The Mental Health Act Commission

Key findings about the use of the Mental Health Act

Taken from the Commission's
Twelfth Biennial Report 2005-2007
Risk, Rights, Recovery

London: **The Stationery Office**

Editorial Note

This briefing note contains some of the key contents of the Mental Health Act Commission's Twelfth Biennial Report, *Risks, Rights, Recovery,* which reviews the operation of the Mental Health Act 1983 between 2005 and 2007. It is not a full summary of all aspects of the Biennial Report, but seeks to describe the use of the Act and the experience of detention for people who may be less familiar with the legislation and its operation.

The Mental Health Act Commission is the statutory body in England and Wales charged with monitoring the operation of the Mental Health Act 1983 (as amended 2007). It provides important safeguards to patients who are detained under the powers of the Act. As part of its work, it visits hospitals in the NHS and independent hospitals and interviews (in private) around 6,000 patients each year who are detained under the Mental Health Act. It also administers the statutory second opinion appointed doctor (SOAD) service, whereby members of an appointed panel of consultant psychiatrists provide an independent review of the treatment plan proposed by a patient's doctor for those patients who after three months' detention do not or can not consent to treatment.

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ISBN 978 0 11 322807 2

Introduction

> I initially thought when I went into hospital that I would lose all my rights and freedom, but it hasn't proved to be the case.
>
> *Dawn Cutler-Nichol, s.37/41, Derbyshire*

1. Nearly fifteen thousand people, or well over a third of patients who were in mental health hospitals in England or Wales on the 31 March 2006, were detained under the Mental Health Act 1983[1]. Most patients are detained for the treatment of mental illness, which includes a wide range of diagnoses, often involving psychotic illness, but also depression and dementias. More than half (55%) of mental illness patients are detained in general mental health wards; 20% are in low secure wards; another 20% in medium secure wards, and about 5% in the three High Security Hospitals (Ashworth, Broadmoor and Rampton).

2. Each year there are some 45,000 detentions under the Mental Health Act 1983[2]. Patients who are detained under Mental Health Act powers, unless they are too ill to consider such matters at all, often tell us that they view their new status with fear and sometimes anger. Many people are very unclear about the reality of the process of being 'sectioned'[3]. However, these fears are not always borne out; patients may be relieved to find that the law which takes away their liberty also contains some checks and balances that a patient can use to regain control throughout their recovery process: the Mental Health Review Tribunal (MHRT) hears appeals against detention; the Mental Health Act Commission (MHAC) monitors the way in which the powers and duties of detention are exercised.

3. Patients may be detained under the Mental Health Act at any age. Nearly 900 11 to 17 year olds were resident in hospitals on 31 March 2007, of whom just over a third were detained. The mean age of all detained patients is 43. About a third of detained patients are women. There is overrepresentation of Black and Minority Ethnic patients, with admission rates amongst Black and Black/White mixed groups three or more times higher than

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1 Of 36,846 patients in hospital on the 31 March 2006, 12,157 were detained primarily for the treatment of mental illness, 1,636 were detained who had learning disability, and 918 were detained for the treatment of personality disorder. Data from the National Mental Health and Ethnicity Census *Count Me In*, which was conducted by the Mental Health Act Commission and published by the Healthcare Commission. See also http://www.mhac.org.uk/census2006/2006Results.php.

2 The total number of times that the Act was invoked in England stood at 44,891 in 2004/05 and 45,484 in 2005/6.

3 In pre-Mental Health Act days, the term would be 'certified'. We do not use the term 'sectioned' in our work, preferring the descriptive term 'detained'. Throughout this report generally we refer to those detained or otherwise resident in hospital as 'patients' and people who receive outpatient mental health services as 'service users' (one notable exception to this general rule is the MHAC's own 'service user reference panel', which is comprised of both hospital patients and other service users).

average, with other indicators of coercive treatment (such as seclusion rates) also disproportionately high[4].

4. The length of hospital stay for detained patients varies considerably. The average length of stay[5] for section 2[6] patients with a mental illness is two weeks; for section 3[7] patients it is one year (although many section 3 patients have much shorter hospital stays). The longest hospital stay recorded in March 2006 was more than 70 years[8].

5. Patients may be detained through a civil route or via the criminal justice system. The number of patients admitted from the community to hospital under civil powers of the 1983 Act in England rose slightly in 2004/05 and 2005/06 to 25,618. The number of informal patients subsequently detained under the Act's powers was 18,202 in 2005/06. Forensic mental health services provide care for people who have come into contact with the criminal justice system and have been transferred to secure NHS services. The number of people detained in forensic services has increased year on year for more than a decade, rising from 2,650 in 1997 to nearly 4,000 by July 2007[9]. In 2005 independent hospitals provided 1,827 medium secure beds, or 39% of the total provision of 4,713 such beds[10].

Responsibility and co-operation in using the Mental Health Act

6. Admitting someone to hospital under the Act is a very serious responsibility for all those involved and it is essential for the patient that it is carried out legally and in accordance with the Code of Practice. The Act places very specific duties on a number of different professions, individuals and public authorities. In most cases these are fulfilled correctly, and across both England and Wales there is considerable knowledge and experience at local level of what is important in the day to day management of this complex and important legislation. Mental health services have a long tradition of partnership working across professional and organisational boundaries (and similarly, in pioneering patient or service user involvement). During this period however the MHAC has continued to hear of problems in accessing the required professionals to complete applications for admission under the Act, as well as delays in admitting patients to hospital once an application has been completed. These difficulties can be eased where social services and other authorities, including the police, agree protocols over attendance for Mental Health Act assessments and monitor their operation.

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4 *Count Me In* Census finding: see n.1 above.

5 In an attempt to avoid any distorting effects of the extreme outlying cases, we have calculated the "5% trimmed mean" (an average taken from data shorn of the highest and lowest 5% of returns).

6 Section 2 of the Act relates to admission for assessment (as opposed to treatment once diagnosed).

7 Section 3 allows for the detention for treatment of mental disorder for up to six months, renewable for another six months and then renewable annually.

8 Perhaps surprisingly this was a civil (rather than a forensic) patient.

9 Rutherford M & Duggan S (2007) *Forensic Mental Health Services: Facts and figures on current provision.* Sainsbury Centre for Mental Health 'Forensic Factfile 2007', September 2007. Appendix (based on Laing & Buisson (2006) *Mental Health and Specialist Care Services UK Market Report 2006*).

10 *ibid.*

The Care Programme Approach

7. The Care Programme Approach (CPA) is designed as a framework for effective mental health care for people with severe mental health problems, which should ensure that health and social care needs are assessed and addressed through a regularly reviewed care plan, overseen by a key-worker but designed in consultation with the service user and, where appropriate, any carer[11]. In this reporting period, a number of inquiries into homicide and suicide have underlined deficiencies in the implementation of the CPA[12], and the Department of Health has acknowledged "increasing concern that a number of key groups which should meet the characteristics for enhanced CPA are not being identified consistently"[13].

8. Good care planning, especially in acute and rehabilitation wards, requires a seamless service between the hospital and the community. Some patients' discharges are unnecessarily delayed for want of arrangements having been made for their support in the community. The most common cause of transfer delays – accounting for nearly 40% overall – is a lack of residential or nursing home accommodation to receive discharged patients. Department of Health data suggests that approximately 9% of psychiatric beds are occupied by patients who should no longer be there but cannot move on for want of an agreed follow-on destination[14].

Children and adolescents

9. The MHAC has long pressed for the issue of detention of young people on adult wards to be addressed[15]. The revisions of the Mental Health Act 2007 to the 1983 Act create a duty on PCTs and Local Health Boards to notify social services authorities of hospitals in their area that provide accommodation suitable for persons under the age of 18[16], and places hospital managers under a duty to ensure that children and adolescents (whether detained or not) are accommodated in an environment suitable to their age, subject to their needs[17]. We are

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11 Department of Health (2006) *Reviewing the Care Programme Approach 2006. A consultation document.* November 2006, para 1.

12 See, for example, the *MN Inquiry Report* (*Avon, Gloucestershire & Wiltshire Strategic Health Authority,* 2006); *Barrett Inquiry Report* (NHS London, 2006); Francis R, Higgins J & Cassam E (2000) *Report of the independent inquiry into the care and treatment of Michael Stone*. South East Coast Strategic Health Authority; Maden T (2006) *Review of Homicides by Patients with Severe Mental Illness* (report commissioned by the Department of Health); National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2006) *Avoidable Deaths: five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, December 2006.

13 Department of Health (2006) *Reviewing the Care Programme Approach 2006, a consultation document.* para 3.4.

14 Department of Health SitReps (Situation Reports) collected by NHS Trusts: see www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4070304

15 For example in its report *Safeguarding children and adolescents detained under the Mental Health Act on Adult Wards*, Mental Health Act Commission, December 2004.

16 MHA 1983 s.140 as amended by MHA 2007 s.31(4).

17 MHA 1983 s.131A(2) as inserted by MHA 2007 s.31(3). The 2007 Act also amends MHA 1983 s. 39 concerning the court's powers to request information about suitable accommodation for child and adolescent mentally disordered offenders.

delighted at the announced investment to increase bed capacity and improve children's facilities, and the commitment to end the treatment of under 16 year olds on adult wards by November 2008[18].

10. The ending of admissions of children or adolescents to unsuitable adult facilities is an ambitious undertaking. Between October 2004 and November 2006, the Mental Health Act Commission encountered 116 adult wards where one or two children under the age of 18 were detained[19]. In all, 132 children were accommodated in such situations. Eighteen of these wards were psychiatric intensive care units where the most disturbed adults are treated.

The experience of detention

11. A key feature of our findings during 2005-07 is the pressure on admission wards, which we believe makes it very difficult to provide good care to patients. Over this reporting period, 37% of all wards visited by Mental Health Act Commissioners were running at over 100% occupancy[20] when we visited. Problems with high rates of bed occupancy in acute wards are most prevalent in urban areas, with London showing almost half of such wards running at over 100% occupancy during 2005-07.

> K was detained for four months on an over-occupied ward. Although she did not have to move or go on leave, she shared a locker and en-suite bathroom and toilet with a woman who did "sleep out" on another ward. As the dispensing of medication was done late at night (sometimes as late as midnight), the other patient could not go to her own bed until after that time, and consequently was still sharing K's space until then.
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> Service user experience, from *Who's been sleeping in my bed?*[21]

12. NHS Trusts have identified a range of methods for managing bed pressures, and we recommend that innovative and beneficial practice should be shared more widely between and within Trusts. There is some evidence to suggest that as crisis resolution and home treatment services become more established this has resulted in some easing of pressure on beds.

Safety of detained patients

13. The busy acute wards that we visit appear to be tougher and scarier places than we saw a decade ago. Many female patients reported fear for their safety and actual incidents of physical or sexual abuse. In many mixed units, women will be in a minority. Bed

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18 "Government invests £31m in children and young peoples' psychiatric wards". Department of Health Press Release, 14 November 2007.

19 This data was first presented to Parliament in the Mental Health Bill debates by Lord Patel of Bradford, the MHAC chairman: see Hansard (HL) 15 January 2007: col 549 - 552

20 MHAC bed occupancy data counts patients "on the books" of a ward, whether or not they are physically present at the time of our visit. A number of such patients will in fact be on leave (under section 17 of the Act).

21 MHAC (2006) *Who's been sleeping in my bed? The incidence and impact of bed over-occupancy in the mental health acute sector. Findings of the Mental Health Act Commission's Bed Occupancy Survey*. Suki Desai & Mat Kinton. December 2006 www.mhac.org.uk

management can frustrate attempts to segregate sleeping areas in mixed units. We also have some concerns over the placement on acute mental health wards of older patients[22] including some suffering dementia, who have complained to us of feeling vulnerable and unsafe. They felt anxious witnessing the volatile behaviour by some of the more acutely ill younger patients and by the constant loud noise.

14. It is scandalous that vulnerable people are forced to reside on mental health wards that are frightening and dangerous places. This should not happen at all, but it should be a matter of extreme priority that children and young people are not placed in such situations, and that women's safety from sexual harassment, abuse and assault is addressed within the mental health service. We note that the government has recognised these problems, and that funding has been pledged to address the safety of women and children in psychiatric hospitals[23]. We hope that, whether or not they are in receipt of the new funding, all services will give real priority in the next reporting period to the provision of suitable accommodation and care to all patients, including women and children.

Black and Minority Ethnic Patients

15. Too many NHS Trusts show poor evidence of fulfilling their duties under the Race Relations (Amendment) Act 2000. We continue to find instances where the basic NHS Trust responses to Black and Minority Ethnic patients is unacceptable. It is also clear that recording of self-reported ethnic status in Trust records continues to be significantly incomplete[24]. The MHAC considers ethnic monitoring of all patients subject to formal coercive powers to be an absolute minimum requirement in terms of compliance both with the Race Relations (Amendment) Act 2000 and with general good practice for hospital boards.

Staffing

16. During this period there has been concern about the adequacy of staffing levels in mental health services[25]. As yet there are no universally agreed standards in this area. We have observed staffing levels that we feel to be unsafe, and that have been identified as such to us by the nursing staff themselves. Patients complain that staffing shortages reduce opportunities for escorted leave from the ward, and that it is very difficult to develop a rapport with a constantly changing nursing staff. In many wards we noted staff observing but not interacting with patients, alongside a general lack of meaningful activities for patients. Some patients complained that nurses 'relied upon' restraint, medication and confinement in order to manage them. In other wards, 'patient protected time' initiatives are

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22 i.e. patients over 65 years of age.

23 "Government invests £31m in children and young peoples' psychiatric wards". Department of Health Press Release, 14 November 2007; Department of Health (2006) 'Capital allocation process: £30 million for improvements in safety on adult inpatient mental health wards' letter to all chief executives of NHS mental health Trusts & SHA chief executives, 2 November 2006.

24 Raleigh V S, Irons R, Hawe E, Scobie S, Cook A, Reeves R, Petruckevitch A & Harrison J (2007) 'Ethnic variations in the experience of mental health service users in England' *British Journal of Psychiatry* **191**, 304-312

25 Royal College of Nursing (2007) *Untapped potential: a survey of RCN nurses in mental health 2007.* RCN, London, August 2007.

used effectively to ensure that nursing staff have the opportunity to interact with patients for at least some set periods without distractions of administration or other tasks.

The impact of hospital environments on detained patients

17. The MHAC continues to be concerned about ward environments, both in the sense of the physical state of wards within which patients are detained, and in relation to the atmosphere on such wards. There are some examples of excellent new facilities for acute inpatient care, but all too often patients' experience of inpatient care at times of mental health crisis involves dirty or shabby wards where patients are inactive, confined, bored and anxious over their safety or for the security of their possessions.

18. Patients who are detained under Mental Health Act powers are placed in a quite different situation from many other NHS funded inpatients. They have not agreed to come into hospital and in some cases do not accept that need for admission, yet they may not discharge themselves from a ward that they find insupportable. They may experience no physical disability through their illness, and yet be confined, even by force, within a building with little access to exercise or fresh air. Ideally an acute inpatient ward should perform the positive function of asylum: a safe and supportive place that facilitates recovery. We have found wards that are unventilated and hot in summer but cold in winter; wards where there is little natural light; noisy and smoky wards; broken, worn and stained furniture, sticky floors and bad smells; vermin and cockroach infestation; peeling paint and graffiti; non-existent or broken lockable storage for patients' belongings. We have had cause to comment on broken and dirty toilet facilities, and on inadequate numbers of toilet and bathroom facilities.

19. We welcome and commend initiatives such as Star Wards[26], which promulgate solutions to such problems of patient care, *The Search for Acute Solutions by the Sainsbury Centre*[27] and the Department of Health's Essence of Care which provides assistance for Trusts to establish 'benchmarks' for the patient care environment[28].

20. A number of wards about which we have raised environmental concerns are those built in dormitory style. There is however considerable refurbishment work being undertaken in some of the older hospital sites. In the best of these refurbishment projects, service users and staff are involved in the planning and decision-making processes.

Patients' contact with their families

> I was detained about 50 miles from where I live and only got to see my children once a week for an hour
>
> Deborah Hickman, s.3, Bolton

21. In 2006, in collaboration with Barnardo's and the Family Welfare Association, we looked at how mental health services can promote family contact when a parent is in hospital[29].

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26 Marion Janner (ed) (2006) *Star Wards: Practical ideas for improving the daily experiences and treatment outcomes of acute mental health in-patients.* www.starwards.org.uk

27 Sainsbury Centre for Mental Health (2006) *The Search for Acute Solutions*

28 Department of Health (2007) *Essence of Care: Benchmarks for the Care Environment.* 31 Oct 2007.

29 Robinson, B, Scott S & Day C (2007) *Parents in Hospital: How mental health services can best promote family contact when a parent is in hospital. Final Report.* CSIP, MHAC, FWA & Barnardo's, July 2007. The reports from this project are available on the MHAC website

Overall, visiting policies were good; but evidence provided by Commissioners' observations for some units was disappointing in the light of good policies in their Trust. The quality of facilities provided for visiting children varied within Trusts. Only 5 of the 39 identified family visiting facilities were deemed to be 'good', in that they had flexible booking arrangements; a dedicated family room in an appropriate location; pleasant décor and furniture; and a range of toys and activities for children. Thirteen settings were identified as being 'poor', meaning that little effort had been made to create a space where children would feel welcome and comfortable. The evidence of this review is that the identification of patients as parents is not automatic, that patients and their carers take most responsibility for maintaining family contact and would welcome more support, and that families often feel that children are not entirely welcome visitors.

22. Patients also report finding it difficult to maintain contact with adult relatives and even partners, despite the importance of maintaining contact with relatives and carers throughout the inpatient stay.

Physical health on psychiatric wards

23. People with a severe mental health problem (schizophrenia or bipolar disorder) are twice as likely as the rest of the population to die prematurely[30]. They are more likely to smoke, to be obese, and have significantly greater risk of heart disease, respiratory disease and stroke[31]. They are more than twice as likely as the general population to have diabetes[32]. There are significantly higher rates of bowel and breast cancer amongst people with schizophrenia than in the general population[33]. People with learning disability are also more likely to die prematurely and have high rates of obesity and unmet health needs[34]. Despite this, hospital wards where patients are detained under the Act can be difficult places to maintain or promote healthier lifestyles.

> I was greatly concerned about lack of motivation and activity on the ward. A large proportion of patients were encouraged to get up for breakfast but then went back to bed until lunch time. Patients complained that they were bored and that planned activities did not take place as no-one was interested in them.
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> Visit report to an acute ward in south London, November 2006

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30 Harris SC, Barraclough B (1998) 'Excess mortality in mental disorder' *British Journal of Psychiatry* 173; 11-53, referenced in Nocon A, and Owen J (2006) 'Unequal treatment' *Mental Health Today,* February 2006, 27-30.

31 Disability Rights Commission (2006) *Equal Treatment: Closing the Gap*. London, DRC, chapter 3. For research paper see Hippisley-Cox J and Pringle M (2005) *Health inequalities experienced by people with schizophrenia and manic depression: analysis of general practice data in England and Wales* at http://www.drc.gov.uk/library/health_investigation/research_and_evidence.aspx

32 Disability Rights Commission (2006) *op cit*. In its response to the DRC recommendations, the Department of Health recognises that the antipsychotic drugs Olanzapine and Risperidone have been associated with increased risk of diabetes. See Department of Health (2007) *Promoting Equality,* p.7.

33 Disability Rights Commission (2006) *op cit*. For research paper see Hippisley-Cox J, Vibogrdova Y, Coupland C, and Parker C (2006) *Risk of malignancy in patients with mental health problems* at http://www.drc.gov.uk/library/health_investigation/research_and_evidence.aspx

34 Disability Rights Commission (2006) *op cit*. Researchers for the DRC were unable to identify learning disabled people accurately from primary care records to provide reliable data on specific health conditions such as diabetes, etc (see p.40 of the DRC report).

24. The physical health of detained patients might be improved if, in keeping with current government guidelines, opportunities were provided for all to undertake at least 30 minutes of moderate intensity activity (such as brisk walking or sport) on at least five days of the week[35]. Many detained patients do not have sufficient opportunity to achieve this.

25. A number of hospitals have good relations with general practitioners who provide primary care physical healthcare for their patients. However, regular medical examinations for long-stay patients are far from universal, and patients whose mental health treatment involves high doses of antipsychotic medication or polypharmacy do not always receive the physical health monitoring recommended by the Royal College of Psychiatrists.

Food

26. Food is of particular importance to patients who stay on the ward for a very long time. Indeed, patients from all kinds of wards often comment to us about the quality and quantity of food available to them. Patients often supplemented hospital food provision through the purchase, not only of snacks, but of take-away meals. This was a particular problem in those services which served the last cooked meal of the day as early as 4.30 p.m. Religious or ethnic food requirements are not always met: even in hospitals in large cities such as London we have found halal or kosher food to be unavailable to patients who request them. Patients who were vegan, vegetarian or who had special dietary requirements were also too often poorly provided for.

Facilities for the physically disabled

27. We continue to hear of instances of poor facilities for and management of physical disability in mental health services[36]. We have noted poor services provided to patients with a range of disabilities, including deaf and blind patients, and patients requiring walking aids or special equipment for safe and comfortable living. From December 2006 NHS Trusts have been under a legal duty to promote equality of opportunity for disabled people and should address facilities for disabled patients in their Equality Action Plans.[37]

> It took weeks for the ward to find a chair with a high back for me to sit in, there were no facilities for bathing for disabled patients, no suitable furniture anywhere on the ward, in the day room, television room, or anywhere to support my needs. I spent nearly seven months sitting in my room, all alone, on the chair they finally found for me… patients who came to my room to talk to me were removed at once as there was a no accessing other rooms policy…I got patients to move my chair into the doorway … but nurses then said I was creating a fire hazard.
>
> Monica Endersby, detained under ss.2 and 3

Locked doors

> "[I] felt embarrassed, claustrophobic, locked in, an inmate … fourteen again"
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> Unnamed service user view from Humber M H Trust research on user experience of locked wards

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35 Department of Health (2002) *National Service Framework for Diabetes: Implementation details and draft service models*, p.2.

36 MHAC (2006) *Eleventh Biennial Report 2003-05: In Place of Fear?* Chapter 4.105 *et seq*.

37 See http://www.dotheduty.org/files/Code_of_practice_england_and_wales.doc

28. The majority of acute wards that we visit operate a locked door policy. A patient admitted to an acute ward, whether detained or informal, is more likely to be held in a locked environment than not. The advantages of locked wards include having control over patients; creating a secure and structured environment; protecting patients from theft, drugs or harassment from outside; reassuring relatives, carers or the patients themselves; and having the door locked as a matter of policy reduces anxiety and discussion that would be caused on the occasions where it might otherwise have to be locked. The disadvantages included patients feeling confined, frustrated, aggressive, depressed or anxious; increasing patients' sense of helplessness, dependence and ill-health; adapting the ward for the sake of those who are most unwell to the detriment of others; reinforcing the power relationships between nurses and patients; and creating the impression of a non-caring environment with an emphasis on keys and physical barriers[38].

29. For patients who are not detained under the Act who wish to leave a locked ward, the door should be opened at their request, although we know that this is not always done and as such informal patients may be subject to the unlawful deprivation of liberty or *de facto* detention[39]. We remain concerned about unlawful deprivation of liberty, whilst recognising that even on an open ward some patients' movements may be restricted or supervised. The issue is not whether there should be controls, but what sort of controls are appropriate, and we would encourage all hospitals to give this proper consideration.

Seclusion and restraint

30. Psychiatric services will sometimes have no option but to resort to the physical restraint and/or seclusion of patients to prevent harm to self or to other people. However, the very real dangers of physical restraint were highlighted again during this reporting period, first by the findings of the coroner's court into the death in 2003 of Andrew Jordan[40], and also by the report of the inquiry into the 2004 death of Geoffrey Hodgkins[41]. Services with high incidences of restraint and/or seclusion should look carefully at their clinical practice, staffing levels, patient mix and ward environment for any possible improvements that could reduce patient frustration and distress.

31. We continue to see euphemisms used for seclusion practice, so that patients are in effect secluded but without any of the appropriate safeguards. Confining a patient in a room without adequate sanitary facilities is a potential breach of the ECHR Article 3 prohibition of degrading treatment[42]. In this reporting period we have witnessed disturbing treatment

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38 Haglund K, von Knorring L & von Essen L (2006) 'Psychiatric wards with locked doors – advantages and disadvantages according to nurses and mental health nurse assistants'. *Journal of Clinical Nursing* **15**, 387-394.

39 See MHAC (2006) *Eleventh Biennial Report 2003-05*: *In Place of Fear?* para 3.18 – 3.26 for an extensive discussion of locked wards and *de facto* detention.

40 'Prone to fatal error' *The Guardian,* 8 February 2006.

41 Hampshire and Isle of Wight Strategic Health Authority (2006) *Independent Mental Health Inquiry into the Care and Treatment received by the late Geoffrey Hodgkins*, September 2006.

42 See MHAC (2006) *Eleventh Biennial Report 2003-2005: In Place of Fear?* para 1.200 on *Napier, re petition for judicial review* [2004] ScotCS 100. On the environment of seclusion rooms, see Curran C *et al* (2005) 'Seclusion: factors to consider when designing and using a seclusion suite in a mental health hospital' *Hospital Development* Jan 05, 19-26. www.hdmagazine.co.uk

of patients in seclusion in this respect, with seclusion rooms left unclean when patients had urinated or even defecated in them. The Code of Practice requires all hospital managers to have written guidelines on seclusion and to monitor and regularly review seclusion practice[43]. We have seen some excellent examples of such monitoring in practice, including within the high security and independent sector.

Service provision for patients with learning disability

32. Between the census collections of 2006 and 2007, the NHS closed approximately 12% of its learning disability inpatient beds. The 2007 census counted 3,217 occupied beds of this type in the NHS, compared to 3,669 in 2006. During this period the number of learning disability beds in the independent sector appeared to remain roughly constant at about 940 beds, two-thirds of which were occupied by detained patients in 2007[44]. The absolute number of specialist learning disability beds may have fallen in the period between the two most recent census counts, but this does not mean that hospital-based care for learning disabled patients is in any sense being phased out. The independent sector provides an increasing share of the market, especially in the provision of secure beds. Much of the growth in long-stay facilities is taking place in modern, purpose-built facilities.

33. There is a danger that long-stay ward environments may be institutionalising and unnecessarily confining for many patients with a learning disability, and indeed some such wards have been exposed as 'institutionally abusive' towards such patients in this reporting period[45],[46]. It is our view that any learning disability unit, whether or not it detains patients under the Act, should be subject to regular independent visiting. This is imperative for government to ensure, both to comply with its obligations as a signatory to the Optional Protocol to the UN Convention against Torture (OPCAT)[47] and to make good its commitment to preventing further neglect and abuse of this vulnerable population.

34. A number of people with a learning disability continue to be in hospitals a long way from their home (in "out of area placements") in low and medium secure units. We welcome the Department of Health's best practice guidance *Commissioning Specialist Adult Learning Disability Health Services*[48] .

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43 *Mental Health Act 1983 Code of Practice*, paras 19.17, 19.23.

44 MHAC, CSIP, Healthcare Commission (2007) *Information from the 2007 Census*. See [web ref?]. Additional data from Jo Simpson.

45 Healthcare Commission (2007) *Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust*, January 2007.

46 In 2007 the Healthcare Commission audited learning disability services through self-assessment questionnaires. A sample of 154 sites was peer-reviewed, "including the best performing organisations, those that need most improvement and a random sample". See Healthcare Commission (2007) *A Life Like No Other,* December 2007.

47 For further information consult the Association for the Prevention of Torture at apt.org.ch

48 Department of Health (2007) *Commissioning Specialist Adult Mental Learning Disability Health Services: Good Practice Guidance*. Office of the National Director: Learning Disabilities, 31 October 2007.

Particular aspects of the Act

The role and displacement of the nearest relative

35. In past reports we have written of our longstanding concerns at the 1983 Act's framework for the appointment of 'nearest relatives', insofar as this is founded upon a hierarchical list without reference to patients' own wishes over whom amongst their family might be considered for this role[49]. This automatic identification of 'nearest relatives', coupled with the powers granted to persons who are so identified, has been found in certain circumstances to be in breach of Article 8 of the ECHR, as a disproportionate interference with the right to private and family life[50]. The Mental Health Act 2007 provisions which widen the criteria upon which an 'unsuitable' nearest relative may be displaced are designed to address this. We are concerned that this is not a perfect solution to Article 8 interference, in that some patients will be put in the invidious position of having to explain to a court why their nearest relative is not suitable to act as such, and the definition of unsuitability is as yet unclear. However this is clearly an improvement on the previous situation.

Section 17 leave

36. Detained patients may be given short or long-term leave from hospital under section 17 of the Act. We found some staff to be lax in their practice in this area. It is a legal requirement that the RMO authorises the parameters of all leave, which may then be managed by ward staff[51]. The language used by the RMO to describe the parameters of leave should be precise. It is unhelpful, for example, to specify that a patient may have leave to go to 'local' shops if that term is capable of different interpretations by nursing staff acting in a gate-keeping role. Inconsistency is unlikely to encourage patients to regard leave parameters seriously. Staff do not always record whether or not a patient's leave from hospital went well, or whether staff or the patient had any concerns in relation to the period of leave. In some hospitals, patients are encouraged to complete leave reports to put their view on record. Such reports, or verbal debriefing sessions leading to a nursing note in the records, are useful in terms of risk assessment and as a means to engage patients in discussion about their care planning.

The provision of information to patients under section 132

> Resolutions were taken as to the disposal of my person and my property, and communicated to me with about as much ceremony as if I were a piece of furniture, an image of wood, incapable of will and desire as well as of judgment
>
> John Perceval (1840) A Narrative of the Treatment Experienced by a Gentleman During the State of Mental Derangement[52]

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49 MHAC (1999) *Eighth Biennial Report*, para 4.46-51; (2001) *Tenth Biennial Report 2001-03; Placed Amongst Strangers*, para 2.56; (2006) *Eleventh Biennial Report 2003-05: In Place of Fear?,* para 1.25-34

50 MHAC (2006) *Eleventh Biennial Report 2003-05: In Place of Fear?,* para 1.32

51 *MHA 1983 Code of Practice,* para 20.4.

52 Bateson G (ed) (1961) *Perceval's narrative; a patient's account of his psychosis 1830-1832*. California, Stanford University Press, p.179

37. From August to October 2006 the MHAC asked patients that it visited a series of structured questions concerning their experience of being given information about their rights under the Act. Nearly one quarter of the patients that we encountered in these three months told us that they had not received information from nursing staff to which they had a statutory entitlement. About one in five patients told us that staff had failed to explain to them the legal powers under which they were detained, how long they would be in hospital, or how to appeal. A similar proportion had not received the Department of Health leaflet (or any other leaflet) explaining these matters. One in three patients told us that staff had not talked to them about their medication. These findings suggest that a significant number of services are failing to meet their responsibilities under s.132 of the Act, and consequently may also be failing in their human rights responsibilities towards those that they detain.

Medical Treatment under the Mental Health Act 1983: the statutory second opinion service

38. Although the benefits of psychiatric treatment outweigh the risks and consequences for most patients who are detained under Mental Health Act powers, the imposition of psychiatric treatment without consent must be justified not only in terms of the violation of the human right to personal and bodily integrity, but also against the physical risks that such treatment poses to its recipient. The Second Opinion system is designed to provide an independent view of the possible justification for treatment without consent.

39. The number of Second Opinions arranged by the MHAC continues to rise. While there has been a slight decrease in the number of Second Opinions for ECT (electro-convulsive therapy) since the late 1980s, the volume of Second Opinions for medication has increased tenfold over the lifetime of the Act. Over the last five years, the number of Second Opinions has risen by 22%. The reason for these increases is not known, but we suspect a combination of increasingly unwell patients and increasing awareness of consent issues by clinicians[53].

40. 11% of Second Opinions between 2002 and 2007 resulted in some change to the patient's treatment plan. Although only 2% of all Second Opinion visits result in a 'significant' change, this still amounts to an average of three patients in every working week whose treatment plan is significantly changed as a result of the SOAD visit. An average of 14 treatment plans are slightly changed in each working week as a result of SOAD visits.

41. Under the 2007 Act, the role of SOADs will be extended into the community to provide Second Opinions for those patients who are on Community Treatment Orders. We expect that this will create an increase in the number of Second Opinions, particularly because of the requirement to perform a Second Opinion on consenting as well as non-consenting patients who are on CTOs.

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[53] MHAC (2006) *Eleventh Biennial Report 2003-2005: In Place of Fear?,* para 4.65.

High-dose and combination prescribing of antipsychotic medication

42. In its most recent consensus statement on high-dose antipsychotic medication, the Royal College of Psychiatrists continues to state that current evidence does not justify the routine use of high-dose antipsychotic medication[54]. Despite this, a number of studies have shown that there is widespread prescription of antipsychotic medication in dosages in excess of those recommended in the British National Formulary (BNF)[55], with the highest prevalence figures being found in psychiatric intensive care units, rehabilitation wards and forensic units. The MHAC has provided a guidance note to its Commissioners on the RCPsych consensus statement, which is available on our website[56]. Over the last two years we have introduced the consensus statements onto a number of wards where it appeared not to have been previously noted.

Prison transfers

43. The massive and continuing increase in the prison population has inevitably resulted in many more mentally disordered persons being kept in prison. In its thematic report on the mental health of prisoners, published in October 2007[57], HM Inspectorate of Prisons stated two things stood out starkly from their study:

- there are too many gaps in provision of healthcare screening and healthcare provision in prisons, leading to too much unmet and sometimes unrecognised need; and
- the need will always remain greater than the capacity, unless mental health and community services are improved outside of prison and people are appropriately directed to them, before, instead of and after being received into custody.

44. We welcome the Department of Health's renewed focus during this reporting period on transferring mentally disordered prisoners to hospital under the powers of the Act, with a number of policy initiatives to improve mental health services for offender patients[58] and to reduce the time taken to effect such transfers. In 2006, an average of 42 patients per quarter waited for longer than three months for a transfer: this is an improvement on the previous year (an average of 53 patients per quarter) but only a slight improvement on 2004 (44 patients per quarter)[59]. In the most recent year for which data is available, more mentally

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54 Royal College of Psychiatrists (2006) *Revised consensus statement on high-dose antipsychotic, medication*. Council Report 138.

55 Joint Formulary Committee. (2007) *British National Formulary*. 54 ed. London: British Medical Association and Royal Pharmaceutical Society of Great Britain; Sept 2007; Harrington M, Lelliott P, Paton C, Okocha C, Duffet R, Sensky T (2002) 'The results of a multi-centre audit of the prescribing of anti-psychotic drugs for in-patients in the UK. Psychiatric Bulletin 26:414-418; Prescribing Observatory for Mental Health-UK (POMH-UK) (2007) Topic 3 report 3a. Prescribing of high-dose and combination anti-psychotics on forensic wards: baseline audit. May 2007, Royal College of Psychiatrists.

56 MHAC (2006) *Guidance for Commissioners: The RCPsych consensus statement on high-dose antipsychotic medication.* 2006. www.mhac.org.uk/

57 HM Inspectorate of Prisons (2007) *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs.* October 2007.

58 See www.hsccjp.csip.org.uk/our-workstreams/mental-health.html

59 Sainsbury Centre for Mental Health (2007) *Forensic Mental Health Services: facts and figures in current provision.* Figure 7.

disordered offenders were transferred from prison under the Act's powers than at any time during the previous two decades that it has been in force, with over 830 transfers in each of the last two years recorded. We welcome this progress, but remain concerned that whilst absolute numbers of transfers may be at a record level, the proportion of transfers from prison relative to the total prison population is actually lower than in many previous years.

Future operation and monitoring of the Mental Health Act

45. The coming year will be a particularly busy one for mental health services, as they prepare for the full implementation of the Mental Health Act 2007. Providers of NHS mental health services have received a self-assessment tool from NIMHE/CSIP to gauge their preparedness for the changes to mental health legislation[60]. We have seen some very positive responses to this from some services, with active engagement from Trust Boards in overseeing implementation of the changes. Such arrangements are vitally important to instigate local action to ensure that the services provided to detained patients are appropriately resourced and safe for patients, and to ensure that the service for which they are responsible meets its statutory obligations and discharges its legal duties in operating the Act.

46. 2008 also sees changes in the regulation of services including monitoring of the Mental Health Act. If enacted, the Health and Social Care Bill 2007 will dissolve the MHAC and create a new regulator for health and adult social care, the Care Quality Commission. Our primary concern is that safeguards for detained patients are strengthened not weakened in the transition and that the visiting role of the MHAC is maintained when our organisation is dissolved. We believe firmly that regular and frequent visiting is vital as a preventive mechanism for all those deprived of their liberty, wherever this may occur. We are also concerned that the new regulator should involve the users of services directly and proactively in its work. The MHAC is particularly proud of our success during this period in increasing the involvement of detained patients in our work. Service user involvement is part of a wider strategy that puts equality and human rights at the centre of our work, to help us to be inclusive of the rights of all detained patients and respond well to the complexity of individual service users' needs. We do this for the simple reason that we believe it makes us more effective in fulfilling our statutory functions. Our Service User Reference Panel (SURP) in particular has had a very significant impact on the MHAC's work and provides a legacy that we hope the Care Quality Commission will take forward and strengthen, as well as a possible model for other public and independent sector bodies, including providers of services.

Mental Health Act Commission
January 2008

[60] See http://www.mhact.csip.org.uk/isat.html