guide 2002

11 TSH Annual Report 2005 accessed at http://www.tsh.scot.nhs.uk/About_Us/Index.htm

12 Latest version dated November 2006.

13 Emphasis added.

This approach is in notable contrast to an earlier policy on one of the original components of the PMVA suite of policies - dealing with Psychiatric Observations policy - dated October 2002, which made no mention of human rights issues at all.

Development of a Human Rights Charter

The intention to develop and publish a Human Rights Charter for TSH was not completed. Although a draft charter was prepared, it appears that this process was halted with the introduction of new equality legislation in 2006 which led to a shift in emphasis from implementing a human rights-based approach towards a recognition of the imperative to deliver on specific equality duties including the production of an equality scheme. This led to TSH developing a form of combined approach to equality, diversity and human rights.

Evolution of the human rights-based approach (2005-2009)

During 2004/5 in line with national guidance produced for all NHS Boards TSH established a Patient Focus Public Involvement Forum (PFPI) in order to "*ensure that all patients who use the NHS services, and the general public, have a greater say in how it is run and in particular how it affects them as individuals.*"[14] This has included the development amongst other things of: a Patient Partnership Group, Ward Community meetings, Carers Reference Group, Public Board meetings, appropriate patient involvement in their care reviews, an annual patient survey, information leaflets for patients and carers and a responsive complaints procedure.[15] Whilst the primary driver for this forum was independent of the human rights-based approach, it coincided with and gained momentum from the human rights programme of work as promoting participation is a central pillar of the human rights-based approach.

On 5th October 2005, the Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect across Scotland. This Act is based on a series of principles, many of which are human rights-based. They include: non-discrimination, equality, participation, least restrictive alternative[16] and benefit[17].

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[14] http://www.tsh.scot.nhs.uk/PFPI/docs/PFPI%20leaflet.pdf

[15] Ibid.

[16] "service users should be provided with any necessary care, treatment and support in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and

In addition to this Act a series of other duties on Scottish public authorities were developed in legislation including the specific duties to demonstrate implementation of equality and non-discrimination legislation.

Responding to each, TSH developed a consciously integrative approach to these duties, integrating them within the overall framework of its human rights-based approach. This was based on their conclusion that all of these legislative approaches were, in essence rights-based. For example, the Human Rights Workshops evolved in the period 2005/2006 into the Equality, Diversity and Rights Workshop. This is a compulsory programme for staff and, as of September 2009, approximately 185 staff had completed this training. This workshop is also now part of the compulsory induction training programme for new staff and all new staff since 2006 have completed a training session on equality, diversity and rights.

Oversight of human rights matters at TSH was also taken on by a new Equalities, Diversity and Human Rights Group which produced a Single Equality Scheme in 2007. Rather than produce a scheme solely on equality, TSH sought to replicate their integrated approach to equality and human rights. This extract from the introduction to the Scheme sets the scene:

> *"This is the hospital's first Single Equality Scheme ... It takes account of the legal requirements for race, religion, belief, gender, sexual orientation, disability, age and due to our unique service, provision of the legislation for mental health and human rights."*

The development of this shift in focus to an integrated equality, diversity and rights approach can be traced in the Hospital's Annual Reports,[18] which included a new section on Diversity, including reference to the human rights-based approach in 2004/5; and reference to the development of Equality, Diversity and Rights Training and a Rapid Equality and Diversity Impact Assessment toolkit to be applied to all policies from 2006/2007. This assessment process involves anticipating as far as possible the potential consequences of policies or practices

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effective care, taking account where appropriate of the safety of others" (http://www.nes.scot.nhs.uk/mhagp/one.htm)

[17] "Any intervention under the act should be likely to produce for the service use a benefit that cannot reasonably be achieved other than by intervention." Ibid.

[18] All annual reports can be accessed here: http://www.tsh.scot.nhs.uk/About_Us/Index.htm

on relevant groups and making an effort to ensure that, where possible, any potential negative consequences are removed or reduced and the opportunities for the promotion of equality and rights are maximised[19]. The 'Rapid' nature of the assessment is to provide the board with a strong indication of whether or not a full impact assessment is required for any particular policy, procedure, function or service.

Consequently TSH's human rights-based approach has evolved over the period 2005 to 2009 due to the influence of other legislation and public sector duties. However, overall TSH has retained a focus on human rights, reflecting the original model whereby human rights are seen as the bedrock of equality, diversity and mental health policy and practice.

[19] Further information of RIAs can be accessed here: http://www.tsh.scot.nhs.uk/PFPI/RIA.htm

Chapter 2: Key Findings

Creating Successful Cultural Change

The main aim of the human rights-based approach at TSH was to move to a situation where human rights were acknowledged in policy development and in day to day practice. From the accounts of staff (including senior management), patients, carers and external commentators, it is fair to say that the majority whole heartedly agree that a positive rights respecting culture, where the rights of staff, patients and carers are respected, was created at TSH as a result of the human rights-based approach. This is reflected in the leading statement in TSH's first Human Rights Working Group newsletter *Rights Minded* (2004:1):

> *"Our patients have rights, our staff have rights and the public we serve also have rights. We must never forget that, and [must] balance in a transparent and justifiable way, these competing rights".*

In particular for those staff, patients and carers who had been working, living or supporting patients within the hospital from before the human rights-based approach began, there was a general consensus that there has indeed been a significant change and improvement in the culture at TSH. There was also a general consensus that significant improvements have been made in care & treatment conditions of patients as well as employment conditions of staff as a direct result of the policy and practice review process that arose from the human rights audit.

Prior to the human rights-based approach, TSH was described by many staff, patients and carers as an institution where human rights were largely *"left at the door".* Patients were not viewed as having rights; instead they were stripped of their rights on entry, some of which could be earned back as privileges. On the whole policies were not tailored to individual need or risks but rather blanket policies were applied to all patients, across all wards throughout the entire hospital.

There was also what staff and patients described as a "*them and us"* culture, where little respect or trust existed between the staff and patient population. Patients had things done to them with little ability to participate in decisions

about their own care and treatment and staff worked in fear of human rights being used against them. When the human rights-based approach was first introduced, it was not readily accepted by all staff as a good thing. Senior management described how many staff were very sceptical as to what this approach would achieve. There was a fear that this was an initiative that would place all the power in the relationship between staff and patients, with the patients.

It appears that one of the by-products of the original audit process itself (by involving staff and patients across all wards) was an increased understanding throughout the hospital of what human rights actually were and what a rights-respecting culture meant. This understanding was then developed through further training for clinical and non-clinical staff and through the review of policy and practice.

Whilst a minority of staff still admitted a continued resistance to the need for a human rights approach, the majority of staff, patients and carers appeared then to understand that a rights-approach was about everybody's rights and believed that there was now a much more positive culture within the hospital than there had been prior to the human rights-based approach. As one patient described:

> *"I was told when I was coming to Carstairs that I would be leaving my rights at the front door – and it isn't like that now."*

Staff also noted that there had been a significant reduction in their own anxieties, even fear, about the implications of human rights, once they had learned more about what human rights were and were not. Most staff had gained an understanding that their discretion still counted alongside regard for human rights. Some members of the working group also noted that TSH had become a *'more attractive place to work'* as the human rights-based approach led to a better working culture.

In relation to policy and practice development helping to foster a cultural change, the initial audit highlighted where potential problems were. Most importantly in terms of cultural change, however, the audit had highlighted the existing gap between policy and practice and the need to address this. All policies were checked for human rights compliance and all new and reviewed policies at the

hospital continue to go through a Rapid Impact Assessment, which includes human rights compliance.

Staff, patients and carers all noted the move towards more patient-focussed approaches to care and treatment with an increased individualisation of policies and practice, *"the end of blanket policies"*. As one staff member noted:

> *"Patients are no longer invisible in a blanket policy; you see them as individuals not as a group"*

The concept of individualisation of care and treatment was frequently referred to by all staff, although it is evident that newer staff did not always relate this specifically to the human rights-based approach.

In relation to individualised policy and practices, some staff did note that it was easier to have a blanket policy. In the absence of such policies, staff had to "*think for themselves*" which was "*more challenging in some ways but more rewarding*".

Taking the issue of patient restraint as an example, a number of longer stay patients commented that use of restraint was now much *"more measured"* at TSH:

> *"10 – 15 years ago, restraint could be pretty robust. These days, it's applied in a gradual way."*

With patients being helped to understand why it was that they were being subjected to restraint:

> *"It felt unpleasant and painful at the time but now I realise it was necessary."*

The key human rights tests of legality, necessity and proportionality appear to be well entrenched within policy and practice. As one member of staff noted:

> *"We absorbed the mantra of: is it legal? Is it legitimate? Is it proportionate?"*

Staff and patients noted that there had been an end to the assumption that there were no human rights for patients, with a shift to a culture in which any restrictions to a patient's rights had to be justified. It also saw an increased focus on the rights of every member of staff, patient and carer. Applying this to all

decisions related to treatment and care, restrictions of freedoms, employment practice and other areas led to a fairer environment and better relations between staff and patients. As one member of staff said,

> *"Patients have increasingly recognised their responsibilities as well as their rights".*

Longer-serving patients noted far better relations between staff and patients in recent years and patients with previous experience of prison environments commented that the atmosphere in TSH is far better. A relatively new admission commented: *"Yes, you are treated with respect.*" Patients consistently referred to human rights as meaning entitlements to treatment with respect, dignity and fairness. However, patients similarly acknowledged that these rights were matched by responsibilities for example to control themselves and to behave properly to other patients and staff.

Carers also referred to comparisons with other settings such as prison and other mental health institutions and commented that TSH staff, culture and procedures were far superior and that patient/staff relations in TSH appeared to be excellent. One carer who had been visiting TSH for around 30 years called the previous culture *"pretty barbaric"* but felt that the culture had transformed for the better: "*staff used to be prison officers, now they are nurses*."

A number of external commentators from the mental health field in Scotland were also aware of the human rights-based approach at TSH and were complimentary of what had been achieved. In the early 2000s TSH was considered to be 'ahead' of the NHS in Scotland by adopting a rights-based model. Moreover, TSH's approach was seen as all the more impressive for not having had a clear external stimulus such as a clear and consistent guidance or policy on human rights for Scottish public authorities, on human rights in a health setting, or specific human rights duties such as those that exist in relation to equality legislation.

Embedding a Rights Respecting Culture

Whilst the majority of staff, patients and carers were of the opinion that the human rights-based approach had created a cultural change within the hospital, some did point to a need to ensure this continued in practice.

Amongst those involved in the original human rights working group and amongst senior management there remains a strong consistent view that human rights are very much at the heart of TSH policy and practice. Human rights are seen to be the foundation on which daily practice is built and they regard human rights considerations as having become implicit, if no longer explicit, in *"the way we do things around here"*. These staff also expressed a firm belief that this solid rights foundation paved the way for a more straightforward incorporation of legislative obligations and duties that followed, including those within the Mental Health (Care and Treatment) (Scotland) Act 2003 and later equality duties. Whilst, as discussed in the previous chapter, TSH now takes an integrated Equality, Diversity & Rights approach, senior management and working group staff do not believe that this has detracted focus from human rights and a rights respecting culture.

Amongst other staff there is varied understanding of the origins of the human rights culture but there remains broad buy-in to it. Whilst clinicians in particular feel that this focus on human rights had been sustained at TSH by continued adherence to the principles and precepts of mental health legislation and the human rights-based principles which underpin it, newer staff were less aware that the origins of the rights-culture. However, for newer staff, there was a strong sense of the values and culture of TSH as being patient-focused, with a proper and healthy regard also for the human rights of staff.

From the view of patients and carers, there appeared to be less of an inclination to use the language of human rights in this evaluation without prompting, however, it was clear that there was awareness that there had been a noted development in culture, the timing of which could be attributed to the human rights-based approach.

Attributing cultural change to the human rights-based approach

It is often very difficult to attribute change to a specific initiative or approach, especially when other initiatives are occurring concurrently or within a short timeframe. Indeed one of the strengths of the experience of TSH is that fact that TSH used the human rights-based approach as a foundation for delivering intervening, complementary and more specific duties such as those in mental health and equality legislation. However, what can be attributed to the human

rights-based approach from the collated evidence here is: the increased awareness and understanding about human rights provided to staff and patients via the human rights audit; the review of all policies and practice for human rights compliance that followed the audit; the policy and practice changes that ensued as a result of that review; the human rights training for staff which was based on case-study examples designed and developed in a participatory manner to make 'human rights' issues real for staff; the continued reference of the language of human rights by staff (e.g. legality, necessity and proportionality). It is also apparent that the audit process and policy review prepared TSH for a smooth incorporation of the Mental Health (Care and Treatment) (Scotland) Act 2003 and subsequent equality duties. In respect of the former, the rights respecting culture had already changed the manner in which TSH approached specific restrictions of rights such as seclusion and restraint, and had already sought to maximise participation and other principles in the Act. In respect of the latter, the human rights-based approach included non-discrimination and equality as a central component, making the integration of specific equality duties a relatively straightforward task.

The acknowledgement that these actions and changes had come as a direct result of the human rights-based approach was felt most strongly amongst staff who had been involved in the original HRWG and audit and amongst those patients and carers who had been at or supporting someone at the hospital for a long time. However, whilst they felt that they couldn't state that the positive cultural changes witnessed at TSH were only as a result of the human rights-based approach, most other staff did note the coincidence in timing between the perceived shifts in culture and the original implementation of the human rights-based approach.

Analysis of current practice

To objectively verify whether current practice in TSH is consistent with a human rights-based approach, the Commission has identified a framework of structural, process and outcome human rights indicators[20] based on the PANEL model described above. This is not a comprehensive human rights audit of TSH policy and practice. Consequently, while the evaluation provides insights into the extent to which human rights considerations guide and shape policy and practice today, and how this happened, it does not result in conclusions on the state of human rights in practice in TSH.

Participation

Everyone has the right to participate in decisions which affect their human rights. A human rights-based approach requires a high degree of participation of rights holders in the development of policy and practice, as well as the involvement of affected communities, civil society and others.

According to the International Covenant on Civil and Political Rights[21] (ICCPR, Article 25) people have a right to participate in decisions which affect the realisation of their human rights. [22] The Convention on the Rights of Persons with Disabilities[23] contains several protections of the right to participate in decisions (CRPD, Article 4 on general principles, Article 21 on access to information, article 26 on support for participation, article 29 on right to participate in public life).

Article 8 of the European Convention on Human Rights,[24] the right to respect for private and family life, home and correspondence,[25] includes a right to informed

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[20] This process was done in conjunction with a range of national and international experts in mental health, human rights law and research methods.

[21] The UK has been a party to this convention since 1976.

[22] Interpreted to cover "all aspects of public administration, and the formulation and implementation of policy", Human Rights Committee, General Comment No. 25, *The right to participate in public affairs, voting rights and the right of equal access to public service (Article 25)*, UN Doc. CCPR/C/21/Rev.1/Add.7. The Human Rights Committee has found that individuals have the right to participate in decision-making which may affect the realisation of their rights in e.g. *Apirana Mahuika et al v New Zealand* (CCPE/C/70/D/547/1993).

[23] The UK has been a party to this convention since 2009. The Scottish Human Rights Commission, together with the Equality and Human Rights Commission, the Northern Ireland Human Rights Commission and the Equality Commission for Northern Ireland, is an independent mechanism named by the UK under the convention to promote, protect and monitor the implementation of the Convention in the UK.

[24] The UK has been a party to this convention since 1953. Most of the rights in the convention were incorporated into the law of Scotland by the Human Rights Act 1998 and the Scotland Act 1998.

consent to limitations of human rights and to participation in decisions which affect human rights. The European Court of Human Rights has stated that this right encompasses, among other things, *"the right to personal autonomy, personal development"*[26] and the right *"to conduct one's life in the manner of one's choosing"*.[27] The Grand Chamber of that Court has also found that Article 8 includes a right to *free* and *informed consent* to limitations of human rights.[28] Article 8 is not an absolute right; it is a limited right. Action contrary to this right can be justified where it complies with the principles of legality, necessity and proportionality.

The right to information is also a component of the right to freedom of expression (article 10, ECHR; article 19 ICCPR; article 21 CRPD[29]) and increasingly recognised as a freestanding right to information in a form and language which enables an individual to participate in decisions which affect their human rights. This includes the right to accessible information for people with disabilities. CRPD Article 9(2)(f) requires the promotion of, "*other appropriate forms of assistance and support to persons with disabilities to ensure their access to information*".

Participation structures for staff, patients and carers

Staff

At TSH there are extensive mechanisms available for staff to contribute opinions and ideas about their working environment and circumstances surrounding the care and treatment of patients. These include: discussions with line managers; team meetings; staff meetings; corporate workshops; monthly ward community meetings; staff and Union representatives; newsletters; the Board's Annual Report; the e-library; Ward and Departmental representatives; and the Hospital Management Team. There is also a staff survey and regular formal and informal consultation processes, for example in relation to the current hospital rebuilding works.

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25 Also included in Article 17, ICCPR and in Articles 22 and 23, CRPD.

26 *Evans v UK*, Grand Chamber (2007) citing *Pretty v UK* (2002)

27 *Pretty v UK* (2002)

28 *D. H. and others v Czech Republic*, Grand Chamber, application no. 57325/0, 13 November 2007.

29 This latter includes a specific requirement to take appropriate measures including: "Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost".

TSH formalised the obligations they have to staff (and the corresponding responsibilities of staff) within its Staff Charter[30] which complies with the Staff Governance Standard for the NHS in Scotland. This charter was also jointly agreed in consultation with staff and their representatives and the staff survey[31] shows a consistently good level of awareness (78-80%) of their and their organisation's responsibilities. The staff survey is also used to review the Staff Charter.

Patients

Since the beginning of efforts to adopt a human rights-based approach there has been progressively increased and improved patient engagement and involvement. The hospital has taken measures to improve communication and to examine where more mutually informed decision making would be appropriate. Clearly, given the nature of the service, some limitations on decisions over treatment, care and accommodation will be appropriate (proportionate), however in general the starting point seems to be to secure the greatest involvement possible of everyone in relevant decisions as possible. There are regular opportunities for patients to contribute to developing policy and practice, for example in relation to the rebuilding work at the hospital. In relation to their own care and treatment, and on a day to day basis, patients have regular contact with nursing staff, with other clinicians, and also to advocacy if required.

The board has taken several steps to encourage feedback, promoting what it calls the four Cs: compliments, comments, concerns and complaints. A number of methods are made available for patients to provide TSH with their views on many areas of their treatment, care and accommodation. These include: suggestion boxes in all clinical areas; patient group meetings; feedback posters; extensive information points on wards and a weekly newsletter. Ward meetings are held at least once a month and are now monitored by the PFPI steering group. Since the creation of the PFPI there has also been a FREEPHONE number which is unsupervised for patients to express views and opinions. Through PFPI, a Patient Partnership Group has been established. This group meets regularly, has its own information boards and is considered a useful and clear process for patient

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[30] The latest 2008 version is accessible at: http://www.tsh.scot.nhs.uk/About_Us/docs/Staff%20Charter%20-%20Oct%2008.pdf

[31] Staff surveys can be found here; http://www.tsh.scot.nhs.uk/About_Us/Staff.htm

participation. There is also an annual patient survey, where patients views are sought on a wide range of aspects of their treatment and care. The most recent survey, in May 2009, had an 84% return rate. Patients' views are then fed back for consideration to the Hospital Management Team via the PFPI steering group and decisions are fed back to patients through Patient Partnership Group.

A number of patients commented during the evaluation that there was some opportunity to influence medication by mutual discussion with the Key Worker or clinical team and they also noted that there was plenty of information on wards on issues such as possible side-effects of medication. Patients are also invited to attend their periodic case reviews and patients noted that they were aware that they could access their own medical records and they often did so, in order that they could participate in discussions regarding their care and treatment. However, some have noted that this request process can take time and for bulky files, can cost them money.

Some of the institutional policies and overall service developments are also discussed and developed with patient groups. Most recently this has included policy discussions on the changes due to smoking legislation, the Scottish Government's consultation on a Patients Rights Bill, healthy food and diet and the hospital rebuilding works/Clinical Model. There is a specific group which looks at the current rebuilding work at the hospital and this is open to all patients. It includes a question and answer session which is fed back through the weekly newsletter for all patients.

Patients are not directly involved in certain more sensitive policy and procedure developments relating to security issues such as policy on search procedures and PMVA. However, all policies are rapid-impact assessed for equality, diversity and human rights prior to implementation.

Carers

TSH has recognised the importance of effectively engaging with the families and carers of its patients and has made considerable efforts to engage with carers. There are systematic approaches to carer engagement including information provided via the hospital ABC information booklet, an annual carers' survey, a regular carers' focus group meeting, an annual carer's conference, a regular

carers' newsletter and since its creation carers have also attended the PFPI steering group.

In recent years, a dedicated Carers Centre has been opened and a Carer Coordinator has been in post to undertake a number of roles including: managing the carers' centre, providing information and advice to carers; supporting carers in the use of carers' needs assessments; promoting the providing of carer advocacy; obtaining and sharing carers' views with the hospital, and informing carers of their rights in relation to a Carers' Charter, hospital policies, the Mental Health (Care and Treatment) (Scotland) Act 2003 and other related legislation.

Within the carers' centre there is also now a suggestion box for carers to comment on day to day matters, and information for carers is also posted on the intranet which carers can access via the centre.

For those carers who are also a named person[32] access can also be granted to patient information. There are occasions when patients do not want carers to be involved and this right is respected as out with the named person, patients require to consent to the sharing of information. Satisfaction with the provision of this information is monitored via the annual survey and annually satisfaction rates are good. In relation to patient tribunals, TSH has a DVD which it can give to carers with a member of staff seconded to work with the tribunal service to support patients and carers with this process.

Relatives also had the opportunity to participate in a carer reference group, however, this is currently under review as only two relatives have attended over the past couple of years. Questions of the use of this facility will be included as part of the next carers' survey.

Ensuring participation for all

A key element of realising the right to participate in decisions which affect your human rights is supporting people to participate. Article 12 of the UN Convention on the Rights of Persons with Disabilities, for example, requires appropriate support to be provided where needed to enable those who require it to exercise capacity, and that safeguards must be in place to ensure that,

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[32] http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1

> *"measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests."*[33]

According to the World Health Organisation,

> *"any proxy or surrogate [decision maker] should be bound by a 'substitute judgement' standard in making a decision for a person without capacity. That is, surrogates should make the decision they believe the incapacitated person would have made if that person had the capacity to make the decision."*

Where a person has never had capacity this merges with a best interests standard, but even there, "*surrogates should strive to learn about the person's particular situation so that they can make the decision that is closest to their perception of the known wants and needs of the incapacitated person*."[34] Looking at positive steps to fulfil the right to informed consent, the European Court of Human Rights has also considered that efforts should be made, where appropriate, to mechanisms to pursue prior consent, such as in degenerative conditions such as dementia or in conditions which include acute episodes and periods of capacity[35].

TSH has an Appropriate Adults Policy which sets out the support available to patients and patients are made aware of their ability to utilise a service of independent advocacy. As envisaged by the Mental Health (Care and Treatment) (Scotland) Act 2003 TSH makes use of advance statements, which are legal instruments documenting, during periods of capacity, patients' preferences for treatment during a future mental health crisis or period of incapacity[36]. Advance

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[33] Article 12 (2) and (3) of the CRPD.

[34] *WHO Resource Book on Mental Health, Human Rights and Legislation*, World Health Organisation, Geneva, 2005, p 56.

[35] See for example *Glass v UK* (2004)

[36] The MHCTSA introduced advance statements as a means of improve patient participation, in accordance with the Millan principles, which form the backbone of the Act. According to the independent

statements must be made in writing and be signed by the person making it in the presence of a witness (a list of possible witnesses is included in the Act). This witness certifies that the patient has the capacity to make this decision, or express these wishes, at the time and can be withdrawn once the patient has the capacity to do so, again through the process of singing in front of a witness. Treatment in opposition to an advance statement can only be given where the responsible medical officer provides their reasoning in writing to the following: the patient concerned; the named person under the act; the guardian; the welfare attorney; and the Mental Welfare Commission. The responsible medical officer must also put a copy in the person's medical records.

While overall, awareness and use of advance statements has been found to be low across Scotland,[37] use of advance statements is actively promoted in TSH, and educational sessions have been provided at Patient Partnership meetings to promote their use. Patient annual surveys have shown annual rises in the use of advance statements by patients, increasing from 27% in 2007 to 42% in 2009[38].

In order that carers can support patients, they are given information via one-to-one meetings with social work and they can also access information on TSH intranet.

Accessibility of information

Meaningful participation not only requires established procedures for participation, it also requires information to be provided and in accessible formats that enable all staff, patients and carers to participate in these discussions. One of the findings of the original review of policy resulting from the human rights-based approach, was the recognition that many policies were not available in patient friendly formats. Therefore, following this review, TSH has been working with patients to develop patient versions of policies. The first to be developed soon after the policy audit was the Expression of Sexuality Policy. In total six policies have been developed that are patient friendly. The Scottish Minister for Public

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review of the Act completed in 2009, *Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: report, as presented to Scottish Ministers March 2009*, pp 8-9.

[37] Ibid.

[38] Statistics only available from 2007 and accessed at http://www.tsh.scot.nhs.uk/PFPI/docs/PPG%20-%20PatientExperienceReport2009%20(2)%20-%20Sep%2009.pdf

Health and Sport annual review of TSH[39] this year, did however, note that more could be done in developing further policies. At the time of writing, fifteen further patient versions of policies are currently with the Board for consideration and work is underway to develop an accessible statement of human rights for patients. The NHS Quality Improvement Scotland Learning Disability review in 2009 also noted this work to increase the provision of easy read materials, which had resulted from the easy read training programme available to all staff groups including clerical and medical staff[40].

The Patient Partnership Group also conducted an information audit which revealed that many pieces of information are currently provided in different format and requests for alternative formats and languages are recorded. TSH's translation and interpreters policy was also reviewed in June 2009.

Staff noted that all information is available to them in a form and content that they understand to enable them to participate in decisions relating to their employment, the treatment, care and accommodation of patients and the development of TSH policies. The majority of such information is provided through the staff intranet.

Meaningful participation reflecting freedom of expression

In order to have meaningful participation in discussions it is important that staff and others feel that their views are listened to and acted upon and that an enabling environment exist where staff, patients and carers feel that they can express themselves and their views freely.

Staff

This evaluation highlighted that many staff felt very positive about opportunities that they had to be involved in key decisions. An example of good consultation on their working environment was cited as the movement of medical records where *"staff were fully involved"*. A number of staff also commented that as an

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[39] Accessed at http://www.tsh.scot.nhs.uk/About_Us/docs/Annual%20Review%20Letter%20from%20Shona%20Robison%20-%20August%202009.pdf

[40] Accessed at http://www.tsh.scot.nhs.uk/About_Us/docs/NHS%20QIS/Learning%20Disability%20Services/2009/QIS%20Learning%20Disability%20Review%20-%20Local%20Report.pdf

employer, TSH was a much more open and consultative working environment than others, notably prisons, with due attention paid to patients' and staff rights.

An independent review by QIS Scotland into the Clinical Governance & Risk Management of TSH in June 2007 also commented favourably about the communications mechanisms:

> *"Communication between staff, patients and the pubic within TSH is viewed as an essential component of patient care/service delivery and considerable emphasis is placed on enhancing communication methods between these different groups"*[41].

Staff also commented very positively on the information that was available to them, *"the intranet is excellent"*, including online training modules, electronic forms, and the Staff Bulletin. A number of newer staff commented that there had been a full and valuable discussion of this year's staff survey answers and ways of improving on the results. Many clinicians were also able to point to significant changes in the planned policy and practice on admissions at the hospital rebuilding works, following response to consultation.

In relation to the hospital rebuilding works, however, some staff commented that whilst they had been informed about, and consulted on, the physical plans, there had to date been limited opportunity to comment on working practices. As one stated:

> *"The draft Clinical Model for the new Hospital doesn't tell me what I'll be doing."*

A number of more senior staff commented that whilst top level consultation and communication appeared to be good, key messages did not always cascade down, or filter back up, the tiers of management. Some of these issues were also reflected in the recent staff surveys. Some ward-based staff also commented that

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[41] NHS QIS 2007 Local Report (The State Hospitals Board for Scotland): Clinical Governance and risk management – June 2007, Page 11. Accessed at http://www.tsh.scot.nhs.uk/About_Us/docs/NHS%20QIS/Clinical%20Gov%20and%20Risk%20Mgt%20Standards/2007/CGRM%20TSH%20Local%20Report%202007.pdf

participation in consultation could be more difficult in view of shift patterns and the requirement for nurses to remain on their wards.

However, some staff involved in the evaluation considered that there were numerous opportunities for staff to comment on a range of issues which were advertised, for example, in the widely read Staff Bulletin[42]. Some felt that any gap in participation was mostly due to opportunities not being taken up, rather than not being available.

Patients

Patients in this study generally had a very positive view of the processes for participation. Taking the example of the current hospital rebuilding works, patients did feel that they had been given considerable opportunities to hear about and comment on the proposals, in particular through patient representatives on an ad hoc participation forum on the rebuilding works. They also recognised that although change could often take time, they were able to see where their input was having an impact:

> *"Things do happen for example on catering... and on telephone access, although it took quite a few years"*

However, whilst patients were generally positive about their opportunities to participate, they also raised some concerns about specific issues, notably proposals currently under consideration in relation to restrictions on smoking and proposed dietary restrictions[43]. Whilst senior management have explained the thorough consultative process that both these issues are currently going through, a number of patients did express concerns that they sensed a growing tendency for TSH *"to tell us what to do – rather than asking our opinions"*.

Despite these few case examples where patients were unhappy about potential policy changes, overall, patients commented favourably on their opportunities for participation in their own treatment, care and accommodation. Staff, too, were particularly proud of the efforts put into encouraging patient participation and this

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[42] Staff surveys repeatedly show good readership of the Staff Bulletin.

[43] Further details on these potential restrictions on rights are addressed later in relation to Legality.

was reflected in the 2009 annual review by the Minister for Health and Sport who noted that a strength of TSH was its patient engagement:

> *"I was impressed that the patients feel they are listened to and that they expressed that they are taking small steps to improve things for themselves in a number of areas around the hospital".*[44]

Carers

Carers generally acknowledged that they have opportunities to influence policy and practice at TSH. Some contrasted TSH staff and procedures positively with settings such as prison and other mental health institutions. However, some did point to areas for improvement. Noting that many travel long distances, they pointed out that the Carers Centre, which most found to be of a high standard, was not always open when they arrived, nor was it stocked with basic supplies such as coffee and tea.

The carers who participated in this evaluation also appeared to lack awareness about the hospital rebuilding works. This may partly be explained by the fact that several carers commented that they were unable, or had not thought, to consult the TSH website where a considerable amount of this information is available.

Accountability

All duty bearers must be accountable for the realisation of human rights. To be accountable requires effective monitoring (through data collection and inspections), effective remedies (including independent complaints mechanisms and access to justice) and effective corrective action to be taken where deficiencies are identified. It requires the existence of appropriate law and policy structures , institutions, administrative procedures and other mechanisms where individuals can seek remedies and have access to justice where needed.

Accountability structures

Within TSH this translates into an over arching question of how TSH approaches its duty to protect and ensure the rights of staff, patients and carers in practice. At the organisational level, this could mean asking who TSH is accountable to and in

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[44] Accessible at http://www.tsh.scot.nhs.uk/About_Us/docs/Annual%20Review%20Letter%20from%20Shona%20Robison%20-%20August%202009.pdf

what ways; who is responsible for monitoring compliance with human rights and how TSH ensures that human rights are adequately protected in practice.

External accountability structures

TSH is accountability for its policy and practice to a number of independent external bodies including: the Mental Welfare Commission for Scotland (MWC),[45] Audit Scotland,[46] the Equality and Human Rights Commission (EHRC)[47] and NHS Quality Improvement Scotland (QIS).[48] Specifically in relation to complaints TSH is also accountable to the Scottish Public Services Ombudsman (SPSO).[49]

The MWC has a responsibility under the Mental Health (Care and Treatment) (Scotland) Act 2003 and other mental health laws to ensure that people with a mental disorder are properly treated. The MWC visits people with mental disorders in a variety of settings, including in TSH. The recent review of the Mental Health (Care and Treatment) (Scotland) Act 2003 noted the important role which the MWC plays as "*one of the central safeguards of the Act*" and the need for a body which can perform all the functions of a National Preventative Mechanism under the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.[50]

In relation to the EHRC, TSH is accountable like other Scottish public bodies to put in place Schemes and Action Plans and to report annually on the fulfilment of their equality duties. This accountability applies to equality and diversity issues primarily, and not to other, broader human rights issues.

There is no specific reporting mechanism on human rights for TSH or other Scottish Public Authorities. However, a number of the NHS QIS reports do explore some issues related to the rights of staff, patients and carers. For example in 2007 the NHS QIS undertook an independent inspection of *"Clinical Governance & Risk*

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45 http://www.mwcscot.org.uk/

46 http://www.audit-scotland.gov.uk/

47 http://www.equalityhumanrights.com/

48 http://www.nhshealthquality.org/

49 http://www.spso.org.uk/

50 *Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: report, as presented to Scottish Ministers March 2009*, p 72. The UK National Preventative Mechanism under OPCAT includes both MWC and the Scottish Human Rights Commission, among others.

Management: Achieving safe, effective, patient-focused care and services"[51]. The national standards for clinical governance and risk management were published in 2005 and these standards are being used to assess the quality of service provision across NHS Scotland.

Three key standards were reviewed, namely: 1. Safe and effective care services; 2. The health, well being and care experience and 3. Assurance and accountability. NHS QIS reported favourable in all three areas summarising that:

> *Standard 1: TSH is implementing its policies, strategies, systems and process to control risk, continually monitoring care and service, and work in partnership with staff, patients and members of the public.*
>
> *Standard 2: TSH is monitoring the implementation of its policies, strategies, processes and procedures to provide services that take into account individual needs, preferences and choices.*
>
> *Standard 3: TSH is monitoring the implementation of its policies, strategies, processes and procedures to promote public confidence about the safety and quality of the care and services it provides*[52].

In reviewing these standards NHS QIS made a number of positive references to TSH's consideration for human rights. Although it was not entirely clear what criteria or indicators NHS QIS were using the make this judgement, or indeed what human rights they were focusing on:

> *"Given the compulsory detention of patients within The State Hospital, a high level of autonomy and consideration of human rights is provided to patients. The views and rights of carers are also given high priority and innovative methods of enabling patient/carer involvement are practised."*[53]

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[51] NHS QIS 2007 Local Report (The State Hospitals Board for Scotland): Clinical Governance and risk management – June 2007. Accessed at http://www.tsh.scot.nhs.uk/About_Us/docs/NHS%20QIS/Clinical%20Gov%20and%20Risk%20Mgt%20Standards/2007/CGRM%20TSH%20Local%20Report%202007.pdf

[52] Ibid. Pages 11-12.

[53] Ibid. Page 11.

They further commended TSH for its policies regarding access, referral, treatment and discharge which it classed as well developed. Finally they found well-evidenced examples of the partnership approach to care taken by the hospital.

NHS QIS also reviewed TSH regarding its healthcare services for people with learning disabilities in 2009, (more of which is covered in relation to Non-discrimination). It is worth noting here that in relation to meeting the needs of people with learning disabilities; procedures and arrangements being based on sound, integrated approaches across the hospital; and the existence of robust strategies and systems of monitoring impact of these on the quality of services provided; TSH was classed as being comprehensively or substantially developed in all areas[54].

Finally, NHS QIS has also been responsible for the accreditation process for the Integrated care pathways (ICPs) in mental health, which has developed from the Scottish Government's commitment to improving mental health services, (Delivering for Mental Health (2006)). NHS QIS was tasked with developing standards for ICPs which all NHS board areas were to develop and implement and which would be accredited from 2008 onwards. NHS QIS asked that all boards provide sufficient evidence that they are at foundation level between March and July 2009, the focus of which is on the 'building blocks' for ICP development and implementation, and more specifically in relation to the ICP process standards. The Scottish Government set a target date of September 2009 for achievement of foundation level accreditation. TSH was granted foundation level accreditation by the panel in April 2009[55].

Internal accountability structures

Within TSH, those responsible for monitoring compliance with human rights are the PFPI Steering Group and the Equalities, Diversity and Rights Group who report to the Clinical Governance Committee and the Hospital Management Team.

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[54] NHS QIS 2009 Local Report (The State Hospitals Board for Scotland): Healthcare Services for People with Learning Disabilities –March 2009. Accessed at http://www.tsh.scot.nhs.uk/About_Us/docs/NHS%20QIS/Learning%20Disability%20Services/2009/QIS%20Learning%20Disability%20Review%20-%20Local%20Report.pdf

[55] Information accessed at Integrated care pathways (ICPs) in mental health - Foundation level accreditation - Accreditation panel – 28 April 2009 and Baseline Information Report - September 2008 - Integrated Care Pathways for Mental Health.

Information on the rights of those within the hospital is contained within the Charters for Staff, Patients and Carers. Patient policy in relation to Human rights in an accessible format is currently being developed.

Following the initial human rights audit a full review of all policy and practice was launched in 2004, to ensure that everything the hospital did and said that it did was human rights complaint. This focused on the rights of everyone in TSH and considered non-discrimination and equality as a core element of human rights. Since the Equality Act (2006) TSH has adopted a Single Equalities scheme and has further developed the tool used in the full review (a form of human rights impact assessment) into be a Rapid Impact Assessment tool for Equality, Diversity and Rights.

In 2008 a second audit was performed this time commissioned by the Equality, Diversity and Rights Group in order to identify the impact of the actions taken after the initial audit in 2004 and to identify any gaps. The 2008 audit revealed that whilst there had been a great deal of training following the initial audit this had reduced over the years. Therefore it recommended the introduction of an induction training programme on Equality Diversity & Rights, which has since been developed and is delivered to all new staff. Workshop training days were also set up to target areas of the hospital where numbers trained were lowest.

Information on Equality, Diversity and Rights was included in the Staff Bulletin, the staff intranet and on information posters and leaflets with information on who to contact. Finally the idea of developing a folder for all wards and departments containing Equality, Diversity and Rights information is currently being explored[56].

Data collection

In order to monitor compliance with human rights it is important to gather appropriate and accurate data. Currently there is no nationwide measurement

[56] Accessed at http://www.tsh.scot.nhs.uk/PFPI/docs/SES%20-20Equal%20Div%20Rights%20Audit%20Jan%2008.pdf

framework, or comprehensive set of rights-based indicators or guidelines for data collection.[57]

TSH collects a wide range of data using a variety of methods. This includes BPASS (Patient Administration system) to monitor patient information and nursing notes to monitor patient activities. All physical interventions, including seclusions, restraints and violent incidents are monitored through risk management software and a 24 hour security report is also produced. Relations between patients and staff are considered at community ward meetings, while staff, patients and carers' complaints are collated and numbers of patient and carer complaints[58] is now annually submitted to Information Services Division (ISD) Scotland[59]. Local delivery plan targets record access to services and other forms of care. Data is collected regarding attendance at community meetings and PPG; staff, patient and carer information is collected in line with the requirements of the single equalities scheme and equal opportunities policy; background data and views on care & treatment and employment are collected in the annual surveys of staff, patients and carers; information on patient and carers views on care and treatment are also collected from the patients' and carers' suggestion boxes and initial information is collected from carers when an application to visit is made.

Complaints mechanisms

Article 5 of the ECHR (and the Human Rights Act) enshrines the protection of the individual against arbitrary interference by the State with her right to liberty. The notion of "arbitrariness" in Article 5 (1) extends beyond lack of conformity with national law, so that a deprivation of liberty may be legal in terms of domestic law but still arbitrary and therefore unlawful in respect of the Convention.[60]

According to Article 5 (4) "everyone who is deprived of his liberty by arrest or detention" has the right to bring proceedings to test the legality of the detention and to obtain release if the detention is found to be unlawful. Article 5(4) of the

[57] The Scottish Human Rights Commission is working with the Equality and Human Rights Commission to develop a Human Rights Measurement Framework for Scotland. The framework is due to be published in 2010.
[58] Issues relation to complaints is explored in more detail below)
[59] http://www.isdscotland.org/isd/CCC_FirstPage.jsp
[60] *Saadi v. the United Kingdom,* Application No 13229/03.

ECHR requires additionally that the determination of the lawfulness of detention be carried out 'speedily'.[61]

The European Court of Human Rights has approved the use of an administrative body instead of a court as long as that body has a judicial character, provides procedural protections, and is independent from the parties in the case.[62] The European Court insists that the review body be part of a branch of government different from the mental health facility. A person must still have a right to appeal a decision of such an administrative body to a court.[63]

The European Court of Human Rights has found[64] that detention on mental health grounds can only be justified as long as a mental disorder continues to persist at the level of severity originally required for involuntary commitment. Additionally, "where there is no automatic period of review of a judicial character" an individual subject to psychiatric commitment has a right "to take proceedings 'at reasonable intervals' before a court to put in issue the 'lawfulness' – within the meaning of the Convention – of his detention."[65]

Article 6 of the ECHR (and the Human Rights Act) guarantees the right to a fair trial and a fair hearing. It contains a series of procedural guarantees in relation to decisions which determines a person's civil rights or obligations, or a criminal charge. Its protections may extend, in some circumstances broadly to processes such as disciplinary proceedings.[66]

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[61] In *E v. Norway,* the European Court of Human Rights found a delay of eight weeks to violate the right to speedy review by a court (Judgment on 29 August 1990, 181 Eur. Ct. H.R. (ser.A), ¶ 63 (1990))

[62] *See* discussion in Lawrence O. Gostin, *Human Rights of Persons* with Mental Disabilities: The European Convention of Human Rights, 23 INT'L J. L. & PSYCHIATRY 125 (2000) at 145.

[63] The Court has stated that "[w]here a decision depriving a person of his liberty is one taken by an administrative body, there is no doubt that Article 5(4) obliges the Contracting States to make available to the person detained a right to recourse by a court." *Versyp v. Belgium*, 12 ECHR (ser. A) ¶ 76, June 18, 1971. 15 EHRR 584, ¶ 22.

[64] *Winterwerp v. Netherlands*, 33 Eur. Ct. H.R. (Ser. A) at 26 (1979).

[65] *Megyeri v. Germany*, (1993) 15 EHRR 584, ¶ 22.

[66] *Le Compte v Belgium* [1981] 4 EHRR Article 6 was engaged in respect of disciplinary proceedings involving medical practitioners. In that case The Court said that Article 6 rights were not usually engaged in disciplinary proceedings but that they could be in some circumstances. What those circumstances might be was not explained. However the case did find that the right to practise medicine was a civil right and proceedings which effectively determined whether an individual could practice medicine therefore engaged article 6. The European Convention on Human Rights is of course a "living instrument" and the circumstances in which Article 6 applies may well alter over time as practice across States' parties to the Convention apply

The NHS complaints procedure is used for staff, and the staff charter lists procedures and policies to follow in the event of any grievance or dispute that a member of staff may have which is not resolved through discussion with a line manager. Staff can make complaints up the hierarchy, against individuals and about any implementation of policy or practice that they view as inappropriate. They also have access to their Union for support. If a claim has been lodged and the Central Legal Office advises TSH that it is liable, then a settlement figure will be negotiated. Where complaints are made against staff (by other staff or patients/carers), a copy of the complaint is made available to that staff member as well as a copy of the outcome of the investigation.

Regarding complaints, staff generally said they were well aware of, and understood, the avenues for comment and complaint. Typically, staff said that they would raise matters first with their Line Managers, and then take it further if necessary. Some staff commented that there were currently more formal grievances underway because of the Agenda for Change[67] process.

A significant proportion of staff commented that complaints did not always come to the surface. Many were dealt with informally through Line Managers: *"they've got better at resolving problems"*. For some, the culture in the hospital acts as an inhibitor to complaining. TSH is very close community, with many family and

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article 6 protections in practice in diverse circumstances. The House of Lords has recently held (in the case of *R (on the application of Wright and others)(Appellants) v Secretary of State for Health and another (Respondents) [2009] UKHL 3*) that article 6 applies to proceedings (including interim orders by the Secretary of State) to suspend workers who have access to vulnerable adults under the (English) Protection of Vulnerable Adults legislation. It found that in such circumstances an interim order would, in practice, effectively make the individual unemployable and consequently they should have the opportunity to be heard (the previous system had involved the Secretary of State making an interim order without the individual having any opportunity to state their side of events). Two English Court of Appeal cases provide further examples: the recent case of *Kulkarni v Milton Keynes Hospital NHS Foundation Trust and another, [2009] EWCA Civ 789; [2009] WLR (D) 257*, involved disciplinary proceedings against a medical practitioner was decided without the need to consider the application of Article 6, however it was stated by Smith LJ that, "had it been necessary for me to make a decision on this issue, I would have held that Article 6 is engaged where an NHS doctor faces charges which are of such gravity that, in the event they are found proved, he will be effectively barred from employment in the NHS ." Additionally, in the case of *R (on the application of G) v Governors of X School [2009] All ER (D) 181*, which found that Article 6 protections should apply to disciplinary proceedings involving a teacher.

[67] Agenda for Change is the most radical shake up of the NHS pay system since the NHS began in 1948. It applies to over one million NHS staff across the UK. More information can be found at http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Pages/Afc-AtAGlanceRP.aspx

friend relationships amongst staff. Staff often commented that there was a reluctance to make complaints, not least because staff would have to rely on each other in potentially challenging situations. This understanding particularly affects the willingness of some staff to raise issues about treatment of patients by other members of staff. Overall, staff in this evaluation said that they were relatively positive about their experiences of TSH policy and practice around their ability to comment and/or complain, but the annual survey (this and in previous years) shows that relatively few staff feel comfortable making a complaint[68].

Patients

Regarding complaints procedures for patients, everyone is provided with a flow chart which sets out local and NHS-wide complaints mechanisms that they have the right to access. All patients are given NHS Complaints Procedure leaflet on admission to the hospital. Details are also available of the complaints contact within the ward areas and any new complainant receives a copy of the NHS leaflet. A FREEPHONE number is also available to consult advocacy to assist in making a complaint. Complaints are recorded on a software system. In the event of a patient complaint against a member of staff, the local line manager will first review evidence and seek any necessary additional witnesses. There may then be further review by a senior manager. Staff are reminded during staff induction and again during health and safety training days of the fact that patients may need to be helped to understand their right to complain. Patients' advocates would also bring any matters of concern to the attention of the complaints officer.

Patients consulted for this study appear to have a good understanding of the complaints procedure at TSH. A number of patients had used the process and commented favourably on the system. A number of patients were dissatisfied with the outcome however, but generally chose not to take things any further:

> *"Complaints can take a very long time to be handled; and by then it sometimes doesn't matter anymore".*

[68] Accessed at http://www.tsh.scot.nhs.uk/About_Us/docs/Staff%20Surveys/TSH%20Staff%20Survey%202008%20-%20Results.pdf, page 9.

Patients did, however, comment very favourably on the role of advocacy both in relation to complaints, and more generally. Patients also noted that escalation options were available to them:

> *"It can be a bit difficult if your complaint is about the Ward Manager but there are ways of taking things further."*

Patients have the right to request Scottish Public Services Ombudsman review if they have exhausted the internal complaints procedure.

Data on complaints made by patients and carers is now routinely provided to ISD Scotland and current figures [69] show an almost 4-fold decrease from 2000/1. That is to say there are now four times fewer complaints from patients or carers than there were prior to the adoption of a human rights-based approach.

Carers

Carers have access to the same complaints process as patients and are provided with relevant leaflets on TSH and NHS procedures. Further information is provided in the carers' centre via Leaflets and posters in carers centre via leaflets and satisfaction with this service is monitored through the carer survey. A couple of the carers commented that they felt that their complaints were generally ignored, but others could point to examples where they felt complaints had been handled well and in a timely fashion.

Review of patient detention mechanisms

The Mental Health Tribunal Scotland (MHTS)[70] is the body responsible for reviewing compulsory detention. Patients have a right to a review of their circumstances on a regular basis and if their responsible medical officer wishes to introduce or extend such arrangements, they must apply to the Tribunal Service. There is a Tribunal Service suite on site at TSH. In circumstances where the Tribunal determines that a patient should remain at TSH, the hospital puts in place appropriate care and treatment plans. Where the Tribunal agrees a patient should leave TSH, the onus is on the host Health Board to find them an

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[69] These figures were provided by The State Hospital complaints officer and vary slightly from ISD statistics as ISD do not recognise where formal complaints were dealt with internally and hence withdrawn which is said to be fairly commonplace at the State Hospital.

[70] http://www.mhtscotland.gov.uk/

appropriate setting within 3 months. Generally this process is seen as a positive one, although some members of staff were of the opinion that some patients had remained too long at TSH and could have been moved to Medium Secure Units earlier.

Non-discrimination and equality

The Human Rights Act (1998) and international law and Conventions which the UK has ratified include obligations to prohibit, prevent and eliminate all forms of discrimination to promote equality[71]. It is crucial in a human rights-based approach that particular attention is given to discrimination, equality and the protection and prioritisation of marginalised, excluded and vulnerable groups.

Non-discrimination & equality policy

In the context of TSH, the promotion of non-discrimination and equality should be evidenced in the first instance by the existence of an equality and non-discrimination policy. Prior to the arrival of the Equality Act (2006) and duties flowing from this Act, TSH had already begun to seriously consider its equality and non-discrimination responsibilities. At the time TSH was beginning to re-think it's policy and practice in relation to human rights, it had already begun to consider the implications of various other legislation relating to equality including the Disability Discrimination Act 1995 and the Race Relations Act 1976 which was amended in 2000.

In adopting the human rights-based approach prior to the Equality Act 2006, TSH found subsequent adoption of equality duties relatively straightforward due to the fact that non-discrimination and equality form a fundamental pillar of human rights.

TSH now operates an unusually broad Single Equality Scheme which applies to their whole community: staff, patients, visitors and carers and addresses the full range of equality and diversity legislation and associated requirements and obligations, as well as mental health and human rights legislation. The Board has also made a public commitment to non-discrimination of all which is displayed in

[71] A clear overview of international law obligations related to non-discrimination and the promotion of equality can be found in Interights, *Non-Discrimination in International Law: A Handbook for Practitioners*, London, 2005.

reception and in the carers' centre. There is also an equal opportunity and non-discrimination policy in place in relation to recruitment and conditions of employment for staff and the Staff Charter reaffirms its non-discrimination and equality commitments to staff:

> *"We are committed to creating a working environment with equality of opportunity, a diverse workforce and equal respect for each individual's contribution to the aims, values and goals of The State Hospital"*[72].

NHS QIS also formally recognised that TSHs Board had in its opinion:

> *"demonstrated its commitment to the equality and diversity agenda and is taking systematic steps towards ensuring that all of its functions and processes are equality and diversity impact assessed."*

Non-discrimination & equality in practice

When all policy and practice was reviewed for its human rights compliance in 2004 consideration was given to their non-discriminatory nature. The adoption of equality legislation and subsequent duties lead to the development of an Equality, Diversity and Rights Group (developing from the previous human rights working group) and an Equality, Diversity and Rights Rapid Impact Assessment tool for all new policy to ensure that it is compliant with equality and human rights legislation. This tool is also being developed to move on and assess practice and services.

In order to make sure that the equality and diversity of patients is properly addressed, the independent patient advocacy service plays an important role. The high profile of advocacy services within TSH and the high level of uptake amongst patient was also noted in an independent review by NHS QIS[73].

In terms of awareness, staff appeared to be generally very well aware of their rights to equal treatment without discrimination of any kind and patients and carers had few observations to make on discrimination risks at TSH.

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[72] The latest 2008 version is accessible at: http://www.tsh.scot.nhs.uk/About_Us/docs/Staff%20Charter%20-%20Oct%2008.pdf

[73] Accessed at http://www.tsh.scot.nhs.uk/About_Us/docs/NHS%20QIS/Clinical%20Gov%20and%20Risk%20Mgt%20Standards/2007/CGRM%20TSH%20Local%20Report%202007.pdf

In terms of day-to-day practice from a patient's perspective, in relation to religion, TSH makes available various worship options, including Muslim prayer on Fridays and there will be a multi-faith centre in the new hospital. In relation to age and gender issues, all patients are over 18, nine of whom are currently over the age of 60 and there are no longer any female patients at TSH. On sexual freedoms, formally there is no provision for sexual activity at TSH and this is clearly set out in the Expression of Sexuality Policy, of which there is a patient friendly version. In relation to physical disabilities, there are currently some limitations in the current Hospital estate, for both patients and staff, but these are expected to be resolved in the new hospital buildings. Patients with learning disabilities are currently separately accommodated in Cromarty Ward, where all of the services offered by the patient activity and recreation service (PARS), the resource centre (occupational therapy) and the health centre have been developed with a view to the requirements of the Disability Discrimination Act. All patients that require these services have access as required.

These provisions were commended in the recent 2009 NHS QIS report on healthcare services for people with learning disabilities[74]. NHS QIS also concluded that TSH demonstrated a very clear commitment to the educational needs of its staff and a range of training initiatives relating to Equality, Diversity and Rights were in place including induction courses on the DDA and the Mental Health (Care and Treatment) (Scotland) Act 2003; disability awareness and disability equality duty training full day and half day workshops (which more than 80% staff have attended and which also forms part of induction training) and an online module was in the process of being developed around equality, diversity and rights training. The 2008 Equality, Diversity and Rights audit also revealed a high awareness level amongst staff about who to contact to get additional, specialist information on these issues.[75]

Whilst most staff, patients and carers were generally happy with the information that they had on equality issues, a number of patients raised specific concerns

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[74] Accessed at http://www.tsh.scot.nhs.uk/About_Us/docs/NHS%20QIS/Learning%20Disability%20Services/2009/QIS%20Learning%20Disability%20Review%20-%20Local%20Report.pdf

[75] Ibid.

during the course of this evaluation. For example, one Muslim patient commented that he found the halal food options so limited that he simply ate whatever was available. Another patient reported that a proposal for a visiting Imam had been described as 'problematic' by staff, with no further action or explanation given. Another patient stated that although there was an expression of sexuality policy, he personally did not feel safe in revealing his homosexuality.

Equality duties impact on human rights

There are merits of any approach which emphasises human rights above, or at least alongside, equality and diversity considerations. It is clear that at TSH the focus on human rights, for all: staff, patients and carers, has been beneficial. Human rights concern everyone in contrast to potential areas of inequality and discrimination which concern particular groups or individuals.

The evaluation supports the claim that the human rights-based approach at TSH has contributed to a general heightening of awareness and sensitivity to everyone's human rights and that this has helped everyone to acknowledge the risk of infringing those rights on the grounds of non-discrimination or equality.

Given that other organisations and services are likely to be starting from a point where equality duties will have preceded a human rights-based approach, it is important that future specific equality duties are linked to human rights and delivered through a human rights-based approach. Interviews and focus groups conducted during this evaluation suggest that the focus on equality duties which came subsequent to the adoption of the rights approach have to some extent risked diverting attention, particularly amongst newer staff, away from the human rights culture in TSH. However, the conscious efforts of TSH to integrate the two in practice have significantly mitigated this risk.

Empowerment of rights holders

With a human rights-based approach, the individual person should always be at the centre of public authority action and policy development. The goal is to give individuals the power, capacities, capabilities and access needed to control their own lives, improve their own communities and influence their own futures and the fulfilment of their rights. To have full participation and to be able to hold

someone to account for their own or their organisation's actions, empowerment and awareness of rights is essential.[76] Mechanisms can be in place for individuals to participate in discussions about their rights, but they need to be empowered to do so. They must understand what their rights and responsibilities are and who is accountable to realise their rights have been breached. .

Human rights policy?

In the context of TSH, the empowerment of staff, patients and carers could be encouraged via a written human rights policy, code of ethics or similar document that aims to codify best practice in human rights. Shortly after the adoption of the human rights-based approach TSH began the process of developing a human rights charter. This charter focused on explaining the rights and the responsibilities of everyone (staff, patients, carers and visitors) as well as the duties of TSH to everyone. However, as this charter was developing so too was the momentum for the equality duties and development of the single equalities scheme, which in TSH had a focus on equality, diversity and rights took precedence.

Presently there is no formal overall explicit statement about the human rights of everyone in the form of the draft charter. However, rights and responsibilities are mentioned in a number of TSH's publications including the single equality scheme, the staff charter and materials provided to patients and carers on a patient's admission is concerned with various aspects of the patient's care and treatment as well as the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003, including the human rights-based principles which underpin the Act.

Early in 2009, the decision was taken to develop a patient friendly version of a human right's charter (similar to the original draft charter). The impetus for this development appears to be two-fold: first, as noted above, the Minister's recommendation for an increased number of policies and publications to be made available in patient friendly formats; second, it is possible that the process of evaluation by the Commission has itself encouraged a refreshed focus by TSH on human rights.

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[76] CRPD, Article 8 (Awareness Raising) provides for example that States Parties should *"2. (d) [Promote] awareness-training programmes regarding persons with disabilities and the rights of persons with disabilities."*

Human rights education and information for staff, patients and carers

The results of this evaluation clearly show that the introduction of the human rights-based approach led to several efforts aimed at empowerment. This began with the actual process used to undertake the human rights audit, which involved patients and staff of all levels and disciplines. Using the audit itself as an educational mechanism helped not only to raise awareness of human rights and to engage everyone in the process of identifying what policies and practices may not be human rights complaint, but it also helped to dispel many of the myths about human rights, for staff and patients.

Staff

Following the initial human rights audit the A-Z guide was produced for staff as a reference guide for anyone requiring information about what human rights issues may arising in any given practice at TSH.

As noted already, a key finding of the audit was that there was routinely a gap between the existence of good human rights compliant policy and practice and hence one of the main recommendations taken forward was for staff to receive a thorough training programme on human rights complaint policy and practice. To ensure that this training had the greatest impact possible, the training was developed with staff input and staff members helped to develop the case studies that would be used to ensure that the human rights training made sense to staff in relation to their day-to-day practice. This training took place from 2003-5 and approximately 200 staff were said to have participated.

As noted above, the 2008 Equality, Diversity and Rights audit lead to the development of further training including compulsory induction training workshops on equality, diversity and rights and information in the Staff Bulletin, on the staff intranet and information posters and leaflets. These workshops are also available as a continuous professional development course for staff (along with online courses via the intranet). At induction training staff also receive mandatory training in PMVA (prevention and management of violence & aggression) which includes elements of human rights. This training is repeated periodically.

Patients

On arrival at TSH, patients are first informed of why they are at the hospital before being provided with a substantial introductory pack of information. This includes among other things: A comprehensive ABC Guide to TSH; generic NHS Scotland material on patients' rights to access records, and information held about them; specific TSH materials on personal health information and since 2003, information on The Mental Health (Care and Treatment) (Scotland) Act 2003, including a detailed guide to Advance Statements (with follow-up educational sessions for patients available on this topic) and specific information about surveillance and correspondence monitoring policies and the hospital's complaints procedure. Since the creation of the PPG, information is also provided to patients on arrival about this group.

At any point when patients wish further information about their situation or their rights they are referred in the first instance to their responsible medical officer, key worker, or to advocacy. If they want more detailed information, they are directed to the Data Protection Office, the Records Services Manager or to the Hospital's Medical Director.

In addition to the information on admission, various measures are in place to inform patients about their rights whilst in TSH including a library in the community centre; access to staff e.g. responsible medical officer, Key Worker, Data Protection Officer, Records Services Manager or to the Hospital's Medical Director or to independent advocacy. In particular, there is extensive material available to patients about the workings of the Mental Health Act. This includes information on their rights, for example, their right to appeal against their (continued) detention where relevant.

Finally, a patient-friendly information leaflet which explains human rights is currently under development.

Carers

Carers are provided with extensive information about TSH and about the care and treatment of patients and the patient's rights. They are also provided with TSH ABC guide and there are a wide range of booklets and leaflets available in the Carers Centre, as well as the extensive information available on TSH website and

via the Carer Co-ordinator. There is also a regular carers' newsletter which often contains information about issues relating to patient and/or carers' rights.

In addition, if the carer is also a patient's named person then specific information about their rights and responsibilities in that capacity is sent out to them and they also get information face to face from social work and the externally appointed mental health officer.

Views about human rights education and information for staff, patients and carers

Staff

Overall, staff were relatively positive about their experiences of TSH policy and practice around human rights awareness and training and awareness of general human rights issues among staff was quite high. This was generally more marked amongst longer-serving staff, staff who formed part of the original human rights working group and staff who have regular contact with patients. Amongst newer staff, there was generally reference to the induction training that they had received and also very positive comments on the Equality, Diversity and Rights Workshop. A number of staff commented that, whilst human rights were not always expressly cited, they were the values that staff worked to on a daily basis. Some staff also referred to the values based training arising from the review of mental health nursing, and also to the training course, 'New to Forensics' as other sources of training about rights that staff had enjoyed.

Regarding restrictions on staff, staff generally said that they were well-informed about them and that they appeared proportionate and justified in the circumstances of TSH. As one staff member commented: *"I feel well supported and very safe".*

Patients

Patients reported generally positively about the information that they received about their rights. Some noted that, on admission, they can be quite seriously ill and as such it was often a while before the information provided on arrival was actually fully digested:

"There is plenty of information but you may not be able to do much with it at first. But over time, you get to know the ropes and staff advocacy and others are always willing to help."

Patients consulted for this study also appeared to have a good understanding of their rights in general, as well as in relation to specific important issues where their rights may be limited and the reasons why; the complaints procedure at TSH and their rights to independent advocacy as necessary.

Some difficulties were noted, however. Where patients were confined to wards for longer periods of time they reported that they could not access information as easily as those who could access the library, as in some cases it was felt that information was not readily available on the ward.

Carers

Carers were also generally happy with the information (including information on rights) that was provided to them. This is also reflected annually in the carers' survey in relation to amounts of and how understandable the information provided is[77].

Mechanisms to ensure information is understood

When a patient arrives at TSH, frequently in very challenging circumstances, proprieties of patient information are broadly observed, but in providing the information on arrival, staff recognise that the patient may not be very receptive at that time. Therefore, in order to make sure that the information provided on admission has been understood, patients are subsequently provided with extensive information in written and verbal form once they have had time to settle in. Patient surveys (like the carers' surveys) are also used to check that patients have received relevant information and understood that information. At any time patients (and carers) also have access to advocacy if they wish clarification on any information that they don't understand.

In the patient and carer surveys, information is also now requested about alternative formats for information that would make it more accessible and as noted above, a number of staff have undergone training to enable them to

[77] Carers' survey can be accessed here: http://www.tsh.scot.nhs.uk/Carers/survey.htm

develop easy-read versions of information and the process of translating hospital information and policy into such formats began following the original human rights-based approach process and has regained some momentum over the last year.

Evidence that TSH had in place means of habilitation and rehabilitation

One final area where empowerment can be seen to play a key role within this particular population is in relation to habilitation and rehabilitation, both explicitly provided for in the Convention on the Rights of Persons with Disabilities.[78] At the most basic level habilitation means to enable, or make able an individual and rehabilitation is to restore ability or capacity of the individual. For patients within TSH, there is a need to enable them to participate in life during their care and treatment and also to prepare them for life once they leave this hospital. As is clear from the provisions of CRPD, (re)habilitation also goes beyond medical treatment to encompass a wide range of issues including social counselling, education and work-related learning.

The Hospital does indeed provide extensive mechanisms for (re)habilitation which are designed to enable patients to assimilate to life in settings both within and outside of TSH. These include a wide variety of placements for example in the garden or pet centre, as well as a wide range of cognitive and other psychological therapies, via Patent Activity and Recreational Service (PARS) activities and Occupational Health therapy programmes.

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[78] CRPD, Article 26 provides, *"**Habilitation and rehabilitation***
1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

(b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.
3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation."

There was recognition amongst staff of the importance of developing good (re)habilitation facilities and staff felt that the current services available to patients were very good. Particularly for those staff who had experienced working in other mental health settings, there was recognition that these facilities were notably better.

Patients also commented favourably about their (re)habilitation opportunities and about the range of activities and therapies. Although there was a desire from some for more work-related opportunities, there was also recognition that the variety of opportunities had improved over the years.

Relatives are informed via the patient and the clinical team at case reviews or through treatment plan reports which are sent (with the patients consent) about the activities and treatment programmes that patients attend and TSH also provide leaflets in the carer centre and on the Website for all the psychological interventions. PARS also produce an information activity folder which can be given to carers, and the ABC booklet contains information which outlines all TSH's services and functions including those relating to (re)habilitation. Many carers noted improvements in patients as a result of (re)habilitation programmes.

Legality

Adopting a human rights-based approach in practice requires an explicit link to national and international human rights law. In Scotland this should mean that a public authority or organisation examines its policy and practice through the lens of the Human Rights Act, and other national laws which implement aspects of human rights, as well as international human rights instruments as relevant. In TSH context this will mean, in particular, the Human Rights Act 1998 (HRA), the Mental Health (Care and Treatment) (Scotland) Act 2003, the Adults with Incapacity (Scotland) Act 2000; and international instruments including the European Convention on Human Rights (ECHR), the UN Covenants on Civil and Political and on Economic, Social and Cultural Rights (ICCPR and ICESCR) and the UN Convention on the Rights of Persons with Disabilities (CRPD).

The relevant human rights instruments will of course vary according to the public authority or organisation's mission and purpose. Consequently the human rights-based approach should not be seen as a 'one size fits all' but rather as a flexible tool which should be adapted to each individual context.

In creating the evaluation framework, the key questions and the evaluation of answers were drawn directly from the requirements of national and international human rights law. For example:

- The Right to life (HRA & ECHR, Article 2; ICCPR, Article 6)
- Freedom from inhuman or degrading treatment or punishment (UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, CAT, Article 1; HRA & ECHR, Article 3; ICCPR, Article 7)
- The right to freedom from discrimination and the right to equality (HRA & ECHR, Article 14; ICESCR, Article 2(2); ICCPR, Article 2(1) and 26; CRPD, Article 5)
- Freedom of expression and the right to information (HRA & ECHR, Article 10; ICCPR, Article 19; CRPD, Article 3, 21, 29)
- Freedom of thought, conscience and religion (HRA & ECHR, Article 9; ICCPR, Article 18)
- The right to form and join trade union, the right to strike (ICESCR, Article 8)
- The Right to just conditions of work (fair wages; equal pay for equal work; safe and healthy working conditions; equal opportunity for promotion; rest and leisure) (ICESCR, Article 6 and 7; various ILO conventions)
- Freedom of association (HRA & ECHR, Article 11; ICCPR, Article 22)
- The right to the highest attainable standard of physical and mental health (ICESCR, Article 12)
- Right to respect for private and family life (HRA & ECHR, Article 8; ICCPR, Article 17)
- Right to participate in decisions (CRPD, Article 3, 21, 29; ICCPR, Article 25)
- Right to an effective remedy (ECHR, Article 13; ICCPR, Article 2)
- Access to justice (CRPD Article 13)

- Right to a fair trial and a fair hearing (HRA & ECHR, Article 6)
- The right to freedom from arbitrary deprivation of liberty (HRA and ECHR, Article 5; ICCPR, Article 9)
- No punishment without law (HRA & ECHR, Article 7)
- Equality before the Courts and Tribunals and Due Process (ICCPR, Article 14)

Legality of interference with rights

Some rights outlined in the various conventions and treaties are absolute and no organisation or individual is ever justified in breaching these rights, for example: the right to life and the right to freedom from inhuman or degrading treatment or punishment.

Other rights are described as qualified and this means that any infringement of any of these rights must have a legitimate aim, it must be necessary and the response must be proportionate. Some examples include the right to respect for private and family life; freedom of thought, conscience and religion; freedom of expression; and freedom of assembly and association.

For TSH, a key element of the human rights training that followed the initial audit was focused on exploring the tests of legality, necessity and proportionality for limitations on rights, and a strong lesson which emerged from senior management during the course of this evaluation is that it is communicating and reinforcing an understanding of proportionality which requires perhaps the most attention. It is not enough simply to explain the concept to staff and then assume it will be absorbed day to day. Tailoring training to the day-to-day experiences of staff, including through a participatory approach to developing relevant case studies was felt to be key in developing this understanding.

At TSH, the responsible medical officer and clinical teams are responsible for advising patients and determining with them, their care and treatment plans. Clinical teams will make decisions on for example, medication, diet and exercise and therapies, for a patient. They are also responsible for assessing matters such as restrictions on personal mail. The clinical teams, in other words, determine the care and treatment plan of an individual patient and this is then delivered through the various therapeutic staff and processes available, notably psychologists and

other PARS staff. The clinical teams stated that they are guided in this by their professional knowledge and by statute, notably the Mental Health (Care and Treatment) (Scotland) Act 2003, but also readily acknowledged the importance of human rights considerations in this process.

When TSH undertook the initial human rights audit, a number of areas where breaches of rights were likely to be frequent were considered to be in need of tackling in the first instance. This included the prevention and management of violence and aggression (PMVA); Mail Vetting; Searching; Grounds Access; Entrapped Patients; Staff Restrictions; and Employment Practices. These and some other issues are considered in relation to their relevant rights below.

"Prevention and Management of Violence and Aggression"

Following the policy and practice review, one of the issues which demanded the most immediate attention to ensure human rights compliance and good practice policy and practice on the management of violent incidents. The review revealed that prior to the development of a human rights-based approach, the manner of dealing with patient violence was a through a *"blanket policy"* of procedures rather than a process which took proper account of the context and individual circumstances in order to justify limitations on rights in each instance and also ensure effective risk management and protect the rights of other patients, staff and others as relevant.

The use of seclusion, restraints or other interventions with physical and mental integrity of an individual must be carefully considered to ensure that it is consistent with human rights. Where such interventions do not reach the threshold of inhuman or degrading treatment or punishment, they should be considered as interferences with article 8 of the ECHR and HRA[79] and must therefore be considered using the three stage tests of legality, necessity and proportionality. However, in certain circumstances they may amount to ill-treatment prohibited under article 3 ECHR and HRA, which can never be justified. Consideration of human rights must then take into account all relevant circumstances in the particular case.

[79] See e.g. the English case of *R (Wilkinson) v Broadmoor Special Hospital Authority* [2002] 1 WLR 419.

In recent years both UN human rights bodies and the European Court of Human Rights have clarified for example that the prohibition of inhuman and degrading treatment includes a prohibition of mental, as well as physical trauma. The UN Human Rights Committee (which is charged with monitoring the International Covenant on Civil and Political Rights) has stated in an authoritative interpretation that, *"Article 7 [of the ICCPR] relates not only to acts that cause physical pain but also to acts that cause mental suffering to the victim."*[80] The European Court of Human Rights has also found that special scrutiny is required in the case of people detained in psychiatric facilities[81] and that determination of whether an act amounts to ill-treatment will depend on the situation of the individual:

> *"The Court recalls that ill-treatment must attain a minimum level of severity if it is to fall within the scope of [the convention.] The assessment of this minimum level of severity is relative; it depends on all the circumstances of the case, such as the duration of treatment, its physical and mental effects and, in some cases, the sex, age, and state of health of the victim."*[82]

UN[83] and other regional human rights bodies have considered that the use of seclusion, particularly for people with mental disabilities, may amount to ill-treatment.[84]

A great deal of emphasis was placed during training on helping staff to ensure a proportionate response to an incidence of patient violence. A mechanism for monitoring all such incidents and how they are dealt with was developed and staff surveys annually have shown a high level of willingness to and actual reporting of such incidents[85]. The use of any physical intervention is monitored by software and all such interventions are subject to a post-incident review. Since the PMVA training was provided to staff, there has been a noted 25%[86] reduction in reported

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80 Human Rights Committee, *General Comment 20*, 1992, para 5.

81 *Herzcegfalvy v. Austria,* Judgment of 24 September 1993, 244 Eur. Ct. H.R. (ser. A), ¶ 82, 15 E.H.R.R. 437 (1993). The Court observed that, *"[t]he position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with."*

82 *Price v. United Kingdom,* Application No. 3394/96, 10 July 2001.

83 The UN Human Rights Committee specifically mentions "prolonged solitary confinement" as a practice that may amount to a violation of Article 7 of the ICCPR, General Comment 20, 1992, para 6.

84 *The Case of Victor Rosario Congo,* Inter-American Commission on Human Rights Report 29/99, Case 11,427, Ecuador, adopted in Sess. 1424, OEA/Ser/L.V/II.) Doc. 26, March 9, 1999, para. 54.

85 Staff surveys can be found here; http://www.tsh.scot.nhs.uk/About_Us/Staff.htm

86 Data provided by The State Hospital, figures are for 2004-2008.

violent incidents within the hospital. Staff undergo regular break away training[87] and PMVA intensive training and refresher courses are also available to all staff.

Prior to the human rights-based approach being developed, seclusion was routinely used as a mechanism to respond to a violent incident. This is no longer considered to be a standard practice and is used as a measure of last resort. Although there is currently one patient who is frequently nursed in isolation from his peers, there are specific governance arrangements in place for this practice. In general, the policy regarding the use of seclusion forms part of PMVA policy, which is similar to other high secure hospitals.

As with other PMVA policy, the approach to use of seclusion is now couched in human rights terms. Seclusion is stated not to be a treatment and so cannot form part of any planned process. It is a practice of last resort where other measures have failed and is to be kept to a minimum by regular review by competent staff. In recent years the Mental Welfare Commission has also issued good practice practical guidance on a number of significant compulsory interventions, such as restraints and seclusion.[88]

The use of restraints is an area highlighted in a review of the Mental Health (Care and Treatment) (Scotland) Act 2003 as one which requires clarification and where Scottish hospitals require additional guidance.[89] During the course of this review, however, a positive picture of the interaction between the human rights-based approach and mental health legislation has emerged where the use of restraints is considered in general much *"more measured".* Similar comments were made about the use of seclusion. Patients stated that they felt that their rights were

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[87] This training provides techniques for non-clinical staff to remove themselves from threatening patient approaches.

[88] E.g. Mental Welfare Commission for Scotland, *The use of seclusion: guidance on good practice*, Edinburgh, 2007; Mental Welfare Commission for Scotland, *Covert medication: legal and practical guidance*, Edinburgh, 2006; Mental Welfare Commission for Scotland, *Consent to treatment: a guide for mental health practitioners*, Edinburgh, 2006. These are based primarily on mental health law. Mental Welfare Commission for Scotland, *Rights, risks and limits to freedom: principles and good practice guidance for practitioners considering restraint in residential care settings*, Edinburgh, 2006, this last includes a consideration of human rights dimensions, particularly in pages 29-31.

[89] *Limited Review of the Mental Health (Care and Treatment) (Scotland) Act 2003: report, as presented to Scottish Ministers March 2009,* p 74, *"we recommend that there is a review of this important and complex area of care and treatment before considering whether any legislative changes are required. Such a review could also address the very limited guidance available for Scottish mental health and learning disability hospitals on the use of force in hospital settings."*

generally respected and that staff treated patients fairly and honestly, even in circumstances where some restraint may be required: *"staff now deal very sensitively with aggression and violence; it used to be much more severe and prolonged".*

In statistical terms the reduction in the use of seclusion is striking. Figures provided from the late 1990s, prior to the human rights-based approach, show that it was not be unusual for the number of seclusions on *one ward* in the period of *one month* to be over 30. Last year 12 seclusions were reported for the *whole year*, across the *whole hospital*[90].

The use of electro-convulsive therapy is now no longer performed onsite at TSH and is another procedure that is considered to be very much a measure of last resort, only to be used when many other care and treatment options have been tried.

Privacy & respect for family life

Given the nature of TSH context, a number of elements of the right to privacy and respect for family life are limited in respect of everyone: staff, patients and carers. These include mail vetting, searching, communications and continued family life, the first two of which were raised as particular areas of concern during the audit. Prior to the human rights-based approach, there was a blanket approach where everyone would be subjected to searching procedures or have their mail vetted irrespective of their individual risk. This has now changed and all such procedures are assessed on a case-by-case basis as limitations of the right to privacy and respect for family life which must be justified according to the tests of legality, necessity and proportionality.

The Patient Mail Policy notes that 'In general the mail of detained patients should not be withheld and they should be able to correspond with whoever they wish' and the policy opens with a clear statement about the human rights legislative basis and context for the policy. The policy also refers to provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003, and the associated regulations under section 281 of the Health (Definition of Specified Person: Correspondence)

[90] Data provided by The State Hospital.

(Scotland) Regulations 2005, which provide for patients' mail to be withheld and outgoing mail to be inspected and withheld. Therefore on a case-by-case basis decisions on any restriction are made by a patient's RMO, based on their individual risk assessment. The same is true of searching of patients' belongings and patients' general correspondence.

Patients in this study were very aware that where there may be limitations of their rights, such as, communications being monitored under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Patient Partnership Group periodically reviews patients' sense of respect for their privacy. This issue is also monitored by the annual patient survey. TSH has also considered further ways in which is can meet its duty to ensure privacy by responding where possible to the requests made in the annual survey. This has most recently lead to piloting schemes to increase contact of some patients with the outside world. This was welcomed by the Minister for Health and Sport and is currently being evaluated

With regards to relations between patients and their carers/family, a policy on visiting patients is sent out to visitors when they apply to visit. This information is also available in the carers centre and within the ABC booklet. With regard to visitors, there was recognition amongst staff that there is a delicate balance to be struck between privacy and maintaining visitor safety. This policy includes information on what restrictions are placed on items which carers and others may bring into the Hospital grounds.

TSH has made a number of changes in recent years to help facilitate carers to visit patients. The carers' centre and family visiting centre are available for meeting patients in addition to ward visits and meetings within the community centre. Visits are carefully assessed to ensure the correct levels of supervision staff are readily available; this is monitored through the carer survey. The hospital supports a bus service for relatives from Aberdeen, Glasgow and Edinburgh and it also provided travel expenses where needed to facilitate family visits to patients. On application to the senior management team, on occasion, overnight accommodation to support visits can be provided. TSH are also actively putting measures in place to improve the visiting experience within the new clinical model, and relatives are invited to attend a small number of events with patients, including religious celebrations.

The expressions of sexuality policy includes a restriction on physical relations between patients and between patients and their partners or other visitors. Although some patients and others expressed frustration at the policy, they also expressed awareness that the origin of this restriction was necessary to protect patients and staff from harassment or exploitation, and to protect TSH from the risk of being sued on the grounds of a failure to protect human rights of vulnerable people. Most patients commented that staff intervened quickly if an unacceptable situation arose, and explained the justification clearly.

Although some additional concerns were raised in regard to two pending policies (a smoking ban and a new policy on unhealthy foods and drinks), information on proposals and concerns gathered in the evaluation does not permit conclusions to be drawn.

Staff restrictions

As a result of the secure nature of the hospital, staff too are subjected to many restrictions of their rights. There are considerable restrictions on staff regarding their freedom of movement into, out of, and within TSH and there are limitations on the possessions that they can bring onsite; there is an extensive list of items, approximately 40, which of are either prohibited or restricted. Most electrical devices (including mobile phones) are restricted for example, and may have to be screened or be allowed only at the discretion of the Security Director. Once inside the hospital, staff are limited regarding access to certain internet sites in addition to common workplace limitations on the use of information and communications technologies. TSH reserves the right to record, open and read any emails. Staff belongings, and their person, may be searched on arrival and departure.

Chapter 3: Discussion, Key Learning & Recommendations

What TSH did to adopt a HRBA

Following a decision by the Board to adopt a HRBA, TSH established a Human Rights Working Group led by senior management and involving clinical and non-clinical members of staff. The Group underwent training in human rights with a human rights expert who helped them to identify specific human rights which were relevant to TSH. Through discussions with around 100 staff and patients, the Group assessed all policies and practices using a Traffic Light assessment tool:

Red = policy/ practice is not human rights compliant

Amber = policy/ practice has significant risk of non-compliance

Green = policy/ practice is human rights compliant.

No policy was given the red light and many were given a green light. However, some policies and practices, such as those related to seclusion and restraint, were given an amber light and further policy development and training needs were identified accordingly.

The Group worked with a human rights expert to develop human rights training for staff and tools for the assessment of future policy and practice. Other steps taken included the creation of a forum for staff, patient, and carer involvement in decisions, and ultimately the creation of an Equality, Diversity and Human Rights Group to ensure a human rights approach to the delivery of equality duties.

Adopting a human rights-based approach worked

TSH sought to adopt human rights as the vehicle for culture change in the hospital two years after the Human Rights Act entered into force. Despite this, at the time there had been little active promotion of a human rights nor clear and consistent guidance or policy on human rights for Scottish public authorities, on human rights in a health setting, or specific human rights duties such as those that exist in relation to equality legislation approach. Nevertheless, TSH in conjunction with a human rights expert, put together an approach which has seen significant

integration of a human rights culture across policy and practice. It has clearly led to significant increases in participation of staff, patients and carers in decision making. It has increased accountability and empowerment of everyone to understand their rights and paved the way for integration of non-discrimination and equality duties. The focus in the intervention on the tests of legality, necessity and proportionality have lead to a culture of understanding that limitations on rights must be individually justified, rather than the subject of blanket policies. Overall, the human rights-based approach has been a success.

A human rights-based approach is better for everyone

First and foremost, this evaluation has concluded that the adoption of a human rights-based approach was indeed successful in supporting a positive cultural change to bring about a working and living environment which in policy was human rights compliant and in practice human rights respecting. It was apparent that through the vehicle of human rights, a culture was created where a constructive and more positive atmosphere existed where mutual respect was developed between staff, patients and carers.

Importantly the human rights-based approach has managed to achieve an understanding of human rights as the means of achieving a cultural change as well as the end goal of a cultural change. By involving staff and patients during the initial policy and practice audit a greater understanding of what were and what were not human rights issues was gained and this helped staff to recognise that their discretion still counted alongside regard for human rights. Staff recognised that more judgement was required when consideration had to be given to each individual's circumstances, but that ultimately this was more rewarding than the previous blanket approach to policy and practice, where every patient was treated the same regardless of individual circumstance and risk.

In turn an important finding was that in understanding more about human rights compliance and what it meant in day-to-day practice, staff felt less anxiety and fear about human rights and this was reflected in decreased stress levels. There was a noted increase in their understanding of how to make choices and take decisions in a rights-respecting manner as well as understanding the meaning and benefit of their own human rights.

Patients and their carers also noted a significant improvement in their care and treatment and in the overall culture at TSH following the introduction of the human rights-based approach. There was a strongly attested shift in the culture of TSH from a prison to a hospital. The reduction in *"blanket"* policies and an increased focus on individual patient's circumstances and risks to others, meant in turn that the care and treatment of patients was individualised. For example, procedures to manage violence and aggression were now seen as proportionate. Patients also noted a large and sustained increase in their ability to participate in decisions about their care and treatment, something which has continued in focus and investment with the creation of the PFPI and PPG in the mid 2000s. Understandings of human rights had changed and rights were no longer seen as something which were relinquished on arrival, but rather they could only be restricted with justification and in a proportionate way.

One key learning point drawn from the approach taken by TSH which was clearly key to its success was the decision to focus on the rights of everyone at the hospital. The human rights-based approach has delivered:

- Positive, measurable benefits in terms of patient outcomes;
- Positive outcomes for staff, particularly in terms of reduced stress levels and their confidence in dealing with human rights issues;
- Genuinely sustained improvements in the culture and working environment of TSH.

Staff who were closely involved in the original implementation of HRBA generally continue to regard human rights as a key element in policy and practice and regard human rights considerations as having become implicit, if no longer explicit, in *"the way we do things around here"*. Applying human rights in all decisions, related to treatment and care, restrictions of freedoms, employment practice and other areas had led to a fairer environment and better relations between staff and patients.

Taking a human rights-based approach reduces risks

Taking a human rights-based approach is primarily about promoting a genuine rights respecting culture within your organisation or authority. In doing so, this

can also help organisations to avoid the risks of having to react to critical media comment, negative public perceptions or legal proceedings, as well as complaints when its policy and practice is shown to breach human rights.

Using and applying the support of tailored human rights expertise to audit policy and practice, combined with the use of very straightforward 'traffic light' warning system linked to these simple tests made human rights at The State Hospital user-friendly, and helped to reduce human and organisational risks.

Human rights are the foundation for other duties

Since the Human Rights Act all relevant legislation has to be read through the lens of human rights. TSH experience shows that taking a human rights-based approach acts as the foundations for the smooth integration of other specific duties which must all be compatible and build on human rights standards. Over the 2000s for TSH this involved new equality, freedom of information and mental health duties. In the first instance, TSH was able to integrate specific requirements of the Mental Health (Care and Treatment) (Scotland) Act 2003, with the bedrock of human rights-based approach. The rights respecting culture had already changed the manner in which TSH approached specific restrictions of rights such as seclusion and restraint, and had already sought to maximise participation and other principles in the Act.

Later, the development of the Single Equalities Scheme was seen to be a relatively straightforward process as non-discrimination and the promotion of equality are fundamental human rights principles. The initial emphasis on human rights helped the process of assimilating policies and practices on equality because staff and patients already had a good basic understanding of 'rights for all'.

While each of these steps has contributed to the overall human rights outcomes the human rights-based approach set the course for culture change with subsequent duties refining the direction in some areas.

For those members of staff and patients who came after the initial interventions, there is still an understanding that the policy and practice at TSH is rights-based, which is testament to the sustained culture change. Given that other organisations and services are likely to be starting from a point where equality

duties will have preceded a human rights-based approach, it is important that future specific equality duties are linked to human rights and delivered through a human rights-based approach. Interviews and focus groups conducted during this evaluation suggest that the focus on equality duties which came subsequent to the adoption of the rights approach have to some extent risked diverting attention, particular amongst newer staff, away from the human rights culture in TSH. However, the conscious efforts of TSH to integrate the two in practice have significantly mitigated this risk.

Crucial to the success of The State Hospital human rights-based approach was the involvement of staff, and the reflection of their rights throughout the process. In any organisation there will be a natural turnover off staff and therefore another key lesson from the evaluation is the need to regularly refresh the human rights-based approach to respond to changes in personnel and in circumstances for example through periodic training, as well as an ongoing assessment and evaluation of policy and practice.

Key process and implementation lessons

The experience of The State Hospital provides clear lessons for the integration of human rights into other public authorities in the health and social care sectors as well as others. The human rights-based approach promoted an understanding of everybody's rights, and how to balance one person's rights against those of another, as well as how to justify limitations of rights. The following elements were seen as crucial to its success:

1. Top level buy-in and vision from the Board, Chief Executive and senior management;
2. Clear executive leadership in implementation by a senior management team;
3. Involvement from an early stage of human rights expertise to support the development and tailoring of a human rights-based approach;
4. A participatory diagnostic process, 'the human rights audit', involving staff and stakeholders of an organisation;

5. Investment of appropriate time and resources to facilitate the process and any resulting work plan, i.e. staff training, policy & practice audit etc.;
6. A proportionate approach, consistent with human rights principles itself, so that the human rights-based approach effort reflects the significance of the issues;
7. An approach which focuses on the rights of everyone affected, in this case, staff as well as patients and their carers.

Recommendations

Next steps for The State Hospital

At TSH the human rights-based approach has been successful and continues to affect, positively, the culture at The State Hospital. However, a small number of recommendations to facilitate continued best practice would include the following:

- Some refreshment of human rights principles and practice would be beneficial, especially where human rights are reinforced as the framework within which equality and diversity naturally sit.
    - There also exist other current vehicles which might be used within which to do this, such as the Values Based training currently rolling out in this Hospital.
- The development of some key indicators set within the *PANEL* framework to facilitate a more structured human rights accountability mechanism for the purpose of internal monitoring over time.

Next steps for The Commission

The Commission would like to work with the Scottish Government and Scottish Public Authorities to:

- Promote the experience and lessons from the evaluation of The State Hospital approach to see how the human rights-based approach can be applied elsewhere;

- Support the lessons from this being taken forward in other key health initiatives including the Patients' Rights Bill and the review of the Mental Health (Care and Treatment) (Scotland) Act 2003;
- Develop clear guidance on how all Scottish public authorities should take human rights into account in delivering equality duties, including in the context of the new specific duties under the forthcoming Equality Act;
- Develop human rights impact assessment tools, and other mechanisms for integrating human rights into the culture of health and social care institutions.
- Develop evaluation tools to enable others to monitor the effectiveness and qualify the impact of the human rights-based approach that they take.

Appendix i: Limitations of the evaluation

An ideal evaluation would involve an evaluation team undertaking a base-line study prior to the human rights-based approach intervention in order to have a high degree of casual probability that an intervention has resulted in certain outcomes or improvements. As the human rights-based approach at TSH began in 2002, it was not possible for this to happen and as a result, the noted outcomes are for the most part based on perceived outcomes. In other words this evaluation has had to rely on documentary evidence, limited statistical data and a range of qualitative testimony to present a comparative picture of what the policy, culture and day-to-day was like at TSH before and after the introduction of the human rights-based approach. However, by combining (triangulating) and comparing the different sources of data, especially the testimony of the key stakeholders about what was said to have happened with the fairly consistent views of staff, patients and carers about what they feel actually happened, the evaluation can assert a degree of reliability in the data collected.

A noted in Chapter 2 the key outcome objective of TSH at the outset was largely aspirational, to see an improvement in the working culture at the hospital. Had the *PANEL* approach existed at this time, more concrete objectives could have been set with regards to evidencing this cultural change quantitatively as well as qualitatively. Robust statistical mechanisms could have been set up whereby over time it would be possible to explore for example: increases in participation rates of patients in patient-staff forums, an increase in the number of policies made available to staff, patients and carers in alterative formats, a decrease in violent incidents, a decrease in staff off sick as result of work stress, a decrease in the use of seclusion as a means of dealing with violent patients, and so on. A useful proportion of this data is available retrospectively, but in some cases for example, the collection methods have changed and so data is not directly comparable. Lessons from the evaluation have been translated two-fold. First individualised feedback to TSH will highlight the types of data that it would be useful for the hospital to collect from this point on in order that a base-line of current practice can be developed for further comparison and evaluation in years to come.

Second, a number of lessons have been learned in relation to improving the evaluation process for future evaluations, including:

- A robust evaluation depends on a systematic policy and practice development process at the outset, to observe and calibrate the base-line situation and to set objectives for the change;
- This initial work should draw on the use of authoritative external expertise to draw out the specific human rights issues for the particular organisation;
- This should then be used to populate a *PANEL* style framework to help shape the initial objectives, to identify required statistical data and mechanisms for collection of such data and to provide a robust evaluation tool;
- Using such an evaluation framework should not only be viewed as a development and evaluation tool, but also as a means of monitoring the progress of an initiative as it unfolds.