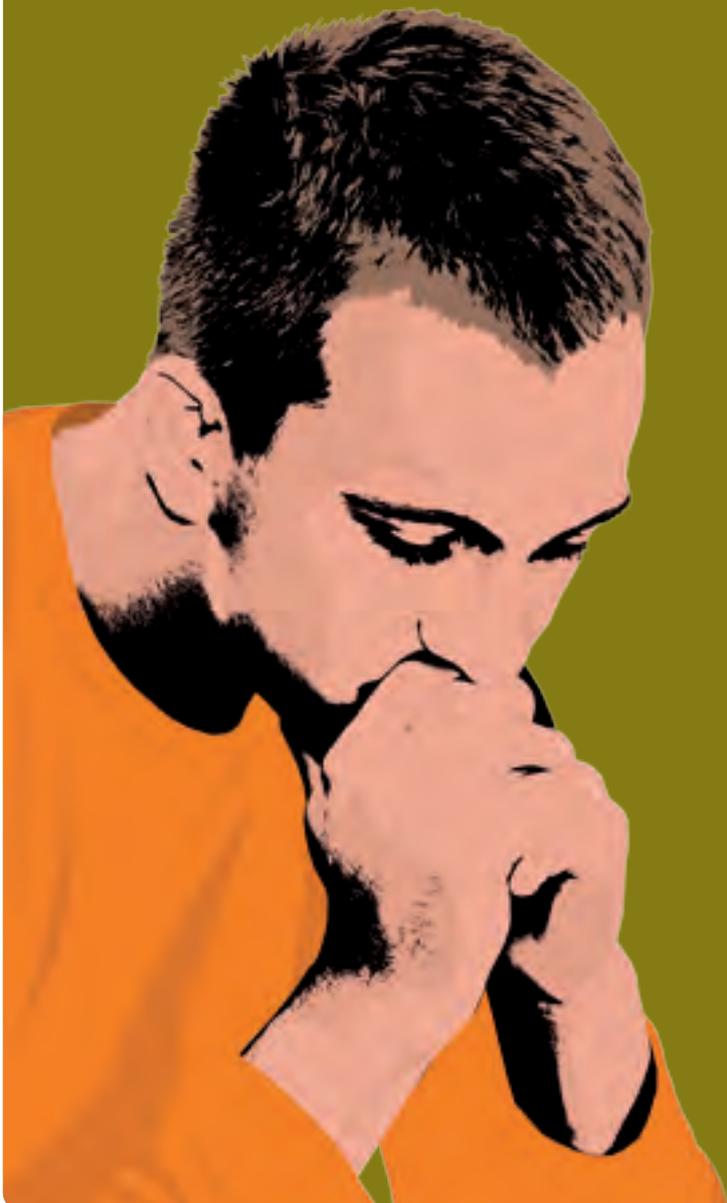


Monitoring the use of the Mental Health Act in 2009/10

An overview of CQC's findings and recommendations from our first annual report on our monitoring of how the Act is used





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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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 overview 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 publication is an overview of the findings and recommendations in our report on our 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.

Foreword

From April 2009, CQC has been responsible for monitoring how the Mental Health Act is used in England. I am pleased to present this overview of 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.”

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

Each year, more than 45,000 men and women are detained in hospital under the Mental Health Act for assessment and treatment for mental disorder. Some will be detained for only a few days or weeks; others remain in hospital for years. At any given time, about 15,000 patients are detained in hospital. The Mental Health Act also provides limited powers over some patients in the community. About 900 people are subject to guardianship and more than 4,000 people are now subject to CTOs.

People who are subject to the Mental Health Act are in a particularly vulnerable position. They can be legally prevented from choosing whether or not to receive treatment and care, or how it is provided to them, even if they have the mental capacity to consent to treatment. The Act therefore sets up safeguards to ensure that powers of compulsory treatment are used properly, so that people's human rights are respected and they are treated with dignity and respect. Our role under the Act is one of these safeguards.

Visiting patients subject to the Mental Health Act

When visiting wards, our main aim is to identify where the Act is not being used correctly and where detained patients have concerns about their care and treatment. The visits are not formal assessments of the overall standard of care and treatment in the hospital. Our visiting Mental Health Act Commissioners meet with patients in private to discuss their experiences and concerns, to make sure that they understand their rights and to check that

staff are using the Act correctly. They speak to staff about their experiences, plans and concerns, and review legal documents and patients' notes. Afterwards the Commissioner sends written feedback to the ward, and each year we send a summary of our findings to the hospital managers.

The aim of our visits

The aim of our visits is to improve the standards of care and treatment for detained patients. However, due to the nature of our visits, we often highlight more problems than positive practice. Similarly, our annual report highlights more problems and concerns with the operation of the Mental Health Act than examples of good practice. It is not intended to give a rounded picture of mental health services for patients subject to the Act. For example, it describes cases of care that are poor or that raise concerns, but this care is of much lower quality than that which most detained patients receive. However, there are some areas in which many services need to improve – such as involving detained patients in planning their care and treatment.

5,078

Our commissioners met with 5,078 patients

1,711

Visits to wards – around 1 in 3 of them unannounced

13,000

Second opinions provided

We recognise the vast amount of hard work, dedication and compassion that staff bring to their roles in the services we visit. Our Commissioners often note the dedication and skill of staff, and we encourage good practice where we find it. But we also find examples of inappropriate and unacceptable treatment and care, and poor use of Mental Health Act powers. We believe that – even in the current difficult economic climate – there are opportunities to improve practice generally, as we discuss in “What happens next” on page 22.

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 a treatment or is considered incapable of consenting to it. 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. During 2009/10, we received around 13,500 requests for a second opinion.

Making sure that detained patients have a voice

Our visits to wards and confidential meetings with detained patients give us valuable information about their experience of care. We also have a service user reference panel, made up of 20 people who have been detained patients in the past. The panel brings a unique and expert perspective to our work in monitoring use of the Mental Health Act, including when they accompany our Commissioners on visits to wards.



Summary of our general findings

Admission and detention

Over the last decade, there has been a steady decline in the overall number of people treated as inpatients in mental health hospitals, while community-based services have expanded. Meanwhile, the number of people detained in hospital for assessment and/or treatment has generally remained the same, at around 45,000 each year. This means that the proportion of people being treated in hospital as detained patients, rather than as informal (voluntary) patients, is growing. In 2009/10, the Mental Health Act was used more than ever before. There were 45,755 detentions during the year of people admitted under detention or who were detained while in hospital.

There has been a fall in the number of informal patients who have been detained under the Act when they have tried to discharge themselves from hospital. This probably reflects a higher threshold for being

treated as an inpatient, as community services are increasingly expected to support patients. Patients may be more severely ill when admitted, and therefore more likely to be admitted under detention than voluntarily.

Admission and detention of children and adolescents

From 1 April 2010, hospital managers must ensure that they place children or young people under the age of 18 in an environment that is suitable for their age and needs. During 2009/10, we found that many services were anticipating this new legal duty in their practice.

There has been a marked reduction in the number of young people admitted to adult psychiatric wards under the Mental Health Act, especially of those under 16 years of age. During 2009/10, we were notified of 88 children and adolescents being admitted to adult wards, and our sample analysis indicated that most of them were then transferred or discharged within a few days. This indicates that mental health services are making progress with implementing national policy and legislative changes.

To ensure that this positive trend continues, services must of course have enough facilities that are suitable for children and adolescents. It is also important that child and adolescent mental health services (CAMHS) provide a nurturing, therapeutic environment for young people, including those detained under the Mental Health Act. In 2009/10, we visited some excellent CAMHS units with a stimulating environment that enabled young people to continue their personal, social and educational



development. However, 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 disorder units, which appeared to restrict personal liberty more than would be the case in most other types of psychiatric unit.

Police use of the Mental Health Act

Section 136 of the Mental Health Act allows any police officer to take someone who they believe is suffering from a mental disorder and in need of immediate care or control from a public place to "a place of safety". The person can be held in this place of safety for up to 72 hours, to allow a doctor and approved mental health professional to determine whether they need to be admitted to hospital or need other types of help.

If a place of safety is not available in a hospital, the alternative is usually a police cell. Police stations are often unsuitable as places of safety for vulnerable and distressed people, who may feel unsafe and criminalised when held in police custody. We welcome the fact that many more places of safety are now available in hospitals than was the case even a few years ago, and that, in many areas, this seems to have reduced the use of police cells.

However, we found that sometimes the opening of hospital-based places of safety appears to have led to local police increasing their use of section 136. We also found cases where the police had to use cells because they could not gain access to places of safety in hospitals – often because of a lack of nursing staff. We also have evidence of hospitals refusing to take a young person into a place of safety because it was not considered to be age-appropriate accommodation, and of detainees being turned away because they were intoxicated, or exhibiting disturbed or aggressive behaviour. Anyone turned away from a hospital-based place of safety will probably be held in a police cell, which may be even less suitable.

Our recommendations 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 having been admitted to inpatient care.

→ Providers of CAMHS services

Providers of inpatient CAMHS should consider what more they can do to maintain the privacy, dignity and safety of young people and 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.

We identified some concerns about police arrest and assessment practices under section 136, including:

- Cases where a person has been taken to a place of safety from their home rather than from a public place, which means the arrests may not have been lawful.
- Police custody officers' understanding of the detail of the section.
- Lack of availability of forensic medical examiners approved as having special experience in the diagnosis and treatment of mental disorder.

10 Summary of our general findings

- People not being assessed properly before being transferred or discharged from the place of safety, including not involving an approved mental health professional when appropriate.

In 2009/10, CQC was part of a multi-agency group led by the Royal College of Psychiatrists to establish standards on the use of section 136. The group's recommendations included setting up local working groups to develop policies and procedures for police use of section 136, and to monitor detentions. This will help to identify training needs, and mental health services can support the police to avoid the misuse of the section. The police force's plans to develop standardised data collection on the use of section 136 will also help to improve practice.

Assessment for detention

An approved mental health professional (AMHP) may apply to have a person admitted to hospital as a detained patient up to 14 days after the last medical examination. We were concerned to learn of cases in which staff were retaining medical recommendations for detention for this 14-day period, even though the assessment had concluded and the patient had agreed to go into hospital informally. The medical recommendations were held in reserve in case the patient tried to discharge themselves. We stress that patients should be given clear and accurate information about the outcome of their assessments.

Use of the Mental Health Act in acute hospitals

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

Our recommendations

Use of section 136

→ **Providers of mental health services and police authorities**
Implement the Royal College of Psychiatrists' standards on the use of section 136, including the development of local multi-agency section 136 groups to monitor these detentions, identifying where improvements in interagency working are needed and developing solutions to address problems.

→ **Police authorities**
Introduce standardised data collection of the use of section 136.

this activity. In one example given in our full report, the hospital's management welcomed a focused visit by a Commissioner to help identify areas in which they could improve their practice.

Experience of detained patients

Bed occupancy and staffing

As in 2008/09, we continue to identify problems with over-occupancy on inpatient wards – 29% of acute wards visited in 2009/10 had occupancy rates of more than 100%. Often, patients who were the least unwell were being sent home or refused re-admission because no bed was available, rather than because they did not need to be inpatients.

When visiting wards throughout England, our Mental Health Act Commissioners have found little change in the proportion of trained to non-trained staff, or agency to permanent staff, in the last five years. Many patients and staff tell us that their wards are inadequately staffed. This can affect a service's ability to provide people with the full range of treatments they need, ensure continuity in their care and promote dignity and safety.

“ ...staff shortages have 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. ”

Member of CQC service user reference panel

Our Commissioners often raise concerns about the 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.

Increase in security and the rise of secure services

Patients' feedback to our Commissioners in 2009/10 suggested that hospital life is becoming much more focused on rules and security. More acute inpatient mental health wards are now locked wards, even though they are usually providing care to voluntary patients as well as to detained patients. In 2009/10 – as in previous years – we voiced our concern that voluntary patients in locked wards are at risk of being unlawfully deprived of their liberty. They are prevented from leaving the ward and denied control over their circumstances, but in law are subject neither to formal powers under the Mental Health Act nor to Deprivation of Liberty Safeguards under the Mental Capacity Act.

The proportion of people in low secure beds has increased significantly since 2006, both for men and, more markedly, women. In 2009/10, we continued to find variation in their treatment and care regimes, which can have significant implications for patients' experience of care and possibly for their clinical progress. In some low secure services, we felt that rules or practices that were being applied as 'blanket measures' on the grounds of safety or security were difficult to justify for all of the patients – for example,

Our recommendations

Bed occupancy and staff

→ Commissioners of inpatient mental health services

Ensure that there is a strategic approach to reviewing and addressing problems of over-occupancy, staffing levels and skill mix.

banning patients' use of mobile phones or the internet. These blanket measures did not meet the Code of Practice's principle of applying the least restrictions practicable and risked infringing human rights law.

Our Commissioners also encountered a number of situations where the service's disregard for privacy and dignity in the name of patient security was verging on unsafe or potentially abusive practice. Examples included patients having restricted access to toilet paper; observation panels to bedrooms being locked open on a corridor used by men and women patients; and male nurses being assigned to close or night-time observation of vulnerable women patients.

Smoking restrictions in psychiatric hospitals

Patients and staff continue to raise concerns with us about the effect of legal restrictions on smoking indoors, in some cases coupled with local policies banning smoking on hospital property, even outdoors. We have received accounts of detained patients

Our recommendations

Security levels

→ **Commissioners and providers of low secure inpatient services**
Review how national policy on standards in low secure settings are being applied in practice.

using leave solely to smoke, or smuggling in cigarettes and lighters (with the associated fire risks) and charging other patients high prices for cigarettes. Valuable nursing time is taken up searching patients and wards for cigarettes.

National policy emphasises that patients should be encouraged and helped to stop smoking. However, many patients see the removal of their opportunity to smoke where and when they wish as yet another way in which the service is restricting their autonomy, particularly as doing so does not relate to their treatment for mental disorder. We have encouraged services to facilitate safe outdoor spaces for the use of detained patients who are smokers.

Participation and protecting patients' rights

Patients' participation in their treatment

Mental health services should provide treatment in the least restrictive manner possible. They should have respect for the patient's wishes and feelings when exercising their powers under the Mental Health Act, and focus on promoting recovery and autonomy. The patient should have the opportunity to be involved in planning, developing and reviewing their care and treatment, and so should their carers or families, providing the patient agrees to this.

Our Commissioners' meetings with patients have shown that services still vary in the extent to which they are implementing national policy on involving patients in assessing their needs and planning their care. We have seen some excellent examples where the service involves the patient at each stage, and where patients' care plans are carefully tailored to their individual needs and show their recovery goals. These examples demonstrate that it is possible for services to involve patients fully even when their rights are restricted.

However, we found that many services needed to substantially improve their practices, including making sure that all detained patients are:

“ ... there were many occasions where the whole ward suffered due to the activities of one or two patients. As a result, security was tightened for every patient. Collective punishment is demoralising. ”

Bal, CQC service user reference panel

- Present at Care Programme Approach meetings about their care, wherever possible, and included in decision-making.
- Involved in developing their care plans, rather than being presented with a completed plan to sign.
- Not made to feel intimidated or patronised by staff during meetings about their care.
- Given fully personalised care plans, rather than a 'template' plan, with their medium and long-term recovery goals clearly set out.
- Given full access to their care plans where possible.

Providers have a major role to play in encouraging their staff to develop the approach and skills needed to enable patients to participate fully in their care and treatment. We have asked all service providers to check and monitor the practice of staff in this area, with the aim of embedding genuine involvement in day-to-day life on the ward.

Patients' access to legal advocacy services

Since April 2009, primary care trusts (PCTs) have been legally responsible for commissioning independent mental health advocate (IMHA) services for people whose rights are restricted under the Mental Health Act, to help and support patients to understand and exercise their legal rights. In addition, the managers of the detaining hospital must make sure that patients know that the advocacy service is available to them. CQC is responsible for checking that these duties are met.

During 2009/10, we found that some PCTs had not commissioned IMHA services for a number of their mental health services, or that patients' needs may not have been met fully because of inadequate levels of service. When visiting 311 wards between January

and March 2010, we systematically collected data on the availability of IMHA services. It showed that:

- 56 of the wards (18%) did not have access to IMHA services, although 54 had access to general advocacy services.
- IMHA services were not available to patients in some NHS specialist or forensic wards, yet were available in general wards in the same trust.
- Some independent providers had had difficulty accessing funding from the PCTs responsible for funding their patients' care.
- 40% (123) of the wards that we visited did not display information about any type of advocacy service.

We also conducted a survey of IMHA services, to which 71 responded. The key findings were:

- The services had seen 1,472 patients in the month before they completed their questionnaires: a mean average of 21 patients for each service.
- The largest number of patients seen during that month was 112, in a high security hospital, but some IMHA services reported no contact at all with patients during that time.

Our recommendations

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 principles of least restriction, respect and participation for detained patients in the Mental Health Act Code of Practice.

“ I had an interview with an advocate with regard to writing a letter of complaint. All the details I gave were typed out for me in draft form and I was asked if there was anything I wanted to change or add... I was very pleased with the help and advice I received. ”

David, CQC service user reference panel

Our recommendations

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.

- Although the law requires all IMHA services to make an annual report to the PCTs that commission them, only 56 (79%) were required to do so in practice. Five services (7%) were not required to do so, and 10 (14%) did not know whether their PCT required an annual report.
- Just over half (56%) of all referrals resulted from the patient's direct request for advocacy; 23% of referrals were made by mental health professionals; and 3% by the patient's nearest relatives.

- The most common issues causing people to seek advocacy were: leave of absence; applying to a Mental Health Tribunal; medication; and the patient's legal status.
- Services spent slightly more of their time (54%) on helping patients to exercise their rights, than on explaining their rights to them.

We concluded that many IMHA services provide a valuable contribution to advocacy for detained patients. However, further improvement is needed to ensure that all detained patients are aware of these services and have access to them. We have recommended that commissioners of IMHA services should ensure that they are monitoring access and provision for patients on a routine basis.

Mental Health Tribunals

If a patient wishes to appeal against being detained, or to being under a community treatment order (CTO) or guardianship, they can do so through the Mental Health Tribunal. Most cases that the Tribunal hears are a direct appeal by a patient whose rights are restricted under the Mental Health Act. However, hospital managers have a duty to refer patients to the Tribunal if they have not applied themselves after a certain time, or after the renewal of their CTO.

In 2009/10, the number of applications to the Tribunal rose sharply, to 12,122 hearings in the year compared to an annual average of just under 10,000 in the previous nine

years. However, the percentage of hearings that resulted in the patient being discharged dropped to 12%, the lowest since 2004.

Appeals and referrals by, or on behalf of, patients on CTOs were a major part of this increase in Tribunal applications in 2009. They also appear to be less likely to succeed than appeals against detention. Information gathered by the Mental Health Alliance for the period November 2008 to March 2010 shows that less than 5% of CTO appeals succeeded, compared with a success rate of 14% for appeals by detained patients.

Patients and staff continue to report long delays between making applications to the Tribunal and the hearing and, in some cases, hearings have been postponed more than once. Many hearings are adjourned because of a lack of information, such as the patient's social circumstances reports or evidence about the aftercare, services and support that would be available to them if they were to be discharged. Some patients told us of staff completing their social circumstances reports without contacting them about it. Sometimes the information in these reports had been a complete surprise to the patient.

Patients and members of our service user representative panel have expressed dissatisfaction with the Tribunal process. They also sometimes had concerns about their legal representation – as did some hospital staff and legal members of the Tribunal. In response to these comments, we are carrying out further monitoring of patients' experience of the Tribunal service.

It is very important that patients who are incapacitated by their illness receive help both to understand their right to appeal, and to make an appeal if they wish to do so. However, we discovered that one doctor had made applications on behalf of several patients who did not want to appeal. We pointed out that, in rare cases where clinical staff want a hearing but the patient is

reluctant or unable to make an application to the Tribunal, the law allows staff to refer the case to the Tribunal, either directly or through the Secretary of State, without pressurising the patient to make their own application or purporting to make it on the patient's behalf. Clinicians and legal representatives should always bear in mind that a patient has only one chance to appeal during a period of detention. If they are pressurised into applying to the Tribunal too early and their appeal is unsuccessful, they may not be able to apply again for several months.

Under a new ruling introduced in 2009, an application to the Tribunal made by or on behalf of a detained patient does not lapse if that person becomes subject to a CTO before the Tribunal determines the outcome of their application.

Our recommendations

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.

Key areas for special focus

To complement CQC's more general findings, section 2 of our full report looks at three aspects of care and treatment that have a major influence on patients' experience:

- Use of control and restraint, and seclusion
- Consent to treatment
- Community treatment orders.

Use of control and restraint, and seclusion

The Mental Health Act Code of Practice stresses the need for a positive therapeutic environment to help reduce the type of incidents that call for control and restraint. However, there are times when hospital staff need to use methods of control and restraint in response to a patient's disturbed behaviour.

In 2009/10, our Commissioners visited a number of wards where a 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. In a few exceptional cases, patients had been subject to control and restraint that was not carried out in a way that minimised risk to their health and safety or interference with their privacy and dignity.

Mechanical restraint

The Code indicates that 'mechanical restraint' should not be used in acute mental health settings as a standard means of managing disturbed behaviour. However, this recommendation does not extend to other types of mental health or learning disability service, where we tend to encounter its use. 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 restraint by professional staff. We think there is a strong argument for introducing a system of

notifications about their use, as government has suggested in the past.

Use of seclusion

Seclusion is the supervised confinement of a patient in a room, which may be locked, to contain severely disturbed behaviour that is likely to cause harm to others. It should only be used as a last resort, and for the shortest possible time. In 2009/10, we had reason to question whether some hospitals could have done more to de-escalate situations before using restraint or seclusion. If patients are kept in seclusion longer than necessary, or for reasons other than containing severely disturbed behaviour, the hospital's actions may be challengeable in law.

If the ward manager decides to use seclusion or long-term segregation, the Code of Practice requires that multidisciplinary reviews are carried out with the aim of ensuring that the patient is returned to the ward as soon as possible. Our evidence shows that this is not always being done routinely. Furthermore, our Commissioners have noted major shortcomings in the rooms that some hospitals use for seclusion, including a lack of facilities to meet basic needs.

Support and review after incidents

The Code of Practice emphasises the importance of "support and review" after using control and restraint or seclusion. There should be arrangements to provide support to the patient and staff involved, and any patients or visitors who witnessed the incident, and to enable staff to learn from the experience. Services' compliance with these requirements is variable – quite often our Commissioners find little or no evidence that they are being met.

Our recommendations

Use of control and restraint, and seclusion

→ Department of Health

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

→ Providers of inpatient services

Review practices of recording restraint and seclusion episodes, to ensure a record of the steps that have been taken to de-escalate a situation before other interventions are considered or used, and audit the content to inform practice development.

→ Commissioners and providers of inpatient services

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

Patients' consent to treatment

The Mental Health Act provides a legal framework by which a detained patient's treatment may be made compulsory in the absence of their consent or their refusal to consent. However, the patient's consent should always be sought and their mental capacity and consent or refusal should be recorded in full. A crucial part of our work to protect patients' rights is to provide a second opinion service and to monitor services' practice in this important area.

When patients are detained under the Act, they may be given treatment with medication for their mental disorder for the first three months of their treatment, even if they refuse to consent or are incapable of giving consent to that treatment. After this time (except in emergencies), the 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, either the approved clinician in charge of it or a second opinion appointed doctor (SOAD) will certify that consent on 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 form T3, that it is appropriate for it to be given.

Recording and reviewing capacity and consent

A patient's capacity and consent status should be under continuous review, especially when they have been certified as consenting to treatment by the clinician in charge of their treatment. Despite this, our visiting Commissioners have met with many patients who were certified as consenting, although they appeared to be refusing to give consent or to lack the capacity to do so. Patients often showed a limited understanding of their treatment, and say that their doctors have only very briefly discussed it with them. Many clinicians are not routinely recording their assessments of patients' capacity to make decisions about treatment, nor recording the information they give them about the proposed treatment and possible alternatives.

A key area for improvement

We believe strongly that assessment of capacity and consent, and recording of related discussions, is an area in which services need to improve significantly. Consent to treatment is one of the key outcome areas in CQC's new regulatory system. When we registered the 66 NHS trusts that provide specialist mental health services in England, four had conditions placed on their registration; for three of these trusts, the condition related to the need to improve their practices for assessing and recording patients' consent. Our full report describes the improvements noted in one of the trusts as a result. We will be watching this issue closely through our monitoring of providers' compliance with the registration requirements.

“ There is no discussion or choice or any information leaflets given to you to help. The only option... is to refuse the medication, which results in an independent doctor visiting you, who then can give you the information you need. ”

Mark, CQC service user reference panel

The SOAD service in 2009/10

CQC is now required to provide a second opinion for patients subject to community treatment orders, the numbers of which have proved to be much higher than the Department of Health's predictions. We therefore encountered challenges with administering the SOAD service in 2009/10. In addition, our SOADs experienced the practical difficulty of many CTO patients not turning up for their appointments, despite repeated attempts by the SOAD to meet with them. We have reminded services that they are responsible for making sure that patients attend SOAD visits. We have also 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.

Certifying use of medication

Our data from SOAD visits relating to patients' medication shows:

- 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. This could be due to greater severity of illness among detained patients than in past years, and/or clinicians' improved ability to assess and recognise incapacity as a result of receiving training in the Mental Capacity Act.
- About a quarter of the visits resulted in some change in the patient's treatment plan.

- Black and minority ethnic patients were more likely than White patients to be deemed incapable of consent, or capable but refusing consent.

We received 8,781 requests for a SOAD to visit detained patients to certify medication in 2009/10, a fall of 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 this increase may to some extent reflect more robust data collection at the point of request for a second opinion, it may also be the result of difficulties in arranging timely second opinion visits.

Certifying use of ECT

Before electro-convulsive therapy (ECT) treatment may be given to a patient who is incapable of consenting to it, a SOAD must certify that it is appropriate for the patient, except in an emergency. We have seen a decline in the number of requests for SOADs to certify use of ECT over the last five years. However, we are concerned that of the 1,339 patients referred for a second opinion in 2009/10, a third (445) were given at least one application of ECT by the service under urgent treatment powers before it requested a SOAD visit. We are aware that services' anticipation of delays with receiving a SOAD visit may be a factor in the rise in patients given emergency ECT. However, there may also be other

explanations, such as an increased severity of illness among detained patients. This is an area that needs to be studied further.

Statutory consultees

When providing a second opinion, a SOAD must consult with two people concerned with the patient's care, neither of whom may be the doctor proposing the treatment. For detained patients, this must be a nurse and someone who is neither a nurse nor a doctor. For CTO patients, at least one must not be a doctor. These consultees should make a record of their consultation with the SOAD and place it in the patient's notes. We often find that no record has been made, especially by the consultee who is not a nurse. Furthermore, the clinician in charge of the treatment should tell the patient the results of the SOAD visit as soon as possible, unless they think this would cause serious harm to the patient's mental or physical health or that of another person. Our Commissioners often found that the record of this process was inadequate, and in some cases the process did not appear to have taken place.

Under section 57 of the Mental Health Act, a panel appointed by CQC must give approval before any patient undergoes a surgical operation to destroy brain tissue as treatment for their mental disorder. The panel, made up of a doctor and two other people who are not doctors, must consider whether it is appropriate for the treatment to be given and whether the patient has given valid consent to it. In 2009/10, we received only one request to consider such treatment, which was authorised by the panel. This was the first case of a patient who had undergone deep brain stimulation (DBS) before undergoing a stereotactic anterior cingulotomy. DBS is a procedure related to leucotomy, but involves implanting electrodes in the brain rather than cutting brain tissue. We are concerned that DBS itself is not subject to the section 57 safeguard and would welcome consideration of this matter by government.

Our recommendations

Consent to treatment

- **Providers of mental health services, particularly front line managers and staff**
Improve practice in assessment 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 a record that the patient has been informed of the outcome of the second opinion process.
- **Department of Health**
Consider extending the section 57 safeguard to people receiving deep brain stimulation (DBS).



Community treatment orders

The most significant change brought about by the revisions to the Mental Health Act in 2007 was the introduction of the community treatment order (CTO), otherwise known as supervised community treatment.

The purpose of a CTO is to allow people to be safely treated in the community rather than under detention in hospital, to help them maintain stable mental health and to promote their recovery. It is aimed at people who are ready to be discharged from hospital indefinitely, but for whom there is a risk of community arrangements breaking down (for example, by not complying with their medication regime). The CTO allows for the patient to be recalled to hospital if necessary, subject to certain conditions.

Community treatment orders were introduced in England in November 2008, so 2009/10 was the first full year in which CTOs have been implemented in England. National statistics show that 4,107 CTOs were made during 2009/10. Furthermore, between their introduction in November 2008 and the end of March 2010, a total of 6,241 CTOs were made – an average of 367 a month.



Building a profile of people subject to CTOs

Through our work, we have gained a unique insight into the people that are subject to CTOs, their experience and clinical treatment. To help determine their overall profile, we analysed a sample of 208 reports by our SOADs after they visited people subject to CTOs in 2009/10. 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.
- Most of the patients involved had a diagnosis of schizophrenia and other psychotic disorders (81%), and 12% had a diagnosis of mood disorders.
- Almost all (98%) of the sample were prescribed some form of antipsychotic medication, and 65% received depot antipsychotic injections.
- 35% of the sample were prescribed medication above the limits recommended by the British National Formulary. While for some patients there can be legitimate reasons for this, each case needs to be reviewed regularly to ensure that it remains appropriate, and that the patient has the opportunity to discuss any concerns about side-effects and receive basic health monitoring. It is not clear that all CTO patients receive such reviews.

In addition, 30% of the patients in this 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.

The SOAD service for CTOs

There is a key difference in the SOAD's role for patients receiving supervised community treatment, in that the second opinion safeguard applies to consenting patients on CTOs as well as those that refuse or who are unable to consent. Consenting patients account for about 45% of the requests we receive for SOAD visits relating to CTOs. However, it could be argued that this group has a less compelling need for the safeguard and it might not be the most effective use of the limited SOAD resource.

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, whereas those who felt less well involved tended to see the CTO as just a mechanism for forcing them to take their medication. We are concerned to find that some patients did not know or did not understand the conditions with which they were expected to comply.

Administration of CTOs

Our analysis also revealed some problems with continuity of care for CTO patients, often due to poor communication and handover between inpatient services and community teams. We also identified cases in which there had been a substantial period of time between the completion of statutory forms by the responsible clinician and the approved mental health professional's confirmation that the criteria for CTOs have been met – in one case a lapse of seven months. We consider that the lack of positive legal rules on this matter does not prohibit a challenge to the legality of the subsequent CTO. Long periods between these two statements should therefore be avoided.

Our recommendations

Community treatment orders

→ 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 MHA 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.

Our feedback from clinicians involved in implementing CTOs has highlighted:

- Confusion about who may act as a statutory consultee for a second opinion, as a result of misleading advice in the Code of Practice.
- Some difficulty over arranging for patients to be recalled to hospital if necessary, often linked to locating an available bed.
- Procedural difficulties when patients have been re-admitted to hospital on a voluntary basis but then seek to leave the ward, as they are exempt from holding powers under section 5 of the Mental Health Act.

- Some clinicians did not understand that a patient's refusal to consent to treatment could not be overridden at any stage of their CTO unless they were recalled to hospital for that purpose.

What happens next

In this overview of our first annual report on our work in monitoring the operation of the Mental Health Act, our observations and recommendations focus on areas where improvements are needed. This reflects the purpose of our 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. We also note some commendable progress in implementing a range of national policy initiatives and, in our full report, include examples of positive practice that our Mental Health Act Commissioners and members of our service user reference panel have identified.

This year, we highlight the need for services to develop and monitor their practices in the following areas, to ensure their compliance with the Act and the 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 circumstances reports and how they are produced; also reviewing the quality of these reports on a regular 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 the content of these records to inform the development of practice.



- **Carrying out duties as statutory consultees:** ensuring records are made of conversations with SOADs and indicating that patients have been informed of the outcome of second opinions.

We encourage service managers, frontline staff and other partners to take particular note of our practice recommendations.

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:

1. Involving detained patients in their care and treatment

Our analysis shows that improving practice in involving detained patients in their care and treatment should be a major priority for many services. This is not only needed to enhance patients' experience of care, but also as a key factor in promoting recovery and the success of interventions. The need for detained patients to be better involved in their care underpins a number of our recommendations.

We have recommended that services should focus attention on ensuring that they actively involve detained patients in the following key areas of service planning and delivery:

- Assessment, care planning and review processes, as a basis for developing a personalised care plan for the patient.
- Planning the patient's CTO, 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 the content of 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 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.

“ The CPA meeting is the patient's meeting. I chose to actually chair my own CPA ... It really boosted my confidence and I felt extremely involved ... 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 the chance to listen and ask questions. They were very proud of me. All in all, I felt everyone was in the picture. ”

Member of CQC service user reference panel

2. Practice relating to patients' capacity and consent

Assessment and recording of capacity and consent is another key area where significant improvement is needed. The discrepancies that our visiting Commissioners often identify between patients' recorded consent status and their apparent lack of capacity or refusal of consent is concerning. We would also like to see much more evidence that assessments and recording of consent and capacity discussions are ongoing as an integral part of treatment planning.

We have identified consent to treatment practice as an ongoing problem in many mental health services, and will be looking for evidence of improvement during 2010/11.

3. Unnecessary restrictions and blanket security measures

We recognise the importance of ensuring the safety of patients, but would also urge providers to give more thought to how they can minimise restrictions on detained patients and avoid blanket security measures if these compromise patients' privacy or dignity, or place unnecessary restrictions on their autonomy. These may be counter-therapeutic, could breach human rights principles and are wrong. We have also emphasised the importance of a positive therapeutic environment, supported by appropriate staffing levels and skill mix, to promote dignity and safety and help reduce the chance of incidents that might lead to the use of more restrictive interventions.

Involvement is the key to addressing the priority areas noted above. Where a patient is properly involved in establishing and reviewing their care plan, and that care plan shows flexibility in taking into account the patient's needs and wishes, services will find it much easier to meet good practice requirements regarding consent to treatment practice, and in providing services in the least restrictive manner possible. The members of our service user reference panel have told us how important involvement is, what a positive impact it can have on people's experience and their overall feelings about being detained, and how it can help in their journey to recovery.

Monitoring progress

We will continue to monitor 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 their experience to monitor the operation of the Mental Health Act and will also use their feedback and the information from our visits to inform our wider monitoring of services to ensure that essential standards of quality and safety are met.

Where we identify systemic problems that have not been adequately addressed by hospital managers, we may impose conditions on the provider's registration to require change. In our full report we describe one example where we have taken such action in relation to consent to treatment practice, with positive results.

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How to contact us

Telephone: 03000 616161

Email: enquiries@cqc.org.uk

Website: www.cqc.org.uk

Registered office

Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

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