Practitioner views on the Mental Welfare Commission's good practice guides

Final report

Dawn Griesbach and Alison Platts
Griesbach & Associates

April 2014

Table of contents

Executive Summary **1**

1. Introduction and background **3**
Objectives of the study 3

2. Methods **4**
Survey of practitioners 4
Follow-up interviews 5
Documentary review 6
Review of the process of developing the guides 7

3. Are practitioners aware of the good practice guides? **8**
Practitioner awareness of the guides 8

4. How do practitioners view the content of the guides? **11**
Perceived usefulness of the guides 11
What practitioners value about the guides 11
Critical comments on the guides 12
Suggestions for improvements 12

5. How do practitioners use the guides? **14**
Extent to which practitioners referred to the guides in the last 12 months 14
Extent to which people recommended or shared the guides with others 15
How the guides are used by practitioners 16
Participation in training where the guides have been featured 18
Use of the guides in the delivery of formal training 19
Informal training and education 19
Experiences of sharing the guides with service users and carers 20
Experiences of contacting the Commission for advice 20

6. How accessible are the guides? **22**
Accessibility of the Commission's good practice guides 22
Publicity 23
Suggestions for improving accessibility and publicity 23

7. Can the process of developing the guides be improved? **25**
The process for developing the guides 25
The process for reviewing guides 26
Positive aspects of the process 26
Could the process for developing the guides be improved? 27

8. Are the guides consistent in their human rights messages? **29**
Findings from the documentary review 29
Findings from the interviews 30

9. Conclusions **32**
Are practitioners aware of the guides? 32

How do practitioners view the content of the guides? 32
How do practitioners use the guides? 32
How accessible are the guides? 33
Can the process of developing the guides be improved? 33
Are the guides consistent in their human rights messages? 34
General comments about the work of the Commission 34
Conclusion 34

Annex 1: Template for documentary review 35

Acknowledgements

We would like to thank the large number of practitioners from around Scotland and staff from the Commission who generously gave of their time to participate in this study. We are also grateful to Karin Dowell (Karbry Transcription and Administration) for her assistance in arranging and transcribing interviews.

Abbreviations

The following abbreviations will be used in this report.

MHA 2003:	Mental Health (Care and Treatment) (Scotland) Act 2003
AWIA 2000:	Adults with Incapacity (Scotland) Act 2000
HRA 1998:	Human Rights Act 1998
the Commission:	Mental Welfare Commission for Scotland

Executive Summary

1. The Mental Welfare Commission for Scotland (the Commission) produces a series of good practice guides for practitioners working in mental health and learning disability services in Scotland. The guides are intended to support the Commission's duty to promote best practice in relation to the observance of the Mental Health (Care and Treatment) (Scotland) Act 2000 (MHA 2000). The aim of this study, carried out by Griesbach & Associates on behalf of the Commission, was to gather feedback from practitioners about the guides in order to learn more about how they were being used in practice and to consider how the series might be improved or enhanced.

2. The study sought information about people's awareness of and views on the guides. The study also examined the process for developing the guides and the extent to which the human rights messages in the guides are consistent. Views were gathered via an online survey and follow up interviews with practitioners, as well as via a focus group and interview with representatives of the Commission.

3. The study participants were, for the most part, already in contact with the Commission, and thus were not a representative sample of mental health and social care practitioners in Scotland. Nevertheless, the findings provide a valuable insight into how the guides are viewed and how they are being used by this group of people.

4. Overall, the study found strong satisfaction with the Commission's good practice guides, and identified a variety of ways in which practitioners have used the guides. While there was a number of issues highlighted in terms of possible improvements or enhancements, particularly in relation to publicity and accessibility, the clear message from participants was that the series as a whole was well-used and valued amongst the target audience. Key findings from the study are summarised below.

Are practitioners aware of the guides?

5. There was a very high level of awareness of the Commission's good practice guides among survey respondents; nine out of ten people reported that that they were aware that the Commission produced good practice guides.

6. The survey identified greater level of awareness of some guides, as compared with others. Those guides with particularly high levels of awareness (*Working with the Adults with Incapacity (Scotland) Act; Consent to treatment; Covert medication)* had application to a wide range of situations both for community and hospital practitioners. The lower levels of awareness and familiarity with guides such as *Zero tolerance* and *Use of seclusion* were not unexpected given the specific focus of these guides on situations likely to arise relatively infrequently, and mainly in acute hospital settings.

How do practitioners view the content of the guides?

7. Practitioners' views of the guides were by and large very positive. They found them relevant and useful, and particularly appreciated the concise, easy-to-read, jargon-free style of the documents, and the use of case studies which helped them to apply the principles set out in the guides to the real life situations that they faced.

8. The small number of critical comments focused on specific guides rather than the series as a whole. Proposals for improving the guides also tended to be specific in nature and included suggestions to review how guides address the issue of technology and another to consider the implications of adult protection legislation (as well as the MHA 2003, Adults with Incapacity (Scotland) Act 2000, and Human Rights Act 1998) in relevant contexts.

How do practitioners use the guides?

9. The guides are well-used, recommended and shared among mental health and learning disability practitioners. Examples were given where the guides were referred to in relation to complex cases, cases where there are differences of opinions among clinicians or concerns about the way in which a service was being provided; in the development of local policies and protocols; and to support improvements in local services. Many examples were also given of the guides being used in training situations.

10. Practitioners had less experience of sharing the guides with service users and carers. Although the content was seen as relevant to service users and carers, there was a view that the guides would need to be adapted if they were to meet the needs of this group.

How accessible are the guides?

11. Practitioners generally felt that the guides were accessible. People were largely content to access the guides electronically, although there were some calls for greater availability of printed hard-copy versions.

12. Practitioners often heard about new guides directly from the Commission, or through their own organisation's internal communications. Suggestions for improving dissemination included encouraging senior managers to cascade information about new guides; developing an app to notify practitioners directly, publicising via professional bodies, and targeting the guides to certain groups, including GPs.

Can the process of developing the guides be improved?

13. There was a general feeling that the process for developing the guides worked well. Suggestions for improving the process focused on increasing the consultation period and strengthening the facilitation role at consultation events.

Are the guides consistent in their human rights messages?

14. The documentary review identified a strong human rights focus in the guides. Practitioners also recognised and valued the human rights focus – although there were a few who wanted this to be strengthened further.

General comments about the work of the Commission

15. Respondents often commented favourably on the wider work of the Commission and on the expertise and helpfulness of staff. Although respondents cited a wide range of professional bodies and published materials as other possible sources of advice, there was a strongly expressed view that the Commission was the key source in this area.

1. Introduction and background

1.1 The Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA 2003), Part 2, section 5, places a statutory duty upon the Mental Welfare Commission (the Commission) to – among other things – promote best practice in relation to the observance of Part 1 of the Act. To fulfil this duty, the Commission has produced a series of good practice guides for practitioners working in mental health and learning disability services in Scotland.

1.2 The guides have been developed to support practitioners specifically in relation to the practical and / or ethical difficulties that they may encounter in applying Scottish mental health and incapacity law in the course of their work. In particular, the guides provide practitioners with a set of principles which they can use when making decisions about how best to address the needs of individuals with a mental illness or learning disability, who may resist or oppose treatment or who may lack the capacity to consent to treatment. As such, the guides complement the telephone advice service provided by the Commission. The guides are developed through consultation with stakeholders, and published guides are reviewed approximately every three years.

1.3 In December 2013, the Commission appointed independent researchers to obtain feedback from practitioners on their knowledge and use of the guides. This document is the report of that study.

Objectives of the study

1.4 This study sought to answer the following questions:

- To what extent are practitioners working in mental health and learning disability services familiar with the guides?
- What are practitioners' views about the content and usefulness of the guides?
- How do practitioners use the guides?
- How accessible are the guides, and could accessibility be improved?
- Is the mechanism for producing the guides satisfactory or could it be improved?
- To what extent do the guides consistently reflect the human rights principles which guide the work of the Commission?

2. Methods

2.1 The evaluation was carried out between December 2013 and February 2014. To address the questions set out above, a mixed-methods approach was used. This involved:

- A survey of practitioners
- Follow-up interviews with a sample of survey respondents
- Focus groups and interviews with Commission staff and other individuals who have had a role in developing or reviewing the guides
- A review of the content the guides.

2.2 Further details about the study methods are provided below.

Survey of practitioners

2.3 A web-based survey of practitioners working in mental health and learning disability services was carried out. The survey included 22 questions which sought information on people's familiarity with the guides, the extent to which they use the guides in their daily practice, and the perceived usefulness of the guides. It also asked about the ways in which people have used the guides, and how the guides could be made more widely available.[1]

2.4 The survey was sent to approximately 1,100 practitioners on the Commission's mailing lists. It was also publicised through a variety of forums, including:

- Scottish Association of Social Work
- Royal College of Psychiatrists
- Royal College of General Practitioners for inclusion in their newsletter
- Mental health nurses forum
- Learning disability nurses forum
- Mental Health Officers' newsletter
- Scottish branch of the British Psychological Society
- Care Inspectorate for inclusion on their intranet and external website.

2.5 The survey was carried out over three weeks between 7 and 30 January 2014.

About the survey respondents

2.6 In total, 463 survey responses were received. However, the analysis presented in this report is based on 421 responses.[2] Forty-two respondents were excluded from the main analysis as they did not proceed beyond the opening questions seeking information about their job and whether they were aware that the Commission produced good practice guides. Among this group, all who offered a response to the latter question said that they **were** aware the Commission produced good practice guides.

[1] A copy of the survey questionnaire is available from the Commission upon request.

[2] Note that, in the tables and charts throughout this report, the figure shown for total number of respondents varies because not all respondents answered every question.

2.7 Responses were received from every NHS Board and local authority area in Scotland. In addition, some respondents reported that they worked across multiple NHS Board or local authority areas.

2.8 Nearly two-thirds of survey respondents reported that they worked for an NHS organisation, while a quarter said they worked for a local authority. See Table 2.1. The remaining respondents worked for voluntary / third sector service providers, private care homes, or other types of organisations.

Table 2.1: Number of respondents, by employing organisation

Employing organisation	n	%
NHS	270	64%
Local authority	102	24%
Voluntary / Third sector service provider	15	4%
Private care home	11	3%
Other*	21	5%
Total	**421**	**100%**

* - 'Other' includes: the Care Inspectorate, the Mental Health Tribunal for Scotland, independent or private hospitals or other care services, higher education institutions or self-employed consultants.

2.9 Survey participants included a wide range of care professionals. Table 2.2 below shows a breakdown of respondents by job. Together, psychiatrists and community mental health or learning disability nurses comprised about two-fifths of the respondents.

Table 2.2: Number of respondents, by job

Job	n	%
Psychiatrist	79	19%
Community mental health / learning disability nurse	75	18%
Mental Health Officer	55	13%
Hospital based mental health / learning disability nurse	51	12%
Other social worker	29	7%
Clinical psychologist	29	7%
Care home manager	13	3%
Member of the allied professions (OT, physiotherapist, etc.)	13	3%
Voluntary / Third sector service manager	8	2%
General practitioner (GP)	8	2%
Other*	61	14%
Total	**421**	**100%**

* - 'Other' includes: Senior nurses or nurse consultants; social work team leaders or managers; voluntary / third sector support workers; addictions services (nurses or other staff); midwives; pharmacists; other doctors; legal professionals or advisors; trainee Mental Health Officers; and individuals with multiple roles.

Follow-up interviews

2.10 All those who took part in the survey were invited to participate in a short telephone interview to discuss their views and experiences of the good practice guides in more depth, with a focus on:

- Views on the guides, including their human rights focus
- Experience of using the guides in their work
- Accessibility of the guides and how this could be improved
- Any other comments interviewees wished to make.

2.11 Interviewees were also asked whether they had any experience of being involved in the process of developing any of the guides (for example, by attending a consultation event, or commenting on a draft guide). Those who said they had this experience were asked further questions about this.

About the interviewees

2.12 In total, 51 respondents agreed to participate in an interview, and 21 interviews were carried out. The majority of interviewees (two-thirds) comprised mental health officers, other social workers, psychiatrists and nurses. The remainder were voluntary sector service managers, local authority solicitors, a pharmacist and a general practitioner (both of whom had specialist interests in mental health).

Interpreting the findings

2.13 It should be noted that the views and perceptions presented in this report are those of the research participants, and are based on their knowledge and perspective. Factors which will influence the views of participants are their role, work place setting and seniority. However, the scale of the study did not allow analysis at sub-group level to be carried out, and this may be an issue which could be explored further.

Documentary review

2.14 The documentary review involved assessing the human rights focus of the guides using a set of 'indicators' based on selected Articles from the Human Rights Act 1998 (HRA 1998). The review focused on nine good practice guides listed below. These were chosen because the Commission had identified them as the most frequently requested guides or areas where rights are restricted and guidance is important for practitioners:

- *Working with the Adults with Incapacity (Scotland) Act* (March 2007)
- *The use of seclusion* (March 2007)
- *Consent to treatment* (December 2010)
- *Right to treat?* (May 2011)
- *Consenting adults?* (May 2012)
- *Zero tolerance: measured response* (May 2012)
- *Carers and confidentiality* (March 2013)
- *Rights, risks and limits to freedom* (March 2013)
- *Covert medication* (November 2013).

2.15 The template use for the documentary review and an example of a completed template are attached as Annex 1.

Review of the process of developing the guides

2.16 Finally, a review was undertaken of the process of developing the guides. The purpose of this review was to understand the process, and to identify what works well and any areas for improvements.

2.17 To address these issues, a focus group was carried out with Commission staff who have been involved in developing / reviewing one or more of the good practice guides. In addition, interviews were undertaken with the (then) Chief Executive of the Mental Welfare Commission and five external individuals who had experience of being involved in the process of developing one or more guides. The latter group comprised three psychiatrists, a pharmacist and the director of a third sector organisation.

3. Are practitioners aware of the good practice guides?

3.1 The first objective of this study was to identify the extent to which practitioners working in mental health and learning disabilities services are familiar with the guides. This section provides information from the survey about people's awareness of the Commission's good practice guides.

Practitioner awareness of the guides

3.2 Of the 421 respondents who completed the survey, the majority (90%) said they **were** aware that the Commission produced good practice guides. Forty-one respondents said they were **not** aware of the guides. Because of the small numbers involved, it is not possible to make any definitive statement about the types of people who were not aware of the guides. However, it would appear that the general practitioners who took part in the survey were more likely to say that they were not aware of the good practice guides as compared to other respondents. **All** of the Mental Health Officers, hospital based mental health and learning disability nurses, care home managers and voluntary / third sector service managers who took part in the survey **were** aware of the Commission's good practice guides. See Table 3.1.

Table 3.1: Were you aware that the Mental Welfare Commission produces good practice guides?

Job	Yes (n)	No (n)	Total (n)
Psychiatrist	74	5	79
Community mental health / learning disability nurse	68	7	75
Mental Health Officer	55	–	55
Hospital based mental health / learning disability nurse	51	–	51
Other social worker	23	6	29
Clinical psychologist	21	8	29
Care home manager	13	–	13
Member of the allied professions (OT, physiotherapist, speech or language therapist, etc.)	11	2	13
Voluntary / Third sector service manager	8	–	8
Voluntary / Third sector support worker	2	3	5
General practitioner (GP)	2	6	8
Other*	52	4	56
Total	**380**	**41**	**421**
Total percentages	**90%**	**10%**	**100%**

* - 'Other' includes: Senior nurses or nurse consultants; social work team leaders or managers; midwives; pharmacists; addictions services (nurses or other staff); legal professionals or advisors; trainee Mental Health Officers; care home staff; other doctors; and individuals with multiple roles.

3.3 The 380 respondents who said they **were** familiar with the good practice guides were given a list of the Commission's nine most frequently requested guides, and asked to indicate which they had read (entirely or partly), which they had seen, and which they had not seen at all.

3.4 The findings indicated that respondents were most familiar with the following three guides:

- *Working with the Adults with Incapacity (Scotland) Act*
- *Consent to treatment*
- *Covert medication*

3.5 Around four out of five respondents (ranging from 76% to 82%) said they had read some or all of each of these three guides.

3.6 Respondents were least familiar with the following two guides:

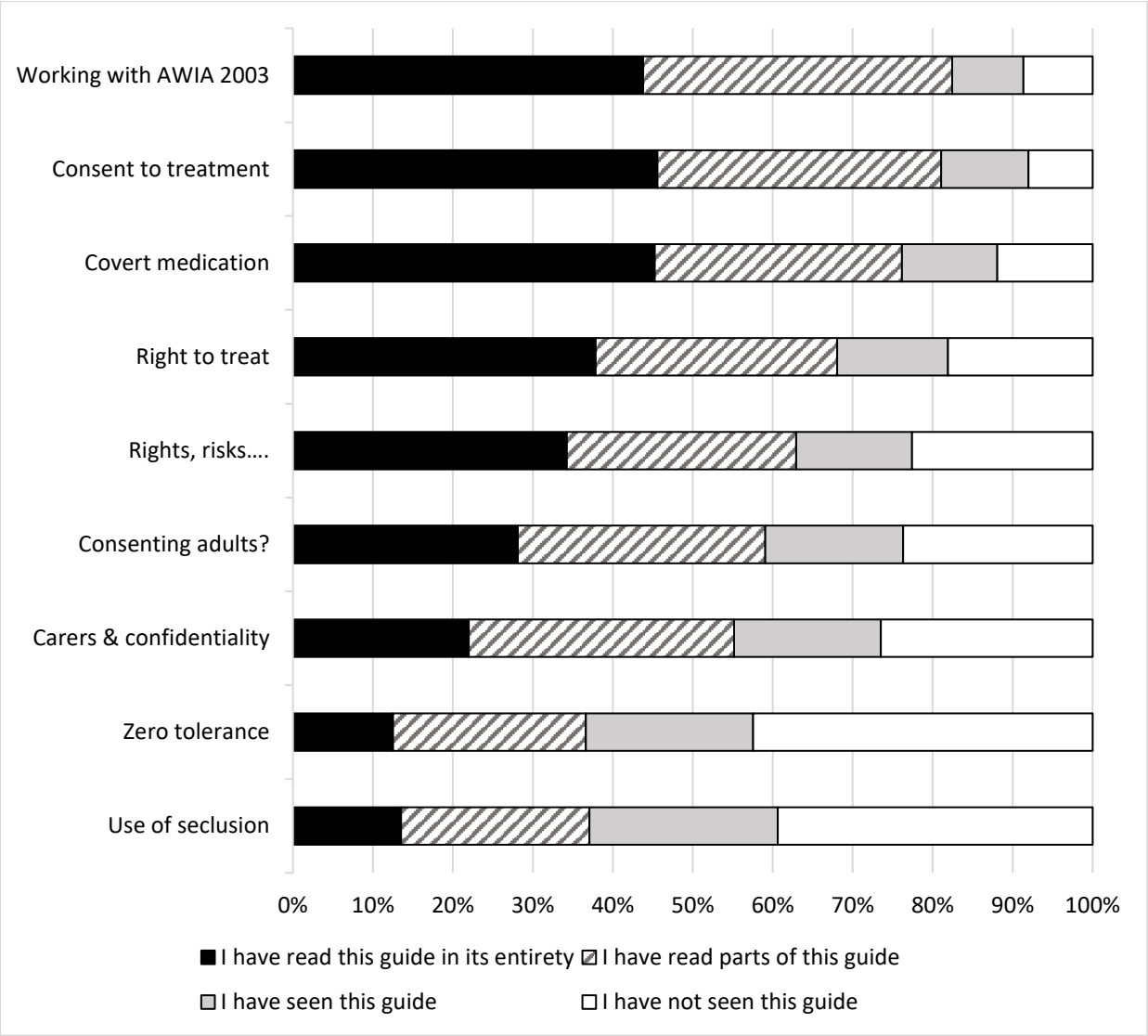
- *Zero tolerance*
- *Use of seclusion*

3.7 Less than two-fifths of respondents (37%) said they had read some or all of either of these two guides. In addition, a significant minority of respondents (again, around two-fifths in both cases) reported that they had not seen either of these two guides. See Table 3.2 below and Figure 3.1 on the following page.

Table 3.2: Which of the following guides are you familiar with? (n= 375)

Title of guide	% who had read some or all of the guide	% who had seen, but not read the guide	% who had not seen the guide
Working with the Adults with Incapacity (Scotland) Act	82%	9%	9%
Consent to treatment	81%	11%	8%
Covert medication	76%	12%	12%
Right to treat?	68%	14%	18%
Rights, risks and limits to freedom	63%	14%	23%
Consenting adults?	59%	17%	24%
Carers and confidentiality	55%	18%	26%
Zero tolerance	37%	21%	42%
Use of seclusion	37%	24%	39%

Figure 3.1: Extent of respondents' familiarity with nine good practice guides (n=375)



4. How do practitioners view the content of the guides?

4.1 The second objective of the study was to ascertain practitioners' views about the content of the guides, and in particular, their views on the usefulness of the guides. This section presents a summary of practitioners' general comments on the guides and any suggestions for improvement that they made.

4.2 This information comes largely from the interviews with practitioners. In the interviews, people were asked: (i) what they valued about the guides; and (ii) how the guides could be made more relevant to practitioners like themselves.

4.3 The survey included a question about the perceived usefulness of the guides, but did not otherwise ask for details of respondents' general views. However, the final question in the survey asked respondents for any other comments they had about the Commission's good practice guides. Ninety-three people offered comments in response to this question, and as most of these were general comments about the guides, they are included here.

Perceived usefulness of the guides

4.4 In the survey, respondents were asked their views about the usefulness of each of the nine guides. Among those who responded (n=337) nearly all said they found the guides 'very useful' or 'quite useful'. For each of the individual guides, only a very small number (ranging from one to six) rated them as 'not useful'.

What practitioners value about the guides

4.5 Comments from survey respondents provided an indication of the positive regard which practitioners had for the guides; this view was reinforced further in the comments from the interviewees. In both the survey and the interviews, practitioners repeatedly said that they appreciated the guides for:

- **Their style:** they were described as: *"concise", "easy to read and understand", "jargon-free", "clear", "thoughtful"*, *"authoritative"* and *"informative"*
- **Their value in practical situations:** they were described as *"useful", "relevant", "practical"* and *"workable"*.

4.6 Practitioners particularly liked the fact that the guides include case studies, which show how the principles set out in the guides can be applied in specific situations.

> *"I think they're clearly written and that the material is presented in a thoughtful way that discusses and acknowledges the kind of grey areas around stuff that's difficult, both practically and ethically difficult. They use good case examples, so it's very easy to link the material in with real life dilemmas." (General practitioner)*

4.7 The point was also made that the guides can have the effect of improving knowledge of certain subjects among certain groups. An example was given in relation to the role of advocacy for people with mental illnesses.

> *"I think [the guides] make subjects more accessible to certain groups that wouldn't actually access it normally. And in the context of advocacy, it provides*

a level of transparency around the role of the advocate, which hopefully… the outcome of all of this would be that professionals are much more understanding and more aware of the role of the advocate, much more aware of people's rights to access advocacy…." (Senior manager, third sector service)

Critical comments on the guides

4.8 There were also a small number of more critical comments. One survey respondent suggested that some of the case studies seemed to be *"a tiny bit contradictory",* leaving this particular individual feeling *"more confused than when I started".* This comment was echoed by a second respondent who stated that:

"… the guidance on treating physical health in incapax patients [patients who lack capacity], though recent, is not helpful on a practical basis and seems a bit contradictory in aspects re how form 47s are supposed to be used." (Psychiatrist)

4.9 Another survey respondent observed that it can be difficult to reconcile the practice recommended in the guides with *"current common practice"* within some services. This individual suggested that adopting the Commission's recommended practices would *"represent quite an abrupt change".*

4.10 It is perhaps worth noting that, within the survey findings, most of the critical comments on the guides were voiced by psychiatrists.

4.11 There were also a small number of concerns expressed about one guide in particular – *Zero tolerance:*

"I think the good practice guidelines regarding zero tolerance seems to imply we should accept nurses being hit by patients who have a diagnosis of mental illness." (Hospital based mental health / learning disability nurse)

"I have concerns that at least one of the guides does not represent good practice – 'Zero tolerance' – and I think great care needs to be taken before this is adopted across health boards in Scotland. The Commission needs to be mindful that although these documents are described as 'guides', they are likely to be adopted in their entirety by health boards across the country and are very influential." (Psychiatrist)

Suggestions for improvements

4.12 Interviewees were asked whether they could think of any ways that the good practice guides could be improved, or made more relevant to practitioners like themselves.

4.13 In response to this question, interviewees generally re-iterated their satisfaction with the guides and said that they and their colleagues used and referred to them often. If interviewees made any suggestions at all, they tended to focus on how to improve the publicity and accessibility of the guides. (These comments are discussed in Chapter 6 below.) However, a few suggestions were offered in relation to improving the relevance of the guides:

- **Review the way in which the guides address the issue of technology**

  "…Living in a 21st century world where technology forms so much a part of our lives, and the Act and the guidance hasn't kept up with the way in which everything connects now, in terms of phones, tablets, internet, everything connects to everything. And the restrictions that are placed on people detained under the Act… denying someone access to a phone has much wider implications than it did have say five years ago…. So I'd say [there needs to be] some modernisation in terms of the cultural – or the technological – world that we're living in." (Hospital senior manager)

- **Consider the implications of adult protection legislation[3] in relation to certain issues**

  "My focus is on adult protection legislation as well, and I'm not sure they're quite there yet in regards to the interaction of adult protection legislation, alongside the mental health and adults with incapacity legislation that they're probably more familiar with. For example, with 'Consenting adults?', one of the guides that they have, which is actually a useful guide, I would have liked to have seen a little bit more about the difficulties in judging consent to have sexual activity, at what point it should be considered to be adult protection, at what point you would consider it being abusive or a power differential or an imbalance. Now they do touch on that in there, but I would perhaps have liked that to be a little bit more explicit in the use of the adult protection legislation as well." (Senior social worker, adult protection)

4.14 A small number of survey respondents also offered suggestions for how to improve the guides, concentrating more on issues of presentation and accessibility*: "make them available with an executive summary with relevant bulleted learning points"* and *"collate learning points into a once-a-year dispatch"*.

[3] Adult Support and Protection (Scotland) Act 2007.

5. How do practitioners use the guides?

5.1 The third objective of the study was to explore the ways in which practitioners use the Commission's good practice guides in their work. This section presents these findings.

5.2 In the survey, a range of questions sought information about people's use of the guides. Survey respondents were asked:

- How often they had referred to one or more of the nine guides in the last 12 months
- The extent to which they shared the guides with other people
- Their experience of attending or delivering training in relation to the guides
- Whether they had ever phoned the Commission with a question about one of the guides.

5.3 In both the survey and the interviews, practitioners were asked to describe a situation in which they had either referred a colleague to one of the guides, or where they had used one of the guides themselves in a work-related situation. There was also a separate question in the survey which asked respondents whether they had ever phoned the Commission for advice.

Extent to which practitioners referred to the guides in the last 12 months

5.4 Survey respondents were asked how often they had referred to the good practice guides in the last 12 months. In total, 371 respondents answered this question, with the findings indicating that two guides were referred to more frequently in the last 12 months than the others. These were:

- *Working with the Adults with Incapacity (Scotland) Act*
- *Consent to treatment*

5.5 Half of respondents (52%) had referred to *Working with the Adults with Incapacity (Scotland) Act* occasionally (several times) or often (at least once a month) in the past year; the figure for *Consent to treatment* was 44%.

5.6 In contrast, the two guides referred to least frequently were:

- *Zero tolerance*
- *Use of seclusion*

5.7 Around two-thirds of respondents (63% and 66% respectively) said they had **not** referred to these two guides at all in the past 12 months. See Table 5.1 below. This finding is undoubtedly linked to respondents' general lack of familiarity with these two guides, as discussed in Chapter 3.

5.8 Between 25% and 35% of respondents said they had referred to each of the other five guides often or occasionally in the past 12 months.

Table 5.1: In the past 12 months, how often have you referred to the following good practice guides in your job? (n=371)

Title of guide	Often (at least once a month)	Occasionally (several times in the past year)	Rarely (once or twice in the past year)	Not in the past 12 months
Working with Adults with Incapacity (Scotland) Act	15%	37%	26%	23%
Consent to treatment	13%	31%	30%	26%
Right to treat?	10%	26%	30%	34%
Rights, risks and limits to freedom	8%	27%	27%	39%
Covert medication	7%	26%	33%	33%
Consenting adults?	6%	22%	29%	44%
Carers and confidentiality	3%	22%	31%	44%
Zero tolerance	1%	12%	24%	63%
Use of seclusion	1%	10%	22%	66%

It should be noted that there a range of reasons why practitioners may not have referred to a guide including: (a) they were already very familiar with the guidance; or (b) no situation had arisen in their work for which the information in the guide would be needed.

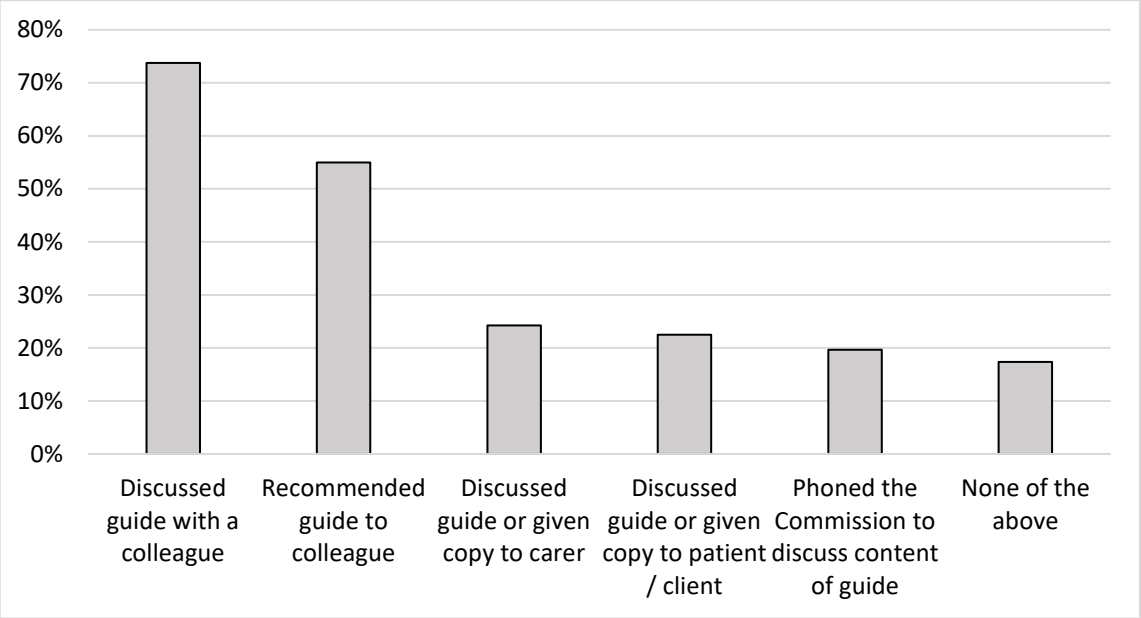
Extent to which people recommended or shared the guides with others

5.9 Survey respondents were asked to indicate whether (in the last 12 months) they had:

- Recommended a guide to a colleague
- Discussed the content of a guide with a colleague
- Discussed the content of a guide or given a copy to a patient / client
- Discussed the content of a guide or given a copy to the carer of a patient / client
- Phoned the Commission to discuss information in the guide
- None of the above.

5.10 In total, 351 respondents replied to this question. Around three-quarters said they had discussed one or more of the guides with a colleague, while just over half said they had recommended a guide to a colleague. Fewer reported discussing a guide or giving a copy to a carer or a patient / client, or phoning the Commission to ask for further information about the content of a guide. Just 61 respondents said they had done 'none of the above'. See Figure 5.1

Figure 5.1: In the last 12 months, have you ever done any of the following with one or more of the Commission's good practice guides? (n=259)



How the guides are used by practitioners

5.11 Survey respondents were asked to provide details about the context in which they had used one or more of the Commission's good practice guides in the last 12 months. Ninety-nine respondents offered comments. Interviewees were also asked to describe a situation in which they had used a guide themselves, or had recommended a guide to a colleague.

5.12 In addition to using the guides in the delivery of staff training (which is discussed below), practitioners also reporting using the guides in the following ways:

- **To help address a challenging situation related to the care of a patient / client**: People gave examples of a wide range of situations where they had referred to the guidance:

  "Discussing the boundaries and implications of confidentiality and consent to treatment with patients, carers and colleagues." (Community mental health / learning disability nurse)

  "I have used the covert medication guide, passed to and discussed with a colleague and discussed with a carer who had Welfare Power of Attorney and was giving covert medication." (Allied health professional)

- **To help resolve differing views and practices between different professionals:** Practitioners commented that the guides helped to ensure more consistent and equitable practices within services and teams.

  "They have proven very useful when there has been a difference of opinion with professionals regarding an approach to take, especially for NHS staff who have a caring, protective attitude rather than a rights based ethos." (Mental Health Officer)

"When we have challenging cases with differing views from professionals, I regularly seek guidance from these documents and circulate to all involved." (Community mental health / learning disability nurse)

- **To inform the development of local service policies and protocols:** Specific examples were given where certain guides were used to develop protocols for use of covert medication and use of restraint, and to develop more consistent practices between health and social care professionals and between different groups of health professionals.

  "We use the guides to inform policy and practice, as reference material and in shaping service delivery." (Care home manager)

  "I have used the guidance to influence local policy to develop consistency of approach across Health Boards. I have also used the guidance in workshops with staff groups and with management groups to encourage service and policy development." (Senior manager – strategic planning)

- **To challenge a perceived breach of a patient's rights:** The examples given often related to people being restrained or locked in.

  "I had been working with someone who didn't have capacity with a learning disability and he was a delayed discharge in a general hospital, and I found him to be in a locked ward. So his liberty was being deprived, but there was no order in place. There was no consideration to other safeguards that may have been used. So I was surprised that nobody had given consideration to this man's deprivation of liberty. And when I asked the GP, what the GP said was that the ward was locked to keep people out – not to keep people in. And she went on to say this man can leave the ward any time he wants. But he couldn't actually coordinate himself to use the keypad for example. I had just read that good practice guide about deprivation of liberty so I have to say we went on to get a guardianship for this gentleman, who…he was voicing his opinion, he wanted out of the ward, he didn't want to be there, and there were no safeguards in place for him, and somehow when I spoke to the GP about it, and the ward staff, they didn't think for one minute that there could be an issue of deprivation of liberty." (Mental Health Officer)

- **To support improvements in local service provision:** References were made to using the guides for clinical audits and other activities to improve standards of care.

  "In relation to 'Consent to treatment', we now audit our T2 s and T3s every year using what the MWC has as their standards for Scotland. We use that as the standard we're trying to match, so that the T2s and T3s here in [health board] are completed correctly in the same way for inpatients and outpatients." (Psychiatrist)

- **Use in court / Tribunal proceedings:** Practitioners reported citing or submitting the guides as evidence in court cases or Tribunals.

  "I know of another case where one of my colleagues actually lodged the Mental Welfare Commission's good practice guide in court, in a situation where there was a need for restraint to be used in a care home setting." (Solicitor)

- **For personal development:** Practitioners spoke of "updating" and "refreshing" their own skills through reference to particular guides.

  "Seclusion: I have had to recently update myself with this." (Hospital based mental health / learning disability nurse)

  "I have used the guides on a regular basis. They have provided me with good educational tools and helped me to reflect on my practice." (Mental Health Officer)

Participation in training where the guides have been featured

5.13 The other area where practitioners frequently reported using the guides was in relation to staff training – both formal and informal.

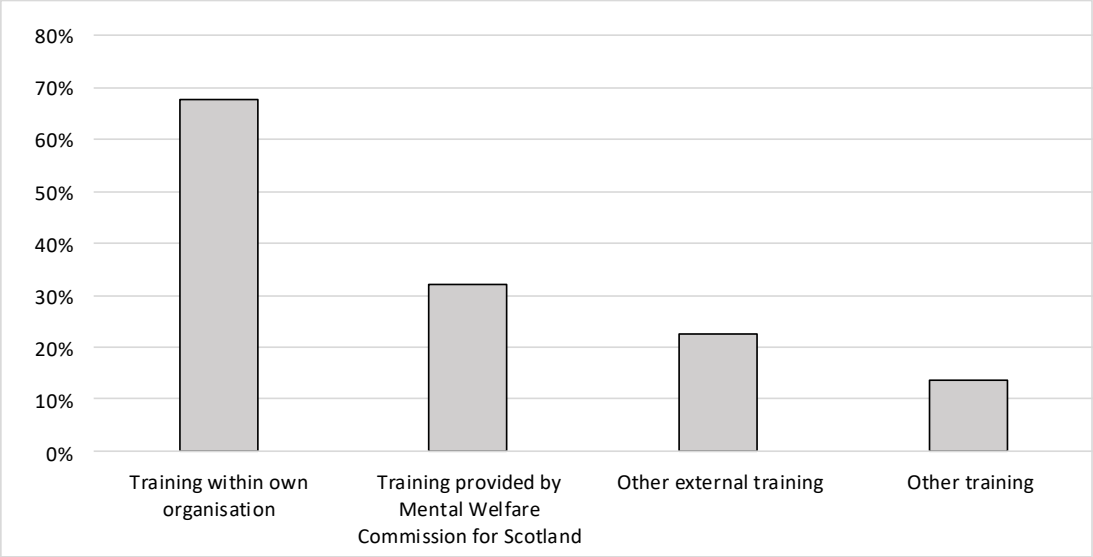
5.14 In the survey, practitioners were asked whether they had ever attended training in which one or more of the Commission's good practice guides had been presented or discussed.

5.15 In total, 218 respondents replied to this question and the findings suggest that the guides are frequently used for in-house training among mental health and social care staff. Two-thirds of respondents said they had taken part in training delivered within their own organisation where one or more of the guides had been discussed or presented. In addition, nearly one-third said they had participated in seminars or webinars delivered by the Commission in which the guides were presented. A fifth said they had attended external training (not delivered by the Commission) where one or more of the guides were used. Fourteen percent (14%) of respondents indicated that they had taken part in other forms of training in which the guides were featured. (See Figure 5.2 below.) Examples included:

- (University-level) training for Mental Health Officers (MHO)
- Local MHO forums (where practice issues are discussed)
- Training in adult support and protection
- Training provided by the British Psychological Association
- Training for senior charge nurses and refresher training for clinical supervisors
- Induction for independent advocates
- Training delivered by a local mental health advisor
- Presentations / discussions in local journal clubs

5.16 Some respondents commented that they would welcome additional training on topics covered by the guides. Positive comments were also received about the Commission's webinars.

Figure 5.2: Have you ever participated in any of the following forms of training in which one or more of the good practice guides was presented or discussed? (n=218)



Use of the guides in the delivery of formal training

5.17 In the survey, respondents were also asked if their role involved the delivery of training and if so, whether they had ever used one or more of the guides for this purpose.

5.18 In total, 187 respondents reported that their role involved the delivery of training. Of these, just over half said that they had used the Commission's good practice guides in their training. The guides were reported to be used in the training of a very wide range of groups, including practitioners in NHS, local authority and third sector mental health, learning disability and care home services; and students and trainee doctors, social workers and social care staff.

Informal training and education

5.19 In addition, it was very common for survey respondents and interviewees to say that they had used one or more of the guides in more informal training or educational situations. The following quotes illustrate the range of ways practitioners used the guides to mentor, support and share learning with their colleagues, including colleagues in different services:

> *"AWI [Adults with Incapacity] is an area that arises frequently in the care of people with dementia, particularly in acute general and community hospitals. Sometimes there is the potential that people who do not have the capacity to make informed decisions about their care may be treated without consideration of AWI. This is a subject that I share, educate and advise on at every opportunity." (Dementia nurse consultant)*

> *"There was a situation fairly recently with an elderly person in one of the care centres that I look after where we were considering using covert medication,*

and I remembered… there was a Mental Welfare Commission guide about administering covert medication. So I went and looked for it, and read it through, and that was useful in helping us to think about it. And I printed off a copy and actually gave that to the manager of the care home as something for the staff to look through. I just thought it was an interesting read for anybody involved in that area." (General practitioner)

"We're using it in the training of staff, and as I say, we're also using it when we're dealing with particular situations, because what tends to happen is, if there's any sort of like adult support protection, any issues, any duty of care, whatever things come to my attention, at least I can say well I'm aware of this document, and I think it would be quite useful for you to read that and see if there's anything that we could learn or anything that we could do differently." (Third sector service manager)

Experiences of sharing the guides with service users and carers

5.20 Figure 5.1 above showed that relatively few of the survey respondents (around 20%) had shared or discussed the content of a guide with a patient / client, or a carer. The interviews generally corroborated this finding: in general, the practitioners who were interviewed had *not* shared the guides with a service user or carer. There were some exceptions, however, and examples were given where the guides had been used to provide information to service users and carers about advocacy, advance statements and issues related to patient confidentiality.

5.21 Practitioners generally believed that, in order to be useful for these groups, the guides would need to be shorter and the language simplified. Further, some noted that the guides are intended to promote good practice for professionals, and so they questioned whether it would be helpful to give a guide with that type of focus to a service user.

5.22 Sometimes practitioners recognised the relevance of the material for service users or carers, and there were examples / was an example of the guides being summarised into a shorter document for this group:

"There was guidance on advanced statements, and as memory serves that's quite a lengthy one – it's about 20-odd pages. We summarised it into a single page and we included it with our patients' information booklet. So patients coming to the ward, or before they're admitted, they get a booklet explaining what the service is, and there's a page there on advance statements, and that has been summarised from the guidance." (Senior hospital manager)

Experiences of contacting the Commission for advice

5.23 The Commission's good practice guides are intended to complement the telephone advice service provided by the Commission. Therefore, as part of this study, survey respondents were also asked if they had ever contacted the Commission for advice. In total, 352 respondents answered this question. Nearly three-fifths (57%) of these said that they had contacted the Commission for advice. The findings indicated that

this group of respondents included relatively high proportions of hospital based mental health / learning disability nurses, MHOs and psychiatrists.

5.24 In total, 174 respondents provided further details about their reasons for contacting the Commission. A very wide range of issues were described. These largely related to individual cases where there was a challenging ethical or legal situation related to a patient / client who lacked (or appeared to lack) capacity to make their own decisions. There were also situations where the challenges appeared to be related to carers or individuals who had Welfare Guardianship or Power of Attorney.

5.25 No information was collected to ascertain the extent to which people phone the Commission for advice before, after or instead of consulting one or more of the good practice guides. It is, though, generally accepted that practitioners may sometimes prefer to speak to someone at the Commission about challenging or complex cases.

6. How accessible are the guides?

6.1 The good practice guides are available on the Commission's website in PDF format and are also available in hard copy on request. Upon publication of a new guide, the Commission circulates an email message with a web link to those on their distribution list.

6.2 Therefore, the fourth objective of this project was to obtain feedback from practitioners about the accessibility of the good practice guides, and to identify whether the accessibility of the guides could be improved. This section summarises these findings.

6.3 The initial question in the survey asked respondents if they were aware that the Commission produced good practice guides. Those who said 'no' were asked for suggestions about how the Commission could improve publicity of the guides. Respondents who answered 'yes' to this initial question were asked whether they had ever had any difficulties in accessing the guides, and if so, to explain the circumstances in which they tried to access them but could not.

6.4 Interviewees were also asked how they accessed the guides, and whether they had any suggestions for improving access or publicity of the guides.

Accessibility of the Commission's good practice guides

6.5 Survey respondents who said they were familiar with the Commission's good practice guides were asked whether they had ever had any difficulties in accessing the guides. In total, 349 respondents replied to this question. Of these, most (93%) said they had not had any difficulties. Among the relatively small proportion who reported difficulties accessing the guides, the following issues were raised:

- Difficulties in navigating the Commission's website – and related difficulties of finding the guides through other means (i.e. internet searches)
- Difficulties with accessing or using computers
- Insufficient availability of printed copies – and a related dissatisfaction with the process of having to print them locally
- Lack of information about the availability of the guides
- Work-related pressures resulting in a lack of time to look for relevant guides.

6.6 Clearly, not all of these difficulties would be able to be addressed by the Commission (i.e. lack of access to computers, lack of time).

6.7 In general, interviewees reported that they accessed copies of the good practice guides through the Commission's website. Furthermore, they largely seemed happy with this form of access. Some reported that they downloaded copies of the guides onto their own computers or laptops, and thus had them available for reference when they needed them – including when they were out visiting clients / patients, or at meetings. Others said that they printed copies as the guides became available.

6.8 There was a suggestion that some practitioners would prefer to have nicely printed and bound copies of the guides. However, there was also a recognition that printed guides would cost money, and perhaps this cost could not be justified in the current

economic climate. It was not common for interviewees to say that they automatically received printed and bound copies of the guides – although two managers of third sector organisations both said this.

Publicity

6.9 Interviewees sometimes said that they received a notification from the Commission when new guides were available – and there was a general view that this was helpful. Others said they received a notification through their own organisation's internal mailing lists. Less often, interviewees said that they themselves had responsibility for disseminating information about the Commission's good practice guides to other staff within their organisation. There were also a relatively small number of interviewees who were not sure that they received any notification about the availability of new guides. This group said, however, that they frequently visited the Commission's website anyway, and knew where to find the guides if they wanted them.

Suggestions for improving accessibility and publicity

6.10 It was noted briefly in Chapter 3, that 41 respondents to the survey said they were **not** familiar with the good practice guides. These individuals were asked for their views about how the Commission could better publicise their guides. Twenty-eight offered suggestions, the most common of which were to include information about the guides on local authority or local NHS websites or intranets, or through internal NHS / council staff email communications.

6.11 Less common suggestions were to advertise on television; via Athens (bibliographic database); at seminars, conferences, lectures or training events; through posters in hospitals or health centres; or through the newsletters of professional bodies such as the British Medical Association or the Royal College of General Practitioners.

6.12 Survey respondents and interviewees who **were** familiar with the guides also made some suggestions about how to improve their accessibility / publicity:

- Publish a complete list of guides (and investigation reports), with a short abstract for each, and circulate this occasionally for local distribution.
- Locate information about the guides on a single webpage on the Commission's website, rather than having the information spread over 2-3 pages. Again, it would be important that a brief abstract is included with each.
- Use a mobile phone app to notify practitioners of the availability of new guides.
- Publish details of new guides in Third Sector News
- Send information about new guides to heads of community care and mental health services and ask them to cascade the information to their local staff.

Need for targeted awareness raising

6.13 There were also recurring calls for the good practice guides to be better targeted at GPs. One interviewee suggested that a paper flyer could be sent to GPs (or perhaps better, to practice managers) once a year, and that this might help to raise awareness of the guides and their relevance to GPs, particularly given the role of GPs

in authorising certificates of incapacity. There was a feeling that information from the good practice guides needed to be routinely incorporated into GP training.

6.14 Other groups which interviewees suggested should have greater awareness of the Commission's guides included: general hospital nursing staff and doctors; community care services; and some community mental health nurses. In each case, interviewees suggested that awareness of the guides among these groups should be improved.

7. Can the process of developing the guides be improved?

7.1 The fifth objective in this study was to explore whether the mechanism for producing the guides was satisfactory, or whether it could be improved in any way. This section presents information about how the Commission's good practice guides are developed, and presents possible areas for improvement.

7.2 This information comes from a focus group with Commission staff who have had responsibility for developing or reviewing (or who have contributed to the development or review of) one or more guides; an interview with the Commission's then Chief Executive; and interviews with external practitioners who had been involved in the development of one or more guides.

The process for developing the guides

7.3 The process for developing the good practice guides was described as following a broadly standard procedure, although it was clear that the details of this procedure varied slightly from one guide to the next. The process, which was reported to take about six months, can be summarised as follows:

- **Identifying potential topics:** Topics for good practice guides are frequently identified as a result of phone calls that are received by the Commission's advice line, or through investigations carried out by Commission staff. Where an issue or question arises repeatedly, this topic is seen as a possible candidate for a good practice guide. The Commission's Advisory Group is consulted annually for suggestions for new guides. Commission staff may also suggest topics based on their professional interests and / or their knowledge and experience of working in mental health and social care services.
- **Carrying out a review of the information available on that topic:** This aspect of the work involves, primarily, an examination of the legal framework – in particular, the MHA 2003, the AWAI 2000, and in recent years, the European Convention on Human Rights (ECHR). Depending on the topic of the guide, other legislation, regulations or professional codes of practice, may also be reviewed. For example, the guide *Zero tolerance: measured approach* involved an examination of health and safety legislation and regulations. The guide *Carers and confidentiality* involved an examination of data protection legislation and professional codes regarding patient confidentiality.

  This aspect of the process also involves a review of available literature on the topic.
- **Identifying relevant case study material:** Many (though not all) of the Commission's good practice guides contain case studies which are used to illustrate how the legal framework may be applied in the care of individuals. The case studies are identified through calls to the Commission's advice line, through their investigations, or through messages sent out via the Commission's mailing lists inviting practitioners to contribute case studies. All case study material is anonymised and if necessary details of the case are changed to ensure that individuals cannot be identified.

- **Undertaking consultation on the topic:** The nature of the consultation may vary depending on the topic. Consultation may involve a day-long event to which external practitioners, individuals and carers are invited. If this type of consultation is undertaken, the event generally focuses on the discussion of case studies which have been submitted in advance.

  Depending on the topic, consultation may, in some instances, be restricted to key stakeholders or other experts. So, for example, the Office of the Public Guardian was a consultee in relation to *Money matters.* In some cases, the Royal Colleges or the Care Inspectorate may be consulted. The Scottish Human Rights Commission is regularly consulted on the Commission's guides.
- **Drafting:** In general, a team approach is used to drafting the guides, with two or more members of the Commission's staff being involved in drafting different sections. One member of the team acts as editor and takes the lead in drawing all the information together into a coherent document.
- **Peer review:** A draft of the document is then circulated for comments. It may be circulated internally (among the Commission's executive group), and then circulated externally (to previous consultees, or to a wider group). In general, external consultees are given around one month to respond with comments.
- **Sign off and publication:** The Commission's Board is responsible for final sign off of new good practice guides. All good practice guides are printed and published on the Commission's website.
- **Dissemination:** Information about recently published good practice guides is made available through the Commission's mailing lists and practitioner forums.

The process for reviewing guides

7.4 Published guides must be reviewed and updated, particularly if there are changes in legislation which affect the content of the guides. Recently the Commission has tried to ensure that regular reviews (every three years) are carried out on all of their published guides. Reviews enable not only changes in legislation to be incorporated into an updated guide, but also changes in practice and any related issues that may have arisen since the publication of the original guide.

7.5 The process of reviewing published guides follows a slightly shorter process compared to the one described above. In particular, the consultation process for reviews generally takes place by email.

Positive aspects of the process

7.6 Discussions with Commission staff (including the Chief Executive) and interviews with external practitioners highlighted several positive aspects of the process of developing the guides:

- **The identification of topics for good practice guides:** In general, there was a view that the Commission's role in providing advice and in conducting investigations put the organisation in a good position to see clearly what the "gaps" in guidance are.

- **The qualities of Commission staff:** The expertise, skills, motivation and experience of Commission staff were seen as strengths. External practitioners frequently commented that the Commission is highly respected and is seen as a credible source of good practice guidance.
- **The consultation process:** The ways of involving external stakeholders in the process of developing the guides was praised. In particular, both Commission staff and external practitioners saw the process of holding events to discuss anonymised case studies to be a useful and fruitful method of developing consensus about what constitutes best practice.

7.7 When asked to comment on their experience of the consultation process, external practitioners (5 in total) described it as "fair", a process in which "people could express their views openly" and a "productive endeavour". They also expressed satisfaction with the document(s) that resulted from the process.

Could the process for developing the guides be improved?

7.8 In general, the process for developing (and reviewing) the guides was seen as very good, both by Commission staff and external practitioners. However, both groups also made some suggestions for how it might be improved.

- **Carry out a more systematic analysis of questions to the Commission's advice line**. Commission staff acknowledged that the advice line (and their experience of conducting investigations into the care of individuals) provided a useful source of information about where guidance is needed. However, it was noted that a more systematic and in-depth analysis of the advice line questions could uncover areas where additional guides are needed, or where existing guides needed to be updated.
- **Identify a staff member to conduct the initial review of the literature and legal framework**. This suggestion was made by Commission staff. The point was made that it can often take considerable time to conduct this initial review – particularly for staff who are not familiar with the process of carrying out literature reviews. It was suggested that there may be some efficiencies to be gained by training up a member of staff to specialise in this type of work. Once this individual had identified the relevant information, this could then be passed to the staff leading on the development of the guide.
- **Provide a longer period for external review (consultation on draft guides)**. When asked whether the timescales for consultation with external practitioners were adequate, Commission staff noted that the response to email consultations is often very small. It was suggested that one month (on average) may not be enough time for people to respond with comments on draft good practice guides. This point was also raised independently by external practitioners who suggested that it would be helpful if the period of consultation could be lengthened. One interviewee commented that a combination of practitioners' workloads and the number of consultations they respond to made it difficult for people to respond to consultations with short timescales. It was also pointed out that a longer period for consultation would allow draft guides to be circulated more widely, thus

potentially enabling comments to be received from a wider network of practitioners.

- **Strengthen the role of the facilitators at consultation events**. One of the external practitioners (a psychiatrist) expressed strong satisfaction with a consultation event that s/he had attended, but observed that group discussions had been dominated by psychiatrists at her table. This interviewee acknowledged, however, that one of the dominant voices was that of a leading expert on the topic, so it seemed appropriate that this individual should have a great deal to contribute. Nevertheless, the interviewee felt that all voices at the table should be heard, and suggested tentatively that the role of the facilitator may need to be strengthened to ensure that everyone had an opportunity to speak and share their views.

8. Are the guides consistent in their human rights messages?

8.1 The Mental Welfare Commission's values have a strong human rights focus. This is stated in the introduction of many of their good practice guides:

> *"We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens."*

8.2 The final objective in this study was to ascertain whether there is a consistent human rights focus in the Commission's good practice guides. To answer this question, a review of nine of the most frequently requested guides was undertaken. In addition, in the interviews, practitioners were asked whether they had any comments on the human rights focus of the guides. This section presents these findings.

Findings from the documentary review

8.3 The review involved the use of 'human rights indicators' (based on the Articles set out in Schedule 1 of the HRA 1998) which were seen to be particularly relevant to people with mental health problems. The review then examined whether these indicators were evident in each of the nine guides. The four indicators were:

- The right to life (HRA Article 2)
- The right to not be treated in an inhuman or degrading way (HRA Article 3)
- The right to respect for private and family life (HRA Article 8)
- The right to liberty (HRA Article 5)

8.4 The review found that the majority of the good practice guides (7 out of 9) addressed three or four of the indicators. One guide, *Consent to treatment,* addressed two indicators, and another, *Zero tolerance: measured response,* addressed one indicator. The latter guide is somewhat unusual in the group of documents that were reviewed, in that its primary focus is on implementation of staff-related health and safety policies and regulations, rather than on the application of the MHA 2003 or the AWIA 2000 in the care of an individual. This could explain its more limited focus on human rights.

8.5 Table 8.1 below provides a summary of the findings of the documentary review.

8.6 It was notable in conducting the review that, apart from the guide on *Zero tolerance,* all of the more recently published guides (from 2011 onwards) have an **explicit** reference to one or more articles from the HRA 1998, or the European Convention on Human Rights; whereas the older guides are more likely to refer only to the principles of the MHA 2003 or the AWIA 2000. This observation corroborates findings from discussions with Commission staff which indicated that from 2011 onwards the Commission began to adopt more of the language of human rights in their publications.

Table 8.1: Summary assessment of human rights message in the good practice guides

	Indicator 1: Right to life	Indicator 2: Right not to be treated in an inhuman or degrading way	Indicator 3: Right to respect for private and family life	Indicator 4: Right to liberty	Articles of Human Rights Act or European Convention on Human Rights discussed
Covert medication (Nov 2013)	●	●	●	●	●
Rights, risks and limits to freedom (Mar 2013)	●	●		●	●
Carers and confidentiality (Mar 2013)	●		●		●
Consenting adults? (May 2012)	●	●	●		●
Zero tolerance: measured response (May 2012)	●				
Right to treat? (May 2011)	●	●	●	●	●
Consent to treatment (Dec 2010)	●			●	
The use of seclusion (Mar 2007)	●	●		●	
Working with the Adults with Incapacity (Scotland) Act (Mar 2007)	●		●	●	

8.7 Despite the lack of **explicit** reference to human rights legislation, the older guides nevertheless generally had an implicit human rights focus which was often couched in terms of the requirement for care to provide 'benefit' to the individual concerned. For example, *Working with the Adults with Incapacity (Scotland) Act* does not refer to an individual's 'right to life'; however, the guide discusses the possibility that a treatment certificate may be required for an individual who lacks capacity to decide about his / her own medical treatment in relation to a physical (potentially life-threatening) illness.

Findings from the interviews

8.8 In the interviews, practitioners were asked whether they had any comments on the human rights focus within the guides. Among those who did have comments, there were two views.

8.9 The predominant view was that the guides had a clear and helpful focus on human rights.

"I think it's a focus that is evident throughout the documents, and I think that's good to see that. Because for me, it allows me to focus on why I do what I do. So when you actually see it and the way that it's written, that informs my practice." (Social worker, adult care)

"They certainly cover it, and again, that's something that I find useful, obviously it underpins everything that we do from a legal perspective. And the particular issues that I've been looking at, for example, about unlawful detention and so on, is quite well covered…." (Solicitor)

8.10 The second view was that the guides could have a stronger focus on human rights than they currently do. Although this view was less common than the first, it was often strongly expressed.

"I sometimes feel that the Mental Welfare Commission is perhaps not as outspoken as it should be about human rights. It tends to be a bit more conciliatory than I think is always necessary. I do think it might do better to be much clearer that something – no matter that we think it's the easier way to do it – it's entirely unacceptable." (Psychiatrist)

"I think the guides could be much better in terms of human rights. I think they talk about people's rights under the Mental Health Act, and what can happen and what can't happen…. But amongst professionals and service providers, there needs to be a lot of work done." (Senior manager, third sector organisation)

8.11 One individual noted that, while they generally felt the human rights focus of the guides was good, but they nevertheless disagreed with the messages in a specific guide. The example given was in relation to *Covert medication.*

"Usually good. As I said, the one issue I've had is the 'Covert Medication' one, and I suppose I would be more cautious about using covert medication than the guide would come across to me as being. I think most people who… the idea that somebody might be secretly putting drugs into their food… it would be horrifying to libertarians across Britain, so I do worry that there's not enough safeguard for that." (Mental Health Officer)

9. Conclusions

9.1 This chapter draws together the main findings from across the study and considers implications for the Commission in terms of possible areas for improvement.

9.2 The participants in this study were individuals who, for the most part, were in contact with the Commission. Thus, the survey was not a survey of a representative sample of mental health and social care practitioners in Scotland, and so the results cannot be taken as representative of this wider group. Nevertheless, the findings of the study provide a valuable insight into how the Commission's good practice guides are viewed and how they are being used by this group of people.

Are practitioners aware of the guides?

9.3 There was a very high level of awareness of the Commission's good practice guides among survey respondents. Nine out of ten people who took part in the survey said that they were aware that the Commission produced good practice guides. However, as noted above, the survey was sent to people who are largely in contact with the Commission through their own mailing lists or networks, and this is likely to be an influencing factor. Moreover, it is possible that people who were **not** aware of the Commission's good practice guides would have been less likely to take part in the survey in the first place.

9.4 It was clear from the survey findings that there was a greater level of awareness of some guides, as compared with others. The lower level of awareness of guides such as *Zero tolerance* and *Use of seclusion* was not unexpected given the specific focus of these guides on situations likely to arise relatively infrequently, and mainly in acute hospital settings. Whereas those guides with particularly high levels of awareness (*Working with the AWIA; Consent to treatment; Covert medication)* had application to a wider range of situations both for community and hospital practitioners.

How do practitioners view the content of the guides?

9.5 Practitioners' views of the guides were by and large very positive. Those who knew about the guides found them relevant and useful. Practitioners particularly appreciated the concise, easy-to-read, jargon-free style of the documents, and felt that the use of case studies helped them to apply the principles set out in the guides to the real life situations that they faced.

9.6 There were few critical comments, and these focused on specific guides (*Zero tolerance; Convert medication),* rather than the series as a whole – generally because the practitioner did not agree with the messages of these particular guides.

9.7 There were also few suggestions for improvements. Those that were offered included a suggestion to review how guides address the issue of technology and another to consider the implications of adult protection legislation (as well as the AWIA 2000, MHA 2003 and HRA 1998) in relevant contexts.

How do practitioners use the guides?

9.8 The guides are clearly being used, recommended and shared among people working in mental health and learning disability services. Practitioners gave examples of a

wide range of situations in which they had used the guides – not only in relation to complex cases involving the care of an individual who lacked capacity to make their own decisions, but also in the development of local service policies and protocols, and to support improvements in local services. Practitioners also noted that the guides can be particularly helpful where there are differences of opinions among clinicians, and some noted that they had referred colleagues to the guides when they were concerned about the way in which a service was being provided.

9.9 Many examples were also given of the guides being used in training situations and a relatively high proportion of the practitioners in this study (two-thirds of survey respondents) said they had attended training in their own organisation where one or more of the guides had been discussed or presented.

9.10 Practitioners had less experience of sharing the guides with service users and carers. This was not necessarily because they did not feel the information in the guides was relevant to these groups, but rather because the guides were not written to address the information needs of these groups. In general, there was a feeling that the guides would need to be shorter, and written in simpler language for service users and carers.

How accessible are the guides?

9.11 Overall, practitioners felt that the guides were accessible, and they said they knew how to find them when they needed them. People were also largely content with having access to the guides electronically, and some interviewees noted that this allowed them to carry copies with them (on their laptop or ipad) at all times.

9.12 However, it was noted that not all practitioners have easy access to a computer, and it was suggested that there may be a need for more access to printed hard-copy versions for those individuals. On the other hand, it was also acknowledged that there would be a cost associated with this.

9.13 While it appeared to be common for practitioners to hear about newly published guides directly from the Commission, others learned of them through their own organisation's internal email communications, and it was suggested that the Commission should encourage heads of services and other senior managers to cascade information about new guides to their staff. Other suggestions included developing a mobile phone app to notify practitioners directly, or to publish details of new guides in newsletters of professional bodies.

9.14 Practitioners also suggested that there may be a need to better target the guides to certain practitioner groups; GPs, in particular, were perceived to have a lack of awareness of the guides, but there was a strong feeling that some of the guides were very relevant to them.

Can the process of developing the guides be improved?

9.15 In relation to the process for producing the guides, again, there was largely a feeling that the process worked well. Only a few possible improvements were suggested. Among these, there appeared to be some agreement between Commission staff and external stakeholders that the process of external review of draft guides might benefit from a longer period of consultation. There may also be a need to strengthen

the role of facilitators at consultation events to ensure that discussions are not dominated by particular individuals and that all participants get an opportunity to express their thoughts.

Are the guides consistent in their human rights messages?

9.16 The documentary review indicated that there is a strong human rights focus in the Commission's good practice guides, and that this has, in fact, become more explicit in the past few years. Practitioners also recognised and valued the human rights focus of the guides – although there were a few who wanted this to be strengthened further.

General comments about the work of the Commission

9.17 Finally, although it was not a focus of this study to explore the views of practitioners about the Mental Welfare Commission, respondents often commented favourably on the wider work of the Commission (including the usefulness of their published investigation reports) and on the expertise and helpfulness of staff.

9.18 In the context of a discussion about where else (apart from the Commission's good practice guides) practitioners might go to for advice regarding difficult legal or ethical situations, a wide range of professional bodies and published sources were mentioned. However, alongside this there was also a strongly expressed view that the Commission was the key source of advice in this area. Some practitioners who made the point that they always sought advice from the Commission in the first instance, as this was likely to be the most consistent source of information:

> *"It would seem prudent to only consult the official supplier of advice – yourselves." [i.e. the Commission] (Hospital based mental health / learning disability nurse)*
>
> *"Advice from the MWC ensures a consistent view rather than individual LA / NHS board interpretations." (Mental Health Officer)*
>
> *"No where other than the Commission who always respond promptly and are the most reliable and dependable source for us in Scotland for these complex issues." (Community mental health / learning disability nurse)*

Conclusion

9.19 Overall, this study found strong satisfaction among practitioners with the Mental Welfare Commission's good practice guides. It also identified the variety of ways in which practitioners have used the guides, not only in relation to the care of particular individuals, but in relation to wider service design and delivery. While there were a number of issues highlighted in terms of how the guides could be improved or enhanced, particularly in relation to publicity and accessibility, the clear message from participants was that the series as a whole was well-used and valued amongst the target audience.

Annex 1: Template for documentary review

Title	
Publication date	
Purpose of the guide	
Human rights indicators	
Indicator 1: Right to life	
Indicator 2: Right not to be treated in an inhuman or degrading way	
Indicator 3: Right to respect for private and family life	
Indicator 4: Right to liberty	
Other comments about content	

Example of a completed template

Title	**Covert medication**
Publication date	November 2013
Purpose of the guide	This guide provides information about when the use of 'covert medication' – i.e. medication administered without the knowledge of a person for whom it is intended – "medical treatment in disguised form". This often occurs where treatment is necessary for the individual's physical or mental health, but where they refuse to take the medication when it is offered. Inspections of Scottish care homes have found that the use of covert medication is increasing. The guide covers: • When to consider covert medication • The legal framework for its use • Practical guidance on how to administer it • A suggested care pathway for its use • Some case examples.

	The guide only applies to situations in which an individual lacks capacity to make a decision regarding medical treatment and refuses treatment.
Human rights indicators	
Indicator 1: Right to life	A main point made in the guide is that covert medication may be required to protect life and health in an individual who does not have capacity to decide about their own medication, and who is refusing to take their medication.
Indicator 2: Right not to be treated in an inhuman or degrading way	Staff should consider whether covert medication is the best way to achieve a minimum restriction of a person's freedom. The point is made that other forms of administration may result in the need to use restraint or force, and that this could be considered to be degrading.
Indicator 3: Right to respect for private and family life	The guide emphasises that covert medication must never be given to someone who is capable to deciding about medical treatment. If an individual is **capable** of making a decision, then that individual has the right to accept or refuse medical treatment, even where a refusal might lead to a fatal outcome. While the person may be perceived as lacking capacity, there may be a reason for the refusal of medication. The point is made that there is a duty, under the right to respect for private life, for an individual's previous clearly stated views on treatment to be taken into account. These may be in the form of an advance statement, but might also include anything the individual may have said to relatives or friends in the past.
Indicator 4: Right to liberty	Staff should consider whether covert medication is the best way to achieve a minimum restriction of a person's freedom. The point is made that other forms of administration may result in the need to use restraint or force. The guide states that if the administration of medication results in the deprivation of a person's liberty (i.e. by sedating the individual to prevent him / her leaving), then the person should be formally detained.
Other comments about content	Human Rights Act 1998 is discussed at the front of the document along with the MHA and AIA. This guide makes extensive use of case studies. All four of the above indicators are listed near the beginning of the guide. The guide states that interventions provided by care staff must comply with the European Convention on Human Rights, articles 2 (right to life), 3 (right to be free from torture and other inhuman or degrading treatment), 5 (right to liberty and security), and 8 (right to respect for private and family life). The guide emphasises the importance of cafe facilities having policies about covert medication.