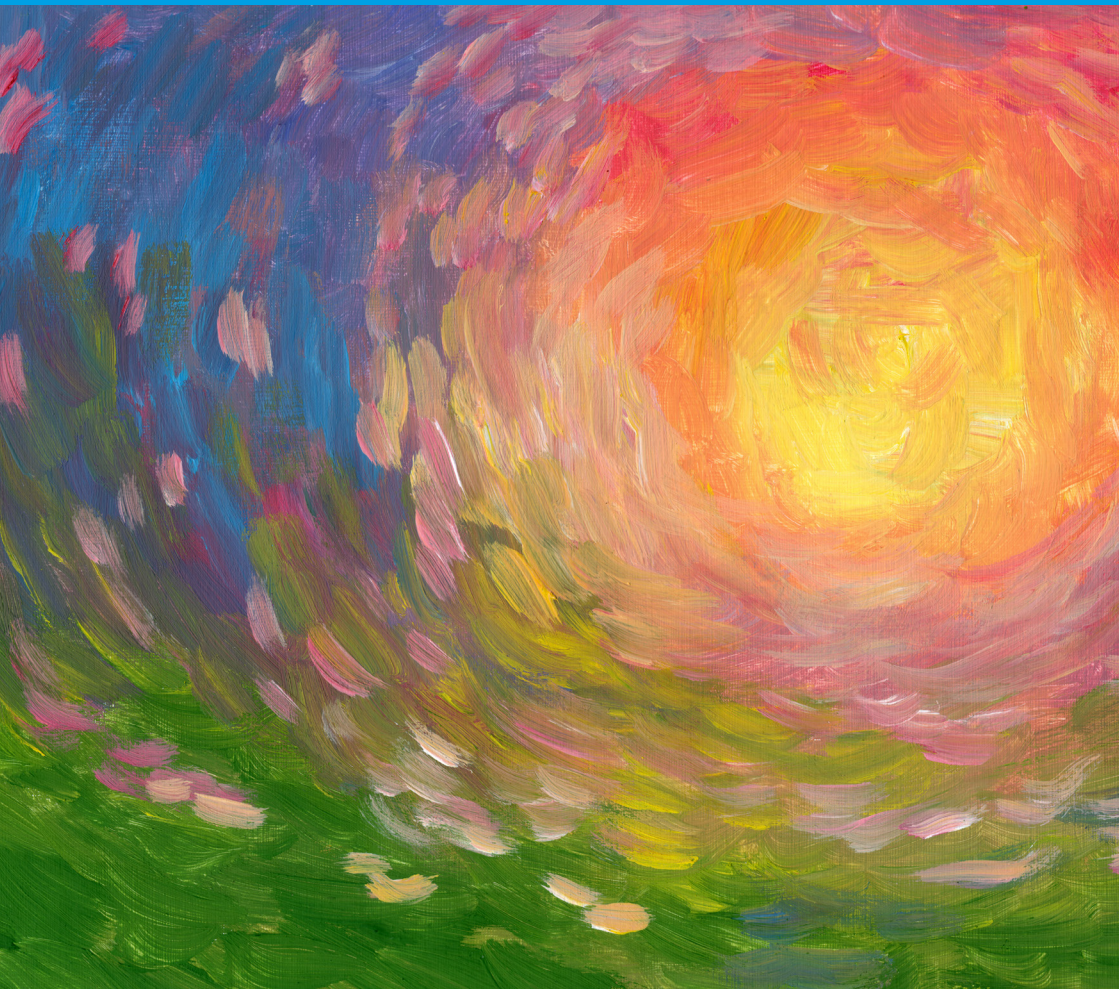
Secure hospital care
Information for carers



University of Nottingham
UK | CHINA | MALAYSIA

the institute of mental health
Nottingham

NHS
Nottinghamshire Healthcare
NHS Foundation Trust

Welcome

This information booklet has been put together by researchers and clinicians at the Institute of Mental Health and carers with experience in secure care.

Having someone you care about admitted to a secure hospital is a traumatic experience that leaves carers with a range of emotions: fear, anger, sadness, helplessness, guilt and many more. You are likely to feel bewildered about the process and disempowered to help your relative or friend.

You don't know what it means for them to be admitted and you will have many, many questions: How long will they be there? Will I be able to visit them? Will they get help? Who can I turn to if I need more information or help? What can I do to help them? etc.

This guide has been put together with extensive consultation and input from carers who have been there. We want to help you to make the journey ahead of you a little less traumatic, to gain some control through being informed, to feel a little less helpless and to enable you to be there for your relative or friend if you want to be.

[1] Department of Health (2008) Refocusing the Care Programme Approach London: Department of Health
[2] Ridley J, McKeown M, Machin K, Rosengard A, Little S, Shelley Briggs S, Jones F & Deypurkaystha M (2014) Exploring Family Carer Involvement in Forensic Mental Health Services Edinburgh: Support in Mind Scotland

What do we mean by 'carer'?

Generally a carer is anyone who provides unpaid help and support to a partner, relative or friend who is seriously ill, disabled or unable to cope alone. There are about 6.5 million carers in the UK. We often think of a carer as someone who cares for an elderly of disabled person who lives in their own or the carer's home.

However, the caring role is wider than that. The Department of Health, in their document 'Refocusing the Care Programme Approach'[1], defines a carer of someone with mental health issues as:

> *"an individual who provides or intends to provide practical and emotional support to someone with a mental health problem. They may or may not live with the person cared for. They may be a relative, partner, friend or neighbour. … A person may have more than one carer."*

The role of a 'forensic carer':

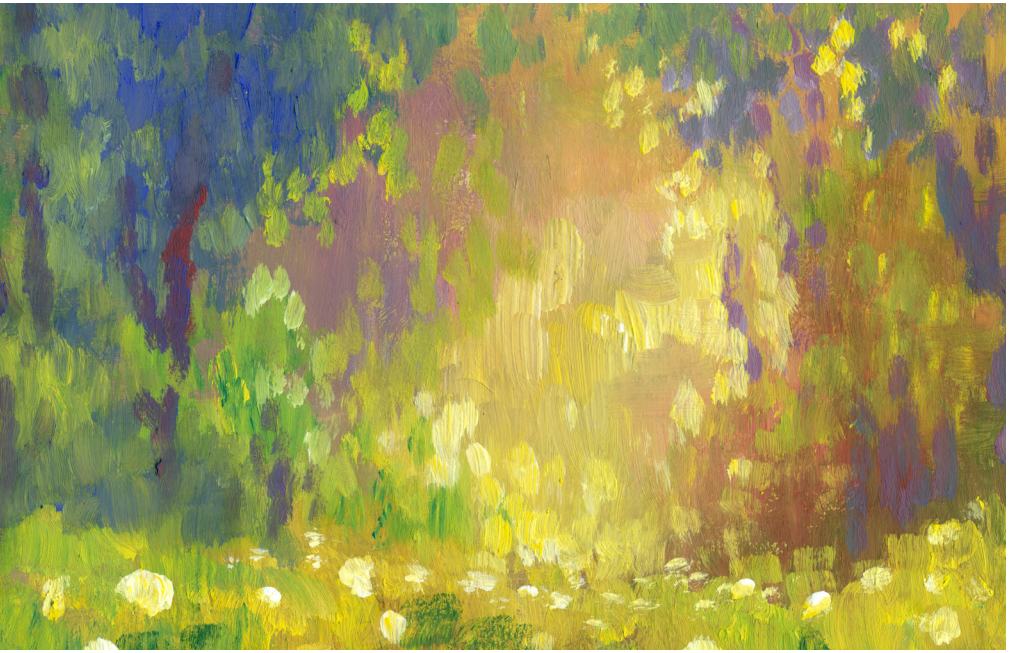
> *"at its core involve[s] practical and emotional support provided to relatives across different secure settings."*
> *(Ridley et al., 2014, p. 3).*[2]

Contents

02 Welcome
04 Types of secure services
06 Legal matters
08 In and out: Admission and discharge
12 The hospital environment
15 Treatment
16 Who's who – the roles of people and organisations involved in the care
18 The rights of carers
18 Tips for carers
19 Questions carers can ask
20 Jargon buster
22 Further information available

Types of secure services

In the UK, secure services are provided at high, medium and low levels of security. Often secure services are also called 'forensic' services. The word 'forensic' comes from a Latin term, 'forensics', meaning 'of or before a forum'; this originates from Roman times where those who had committed a crime were trialed in front of a group of individuals in a forum (a public place). The term therefore implies that the service is for those who have committed a crime. However, 'forensic' services also admit patients with severe disorders who need a secure environment for their care but have not actually committed an offence. We therefore here prefer the term 'secure services'.



High

High secure services are for those presenting a 'grave and immediate' danger; they cost about £275,000 per year per patient. There are three high secure hospitals in England and Wales with an overall capacity for about 750 patients. The first of these was Broadmoor Hospital in Berkshire, which opened in 1863. Two other high secure hospitals opened in the 20th century: Rampton Hospital in Nottinghamshire and Ashworth Hospital in Merseyside. Out of the three high secure hospitals only Rampton Hospital provides services for women, deaf male patients and male patients with intellectual disabilities.

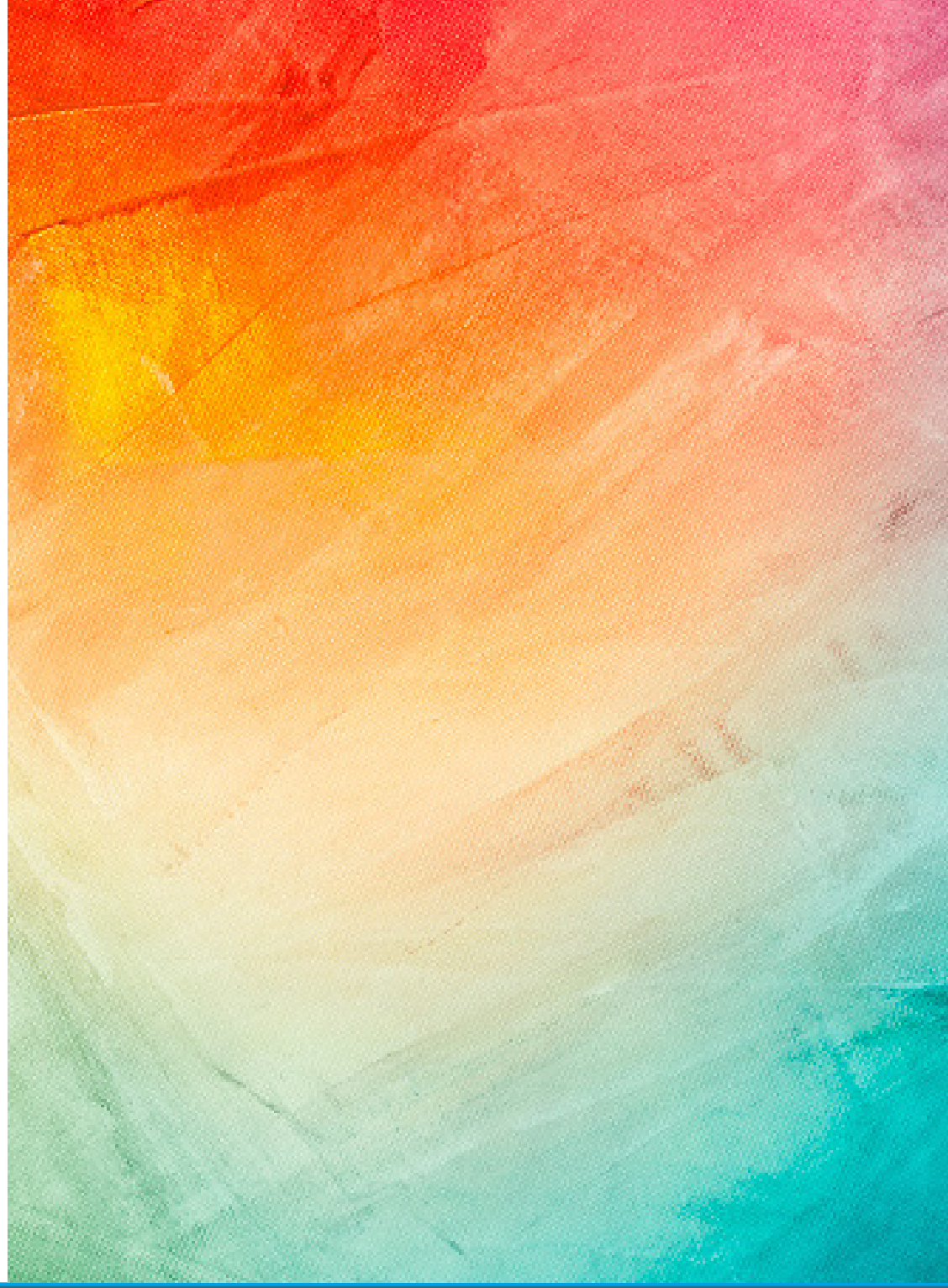
Medium

Medium secure units (also called 'regional secure units') are for patients who are thought to present a 'serious danger to the public' and cost about £175,000 per year for each patient. Medium secure services were only developed from the 1970s onwards. This is as it was recognised then that having only high secure services, often far away from the patient's home area, was too restrictive for many patients. There are about 60 medium secure units in England and Wales, providing a total of about 3500 beds in units with a size of about 50 – 100. Medium secure beds are provided by the NHS but also (just under 50%) in the independent sector though the latter are also paid for by the NHS and require the agreement of NHS commissioners before someone can be admitted there.

Low

Low secure services are for those ‘who pose a significant danger to themselves and others’. They are more difficult to describe as the patients admitted there are a mix between those stepping down from higher secure services and those coming from general psychiatric settings. There are few statistics on these units but it is estimated that there are a similar number of places as in medium secure units.

The average length of stay in a high secure hospital is about eight years. Medium secure services were initially anticipated for shorter admissions of about 18 to 24 months, but more recent research has shown that about one in five patients stay there for longer than five years.



Legal matters

Involuntary admission to secure services (similar to general psychiatric services) is governed by the Mental Health Act (MHA) 1983, last amended in 2007. This is a complex piece of legislation with over 100 different sections. We will try here to briefly describe the ones you are most likely to encounter.

The MHA covers those who suffer from any mental disorder (including, e.g, schizophrenia, bipolar disorder, depression or personality disorder). Intellectual disability (previously called learning disability) is also covered by the Act. On the other hand, the use or abuse of, or dependence on, alcohol or illegal substances in itself does not constitute a mental disorder according to the MHA. Everyone who is detained under the MHA has to have a mental disorder.

The MHA has so-called civil sections and criminal sections, the latter for those who have committed an offence. Everyone detained in a hospital is on at least one section to make their detention legal. Criminal sections allow someone with a mental disorder to be detained in hospital instead of prison to receive treatment. All sections have to be renewed at regular intervals and patients also have the right to challenge their detention. The Code of Practice explains in more detail how the MHA should be implemented in practice. The Code also provides guidance on the involvement of carers.

In addition to the sections shown in the box to the right, other sections cover more specific situations, e.g a transfer from prison to hospital while still on remand.

While on a section treatment can be given against the will of the detained person (e.g. medication) for the first six months. Following this period, if they do not wish to have treatment or if they are not capable of making a decision about their treatment, then a 'second opinion doctor' (sometimes referred to as SOAD) will be called to make an assessment. If this doctor agrees with the treatment plan, treatment can still continue against the person's wishes.

There are other legislations that you might find of interest, e.g. the Human Rights Act 1998 which incorporated the rights under the European Convention on Human Rights into UK legislation so that breaches can be prosecuted in UK courts without having to go to the European Court of Human Rights in Strasbourg. The Act covers 16 rights many of which are of particular relevance to detained people, e.g. the right to life (Article 2), the right to prohibition of torture (Article 3), the right to liberty and security (Article 5), the right to a fair trial (Article 6) and the right to family life (Article 8).

You might encounter the following Sections:

- **Section 3:** This is one of the 'civil sections', meaning it is for people who have not offended. No court is needed to impose this section. People are detained under this section following assessment by two doctors and one Approved Mental Health Professional (AMHP, usually a social worker) if they are deemed to present a risk to their own health or safety or for the protection of others and if treatment cannot be given unless the person is detained in hospital.

- **Section 37** (also called 'Hospital Order') is similar to Section 3 but is one of the criminal sections, imposed by a court. It can be used for anyone convicted of an offence punishable with imprisonment following a recommendation by two doctors that the person is suffering from a mental disorder "of a nature or degree" which makes it appropriate for them to be detained in hospital for medical treatment. Two medical doctors have to assess the person and make a recommendation to the court which will make the decision. Treatment has to actually be available; nobody should be detained in a hospital without treatment being offered to them. A Hospital Order is imposed instead of imprisonment, meaning the person will go directly to hospital from court rather than to prison (though they may have spent some time on remand before).

- **Section 41:** This section (called 'restriction order') can be imposed on someone with a Hospital Order if the court deems this to be "necessary for the protection of the public from serious harm". A restriction order has the effect that the Ministry of Justice has to agree to the transfer or discharge of the person. It also remains in place post-discharge and allows the person to be monitored and more easily be re-admitted to hospital.

- **Section 47** ('prison transfer'): This section allows for a sentenced prisoner to be transferred to hospital if this is necessary for them to receive treatment for their mental disorder. As with a Hospital Order two medical doctors will be asked to make a recommendation though the decision maker in this case is not the court but the Secretary of State.

- **Section 49:** This is a restriction order but for those transferred from prison. It means that the clinical team of a patient cannot just discharge the person unless with agreement of the Ministry of Justice.

All sections have to be renewed at regular intervals and patients also have the right to challenge their detention.

In and out: Admission and discharge

The previous section outlined the different sections of the MHA under which someone can get admitted to a secure hospital. This will involve an assessment by a range of professionals, at least one or two doctors, and depending on the section, also an approved mental health professional. Before an order can be made for someone to be admitted, a specific hospital has to be identified where the person will be admitted to and typically professionals from this hospital will be involved in the assessment. Sometimes a psychologist and nursing staff are also involved to assess specific issues around diagnosis or risk or to make plans for the care of the person once admitted.

Following admission, individuals will typically reside on an admission ward for some months. During this time, more assessments will take place and a detailed care plan be developed with the interventions needed to help with the mental health of the person as well as to reduce their risk. A social worker will get in touch with carers during the assessment period to take a 'social history' and this is a good opportunity for carers to share their knowledge of their relative and help the team getting to know them. It is also an opportunity for carers to learn about the hospital and treatment.

The initial period in hospital may also involve an assessment as to whether admission to hospital is appropriate or whether another hospital would be better suited to meet the needs of the person. Occasionally, therefore, the assessment might find that hospit al admission is not needed or not the best course of action and the person might be transferred back to prison (if they are on a section that allows this) or to another hospital. This is rare, however, and most likely the individual will move to a treatment ward at the end of the assessment period where the actual treatment takes place.

Throughout their admission, individuals have regular review meetings, typically every six months (though sometimes a more comprehensive review meeting only takes place once a year with another 'smaller' meeting to review care plans in between the main meetings). These review meetings are called 'CPA' meetings (Care Programme Approach). The idea behind these meetings is that all professionals involved in the care of the person come together and review how the treatment is going and make further plans for interventions in the coming period. Carers are invited to these CPA meetings as well and a social worker will typically speak to carers before the meetings to establish their views, in particular if they cannot attend in person. Sometimes outside professionals are also invited, e.g. a probation officer (if the person has one; this will not be the case for those on civil section or on a Hospital Order). Ideally, professionals from services where the person will move to later on, e.g. from a medium secure unit, will also be present though they often only attend in person when a transfer is expected to take place in the near future; they will receive the minutes of the meeting though even if they don't attend. Often commissioners, who are responsible for finding and paying for a suitable unit for future treatment, e.g. in conditions of less security, are also present and, again, they will receive the minutes if they don't attend in person. The patient is also present at the CPA meeting and they often are invited to submit their own report to say how they feel things are going for them. These meetings can feel a little intimidating as there are so many people attending but they should nevertheless take place in a relaxed atmosphere and allow everyone to express their views.

Legally, throughout the admission, the responsible clinician for the patient has to submit reports about the patient at regular intervals, depending on their section either to the Ministry of Justice (for prison transfers) or to the Hospital Managers. These annual reports will summarise the progress the patient has made and also comment on whether or not detention in hospital is still necessary. The Hospital Managers will see the patient as part of this process when they receive the reports and formally renew their detention.

There are a number of ways to be discharged from hospital and patients have the right to challenge their detention (see page 10). Usually though discharge or transfer to another, less secure, hospital is a planned process or progression discussed between the patient and the clinical team.

Mental Health Review Tribunals

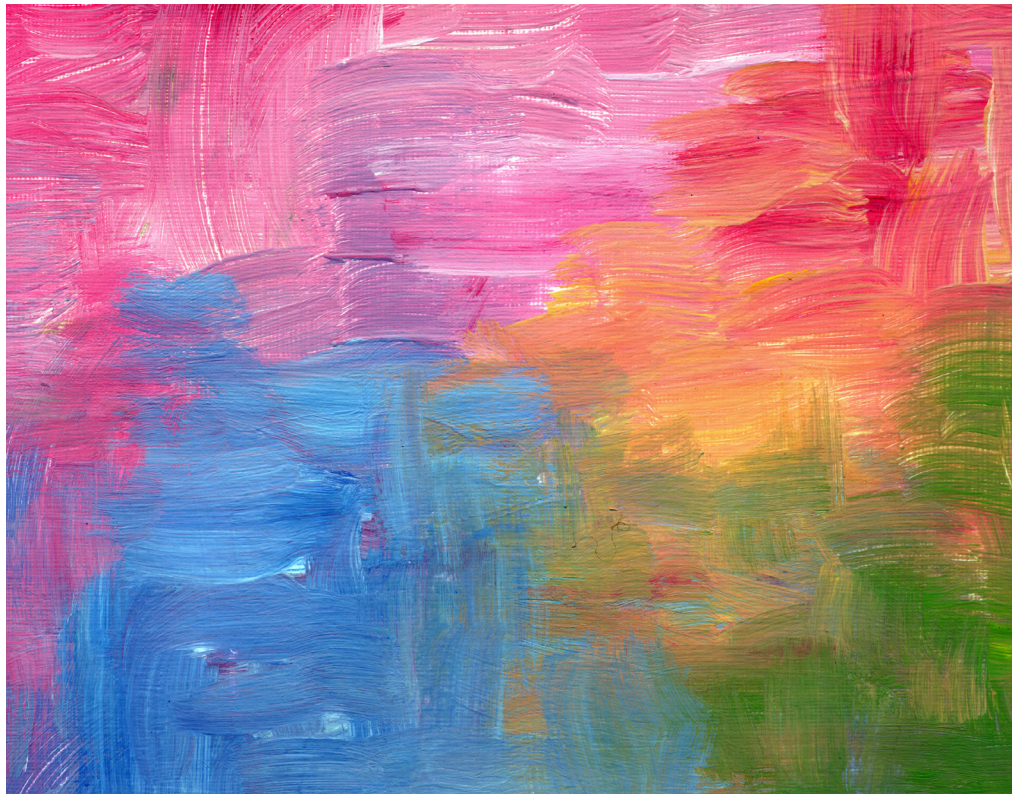
Mental Health Review Tribunals (MHRTs) are completely independent of the hospital. Their role is to review whether the criteria to detain someone in hospital are still fulfilled. Each patient has the right to apply for a MHRT; the timeframes for this application depend on the section the patient is on but most often it is once a year. If the patient does not make an application, they will have a tribunal anyway every three years; this is to ensure that every patient has a formal review of their detention even if they don't ask for it. The MHRT consists of three members: a doctor, a judge and a lay person. The doctor on the panel might see the patient before the hearing.

MHRTs take place in the hospital and are attended by the panel as well as the patient and their legal representative (if they choose to be represented), the responsible clinician as well as the patient's social worker and nurse; these individuals will have submitted reports beforehand. The social worker will consult with the carer during their writing of the report to obtain their views on the detention of their relative. As the purpose of the reports is to evidence that the patient still needs to be in hospital, they can sometimes sound a little negative, focusing on the problems, rather than the good progress made. Patients are allowed to invite their nearest relative or someone else to support them in the hearing. MHRTs are formal meetings where each of the professionals from the hospital gives evidence as to why the patient needs to be in hospital and they are questioned by the panel. The patient and their representative can also ask questions.

It is important to keep in mind that the scope of the MHRT is narrow – to decide whether criteria for detention are still fulfilled or not. Their role is not to comment on the quality of care or whether a patient should move to a less secure setting. They may make a recommendation on the latter nevertheless sometimes, e.g. that a patient should be referred for a medium secure assessment, but these recommendations are not legally binding. MHRTs can, however, discharge patients from hospital - though in secure settings (in particular in high secure care) this does not happen often. If it does, the tribunal would typically allow time to plan for the discharge rather than discharge the patient on the spot. Because of the narrow scope, patients are sometimes disappointed with the process as they expect more than an MHRT can legally do.

Managers' Hearings

Those on civil sections or on a hospital order can also apply for a 'Managers' Hearing' to review their detention at any time. The process of this review is similar to a tribunal though might be less formal and there is no judge. 'Hospital Managers' in this context are not the people in charge of the day to day running of the hospital but an independent panel. The responsible clinician, social worker and nurse have to also write a report for this type of review and a meeting will be convened. The patient may invite their nearest relative or someone else to support them during the meeting. Again, the purpose of the meeting is to decide whether detention in hospital is still appropriate.



The hospital environment

Security

There are different levels of security (e.g. high, medium, low) as described on page 5. Each has different regulations and requirements. For example, high secure hospitals have two external perimeter fences whereas medium secure units have one. All levels of security involve three elements which need to be considered together: physical, procedural and relational.

- **Physical security** relates to the fences, locked doors, personal alarms, CCTV and staff and visitor airlocks.
- **Procedural security** relates to the different procedures that are in place. These include the restriction of certain items (patients, visitors and staff are all subject to restrictions on what they can bring in or have access to). Other examples of procedural security include observations of patients, how patients are escorted when leaving or returning to the ward and searching patients and their environment. These procedures are set out in hospital policies.
- **Relational security** relates to patient-staff relationships and staff having a good insight into the patient and issues relating to risk. This is important as it can help address situations before they escalate into aggression and it helps staff to assess the risk of compromises to security.

Possible restrictions

You and your relative/friend will encounter a number of restrictions related to living in a secure environment or visiting someone there. These are partly a national requirement (e.g. the Secure Directions for High Secure Care) and partly local policy.

The nature of secure hospitals means that everyone who enters the secure area of the hospital is subject to some forms of restriction. Certain restrictions apply to staff, visitors and patients. For example, staff are prohibited from bringing in certain items into the secure area such as mobile phones. Staff can be searched on entering and leaving the hospital, have their bags x-rayed, and undergo pat-down searches.

Patients face several restrictions and procedures. These may include: the type and number of items they are able to have in their room, access to particular areas, and having rub-down searches, e.g. before and after leaving their visit. In high secure settings, patients may also have their phone calls and mail monitored. Patients are not allowed to swap, lend, or sell any personal possessions to other patients.

It's likely that patients will be able to access the ward telephone. The social worker will discuss with the patient which people they would like to be able to call. The clinical team will consider and agree an 'authorised list' of people whom the patient can call. The clinical team may also decide that a patient's telephone calls should be monitored. These calls may be recorded and listened to by ward staff during or after the phone call. Privileged calls, e.g. to patients' solicitors, are not monitored or recorded.

In high secure settings, incoming and outgoing mail may also be monitored. Where appropriate the mail may be withheld, e.g. in the interests of the safety of the patient, or for the protection of others. Such actions are included in the Mental Health Act (1983) (amended 2007). Patients are informed when mail is withheld.

Leave restrictions

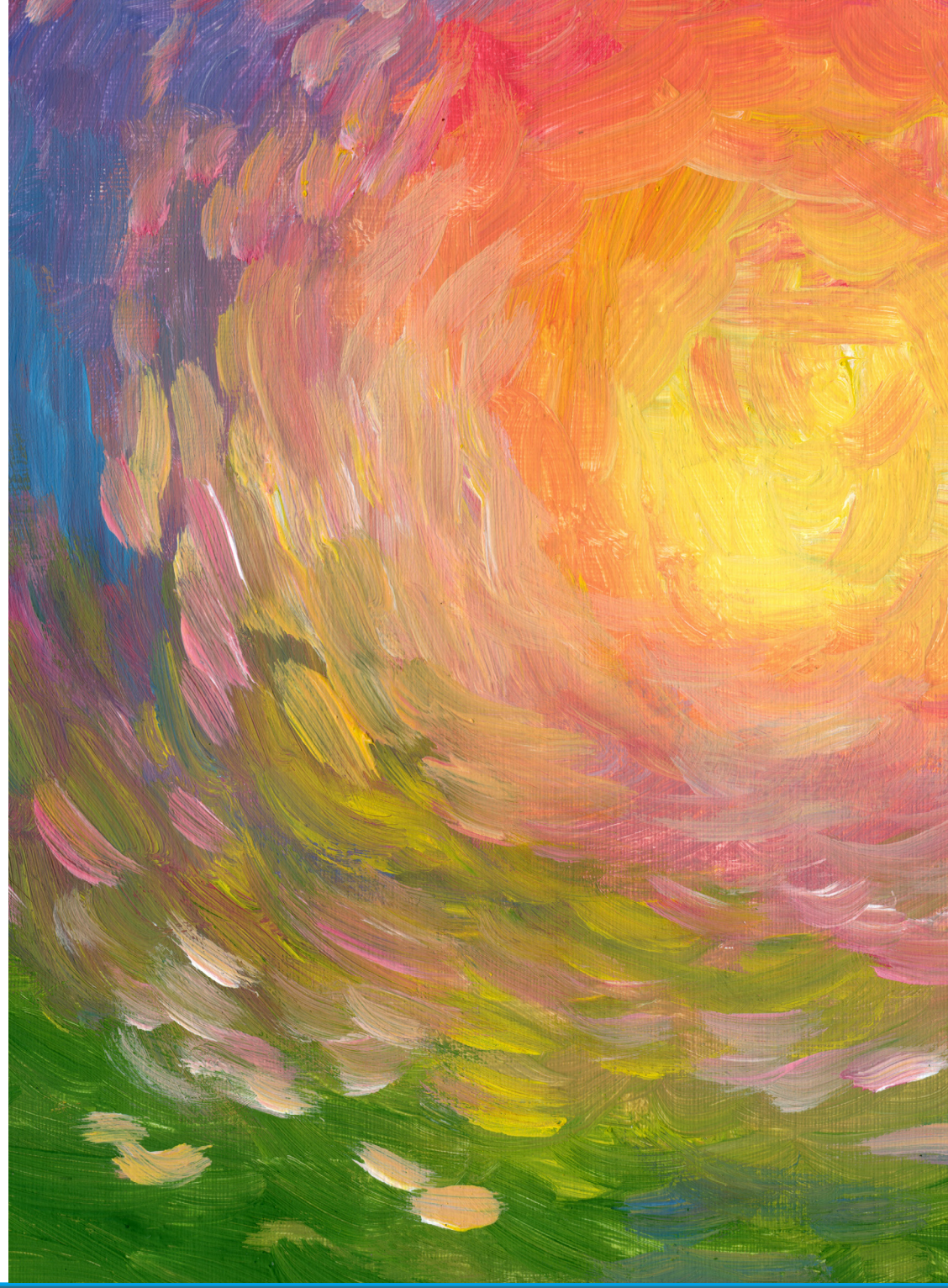
Patients who are detained in hospital are not allowed to leave without permission of the clinical team. Those who are under restrictions (Section 41, 49) or prison transfers also need the approval from the Ministry of Justice. Typically, during the initial stages of admission patients do not have leave (except for medical leave if they have to go to another hospital for a treatment of a medical condition).

As a general rule, in high secure settings, patients are also not allowed to have leave at later stages of their treatment, even if they have been settled for years. These restrictions are mandated nationally; leave can only be given in exceptional circumstances, e.g. compassionate leave if a relative is very unwell or has died or leave to visit another hospital to which the patient might be moving later on.

In medium and low secure settings, leave arrangements are less restrictive. Typically, leave is introduced gradually, e.g. escorted (by a member of staff) within the hospital grounds first and later escorted and unescorted leave into the community. Patients might even have extended periods of leave to take up education or work in the community in the later stages of their treatment.

Visiting restrictions

Each hospital will have their own procedures for visitors. In general, patients will have to complete a visitor request form. Potential visitors have to be approved by the clinical team. Accredited visitors have to provide identification and comply with the hospital's regulations. The hospital will tell you what type of things are not allowed to be brought into the hospital. These include things such as mobile phones, cameras and chewing gum.



Treatment

It would go beyond the scope of this information booklet to describe in detail all the different types of treatments a patient might encounter in a secure setting. The names of specific treatments can easily be searched on the internet and further information obtained that way. However, here we would like to outline some general principles of the treatments delivered in secure settings.

Treatment comprises of different types of interventions, e.g. medication (e.g. for conditions such as schizophrenia or bipolar disorder), nursing care and specific psychological therapies. Being in a secure environment with day structure, consistent rules and the possibility of meaningful interpersonal interactions might also be seen as therapeutic in itself.

Psychological interventions are often delivered in a stepped way. The first level of intervention might consist of those designed to get the person used to psychological therapies, i.e. to reflect upon themselves, and/or group work. Shorter and less complex interventions, focused on few specific targets, e.g. problem solving or emotional regulation, might also be delivered early on.

For individuals with personality disorders, there might then come a phase with treatment targeting symptoms of that disorder. Treatments for personality disorders can be lengthy, e.g. 12 – 18 months, and they are often delivered in individual as well as group sessions. Very personal topics might be reserved for the individual sessions while group sessions can be used to practise new skills and learn from each other. Typically, patients are also asked to complete homework tasks between sessions and to practice what they have learned in their day to day life. Examples of personality disorder treatments include Dialectical Behavioural Therapy and Schema Focused Therapy. Sometimes specific interventions to deal with trauma are also delivered in this phase of treatment.

By this point it will seem that the patient has completed a lot of treatment already, and they have! However, one of the most significant part of their treatment, that to tackle offending behaviour, is yet to come. This is often the most challenging part of treatment which is why it is left to the end, once the patient's mental health has stabilised through completing other treatments. Occasionally, it might be possible to complete offence related work in a less secure setting but more often it is done in the same setting as the other parts of treatment. Offence related work targets different types of offending, e.g. violence (e.g. Violence Reduction Programme, Life Minus Violence), sexual offending (Sex Offender Treatment Programme) or arson. If someone has committed different types of offences, combined programmes might be delivered, so that the person does not have to complete different offence focused courses, one after the other. Offence related work is also often delivered in individual as well as group sessions. Typically, relapse prevention is part of these programmes, i.e. how the person can build a life in a way that makes it less likely that they will offend again.

Who's who – the roles of people and organisations involved in the care

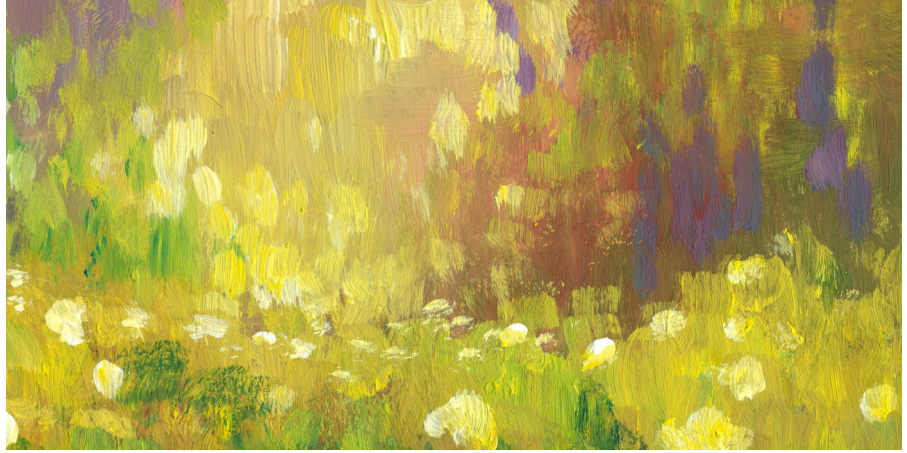
Several people, covering a wide range of roles, will make decisions about the care and treatment of a patient. This team of people is called a multi-disciplinary team (MDT).

Here are some of the main people:

- The **care coordinator** is responsible for preparing, coordinating and reviewing an individual's care, e.g. preparing their Care Programme Approach (CPA) meetings. The care coordinator will be a registered health or social care professional (e.g. nurse, social worker) and in secure settings is often the responsible clinician. They will liaise with the professionals from the relevant services involved in providing care. The care coordinator should also be able to explain the CPA process to carers and should be a main point of contact for carers.

- Each patient is allocated a **Responsible Clinician** (often referred to as the RC). The RC is usually a psychiatrist, particularly in secure services. Although decisions are made in the MDT, the RC has the overall responsibility to meet the obligations within the Mental Health Act. The role of the RC was introduced in the 2007 Mental Health Act and replaced the role of Responsible Medical Officer (RMO).

- Each patient is allocated a **Social Worker**. The social worker has a key role in liaising with the family and taking a social history.



- Each patient is allocated a **named nurse**. The named nurse is a qualified nurse responsible for the overall nursing care on a day to day basis. The named nurse meets with the patient in regular "named nurse sessions" to review care plans, update assessments and promote a therapeutic relationship.

- There wil be an **associate nurse**. The associate nurse assists the named nurse and provides cover when the named nurse is absent.

- The **psychologist** will have training in either forensic or clinical psychology (or sometimes both). The psychologist may be involved in assessments, including of risk, and provide psychological interventions.

- An **Occupational Therapist** (OT) will help people to engage in occupations which help give their lives meaning and value. OTs will assess the individual and then provide interventions which can help improve interpersonal skills and motivation. OTs also help the person to learn and practise other skills which will help them function better. Such structured input is important as it can help to use time constructively outside of other thera py sessions.

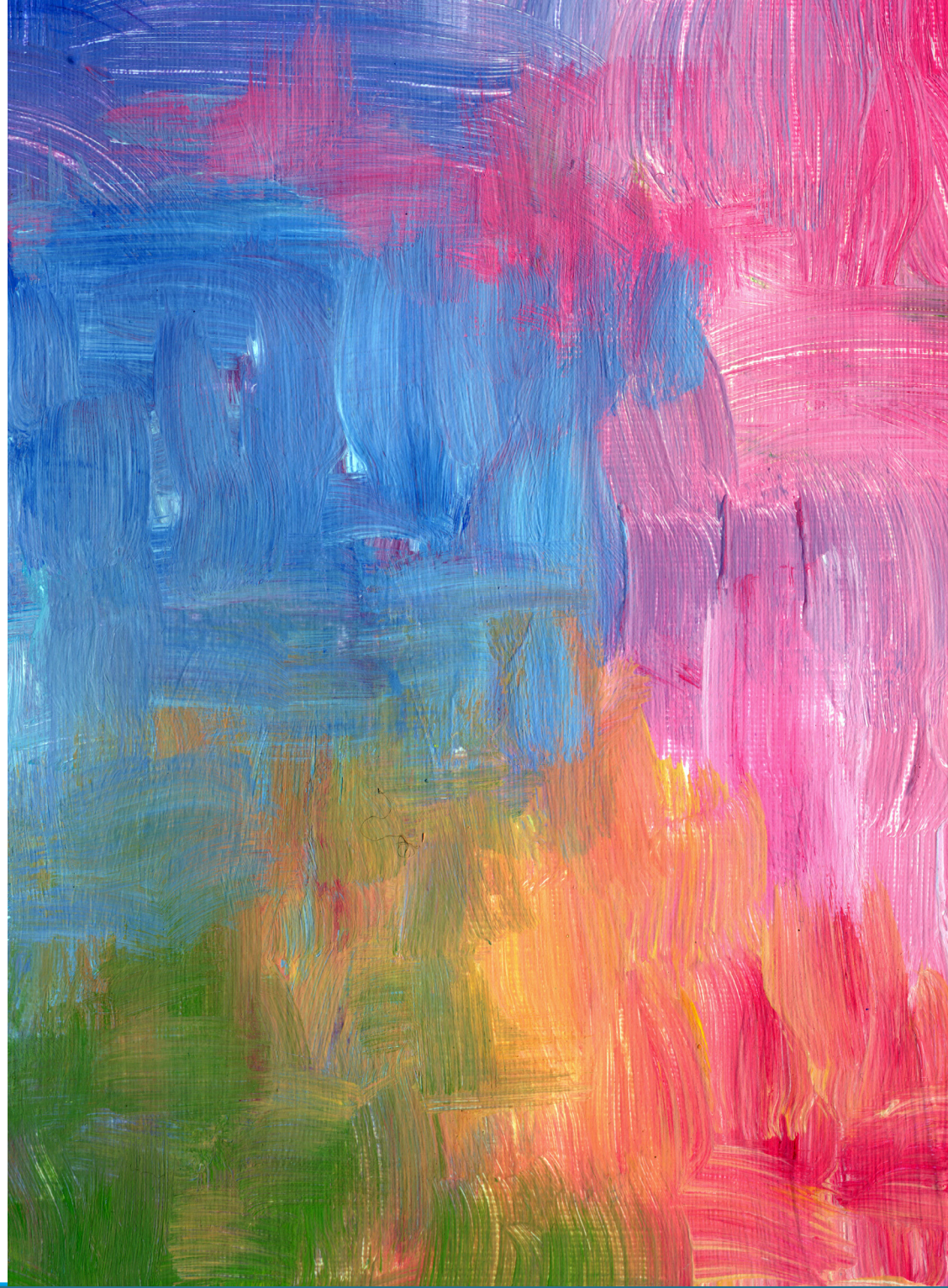
- A **Speech and Language Therapist** (SLT) may be part of the MDT. The SLT will assess communication needs and provide interventions where needed.

Other people or organisations are also involved in providing and overseeing care:

- Secure mental health services are organised and purchased by **Commissioners** at NHS England. The commissioning budget is managed by **Clinical Commissioning Groups** (CCGs).

- Some patients have a restriction order attached as part of their detention under the Mental Health Act (i.e. Section 41 or 49). In these cases, the **Ministry of Justice** (MOJ) is involved in their care and has to agree to transfers between prison and hospitals, leave and discharge. The **Mental Health Casework Section** makes decisions on behalf of the **Secretary of State for Justice**.

- The **Hospital Managers** have the power to discharge some patients, depending on their section (see page 10).



The rights of carers

Confidentiality

Carers naturally want information about their relative or friend. The amount of specific information that can be shared will depend on the wishes of the patient. This makes finding information reasonably straight forward if the patient agrees. However, there are cases where, for whatever reason, patients do not want information about their care to be shared with relatives or friends. When this happens it is important not to breach patient confidentiality. Nevertheless, there may be circumstances when it is necessary to breach confidentiality and share information without the patient's consent, e.g. to ensure safety where there is a risk of serious harm to someone.

Despite this, the clinical team can still give general information to the carer, listen to the carer's concerns, and receive information from the carer. When consent to share information is not given, the service should make clear what general information can be shared. The decision not to share information with their carer should be reviewed at regular intervals.

What meetings are carers entitled to go to?

Carers can attend CPA review meetings with the agreement of the person receiving care. Carers should also be involved in discharge planning. This is particularly important when the plan is for the patient to be discharged to live in the community.

How to complain

You should check the service's complaints process. In general, carers should contact the care coordinator to try and resolve concerns. Alternatively, the patient's doctor (the RC) or ward manager may be able to help. The Patient Advice and Liaison Service (PALS) also provides a point of contact for carers and can help resolve concerns. You can complain to the commissioner of the service – either NHS England or the area clinical commissioning group (CCG).

Tips for carers

- Try to develop and maintain good relationships with your relative's care team.
- Don't be afraid to ask and to complain where necessary but try to resolve things by talking to the team first.
- Make a list of questions and keep the responses.
- Speak to other carers.
- Find out what is offered for carers in your local NHS Trust; go to carers' events.
- Ask your local council for a carers assessment.

Questions carers can ask

It is important that you ask if there is something you don't understand. Here are some questions you might wish to ask:

- Contact details and names of those on [relative/friend] care team.
- Who are on his/her care team (RC, other doctors, named nurse, psychologist, OT, social worker)?
- Which ward are they on (e.g. admission ward, treatment ward, intensive care ward, ward for those with mental illness/intellectual disability/ personality disorder, etc)?
- Is there a hospital philosophy/ ward philosophy document that you can receive?
- What is the diagnosis of [relative/friend]? What does that mean?
- What treatment do they receive (medications and psychological treatment)?
- What are the side effects of that treatment? Is there medication information that can be made available to you?
- What is the likelihood of the treatment being successful?
- What is the timeframe of the treatment?
- What section is [relative/friend] on? Does this allow transfer back to prison?
- What is their proposed pathway (e.g. back to prison or through health route, less secure setting, which one)?
- Which medium secure unit is their "gatekeeper" if in high secure care? (A "gatekeeper" is the unit which will make a decision on behalf of the commissioners as to whether a patient is ready to move to a less secure setting.)
- What is their routine on the ward (when do they get up, meal times, activities, etc)?
- What sort of activities are available for [relative/friend] at the hospital on the ward/off the ward?
- Are they allowed time outside (garden)?
- Do they have leave (within the hospital grounds or further away; escorted or unescorted)?
- When is their CPA meeting, can you attend?
- What support is available for carers at the hospital (are there carers' events, information material, contact person for carers, etc)?
- How do you arrange a visit? What can you bring/ not bring? What other rules are there about visiting (assessment by social worker, advance booking, is the visit supervised/not supervised, etc)?
- Does the hospital provide accommodation if you have to come from far for a visit or to attend a meeting?
- When can you call [relative/ friend]? Which number to call? Can they call you? Will the phone calls be monitored?
- Can you write to [relative/ friend]? Can you send them a parcel? Is there anything that you are not allowed to send? Will the post be monitored?

Jargon buster

- **Community Treatment Order (CTO)** – A CTO allows a patient detained on a Section 3 or 37 to leave hospital to be treated in the community. The person will have to keep to certain conditions, such as taking medication, and can be made to go back to hospital if conditions are not met or they become unwell.

- The **Nearest Relative** is defined in the Mental Health Act and has several rights including asking for an independent advocate to support their relative, objecting to the relative being placed on a section and applying for the relative to be discharged. See www.legislation.gov.uk/ukpga/1983/20/section/26 for a definition of nearest relative.

- **Recovery** can mean different things. However, Rethink Mental Illness distinguishes between clinical recovery and personal recovery. Clinical recovery is about no longer having symptoms of mental ill health. Personal recovery is about having a meaningful life and building hope for the future. There are some practical things that can help with this such as improving skills in particular areas which can help with things such as socialising.

- **Seclusion** – According to the 2015 Mental Health Act Code of Practice to the Mental Health Act, seclusion refers to "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others." It should not be used as the sole mean to manage harm to the patient themselves though sometimes patients who present a risk to themselves and to others will be secluded. It is possible that the patient understands that they need to be away from others to keep everyone safe, so sometimes they might even ask themselves to be secluded. Some patients report a positive effect, e.g. allowing them to regulate their emotions, from being in seclusion.

Seclusion takes place in a designated seclusion room where the patient will have access to toilet and washing facilities. Seclusion should be used for the shortest time possible and as a last resort. Seclusion is authorised by a psychiatrist, other approved clinician, or the professional in charge of the ward (usually a nurse). The patient is continually observed by nursing staff and reviewed regularly by the patient's clinical team as well as an independent clinical team, not involved in the decision to seclude. An Independent Mental Health Advocate should also be involved in reviews. The patient will remain in seclusion until the clinical team assesses that the risks posed by the patient can be safely managed without the need for seclusion. The Code of Practice further specifies that seclusion "should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme". The patient's MDT will develop a post-seclusion care plan for

the time after seclusion has been terminated. Seclusion is not the same as “time-out”, the latter often a short intervention with the agreement of the patient where they voluntarily spend some more time in their room, e.g. to help them calm down.

- **Segregation** – Segregation is used when the clinical team considers there would be a high risk of serious injury or harm to patients or staff if the patient were allowed to mix freely with other patients on the ward or unit on a long-term basis. The 2015 Mental Health Act Code of Practice (26.150) states that “Where consideration is being given to longterm segregation, wherever appropriate, the views of the person’s family and carers should be elicited and taken into account”.

Segregation usually occurs in the patient’s own room and so, unlike being in seclusion, the patient still has access to the things in their room. A patient in segregation does not usually mix with other patients on the ward though over time, whilst they are reintegrated, they might spend increasing periods of time back on the ward. Nursing staff make regular observations and it is possible for therapy sessions to take place (e.g. through the hatch in the door). This should be written into the patient’s care plan and there can be flexibility when the level of risk allows. As with seclusion, there are detailed guidelines regarding the frequency of reviews and these include the patient’s own team as well as independent clinicians. The relevant commissioning authority also has to agree.

Further information available

There are several organisations and resources that you can access to get more information about services, care, treatments and advice for carers.

- **Care Quality Commission (CQC)** – The CQC is the independent regulator of health and social care in England. They monitor and inspect services and publish reports on their website: *www.cqc.org.uk*

- **The Carer’s Toolkit** – NHS England and the University of Central Lancashire have developed a toolkit for family support and involvement in secure mental health services. It is available here: *https://www.england.nhs.uk/publication/carer-support-and-involvement-in-secure-mental-health-services/*

- **Carers UK** provides advice, information and support for carers. *www.carersuk.org*

- **High Security Psychiatric Services Directions** set out the requirements for high secure hospitals to have arrangements for safety and security, and for children visiting patients in their hospital. *www.gov.uk/government/publications/high-security-psychiatric-services-directions*

- **The Human Rights Act 1998** sets out how our human rights are protected by law. Mind has produced some general guidelines on the Human Rights Act from the point of view of a person with a mental health problem. *www.mind.org.uk/information-support/legal-rights/human-rights-act-1998*
  For more information: *www.legislation.gov.uk/ukpga/1998/42/schedule/1*

- **Mental Health Act**
  www.legislation.gov.uk/ukpga/2007/12/contents

- **Mental Health Act Code of Practice**
  www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

- **Mental Health Review Tribunal**
  www.gov.uk/mental-health-tribunal

- **Mind** is a charity which provides advice and support to empower anyone experiencing a mental health problem. Mind also provides advice on how to cope when supporting someone else.
  www.mind.org.uk

- **NICE guidelines** – The National Institute for Health and Care Excellence (NICE) provides national guidance on healthcare in England for specific conditions. Independent committees review evidence and make evidence based recommendations or say where more evidence is needed. Guidance is published on their website:
  www.nice.org.uk/guidance

- **The Patient Advice and Liaison Service (PALS)** offers advice, support and information. They provide a point of contact for patients, their families and their carers.
  www.nhs.uk/chq/pages/1082.aspx?CategoryID=68

- **Rethink Mental Illness** is a charity which challenges the stigma and discrimination which can accompany mental illness, campaigns to change policy, and offers support and information. It provides advice to carers and families, service users and healthcare professionals.
  www.rethink.org

- **The Royal College of Psychiatrists** provide information leaflets for carers.
  www.rcpsych.ac.uk

- **Samaritans** offer emotional support. Call free from any phone on 116 123.
  www.samaritans.org

- **SANE** is a charity working to improve the quality of life for people affected by mental illness.
  www.sane.org.uk

- **Triangle of Care** – The triangle of care refers to the relationship between the service user, the professional and the carer. The second edition was published by the Carers' Trust in 2013. The document sets out key standards in supporting carers and gives examples of best practice.
  https://professionals.carers.org/working-mental-health-carers/triangle-care-mental-health

- You should also ask at the hospital what information is available for carers.

For more information please contact:
birgit.vollm@nottingham.ac.uk

This project is supported by The University of Nottingham's ESRC Impact Acceleration Account.

Primary authors are Birgit Völlm and Martin Clarke.

Published May 2018

www.institutemh.org.uk