

# Mental health act report

## Summary

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.

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.

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

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.

## **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.

## **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 find 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 Mental Health 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.

## **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 the 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.

#### 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 patients who died of natural causes while detained in 2009 and 2010 did so before their 61<sup>st</sup> 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 during 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 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 we 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.

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.