Care Quality Commission

Monitoring the Mental Health Act in 2010/11

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

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Contents

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.

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

Margaret

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."

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 sets out our findings and recommendations in relation to 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. In Part 1, we explain how our inspection teams work with our MHA Commissioners and use their findings as part of our overall check on the quality of services.

Similarly, this 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.

Note: Throughout this report, references to the Mental Health Act Code of Practice refer to the code that applies to England only.

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% 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.

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.

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 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.

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.

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.

> Of the 115 deaths that were due to unnatural causes, most were due to suicide or self-harm.

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.

Part 1
How we monitor the use of the Mental Health Act

Since April 2009, CQC has had a duty under the Mental Health Act 1983 to monitor how services exercise their powers and discharge their duties in relation to patients who are detained in hospital, or subject to community treatment orders (CTOs) or guardianship under the Act.

Each year, there are more than 45,000 instances of men and women being detained in hospital under the Mental Health Act for assessment and treatment for mental disorder. Some will be detained for only a few days or weeks; others remain in hospital for years. At any given time, about 16,000 patients are detained in hospital. The Act also provides limited powers over some patients in the community. More than 4,000 people are subject to community treatment orders (CTOs) and about another 750 people are subject to guardianship.

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

Visiting patients subject to the Act

We visit and interview in private people whose rights are restricted under the Act. We aim to visit every psychiatric ward in England where patients are detained at least once every 18 months. In 2010/11, we made 1,565 visits to wards* 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 Code of Practice.

Our visiting MHA Commissioners meet with patients in private to discuss their experiences and concerns, to make sure that they understand their rights and to check that staff are using the Act correctly. They speak to staff about their experiences, plans and concerns, and review legal documents and patients' notes. Afterwards the MHA Commissioner sends written feedback to the ward.

*MHA visits can involve visits to more than one ward as well as repeat visits to wards. In 2010/11, MHA Commissioners visited 1,693 wards (1,577 distinct wards; 116 were visited more than once).

> In 2010/11, we made 1,565 visits to wards and met with more than 4,700 patients.

We recognise the vast amount of hard work, dedication and compassion that staff bring to their roles in the services we visit. Our MHA Commissioners often note the dedication and skill of staff, and we encourage good practice where we find it. But we also find examples of inappropriate and unacceptable treatment and care, and poor use of Mental Health Act powers.

Making sure that detained patients have a voice

Our visits to wards and confidential meetings with detained patients give us valuable information about their experience of care. Their views and experiences are reflected in the extracts we use from MHA Commissioners' reports.

We also have a Service User Reference Panel, made up of people who either are currently detained or have been detained patients in the past. The panel brings a unique and expert perspective to our work in monitoring use of the Mental Health Act, including when they accompany our MHA Commissioners on visits to wards.

Second opinions to safeguard patients' rights

Another important part of our work to safeguard patients' rights is the statutory second opinion service that we provide to certain groups of detained patients. The doctors that we appoint to do this are known as 'second opinion appointed doctors' (SOADs).

They decide whether the proposed treatment is appropriate for the patient and check that their views and rights have been considered. During 2010/11, we handled more than 13,500 requests for a second opinion.

Working together: linking to our wider regulatory and enforcement role

Starting in 2010, the Health and Social Care Act 2008 (HSCA) introduced a new, single registration system that applies to both healthcare and adult social care. Providers of regulated activities – in both the NHS and the private sector – must be registered with CQC. One of the regulated activities specifically relates to 'assessment or medical treatment for people detained under the Mental Health Act 1983'.

To be registered with us, providers must show that they are meeting essential standards of quality and safety in all of their regulated activities. Under the system, people who use services should expect that all providers meet the same set of standards, and respect their dignity and rights. Most importantly, the standards are focused on the outcomes and experiences of care that people should expect, rather than the processes and policies that providers have in place.

We monitor providers to make sure that they continue to comply with the essential standard outcomes. If they fall below the standards, we can take swift action, using our legal powers where necessary, to make sure they return to compliance.

Link to our monitoring of compliance with the essential standards

At the start of each of the main chapters in Part 3 of this report, we indicate how the issues we have covered link to our monitoring and enforcement of the essential standards of quality and safety under the Health and Social Care Act.

You can see the a full list of standards on our website at www.cqc.org.uk/listofstandards.

The primary focus of our statutory Mental Health Act (MHA) duties is to provide a safeguard for individual patients whose rights are restricted. This is different from our responsibilities under the Health and Social Care Act, where the focus is on regulation at a provider level.

However, the evidence we collect through our MHA activities can help to give a picture of the operation of the Act across a provider and to identify where wider problems may lie. We can use this to help judge whether the provider is complying with the essential standards of quality and safety, and take enforcement action where necessary.

In this way, we can use the wider regulatory framework to strengthen the protection given to people subject to the Act.

We have been reviewing our approach to MHA monitoring and developing our MHA programme – particularly in relation to how our MHA operational and HSCA compliance inspection staff work together in a coordinated way. We are starting to see the benefits of this coordinated working – see the case study below for an example of this new way of working.

Case study:

How our compliance inspectors and Mental Health Act Commissioners work together

We carried out a review of a hospital in London that provides inpatient mental health services, including to people who are detained under the Mental Health Act.

Our compliance inspector for the area visited the hospital with one of our MHA Commissioners. While the MHA Commissioner privately interviewed some people on the wards who were detained under the Act, the inspector carried out a broader inspection of how all patients were experiencing the essential standards of quality and safety. He found that four out of the 16 key standards were not being met. They compared their findings and compiled a joint report on how well the hospital was meeting standards, incorporating the MHA Commissioner's specific comments on people's experience of care when their rights were restricted under the Act.

They found, for example, that the hospital was not meeting Outcome 2, that people should consent to their treatment. Our MHA Commissioner had made a routine visit three months earlier and highlighted concerns about this issue. When she returned on the joint visit, she was unable to find enough evidence that the hospital had carried out capacity tests where appropriate to see if patients were well enough to consent.

Other concerns that the inspector and MHA Commissioner shared related to the lack of personalised care plans for some of the people they spoke to. Together they also observed that some staff were not sufficiently trained and supervised, and were unclear how to set up a person-centred care plan.

The inspector sent his report to the hospital's management, asking them to reply within 28 days by setting out an action plan to make improvements to meet all essential standards.

The team will visit the hospital again to assess what actions have been taken as a result of the inspection and we will continue to monitor the performance of the hospital through future inspections – both separately and together – each time talking to people who are experiencing care, treatment and support as well as reviewing records, legal documentation and talking extensively with staff.

If we find that improvements have not been made in our areas of concern, we have the power to take further enforcement action.

Part 2
Use of the Mental Health Act in 2010/11

Trends in the use of the Act

In 2010/11, the headline total number of formal detentions in hospital did not change significantly from the previous year.[1] There were 45,248 admissions and detentions, compared with 45,755 in 2009/10 **(FIGURE 1)**.

Detentions under the Mental Health Act (admissions and detentions of informal inpatients), 2006/07 to 2010/11*
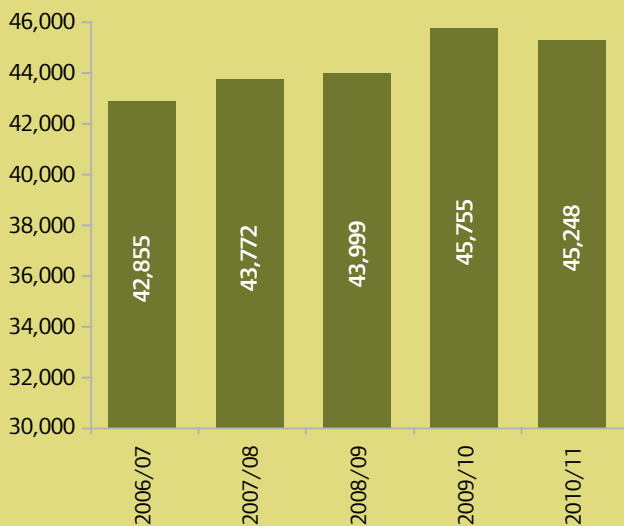
Data source: KP90 (DH/Information Centre Statistical Bulletins)

* We have taken 'detention' only to mean detention in hospital for assessment and/or treatment (s2), or detention in hospital for treatment (s3 and 'part 3' detention powers relating to the detention of mentally disordered offenders). We exclude holding powers (ss5(2), 5(4), 135, 136), detentions under s4 that end within the initial 72 hours, and non-detention powers (ss25A, 17A, and guardianship under s7 or s37).

However, note that this figure excludes revocations of CTOs. People subject to CTOs are only formally admitted once; when a CTO is revoked, the underlying section is revived and this does not constitute a change in legal status. Therefore, revocations are not counted by the Information Centre as formal admissions.

While formal admissions under section 2 rose by 4.2%, section 3 admissions fell quite sharply, by 14.4%. This fall may be connected to the increased use of CTOs. 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 **(FIGURE 2)**. However, many CTOs still in place at 31 March 2011 were made in earlier years. Of the 10,071 CTOs made since November 2008, only 4,150 (41.2%) had ended by the end of 2010/11.
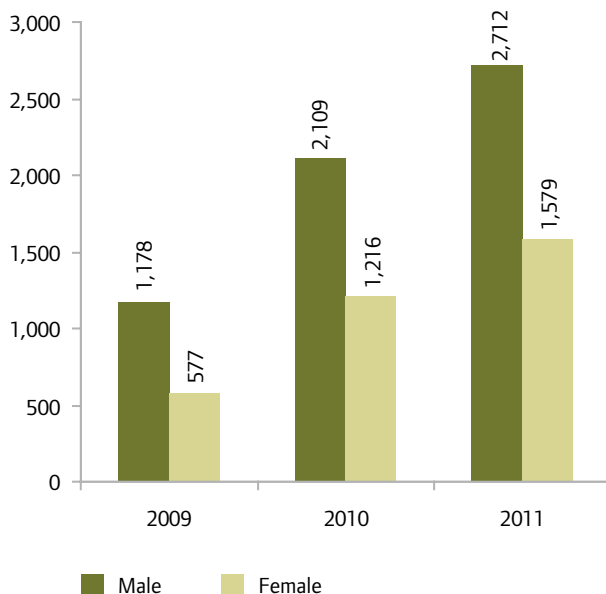
Use of CTOs, 2008/09 to 2010/11
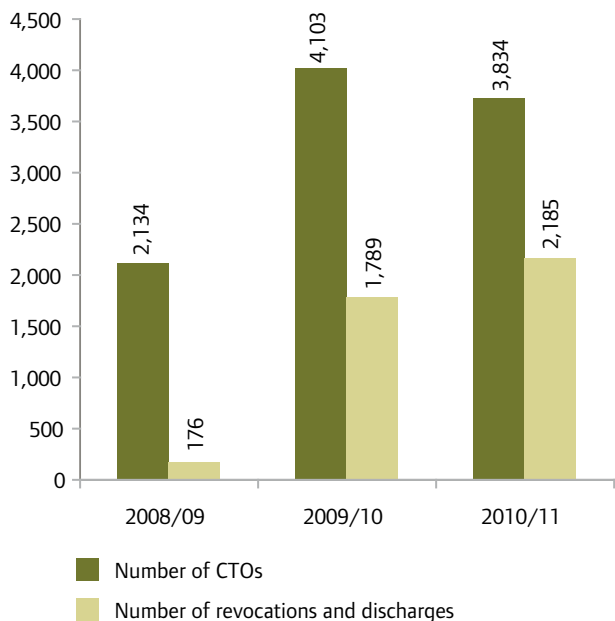
Data source: KP90

Note: Figures for 2008/09 are for five months' of operation only.

Numbers of people subject to a CTO on 31 March, 2009 to 2011

Data source: KP90

Note: Figures for 2008/09 are after five months' of operation only.

Numbers of people subject to the Act

Although the total number of formal admissions to hospital and the number of new CTOs decreased between 2009/10 and 2010/11, the overall number of people subject to the Act as at 31 March 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 overall rise in the number of people subject to a CTO. While the number of new CTOs actually made during the year fell (see above), the number subject to a CTO at 31 March 2011 rose from 3,325 to 4,291, an increase of 29.1% on the previous year **(FIGURE 3)**. This is because the number of new CTOs was higher than the number of existing CTOs being discharged or revoked.

In contrast, the rise in the number of people detained while in hospital under the Act at the end of 2010/11 was very slight: an increase of 0.2% from 16,622 to 16,647 **(FIGURE 4)**. This continues the rising trend since 2008, although the rate of increase appears to be slowing down. And it is notable that the reduction in the number of patients admitted under section 3 has had no real effect on the overall number of people detained.

While formal admissions under section 2 rose by 4.2%, section 3 admissions fell quite sharply, by 14.4%.

FIGURE 4

Number of people detained in hospital on 31 March, 2007 to 2011
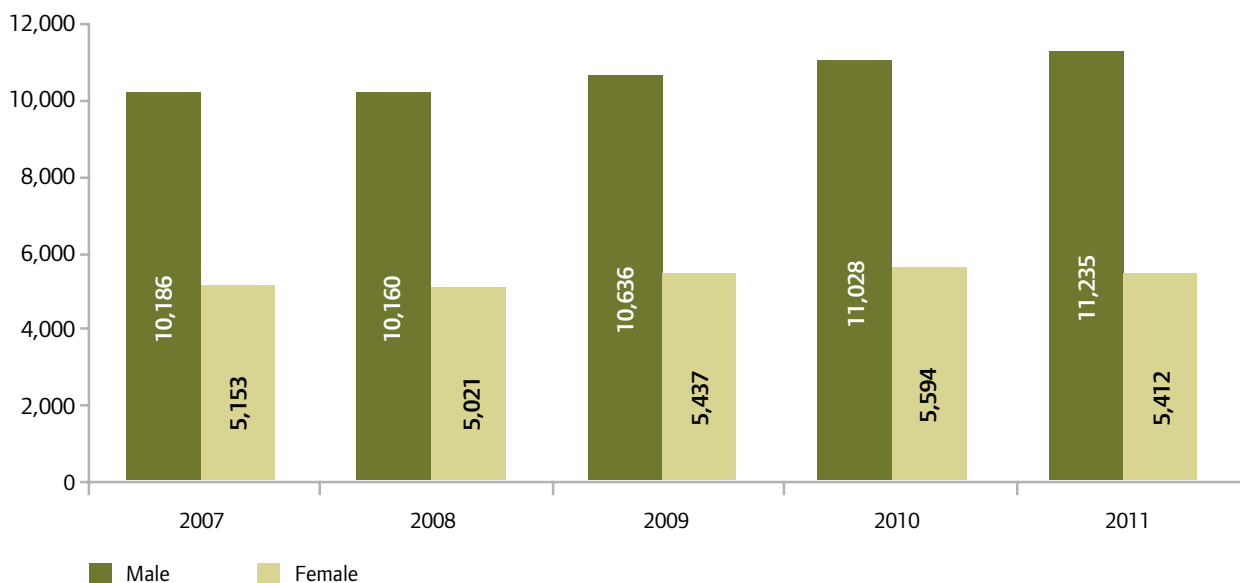
Data source: KP90

Removals to a place of safety

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

The place of safety can be a police cell, a hospital-based facility, or "any other suitable place, the occupier of which is willing temporarily to receive the patient", but it is usually either a police cell, a dedicated facility at a psychiatric unit or, in some large areas, an A&E department.

We covered a number of issues to do with the use of section 136 in last year's report. Once again, the use of hospital-based places of safety has increased substantially. The total number of removals of people by the police to a place of safety for assessment by health professionals rose by 17.2% compared with the previous year, from 12,038 to 14,111 **(FIGURE 5)**.

As with previous years, more males than females were made subject to section 136 orders (55.6% were male). 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.

FIGURE 5

Use of hospital-based places of safety under section 136, 2006/07 to 2010/11
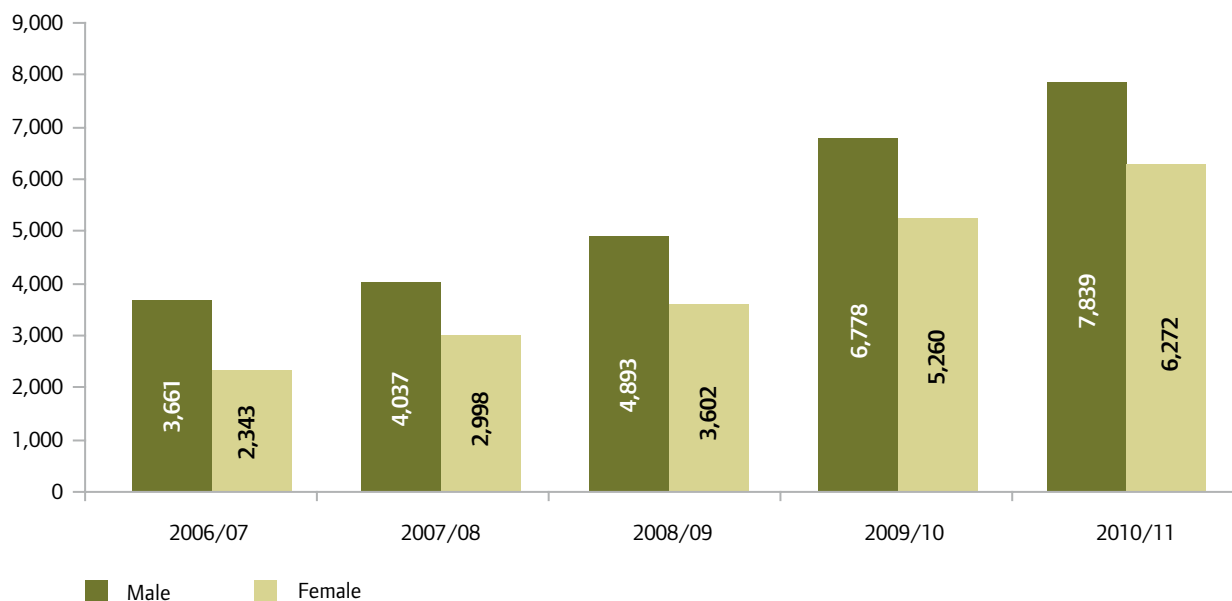
Data source: KP90

Ethnicity and the use of the Act

In 2011, we published the results of the final *Count me in* census about the ethnicity of mental health inpatients. For six years, the census had played a key role in providing data on inpatients using NHS and independent mental health and learning disability services through a one-day snapshot of admission and detention rates. This was designed to support the Department of Health's five-year action plan for improving mental health services for Black and minority ethnic communities, which ended in 2010.

Overall, the findings of the sixth *Count me in* census showed little change from previous years, with differences in mental health admission and detention rates between Black and minority ethnic groups, and also differences within minority ethnic groups. With the publication of the final census, we indicated our commitment to monitor the use of the Act for people from Black and minority ethnic groups using the Mental Health Minimum Data Set (MHMDS) to identify outliers.

TABLE 1 summarises this analysis for the first time as a year-round view for 2010/11. The cells shaded in green show values that are significantly higher than expected given the prevalence in the standard population and values shaded orange are significantly lower. Unshaded cells are not significantly different from expectations.

Key findings from this analysis are:

- Hospitalisation rates were lower than average for patients from the White British group. With the exception of the 'Other' ethnic group, rates were higher than average for all other ethnic groups; they were particularly high for the Black African, Black Caribbean and Other Black groups, who had rates up to two times higher than average.

- Rates of detention were also lower than average for patients from the White British group. Rates were higher than average for Other White, White/Black African Mixed, Other Mixed, Indian, Pakistani, Bangladeshi, Other Asian and Other Black groups; they were particularly high for Black African, Chinese and 'Other' groups who had rates up to two times higher than average.

TABLE 1

Use of the Act for people from Black and minority ethnic groups, 2010/11

Ethnic group	Standardised hospitalisation ratios by ethnic group	Standardised ratios of detention by ethnic group	Standardised ratios of most restrictive detention status by ethnic group	Standardised ratios of people on CTOs by ethnic group
White British	92.7	83.2	90.3	94.6
White Irish	120.3	108.9	98.3	68.9
Other White	116.1	166.1	99.7	82.7
White and Black Caribbean	154.6	129.2	134.4	126.0
White and Black African	161.3	187.4	136.0	133.5
White and Asian	142.3	84.8	121.0	105.4
Other Mixed	143.7	148.6	121.8	129.6
Indian	109.3	127.6	129.6	98.5
Pakistani	119.4	144.2	164.4	100.3
Bangladeshi	126.6	151.2	178.8	96.9
Other Asian	125.0	189.8	137.3	105.9
Black Caribbean	192.8	114.6	164.8	140.1
Black African	237.5	203.4	148.8	141.3
Other Black	198.0	149.1	175.3	114.4
Chinese	157.8	255.7	132.9	75.5
Other ethnic group	96.3	209.8	109.4	105.8

Data source: Mental Health Minimum Data Set

- With the exception of the White Irish and Other White group, all Black and minority ethnic groups had higher rates of more restrictive legal status, particularly among the Bangladeshi, Other Black, Black Caribbean and Pakistani groups. The White British group was the only group where the rate was significantly lower.

- CTO rates were lower than average for patients from the White British, White Irish and Other White groups. Rates were higher than average for Black Caribbean and Black African groups and slightly higher for Other Black group.

There are also higher than expected rates of detention for men and women at certain ages. The picture is more complex when all three demographic characteristics (age, gender and ethnicity) are taken into account.

The themes in the MHMDS analysis and the census are similar: people from all Black and minority ethnic groups can be overrepresented within inpatient mental health services and higher rates of people from Black and minority ethnic groups are subject to the Act, particularly from some groups. As in the past, we stress that greater understanding is needed about the factors that lead to the variations that exist between the proportions of some ethnic

groups on mental health wards and that early intervention is vital to reduce the need for admitting people to hospital.

The Government's new mental health outcomes strategy has indicated the intention to reduce mental health inequality, including improving the outcomes for people from Black and minority ethnic groups who have mental health problems.[2] Mental health services have a key role, but collaborative working is needed between statutory agencies and other organisations in the health care sector and also outside the sector, such as education authorities, police authorities, the criminal justice system, primary care services, voluntary organisations and Black and minority ethnic community groups. The Equality workstream of the Government's mental health strategy implementation programme will provide oversight on the progress on reducing inequalities and on promoting early intervention so there is less reliance on the use of the Mental Health Act.

We would also urge providers to ensure that the data they supply to MHMDS is accurate and complete, and for providers and commissioners to make full use of the data set to monitor the use of the Mental Health Act locally.

The NHS Information Centre for Health and Social Care is planning to carry out a consultation in early 2012 on using MHMDS as the source data for Mental Health Act monitoring in the future and to find out what information would be helpful to make public. Based on our analysis, we would recommend that comparative provider level data on use of the Mental Health Act is made public, including where possible standardisation by age, gender and ethnicity to inform local monitoring and service development. Ensuring comprehensive coverage of the MHMDS is also important to providing a complete picture of the use of the Mental Health Act, particularly in relation to patients in the independent sector and high secure settings (and for people not paid for by the NHS – MHDMS is collected from providers, not commissioners, so comprehensive coverage of the independent sector providers will include this small group of patients, but they won't be identifiable).

We are developing indicators derived from MHMDS to help us prioritise and target our Mental Health Act visits. We also intend to introduce a number of these indicators into our provider quality and risk profiles. Providers with poor quality data may be considered higher risk.

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.

Part 3
Our detailed findings

In the rest of this report, we look at our key findings from the visits that our Mental Health Act Commissioners have made to services during the year. It also includes any issues that have arisen through the work of our Second Opinion Appointed Doctors.

3.1 Patients' involvement and protection of their rights

'Participation' is one of the five key underpinning principles of the Mental Health Act Code of Practice – it emphasises that patients should be involved in developing and reviewing their own treatment and care.

Last year, we identified this as one of three priority areas for improvement – not only to enhance patients' care but also as a key factor in promoting recovery. Although we saw some good examples during our visits in the year, improvement in this area remains a priority.

In this section, we look at patients' involvement in planning their own care and how the service is run, and at our findings on independent advocacy services. We also report on the Mental Health Tribunal, and a joint report we published with the Administrative Justice and Tribunals Council on patients' experiences of the Tribunal.

Key findings

- Detained patients had regular access to independent mental health advocacy (IMHA) services on 65% of wards we visited. We were told that IMHAs would come when requested on 85% of wards. Problems continued with the commissioning arrangements for some IMHA services, particularly for patients placed out of area.

- A common concern about IMHA was whether patients and their 'Nearest Relatives' knew about the service and how to get in contact with it.

- Some staff who should be fulfilling the legal duty to explain the IMHA service to patients did not understand it, or know of its existence.

- We saw good examples of patients having significant input into their care planning and of detaining authorities addressing the communication needs of patients, although this is far from universal.

- We also saw a number of good examples where detaining authorities have helped patients to become involved in the day-to-day running of the service.

- Hospital managers often did not ensure that their CTO patients understood their legal position.

- Applications to the First-tier Tribunal rose over the last two years; the rate of successful appeals stayed the same.

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

Patients' involvement in their care planning

The MHA Code of Practice says that patients should be given the opportunity to be involved in planning, developing and reviewing their own treatment and care.[3] This is a key part of the recovery model of mental health services, as it focuses on helping patients build a meaningful and satisfying life, as defined by themselves, whether or not there are ongoing or recurring symptoms or problems.[4]

We saw some good examples of patients having significant input into planning their care:

Since August 2010, a recovery care plan has been introduced for every patient (based on the *Mental Health Concern* model[5]). This is in its early stage, but has to date involved all of the patients being asked to contribute to a 'recovery focused assessment' tool, asking them to provide details of what issues are important to them in their recovery to good mental health, and asking them to self-assess how far along they see themselves in six areas, for example in what gives purpose and meaning to their life; or engagement with others within their family and caring circle; or with the wider world.

Patients have then been invited to set out for themselves the support they need to help then reach their individual goals.

Individuals' progress towards their goals is to be reviewed in three months' time. I would hope that the next step will be to integrate current care planning with this new information, to enable plans to be developed to allow patients to reach their goals, and for this to be reflected in the care plan documentation that is kept within notes and shared with patients.

I was told that the fact that nursing assistants had been closely involved in drawing up these assessments, alongside the patients, has led to better relationships between staff and patients. I certainly observed very positive and caring attitudes demonstrated by staff towards those patients in their care during my visit (exemplified by a swift and caring response to a distressed patient), and patients themselves told me that they trusted and liked the staff at the unit. One patient commented: "The nurses here are brilliant – kind and caring. They can spot when I'm upset and will come and see me to help me. They are very kind and considerate".

September 2010

> ❝ 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

However, many services still found the recording of patients' views and aspirations a challenge, which raises questions about clinical practice in respect of participation:

Although care plans were individualised and regularly reviewed, there was very little evidence of the patients' own views and wishes, and what little evidence was found was not in the patients' own words. The care plans were all 'about' the patient. Although most patients at the unit have limited capacity, there was little evidence found that attempts were made to try to ascertain the 'patient's view'. There was also very little evidence found that patients had been given copies of their care plans, and none were found in patient folders in their rooms. This meant that they were not readily available for staff to go through with the patient or for carers to read.

April 2011

We found similar examples in many providers in the year. Concerns about a lack of patient involvement in care planning continued to be one of the issues most frequently raised by our MHA Commissioners.

We saw good examples of detaining authorities addressing the communication needs of patients:

Many of the patients have severe communication problems. A huge amount of thought has gone into everything from pictorial signage, patient-centred approaches to information sharing and respectful care delivery. The availability of audio-based information about medicines and the use of pictogram-supported care planning is an exemplar of good practice for the rest of the trust. The Commissioner also observed innovative use of specialist computer games, designed to support a fun approach to learning. Staff are to be congratulated on their work.

April 2010

On the other hand, in one low secure unit for people with a learning disability, we noted a mismatch between the Easy Read versions of care plans, which reflected the patient's own issues and aspirations, and the care plan used by the professionals, which was much more medical in tone and focused on the patient's index offence. Although patients had been encouraged and helped to contribute to their Easy Read care plans, these seemed to be separate to the main document. This perception was reinforced by patients' marginal involvement in monthly meetings, where the care plan would be discussed by the multi-disciplinary team before the patient was invited in to 'ask questions'.

Patients' involvement in the ward

Our MHA Commissioners check whether patients have an opportunity to influence how the ward is run, for example through community meetings or patient councils. They confirmed that these were available on 90% of the wards where they carried out this check.

We saw a number of good examples where detaining authorities help current and ex-patients get involved in how the ward is run. In one NHS trust, patient meetings are run by ex-patient volunteers without staff involvement; having staff present was getting in the way of discussions. Notes are taken of these meetings and the ward manager then responds in writing to any issues raised. A copy of this is put on the patients' and carers' notice board. The meetings are having an effect: for example, doctors are now asked to make sure that they give patients a written note of important conversations that they have with them about their care, as patients said that it could be difficult for them to take in, or recall, all the information they receive.

There are now plans for the ex-patient volunteers to have contact with carers, answer their questions and share their experience of being on the ward. The ward also has a Social Support Officer, responsible for providing advice on debt and money issues, and finding accommodation for patients who need it on discharge. This helps to avoid unnecessary delays in the discharge of these patients.

At a medium secure unit in Greater Manchester, the ward manager made considerable efforts to address our previous concerns about activities for patients. Structured days were introduced, with 25 hours of activities both on and off the ward each week. Patients have got involved in making suggestions and staff have seen an increase in motivation levels and an uptake of activities. The ward has introduced competitions, such as a football tournament with other wards, and an in-house *"Come dine with me"* competition that has already resulted in one patient's dish being put on the main menu.

" I was asked by the head of security if I would not mind showing some inductee staff around the ward. I agreed and regularly provided tours to the new staff. I feel in some way this has helped my confidence, providing a patient's perspective and I always receive positive feedback. "

View from a SURP member

Providing CTO patients with information

Providing accessible information to patients is fundamental to promoting rights and choices. On our visits, we point out when patients say that their rights have not been properly explained to them. This year, we saw similar issues when we spoke to CTO patients.

The managers of responsible hospitals are required by section 132A of the Act to make sure that their CTO patients understand their legal position, and right to apply to the Tribunal. These must include giving the information verbally and in writing to the patient and, unless the patient objects, a copy of the information to the Nearest Relative.

Often, these legal duties were not met. For example, on a CTO-themed visit in London, we found little or no evidence in patients' notes that they were given information about their rights. Some patients who had received a leaflet in the post said they did not understand it, did not know who might explain it, and were afraid to ask in case they were recalled. One patient had only been told by letter that she was subject to a CTO almost 10 weeks after it was implemented. It is not clear how the CTO had been managed over the time that the patient was unaware of being subject to its powers.

The following is an extract from feedback that we gave to a different trust:

From the Commission's contact with patients during the CTO visit in November 2009, it was evident that patients had limited information about the parameters of the order. With the exception of one patient, the Responsible Clinicians did not discuss the CTO with patients in any meaningful way prior to the order being made. Patients were often unaware when the order would be renewed; were vague about the conditions to their order; and several patients expressed dissatisfaction with their medicine.

A number of patients felt that the order was too intrusive and appeared not to be involved in the care planning process. It was unclear if patients had been provided information regarding their right to an IMHA or access to a Mental Health Review Tribunal.

MHA Commissioner's annual report for 2010

In our last report we pointed out that patients who had a more positive approach to their treatment under CTO almost invariably felt supported by, and involved in, their care plans. Conversely, patients who were poorly involved in their care planning tended to regard their CTO simply as a way for doctors to enforce their compliance with medicine. By failing their duties to give information to patients, responsible authorities are in breach of the law but also have no possible means of engaging with the inpatients.

Privacy and dignity

Article 8 of the European Convention on Human Rights requires public authorities to respect a person's right to a private life. This includes people detained under the Mental Health Act. The Code of Practice (16.2) indicates that hospital staff should make conscious efforts to respect the privacy of patients while maintaining their safety. This includes, for example, supporting patients in making and maintaining contact with family and friends by telephone (and to enable such calls to be made with appropriate privacy), and providing adequate lockable facilities (with staff override) for the storage of their clothing and other personal possessions. To comply with registration regulations, providers are also required to balance the provision of a suitable environment that takes account of identified risks while also ensuring that wards protect people's rights to privacy, dignity and autonomy.

In 2010/11, our MHA Commissioners reported on a number of issues relevant to promoting patient privacy and dignity **(TABLE 2)**. There were approximately 1,400 separate checks on whether patients were able to lock their room or whether they had a lockable space that they could control. Almost a third of wards lacked these basic facilities for patients in their care. In view of this, we have indicated that national guidance on the secure management of patients' property could be strengthened to clarify what patients can expect (particularly detained patients, patients lacking capacity and patients in high secure hospitals) in response to the NHS Protect consultation on the secure management of patient property guidance.[6]

Advocacy

Last year, we carried out a survey on the provision of Independent Mental Health Act Advocacy (IMHA) services, which PCTs have been under a statutory duty to provide since April 2009.[7]

In 2009/10, we collected a range of information during visits to 311 wards and found that 18% of them did not have access to IMHA services. This year, we looked at access to IMHA services on all our visits, with only one or two exceptions. We found that:

- Detained patients had regular access to an IMHA on 65% of these wards.
- IMHAs would come when requested on 85% of wards.
- There was evidence of an IMHA service on 81% of wards.

TABLE 2

Privacy checks carried out by MHA Commissioners, 2010/11

Privacy issue	Yes	No	Number of wards where we carried out this check
Patients have the ability to lock their rooms securely and the means to do so	973 (69%)	431 (31%)	1,404
Patients have lockable space which they can control	969 (70%)	425 (30%)	1,394
There are arrangements to cover viewing panels in bedroom doors adequate to protect patient privacy	1,105 (86%)	176 (14%)	1,281
There are curtains or other window coverings in patient bedrooms adequate to protect privacy from people outside the ward	1,310 (95%)	64 (5%)	1,374
Patients have access to their bedrooms throughout the day	1,284 (93%)	95 (7%)	1,379

Data source: CQC

Problems continued with commissioning arrangements for some sites – often in relation to hospitals whose patients came from a range of different PCT commissioning areas, such as specialist units, or independent sector hospitals taking 'out of area' placements. The Department of Health's guidance on commissioning IMHA services 'expected' that:

Different models of IMHA provision will be set up that reflect different configurations of mental health service provision, including large specialist mental health trusts, small providers of psychiatric services and provision for qualifying patients in the independent sector.[8]

The guidance suggests that the better arrangement in cases where patients are treated outside of their own PCT area would be to allow the same IMHA service provider to work with all qualifying patients in a particular ward or hospital: in effect a flexible approach where PCTs would agree to part-fund advocacy services out of their area.[9]

In some cases, this expectation has led to an impasse and no practical IMHA provision for out of area patients. Hospitals themselves cannot directly commission IMHA services. One solution would be for hospitals to write, as a matter of routine, to any PCT that commissions a bed in its service, stating that the hospital's IMHA service (as designated by its local PCT) will be used unless the PCT makes its own arrangements, and making an appropriate charge that could be passed on to the advocacy service.

The MHA Code of Practice says that IMHA services "do not replace any other advocacy and support services that are available to patients, but are intended to operate in conjunction with those services".[10] The Department of Health's commissioning guidance states that IMHA services should be seen as an addition to advocacy provision and not a replacement for non-statutory advocacy services.[11] However, some commissioning bodies have cut back on non-statutory advocacy in order to make efficiency savings, on the implicit or explicit rationale that advocacy is being provided by IMHA services to the degree required by law.

The most common concern raised on MHA Commissioners' visits in relation to IMHA was whether patients and their Nearest Relatives are aware of the nature of the service and how to get in contact with it. In a number of cases we found that staff who should be fulfilling the detaining authority's legal duty to explain the IMHA service to patients did not understand it, or know of the existence of that service.

A number of IMHA services told us that they had little or no practical contact with community patients, which may partly be explained by responsible authorities' failure to give CTO patients information about the service. It may also be due to a reluctance of CTO patients to engage with professionals or to be seen as 'difficult' in case they are returned to hospital. In many cases, IMHA services do not have the resources to meet with patients outside hospital premises, or are reluctant to use what resources they have in this way when they could meet with more patients for a similar cost in time and money on a visit to a hospital. PCT contracts that measure IMHA work by the number of patients seen could be a disincentive for IMHA services to engage with CTO patients.

Some IMHA services have found that their funding is inadequate to cover the demand for their services from detained patients, and as a result have waiting lists of patients who have requested their help. The existence of a waiting list could indicate that the service is underfunded. Where the IMHA service is running a waiting list that involves delays of any significant duration, the detaining authorities that they visit are faced with a dilemma over fulfilling their legal duties to inform qualifying patients of the service and their theoretical right to access it, when doing so may add to the stresses and frustrations of the patients concerned.

Similarly, advocacy services without the resources to meet the demands of qualifying patients are unlikely to have, or want to use, any resource in having a presence on wards, and could as a consequence be unavailable to patients.

The Mental Health Tribunal

The First-tier Tribunal (Mental Health) is the primary mechanism in England for appeal against the use of the Mental Health Act's powers of detention, guardianship or supervised community treatment. It is an independent judicial body administered by the Tribunals Service and provides one of the key safeguards under the Act.

TABLE 3 shows the activity and outcomes of the Tribunal over last 11 calendar years. The number of applications rose in the last two years, although this has not increased the rate of successful appeals, measured in terms of discharge from detention. Successful appeals to the Tribunal in 2010 accounted for 12% of all outcomes, the same as in 2009.

The Tribunal secretariat has also supplied us with data for discharges prior to hearings and for withdrawn applications over the last six years. The proportion of patients who applied for a

Tribunal hearing and were discharged by their doctor before the hearing took place has been consistent at around a third over this period. The percentage of applications that were withdrawn by patients has increased: in 2010 it accounted for 19% of the outcomes of applications, up from 11% in 2005 and 16% in 2009.

More detailed data is shown at **TABLE 4**. This shows Tribunal activity for the financial year 2010/11, broken down by the legal powers of the Act to which the appellant is subject. This enables us to see, for example, that the proportion of appeals against community treatment orders (CTOs), a power that has only been in existence from 2008, amounted to 12% of all applications received, and 14% of all hearings within the financial year. The success rate for CTO appeals (again, measured in terms of discharge from CTO) is only around 5%, which may be in part because of the considerable number of 'automatic' hearings generated by the CTO process.

TABLE 3

Outcomes of applications to the Tribunal 2000 to 2010 (calendar years)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total applications					n/a	16,155	15,367	17,648	15,605	23,957	23,533
Absolute discharge	858	854	744	923	709	784	655	643	535	776	733
Delayed discharge	342	334	427	518	317	364	287	298	215	279	234
Conditional discharge	39	89	90	141	145	222	195	265	132	289	216
Deferred c. discharge	97	74	101	265	180	217	224	196	85	114	191
Total discharge	1,336	1,351	1,362	1,847	1,351	1,587	1,361	1,402	967	1,458	1,374
No discharge	10,199	10,229	8,637	9,906	10,546	7,935	7,417	7,158	6,328	10,664	9,982
Discharge by RC prior to hearing						4,790	4,629	6,344	5,862	8,056	7,631

Data source: Tribunals Service

Anecdotally, we understand that a considerable number of CTO patients fail to attend such hearings. In any case, this 'success' rate for the CTO patients (many of whom may not, in any meaningful sense, be 'appealing' their legal position) is not different to that for the category 'unrestricted detained patients other than those held under section 2'. This latter, rather unrefined category of detained patients used by the Tribunals Service for its statistics collection includes both patients subject to criminal justice powers and (predominantly) those under section 3, the 'civil' power of detention for treatment. We continue to recommend that the Tribunal collect statistics to distinguish not only individual sections of the Act that are subject to appeal, but also other demographic characteristics such as the gender and ethnicity of appellants.

TABLE 4

Tribunal hearings and outcomes, by legal power appealed, 2010/11

		A	B	C	D	E
		Restricted detained patient (ss. 37/41, 47/49 etc)	s.2 detained patient	Unrestricted detained patients other than s.2 (ss. 3, 37, 47 etc)	All detained patients (A+ B + C)	CTO patient
Applications		3,071	7,103	14,151	24,325	3,284
Withdrawn applications		951	495	3,100	4,546	0
Discharges prior to hearing *(% of all applications)*		79 (3%)	2,319 (33%)	5,233 (37%)	7,631 (31%)	0 -
Tribunal hearings*		2,490	4,755	8,086	15,331	2,457
No discharge by Tribunal *(% per Tribunal hearings)*		1,333 (54%)	3,296 (69%)	5,256 (65%)	9,885 (64%)	2,048 (83%)
No decision (i.e. adjournment) *(% per Tribunal hearings)*		590 (24%)	857 (18%)	2,459 (30%)	3,906 (25%)	297 (12%)
Discharges by Tribunal *(% per Tribunal hearings)*		567 (23%)	602 (13%)	371 (5%)	1,540 (10%)	112 (5%)
Type of discharge	Absolute discharge	97	448	246	791	112
	Delayed discharge	2	154	125	281	
	Conditional discharge	468†				

Data source: Tribunals Service

Note: The data in this table relates to the financial year 2010/11, so figures will differ from the previous table where the figures relate to the calendar year.

* The number of hearings and the number of applications will not match as there will be outstanding applications from the previous financial year.

† 180 of which were deferred.

This data shows how important the Tribunal is as a means of ending restricted hospital orders (or at least conditionally discharging patients from them, subject to recall): the national 'success' rate was 18.5% of applications. It also shows 79 discharges of restricted patients (presumably these were mostly or all conditional discharges) prior to the hearing date.

The discharge of restricted patients in this way requires the permission of the Ministry of Justice. The number of such discharges is double that reported in the early years of this century, and the Joint Committee on the then Draft Mental Health Bill stated its concerns that the Home Office (then responsible for restricted patients) were considered by some to have "no people working for it who are qualified to make risk assessments, and yet it frequently and routinely rejects risk-assessments made by professionals".[12]

The Ministry of Justice, in collaboration with psychiatric experts, is currently developing benchmarks for restricted patients' progress so that there are established criteria that Responsible Clinicians will be able to consider when applying for permission to grant leave or discharge, and criteria for Ministry of Justice officials to consider such requests by. We welcome this development. It seems quite appropriate that benchmarks, such as completing therapeutic sessions or courses (such as anger management courses, etc), or successfully taking escorted leave from hospital, are to be established as measurable steps towards discharge, or to further leave as a progress towards eventual discharge.

We have also encountered anecdotal comment from Tribunal members on poor representation for some patients in hearings. We urge Tribunal members to similarly report their concerns to help maintain standards of legal representation.

Patients' experience of Tribunals

In March 2011 we published, in collaboration with the Administrative Justice and Tribunals Council (AJTC), the report *Patients' Experiences of the First-tier Tribunal (Mental Health)*, based on more than 150 interviews with patients on their personal experiences of appearing before the Tribunal.[13]

The key findings of the report were that:

- Patients are not always well placed to ensure their lawyers are providing a good standard of advice and representation.
- Delays are a substantial factor in many patients' negative experiences of the tribunal process.
- A large part of the distress caused by delays was due to a lack of information about how long the process would take.
- The way pre-hearing medical examinations are carried out is very variable.
- Patients had positive experiences of some parts of the tribunal hearing, but there were concerns about the provision of information and access to medical reports.
- A significant minority said they were not given enough time to be heard by the tribunal.
- Nearly all said they received a very rapid decision. However, follow-up information was lacking and patients felt poorly informed of any further right to appeal.

The study broke new ground in accessing patients' experiences of the Tribunal Service. Although it was a limited pilot, it gave new insights into existing problems and highlighted some problems that had not been identified before.

The project was also a testament to the ability of detained patients to be active and valuable participants in shaping the system to which they are subject. Its most important conclusion was that it is both possible and worthwhile to collect feedback from detained patients about the tribunal system. This should pave the way for future research and surveys of the people who use tribunals and stakeholders.

3.2 Consent to treatment

Last year, the assessing and recording of capacity and consent for detained patients was another of the three issues where we identified the need for significant improvement.

This has been an ongoing focus of MHA Commissioners' visits and we have been pleased to note some examples of good practice. However, there is still significant scope for improvement in some hospitals.

Although we focus here on the practice for detained patients, poor practice in this area can provide an indication of more general problems with practice around consent to treatment – another of the essential standards of quality and safety.

Key findings

- We have seen a number of good examples in relation to consent to treatment.
- We have also seen some good and innovative initiatives around the administration of medicine.
- The legal powers of CTOs are often misunderstood, even among mental health care professionals.
- Two-thirds of CTO second opinion referrals are for patients who consent to their treatment. Some of these patients resent having to have a doctor certify treatment to which they consent.
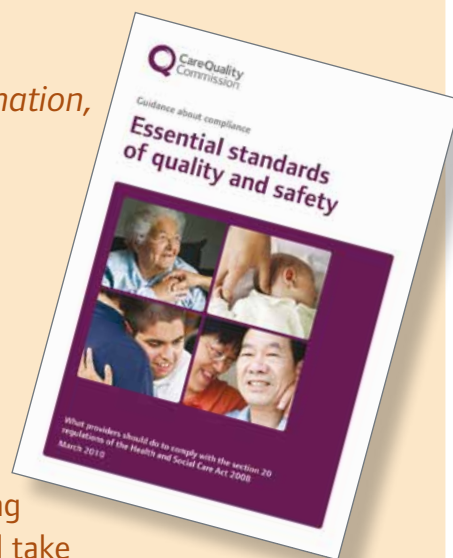
Assessing capacity and consent

Although the Mental Health Act allows some medical treatment for mental disorder to be given without consent (particularly in the first three months of detention), the patient's consent should nevertheless be sought before treatment is given wherever practicable. For someone to give their valid consent, they must have the capacity to do so. It is essential, therefore, that mental health practitioners are knowledgeable about the law governing mental capacity; the MHA Code of Practice cross refers to that legislation as appropriate. Among other things, the Code of Practice requires that "the patient's consent or refusal should be recorded in their notes, as should the treating clinician's assessment of the patient's capacity to consent".[14]

This has been an ongoing focus of MHA Commissioners' visits, and we have seen examples of good practice. In the following case, and in others like it, good practice in relation to consent to treatment is in no small part due to the influence and management of Mental Health Act Administrators within the detaining authority:

Detention documents … were reviewed during the visit and found to be in order and well presented. The Commissioner noted two areas of good practice within the records. Firstly, the detail and completeness of the MHA Administration Record Sheet and including the administration of section 132 patient rights. Secondly, the compliance with consent to treatment under section 58, notably the documentation of the patient's capacity to consent and the record of meaningful discussion regarding consent recorded by the Responsible Clinician.

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It will not always be necessary or appropriate to undertake a full assessment of capacity before treating somebody on the basis that they can and do give valid consent. However, we are concerned about those cases where doctors appear to assume capacity too readily (particularly when we see evidence of reasons to question this). We raised the issue of some patients' assumed, or documented, consent as a concern in our last report.[15] Detaining authorities must remain vigilant to this problem and make sure that clinicians fully document their reasoning where a patient's capacity to consent may be questioned.

The following example highlights some of the tensions around this issue. In the weeks before we visited one London hospital, a patient had been certified on Form T2 as having mental capacity and giving consent to treatment. However, we found no record to indicate that the Responsible Clinician and the patient had had a meaningful discussion about consent. Although the Responsible Clinician had partly completed the trust's "record of RC competence and consent interview", the sections entitled "assessment of the patient's capacity" and "patient's views" on the form were blank. An entry in the patient's notes by the Responsible Clinician seven days before the certification of

consent and capacity on Form T2 had recorded that she was "accepting medication" with "capacity impaired by mental state".

The lack of proper recording by the Responsible Clinician on a form designed for this purpose by the trust left the matter unclear for any member of staff involved in the administration of the patient's medicines. This is not good practice and staff in such situations may leave themselves vulnerable should a patient decide to mount a legal challenge.

It is our view that a meaningful discussion between the prescribing clinician and the patient should take place on admission (and as often as necessary thereafter where there are difficulties in communication), and in good time before the prescribing clinician must decide whether to issue a form certifying consent, or request a second opinion appointed doctor's visit to consider certification in the absence of consent, before the end of the initial three months of treatment with medicine.

Many detaining authorities now provide their clinicians with capacity assessment forms. Such forms, completed appropriately, will ensure that there are always adequate records of capacity assessments.

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.

Administering medicine

We expect hospitals to ensure that legal certificates giving authority for treatment of detained patients who had been receiving medicine for more than three months are available to the staff who administer that medicine. In practical terms, this usually means that a copy of the certificate should be attached to the prescription card. In an innovative arrangement at one trust, a copy of the relevant Responsible Clinician's note was kept with the prescription sheets, so that all nursing staff administering medicine could easily refer to the Responsible Clinicians' discussions about capacity and consent, and understand why they had reached their conclusions.

In contrast, the following example shows how poor instructions by the prescribing doctor can contribute to reducing the efficacy of medicines:

When the medicine cards were scrutinised, it was apparent that one patient had been given a double dose of Quetiapine XL 600mg on the previous night… a brief examination of the medicine cards by the accompanying CQC pharmacist showed some anomalies which would be less likely to occur if more information about each medicine was included on the medicine card. For example, there was evidence that medicines which only work if taken some time before food were being given after lunch and antibiotics being stopped before the full course had been completed.

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Nurses have a duty to ensure that medicines are administered correctly to each patient. Beyond that, they also have an obligation to take all necessary measures to ensure that medicines are administered in a patient-centred, rather than

task-centred, manner. An initiative at one NHS trust has ended the system where patients had to queue on the ward to collect their medicine. Instead, patients go into the clinic room individually and sit down with the nurse with the door shut. This enables a confidential discussion to take place, and any physical checks can be carried out in private. This practice upholds dignity and privacy, and provides patients with an opportunity to ask questions or raise concerns relating to treatment.

Consent and CTOs

Misunderstandings of the legal powers of CTOs

We continue to find evidence that the legal powers of CTOs appear to be misunderstood within some mental health care providers.

For example, it appears to be underappreciated by a number of professionals that a patient on a CTO has the right to refuse treatment with medication while in the community, or that such refusal is not necessarily sufficient cause to recall the patient to hospital (as there must be some sign that the patient needs medical treatment in hospital for mental disorder, and that there would be a risk of harm to the health or safety of the patient or to other persons if the patient was not recalled for such treatment[16]). This misapprehension on the part of some professionals means that patients in their care may, in turn, be misinformed about the effects of a CTO.

We have noted a number of instances where responsible authorities have misunderstood their legal powers in relation to patients on CTOs, leading to unlawful treatment.

A hospital in the East Midlands discharged a patient from section 3 onto a CTO in August 2010. Because of a delay in community accommodation being ready, the patient stayed on the hospital ward for another two months, effectively as an informal inpatient, albeit with

the CTO in force.* During those two months, the patient stated her refusal of consent to depot antipsychotic medication. This was administered to her on two occasions, despite her objections.

Hospital staff failed to recognise that the refusal of treatment by a patient on a CTO could not be overruled without recall to hospital (and then only provided that the conditions for recall are met). The hospital's misapplication of the law even extended to its internal investigation after the patient raised concerns over the legality of her treatment. This concluded, wrongly, that the first administration of depot medication, being within the first month of the CTO, was authorised by the fact that there is no certificate requirement for treatment during that time, and that the second administration, given after the first month of CTO, could have been authorised as urgent treatment.

The failure to realise that the Mental Health Act's supervised community treatment provisions provide no specific power of treatment over a patient on a CTO unless that patient is recalled to hospital is concerning. The authority to treat a patient who is subject to a CTO but has not been recalled to hospital must be sought either under the common law (that is, with the patient's consent) or, where a patient is incapable of giving consent, under the provisions of the Mental Capacity Act 2005.

One factor which may perpetuate confusion is the statutory involvement of a SOAD in certifying medical treatment as 'appropriate' after an initial period of the CTO being in place. Certification for this group of patients does not provide an authority to treat (whereas it does for those who are detained under the Act). Understandably enough, practitioners may be especially confused in those cases where such certificates are issued (correctly) even though the patient in question is known to be refusing consent to the treatment prescribed. The advice of the Department

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* CTOs come into effect at the date and time specified in part 3 of form CTO1 by the responsible clinician, irrespective of whether or not the patient is physically discharged from hospital. If a CTO patient remains in, or is readmitted to hospital without the use of CTO powers of recall (or recall followed by revocation of CTO), they do so as an informal patient.

of Health is such that SOADs are given to understand that a treatment may be certified as appropriate (clinically) even if there is currently no lawful authority for it to be given because the patient refuses to consent. So, although the SOAD has certified that the treatment is appropriate, the Act does not provide the legal authority for its administration against a patient's wishes.

The distinction between a detained patient and one subject to a CTO is, in law, straightforward. Providers need to do more to ensure that there are fewer incidences of unlawful treatment that arise from a misunderstanding of the law in relation to patients subject to supervised community treatment. We shall continue to monitor this aspect of the Act closely during the coming year.

Recommendation

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.

Consenting CTO patients and SOAD certification

For patients who are detained under the Act in hospital, second opinion certification is only required where the patient either cannot consent to the treatment because of the impact of mental disorder on their capacity to make such a decision, or they refuse to give consent. In this way it is always a safeguard against treatment without consent.

The 2007 amendments to the law, introduced in 2008, in relation to patients subject to CTO extended the safeguard of second opinion certification to those patients who consent

themselves to their treatment. This 'consenting' group of patients appeared to account for two-thirds of CTO second opinion referrals in the financial year 2010/11 **(FIGURE 6)**. We have found that this group of patients has been hard to engage in the second opinion process; some patients resent having to have a doctor certify treatment to which they consent. We consider that statutory second opinions are a questionable safeguard for consenting patients, and a questionable use of resources.

FIGURE 6

Second opinion requests for CTO patients, by gender and reported consent status at time of request, 2010/11
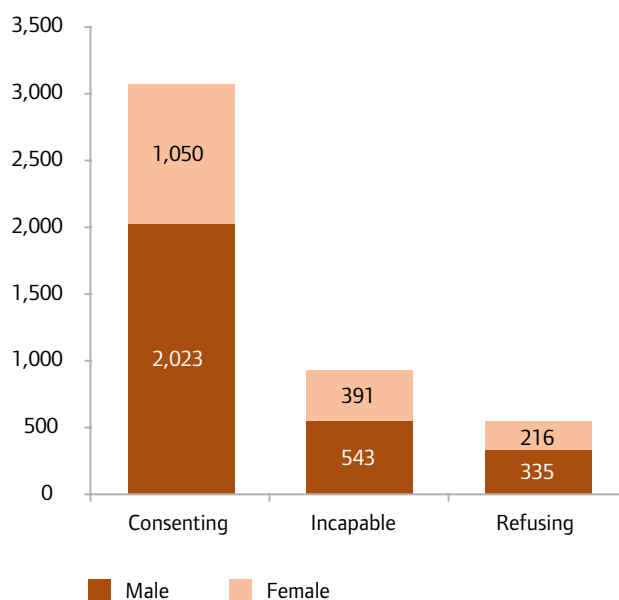
Data source: CQC

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.

The limits of coercion under CTO

Towards the end of this reporting period, we received a request to provide a second opinion for a patient subject to CTO who was regularly recalled to hospital to receive depot medicine. The case was unusual because the patient

physically would only return to hospital if conveyed there by the police under the following arrangement:

> The patient is contacted by phone to inform him of the time the Team and the Police will meet him at his address to escort him to hospital. On arrival at the address, he is once again contacted by phone to advise him that they are outside (downstairs). He comes downstairs and gets into the police car and is taken to hospital. No handcuff or restraint is used. He makes no complaints and often remains in hospital overnight. The recall would end shortly after he had received his depot injection, and he would return to the community until the next time, with limited or no engagement with services in between. Despite this resistance to engagement, and extensive use of recall powers, the CTO was not revoked at any time.

The SOAD's visit was arranged to take place on one of the occasions of recall. We also arranged for a MHA Commissioner to attend on same day, to try and engage with the patient and discuss his position. In the event, before he was recalled, the patient admitted himself informally to hospital, where the SOAD and MHA Commissioner met with him.

> When asked about his views regarding the CTO and the recall process, the patient confirmed… that he wished not to be subject to the CTO, but he has resigned himself to the situation. … I asked him if he would consider alternative ways of receiving his medicine. He said that alternatives had been offered to him …but he preferred to be recalled using the police as this was his way to "protest" against the CTO and continued compulsion under the Act.

We were concerned by this case, as the continued use of recall and conveyance powers seemed to run counter to the assumptions in the MHA Code of Practice over how CTO should be implemented, and for the situations in which it was appropriate. Further, although there is no question that the police had the authority to convey the patient in these circumstances[17], we were also surprised at their willingness to do so on a regular basis. The Code of Practice states that CTO:

*…is suitable only where there is **no reason to think that the patient will need further treatment as a detained in-patient for the time being**, but the responsible clinician needs to be able to recall the patient… relevant factors suggesting ECT [include:]*

- *The patient **appears prepared to consent or comply with the treatment they need** – but risks…mean that recall may be necessary.*

- *The risk of … the patient needing to be recalled to hospital is sufficiently serious to justify [CTO], but **not to the extent that it is likely to happen**.*

Paras 28.5 – 6, (our emphasis)

As such, this case seemed to show CTO powers being extended in ways that are contrary to the Code's guidance, and which specific guidance would seem to suggest might be inappropriate. However, in the circumstances of this case, it was not clear what a better option might be, either for the patient or for the treating team: the alternative (assuming that the clinical team was certain that the depot medicine *had* to be given, by some legal means) would seem to be to recall him and either treat him in hospital as a detained patient, or allow him back into the community on section 17 leave while continuing with the same practical arrangements of forcible conveyance and treatment. Faced with these options, the responsible clinician might well argue that his use of CTO, while contrary to the letter of the Code of Practice guidance, was his best option to comply with its principle of 'least restriction'.

Of course, the Code's guidance is not to be equated with the law. We recognise that, had Parliament wished to use the law to curtail the use of CTO to the sorts of situations described in the Code, it had the opportunity to do so during the debates leading to the Mental Health Act 2007. The law clearly allows for a person to be taken repeatedly to hospital using force, and treated forcibly once there, using the recall powers of CTO. Nonetheless, we highlight this case here as a difficult one which may herald others.

3.3 Patients' experience of care and treatment

Patients' experience of the care and treatment they receive plays a key role in their recovery, and is a significant focus of our MHA visits.

The third priority area we identified in last year's report was about minimising restrictions on detained patients and avoiding blanket security measures. This year we have seen more examples of this, with concerns about the institutionalising effects of these kinds of practices.

This year, we carried out some thematic visits to look at the access that detained patients have to therapeutic activities, and we give an overview of some of our findings.

Key findings

- We still encounter a number of practices that go against the principle of keeping restrictions on liberties to a minimum.
- Patients continue to stay in inpatient facilities because of a lack of community or other placements for them. This is counter to the principle of least restriction.
- We continue to find patients accommodated in makeshift rooms, or in temporary beds placed in general ward areas.
- Patients in hospital are often anxious about whether or not they will have a bed to return to if they take authorised leave from the hospital.
- We have concerns about 'lapsing' recommendations for admission – where a bed is not found before the 14-day time limit on the application expires.
- We welcome the continued development of recovery houses in response to overcrowding, as they are generally popular with patients and studies have shown that they are as effective as inpatient units.
- Between January and April 2011, our MHA Commissioners collected information about therapeutic activities on the wards they visited: a third of patients 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.

Institutionalisation

Our last report pointed to examples where house rules and approaches to physical security prevented some services from meeting the expectation, set out as a principle of care in the Code of Practice, that restrictions on liberties should be kept to a minimum.[18] We continue to encounter customs and practices that have the same effect:

- At one older people's unit, patients with cognitive and memory impairments were required to order their meal choices from a menu for the next day. Many patients could not recall what they had ordered, and wanted what others were eating, exacerbating behavioural problems and leading to their own food, or that of other people, being spoilt. It also meant that patients whose appetites varied could not control the amount of food placed before them, and that it was often cold when it reached the patient. We were told that the hospital had previously brought food to be portioned on the wards, but that staff would then be busy serving out food and would have less time to help patients to feed themselves. This is a question of staffing: we asked the hospital to reconsider its arrangements. (CQC has recently carried out wider work on dignity and nutrition for older people in acute NHS hospitals, and the extent to which providers were meeting Outcomes 1 and 5 of the essential standards of quality and safety.[19])

- On another older people's ward, patients were not offered choices in areas that might make considerable difference to their day. A small example was that all patients were handed three biscuits with their morning tea, and not allowed to pick what they liked. A more worrying example was that of an older patient who was fed by staff at one meal when we were visiting a ward, although she had indicated that she wanted to feed herself and we had seen her do so earlier in the day, using easy hold cutlery and a plate guard. On an adult ward, a patient told us that he was an early riser and liked to get up at 6.30am, but that staff would not allow him a drink of tea until after 8am.

- We have heard complaints from patients in secure facilities that there is little demarcation in security policies and practices between wards or units that have different security classifications – even between medium and low security. For example, patients on one rehabilitation ward had no regular access to the internet or to e-mails, although the ward's purpose was to prepare them for discharge.

- Many wards lock patients' rooms during some of the day, to try to make sure that patients engage with therapies. This should be done with sensitivity, and patients should still have somewhere to go for peace and quiet when the ward day rooms get noisy and pressured.

- Patients in one forensic unit complained to us that staff listened to them make telephone calls from the ward. This practice was justified as a means of preventing sensitive information about other patients being communicated. We questioned the proportionality of this blanket approach and its logic, given that some patients had unsupervised time with visitors and unsupervised leave from the unit.

Unacceptable practices can pass unnoticed where they go under the guise of a clinical intervention. We saw an example of this on a mid-week visit to a secure unit in North West England. A patient had had all of his possessions (including clean clothes) removed from his room by staff following a series of incidents the previous weekend. Removing items of property from a patient who is self-harming or causing damage may sometimes be necessary, but this appeared excessive. Also, although the patient was no longer exhibiting the behaviour that had prompted the intervention, we were concerned to hear that the multi-disciplinary team had decided he should not have his possessions returned for two more days.

We could see no rationale for the delay, not least because we noted that the patient had left wet towels and soap in his room on his return from showering earlier in the day. This showed either a lack or consistency in risk assessment, or that no risk assessment was taking place. The patient had not had access to clean clothes while denied his possessions, and we found these stored carelessly in the laundry room, where there was a risk of them becoming lost. We asked the hospital to investigate the whole incident.

On another visit to a secure hospital site in North West England in February 2011, patients complained that they felt more restricted when transferred to units away from the main hospital site, due to loss of ground leave and activities at the weekend. Patients were getting limited opportunities for section 17 leave and we found an over-reliance on services brought into the units for patient activities, which seemed limited to art, cooking, gym or rambling. Patients told us that they felt these activities did not meet their needs, but that their section 17 leave was cancelled if they refused to attend, and there was no provision made for time off 'holidays' from activities as at the main hospital site. We urged the hospital managers to view the shortcomings of activity provision at these units as an opportunity to intensify efforts to make links with the community, including the local college, paid or voluntary work, and leisure facilities.

Night time confinement in high security hospitals

The high security hospitals have operated under statutory security directions since 2000. These were first issued following a review of security in the hospitals, commissioned by the Department of Health in the wake of the 1997 Ashworth Hospital Inquiry and undertaken by Sir Richard Tilt, who had been the director of security in the prison service.

The security directions have undergone successive amendments in the last decade, with their latest iteration issued in the summer of 2011.[20] These introduce a permissive power for the extension of night-time confinement – the routine, pre-determined locking of patients into their rooms at night – to any part of the hospitals.

The Department of Health's guidance on the new directions states that "arrangements should only be put in place where it is considered that this will maximise therapeutic benefit for patients as a whole in the hospital. For example, confining a group of patients at night may release staff to facilitate greater therapeutic input for patients during the day".[21] It has been made clear to us that this is, indeed, how some hospital managers, who are faced with a requirement to make efficiency savings, intend to use them. The approach is currently being piloted in one hospital and will be evaluated carefully.

In our view, the extension of prison-style lockdown in the high security hospitals is unquestionably a regressive move. One hospital has justified its plans for locking patients in their rooms at night on the grounds that patients have supported this, and feel safer with their doors locked from the outside. The emphasis, through our wider regulatory activity, is on ensuring that hospitals comply with essential standards so as to provide an environment that is safe enough without recourse to such regressive practices.

The Court of Appeal, in its judgment on the 2003 Munjaz case, determined that locking patients into their rooms at night under the security directions is not to be considered as 'seclusion', so that the safeguards of the Code of Practice regarding seclusion do not apply.[22] Nevertheless, the security directions recognise explicitly that there are risks to patients' wellbeing, and require the following measures:

- A patient's room may only be locked at night if it has integral sanitation facilities and a staff call system or the patient is subject to continuous observation by a member of staff.

- No patient should be locked in their room at night if it is considered this would have a detrimental effect on their wellbeing.

- The hospital policy should include a requirement that, before a decision is taken to lock each patient in their room at night, the patient's clinical team must regularly consider whether there are clinical or psychosocial grounds for not locking the patient up at night.

- Arrangements should also be made for reviewing decisions if there are circumstances, for example the risk of suicide or self-harm, that would indicate that locking the patient in their room at night might have a detrimental effect on their wellbeing or be unsafe.[23]

These are difficult requirements to satisfy when implementing a practice that, to make any significant reduction in night staffing costs, must apply across whole wards. The directions make it clear that the risk assessment and any decision to introduce night time confinement must be included in a risk management plan prepared by the patient's clinical team, with

regular review. The clinical team will need to define on an individual basis what amounts to "a detrimental effect" on a patient's "wellbeing", and decide what would be a "detrimental effect" on a patient when or if that patient is subject to lockdown at night. We will be watching the implementation of this policy carefully and the evaluation of the pilot, with a particular focus on how patients' individual views and concerns are ascertained and taken into account in making decisions over lockdown periods.

Therapeutic activities

For the purposes of the Act, medical treatment includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.[24] The Code of Practice acknowledges the contribution of therapeutic activities to promoting both recovery and safety, and promotes the provision of appropriate activities for all patients, including exercise, and encouraging patients to take part in activities appropriate to them.[25] It also identifies boredom and lack of environmental stimulation as one of the factors that may contribute to disturbed behaviour.[26]

Past studies and reports have highlighted concerns, particularly from a patient perspective, that people have not had enough to do in hospital or are dissatisfied with the activities they undertake.[27] A range of benefits have been identified of having an actively therapeutic time in hospital, including increased patient satisfaction, reduced use of medicine and observation, and reduced rates of readmission.[28] There is some evidence that wards with more social interaction are associated with better clinical outcomes.[29] The City 128 study in 2007 reported that comprehensive programmes of activity may act to reduce more serious self-harm and are highly valued by patients.[30]

Nationally, the Star Wards initiative has had a key focus on improving the quality of patients' experience of inpatient mental health wards through developing the programme of daily activities, not only to eliminate boredom but also to actively contribute to accelerating recovery.

Despite the progress made nationally to develop the provision of therapeutic activities, we still meet with patients during the course of our MHA visits 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 focus on this issue during 2010/11. Between January and April 2011, our MHA Commissioners collected information about therapeutic activities from patients and staff on the wards they visited. This resulted in getting the views of 299 patients and of staff from 261 wards.

Availability of activities

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. Patients in secure settings were more likely to report the availability of activities off the ward than for those in general mental health wards. Staff from just over half of the wards (54%) said that external organisations facilitated one or more of the activity sessions.

Staff indicated the range of activities that were provided for patients **(TABLE 5)**. Most types of activity were available during weekdays (notably therapy, treatment, creative and personal development activities) than at other times. Recreational, physical and relaxation activities were the activities most likely to be available during the weekends and evenings.

TABLE 5

Availability of activities for patients

	Weekdays	Evenings	Weekends
Talking groups (for example ward community meeting, psychodynamic discussion group, depression management, anxiety management, coping with psychosis, hearing voices, substance misuse, pre-discharge groups)	237 (91%)	87 (33%)	77 (30%)
Non-verbal therapy (music therapy, art therapy, drama therapy)	194 (74%)	86 (33%)	83 (32%)
Creative/expressive (art and craft, woodwork, pottery, creative writing)	236 (90%)	114 (44%)	125 (48%)
Skills/information (cooking, careers advice, local college education advice, outings to local resources)	231 (89%)	100 (38%)	107 (41%)
Physical/relaxation (aerobics, gym, yoga, walking group, relaxation, meditation)	249 (95%)	153 (59%)	157 (60%)
Recreation (videos/DVDs, table tennis, pool competitions, table football, music appreciation, leisure outings)	247 (95%)	220 (84%)	220 (84%)
Other	149 (57%)	144 (55%)	133 (51%)
None of the above	1 (<1%)	6 (2%)	10 (4%)

Data source: CQC

We asked staff whether any activity sessions had been cancelled in the previous week and if so, how many. Around two-thirds (65%) of wards indicated that there had been no cancellations of activities. Where there had been cancellations, this tended to affect only a small number of sessions (on average 2.45 sessions cancelled), although this ranged from cancelling one session up to cancelling 21 sessions during the previous week on one ward. Where staff gave reasons for sessions being cancelled (80 respondents), 55% said that this was because of staff shortages, 25% because of a lack of uptake/interest by patients, 13% because patients were not well enough to take part, 18% because of an incident on the ward and 16% for other reasons (including building refurbishment, bad weather, equipment not available and double bookings). Where an activity was cancelled, 64% of these respondents said that an alternative activity was offered to patients instead.

Participation in activities

Patients' participation in these activities broadly reflected the availability of activities **(TABLE 6)**, although a quarter (25%) and more than a third (37%) of patients said that they did not take part in any of the available activities during the evenings and weekends respectively.

By far the most common activity in the 'other' category was 'television', followed by 'listening to music/the radio', though a number of respondents also mentioned the availability and use of games consoles on the ward. For the weekend, patients mentioned a wider range of social activities in the 'other' category including 'access to a library', 'church on Sundays', 'community meetings on Sundays', 'family visits', 'go on leave every weekend', 'walking, bird watching ', 'café', 'take away meals', 'visitors', although more patients commented about the lack of things to do at a weekend, including:

- 'It's very quiet at weekends, nothing to do'.
- 'Activities are now stopped'.
- 'There's nothing really – just the TV in the bedroom'.

TABLE 6

Patient participation in activities

	Weekdays	Evenings	Weekends
Talking groups	157 (53%)	20 (7%)	14 (5%)
Non-verbal therapy	79 (27%)	25 (8%)	18 (6%)
Creative/expressive	156 (52%)	31 (10%)	27 (9%)
Skills/information	137 (46%)	26 (9%)	24 (8%)
Physical/relaxation	192 (64%)	84 (28%)	71 (24%)
Recreation	181 (61%)	128 (43%)	105 (35%)
Other	156 (52%)	128 (43%)	103 (35%)
None of the above	22 (7%)	74 (25%)	111 (37%)

Data source: CQC

Most patients said that they had been able to take part in some or all of the planned activities, although 59 patients (20%) said that they had not. One hundred and two (34%) patients explained why they had not been able to take part in one or more of the activities on offer. The most common reasons for not being able to take part were that the activities did not reflect their interests (38%) or because of staff shortages (28%). One in 10 said that they didn't want to take part, with others citing their physical (8%) or mental health (4%) as factors which stopped them taking part. Other reasons given included:

- 'There's not enough to do – it's mainly games'.
- 'I've not been given leave for off ward activities'.
- 'I often miss sessions because I sleep late'.
- 'The side effects of my medicine prevent me'.
- 'I'm unable to attend community activities as the MOJ has not approved my leave'.
- 'The Christmas period'.

Patients' views on activities

We asked patients whether they thought there were enough activities available at different times of the week. Around a third of patients (34%) who responded thought there wasn't enough for them to do on weekdays **(TABLE 7)**. From their point of view, the situation was worse during other times in the week, as over half (58%) considered there was not enough to do during the evenings with almost two-thirds (65%) indicating that this was the case at weekends.

We asked patients what activities they would like which are not offered at the moment. Over half (56%) of the patients responded to this question, including a few who commented generally: 'anything to keep occupied', 'more to do at weekends', 'more recreational activities to relieve boredom'. The most common suggestions were for outings/trips off the ward and for additional physical activities (gym, swimming or sport more generally) and recreational activities (arts, crafts, games, dance, music and bingo).

TABLE 7

Patients' views on sufficiency of activities

	Yes	No	Don't know	No response
In your view, do you think there are enough activities available for you during the **weekdays**?	170 (59%)	97 (34%)	20 (7%)	12
In your view, do you think there are enough activities available for you during **evenings**?	97 (35%)	161 (58%)	22 (8%)	19
In your view, do you think there are enough activities available for you during the **weekends**?	76 (27%)	180 (65%)	21 (8%)	22

Data source: CQC

❝ 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

We also asked staff if there were activities that carers could be involved in. Of the 254 staff members that responded, only just over a half (52%) said that this was the case. Mostly staff said that this was involvement with recreational activities, other group work, or outings, although 10 staff members specifically mentioned carers' support groups and another four mentioned the provision of family therapy or psychoeducation for carers.

Involving and informing patients

The Royal College of Psychiatrists' Accreditation for Inpatient Mental Health Services (AIMS) includes a standard that states that patients should have the opportunity to be involved in negotiating an activity and therapy programme, relevant to their identified needs that includes evening and weekend activity. This should be recorded in their care plan, and regularly monitored and reviewed.

Of the 254 staff members who responded to the question, 96% confirmed that all patients had daytime activities identified as part of their care package. Although to a slightly less extent, the vast majority (79%) of the 287 patients who responded to the question confirmed that a member of their care team had asked them about the kind of activities they would have liked to take part in; 15% said they hadn't been asked while 6% said they didn't know.

Ninety per cent of staff members said that all patients on the ward had had an activities assessment carried out as part of their care plan. As **TABLE 8** illustrates, occupational therapists were the main professional that carried out these assessments, though sometimes in collaboration with others. Eighty-four per cent of staff said that they had had occupational therapy and/ or activities co-ordinator sessions based on the ward. Just under two-thirds (64%) of the 235 staff that responded indicated that there were enough staff trained to facilitate gym work.

TABLE 8

Staff that carry out activity assessments

	Number of respondents	%
Occupational therapist (OT)	114	47%
OT and nurse	47	19%
Nurse, OT and activities coordinator	28	12%
Nurse	17	7%
Multi-disciplinary team	11	5%
Nurse and activities coordinator	7	3%
OT and activities coordinator	9	4%
Activities coordinator	7	3%
Total respondents	**240**	**100%**

Data source: CQC

Patients were asked whether they knew if activities were detailed as part of their care plan. Of the 224 who answered, only 55% confirmed this, 27% said they didn't know either way, and 18% said that this wasn't the case.

The most common way of advertising or informing patients about activities was through the ward notice boards (87% of wards). Aside from this, information about activities was communicated through:

- Individual care plans and one-to-one meetings (70%)
- Community meetings (69%)
- Ward rounds (52%).

Monitoring and reviewing activities

Of the staff members that responded, 97% said that they monitored the take-up of activities and 94% confirmed that patients were involved in reviewing and planning new activities. Ward meetings were cited as the most common way of doing this by 80% of respondents, though

involving patients through CPA meetings (38%) and ward rounds (36%) were also reasonably common.

Of the staff that responded, around a third (34%) indicated that the schedule of activities had been reviewed within the last week to check that the activities offered are meeting the needs of the patients on the ward. Staff from other wards indicated that this had been done:

- Between one week and one month ago (31%)
- Between one to three months ago (23%)
- Between three months and a year ago (6%)
- A year or more ago (2%)
- On an ad hoc basis/as required (5%).

Overall, the findings of this thematic survey suggest that there is a wide range of therapeutic activities available on most inpatient mental health wards, which are advertised reasonably well and reviewed on a regular basis. However, the analysis does continue to raise questions about:

- The provision of activities during evenings and at weekends.
- How well activities are tailored to individual needs and interests.
- How effectively patients are encouraged and motivated to engage in activities.
- How well patients are supported to understand the benefits of taking part in activities to support their recovery.

Recommendation

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.

Mental Health Act care pathway

Bed occupancy and availability

The first of the Royal College of Psychiatrists' 10 suggested standards for adult inpatient wards is a "bed occupancy rate of 85% or less".[31,32] This parallels the acute sector, where research has indicated that risks are discernable when average bed occupancy rates exceed 85% and that bed shortages and periodic bed crises are likely if the rate exceeds 90%.[33] However, we still visit some acute inpatient mental health wards that are running at full or over capacity, leading to overcrowding and patients sleeping out.

There are a number of problems associated with overcrowding, which have a significant impact on patient care and experience. The Code of Practice identifies too much stimulation, noise and general disruption as one of the factors that may contribute to disturbed behaviour.[34] A number of MHA Commissioners report a sense that these are increasing. The most common observation in relation to over-occupancy is simply that it overstretches staff, and places serious pressures on patients.

We continue to find patients accommodated in makeshift rooms, including temporary beds placed in general ward areas or in other rooms that normally serve other purposes:

> On the day of visit, there were 26 patients allocated to this 20-bed unit. Four patients were on leave, with the remaining two patients using the de-escalation room and a 'quiet room' as bedrooms. Patient 3 complained to the Commissioner that due to there being no quiet space on the ward, he spent the majority of his time in his room.
>
> **September 2010**

In this example, the trust has informed us that, partly to address the pressures on admission, they are in the process of developing recovery houses (also called crisis houses). Such developments are very welcome, as recovery houses can provide care in a less restrictive setting, are generally popular with patients, and studies have shown that they are as effective as

inpatient units in clinical terms.[35,36] Nevertheless, we will continue to closely monitor instances of inappropriate accommodation being offered to patients. Where necessary we will ensure that such concerns inform those who have responsibility for monitoring compliance with the essential standards of quality and safety.

Patients in these services 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:

> The Commissioner was made aware during interview with the Ward Manager that when patients are away from the ward on overnight (or longer) leave, then it is trust policy to fill any empty beds should new admissions be sought. It was stated that not only does this cause difficulty for the staff, but it also leads to patients being reluctant to take overnight leave that they are entitled to for fear of losing their beds. This concern has been brought to the attention of the trust on a number of previous occasions with regard to other wards.
>
> **February 2011**

In response, this trust told us that it had reviewed its bed management policy, given new advice to staff about the use of leave beds, and was implementing this policy in collaboration with community teams. The policy now states that new patients will be admitted to a vacant bed (even if this is elsewhere in the trust) rather than a local leave bed, unless there are sound clinical reasons as to why a local leave bed must be used (i.e. disturbed and violent behaviour preventing safe transfer). We welcome efforts like this to address this long-standing problem.

In some cases, we found patients being admitted to wards that are unsuitable for their care:

> On the day of the visit, two patients had slept over night on the PICU as they had returned from leave on a different ward, and their leave beds had been used for other patients. They were both seen by the MHA Commissioner – one patient was exhibiting clear signs of a psychotic illness and was very confused as to why they were on the PICU. The other patient determined that the move

was linked to his appeal hearing and that they were in some penitentiary. In both cases, the moves had appeared to be disruptive not just to the individual patients but also to the staff. Staff stated the circumstances were extraordinary. The Commissioner questions the appropriateness of using PICU to manage bed crises.

June 2010

Recommendation

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.

Delays in admission due to bed occupancy

We have repeatedly raised concerns in previous reports about delays in admissions due to bed availability.[37] We have reported on cases where applications for admission (which are valid for 14 days after the last medical recommendation supporting admission was completed) have expired before a bed could be found, or even where consecutive applications expire one after the other.

The issue of 'lapsing' recommendations for admission is of very great concern. There are likely to be some cases where delays in implementing an application for admission provide a breathing space, during which time the patient is (ideally) being supported closely by community teams, so that matters settle down to the extent that implementing the admission is no longer appropriate. But in a number of cases the criteria for admission – the need to receive treatment in hospital which cannot

be provided without detention, in the case of section 3 applications – are just as forcibly met after a lapse of 14 days as they were when the application was made. In such cases the patient, at the very least, is being placed at great risk.

There may well be instances of course where a patient needing informal admission is prioritised above one who is to be admitted under the Act. Nevertheless, it should be seen as a very serious matter when the admission of someone judged to need detention under the Act is delayed for any significant period because of a lack of resources or because more urgent cases are prioritised above them.

Recommendation

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.

Delayed discharges and inappropriate placements

We continue to find patients who are detained in hospital longer than necessary because of a lack of community or other alternative placements. This raises a genuine concern that the principle of least restriction established in the MHA Code of Practice cannot be fully realised. Some of the needs for patients' discharge may be complex and shows the necessity of effective joined-up working between health and social care providers. But, nonetheless, the shortfall in suitable follow on placements for some patients may well be putting their recovery at risk.

There are currently five delayed discharges on this unit, mainly as a result of suitable housing not being available in the community. In respect of patient 3 in particular, this patient has now been on this **short stay unit for five years** [emphasis added].

January 2011

It was very evident …that a significant change had taken place since the last visit in that there were several patients on the ward who no longer needed the specialist service provided by a PICU. This was confirmed by ward staff who said that they are experiencing difficulty in discharging patients due to the unavailability of more appropriate services, and that this situation worsened when [a different, 20 bedded ward at the hospital] closed last year.

February 2011

As noted in our last report, there has been a considerable rise in the number and proportion of secure inpatient wards. There is some evidence, however, of a lack of appropriate and available 'step-down' services to enable patients, once they have entered secure services, to get back out.[38,39] In some cases, lack of rehabilitation opportunities in step-down and other pre-discharge units is a source of great disappointment to the patients who feel they have worked through the system to get there.

Our MHA visits have raised questions this year about how inpatient units are being used for people with a learning disability, particularly assessment and treatment units. These units are often low secure, provide short-term assessment and treatment services and, where appropriate, rehabilitation services for people with a learning disability, most of who are detained under the Mental Health Act. Given the specialist nature of this provision, some units predominantly admit people from out of the area. Where services are geographically isolated, unacceptable practices can become normalised and staff may be cut off from new ideas and information about best practice.[40]

One of the aims of the last government was to ensure the closure of NHS residential campuses for people with a learning disability by 2010 as a national priority for NHS learning disability services. In 2010, we published the final *Count me in* census of people in inpatient mental health and learning disability services.[41] This showed that the total number of providers of inpatient learning disability services had not changed much from the baseline year of 2006, although the number of NHS providers had fallen steadily

and the number of independent healthcare organisations increased over this period.

The findings were similar over the six years up to 2010: people with a learning disability were more likely to be in low and medium secure settings and, probably linked to this, were in hospital much longer. Overall, the average (median) amount of time that women with a learning disability had spent in hospital was about 31 months, and for men with a learning disability was about 27 months. This compares with an average for people with mental health problems of 2.5 months for women and 5.8 months for men **(TABLES 9 AND 10)**.

In 2009, we published the findings of a follow-up audit of inpatient learning disability services.[42] One of our recommendations was that independent healthcare providers and NHS trusts should be able to justify the care, treatment and assessment they provide, ensuring that it meets with national guidance and best practice. Assessment and treatment services should not become campus provision under a different guise. We urged commissioners across health and social care to work collaboratively with providers to ensure that they do not allow people to remain who are not being treated or assessed.

TABLE 9

Length of stay – learning disability (LD) and mental health (MH)

	0-7 days	8-30 days	1-3 months	3-6 months	6-12 months	1-2 years	2-5 years	>5 years	Invalid
LD numbers	181	146	208	220	359	470	745	1,045	2
LD %	5.4%	4.3%	6.2%	6.5%	10.6%	13.9%	22.1%	31.0%	0.1%
MH numbers	2,429	4,697	5,453	3,451	3,130	2,912	3,414	2,195	2,759
MH %	8.0%	15.4%	17.9%	11.3%	10.3%	9.6%	11.2%	7.2%	9.1%

Data source: *Count me in* census

TABLE 10

Ward security level – learning disability (LD) and mental health (MH)

	General	Low security	Medium security	High security	Invalid	Total
LD numbers	1,755	1,186	388	47	0	3,376
LD %	52.0%	35.1%	11.5%	1.4%	0.0%	
MH numbers	22,862	4,117	2,707	754	0	30,440
MH %	75.1%	13.5%	8.9%	2.5%	0.0%	100.0%

Data source: *Count me in* census

3.4 Promoting patient safety

Promoting patient safety is an extremely important issue for mental health 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.

People who are compulsorily detained in hospital cannot exercise choice about being there, nor at times about the treatment they receive. Although people are likely to be unwell, providing a positive environment, appropriate use of interventions and evidence-based treatment are essential to ensuring their safety.

In this section, we report on a number of issues that are relevant to promoting the safety of detained patients: restraint and seclusion, single sex accommodation and staff shortages. We also summarise the information from the notifications we have received on absence without authorised leave.

Key points

- Detaining authorities must be vigilant about safeguarding people from abuse.
- Many services could markedly improve their restraint and seclusion practice through patient involvement in care planning and post-incident reviews.
- Patients' biggest concern about staff shortages is the lack of continuity of care.
- Detaining authorities are now required to notify CQC of any absence without leave of any person detained or liable to be detained under the Act.
- In 2010/11, we were informed of 4,315 absences without leave. Thirty-eight per cent of returns of patients to hospital were carried out by the police. The second largest category of returns (30%) was when a patient returned voluntarily.

Restraint and seclusion

Control and restraint

In our last annual report we cited two examples from our visits where patients had raised concerns about possibly abusive restraint, in one case with us, and in the other directly with the hospital.[43] While noting that most people working in mental health are compassionate and professional, even under the considerable stresses of their work, we remarked then that "detaining authorities must always remain vigilant against ill-treatment of patients by their employees".

Training in control and restraint is variable and unregulated. In discussions with the Independent Advisory Panel (IAP) on deaths in custody, we have shared concerns over the deaths of three detained patients during restraint in the prone position, where lack of training was identified at inquest as a contributory factor, and highlighted the Mental Health Act Commission's concern in 2009 over the lack of action in implementing the recommendations over training from the Inquiry into the death of David Bennett, which reported in 2004.[44] We understand that the IAP is developing common principles for the use of restraint in custodial sectors, and look forward to further work on this matter.

The stresses on ward life (such as noisy, closed environments with little activity and a perception that nursing staff have little time to spare with patients) can cause unsettled behaviour that creates a culture of physical restraint, and all services with high levels of such restraint should consider what environmental and social factors may be triggering incidents.

In last year's report we wrote of the importance of including possible responses to disturbed behaviour in the individual care planning process, both when this is likely to be an issue, and on every occasion after a restraint incident. We pointed out that:

the Mental Health Act Code of Practice recommends that staff should … give [patients] an opportunity to write an account of the episode that will be filed in their notes. Many services find this requirement challenging, but compliance with the Code's guidance would mark a positive cultural shift for many hospitals and we will continue to promote it through our visits.[45]

The following visit feedback shows both how and why we do this:

Patient 2 had been subject to restraint on two occasions, involving four or five staff and being held in a face down position. One restraint took place over a 20 minute period.

We take the view that the wider patient involvement in care planning can be, the better the service will be, and that this should include reviewing and planning for the management of disturbed behaviour where this is an aspect of a patient's treatment. If there is an ethic of genuinely helping patients to have a say in their treatment, including real opportunities for patients to record their own views and experiences following, for example, restraint incidents (through the help of independent advocacy if necessary), then there is a smaller likelihood that abuse can occur.

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.

Mechanical restraint

Physical restraints – usually handcuffs – are sometimes used in moving or transporting patients, but not always as an apparent last resort.[46] Towards the end of the year, we raised the appropriateness of a proposal by managers of an independent forensic unit to use handcuffs to facilitate community leave for a patient who wished to visit his bank. The proposal was that the patient could visit his bank, but would be handcuffed to a member of staff when he did so. We questioned whether this was necessary and, indeed, how it might be perceived by bank staff and members of the public. We were pleased that the hospital decided not to use handcuffs in this instance.

During the year we visited the women's wards at Rampton Hospital (the last part of the high security hospital estate to care for women patients), and reviewed the use of mechanical restraint in the care of the more disturbed patients there. Such restraints are, mostly, strap-based arrangements designed to restrict arm movements, used to prevent self-harm by clawing at the face. The alternative to the use of such devices would probably involve manual restraint by one or more nursing staff over considerable periods of time, and as such we were satisfied that the mechanical restraint was justified. The hospital has produced a very thorough policy on mechanical restraint, and we are pleased to see that this is being implemented in practice.

In September 2010, we met with a patient who was not in the high secure sector, but was subject to mechanical restraint (mittens taped to her wrists) when placed in seclusion to prevent self-harming. The patient had transferred to the unit in question some months earlier, in part to be nearer her family, and had needed seclusion on a number of occasions. We had previously been informed of these interventions and provided with a management plan and care plans for the use of the restraints, which had been ratified by the senior management team in the forensic directorate and by the trust's ethics committee. The patient had a solicitor and an advocate. We were satisfied that seclusion and mechanical restraint were being used as a last resort and in line with the Code of Practice principles and requirements. The patient told us that she was happier in her present situation than in her previous placement, and we observed good rapport between her and the members of staff.

Seclusion

As with restraint, many services could markedly improve their seclusion practice through patient involvement in care planning and post-incident reviews. In the following example, we found significant use of seclusion as a way of dealing with difficult behaviour, and were concerned that not enough was being done to prevent it becoming a cultural expectation on the unit:

The Commissioner did not find up-to-date care plans in relation to patients that were in seclusion. There were no ... plans in place to identify triggers and de-escalate in order to divert patients away from seclusion. The trust is asked to identify the clinical governance arrangements to monitor seclusion; audit the use of seclusion, establishing for each patient how many times they have been in seclusion since admission; and develop care plans to manage this behaviour.

March 2011

On a visit to a women's medium secure unit in May 2010, we spoke with a patient in seclusion who told us that she was "ok in seclusion" as it was "good to have a break from the noise and stress of the ward". Services should be alert to the danger that patients may be using seclusion as a refuge in this way, and make sure that there are alternative means of obtaining quiet and rest. In this case we asked if the named nurse could talk with the patient about resources she might use if she needs a break from the ward without instigating a seclusion episode.

In the following example from a different unit, we encountered the common problem of a lack of active engagement with the secluded patient by those engaged on observations; little or no planning by staff to end the seclusion episode; and a failure to take account of and record the patient's subjective experience:

The Commissioner examined records of patient 6 who had recently been nursed in seclusion. Some of the observation comments were rather passive and did not reflect that there was any care plan or attempted meaningful engagement or activity with the patient. Notes on the reviews tended to refer just to the risk factors and often ended with comments like 'continue seclusion'. Please ensure that observation comments and reviews reflect the patient's own views and comments about the care and treatment while in seclusion and that the patient is clear about what factors or behaviour might lead to its termination.

March 2011

In September 2010, we visited a ward in an independent hospital that was caring for a patient who was (unbeknown to him) waiting for transfer to a high security hospital, while effectively in conditions of long-term segregation, although with none of the safeguards suggested by the Code of Practice in place for his care.[47] We met with the patient in the 'observation lounge' where he had been nursed for a number of months. His 'management plan' said that "interactions with peers are not permitted at all".

It was clear from talking with the patient that he did not know what was needed of him for this practice to be stopped and for him to be allowed to associate with other patients in the general ward areas. His behaviour had been recorded as 'settled' for a number of weeks but his CPA documentation contained the directive that "he will be transferred to Ashworth Hospital in due course and his management plan will not be altered prior to his transfer". The patient had also been sleeping under a towel until shortly before our visit, having been denied a pillow and duvet on the basis of reducing his opportunity to self-harm by ingesting objects. We suggested that the overall treatment raised human rights concerns and that his segregation from other patients should be subject to regular review rather than set as an indefinite management plan. The hospital agreed to an immediate review of the situation.

In contrast, our MHA Commissioners have been complimentary over the arrangements for patients in longer-term segregation at Ashworth Hospital itself. In December 2010, we visited a ward in the hospital where four patients were in longer-term segregation, and commended the hospital for its attempts to meaningfully engage with patients through its positive intervention programme. The programme works on increasing structured rehabilitation activity, identifying

and assessing dynamic risk factors, promoting an integrated approach with ward-based staff through the coordination of parallel activities, and supporting progressive integration including association with other patients. The patients also have the safeguards of regular reviews by the patients' own clinical teams and the seclusion monitoring team.

We have continued to find examples of very poor seclusion facilities. In October 2010 we visited a women's unit in the East Midlands and found a completely unfurnished seclusion room in use, without even a mattress, so that patients in distress would have to sit or lie on the floor. We also found that a doctor did not attend every seclusion episode as required by the Code of Practice. The hospital resolved these matters when we raised them. We have also noted two further examples (having raised one in our annual report last year) of seclusion rooms being put back into use with human excrement on their ceilings.

Example of using MHA Commissioner input in a review of compliance with the essential standards

Major concern with Outcome 4: Care and welfare of people

In September 2011, we carried out a review of compliance under the Health and Social Care Act at a private hospital in the West Midlands. The service is registered to provide care and treatment to both adults and young people with mental health problems.

We visited the service following concerns raised by an MHA Commissioner that people using the service were not having their care appropriately planned, which could have put people at risk of harm.

We found that care plans and risk assessments did not provide enough information to ensure that staff could fully understand the care needs of the patients. For example, we found that the care plans of one person did not inform staff what their treatment programme was and how staff should support them to follow the programme.

The care plan said that the person was frequently of low mood, but it did not say what staff should do to lift the person's mood and reduce the risks of self-harm or suicide. The person had deliberately used boiling water to hurt themselves, but there were no further risk assessments or measures in place to make sure that this kind of incident would be prevented in the future. We observed on the day of our visit that people could use a communal kitchen and access to boiling water was unsupervised.

We also found that there were no appropriate guidelines for staff to follow to make sure that any restraint was done safely. We looked at the risk assessment of one person and found it did not detail when restraint should be used. It also failed to detail which staff and how many staff should be involved in any restraint. The nurse responsible for that person was not able to inform us of how the restraint should be carried out safely to make sure the person came to no harm.

As a result of our review, we had major concerns that the hospital was not complying with Outcome 4. We asked the provider to send us a report within seven days, setting out the action they would take to improve, and we are following this up with a further inspection.

Dormitory-style wards and the safety of women patients

In some cases, we found that the infrastructure of wards raised concerns over the privacy and dignity of women, and showed continued breaches in terms of mixed-sex accommodation arrangements in particular.

The physical layout of this ward means that not only are male and female wards in close proximity, but also the women in the female dormitory have to walk some distance past the male dormitory to access a toilet. In addition, there are no separate male and female day rooms.

October 2010

In the above example, we referred the managers to the MHA Code of Practice's requirement that members of one sex should not have to walk through an area occupied by the other sex to reach toilets or bathrooms, and that separate male and female day rooms should be provided[48], and to the NHS requirements*.

NHS trusts are required to monitor all mixing of sleeping accommodation, mixed-sex sharing of bathroom/toilet facilities (including passing through accommodation or toilet/bathroom facilities used by the opposite gender), and all mixed provision of day space in mental health units at a local level (although central reporting has been mandated for mixed-sex accommodation breaches in respect of sleeping accommodation only and, as such, government statistics do not show the many breaches of mixed-sex accommodation in relation to bathroom and dayroom facilities that we see on our visits[49]). Our *Count me in* census data

showed that, in 2010, 16% of women inpatients on psychiatric wards did not have access to single-sex washing and toilet facilities, and 39% had no access to a designated single-sex dayroom.[50] During 2010/11, our MHA Commissioners checked this issue on 1,290 wards and found that 88% of wards were complying with national policy in providing all of the following: single gender sleeping areas, toilets, bathrooms and lounges.

On a visit in February 2011, we raised concerns over the practice of using 'swing beds' within single-sex wards for the emergency accommodation of patients of the opposite sex. Although attempts had been made to segregate these beds so that they have their own lounge and toilet, the swing bed facility on the female ward, which was occupied by a male patient on the day of our visit, was placed between the day room and patient bedrooms used by the female patients. The arrangement seemed an unfortunate compromise of the designation of the ward as being for women only. At the very least, we suggested that, given the vulnerability of the female patients on that ward, where a male patient had to be housed in its swing bed facility due to an emergency admission, it might be better to transfer an existing and more settled patient from the male ward so that the acutely ill male admission could be housed there, and not placed directly onto the women's ward on admission.

Not all threats to the safety and dignity of women patients are attributable to ward layout or infrastructure. The following was from a visit to a ward that had mostly single rooms, and whose accommodation was compliant with the requirements for gender separation:

When asked by the Commissioner about privacy and feeling safe on the unit, a female patient said that she and another woman had been woken that morning by a man who had opened the doors to the women's area, shouting loudly in a sexually abusive and unpleasant manner to and about women. Neither had reported this to staff, not wanting to be seen to cause trouble.

September 2010

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* The commitment to eliminate mixed-sex accommodation can be found in the *2011-12 NHS Operating Framework*, which states "All providers of NHS funded care are expected to eliminate mixed-sex accommodation except where it is in the overall best interest of the patient". A professional letter (Ref: PL/CNO/2010/3) was sent by the Department of Health in November 2010 to update NHS trusts on requirements with regard to recognising, reporting and eliminating breaches of this policy. The policy for mental health units dates back to a letter issued by the National Director for Mental Health in 2007.

In this case, staff members were aware that the male patient concerned could be verbally abusive and was unwell, and had dealt with this appropriately when they were aware he was making other patients uncomfortable. We asked staff to consider ways in which they might be more proactive in preventing unwarranted and frightening intrusions by male patients and, just as importantly, in encouraging patients to report such incidents. We also asked the ward to reconsider its arrangements for a women-only day area, which was used by male patients unless and until a member of staff asked them to leave. In our view this could prove a barrier to women using the space as it was intended, perhaps again because of 'not wanting to be seen to cause trouble'.

Staffing

During this year we have raised concerns in a number of hospitals over reductions in staffing. Such reductions may compromise the safety and quality of care. In a visit to an 18-bedded forensic ward, for example, we learnt that staffing levels had been reduced from five to three people on night duty, and from five to four people during the daytime. Staff told us that this had led to problems facilitating patients' leave, and had led to an increase in staff sickness.

There are no enforceable standards regarding staffing quotas for inpatient care in England (although they exist in other jurisdictions[51]), and the Department of Health has taken the position that staffing levels are a matter for 'local solutions', reflective of local need and service configuration[52], although guidance for commissioners and providers has also been published to support acute care planning and service redesign.[53] The Centre for Mental Health (under its previous name the Sainsbury Centre) published some advisory guidelines in 2007 on nurse staffing levels.[54]

It is also a condition of registration under the Health and Social Care Act 2008 that hospital providers, as detaining authorities, make sure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed to care for detained patients.[55] In practice, this means that the onus is on

managers to show that they have carried out a needs analysis and risk assessment as the basis for deciding sufficient staffing levels, and that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of the patients at all times.[56]

Most frequently, staffing shortages are experienced by patients through a lack of attention, personalised care and opportunities for therapeutic activities. In February 2011, we visited a learning disability unit where most of the patients were only allowed community leave if accompanied by a qualified member of staff, and in a number of cases leave conditions stipulated that that nurse should be male. Patients saw this as staffing levels preventing them from getting community leave. Where we encounter this, we will usually ask the detaining authority to audit staffing levels and keep an auditable record of actions taken in response to any patient request for leave (within the parameters of that allowed by that patient's responsible clinician), including where the request could not be met for want of escorting staff.

The state of flux in many services – with many service reviews and reorganisations pending in anticipation of budgetary limitations or structural changes under the Health and Social Care Bill – has significant potential for worsening staff situations. In some cases, this has resulted in long delays in dealing with staff vacancies, including for some key medical staff: in one hospital we have been raising our concern at the lack of a dedicated permanent consultant psychiatrist since 2007.

More generally, however, patients' concerns are simply the lack of continuity of care that reliance on agency or bank staff often entails, as in the following example from a service for people with dementia:

…on the female wing on the day of the visit… the doors to part of the wing and to one of the lounges were locked to keep patients in a more restricted area. This was to help the bank staff, who were unfamiliar with the ward, to supervise the patients. The bank staff were not issued with fobs to open the doors, which created

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In one independent medium secure unit, which cares for patients with mental illness and personality disorder, patients reported feeling 'insecure' with agency staff that they did not know. The hospital has, from winter 2010, initiated regular reviews of its use of agency staff with the aim of reducing this to zero usage. This is to be attempted through weekly planning meetings between ward managers, to maximise the use of regular staff across its site, and any agency use having to be justified to the hospital manager. Other services have tackled this through the development of a consistent bank service.

A related problem picked up on a number of visits stems from the redeployment of staff within larger mental health trusts undergoing service retraction or other changes. In some cases, we have found that staff are redeployed to specialist units without having received sufficient retraining. In February 2011, we raised concerns about a lack of training around communication on a unit caring for people with autism, where some members of staff who had been redeployed there from elsewhere in the trust responsible for the unit had received little or no autism training. The trust responded with an assurance that training would be given.

Some services are trying to address questions of staff and patient interaction in imaginative ways. On a visit to a unit in a London NHS trust, we commended a patient-led 'staff activity monitoring project' which showed a healthy collaboration between patients and ward staff and some learning on both sides as a result. Patients said they were surprised that staff spent more time with them than they expected. Likewise, staff were reminded of the impact on patients of being subject to high levels of observations, as well as the impact on

staff of having to observe patients as part of their nursing role. This was a good example of putting into action the Code of Practice principle regarding participation and respect, and we suggested to the trust that it should disseminate the results of this research broadly and enable other organisations to consider similar patient-led research.

A further concern raised on visits related to the adoption of long shifts of 12 or 13 hours for nursing staff. Some patients have told to us that they liked the continuity of having the same staff members all through the day, but that staff appeared to have even less time to interact with them under these arrangements, particularly due to having to take more rest breaks or cover the rest breaks of others.

Thirteen-hour shifts are particularly mentally and physically demanding on staff and, where they are in use, we will be vigilant on our visits as to any effect on the standard of care for patients. At the time of writing, at least one trust was looking at the cost implications of returning to the older shift pattern of three shifts a day following concerns raised by patients and by MHA Commissioners about the impact on the quality of patient care of the 13-hour shifts.

Administrative posts are vulnerable as trust boards look for budgetary savings, and in many hospitals we have been told by Mental Health Act Administrators that their posts are under review or in danger of being cut. In many detaining authorities, the Mental Health Act Administrator performs a key role in ensuring the timeliness and legality of renewals of detention or community treatment orders; the lawful operation of the consent to treatment provisions of the Act; the effective discharge of hospital managers' duties in relation, for example, to the provision of information to patients and facilitating appeals against detention; and a source of advice and expertise to clinical staff on the complexities of the Act itself. Mistakes or maladministration in these areas are serious matters both in relation to detaining authorities' legal and human rights practice, and for the avoidance of potentially high legal costs through involvement in judicial review or claims for unlawful detention or treatment.

Absence without leave

From 2010, detaining authorities have been required by statutory regulation to notify CQC without delay of any absence without leave of any person detained or liable to be detained[*] under the Mental Health Act.[57] This reporting period is therefore the first for which we can report on this data.

It is important to take the results below in the correct context. A high proportion of absences without leave are merely because the patient has come back late from a spell of authorised leave, or has wanted to stay longer with their family than has originally been authorised. However, detention under the Act has to be justified on the grounds of necessity for the health or safety of the patient concerned, or for the safety of others, the latter being by far the least common. Although many detained patients are not at any immediate risk of suicide or self-harm, a quarter of all inpatient suicides have occurred when people have gone missing from the ward. Failure to take adequate measures to keep a detained patient safe from fatal harm is potentially a breach of Article 2 of the European Convention on Human Rights.

We ask services that are designated as low, medium or high security, or Psychiatric Intensive Care Units (PICUs), to notify CQC of all incidences of absence without leave. There are different reporting requirements depending on the security level of a service: services that are designated as low, medium or high security, or Psychiatric Intensive Care Units (PICUs), are required to notify us of all incidences of absence without authorised leave; services designated as 'general' security level (i.e. all services other than those listed above) are required to notify us of any incidence of absence without authorised leave when that absence occurs over midnight on any day.

Over 2010/11, we were informed of 4,321 incidences of absence without leave. Two-thirds of these (2,908) were from hospitals of no specified security level. The type of absence in the remaining third are shown in **TABLE 11**.[†] These are categorised either as an absence directly from hospital (sometimes referred to as an 'abscond' in government publications); as an absence from escorted leave; or as a failure to return from authorised unescorted leave.

The latter category is the most numerous overall, and accounts for roughly half of absences without leave in the low and medium secure sector. This is as we would expect, and such figures may, for example, just reflect patients returning late from authorised day leave, or staying longer with families during home leave than had been originally authorised by their responsible clinician. It would be a mistake to view all such incidences as in some way reflecting poorly on the detaining authority involved, or indeed to draw any generalised conclusion from them: it is in the nature of positive risk taking that boundaries may, at times, be overstepped. We do, however, monitor trends in absence without leave and have followed up with particular providers in relation to specific incidents or patterns of absences.

There is no regulatory requirement that services notify CQC of the return of a patient who has been absent, but we have asked authorities to inform us of the return of a patient who has been absent without leave of the end of an incident to inform our monitoring. Around 80% of providers that have notified us of absences without leave have also notified us when a patient has returned. As **TABLE 12** highlights, the burden on police services of returning these patients to hospital places is considerable: we have recorded 1,616 instances of the police returning absent patients, or 37% of all known incidents. The next largest category in our outcomes is that the patient returns to hospital voluntarily: this accounts for 31% of all outcomes. These cases will include, in the secure sectors, those patients who are late returning from authorised leave.

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* People liable to be detained include, for example, those on Section 17 leave of absence from hospital, or those held under short-term powers of Sections 5, 135 or 136.

† The data does not include the single incidence of absence without leave relating to a high security hospital patient reported in 2010/11. The patient absconded from his escorts while on leave, but was returned within 10 minutes with the help of police.

TABLE 11

Incidences of absence without leave reported to CQC, by type of absence, 2010/11

Type of absence	Medium secure unit		Low secure unit		PICU	
	Number	%	Number	%	Number	%
From hospital	39	17%	246	29%	96	28%
From escorted leave	82	35%	127	15%	127	37%
Failed to return from leave	112	48%	465	55%	118	35%
Total	233	100%	838	100%	341	100%

Data source: CQC

TABLE 12

Incidences of absence without leave reported to CQC, by method of return, 2010/11

Method of return	Medium secure unit		Low secure unit		PICU		General	
	Number	%	Number	%	Number	%	Number	%
By police	85	36%	284	34%	144	42%	1,105	38%
By hospital staff	33	14%	110	13%	16	5%	175	6%
By relatives	8	3%	32	4%	14	4%	108	4%
Of own accord	64	27%	281	34%	89	26%	893	31%
Other/not stated	43	19%	131	16%	78	23%	627	22%
Total	233	100%	838	100%	341	100%	2,908	100%

Data source: CQC

Note: Because of rounding, percentages do not all add up to 100.

It is important that providers monitor and review absences without leave to understand why patients go absent and to help develop strategies to address identified issues. For example, research has indicated that a nursing intervention targeting patients at high risk of absconding can reduce it by 25% and that a high quality physical environment, including secure access to fresh air, reduces the risk of absconding by 12%.[58] In 2009, the National Mental Health Development Unit published a practical workbook, including advice and positive practice examples to help to reduce the numbers of people who go missing.[59]

This year, we have been in discussion with the Department of Health about whether the absence without leave reporting requirement for general security wards might be lifted, because of the level of burden that the introduction of this notification has caused and because NHS providers of most specialist adult mental health services are already required to complete information about unauthorised absence in the mental health minimum data set (MHMDS) which could offer an alternative means of monitoring this issue for these wards. This possible amendment was included in the Department's consultation on proposed changes to Care Quality Commission registration regulations, along with a proposal to require providers to notify us when absent patients have returned. The outcome of the consultation is likely to be known in early 2012.

3.5 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. This may involve revisiting the detaining hospital; writing for information; or attending an inquest, sometimes with official recognition as a 'properly interested person' enabled to ask questions of witnesses.[60]

This chapter is based on data and follow-up activity in the calendar years 2009 and 2010. These findings are presented so as to be broadly comparable with previously published data.[61]

Key findings

- We were notified of 294 deaths of detained patients in 2009, and 283 in 2010; 75% of these were ascribed to natural causes.

- About a third of patients who died of natural causes did so before their 61st birthday, which supports findings of reduced life expectancy among people with long-term serious mental disorder.

- Most of the 115 deaths in 2009 and 2010 attributed to 'unnatural causes' were due to suicide or self-harm.

- We continue to identify potential ligature points in hospital environments as safety issues.

- We were surprised to find examples of risk assessments not being reviewed following incidents such as absconding; breaches of leave parameters; physical violence; or where a patient expressed suicidal ideas or intentions to self-harm.

- One common risk assessment failure is that patients who receive bad news are not adequately supported by staff.

Policy background

In March 2011, the Government announced its intention to bring into force the 'custody provisions' of section 2(1)(d) of the Corporate Manslaughter and Corporate Homicide Act 2007. Hospitals that detain patients under the Mental Health Act are already liable as **hospitals** to charges of corporate manslaughter, where their management of the organisation, coupled with a gross breach of a relevant duty of care (such as a duty of clinical care), leads to the death of a detainee. The coming into force of the custody provisions in the Corporate Manslaughter Act can be viewed to extend its scope to **all** duties implied by detention, which are potentially wider than those that are concerned with medical treatment and care.

While it is appropriate that the state, in removing a person's liberty for the purposes of health and safety, should be held to account for its actions in doing so, we should beware of instilling a culture in psychiatric services that is solely concerned with the avoidance of risk. Our first annual report and the reports of our predecessor organisation have highlighted dangers of institutionalisation resulting from risk-averse practice.[62]

This is not to say that the reduction of risk is not a legitimate concern in mental health services, or that there are no lessons to be learned and preventative measures to take following inpatient suicides. But it is to point to a tension between proving asylum and promoting recovery that may help services achieve a workable balance of safety and appropriate risk-taking. One of the Royal College of Psychiatrists' 10 suggested standards for adult inpatient wards is a "proportionate and respectful approach to risk and safety" for which "a balance is required: the ward culture should not be unduly risk averse as recovery requires a careful level of risk taking".[63]

In the past financial year, CQC has been represented on, and worked alongside, the Independent Advisory Panel (IAP) 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 and been happy to make data available for its use. We discuss some of this data below.

In March 2009, following recommendations by Lord Darzi, the National Patient Safety Agency (NPSA) introduced a 'Never Events Policy'.[64] 'Never events' are serious patient safety incidents that should not occur if preventative measures have been put in place. Of the eight core 'never events' identified by the NPSA, the two that are particularly relevant to mental health units are:

- Incidents of suicide using non-collapsible curtain or shower rails by an inpatient in an acute mental health setting.
- Any patient who is a transferred prisoner escaping from medium or high secure mental health services where they have been placed for treatment on a Home Office restriction order.

We discuss the question of absence without leave in the previous chapter, and suicide from ligature points in this chapter. The NPSA's toolkit for preventing suicide provides methods for establishing systems for local audit, developing local suicide prevention strategies, and identifying risks and trends for further learning (see www.nrls.npsa.nhs.uk/resources). Following its review of arm's length bodies in July 2010, the Government has announced its intention to abolish the NPSA by summer 2012, with elements of its patient safety work incorporated into the new NHS Commissioning Board. We are aware that discussions continue over the scope and detail of these responsibilities.

Our own monitoring of the use of the Mental Health Act will strive to maintain the momentum in addressing patient safety on wards during this period of uncertainty and transition. As discussed below, for example, MHA Commissioners continue to identify ligature points in inpatient environments and seek to have these risks addressed.

Overview of deaths of detained patients in 2009 and 2010

We were notified of 294 deaths of detained patients in 2009, and of 283 such deaths in 2010. The majority of these deaths (75% of all reported deaths) were ascribed to natural causes. The numbers are shown at **TABLE 13** below.

In a review of data collected between 1 January 1999 and 31 December 2009, instigated by the IAP to the Ministerial Board on Deaths in Custody and analysed by the Department of Health Offender Health team, deaths of patients detained under the Mental Health Act accounted for a majority (62%) of all deaths in state custody. Overall, 78% of deaths of patients detained under the Mental Health Act were due to natural causes.

Deaths by natural causes

The age range of detained patients who died from natural causes is shown at **FIGURE 7** below. About a third (32%) of patients who died of natural causes did so before their 61st birthday. This appears to support findings of reduced life expectancy among people with long-term serious mental disorder, which has been attributed to a combination of factors including multiple social disadvantage, long-term antipsychotic medicine use and higher-risk lifestyles, particularly smoking.[65] Dr Rob Stewart, of the King's Biomedical Research Centre for Mental Health, has commented that:

Most of the differences in survival [due to the impact of mental health conditions] will be related to 'natural' outcomes such as heart attack, stroke and cancer, rather than deaths from suicide or violence. We need to improve the general health of people suffering from mental disorders by making sure they have access to healthcare of the same standard, quality and range as other people, and by developing effective screening programmes.[66]

TABLE 13

Reported deaths of detained patients by natural or unnatural causes, 2009 and 2010

	2009		2010		
	Male	**Female**	**Male**	**Female**	**Total**
Natural causes	126	100	126	81	433
Unnatural causes	34	11	23	20	88
Cause unknown	14	9	21	12	56
Total	**174**	**120**	**170**	**113**	**577**

Data source: CQC

It is a continuing concern that people who suffer from serious mental disorder may, for a number of reasons, have reduced access to physical healthcare (including when they are detained in psychiatric facilities). Carrying out physical health checks is important if the Government's ambition is to be realised to reduce the numbers of people with mental health problems who die prematurely.[67]

Even though restricted patients are likely to spend longer periods of time detained in hospital, there was no notable difference in the patterns of age at time of death in this group compared to the whole.

In the study of data held by CQC, the Department of Health Offender Health team looked at the most frequent causes of the 1,671 'natural' deaths of detained patients between mid-2003 and 2009. These are set out at **TABLE 14** below.

Ninety-four of the deaths listed in table 14 involved patients who were between 15 and 39 years of age. This number of deaths was likely to be significantly higher than would be expected for their counterparts in the community, although there is no single comparator that would substantiate that claim unequivocally. Nevertheless, it was noted that the most common causes of death in this age group (12 by myocardial infarction and 11 by pulmonary embolism) were unusual for people younger than 40 years of age. There were also seven deaths from pneumonia.

FIGURE 7

Age at death by natural causes, 2009 and 2010
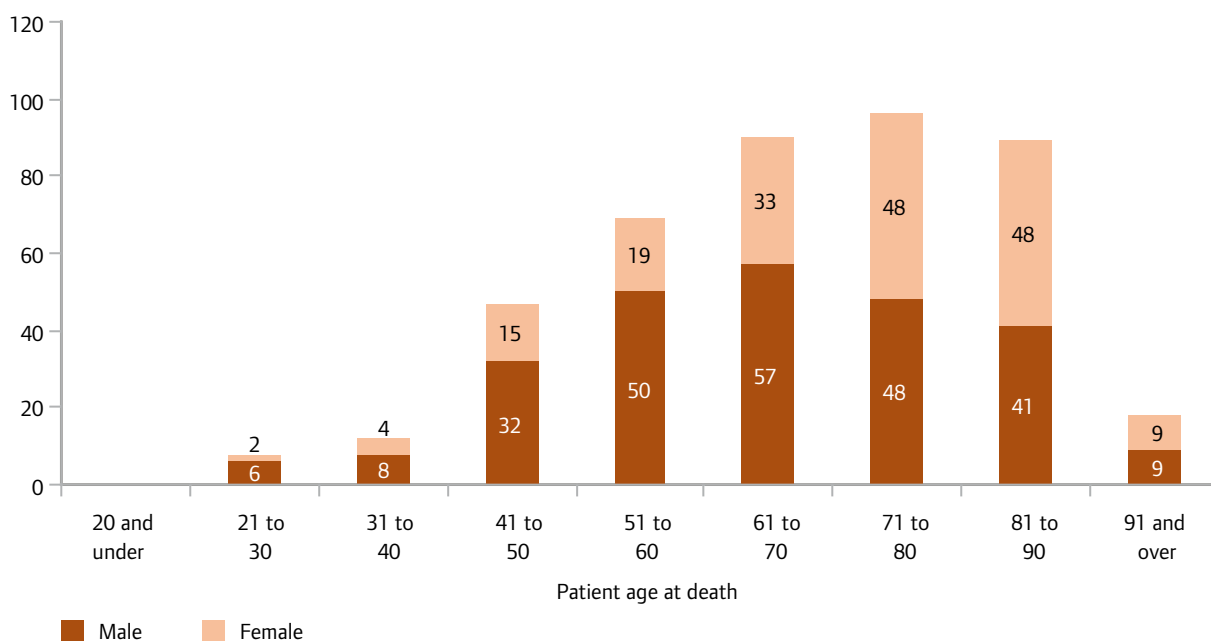
Note: Information about the patient's age was missing for four patients.

Data source: CQC

TABLE 14

Deaths of detained patients, natural causes,
mid-2003 to 2009

Pneumonia	381	22.8
Myocardial infarction	333	19.9
Pulmonary embolism	125	7.5
Sepsis	66	3.9
Chronic obstructive pulmonary disease	63	3.8
Stroke	62	3.7
Dementia/Alzheimer's	57	3.4
Arrythmia/cardiac arrest	42	2.5
Heart failure	42	2.5
Aspiration pneumonia	39	2.3
Other conditions	*	*
Total	**1,671**	**100**

Data source: CQC/MHAC

It is possible that one factor in some 'natural' deaths, whether unusually premature or otherwise, is the side-effects of psychiatric medicine. A study of users of relatively low-dose antipsychotic medicine in primary care has found an increased risk in venous thromboembolism associated with that use[68]; and a Finnish study has shown a potential link between unwanted physical effects of antipsychotic medicine (e.g. aspiration and ileus) that increase vulnerability to pneumonia.[69] Smoking has also been identified as responsible for the largest proportion of health inequality in people with mental health problems, so access to support to quit smoking is also important, particularly as people with mental health problems are less likely to be offered this.[70]

TABLE 15

Possibly avoidable deaths of detained patients from medical or surgical emergencies, mid-2003 to 2009

Cause of death	Number	% of all deaths by natural causes
Digestive bleed/bleed secondary to gastro-intestinal ulcer	32	1.9
Perforated viscus (gut)	31	1.9
Digestive obstruction	14	0.8
Abdominal aortic aneurysm, thoracic aortic aneurysm	11	0.7
Ischaemic gut	8	0.5
Peritonitis	*	0.2
Diabetic emergencies (hyper-osmolar non-keotic coma, diabetic ketoacidosis)	*	0.2
Choking/respiratory arrest	*	0.1
Ischaemic limb	*	0.1
Total	**106**	**6%**

Data source: CQC/MHAC

The researchers also noted an average of 15 deaths per year that were due to medical or surgical emergencies, and as such potentially avoidable. These are categorised at **TABLE 15**, with small numbers suppressed. This data suggests that such medical emergencies may go unrecognised in psychiatric settings, so that transfer to general acute hospital is delayed or not undertaken. It is therefore important that staff caring for detained patients are trained to recognise such emergencies and expected to call an ambulance for transfer when they do so.

In this reporting period we attended the inquest on the death of a young male patient, which was the result of a massive pulmonary embolism caused through deep vein thrombosis. The case is instructive, not only as an example of the dangers in not attending to physical healthcare risks, but also in the way in which placement of patients in inappropriate levels of security can be counter-productive to their recovery. The patient had broken an ankle in climbing out of a first floor domestic window in the first presentation of a paranoid state (he had, at the time, been referred by his GP to psychological services for an assessment, but due to ensuing events this did not take place). While on a surgical ward, he had climbed from a window onto a flat roof and had to be coaxed back by staff. With the injured ankle having been placed in a cast, he was transferred under section 2 to a secure psychiatric ward.

We have no doubt that the secure ward was an inappropriate placement and was recognised as such at the time: an attempt to transfer him to an open ward was only thwarted when the available bed there was taken at short notice by another patient. The placement was detrimental to his mental and physical health: he was disturbed and made more nervous by the behaviour of the other patients on the ward, and he was not allowed to have crutches or, after he had retired to bed at night, his wheelchair, for reasons of security. These physical aids would have been allowed on a ward of lesser security. As a result he became increasingly anxious and immobile. He was found dead 12 days after admission to the ward, in his bed. The detaining authority have since implemented an action plan involving the recruitment of a physical healthcare lead and staff training, including training over the screening and management of venous thromboembolism, which recognises both antipsychotic prescription and reduction in mobility as risk factors.

The research findings discussed above, for which we are grateful to the researchers from the Department of Health Offender Health team, were discussed at a meeting with the Ministerial Board on Deaths in Custody in March 2011. We are in further discussion with the Department of Health and the Ministerial Board over how we might further address the questions raised by these findings in our monitoring and regulation work.

Deaths by unnatural causes

Of the 115 deaths in 2009 and 2010 attributed to 'unnatural causes', most were due to suicide or self-harm, although it is not always possible to tell, even at inquest, whether the patient intended suicide in taking the action that led to their death. A very small proportion of inquests (about 1% of inquest verdicts recorded over the two years) were explicit in recording a verdict of accident/suicide, and a further 1% recognised the death concerned to be simply an accident. However, in many further cases inquest verdicts are given in narrative form, leaving aside the question of whether the death was deliberately self-inflicted.

Over the financial years 2009/10 and 2010/2011, we attended 120 inquests into the deaths of detained patients, usually having been recognised by the coroner as having a proper interest in the inquest proceedings, and thus enabled to ask questions of witnesses.

The methods of unnatural deaths of detained patients since the year 2000 are set out at **TABLE 16**. Overall, 44% of unnatural patient deaths resulted from hanging or self-strangulation, where the former implies suspension (usually resulting in a fractured vertebrae) and the latter involves compression of the airway using any tourniquet or ligature point (although it is likely in practice that there is some blurring of these two categories in our data).

TABLE 16

Methods (where known) of unnatural deaths, detained patients, 2000 to 2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total	Total %
Hanging	22	25	17	24	26	27	18	20	15	13	14	**221**	**39%**
Self strangulation	1	2	1	1	1	2	1	4	4	5	4	**26**	**5%**
Self suffocation	7	3	3	-	2	3	-	5	3	2	2	**30**	**5%**
Jumping/falling (including railways)	17	20	11	14	8	12	34	19	20	8	8	**171**	**30%**
Self poisoning by medicine/alcohol overdose	6	4	6	3	1	1	7	11	8	5	5	**57**	**10%**
Drowning	2	6	2	1	1	9	2	1	-	2	4	**30**	**5%**
Fire	2	-	2	1	2	1	2	-	-	-	1	**11**	**2%**
Hosepipe to car exhaust	-	2	-	-	1	-	-	-	1	-	-	**4**	**1%**
Iatrogenic	1	-	-	2	1	2	-	1	-	4	-	**11**	**2%**
Caused by another person	2	-	1	-	1	-	1	-	-	-	-	**5**	**1%**
Total	**60**	**62**	**43**	**46**	**44**	**57**	**65**	**61**	**51**	**39**	**38**	**566**	**100%**

Data source: CQC/MHAC

Note: Data includes unnatural deaths in Wales prior to 2009

Ligature points

The NPSA has recognised the need to address potential ligature points created by non-collapsible curtain or bathroom rails, and describes suicide using such a ligature point as an event that need never happen. We continue to identify potential ligature points in hospital environments as safety issues:

Door closers have been put on the dormitory doors. This makes them hard to open, as well as presenting a possible ligature point. The curtain rails on the …dormitories are not collapsible.

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We recognise that it is not always possible to remove all ligature points. This is a complex area and 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.

Nevertheless, the design elements of some purpose-built units seem to have paid insufficient attention to ligature risks, as in the following example.

A patient in a Psychiatric Intensive Care Unit fenced courtyard area died of self-inflicted injuries using hinges to a gate as a ligature. The unit managers replaced the ordinary hinges with a 'piano hinge' (which runs continuously down the length of a gate or door). The visiting MHA Commissioner pointed out that the fencing, of which the gate was a part, nevertheless constituted a ligature risk, being made of spaced vertical slats along a horizontal rail, and that

drainpipes which were covered by a rigid mesh wire also created potential ligature points. The managers accepted that there were many ligature points in the external areas to the unit, but suggested that as the area was designed for a PICU environment, clients should be fully observed at all times when in these areas, therefore mitigating the risk. They also accepted that this did not happen in the case of the fatal incident, but assured us that subsequent to that they had ensured that patients using the fenced courtyard area were supervised at all times.

It is not always possible to address the risks posed by the structure of units through closer observation of patients. In one example, a patient was fatally harmed having used as a ligature a shoelace anchored to a bedroom sink tap. We challenged the hospital's response to its own internal investigation, which did not seek to replace the taps with a more suitable design, and pointed out that the risk would remain as it was without constant observation of all patients' rooms.
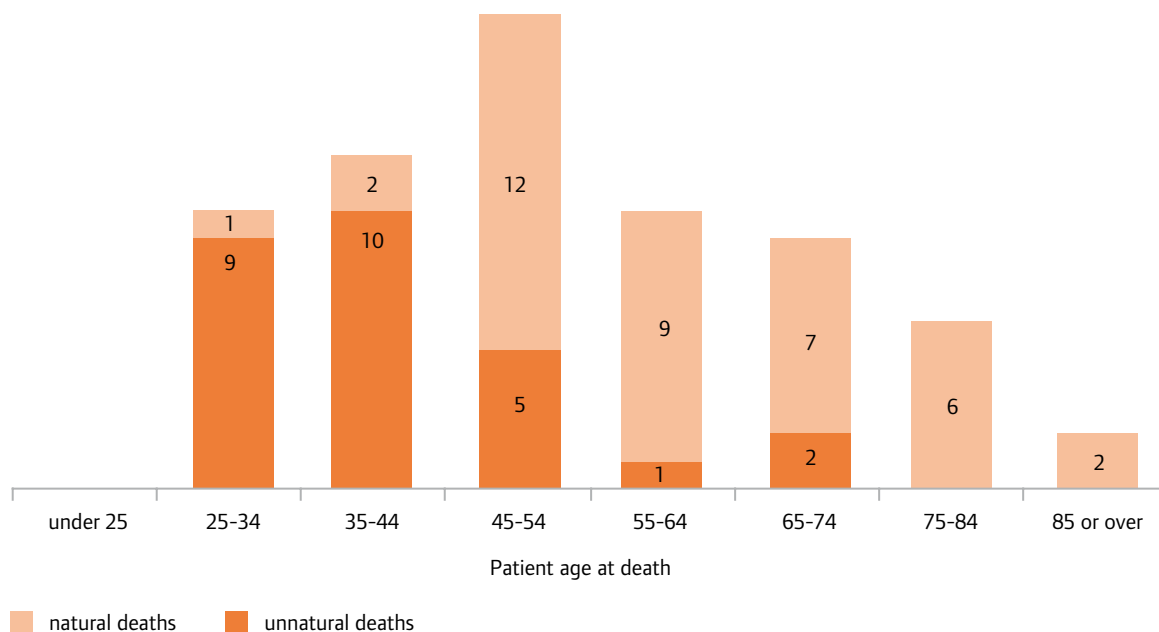
Deaths of CTO patients

FIGURE 8 shows the ages of 66 patients subject to CTO whose death was notified to CQC in 2009 and 2010. In contrast to the position with detained patients, there is no explicit regulatory requirement on services to notify CQC of the death of a patient who is subject to CTO, but we ask for such notifications under our general monitoring remit. As such, it may be the case that this data represents an incomplete picture of fatalities among CTO patients during this time.

Although the numbers of deaths are insufficient for statistical analysis, they do seem to conform to the general patterns shown for detained patients. Unnatural deaths of patients (largely through suicide or self-harm) are less prevalent in the older CTO population, whereas deaths deemed to be from natural causes are rare in the younger age group, although they start to be prevalent at a worryingly early age. The proportion of older people among CTO patients is probably less than that among detained patients, probably because many of the conditions for which the Act might be used in relation to older people frequently need hospital care, or need hospital care in their later stages.

FIGURE 8

CTO patients, age at death by natural and unnatural causes, 2009 and 2010

natural deaths   unnatural deaths

Data source: CQC

The cause of the 27 reported unnatural deaths is given at **TABLE 17**.

CTO patients, cause of unnatural death, 2009 to 2010

	2009	2010	Total
Hanging	5	2	7
Jumped before train	-	2	2
Jumped before road vehicle	1	-	1
Jumped from height	2	3	5
Self poisoning by medicine/alcohol overdose	1	-	1
Drowning	-	1	1
Unsure/accident	2	-	2
Accident	1	-	1
Method unclear/awaiting information	2	5	7
Total	**14**	**13**	**27**

Data source: CQC

Risk assessments

We have been surprised to find examples where risk assessments were not reviewed following incidents such as absconding; breaches of leave parameters; physical violence; or where a patient expressed suicidal ideas or intentions to self-harm. In some cases, we could find no evidence of observation levels having been reviewed, despite several untoward incidents prior to a patient's death.

In one of these, a young man was known to be upset that staff were considering his further detention under section 3 following admission under section 2, fearing that he might never leave hospital. He had expressed suicidal ideas (while also, paradoxically, talking about wanting to go home to redecorate, although it is not uncommon that patients present a heightened suicide risk as they begin to feel better). Staff observation levels were not reviewed on the day that the section 3 application was being

considered, and he absconded to take his own life. He had absconded over the same low garden wall on three previous occasions. After his death, the hospital raised the height of the wall.

Patient counselling and support

One failure in risk assessment common to a number of cases in recent years is that patients who receive bad news, whether to do with their personal life outside hospital or their progress through the hospital system, are not adequately supported by staff, and/or staff do not reconsider their assessment of risk in relation to the patient after the patient hears bad news. Examples include patients hearing on ward rounds that they were to be refused leave; that their detention was being extended; that their transfer was delayed; or, in one case, that their prescribing doctor wanted to impose a 'medicine holiday' in relation to anxiolytic medicine, when the patient wanted the dosage increased.

It is in the nature of detention under the Act that many patients will have to be told things that they do not like, or have their wishes overruled, however much patients are involved and included in decision-making about their care. It is vital that in such circumstances patients receive support from staff and that a fresh assessment of risk is undertaken, and that this is attended to at critical points of patients' detention, such as renewals, unsuccessful appeals, or when explaining the outcome of a Second Opinion Appointed Doctor visit, even where the patient shows no obvious signs of distress.

In many hospitals, staff can now expect some counselling as a part of post-incident reviews following patient suicides or other serious untoward incidents. Such counselling is not always available for patients who may be affected by such incidents, whether as onlookers or as friends of the person concerned. It should be a basic expectation that any patient who is involved in any way with a patient who dies or is otherwise involved in a serious untoward incident should be offered counselling as a matter of course.

Communication

We have noted cases where staff have failed to record or report events that should have informed risk assessments. For example, one patient who subsequently committed suicide breached a condition of his first unescorted leave from the ward by drinking alcohol while out. This was not raised as an issue when he requested further unescorted leave the next morning, and no reference back to his responsible clinician was made. We also noted a failure in this case to consider safeguarding procedures, either to deal with the patient's own feelings of being unsafe on the ward, or (given that unescorted leave was being granted) in relation to his threats to harm a member of his family.

Observation levels

Often patients know how frequently they are being observed, and this can undermine the usefulness of observation. In one case, a patient who hanged herself in hospital knew that she had an hour between observations in which

to act. Her family had informed staff that her behaviour was similar to that prior to previous incidents of self-harm, but no record was made of this discussion in her notes, and there were no individual risk plans for patients regarding ligature risks until steps could be taken to remove these from the environment.

Self-harming and risk assessment

Some patients present with self-harming behaviour that can be difficult to differentiate from high risk, suicidal self-harm. We have noted examples where female patients diagnosed with personality disorder have been cared for on acute wards, and staff have struggled to deal with their self-harming behaviour, in part because of the everyday pressures of such a ward, but also for want of training or specialist resources. Such patients may be a great risk of being treated as having 'cried wolf' when exhibiting signs of distress or self-harm. In this period we have noted at least two deaths in which this process had some part to play.

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