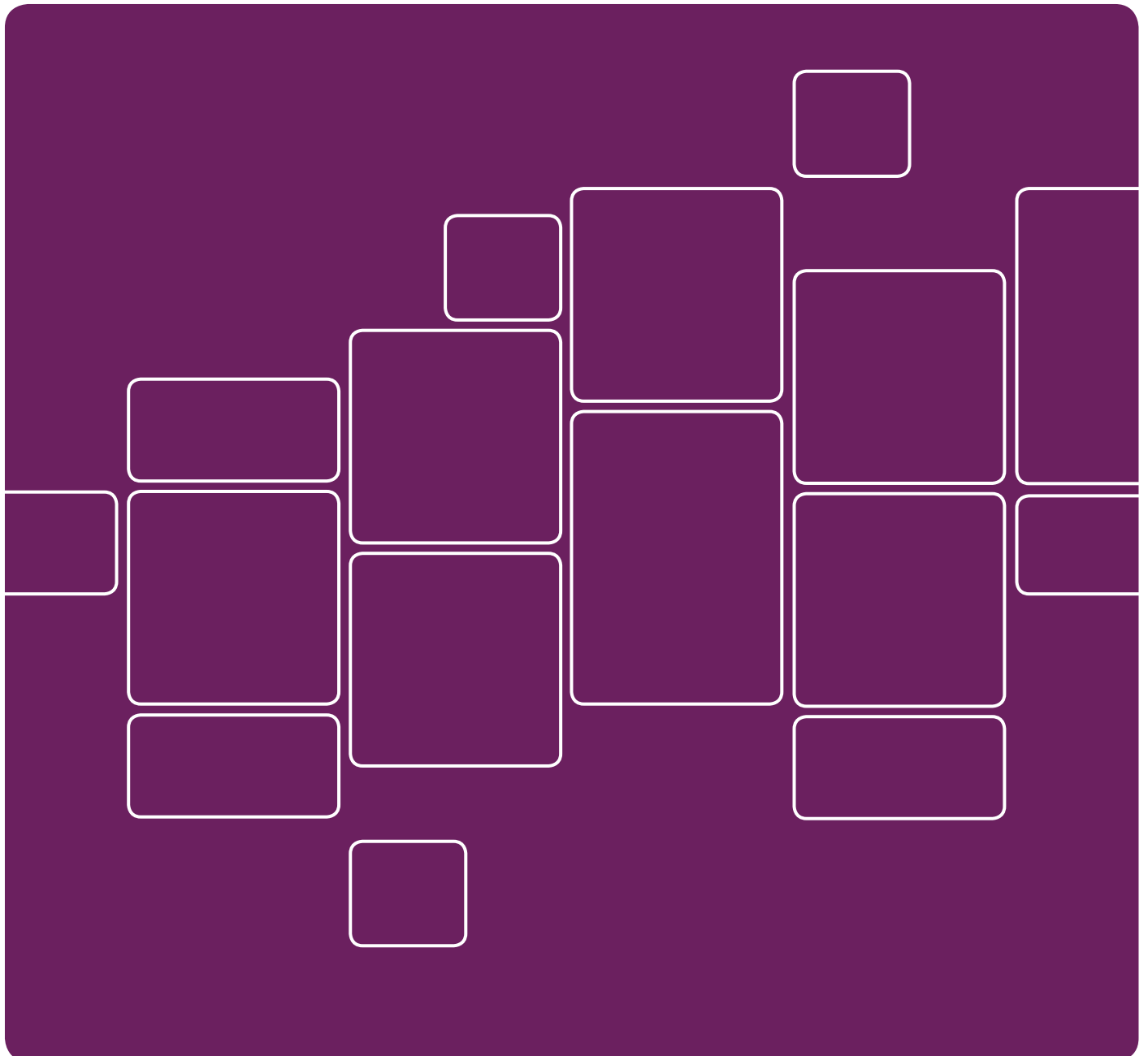


Monitoring the Mental Health Act in 2010/11

A summary of CQC's findings and recommendations from our annual report on our monitoring of how the Act is used



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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 publication is an overview of our findings and recommendations in our full report on the use of the Act from 1 April 2010 to 31 March 2011.

It has key implications for professional staff advising and operating the Act, including Mental Health Act administrators, boards and senior managers of mental health providers, and commissioning bodies. It is also relevant to representative groups of patients and carers.

It is based on our findings from the visits that our MHA Commissioners have made to services and patients, as well as the work of our Second

Opinion Appointed Doctors. The aim of the MHA Commissioner visits is to identify where the Act is not being used correctly. As a result, our visits often highlight more problems than positive practice. The visits are not assessments of the overall standards of care and treatment in the hospital. This work is carried out by our compliance inspection teams.

Similarly, our annual report highlights more problems and concerns with the operation of the 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. We focus on what we think are the key issues in relation to the Act that providers and practitioners should be aware of and act on where necessary.

Foreword



I am pleased to present our second annual report to Parliament on our monitoring of how the Mental Health Act is used in England.

It is based on the findings of our MHA Commissioners and Second Opinion Appointed Doctors when meeting with patients whose rights are restricted under the Act during 2010/11.

Our role in monitoring the use of the Mental Health Act is to focus on the concerns of individual patients and to safeguard their rights. And the number of people subject to the Act rose once again: 5% higher than the year before. Almost all of this is due to the use of community treatment orders (CTOs). These are still relatively new – introduced in November 2008, CTOs enable patients who are detained in hospital to be discharged into the community and receive their treatment there. The number of people subject to a CTO at the end of the year grew by nearly 30%, even though fewer new CTOs were started this year. This suggests that CTO powers, once implemented, may last for quite some time, and that the population subject to CTO will continue to grow.

In last year's report, we highlighted three priority areas where services needed to do much better: involving patients in decisions about their care and treatment, assessing and recording patients' consent to treatment, and minimising restrictions on detained patients. Although we have seen some examples of good practice this year, we still see improvements in these areas as the main priority for providers.

Involving patients is a key factor in promoting their recovery. We saw some good examples of patients having significant input into planning their care, as well as current and ex-patients being actively involved in how their ward is run. But equally, concerns about a lack of patient involvement continued to be one of the issues most frequently raised by our MHA Commissioners.

Independent advocacy services are an important safeguard that help and support patients to understand and exercise their legal rights. We have some concerns about access to these – some staff who should have been fulfilling the detaining authority's legal duty to explain the advocacy service to patients did not understand it, or even know of its existence.

Similarly, we have seen examples of good practice in relation to consent to treatment, but there is still significant scope for improvement in some hospitals. In some cases, we found that doctors appeared to assume too readily that patients had the capacity to give their consent. Detaining authorities must watch out for this, and make sure that clinicians fully document their reasoning where a patient's capacity to consent may be questioned. Also, the legal powers of CTO are often misunderstood.

The third priority area is about minimising restrictions on patients. This year, we continued to encounter customs and practices that go against this principle. Another concern is that of delays in admissions to hospital due to bed availability – a long-standing problem that in some cases places the patient at great risk. We still found patients being accommodated in makeshift rooms and temporary beds, and patients frequently raised with us their anxieties over the pressure on beds. We also continued to find patients being detained in hospital longer than necessary because of a lack of community or other alternative placements – which raises a genuine concern that the principle of least restriction is not fully realised.

Our work to monitor the Mental Health Act helps to protect the rights of patients. We have a wider regulatory role – under the Health and Social Care Act 2008 (HSCA) – to register care providers and check that they continue to meet essential standards of quality and safety laid down by law. If they don't, we can act quickly and use our strong enforcement powers if necessary to make sure they return to compliance.

Increasingly, we are using this wider framework to strengthen the protection given to people. Our MHA Commissioners and HSCA compliance inspectors are now working closely together, sharing overall provider-level findings and coordinating activity. We have started to see how concerns about a provider's use of the Mental Health Act have triggered regulatory action from us under the HSCA, and we look forward to being able to report more on this in future reports. However, the two functions will remain separate – we are committed to keeping focus on protecting the rights of people subject to the Act, and using the extensive expertise and knowledge of our MHA Commissioners to help us do this.

Jo Williams
Chair

Margaret's story

We monitor the use of the Mental Health Act above all to make sure that patients are treated with dignity and their human rights are respected. Talking to patients and listening to what they tell us is at the heart of what we do. Margaret, a member of our Service User Reference Panel, offers her view on what it is like to be subject to compulsion and the impact it has had on her life.

"It is very hard for me to find anything positive to say about my experience of being sectioned five times between 1998 and 2005.

It was not just the fact that the ward I was on was in a converted nurses' home and totally unsuitable for its purpose, offering very little space for activities and few places to meet visitors or socialise with other patients. It wasn't just that the T-shaped ward made it impossible for the nurses to keep an eye on everyone to prevent them from harm.

The very worst was the total reliance on medicine and the expectation of unquestioning compliance with this, regardless of the unpleasant side-effects – accompanied by a complete lack of curiosity as to why I might be consistently refusing most of my medicine and whether there might be things going on in my life that were triggering my repeated relapses. This was particularly surprising as I had been well for 21 years prior to this period.

The only good thing was that, on the whole, the nurses were kindly and well-intentioned. They worked hard and did not spend large parts of their time in the office. But the ward housed 18

older people with hugely diverse problems; some were bed-ridden and some doubly incontinent, while the ward only had two bathrooms and one shower, and the washbasins were virtually useless for hygiene purposes as the plugs had all been removed and the water never ran hot. It is a tribute to their hard work that they managed to keep us clean and there were no unpleasant smells. But this meant that they had no time to talk to people. One-to-ones were unheard of.

Tribunals were also difficult. On one occasion, the social work report was prepared by someone who had only met and interviewed me the day before. His report was full of inaccuracies and it was hugely distressing that I was not allowed to challenge it when it was read out, as I had had no chance to discuss it with my solicitor.

But my story has a very happy ending. If the years when I was being repeatedly sectioned were the worst and unhappiest of my life, the six years since have been about the best. I have a care plan exactly suited to my needs and a care co-ordinator who likes and trusts me as I like and trust her.

I am now a member of CQC's Service User Reference Panel, and this has greatly contributed to my well-being. What could be better for my mental health than having my opinions listened to and respected, especially at my advanced age of 79? I am aware, too, that there have been great improvements both in the physical environment and the regime on the ward where I was detained. One-to-ones are now held on a regular basis.

I am in hearty agreement both with the Mental Health Act Code of Practice and the NICE guidelines, particularly where they relate to patient involvement and especially in the drawing up of care plans. The Royal College of Psychiatrists is doing sterling work in its recommendations on what makes a good ward. And the CQC now has standards which it can start to enforce on wards.

The legislators need to think hard about the wisdom of compulsory 'treatment'. The human mind is an immensely complex thing, and there is absolutely no consensus about the best way to help us. What works for one, makes another worse. The lithium that I reluctantly took for a while was of no discernible benefit to me and made me feel very physically unwell – yet there is someone at my bridge club who absolutely swears by it.

One last word: I shall never think I have any worthwhile human rights while it is perfectly legal to deny me access to fresh air for weeks and even months on end. I do so need a good brisk walk to burn off all that manic energy! It helps me get the good night's sleep I so badly need."

“What could be better for my mental health than having my opinions listened to and respected, especially at my advanced age of 79?”

Margaret

Monitoring the Mental Health Act in 2010/11

At any given time, about 16,000 patients are detained in hospital under the Mental Health Act, and more than 4,000 people are subject to community treatment orders (CTOs). CQC has a statutory duty to monitor how services exercise their powers under the Act, to provide a safeguard for patients.

Our MHA Commissioners meet patients in private to discuss their experiences and concerns, to make sure they understand their rights and check that staff are using the Act correctly. Our MHA Commissioners also talk to staff and review legal documents and patients' notes.

We aim to visit every psychiatric ward in England where patients are detained at least once every 18 months. In 2010/11, we carried out 1,565 visits and met with more than 4,700 patients.

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 assessments of the overall standards of care and treatment in the hospital (that work is carried out by our compliance inspection teams), but tell the story of the overall impact on the patient's experience of detention and the level of compliance with the Act and the accompanying Code of Practice.

In 2010/11, we carried out 1,565 visits and met with more than 4,700 patients.

We also safeguard patients' rights by providing a statutory second opinion service to certain patients. The second opinion appointed doctors (SOADs) decide whether the proposed treatment is appropriate for the patient and check that their views and rights have been considered. We handled more than 13,500 requests for a second opinion in 2010/11.

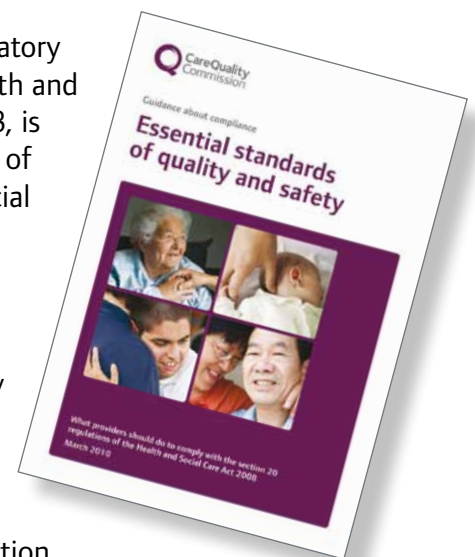
Linking to our wider regulatory and enforcement role

CQC's broader regulatory role, under the Health and Social Care Act 2008, is to register providers of health and adult social care services, and to check that they continue to meet essential standards of quality and safety laid down by law.

If they fall below these standards, we can take swift action, using our strong enforcement powers where necessary, to make sure they return to compliance.

Most importantly, the essential standards set out the outcomes and experiences of care that people should expect, not the processes and policies that providers should have in place. When our compliance inspectors check on a service, they focus on observing the care being given and talking to patients.

Our MHA Commissioners and compliance inspectors are now working closely together.



Inspectors take MHA Commissioners' visit reports into account when assessing a provider's compliance, and inspectors and MHA Commissioners will often combine forces by visiting a service together. In this way, we can use the wider regulatory framework to strengthen the protection given to people subject to the Act.

Use of the Mental Health Act in 2010/11

In 2010/11, the headline total number of formal detentions in hospital did not change significantly from the previous year. There were 45,248 admissions and detentions, compared with 45,755 in 2009/10. However, this figure excludes revocations of CTOs, which are not classed as formal admissions. So some people who would previously have had repeat formal admissions may now be being re-detained in hospital through the revocation of a CTO, following a recall to hospital.

In 2010/11, there was a total of 3,834 uses of CTOs across the NHS and independent sector, a 6.6% decrease from 4,103 in 2009/10. However, many of the CTOs still in place at the end of 2010/11 were made in earlier years – of the CTOs made since November 2008, only 41% had ended by 31 March 2011.

The overall number of people subject to the Act rose by 5%, from 19,947 on 31 March 2010 to 20,938 on 31 March 2011. Almost all of this increase was due to the rise in the number of people subject to a CTO; this was 4,291, an increase of 29.1%.

Once again, the use of hospital-based places of safety increased substantially. The total number of removals of people by the police to a health-based place of safety for assessment under the Act rose by 17.2% compared with the previous year, from 12,038 to 14,111. As with previous years, more males than females were made subject to these orders. However, the number of these detentions is rising more sharply for females than for males: between 2009/10 and 2010/11, there was a 19.2% increase for females and 15.7% for males.

People from all Black and minority ethnic (BME) groups can be overrepresented within inpatient mental health services, and higher rates of people from BME groups are subject to the Act, particularly from some groups – facts well known from previous *Count me in* snapshots. For the first time, we have summarised an analysis of the Mental Health Minimum Data Set information to give a year-round view of the ethnicity of people subject to the Act.

Recommendations

Providers should ensure that the data they supply to MHMDS is accurate and complete, and providers and commissioners need to make full use of the data set to monitor the use of the Mental Health Act locally.

The Information Centre for Health and Social Care should publish comparative provider level data on the use of the Mental Health Act to inform local monitoring and service development.

Key findings

Last year, we highlighted three priority areas where services needed to do much better:

- Involving patients in decisions about their care and treatment.
- Assessing and recording patients' consent to treatment.
- Minimising restrictions on detained patients and avoiding 'blanket' security measures.

Although we have seen examples of good practice in some of these areas, improvements by providers are still the main priority.

Patients' involvement and protection of their rights

'Participation' is one of the five key underpinning principles of the MHA Code of Practice – it emphasises that patients should be involved in developing and reviewing their own treatment and care. It is a key factor in promoting recovery.

This year, we saw some good examples of patients having significant input into planning their care. But equally, concerns about a lack of patient involvement continued to be one of the issues most frequently raised by our MHA Commissioners.

We saw a number of good examples of detaining authorities helping current and ex-patients get involved in how the ward is run. And our MHA Commissioners confirmed that patients have an opportunity to influence this, for example through community meetings or patient councils, on 90% of the wards where they checked this.

We looked at access to independent mental health advocacy (IMHA) services on 311 wards last year and found that almost one in five (18%) of them did not have access to IMHA services. This year, we checked this on almost all our visits and found that detained patients had regular access to an independent mental health advocate

(IMHA) on 65% of wards we visited. We were told that IMHAs would come when requested on 85% of wards. Problems continued with commissioning arrangements for some IMHA services, particularly for patients placed out of the area.

 I helped to set up a Patients Council and became involved in user empowerment. I believe these steps forward, which gave a voice to detained patients, were the best things to happen in advancing our general treatment. Now I feel people are interested in my views and I have input into my care plans and treatment. 

View from a SURP member

A common concern was whether patients and their 'Nearest Relative' were aware of the IMHA service or how to get in contact with it. We also found that some staff who should have been fulfilling the detaining authority's legal duty to explain the IMHA service to patients did not understand it, or even know of its existence.

The First-tier Tribunal (Mental Health) is the primary mechanism in England for appeal against the use of the Act's powers of detention or supervised community treatment. Hospital managers have a duty to make sure that their CTO patients understand their legal position, and their right to apply to the Tribunal. This includes giving the information to the patient and, unless the patient objects, a copy to their Nearest Relative. However, we found that this legal duty was often not met.

The number of applications to the Tribunal rose in the last two years, although this has not

increased the rate of successful appeals (in terms of discharge from detention). They accounted for 12% of all outcomes, the same as in 2009.

Appeals against CTOs amounted to 14% of all hearings in the year. The success rate was only around 5%, which may be in part because of the considerable number of 'automatic' hearings generated by the CTO process.

Appeals against CTOs amounted to 14% of all hearings in the year.

Recommendation

Providers should make sure that the principle of patient participation in care planning is fully embedded in staff training programmes. Clinical leaders should be helped to create ward cultures in which patient participation is the norm.

Consent to treatment

The assessing and recording of capacity and consent was another of the three issues where we had identified the need for significant improvement. Again, we have seen some examples of good practice, but there is still significant scope for improvement in some hospitals.

Although the Act allows some medical treatment for mental disorder to be given without consent, the patient's consent should nevertheless be sought before treatment is given wherever practicable. This has been another focus of our visits and we have seen examples of good practice.

It will not always be necessary to undertake a full assessment of capacity before treating somebody, on the basis that they give valid consent. However, in some cases we found that doctors appeared to assume too readily that patients had the capacity to give their consent. Detaining authorities must watch out for this,

and make sure that clinicians fully document their reasoning where a patient's capacity to consent may be questioned.

The legal powers of CTOs are often misunderstood, which has implications for professionals explaining these powers to patients. For example, some do not know that a CTO patient has the right to refuse treatment with medicine while in the community, or that such refusal is not in itself sufficient cause to recall the patient to hospital.



In 2008, the safeguard of second opinion certification was extended to CTO patients who consent to their treatment. This 'consenting' group accounted for two-thirds of CTO second opinion referrals in 2010/11. These patients have been hard to engage in the process; some resent having to have a doctor certify treatment to which they consent. The Health and Social Care Bill currently before Parliament contains a clause that, subject to the passage of the Bill, will exempt the treatment of consenting CTO patients from the need for SOAD certification. This could help to significantly reduce the pressure on SOAD services for CTO patients.

Recommendations

Providers should make sure that their staff take refresher courses on consent to treatment. Training should be provided in a range of formats – for example, e-learning and simulation/role play.

Revalidation and appraisal programmes for health care professionals should include assessments of knowledge and skills relating to capacity and consent.

Providers should ensure that all staff who care for patients subject to CTOs understand the scope and limitations of this power. Any instance of unlawful treatment of a patient subject to a CTO should be properly investigated, to help detaining authorities to learn about the application of the law as it applies to this group of patients. Patients should be offered due recourse if necessary.

 It is best to take part in activities; it does not reflect favourably if you don't. Usually it is the same boring repetitive stuff: crosswords, word searches, quizzes. Things that are put on for the sake of it, rather than owning any value. 

View from a SURP member

Patients' experience of care and treatment

The third priority area we identified last year was about minimising restrictions on detained patients and avoiding blanket restrictions. We pointed to examples where house rules and approaches to physical security prevented this. This year, we continued to encounter customs and practices that have the same effect.

Although nationally the suggested standard for bed occupancy is 85%, we still visit some acute inpatient mental health wards that are running at full or over capacity, leading to overcrowding and patients sleeping out. We found patients being accommodated in makeshift rooms, including temporary beds placed in general ward areas or in other rooms that normally serve other purposes. And patients frequently raised with us their anxieties over the pressure on beds – in particular on the chance that they might lose their bed if they take home leave.

To address the pressures on admission, we welcome the continued development of recovery houses (also called crisis houses) – these can provide care in a less restrictive setting, are generally popular with service users, and studies have shown that they are as effective as inpatient units in clinical terms.

We have particular concerns about 'lapsing' recommendations for admission – where a bed is not found before the 14-day limit on the application expires. We also continue to find patients who are detained in hospital longer than necessary because of a lack of community or other alternative placements, which raises

a genuine concern that the principle of least restriction is not fully realised.

Our MHA visits this year have raised some questions about how inpatient units are being used for people with a learning disability, particularly assessment and treatment units. These units are intended to provide short-term assessment and treatment services and, where appropriate, rehabilitation services for people with a learning disability (often people who are detained under the Act).

According to the *Count me in* census, people with a learning disability were more likely to be in low and medium secure settings and were in hospital much longer compared with people with mental health problems. It is important that commissioners and providers work collaboratively to make sure that people placed in these services are being assessed and receiving treatment as intended, and take appropriate action if this is not the case.

We still meet with patients who raise issues about feeling bored or wanting more to do while they are in hospital – often with a sense that meaningful activities come some way down the list of considerations in their treatment or care plan. This prompted us to take a special look at this issue in 2010/11.

We found that the vast majority of patients (90%) said that there were activities available on the ward, though fewer (78%) reported access to activities available off the ward. Around a third of patients who responded said there wasn't enough for them to do on weekdays, a figure that rose to more than half of patients during the evening and almost two-thirds at weekends.

Overall, we found that a wide range of therapeutic activities are available on most wards, and these are advertised reasonably well and reviewed on a regular basis. However, the analysis did raise questions about how well activities are tailored to individual needs and interests, and how effectively patients are encouraged and motivated to take part.

Recommendations

All staff with responsibilities for the provision of therapeutic activities should monitor participation in such programmes. Programmes should be reviewed as necessary to make sure they are relevant to patients' needs and interests, and that there is a positive approach to engaging patients in them.

Commissioners of inpatient mental health services should make sure that local needs assessments for mental health services are robust, and that availability of beds and evidence-based alternatives to admission meet the needs of local people, bearing in mind the Royal College guidance on occupancy levels in determining the resources needed.

Where people have been assessed under the Act as needing admission, delays are a major safety issue. We recommend that NHS providers report this as a serious untoward incident (level 4) to NRLS and/or as a safeguarding issue.

Promoting patient safety

Promoting patient safety is an extremely important issue for mental inpatient services. It is reasonable for anyone to expect to be safe when they go into hospital, and that the treatment they receive is therapeutic and appropriate to their needs.

Most people working in mental health are compassionate and professional, even under the considerable stresses of their work. But detaining authorities must always be extremely vigilant about safeguarding patients from abuse.

We take the view that the wider patient involvement in care planning can be, the better the service will be. If there is an ethic of genuinely helping the patients to have a say in their treatment, including creating real opportunities for patients to record their own views and experiences following, for example,

restraint incidents (through the help of independent advocacy if appropriate), then there is a smaller likelihood that abuse can occur.

As with restraint, many services could markedly improve their seclusion practice through patient involvement in care planning and post-incident reviews. In one example, we found significant use of seclusion as a way of dealing with difficult behaviour, and there was a danger of it becoming a cultural expectation on the unit.

During the year, we raised concerns in a number of hospitals over reductions in staffing, which can compromise the quality and safety of care. More generally, though, patients' concerns are simply about the lack of continuity of care because of the reliance on agency or bank staff.

Recommendation

All detaining authorities should give patients the opportunity to record their experience and views after restraint incidents, in line with the Code of Practice guidance, as a part of wider patient involvement in care planning and review.

Deaths of detained patients

Detaining authorities must notify CQC of any death of a patient who is detained under the Act. The main purpose of this is to make sure that we can take appropriate monitoring action in response to individual cases.

In the past year, we have been represented on, and worked alongside, the Independent Advisory Panel to the Ministerial Board on Deaths in Custody and its stakeholder groups. The Ministerial Board was established to consider how to prevent deaths in all forms of custody, and we have welcomed our engagement with it.

We were notified of 294 deaths of detained patients in 2009, and 283 in 2010. Three-quarters of them were due to natural causes.

About a third of the patients who died of natural causes while detained in 2009 and 2010 did so before their 61st birthday. This supports findings of reduced life expectancy among people with

long-term serious mental disorder – this has been attributed to a combination of factors including multiple social disadvantage, long-term antipsychotic medicine use and higher-risk lifestyles, particularly smoking. It also reinforces concerns that people with serious mental health problems may have reduced access to physical healthcare.

Of the 115 deaths in 2009 and 2010 that were due to unnatural causes, most were due to suicide or self-harm. Overall, 44% of these unnatural deaths resulted from hanging or self-strangulation.

The number of self-inflicted deaths of detained patients has dropped significantly since the National Patient Safety Agency (NPSA) highlighted the need to address potential ligature points created by non-collapsible curtain or bathroom rails. In 2010 there were 34 self-inflicted deaths, compared to 51 in 2007. The NPSA describes suicide using such a ligature point as an event that need never happen, but continue to identify potential ligature points in hospital environments as safety issues.

We recognise that this is a complex area and that other factors need to be taken into consideration, including staff observation levels, the quality of engagement of patients by staff, engagement with families and carers, practice in risk assessment, risk management and care planning, as well as the design of the physical environment.

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We have been surprised to find some examples of risk assessments not being reviewed following incidents such as absconding, physical violence, or where a patient expressed suicidal ideas.

And one common failure in risk assessment has been a lack of support for patients who receive bad news, whether to do with their personal life outside hospital or their progress through the hospital system. It is vital that in these circumstances patients receive support from staff and a fresh assessment of risk is undertaken.

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