

Monitoring the use of the Mental Health Act in 2009/10

The Care Quality Commission's first report on the exercise of its functions
in keeping under review the operation of the Mental Health Act 1983



Care Quality Commission

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Mind-full, by Terence Wilde, an artist who has experience of mental health services.

"A mind is always busy, full of images and patterns, faces and sensations; we need to be mind-full of it."

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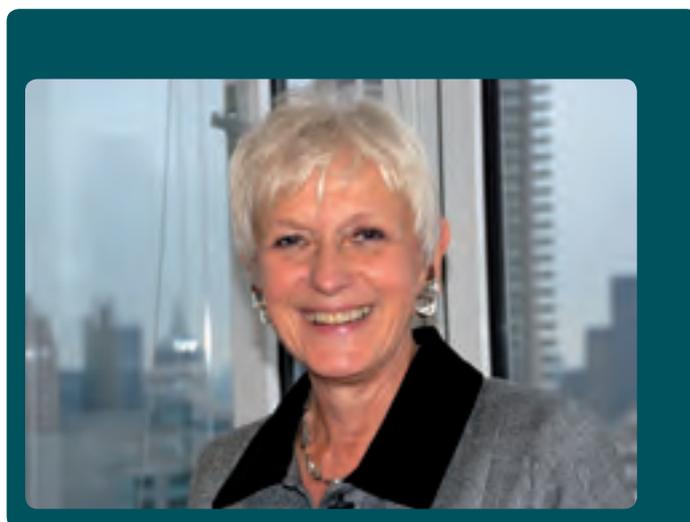
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Foreword

From April 2009, CQC has been responsible for monitoring how the Mental Health Act is used in England. I am pleased to present our first annual report to Parliament on our work to fulfil this important duty. It is based on the findings of our Mental Health Act Commissioners and Second Opinion Appointed Doctors when meeting with patients whose rights are restricted under the Act during 2009/10.



During the year, the Mental Health Act was used more than ever before. The decision to deprive someone of their liberty and enforce treatment under the Act is a very serious one that should never be undertaken lightly. Detention must be a justified, therapeutic experience that promotes the recovery of the men, women and children involved. Too often, we came across patients whose experience fell short of this. In our report, we make clear where services should develop and monitor their practices, to ensure that they are not only complying with the Act, but also following the associated Code of Practice to improve the experience of detained patients.

Three of the guiding principles of the Code of Practice are those of “least restriction” of patients, “respect” and “participation”. In 2009/10, we found that services varied considerably in the extent to which they were implementing these principles. Although we saw some excellent examples of patients being involved at every stage of their treatment, many services needed to improve. Detained patients were often not involved in their care plans until the final stage, by which point “...the staff have already made up their minds”. We are therefore calling for services to improve their practices for involving patients and in the assessment and recording of patients’ capacity and consent. We are also urging services to give more thought to how they can avoid imposing unnecessary restrictions on detained patients or using blanket security measures that risk breaching human rights.

A new and increasingly important strand of our monitoring work related to the use of community treatment orders (CTOs), by which a patient can be discharged from hospital into the community providing they are prepared to comply with certain conditions related to their treatment. Supervised community treatment is particularly intended for patients with a history of repeated admission to hospital or who do not comply with their treatment or engage with community mental health services after leaving hospital. More than 6,000 CTOs have been made since the powers were introduced in November 2008, which greatly exceeds the number anticipated at the time the new legislation was introduced.

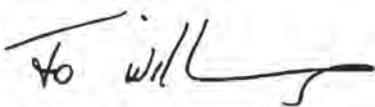
Although it is too early to draw firm conclusions, we had some concerns about how CTOs were being used in 2009/10. A sample of records from our SOADs' meetings with 200 people on CTOs showed that 30% had no history of refusing to co-operate with their treatment, including medication. This raises questions about the basis on which services are deciding to make people subject to CTOs. We also have some concerns about the fact that people from some Black and minority ethnic groups appear to be over-represented among the total number of people on CTOs.

The need for patients to be able to participate fully in planning their care and treatment – a theme that we return to again and again in our report – applies equally to people on CTOs. We found that people's thoughts about being on a CTO were strongly influenced by whether or not they had been able to participate actively in planning the details of their order. Those who had were much more likely to view it positively, whereas those who had been less involved tended to see the CTO simply as a mechanism for forcing them to take their medication.

To make sure that our work monitoring the use of the Mental Health Act focuses on the patient's experience, we constantly draw on feedback and suggestions from our service user reference panel. Made up of 20 people who are, or have been, detained patients, the panel brings a unique perspective, as shown by the illuminating comments and observations from them in each section of our report.

During 2009/10, our work monitoring use of the Act remained centred on visiting detained patients in hospital. We are now looking at how we can develop it to look across the whole pathway of care for detained patients, from initial assessment through to the provision of aftercare, and link it more closely with our wider regulatory framework. Our new, registration-based system requires all health care and adult social care services to meet essential standards of quality and safety, which is a powerful means of leveraging improvement. For example, when we launched registration in the NHS on 1 April 2010, we put conditions on three mental health trusts that were not adequately observing detained patients' rights. These trusts have already made considerable improvements.

Caring for people who are subject to the Mental Health Act inevitably involves tensions and challenges. Nevertheless, detained patients must have the right to self-determination like everyone else. Protecting this right, and empowering patients to have as much control over their care and treatment as possible, will always be a central aim of our Mental Health Act activities.



Jo Williams
Chair

Mark's story

Mark has been a detained patient over a number of years, and is a member of our service user reference panel. Here he talks about aspects of life on his ward.

"The low-secure ward I am on tries to give you as much independence as you can cope with, but at the same time the staff are there if you need them. It's not like a medium or a maximum-secure ward, where more things are done for you.

"The most important thing is the occupational therapy. From Monday to Friday there are all sorts of interesting subjects, from learning ceramics to a language, to doing basic maths and English if you want to strengthen those areas. And art's a pretty big thing – a lot of people on the ward are interested in it and some are winning competitions. Finding an interest and help to develop it can open doors to other areas, giving you self-esteem, making it easier to look at things that you've struggled with over the years."



When it comes to involvement in his care planning, Mark's experiences have been varied: "On my previous ward, I would often just be invited in for 10 minutes at the end of the planning meeting. To wait for two hours, then go along and be told this is what's going to happen to you, this is what we've discussed and this is how it is, I found that pretty degrading. But it doesn't happen on all wards, and certainly not on the ward I'm on at the moment.

"In the past, rules made by the hospital led to notices all over the ward, saying don't do this and don't do that. But now you've got people communicating face-to-face and actually listening. Patients can get involved in their day-to-day routines by having a ward-based rep, who attends patient council meetings and can attend management meetings as well. In some hospitals, you have a regular monthly meeting where you meet with all the managers, in a forum where all the wards can attend, and say this is happening, that's happening."

Mark says that now patients feel more supported about speaking up, they're raising more issues – and sometimes things that management don't want to hear. "Things are improving from that. And one of the biggest things I've noticed is that if you make an internal complaint, the chief executive will have written at the bottom of it: 'We are finding ways to improve this so it won't happen again' and 'Thank you for raising it because we will work on this now.' Before it was a matter of: 'Yes, your complaint is upheld', or 'No it isn't.' Now they are finding ways to improve your quality of life."

A Commissioner's story

Steven Richards combines his work training NHS staff with the part time role of Mental Health Act Commissioner. Like most of our Commissioners, Steven typically works two days a month visiting wards that have detained patients.

"Under the Act, hospitals have authority to restrict a person's rights, not because of anything they have done but because they need treatment for a mental health disorder. We Commissioners provide an extra level of protection for people who are in this situation.

"A lot of patients are not happy about being detained. They like to speak to somebody who is independent and who will listen to their concerns. I'm able to give them a private interview, during which they can talk about their experiences of being detained and the care they are receiving. I also check they know and understand their rights under the Mental Health Act."

During a typical visit – nearly half of which are unannounced – Steven will start by talking to the nurse in charge about facilities for patients. Issues discussed could include information about ward activities, advocacy provision and arrangements for children visiting patients. He also finds out about current pressures on staff and developments since the last visit by a Commissioner. Steven looks at the ward environment in terms of privacy, cleanliness and safety. Most of the day is then spent talking with patients in private. He also checks patients' records and the legal paperwork connected with detaining a person, to make sure that it is correctly completed, and pays particular attention to consent to treatment.



Commissioners cannot discharge patients or change their medication. However, they can raise concerns on a patient's behalf with the ward manager during the visit. And after each visit, Steven produces a report for the hospital summarising his findings. It will include a number of issues he feels should be looked into. The hospital must then formally notify CQC about how it will address each point. If Steven is not satisfied with the actions it promises to carry out, we follow it up.

"The skill is to get an accurate snapshot, in the space of a day, of what that ward is like for the people detained there. You need to look at it from a number of difficult angles, including whether it's meeting the requirements of the Mental Health Act, the Code of Practice and the outcomes that CQC expects for patients. Within a week of my visit, the hospital will have my written report.

"I enjoy meeting with and talking to people who are detained on mental health wards. I feel I am able to take account of people's experiences in a way that helps to bring about positive change on wards. As a Commissioner, I get a real sense of achievement from my work and hopefully contribute to ensuring mental health services provide good quality care."

How CQC monitors the use of the Mental Health Act

The Care Quality Commission (CQC) is the independent regulator of health care and adult social care services in England. Since April 2009, we have had a duty under the Mental Health Act 1983 to monitor how services exercise their powers and discharge their duties in relation to patients who are detained in hospital, or subject to community treatment orders (CTOs) or guardianship under the Act.

Visiting detained patients

CQC must visit and interview in private people whose rights are restricted under the Act. We aim to visit every psychiatric ward in England where patients are detained at least once every 18 months.

Our specially appointed Mental Health Act Commissioners carry out these visits. They meet with detained patients to discuss their experiences and concerns, make sure that they understand their rights and check that staff are using the Act correctly. The Commissioners are empowered to look at any records, including medical records, and to investigate matters of concern.

We also appoint 'second opinion appointed doctors' (SOADs) to check on our behalf that the treatment proposed for detained patients is appropriate and that their views and rights have been considered.

About this report

The Mental Health Act requires CQC to report annually to Parliament on our work in monitoring the use of the Act in England. This report covers CQC's first year of monitoring the use of the Act, from 1 April 2009 to 31 March 2010. It is based on our findings from the visits that our Mental Health Act Commissioners and SOADs have made to services during the year.

Summary

In this summary, our observations and recommendations focus on areas where improvements are needed. This reflects the purpose of our Mental Health Act visits to wards, which is to identify where the Act is not being operated correctly and where detained patients have concerns about their care and treatment.

Our main findings and conclusions are as follows.

Admission and detention

In the last decade, there has been a steady decline in the number of people treated as inpatients in mental health hospitals. However, the proportion of people being treated in hospital as detained patients, rather than as informal (voluntary) patients, is growing. In 2009/10, the Act was used more than ever before. Excluding patients who were only made subject to short-term holding powers, there were 45,755 detentions during the year, involving either people admitted under detention or who were detained after being admitted to hospital.

There has been a marked reduction in the number of notifications we received for young people admitted to adult psychiatric wards under the Act, especially those under 16 years of age. This suggests that mental health services are making progress with implementing national policy and legislative changes. We saw services preparing well for the legal duty – effective from April 2010 – to provide age-appropriate accommodation for patients under the age of 18.

We visited some excellent child and adolescent mental health services (CAMHS) units, which had stimulating environments that enabled young people to continue their personal, social and educational development. But we raised concerns about a lack of gender separation in some

CAMHS units, which was putting young people's dignity and sexual safety at risk. We also had concerns about the treatment regimes in some eating disorders units, which appeared to restrict personal liberty more than would be the case in most other types of psychiatric unit.

Many more 'places of safety' are now available in hospitals than was the case a few years ago. In many areas, this seems to have reduced the use of police cells – although staff shortages have prevented access to hospital-based places of safety in some areas. We also identified some problems about the police's arrest and assessment practices under section 136, and about the availability of forensic medical examiners with special experience in the diagnosis and treatment of mental disorder.

The Mental Health Act is used less often by acute hospitals than by mental health services. We noticed that in some acute hospitals there was poor administration of the Act's requirements, perhaps because it is being used less often and some acute providers do not have formal arrangements in place to support its use. Nevertheless, acute hospitals must comply with the Act and Code of Practice if they detain people with mental disorders under the Act, and their registration by CQC must cover this activity.

Experience of detained patients

We continued to identify problems with over-occupancy on inpatient wards – 29% of acute wards visited in 2009/10 had occupancy rates of over 100%. Often, patients who were the least unwell were being sent home or refused re-admission because there wasn't a bed available, rather than because they did not need to be inpatients.

Our Mental Health Act Commissioners often raise concerns about the low level of staff-patient interaction that they see during their visits. Lack of staff time and skills can lead to a loss of therapeutic engagement with patients, and to unnecessarily restrictive conditions of detention.

Patients' feedback suggests that hospital life is becoming much more focused on rules and security and that more acute inpatient wards are now locked wards. We have continued to voice our concern that voluntary patients in locked wards are at risk of being unlawfully deprived of their liberty.

The proportion of people in low secure beds has increased significantly since 2006, both for men and, more markedly, women. We continue to find variation in low secure treatment regimes. Examples of poor practice being followed in the name of patient security included blanket measures that risked infringing human rights law, and disregard for privacy and dignity that was verging on unsafe or abusive practice.

Participation and protecting patients' rights

We have seen some excellent examples where the service's practice, systems and processes involve the patient at each stage, and where patients' care plans are carefully tailored to their individual needs and show their recovery goals.

However, we found many services that needed to substantially improve their practices. For example, staff should make sure that every detained patient is present at Care Programme Approach meetings about their care, and involved in developing their care plans instead of simply being asked to sign the completed plan. They also needed to give patients fully personalised care plans, rather than a 'template' style plan, with their medium and long-term recovery goals clearly set out.

We have continued to voice our concern that voluntary patients in locked wards are at risk of being unlawfully deprived of their liberty.

From April 2009, primary care trusts have had a statutory duty to make sure that detained patients have access to independent mental health advocates (IMHAs), so that if they need help to understand and exercise their legal rights, it is available to them. The patient's service is then responsible for making sure that they are aware of this support. Many IMHA services provide a valuable contribution to advocacy for detained patients. However, in a study of 311 wards, we found that 56 (18%) did not provide access to IMHA services. Further improvement is needed to ensure that all detained patients are aware of these services and have access to them.

The number of applications to the Mental Health Tribunal rose sharply in 2009, with 12,122 hearings in the year, compared to an annual average of just under 10,000 since 2000. Applications by and on behalf of CTO patients have been a significant part of this rise, although they are less likely to succeed than applications by patients appealing against detention. Patients and staff continue to report long delays between applications to the Tribunal and the eventual hearing and, in some cases, patients' hearings have been postponed more than once. Many hearings are adjourned because of lack of sufficient information – often the patient's social circumstances report, which is either not available or inadequate.

Use of control and restraint, and seclusion

In 2009/10, our Commissioners visited a number of wards where the lack of a stimulating environment and activities for patients and of one-to-one time with staff, was increasing the likelihood of incidents that called for control and restraint. We also thought that some hospitals could have been doing more to de-escalate situations before using restraint or seclusion.

The Code of Practice emphasises the importance of providing support to patients after using control and restraint, seclusion or long-term segregation and of reviewing these incidents to

enable staff to learn from them. The Code also requires multidisciplinary reviews while a patient is being kept in seclusion to ensure they are returned to the ward as soon as possible. Our evidence shows that these requirements are not always being met.

Some forms of ‘mechanical restraint’ that appear to be quite widely used, such as supportive chairs on wards for older people, may not even be recognised as such by professional staff. We believe there is a strong argument for introducing a system of notifications about their use, as government has suggested in the past.

Detained patients and consent to treatment

Many hospitals’ certified records showed that a patient had consented to treatment when it was apparent to our visiting Commissioners that they had refused to give consent or lacked the capacity to do so. This raises questions about how accurate assessments of consent are, and how often wards update them. Patients often showed a limited understanding of their treatment and said that their doctors only very briefly discussed it with them.

In April 2010, CQC registered all NHS trusts in England, including the 66 NHS mental health trusts that provide specialist mental health services. Four of the mental health trusts had conditions placed on their registration, and for three of them this related to the need for improvement in their practices for assessing and recording patients’ consent to treatment.

Our data from visits by second opinion appointed doctors (SOADs) show a steady increase over the last six years in the proportion of patients deemed incapable of consent, rather than capable but refusing consent – from 55% in 2004/05 to 78% in 2009/10. Black and minority ethnic patients are more likely than White patients to be deemed incapable of consent, or capable but refusing to consent. In 2009/10, about a

Community treatment orders were introduced in November 2009, so 2009/10 was the first full year in which supervised community treatment has been implemented in England.

quarter of SOAD visits resulted in changes to the patient’s treatment plan.

In 2009/10, requests for a SOAD to visit detained patients to certify medication fell by around 6% compared with 2008/09. However, services’ use of urgent treatment powers to authorise medication rose significantly. In 2004/05, 6% of patients had been given medication under urgent treatment powers before the SOAD visit. In 2009/10, this figure had increased to 21% of patients referred for a second opinion. While some of this increase may reflect more robust data collection, it may also be the result of difficulties in arranging timely second opinion visits.

There has also been a general decline in the number of requests for visits to certify use of electro-convulsive therapy (ECT) over the last five years. We were concerned to find that a third of the 1,339 patients referred for a second opinion in 2009/10 were given at least one application of ECT under urgent treatment powers before the service requested a SOAD visit.

In 2009/10, we have encountered challenges in administering the SOAD service. We are now required to provide a second opinion for patients subject to community treatment orders (CTOs), the numbers of which have proved to be much higher than the Department of Health’s predictions. We have reviewed our internal systems, and are now working with the Department of Health, the Royal College of Psychiatrists, the General Medical Council and the NHS Confederation to identify ways of increasing the number of SOADs.

Community treatment orders

Community treatment orders were introduced in November 2008, so 2009/10 was the first full year in which supervised community treatment has been implemented in England. National statistics show that 6,241 community treatment orders were made between November 2008 and the end of March 2010 – an average of 367 a month.

We analysed a sample of 208 reports by our SOADs after they visited people subject to CTOs in 2009/10. Most of the patients involved had a diagnosis of schizophrenia (81%) and other psychotic disorders, and 12% had a diagnosis of mood disorders. We found that the proportion of some Black and minority ethnic patients was larger than might be expected from census findings on the detained population liable to be placed on a CTO.

In addition, 30% of the patients in the sample did not have a reported history of non-compliance or disengagement with services after discharge. This may indicate that CTOs are being applied as a preventive measure for a substantial minority of CTO patients, rather than in response to past difficulties with compliance or engagement with services. This raises concerns over the potentially very broad use of the coercive powers of CTO. However, we recognise that our data is, so far, not conclusive and we will be carrying out further study of the use of CTOs.

Thirty-five per cent of our sample was prescribed medication above the limits set by the British National Formulary. While for some patients there may be legitimate reasons for this practice, each case needs to be reviewed regularly to ensure that it remains appropriate for the patient.

Our Commissioners' meetings with patients have shown that their experience of being subject to a CTO is strongly influenced by how actively they were involved in planning the details of it before being discharged from hospital. Those who felt that they had been closely involved tended to view the CTO much more positively. We are

concerned to find that some patients did not know or did not understand the conditions with which they were expected to comply.

What happens next

Conclusions

This year, we have highlighted the need for services to develop and monitor their practices in the following areas to ensure compliance with the Mental Health Act and Code of Practice:

- **Assessing people for detention:** not keeping medical recommendations in reserve when the assessment is completed and the patient has agreed to go into hospital informally, and making sure that the outcomes of the assessment are communicated to the patient.
- **Use of section 136:** supporting the police to avoid misuse of section 136 and ensuring access to hospital-based places of safety.
- **Production of social circumstances reports:** reviewing both the priority given to patients' social circumstance reports and how they are produced; also reviewing the quality of these reports on an ongoing basis.
- **Assessment and recording of patients' capacity and consent:** to ensure this is routinely done and includes evidence of ongoing discussion with patients.
- **Recording episodes of control and restraint:** to ensure that there is a record of the steps that have been taken to de-escalate a situation before other interventions are considered or used, and auditing these records to inform practice development.
- **Carrying out duties as statutory consultees:** ensuring that records are made of conversations with SOADs and indicating that patients have been informed of the outcome of second opinions.

Priority areas for improvement

Our findings on the experience of detained patients raise important general issues for service providers and commissioners, including how effectively providers are putting into practice the Code of Practice principles of least restriction, respect and participation. We have identified three priority areas for improvement. Service providers should take action to review and ensure progress in the following:

1. Involving detained patients in their care and treatment

to enhance their experience of care and promote recovery. We recommend that services focus on ensuring that they involve patients in the following key areas of service planning and delivery:

- Assessment, care planning and review processes, as a basis for developing the patient's personalised care plan.
- Planning of the patient's community treatment order, if they are subject to supervised community treatment.
- Ongoing discussions with the patient as part of assessments of capacity and consent, with these discussions formally recorded on the patient's care plan.
- Ensuring that detained patients are aware of IMHA services and have access to information about them.
- Consulting and informing detained patients about their social circumstances reports

Even within a system that restricts people's rights because of their mental ill-health, services can and must respect and involve patients in their care and treatment. Our evidence shows that, in practice, involvement of patients continues to be variable. However, the positive feedback we have received from some patients shows that genuine involvement can be achieved even where people's rights are restricted.

2. Practice relating to patients' capacity and consent

ensuring that ongoing discussions of these issues with patients are an integral

part of treatment planning. The discrepancies that our visiting Commissioners often see between patients' recorded consent and their apparent lack of capacity or refusal of consent is concerning. We have identified consent to treatment practice as an ongoing problem in many mental health services, and will be looking for evidence of improvement in 2010/11.

3. Unnecessary restrictions and blanket security measures.

We recognise the importance of ensuring the safety of patients, but would nevertheless urge providers to give more thought to how they can minimise restrictions on detained patients and avoid blanket measures that compromise patients' privacy or dignity, or unnecessarily restrict their autonomy. Not only may these be counter-therapeutic, but they could also breach human rights principles and are wrong. To help reduce the chance of incidents that might lead to the use of more restrictive interventions, and to promote dignity and safety, we also emphasise the importance of a positive therapeutic environment, supported by an appropriate staffing level and skill mix.

Monitoring progress

We will continue to monitor services' progress in relation to these issues at the local level through our Commissioners' and SOADS' visits to services and meetings with patients. We will draw on patients' experiences to monitor the operation of the Mental Health Act. In addition, we will use these sources of information to inform our wider monitoring of mental health services' compliance with the essential standards of quality and safety that underpin registration with CQC.

Where we find systemic problems that hospital managers have not adequately addressed, we may impose conditions on the provider's registration to bring about the change needed to improve patients' experience of care.

Introduction

Each year, over 45,000 men and women are detained in hospital under the Mental Health Act for assessment and treatment for mental illness. At any point in time, around 12,500 people are being detained by NHS services and 3,500 by hospitals in the independent sector.

People who are deprived of their liberty, and therefore unable to choose whether or not to receive treatment and care, are in a particularly vulnerable position. It is vital that there are safeguards to ensure that their human rights are respected and that they are treated with dignity and respect. CQC is committed to protecting the rights of everyone who uses services. This particularly applies to people whose circumstances make them vulnerable, including anyone whose rights are restricted under the Act.

The UK is a signatory to the UN Optional Protocol to the Convention against Torture. CQC's role in relation to patients detained under the Act and the Mental Capacity Act Deprivation of Liberty Safeguards is part of the UK's National Preventive Mechanism under this protocol. The protocol requires a system of regular visits to places of detention by independent expert bodies, to prevent torture and other forms of ill-treatment.

Protecting patients' rights and interests

Our Mental Health Act Commissioners visit all wards where patients are detained under the Act. The main aim is to meet detained patients to discuss their experiences and concerns, make sure that they understand their rights, and check that staff are using the Act correctly.

The Commissioners also speak to staff about their experiences, plans and concerns, and review legal documents and patients' notes. Afterwards, they send written feedback to the ward, and each year send a summary report to the managers of each

NHS trust or independent provider visited. We aim to visit every ward in England where patients are detained at least once every 18 months.

Due to the nature of their visits, the Commissioners focus on possible concerns rather more than on what is working well. Their visits are not formal assessments of the overall standards of care and treatment. So it is important to remember that – thanks to the hard work, dedication and compassion of the staff involved – most day-to-day care of detained patients is much better than in many of the examples in this report.

This report is based on the Commissioners' findings when they visited over 1,700 wards and met with approximately 5,000 patients during 2009/10. Thirty per cent of their visits were unannounced and 9% took place at the weekend.

Second opinions to safeguard patients' rights

An important part of our work to safeguard patients' rights is the second opinion service that we provide if a patient refuses to consent to a treatment or is considered incapable of consenting to it. We also provide second opinions for consenting CTO patients. The doctors that we appoint to do this are known as 'second opinion appointed doctors' (SOADs). They decide whether the proposed treatment is appropriate for the patient and check that their views and rights have been considered. In 2009/10, we received around 13,500 requests for a second opinion.

Making sure patients have a voice

Our visits to wards and confidential meetings with patients give us valuable information about their experience of care. We also have a service user reference panel (SURP), made up of a pool of 20 people who have been detained patients in the past. They are available to attend meetings, take part in discussions and inform our thinking and planning in monitoring use of the Mental Health Act. The panel brings a unique and expert perspective to our work, particularly when they accompany our Commissioners on visits to wards.

1

Detention under the Mental Health Act

In part 1 of this report, we set out our general findings from the visits that our Mental Health Act Commissioners and second opinion appointed doctors have made to services during 2009/10.

Detention and hospital admission



Trends in the use of Mental Health Act detention

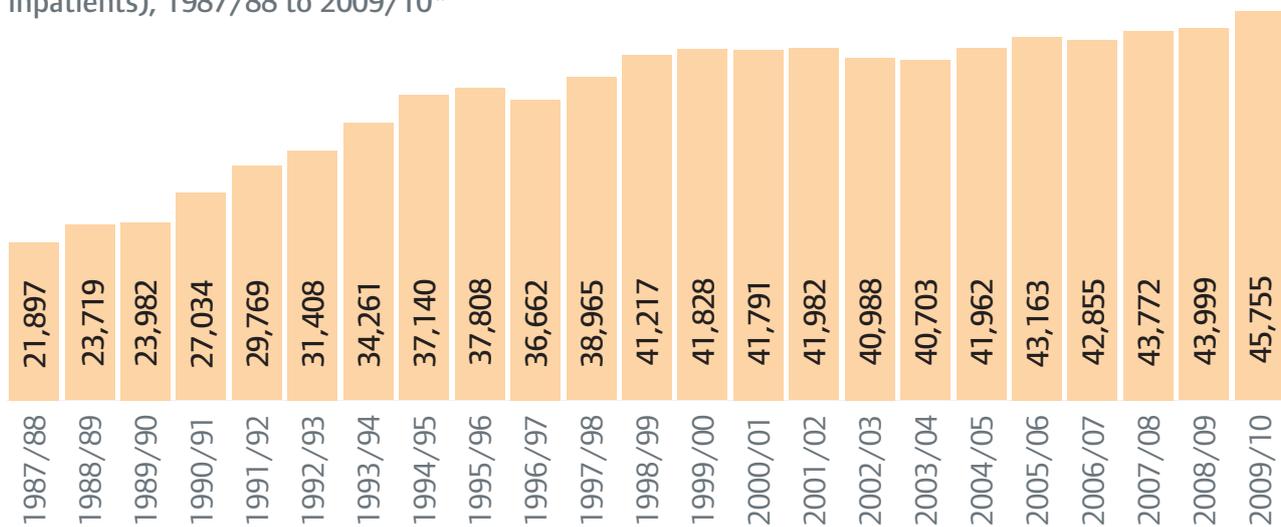
The use of the Mental Health Act to detain psychiatric patients in hospital appears to be increasing. In 2009/10, the year covered by this report, the Act was used more than ever before to admit patients to hospital under compulsion, or to detain informal patients who would otherwise have discharged themselves (figure 1).

Detained patients now occupy a larger proportion of inpatient services as the number of mental health hospital beds continues to decline and alternative community structures of care are developed.

Reductions in the number of psychiatric admissions generally have been more noticeable in patients with depression, learning disabilities or dementia, whereas admissions for schizophrenic and manic disorders have not changed significantly, if at all. Therefore, the patient mix on inpatient wards has shifted further towards people with psychotic (and dual diagnosis substance misuse) disorders, who are more likely to be detained.¹

The patterns of detention are also changing (figure 2). The number of patients who were already in hospital voluntarily at the time of their detention ('changes from informal admission') has been decreasing for the past 10 years, whereas the number of people admitted directly from the community under civil powers (known as

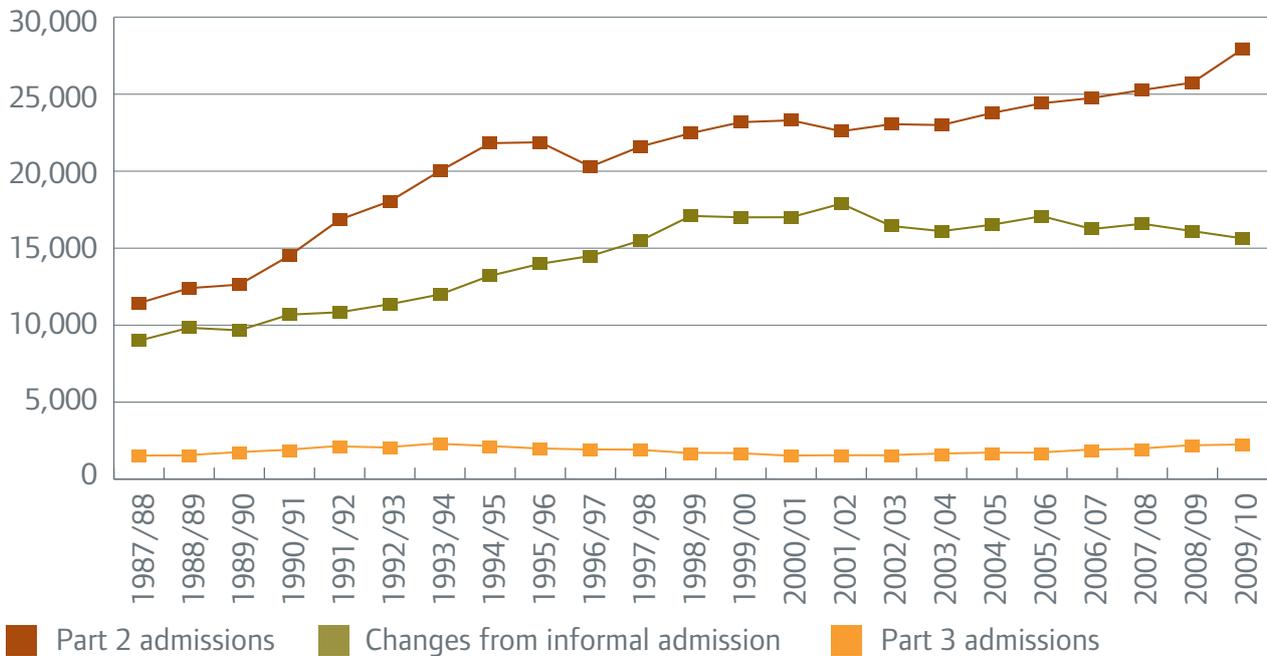
Figure 1: Detentions under the Mental Health Act (admissions and detentions of informal inpatients), 1987/88 to 2009/10*



Data source: KP90 (DH/Information Centre statistical bulletins "inpatients detained under the MHA and other legislation", 1986 to 2010)

* In these figures, we have taken 'detention' only to mean detention in hospital for assessment and/or treatment (section 2), or detention in hospital for treatment (section 3 and 'part 3' detention powers relating to the detention of mentally disordered offenders). We exclude holding powers (i.e. sections 5(2), 5(4), 135, 136), detentions under section 4 that end within the initial 72 hours, and non-detention powers (i.e. sections 25A, 17A, and guardianship under section 7 or section 37). Information Centre bulletins do not exclude these holding powers (see, for example, the October 2009 statistical bulletin *Inpatients detained under the MHA and other legislation*, table 2). We have revised the data, using the above principles, from that given in past MHAC reports. Data prior to 2003/04 does not include any changes to legal status taking place in independent hospitals; data between 2003/04 and 2006/07 does not include such detentions subsequent to holding powers. Where all this data is available (2007/08 to 2009/10) it averages only 340 uses of the Act per year.

Figure 2: Detentions under the Mental Health Act (admissions and detentions of informal inpatients), 1987/88 to 2009/10*



Data source: KP90 (DH/Information Centre statistical bulletins “inpatients detained under the MHA and other legislation”, 1986 to 2010)

‘part 2 admissions’) has risen. This, again, is likely to be a consequence of fewer hospital beds and more community-based care. Patients may be supported – or have to manage – for longer in the community before a hospital admission is deemed necessary, so that they are eventually admitted when they are more severely ill and less likely to enter hospital voluntarily. We explore some of the consequences of this in this report.

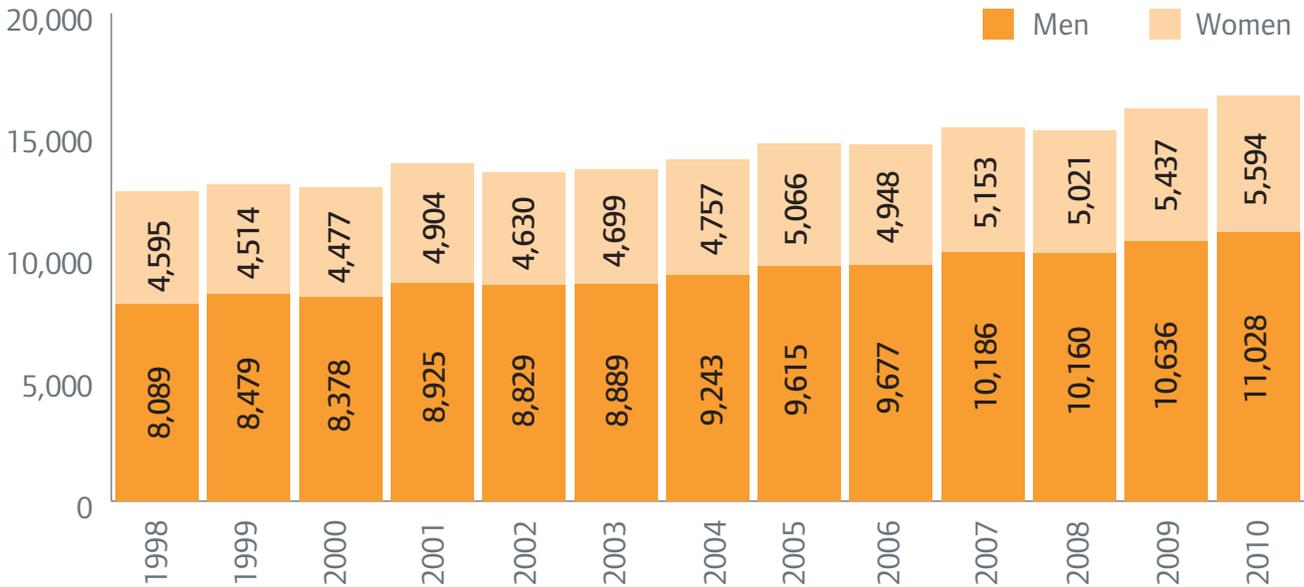
In the course of detaining a patient in hospital, several powers of the Act may be used consecutively. The Act provides short-term holding powers, time-limited powers of assessment and

treatment, and renewable powers of detention for treatment, all of which might be used during a single admission. In figure 2, we have counted the number of times that the Act was used to detain a patient in each year, rather than the total number of times any power of detention under the Act was invoked in the course of each detention episode. However, it is important to remember that some patients will have been detained under the Act more than once during each financial year, and so we are counting detentions and not individuals.

The resident detained population has been increasing for more than 10 years. Including those

* See note on previous page on the definition of ‘detentions’ used here.
 ** The KP90 data in figure 3 is not directly comparable with Count Me In data (figures 4 and 5) because patients held under short-term assessment powers (e.g. section 5) are included in the former but not the latter.
 † The first Count Me In census took place in 2005, but did not extend to learning disability services, and is therefore not comparable with later collections.
 †† Excluding holding powers (i.e. sections 5(2), 5(4), 135, 136) and non-detention powers (i.e. sections 25A, 17A, and guardianship under section 7 or section 37).
 ◇ Section 2 of the Act is essentially an assessment power, allowing for assessment (and treatment) for an unrenovable period of up to 28 days. The exceptions can be when the detention is extended pending an application to displace the Nearest Relative, or when the patient returns to hospital having been AWOL: see Mental Health Act 1983 sections 29(4), 21(1).
 ◇◇ Section 3 of the Mental Health Act is a treatment power, allowing detention in hospital for up to six months, after which it can be extended.

Figure 3: Patients detained under the Mental Health Act on 31 March, by gender, 1998 to 2010**



Data source: KP90

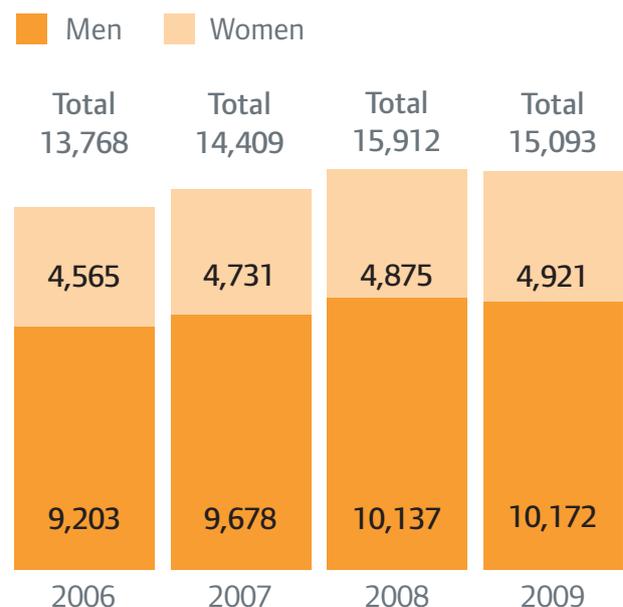
patients subject to short-term holding powers, there are now more than 16,000 people detained at any time (figure 3).

The 2009 Count Me In census recorded just over 15,000 patients detained in hospital on 31 March 2009 (excluding those detained on short-term holding powers)**, a rise from just under 13,800 on that day in 2006† (figure 4).

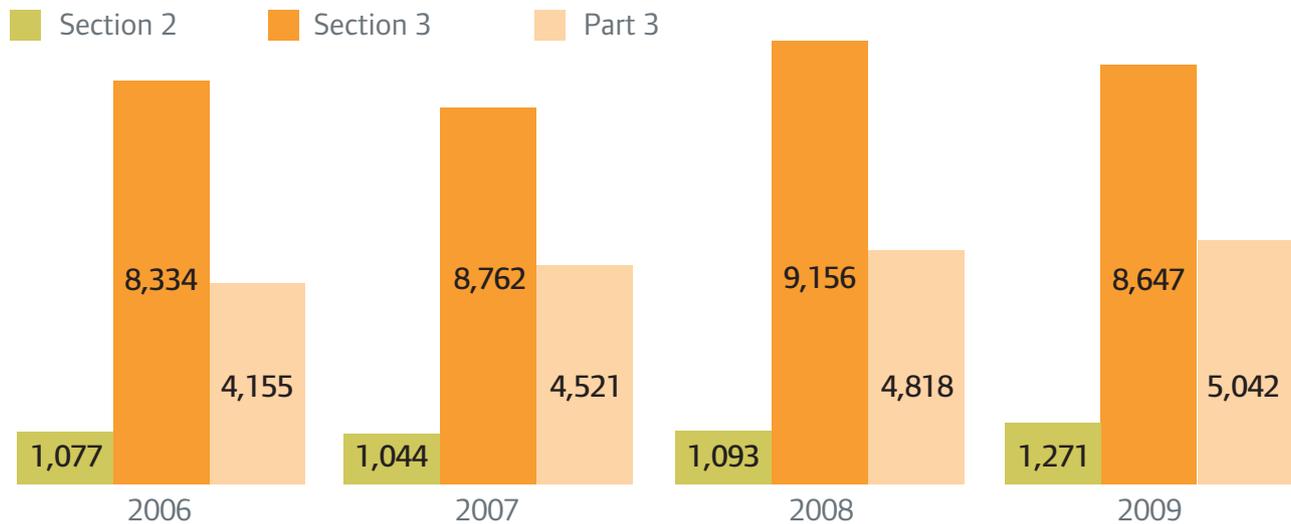
This rise in the number of detained patients could also be a result of an increase in the average length of detention. From 2006 to 2009, there was a notable rise in the number of patients detained under the forensic ‘part 3’ powers (that is, hospital orders made by courts upon remand or conviction, or transfers from prison) and these patients spend relatively long periods in hospital (figure 5).

Most patients detained under ‘part 2’ civil powers spend relatively short periods of time in hospital. Detentions under section 2 are limited to 28 days duration apart from only a few cases.◊ Detention under section 3◊◊ is renewable indefinitely, but most section 3 patients spend only weeks in hospital before they are discharged.

Figure 4: Patients detained under the Mental Health Act on 31 March, by gender, 2006 to 2009††



Data source: Count Me In

Figure 5: Patients detained under the Mental Health Act on 31 March, by section, 2006 to 2009

Data source: Count Me In

The admission of children and adolescents to adult wards

From April 2010, hospital managers have to ensure that any psychiatric patient under the age of 18 is accommodated (whether or not they are otherwise subject to MHA powers) in a “suitable” environment, “having regard to his age (subject to his needs)” (section 131A). To be ready for this new legal duty, many services were trying to ensure that they provided age-appropriate placements to those under 18 during 2009/10.

Admissions of children and adolescents to adult wards in 2009/10

In 2009/10, we were notified of 88 admissions of children and adolescents to adult psychiatric wards. Most were admissions to acute admission wards, and all were to NHS rather than independent hospitals. The numbers suggest some progress towards meeting the new legal duty: over four months in 2008/09, more than 80 cases were notified to our predecessor body, the Mental Health Act Commission.² However, hospitals notify us about these detentions on a voluntary basis, and we cannot be certain that our data is complete. We provide a notification form

to services, the first part of which covers details of admissions; the second part tells us about the outcome of that admission. We received the second part of the notification for just over half (45) of the cases in 2009/10.

The majority of detentions (94%) involved 16 and 17-year-olds. Thirteen 16-year-olds and 62 17-year-olds were detained on adult wards over the year, although eight of the 17-year-olds were admitted twice in the year (figure 6).

The youngest person admitted was 14 and she was detained under section 3. There were four detentions of 15-year-olds (two young men and two young women, all under section 2). All of these cases breached the previous government’s commitment to end admissions to adult wards of young people under 16 from November 2008, but they do all appear to have been quickly transferred to child and adolescent mental health services (CAMHS) within one or two nights of being on the adult ward.

Patients were admitted to their own room on the ward, except in two cases (one young man,

Figure 6: Age and gender of children or adolescents detained in adult wards, 2009/10

Age	no. of admissions		no. of people admitted	
	Male	Female	Male	Female
14 years	-	1	-	1
15 years	2	2	2	2
16 years	6	7	6	7
17 years	35	35	31	31
Total	88		80	

Data source: CQC

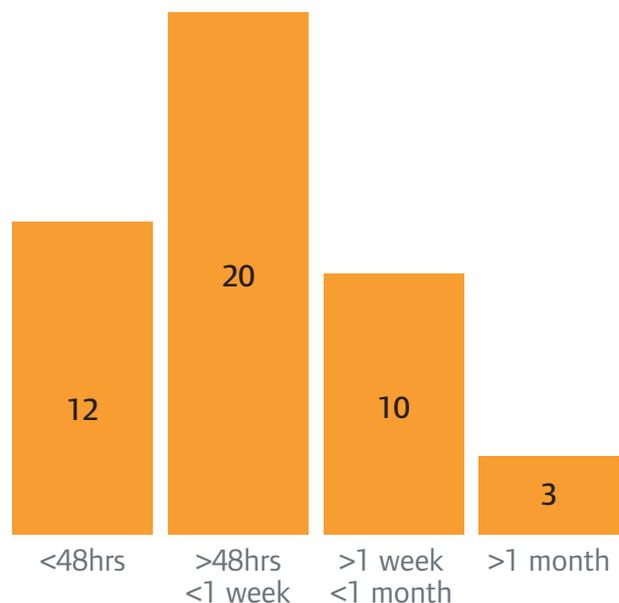
and one young woman, neither under 16). These patients had to share sleeping areas, one in a mixed sex-ward. Overall, there were 42 instances where patients’ bedrooms were in a mixed-sex ward and it is clearly worrying that a number of these were young women.

Data shown in figure 7 suggests that most services managed to transfer or discharge young patients from adult wards within a few days. However, we only have outcome data for half of the notifications received over the year. It is possible that we are more likely to be notified about earlier discharges or transfers than cases where the patient remains on the ward for a long time – partly because hospitals who arrange discharge or transfer early will be keen to inform us of this, but also because the second part of the notification form (dealing with outcome) is more likely to be forgotten the longer a patient stays on the ward.

Even though the legal requirement to admit children and adolescents to age-appropriate facilities is now in force, there will still be cases where an adult placement is unavoidable. In May 2009, we visited a 16-year-old man who had been admitted to an adult psychiatric intensive care unit (PICU). On admission, he had been extremely ill, presenting with significant risk factors that, in our view, meant that the PICU had been the most

appropriate environment available. The trust had ensured that he had been assessed by a CAMHS specialist, and that his responsible clinician was experienced in CAMHS. All staff on the PICU had Criminal Records Bureau (CRB) checks. We asked for and received assurances that, once the initial emergency situation had passed, the trust would find a more suitable age-appropriate placement.

Figure 7: Detentions in adult wards of children or adolescents, 2009/10, by length of stay in adult facility (where known)



Data source: CQC, n=45

Holding powers used on children and adolescents in 2009/10

Over the year, we were notified of seven uses of section 5(2) holding powers to prevent children and adolescents from discharging themselves (or, presumably, being discharged) from an adult ward. One was 15 years old, another was 16 and the rest were 17. Two young women (both 17 years old) were subsequently detained under section 3. All the remaining patients (five young men) were discharged from hospital during the 72-hour holding period; presumably these patients either did not meet the criteria for further detention, or further detention could be avoided by making other arrangements (such as establishing supportive arrangements with parental authorities).

We also learned, during the year, of four young women taken under section 136 to hospital-based places of safety. They were aged between 13 and 16, and all appear to have been discharged or transferred to another unit within roughly 24 hours. Even though such facilities may not be ideal places to hold children and adolescents (for example, they are unlikely to have specialist CAMHS nurses immediately available), the practical alternative in many areas is a police cell, which is clearly worse. We discuss this further on page 29.

“ Admission wards can be difficult. Not only is there culture shock of being in a new hospital; most if not all of the other patients are suffering from acute mental illnesses, and there is very little opportunity for leave. These problems ease as one progresses through the mental health system, with there being more emphasis on rehabilitation rather than security. ”

Bal, SURP member

Detention under the Act on child and adolescent wards

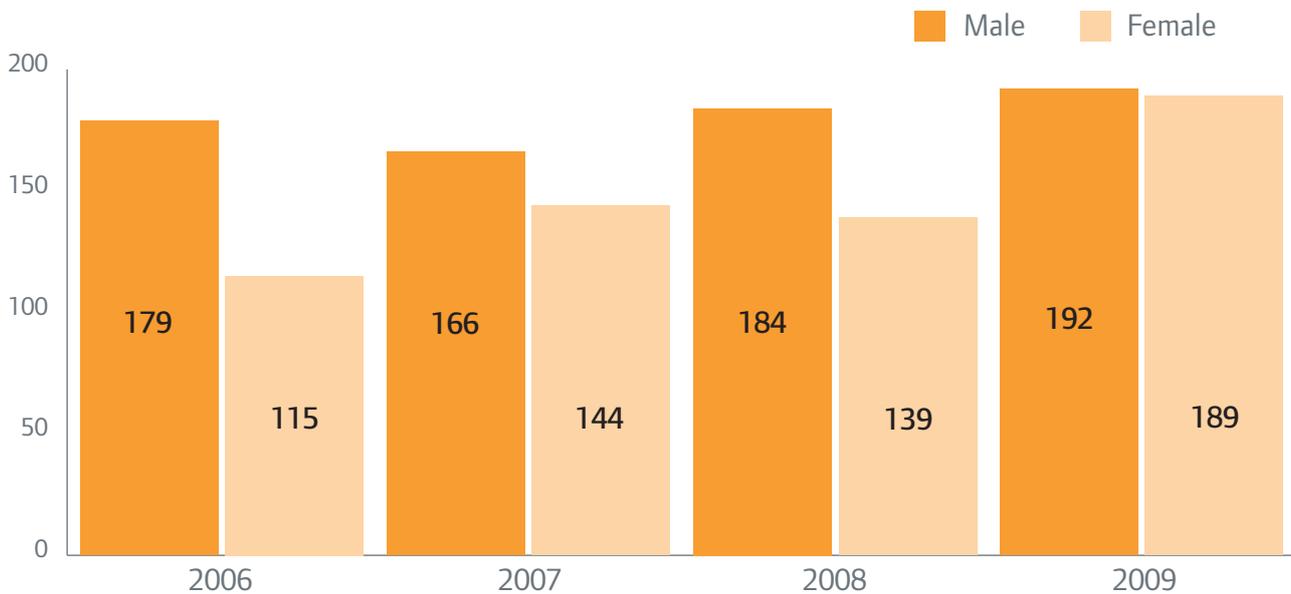
A very small proportion of the population detained under the Mental Health Act – around 2% to 3% at any one time – is resident in inpatient child and adolescent mental health services (CAMHS). There has been a small rise in these numbers from 2006 to 2009, particularly for female patients (figure 8).

We welcome any increase in the use of CAMHS facilities, in preference to adult facilities, for the detention of children and adolescents. But wherever they are placed, there still needs to be close vigilance over their care. For example, some units that care for young people with eating disorders have regimes that are more restrictive of personal liberty than most other psychiatric hospital environments, even though this may be justified clinically. These patients are sometimes placed on ‘restricted mobility’ regimes involving either bed rest or the use of a wheelchair. In May 2009, we met with young women in one unit who were confined to their bedrooms and made to use commodes for toilet facilities. We raised this as an issue of personal dignity, particularly as the bedrooms were on a mixed ward and afforded inadequate privacy. The unit also ran a ‘three strikes’ system, where patients were given a ‘strike’ if they make an issue around eating a meal or snack: three strikes in a week meant that home leave for the weekend would be cancelled. We continue to discuss these issues with the unit’s management.

Some CAMHS units are providing excellent facilities and are clearly focused on providing an environment that provides stimulation for patients and, as the Code of Practice suggests, allows personal, social and educational development to continue as normally as possible³, as in the following example from a Mental Health Act Commissioner’s visit report:

The ... programme is varied, and includes many activities off-ward, as well as being flexible to cater for individual needs and group sessions.

Figure 8: Patients detained under the Mental Health Act in CAMHS facilities on 31 March, by gender, 2006 to 2009*



Data source: Count Me In

In the interviews, the young people confirmed that the programme is one of the good things about being at the unit. Several young people said that they had learned to cope better, had developed new skills, and one was very proud to have new qualifications whilst on the ward.
February 2010

For most children and adolescents today, social and educational activities require internet access, and some units are doing this well, in the style of internet cafés. Children and adolescents who are not allowed to use the internet do raise the matter with us on visits:

The patients all complained that they were denied internet access. They were all desperate to communicate with their peers on MSN and Facebook. Whilst there was internet access at the unit school, it was restricted. Facebook etc is not allowed. The time young people want

to 'surf' is in their spare time. The hospital is urged to ensure that internet access is available to allow these young people to pursue what every other teenager does when not studying.
January 2010

In several CAMHS inpatient services, we have raised concerns over a lack of appropriate gender separation, and consequent risks to people's dignity and sexual safety. In the previous example, there were two male and five female patients on the ward at the time of our visit. The unit does not have separate bedroom areas for male and female patients and, we were told, "relies on staff to observe appropriately".

In the following example, we are pleased that the hospital responded to our request for an immediate review of, and change to, the nursing arrangements for this patient:

* Excluding holding powers (i.e. sections 5(2), 5(4), 135, 136) and non-detention powers (i.e. CTO).

A female patient who was being nursed on high observation and in a shared room had her dignity compromised, as care staff were required to sit outside her bedroom door whilst it was open to observe her. This had an impact not only on the patient in question but also on the individual that shared her room. To compound this further, this female bedroom was immediately opposite a male bedroom which staff sat outside, allowing the male patients to view inside the room whenever entering or exiting the bedroom.
August 2009

In the following example, a meeting with a young man in an adolescent unit raised serious concerns about the regime in an independent hospital that provided more secure accommodation than where he had previously been placed.

One young man spoke to me about issues which clearly concerned and frightened him, and which staff had no reason to doubt. The issues don't relate to the adolescent unit itself, but to his care whilst detained at a private provider hospital. He had been initially a patient at the adolescent unit, but had presented risks such that he needed a more secure seven-day placement, which ultimately lasted for two months. The adolescent unit staff had concerns of their own when they had transferred him. He described frequent occasions of several staff restraining both male and female adolescent patients, two assaults upon himself by fellow patients, and the anxiety caused when his family, who travelled using public transport for several hours, were restricted to an hour's visit, sometimes having to wait several hours for the double booked room to become free to see him.
August 2009

Problems in the adolescent unit described below appeared to stem from the presence of two inappropriately placed young women patients, and a shortage of staff and facilities to contain

difficult behaviour. A more flexible approach to moving the victimised patient or her attackers may have resolved the immediate dangers:

A 17-year-old patient who was admitted to the unit has been assaulted three times during her stay on ward X. She said that she feels unsafe on the ward and is in constant fear that she will be assaulted. Despite being under constant supervision, she was assaulted yesterday and therefore feels that staff are unable to protect her. She reports experiencing nightmares and difficulty in sleeping. The patient reported that she has made two complaints to the hospital and is yet to receive a reply. She believes that it is unfair to be nursed in the day area, where all three patients who participated in the attacks are also being nursed, as they are also restricted to the ward. This patient is not able to leave the ward or participate in activities, as her needs have not yet been assessed. The patient has asked to be moved to another ward.

The ward manager informed the Commissioner that their view was that it would be punitive to move the victim away from the ward. Staff expressed concern to the Commissioner that there appears to be no way of resolving the issue. They believe that the patient will be assaulted again, as the attackers have nothing to lose, and their presence has not deterred them. Staff are also concerned that the current staffing levels are not sufficient to manage this situation. The ward manager has requested that two of the patients who were involved in the attacks, who were now adults, be moved from the ward as soon as possible. The ward manager explored moving the two patients to extra care areas in the other wards within the unit, but they are all in use. The Commissioner remains concerned that the patient's safety on the ward is still at risk.
March 2010

In the above case, we raised concerns directly with the registered manager for adolescent services and asked for assurance that they were taking action. Safeguarding procedures were subsequently implemented. In all such cases, we continue to monitor the service carefully after the initial problems are resolved. The general lesson, however, is that age-appropriate placements do not themselves ensure acceptable care regimes.

Police use of the Mental Health Act

Section 136 of the Mental Health Act authorises any police officer to remove a person to a place of safety if he or she finds a person in a public place who appears to be suffering from mental disorder and to be in immediate need of care or control. Once at the place of safety, the person can be detained there for up to 72 hours to determine whether hospital admission, or any form of help, is required.

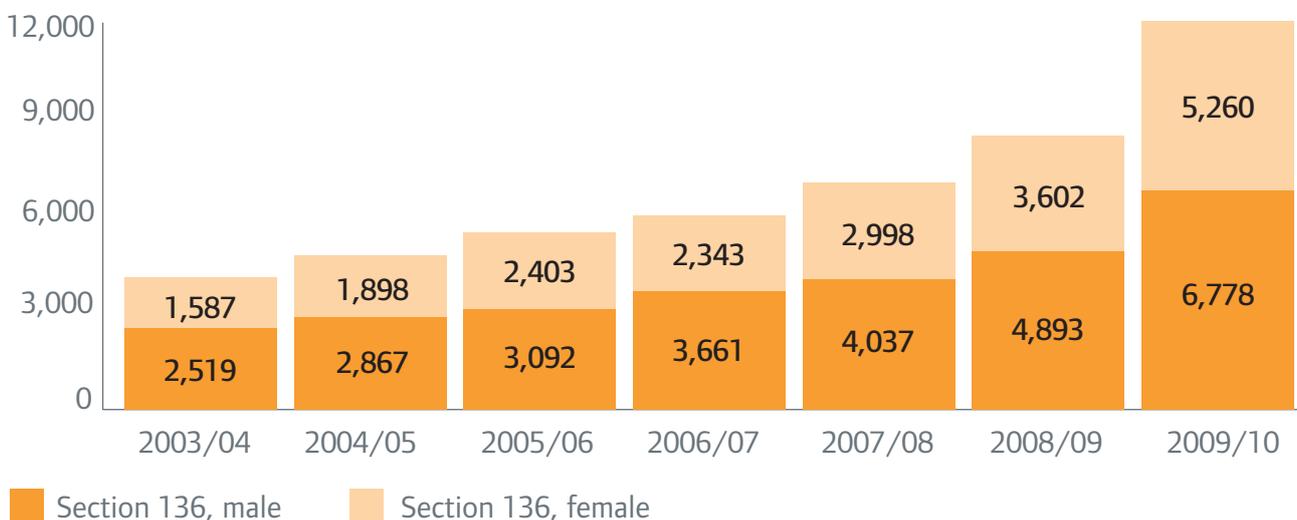
The place of safety can be a police cell, a hospital-based facility, or “any other suitable place, the occupier of which is willing temporarily to receive the patient”⁴, but it is usually either a police cell or a dedicated facility at a psychiatric unit. It is generally

accepted that police cells are not appropriate places of safety for most patients detained under section 136, many of whom neither are aggressive nor have committed any criminal offence.

The use of hospital-based places of safety has increased significantly in recent years (figure 9), due partly to additional capital investment in facilities.

Even though there are no comparable national data on the use of police cells, it is reasonable to assume that the increasing use of hospital-based facilities means that fewer people were taken to a police cell than would otherwise be the case. However, we have also seen that the development of a hospital-based place of safety can itself lead to an increase in the use by police of the detention power. In light of this, police officers may need better advice and support – particularly from community mental health teams – to help them contain a crisis situation without them having to use their powers under section 136. We collected the following example during a pilot visit to some hospital-based places of safety in south-west England at the end of 2009/10:

Figure 9: Use of hospital-based places of safety under section 136 of the Mental Health Act, 2003/04 to 2009/10



The Commissioner was told that the use of section 136 of the Act has increased by about 30% since the opening of the hospital's place of safety. Details of when police have been called to a situation, which has led them to use their section 136 powers, indicate that they may not have needed to use the power had there been better joint working between the police and the trust. In some circumstances, it would appear that expeditious and constructive involvement of an extended hours crisis team may have avoided the need for the police to use section 136. An example is of a patient who was very well known to services and who was self harming in her own home to which police were called. Staff at the place of safety felt she should never have been brought there, but instead supported by community services.

March 2010

Over the year, we were represented on a multi-agency group led by the Royal College of Psychiatrists to establish standards on the use of section 136. The College's report contains many recommendations on the choice of venue for places of safety; staffing of such facilities; transporting patients; and future monitoring and oversight of practice.⁶ In particular, it calls for:

- Sufficient places of safety in psychiatric facilities to meet foreseeable local need, so that police stations are used only on an exceptional basis.
- Local policies specifying a range of places of safety that can be used to assess, for example, the young or elderly in an environment appropriate for their needs.
- The establishment of a multi-agency group to develop jointly agreed policies and procedures, involving all appropriate agencies, including the ambulance service, emergency departments and organisations representing people who use services and carers.
- An adequate number of approved mental health professionals (AMHPs) and doctors approved under section 12 of the Mental Health Act to enable joint assessments to start within three hours, with an expectation that, in the longer term, the target will become two hours.
- Preference to be given to using an ambulance to convey people to, and between, places of safety, and such work to be prioritised by ambulance services to avoid unnecessary delays.
- A body (such as the National Police Improvement Agency) to be tasked with monitoring the standards of care relating to police involvement, including the use of the police custody suite.
- A standard recording form to be used for monitoring and audit purposes.
- Annual reports by the Care Quality Commission on trends in the use of places of safety and outcomes experienced by service users.

We will be promoting these recommendations on our visits and meetings with relevant bodies.

“ I have been sectioned before as police thought I would be danger to myself and others, as I have bipolar disorder, and looking back at it I was glad, to be honest, because anything could have happened to me. ”

SURP member

Our predecessor body, the Mental Health Act Commission, called for standardised data collection on the use of section 136 over many years, and made this an explicit recommendation in its final report to Parliament.⁷ We are pleased that police authorities have accepted the need for this and we look forward to working with them in collating the results for future annual reports on our monitoring of the Act. While we recognise the new budgetary constraints placed on the police

and other public services, we hope that these will not prevent this relatively simple measure from being put into practice.

The standardisation of section 136 records should enable us to monitor not only the number of detentions, but also the characteristics of the group detained; the place of safety used; transfers between places of safety; the time taken to begin and complete the assessment; and the outcomes of assessments. As such, it may help police services in comparing their activity against the national picture, and identify any unjustified variation in the use of section 136 and any issues where practice is not in line with the Act and its Code of Practice.

Problems in accessing appropriate places of safety

We have learned of some difficulties experienced by the police in gaining access to hospital-based places of safety, and so having to use police cells instead:

- In some cases, the hospital place of safety is not operational because of pressure on staffing levels. Understandably, hospitals do not have permanently staffed places of safety – instead they identify members of staff on duty elsewhere who can go to the place of safety when needed. Sometimes, they decide that they can't spare these members of staff. Hospitals should make every effort to protect the availability of staff who provide the section 136 cover, and not rely on them to fill other gaps in the staffing quota.
- We are aware of at least one occasion when a hospital refused to take an adolescent patient into its designated place of safety because it was not considered to be age-appropriate accommodation, as required under section 131A of the Act (see page 22). At the time of our pilot visits, the three places of safety in the south-west of England would not take a patient under 16, and would only 'exceptionally' take patients aged 16 or 17 (although none of the managers could explain the rationale for this

policy). This meant that police cells continued to be the default place of safety for under-18s. Ideally, local policies developed as a result of the Royal College of Psychiatrists' guidance will establish alternative places of safety for children and adolescents, using existing resources (not necessarily hospital-based). This was being discussed in the south-west when we visited, and it was hoped that a place of safety might be established in the CAMHS inpatient facility. Where there are no such arrangements, it is our view that any hospital-based place of safety must usually be a better option for children and adolescents than a police cell, even if the place of safety is not entirely self-contained. This approach is consistent with the guidance in the Code of Practice on emergency accommodation.⁸ We will remain vigilant that services do not misinterpret the age-appropriate accommodation requirements to exclude children and adolescents from places of safety.

- In many cases, people detained under section 136 show signs of alcohol or drug use. We have noted examples where hospital-based places of safety do try to manage such cases, and we recognise the difficulties that this can cause:

Ward 1 contains a section 136 suite. It comprises some chairs, an adjacent toilet and an outdoor exit which is rarely used. The suite is increasingly in demand with regular attendances from persons intoxicated with either drugs or alcohol to such a point that it is sometimes 48 hours before they can be assessed for admission on the grounds of mental illness. During this period, persons are required to either sleep on the sofa in the section 136 room or to take one of the rooms on the ward. It is hoped that a new section 136 policy will clarify the risks and attendant safeguards involved in treating such persons, with particular emphasis on the protection of acutely ill patients on this ward as well as its staff. Some further thought should be given to the contents of the section 136 suite.

October 2009

- Often, however, we hear that section 136 detainees have been turned away from hospital-based places of safety on the grounds of intoxication when this appears to be slight, or where the detainee merely smells of alcohol. Detainees can be highly disturbed by being turned away and taken, or returned, to a police cell after having been taken to hospital but refused entry there. Where local bodies have multi-agency section 136 groups as recommended in the Royal College of Psychiatrists' guidance, one task for such groups could be to monitor the cases that are turned away from hospitals, to ensure that the hospital staff are not being too risk-averse and passing a problem back to the police that could be managed better in a health setting.
- Similarly, while we recognise that police cells may have to be used when a detainee is exhibiting extremely aggressive behaviour, some hospitals have refused to take detainees that probably should have been manageable within health services. Staff working in hospital-based places of safety should be competent in dealing with disturbed and aggressive behaviour, and should have ready access to a qualified clinician, if there is a need for emergency tranquilisation or other intervention.

Failures in assessment

The law describes the purpose of removing a person to a place of safety under section 136 as a means of "enabling him to be examined by a medical practitioner and to be interviewed by an approved mental health practitioner and making any necessary arrangements for his treatment and care".⁹ However, that person must be released from custody, even if the AMHP has yet to see them, if the doctor determines that they are not suffering from mental disorder or, in the case of people held in police custody, if the custody officer at the police station "deems that detention is no longer appropriate".¹⁰

In 2009, we discussed this matter with the coroner who had presided over the inquest into the death of Mr S, a man with a history of inpatient treatment for self-harming. The coroner stated that neither experienced police officers nor the custody officer involved in the case had understood the significance of the provisions of section 136. As a result, Mr S was taken under that power to a police station as a place of safety by police officers who had good reason to believe that he was mentally disordered and at risk of suicide, and was released from custody without any form of mental examination. He went home and hanged himself.

In this case, it would seem that the custody officer failed to appreciate the breadth of the assessment expected under section 136. The test is not whether the person appears to be **sufficiently** disordered to be detained under mental health law, but whether he or she is mentally disordered **at all**, and whether any arrangements can be made to help and support him or her. We have encountered the same misconception in other police stations. This is particularly dangerous where custody officers either appear to make their own judgment over the mental state of the person, or rely upon the judgment of a forensic medical examiner who may not be appropriately qualified to make such an assessment. As in the case of Mr S, this can result in extremely vulnerable people being released inappropriately, either because indications of mental disorder have been missed altogether, or because the release cuts off the possibility of support from mental health services.

A practical way to avoid inappropriate decisions would be to try to ensure that the police station has access to forensic medical examiners who are approved under section 12 of the Act as having special experience in diagnosing and treating mental disorder. Unfortunately, as documented in past reports¹¹, such expertise is not always available. This problem can be exacerbated when police forces contract for their forensic medical examiners with private providers who have few, if any, section 12 approved doctors on their rosters.

If forensic medical examiners are not approved under section 12, they may still be expected to provide medical recommendations for formal admission to hospital under sections 2 or 3 of the Act, although they have questionable experience or expertise to do so. The Act contains an expectation that the two doctors making such recommendations will be section 12 approved, unless one of them has “previous acquaintance” with the patient.¹² In our view, there should be a record explaining the background to any situation where this expectation is not met.

We have heard concerns from some local authority AMHPs about the number of patients being formally admitted to hospital on the basis (in part) of a recommendation from a forensic medical examiner with no particular experience in diagnosing or treating mental disorder. It undermines the aim of Parliament in requiring two medical recommendations for formal admissions if one of these is given by a doctor with insufficient expertise to take an informed, independent view. But many AMHPs will feel pressurised to use such doctors rather than incur the additional delay of obtaining a third doctor to attend the police station.

The Royal College of Psychiatrists’ report *Standards on the use of section 136* rightly argues that, where a police station must be used as a place of safety, the forensic medical examiner supporting the safe care of the detainee should ideally be section 12 approved and, in the longer term, forensic physicians should obtain approval under section 12 to ensure that this is common practice.¹³ Section 12 training and approval arrangements should, therefore, incorporate pathways that will allow forensic physicians to gain approval.

In our pilot visits to hospital-based places of safety, there were a number of cases where patients had been inadequately assessed before

being transferred or discharged from the place of safety. In most of these, detainees had been admitted to a ward on an informal basis, but without being seen by an AMHP. It is perhaps understandable that, having decided that the person’s mental disorder is of such a degree that inpatient admission is appropriate, and informal admission feasible, medical staff feel that it is in the patient’s best interest to be admitted to the inpatient ward adjacent to the place of safety. But by choosing not to involve an AMHP, they may be excluding wider consideration of the patient’s social circumstances and whether there are alternatives to being admitted as an inpatient.

In other cases, patients had been discharged back home without proper assessment. In one example, a patient was discharged home without being seen by either a doctor or AMHP when he “agreed to keep himself safe”. Such cases risk errors of judgment such as that described in the case of Mr S above, and it is surprising to find them in a hospital setting.

The limits of section 136

How police should respond when they encounter a mentally disordered person in need of ‘care or control’ in a private, rather than public, place has been the subject of discussion for many years. The 1983 Act requires that forcible or uninvited access to a private property under its powers may only be granted by a magistrate, following an application by an AMHP.* In the debates over the 2007 amending Bill, Parliament rejected an attempt to insert into the Act broader powers of entry to private property.

Police officers may enter or remain on private premises and, if necessary, search those premises, for the purpose of saving ‘life or limb’ or preventing serious damage to property under section 17 of the Police and Criminal Evidence Act 1984. The case of *Baker v CPS*¹⁴ confirmed

* Mental Health Act 1983, section 135(1): if the patient is liable to be retaken into custody (being already liable to be detained, or subject to CTO or guardianship), the warrant may be applied for under section 135(2) by a policeman or (more usually) any person authorised by the detaining authority.

that section 17 of PACE does cover protecting someone from themselves, as well as from someone else, where the officer believes that serious bodily injury is imminent. This could, therefore, be used to authorise police officers to remain on private property with a person whom they think is actively suicidal. However, this power of entry has no clear procedure for any subsequent action where the police involvement is solely one of preventing suicide, and no arrestable offence has been committed. Police could be left waiting for a civil assessment to be arranged at the person's home (including, presumably, waiting for an AMHP to obtain a warrant), and there would be no clear authority for them to remain on the property.

In practice, these situations are often resolved by police inviting (or indeed forcing) the person to accompany them outside onto public property and, once there, using section 136 to detain them. In 2008, the Mental Health Act Commission reported an audit in one London borough that showed 30% of uses of section 136 were recorded as having been made at or just outside the detainees' homes.¹⁵ Many of these purported uses of section 136 are probably unlawful, as demonstrated by *Seal v Chief Constable of South Wales Police*¹⁶, where it was deemed unlawful to have applied section 136 outside a private house, after the person had been removed from the property under arrest for breach of the peace. A key part of the reasoning was that the police could not be said to have 'found' their detainee in a public place when they had forcibly taken him there.¹⁷

However, in the more recent case of *McMillan v CPS*¹⁸, it was deemed lawful for an officer to physically escort a woman from a private garden to a public footpath and arrest her there for being drunk and disorderly. Legal experts differ over whether this case might be read across to

suggest that the use of section 136 in similar circumstances might be lawful.* It is probably relevant to note that, in the *McMillan* case, the officer had not escorted the woman onto a public highway with the intention of arresting her there, but that her behaviour once she was there warranted the arrest.

The case of Mr S, discussed above, had some similar issues. Mr S had telephoned the police pretending to be a third party and reported that he had attempted to hang himself. The police responded to the call and found him wandering in the street. They were accompanying him, with his ready agreement, to the house of a relative when they stopped off at his house to enable him to secure it. There they noticed a ligature of knotted ties, apparently in preparation for an act of self-suspension. Only then did they decide to use section 136 to take him to a place of safety. The coroner ruled that this use was unlawful, as the detention took place in Mr S's home. However, this may only have been because the police acted too quickly on their decision; had they started back on their journey accompanying Mr S to his relative's house, it is arguable that the technical breach of the law would have been avoided, as the officers would not have had to entice or force him out of his house.

We have, nonetheless, noted from police forms some examples of detentions under section 136 that appear to be inarguably unlawful:

"We were called to flat...as ambulance back-up due to Mr X self-harming. He stated to me that he was feeling depressed and lonely." The place of arrest stated by the police officer was the address, indicating that it was inside the flat.

"Mr Y lives in sheltered accommodation. When he is on his own and has no contact from his care worker...he calls 'help',

* The argument for a read-across is made by David Hewitt in "She took no reasoning': Enticing someone into a public place", *Journal of Mental Health Law* Spring 2009, 101-4). Richard Jones' *Mental Health Act Manual* disagrees with this analysis, suggesting that this "fails to take account of the wording of this section and the different context of mental health legislation, in particular, the option of applying for a warrant under section 135" (*Mental Health Act Manual*, Twelfth edition, p. 519).

'call me a taxi', 'call the police'. This is at all hours of the day or night, causing disruption and noise to neighbours." The place of arrest was stated as the block of flats. (Hospital staff say he was taken from his own flat. The patient is elderly and very infirm. He arrived at the place of safety in a wheelchair. He was well-known to services.)

A vital role of the multi-agency section 136 groups should be to monitor local section 136 detentions for such examples, both as a training issue for police, but also to consider how mental health services could provide practical support to police in the field and so avoid such misuse of legal power.

Police use of the Mental Capacity Act in preference to the Mental Health Act

It has been reported that some police forces have used powers of conveyance under section 5 of the Mental Capacity Act in preference to section 136 of the Mental Health Act to take a person appearing to be suffering from mental disorder to hospital.* The rationale for this is probably either to avoid the difficulties when a person is not in a place to which the public had access (as discussed above) or to avoid the obligations associated with delivering a detainee to hospital using section 136 (such as having to wait with the person during the assessment, or even having to take him or her back to police custody if access to a hospital-based place of safety is denied).

While a police officer may well have a legal power under section 5 of the Mental Capacity Act, this should not be used in preference to the powers specifically provided for this purpose under the Mental Health Act. This is partly a practical question: the Mental Capacity Act provides no readily available holding power once the person is delivered to a hospital, and as such, formal detention under section 2 of the Mental Health

Act could be precipitated without the assessment period of up to 72 hours allowed under section 135 or 136. This both puts a strain on NHS services, and potentially weakens the safeguards of the Mental Health Act over proper assessment prior to detention. Hospital authorities who have experience of police using the Mental Capacity Act to deliver patients to their care should inform us of this so that we can make further enquiries.

Assessments for detention under the Act

The role of approved mental health professionals

A number of professionals are now qualified or in training as approved mental health professionals (AMHPs). Before changes to the Mental Health Act in 2008, the equivalent role (approved social worker) was not open to other mental health professionals, but we have now encountered nursing staff and occupational therapists exercising the powers and undertaking the duties assigned to AMHPs under the Act.

The role of the AMHP requires considerable expertise and sound judgment. Their principal job is to coordinate assessments for possible detention under the Act, and to apply for a patient to be admitted to hospital under the Act's powers. But they also have other statutory roles, including submitting social circumstances reports after such admission, and their agreement is required to initiate or extend community treatment orders.

AMHPs are also frequently used as the 'second professional' needed to authorise the extension of detention in hospital under the Act. When doing so, the statutory paperwork requires the AMHP to state their profession. We have reminded AMHPs that it is not appropriate simply to state "AMHP" – the actual profession of the AMHP should be given.

* *Weightmans Mental Health Newsletter*, April 2010. www.weightmans.com. Section 5 of the Mental Capacity Act provides a general protection from liability when acting in the best interests of a mentally incapacitated person, and can extend to using reasonable force (such as that used to convey a person to a particular place), but it does not provide authority for deprivation of liberty.

Retaining medical applications for use after initial assessment

The Act allows for an application for admission under its powers to be made up to 14 days from the date of the last medical examination.¹⁹ We were concerned to discover a practice in one London borough of retaining medical recommendations for 14 days, even though the assessment had agreed to try an informal arrangement, which was to be used in case the service user did not comply. We believe that this may also be the case in some other authorities, and this raises a general issue of some importance.

In one case, a patient had agreed to work with the crisis team and it was established that the assessment was complete. She was not told that the team was keeping the medical recommendations in case she failed to cooperate, but this was discussed between professionals and they assumed it to be reasonable practice.

This raises a seemingly intractable problem. The Code of Practice does allow that “there may be cases where AMHPs conclude that they should delay making a final decision, in order to see whether a patient’s condition changes, or whether successful alternatives can be put in place in the interim”.²⁰ But it also requires that “having decided whether or not to make an application for detention, AMHPs should inform the patient, giving their reasons”.²¹

In the above situation, it appears that the latter requirement was not met, and it is difficult to justify such a departure from the Code’s principles of engagement with patients. On the other hand, if patients are told that the medical recommendations to enable an application are being held ready to use in case they fail to cooperate with whatever informal arrangements are made for their care, there is no true test of a patient’s willingness to consent to such arrangements during the two weeks that the immediate threat of detention hangs over them, and the validity of that consent must be in

question. Therefore, there are practical, as well as legal and ethical problems involved, whether or not the patient is informed of the situation fully.

In our view, the crucial determination is whether or not the assessment is complete. If it is, then the medical recommendations have no further use. If it is not, then they may be used in the 14 days following the last medical examination. If, in specific circumstances, it is judged appropriate to revisit a patient a few days after the initial assessment to check whether a community option is sufficient for that patient’s needs, this should be made explicit to all involved as a continuing assessment, and the various options should be discussed fully with the patient. AMHPs should be wary of acting on medical recommendations that were made before a change in the patient’s circumstances.

There is a great possibility that the therapeutic relationship between patients and professionals could be damaged by the practice of holding on to medical recommendations, to use if a voluntary arrangement breaks down. The following example of a breakdown in that relationship stemmed from a failure to communicate successfully the result of an assessment, but it illustrates the problem:

A detained patient said that she had not been informed at the time of admission that she was detained — she thought herself to be an informal patient after an assessment at the community team office. Whether or not the admitting AMHP or anyone else did tell the patient that she was detained, the patient herself now says that she has lost faith in her community team and is very angry and distressed about this. She has considered making a complaint. The Commissioner has suggested that a meeting with the people concerned might be helpful for both parties, especially as this patient will be discharged under the care of the community team who have been closely involved in her past care.
February 2010

The relationship between the Mental Health Act and Deprivation of Liberty Safeguards

The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) were introduced in April 2009 as a legal structure to provide the authority to deprive a person of their liberty other than by detaining them under the Mental Health Act.²² In November 2009, the Court of Protection handed down its first ruling interpreting the relation of the DoLS to the Mental Health Act's powers of detention.²³ The case centred on which statutory regime was appropriate to provide authority for the detention of GJ, a patient with dementia and physical disorders who was objecting to his placement in hospital.

The Court recognised and upheld what it called the "primacy" of the Mental Health Act in situations where patients met the criteria for detention under its powers and were objecting to treatment or admission. The DoLS regime was intended to fill a gap left between the Mental Health Act and common law, not to provide an alternative to detention under that Act.²⁴ The Court added that, where the Mental Health Act criteria were met, professionals "cannot pick and choose between the two statutory regimes ... having regard to general considerations (e.g. the preservation or promotion of a therapeutic relationship...) that they consider render one regime preferable to the other".*

Although it upheld the primacy of the Mental Health Act in situations where patients were objecting to treatment or admission and met the criteria for detention under that Act, the Court ruled that it had been correct to use the DoLS safeguards for GJ's deprivation of liberty. On GJ's behalf, it had been argued that, since he objected to his treatment, he was therefore

ineligible for DoLS but should have been made subject to Mental Health Act detention.** The complicating factor in this case – and indeed the principal reason that it came to court at all – was that GJ's care package involved physical treatment (diabetes management) and treatment (in the broadest sense of 'care') as a result of his dementia. The debate was therefore over whether his hospital placement was wholly or in part for the purposes of treatment of mental disorder. The Court agreed with the approach taken by the eligibility assessor (who was a doctor in old age psychiatry) and the AMHP who had decided to use DoLS, on the grounds that:

- a) Hospital treatment would have been unnecessary but for the requirement to manage GJ's diabetes (i.e. his dementia could have been managed without hospitalisation); and
- b) Management of diabetes was not itself treatment for mental disorder; so that
- c) The cause of GJ's deprivation of liberty was therefore treatment in hospital of a physical disorder, making the use of the MHA inappropriate. The authority should therefore be under DoLS.

This approach is likely to be relevant in many cases of deprivation of liberty.

CQC has been given a duty to monitor practice under the Mental Capacity Act Deprivation of Liberty Safeguards from 1 April 2009, and is required to report publicly the findings from this monitoring function. This function relates to the way the safeguards are being applied across health and social care, looking at the role of managing authorities (care homes and hospitals) and supervisory bodies (local councils and PCTs). We will be publishing our first annual report

* Judgment at para 45. In one case reported to us in December 2009, a hospital administrator complained to CQC that an AMHP had refused to admit a patient to hospital under MHA powers, arguing that DoLS could be used instead, and would avoid aftercare responsibilities under the Mental Health Act, section 117. The judgment under discussion underlines that this approach is "not lawful" (see judgment, para 59).

** A person is ineligible for DoLS authorisation of deprivation of liberty in a hospital wholly or partly for treatment of mental disorder (i.e. a 'mental health patient') if (1) they object to being admitted to hospital, or to some or all of the treatment for mental disorder that they will receive there; and (2) they meet the criteria for an application for admission under the Mental Health Act section 2 or section 3. See Mental Capacity Act 2005, schedule 1A, Part 1.

on the operation of the Deprivation of Liberty Safeguards over the winter of 2010/11.

The use of the Mental Health Act in acute hospitals

Mental Health Act Commissioners occasionally visit acute hospitals that have no dedicated psychiatric facilities, and CQC has issued guidance on the use of the Act in such hospitals.²⁵ Mental Health Act powers of detention and treatment are used in such hospitals for a small but significant number of patients.²⁶

We are aware of a broad variation of standards in the administration and use of the Act's powers in acute hospitals. The better examples are usually the result of service level agreements (SLAs) with a local mental health trust to undertake a range of functions, including the provision of hospital managers, scrutiny of detention papers, and training of staff. We are aware that some trusts have declined to sign up to such agreements to avoid incurring costs for the service delivered. The following is an extract from a Commissioner's report following an acute visit:

In March 2010, we revisited a large acute hospital where we had previously raised concerns over compliance with the Mental Health Act. We scrutinised the case records of patients detained over the previous year, looking specifically at the lawfulness of the detentions, the evidence that assessments of the patients' capacity and discussions on consent to medical treatment had taken place, and evidence that the requirements of providing information to the detained patients and their relatives had been met. It was clear that the Act was used rarely in the hospital, and we identified to the trust chief executive a number of systemic failings in relation to the above aspects of its use.

In his response, the chief executive acknowledged that the hospital's management of the Act was unsatisfactory.

He said that the Commissioner's visit had helped to clarify the areas where urgent action was needed and had expedited negotiations with a local mental health trust to secure their support and advice. He added that the trust was wholly committed to achieving immediate and sustained improvements and that the board of directors had approved an action plan which included the securing of specialist training, the recruitment of a specialist nurse, an improvement in the quality of record keeping, a review of the system of patient allocation to a named consultant and the development of a care pathway for patients with anorexia nervosa. The chief executive also said that the board would be monitoring progress and would report to the Commission in six months.

We will continue to monitor how local acute hospitals who detain patients are complying with the requirements of the Act.

Registration and the use of the Act in acute hospitals

The Health and Social Care Act regulations require providers of inpatient services to register with CQC where they carry out assessment or medical treatment of mental disorder (excepting any surgical procedures), where the patient concerned is detained in that hospital under any power of the Mental Health Act, other than the holding powers under sections 135 or 136.²⁷ Registration is therefore required if the general hospital itself detains patients, whether under section 5 holding powers or the more substantial detention powers of sections 2 or 3.

Specific registration is not required to provide assessment or treatment of mental disorder to patients who are detained by another authority, but admitted to the treating hospital under section 17 leave of absence, even if the detaining authority authorises that the patient remains in the custody of the treating hospital.²⁸

If a hospital does not have the correct registration, but nevertheless assesses or treats the mental disorder of someone who it has detained under the Mental Health Act, it will be in breach of its registration requirements. We will take a proportionate approach to this, accepting that unforeseen emergencies will arise and the absence of registration should not deprive people of access

to appropriate services. However, that approach does not extend to foreseeable or planned services outside of a provider's registration. Such a breach is an offence and the hospital will therefore potentially be liable for penalties.²⁹ It is also arguable that the patient concerned would be able to bring an action challenging the lawfulness of his or her detention and/or treatment.*

Detention and hospital admission: our recommendations for improvement

Children and adolescents

→ Providers of adult and CAMHS services

Services should be fully conversant with the national policy on placement of young people on adult wards, particularly the implications of the exceptional circumstances for 16-17 year olds, to ensure that young people are not placed in a worse position by not admitting them to inpatient care.

→ Providers of CAMHS services

Services should consider what more they can do to maintain the privacy, dignity and safety of young people and to ensure that they offer age-appropriate services that meet young people's needs.

→ Commissioners of CAMHS services

Ensure that there are sufficient inpatient CAMHS beds to meet the needs of local young people and that the quality of service is monitored, including appropriate liaison between CAMHS and adult services over the needs of young people.

Use of section 136

→ Providers of mental health services and police authorities

Implement the standards of the Royal College of Psychiatrists on the use of section 136, including the development of local multi-agency section 136 groups to monitor these detentions, identifying where improvements in inter-agency working are needed and developing solutions to address problems.

→ Police authorities

Introduce standardised data collection of the use of section 136.

* Although the Mental Health Act requires only that a detaining authority is a 'hospital', there could be an argument that any detention which itself involves unlawful conduct (i.e. amounts to an offence under the Health and Social Care Act) would fail the tests under Article 5 of the European Convention on Human Rights that the detention of persons of unsound mind should be 'lawful'.

Experience of detained patients



The Code of Practice requires that the Act should be operated with a view to promoting recovery by maximising the mental and physical wellbeing of patients and protecting them and others from harm, while keeping restrictions on liberty to a minimum. During our visits, we look at whether services strike an appropriate balance between the needs of security (which, in most cases, are to protect patients themselves from harm), and the need to provide a relatively normal, 'homely' environment for patients detained in hospital. In this section, we discuss some difficulties faced by services in achieving this, and highlight our concern at an increasing focus on physical security and risk-avoidance.

Bed occupancy

The majority of wards that we visited in 2009/10 were either over-occupied or running at full capacity (figure 10). This has been the same for many years, and as such, might be taken to represent the 'normal' working of mental health inpatient services. However, the Royal College of Psychiatrists continues to recommend bed occupancy levels of 85%.³⁰ Only 21% (101) of all acute wards that we visited could meet this.

It is clear that, on many wards, bed management is time-consuming for staff. This can lead to the least unwell patients being sent home (or refused re-admission) because of a lack of beds rather than on the basis of clinical need:

The Commissioner was very concerned to learn that the ward, which has 16 beds, currently has 24 patients allocated to it [with] ... eight patients on long-term leave from the ward. ... There appeared to be a correlation between the number of patients on extended leave and the dates that leave commenced, and the number and date of new admissions. This raises the concern that

Figure 10: Bed occupancy levels on visits to 486 acute wards by CQC, 2009/10

Occupancy band	Number of wards	Percentage band	
<= 90%	141	< 100%	42%
90%+ to <100	64		
Exactly 100%	142	= 100%	29%
100%+ to 105%	16	> 100%	29%
105%+ to 110%	28		
110%+ to 115%	26		
115%+ to 120%	17		
120%+ to 125%	17		
> 125%	35		
Total	486	100%	

Data source: CQC visiting data

leave may be being used to manage beds. The Commissioner was alarmed to learn that one of these patients was unable to return to the ward due to no bed being available. This is unsatisfactory and an indicator that the ward may be struggling to cope fully with the high number of patients allocated to it.

June 2009

As in the above case, over-occupation of wards is usually managed by giving patients leave to return home, although in some cases we find patients sent to other wards or units while on leave (sometimes involving expensive out-of-area placements), or even housed in temporary beds on the ward.

Many services need to take a more strategic approach to this problem. In particular, we endorse the Royal College of Psychiatrists’ recommendation that “different models of inpatient care, including assessment wards, the integration of crisis teams with wards and crisis houses, and other alternatives

to admission or facilitation of discharge must be evaluated thoroughly”.³¹

Staffing of inpatient wards

Over the last five years, there has been no significant change in the proportion of trained staff to untrained staff, or agency staff to permanent staff on duty when we visit. Figure 11 shows the detailed figures for 2009/10.³²

Again, this does not mean that wards have found their ‘natural’ or appropriate levels, as the following example shows:

Staffing emerged as an area of concern for nursing and medical staff. Short term sickness levels (which make forward planning difficult given the lack of notice) are high and the ward manager said that this caused significant difficulty in finding sufficient staff of the right skill level. The

Figure 11: Number and percentage of agency staff and trained staff on wards visited by CQC Mental Health Act Commissioners, 2009/10

	Agency staff		Trained staff	
	no of wards	% of wards	no of wards	% of wards
≤ 10%	1,557	86.3	16	0.9
10%+ to 20%	113	6.3	112	6.2
20%+ to 30%	52	2.9	199	11.0
30%+ to 40%	47	2.6	484	26.8
40%+ to 50%	26	1.4	501	27.8
50%+ to 60%	2	0.1	182	10.0
60%+ to 70%	5	0.3	139	7.7
70%+ to 80%	3	0.2	123	6.8
80%+ to 90%	-	-	11	0.6
90%+ to 100%	-	-	38	2.1
Total in year	1,805	100	1,805	100

Data source: CQC

Commissioner was told that on some shifts, for example, there is only one qualified member of staff on duty. Several staff said that establishment levels for nursing staff needed reviewing. The reason given was that intensive community-based care now supports people so well that those admitted have higher support needs. The ward manager was, however, of the opinion that staffing levels were adequate and that staff absences were the critical factor.

The above circumstances are also affecting staff morale and concern was voiced about the difficulty of finding time to spend with patients. The Commissioner's observations support the view of an extremely busy staff group managing a number of competing demands and primarily occupied on tasks in the ward office.

June 2009

In some cases, the problem appears to be simply that not enough members of staff of any sort are available on a shift:

The unit functions with two staff per shift. It is unlikely that this will enable coverage of the day care interviews etc and therapeutic involvement with the residential patients. Staff taking a break will leave just one member of staff on duty in an acute setting. Staff were demoralised by the paperwork and ill equipped to carry out OT and other activities such as cognitive behavioural therapy etc. This was reflected in the poor quality of compliance in the files and in the low level of staff/patient interaction.

Much more must be done to enable this unit to function at a higher level. A decision must be made about the future development of this unit. CQC is sufficiently concerned to require a detailed action plan for the improvement of the delivery of patient care by the target date.

March 2010

However, we have seen positive and imaginative approaches in some units to using the skills of all members of staff, and ensuring that skills are kept up to date:

All staff are encouraged to access a range of NVQ qualifications. This includes kitchen staff and the handy man (who is now the health and safety lead). The manager has seen a growth in staff confidence as a result, with full participation in sessions and requests for additional training. This is empowering staff to contribute to service developments as well as their individual continuous professional development.

A student nurse has produced *An Introduction to Pharmacology* for all staff. This will take the form of a short summarised PowerPoint presentation, and a booklet detailing medication and side effects will be available in the clinic area and elsewhere to support all staff in recognition of medication side effects. Once this is completed, annual drug competency tests will be implemented for registered staff.

August 2009

Following our visits, we often feed back our observations to the provider about the level of interaction between staff and patients. In many cases, we recognise the pressures on staff in terms of resources and the knock-on effect on morale. Nevertheless, the result can be a lack of therapeutic engagement with patients, and often unnecessarily restrictive conditions of detention for patients. In the following example, the problem seemed to be one of training and motivation for staff:

The Commissioner was disappointed to observe that, despite this issue having been raised many times over the years, most recently following her last visit, staff still spent most of their time in the ward office. At no time during her frequent visits throughout the day to the patients'

day room did the Commissioner see any staff spending time with patients. Patients themselves commented upon the lack of staff engagement, saying that they themselves invariably had to initiate contact just to talk.

The Commissioner was puzzled when, during the early evening, she saw a member of staff spending nearly all her time in the office doing nothing in particular or using her mobile phone. When asked what she was meant to be doing she replied that she had simply been told to do 15-minute checks on a patient, which she regularly went off to do, returning immediately to the office where she remained until the next check. The Commissioner wonders whether this example is symptomatic of how staff are deployed and of the attitudes of some staff.
July 2009

After this visit, we asked the provider for an action plan to address the issues raised, and suggested that ward managers and other staff may find the *Talkwell* initiative useful. This is a conversation training resource for mental health workers produced by Star Wards, which is designed to help promote general communication and engagement between staff and patients.³³

Some patients also complain that they do not get enough access to their responsible clinicians, or indeed to any clinician, except in ward rounds:

A patient expressed concern that she had not had 1:1 time with the consultant in charge of her care since she had been detained, even though this had been requested repeatedly. The patient in question had been detained for over a month at the time of the Commission's visit.
March 2010

Such examples raise concerns over clinicians' practice over consent to treatment, as it is the personal responsibility of the clinician in charge of a patient's treatment to check whether they

“ We are still dealing with staff shortages and this has impacted on the availability of staff to do more therapeutic work with patients. Also there is far too much time taken up with staff in the office dealing with paperwork. ”

SURP member

can and do consent to it (see “The reality of consent” on page 79). On an even more basic level, patients who have been forcibly detained in hospital should have the opportunity to talk in private with the doctor in charge of that treatment on admission, or shortly after. Hospitals that do not facilitate this, especially after patients specifically request it, provide a very negative message about how patients can expect to be involved and listened to in respect of their ongoing treatment, and how the hospital values them as individuals.

We have also raised with providers particular issues about the impact of staffing capacity and skill mix on the provision of therapeutic activities. In the following example, ward-based activities appeared to decline dramatically with the loss of one of two occupational therapy posts. Ward staff were left to arrange activities for patients on days when there were no occupational therapy staff on the ward (which included all weekends) but, because of the pressures on them, the activities they provided for patients seemed very limited:

When I first visited this ward, in August 2007, I was impressed by the range of activities that patients were involved in. On that occasion, I saw patients engaged in baking (using the ward kitchen), active reminiscence (prompted by and attended by staff), and engaged in craftwork. Patients also spoke to me of engaging in activities in the local community, supported by staff. The nurse in charge told me, with some pride, that the television was available in the day

room but this would only be switched on if a patient actively requested this and the unit's aim was to make sure that there were more interesting activities for patients to involve themselves in. On my visit today, there was a stark contrast. On the day of my visit (a Friday), there were no activities being undertaken by patients, who were sitting in chairs around a television, or who were wandering the ward by themselves. The television was on, but nobody was actively engaged in watching it. Detained patients complained to me about the lack of activities on offer for them.

March 2010

While there is clearly scope for occupational therapy staff to take the leading role in developing structured, meaningful activities on inpatient wards, it is not acceptable that hospitals should rely solely on such staff to deliver them. All nursing and care staff should share in the responsibility to keep patients engaged. The following provides a positive example of measures taken by a hospital to improve engagement and activity with patients.

Occupational therapy continues to run a trust-wide three-day training workshop for ward staff on ways and reasons for providing social and therapeutic activity. We have established the 'meaningful day' project, which we have set up to look specifically at improving the range and the opportunity of therapeutic and leisure activities within the inpatient areas. The group incorporates nursing, therapy, and psychology staff and a service user representative. Its remit is to review facilities and equipment, look at the range of organised activities and therapies and promote staff involvement. The occupational therapists, who are our ward programme coordinators, have established some consistent groups on the ward. The physical activity coordinator now visits the ward two days a week to provide physical

activity, for example, badminton. We now have a volunteer recruited to help out with recreational activities one day per week.

We have recently allocated a small budget and are purchasing items that can be used for patients on the ward: for example, various sports equipment including mats and an exercise bike, Nintendo Wii, craft kits, gardening equipment and cosmetic items, books and DVDs. As a way of increasing the profile of activities as being a core business of the ward, we are looking for each ward to have a nurse designated as lead for activity. We are also seeking to include activities within a patient's care plan, discussed in the 1:1 sessions with an allocated nurse.

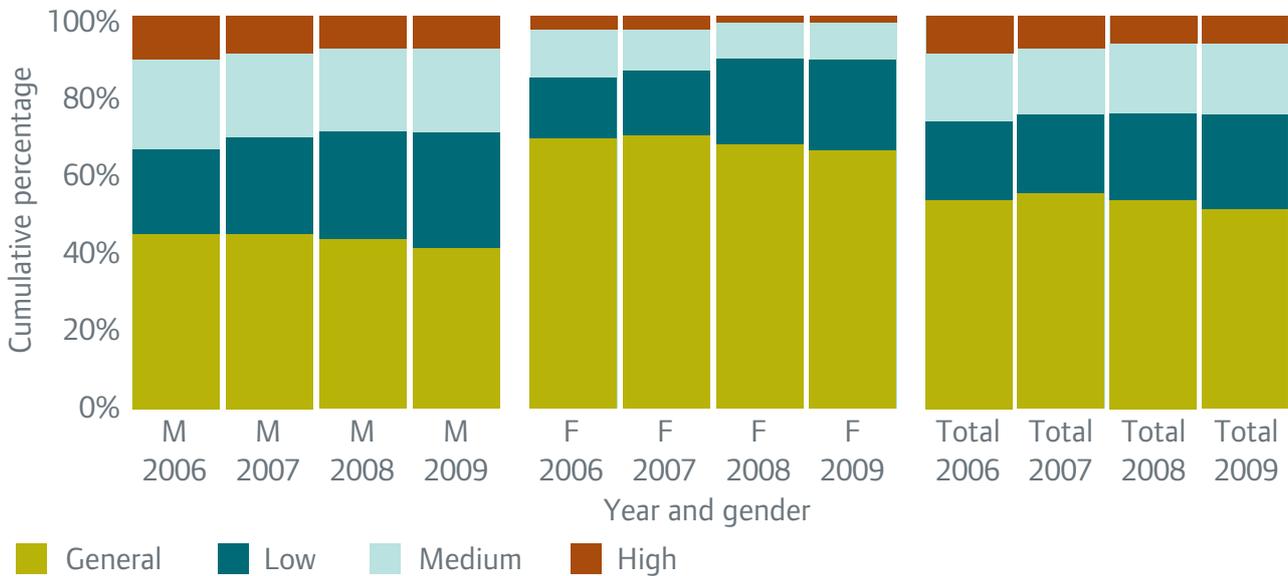
From a hospital's formal response to a CQC visit in September 2009

The rise of secure services

It is perhaps to be expected that institutional rules will often be at the centre of patients' concerns when we visit medium secure or high security hospitals. However, many Mental Health Act Commissioners, and patients who first experienced hospital many years ago, tell us that hospital life has become much more focused on rules, and with a greater emphasis on security, even outside the secure sector. In part, this is shown by the rise in the proportion of locked acute wards that Commissioners have encountered year-on-year³⁴, and which continues today. Three-quarters of acute wards visited over the year were locked.

Many locked wards have no official designation as secure units, and will provide care to informal patients as well as those detained under the Act. This is the case, for example, with almost all acute admission wards. We frequently raise concerns that informal patients in such facilities are at risk of 'de facto' detention – in other words, deprivation of liberty without legal authority. Deprivation of Liberty Safeguards are rarely used in hospital environments.³⁵ The following example

Figure 12: Ward security level of patients detained under the Mental Health Act on 31 March, by gender, 2006 to 2009*



Data source: Count Me In

is from a visit to an independent specialist acute unit. No patients were subject to the Deprivation of Liberty Safeguards at the time of the visit.

The unit currently has 15 patients. Eight of these are detained under section 3 and one under section 37/41. The remaining six patients are informal. The unit is locked. There is a notice informing informal patients that if they wish to leave they should talk to staff. Bedroom doors are alarmed and patients are not allowed to wander freely around the unit at night. Daytime activities are structured and patients are required to stay with their group.

January 2010

The increase in locked acute wards may partly be a consequence of patients being more severely ill at the point of admission (see page 20). However, it is also possible that it marks a cultural shift towards more defensive practices and an aversion to risk, as discussed in past MHAC reports.³⁶ It is certainly the case that the psychiatric sector has also seen

an increase in the amount of low secure provision in recent years. Figure 12 shows the security levels of patients who were detained at the time of the Count Me In censuses in 2006 to 2009. This shows clearly how the proportion of people in low secure beds increased over that time, both for men and, more markedly, women. Some of these patients will have been transferred from higher levels of security, as they move towards rehabilitation and eventual discharge. But the data also indicates a reduction in the proportion of patients detained in ‘general’ units that have no specific security designation.

Services designated as low secure can have very different approaches to security, and consequently they provide very different patient experiences. In February 2010, we visited two low secure units that were geographically close to each other but managed by different independent providers:

- The patients’ forum in the first hospital complained that it was no longer as ‘homely’ as it once had been, and that this had come about with a change of ownership. In

* Excluding holding powers (i.e. sections 5(2), 5(4), 135, 136) and non-detention powers (i.e. sections 25A, 17A, and guardianship under section 7 or section 37).

“ I came from a Special [high security] Hospital. The regime there, especially on block wards, was at times excessive and extreme, but on a villa ward (rehab), and being a hospital trustee, it was very relaxed. Coming here [to a] medium secure unit, rules are pretty rigid. ”

GJ, SURP member

particular, patients disliked the obtrusive physical security – high fences around all the units and entrance ‘airlocks’ to each unit – and they especially objected to being escorted at all times on the site. We were told that the fences had been built to conform with service commissioners’ expectations of what a low secure unit should be like, and had been influenced by objections that residents of the nearby village had to a planned perimeter fence. The escorting arrangements had been introduced during building work but had yet to be withdrawn. Several patients who had moved to the unit as part of their care pathway to rehabilitation said that they felt they had gone backwards, or not advanced in relation to security measures imposed upon them. Although the unit was designated as a low secure unit, it had ‘slipped into’ medium secure practices in the judgment of the visiting Mental Health Act Commissioner.

- The second hospital, although also designated as a low secure unit, had a very different approach to security. It was at the end of a residential road, the gates were wide open and the fences only six feet high. There were no fences or gates between units. The ward doors were locked, but opened with buzzers, the airlocks were unobtrusive and the staff did not carry bunches of ‘prison warden’ style keys. Patients regularly went out to community facilities, such as the swimming pool, the gym,

shops and the pub. While some patients at the first hospital also took part in similar trips, at the second hospital this seemed much more a part of patients’ everyday lives.

These differences are a concern because over-restrictive security measures for placements that are deemed to be rehabilitative may slow down clinical progress or even undo the work that patients and staff have undertaken in previous settings. Commissioners of services – and government – must ensure that an over-emphasis on physical security does not distort clinical priorities in the services that they pay for.

A number of patients commented on the high level of restriction they face. The unit does at times feel quite restrictive. Many had been in the unit several months and still only had leave in line of sight in the grounds. They felt they were making very slow progress and many felt they had more freedom in medium secure units than they have at this unit. The patients were not allowed out in the snow. Whilst for some this may have been a problem because of physical frailty, for others it would have been an opportunity for a different outdoor experience. Similarly patients expressed an interest in walking and swimming as programmed activities, which some had experience of in other units.

March 2010 (low secure unit)

In the following example, ‘house rules’ in one independent sector low secure unit appeared to restrict the discretion of responsible clinicians to exercise their powers under the Act to grant leave to detained patients, which we consider to be potentially unlawful:

It was reported that although ward A is now a rehabilitation ward it is covered by the same policies as unit B in relation to the use of section 17 leave. This would seem to be contrary to the principle of least restriction as unit B is a medium secure unit.

One patient reported that the Tribunal had recommended that she has visits home including overnight stays. The patient has been informed that the independent service provider has no policy to cover overnight leave or unescorted home leave. Another patient reported that there is a hospital policy which states that no patient may be considered for escorted section 17 leave until they have had 12 weeks' unescorted leave in the fenced garden.

The Act is clear that the decision to grant leave is the sole responsibility of the responsible clinician. The Care Quality Commission takes the view that the responsible clinician cannot be prevented from considering the use of overnight leave, for one or indeed many nights, because there is no hospital policy allowing this. Similarly s/he cannot be prohibited from granting escorted leave before a patient has had 12 weeks' garden 'leave'.

June 2009 (women's unit)

Privacy and dignity

In some cases, rules or practices that are apparently justified as blanket measures on the grounds of safety or security appear difficult to justify when applied to all the residents of any particular unit. As such, they risk infringing human rights law, either because they could not be considered to be a proportionate breach of rights to privacy and integrity of person (European Convention on Human Rights, Article 8) or because lack of necessity may open a way to a challenge that the resulting treatment is inhuman or degrading (ECHR, Article 3):

CQC recognises that it is often challenging to manage patients who are at risk of serious self injury while respecting their privacy and dignity. However, it was not acceptable to learn, from all the patients seen during the visit, that their access to toilet paper is severely restricted. They reported that they have to ask staff for paper and are given anything between two and six sheets depending on which staff member they ask. Those patients at most risk of swallowing paper have to request sheets after they have used the lavatory.

It was of concern to learn that patients who have no history of harming by swallowing are subject to similar rules, but are able to access a limited number of sheets before using the lavatory. On the day of the visit, a patient reported that she had used her pants to clean herself (and had then flushed them away), as staff were not available to give her paper when she needed it. This was confirmed in her nursing notes, which revealed that the health care worker had gone to seek permission before giving her paper. Staff confirmed that patients do have to request lavatory paper but the nurse in charge was surprised to learn that this was the case for all patients.

Please ensure that there are clear care plans in place for all patients who are required to request toilet paper. These should be written with due regard to the patient's privacy and dignity, show consideration of the guiding principles including least restriction, respect and participation and:

- show the risk assessment upon which the care plan is based,
- describe the way in which it is to be implemented so staff do not need to leave a patient waiting while they seek permission to give toilet paper,
- be regularly reviewed.

“ In my time in hospital, there were many occasions where the whole ward suffered due to the activities of one or two patients, such as bringing drugs and misusing mobile phones on the ward. As a result, security was tightened for every patient on the ward. Collective punishment is demoralising. ”

Bal, SURP member

Care plans should also be written for individual patients in relation to the refusal to allow shoe laces even to patients with no record of self ligating, as it is patient belief that this is a blanket policy which impacts adversely on their dignity.

October 2009

The Code of Practice clearly sets out that privacy and safety are important parts of the therapeutic regime, and that staff should make conscious efforts to respect the privacy of patients, while maintaining safety.³⁷ In some ward regimes, the focus on safety and security can appear to override awareness of patients’ need for some privacy and dignity:

All patients who spoke with the Commissioner felt that their privacy was often compromised by staff during checks of their bedroom. Patients described incidents where staff very rarely knocked before entering their bedroom. Some patients said there were occasions when they were naked or involved in intimate acts, and had the staff first knocked the door, their privacy and dignity would have been respected. Some patients felt that the night checks which involved shining a light on them was of particular concern.

September 2009

We have seen a number of situations where a disregard for privacy and dignity strays into unsafe or potentially abusive practice. For example, in one hospital in April 2009, the obscuring mechanisms for the glass panels on bedroom doors, which could only be operated from the corridor, were locked in the open position. As both male and female rooms led off this corridor, this was an unacceptable compromise of patient privacy and we asked the trust to look at options for giving patients greater privacy in their bedrooms (and protection from potential harassment) through the technology already in place.

We have also found male nurses being inappropriately assigned to female patients in certain circumstances. We visited a hospital in January 2010 and found that a male member of staff had been assigned to the highest level observation (close continuous supportive engagement – within arm’s length) “to preserve the dignity” of a female patient who, being highly disturbed, was constantly attempting to remove her own clothing. This was a serious breach of the hospital’s own policy that observation should be sensitive to issues of gender. A female patient on 1:1 observation informed us, on a hospital visit in November 2009, that male nurses were involved during night time observation, bathing and toileting. We reported this as a serious concern for the dignity and safety of vulnerable patients and asked for it to be stopped. We have received similar complaints from female patients who have felt uncomfortable being observed by male staff when in seclusion and have asked the service to consider the impact of the gender of staff in this situation.

Blanket measures banning things such as mobile telephones could, in some circumstances, amount to an unwarranted infringement of patients’ ECHR Article 8 rights to a family and private life. The Code of Practice is now clear that it is unlikely to be appropriate to impose a blanket ban on mobile phones, except in units that are specifically designed to provide enhanced security levels for public protection.³⁸

The unit does not allow mobile phones and operates a blanket ban on their use. The revised Code of Practice provides guidance on the issues to be borne in mind on the use of mobile phones (paragraph 16.6). The initial decision was made some years ago due to the abuse of the camera function by a small number of patients. The Commission accepts the restrictions on the secure wards, but suggests on ward X that the use of mobiles is considered by individual risk assessment rather than a blanket ban in the spirit of the least restrictive principle. The Code states that the policy should be reviewed regularly and updated, where necessary, in the light of experience. It was accepted that the policy had not been reviewed for some time.

July 2009

Many patients feel similarly about the internet. The Code of Practice suggests that managers should produce guidance on patients' access to internet and email facilities by means of the hospital's IT infrastructure, including access to such facilities and rules prohibiting access to illegal or inappropriate material.³⁹ Where patients have their own means of access (often through mobile technology), this should be prevented only in circumstances similar to that which justifies restrictions on using mobile phones.

To maintain a therapeutic environment, it is important that hospital managers should not be seen to be petty in enforcing rules, or inflexible when faced with minor obstacles to meeting patients' requests:

The ward uses the cook-chill arrangements common to units across the trust. The Commissioner was told that patients were unhappy at having to eat two hot meals a day and made a written request to be allowed to prepare their own sandwiches and snacks at lunch time. Ward staff were supportive of this idea as being useful to patient rehabilitation but this request was

turned down on the basis that staff did not have the required training.

It is recommended that the trust reconsiders this decision and puts in place plans to enable patients to be more involved in the production of their meals.

July 2009

Smoking restrictions in hospitals

Since July 2008, the legal ban on smoking within enclosed public spaces has extended to psychiatric hospitals.⁴⁰ In this reporting period, a majority ruling in the Court of Appeal rejected a legal challenge to the ban.⁴¹ The majority view of the Court was that health and security

“ Rules are often unnecessary, they are nearly always over-restrictive, and they are nearly always enforced pettily and with little or no flexibility...the letter of the rules is sometimes enforced, when it would be more appropriate to enforce the spirit!! I think that it should be easier for smokers to smoke, that there should be less paranoia around the use of mobile phones, and that there should be less paranoia around use of the internet – in fact, I think that hospitals should provide ample internet access (supervised by a care assistant if this is deemed really necessary)... there should be a senior member of staff on duty whose job it is to adjudicate on “letter” versus “spirit” and “common sense” matters.... ”

Martin Camden, SURP member

considerations justified the smoking ban as implemented at Rampton Hospital, even though the security considerations of that hospital prevented patients from smoking in the grounds as well as indoors. The Court rejected the claim that this breached ECHR Article 8, in part because the hospital was a public institution operating as a hospital, and not simply the patients' home, and in part because (with Lord Justice Keene dissenting) their Lordships decided that the smoking ban was a justified breach of personal autonomy, and that there was no basis for distinguishing the loss of freedom in such an institution to choose what to eat or drink and the ban on smoking.

Publications in the psychiatric sector have largely given positive accounts of the implementation of smoking restrictions in hospital. In one recent account of a 'smoke-free' policy within a medium secure unit (which placed smoking "on a par with the use of alcohol or illegal drugs" within the unit, and preventing any detained patient without leave from the unit from smoking tobacco at all), it was stated that:

The impact on clinical incidents was less than expected: in the first month, only two patients were involved in verbal aggression directly attributed to nicotine withdrawal, there was no significant change in rates of overall aggression or tranquilliser use and no tobacco-related aggression was reported.⁴²

However, in relation to the more general effects of the policy:

Unsurprisingly, there has been a trade in nicotine replacement therapy (particularly lozenges) and a few incidents of illicit use or possession...it is disappointing that our anecdotal observations indicate a resumption of binge-type smoking during unescorted leave and heavy consumption among patients reviewed after discharge.⁴³

On our visits to hospitals, and in particular during our private meetings with patients, smoking restrictions are frequently raised as an issue. In one hospital in September 2009, a patient who had been brought in to the hospital's place of safety under section 136 had been escorted by police to the boundary of the hospital so that she could smoke. The police told us that there were significant risks due to the lack of access to a place for such patients to smoke. The following report is from a forensic unit:

The smoking ban is causing much distress on this ward as most patients continue to choose to smoke. Those who have leave are using it solely to smoke (verified by staff) and those who don't are intent on smuggling in cigarettes, creating a fire risk. I heard on this ward, as I have on others in this trust, that one cigarette is selling for £10! Many of these women are coming from prison or other trusts where smoking is permitted; they have no intention of giving up smoking. Staff and patients are very concerned about the risk of fire.

September 2009

Following our visit, we requested (as we had on previous occasions) that the decision to impose a total ban on this site be reviewed and consideration given to limited access to the garden areas for smoking. The smoking ban was reviewed by the trust's board and subsequently relaxed in some parts of the hospital grounds, and some smoking shelters were built. In February 2010, however, smoking continued to be a major concern of patients and staff:

The continuing smoking ban was reported as impairing the relationship between staff and patients. The ward patient representative reported a general feeling of lack of trust of the staff and an increased propensity on the part of patients to lie since the ban has been implemented. It is clear that cigarettes and lighters are the new contraband and examples were given

of £10 and £20 per cigarette being paid by patients. Nursing time is being taken up with searches and staff stated that there are many confrontations about illicit cigarettes and lighters that serve to impair the therapeutic relationship. Recently there has been a bedroom fire involving a smoker who had a lighter in his possession - he had a history of fire setting and this incident only serves to heighten concern about how these incidents may be on the increase. There is a fear that certain staff may be bringing in cigarettes and lighters for patients and this is currently under investigation.

The relaxation of the absolute ban on smoking in the grounds ... has benefit to patients with escorted ground leave. There was only one patient on this ward in that position. For others, there is no change to the absolute ban and complaints were made from every patient spoken to. Please comment on plans to allow smoking in part of the garden at designated times in future.
February 2010

In other units, where smoking outside is allowed on hospital property, we have come across rules that appear well-meaning (presumably as a preventive health measure), but which appear to patients – and indeed to Mental Health Act Commissioners – to be unnecessary for the management of the unit, and therefore overly paternalistic:

Patients felt that, in particular, the smoking rule of being able to go out for a cigarette every hour was unnecessary and upsetting, as the door is often left open for access to the garden, but they could not smoke until the “magic hour”. Several patients were particularly distressed and verbally complained to staff.

The Commissioners acknowledge that the smoking rule is particularly difficult to manage and that this has been instigated in the interests of patients. They were pleased to note every effort had been made to introduce a smoking cessation programme and that a staff member on the ward has volunteered to undertake training on this topic to encourage patients to stop smoking. It was also encouraging to see information regarding this service on the notice board. However, CQC would be pleased to hear of any possible flexibility with the one hour rule and also of what steps can be taken to ensure the greater participation of patients.

March 2010

Many detained patients are heavy smokers, and should be encouraged to stop smoking and helped if they choose to do so. However, many patients see the removal of their opportunity to smoke when or if they want to as just another way of their detaining authority restricting their autonomy and, furthermore, doing so without justification relating to their treatment for mental disorder.

We are pleased to report that many staff who work with patients on a day-to-day basis seem to appreciate and empathise with this, and are sensitive to detained patients' need to hold on to what personal autonomy they can, even though institutional rules sometimes prevent them from acting on such empathy.

Experience of detained patients: our recommendations for improvement

Bed occupancy and staff

→ Commissioners of inpatient mental health services

Ensure that commissioning and provider bodies take a strategic approach to reviewing and addressing problems of over-occupancy, the numbers of staff and their skill mix.

Security levels

→ Commissioners and providers of low secure inpatient services

Review how national policy on standards in low secure settings and the Code of Practice principle of least restriction are being applied.

Participation and protection of rights



Patients should be involved as far as is practicable in developing and reviewing their own treatment and care. This is the ‘participation’ principle, one of a number that were introduced into the Mental Health Act Code of Practice in 2008. The Code also encourages services to involve carers, family members and other people who have an interest in the patient’s welfare and to take their views seriously.

Making sure that care is centred on people’s needs and that it protects their rights is one of CQC’s five strategic priorities. Our monitoring of the operation of the Mental Health Act is a key way that we can make a difference to protecting people’s rights and ensuring that they receive the care and treatment to which they are entitled.

Also, under the new registration system that came into force in 2010 for the NHS, independent health care and adult social care, providers have a statutory duty to respect and involve all people who use services. We will continually monitor how well people are involved both in planning their own care and decisions about their treatment and in having a say about how services are run.

“ Hospital wards are generally getting better because there is now more input from patients regarding their lives in hospital, for example, through patient representatives and forums. ”

Bal, SURP member

Patient involvement

The Mental Health Act is a legal framework that provides authority for coercive psychiatric treatment, together with safeguards over how that authority is exercised. The guiding principles behind the Act reflect the ethical basis of this coercion – it is not only about maintaining the safety of patients and others, but also aimed at restoring a person’s autonomy through ‘recovery’. The recovery model means that patients should be enabled to actively build a meaningful life for themselves, whether or not they continue to experience poor mental health.⁴⁴

The restrictions imposed upon a patient’s liberty to achieve this should be kept to a minimum. The powers of the Act should be exercised with respect for the patient’s wishes and feelings, and the patient (and where appropriate carers or families) should be given the opportunity to be involved in planning, developing and reviewing their own treatment.⁴⁵ These principles are reinforced by the section 20 regulations of the Health and Social Care Act 2008, which set out the essential standards of quality and safety that providers across the care sector must meet.⁴⁶

Even though legal detention is the intervention most commonly identified with coercion, it may be that the degree of coercion perceived by patients is as much related to their own personal experience as to the intervention itself. A recent literature review concluded that patients who have experience of staff listening to their views feel less coerced, even if involved in legally mandated treatment. On the other hand, “loss of a voice, disrespect by professional staff and violation of integrity lead to feelings of coercion”.⁴⁷

In our visits, we see some excellent examples of care planning and patient involvement. As the following visit report shows, it is not even necessary for patients to agree with the views of the clinical team, or to give consent to treatment, for this to be beneficial:

“ Service users are rarely given choices, and the choices that are made for them are rarely explained well enough!! Service users have to be very assertive to elicit information about other options. ”

Martin Camden, SURP member

As the Commissioner interviewed eight of the detained patients, she was able to verify with the patients their understanding of their legal status; the medication prescribed for them and its effects and side effects; what leave they were authorised and how frequently they received it; and their participation in CPA/117 meetings and clinical team meetings. The Commissioner was pleased to note that the patients were well informed in all aspects of these matters. They all confirmed that they felt confident about asking nursing or medical staff if they needed further explanation about any aspects of their care and treatment. Whilst some of them might not agree with the decisions of the clinical team, they did feel they could voice their concerns. All said that explanations were given to them about their care and treatment plans.

July 2009

We have seen many services attempt, with varying degrees of success, to provide patients with opportunities to take part in decision-making about how services are run. Although there are good examples, the following is perhaps more instructive:

The Commission was pleased to be invited to join the community meeting. However, it was evident that staff needed further training in developing the skills required to facilitate effective participation. It was disappointing

to see that, while the patients continued to have strong views on the changes to the arrangements around mobile phones and visiting, they felt neither able nor willing to raise this in the meeting. The Mental Health Act Commissioner asked one nurse for a rationale for the mobile phone arrangements and was told “it is what the bosses want”. Such a response does not encourage patients to place value on a discussion with ward staff as a way of participating in the management of their care.

March 2010

We have also seen some examples where changes are being implemented that have a direct effect on patients, but in which they have had no say. This approach fails to meet the expectation of the Code, or to treat patients with due regard as individuals:

It was evident that, for both patients and staff, the move to the ward C is full of uncertainty and anxiety. For patients this is focused on a change in ward rules, especially the restricted times they are allowed to access their rooms, and loss of choice or relative freedom. With the move only two days away, there still had been no opportunity for the patients to visit the ward and so much of their concerns were speculative. Indeed, staff had only just had the opportunity to visit themselves.

Although this will be very much after the event has happened, CQC would draw your attention to the Code of Practice principles, and specifically the participation principle. Given that this move will have been planned for some time, why was no provision made for the patients to visit ward C in time for them to adjust to the move, from a more fully informed perspective?

June 2009, high security hospital

Choice and participation in care planning

Patients should participate in drawing up and reviewing their care plans as much as possible, if such care is to result in rebuilding their autonomy and helping their recovery. Patients can sometimes struggle to retain and recall information relating to care plans, or may need support for other reasons to enable them to participate. To help them with this, anyone who is subject to Mental Health Act powers of detention, or has recently been subject to such detention, or is subject to guardianship or a community treatment order, is eligible for support under the revised Care Programme Approach (CPA), and is entitled to the following:

- Support from a CPA care coordinator.
- A comprehensive multi-disciplinary and multi-agency assessment, covering the full range of needs and risks.
- A comprehensive formal written care plan, including a risk and safety/contingency/crisis plan.
- Ongoing review, (that is, a formal, multi-disciplinary, multi-agency review at least once a year, but likely to be needed more regularly).
- Increased advocacy support.

Carers are also entitled to their own needs assessment.⁴⁸

A good care plan would include assessment of daily living and motivation; occupational, vocational and educational needs; social networks; physical and mental health assessments; medication; risk assessment and management; and a discharge pathway and contingency plans for dealing with crises, whether in hospital or post-discharge. The plan should record the patient's views on these matters, and their goals.

It can be useful to encourage patients to use a diary to record their thoughts and feelings

about their progress, treatment and care. When patients take leave of absence from hospital, their feelings of how this went should be discussed and recorded in the care plan. The care plan must also be written in language that patients can understand, avoiding jargon and unexplained acronyms. A properly managed process of care planning and review should enable patients to have a realistic view of how clinical staff think their treatment is progressing, to avoid being surprised or disappointed by any formal assessments or reports that may be produced in the course of the detention.

Detained patients should be periodically reminded of their care plan, and regular checks and reviews should keep them engaged. They should be given a copy of their plan. The following is a description by a member of the service user reference panel (SURP) of how he feels this is achieved in his own hospital:

The hospital pioneered a process called 'CPA standards'. The theme was that the CPA meeting is the patient's meeting and their standards are ideas that the patient can use to make the CPA meeting more about them and their involvement. I personally chose to actually 'chair' my own CPA. It really boosted my confidence and I felt extremely involved, inviting which discipline to present reports, in which order, etc. Within the CPA document, my social worker included my own 'personal statement' and my own 'personal goals'. My parents sat in on all my CPAs, and had chance to listen and ask questions. All in all, I felt everyone was in the picture... my parents were very proud of me. A summary of the standards (shortened versions) follows; some of these are very empowering.

1. The patient should not be excluded from any part of a CPA meeting.
2. Choice of room for meeting, where possible.

3. Invitation to be sent out in patient's name.
4. Cancellations to be done in collaboration with patient and carers.
5. Discussion and agreement on agenda for the meeting.
6. Patient to be informed of the advocacy process.
7. Reports presented 48 hours minimum before the meeting.
8. Opportunity to attend ward round immediately prior to CPA to discuss any issues that may arise.
9. Opportunity to present, verbally or in writing, from my own perspective.
10. Patient can chair meeting, if agreed.
11. Meet people over tea or coffee prior to meeting.
12. Choice over how meeting will begin.
13. Report writers to attend.
14. Action plan at end of meeting.
15. Patient to receive final drafts of report.
16. People reading or summarizing reports should talk to the patient directly to ensure a personalised experience.
17. No jargon.
18. Patient and carers offered paper and pens at meeting, to take their own notes.
19. Respectful of others' rules.

We are encouraged by this account of the degree to which patients can be fully involved in discussions about their care and progress. However, in some hospitals, we get a very different account of patient involvement:

Patient 1 informed me that she had ceased to attend her CPA meetings as she felt patronised and not listened to. Patient 3 was angry that she was told to attend her CPA an hour later than its start time, she

stated that "I don't mind them talking about me when I leave [the meeting], but I wish to have my say first".

April 2009

A similar frustration was expressed by some SURP members in their contributions to this report:

"You are invited to attend your Care Programme Approach meeting towards the end of it for 10 – 15 minutes, where the responsible clinician tells you what is going to happen to you. The multidisciplinary team sit prior to this for an hour or so and you or your relatives or solicitor are not allowed to attend! The care planning should involve the patient spoken about... some hospitals allow this. I would like to see this as a national option within mental health law."

Mark Gray, SURP member

We have helped to effect change in some hospital practices. On a visit to an independent hospital in September 2009, a patient told us that he did not feel involved in discussions about his care and found it difficult to speak up in multidisciplinary meetings. In response, the manager told us that they were implementing a new-style, smaller meeting for patients and professionals who work closely with them. We encourage other services to consider such measures where patients appear reluctant to engage in full ward rounds or other multidisciplinary meetings.

Regular 'protected time' between patients and their named nurse is also an opportunity to discuss the content of care plans. In this way, patients are aware of their care plans, they feel a greater sense of ownership of the plans, and are prompted to ask questions or make suggestions that could feed into the care planning review.

Patients should be encouraged to sign their care plans, if they are prepared to do so. However, it should be made clear that they can withdraw their consent at any time in the future, especially in relation to consent to treatment. If a patient

“ I felt that I was strong enough to make my own choices and decisions about my wellbeing. I felt that the doctors liked belittling me and taking away my self respect and dignity, it seemed like they were encouraging me to be dependent on the system. ”

N Klugman, SURP member

refuses to sign the plan, a record of this should be made in the clinical notes. Signing a care plan should not be an empty ritual that patients think they are required to do, as in the following example:

The patients who spoke with the Commissioner confirmed that they have regular one to one sessions with their primary nurses to discuss their care and future plans. However three of the patients alleged that, even though they had one to one sessions, they were not involved in the development of their care plans. They alleged that the care plans were written by staff and given to patients to sign during the one to one sessions. Two of the patients said they had refused to sign their care plans because they were not involved in developing the care plan and they did not agree with it. One said: “you are forced to sign the care plan without your consent and if you don’t sign you don’t get leave”.
July 2009

The following example, as well as demonstrating the continuing need for unannounced visits, suggests that the care planning documentation available on the visit was not a true record:

Several patients had been asked to sign their care plans just prior to the visit. One patient had been asked to sign his care plan three times in the 48 hours before the

visit. The care plan had been copied from another patient and included their initials rather than his own. He had refused to sign because the content of the care plan was not relevant to his care.

September 2009

We have seen other examples of generic care plans, obviously copied from a template with little sign of personalisation. In a number of cases, we have drawn managers’ attention to care plans that state patients’ gender incorrectly, or appear to propose inappropriate interventions (such as a pregnancy test for a man). This does little to gain patients’ confidence in their care plan or trust in the process, and may actually alienate and distance patients from therapeutic involvement.

Care plans should have long and short-term goals, and include a ‘road map’ that is used to help patients towards discharge. It is not enough to simply log a patient’s mood and compliance with medication. We have visited a number of units where patients express a clear wish to be discharged, but had no knowledge of their care plan or of the outcome that needed to be achieved to enable them to be discharged. In the following example, this appeared to indicate a rigid culture that did not value patient involvement:

During patient interviews, several patients expressed concerns that they were not sure how long they would be at the unit and when they would leave. All patients said that they did not know what was in their care plan.

The Commissioner asked basic questions about patients being listened to or making choices. Several patients said that they felt they were told what to do and that there were a lot of rules on the unit, and that basic things had to happen at set times. The Commissioner raised these issues with ward staff, and was left unclear as to how patients were engaged in both long-term care planning, and day-to-day decision-making.
January 2010 (learning disability unit)

In some hospitals, we have noted that patients' access to their care plan is limited as it is kept as an electronic record (most often the 'RiO' system in NHS services). We advise hospitals to print out the relevant information for patients to keep, or create paper files specifically for patients that are kept in the nursing office:

It was difficult to ascertain from records how residents are involved in their care planning process. RiO documents do not provide clear evidence of patient involvement, nor are they signed. I was told that care plans are not printed off and given to residents as a matter of course, and the practice of going through progress notes with residents no longer happens routinely. Residents can ask to see their records but this takes time to organise due to having to cut and paste various RiO documents.

October 2009

Involvement of families and carers

Involving families and carers is important too. One example of good practice is Somerset Partnership NHS Foundation Trust, which has for some years adopted a strategy to enhance working partnerships with families and carers. This involves staff training, and a family liaison project designed to increase the number of face-to-face meetings between staff, families and carers on inpatient wards, and to hold such a family meeting within seven days of a patient's admission.

The project appears to have worked well. These meetings are now a routine part of the admission process and there has been very positive feedback from families, carers and patients. This is an excellent way to ensure that aftercare planning is started from the point of admission. This, in turn, could help to avoid future re-admissions. We commend this project as a model for other services.

We also welcome the publication of *The Triangle of Care* practice guidance for carer involvement in acute mental health care and will promote its use in our monitoring visits.⁴⁹

Mental Health Act advocacy

From April 2009, primary care trusts have had a statutory duty to make sure that independent mental health advocates (IMHAs) are available to 'qualifying patients'.⁵⁰ A qualifying patient is anyone who is detained under the Act's powers (except the holding powers of Sections 4, 5, 135 or 136, but including detained patients on leave of absence from hospital), or anyone subject to guardianship, conditional discharge or a community treatment order.*

Therefore, throughout this year, any qualifying patient requesting to see an IMHA should have been able to do so, and hospital staff should have been making patients aware that they could make such requests. This was not the case for all services. Over the year, we found that IMHA services had not been commissioned for a number of services and, in some others, the levels of service commissioned seemed hardly adequate to provide patients with meaningful levels of advocacy support.

In the final four months of the year, we systematically collected data on IMHA provision. Despite the fact that this was towards the end of the year in which the new legal duties came into force, 18% of all wards visited (56) did not have access to IMHA services (figure 13 overleaf).

These wards were managed between 17 NHS trusts and seven independent providers. In some NHS services, there was no IMHA provision in specialist or forensic NHS wards (which take patients from many different PCT areas across the country), even though IMHA services were provided to general wards operated within the same trust (most of

* Mental Health Act 1983, section 130C. the duty also extends to informal patients who are either being considered for neurosurgery for mental disorder falling under section 57 of the Act, or (being aged under 18 years) are being considered for ECT treatment.

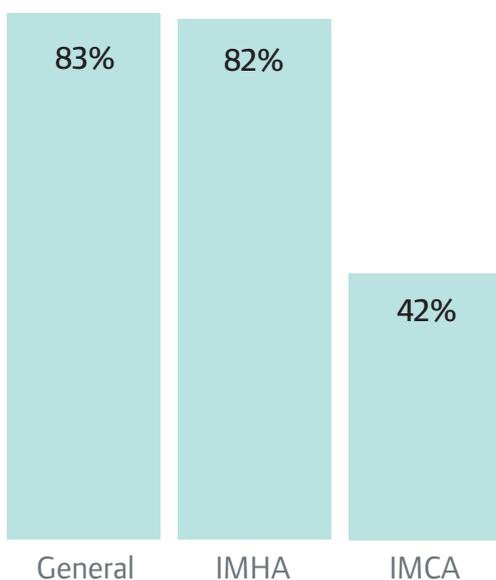
“ I had several advocates who wrote letters on my behalf and attended meetings. Whilst they were very nice, I didn't find them persuasive enough. They were more or less silenced by the doctor. ”

N Klugman, SURP member

whose patients came from local PCTs). Some independent providers reported similar problems in getting access to funding from the geographically wide-ranging PCTs responsible for their patients' care, although it is difficult to see why such funding could not be added to the charges already being levied. Although these 56 wards had no specific IMHA advocacy arrangements, all but two had access to general advocacy.

Hospital managers are legally obliged to make sure that patients understand that advocacy is available, and how they can get it.⁵¹ Many

Figure 13: Types of advocacy provided on wards visited by Commissioners, 1 December 2009 to 31 March 2010



Data source: CQC, n = 311 wards

services provide patients with leaflets and display a poster. Information on any type of advocacy was visible on 60% (188) of the wards that we visited. All wards that have no information on display should seek to rectify this. In the following example, services appeared to be underused because patients were not aware of them.

Ward staff confirmed that there was a very low take-up of advocacy in the unit, and when I spoke to patient 1 she had not previously requested an advocate because she was not sure in what way this could benefit her. When I explained how an advocate could support her, she immediately said that she would like an advocate to assist her. Although the ward does have services available for IMHA and general advocacy, I felt that there was poor access to advocacy facilities, as there was no advertising of services and they do not attend the ward on a scheduled basis, only coming when requested. As the only information that I could see that patients received regarding advocacy was a leaflet on admission, with no further reinforcement of that, I could understand why the take-up of advocacy was low. February 2010

Also, on each of the 311 different wards visited during the last four months of 2009/10, Mental Health Act Commissioners asked staff a series of questions about IMHA services, and left a questionnaire to be completed and returned by the advocacy worker.

Seventy-one questionnaires were completed and returned. Two were completed collectively for advocacy services, while the remainder were completed by individual advocates working within different services. Most advocates worked at more than one site, so the questionnaires reflected advocacy services in at least 132 hospitals.

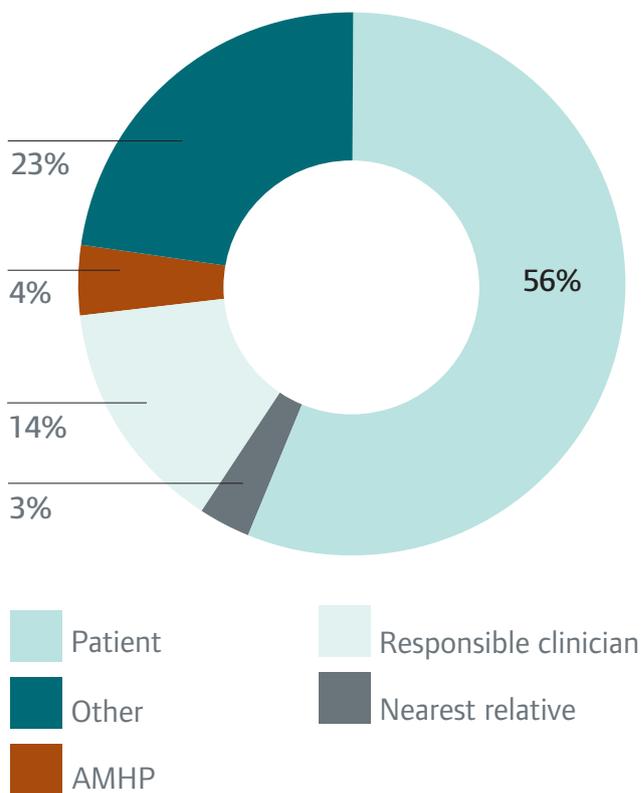
Roughly half of the advocates who responded were employed full-time in their role. Of the remainder who indicated their contracted hours of work, most appeared to have roughly half-time equivalent contracts. Thirteen reported no contracted hours, but appeared to be funded through different arrangements. Overall, the 71 services had seen 1,472 patients in the month before they completed their questionnaires: an average of 21 patients for each service. The median number was 16. The highest number of patients seen was 112 (in a high security hospital), while some services reported no patient contact at all. There was no obvious pattern between the number of patients seen and the contracted hours for advocacy services. The wide variation may be explained partly by the different geographic and organisational areas covered by advocates, or by the nature of the patient contacts counted, but it may also reflect differences within hospital cultures over the promotion of advocacy as a service available to patients.

Commissioning authorities should ask for clear reporting on IMHA activity, because of the apparent wide variation in IMHA services, but also as a useful source of information and feedback on the mental health services that they are commissioning for their patients. The model service specification produced by the Department of Health describes annual reporting, both of advocacy work undertaken and on the issues raised by patients,

“ I used an advocate recently and they came into my ward review – found they weren’t very assertive. One thing they did successfully achieve was to help me formulate my thoughts by talking to the advocate prior to going into my ward review. ”

SURP member

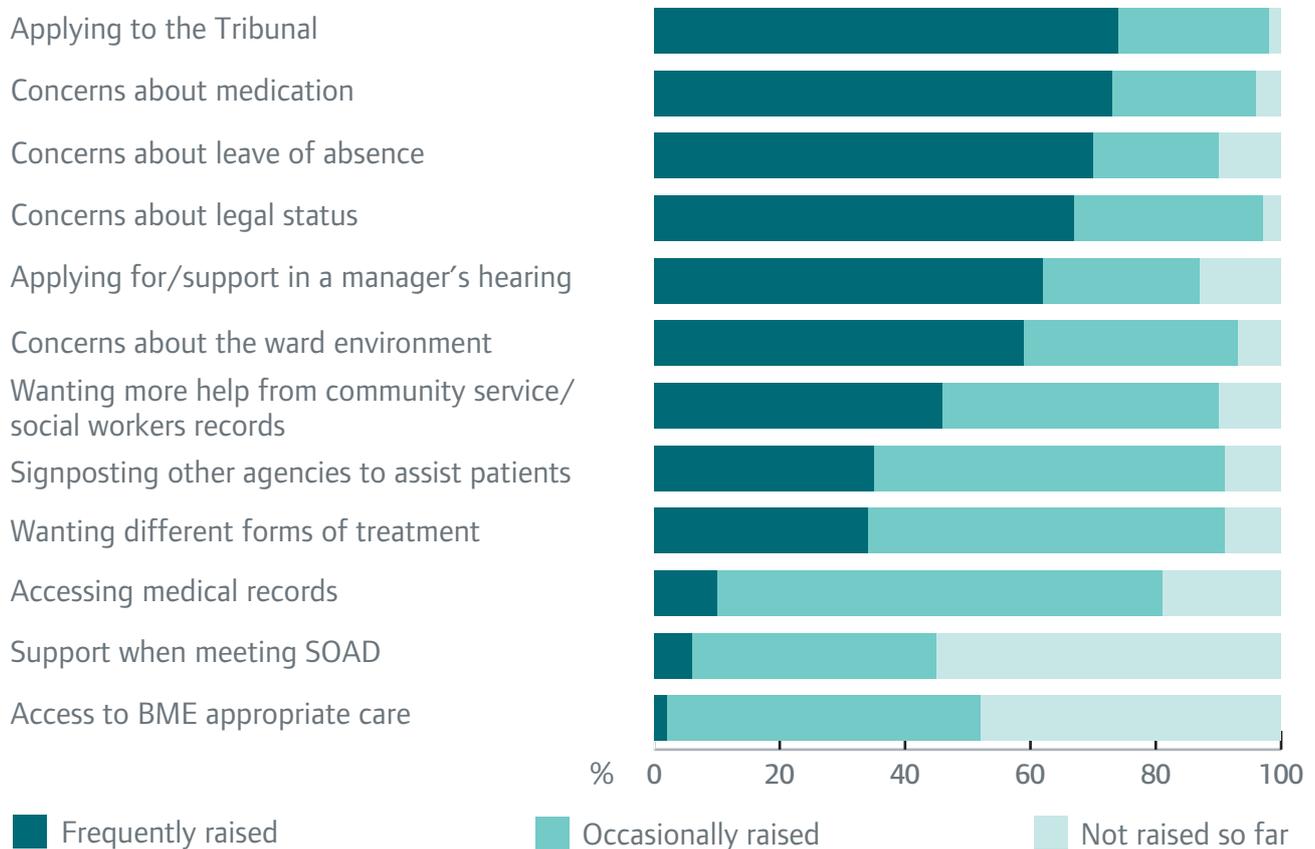
Figure 14: Source of referral to IMHA services



Data source: CQC, n = 71 advocacy questionnaire returns

as a basic requirement of an advocacy service.⁵² Of the 71 IMHA services returning our questionnaire, 56 (79%) were required to complete an annual report to the commissioning body; five (7%) had no such requirement, and the remaining 10 (14%) did not know whether they had to produce an annual report.

We asked IMHA services for the sources of referral to their services. Direct requests from patients accounted for just over half (56%) of all referrals to their service (figure 14). Few referrals (3%) were made by patients’ nearest relatives, but a considerable proportion were made by mental health professionals, including responsible clinicians (14%), AMHPs (4%) and (although they appear in the ‘other’ category in our chart, collectively amounting to 23% of the total referrals) nurses, ward managers and Mental Health Act Administrators.

Figure 15: Advocacy services' experience of frequency of matters raised

Data source: CQC, n = 71 advocacy questionnaire returns

We also asked IMHA services to indicate the frequency with which various matters were raised with them. The most frequent areas for IMHA involvement were in relation to applying to the Tribunal (74% reported this as a frequent issue); concerns about medication (73%); concerns over leave of absence (70%); and concerns about legal status (67%) (figure 15).

The law requires IMHAs to help patients both understand their rights and exercise those rights (by representing the patient or through other means).⁵³ IMHA services responding to our questionnaire said that they spent slightly more of their time (54%) on helping patients to exercise their rights. We have heard some reports of excellent services in this respect.

The Mental Health Tribunal

The First-tier Tribunal (Mental Health) is the primary mechanism for appeal against the use of Mental Health Act powers of detention, guardianship or a community treatment order. It is administered by the Ministry of Justice, and its three-person panels attend hospitals to hear cases. Usually, Tribunals hear cases following a direct appeal by the patient, although patients who have not appealed for some time, or who have had community treatment orders renewed, are referred automatically.⁵⁴

Number and outcome of Tribunal hearings

There has been a sharp rise in Tribunal applications, both in terms of those that lead to hearings and those that do not come to hearings (either because patients withdraw the application or are discharged before a hearing can take place) (figure 16). The Tribunal administration reported 12,122 actual hearings for the year 2009; the average annual number over the previous nine years was slightly below this at 10,000, and in 2008 it only reported 7,295 hearings. The proportion of hearings that resulted in some form of discharge fell to 12% – the lowest since 2004. Applications that did not come to hearing rose by over 40% between 2008 and 2009 although, in more than two-thirds of these cases, this was because the patient was discharged before the hearing was scheduled to take place.

This data deserves closer study. We know that appeals and referrals by or on behalf of patients on community treatment orders form a significant part of the rise in applications to the Tribunal. Information gathered by the Mental Health Alliance shows that CTOs have accounted for 29% of applications to the Tribunal (and also 29% of hearings that actually take place) from their introduction in November 2008.⁵⁵ Appeals against CTOs also appear to be less likely to succeed than appeals against detention: less than 5% of CTO appeals succeeded from November 2008 to March 2010, in comparison with a 14% success rate among detained patients (figure 17).

Figure 16: Outcomes of applications to the Tribunal 2000 to 2009 (calendar years)

Decision of MHRT	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Absolute discharge	858	854	744	923	709	784	655	643	535	776
Delayed discharge	342	334	427	518	317	364	287	298	215	279
Conditional discharge	39	89	90	141	145	222	195	265	132	289
Deferred conditional discharge	97	74	101	265	180	217	224	196	85	114
Total discharge	1,336	1,351	1,362	1,847	1,351	1,587	1,361	1,402	967	1,458
No discharge	10,199	10,229	8,637	9,906	10,546	7,935	7,417	7,158	6,328	10,664
% of discharges to hearings	12%	12%	14%	16%	11%	17%	16%	16%	13%	12%
Withdrawn applications	n/a					1,843	1,960	2,744	2,448	3,779
Discharge by clinician prior to hearing	n/a					4,790	4,629	6,344	5,862	8,056

Data source: Tribunal secretariat

“ I had an interview with an advocate...with regard to writing a letter of complaint. All the details I gave at the interview were typed out for me in draft form and I was asked if there was anything I wanted to change or add... I then received the letter with my amendments along with an envelope to send it in, I also received a copy of my letter to keep for reference. I was very pleased with the help and advice I received. ”

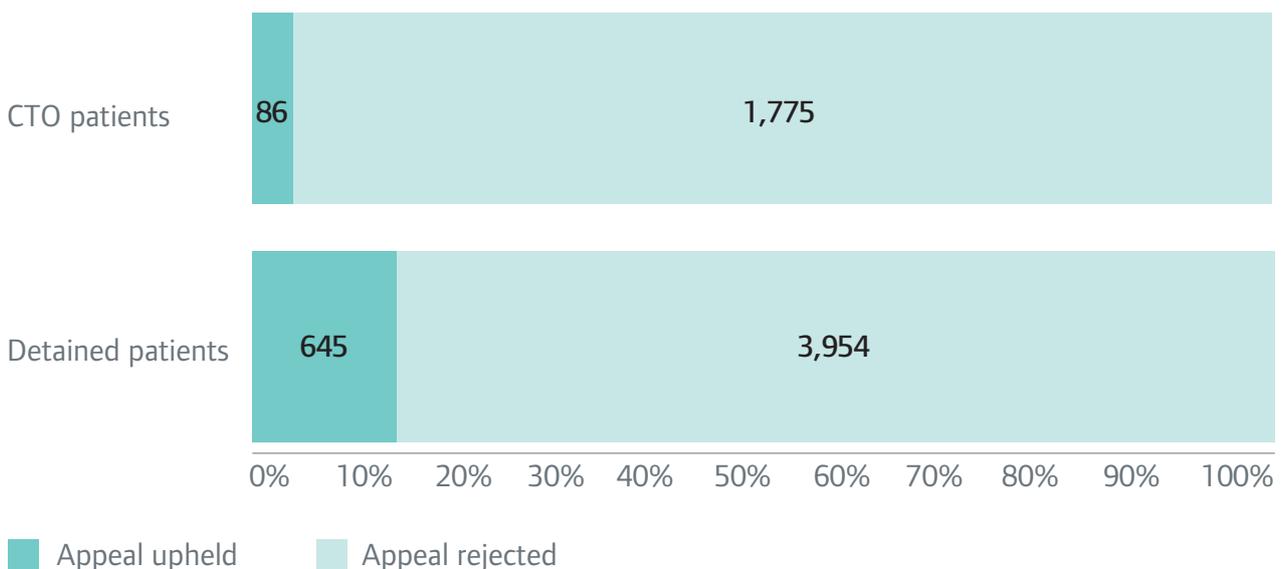
David W, SURP member

We are grateful to the Tribunal secretariat for supplying us with data, but we regret that it has not been possible to provide us with a breakdown of data on applications and discharges by the detaining section of the Act – or CTO – appealed against. We endorse and reiterate the Mental Health Act Commission’s past recommendation that the Tribunal secretariat should collate data on applications against detention and CTO separately, including the appellant’s gender, ethnicity and the section of the Act to which they are subject.⁵⁶ This data is surely relevant in relation to the administration of applications to the Tribunal, not least in the light of duties of the Ministry of Justice under the Race Relations Acts.*

Delays in Tribunal hearings

Patients and staff continue to report long delays between applications to the Tribunal and the

Figure 17: Outcomes of Tribunal hearings, November 2008 to March 2010, CTO and detained patients



Data source: Mental Health Alliance

* The general duty of ministries and other public bodies under section 71 of the Race Relations Act 1976, as amended by the Race Relations (Amendment) Act 2000, requires such bodies to have due regard to the need (a) to eliminate unlawful racial discrimination; and (b) to promote equality of opportunity and good relations between persons of different racial groups. At the very least, this implies ethnic monitoring.

eventual hearing. In one case, a forensic patient told us that, if his hearing went ahead as planned (it was listed for a date some months after we met him), he would have waited 18 months for his Tribunal. We have also found delays of some months' duration for civil patients. In some cases, this has meant that their legal status has changed several times (in particular, switching between detention under section 3 and CTO) while they wait to challenge the initial decision to detain them.

In some cases, hearings have been cancelled more than once. In May 2009, we met one patient whose hearing had been cancelled four times since the start of the year. He was concerned both that the hearing might be cancelled again, and that reports prepared for the original hearing date might not have been updated to reflect the progress he had made over the six months that he had been waiting. We asked the detaining authority to make sure that addendum reports were produced, and the patient informed that this would be done before any hearing took place.

“ It took far too long – I applied at the end of January, had my Tribunal on 17 June (it had been on 20 May but was then adjourned). Relevant documents were slow to be returned from the Ministry of Justice, and when they were responded to, it was only at the last moment. All this delay causes added stress. ”

SURP member

Making applications to the Tribunal

It is very important that patients who are incapacitated by their illness receive help in understanding their right to appeal to the Tribunal, and in making that appeal if they wish to do so. But however much help a patient receives, the position in law is that the patient must make the application to the Tribunal: at the very least the patient must want it to happen*, unless the detaining authority is referring the case to the Tribunal under its duties at section 68 of the Act.** A patient gets only one chance to appeal in any detention period, and an application made too early could leave the patient unable to make another for several months.†

We encountered one instance where this had not been understood, and it did not appear to have been an isolated example. A responsible clinician wanted his patient to get a Tribunal hearing, as she was very 'resistant' to being detained and treated but she would not appeal. He considered that she lacked capacity to decide the matter herself, and made an application on her behalf, despite the fact that the patient and her relatives opposed this, and wanted to wait until later in the treatment, when an appeal would have a better chance of success. The responsible clinician told us that he had appealed in this way before on behalf of patients who lacked capacity and the ability to do so themselves.

In this instance, the appeal was quite correctly struck out as improper before a Tribunal hearing was arranged, as the Tribunal was made aware that the patient did not want to make the application that was purportedly in her name. But it would seem that the past referrals had not been

* Although persons authorised to make decisions on behalf of an incapacitated person (i.e. a donee given a lasting power of attorney by the patient when the latter had capacity to do so, or a deputy appointed by the Court of Protection) could make an application to the Tribunal (or for a managers' hearing) without the patient appearing to want this to happen, if it could be argued that such an application was nevertheless in that patient's best interests.

** The Mental Health Act section 68 places a duty upon managers to refer a patient to the Tribunal after six months of detention or CTO. See Code of Practice, para 30.34 for details.

† For example, a patient detained under section 3 can only apply to the Tribunal once in the first six months, and then once in any period of renewal (section 66). After the first renewal (which extends detention for a further six months), section 3 detention is renewed annually (section 25). A nearest relative may also make an application for a Tribunal hearing in certain circumstances, but this is a separate right to the patient's own right to apply and has no effect on the patient's right to apply within the same period.

recognised as improper. It is possible that, once the process was underway, patients no longer felt empowered to oppose it, and so the impropriety of the application was not recognised. Of course, even a properly made application may be withdrawn at any time before the Tribunal hearing, so preserving the right of appeal until a later date: it is important that patients are told about this right, although not in such a way as to appear to be pressurising them to drop their appeal.

The Act does not set a capacity threshold for a patient to make (or not make) an appeal to the Tribunal. Whether or not a patient appeals is more a question of volition than capacity: it does not matter in law whether the patient understands the process, or the possible consequences, of making or not making an application. Where a patient has not appealed within a certain period of detention, section 68 of the Act requires the hospital managers to refer the case to the Tribunal. But patients must not be pressurised into making applications in their own name against their will, and a patient's perceived 'incapacity' does not allow clinicians to act irrespective of the patient's wishes.

In the rare circumstances where the responsible clinician or any other member of staff within the detaining authority wishes to make an appeal to the Tribunal on a patient's behalf, in circumstances other than those where the case must be referred to the Tribunal under section 68, the hospital managers should be asked to request that the Secretary of State refer the case to the Tribunal. We are aware of one such case in 2010, where the patient was a minor, and neither she nor her nearest relative seemed able or willing to understand or exercise the right of appeal. We suggested in this instance that a managers' review of detention could itself provide a sufficient safeguard, or else the Secretary of State might be asked to refer the case to the Tribunal if that was thought necessary. The Department

of Health has helpfully produced guidance on how to request a reference to the Tribunal by the Secretary of State.⁵⁷

Change of legal status following application

In its Twelfth Biennial Report (2008), the Mental Health Act Commission expressed its concern about the effect on applications to the Tribunal where a patient's detention under section 3 is changed to a community treatment order (CTO) before a Tribunal hearing could be held.⁵⁸ The MHAC noted the case-law precedent that an application to appeal against detention under section 3 would lapse if that detention was converted to aftercare under supervision⁵⁹, so that the patient would have to make a fresh application to appeal against his or her subsequent legal status. It argued that a similar approach for a patient moving from detention under section 3 to a CTO would create an anomaly in law, given that the application for admission under section 3 does not cease to have effect by virtue of the CTO⁶⁰, but is held in abeyance instead.

In December 2008, this issue came for practical determination before the First-tier Tribunal, which decided that an application made by the nearest relative against a patient's section 3 detention had lapsed because the patient had subsequently been made subject to a CTO. This was successfully appealed to the Upper Tribunal In October 2009⁶¹ (even though, in a different case heard in January 2009⁶², that court had accepted that an application would lapse with such a change in legal status, but the point was not then the subject of argument and was not treated as precedent).

The Upper Tribunal found that a literal reading of the Mental Health Act 1983, as it had been amended by the Mental Health Act 2007, gave the Tribunal:

“ When a tribunal is looming, the psychiatric team tend to get adversarial... psychiatric teams should be working with patients, their families and their representatives. ”

Martin Camden, SURP member

the power – or, if the conditions of section 72(1)(c) are satisfied*, a duty – to direct that a person subject to a community treatment order be discharged notwithstanding that that person made the application to the Tribunal while liable to be detained under section 2 or 3.

The Upper Tribunal found “no reasons for giving section 72(1) of the 1983 Act [as amended by the 2007 Act] anything other than a literal construction”. It noted that this construction was different to that considered in the 2005 case of *SR*, in relation to the question of whether an application to the Tribunal survived a patient’s discharge from detention to aftercare under supervision.

Therefore an application to the First-tier Tribunal made by or on behalf of a person detained under section 2 or 3 of the 1983 Act does not lapse if a CTO is made in respect of that person before the application is determined. As such, it is important that services prepare the required information for such a hearing when a patient has an outstanding application on his or her change of legal status.

Tribunal reports

Large numbers of Tribunal hearings are adjourned because of a lack of sufficient information – often the unavailability or inadequacy of social circumstance reports. The main purpose of these is:

to provide the Tribunal with ‘hard’ evidence of the patient’s circumstances if discharged from hospital, and in particular, what medical, social services and other support will be available in the community, together with ‘soft’ – but also potentially significant – evidence about the views of the nearest relative and non-professional others who play a significant part in the patient’s care, the patient’s own views and an assessment of the patient’s strengths and positive factors. The social circumstance report should provide evidence of planned aftercare, in line with the guidance in the MHA Code of Practice ...on the duty to provide aftercare under MHA 1983 s.117, and ...policy guidance on the Care Programme Approach (CPA).⁶³

Detaining authorities are responsible for providing social circumstance reports to the Tribunal. Their production is mandatory for all hearings except those arranged for section 2 patients, in which case the law acknowledges that it may not be practical to produce them in the time available before the hearing.⁶⁴ We recommend that detaining authorities read the guidance on the content of social circumstance reports that was set out in an article of the *Legal Action* journal of July 2010⁶⁵, and we suggest this as a source of information where we encounter problems in the provision of such reports. The Tribunal Service has also published its own guidance on reports, which is available on its website.

Patients often find the process of a Tribunal hearing demoralising, particularly if members of the clinical team with whom they have worked present the case against their release to the Tribunal panel. While this is sometimes unavoidable, it is a sign of poor care planning if patients are surprised, either by the reports prepared about their progress, or about the

* That is if the Tribunal is not satisfied that the patient is suffering from mental disorder of a nature or degree making medical treatment necessary; or that it is necessary that he should receive such treatment; or that it is necessary that the responsible clinician should be able to exercise the power of recall; or, if the hearing follows the renewal of the community treatment order, that the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself (Mental Health Act 1983 section 72(1)(c)) (our note).

answers given by professionals to questions at the hearing itself:

One patient mentioned that on reading the reports for his Tribunal, he felt that comments were very negative and that there was a “culture of medication and lack of consultation” on the ward.

While this may have been an isolated opinion, the Commissioner feels it should be seen in the context of the issues constantly raised with the trust regarding engaging patients in discussion regarding their treatment and implementing the participation principle in the Code of Practice.

September 2009

In their response to the above observation, the trust concerned promised systematic change, and we will be following progress with interest.

Legal representation for Tribunals

Patients and SURP members have expressed dissatisfaction with the process of Tribunals, and sometimes with the legal representation that they received:

“The process itself is too fast. The time the solicitors gave was too short to prepare by way of comments from myself.”

Donna Paula, SURP member

We are aware of the concerns of the Mental Health Lawyers’ Association over Legal Aid arrangements for Tribunal work. They point to a reduction of their number by a quarter since the statement by Lord Justice Brook, a decade ago, that:

Mental health law is difficult enough today. Reading the report of a psychiatrist, identifying its areas of weakness, commissioning evidence from the appropriate expert to challenge it, and representing a client at a Tribunal requires expert professional skills born, as we have said, of education and practical experience. It is not like going down to the magistrates’ court as a duty solicitor, arduous though those duties are.⁶⁶

We have heard a number of critical comments from patients, staff and legal members of the Tribunal on the conduct or ability of patients’ legal representatives. In its last report, the MHAC called for an independent review of the effects of the revised fee system, with a particular focus on Tribunal representation. We agree that such a study is still warranted. In the meantime, in 2009/10 we established a joint project with the Administrative Justice and Tribunals Council (AJTC) to examine patients’ experience of Mental Health Tribunals. We hope to publish the results in 2010/11.

“ I’ve had several Tribunals... some good and positive, some bad and deceiving. Deceiving because the staff that nursed you from day to day often reassure you of how well you are and are doing. Then turn quite the opposite during Tribunal, therefore causing a false sense of security and animosity. ”

Donna Paula, SURP member

Participation and protection of rights: our recommendations for improvement

Participation

→ **Providers of mental health services, particularly front line managers and staff**

Check and review how effectively national policies on involvement are being implemented, particularly in the context of the Mental Health Act Code of Practice's principles of least restriction, respect and participation for detained patients.

Access to independent mental health advocacy (IMHA)

→ **PCTs and their successors with responsibility for commissioning IMHA provision**

Review their arrangements for commissioning IMHA services to ensure that access/coverage is comprehensive; where they are not doing so, require annual reporting on IMHA activity.

→ **Providers of inpatient mental health services**

Where this is not being done, ensure that information on IMHA and how to access the service is available and clearly visible on wards that detain patients.

Mental Health Tribunals

→ **Local authorities and providers of mental health services, particularly front line managers and staff**

Review the priority given to social circumstances reports; conduct reviews of the quality of reports and the practice of producing them.

→ **The Tribunal Secretariat**

Data on applications and the outcome of applications should be revised to distinguish the appellant's gender, ethnicity and the section of the Act to which they are subject, including distinguishing between applications against detention and CTOs.

→ **Ministry of Justice/Legal Services Commission**

Conduct an independent review of the effects of the revised fee system, with a particular focus on Tribunal representation.

2

Key areas for special focus

To complement our general findings, in part 2 we look at three aspects of care and treatment that have a major influence on patients' experiences: use of control, restraint and seclusion; consent to treatment; and community treatment orders.

Use of control and restraint, and seclusion



The Mental Health Act Code of Practice expects all hospitals to have a policy on recognising and preventing disturbed or violent behaviour. The Code recommends that interventions such as physical restraint, rapid tranquilisation, seclusion and observation should be used only where de-escalation on its own does not prove sufficient. They should always be used in conjunction with further efforts at de-escalation, and they must never be used as punishment or in a punitive manner.

Control and restraint

Hospital services may use different methods to control and restrain patients while treating them, or in response to disturbed behaviour. Where this includes physical force or confinement alone in a room, the patient may experience this as a violation and should be given support and counselling.

Individual care planning should include possible responses to disturbed behaviour, when this is likely to be an issue, and should always address this after an incident. In this way, patients can discuss the triggers that cause their problem behaviour and express how they would prefer the service to respond. The Mental Health Act Code of Practice recommends that staff should re-assess the patient's care plan and help them re-integrate into the ward environment, and also give them an opportunity to write an account of the episode that will be filed in their notes.⁶⁷ Many services may find this requirement challenging, and we find that it has not been met on many visits, but compliance with the Code's guidance would mark a positive cultural shift for many hospitals and we will continue to promote it through our visits.

Ensuring therapeutic environments

The Code of Practice also encourages services to promote a therapeutic culture on wards, and to identify and manage problem areas that might lead to disturbed behaviour among patients.⁶⁸ It has an extensive list of general measures that should be addressed, ranging from patient and therapeutic engagement to ensuring an appropriate patient mix. It includes providing personal or quiet space for patients and ensuring that they have access to activities and are able to go outdoors.⁶⁸

We frequently highlight this aspect of the Code on our visits. We have received some positive responses from providers and we expect that this will lead to a real difference in the treatment of patients as a result:

During your visit, a number of patients raised concern regarding the high levels of violence on ward X. You asked the hospital management to address this concern and reassure patients of their safety on the ward... In response to such concerns ... a number of measures were agreed, including that patients, when suitably settled in their mental states, would be engaged in a wider variety of off-ward activities including using the unit's garden areas on a more regular basis. Allocated nurses would also ensure that they see patients individually at least once per shift and the two multidisciplinary teams working on ward X would agree more consistent care plans to be used in the event of a violent incident and following such incidents. In addition, we will continue to liaise closely with patients on the wards to ascertain from them whether they feel safe and to closely monitor the number of violent incidents on the ward.

From a hospital's formal response to a CQC visit in November 2009

In the following example, we asked hospital managers to consider how the ward environment may have contributed to unsettled behaviour, and whether it might help to designate a facility to care for disturbed patients away from the day area, with less disruption to the main patient group.

Patients complain that when there is an incident on the ward or a patient is distressed or noisy there is no way of getting away from it. This increases their stress levels. This was evidenced in the notes which, in one case, recorded the patient being unable to attend an activity 'due to an incident on the ward' and then 30 minutes later being involved in an incident herself which led to a period of restraint. Staff confirmed how difficult it is to support patients while also managing a period of restraint on the ward. Patients also complained about noise levels on the ward due to the constant music coming from the TV music channel. They also reported that they were generally unable to access fresh air other than at 'smoking' times.

October 2009

Some patients who have been restrained in response to disturbed behaviour said that it was triggered because they were not receiving planned one-to-one (1:1) time with a member of staff. This is often included in care plans to help reduce such behaviour, but ironically it can be particularly difficult to implement on a ward where there are high levels of disturbance.

Patient 3 talked about experiencing staff as using restraint in favour of 1:1 time. I looked at his notes and saw that his care plans include him having 15 minutes 1:1 time each morning and afternoon. Similarly, his care plan relating to the management of violence and aggression refers to 1:1 being offered to him regularly. I was unable to find evidence that he was being offered 1:1 time in accordance with these care plans. The last entry on the sheet recording 1:1 time was dated in September.

October 2009

Ill-treatment and restraint

Regrettably, detaining authorities must always remain vigilant against ill-treatment of patients by their employees. We recognise that ward staff in general are compassionate and professional, even under the daily pressures in hospital when they may be caring for very disturbed people. Nevertheless, we do encounter isolated incidents where this does not appear to have been the case:

Patient 4 raised many concerns about his care and treatment and showed me an injury to his shoulder which he said had been caused when he was restrained. Please clarify if all patients have a physical examination by the general practitioner if they report an injury after restraint. He also stated that a member of staff, who I named in my discussion with the manager, put the written complaint patient 4 handed to him in the shredder.

October 2009

It was reassuring to hear that patient B was satisfied with the way in which her complaint, about having her clothes cut off her when restrained, was addressed by the hospital and to learn that the nurse involved is no longer used by the hospital and appropriate external bodies have been informed about her practice.

January 2010

Mechanical restraints

The Code of Practice states that mechanical restraint should never be a standard way of managing disturbed or violent behaviour in acute mental health settings. But it is silent about its use in other types of mental health or learning disability service.⁶⁹ This is unhelpful, as the examples of mechanical restraint encountered by Mental Health Act Commissioners have rarely, if ever, taken place in acute mental health services. They are usually confined to learning disability units, forensic services and services for older people.⁷⁰

Some forms of mechanical restraint that appear to be quite widely used, such as supportive chairs on wards for older patients, may not even be recognised as such by professional staff. In 2003, the Mental Health Act Commission suggested that mechanical restraint might be a focus for future mental health monitoring⁷¹, and in 2006, the Department of Health suggested that they introduce a system of notifications to inform future government actions. However, the Commission stated that this would require its legal remit to be extended beyond patients detained under the Mental Health Act, even if only in relation to such restraint, and the discussions appear to have ended at that time.⁷² This idea could now be reconsidered, given that the scope of CQC extends across all the services that would need to be included, to obtain a true picture of the use of mechanical restraint.

When any form of mechanical restraint is used, it is important that it is supported by a clear policy⁷³, and that there is a clear record of the rationale for using it. We found this did not happen in the following example:

The patient was being restrained in a chair due to his constant aggression and violence resulting in serious injury to patients and staff. One staff member almost lost her eye. Whilst the Commissioner was shown a care plan dated May 2007 and the trust's policy on the use of restraint (*Guidelines for the use of Restraint Devices as a Safety Measure to Prevent Injury*), no up-to-date care plan could be located.

June 2009

We asked the trust to review this practice against their own policy and the Code of Practice, and to produce an up-to-date care plan providing the rationale for the restraint and how it was to be monitored. The plan also had to consider the least restrictive option and the patient's own views on the matter, which would enable him to participate in the decision-making process.

Handcuffs are probably the most common mechanical restraints used on detained patients, usually when moving forensic patients between hospitals or to and from court appearances. In the following example, handcuffs were used when taking a patient to another hospital for physical health care:

Patient 2 stated that he had recently been taken for a hospital appointment during which handcuffs had been used. He was very unhappy about this, as he was late for the appointment and had to wait in a waiting room with handcuffs on, in view of others. The Commission had sight of the unit's policy on the use of handcuffs and of discussions that had been held with senior members of the team before handcuffs were used. However, the Commissioners could not find evidence of a record of the patient's views and feelings about the use of handcuffs.

March 2010

Seclusion

The Code of Practice defines seclusion as "the supervised confinement of a patient in a room, which may be locked".⁷⁴ If the room is not locked, it is still seclusion. Any practice that fits the Code's basic definition should be treated as seclusion and given the safeguards and standards in the Code:

Some patients reported being nursed in their bedrooms, isolated from other patients for periods of several days. They refer to this as being kept in 'low stimulus'. Please send the CQC a copy of the policy covering this.

September 2009

Seclusion should be used only as a last resort, and for the shortest possible time.⁷⁵ We sometimes question whether this is the case in some hospitals that we visit:

Seclusion is frequently used on the ward. At the time of the visit on 22 September, there were records of 19 episodes of seclusion that month. Most of these were for short periods. It was not clear from the records what steps were taken to de-escalate the situation before the decision to seclude was taken. The seclusion record form used within the learning disability services asks for a description of the antecedents (what triggered the incident) and the incident (what actually happened). It does not ask staff to clearly record what steps were taken to defuse the situation prior to the use of seclusion. Clearly frequent use of seclusion raises questions about the application of both the Code of Practice purpose principle and the least restriction principle.

September 2009

As in the example above, we recommend that staff should include in the seclusion record forms the steps they had taken to de-escalate a situation before considering seclusion. This should act as a reminder of the importance of this aspect of nursing care. It could also help to reinforce staff training, or highlight areas that need such training.

Where seclusion is used too readily, or for reasons other than containing severely disturbed behaviour, it may be challengeable in law.

There was one episode of seclusion in July 2009, which was deemed to be potentially unlawful from the recording of the incident viewed. The reasons for this conclusion were as follows:

- The patient was secluded on assessment because of his refusal to participate in the assessment and due to his past history rather than his current presentation, with no obvious severely disturbed behaviour.
- Despite significant and continuous periods of settled behaviour, he

continued in seclusion because of his ongoing refusal to participate in the assessment and not according to presentation issues.

- Whilst medical and nursing reviews occurred at appropriate times, they failed to safeguard the patient's rights around the termination of seclusion, as there was no reason for the continued use of seclusion according to the records.

The Code of Practice states that seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others (paragraph 15.43). It should be used as a last resort and for the shortest possible time (15.45). From the records viewed, the Commission is extremely concerned that the threshold for seclusion did not appear to be met, nor was it used for the shortest time, nor as a last resort. Whilst there were concerns about the patient's potential risk, there appeared to be no consideration of managing this differently. Human rights issues are possibly engaged based on the poor recording and rationale for initial and ongoing seclusion.

January 2010

After this visit, we recommended that a senior manager review the episode of seclusion, recommend ways to prevent such episodes happening again, and supply CQC with a copy of the report and an account of action taken to meet its recommendations.

Reviewing seclusion

The Code of Practice states that the decision to begin seclusion can be made by a doctor, an approved clinician deemed 'suitably qualified' by the hospital management, or the professional in charge of the ward.⁷⁶ When the professional in charge of the ward makes the decision, the Code expects that the patient's responsible clinician or a duty doctor will be notified at once and attend immediately,

unless the seclusion is only for a very brief period. There should then be a multidisciplinary review to establish the care needs of the patient and the steps needed to end the seclusion.

We have found that a number of hospitals do not follow the Code's guidance, and patients have been secluded for periods of more than a few minutes without a doctor attending at all. On a visit in March 2010, the seclusion log in one hospital showed that doctors attended fewer than 70% of recorded seclusion episodes. The reason was often recorded as "no need".

The Code also requires four-hourly medical reviews, unless the initial multidisciplinary review decides on different arrangements. Local policies may make different arrangements at night when patients in seclusion are asleep.⁷⁷ However, some hospital policies go further than this. In one example on a visit in August 2009, the policy said not only that four-hourly medical reviews did not have to take place between 10pm and 10am, but that the patient's on-call manager, responsible clinician or duty doctor did not need to be notified until 7am of any seclusion episode initiated after 11pm the previous night. This seems to be potentially dangerous, as seclusion episodes during the night will be managed with fewer staff than during the day, and quite possibly with fewer senior staff. We therefore challenged this approach on our visit. A patient who starts to exhibit severely disturbed behaviour during the night is no less at risk, or in need of attention, than a patient who does so during the day.

Seclusion rooms

Many seclusion rooms are carefully constructed to provide a safe environment that is adequately comfortable. Nevertheless, for most people, the process of being secluded is extremely unpleasant, both psychologically and physically. The following environments cannot be anything other than unpleasant and, in each case, we have asked that the hospitals concerned address their shortcomings.

One of the padded seclusion rooms has been removed. There are considerable concerns about the remaining one. The most concerning matter was the human excrement still attached to the ceiling. Staff were well aware that this was unacceptable and removed it. How it could have been overlooked when the room was cleaned is of great concern.

May 2009

Although good policies exist regarding the use of seclusion and time-out, it appeared doubtful that the environment within which seclusion may occur was fit for purpose. They were padded rooms, without furniture, with switches located inside the room, with an inability to control light and temperature from outside the room, and self-inflicted harm could be achieved at several points around the window.

March 2010 (children's service)

The room used for seclusion is away from the ward area and has access to en suite facilities but patients are not always allowed to use these. They report that when this happens, they are not provided with disposable pots so have no alternative but to urinate on the floor.

The room is completely without furniture. Patients complain that they feel like animals having to sit or lie on the cold floor and say the room is often cold. Staff report that if patients are secluded at night, they are provided with a mattress. Please arrange for the room to be fitted with safe, appropriate seclusion room furniture so patients do not have to sit/lie on the floor and ensure it is warm enough and if necessary provide strong bedding to keep patients warm.

Patients complain that they are often observed by male staff. They experience this as uncomfortable especially when they are not fully dressed. Please ensure that

consideration is given to the impact that the gender of observing staff may have on individual patients, in line with the principle of respect. Please ensure patients are always given appropriate clothing to wear to protect their modesty. This may involve the use of strong nightwear if the patient is at risk of self ligating.

Patients complain of observing staff talking loudly and playing the radio in the observation area. Please remind staff that noise outside the seclusion room may increase a patient's distress.

September 2009

Long-term segregation

The revision to the Code of Practice in 2008 introduced the concept of 'long-term segregation' as a category of seclusion.⁷⁸

This recognised that, for patients who were in seclusion for sustained periods, the usual safeguards of four-hourly medical reviews might serve little purpose. Instead, local policies might make specific provision for appropriately timed multidisciplinary review of the patient's situation. The following example shows a typical purpose-built facility used to house patients in long-term segregation, and, although the unit had not formalised its practice in a policy at the time of our visit, includes the essential elements of appropriate planning and review.

On both units, there are purpose-built annexes which each house one individual patient. Both patients are secluded from ward activities within these suites. The suites are well-equipped with a patio area, lounge, bedroom and bathroom. Both suites are sparsely furnished, but have safe fixtures and fittings to provide a more homely feel.

The Commissioner was pleased to note that both patients had clear plans to re-integrate them back into ward activities and both have long episodes out of seclusion. The

care notes show evidence of regular multi-disciplinary review.

June 2009

In the following example, however, we were concerned that the lack of review could lead to segregation practices being carried on after they were necessary:

One acutely ill patient was being nursed on level 4 in the ward's new quiet room due to the risks that he was assessed as posing to himself and others. When such risks were considered to be low, he was spending time with other patients and observation sheets indicated that this was happening every day. Whilst overall treatment plans were detailed and family involvement was clear, review of the above circumstances was not.

May 2009

During the visit from which the above example is taken, we asked the ward manager to ensure immediately that the use of longer-term segregation was reviewed by a senior clinician not involved with the case. We also asked the trust to make sure that the multidisciplinary team more explicitly reviewed the way in which the patient was being cared for, and we asked to see copies of the trust's policies in relation to both seclusion and longer-term segregation.

Problems can arise after deciding that a patient needs to be transferred or moved to more secure facilities because of their highly disturbed behaviour. Such transfers can take some time to set up, and secure facilities may not assess the patient as being appropriate for a place. There is a risk of therapeutic nihilism until the transfer is made, which can itself lead to a lack of alternative planning and a danger that the patient may remain in the limbo of segregation indefinitely:

Patient 1 is being nursed in long-term segregation. This patient has made six assaults on staff with a weapon, including one serious assault. She has been secluded

either in the seclusion room or in her bedroom, and has now been in constant seclusion for three weeks. During her time in seclusion, the patient tied a ligature around her neck and was admitted to the general hospital for care.

The patient has had a troubled time on the ward and both staff and patients are anxious about her spending any time on the ward due to her self-harm and violent behaviour. The management plan is to nurse her in seclusion until she has been assessed for a high-secure placement. The management plan focuses on the risk that her behaviour presents and the response of staff. There appears to be little record of her care needs and attempts to involve her in such planning. The patient said that she was comfortable, understood her rights, and that she had her basic needs cared for. She requires 6:1 nursing for any intervention according to her care plan.

The seclusion records on the file and in the record book are fairly difficult to

follow due to the quality of recording, the legibility of handwriting and basic filing. The standards of recording are variable. Generally, the recording focuses on negative behaviour and risks, and it is not clear from the records as to which interventions are successful and why the patient has good days or indeed any strengths that she has. Most of the records demonstrate little attempt to engage the patient, but list basic observations. The ongoing plan is often stated as “continue to seclude”.

Clearly, this patient has presented a risk to staff and patients that the ward has so far been unable to contain. The Commissioner is concerned that this patient is now segregated long-term with no clear plan for re-integration, and no plan for nursing other than referral to high security hospital. Therefore should the patient remain on the ward, there are serious concerns as to how the ward can provide adequate care and treatment.

November 2009

Use of control and restraint, and seclusion: our recommendations for improvement

→ Department of Health

Consider introducing notifications about the use of mechanical restraint or including it in appropriate national data collections for monitoring purposes.

→ Providers of inpatient services

Review practices of recording restraint and seclusion episodes, to ensure that a record is kept of the steps that were taken to de-escalate a situation before other interventions were considered or used, and audit the content to inform how this practice is developed.

→ Commissioners and providers of inpatient services

Where seclusion rooms are used, review patients’ access to basic provisions to meet their needs and ensure their dignity.

Detained patients and consent to treatment



When a patient is detained under the Mental Health Act, treatment with medication may be given under the authority of the approved clinician in charge for the first three months of treatment (whether or not the patient consents, and without any formal certification). After that, except in emergencies, treatment can be given only under certain conditions and the authority for that treatment must be formally certified.

Where the patient consents to the treatment, and has the capacity to do so, either the approved clinician in charge of it or a second opinion appointed doctor (SOAD) may certify that consent on a form T2. Where the patient lacks capacity to consent, or refuses to consent, the treatment may only be given following a SOAD's certification on a form T3 that it is appropriate.

The reality of consent

In many cases, the decision to detain a patient under the Act is determined both by an immediate need to provide a safe environment for a person who is at risk, and to provide an opportunity to impose medication for their mental disorder, in the hope that the patient will see the benefit of such treatment and continue with it voluntarily. Patients' attitude to, and involvement in, treatment decisions is therefore often seen as a good predictor of future compliance and positive outcomes.

This, together with the fact that the Act's consent to treatment procedures are simpler for consenting patients than those who refuse or are incapable of consent, can mean that both patients and staff are under pressure to be able to state that treatment is being given with the consent of the person receiving it.

There is inevitably some conflict in the concept of true, free consent to treatment when this is given by someone who is detained in hospital for treatment, and where such consent may speed up the end of that detention. The Mental Health Act Code of Practice recognises that "permission given under any unfair or undue pressure is not consent", although the Mental Health Act Commission has previously noted that the UK courts seem to have set a very high threshold for 'unfair or undue pressure' in rulings over conditional discharge.⁷⁹

More practically, the Code requires that "in every case, sufficient information must be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it".⁸⁰ On our visits, we usually speak with patients about consent to treatment and check the documentation of their consent.

In a large number of our hospital visits, we find that patients have been certified as consenting when they were in fact refusing consent or lacked the capacity to give it. We talk to many patients who describe very cursory discussions about treatment with their doctors, and show a limited understanding of the treatment being given.

A number of patients (deemed to be consenting) that I spoke to did not believe that they were mentally unwell or that they needed medication. There was nevertheless a lack of evidence in the files I looked at, of a consideration of the patients' consent or the capacity to consent.

January 2010

A significant number of patients (deemed to be consenting) were unable to describe the medications they were prescribed. Some were unable to identify what the medication was for, or how it was supposed to help.

Others cited dissatisfaction with medication and with their ability to influence prescribing practices.

February 2010

Many clinicians are not routinely recording assessments of capacity and consent to treatment, nor making a record of the information given to patients about the proposed treatment and any alternatives to it. Some record observations on patients' "insight" and "compliance", but not their capacity and consent. This could hinder working towards gaining the patient's capacitated consent, rather than settling for mere compliance. Actively striving for consent is the better basis for personalised treatment that involves the patient as a decision-maker, and is a better basis on which to make decisions about leave or discharge from detention in hospital.

As the Code of Practice makes clear, even though there is neither a statutory procedure nor a certification requirement for giving medication in the first three months of treatment, "the patient's consent should still be sought before treatment is given, wherever practicable. The patient's consent or refusal should be recorded in their notes, as should the treating clinician's assessment of the patient's capacity to consent".⁸¹ In the following example, there appeared to be a lack of attention to consent and capacity in this early stage of the patient's detention, even though consent to treatment practice after the initial three months seemed to be quite good:

We found very positive evidence of tests of capacity for different decisions ... however (we) were not able to find clear evidence in this regard, specifically within the first three months of treatment under detention before a SOAD would be required. There was evidence of discussions about medication at multidisciplinary team meetings, but not a linked assessment of capacity. CQC requests confirmation of action to ensure compliance with this part of the Code.

December 2009

“ On many occasions I have had my medication changed without explanation, and I have not had the energy or gumption to ask questions and challenge decisions! This is why all medication options should be explained fully... and this should be done proactively by psychiatric staff – getting a complete picture should not depend on the skill and mental state of the service user! ”

Martin Camden, SURP member

Such examples are common in our visit reports. Less common, but equally instructive, is an example from a visit in December 2009. Here, more than one patient appeared to have had a capacity assessment on the day they were admitted, but not in the weeks before our visit, and there was limited evidence of any discussion about consent. This failed to recognise that capacity is not a constant – it changes over time and in relation to the decision being made.⁸² Indeed, patients may be least likely to have the capacity to make some decisions on the first day in hospital, but may quickly recover such capacity. Assessments and the recording of consent and capacity discussions should be an ongoing process – an integral part of treatment planning – and not a single event.

Recording of capacity and/or consent status is not always better after the first three months, when statutory certification is required. While the statutory certificate T2 requires the doctor to state that the patient gives valid consent, this 'certification' is no more than a statement:

There were two patients who had been 'assessed' as capacitous, but the commissioner was left following the interview with doubts and concerns about this assessment for two reasons:

1. There is no evidence of the assessment on the files.
2. The substantive assessment of capacity itself appeared to be overly optimistic in the case of two male section 3 patients, particularly as one patient was expressing paranoid ideas and thoughts about the effects of the medication on his skin and breasts, etc, and the other patient had difficulty understanding some of the questions the Commissioner asked concerning the medication, its purpose and side effects, etc.

T2 forms are in place as required, but a more thorough approach to the assessment of capacity would be welcome ... perhaps some training with responsible clinicians around capacity? It seems inconsistent across the service.

March 2010

We therefore often emphasise on our visits the argument in the Code of Practice that it is not good practice simply to state a patient's consent status on the statutory form; there should also be a documentary record of the process that led to it, including an outline of discussions with the patient.⁸³

It is irrelevant to us whether or not these records in the patients' notes are made on specifically designed forms, but pragmatism suggests that some kind of form can support clinicians in making their assessments, and prompt them to address and record the relevant aspects. Many hospitals have devised such forms for use in making capacity determinations (under the Mental Capacity Act), which can be used or modified for the purpose.

Changing consent to treatment practice through the registration process

In March 2010, under the new system of registration that came into force for the NHS, we placed conditions on the registration of one NHS foundation trust that:

By 1 July 2010, any person detained under the Mental Health Act have their discussions about consent to treatment, the assessment of their capacity to consent and the outcome of their consent to treatment procedure under section 58 of the Mental Health Act 1983 documented in accordance with the Act and the Code of Practice

We visited the trust in August 2010 to check its compliance with this condition. We examined the records of 67 detained patients from a variety of wards across the trust, including services for adults of working age, older people, and people with a learning disability. We looked for evidence of assessment of capacity to consent and consent to treatment (for which the trust had devised a record form); we checked the written progress notes for a record of patients' consent or refusal and the treating clinician's assessment of patients' capacity to consent (as required by the Code of Practice, 23.37) and for a record in consenting patients' notes of their discussions with approved clinicians regarding the proposed treatment; and we looked for a statement of the steps taken to confirm that such consenting patients have the capacity to consent (Code of Practice, 24.16).

We found at least one completed trust form assessing consent and capacity to consent on every file – a huge achievement. The only exceptions were for two patients who had been detained in the previous 24 hours, and for whom there had not been time to complete the assessment and upload the form.

The Code of Practice does not specify the intervals for completing fresh assessments. The trust's policy established a reasonable rule of thumb to be "by the first ward round following detention... after the first three months' detention and every three months after that... when there is a permanent change of responsible clinician... and at times when there is a significant change in mental state". We found a fresh assessment in most of the cases where one was due.

In most cases, there was evidence of recording in the progress notes. Some, but not all, multi-disciplinary teams used a template for recording discussions with patients. Some senior house officers (SHOs) had used this template, but had described mental state, insight, compliance, etc, under the heading “capacity” without necessarily commenting on capacity. This need for training was flagged up separately with the Mental Health Act Administrator.

The trust had clearly devoted a huge amount of time and effort to the assessment of capacity and consent in order to have the condition of registration lifted. Filling in forms and recording in the progress notes appeared to be more confident by the end of July, perhaps indicating that the new processes were becoming embedded. We hope to continue to see good consent to treatment practice, and real benefit to patients’ treatment, care, and perception of that care. We have used this type of conditional registration to ensure improvement in other trusts and we will continue to do so.

Reviewing certificates of consent (forms T2)

Many services have contacted us with concerns over the statement in the Code of Practice (paragraph 24.79) that a form T2 (certifying that a patient consents to treatment) ceases to authorise that treatment where the approved clinician who completed it “stops being the approved clinician in charge of the treatment”. This interpretation of the Act is based on a reading of section 58(3)(a), which states that relevant treatment “shall not be given...unless... the approved clinician in charge of it ... has certified in writing that the patient is capable of understanding its nature, purpose and likely effects, and has consented to it”.

The person who is the “approved clinician in charge of the treatment in question” is a question

of fact, and the role may pass from one clinician to another frequently during a patient’s detention in hospital. This can be because the patient moves to a different ward or security level; because clinicians leave or enter employment with the detaining authority, or their responsibilities are reorganised; or simply as a result of a clinician taking leave or being otherwise unavailable to fulfill the role.

It is impractical of the law to require re-certification of the patient’s capacity and consent in all these circumstances. Where a clinician is only fulfilling the role temporarily, it appears to be unnecessarily bureaucratic. Also, requiring re-certification before any routine treatment may be counter-productive in terms of a safeguard for patients, as it could encourage clinicians to ‘rubber-stamp’ certificates without spending an appropriate time to review the medication, and personally check that the patient is giving informed consent and has the capacity to do so.

Some legal commentators have suggested that the interpretation of the revised Code on this matter is open to doubt.⁸⁴ Detaining authorities may choose to disregard the Code’s advice on such grounds, and on the impracticality of following it to the letter. We hope that, if they do disregard the advice, they will continue to require that a new form T2 is completed when there is a permanent change of approved clinician in charge of the treatment*, even if they allow (as has been common practice for many years) a ‘hand-over’ period. In these circumstances, we take the view that the old form continues to be the authorising treatment until the new clinician has had time to speak with the patient and assess whether re-certification is appropriate.

During any such interim period, it is important that all clinical staff who are administering medication to the patient are especially vigilant in checking that he or she still appears to be consenting to the medication, and still appears

* As has been required under the Mental Health Act Code of Practice for many years (e.g. 1999 edition, para 16.35).

to have the capacity to do so. Because there will be a break in the therapeutic relationship with a particular clinician, the patient's consent should not be assumed to continue. This is important for the protection of the patient and also for the detaining authority, which may be especially vulnerable to legal challenge where a patient is incorrectly assumed to have capacity or to consenting during any such handover period. Where a patient loses capacity or withdraws consent, it may be possible to continue to administer it under the authority of section 62(2), but this should trigger a request for a SOAD review of treatment.

Treatment without consent

A core purpose of the Act is to provide a legal framework for psychiatric treatment without consent. This cannot always protect patients from feeling or being damaged by compulsory interventions, however much these might be justifiable from a clinical or ethical point of view:

One patient recently admitted to the ward was forcibly injected. The Commissioner has spoken to some of the staff involved and is satisfied that the procedure was in the patient's best interests and was carried out in the safest possible way under the circumstances and with respect to the patient's dignity. However, the patient is clearly still traumatised by the event and CQC would ask that staff talk about this and counsel her on the reasons for the injection.
March 2010

When detaining authorities use force to administer treatment, they must make sure that they follow the Code's guidance wherever possible. The Code suggests that the decision to use restraint should firstly be discussed within the clinical team, and the discussion and reasons for the decision should be documented in the patient's notes.⁸⁵ We expect this guidance to be followed in all but emergency situations.

The Code also recommends holding a debriefing with the patient who has been restrained in order to administer medication (and with family or carers where appropriate) to give them an opportunity to write an account of the incident for their medical record, as well as reviewing their care plan in collaboration with them (so that, for example, the patient's preferred action in any future incident can be discussed). Such a debriefing process is an important aspect of care that reflects the Code's principles of respect and participation, but in many services it is overlooked.

Detained patients: second opinions for medication

The Care Quality Commission is required by the Act to administer the second opinion appointed doctor (SOAD) system. After the first three months of treatment, any detained patient who either does not or cannot consent to medication for mental disorder may only be given it, except in an emergency, if it is certified by a SOAD.

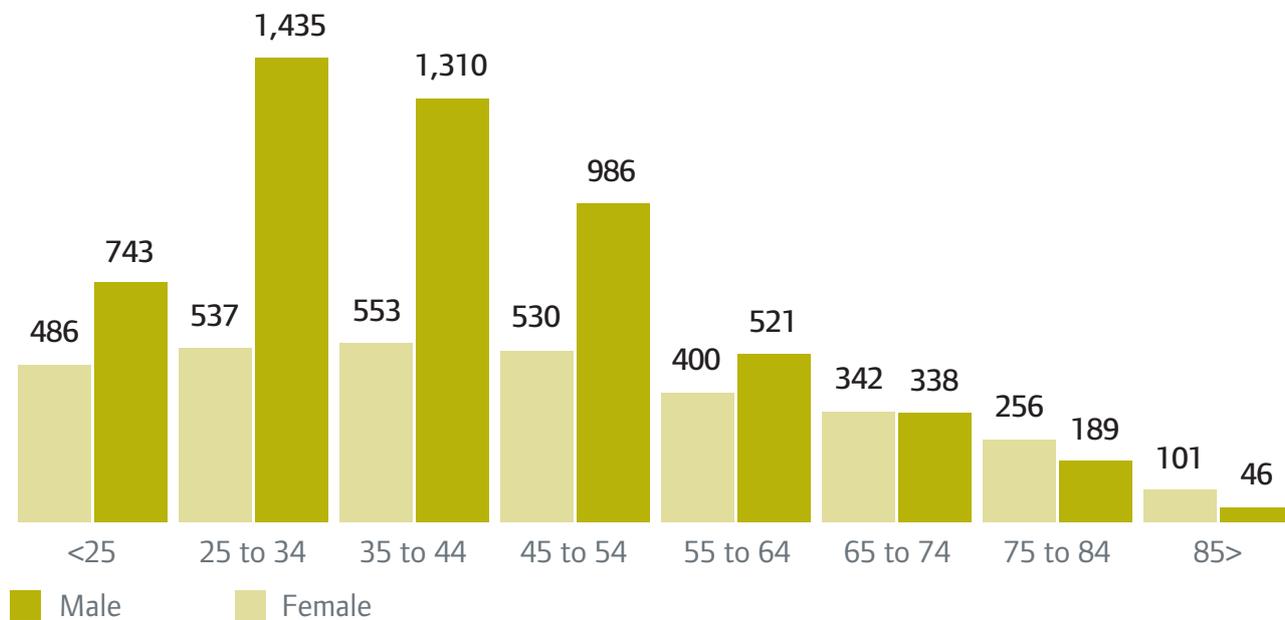
We received 8,781 requests for a SOAD to visit a patient for such certification in 2009/10, a reduction of 6% from the 9,367 requests in 2008/09.

Despite the slight drop in the number of requests to certify treatment of detained patients with medication, our administration has continued to be under considerable strain, largely due to the demands placed upon it by the number of second opinion requests in relation to patients subject to supervised community treatment orders (CTOs). These are discussed on page 109.

The age and gender of patients for whom second opinions were requested is shown at figure 18. The split between men and women reflects the gender distribution in the detained population as a whole.

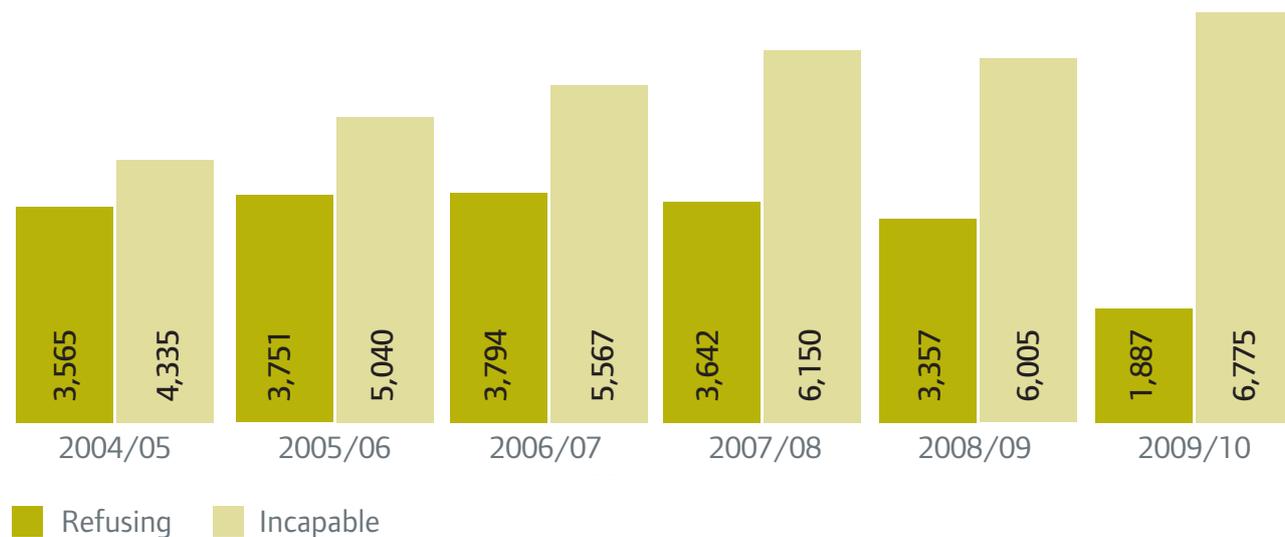
The proportion of patients referred for a second opinion visit who are deemed incapable of consent, rather than capable but refusing consent, has

Figure 18: Requests for second opinion to certify treatment of detained patients with medication, by patient age and gender, 1 April 2009 to 31 March 2010



Data source: CQC, n=8,773 (8 missing data excluded)

Figure 19: Requests for second opinion to certify treatment of detained patients with medication, by reported consent status at time of request, 2004/05 to 2009/10

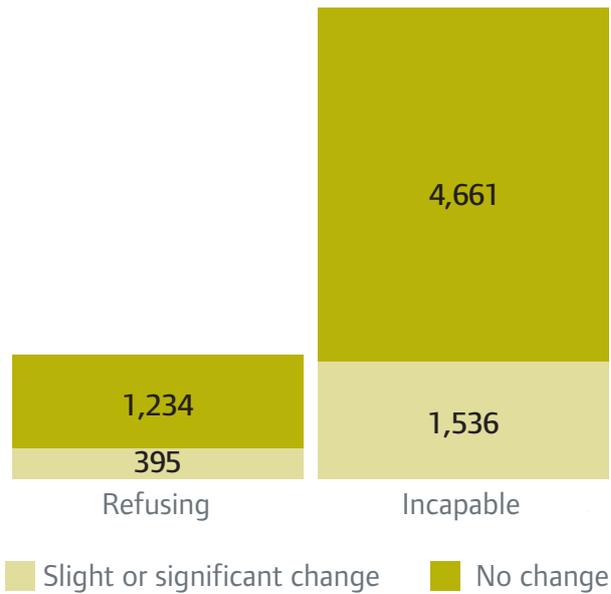


Data source: CQC, missing data excluded*

increased steadily in recent years (see figure 19).⁸⁶ In its last Biennial Report, the Mental Health Act Commission suggested that the reasons for this rise could include an increasing severity of illness in patients detained in hospital (rather than treated through community services), and/or improved clinical practice in assessing and recognising incapacity, possibly as a result of training in the Mental Capacity Act.

SOADs are asked to indicate on their visit reports whether they have made any change to the proposed treatment plan and, if so, whether in their view it was a 'slight' or 'significant' change. About a quarter of all second opinion visits result in some change to treatment. This proportion appears to be the same whether the patient is refusing consent or incapable of giving consent (see figure 20).

Figure 20: Outcome of second opinion visits, detained patients, medication only, by reported consent status at the time of request, 2009/10



Data source: CQC, n=7,826**

“ The doctor tells you what you should have and then prescribes it. There is no discussion or choice or any information leaflets given to you to help you understand it. The only option left open to the patient is to refuse the medication which results in an independent doctor visiting you, who then can give you the information you require and a helpful discussion. ”

Mark Gray, SURP member

* For example, for 2009/10, 119 patients (1.5% of the total number) are excluded as their reported consent status at the time of SOAD request was unclear from our records.

** 282 visits to consider medication and ECT, and 673 otherwise missing data excluded.

Figure 21: Ethnic categories of detained patients referred for a medication second opinion, 2009/10

	Number of patients	%	General population (%) ONS 2007	All inpatients (%) Count Me In 2008
African	361	4.1	1.5	2.5
Any other Asian background	207	2.4	0.7	1.0
Any other Black background	248	2.8	0.2	1.3
Any other ethnic group	161	1.8	0.7	1.2
Any other mixed background	109	1.2	0.4	0.5
Any other White background	441	5.0	3.4	4.7
Bangladeshi	62	0.7	0.7	0.5
Caribbean	540	6.1	1.1	5.1
Chinese	23	0.3	0.8	0.3
Indian	133	1.5	2.6	1.5
Irish	101	1.2	1.4	1.9
Pakistani	126	1.5	1.8	1.4
Welsh	9	0.1	0.0	0.0
White & Asian	33	0.4	0.5	0.4
White & Black African	34	0.4	0.2	0.4
White & Black Caribbean	95	1.1	0.5	1.2
White British	5,721	65.2	83.5	76.1
Not stated	377	4.3		
Total	8,781	100.0		

Data source: CQC

Figure 21 shows the ethnicity of detained patients referred to CQC for a second opinion. Comparative data showing the ethnicity of patients on a community treatment order against census populations is on page 98. The data does not include the majority of detained patients, who are treated on the basis of consent and therefore not referred for a second opinion.

It is therefore a breakdown of the ethnicity of patients who, after three months' treatment, remain incapacitated by their illness, or refuse consent for further treatment. The proportion of this detained group who are from Black and minority ethnic groups is higher than in the general detained population.

Use of urgent treatment powers

Despite the fall in requests for a medication second opinion for inpatients, the use of urgent treatment powers to authorise the administration of medication has risen considerably in the last few years (see figure 22). While some of the increase may reflect more robust data collection*, it seems likely that there has, in fact, been a significant increase in the use of urgent treatment powers, probably resulting from difficulties in arranging timely second opinion visits.

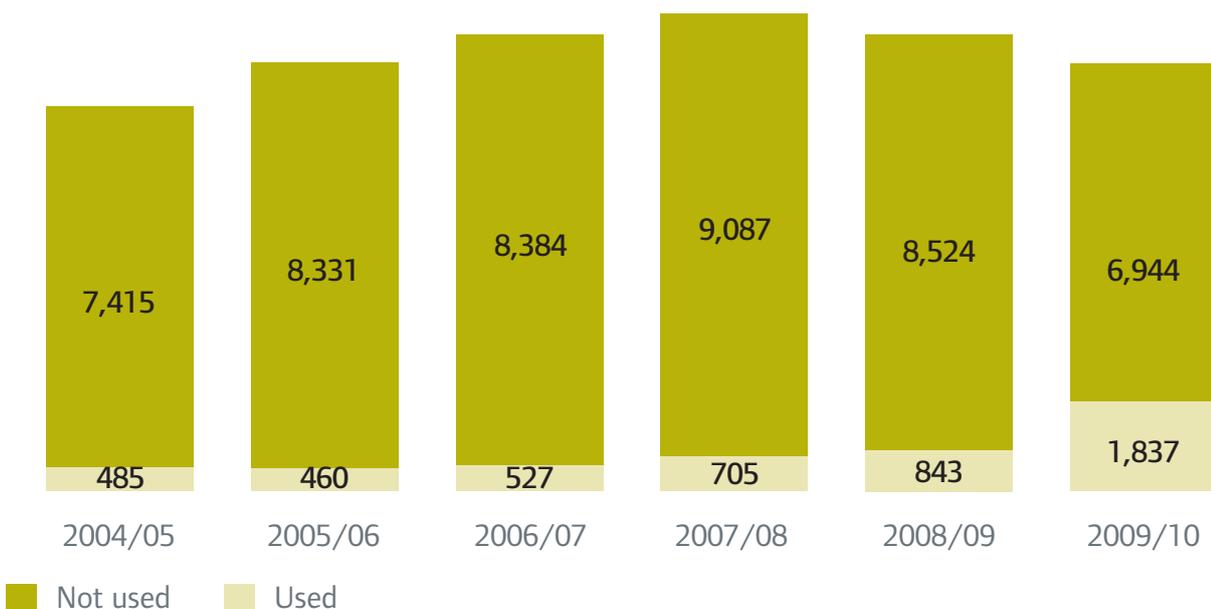
The administration of second opinions

We recognise that, as the body responsible for administering the second opinion system, CQC is compromised as an independent monitor of this aspect of the operation of the Mental Health Act. From the introduction of community treatment orders in 2008, we have experienced problems in providing a second opinion service, particularly in relation to the timeliness of visits.

We have increased the resources allocated to the SOAD service, and increased our pool of doctors by 33 to a total of 116 by the end of 2009/10, and we have continued to expand the pool since then.

There are a number of large mental health trusts who, although they make a significant number of requests for second opinions, provide no doctors to our panel or provide only one or two. The medical directors of some of these trusts may have taken the view that they cannot afford to spare doctors whose time is already under pressure, or to provide a resource that would principally benefit neighbouring trusts. This may be a false economy. While the time commitments of SOAD work need not be great, the opportunity for professional development in seeing a wide range of practice is significant and, where a trust manages a number of relatively discrete services, particularly over a wide geographic area, there is often no reason (subject to other considerations

Figure 22: Use of urgent treatment powers prior to second opinion visits for medication, detained patients, 2004/05 to 2009/10



Data source: CQC

* Services are now required to complete an application form, rather than make a request by telephoning the CQC office, which may have resulted in better reporting of the use of urgent treatment powers.

over conflicts of interest) why a doctor working in one service may not visit another as a SOAD, even though both services are ultimately managed by the same trust.

We discuss the administration of second opinions for patients subject to supervised community treatment on page 104.

Statutory consultees

SOADs are required to consult two people when carrying out a second opinion. For a detained patient, this must be a nurse and another person who is neither a nurse nor a doctor, but who is professionally involved with the patient's treatment.⁸⁷ The Code of Practice incorrectly implies, at paragraph 24.29, that this is also the rule for patients subject to community treatment orders, but in such cases the range of consultees is much wider (as discussed at on page 104).

The Code of Practice requires the consultees to ensure that they record their consultation with the SOAD, and that this record is placed in the patient's notes.⁸⁸ We frequently find that this is not done, especially by the non-nursing consultee, and we ask ward managers to bring these requirements to the attention of their colleagues.

Informing patients of the outcome of second opinions

The Code of Practice states that it is the personal responsibility of the clinician in charge of the treatment to communicate the results of the SOAD visit to the patient as soon as possible, unless he or she thinks that it would be likely to cause serious harm to the physical or mental health of the patient or any other person.⁸⁹

On many visits we find that there is an inadequate record of this process, and in some cases we have good cause to doubt that it has taken place. This can be very alienating for the patient concerned. Clinicians should always make a clear record that they have informed the patient of the SOAD's

decision and discussed the treatment plan now authorised with the patient, or else record the reasons why it is not appropriate to do this.

Concurrent use of forms T2 and T3

The second opinion system can only be a meaningful safeguard if it is able to set the parameters of treatment that may be appropriately imposed on a patient subject to coercion. For this reason, it is important that the second opinion authorisation states clearly the number and type of drugs that may be given, and to what individual or combined dosage.

This task has been complicated by the practice, described in the last report from the Mental Health Act Commission,⁹⁰ of issuing concurrent T2 and T3 certificates – the first authorising those elements of a treatment plan to which the patient consents, and the second authorising the part to which the patient does not consent.

Many patients will consent readily to some, but not all, aspects of their treatment plan. They may consent to those treatments that they consider to be the least invasive, or that have fewer side-effects, while objecting to other treatments that they feel to be invasive or harmful to their general wellbeing. For example, a patient being treated for psychosis may consent to taking antidepressant or anxiolytic medication, or oral antipsychotic medication, but withhold consent to concurrent depot antipsychotic injections.

In these circumstances, the responsible clinician and SOAD need to consider whether a plan limited to those treatments to which the patient gives consent would be sufficient to treat the mental disorder and work towards the patient's discharge from detention. If so, the principle of least restriction would require that no treatment is given without consent. If not, alongside the more difficult ethical issues that arise, it is necessary to ensure that the role of the SOAD in setting parameters of treatment without consent is not undermined.

A CQC assessor provided the following example where the issue of concurrent forms can directly undermine the SOAD safeguard:

One doctor had requested a SOAD who did not agree to all of the treatment plan. The SOAD duly completed the T3 with the treatments that she approved. The responsible clinician then interviewed the patient and decided that the patient was happy to consent to the treatment that the SOAD had not approved.

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It is of great concern that a patient may be found by his or her treating doctor to be consenting to a treatment after a SOAD determined that the patient did not consent to it and that it should not be given. This directly undermines the role of the SOAD. (see “The reality of consent” on page 79). However, we have only found a few such examples. It is more likely that a patient has consistently given consent to a part of the treatment plan, but refuses an aspect of it that is agreed to be necessary by the responsible clinician and SOAD. The problem for the SOAD is how to set meaningful and safe limits on the number of drugs prescribed and the dosages given without consent, when what may be given concurrently with consent could be outside of their control.

We have suggested to SOADs that they should make an explicit link between the validity of their authorisation on form T3 and the limits of treatment established on any extant form T2 (whether or not they have completed the latter). This would mean that, if treatments are added to any subsequent form T2, a further second opinion will be required for any treatment given without consent. Whether or not SOADs have made this explicit on their T3 forms, if visiting Commissioners find that a form T2 has been

issued subsequent to a SOAD visit, extending the treatment plan beyond that considered by the SOAD, we will consider using our powers to request a report on the patient’s treatment and/or withdraw the T3 form for a fresh SOAD opinion.⁹¹

Electro-convulsive therapy

Electro-convulsive therapy (ECT) treatment of detained patients or patients subject to community treatment orders must be certified by a SOAD, unless urgent powers of treatment are invoked.⁹² From November 2008, the law has only allowed SOADs to certify ECT treatment for patients who are consenting* or incapable of consenting to it. Patients with capacity who refuse consent can only be treated under strict criteria set out in the urgent treatment provisions of the Act (discussed under the next heading).

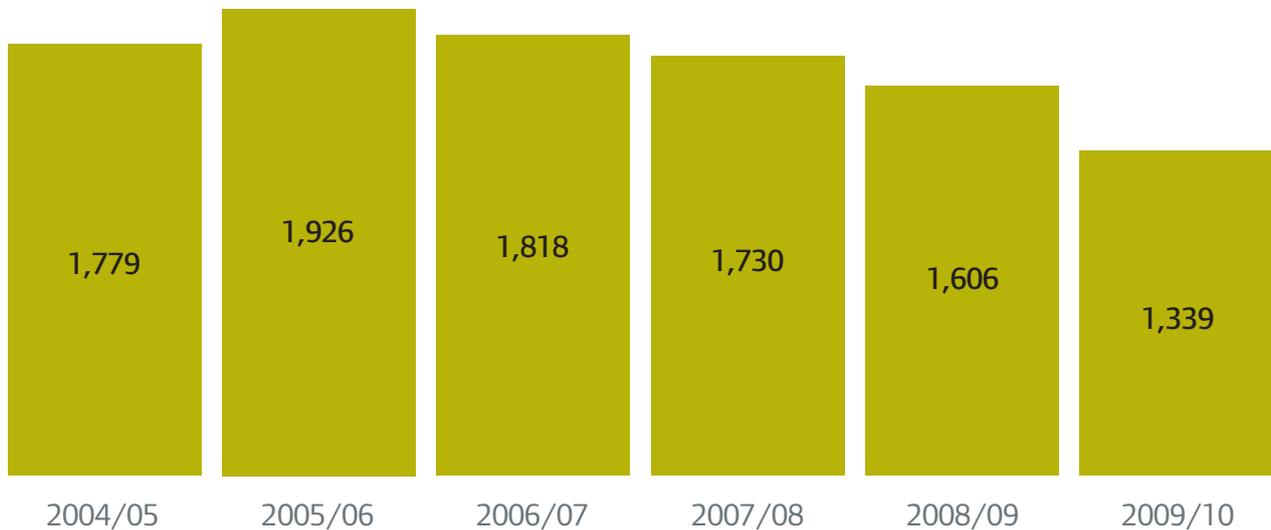
There has been a general decline in the number of requests for ECT certification over the last five years, as shown in figure 23 (overleaf).** Of the 1,339 requests in 2009/10, 288 also requested authority to give medication. Three requests related to patients subject to supervised community treatment (SCT) (compared with two such requests in 2008/09, the first year that SCT was in force). There is nothing inherent in ECT treatment that makes it unsuitable for patients living in the community but, in at least two of the five cases seen so far, the SOAD (while agreeing that ECT treatment was appropriate), questioned whether the patients concerned were well enough to be out of hospital.

Figure 24 (overleaf) shows the age and gender profile of patients referred for ECT second opinions. Patients are mostly in the older age groups, female, and suffering from depressive or schizo-affective disorders, often involving refusal of food and fluids.

* The approved clinician in charge of the patient’s ECT treatment may also certify their consent to it, but only a SOAD may certify it if the patient lacks capacity to consent. Nobody may certify ECT as appropriate if the patient is capable of refusing consent.

** On the retraction of ECT services, see Mental Health Act Commission *Risk, Rights, Recovery: Twelfth Biennial Report*, para 6.80, 2008, reporting a “trend of clinic closure and amalgamation” as a result of standards established by the voluntary ECTAS accreditation scheme.

Figure 23: Second opinion requests for ECT, detained and CTO patients, 2004/05 to 2009/10

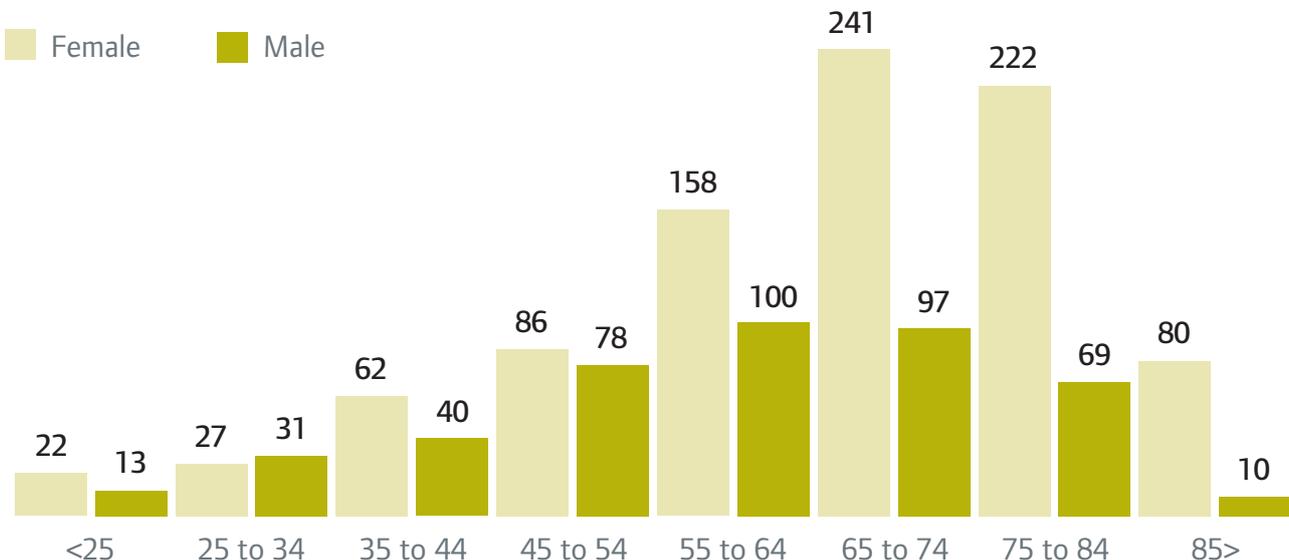


Data source: CQC (CTO requests only applicable from November 2008)

From November 2008, the law has required second opinion certification before ECT can be given to any patient under the age of 18, regardless of whether that person consents to the treatment or is detained under the Act.⁹³ During the year, we received one request for a

second opinion to consider ECT treatment for a young woman aged 16, and another for a young woman who, at the time of the request, was just weeks away from her 18th birthday. Both patients were detained under the Act. Treatment was not authorised for the 16-year-old.

Figure 24: Second opinion requests for ECT, detained patients, by patient age and gender, 1 April 2009 to 31 March 2010



Data source: CQC, n=1,336

We received no requests to arrange ECT second opinions for informal patients under the age of 18, although we cannot assume that all clinicians caring for such patients will know that certification is required, and therefore cannot say with certainty that no such treatments were given.

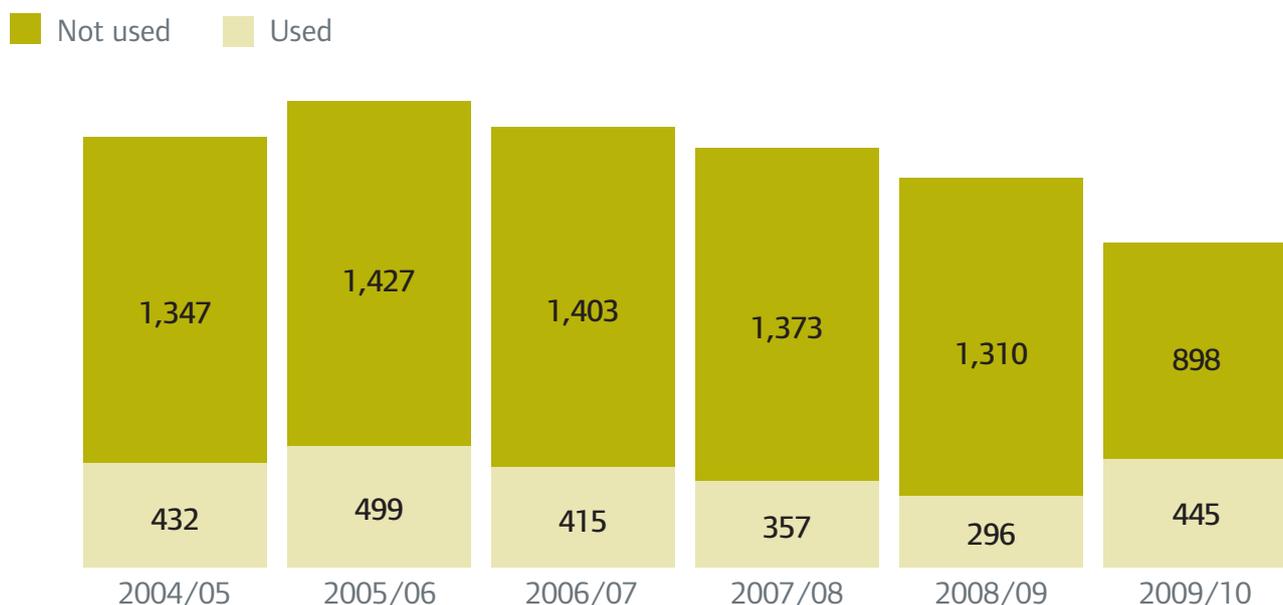
Urgent treatment with ECT

From November 2008, the Mental Health Act restricted the criteria for urgent ECT treatment to that which is immediately necessary either to save the patient's life or to prevent a serious deterioration of the patient's condition.⁹⁴ This is a stricter test than previously, and the initial data from 2008/09 suggested that there might be, as would be expected, a consequent reduction in the number of treatments given under urgent powers. However, in 2009/10, a third of all patients referred for an ECT second opinion were given at least one ECT treatment under urgent treatment powers before the SOAD visit was requested (see figure 25). This is a greater proportion than in previous years.

While some of this increase may be accounted for by better data collecting, more detained patients are undoubtedly receiving ECT without the safeguard of a second opinion than in previous years. This is a matter of concern to CQC. We are aware that delays in arranging SOAD visits may be a significant factor in this rise (on average it took six days from the request to the SOAD visit for ECT cases, considerably longer than in previous years), and we are further prioritising second opinion requests for ECT treatment in light of this. However, in many cases the urgent treatment powers have already been used at the point at which the second opinion is requested, which may suggest other explanations for the rise, such as increasing severity of the patient's condition on admission. This is clearly an area that needs to be studied further.

In February 2010, we were contacted by a responsible clinician who claimed that the legal provisions over ECT had done his patient "a great disservice". The patient, who was detained under section 3, was suffering from a severe depressive

Figure 25: Use of urgent treatment powers prior to second opinion visits for ECT, 2004/05 to 2009/10



episode with psychotic features as part of a bipolar disorder. She was in a highly tormented state, with a range of distressing nihilistic delusions, including believing that she had been responsible for the recent earthquake in Haiti. Knowing of her past resistance to treatment, the clinician proposed ECT. Although the patient did not object, she did not have capacity to give consent, so a SOAD visit was requested. The SOAD visited and authorised ECT treatment, but the time taken to do this delayed treatment by a full week.

Before the change of law in November 2008, it would have been an option to give ECT as an urgent treatment while awaiting the SOAD visit, on the grounds that it was “immediately necessary to alleviate serious suffering”.⁹⁵ The amended Act no longer allows urgent ECT treatment to be given on this basis, as discussed above.

The case provides an unusual example of a patient who did not need ECT to save her life (she was eating and drinking reasonably well) or to prevent a serious deterioration of her condition, but the lack of treatment while a SOAD visit was arranged may have caused her serious suffering. To the clinician, the law appeared to be callous; but any absolute legal restriction on the circumstances whereby a certain treatment can be given risks creating these situations. We therefore raise this case to stimulate debate among practitioners and legislators.

We will make every effort to speed up second opinion arrangements for ECT where clinicians feel that delays would cause suffering to their patients, but we urge clinicians to make such situations clear when they make the request for a SOAD visit.

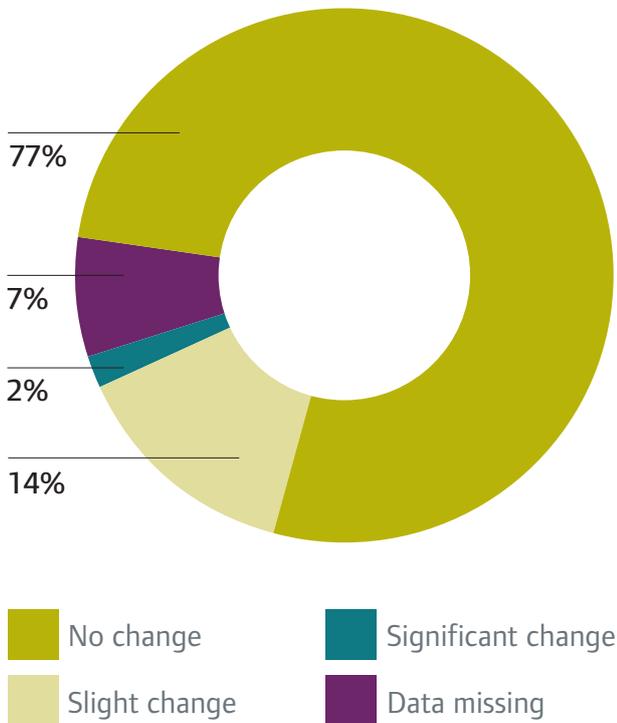
Outcome of ECT second opinions

The way in which outcomes of second opinions are presently recorded and collated is not very helpful in producing a meaningful account of the result of SOAD activity in relation to ECT. The categories of ‘slight’ or ‘significant’ change that SOADs are asked to use to indicate alterations to the proposed treatment plan are insufficiently precise to determine whether or not ECT was authorised and, if so, how many sessions were authorised as a course of treatment. We intend to address this over the next year. What data we have is shown in figure 26. We have only included the 1,029 visits where ECT was the only proposed treatment, which meant that we excluded over 300 visits where both medication and ECT were considered, as we are unable to differentiate between the two types of treatment in terms of reported outcome. For 77 visits (7.5% of all 1,029), our database was inconclusive.

In 145 cases (14% of the total), the treatment plan was slightly changed, usually indicating that the SOAD authorised fewer ECT sessions than were proposed by the responsible clinician. Most authorisations allow for 12 sessions as a ‘course’ of ECT, although in some cases this will be reduced to take account of any sessions given under urgent treatment powers. Such powers had been used before the SOAD visit was requested in 26 cases resulting in a slight change to the treatment plan.

In 18 cases (2% of the total) SOADs had indicated a significant change, which we were able to verify on a case-by-case basis. In two of these cases, the SOAD had approved far fewer ECT sessions than were requested by the responsible clinician (three and six sessions, respectively, rather than the 12 sessions proposed). In this way SOADs can ensure that the patient’s case is reconsidered within a short

Figure 26: Outcome of second opinion visits for ECT only, 2009/10



Data source: CQC

time. In four cases, SOADs determined that the patients were capable of giving or withholding consent to ECT at the time of the visit: in one example, the SOAD certified that the patient was consenting, but the remaining three were deemed to be making a capacitated refusal of consent that precluded treatment, and the responsible clinician was advised that they could not give ECT treatment unless and until the patient gave consent. In two further cases, patients had responded to medication at the time of the visit and the SOAD and responsible clinician agreed that ECT was no longer needed. Our records showed that in other cases, responsible clinicians did not agree with SOADs' decisions to decline ECT authorisation.

Neurosurgery for mental disorder

The Mental Health Act requires the approval of a CQC-appointed panel before any patient can undergo a surgical operation with the aim of destroying brain tissue for the treatment of mental disorder. The panel, consisting of a doctor and two other people, must consider whether the patient gives valid consent to the treatment, and whether it is appropriate for the treatment to be given.

We received only one request to consider this treatment in 2009/10. The patient concerned had a long history of severe depressive illness, with persistent and disabling symptoms including suicidal plans and actions, high anxiety, and marked anhedonia. She had been treated with a combination of medication, ECT, Deep Brain Stimulation (DBS) and various forms of psychological therapy, but none had achieved any lasting improvement.

The panel authorised the treatment and the patient underwent a stereotactic anterior cingulotomy at Frenchay Hospital in Bristol in February 2010. The surgery went well, with the patient reporting very positive benefits. We shall be taking a close interest in the longer-term results.

This is the first referral to a section 57 panel of a patient who has undergone DBS, a procedure discussed in past Mental Health Act Commission biennial reports⁹⁶ and described by some clinicians as the likely successor to neurosurgery involving the cutting (ablation) of brain tissue.⁹⁷ In this case, it appeared that the benefits of DBS were not sustainable, and the consultant who had carried out the DBS trial referred the patient for the older ablative procedure, and personally carried out the operation.

In its last biennial report, the Commission repeated its call for DBS to be afforded the safeguards of section 57 (as it is under the equivalent legislation in Scotland). It said that “DBS remains at an experimental stage, and is certainly not likely to be in widespread use in the immediate future” but argued for “regulating such procedures as soon as cases appear or are likely to appear, no matter how rarely”.⁹⁸ As the above example shows, while DBS is still an experimental procedure as a treatment for mental disorder, it is now used in some locations.

During 2009/10, we were also contacted by clinicians who were planning a trial of DBS as a treatment for Tourette syndrome (which has been classified as both a neurological and psychiatric disorder), asking whether the legal safeguards of section 57 were applicable to patients who might take part in the trial. Of course, they are not. However, the nature of DBS – a procedure related to leucotomy but carried out by placing electrodes in the brain rather than cutting brain tissue – suggests that additional safeguards are needed. We would welcome consideration of this matter by government.

Detained patients and consent to treatment: our recommendations for improvement

→ **Providers of mental health services, particularly front line managers and staff**

Improve practice in assessing and routine recording of capacity and consent, including evidence of ongoing discussion with patients.

→ **Providers of mental health services**

Increase the size of the SOAD panel to meet the growth in demand for this service by releasing consultant psychiatrists to act as SOADs.

→ **Providers of inpatient mental health services, particularly ward managers and inpatient staff**

Ensure that statutory consultees make a record of their conversation with the SOAD and that there is record that patients have been informed of the outcome of second opinions.

→ **Department of Health**

Consider extending the section 57 safeguard to people receiving Deep Brain Stimulation.

Community treatment orders



Community treatment orders (CTOs) were introduced from November 2008, and so 2009/10 was the first full financial year that they were in force. Patients who are detained in hospital for treatment (whether under section 3 or an equivalent part 3 power without restrictions*) can be discharged into the community if they still require treatment for mental disorder on the grounds of their own health or safety or for the protection of others, but it is agreed that such treatment can be given outside hospital, provided that there is a power to recall the person to hospital if the arrangements in the community are deemed not to be working.

The use of community treatment orders

According to official data collections, there were 4,107 CTOs made in 2009/10, with a total of 6,241 orders in the 17 months from their introduction in November 2008 (figure 27). This is an average of 367 each month: a much greater use of CTOs than had been anticipated by the Department of Health before the power was introduced.⁹⁹

The recall power was used 1,217 times in 2009/10, or 1,424 times from the introduction of the power. Therefore, approximately one in five patients placed under a CTO have been recalled at some point, although we cannot be more precise as some patients may have been recalled more than once. Just under a third of all CTOs implemented up to the end of March 2010 had ended at that time: 922 patients (15%) were returned to detention and 1,043 (17%) released from compulsion.

Figure 27: Use of community treatment orders, 2008/09 to 2009/10

	2008/09* *	2009/10
From Section 3	1,602	3,736
From Section 37	56	121
From Section 47	2	6
From other sections [†]	474	244
Total	2,134	4,107
Recalls	207	1,217
Revocations	143	779
Discharges	33	1,010

Data source: KP90

* That is, hospital orders or transfers from prison

** Data from 3 November 2008, when CTO powers implemented.

† Including transitional powers operative in 2008/09 that allowed that patients subject to Aftercare under Supervision (section 25A), a community power abolished with the introduction of CTOs, could be transferred onto CTO provided they met CTO criteria.

Currently, only a very small percentage of CTOs appear to involve people who were detained in hospital following conviction of a criminal offence: less than 3% of people discharged onto a CTO were detained under a section 37 court order. However, discharge rates are much less for section 37 than for section 3, and proportionately, CTOs are used as often upon discharge from either power.

As courts become accustomed to CTOs as an eventual route for patients' discharge from detention that they order, this proportion may grow. When a court considers making a hospital order under section 37 of the Act, the patient's legal representative or doctor may be able argue that a restriction order is unnecessary, as a CTO enables clinicians to replicate the powers of conditional discharge that a restriction order brings, without passing the control of the patient's treatment out of clinical hands to the Ministry of Justice. We are aware of one case where the judge agreed with such a proposal, after the defendant had been convicted of reckless arson. The judge asked that a letter be kept on the patient's file to say that he had declined to make a restriction order only on the basis that a CTO be considered at the point of discharge from detention in hospital, but that this was a matter appropriately left to clinical discretion.

Figure 28 shows some demographic data of the CTO populations counted on 31 March in the first two years of the power. Gender does not appear to be a determining factor in whether CTOs are used: both the detained and CTO populations are roughly two-thirds male. A smaller proportion of CTO patients have learning disability as the primary reason for using the Act (4% of CTO patients compared to 8% of the resident detained population). This may be a reflection of the Act's requirement that learning disability must be associated with abnormally aggressive or seriously irresponsible conduct for its powers to be applied:¹⁰⁰ this group of patients may be particularly difficult to settle into community placements.

Data collected as a result of our management of the second opinion service is a rich source of information on the use of CTOs. From this, we know that there are more Black and minority ethnic (BME) patients referred for a second opinion than might be expected from the census findings of the general population, or even the detained population liable to be placed upon a CTO (see figure 29 showing the figures for 2009/10). (Of course, we recognise that this is not a direct comparison, as the census data is collected on a single day, whereas our CTO data is collected over the year.)

Figure 28: Patients on CTOs at 31 March, by gender and primary aspect of mental disorder, 2008/09 to 2009/10

	2008/09	2009/10
Male, learning disability	56	96
Male, mental illness*	1,122	2,013
Female, learning disability	8	45
Female, mental illness	569	1,171
Total	1,755	3,325

Data source: KP90

* While this category is predominantly 'mental illness' it will also include patients with personality disorder, autistic spectrum disorders, etc

Figure 29: Ethnic backgrounds of patients referred for CTO second opinions, 2009/10, with Count Me In 2008 and ONS 2007 population assessment comparators

Ethnicity	Community treatment order patients						General population ONS 2007	All inpatients Count Me In 2008	Eligible patients Count Me In
	Male		Female		Total				
	no.	%	no.	%	no.	%			
African	107	4.6	52	4.0	159	4.4	1.5	2.5	3.6
Any other Asian background	82	3.6	36	2.8	118	3.3	0.7	1.0	1.3
Any other Black background	96	4.2	25	1.9	121	3.4	0.2	1.3	1.9
Any other ethnic group	38	1.7	21	1.6	59	1.6	0.7	1.2	1.4
Any other mixed background	33	1.4	15	1.2	48	1.3	0.4	0.5	0.8
Any other White background	111	4.8	82	6.3	193	5.3	3.4	4.7	5.1
Bangladeshi	19	0.8	6	0.5	25	0.7	0.7	0.5	0.6
Caribbean	141	6.1	76	5.8	217	6.0	1.1	5.1	6.5
Chinese	4	0.2	5	0.4	9	0.3	0.8	0.3	0.4
Indian	48	2.1	23	1.8	71	2.0	2.6	1.5	1.7
Irish	18	0.8	11	0.8	29	0.8	1.4	1.9	1.6
Pakistani	51	2.2	8	0.6	59	1.6	1.8	1.4	1.7
Welsh	1	0.0	0	0.0	1	0.0	0.0	0.0	0.0
White & Asian	6	0.3	4	0.3	10	0.3	0.5	0.4	0.4
White & Black African	13	0.6	6	0.5	19	0.5	0.2	0.4	0.5
White & Black Caribbean	29	1.3	6	0.5	35	1.0	0.5	1.2	1.5
White British	1,416	61.4	874	66.8	2,290	63.3	83.5	76.1	71.0
Not stated	95	4.1	58	4.4	153	4.2			
Total	2,308	63.8	1,308	36.2	3,616	100			

Data source: CQC / ONS

The BME composition of CTO patients referred for a second opinion is also higher than the BME composition of detained patient referrals (figure 21), although any comparison is complicated by differences in the criteria for referral in the two groups (see 'The role of the SOAD for CTO patients on page 107). We recommend that further research on the possible race equality impact of CTOs is carried out.

Our demographic and clinical study of a sample of CTO patients

Over the year, we analysed a sample of 208 CTO second opinions, to look into the clinical and demographic aspects of the CTO and SOAD practice in authorising treatment. We included as many examples as possible where SOADs had changed treatment plans, so that we could also gauge the effect of SOAD visits on the treatment of these patients. We also selected at random an equal number of second opinions where the treatment plan was unchanged, to help with some general observations on the demographic and clinical aspects.

The majority of people under CTOs (81% of our sample) were suffering from schizophrenia or other psychotic and delusional disorders

falling within category F20 of the International Classification of Diseases (ICD-10)¹⁰¹ as shown in figure 30. This is as expected, as these people are the most likely to be prescribed antipsychotic medication as a long-term, maintenance therapy. The remainder were mostly patients with mood disorders falling with ICD-10 categories F30-F39, particularly bipolar affective disorder (12% of our sample). Again, people in this category are likely to be prescribed medication for extended periods to prevent relapse or unmanageable symptoms.

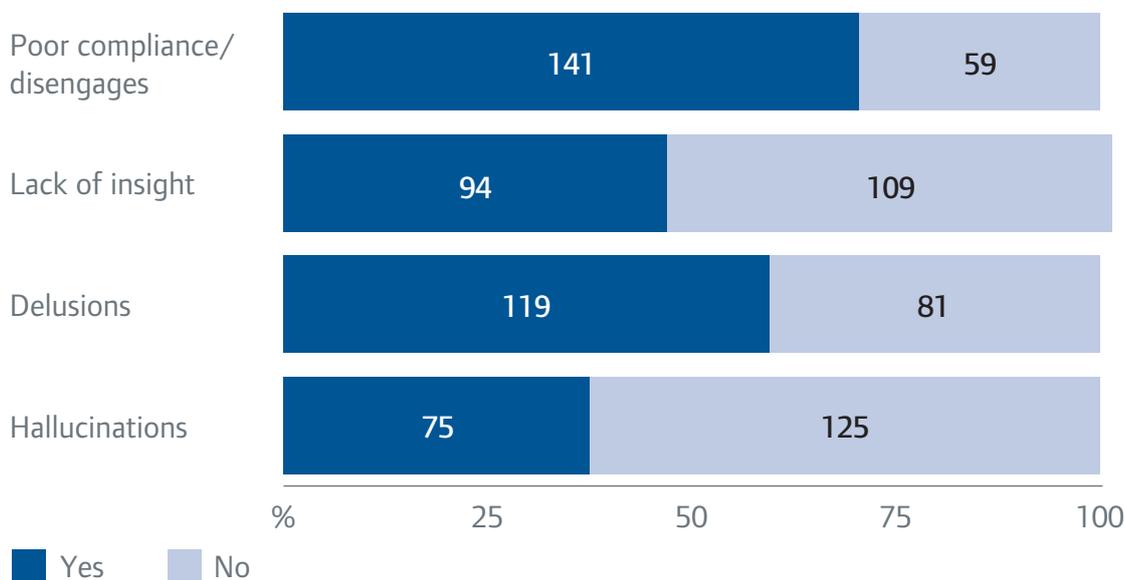
Less than half of the patients (45%) were perceived to lack insight into their illness. Fifty-seven per cent had a history of delusional symptoms, and 36% a history of hallucinatory symptoms (figure 31 overleaf). Surprisingly, given that CTOs are meant to help 'revolving door' patients who would otherwise disengage with services, 30% of the patients in our sample did not have a reported history of non-compliance or disengagement. This suggests that the high use of CTOs – much greater than government estimates at the time the law was passed¹⁰² – could be a result of the powers being applied preventatively beyond the group of patients for whom they were primarily designed. It would be an extremely unfortunate distortion of

Figure 30: CTO sample – stated diagnosis

Stated diagnosis	Frequency (%)
F00-F01 Organic disorders	1 (0.5%)
F20 Schizophrenia, schizoaffective or delusional disorder	169 (81%)
F30-F39 Mood disorders	24 (12%)
F50-F59 Associated physical/psychological disorders	2 (1%)
F60-F69 Personality disorders	2 (1%)
F70-F79 Learning disability	1 (0.5%)
F80-F89 Psychological development	3 (1.5%)
Non-specific	6 (3%)

Data source: CQC, n=208

Figure 31: CTO sample – history and symptom clusters

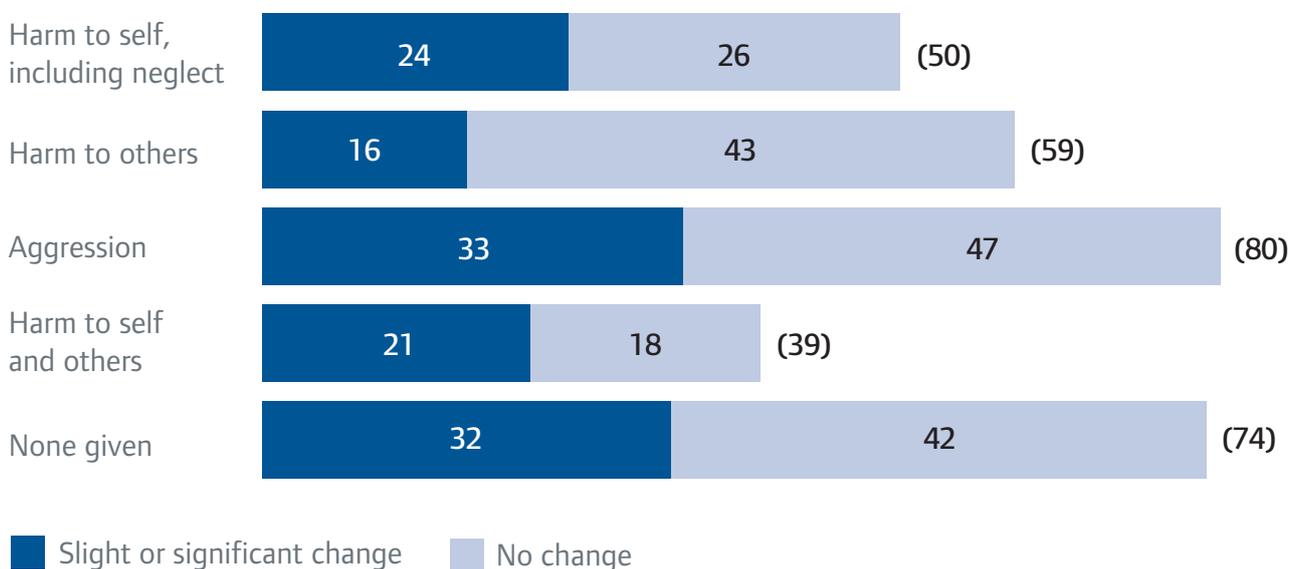


Data source: CQC, n=208, missing data excluded

Parliament’s intention if CTOs were to become the ‘normal’ route for the discharge of civil detainees from hospital.¹⁰³ This is a question that requires more research.

Figure 32 sets out the types of risk that SOADs recorded in their reasons for certifying treatment. The categories are not all mutually exclusive: for example, ‘aggression’ is likely to be cited alongside categories such as ‘harm to self and

Figure 32: CTO sample - risks mentioned in SOAD reasons for certifying treatment

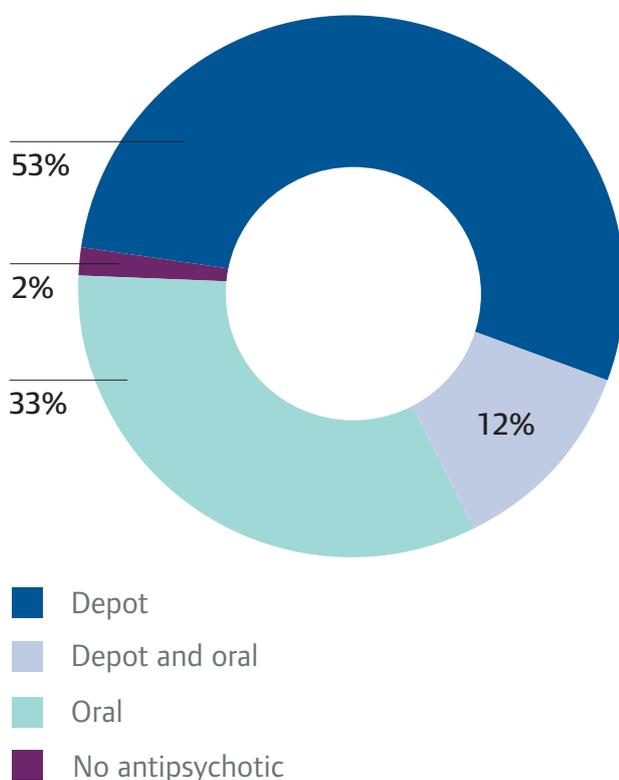


Data source: CQC, n=208

others'. However, it is clear that, in roughly half of all cases, some form of risk to others was a factor in approving the treatment, and by implication for the rationale behind the CTO. There was no identifiable statement of risk in 36% of the sample (74 reports). This may be largely explained by the fact that 33% of the sample (69 reports) consisted of consenting patients, for whom such statements may be unnecessary. Nevertheless, we will continue to focus on report writing and providing reasons for decisions in future training events for SOADs.

Almost all CTO patients seem to be prescribed some form of antipsychotic medication. Figure 33 shows the route of administration of such medication in our sample. Overall, 65% were being given an antipsychotic depot injection as a part of their treatment plan.

Figure 33: CTO sample – antipsychotic use



Data source: CQC, n=193 (15 missing)

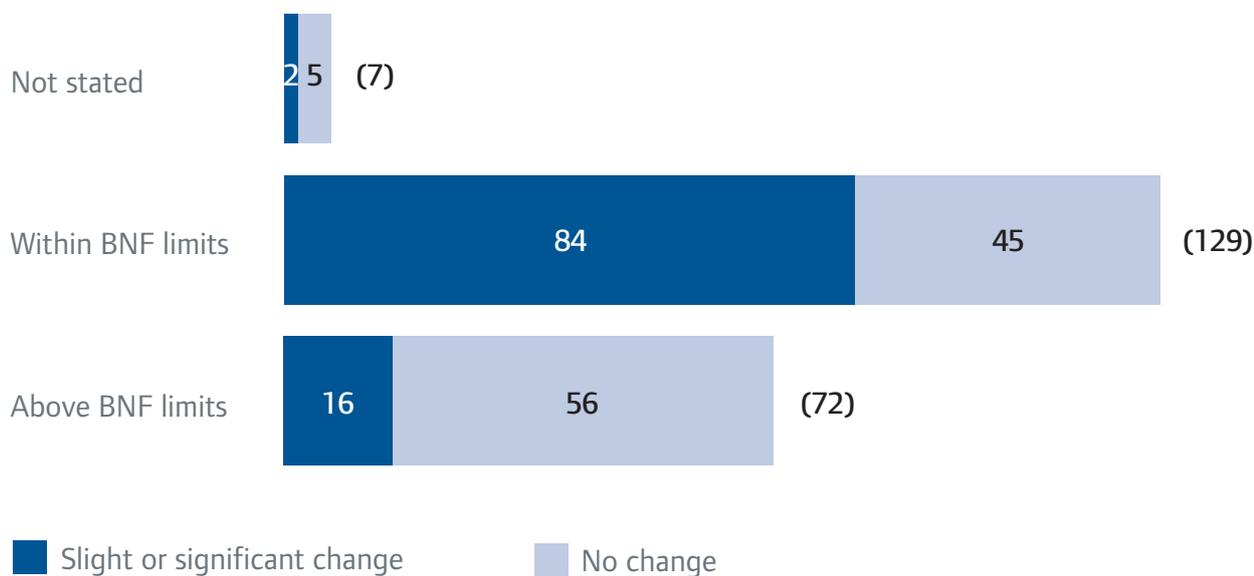
From a clinical perspective, depot injections may be the preferred form of treatment for CTO patients, given that professional staff can manage its administration directly. However, many patients that we speak with would prefer not to be given depot injections, in some cases because of side-effects, but also because they may feel humiliated, either by the physical process of the injection itself (which is normally given in the buttock), or because they see it as a sign of a lack of trust or confidence in their willingness or ability to manage their own medication.

Seventy-two patients (35% of the sample) were receiving dosages above the recommended limits of the British National Formulary (BNF) (figure 34). This is not, in itself, necessarily a sign of bad practice. Some patients with severe psychosis may be medication resistant, and BNF limits often reflect the efficacy of treatment among outpatient populations with moderate symptoms.¹⁰⁴

However, CTO patients who are receiving doses of antipsychotic medication above BNF limits should be able to expect basic health monitoring as recommended in the Royal College of Psychiatrists' *Consensus statement on high-dose antipsychotic medication*¹⁰⁵, and regular reviews of medication, including opportunities to discuss concerns about side-effects with the prescribing physician. The care arrangements for CTO patients are not always conducive to this, as not all CTO patients appear to have the level of access to professional support that this implies.

In some cases, questions of access to professional support arise because the responsibility for prescribing psychiatric medication to a CTO patient has been passed to a GP. This raises several connected issues: whether the trust will be able to monitor compliance with the SOAD certification; whether GPs can be expected to be familiar with the Act to ensure continuing legal compliance; and whether the patient will have access to specialist pharmacological monitoring of appropriate dosage, or to the monitoring recommended by the Royal College of Psychiatrists in cases of high-dose medication.

Figure 34: CTO sample - whether treatments approved were within BNF limits



Data source: CQC, n=208

Services should review their caseloads to ensure that they are providing patients on CTOs with safe and appropriate treatment, including regular specialist medication review, where appropriate, and opportunities for patients to raise any concerns over medication with the prescribing doctor.

The administration of community treatment orders

On our visits and in other discussions with professionals and patients, we have noted some issues in the administration of CTOs.

Professional roles

Many trusts have adopted the ‘functional’ model, the core feature of which is that consultants work with either inpatient or community services, with a dedicated specialist team replacing older-style geographic sectors. A common criticism is that this can lead to problems with continuity of care, although these can be solved with careful coordination and good communication.¹⁰⁶

We have found that continuity of care can be a problem for patients and professionals alike. In some cases, it was clear that there were communication problems at the start of the CTO process:

It was of concern to hear from a number of different professionals how little communication there sometimes is between the team responsible for the care of the patient in hospital and the Community Mental Health Team responsible for aftercare. We were informed of patients being discharged from hospital on CTO without the community team being aware that the patient had been discharged or a CTO made... We were informed that the responsible clinician making the CTO does not always consult the community team before making the conditions attached to the CTO. Those working in the community expressed concerns that conditions made might not be achievable if the responsible clinician making them was not fully aware of what was available in the community.

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Unsurprisingly, the later care arrangements of CTO patients, who are liable to formal recall to hospital at any time, also tend to show up the stresses on each functional team – both may be struggling with its workload of patients and keen to assign responsibility to the other for the patient’s care. In a typical example, CTO patients arrived at the hospital on recall by their community-based responsible clinician, but on arrival the hospital-based consultant became the responsible clinician and, with little or no prior knowledge of the patient concerned, had to determine the next action, including deciding whether or not to revoke the CTO. The hospital administrator tried to ensure that the approved mental health professional (AMHP) involved in such decisions was, wherever possible, someone from the patient’s team, rather than a duty AMHP who may be unfamiliar with the patient.

The role of AMHPs as a safeguard in the use of CTOs

To make a CTO, the responsible clinician must complete a statement on form CTO1 that the criteria for imposing the order are met, and an AMHP must then sign a similar statement on the same form. The AMHP should play an important role as a safeguard against any unwarranted use of CTO powers:

It was interesting to learn that an AMHP had refused to agree to the making of a CTO on the grounds that there was no evidence that the patient would not comply with treatment without one.

November 2009

In contrast to applications for detention, the Act sets no limit to the time that may pass between these two statements. In our view, this does not exempt any extended lapse of time between the two professionals’ certification from calling into question the legality of the subsequent order. In January 2010, we were made aware of one case where this arose: a Mental Health Act manager was presented with a form CTO1 where the initial doctor’s statement had been completed

seven months before the AMHP had certified that conditions were met and the power to make the CTO was exercised. We agreed that this lapse of time was not acceptable – the patient’s circumstances could have changed radically in the period between the two statements. It would have been better if the responsible clinician had re-certified at the later time his opinion that the conditions for the CTO were met.

We have noticed a similar issue during the CTO renewal process. The Act’s only limitation on the time that may elapse between certification by the responsible clinician and by the AMHP that renewal conditions are met is established by the requirement that the responsible clinician must initiate the process no earlier than two months before the CTO would otherwise expire.¹⁰⁷ Although this means that there could be a gap of nearly two months between the responsible clinician and AMHP statements, in our view it is good practice to try to avoid such long periods between the two statements wherever possible.

Even more importantly, neither the Act nor the Code of Practice requires the AMHP to actually meet with the patient. We have seen examples where it is not clear that the AMHP has consulted any wider than reading the medical file and the responsible clinician’s statement. In some cases, the AMHP’s role appears to have been limited by their late involvement in the process (i.e. when the authority for detention or CTO is shortly to expire). Ideally, the AMHP who is consulted over starting or renewing a CTO should already be involved in the patient’s care, and therefore well placed to take into account the patient’s wider social context. But whether or not the AMHP is involved personally with the patient, it is imperative that he or she is given time and opportunity to meet with the patient and explore that social context through, for example, follow-up contact with family members.

AMHP background reports for CTOs

When a patient is first admitted under detention, it is good practice for the AMHP making the

application to leave an outline report for the hospital, giving reasons for the application for admission and details of any practical matters about the patient's circumstances that the hospital should know about.¹⁰⁸ In our view, it is good practice for the AMHP to make a similar report when supporting the initiation, renewal or revocation of a CTO.* For CTO, the Code explicitly suggests consideration of whatever support networks the patient may have; the potential impact of CTO on the patient's family; and employment issues.¹⁰⁹ We raised this issue at a CTO visit to a trust in March 2010, and are pleased that the local authority has responded with a new policy and training for AMHPs, requiring them to make such independent reports of their assessments.

Statutory consultees for second opinions

As discussed on page 88, the Code of Practice gives apparently misleading advice over who may be a statutory consultee for a second opinion in relation to a patient subject to a CTO. For patients detained in hospital, such consultees must be a nurse, and another who is neither a nurse nor a doctor.¹¹⁰ For CTO patients, one consultee must not be a doctor, and neither may be the approved responsible clinician or the clinician in charge of the patient's treatment.¹¹¹ The Code should be amended to give correct advice as soon as the opportunity arises, as this has led to unnecessary confusion.

Recall to hospital

The power to recall a CTO patient to hospital is, according to the Code of Practice, "intended to provide a means to respond to evidence of a relapse or high-risk behaviour relating to mental disorder before the situation becomes critical and leads to the patient or other people being harmed".¹¹² When used for this purpose, recall should be a proportionate response to risk and implemented only after other means – such as visiting the patient in the community, or

arranging for informal hospital admission – have failed.

However, recall can also be used to enforce the mandatory conditions of CTO – that the patient makes him or herself available for medical examination (whether by the clinical team or a SOAD) or so that the power can be renewed. In these circumstances, the Act does not set any additional test or threshold for the use of recall other than if it is necessary to enforce the mandatory condition. Nevertheless, responsible clinicians are often reluctant to use recall to enforce a meeting between the patient and a SOAD, feeling that this can be damaging to the therapeutic relationship between the patient and the community teams responsible for delivering their day-to-day care:

Professionals highlighted the number of times a patient is required to be available to be seen by professionals from other organisations. For example, the SOAD from CQC, the hospital manager's hearings for the renewal of the order, and first-tier Tribunal hearings as a result of the patient's case being referred. Many instances were given of the frustration and irritation patients feel at being "reminded" of their status every time they have to present themselves for examination. As the task of coordinating and conveying the patient to these appointments usually falls to the care coordinator, there was concern expressed that the therapeutic alliance the teams are trying to foster with the patient can be disrupted by these requests.

November 2009

This highlights a tension in the very nature of CTOs: the aim is to settle a patient into engagement with community services, but the sanction of removal to hospital itself can cause the patient to disengage from the community team.

* The Code is silent about this, although it does require that AMHPs who decide *not* to support the making of a community treatment order leave a record of their decision, and the reasons for it (Mental Health Act Code of Practice, para 25.27)

Problems with recall

We have encountered some examples of difficulty in recalling a patient when it has been considered a proportionate response to risk. In most cases, the problem is locating an available bed. In the following example, the recall of a 17-year-old CTO patient was unacceptably delayed because of concerns over age-appropriate accommodation:

This patient was made subject to the conditions of a CTO in August 2009, and again in October 2009 following a revocation of the first CTO. From discussion with a doctor involved in his care, it is apparent that efforts have been made for several weeks to again recall him to hospital, but difficulties were being experienced in identifying an ‘age appropriate’ bed. The trust’s attention is drawn to the Code of Practice, paragraphs 36.67 - 36.74. Where the need to be in a safe environment overrides the suitability of that environment for their age, a short-term placement would be acceptable. If there is any delay in finding an age-appropriate placement outside the trust, it should ensure any risks to the patient or others are mitigated by adapting, as a short-term measure, an internal placement which meets the patient’s needs.
February 2010

A tragic death in October 2009 provided some practical lessons about recall. The Act requires that the patient is served with a written notice of recall to hospital on form CTO3, which the Code of Practice suggests should normally be handed to the patient personally (in which case it takes immediate effect)¹¹³, but should otherwise be delivered to the patient’s usual or last known address.¹¹⁴ The Code generally advises against posting the notice.¹¹⁵ Where it is posted, it is deemed to have been served on the second working day after posting.¹¹⁶ However, even when the notice is delivered to a patient’s address (but not to that patient personally), the law requires that it is only deemed to have been served on the following day.¹¹⁷ Technically, this means that a

notice put through a patient’s letterbox by hand is not effective until just after midnight that day. This may leave a dangerous gap in the authority to convey a patient back to hospital when the need to recall is urgent.

Mrs X was a woman in her 40s, suffering from a schizoaffective disorder with a history of admissions under the Act and at least two serious suicide attempts in the past. She lived alone but near her mother, who had alerted services at times of crisis in the past. Mrs X had been put onto a CTO at the end of June 2009 after about nine months as an inpatient, following a pattern of multiple admissions. She had seemed relatively settled on the CTO, accepting depot and attending as an outpatient, but then refused medication, failed to keep appointments and withdrew from engagement with services. As there was also a clear deterioration of her mental state, it was decided to recall her to hospital.

Medical notes record that, on 13 October:

“recall paperwork prepared tried to deliver this at 4.40 pm X not at home. Spoke to her on the phone X stated she is not happy to see anyone from the team. Unable to access letter box therefore paperwork to be posted as per MHA”.

On the basis of this, the records state that:

“recall ... becomes activated on 16th when X will have received it and if not presented to [hospital] a warrant will be obtained to remove her”.

The police were asked to do a welfare check on Mrs X in the meantime:

“police report that X was well the day before at the time of their well-person check and no concerns were raised. She hadn’t been aware that she was to be recalled”.

In the event, the team did not get to act upon their recall notice. Mrs X's mother contacted services again on the morning of 15 October saying that she was very concerned about her daughter. She was advised to go back to the police. At about 2:30pm, the police, an ambulance and Mrs X's mother were assembled outside the flat. Mrs X was not answering her phone, and the key was inside the locked and chained door. Police broke down the door, and a constable entered to find Mrs X suspended by a dressing gown cord from the corner of a bedroom door, already dead.

We do not, at the time of writing, know the findings of the inquest into Mrs X's death, but the immediate lessons of the case need to be considered widely. We are uncertain whether Mrs X died knowing that she had been recalled to hospital, but nevertheless we would urge services to recognise that a recall notice may trigger dangerous reactions in patients whose mental state is in crisis, and that any period between receiving that notice and it being acted upon must be a time of heightened danger.

Authorities may feel that they have no authority to act, other than to rely upon general police powers of entry to save life or limb, on the day that a recall notice is delivered by hand to the patient's address. However, this may be incorrect: although the power to apply for a warrant to retake the patient under section 135(2) will not come into force until after midnight of that day (when the patient becomes liable to be retaken as a recalled CTO patient), in the meantime it may be possible to apply for a warrant under the more general powers of section 135(1). This would enable the patient to be taken to a place of safety prior to the recall notice being put into effect.

Recalling inpatients subject to CTO

We are aware that patients subject to CTOs are frequently treated as 'informal' inpatients, either because they have asked for admission, or because they have agreed to remain in hospital on an 'informal' basis following a recall.

Such arrangements are clearly in the spirit of the principle of using the least restrictive means for patients that is practicable*, and should be encouraged insofar as patients are truly exercising a free choice to enter or remain in hospital.

However, procedural problems may arise if a CTO patient wants to leave the ward, and nursing staff or clinicians feel that this should be prevented. Patients subject to a CTO are excluded from the scope of holding powers under section 5 of the Act**, although they can be 'recalled' under section 17E notwithstanding the fact that they are already in hospital. But the recall of a CTO patient can only be undertaken by the responsible clinician (whereas section 5 holding powers can be exercised variously by any doctor, approved clinician, or any registered mental health or learning disabilities nurse). The responsible clinician is unlikely to be as readily available as the range of people who can use section 5 holding powers. It may be possible, if the 'usual' responsible clinician is unavailable, to recognise another professional as undertaking that role, but this would still require finding an approved clinician who could undertake the role for the purposes of issuing a recall notice.

In practical terms, staff who recognise a genuine need to prevent a patient from leaving a ward in such circumstances may have to resort to common law powers of restraint or detention† until the power to recall can be exercised. It is important that staff do not purport to hold a

* The *least restriction principle* in the Mental Health Act Code of Practice (para 1.3: "...keep to a minimum the restriction ... impose[d] on the patient's liberty, having regard to the purpose for which the restrictions are imposed") only extends to taking action without a patient's consent, which may not be relevant in the circumstances described above, but we suggest that a similar general principle applies to all mental health care.

** Mental Health Act 1983, section 5(6) states that CTO patients are excluded from the definition of 'inpatient' to whom holding powers may be applied.

† See Jones R (2009) *Mental Health Act Manual*, Twelfth Edition. London; Sweet & Maxwell. Annex A gives an account of common law powers to restrain and/or detain mentally disordered patients.

CTO patient under section 5 powers, as they would have no lawful authority for their actions. We recently drew one such case to the attention of hospital managers, who accepted that an unlawful use of the Act's powers had taken place. They sent the patient, his solicitor and CQC a full letter explaining the position, making an apology and recommending that the patient should seek legal advice if he has any concerns.

Equally, however, it is important that these questions of legal powers to hold a patient do not create a reluctance to offer informal admission to CTO patients where it would be otherwise appropriate, or indeed to put pressure on the AMHP to support revocation to section 3 where this is not really necessary and may itself be potentially unlawful.

Consent to treatment and CTO patients

In almost all cases, CTOs are used to try to ensure a patient's compliance with psychiatric medication after discharge from hospital. However, the patient placed on a CTO cannot be compelled to take medication to which he or she refuses consent, at least while he or she remains in the community and is not recalled to **hospital**: in law, hospital remains the locus of enforced treatment.

The CTO conditions may require that a patient complies with medication while in the community, but if that patient chooses not to do so, medication may only be forcibly given if there are grounds to recall the patient to hospital. As discussed below (figure 35), the application of CTO powers in practice does not always appear to reflect these theoretical boundaries: in common with much 'consent to treatment' practice under the Mental Health Act, legal distinctions between capacitous refusal and incapacity, or between incapacitous compliance and consent, are not always recognised, or are ignored.

As we receive most of our information on CTO patients through our administration of the second opinion system, we would not usually get to hear of patients who are placed under CTO with no condition that they comply with psychiatric medication. In one case, however, we were informed of a CTO that enabled a patient to leave hospital while still on a 'drug holiday'. The patient was elderly, suffered from persistent delusional disorder and had a long history of non-compliance with medication and disengagement with her clinical team, followed by relapse. One such relapse led to her detention under section 3. Her responsible clinician was prepared, in discharging her onto a CTO, to respect her refusal to take oral antipsychotic medication – partly because she had experienced some difficulties with side-effects in the past, and partly because her symptoms had, as usual, disappeared with her removal from her usual environment to hospital. As such, the immediate purpose of the conditions was simply to ensure that her team retained access to monitor her mental state, although one condition was that she should comply with "medication for her mental health problems should these deteriorate on discharge back to her own home".

The role of the SOAD for CTO patients

The role of the SOAD for CTO patients is fundamentally different to that for patients detained in hospital under the Act. When a SOAD certifies treatment for a detained patient under Part 4 of the Act, the certificate itself provides the lawful authority to give that treatment. Legal authority to treat a CTO patient in the community ultimately comes either from the patient's valid consent to that treatment, or from the Mental Capacity Act 1998 if the patient is incapable of giving such consent (although in either case, there must also be a SOAD certificate in place after an initial period).^{††}

†† This initial period when there is no 'certification' requirement is the first month of a CTO being in force, or the end of a three-month period starting with the first administration of medication for mental disorder to the patient when detained under the Act in hospital, whichever is the later.

This means that, for a CTO patient, the certificate issued by the SOAD under Part 4A of the Act is necessary but not sufficient lawful authority to treat, at least while the patient remains in the community.* The practical consequences of this difference include the requirement of a SOAD certificate for consenting CTO patients at least after an initial period (whereas consenting detained patients may be treated upon certification by the clinician in charge of that treatment), and the fact that neither the SOAD nor the clinician in charge of treatment can provide lawful authority for the enforced treatment in the community of a CTO patient with mental capacity who refuses to give their consent.

Unsurprisingly, some practitioners do not understand this difference in the sources of legal authority to treat patients. It is unfortunate that the law in this area is so complex.**

As a result, it is likely that some CTO patients' competent refusal of consent has been unlawfully ignored in the initial period of their CTO treatment, before there was any requirement for a SOAD visit. It is important that clinical staff appreciate that (in contrast to the position with detained patients) a CTO patient's competent refusal of consent cannot be overridden at any stage of their treatment under CTO, unless they are recalled to hospital for that purpose.

A significant proportion of CTO patients are deemed to be refusing medication by their clinical teams. Our records show that patients were reported to us to be refusing consent in 20% of all CTO second opinion requests from the implementation of CTO in November 2008 to the end of the March 2010 (figure 35). For 2009/10 alone, this falls to 13%. In many cases, it would appear that the patient is still taking that

medication when seen by a SOAD: if the referring clinical team really believed the patient to be refusing consent, there was no lawful basis for this treatment.

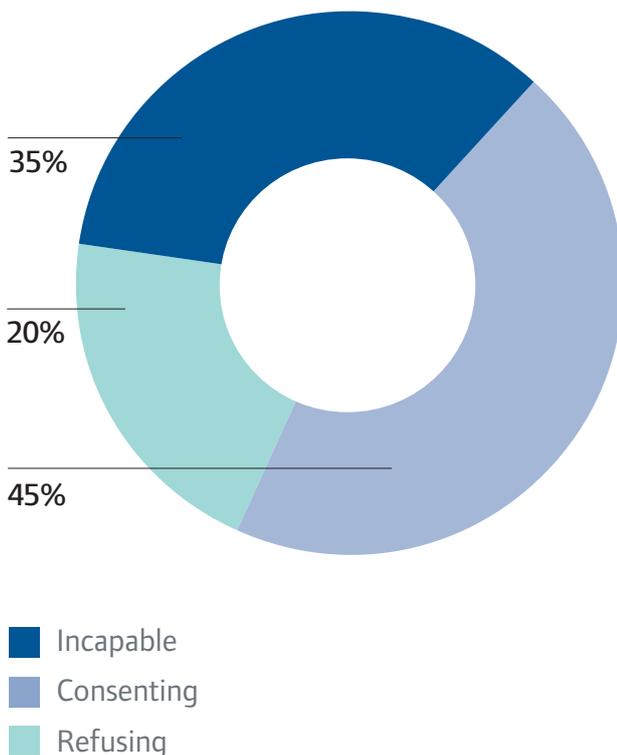
SOADs indicate on their visit reports the degree to which they think that they have changed the treatment plan that we originally proposed when the request for a second opinion was made. During this period, we have used three broad categories of outcome: unchanged, slight change, and significant change. Figure 36 shows the percentage of treatment plans that were changed as a result of a SOAD visit during 2009/10, broken down by the consent status of the patient concerned. We were unable to determine the degree of change in 414 reports (12% of the total in the year), usually because this had not been indicated on the SOAD report, or had not been entered onto the database. This is why none of the three category bars reaches 100% on the scale.

As is shown in figure 36, just over 15% of all second opinion visits to CTO patients in the year resulted in some kind of change to the treatment plan proposed. This is a smaller proportion of changes than were recorded for visits to detained patients (see figure 20 on page 85). This difference does not appear to be accounted for by the 51% of consenting patients in the CTO sample, who are as likely as non-consenting patients to have their treatment plans changed to some degree by the SOAD. One important factor may simply be that patients who are ready for discharge into the community may be more likely than detained patients to be on a settled medication regime, or to be taking a simpler medication regime than at the point of their acute crises.

* The Part 4A certificate can be used to provide sufficient legal authority to treat a refusing patient when that patient is recalled to hospital.

** On the unfortunate complexity of the Mental Health Act as amended in 2008, see Mental Health Act Commission *Coercion and Consent: Thirteenth Biennial Report*, 2009, para 3.64 *et seq.*

Figure 35: Second opinion requests for CTO patients, 2008/09 to 2009/10, by reported consent status



Data source: CQC, n=5,102

Delays in administration of SOAD certification for CTO patients

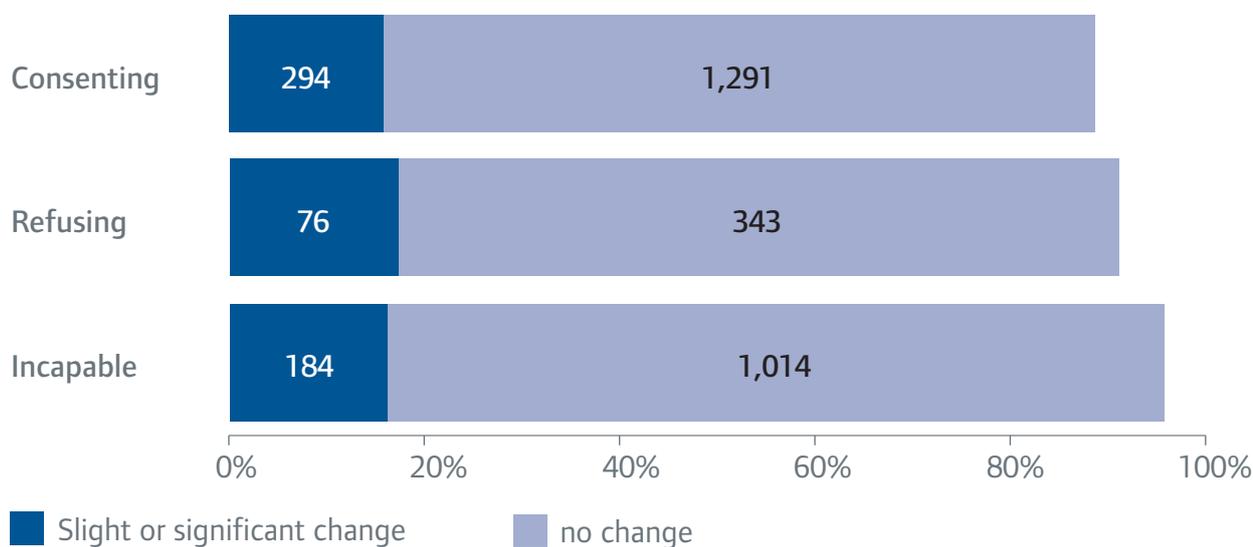
We very much regret that delays in the certification of CTO patients' treatment continue to be a problem in our administration of the SOAD service. These delays have a number of causes. We have had some difficulties in meeting the high demand for CTO visits, which was not anticipated by those drafting the legislation. We are continuing to recruit doctors to address this (see page 87)

In many cases, SOADs made multiple attempts to meet with CTO patients to complete their second opinion, but patients failed to turn up for appointments. In some cases, SOADs have made many attempts over a number of weeks to see

patients. This is costly and using up a lot of CQC's resources, and we have now indicated that, where a second opinion visit is unsuccessful because the patient does not attend a meeting with the SOAD, it will be for the responsible clinician to review the matter, and make a fresh request for a second opinion if one is still needed.

We understand, as noted above, that it may not be appropriate from the view of maintaining a therapeutic relationship with the patient to recall them to a hospital facility just to meet with a SOAD. This will especially be the case for a number of patients who have given their consent to the treatment that they are taking, and resent being asked to attend for examination by another doctor whom they did not ask to see. Given that the Act does not explicitly require that the SOAD meets face-to-face with the patient, we have suggested that SOADs might consider speaking with the patient only by telephone, and then making a judgment whether a physical meeting with the patient is necessary to make a decision over certification. There is some precedent for this in our experience of arranging second opinions for detained patients: in some cases where such patients insist that they will not see or speak to a SOAD, and the SOAD has ascertained personally that this is the case, SOADs have considered treatments proposed on the basis of the patients' notes and on interviews with professionals involved in their care.

However, it is also the case that in 2009/10, for a significant proportion of those cases where the second opinion was not completed within the first month of the CTO being in place, the request itself had not been received until that month was over. For example, of the 94 cases over March 2010 where patients' treatment was certified after the initial month of CTO, 40 (43%) had been requested 28 days or more from the initiation of the CTO. We have requested that hospital administrators now make the request for CTO certification within 48 hours of the CTO being put in place, to try to avoid this unnecessary cause of delay, and we are grateful for their cooperation in doing so.

Figure 36: Outcome of CTO second opinions, 2009/10, by patients' consent status

Data source: CQC, n=3,616

The delays in providing certification of CTO patients' treatment have inevitably led to a wide use of urgent treatment powers to authorise to continue medication. This, too, is a matter of regret, although in many cases the patient concerned is, in any case, consenting to the medication being administered. As with urgent treatment powers for detained patients, there are no statutory forms to certify authority to treat or record that such treatment has been given, although some trusts have devised their own local forms for recording and monitoring.

Patient involvement as a key to successful CTO interventions

Almost invariably, those patients who are positive about their experience under a CTO feel supported by and, just as importantly, involved in their care plans. As in the following example, these are not just questions of perception – they often reflect objective differences in the approaches of community teams, sometimes within the same trust:

It was interesting to hear such very contrasting stories from patients of their experience of CTOs. It is perhaps significant that those telling positive stories were supported in the telling by members of their community mental health team who accompanied them. It was apparent in these cases that patients and their community teams had been actively involved in the planning of their CTOs and were working collaboratively with robust care plans which took a holistic approach to patient care. It was lovely to hear one patient describe the support he was receiving as "brilliant". At his last CPA he had requested that nothing was changed as everything was going so well. Another patient was also enthusiastic and clearly had great confidence in her community team.

Other patients reported a different experience. They had not felt involved in the construction or implementation of their CTO and appeared to have had little contact with

their community teams prior to discharge from hospital. They described limited support and a sense of isolation. It was of concern that in two cases we were unable to find robust care plans which would have enabled us to challenge their stories.

November 2009

Where the feedback is more negative, we ask the trusts concerned to consider, and report back to us, what steps they can take to ensure that all patients are actively involved in the planning of their CTO and meeting the members of their community teams before being discharged from hospital.

We have found that, where patients are poorly involved in their care planning, they tend to view the CTO as simply a mechanism to enforce compliance with medication, and as such a means to achieve the lesser evil of being subject to coercion without detention in hospital.

Whilst still in hospital, prior to discharge, none felt they had been fully involved in the planning of their CTO and although some knew about their care plan, none had a copy of it. They all said they felt they had no choice if they had wanted to leave hospital and believed the only purpose of the CTO was to ensure they took their medication. None of them were in full agreement with being subject to CTO and, apart from patient 1, did not think they needed to be on it. Patient 1 did say that he felt the CTO kept him and others safe but he was not in agreement with the system, but “considering the circumstances...it was okay”.

Patient 2 said that he ...did not fully understand the details of the CTO (e.g. he did not know it could be extended) and he had questions about his medication. He said things are not explained fully to him and that he is just told “this is what we want

you to do”. He said he would like someone to explain his medication to him, e.g. reasons, side effects etc, which Dr A agreed to follow up.

March 2010

A key factor that points to the appropriateness of a CTO is where the patient “appears prepared to consent or comply with the medication they need”.¹¹⁸ In the above example, the lack of communication and involvement with patient 2 was clearly undermining his willingness to comply with his medication regime, and precluded him from giving informed consent to it. On some visits, we have found patients who either do not know about, or do not understand, the conditions with which they are expected to comply:

In almost all instances there was no evidence that information under section 132 had been provided to patients regarding the CTO and their rights to seek discharge. Indeed, there was little evidence that patients routinely understood the conditions attached to the order.

November 2009

Such patients, especially those who did not have a carer who was taking effective responsibility for their compliance with the CTO’s conditions, had been placed in a position where they were almost bound to fail.

The most positive accounts of CTOs from professionals often emphasise the importance of the patient’s willingness to comply with the conditions set:

One responsible clinician who worked within an assertive outreach team said that, since using CTOs, it had not been necessary to admit any of their patients to hospital in the past year. In the previous year, there had been 12 admissions to the

acute service. Other professionals spoke of patients who had had repeated admissions to hospital (usually through non-compliance with medication) whose lives had been less disrupted by illness since being subject to a CTO. These patients had been able to remain in their own homes and had been given opportunities to restore, maintain and sustain their lifestyles. For some patients, this had meant being able to return to education, to rebuild family relationships, to have a routine to their life and to sustain friendships.

All of the professionals spoken with were consistent in the view that the person's cooperation to work with the team was an important consideration before using a CTO. In instances where a CTO had been used and the patient was reluctant to participate with the conditions, these had not been successful.

December 2009

In a number of services, however, even where patients showed general satisfaction and willingness to cooperate with their care teams, we have identified areas where lack of information or support might hamper them in doing so:

- Patients often questioned whether advocacy services were available to them in any practical sense, even though they had a legal entitlement to them.
 - Some patients have approached Mental Health Act Commissioners with concerns over the side-effects of their medication, and said that they did not know who to ask about such matters in their own care team. Such patients may not be receiving adequate support and opportunities to review their medication with prescribers.
- We will continue to address these issues with services where we encounter them on our visits.
- CTO patients often did not have access to an out-of-hours telephone number so that they can contact professionals in a crisis. Patients tell us that they would rely on family members or friends in such circumstances.
 - Many families and carers did not know whether respite care would be available, or who to contact about this.
 - Some patients had no contact with occupational therapy services and had no daytime activities provided as a part of their care package, although this clearly seemed appropriate.

Community treatment orders: our recommendations for improvement

→ Local authorities and providers of mental health services, particularly AMHPs and Responsible clinicians

Services must give careful consideration to how CTOs are being implemented to ensure that:

- Patients are actively involved in planning their CTOs and are consistently informed about the conditions with which they need to comply.
- Their statements for applications and renewals for CTOs are completed close in time.

→ Department of Health

Revisions should be made to the Mental Health Act Code of Practice to clarify:

- The period of time for approved mental health professionals and responsible clinicians to complete their statements for applications and renewals for CTOs.
- Who may act as a statutory consultee for a second opinion in relation to a patient subject to a CTO.

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