Monitoring the Mental Health Act in 2012/13
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Summary

This is CQC’s fourth annual report on our statutory monitoring of the use of the Mental Health Act (MHA).

In 2012/13 people were detained or treated under the MHA more than 50,000 times and community treatment orders were imposed more than 4,600 times. The total number of people who are subject to the MHA has risen by 12% in the last five years, with 17,000 people detained at the end of 2012/13.

The ambition of national policy is to give mental health ‘parity of esteem’ with physical health within the health and social care system. The implementation framework for the Government’s strategy No Health without Mental Health underlines the importance of providing equal access to age appropriate services for everyone. The framework emphasises the interconnected nature of physical and mental health. It focuses on improving outcomes, quality and value for money, and making sure that people who use mental health services, their families and carers, are fully involved in all parts of mental health services, contributing to the goal of “no decision about me, without me”.

In our publication A fresh start for the regulation and inspection of mental health services, we have set out our own aims to strengthen our regulation of mental health services and to integrate our work under the Mental Health Act through our new approach to inspecting and monitoring specialist mental health services.

High on our agenda is the need to promote ‘what good looks like’ in all aspects of care and support for detained patients. Our new approach to inspection will focus on identifying good practice, challenging poor practice wherever we find it and promoting continued improvement in people’s experience of services.

Feedback from our MHA visits offers positive examples of outstanding care delivery and a true commitment to advancing services and providing humane psychiatric care. These are the stories we want to capture and promote. Through the success of others we want to help leaders, at all levels, to build an understanding of how practice can be changed for the benefit of people in need of mental health care and treatment. We welcome and support initiatives that promote positive practice and will be seeking examples of sustained, high-quality and safe care that has found practical solutions to the themes we report.

However, we also continue to receive reports of significant concern about the experience of people subject to the MHA. Our monitoring visits offer us a unique opportunity to identify issues and work collaboratively to improve the quality and safety of care.

CQC visits to detained patients

In 2012/13, we carried out 1,502 MHA visits which were specific to our duty to keep under review the operation of the Act. We met with 4,478 patients, most of whom were detained in psychiatric hospitals. These visits are different to, but coordinated with, our inspection programme. We also made 16 visits to meet people who were subject to community treatment orders after discharge from detention.

We made 21 visits to focus specifically on admission and assessment processes under the Act – this involves meeting local authority social workers, the police, ambulance services and other agencies. We visited 32 wards specifically to examine seclusion practices, and four wards to review procedures for administering electro-
convulsive therapy. We also visited 21 non-psychiatric hospitals (mostly A&E departments). We arranged 13,520 visits by Second Opinion Appointed Doctors (SOADs). Their authorisation is needed for certain treatments for mental disorder to be given without a patient’s consent. This was the heaviest demand for second opinions to date.

After every visit we write a summary report and share this with the relevant agencies. If we have any concerns, we require a response and action plan from the detaining authority. Our specialist MHA visitors and inspector colleagues increasingly work and visit together, and we can use our full range of CQC powers under the Health and Social Care Act to bring about improvement.

What we found

Our findings on the experience of people detained under the MHA are in the context of a system where:

- The number of people subject to the MHA continues to rise.
- There are nationally recognised problems with access to care during a mental health crisis. There is evidence that pressure on services continues to obstruct timely access to less restrictive crisis treatment. Service commissioners in local authorities and clinical commissioning groups need to give a higher priority to translating local needs assessments into evidence-based commissioning of services.

Against this backdrop, we continue to strive to make sure that dignity, respect and involvement are the primary focus of all those involved in the care of people affected by the MHA.

Our key findings:

- On almost all wards, patients had access to independent advocacy services. This is a considerable improvement.
- We saw improvements in helping patients draw up advance statements of their preferences for care and treatment.
- But more than a quarter (27%) of care plans showed no evidence of patients being involved in creating them. More than a fifth (22%) showed no evidence of patients’ views being taken into account. This is no improvement on the previous year, and is unacceptable. Services who do not demonstrate good practice in this area should learn from areas who are demonstrating that it is possible to deliver best practice.
- We continue to see widespread use of blanket rules including access to the internet, outside areas, room access, and rigid visiting times. Some type of blanket rule was in place in more than three quarters of the wards we visited. Such practices have no basis in law or national guidance on good practice and are unacceptable.
- We continue to hear accounts of patients’ experiences of being restrained. In this report we promote examples of good practice where providers of inpatient mental health services have taken positive steps to reduce the use of restraint.
- Health-based places of safety, for people experiencing a mental health crisis, are often not staffed at all times. Some have lain empty while a patient has been taken to police custody.
- Only 17% of recorded uses of hospital-based places of safety under section 136 resulted in further detention, following assessment by mental health professionals.
- Carers have told us they are not always provided with enough information on how to get help in a crisis.
- In one area police told us that 41 young people had been detained in police cells over the previous year; the youngest was 11. This is unacceptable.
- In 2011/12 and 2012/13 we were notified of 595 deaths of people subject to the Act. There were 511 deaths of detained patients, and 84 deaths of patients subject to CTOs. The majority of deaths reported to us were natural causes with a third of those taking place before the person reached the age of 60. Attendance to the physical health needs of
people with mental illness must be a priority for all services. We will be working with partner organisations to review national data on all deaths and how this can be combined and shared to improve scrutiny and embed learning.

Conclusions and next steps

There are clear, recurring themes that come out of our findings. All parts of the health and care system need to work together to make the changes that are urgently needed and, in most cases, required as a minimum by the Mental Health Act and the accompanying Code of Practice.

We expect to see change in the following areas:

1. Services and hospitals must ensure their values, policies and practices promote the principle of least restriction and that all staff are supported in using person-centred approaches, promoting dignity and respecting the autonomy of people throughout their care and treatment.

2. Services and hospitals must promote cultures that support therapeutic practices and reduce to a minimum the use of restraint and seclusion. The principles of the Code of Practice and the emerging national evidence on restraint need to be considered by all services. We expect detaining authorities to audit and review their local practices to minimise the use of restraint and seclusion. We also expect to see evidence of coordinated care planning that allows people’s preferences to be taken into account and collaborative working to promote individual involvement in avoiding or managing episodes that may result in restraint or seclusion.

3. NHS and local authority service commissioners of mental health services must act on these findings and on guidance in the Implementation Framework to the national mental health outcomes strategy to improve access to services and outcomes for people with mental health problems. We expect Clinical Commissioning Groups to ensure that local special urgency arrangements (section 140) are clear and provided to local authorities.

4. Commissioners and providers of mental health services must be proactive in initiating and embedding learning from the deaths of people subject to the MHA. We expect to see alignment of local preventative and investigative work with the national findings on mental health related deaths. This includes emerging guidance from national bodies and the use of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness toolkit. We expect services to notify us of deaths of detained patients and patients who are on a community treatment order at the time of their death.

What CQC will do:

We have identified five key areas of action for CQC. These are in line with and complement our strategic intentions.

- Use of the Mental Health Act
  It should be a source of considerable concern to the health and social care system in this country that use of the MHA continues to rise – despite the objectives of the national mental health policy and the investments in community services of recent years. People should have access to the right services at the right time and for the right reasons with detention never being the consequence of local system failures in facilitation of timely and appropriate access to care. Under our new integrated approach to inspection we will place a much stronger emphasis on community services and on our understanding of people’s experiences of accessing appropriate mental health care in a crisis.

- Deaths of detained patients
  People in the care of specialist mental health services are a high risk group for suicide and unidentified, poorly treated or preventable physical ill-health. We are concerned about how services respond to, review and report
on deaths, so we are committing to include the information we hold on deaths in psychiatric detention in all future annual reports. We will work with partners, including NHS England and the National Confidential Inquiry into suicide and homicide by people with mental illness, to look at how we can do this in a way that offers better intelligence and opportunities for shared learning and preventative action.

**Access to care during a mental health crisis**

Our reports have consistently reported issues about the availability and responsiveness of services when people are in mental health crisis. This report has noted several significant pieces of national work that are aimed at improving this area and ensuring that parity of esteem becomes a reality.

CQC will work with key partners in developing the Mental Health Crisis Care Concordat. This will focus attention on the issues that have been highlighted around emergency mental health care. CQC has committed to delivering a thematic programme around the experiences and outcomes of people experiencing a mental health crisis, and will take this forward over the course of 2014 with the intention of publishing a national report in the autumn.

**Complaints about the exercise of the powers of the Mental Health Act**

We have a statutory duty to make arrangements to investigate complaints relating to the use of the MHA. We will be looking at how we review the content and trends of these complaints. We will consider the way in which providers address complaints in our new regulatory approaches to complaints in our inspections and assessments of providers. We will be specifically looking at how local services respond to the MHA complaints from detained patients to the CQC and what mechanisms they have in place to make sure they are responded to and reported. Most importantly we will also check what system-wide learning takes place as a result of the themes that emerge from our MHA complaints data.

In next year’s report, we will look at how the voices and experiences of detained patients are heard through the CQC MHA complaints system, and what we may do to improve the way we respond, collate and share that information with the wider system.

**Involving people who use services**

In our new integrated regulatory model, we will increase the voice of people who use services in our understanding of the operation of the MHA. We will spend more time talking to people who are affected by the MHA and working with local Healthwatch, and use this information more to inform our judgements of services. We will continue to ask people with experience of detention to be on our expert panels, and include MHA experts in our inspections and monitoring visits.

Our new inspection reports in 2014 will combine our findings in a single report that covers both service inspection and MHA monitoring. Our aim is to increase public understanding and awareness of the experience of people who are detained.
Introduction
Our activity in monitoring the Mental Health Act

“What an incredible achievement it is that the majority of patients have positive experiences of inpatient care, including those who are there very much against their will and perhaps believing they aren’t even ill (...it is an incredible achievement, along with impressive safety levels and falling suicide rates.) And these are particularly tough times on mental health wards, with service re-organisation, cuts in staffing and resources and patients’ stress levels being greatly exacerbated by the benefits cuts programme.”

Marion Janner, founder of Star Wards¹
The Mental Health Act 1983 (MHA) provides a framework of powers and duties relating to the detention and treatment of psychiatric patients in England. People may meet the criteria for detention and holding powers under the MHA even if they are deemed to have mental capacity sufficient to refuse to consent to admission or treatment: the Act allows such refusal to be overridden.

CQC has a duty under the Act to monitor how services in England exercise their powers and discharge their duties in relation to patients who are detained in hospital, or subject to CTOs or guardianship. The primary purpose is to provide a safeguard for individual patients whose rights are restricted, and to review how legal powers of compulsion are being used.

This is our fourth annual report on our monitoring of the Act. This report does not include information from our inspection of services under the Health and Social Care Act, though all information contained in this report will inform our inspections of the relevant service providers.

The UK ratified the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2009. This requires participating states to prevent torture and other forms of inhuman or degrading treatment through regular visits to places of detention by bodies known as National Preventive Mechanisms (NPM). As the visiting body to places of psychiatric detention in England, CQC is part of the UK’s NPM and our work helps to fulfil the UK’s legal obligations under the Convention.

In 2012/13, we carried out 1,502 visits specific to our duty to keep under review the operation of the Act. Our specialist Mental Health Act visitors met with 4,478 patients, most of whom were detained in psychiatric hospitals. They also spoke with staff and looked at documentation and the places of detention. A small proportion of patients we met with were subject to community treatment orders after discharge from such detention: 16 of our visits over the year were specifically designed to meet with such patients.

During 2012/13 we sought to be flexible in ways of using our specialist expertise in monitoring the Act. We made 21 visits focused exclusively on the admission and assessment processes under the Act, where we met with local authority social workers, the police, ambulance services and other agencies involved.

We visited 32 wards specifically to examine seclusion practices, and four wards to review facilities and procedures for administering electro-convulsive therapy (ECT). We also visited 21 non-psychiatric hospitals (primarily but not exclusively to visit A&E departments), as detentions under the Act do not only take place in psychiatric facilities.

After every visit we write a report summarising our findings, which is shared with the relevant agencies. When we send a report to a detaining authority, we require a response and action plan to address areas of concern we have raised. Our MHA specialists increasingly visit alongside CQC inspector colleagues, and where we find problems we use the full range of CQC powers given to us under the Health and Social Care Act to ensure compliance with national standards of care.

Detainees under the 1983 Act are particularly vulnerable, unable to choose whether to engage or disengage with services and subject to legal powers of coercion which can extend to physical force. No-one reading this report will need reminding of the horrific abuse suffered by patients at Winterbourne View hospital, and many will know of the precedent abuse scandals such as that at Ely Hospital in the late 1960s. While we mainly find hospitals are staffed by people whose motivation is care and who are anxious to ‘do the right thing’ in often complex and contested situations, we are occasionally given a striking demonstration of the imbalances of power between staff and detainees:
Some patients who spoke with us, when raising critical issues, wished to make sure that their identity was protected. We note the look and comment a staff member briefly made when it was made apparent a concerning issue had been raised appropriately with us.

Such experiences are rare, but they always show the continued need and core purpose of a visiting body to places of psychiatric detention. But this should not overshadow the good work undertaken by most care providers, and the great advances towards a more person-centred and humane psychiatric system in recent years. The contribution of initiatives such as Star Wards continues to be significant – through promoting achievable good practice on a day-to-day level, developed and promoted by staff and patients. We anticipate a similar contribution will be made by the Safewards model of feasible interventions to manage conflict and containment. We also welcome and support the initiatives that celebrate national innovation including the work by Breakthrough, a national mental health service user led organisation who have re-established the Positive Practice in Mental Health Awards⁴, to celebrate positive practice and people in mental health services. They are also launching a positive practice community which among other initiatives will be compiling a positive practice/patient journey guide showing positive examples of service from engagement with services to discharge and beyond. Their work is supported by many in the mental health field from both statutory and voluntary services

Working with people who use services

We expect mental health services to give the people who use their services a central voice in the planning and delivery of care and treatment. We involve people in our own work in the following ways:

The Mental Health Service User Reference Panel (SURP) is a panel of 20-30 people who have experience of being detained under the Act who work with us on a regular basis. We ask them for their views on a variety of topics related to our work including strategy, methodology and information for the public. In preparing this report, we met twice with SURP members in a group, and took written evidence and experiences from all members. Their experiences and views are highlighted throughout this report.

Experts by Experience are trained members of the public who help us to carry out inspections. They observe care and speak to people receiving it, and their observations and information is fed into our reports of the service. A report by Peter Jones, an Expert by Experience who visited a regional secure visit on a Mental Health Act monitoring visit, is at page 10.
**Production of this report**

In this report we have collated findings of CQC’s specialist MHA visits, the concerns of people who use services and professional stakeholders, and policy issues that are relevant to psychiatric detention in England. We are most grateful for assistance in this work from our Advisory Group of people with experience of detention under the MHA and external stakeholders. Membership of the group is listed in the appendix.

Last year we set out our clear expectations for change and improvement on three key issues.

We said:

1. **Care planning should have clear statements about how a person is to be helped to recover, and follow guidance set out in the national Care Programme Approach. Plans should focus on individual needs and aspirations, involving patients at all stages so as to reflect their views and individual circumstances.** Care planning should be multidisciplinary. CQC recognises that on occasion treatment and care decisions cannot always reflect what the patient wants. However, within these constraints, every effort should be made by providers to involve people in their own care, treatment and recovery. From a patient’s position there should be “no decision about me, without me”.

2. **Hospitals should continually review their policies, procedures and practice to ensure there are no ‘blanket rules’ that cut across treating each person as an individual with rights to autonomy and dignity.**

3. **Clinical staff must be appropriately trained in assessing and recording whether the patient has mental capacity to make decisions and whether they consent to treatment. Ongoing dialogue with the patient is essential.** This conversation or dialogue should consider what treatment a person prefers and also how a person would like to be treated in the future (advance planning).

We report on progress against these expectations in this year’s report. We also focus on the key topic of access to mental health care during a crisis and report on deaths of patients subject to the Mental Health Act.
A day in the life of an Expert by Experience

Enabling advocacy and involving people who use services

By Peter Jones, Expert by Experience

I have been an Expert by Experience for the past 18 months. I have a long-term, severe and enduring mental health condition, and have been detained under the Mental Health Act numerous times. I manage my mental health with medication and one to one therapy. I am also a trained mental health advocate.

This was a Mental Health Act monitoring visit to Wathwood Regional Secure Unit, a medium secure unit. It was an announced visit, whereby the focus was on the seclusion experience of people detained under the act. The visit involved talking to people who had been secluded, or were in seclusion, and looking at the seclusion environment.

We looked at the care plans that were in place, and ensured the Mental Health Code of Practice was being followed. We also looked at the measures in place to re-integrate people following seclusion into the community of the ward. This was the third seclusion visit we had carried out across this large provider, Nottinghamshire Healthcare NHS Trust.

Meeting the people using the service, staff, and advocate workers

I met with two CQC Mental Health Act Commissioners at 9.30am at the entrance of the unit, where we were greeted by the medical director and general manager. We were taken to a large room where there was already a group waiting, including patients and staff.

I was pleased to find this group included four patients who formed part of the Service User Group. This group meets regularly and holds discussions regarding all aspects of the organisation, so it a good source of information for us on a MHA monitoring visit.

It was also pleasing to see the patients knew the medical director and the general manager, and they greeted them in a friendly manner. I observed there was a shared genuine respect and warmth in the room. It was also impressive that the patients were prepared to share their stories in this group format.

The staff also displayed a great deal of respect for the patients, who were able to provide their information without any interruption. These were often very traumatic accounts, which were very moving.

All of the patients showed great insight into their own illnesses, and although they obviously did not like being secluded, they said that it had been administered well and fairly. They also told us the ‘low stimulation room’ was used in a very positive way; rather than going straight into seclusion, patients were given the chance to let off steam and calm down first.

This was the first time, in many visits, that I had been introduced to a group of patients, and staff and managers, right at the start of the visit. Usually managers like to take some time at the beginning of an inspection to talk about their service. It was also the first time I had been asked to feed back directly to patients. I was very pleased the organisation had taken this approach, and it took the feedback very seriously.

A tour of the facilities

After a brief coffee break, we took a tour of the facility, including a large gym, basketball court, and an indoor heated swimming pool. We also visited an art, woodwork and pottery room, and met patients who were engaged in woodwork activities. Their views were very...
positive about the unit, and chimed with the views expressed in the earlier meeting.

Some of the things being made in the workshop were being sold in the on-site farm shop. The farm shop sold a range of produce, and they went to market to buy local goods they would promote and sell. I met one patient in the shop who was incredibly proud of what he had accomplished. He told me ‘being in this shop had changed my life around’, and ‘I look forward to getting up and coming here’.

**Talking to the advocates**

All of the staff approached the advocates as if they were also members of staff, and were not guarded in their attitude. However, there were two particular complaints raised by the advocates:

1. They had been requesting a new computer for some time, to no avail.
2. The organisation needed to provide patients with free confidential access to the advocacy service, on a 24/7 basis. This was not happening.

Patients also had inadequate access to their personal finances, with the relevant office only opening on a Tuesday morning. When I raised a concern about this, the advocates claimed the manager took my concerns more seriously than when the advocates had raised them. This may have been due to how close they had become to the staff and managers.

The advocates were pleased I was able to raise a number of issues with management, particularly as the more mundane ‘bread and butter’ issues were not always taken seriously. The advocates still felt that this was a very good therapeutic institution though, and patients did recover and get better here.

**Conclusion**

On several of the wards that I visited, patients had commented they really valued the patients’ forum. Even one of the patients who had been very negative in general said how much they liked the commitment the staff and managers had made, which meant this was a meaningful body.

And the final feedback session was further evidence of the organisation’s good practice in involving patients, as I mentioned earlier. It sends a powerful signal to all those at the organisation that the MHA commissioners feed back initial findings to a mixed group of both staff and patients. This reminds us who the most important people are when we are conducting our inspections.

Personally, my concluding thoughts were although there were a few areas where improvement could be made, they were getting the big things right.
1. The use of the Mental Health Act in 2012/13

Key findings

- The number of detentions continued to rise, with the highest number of uses of the Act ever recorded. The national statistics on use of the Act showed a rise in detentions, whether these are at the point of admission to hospital or subsequent to informal admission.
- In 2012/13, 27% of recorded outcomes of section 2 detentions showed that the patient continued to be detained. This is a small but significant rising trend from the 24% in the previous year.
- Since the introduction of community treatment orders (CTOs) in 2008, the power had been used 18,942 times by 31 March 2013.
- Data available for 2012/13, as in previous years, showed a continuing trend in high rates of detention among certain black and minority ethnic groups.
- Data on self-harm, restraint, assaults and seclusion, which were previously collected for inpatients in the Count Me In census, are now being collected through the Mental Health Minimum Data Set. CQC is looking at how we can use this data to monitor the experience of inpatients, including any associations with ethnicity.

Rising numbers of detentions

In 2012/13 there were over 50,000 uses of the Mental Health Act to detain patients in hospital for assessment or treatment, not counting the use of short-term holding powers. This is the highest number of uses of the Act ever recorded.
In our last report we urged policy makers to consider the reasons for the rising use of the Act and develop an appropriate policy response. The House of Commons Health Committee heard representation on the possible causes in its post-legislative scrutiny of the Act’s amendments. It was particularly concerned at suggestions that one factor in the rising rates of detention might be that “some clinicians may resort to the use of sectioning powers to secure hospital access for some patients who would otherwise have been informal patients”.

This is linked to a concern that the threshold criteria for access to a hospital bed may be set too high, effectively excluding informal hospital admissions. The Department of Health have responded to the Committee with a clear statement that no one should be detained unless they meet criteria and there is to be no complacency about the suggestion people are detained in order to ensure hospital treatment.

The national statistics over the use of the Act (FIGURE 1) show a rise in detentions, whether these are at the point of admission to hospital or subsequent to informal admission. This challenges the suggested explanation of why the numbers of detentions are rising. The statistics show nationally there was a big rise in the number of patients who were detained after having been admitted informally to a hospital bed. Clearly, informal admission was not barred to such patients – although the fact so many people admitted informally for care and treatment are subsequently detained is in itself a serious cause for concern.

In the Serious Case Review completed on Winterbourne View Hospital Margaret Flynn considered the practice of informal admission followed by subsequent detention and made the following recommendation:

“The CQC, in discharging its responsibilities to monitor the use of the Mental Health Act, should ensure that all the requirements of the Act are applied when a patient moves from being an informal patient to being detained under the Act in the same hospital.”
At the time of writing this report we are in the process of developing new regulatory and monitoring frameworks and are increasing our focus on understanding the experiences of people subject to the MHA. We will pay particular attention to staff and patients’ perspectives on the issue of detention following informal admission.

We have heard strong anecdotal evidence that in some geographical areas, bed availability or similar systemic pressures are distorting the thresholds for detention. It is accepted the system is running over capacity, and research indicates a relationship between lack of bed capacity and increases in detention.

We are pleased to note research is being completed by the National Institute of Health Research funded study “Understanding the increasing rate of involuntary admissions in NHS Mental Health Care.” This will report to policy makers to inform their understanding of the increasing rates of detention and indicate possible policy changes to reduce or reverse the increase. The research team, which is being led by Warwickshire University, have previously reviewed national data for England as a whole but will be narrowing the focus to deprived communities and areas with the highest and fastest growing rates of detention. This will include areas with the highest minority ethnic populations who continue to have some of the worst experiences of mental health services. This approach will allow them to look at differences in rates of detention for individual patients who access both NHS and private hospitals in England.

The researchers will also be working in partnership with people who use services and senior NHS managers to ensure the findings are of interest to a wider audience and offer actionable conclusions for NHS commissioners and chief executives. We welcome this approach and will be working closely with the Department of Health in this area to explore the emerging findings and consider the impact of these on national policy when the research is published in June 2014.

The College of Social Work surveyed Approved Mental Health Professionals (AMHPs) over common themes and concerns in 2013, getting responses from 94 local authority areas in England. Roughly one in six respondents stated that on one or more occasion a person had been detained under the Act because an informal admission to hospital was not available.

“Reduction in admissions is our goal but it requires models of community support and alternatives to admission that are not currently consistently effective or accessible. AMHPs are reporting on occasions they can only admit under detention rather than informally because of thresholds and bed pressures. The least restriction principle is becoming increasingly hard to maintain.”

Dr Ruth Allen, Chair of the Mental Health Faculty of The College of Social Work
The principle of least restriction is a fundamental consideration for professionals making decisions about a course of action under the Act. It would not be lawful to use detention powers solely as a mechanism to secure access to hospital treatment, but in practice the thresholds for detention can be influenced by what alternative provision is available. For example, we have heard of occasions where patients have been detained not because they object to hospital admission as such, but because they object to admission to the available hospital bed which is out of their home area. We look at this issue in more detail in chapter 2 of this report.

The detained inpatient population

On 31 March 2008, there were 15,182 patients recorded as being detained across England, excluding those detained on short-term holding powers (FIGURE 2). Five years later, in 2012/13, that detained inpatient population had risen by 12% to just under 17,000. There was, however, a 3% drop in the recorded inpatient population between 2012 and 2013.

FIGURE 2

Number of people detained in hospital (excluding holding powers) on 31 March, 2008 to 2013, by gender

Where a doctor is not immediately available to consider implementing section 5(2), but it is immediately necessary to prevent an informal inpatient from leaving hospital, nurses are empowered under section 5(4) of the Act to hold the patient for up to six hours pending the doctor’s arrival. Such powers were used 1,761 times in 2012/13, roughly two-thirds of which led to a doctor instigating section 5(2). The data available does not enable us to say how many of the 599 patients who were not detained

Holding powers

There has been a rise in the recorded number of uses of short-term ‘holding powers’ applied to informal patients who would otherwise discharge themselves from inpatient settings. The most frequently used power is under section 5(2), which allows doctors to order that a patient be held for up to 72 hours on the grounds an application for further detention ‘ought to be made’ (FIGURE 3). In 60% of all uses of section 5(2) an application for further detention under section 2 or 3 of the Act was made in 2012/13.

FIGURE 3

All uses of section 5 holding powers on informal inpatients, 2007/08 to 2012/13

* Figure 1.3, being a representation of the overall use of section 5 powers, includes these uses in the figures for section 5(2) as the latter (based on potential duration of detention) is the more restrictive power of the two.
further after being held on 5(4) remained in hospital informally, rather than insisting on leaving as they had originally intended.

In discussion with senior staff on an acute admission ward in December 2012, we learned that a factor in the significant local use of holding powers under section 5 was some patients who arrived on the ward on an informal basis, or under the purported authority of the Mental Capacity Act, appeared to be unaware of where or for what purpose they had been brought there. We heard of examples of patients being told they were coming into hospital “for a nice chat”, “a cup of tea” or “to see a doctor”. Their subsequent distress on realising their actual situation as an admitted inpatient led to them trying to leave, and holding powers being invoked.

Subterfuge or euphemism should never be used to admit a patient into hospital. Such practices breach the guiding principles and specific guidance of the Code of Practice, and must be open to legal challenge in any individual case as unlawful deprivation of liberty.  

**Use of sections 2 and 3**

The most frequently used powers of detention are section 2 and section 3 – the first a power of assessment and treatment lasting up to 28 days, and the second a renewable power of treatment initially lasting six months. The Act allows professionals some discretion as to which power they use, although the choice should be guided by the Code of Practice requirement that the least restrictive option is always preferred. Increasingly, professionals appear to view section 2 as the appropriate initial power of detention (FIGURE 4).

---

**FIGURE 4**

Use of sections 2 and 3 (admissions and detentions of informal patients), 2007/08 to 2012/13

<table>
<thead>
<tr>
<th>Year</th>
<th>Section 2</th>
<th>Section 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>32,524</td>
<td>14,404</td>
</tr>
<tr>
<td>2011/12</td>
<td>30,142</td>
<td>14,752</td>
</tr>
<tr>
<td>2010/11</td>
<td>27,904</td>
<td>15,206</td>
</tr>
<tr>
<td>2009/10</td>
<td>26,446</td>
<td>17,118</td>
</tr>
<tr>
<td>2008/09</td>
<td>24,389</td>
<td>17,819</td>
</tr>
<tr>
<td>2007/08</td>
<td>23,623</td>
<td>18,507</td>
</tr>
</tbody>
</table>

0% 20% 40% 60% 80% 100%

Source: Health and Social Care Information Centre, KP90

Figure 5 shows the recorded outcomes of detentions under section 2 in the last six years. On average overall, 38% of the detentions were extended through an application being made under section 3.* In 2012/13, 27% of recorded outcomes of section 2 detentions showed that the patient continued to be detained. This is a small but significant rising trend from the 24% in the previous year.

---

* Such ‘extension’ would not always be at the end of the 28-day maximum duration of detention under section 2: see Code of Practice (para 4.27) for criteria for using section 3. If such criteria are met at any point within the 28 day maximum duration of section 2, it may be appropriate to apply for section 3 detention at that point.
1. The use of the Mental Health Act in 2012/13

Patients concerned with criminal proceedings

Part 3 of the Act contains powers of admission available to the courts, and powers to transfer remand or sentenced prisoners to psychiatric hospitals. The total use of such powers in 2012/13 fell by 16% from the previous year and was the lowest recorded in six years (FIGURE 6).

While the use of the Act across all Part 3 powers fell slightly, the most notable fall was in the use of the Act by the courts. The drop in such court orders was spread evenly across cases where the court applies a restriction order and where a court order is made without any restrictions on discharge (FIGURE 7). In our report on monitoring the Act in 2009/10 we suggested that the introduction of community treatment orders (CTOs) might reduce the numbers of restriction orders made by the courts, as patients’ legal representatives could argue that using a CTO was the least restrictive option to ensure that future discharge would be subject to conditions and oversight.14 This would not, however, account for an overall fall in court orders, the reasons for which are unclear.
The use of the Act in relation to people with a learning disability

Learning disability shares few features with the serious mental illnesses that are the most common reason for using the Act. The Code of Practice suggests that people with a learning disability are usually detained under the Act because they are also suffering from a mental illness. Community treatment orders and most detention powers of the Act (with the exception of holding powers or detention under section 2 or 4) can only be applied on the basis of a learning disability if the patient exhibits abnormally aggressive behaviour or seriously irresponsible conduct (MHA section 1(2A)). The numbers of such detentions on admission are shown in table 1.*

We welcome the commissioning of the Learning Disability Census, an audit of services to take a snapshot of provision, numbers of out of area placements, and lengths of stay. In August and September 2012 we organised awareness events to help providers prepare for the first census, which took place on the 30 September 2012. The census will be repeated in 2014 to assess progress in addressing poor quality and inappropriate care.

* Data on the use of the Act to detain patients who are already in hospital, showing whether learning disability was the primary reason for the use of the Act, is not available.

### TABLE 1

<table>
<thead>
<tr>
<th>Section 2</th>
<th>Section 3</th>
<th>Part 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Learning disability primary reason for using Act</td>
<td>127</td>
<td>70</td>
<td>168</td>
</tr>
<tr>
<td></td>
<td>(1.1%)</td>
<td>(0.6%)</td>
<td>(4.0%)</td>
</tr>
<tr>
<td>Learning disability not present or not primary reason for using Act</td>
<td>11,332</td>
<td>10,940</td>
<td>4,061</td>
</tr>
<tr>
<td></td>
<td>(98.9%)</td>
<td>(99.4%)</td>
<td>(96.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>11,459</td>
<td>11,010</td>
<td>4,229</td>
</tr>
<tr>
<td></td>
<td>(100%)</td>
<td>(100%)</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre, KP90
Community treatment orders

Since the introduction of community treatment orders (CTOs) in 2008, the power had been used 18,942 times by 31 March 2013. The Oxford Community Treatment Order Evaluation Trial (OCTET) concluded in 2013 with the finding that CTOs in the study had made no appreciable difference in readmission rates to hospital compared with using leave under section 17 of the Act, and concluded (because CTOs extended longer than such leave) that benefits in terms of hospital readmission could not “justify the significant curtailment of patients’ personal liberty”.

We have heard some clinicians dispute that readmission rates are the only valid measurement of the success of CTOs, or challenge whether the conditions of the controlled trial mirrored practice elsewhere.

More recently, research by Stroud et al (2014) on service user and practitioner experiences of CTOs in one provider, echoes some observations from our own past monitoring. The emergent themes suggested a CTO provides an enhanced legal recognition of the need for care and that people’s definitions of care are medically driven, although it was recognised increased stability in mental health could facilitate subsequent engagement with social interventions. The report identifies ‘ambivalence’, or mis-perceptions surrounding the power and conditions of the CTO. These findings are to be welcomed for the additional insight they bring to the operation of this aspect of the MHA. However they are also troubling in the context of the national policy focus on community service development, personalisation and least restriction as core elements of the recovery model.

We agree with the House of Commons Health Committee’s view that positive evidence of benefit from CTOs remains sparse, and in light of this more research is needed into the value of CTOs in different clinical and social circumstances. We urge commissioners and providers of services to consider the evidence base on the positive outcomes and cost benefits to be achieved through social care, social network and employment focused interventions in their needs analyses and associated decisions on service priorities.

Over 4,500 patients were discharged from detention in hospital onto a CTO in 2012/13 (TABLE 2). Of these, 95% were discharged from detention under section 3, and 63% were male.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>From section 3</td>
<td>1,602</td>
<td>3,736</td>
<td>3,606</td>
<td>4,004</td>
<td>4,389</td>
</tr>
<tr>
<td>From section 37</td>
<td>56</td>
<td>121</td>
<td>152</td>
<td>180</td>
<td>196</td>
</tr>
<tr>
<td>From section 47</td>
<td>2</td>
<td>6</td>
<td>12</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>From other sections</td>
<td>474</td>
<td>244</td>
<td>64</td>
<td>31</td>
<td>55</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,134</strong></td>
<td><strong>4,107</strong></td>
<td><strong>3,834</strong></td>
<td><strong>4,220</strong></td>
<td><strong>4,647</strong></td>
</tr>
<tr>
<td><strong>Recalls</strong></td>
<td>207</td>
<td>1,217</td>
<td>1,601</td>
<td>2,082</td>
<td>2,272</td>
</tr>
<tr>
<td><strong>Revocations</strong></td>
<td>143</td>
<td>779</td>
<td>1,018</td>
<td>1,469</td>
<td>1,509</td>
</tr>
<tr>
<td><strong>Discharges</strong></td>
<td><strong>33</strong></td>
<td><strong>1,010</strong></td>
<td><strong>1,167</strong></td>
<td><strong>1,712</strong></td>
<td><strong>2,162</strong></td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre, KP90
The number of patients discharged from a CTO in 2012/13 (2,162) represented a 26% increase from the previous year. Given our previously stated concerns over the lack of clarity as to when a CTO will be deemed to have served its purpose, this is perhaps encouraging. A significant number of CTOs are revoked and the patient returned to detention in hospital. We cannot tell from these statistics how long such periods of revocation were, or whether patients have been repeatedly discharged onto CTO. The population of patients subject to a CTO stood at 5,218 on 31 March 2013, a 10% increase from the previous year (FIGURE 8).

Population subject to CTOs, by gender, as at 31 March 2009 to 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>577</td>
<td>1,178</td>
</tr>
<tr>
<td>2009/10</td>
<td>1,216</td>
<td>2,109</td>
</tr>
<tr>
<td>2010/11</td>
<td>1,579</td>
<td>2,712</td>
</tr>
<tr>
<td>2011/12</td>
<td>1,642</td>
<td>3,122</td>
</tr>
<tr>
<td>2012/13</td>
<td>1,775</td>
<td>3,443</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre, KP90

**Ethnicity**

“Minorities are policed more – they have more chance of coming into contact with the coercive arm of the state.”

Data from the Mental Health Minimum Data Set (MHMDS) analysis continues to show 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.

Data available for 2012/13, as in previous years, shows a continuing trend in high rates of detention among certain black and minority ethnic groups (FIGURE 9).

- Hospitalisation rates as informal patients were higher than expected for patients from the White British, White Irish, Other White, Black Caribbean, Other Black and Other groups. In the Other Black group the rate was 2.7 times higher.
- Hospitalisation rates as informal patients were lower than expected for patients from the White/Black Caribbean Mixed, White/Black African Mixed, White/Asian Mixed, Indian, Pakistani, Bangladeshi, Chinese, Black African and Other Asian groups.
- Detention rates were higher than expected for patients from the White Irish, Other White, White/Black Caribbean Mixed, White/Black African Mixed, Other Mixed, Pakistani, Other Asian, Black Caribbean, Black African, Other Black and Other groups.
- Detention rates were particularly high for, Black African (2.2 times higher), Black Caribbean (4.2 times higher), Other Black (6.6 times higher) and Other groups (2.1 times higher).
- Detention rates were lower than expected for patients from the White British, White / Asian mixed, Indian and Chinese groups.
The use of the Mental Health Act in 2012/13

FIGURE 9

Standardised rates of use of the Act by ethnicity, all ethnic groups, 2012/13

Note: A standardised ratio is a comparison of the number of observed events in a population with the number of expected events if the age and gender specific event rates were the same as a standard population. It is expressed as a ratio of observed to expected event, multiplied by 100. A standardised ratio of 100 therefore implies that the observed event rate is the same as would be expected in a standard population. A number higher than 100 implies an above average event rate, whereas a number below implies a below average event rate.

Source: Health and Social Care Information Centre, Q1 – Q4 2012-2013 Routine Quarterly Mental Health Minimum Data Set

The reasons for such overrepresentation remain a contested area. A study of outcomes of MHA assessments found no correlation between an outcome of detention and ethnicity. The researchers suggest “the previously reported association between ethnicity and detention may reflect a lack of adjustment for variations in service provision and pathways, and disappear when confounders are adjusted for”. The research showed apparently lower rates of detention in Asian patients compared with White patients are confounded by fact the ‘bulk’ (61.4%) of Asian patients were assessed in Birmingham, but the highest proportion of White patients was in London (41% of all White patients). This suggests Asian patients were subject to a lower detention rate simply by being assessed in Birmingham rather than London as a reflection of different service provision in these cities.

At a national level, the Mental Health Minimum Data Set (MHMDS) data returns provide information about the pathways of individuals across mental health services and about use of the Mental Health Act. We can use this data for analysis, to highlight issues of concern, promote debate and work with stakeholders on solutions. Figure 9 and table 3 show examples of use of this data.
### TABLE 3

Most restrictive legal status by aggregated ethnic group, 2012/13

<table>
<thead>
<tr>
<th>Most restrictive legal status during hospital stay</th>
<th>Asian or Asian British</th>
<th>Black or Black British</th>
<th>Mixed</th>
<th>White</th>
<th>Other ethnic groups</th>
<th>Not stated/invalid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Section 135 or 136</td>
<td>55</td>
<td>2.0</td>
<td>68</td>
<td>1.4</td>
<td>15</td>
<td>1.5</td>
</tr>
<tr>
<td>Section 4</td>
<td>9</td>
<td>0.3</td>
<td>-</td>
<td>-</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Section 5</td>
<td>86</td>
<td>3.1</td>
<td>115</td>
<td>2.4</td>
<td>31</td>
<td>3.1</td>
</tr>
<tr>
<td>Section 2</td>
<td>1,082</td>
<td>38.9</td>
<td>1,604</td>
<td>33.8</td>
<td>322</td>
<td>31.7</td>
</tr>
<tr>
<td>Section 3</td>
<td>1,376</td>
<td>49.4</td>
<td>2,495</td>
<td>52.5</td>
<td>510</td>
<td>50.2</td>
</tr>
<tr>
<td>Other sections / Acts</td>
<td>19</td>
<td>0.7</td>
<td>60</td>
<td>1.3</td>
<td>11</td>
<td>1.1</td>
</tr>
<tr>
<td>Part 3 detentions</td>
<td>157</td>
<td>5.6</td>
<td>403</td>
<td>8.5</td>
<td>126</td>
<td>12.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,784</strong></td>
<td><strong>100</strong></td>
<td><strong>4,750</strong></td>
<td><strong>10</strong></td>
<td><strong>1,015</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Note: Where MHMDS counts include low numbers (between 1–5) the data are redacted according to agreed data sharing protocol.

Source: Health and Social Care Information Centre, Q1 – Q4 2012-2013 Routine Quarterly Mental Health Minimum Data Set

Table 3 shows the use of the Act in 2012/13 by aggregated ethnic group, counting only the most restrictive power used in any individual episode of detention. Patients from Black or Black British ethnic groups appear to be more highly represented in the group of detentions related to criminal justice powers, suggesting the pathways into mental health care are different for black and ethnic minority patients.* Such adverse pathways could be a result of inequalities in access to, or outcomes from mental health services, even if this is a reflection of different service provision in different areas of the country. Table 4 shows that the Black or Black British ethnic groups had the lowest percentage of recorded episodes where patients were made subject to the Care Programme Approach on detention.

* Criminal justice powers are described in the table as ‘part 3 detentions’. The category ‘other sections / Acts’ may also include a significant number of criminal justice powers.
Data on self-harm, restraint, assaults and seclusion which were previously collected for inpatients in the Count Me In census are now being collected through MHMDS. CQC is looking at how we can use this data to monitor the experience of inpatients, including any associations with ethnicity.

Services should ensure they undertake ethnic monitoring of their activities. Submitting accurate MHMDS returns can help with this process, particularly now the Health and Social Care Information Centre produces monthly totals of people subject to the Act readable at a provider or clinical commissioning group level, with some clearly described methods for re-producing these measures locally for further analysis.

The Mental Health Tribunal

The first-tier Tribunal (Mental Health) continues to receive a large number of applications for review of detention (TABLE 5) and community treatment orders (CTOs) (TABLE 6). In 2012/13 it received a total of 30,320 applications for hearings, up from 29,605 the previous year. In 2011/12 the Tribunal held 19,320 hearings. In 2012/13, it held 19,941 hearings and, under new procedures, undertook an additional 368 ‘paper reviews’ of uncontested CTO cases.
### TABLE 5

Applications against detention to the first-tier Tribunal, excluding CTO (Mental Health), 2012/13

<table>
<thead>
<tr>
<th></th>
<th>s.2</th>
<th>Other unrestricted</th>
<th>Restricted</th>
<th>All detained patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications</td>
<td>8,193</td>
<td>14,770</td>
<td>3,146</td>
<td>26,109</td>
</tr>
<tr>
<td>Withdrawn applications</td>
<td>629</td>
<td>2,764</td>
<td>999</td>
<td>4,392</td>
</tr>
<tr>
<td>Discharges by clinician prior to hearing</td>
<td>2,703</td>
<td>2,401</td>
<td>84</td>
<td>5,188</td>
</tr>
<tr>
<td>Hearings</td>
<td>5,608</td>
<td>9,039</td>
<td>2,493</td>
<td>17,140</td>
</tr>
</tbody>
</table>

**Decision of Tribunal (where hearing completed in year)**

<table>
<thead>
<tr>
<th>Decision</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute discharge</td>
<td>421</td>
<td>218</td>
<td>78</td>
</tr>
<tr>
<td>Delayed discharge</td>
<td>177</td>
<td>122</td>
<td>-</td>
</tr>
<tr>
<td>Conditional discharge</td>
<td>-</td>
<td>2</td>
<td>290</td>
</tr>
<tr>
<td>Deferred conditional discharge</td>
<td>-</td>
<td>0</td>
<td>149</td>
</tr>
<tr>
<td>Total discharge by Tribunal</td>
<td>598</td>
<td>342</td>
<td>517</td>
</tr>
</tbody>
</table>

| No discharge                       | 3,983   | 5,524   | 1,484   | 10,991   |

Note: Numbers in columns may not calculate due to applications or hearings outstanding at the end of each financial year.

* Outcomes do not add up to applications, as some cases for which outcomes are recorded would have commenced in the preceding year and other applications would reach a conclusion in the subsequent year.

Source: Tribunal secretariat

### TABLE 6

Applications against CTOs to the first-tier Tribunal, 2010/11 to 2012/13

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications</td>
<td>3,284</td>
<td>3,901</td>
<td>4,211</td>
</tr>
<tr>
<td>Withdrawn applications</td>
<td>0</td>
<td>713</td>
<td>834</td>
</tr>
<tr>
<td>Hearings</td>
<td>2,457</td>
<td>3,272</td>
<td>2,801*</td>
</tr>
<tr>
<td>Discharges by Tribunal</td>
<td>112</td>
<td>161</td>
<td>132</td>
</tr>
<tr>
<td>No discharge by Tribunal</td>
<td>2,048</td>
<td>2,740</td>
<td>3,040</td>
</tr>
</tbody>
</table>

* Plus 368 ‘paper reviews’

Source: Tribunal secretariat
In October 2013 the European Court of Human Rights ruled that some form of procedural safeguard to ensure the right to contest detention guaranteed by Article 5(4) of the European Convention on Human Rights should be practical and effective for detainees who lack the ability to exercise this right independently.\(^\text{22}\)
The case in question related to MH, a patient detained under section 2. Although any patient detained under section 2 has a right to appeal to the Tribunal in the first 14 days of detention, the Court found that such a right was not exercisable in practice by MH, as she lacked capacity to instruct a solicitor.

At the time of writing, we do not know what the Government will propose as a procedural safeguard. In the meantime, detaining authorities should ensure that patients who may have difficulty in exercising their legal right to appeal are supported to do so and have timely access to Independent Mental Health Advocacy services. Consideration may also be given to requesting the Secretary of State to exercise their referral powers for any patient who lacks capacity to initiate their legal appeal.

To ensure compliance with human rights law, detaining hospitals should also ensure that any Tribunal application which a patient hands to a member of staff is submitted to the Tribunal without delay. In July 2013, Lady Hale suggested in a Supreme Court ruling that it would be helpful for the next edition of the Code of Practice to underline this legal duty, after a patient whose detaining authority had failed to pass on an application over the new year holiday had “undoubtedly been let down by the system”.\(^\text{23}\)

On a visit to a learning disability unit in August 2012, we were concerned that staff appeared to think an appeal to the Tribunal could only be made through a solicitor. A patient had expressed a wish to appeal in the week before our visit but told us staff had just given him the telephone number of a solicitor. The patient had contacted the solicitor and was waiting for him to attend before lodging his appeal. When we explained the correct procedure to staff, they obtained the correct forms from their Mental Health Act Office and dealt with the matter. We also asked the ward to obtain a list of solicitors for patients to choose from: it appeared they were relying on a single business card at the time of our visit.

> With care in the community, they’ve tried giving people who are service users more independent lives, but they don’t give them the tools to assist them. Setting you up to fail with everyday living, like putting you in the worst accommodation. If you’re in bad accommodation it just reinforces how you feel and might not necessarily be your illness, but just the circumstances of being in that situation, feeling helpless. It’s all about choices – if you’ve got choices …

Person detained under section 3
2. A service responsive to people’s needs

Key findings

- Some progress has been made in this area, although there is still a long way to go, with evidence that care plans and risk assessments had not considered the principle of least restriction in 10% of wards visited.
- 27% of care plans we reviewed in six months of 2012/13 showed no evidence of patients being involved in their creation. And at least 22% of care plans showed no evidence of patients’ views being taken into account. This is no improvement on our finding in 2011/12.
- Inadequate discharge planning can lead to prolonged periods of detention and we are very concerned there was a lack of evidence of discharge planning in 29% of the care plans we viewed. The Code of Practice is clear in its expectations for providers to consider aftercare with all detained patients and we expect this to be evident for all patients subject to the MHA.
- We are pleased to report almost all wards had access to Independent Mental Health Advocacy (IMHA) services. This is a considerable improvement in basic access to IMHAs with 92% of wards reporting direct access for patients to IMHA.
- However, there was no improvement in evidence of patients’ rights being explained to them. In the last two years we have not seen adequate evidence of discussions with patients about their rights in at least one in 10 wards.

Good practice example

“In my last admission my care plan was very detailed and most of it was based on my views of care and need, that is:

- What I thought helped
- What I thought my early warning signs were
- What my short and long term goals were
- What my views on medication were
- How I wanted situations to be dealt with.

I had time each week to update and discuss my care plan with my named nurse.”

Person detained under section 3

In our last report we set out a clear expectation of change and improvement in care planning for people detained under the Act.

We said care planning should have clear statements about how a person is to be helped to recover, and follow guidance set out in the national Care Programme Approach. Plans should focus on individual needs and aspirations, involving patients at all stages so as to reflect their views and individual circumstances. Care planning should be multidisciplinary. We recognise that on occasion treatment and care decisions cannot always reflect what the patient wants. However, within these constraints, every effort should be made by providers to involve people in their own care, treatment and recovery, both personal and clinical. From a patient’s position there should be “no decision about me, without me”.24
“My current care plan is almost two years old and not reflective of my current situation. It describes my diagnosis and behaviour of past experiences, in what is described as crisis. The plan mainly contains what support services would be available, how the care team would react if I was to go into crisis again. The remainder is totally insignificant and just a box ticking exercise.”

**Person subject to a CTO**

Overall in 2012/13, we found there was some progress made in this area, although there is still a long way to go.

**Care planning and patient involvement**

Over six months of 2012/13, we recorded whether care plans and risk assessments showed evidence that the principle of least restriction had been considered. There was a lack of such evidence in 10% (201) of 1,965 care plans (FIGURE 10).

**FIGURE 10**

Care planning and the principle of least restriction, October 2012 to March 2013

Do care plans & risk assessments show evidence of consideration of the minimum restrictions on patients’ liberty?

<table>
<thead>
<tr>
<th>2012/13</th>
<th>1,433 (73%)</th>
<th>201 (10%)</th>
<th>331 (17%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Source: CQC visits – data for 2012/13 taken from the third and fourth quarter of the financial year only, due to change in data systems

Overall, 27% of care plans showed no evidence patients had been involved in their creation (FIGURE 11).

**FIGURE 11**

Patient involvement in care planning and risk assessment, October 2012 to March 2013

Do care plans & risk assessments show evidence of patients’ involvement?

<table>
<thead>
<tr>
<th>2012/13</th>
<th>1,106 (57%)</th>
<th>527 (27%)</th>
<th>322 (17%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Source: CQC visits – data for 2012/13 taken from the third and fourth quarter of the financial year only, due to change in data systems

**Good practice example**

“On my CTO I was listened to in care planning. With the help of an advocate and an excellent community mental nurse and psychiatrist, I was allowed a period without medication. This did not work out but now I know I have tried being without medication. I know I need to take it.”

**Person subject to CTO**

61% of care plans showed evidence patients’ views had been taken into account (FIGURE 12). This is no improvement on our finding in 2011/12.

**FIGURE 12**

Taking account of patients’ views in care planning, October 2012 to March 2013

Do care plans & risk assessments show evidence of consideration of the patient’s view about their treatment?

<table>
<thead>
<tr>
<th>2012/13</th>
<th>1,204 (61%)</th>
<th>441 (22%)</th>
<th>320 (16%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Source: CQC visits – data for 2012/13 taken from the third and fourth quarter of the financial year only, due to change in data systems
“When care plans have been written, mostly I have not been consulted. I found this both frustrating and disempowering.”

**Person detained under section 3**

Many detaining authorities have put effort into improving their care planning practice and documentation, and we have noted some very good practice:

Care plans reflected the views of clients, showing adherence to the respect and participation principles in the Code of Practice. These care plans have improved considerably since the last visit by the CQC and staff are to be commended for this good practice. There was a clear indication of clients and nursing staff views throughout the plan and these were clearly differentiated. Direct quotations from clients made it clear what their views were and what the goals were.

**CQC report from a MHA monitoring visit, Ivy Willis House, Oxleas NHS Foundation Trust, July 2012**

On the other hand, some services have continued to struggle with patient-centred care planning. We have seen care plans written in the first person, as if in the patient’s voice, when the patient has not been directly involved in preparing them.

On a visit to an acute psychiatric admission ward, we had significant concerns about the wording in one patient’s care plan:

The following behaviours are not acceptable…’no singing in the day areas in my own language… when I want something to be dealt with I won’t keep asking the same thing either of one member of staff or of different members of staff... nursing staff may speak to [the patient] with regards his behaviour... the instructions he receives from nursing staff should be adhered to.’

**CQC report from a MHA monitoring visit, March 2013**

The patient told us his care plan was “nonsense” but “I had no choice. They said it is going to look good for you if you are abiding.” We raised related concerns in our feedback to the NHS trust. We continue to monitor the application of the Code of Practice principles in this unit and expect practice to improve.

Care planning should, of course, be an ongoing process that reacts to changed circumstances. One trust has introduced ‘72 hour care plans’ when a patient is admitted. We were impressed to see one of these plans for a patient who had only been on the ward for a few hours. But we then went on to find another patient on the ward who still had a ‘72 hour’ plan 12 days after his community treatment order had been revoked.

“Care plans that let service users know precisely where they stand are not updated frequently enough. Patients do not have enough access to doctors, social workers and nurses for the purpose of getting clarity about where they stand.”

**Person subject to a CTO**

We found that on 11% of wards care plans and risk assessments had not been updated following incidents or changes to care needs *(FIGURE 13)*.

**FIGURE 13**

Review of care planning and risk assessment, October 2012 to March 2013

Are care plans & risk assessments reevaluated and where appropriate updated follow any incident and changes to care needs?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>1,333 (68%)</td>
<td>216 (11%)</td>
<td>416 (21%)</td>
</tr>
</tbody>
</table>

0% 20% 40% 60% 80% 100%

Source: CQC visits – data for 2012/13 taken from the third and fourth quarter of the financial year only, due to change in data systems

**Advance statements**

A number of services have developed leaflets and user-friendly tools for writing advance statements. Some of these are based on pioneering work at South West London and St George’s Mental Health NHS Trust. For example,
Nottingham Healthcare NHS Trust has accessible printed information and booklets that patients can complete to give a comprehensive account of their preferences at times of crisis. This includes their preferences for where the crisis should be managed and the types of medication or other intervention. The trust also has an easy-read version. This work is excellent in helping patients of all abilities to contribute towards their care planning.

We say more about advance statements and advance decisions in chapter 4.

**Aftercare and discharge planning**

On our visits from October 2012 to March 2013, we found evidence of discharge planning on 941 wards (FIGURE 14). This means about a third of care plans do not show any discharge planning. This has stayed the same over the last two years and is not acceptable.

**FIGURE 14**

Discharge planning in care plans, October 2012 to March 2013

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>941 (48%)</td>
<td>567 (29%)</td>
<td>457 (23%)</td>
</tr>
</tbody>
</table>

Source: CQC visits – data for 2012/13 taken from the third and fourth quarter of the financial year only, due to change in data systems

Inadequate discharge planning can prolong detention. On a visit to a learning disability ward in September 2012, two patients told us they did not have a discharge plan. We established there was a discharge plan for one patient, but it was several months old. The other patient’s Tribunal hearing had been adjourned because of a lack of adequate paperwork, even though he had been subject to recurrent detention under section 3 for several years. The hospital was failing to meet its responsibility under the Code of Practice to provide ongoing planning of aftercare. We demanded this was addressed by the provider.

“Patients can fail to be discharged or recommended for discharge because their MDTs simply haven’t put any thought let alone action into formulating discharge plans.”

**Person detained under section 37/41**

On a number of occasions, the courts have considered the duty to provide aftercare under section 117 of the Act, and whether this includes the provision of (and payment for) accommodation. It is generally understood that aftercare duties may extend to providing specialised accommodation, with elements of support that are needed because of the patient’s mental disorder. In a judgment in 2013, Mr Justice Mostyn suggested this will only be the case where the placement in the accommodation is ‘involuntary’ due to the patient’s incapacity to agree to it.

“It took a long time for my community mental health trust to agree to fund aspects of my care package but when I got a new social worker she was lovely and the process went very smoothly. I felt that finally the gaps in my care were acknowledged and addressed. I see being on section 117 as positive as I’m protected from having to contribute to my domiciliary care costs. I doubt I would stay afloat if I had to contribute.”

**Person discharged from section 3**

“When I went into hospital for physical reasons the doctors asked how I managed, and when they realised how ill I got, physically and all this other stuff, they went and got me all this care. The hospital social worker came to see me and one of my friends mentioned I was on section 117, and she arranged all this help. Sometimes you get so drawn in to the mental health stuff that you forget there are other services you might access because of age, or various reasons. It’s made quite a difference in my aspirations – things I can do at home and from home.”

**Person detained under section 3**
Recovery

“There is a need for ‘well-being and recovery’ discussion groups for patients. There is a need for ‘well-being and performance’ groups for staff. Demotivated and demoralised staff are of no use to patients.”

Person subject to a CTO

Mental health professionals and service users may mean different things by the term ‘recovery’. Service users have also suggested the growing focus on risk assessment and risk management within the Care Programme Approach, and the link between that approach and use of coercive elements of the Mental Health Act, is at odds with the holistic approaches they view as important for recovery”.  

“I have hardly learned any new skills or even life skills in ten years due to being locked up. My personal life is slowed down a million times. I think that mental health services should concentrate more on social issues and work in the community.”

Person detained under section 3, age 27

There is a tension between the Act’s powers of detention and compulsory treatment, and the emphasis on choice and empowerment that lies at the heart of Government policy. The Mental Health Foundation commissioned user-led research into recovery. The study explored how effective people who use services found the Care Programme Approach (CPA) in promoting recovery. It set out their views and recommendations about the CPA’s recovery role, and developed a checklist of good practice for mental health professionals. We recommend that all detaining authorities and service commissioners consider using this locally.

Independent Mental Health Advocacy

In our last report we found that some detained patients did not have access to Independent Mental Health Advocates (IMHAs), even though commissioning bodies have been under a duty to provide an IMHA service since 2009. In the six months from October 2012 to March 2013, we found very few wards did not have access to commissioned IMHA services (FIGURE 15). This is a considerable improvement in basic access to IMHAs.

In April 2013 local authorities took over commissioning responsibility for IMHA services. We continue to monitor patients’ access to the service, and will expect commissioning concerns to be addressed by the local Director of Adult Social Services. Local authorities’ engagement work with mental health services could improve commissioning through a needs analysis based on local rates of use of the Act among other quality indicators.*

FIGURE 15

IMHA provision, ward manager responses, October 2012 to March 2013

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there evidence of an IMHA service?</td>
<td>547</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>(98%)</td>
<td>(1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do patients have direct access to an IMHA?</td>
<td>512</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>(92%)</td>
<td>(7%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CQC visits, third and fourth quarter of the financial year 2012/13

We have not seen adequate evidence of discussions with patients about their rights in 9% of care plans (FIGURE 16). When we looked for evidence patients had been informed of their right to access the IMHA service, this rose to 18% of care plans.

* See for example the research completed by UCLAN in 2012 which included quality indicators for all areas of IMHA provision http://www.uclan.ac.uk/research/environment/projects/the_right_to_be_heard.php
Advocacy services play a key role in ensuring patients’ views and experiences are heard, and patients are involved in care planning. It would be preferable for patients to be allocated an IMHA unless they decide to opt-out, in place of the current opt-in system, as the House of Commons Health Committee has recommended. The Government’s response to this recommendation noted that a change to primary legislation would be required to realise this and a full impact assessment would need to be completed. In the meantime there are plans to continue funding for further work supporting improvements in commissioning of IMHA services and to consider appropriate amendments through the update of the MHA Code of Practice.

In the short-term, for advocacy services effectively to reach the patients who need them most, consideration should be given to funding regular advocacy presence on wards so that advocates can approach patients and explain their role personally.

We continued to see some patients subject to CTOs have less access to IMHAs. Some of these omissions were easily avoidable. For example, one trust had no system to ensure IMHAs were contacted in time to take part in managers’ reviews.

We welcome the publication of the British Institute of Human Rights guide to mental health advocacy and human rights. This is designed to help both patients and advocates to understand and apply human rights in an advocacy context. We recommend advocacy services and detaining authorities circulate it widely.

Peer support on mental health wards

We welcome research into the introduction of peer worker roles for mental health services, including inpatient wards. Peer workers are people with experience of mental health problems who are employed, in a paid or unpaid capacity, to support others who are using mental health services. The research project aims to identify how peer worker roles can be most effective in developing personalised services that are focused on recovery.

Physical healthcare needs of detained patients

The Royal College of Psychiatrists report Whole-person Care: from rhetoric to reality sets a comprehensive agenda for NHS commissioning and Government to tackle disparities in the provision of physical and mental health care. We were part of the steering group for that report.

In reviews of more than 550 patient records in 2012/13, we found 81 patients (14%) were on a ward with no clear access to a GP service, and 97 patients (17%) were not registered with a local GP (FIGURE 17).
Detained patients’ access to GP services, October 2012 to March 2013

**FIGURE 17**

Does the ward have access to a GP?

<table>
<thead>
<tr>
<th></th>
<th>412, (74%)</th>
<th>81, (14%)</th>
<th>66, (12%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not answered</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are all patients registered with a local GP?

<table>
<thead>
<tr>
<th></th>
<th>384, (69%)</th>
<th>97, (17%)</th>
<th>78, (14%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not answered</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0% 20% 40% 60% 80% 100%

Source: CQC visits – data for 2012/13 taken from the third and fourth quarter of the financial year only, due to change in data systems

In other cases, a lack of physical health care pointed to an underlying problem ensuring even basic standards of care:

A patient advised us that for the week that she had been an inpatient she had no access to her glasses, her dentures or a change of clothes. She also told us she had not changed her underwear for that period of time, but did not want to disturb the nurses as they seemed busy. On reviewing her case notes we found entries over the previous week stating plans had been made to contact her family members to bring in her dentures, glasses and a change of clothes, and then to accompany her home to fetch these things herself, but none of these plans had been carried out. We also noted an acknowledgment in the notes that the patient had requested a dressing for a wound on her foot on the day before our visit, but this too had not been done. The patient again told us she did not want to bother staff. We were told that there was an issue finding a suitable bandage.

**CQC MHA monitoring visit, November 2012**

In the above example, we were extremely concerned that the patient’s very basic needs were not dealt with appropriately. It was not clear how the matter of personal care needs were identified, monitored and reviewed during an admission. Staff said they would review these issues immediately and take action. But we also asked the trust to consider the wider implications of this and tell us in its action plan how it would satisfy itself that patients’ basic care needs were regularly identified and met.

In the following example, poor management of a patient’s physical health had contributed to her being secluded:

A patient had been discharged from nursing in segregation the day before our visit. She was taken to a local hospital for an investigatory procedure under sedation. She left the hospital before breakfast and returned after lunch, having not eaten. She was given a wrap to eat and was then told to get ready to go shopping. She did not feel well enough to do this but was told she must as there were insufficient staff to enable her to remain on the ward. On her
return she felt very unwell and her behaviour led to a decision to seclude her. In her file on the ward we found a letter about the procedure she had undergone in which she was advised she would need someone with her when she returned home. Clearly the expectation is that patients having undergone the procedure will need someone with them while they recover. This patient was not given the opportunity to recuperate and her individual circumstances were not considered.

CQC report from a MHA monitoring visit, December 2012

Commissioners of NHS care need to make sure mental healthcare providers have the infrastructure in place to monitor and address people’s physical health needs. Physical health and well-being are essential components of a recovery-based model and should lie at the core of all mental health services.

Staffing

There is as yet no national guidance on minimum staffing ratios. However, the National Advisory Group on the Safety of Patients in England has called for the development of National Institute for Clinical Excellence (NICE) guidance. The link between staffing levels in hospital wards and the quality of care provided was clear in a number of our visits.

- Patients on one adolescent unit told us they were unhappy the ward did not seem to have sufficient staff for them to consistently engage in activities, and that this caused cancellation of swimming and delays in getting to educational activities. Two patients told us that this was because their ward was seen as ‘settled’ and that staff could therefore be easily released elsewhere. Worryingly, another patient suggested that the only way to ensure adequate staffing was to ‘kick off’.
- On a ward in an independent secure hospital, eight out of 13 patients interviewed told us that insufficient levels of staff had caused cancellations of leave opportunities, especially when staff were required to provide 2:1 observations for any patients on the ward.

Trips to the social club, opticians and cinema had been cancelled in this way, and patients reported increased frustration leading to conflict between patients, and worsening relationships between patients and staff as a result. One patient told us that “it’s not fair on staff, they don’t have a break”. We asked the hospital concerned for audits of its staffing and serious incidents following this visit.

“In the place where I am now there’s a lot of frustration because every morning meeting they work out the numbers of people granted leave against the numbers of staff. But come the time that the first person is due to go out there’s never enough staff – staff have been borrowed by another ward, or are otherwise busy. Much as they get agency staff in to cover regular staff, agency staff can’t do escorts, and the permanent staff are all tied up. If they’re talking about having to lessen risks on wards, and maintaining security by not letting staff off the ward – what about the tension that arises from those patients having to stay on the ward?”

Person detained under section 37

These examples support the view that pressures on staffing levels can exacerbate problem behaviour or otherwise impede the process of recovery. Inadequate staffing levels, as well as posing a serious risk to the provision of a caring and patient-focused service, may be a false economy.

In the four months from December 2012 to April 2013, managers of 38 wards (14% of the 270 wards visited) said there had not been enough staff for all patients’ authorised leave to take place (FIGURE 18). Around one in six rehabilitation wards acknowledged that staffing levels had curtailed patients’ leave. This is a particular concern, given the important role that community leave has in preparing patients for discharge from hospital (see Code of Practice, para 21.8).
Ward managers’ reports on whether staffing sufficient to meet all ground leave or community leave requirements in the week before, December 2012 to March 2013.

<table>
<thead>
<tr>
<th>PICU</th>
<th>5, (56%)</th>
<th>2, (22%)</th>
<th>2, (22%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute admission</td>
<td>54, (83%)</td>
<td>8, (12%)</td>
<td>3, (5%)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>50, (76%)</td>
<td>11, (17%)</td>
<td>5, (8%)</td>
</tr>
<tr>
<td>Learning disability</td>
<td>38, (84%)</td>
<td>6, (13%)</td>
<td>1, (2%)</td>
</tr>
<tr>
<td>Old age</td>
<td>26, (87%)</td>
<td>2, (7%)</td>
<td>2, (7%)</td>
</tr>
<tr>
<td>Other</td>
<td>39, (78%)</td>
<td>7, (14%)</td>
<td>4, (8%)</td>
</tr>
</tbody>
</table>

Source: CQC

“I’ve seen ladies kick doors, punch doors; go to attack another patient because they can’t get one-to-one time with staff. They’re clearly distressed beforehand – it’s not just that they feel like a conversation, these are really distressed people who need help.”

Person detained under section 37

The Code of Practice (para 16.33) specifically requires managers of hospitals offering accommodation with enhanced levels of security to ensure the accommodation has adequate staffing levels. We drew this to the attention of managers at the following low secure unit:

Staff reported low morale on the ward. They associated this with the amount of change the ward had undergone, the high turnover rates and the high sickness levels. They reported that at times there has only been one qualified nurse on duty on the ward (contrary to the minimum limit set for the ward of two). They reported a number of consequences of this, in particular:

- A reduction in the amount of time available to engage in therapeutic relationships with patients.
- An impact on their ability to facilitate section 17 leave.
- An impact on the ability to escort patients to the dining room for meal times, with some having to wait.

CQC report from a MHA monitoring visit, December 2012

We have also seen some local authority and health services cut back their social care input into inpatient care, as in the following example:

The ward no longer has dedicated social work input. This has resulted in patients being allocated to generic neighbourhood teams and often they do not have named individual social workers. Patients and their families and carers are therefore unable to build up a relationship with a named individual who can assist the patient and their carers through the often difficult and complex transitions involved in dementia care.

CQC report from a MHA monitoring visit, September 2012

Here, we were told there were ongoing discussions to improve social work input. We required an action statement to show how the unit would meet the joint health and social care needs of its patients, ensuring the most appropriate care and ensuring that patients were not subject to ward-based treatment for longer than necessary.

“**I’ve known family visits being cancelled for lack of staff. After the families’ arrival, they’ve been told that nobody can come down to escort service users to the visit because there’s not enough staff, or the ward’s on lock down. Sometimes those families come from miles away.**”

Person detained under section 37
Pressures on service provision

For many years we (and our predecessor body) have reported over-occupancy of mental health wards. In March 2013 the Department of Health told the House of Commons Health Committee that this was evidence of wards running “too hot”.39

Pressure on beds and access to other services often affects the admission and discharge of patients. At one hospital in February 2013, we were told there can be pressure to discharge patients onto CTOs as a quick option to secure aftercare services. There were also difficulties in being able to recall CTO patients to a local bed at short notice. There is a risk patients could be prematurely discharged, perhaps using CTO powers as a safety-net. If patients did not do well under such arrangements and need to be re-admitted, they might have to go to a hospital out of their home area. Such a pathway can be damaging and counter-productive to recovery.

Some services have sought to manage bed pressures through particular triage arrangements. In March 2013 we visited a triage ward that was under significant pressure to admit patients from a community team and from A&E. Twenty per cent of patients appeared to return to the ward within a short space of time. Discharges were often obstructed by patients who had no accommodation to go to, or because of a shortage of beds on treatment wards.

There was a risk that the primary purpose of the triage ward was being undermined by the pressures in the system. This included the ward being used to meet shortfalls elsewhere, so patients who should not be in hospital were being admitted for want of an alternative.

Bed pressures slow down patient movement across the system. In some cases this can mean patients are treated in conditions that are inappropriate, and a potentially disproportionate interference with their human rights.

Patient C informed us he was discharged from section by the Tribunal in May 2013 and still remained on the low secure ward. He informed us he has been told each day he would be transferred to an acute ward in another trust, but this has not materialised. He raised the concern that even though he was allowed to leave the ward between 9.00am and 8.30pm he was still subjected to full search each time he returns to the unit. We are of the opinion this is contrary to least restriction principle and he should be transferred to an acute ward without further delay.

CQC report from a MHA monitoring visit, June 2013

The Act states as a criterion for detention ‘appropriate treatment’ must be available in hospital. In 2013 it is reasonable to expect this should be defined in practice by reference to the evidence base on effective interventions. The provision of inappropriate or inadequate treatment raises potential legal as well as ethical considerations.40 This is particularly the case where delays in access to treatment prolong detention, which raises human rights concerns.

Not all hospital environments are entirely suitable for their patient groups – which puts additional pressures on staffing. In a learning disability hospital we visited in December 2012, we saw the building was not well suited to the patient group. We found the quiet sitting area, located up a stairway from the main floor, could not easily be observed. Staff told us patients sometimes sit there when they are distressed. We identified a significant number of ligature points in the building. We also noted the corridors on the ward were extremely narrow. This raised a further concern when staff told us if restraint was necessary for any of the patients they would “try to ensure this was not done on a corridor”. While few wards will have such a combination of hazards, many have areas that are difficult to observe and/or ligature points, which can only be managed with adequate numbers of staff engaged with patients on the ward.
Night-time confinement in the High Security Hospitals

All three High Security Hospitals have now piloted and at least partially introduced night-time confinement, partly as a means to reduce expenditure. Mersey Care NHS Trust estimates that, by 2015, wider use of night-time confinement could save Ashworth Hospital £3.5m.\textsuperscript{41} All three hospitals report positive experiences in locking patients into their rooms at night. We have heard a more mixed account from patients.

Patients on the ward are now subject to night-time confinement from 21.00 to 07.45. Patients’ views on this were mixed. In common with other wards we have visited recently, several patients spoke of feeling like they were now in prison. One patient raised that they were detained under section 3, having committed no offences, but was still being locked in at night. Patients raised concerns over their safety at night due to low staff numbers and the time taken to respond to calls being as long as 15 minutes.

CQC report from a MHA monitoring visit, July 2012

At one hospital, we heard patient concerns that it is difficult to access help from staff at night because of night-time confinement. Staff often take up to 15 minutes to respond to the call buttons installed in patients’ rooms, perhaps because the call button only illuminates a light outside the room which might not be seen. Patients were unaware of the fire evacuation procedure, and were concerned at how this might be managed with fewer staff and locked bedroom doors.

In August 2013 we visited one High Security Hospital ward and, while there was much we found to be good, five out of eight patients we interviewed complained about the absence or cancellation of activities. One patient described having seven hours of activities a week, spread over five sessions, plus two hours of treatment: another spoke of there being nothing to do “80–90%” of the time. A further patient said gym sessions don’t run due to a lack of qualified staff to supervise. Patients also pointed out that a social group evening that ran monthly has now been stopped, and they had been informed more cuts are due to happen.

We find it a real concern that patients are experiencing a reduction in services at the hospital, and that more cuts are planned. One rationale for the introduction of night-time confinement was to prevent the need for cuts elsewhere, but we find these are happening nonetheless. While we appreciate the financial pressures on the hospitals, we are taking a close interest in how their managers collect patients’ experiences and what actions they take to address concerns.

“Cost improvements are challenging... night-time confinement has only covered the cost improvement programme, which has required the High Security Hospitals to release 4.5% of their budgets in real terms in years one and two of the programme. While commissioners require cash releasing cost improvements year on year, although we will strive to ensure we deliver a safe and therapeutic service to our patients, the quality of services will undoubtedly suffer.”

High Security Hospital manager, September 2013
3. Ways in which people are subject to restrictions

Key findings

- We continued to see widespread use of blanket rules. Some type of blanket rule was in place in more than three quarters of the wards we visited. Such practices have no basis in law or national guidance on good practice and are unacceptable.

- In 46% of cases reviewed the reason given for the blanket rules was ‘hospital policy’. We were also told it was because of a historical incident, or in 13% of cases no one seemed able to give a reason.

- The most common restrictions related to using the internet and mobile phones, smoking, and access to secure outdoor space and communal rooms. In many cases these rules applied across the ward to both detained and informal patients.

- Overall, about a third of ward managers told us the police had been called to their ward at least once in the previous 12 months to help contain patient behaviour.

- We continue to hear accounts of patients’ experiences of being restrained. We promote examples of good practice where providers of inpatient mental health services have taken positive steps to reduce the use of restraint

“We when hear of more plans for ‘risk management’, I see a system creating more future lives of stifled dependency. That’s not only tragic, but it makes no economic sense: without taking healthy risks, people will remain dependent, and utilize far more services in the long term.”

**Person subject to a CTO**

In our last report we set out our clear expectation that hospitals should continually review their policies and practices to make sure that they do not have blanket rules preventing them from treating each patient as an individual with rights to autonomy and dignity.42

We looked into blanket restrictions during our routine visits to hospitals between December 2012 and March 2013. We collected 267 questionnaires completed by our specialist Mental Health Act Commissioners, and 249 questionnaires completed by the ward manager.*

Our conclusion from this and from our other visits throughout the year is we continue to see widespread use of blanket rules. Such practices have no basis in law or national guidance on good practice and are unacceptable.

**Blanket rules and restrictive practices**

All hospital wards have rules, whether these are written or matters of custom and practice.

* There were 386 visits in total, so the 267 MHA visitor questionnaires amount to a 69% return, and the 249 ward manager questionnaires a 65% return.
Unless they are an unavoidable requirement of the ward’s security level, limitations on patients’ choice and action resulting from inflexible ward rules do not meet the Code of Practice principle of least restriction. They may be a breach of patients’ human rights.

Our Mental Health Act visits reported some type of blanket rule in just under three quarters of the wards where information was collected between December 2012 and March 2013 (FIGURE 19). These are listed in table 7 below.

**FIGURE 19**

Evidence of blanket rules or restrictions being applied to all patients in 267 wards visited, by ward type, 3 December 2012 to 31 March 2013

<table>
<thead>
<tr>
<th>Ward Type</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PICU</td>
<td>9 (82%)</td>
<td>2 (18%)</td>
</tr>
<tr>
<td>Acute admission</td>
<td>54 (82%)</td>
<td>12 (18%)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>33 (52%)</td>
<td>30 (48%)</td>
</tr>
<tr>
<td>Learning disability</td>
<td>35 (81%)</td>
<td>8 (19%)</td>
</tr>
<tr>
<td>Old age</td>
<td>20 (67%)</td>
<td>10 (19%)</td>
</tr>
<tr>
<td>Other</td>
<td>63 (84%)</td>
<td>12 (16%)</td>
</tr>
<tr>
<td>Total wards</td>
<td>197 (74%)</td>
<td>70 (26%)</td>
</tr>
</tbody>
</table>

Note: As some wards may fall into more than one category of ward type (e.g. learning disability and rehabilitation), the same ward may appear in different rows designating speciality. The row designated ‘total’ shows the data without these duplications.

Source: CQC

We did meet some ward managers and other staff who were committed to reducing as far as possible the restrictions placed on patients.

- Some wards had planned environmental changes that showed staff had thought about whether restrictions really needed to be placed on patients. One, for example, had given patients their own bedroom keys, having recognised this as an issue of concern to patients.
- A number of wards impressed us with a focus on meaningful activity and staff interaction with patients. In these cases some restrictions – such as limiting mobile phone use or locking off bedrooms during the day – were more likely to be accepted by patients as proportionate measures to encourage them to take part in the ward programme.

“Where I am now is more therapeutic softly-softly approach around every situation. It was hard for me to adjust because where I came from was very much the opposite very restrictive; very cordoned-off; very dismissive. But these people are a lot more relaxed.”

**Person detained under section 37**

Where patients may lack capacity to make decisions or engage in ward meetings, hospitals may still challenge restrictive cultures in partnership with carers and relatives:

A carers’ representative described a range of improvements relating to patients’ dignity have taken place within the trust over the last five years. This work is led by a dignity group and dignity champions and has included training for support workers on caring for patients in confused states. As a result historical practices which could have been construed as blanket restrictions on patients who lack capacity have been greatly reduced.

**CQC report from a MHA monitoring visit, November 2012**
We asked ward managers for their rationale for certain restrictive practices. Their responses are shown in figure 20.

We are concerned that in almost two-thirds of cases (65%), the reason given for the blanket rules was either ‘hospital policy’, or it was a historical incident, or no-one seemed able to give a reason.

FIGURE 20

Reasons given by staff from 136 wards where blanket restrictions were applied, from visits 3 December 2012 to 31 March 2013

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient actions</td>
<td>16 (12%)</td>
</tr>
<tr>
<td>Hospital policy</td>
<td>63 (46%)</td>
</tr>
<tr>
<td>Staff shortages</td>
<td>30 (22%)</td>
</tr>
<tr>
<td>Financial savings</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Historical Incident</td>
<td>8 (6%)</td>
</tr>
<tr>
<td>No reason given</td>
<td>17 (13%)</td>
</tr>
</tbody>
</table>

Source: CQC

Ward managers should make sure patients are not subject to disproportionate restrictions as a result of unimaginative, institutional responses to the challenges of daily life on the ward, as in this example:

Staff informed us of their concern that the toilets in the main unit dining area are kept locked all the time, resulting in patients urinating in the courtyard in front of the dining room. When we discussed this with in the feedback meeting, it was stated the patients could access these toilets if they asked the staff to open them. The decision to keep the toilets locked was made after a serious incident. We questioned whether it was appropriate to implement such a blanket policy following an incident in the past, and asked the detaining authority to ensure, if it continued to maintain the view that it is important to keep these toilets locked to maintain safety and security, that all the staff and patients are aware that the patients can access them when they need to.

CQC report from a MHA monitoring visit, November 2012

In some cases, we heard conditions attached to the commissioning of low or medium secure units impose restrictive practices on providers. Both commissioning bodies and service providers should keep such conditions and the way they are implemented under review, to ensure there are no disproportionate or unnecessary restrictions on patients’ daily life.

The most common restrictions related to the internet and mobile phones; smoking (such as set cigarette allowances or set times for smoking); and access to secure outdoor space, communal rooms in the ward (such as a quiet room or kitchen); or bedrooms (TABLE 7). In many cases these rules applied across the ward to both detained and informal patients.
## TABLE 7

Blanket rules applied on wards visited 3 December 2012 to 31 March 2013

<table>
<thead>
<tr>
<th>Rule</th>
<th>Applies to all patients</th>
<th>Applies to all detained patients only</th>
<th>No blanket rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited or no access to internet</td>
<td>116</td>
<td>12</td>
<td>112</td>
</tr>
<tr>
<td>Cigarette allowance and/or set smoking times</td>
<td>94</td>
<td>19</td>
<td>140</td>
</tr>
<tr>
<td>No possession of bedroom keys</td>
<td>88</td>
<td>8</td>
<td>153</td>
</tr>
<tr>
<td>Limited access to certain rooms (not bedroom) e.g. kitchen, quiet room</td>
<td>83</td>
<td>8</td>
<td>165</td>
</tr>
<tr>
<td>Limited access or ban on mobile phones and chargers</td>
<td>81</td>
<td>8</td>
<td>155</td>
</tr>
<tr>
<td>Limited access to secure outdoor space or access only at set times</td>
<td>76</td>
<td>15</td>
<td>162</td>
</tr>
<tr>
<td>Rigid visiting hours</td>
<td>52</td>
<td>5</td>
<td>188</td>
</tr>
<tr>
<td>No lockable space that patients can control</td>
<td>49</td>
<td>7</td>
<td>193</td>
</tr>
<tr>
<td>Limited access to money or ability to make personal purchases</td>
<td>47</td>
<td>9</td>
<td>179</td>
</tr>
<tr>
<td>Restrictions on use of ward telephone</td>
<td>42</td>
<td>3</td>
<td>205</td>
</tr>
<tr>
<td>Limited access to drinks (including hot drinks)</td>
<td>41</td>
<td>2</td>
<td>215</td>
</tr>
<tr>
<td>Set time to get up in the morning</td>
<td>34</td>
<td>1</td>
<td>219</td>
</tr>
<tr>
<td>No access to bedrooms at certain times of day</td>
<td>31</td>
<td>1</td>
<td>226</td>
</tr>
<tr>
<td>Not able to take part in preferred activities (including fitness activities) or no meaningful choice of activities</td>
<td>27</td>
<td>3</td>
<td>200</td>
</tr>
<tr>
<td>Night (or day) time confinement or set bed times</td>
<td>26</td>
<td>1</td>
<td>223</td>
</tr>
<tr>
<td>No control over food portion size</td>
<td>24</td>
<td>3</td>
<td>209</td>
</tr>
<tr>
<td>Restrictions on incoming or outgoing mail other than section 134</td>
<td>16</td>
<td>0</td>
<td>212</td>
</tr>
<tr>
<td>No food outside set mealtimes</td>
<td>13</td>
<td>3</td>
<td>237</td>
</tr>
<tr>
<td>Not able to wear own or preferred clothing</td>
<td>7</td>
<td>1</td>
<td>249</td>
</tr>
<tr>
<td>No choice of food at mealtimes</td>
<td>6</td>
<td>1</td>
<td>244</td>
</tr>
<tr>
<td>Cultural or religious needs of patients not met</td>
<td>6</td>
<td>1</td>
<td>215</td>
</tr>
</tbody>
</table>

*Source: CQC*
We have challenged examples of blanket rules that may not be in line with the Code of Practice* and that undermine the effectiveness and therapeutic purpose of wards:

Patients cannot access the internet on the ward despite it being identified as a rehabilitation ward and clear argument being provided as to why it would be useful for patients in terms of their education and rehabilitation. We met with a senior lecturer who spoke passionately about the educational activities he is doing on the ward. He described a number of ways that having supervised access to the internet may enhance the educational and vocational opportunities for patients and more generally in terms of access to the world outside of hospital. We were unable to find any clear evidence in individual care plans/ risk assessments related to patients’ lack of access to the internet. We were unclear of the reasoning for this blanket ban as were the staff and patients we spoke to about it.

CQC report from a MHA monitoring visit, February 2013

“For me, restrictions of fresh air breaks and the smoking ban constitute a worrying denial of civil liberties and human decency, particularly in cooping people up.”

Person detained under section 3

We recognise the tensions that issues around access to cigarettes can cause on inpatient units and that the way in which smoking bans are implemented can be unnecessarily restrictive on some wards. We are working with Public Health England and NHS England to try to balance these concerns with the undoubted public and physical health implications of smoking.

Locked wards and de facto detention

Some inpatient wards have a designated security level and are likely to be always locked. Others have no designated security level and may or may not be locked, according to local policies or requirements. On our visits between December 2012 and March 2013, more than three-quarters of wards which had no designated security level were locked (FIGURE 21). We found evidence that, in one in five of these wards, patients who were not formally detained may be prevented from leaving. Measures of this included whether informal patients said that they were unable to leave the ward, where staff reported that they would automatically use holding powers to stop an informal patient leaving, or where staff were uncertain which patients were informal and which were detained.

FIGURE 21

Locked wards and de facto detention in 157 non-secure wards visited, 3 December 2012 to 31 March 2013

<table>
<thead>
<tr>
<th>Is the ward locked?</th>
<th>Yes</th>
<th>No</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>121, (77%)</td>
<td>26, (17%)</td>
<td>10, 6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there evidence that non-detained patients are aware of their right to leave?</th>
<th>Yes</th>
<th>No</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>98, (81%)</td>
<td>11, (9%)</td>
<td>12, (10%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there evidence that non-detained patients would be prevented from leaving?</th>
<th>Yes</th>
<th>No</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>32, (20%)</td>
<td>108, (69%)</td>
<td>17, (11%)</td>
</tr>
</tbody>
</table>

Note: Data that is missing or unclear is shown in the table by the shortfall to 100% in each row.

Source: CQC

For wards without a designated security level, it is a decision for individual hospitals as to whether wards should have locked doors. Wards are not always locked to prevent patients leaving. For example, it may be to protect patients and staff from unwarranted intrusions into the ward.

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* The MHA Code of Practice, para 16.7, states that detaining authorities should have guidance on patients’ access to e-mail and internet facilities by means of the hospital’s IT infrastructure. This guidance should cover the availability of such facilities and rules prohibiting access to illegal or what would otherwise be considered inappropriate material.
Whatever the rationale, it is important it does not result in the unlawful deprivation of liberty (or ‘de facto detention’) of patients who are not subject to legal powers of detention. Services should also consider how to reduce the negative psychological and behavioural effects of having locked doors, whether or not patients are formally detained.\(^4\)

On 11 visits (9% of visits to locked wards that accommodated informal patients) we found no evidence informal patients were aware of their right to leave the hospital at any time, as in the following example:

We met with a patient whose section 2 detention had been rescinded a few days previously. She seemed to understand neither that she had been detained, nor that she was now in hospital as an informal patient. Furthermore, her altered legal status was not updated on any care plan, and nursing entries in her medical record showed that staff had thought that she was detained after the detention powers had ended. There was no record of any assessment of her mental capacity or consent to her care.

CQC report from a MHA monitoring visit, January 2013

Services must help patients understand their true legal status and, especially, their right to leave a hospital if they are not formally detained there. This is a central component of a collaborative approach to care and treatment. While there is no specific legal duty on authorities to make sure informal patients understand their legal position and rights (as there is in relation to patients subject to the Mental Health Act), failure to do this could leave them open to legal challenge.

Restrictive practices and ward security

We asked our MHA Commissioners to identify wards where they thought the security arrangements were above or below what might be expected of the designated security level.

Based on available standards and guidance, we identified 12 wards (11% of secure wards visited) where the security was above the expected level (TABLE 8). One of these was a medium secure unit. The rest were either low secure wards, or general wards operating as if they were low secure. We also identified two low secure wards that were not meeting their security requirements. We raised these matters with the hospitals concerned.

### TABLE 8

<table>
<thead>
<tr>
<th>Security arrangements correspond with official ward designation</th>
<th>Security arrangements indicate a higher level of security than official ward designation</th>
<th>Security arrangements indicate a lower level of security than official ward designation</th>
<th>Unable to answer/blank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>High</td>
<td>5</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td>Medium</td>
<td>34</td>
<td>79%</td>
<td>1</td>
</tr>
<tr>
<td>Low</td>
<td>25</td>
<td>40%</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>64</td>
<td>58%</td>
<td>12</td>
</tr>
</tbody>
</table>

Note: Percentages indicate the percentage of wards identified within each security designation: i.e. 1 medium secure ward identified to be operating above official security designation accounts for 2% of all medium secure wards visited.

Source: CQC
On several visits to low secure units, patients raised the level of restriction with us:

Patients who have moved from the medium secure wards have been surprised to find that some aspects of their treatment on this low secure ward are more restrictive. The most obvious example is the restricted access to the outside area. The door to this area is opened for only fifteen minutes each hour. Patients on the medium secure wards have more or less unrestricted access to the outside area – the door is open all day. One patient said that it felt like there were ‘more rules’ on this low secure wards, and gave the example of not being allowed to drink cola in the morning or after a certain time at night.

CQC report from a MHA monitoring visit, June 2012

Secure units that follow the Code of Practice’s principle of least restriction will make therapeutic use of the minimum measures needed to provide a safe and recovery focused environment. This requires patient-focused care; individual care planning and risk-assessment; and support for recovery and rehabilitation through engagement and self-management.

Blanket rules can undermine these basic requirements, as in the following examples from visits to different low secure units:

- Irrespective of patients’ assessed risk, all patients’ rooms were searched monthly, and patients were given a rub-down search each month and at any time when they returned from unescorted leave.

- Patients were banned from the ward kitchen and there were no alternative facilities for making hot drinks. Staff told us the policy prohibiting kitchen access was justified because some patients would pose a risk, although others would not.

- We challenged an unusual blanket policy implemented at a unit for women with learning disabilities. Any patient from the unit who was being considered for community leave would automatically be referred to the Multi Agency Public Protection Arrangements (MAPPA). Although the unit catered for women with behavioural disturbance, many would be subject to civil detention powers rather than those of the criminal justice system and it did not seem likely all patients passing through the unit would pose a risk of harm to the public. The blanket policy seemed to us to be unwarranted and overly restrictive.

Many wards will impose greater restrictions on new patients while assessments are made of their needs. We found patients who transfer from medium to low secure wards within one hospital are treated as new admissions, and subject to higher restrictions as a result. This is frustrating for patients, who should be able to expect an integrated pathway through secure care.

In the following example, we were pleased to note the action taken by the hospital director in response to a patient’s complaint:

“I had an internal hospital move from medium to low secure provision. When I was on the medium secure ward I was going out on section 17 visits to the community; going out on ground leave, walking around the hospital; able to access the dining room and so on. When I was moved to the low secure ward I was given an admission care plan – a blanket care plan which everybody got, whether they were known and came from within the hospital or whether they were unknown and came from outside. I wasn’t allowed out to walk around the grounds; I couldn’t go to the dining room; and all my section 17 leave was stopped. I said ‘this is not right – this should be continuing care, everybody knows me in here from the medium secure ward – now I’m on a low secure ward and I’m not allowed out’. They said ‘well, this is what everybody gets’. That’s an example of a blanket care plan which made me very anxious – I didn’t know how long it would last. Others on the ward told me they’d had it for three months. I thought, what have I got into here? I took this to the hospital director and he said ‘this is not right at all: for an internal move, within our hospital, with a patient we know, the move from medium to low security should be an advancement and not a big step back’. The practice was stopped.”

Person detained under section 37
Restrictive practices in learning disability wards

The CQC is a signatory to the concordat plan of action in response to the Winterbourne View Review. This acknowledges, despite examples of good practice, too many people with a learning disability have ended up in hospital and have stayed there for too long. The concordat, agreed between a broad range of agencies, says this must stop. An annual census of learning disability units will measure progress. Hospitals should be a place of treatment rather than residence. There is, and will continue to be, pressure on existing units to have a clear rehabilitative aim of helping patients to move on to live elsewhere.

A number of the examples of restrictive practices in this chapter come from learning disability units. Despite the small number involved, learning disability units were most likely to be identified through our MHA visits as operating at an inappropriately high security level. In some cases, services were in transition. One unit had recently been re-graded from a low secure unit to a step-down rehabilitation ward. However, we found no evidence this had led to a review of security arrangements and we required this to be done.

Research has shown hospital services for people with a learning disability are typically commissioned with an emphasis on ‘care’ and ‘protection’, but this may not be balanced with an approach that empowers individuals and allows choice and positive risk-taking. This may be particularly marked where patients are detained on the basis of abnormally aggressive behaviour or seriously irresponsible conduct. We do recognise, however, that some learning disability services – especially in high secure hospitals – deal with enormous challenges in providing care and protection to patients with very complex needs. Even among these settings there are innovative approaches being established, such as the therapeutic community for patients with mild learning disability and personality disorder at Rampton Hospital.

Delayed transfers and discharges as a cause of overly restrictive care

Delays in moving patients within the hospital system can lead to over-restrictive treatment. We visited a London Psychiatric Intensive Care Unit (PICU) in February 2013 where we had previously been critical of inappropriate admissions in response to pressures on bed numbers. We noted that inappropriate placements continued because of delays in transferring patients when their clinical presentation improved. There was no clinical justification for the placement of at least three of the 10 patients on the unit. Two were discharged directly into the community during our visit. A decision had been taken 24 days previously to transfer the other patient to an open ward when a bed became available. This patient expressed their frustration at the delay.

This was not an isolated example:

- We visited a PICU in the north of England in August 2012 where there had been a number of serious incidents on the ward. The ward manager was concerned NHS commissioners were slow to find alternative placements for patients as they recovered, and this created problems of behaviour on the ward. One patient’s transfer had been cancelled at the last minute. Just before starting the journey staff checked with the receiving hospital, to be told there was no bed.

- Staff and patients at a low secure learning disability unit described their frustration at delays in transfers to less secure placements. Although staff recognised these delays were contrary to the principle of using least restriction, we found no evidence that aftercare planning was being considered as

“People end up in inappropriate services because they are all that is available, and because of a crisis management approach. Even though government policy is personalised support, we still register and commission services that deliver institutionalised care.”

Vivien Cooper, Chief Executive, Challenging Behaviour Foundation

* See the section on ‘the use of the Act in relation to people with a learning disability’ in chapter 1 of this report
soon as patients were admitted. This may have been a contributory factor in the delays. Without aftercare planning, units are more likely to continue the inappropriate use of hospital accommodation for patients with learning disability that government and other agencies have committed to end. It is a Code of Practice requirement (para 27.8) that aftercare planning for all detained patients begins from the point of admission.

“When I was last admitted it took almost two years too long to get discharged. Those two years could have been used to give someone else the bed. It’s the same where I am now: I’ve been waiting since March to discuss discharge because my funders didn’t attend a meeting then. There have been e-mails and God-knows what sent back and forth: but it’s a bit of a catch-22 because they’re saying I need a new social supervisor and a new team but I can’t get a new team until I get an address and sign on with a GP in that area.”

Person detained under section 37

Conditions of community treatment orders

The Act requires Approved Mental Health Professionals (AMHPs) to provide an important safeguard against the disproportionate exercise of the powers given to responsible clinicians in relation to community treatment orders (CTOs). Occasionally we saw AMHP agreements to the conditions imposed under the CTO that did not show clear reasoning. On a visit in March 2013, we noted a series of CTO applications and extensions where the AMHP had recorded only that the criteria for a CTO were met. They had not provided a rationale for imposing a CTO with reference to the wider circumstances of the case. Examples included:

- A patient whose CTO was extended twice without any documented rationale for it. In the second extension there was no evidence the AMHP has even considered whether the criteria for a CTO continued to be met, just the statement “discussed CTO with the patient and he did not object”.

- A record of a decision to place a patient onto a CTO stated only, “I am of the opinion that [the patient] meets the criteria for a CTO. I am assured by [the responsible clinician] that a new allocated care co-ordinator will discuss the care plan and aware that this must be provided in two weeks of CTO application being completed”.

- A rationale that said only, “I am satisfied that she meets the criteria for a CTO. I therefore signed a recommendation that she is placed on it”.

CQC report from a MHA monitoring visit, March 2013

The Code of Practice (paras 25.24 and 25.25) expects AMHPs to consider the patient’s wide social and cultural background when asked whether to support a CTO. This is a demanding role. We have heard AMHP concerns that limited resources or alternative options can limit their ability to safeguard the rights of patients.

While for the majority of the files scrutinised and the patients spoken to the conditions were clear and understood, there was discussion and concerns raised by the AMHPs over the nature and number of conditions being enforced in some instances, particularly where patients with a learning disability are resident in private supported or residential accommodation.

CQC report from a MHA monitoring visit, February 2013

In some services, better co-ordination between community and inpatient teams could establish support for patients without relying on CTOs. On the same February 2013 visit, we were told by responsible clinicians, if a patient is known to the assertive outreach team (AOT), they would be less likely to consider a CTO. Members of the AOT agreed with this, but thought few patients who were being considered for a CTO were actually being referred to them. If CTOs are not to become the default discharge arrangement for section 3 patients, many areas need to coordinate better in providing alternative support structures. The following is an example of good practice we found:
In meetings with care co-ordinators for CTO patients in Cumbria, we have heard that communication between professionals and continuity of care is very good. Care co-ordinators talked about the excellent relationships they had with patients’ clinicians, and that weekly meetings enabled them to discuss their caseloads and request clinician visits where they had particular concerns about patients. They said that excellent relationships existed between ‘inpatient’ and community teams and they would be included in early discussions concerning discharging patients onto CTOs.

Our scrutiny of documents supported care coordinators’ claims that CTO conditions were kept to a minimum and were individual and appropriate for each patient. We found clear and not overly restrictive conditions in care plans, alongside a contingency plan with names and telephone numbers of who to contact in an emergency. With one client, a mental health and social needs assessment had been used as a tool to determine if recall was appropriate, and it was therefore clear and undisputable why the recall took place. It was also clear that the conditions of the CTO had been reviewed on a regular basis and loosened, giving more control to the client when appropriate and tightened again if there were signs of relapse. This allowed for positive risk taking within the framework of the CTO and constant testing out as to whether the CTO is still appropriate with a view to discharge at the earliest opportunity.

Feedback from a MHA monitoring visit, Cumbria, 2013

Restrictions on patient communication

Many patients, especially in secure hospitals, have limited or no access to the internet. Therefore writing letters and using the phone are still important means of contacting the outside world.

The Act sets quite strict parameters around detaining authorities’ powers to interfere with patients’ mail. * This interference can be felt very strongly by detained patients. In November 2012 one patient told us he did not want to be transferred to a ‘step-down’ unit as he had recently complained about the staff of that unit withholding his letters. The matter was resolved following our visit. Unless the recipient of a letter has asked for mail to be withheld, only the three High Security Hospitals have powers to withhold mail. In some hospitals patients are required to open their post in the presence of staff, in some cases to check for contraband items. Sixteen wards (6% of the 267 wards included in the four-month study of restrictive practices) had some controls over all patients’ mail as a blanket policy (table 7 above).

Patients in high security can appeal to CQC about the withholding of their mail. We have the power to tell the hospital to release the withheld items. We have a similar appeal function for the high secure hospitals’ monitoring of phone calls. Table 9 shows the number and outcomes of these appeals. Two of the appeals against withheld mail came from members of the public to whom they had been addressed. In both cases we upheld the hospital’s decision to withhold the item. All other appeals came from patients.

* Most detaining hospitals may only withhold outgoing mail on the request of the intended recipient. High Security Hospitals have specific powers to withhold outgoing or incoming mail under MHA 1983, section 134 & Regulation 29 & 30 of the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (No 1184). In addition high security hospitals have powers under paragraph 23 (1) of the Safety and Security Hospital Directions 2011 to withhold internal patient to patient post on one of the grounds specified in MHA 1983 section 134(1) or (2).
3. Ways in which people are subject to restrictions

TABLE 9

<table>
<thead>
<tr>
<th></th>
<th>Mail</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital decisions appealed</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Hospital decisions upheld</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Hospital decision overturned</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Other outcome*</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

* Including changes of circumstances (patient discharged, telephone monitoring ceased etc) or negotiated outcomes regarding withheld mail.

Source: CQC

We also monitor the high security hospitals’ practices at a general level. During the year, we raised a number of issues and continue to have constructive responses from the hospitals.

We expect every effort to be made to make sure patients are aware of why restrictions are imposed and what they need to do to be taken off monitoring. This is in line with the principles of the Code of Practice, and a patient’s right to respect for their private life under Article 8(1) of the European Convention on Human Rights.

We found instances where mail to patients was withheld on the statutory grounds of being in the interests of the patient’s safety, due to it possibly causing the patient distress. Legal advice received in 1997 said the statutory criteria for withholding patients’ mail in the interests of their own safety should not be deemed to extend to include the patient’s health and/or welfare.50

There is, therefore, no power to withhold incoming mail on the grounds it would cause distress to the patient.

There is no specific power under the Act to prevent a patient from making or receiving a phone call. Sometimes hospitals need to prevent misuse of its phones, for example to stop a patient suffering delusions from repeatedly calling the emergency services, or when someone has asked not to be contacted by the patient. Actions taken in such circumstances should be clearly documented, alongside their rationale. One patient in a learning disability ward said he had not been allowed to speak to his friend when she phoned, and he had not been told why. Staff could not adequately explain why such a restriction would be either appropriate or lawful. The trust agreed an action plan in response to our concerns.

Restraint

The Code of Practice (chapter 15) emphasises that physical restraint is a last resort in the management and containment of conflict on mental health wards. The Code also identifies factors which may contribute to disturbed behaviour. Attention to these factors is a primary component of action planning to reduce the use of restraint. In our last report we set out our expectations of detaining authorities in managing this difficult area of patient care.51

We continue to hear accounts of patients’ experiences of being restrained. The following is from a learning disability ward:

There were high levels of restraint being carried out. We were unable to fully discuss this with one patient due to communication difficulties, but the records and testimony of staff confirmed that restraint is being carried out on almost a daily basis. The other patient alleged that restraint was not carried out in accordance with the correct procedure. She has complained that staff often put their elbows on her stomach or neck and that she has also observed this when the other patient is restrained. She feels this is dangerous and that she could be injured or fall down the stairs.

CQC report from a MHA monitoring visit, March 2013
None of this is acceptable. A patient in the same detaining authority spoke of his experience of restraint:

“When I misbehave, they all jump on me, and drug me up. I am also kept on plastic [cups and plates] and I lose TV for the weekend, and when I make a mistake I get shouted at”.

In addition to seeking reassurances about staff training (including de-escalation approaches and what debriefing staff were having with the patient), we asked staff to discuss with this patient whether he would like to make an advance statement of preferences in managing his behaviour, so this might be used to reach a negotiated position.

The extent of restraint was highlighted in a 2013 report by Mind, based on freedom of information data from NHS mental health trusts about nearly 40,000 restraint episodes in 2011/12. Mind found prone or face-down restraint – defined as ‘pinning and holding someone face down on the floor for a period of time’ – had been used more than 3,000 times in NHS trusts in 2011/12. It said some trusts have worked hard to eliminate the use of face-down restraint altogether. It recommended that Government should end its use across the entire mental health sector, in part by treating face-down restraint as a reportable ‘never event’.

We share Mind’s concerns over the physical risks and dehumanising effects of face-down restraint. The Independent Commission on Mental Health and Policing recommends a person who is restrained by police in a prone position should be moved as soon as possible. It points to stricter regulation of such restraint when it is used by the prison service rather than the police service (or, we would add, mental health services).

In July 2013 the Independent Advisory Panel on Deaths in Custody (IAP) published a document setting out common principles for the safer use of restraint in all custodial settings. It is not yet clear whether, or how, these will be adopted as common principles across different sectors, although the IAP intends to evaluate this in 2014.

“An admission to a medium secure unit slowly but surely taught me that I could learn to trust the staff, that they weren’t going to restrain me and drag me into seclusion unless I was being obviously destructive. This change in my relationship with staff and with the unit itself happened because I was there on a longer term basis than on acute units and PICU units and there was time for one-to-ones, and psychology, and involvement with the running of the unit. No longer did I struggle against staff physically and mentally – there was no reason to. From this point I could grow and learn my strengths and weaknesses and make progress that I could carry with me for the rest of my life.”

Person detained under section 37

We will expect detaining authorities to take the Mind report and IAP principles very seriously. In compliance with their registration under the Health and Social Care Act, all providers must make sure staff are trained and competent in de-escalation and restraint techniques. Best practice guidance and advice, including the Code of Practice and relevant NICE guidance, should be used to look hard at the practices for which providers are responsible. We would expect to see evidence of the emergent national reports and recommendations being used to inform these reviews.

Safewards interventions: clear mutual expectations, soft words, talk down, positive words, bad news mitigation, know each other, mutual help meeting, calm down methods, reassurance, discharge messages.

www.facebook.com/groups/safewards
3. Ways in which people are subject to restrictions

A number of trusts have addressed their use of physical restraint with encouraging results. Sheffield Health and Social Care NHS Foundation Trust has provided a useful public account of its actions to stop face-down restraint. This acknowledges the constraints on much of the service – including pressures on funding to provide suitably therapeutic environments while having to manage an increasingly unwell inpatient group. It has some innovative ideas, such as the use of ‘green rooms’ for de-escalation and, when these are not available, ‘green bags’ that contain portable items that can be used to create a relaxing space elsewhere on wards. The trust reported success not only in stopping face-down restraint but also in reducing the overall use of restraint.

We welcome the new Safewards model, which in a random controlled trial appeared to show a set of feasible interventions can decrease both conflict and measures taken to contain it.

We are working with the Department of Health, NHS England and other partner organisations to support the development of national guidance on positive behaviour interventions and the use of restraint.

**Mechanical restraint**

Detaining authorities must ensure mechanical restraint is only used as a last resort, and that there are robust procedural requirements to ensure this is the case. We would expect any use of mechanical restraint to be considered as a serious incident requiring investigation and services to undertake a full analysis of the reasons for such restraint.

In practice, mechanical restraint is sufficiently rare that providers may notify us of the use directly. For example when mechanical restraint was used at a forensic learning disability services at Tees Esk and Wear Valley NHS Foundation Trust the service contacted CQC. The provider offered us details of the care being given to one patient who exhibited extreme behaviour, and the restraint being used to allow CQC an opportunity to investigate further or make arrangements to visit the patient. We reviewed the details provided by the trust and were reassured by the thoughtful approach of the care team. The restraint is no longer in use and the patient has now progressed from secure services.

**Police involvement in restraint**

Even in authorities where staff are fully trained in accordance with Code of Practice guidance (paras 15.36, 16.33), there may be rare situations where it is necessary to call the police to manage patients’ behaviour. For example, mental health professionals will not usually be trained in restraining someone with a weapon. We have seen examples where police were called when patients armed themselves with broken furniture or glass, or brought a weapon onto a ward. If the police are called to handle such potentially dangerous situations, it is to be expected they will use whatever methods they feel are appropriate to safely regain control.

Overall, about a third of ward managers told us the police had been called to their ward at least once in the previous 12 months to help contain patient behaviour. This may have included the use of physical restraint (FIGURE 22).

**FIGURE 22**

Reported police involvement on 249 wards in 12 months prior to MHA monitoring visit, by security level.

<table>
<thead>
<tr>
<th>Security Level</th>
<th>Police not called</th>
<th>Police called once</th>
<th>Police called more than once</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>General security</td>
<td>80 (56%)</td>
<td>25 (17%)</td>
<td>37 (26%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Low security</td>
<td>39 (67%)</td>
<td>6 (10%)</td>
<td>12 (21%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Medium security</td>
<td>32 (76%)</td>
<td>8 (19%)</td>
<td>1 (2%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>High security</td>
<td>4 (80%)</td>
<td>1 (20%)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: CQC
Ninety wards that reported calling the police were able to say whether the police had used Taser, CS spray, handcuffs or tape. Twenty wards (22%) reported such use (TABLE 10).

**TABLE 10**

Police technologies used in control and restraint on psychiatric wards, December 2012 to March 2013

<table>
<thead>
<tr>
<th></th>
<th>Shown but not used</th>
<th>Used 1-3 times</th>
<th>Used 10+ times</th>
<th>Total wards responding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Handcuffs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Medium</td>
<td>-</td>
<td>3 (33%)</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Low</td>
<td>-</td>
<td>4 (22%)</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>Non-secure</td>
<td>-</td>
<td>10 (16%)</td>
<td>1 (2%)</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>17 (19%)</td>
<td>1 (1%)</td>
<td>90</td>
</tr>
<tr>
<td><strong>Tape/binding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Medium</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Low</td>
<td>-</td>
<td>1 (6%)</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>Non-secure</td>
<td>-</td>
<td>1 (2%)</td>
<td>-</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>2 (2%)</td>
<td>-</td>
<td>90</td>
</tr>
<tr>
<td><strong>CS spray</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Medium</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Low</td>
<td>-</td>
<td>1 (5%)</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>Non-secure</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>1 (1%)</td>
<td>-</td>
<td>90</td>
</tr>
<tr>
<td><strong>Taser</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Medium</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Low</td>
<td>-</td>
<td>1 (6%)</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>Non-secure</td>
<td>3 (5%)</td>
<td>2 (3%)</td>
<td>-</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>3 (3%)</td>
<td>3 (3%)</td>
<td>-</td>
<td>90</td>
</tr>
</tbody>
</table>

Source: CQC

Tasers were reported to have been used six times. On three further occasions (all on non-secure wards) the Taser was presented but not fired. For example, one incident was reported as “Taser was not actually used but patient was moved to seclusion under threat of use of a Taser due to weapons and threats”.

In some cases the police had managed the situation without using force:

- “The dining room was damaged on a couple of occasions and a patient grazed himself with weapons. Police were called but used friendly ‘come alongs’.”
• “The presence of uniformed police was sufficient to de-escalate the situation. No physical intervention required.”

In other cases, police manually restrained patients:

• “The patient was restrained by four policemen. No equipment was used. It was not fully witnessed by staff as it was in the patient’s bedroom. The patient was taken to the floor from a standing position.”

Sometimes mechanical restraints were used when manual restraint was ineffective:

• “Patient handcuffed on one hand for a short period as he became very distressed.”

• “Four police officers attended to assist ward staff with restraining a patient. Prone position was used and the police had to use handcuffs (while standing) because the patient was still struggling.”

In at least four cases, police used riot shields and other protective clothing, either while removing a weapon from a patient or in moving a patient into seclusion or another part of the hospital.

“When I left the Psychiatric Intensive Care Unit to go to low secure, I was taken in a police van. I found this degrading and unacceptable.”

Person detained under section 3

It is important to make sure that calling the police remains a response to exceptional circumstances where staff are not able to safely manage behaviour, despite implementation of all relevant national guidance on staff training and the establishment of therapeutic environments. Police presence on wards can damage the therapeutic alliance between patients and staff. As soon as the police are on site, the detaining authority has effectively handed over responsibility for managing the situation and has no control over the ultimate actions of the police or the methods they will use. There is a need for clear protocols, shared between all relevant organisations, setting out expectations on both sides.

Seclusion

We continue to encourage detaining authorities to audit and review their seclusion practices with a view to minimising them. Care planning should play an important role and allow patient preferences to be taken into account, both in avoiding seclusion through de-escalation and in managing any seclusion episode itself.

We have seen examples of patients being nursed in seclusion with inadequate regard for their privacy and dignity:

We saw one woman in seclusion being observed by a male healthcare worker. She was menstruating and blood was seeping through her clothes. The door to the en-suite shower and WC was open and the room could be seen on CCTV. We asked why the patient was being observed by a male worker and were informed that it was inevitable as half the staff were male. We were told a female worker would take over if the patient used the lavatory. We were unable to find evidence of the patient being asked her views about how she would like to be managed during seclusion or of staff considering the impact observation by a male worker might have on the patient.

CQC report from a MHA monitoring visit, October 2012

Care planning should also enable patients to know what they should do so that seclusion can end. This is especially important for patients who are held in seclusion for longer periods, when the safeguards of multidisciplinary review may be less frequent.

In one high security hospital, patients did not appear to know what they needed to do to end their long-term segregation. One patient had been told he was not “emotionally ready” but did not know what this meant or how he could prove he was. Other patients told us they understood they needed to be “settled” to end their segregation, but that in practice this made little difference. We saw records of continued segregation, without explanation, for patients described as settled in their medical notes.

While care plans for nursing in segregation were
detailed, they did not address what needed to happen to facilitate reintegration.

We have found some seclusion facilities to be unfit for use. A totally padded seclusion room in one learning disability unit was poorly ventilated, had distorted acoustics and extremely bright lighting, and was extremely hot. This seclusion facility was replaced after our visit.

That particular seclusion room had been used seven times in the month before our visit. Staff there were clear that seclusion was used as a last resort. On a neighbouring ward in the same hospital, seclusion had been used 58 times in the previous month. We found the ward to be noisy and chaotic, with staff apparently aware that they were not providing adequate care to their patients:

Staff were observed to have difficulty in managing the challenging behaviour of a number of patients. One staff member said the atmosphere was not unusual. One of the support workers told us that staff shortages may lead to excessive use of seclusion and that the threshold for placing someone in seclusion can sometimes be quite low. We were told by support workers that not enough de-escalation is attempted which can lead to pre-emptive use of seclusion. A senior member of staff also told us that staff were frequently described as having to ‘fire-fight’ situations.

CQC report from a MHA monitoring visit, July 2012
4. Consent to treatment

Key findings

- We continue to observe that in a significant proportion of records there are no recorded assessments of patients’ consent or capacity at the point of admission or at the three month stage in detention.

- We noted improving good practice in helping patients to draw up advance statements of their preferences for care and treatment.

- In 2012/13, we arranged 13,520 visits by Second Opinion Appointed Doctors (SOADs). This is the heaviest demand for second opinions to date. This was despite an amendment to regulations that, from June 2012, removed the legal requirement for second opinion certification in the case of consenting CTO patients.

- Where the treatment plan proposes medicine above BNF limits our SOADs are twice as likely to make significant (8%) or slight changes (32%) to the prescribed treatment as when it falls within BNF limits. This gives an indication of the safeguard provided by our SOADs against unwarranted treatment.

“It is an extraordinary situation to find yourself in when you have learned through experience what does and does not help you manage your disorder, and can prove this, yet it is your responsible clinician (who regardless of his ability will only have a partial knowledge and therefore understanding of you) who decides what you are allowed to do.”

Person detained under section 37/41

The Mental Health Act provides legal authority for the treatment of patients without their consent, even (in the case of medication for mental disorder) where a patient has mental capacity to consent but refuses to do so. The Act’s safeguards over the use of these powers – a statutory requirement to have treatment without consent certified as appropriate by an independent doctor – do not apply for the first three months of treatment under detention. During this initial period, section 63 of the Act states simply that consent to treatment is not required.

It has been suggested that a 2012 ruling of the European Court of Human Rights may imply that this provision of the Act fails to meet requirements of Article 8 of the European Convention on Human Rights. The Court found that similar provisions in Finnish law did not provide adequate procedural and substantive safeguards over compulsory psychiatric treatment for compliance with Article 8.

The third of our clear expectations of change, set out in last year’s report, was improvement in practice around consent to treatment. We said that clinical staff must be appropriately trained in assessing and recording whether the patient has mental capacity to consent to treatment, and if so whether they do consent to treatment. Ongoing dialogue with the patient is essential. This conversation or dialogue should consider
what treatment a person prefers and also how a person would like to be treated in the future.61

We found that there was some progress made overall in 2012/13, although there is still a long way to go.

**Assessing capacity and consent to treatment**

In a significant proportion of patient records checked in the last two quarters of 2012/13, we found no recorded assessments of capacity to consent to treatment (FIGURE 23).

**FIGURE 23**

Evidence that the approved clinician had assessed capacity to consent to treatment, October 2012 to April 2013

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>At three months or most recent administration of medication</td>
<td>802, (41%)</td>
<td>344, (18%)</td>
<td>819, (42%)</td>
</tr>
<tr>
<td>At first admission</td>
<td>721, (37%)</td>
<td>508, (26%)</td>
<td>736, (37%)</td>
</tr>
</tbody>
</table>

Source: CQC

However, we saw good practice and improvement in many detaining authorities, for example:

We found good recording of capacity to consent on admission and on an ongoing basis, with an explanation of how the responsible clinician reached the decision together with the discussion held with the patient.

**CQC report from a MHA monitoring visit, Priority House, Kent and Medway NHS and Social Care Partnership Trust, June 2012**

Other authorities took clear steps to improve:

In response to a thematic visit monitoring the use of Mental Health Act powers, which included issues of capacity and consent to treatment, the board of Sussex Partnership NHS Foundation Trust agreed a protocol and standard for ensuring consent to treatment is appropriately recorded for all patients. Training and on-line presentations to promote the standard across the trust were being rolled out from June 2013.

**CQC report from a MHA monitoring visit, June 2013**

Many detaining authorities now have forms for prompting and recording assessments of capacity. It is important that these forms do not encourage a ‘tick-box’ approach to assessments.

The Code of Practice establishes a clear expectation that, from the start of any treatment, consent will be sought and the patient’s capacity to give consent considered, even though the Act provides powers to treat without consent. The Code (para 23.37) also states that these attempts should be clearly recorded.

Some hospitals have developed much better practice, often using local forms:

Medical staff were using the trust form ‘first administration of medication following detention’ on a relatively consistent basis. They were also describing with commendable detail how they had determined the capacity of the patient.

**CQC report from a MHA monitoring visit, August 2012**

In this example, the form did not provide clinicians with a prompt to record the attitude to treatment shown by those patients who were deemed incapable of giving or withholding consent. The Code of Practice could be better at emphasising the importance of recording this. Whether a patient is complying with treatment, or is verbally or physically resistant to it, can be relevant both to subsequent outcomes and to the legal question of whether its imposition is proportionate.

Clinicians should remember that capacity assessments are decision-specific (Code of Practice, para 23.39). On a visit in February 2013 we saw one capacity assessment where the decision had been recorded as “admission, medication and generic”, and another where
there were many general references to the patient “lacking capacity and having no insight”. Such ‘generic’ capacity assessments can inappropriately exclude patients from being involved in their care, and are not meaningful in law.

Clinicians should only consider a person to lack capacity when all practicable steps to help them to make a decision have failed. We occasionally find that patients are deemed to lack capacity because of communication difficulties. On a visit in August 2012 we met a patient who had no verbal communication, but was able to answer questions and state preferences through moving their head. In relation to consent to treatment, the responsible clinician had recorded that the patient was incapable of a decision, in part because of an inability to communicate. We suggested that this be reconsidered.

The Code’s requirement that consent should be sought, and that records of consent and capacity assessments should be made, are equally applicable to treatment other than medication, ECT or neurosurgery:

Two of the detained patients were subject to nasogastric feeding. We were not able to find evidence that the patients’ consent was sought or their capacity to consent was assessed prior to treatment. If consent was not given, under section 63 the responsible clinician could still proceed with the required treatment. The recording of such a discussion though demonstrates the hospital’s compliance with the principles of participation, respect and least restriction. Bearing in mind the invasive nature of the treatment and the associated risks of nasogastric feeding, such a record is vital in promoting accountability and demonstrating good practice.

CQC report from a MHA monitoring visit, June 2012

Advance statements and advance decisions

In chapter 2 we noted good practice in helping patients to draw up advance statements of their preferences for care and treatment, for times when they become unable or unwilling to express their views or participate in decisions about their care. Patients should be encouraged to draw up advance statements as a part of care planning. Patients who have mental capacity to do so may also wish to make an advance decision under the Mental Capacity Act, to refuse specified treatments should they lose capacity at a future point.

National Institute for Health and Care Excellence (NICE) guidelines advises services to develop advance statements and advance decisions with patients who wish to do so.

“I did an advance statement, so that if I’m ill again they can access what treatment you prefer, what type of environment you want, what you don’t like and so on. Including what kind of medication works and what doesn’t. I was encouraged to do it by the CPN who went through it in detail.

If you’re well enough to make an advance statement it gives you a bit of protection, even though it’s not binding.”

Person detained under section 3

Some services are still coming to terms with advance decisions and advance statements. Our Second Opinion Appointed Doctors (SOADs) have been approached by clinicians who are unsure whether they might get a second opinion to consider ECT when a patient has made an advance refusal of consent. They cannot. A SOAD could not authorise treatment in such circumstances and there would be no point in arranging the visit. Similarly, SOAD visits have been cut short when it became clear that a valid advance decision was in place refusing consent to ECT.

Advance statements relating to medication are not binding, although they should always be considered. Decisions not to abide by them should be recorded, along with the reasons for such a decision (Code of Practice, para 17.22). Evidence from our visits shows that this is not always done. Hospitals must have systems to allow the clinical team to record and easily
retrieve information about advance statements, so that these are not overlooked.

**Second Opinion Appointed Doctor visits**

CQC is responsible for appointing independent doctors to carry out statutory second opinions to consider whether treatment without consent is appropriate.* In 2012/13, we arranged 13,520 visits by Second Opinion Appointed Doctors (SOADs). Of these, 10,820 were for detained patients (FIGURE 24), and 2,700 for patients subject to community treatment orders (CTOs) (FIGURE 25).

**FIGURE 24**

Completed second opinions for detained patients, 2009/10 to 2012/13

<table>
<thead>
<tr>
<th>Year</th>
<th>Medication</th>
<th>Medication and ECT</th>
<th>ECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>1,051</td>
<td>288</td>
<td>207</td>
</tr>
<tr>
<td>2010/11</td>
<td>8,493</td>
<td>8,146</td>
<td>351</td>
</tr>
<tr>
<td>2011/12</td>
<td>7,652</td>
<td>223</td>
<td>103</td>
</tr>
<tr>
<td>2012/13</td>
<td>9,356</td>
<td>1,007</td>
<td>183</td>
</tr>
</tbody>
</table>

**FIGURE 25**

Completed second opinions for CTO patients, 2009/10 to 2012/13

```
Year     | Medication | Medication and ECT | ECT |
----------|------------|--------------------|-----|
2009/10   | 3,616      | 2,799              | 3,239 |
2010/11   | 3,616      | 2,799              | 3,239 |
2011/12   | 3,616      | 2,799              | 3,239 |
2012/13   | 3,616      | 2,799              | 3,239 |
```

*Except when urgent treatment criteria apply, certification by a SOAD is a requirement: before medication for mental disorder may be given without consent (whether the patient is refusing consent or incapable of giving it) after the first three months of treatment under detention; or before ECT may be given to a detained patient who lacks capacity at any time; or before treatment may be given to a CTO patient who is incapable of giving consent, after the first month of the CTO or the end of the first three months of treatment under detention and CTO, whichever is the greater.

This is the heaviest demand for second opinions to date. This was despite an amendment to regulations that, from June 2012, removed the legal requirement for second opinion certification in the case of consenting CTO patients. That requirement had accounted for 2,464 visits in 2010/11 and 2,370 visits in 2011/12.

**FIGURE 26**

Age of detained patients receiving second opinions, 2012/13

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>626</td>
<td>874</td>
</tr>
<tr>
<td>25 to 34</td>
<td>524</td>
<td>1,476</td>
</tr>
<tr>
<td>35 to 44</td>
<td>590</td>
<td>1,180</td>
</tr>
<tr>
<td>45 to 54</td>
<td>741</td>
<td>1,035</td>
</tr>
<tr>
<td>55 to 64</td>
<td>606</td>
<td>653</td>
</tr>
<tr>
<td>65 to 74</td>
<td>681</td>
<td>567</td>
</tr>
<tr>
<td>75 or over</td>
<td>715</td>
<td>552</td>
</tr>
</tbody>
</table>

**Source:** CQC

The age profile of patients receiving second opinions (FIGURES 26 AND 27) was the same as previous years. The most common are men between 25 and 55. Women begin to outnumber men in the older age bands.
Outcome of second opinion visits

Second opinion reports returned to CQC should say whether the SOAD has changed the treatment plan from that proposed by the patient’s Responsible Clinician, and if so whether that change was ‘slight’ or ‘significant’. Reports do not always include this. However, the available data (FIGURE 28) shows that at least one in five (2,047 or 22%) of second opinion visits to consider the treatment of detained patients with medication resulted in a change of treatment.*

A similar proportion of changes were made by SOADs visiting CTO patients being treated with medication for mental disorder. Around 20% of second opinions alter treatment plans for the medication of CTO patients (FIGURE 29).**

* The calculation that at least one in five (22%) of visits result in some change is calculated from the total number of visits, including those for which outcome data is missing. Visits that result in changes to the treatment plan amount to 29% of visits where the outcome was recorded.

** The calculation that 20% of visits result in some change is calculated from the total number of visits, including those for which outcome data is missing. Visits that result in changes to the treatment plan amount to 29% of visits where the outcome was recorded.
“The adverse effects of the drugs and powerless to change my situation – I began losing the will to live, never mind the plot.

The turning point began – thanks to a SOAD who listened and my family who never gave up on me. They pressured my consultant into rethinking my treatment – while still protesting, he agreed to my request for oral medication and a programme of medication reduction.

The fact it took a SOAD and my family to afford me the opportunity to make decisions about my treatment was disappointing – but also empowering – they believed in my ability to make my own decisions and choices of treatment. This gave me the courage and determination to find my own pathway to wellness.”

*Person now subject to CTO, on detention in hospital*

SOADs may be more likely to demand changes to treatment when it involves medication prescribed in excess of the recommended dosage of the British National Formulary (BNF). Figure 30 shows the numbers of SOAD visits in 2012/13 that considered only medication.* The proportion of visits that result in changes doubles if the proposed treatment exceeds BNF prescribing limits. SOADs made significant changes to 4% of treatment plans proposing medication within BNF limits, and slight changes to a further 15% of such plans. By contrast, SOADs made significant changes in 8% of plans proposing medication above BNF limits, and slight changes in a further 32% of such plans. This gives some indication of the material effect that SOAD visits have as a safeguard against unwarranted treatment.

*Thus excluding a much smaller number of visits that considered both medication and ECT proposals: our dataset cannot distinguish whether any SOAD limitations to treatment plans in such cases relate to medication or ECT.*

**FIGURE 30**

Outcome of completed second opinions for detained patients (medication only), by whether treatment proposed is above BNF recommended limits, 2012/13

<table>
<thead>
<tr>
<th>Medication above BNF limits</th>
<th>845 (60%)</th>
<th>449 (32%)</th>
<th>118 (8%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication within BNF limits</td>
<td>4,290 (54%)</td>
<td>1,178 (15%)</td>
<td>307 (4%)</td>
</tr>
<tr>
<td>2,166 (27%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0% 20% 40% 60% 80% 100%

No change  Slight change  Significant change  Missing data

Source: CQC. Excludes three second opinions for medication above BNF levels where the outcome data was missing.

**Limitations on the safeguard of second opinions**

“All through the interview the SOAD told me that he agreed with me, and understood my fears about trying a new medication. But then he went away and heard the other side of the story. As much as he was on the fence, he was very open to the possibility that I didn’t need to change medication. I did say to him that, if at the end of this you feel that it’s right for me to take this – that it’s the right thing to do to change medication – then I’ll stand by that, I just need to have you here to give me a fair answer to whether I should or not.”

*Patient detained under section 37*

The SOAD safeguard is limited in a number of ways:

- The second opinion system only works as a safeguard if the SOAD can establish meaningful boundaries to the treatment authorised without consent. In our 2009/10 report we raised concern about situations, where a patient consents to some aspects of their treatment but not others (ie concurrent use of Forms T2 and T3). It may be helpful
to address this question in the next edition of the Code of Practice.

- In some cases the safeguard is undermined by the certificate being misinterpreted or ignored when treatment is administered.

- Second opinions are only initiated if the patient’s Responsible Clinician recognises that the patient is refusing to give consent, or is incapable of doing so. Patients who have capacity to give consent may feel pressured to do so for a number of reasons. Sometimes incapacity is not recognised, meaning that compliant patients are treated without proper lawful authority.

“A lot of people don’t realise or know that they can say no to their doctor and may get a second opinion.”

**Patient detained under section 3**

**The reality of consent**

The Code of Practice (para 23.31) states that permission given by a patient under unfair or undue pressure is not consent. There is no simple threshold of ‘unfair or undue’ pressure in a system where patients may, under certain circumstances, be coerced to accept treatment without consent. We have drawn attention to some practices that seem to us to cross that threshold.

In one example, a care plan drawn up for a patient deemed to be consenting to her treatment stated “I will comply with my prescribed medication. If I don’t, my leave will be cancelled or postponed”. We asked the detaining authority to reassure both the patient and CQC that compliance with medication was not the only factor involved in the decision to grant leave, and to reassure us that the patient’s consent was fairly given.

“More than one treatment option is rarely given and rarely discussed. There is no ‘informed consent’.”

**Person subject to CTO**

The certification of a patient’s consent by their treating doctor can prove to be a weak safeguard for the patient. On a visit in October 2012 we were told by one patient that he thought he was on too much medication, was experiencing unpleasant side effects. He said he had talked to staff but had not been listened to. We found a record in his notes that he had raised his concerns on the day before our visit. However, there had been no action to review the statutory form that certified his consent “to take the depot for the time being”. On another visit, a patient who had been certified as consenting by his responsible clinician told us that he had had no discussion about his treatment: “Nothing at all – a dead loss”. His clinical notes seemed to support this: we found no record of any discussion about treatment or consent.

“We know that medication serves a purpose and it helps, but sometimes side effect make it very difficult to lead a normal life, whether it’s volunteering, or being in a support group, or working. I wish there was more understanding of that instead of just “take your meds, take your meds”.”

**Person detained under section 3**

**Consent to treatment, and recall from or revocation of community treatment orders**

The law relating to authority for treatment on recall from or revocation of community treatment orders (CTOs) is complicated and little understood. We have seen a number of cases where it is not clear what authority for treatment is being relied on. The problem may stem from the complicated drafting of this area in the Act, and from the overlapping sources of treatment authority that the Act provides for CTOs. Examples of difficulties we have observed in practice are:

- In some cases, staff have mistakenly assumed that the revocation of a CTO initiates a new ‘three-month period’ when treatment could be given without certification, under the general authority of section 63.
• On occasion, hospitals appear to have administered treatment to patients after recall from or revocation of a CTO on the purported authority of a consent form T2 or a SOAD certificate T3, although such forms had been completed prior to discharge onto the CTO.

• In general, many clinicians seem unsure of which is the ‘correct’ authority to treat patients on recall from or revocation of a CTO. SOADs may have stated treatment that would be appropriate in such circumstances on certificates issued while the patient was subject to a CTO, although in many cases doctors show caution in anticipating the appropriateness of treatment in circumstances they cannot predict.

While it is not surprising that some clinicians find the certificate requirements difficult it is not acceptable that this might result in the unlawful treatment of detainees. On this basis, and in the light of the findings of the Office of the Parliamentary Counsel, any opportunity to review the statutory provisions around CTOs should be taken, at the very least, as an opportunity to simplify the law in this area.
5. Access to care during a mental health crisis and the Mental Health Act

Key findings

- In some areas difficulty in accessing Approved Mental Health Professionals (AMHPs), with waits of over four hours out of hours, are being reported.
- In 2012/13, there were 21,814 uses of section 136, with over 7,500 estimated to involve the use of a police cell. This is a decrease of 7% on the previous reporting period.
- Only 17% of recorded uses of hospital-based places of safety under section 136 resulted in further detention, following assessment by mental health professionals.
- In one area police told us that 41 young people had been detained in police cells over the previous year, the youngest of whom was 11. This is unacceptable.
- Health-based places of safety are often not staffed at all times. This has led to hospital places of safety lying empty while a patient is taken to police custody.
- When we met with carers through our MHA monitoring they told us they were not always provided with enough information to understand the role and function of services or how to get help in a crisis.

“I have been assessed for detention under section 2 or section 3 and have experienced section 136 at a police station on a couple of occasions. I have never been offered admission to a crisis house and I think that this was maybe a better alternative at times.”

Person subject to CTO

People with mental health problems who are in crisis should have an emergency service that is equal in speed and quality to that provided to people with a physical health emergency.

We welcome the Government’s recognition that mental health crisis care in England is falling short of these aspirations, and the development of a national concordat for improving outcomes for people experiencing mental health crisis. The Concordat sets expectations on all the signatories to work together to ensure the quality of response in crisis situations when people – of all ages – with mental health problems urgently need help.

On CQC’s part, we have announced plans to start a thematic review of access to care during a mental health crisis by the end of 2013/14. We want to highlight good practice, as well as point to areas for improvement.

During 2012/13 we made 21 visits focused exclusively on the admission and assessment processes under the Act. We met with local authority social workers, the police, ambulance...
services and other agencies involved. We are continuing these visits in 2013/14 and they will help inform our work on emergency access and crisis care.

We already see some services that are working hard at co-ordinating their crisis services to achieve the best outcomes for patients:

Shropshire local authority representatives told us that there was a real desire between the various agencies to work together. They told us that there were regular meetings and forums at which issues relating to assessment and admission could be discussed with/between partner agencies and pointed to meetings of the Partnership Board, Team Meetings with the trust, Police Liaison Meetings and monthly meetings of the Approved Mental Health Act Practitioner (AMHP) Forum. We were told that the latter in particular are well attended. AMHP training and supervision were said to be robust and improving. Plans are also in place to ensure closer working between AMHP and emergency and community teams.

The AMHP Focus Group told us that they were able to maintain a depth and breadth of practice through the operation of a rota system. They told us that they are able to get specialist advice when needed, including legal advice and advice in relation to learning disability and adolescents. They had good relationships with community mental health and considered that there are good alternatives to admission.

The Independent Mental Health Advocacy (IMHA) service reported that people being informed about advocacy services was getting better, with only a small number of AMHPs and wards who never make referrals. They said that some AMHPs were fantastic in the way they referred patients to their service on a regular basis. They felt nurses and consultants were more responsive to advocacy and used them in a way to de-escalate concerns. The IMHA service responds to referrals the same day. The service stated they worked well with the Crisis and Home Treatment Team so that they could, if necessary, work up to the assessment process if the patient was already known to them in order to provide transitional support.

CQC report from a MHA monitoring visit, South Staffordshire and Shropshire NHS Foundation Trust, September 2012

However, we also see difficulties in accessing resources and coordinating services across the system:

We were told that the only real alternative to admission to an inpatient ward was input from the crisis and home treatment service. However we were told that the amount of input required might not be available at the appropriate time with a delay of 24 to 48 hours before a patient could be seen. We were told that day hospital places were viewed as appropriate for other client groups but not those in crisis, and we were told no respite places or crisis units were available.

CQC report from a MHA monitoring visit, March 2013

“I’ve had to wait six hours to be assessed and a further five hours to be transported to hospital. I’ve always had to go to hospitals out of area as there are never any beds.”

Person detained under section 3

Routes of admission and crisis care

Clinical commissioning groups have a legal duty to designate an inpatient unit where patients can be admitted in “cases of special urgency”, and tell local authorities about this (MHA s140).

In a 2013 College of Social Work survey of Approved Mental Health Practitioners (AMHPs) from at least 94 local authorities, 42% said they did not have a ‘special urgency’ arrangement in their area, and 45% did not know whether there was one or not.
The evidence from our visits also suggests this duty is not being met in many areas – for example:

AMHPs reported delays of four to five hours in getting a bed were not uncommon. When a bed was found, there was a high probability this would not be in the area where the patient lived and could involve placement at the far end of the trust in the neighbouring county.

One AMHP reported one patient was assessed three times under the Act in 24 hours because beds, that were eventually found, disappeared by the time the ambulance arrived. AMHPs also reported being told that there would be a bed available in several hours’ time and being instructed not to convey the patient until the bed was ready. AMHPs did not find this a realistic plan because of issues in getting an ambulance. We were told AMHPs might have to wait several hours with a patient in the hospital until the bed was ready. There were reported occasions when the AMHP and the patient were not allowed on the ward until the bed was ready.

AMHPs also reported the trust prioritised detained patients for beds, which meant that if, following a MHA assessment, the decision was for the patient to be admitted informally, there was extreme difficulty in obtaining a bed. AMHPs stated that when they explained to informal patients the only bed available was some distance away, they might refuse admission. This left a dilemma for AMHPs who then had to decide if they would make an application under the Act or not. Several AMHPs stated doctors had at times wanted a patient detained as this was the only way for them to obtain a bed. AMHPs also reported they could not use an ambulance for informal patients.

CQC report from a MHA monitoring visit, March 2013

In one rural area, lack of an appropriate bed was a factor in admissions being delayed, and the reason for informal patients being directly admitted to a Psychiatric Intensive Care Unit (PICU). Admitting a patient to a more intensive or secure regime than is clinically justifiable is likely to breach the Code of Practice principle of always using the least restrictive alternative to provide care.

We also found and challenged this practice in one London trust. It wrote to its bed managers saying it was inappropriate to manage bed pressures by using unoccupied beds on PICU wards for patients who do not fit the ward profile. When we visited in 2012/13, we noted they had changed their admission practices (although problems with inappropriate PICU placements did continue due to delayed discharges).

We have also heard of very long distance placements away from home areas, such as patients from the South East being sent to North Yorkshire.

In chapter 1 we noted concerns raised by the House of Commons Health Committee over whether the Act’s powers of detention were being used improperly to access services. We have no direct evidence of unlawful practices, although some professionals have acknowledged the thresholds for detention may depend on available resources. In some areas we did hear professionals’ and patients’ frustration at the lack of viable alternatives to detention:

Scrutiny of the detention records showed AMHPs considered there wasn’t a realistic alternative to detention in hospital for patients in crisis who could not remain in their own homes.

The police service endorsed this view. The lack of alternatives to admissions, which are available in many other local authorities, may increase the number of detentions and pressure on hospital beds. Above all it diminishes the ability of services to comply with the least restrictive principle laid out in the Code of Practice

CQC report from a MHA monitoring visit, January 2013

We expect Clinical Commissioning Groups to ensure that local section 140 arrangements, special urgency arrangements, are clear and provided to Local Authorities. We will be considering how we work with Clinical Commissioning Groups and how this may inform our wider thematic work.
Carers

We have seen some very positive developments in some areas in involving carers in the provision of mental health services. Greater Manchester West Mental Health NHS Foundation Trust has a number of initiatives as part of its User Action Team. One pilot in Bolton has given a carers’ perspective on services, and enabled more patient and carer involvement in operational matters.

Many carers we spoke to told us they were happy with the way they had been treated by assessing teams, or by mental health staff more generally. But we also learned information was not always available on how to access services, particularly in a crisis. The following discussion with a group of carers showed they recognised the disparity between crisis provision in mental health and other health services, but were also prepared to help services address this:

The group of carers spoke to us in a compelling way about their experiences, and we heard about the feeling of being left with an escalating situation, not knowing where to turn. This was a common theme to all carers present, especially out of hours. We were told of the difficulties carers experienced in being properly involved in the care of their friend or relative and heard also of the expectation they would take responsibility, for example on discharge. We were told “patient confidentiality” sometimes appeared to be used as a defence against genuine communication and there was clearly a wish expressed from this group to collaborate in the “triangle of care” between service users, carers, and organisations to achieve better outcomes. The group of carers together formulated this view during the meeting and told us: “There is a need for a 24 hour service to respond effectively to mental health crises, similar to the process begun by a 999 call for physical health crises”. Some of the carers would be able and willing to be involved in drawing up this process.

CQC report from a MHA monitoring visit, March 2013

In November 2012 a group of carers told us:

There appears to be some disparity between what constitutes a crisis in the view of service users and carers and that of the CRHTT. Carers in particular talked about the difficulties they experienced in getting services for their relatives and the reluctance of services to intervene early enough. This appears to be a particular problem where service users are unwilling to engage even though carers recognise a substantial deterioration has occurred in their mental health.

CQC report from a MHA monitoring visit, November 2012

Carers are not always provided with enough information to understand the role and function of services or how to get help in a crisis. On the November 2012 visit above, we met with a long-standing carer who had been told, on contacting her crisis team with concerns at her daughter’s rapid relapse, she should seek help from the police instead.

Neither this carer, nor another with a similarly long involvement with mental health services, was aware of her right as Nearest Relative to ask for an assessment under the Mental Health Act (s13(4)).

Community services should make sure any carer or other person who would be the Nearest Relative is aware they can ask for an assessment of their relative under the Act, that this request will be given proper consideration, and any decision not to proceed will be communicated to them in writing (Code of Practice, para 4.80).

Approved Mental Health Professionals

Evidence in London shows it can be difficult to access an Approved Mental Health Professional (AMHP) outside office hours. There have been some delays of more than four hours. Common causes are reported to be, outside office hours, social workers are providing both AMHP and children’s services, and duty social workers are tied up with child protection or other child welfare issues. This has been addressed in some areas by separating the functions, or operating
The development of AMHP roles for professionals other than social workers (possible since the implementation of the 2007 amendments to the Act) may help alleviate pressure on the system.

In one rural county, we found AMHP numbers had reduced by half, in part due to the local authority removing AMHP pay enhancements and offering early redundancy packages. This had left too few AMHPs to provide a safe service. The remaining AMHPs were working long hours, being called in to provide emergency cover, and less able to provide a suitable service both in terms of assessment and for existing caseloads. On one Friday night the single AMHP on duty was called to assessments in three different places would have entailed a round trip of nearly 400 miles: a colleague had to come in from leave to help manage the situation.

Before 2008, the Mental Health Act imposed a statutory duty on local authorities to make sure they “appoint sufficient numbers” of AMHPs. However, the 2007 Act amendments removed this phrase.* The Code of Practice states local authorities must have arrangements in place to provide a 24-hour AMHP service.**

Section 12 approved doctors

Section 12 of the Act requires that one of the doctors assessing a patient for detention is approved by the Secretary of State as having special experience in the diagnosis and treatment of mental disorder. In 2012 it emerged four Strategic Health Authorities had delegated authority for such ‘section 12 approval’ to NHS trusts in an irregular manner. As a result, approximately 2,000 doctors had been making decisions that they were technically not able to make: up to 45,000 detentions may have been invalid but for emergency retrospective legislation passed in October 2012.69 There has, however, never been any suggestion that the detention of any patient was clinically inappropriate.70

Since April 2013, the approval functions for section 12 doctors and Approved Clinicians have been discharged directly by the Department of Health.

In practice, the quality of patient assessments may depend on having sufficient section 12 doctors available. We are pleased to note an example of local action to improve services and ensure access to section 12 doctors:

The deputy medical director for the trust explained how a new rota system has enabled more local NHS consultant psychiatrists to be available for Mental Health Act assessment work both in working hours and out of hours. This has led to a high proportion of doctors involved in assessments having had prior knowledge of the patient involved…and greater knowledge of bed availability as well as a greater understanding of alternatives available to detention under the Act.

CQC report from a MHA monitoring visit to Sussex Partnership NHS Foundation Trust, March 2013

The Royal College of Psychiatrists recommends that the AMHP and the section 12 doctor should attend within three hours of the initiation of section 136, unless there are good clinicalgrounds to delay assessment.71On our visits we heard concerns at delays in assessments extending far beyond this timescale.

Analysis of the section 136 documentation indicated that some patients had to wait up to 20.5 hours for their assessment under section 136 to be completed. For those who presented in working hours, the assessment was completed more quickly. Staff told us that out of hours resources have to prioritise child protection and custody issues. It is common that a section 136 referral from the previous evening is handed over to day services the following morning.

CQC report from a MHA monitoring visit, November 2012

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* The Mental Health (Amendment) Act 2007 substituted a revision of Mental Health Act 1983 section 114. Prior to the 2007 Act, ‘AMHPs’ were termed Approved Social Workers’ (ASWs).

** The MHA Code of Practice continues to refer to the ‘statutory duty’ on local authorities at para 4.33.
Ambulance services

In the College of Social Work survey, 66% of AMHPs said their local authority had a formal arrangement with ambulance providers for transport to hospital. However, 42% said the arrangement was not working well enough, and 10% that it was not working at all. This is clearly an area where good practice is hampered by co-ordination problems, as we have noted on some visits:

AMHPs reported there had been a significant improvement in the response times from the ambulance service over the last six months, following the AMHPs being given the same status as general practitioners in requesting ambulances and therefore securing a response time of one to two hours. AMHPs also reported the professionalism and clinical skills of the ambulance crews were usually of a high standard. Ambulance crews, on the whole, were happy to support the AMHP in using the minimal restraint to enable the patient to get into the ambulance. However, AMHPs reported there were problems coordinating a joint response from the police and ambulance services, as sometimes one would not attend until the other had arrived. Also, AMHPs reported they could not get the two control rooms to speak to each other. However, when police did arrive, they were usually very supportive of the AMHP and used proportionate force to enable the patient to be conveyed to hospital using the ambulance whenever possible.

CQC report from a MHA monitoring visit, March 2013

Section 136 and the role of the police

The Independent Commission on Mental Health and Policing was set up in September 2012 at the request of the Metropolitan Police Commissioner, Sir Bernard Hogan-Howe, in the wake of the inquest into the death of Sean Rigg. It reported in May 2013 on its examination of the role of the Metropolitan Police Service in dealing with mental health crises, stating mental health is, and should be, seen as a part of the core business of policing. The report calls for all police stations to have immediate access to mental health support, including liaison and diversion services. It endorses the recommendation in the 2009 Bradley Report that health care in police stations should be commissioned by the NHS, and emphasises the role ambulance services have in ensuring the response to a mental health crisis is similar to that in a physical health crisis.

The Mental Health Act gives police officers the power to take to a place of safety any person who is in a public place and appears to be mentally disordered and in need of ‘care or control’. This power, under section 136 of the Act, is technically a form of arrest. In 2011/12 the power was used at least 23,500 times. More than a third of these resulted in a police cell being used as a place of safety. In 2012/13, there were 21,814 reported uses of section 136, of which 7,761 involved the use of a police cell. This appears to reflect a fall in the use of police cells as places of safety from the previous year. The improvement in data collection this year should enable this use to be tracked accurately in future years.

FIGURE 31

Outcomes of section 136 in a hospital-based place of safety, 2009/10 to 2012/13

<table>
<thead>
<tr>
<th>Year</th>
<th>Section 136</th>
<th>Section 136 of whom admitted</th>
<th>Section 136 of whom arrested</th>
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<td>2012/13</td>
<td>2,135</td>
<td>291</td>
<td>11,393</td>
</tr>
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<td>2011/12</td>
<td>2,142</td>
<td>440</td>
<td>11,567</td>
</tr>
<tr>
<td>2010/11</td>
<td>1,948</td>
<td>428</td>
<td>10,754</td>
</tr>
<tr>
<td>2009/10</td>
<td>1,553</td>
<td>367</td>
<td>9,211</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre, KP90
The outcome of detentions in hospital-based places of safety under section 136 over the last four years is shown at Figure 31. Outcomes where the police station is used as a place of safety cannot be specifically identified in the existing data collection.

Figure 5.1 shows that as the number of uses of section 136 rises the number of people who do not require further detention following section 136 assessment is decreasing. In 2012/13, only 17% of recorded uses of hospital-based places of safety under section 136 resulted in further detention compared to 29% reported in 2007/08.

We welcome the interest shown by Government in providing alternatives to the use of section 136 through a ‘street triage’ pilot scheme in nine police force areas. In the scheme, mental health nurses directly advise police officers during incidents where the police believe someone may be in need of immediate mental health support. Early reports suggest the reduction in police use of section 136 under the pilot may be substantial.

There are other encouraging examples of co-ordination between services to address shortcomings in access to mental health care during a crisis. In 2012 the chief executive group representing the London Mental Health trusts launched a project to improve section 136 practice across London. The resulting action contains a number of actions may be usefully adopted in other areas. One simple measure is a flowchart that shows best practice procedure and is displayed for staff in all relevant locations. Services outside of London should consider adapting this flowchart to their own localities and making it available to their staff.

**Police cells as places of safety**

The use of police cells as a place of safety continues to be a cause for concern across the systems. Many police representatives we meet acknowledge police custody is unsuitable for section 136 detainees.

During May and June 2012, in collaboration with HM Inspectorates of Constabulary (HMIC) and Prisons and Healthcare Inspectorate Wales, we inspected places of safety across seven police forces.* We interviewed staff; reviewed policies and protocols; examined a sample of custody records and spoke to a number of people who had been detained and taken into police custody as a place of safety. HMIC published the report of our findings, *A Criminal Use of Police Cells?*, in June 2013. The report made a number of recommendations.

In many cases, the reason why police custody was used as a place of safety was not documented in custody records. When it was, the most common reasons were:

- Not enough staff at the health-based place of safety.
- Not enough beds at the health-based place of safety.
- The person was intoxicated.
- The person was displaying violent behaviour, or had a history of violence.

Health-based places of safety are often not staffed at all times, which has led to situations where there have been hospital places of safety lying empty while a patient is taken to police custody. CQC will be asking NHS trusts to complete a survey that assesses the availability in practice of health based places of safety; capturing information on when it is open, staffing and local working arrangements. This assessment will be completed by March 2014 and an interactive map of our findings will be published. This work is in line with the approach of the national concordat for improving outcomes for people experiencing mental health crisis in which CQC has an active role.

There is a strong commitment on the part of the police to avoid police custody as a place of safety. The police do not see the custody as appropriate: risk management in custody can mean strip searching, removal of clothing and use of safety suits. The police reported that quite often the hospital places of safety are closed. Hospital staff also acknowledged

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* Kent, Lancashire, Leicestershire, Norfolk, North Wales, Suffolk and Sussex, alongside two Metropolitan Police boroughs (Bromley and Lewisham).
that from time to time they have to close the places of safety, due to the shortage of staff. Most places of safety are staffed by nurses from the wards. As the wards are run with minimum numbers of staff, sometimes it is impossible to take staff off the ward. This is more of an issue during the night when staffing is less than during the day.

CQC report from a MHA monitoring visit, July 2012

People detained under section 136 who are intoxicated

The exclusion of people who appear to be under the influence of drink or drugs from health-based places of safety has been a long-standing issue. Some mental health services justify this practice on the basis that no meaningful mental health assessment can be carried out on someone who is intoxicated. Police officers have argued to us this approach can be used to exclude people who only show signs of alcohol or drug use. We have seen examples where hospitals have refused to admit detainees because they smell of alcohol.

On a visit in July 2012, we found one hospital-based place of safety had a criterion for excluding detainees who appeared to be experiencing the effects of alcohol and were “intoxicated preventing assessment within two hours”. In this way, local targets for the completion of assessments, while useful in themselves, may lead to greater exclusion of more difficult presentations. This leads to the use of police cells.

Children and young people

In our 2009/10 report, we raised concerns that three hospitals in the South West were refusing to admit adolescents into their places of safety, on the grounds these were connected to an adult ward and therefore not age-appropriate accommodation. This meant police cells continued as the default place of safety for patients under 16, and for patients aged 16 or 17 in all but exceptional circumstances. In a meeting in March 2013, police told us practice had not changed and 41 young people had been detained in police cells over the previous year, the youngest of whom was 11. This is unacceptable. Even if hospital managers are correct to consider their place of safety not to be age-appropriate for this group, the Code of Practice (para 36.71) allows the need for safe accommodation to take precedence in the short-term. We will be completing further reviews of this concern and taking appropriate action relating to this issue with the provider through our regulatory and MHA powers.

A&E departments and hospital-based places of safety

The Royal College of Psychiatrists recommends every A&E department should have at least one interview room for psychiatric consultations, close to or part of the main A&E receiving area, to enable assessments to take place in a setting that provides privacy, confidentiality and respect.

In February 2013 we visited the Royal Sussex County Hospital, where the A&E department had been provided with an assessment lounge. Clinical staff told us it was ‘invaluable’ in allowing people who may be suffering from a mental disorder to remain in a calm environment and to respect their privacy and dignity. The introduction of the lounge had reduced the numbers of people leaving prior to assessment due to the busy and noisy environment, and also reduced numbers of hospital admissions.

The Royal College of Psychiatrists’ guidance also stresses the importance of liaison arrangements between A&E departments and local mental health services, and the need for basic training of A&E department personnel on mental health issues.
6. Deaths of patients subject to the Mental Health Act

Key findings

- In 2011/12 and 2012/13 we were notified of 595 deaths in total. There were 511 deaths of detained patients, and 84 deaths of patients subject to CTOs.
- We support the recommendation of the Ministerial Board on Deaths in Custody that, NHS England – with input from CQC and the Coroner’s Society – should produce clear and consistent guidance on how all mental health providers should undertake investigations following the death of a detained patient.
- We will be working with others to review national data and how this can be combined and shared to improve scrutiny and embed learning. We believe this will improve national understanding and our ability to work together to protect patients’ rights and increase safety.
- We have introduced a patient safety outliers programme in mental health and will be using the data from this and our collaborative work with other national organisations to inform our understanding of providers and our assessment of how safe their services are.
- The total number of reported deaths by unnatural causes for detained patients deaths reported to CQC rose from 36 to 48 in 2012/13 compared to the previous year.

Under the Health and Social Care Act, providers must notify CQC of all deaths of detained patients or those liable to be detained. NHS England and clinical commissioning groups have access to a wide range of data about deaths and serious incidents requiring investigation, but detained patients are not identified as a specific group in this data. Data relating to suicides are also collected by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness from national statistics.

CQC believe the figures we hold relating to the deaths of patients can be improved and this will be part of our improvement work in 2013/14. We believe the statistics provided within this report should inform policy decisions in this area and we will be completing rigorous reviews of how we can achieve consistent reporting with other national bodies but also seeking ways to improve our approaches to individual cases. This work will be an essential part of our commitment to

* Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 requires service providers registered with CQC to notify CQC of deaths of service users who is detained or liable to be detained under the MHA. In the regulation ‘liable to be detained’ includes a community patient who has been recalled but does not include patients who has been conditionally discharged and not recalled to hospital in accordance with section 42, 73 or 74 of the MHA. Current notification templates can be found at http://www.cqc.org.uk/organisations-we-regulate/mental-health-services/mental-health-act-guidance/mental-health-act-notification.

** i.e. the Strategic Executive Information System (STEIS) does not identify whether patients are subject to MHA powers at the time of a death or serious untoward incident.
protecting the rights of people who use services and informing our work on issues relating to the safety of patients. There are currently a number of challenges in the aggregation of data relating to the deaths of detained patients and we will be working across the health and care system to seek ways to overcome these. Wherever possible the existing data quality issues are highlighted within this chapter with an explanation of cause or our plans to improve.

One of the improvements to data quality will be made through the national data joint work between CQC, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness and the Health and Social Care Information Centre which is already in progress. This work will aim to expand the coverage of existing data sets and review and increase the verification methods in place. This will increase the reliability of the data we hold nationally and ensure we are working collaboratively to share information.*

For CTO patients who are not recalled there is no explicit regulatory requirement on services to notify CQC directly of such deaths. We believe the deaths of patients subject to a CTO are of significant importance to our understanding of quality and safety of services for people subject to the MHA and to related policy on the MHA. CQC expects providers to notify us directly of the deaths of people on CTOs using the MHA notification format. As this is not a clear requirement in regulation we cannot offer absolute assurance that the data provided in this report is a complete picture of all CTO fatalities during the periods reported.

CQC does not have specific statutory remit to investigate the deaths of detained patients. However, we do have a process to review deaths notified to us and we can take further investigatory or regulatory action where we think it is indicated by the circumstances of the death. Our approach to this has been developed in consultation with partner agencies which resulted in the establishment of an escalation framework for reported deaths. To complete reviews we may ask for records from the detaining authority, carry out a monitoring or regulatory visit, or undertake other regulatory interventions in line with our responsibilities under the Health and Social Care Act.

## Total death notifications

We were notified of 595 deaths in total for 2011/12 and 2012/13 (TABLE 11). Of these reported deaths we received notifications of 84 deaths of patients subject to community treatment orders (CTOs).

### TABLE 11

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(where date of death has been notified to us as between 1 April 2011 to 31 March 2012 and 1 April 2012 to 31 March 2013)</td>
<td>275</td>
<td>320</td>
<td>595</td>
</tr>
<tr>
<td>Detained</td>
<td>236</td>
<td>275</td>
<td>511</td>
</tr>
<tr>
<td>CTO</td>
<td>39</td>
<td>45</td>
<td>84</td>
</tr>
<tr>
<td>Total</td>
<td>275</td>
<td>320</td>
<td>595</td>
</tr>
</tbody>
</table>

Source: CQC
Causes of death – detained patients

There were 236 deaths of detained patients in 2011/12, and 275 deaths in 2012/13 (TABLE 12). We have used a range of sources to categorise the data we hold into natural, unnatural and undetermined causes. The data for 2011/12 has been cross checked against the data held by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

The methodology for determining the cause of death, following notification to the CQC, may be taken from the original notification, following an investigative review completed by CQC or on receipt of the verdict of the coroner’s inquest.

Where we have categorised the cause of death as undetermined this may be because the coroner has recorded an open verdict or where we are awaiting an updated cause from the coroner’s inquest.*

* At the time of writing this report there are 25 records awaiting further information, 16 records where the cause is recorded as not known and 9 records of unascertained cause in the CQC database.

Death by natural causes

Table 13 shows the most common causes of natural deaths in the two years. The most common causes of death, where known, were pneumonia, heart disease and pulmonary embolism.

Some of the deaths in the category of ‘other’ natural deaths appeared to involve bowel obstruction. In response to deaths linked to the antipsychotic drug Clozapine and bowel obstruction, many trusts have reminded staff about the risk of gastrointestinal hypomobility as a side effect of the drug, citing the letter distributed across Wales by its chief pharmaceutical officer.84

We have seen an increasing national focus on the physical health checks being completed with both community and inpatients. Projects to increase health screening are often jointly undertaken with providers and public health or advocacy services. Our findings reinforce the need for health screening programmes among detained patients85 and we will continue to look for evidence of access to health screening through our monitoring and regulatory visits.

**TABLE 12**

Regulation 17 deaths of detained patients by causes, 2011/12 to 2012/13

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>191</td>
<td>200</td>
<td>391</td>
</tr>
<tr>
<td>Unnatural</td>
<td>36</td>
<td>48</td>
<td>84</td>
</tr>
<tr>
<td>Undetermined</td>
<td>9</td>
<td>27</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>236</strong></td>
<td><strong>275</strong></td>
<td><strong>511</strong></td>
</tr>
</tbody>
</table>

Source: CQC
### TABLE 13

**Cause of death of detained patients, natural causes, 2011/12 to 2012/13**

<table>
<thead>
<tr>
<th>Natural causes</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>34</td>
<td>33</td>
<td>67</td>
<td>17%</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>18</td>
<td>16</td>
<td>34</td>
<td>9%</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>6</td>
<td>11</td>
<td>17</td>
<td>4%</td>
</tr>
<tr>
<td>Cancer</td>
<td>18</td>
<td>12</td>
<td>30</td>
<td>8%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>27</td>
<td>17</td>
<td>44</td>
<td>11%</td>
</tr>
<tr>
<td>Aspiration pneumonia</td>
<td>5</td>
<td>11</td>
<td>16</td>
<td>4%</td>
</tr>
<tr>
<td>Respiratory problems</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>51</td>
<td>79</td>
<td>20%</td>
</tr>
<tr>
<td>Unknown</td>
<td>45</td>
<td>44</td>
<td>89</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>191</strong></td>
<td><strong>200</strong></td>
<td><strong>391</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: CQC

Table 14 shows the age ranges of people who died by natural causes. Over the two year period 133 deaths took place before the patient reached the age of 60 which is a third of reported deaths from natural causes. Seventy-nine per cent of deaths in the under 60 year olds occurred between the ages of 40 to 59 years old. This remains consistent with our previous national reports and other emerging research across all mental health deaths. NHS England has issued a “call to action” in November 2013 to help tackle inequalities between people who suffer from physical and mental illness. Average life expectancy is now 83 for women and 79 for men but for those with serious mental illnesses it is significantly lower 69.9 for women and 64.5 for men.

### TABLE 14

**Age at death of detained patients, natural causes, 2011/12 to 2012/13**

<table>
<thead>
<tr>
<th>Age at death (natural causes)</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 and under</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20-29</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>30-39</td>
<td>13</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td>40-49</td>
<td>23</td>
<td>21</td>
<td>44</td>
</tr>
<tr>
<td>50-59</td>
<td>33</td>
<td>27</td>
<td>60</td>
</tr>
<tr>
<td>60-69</td>
<td>35</td>
<td>26</td>
<td>61</td>
</tr>
<tr>
<td>70-79</td>
<td>35</td>
<td>43</td>
<td>78</td>
</tr>
<tr>
<td>80-89</td>
<td>44</td>
<td>61</td>
<td>105</td>
</tr>
<tr>
<td>90 and over</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>191</strong></td>
<td><strong>200</strong></td>
<td><strong>391</strong></td>
</tr>
</tbody>
</table>

Source: CQC
Death by unnatural causes

Table 15 provides details of causes of death, where known, not attributed to natural causes.

Table 16 provides details of the reported age at death where known. At the time of death due to unnatural causes, 87% of patients were younger than 60 years of age.

**TABLE 15**

Cause of death of detained patients, unnatural causes, 2011/12 to 2012/13

<table>
<thead>
<tr>
<th>Unnatural causes</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanging</td>
<td>10</td>
<td>14</td>
<td>24</td>
<td>29%</td>
</tr>
<tr>
<td>Jumped in front of vehicle/train</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>11%</td>
</tr>
<tr>
<td>Jumped from building</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>10%</td>
</tr>
<tr>
<td>Self-poisoning</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Drowning</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>Self-strangulation/suffocation</td>
<td>8</td>
<td>10</td>
<td>18</td>
<td>21%</td>
</tr>
<tr>
<td>Method unclear</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Accidental</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Another person</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Unsure suicide/accident</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>Iatrogenic</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
<td><strong>48</strong></td>
<td><strong>84</strong></td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: CQC

**TABLE 16**

Age at death of detained patients, unnatural causes, 2011/12 to 2012/13

<table>
<thead>
<tr>
<th>Age at death</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 and under</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>20–29</td>
<td>8</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>30–39</td>
<td>11</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>40–49</td>
<td>9</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>50–59</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>60–69</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>70–79</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>80–89</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>90 and over</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No date of birth supplied</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
<td><strong>48</strong></td>
<td><strong>84</strong></td>
</tr>
</tbody>
</table>

Source: CQC
Restraint and deaths of detained patients

The CQC notification form requires providers to inform us where restraint has occurred within seven days of the death. Where the cause is known to us we do not believe the death occurred immediately following or during restraint although we will be reviewing how we may improve our data including additional categories in our database to determine where restraint has occurred within an hour or 24-hour period before. This is the approach taken by the National Confidential Inquiry currently and will improve our ability to include additional information in future reports.

### TABLE 17

Causes of deaths of detained patients where restraint used within seven days prior to death, 2011/12 to 2012/13

<table>
<thead>
<tr>
<th>Cause</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>7</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Hanging/self-suffocation</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Jumped off tall building</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Unascertained</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Awaiting information</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>18</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

Source: CQC

Deaths of patients subject to CTOs

In 2011/12 we were notified of 39 CTO patient deaths and in 2012/13 there were 45 reported to us. Table 18 provides the total by causes for the reported periods.

### TABLE 18

Deaths of CTO patients by cause, 2011/12 to 2012/13

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>27</td>
<td>26</td>
<td>53</td>
</tr>
<tr>
<td>Unnatural</td>
<td>10</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Undetermined</td>
<td>2</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
<td><strong>45</strong></td>
<td><strong>84</strong></td>
</tr>
</tbody>
</table>

Source: CQC
Death by natural causes

**TABLE 19**
Cause of death of CTO patients, natural causes, 2011/12 to 2012/13

<table>
<thead>
<tr>
<th>CTO natural causes</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>5</td>
<td>3</td>
<td>8</td>
<td>15%</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Cancer</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>Aspiration pneumonia</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Respiratory problems</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>23%</td>
</tr>
<tr>
<td>Unknown</td>
<td>6</td>
<td>9</td>
<td>15</td>
<td>28%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>26</strong></td>
<td><strong>53</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: CQC

**TABLE 20**
Cause of death of CTO patients, unnatural causes, 2011/12 to 2012/13

<table>
<thead>
<tr>
<th>Unnatural causes</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanging</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Jumped in front of vehicle/train</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Jumped from building</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>Self-poisoning</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Drowning</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>Self-strangulation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Self-suffocation</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Method unclear</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Accidental</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>9</strong></td>
<td><strong>19</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: CQC
Key developments

Since we last reported on the deaths of detained patients in our 2010/11 report there have been a number of national developments, publications and judgments that relate to deaths of detained patients. These will inform and drive improvement to responses. It is vital that all agencies work together when a death occurs but also to continuously review the methods for system wide learning to prevent future deaths.

We are working collaboratively with the agencies involved in several national projects, looking at ways we can improve information sharing, learning and intelligence. An example of the practical outcomes from this work is our memorandum of understanding that is being developed with the Coroner’s Society. The memorandum will set the principles of joint working for the CQC and individual coroners and will allow us to establish robust frameworks for information sharing in line with our separate legal duties in individual deaths but also to promote national learning.

In our 2010/11 report we referred to the Government’s plan to incorporate the work of the National Patient Safety Agency into NHS England. Since April 2013, the NHS England Patient Safety Domain team have been reviewing how they can use their role to improve the NHS approach to deaths in detention in a range of settings, including patients detained under the Mental Health Act. We have been involved in the review and analysis, and now await the release of the detailed plans that will set out the key issues and provide greater clarity to NHS organisations on the expectations when a death occurs.

The Independent Advisory Panel on Deaths in Custody (IAP) raised concerns to the Ministerial Board on Deaths in Custody that the Department of Health’s current arrangements may not meet the state’s positive duty, under Article 2 of the European Convention on Human Rights. The criteria to be applied under the broad description of an Article 2 compliant investigation is that it is initiated by the state of its own volition, independent, effective, sufficiently open to public scrutiny, reasonably prompt and the family should be involved. The Department of Health has re-stated that the coroner’s inquest is the primary means by which the state fulfils its Article 2 duties and in October 2013 this was supported by a judgment handed down in the high court. However, the IAP questioned whether the coronial system is responsive or resourced enough to carry out prompt and effective investigation. It is recognised that a quarter of inquests of deaths in custody take more than two years to complete.

We also continue to play an active role in the Ministerial Board on Deaths in Custody and work with other agencies to review and deliver the recommendations partner organisations have made through this Board to improve investigations in healthcare. This includes working with the Department of Health to review and improve the information we collate through the notifications of deaths.

Research focus: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The Inquiry released their findings in July 2013. The Inquiry reviews suicides and homicides committed by people who have been in contact with secondary mental health services in the previous 12 months and produces recommendations and guidelines aimed at improving outcomes and reducing suicide rates for patients with mental illness. The report covers the period 2001 to 2011.

Some of the key findings from the Inquiry in relation to detained patients, those who had absconded and those subject to community treatment orders (CTOs) are highlighted below:

- 375 or 26% of inpatient suicides were inpatients detained under the Mental Health Act which is an average of 34 a year. The number of these deaths decreased between 2001 and 2010 but have remained at an average of 23 a year since 2008.
30 (8%) of the deaths reported to the inquiry of detained patients died in the first week of admission (compared to 17% of other inpatient suicides in the Inquiry report).

139 (38%) detained inpatient deaths occurred on the ward; in 40% of these cases this was an open ward.

There were 351 inpatients who died after absconding from the ward, 24% of all inpatient suicides, an average of 32 deaths a year.

There was an overall fall in the number of suicides after absconding, numbers have been substantially lower since 2006.

There were 20 suicide deaths among patients subject to a CTO between 2008 and 2011, less than 1% of all patient suicides in this time period. In addition, 13 patients who died had previously been on a CTO but were not on a CTO at the time of suicide.

12 of the 20 deaths under CTO occurred within three months of hospital discharge.

The Inquiry report also made recommendations for services based on the work completed over the last decade. A toolkit has been produced that provides practical steps for professionals and managers to improve safety and reduce risks.

In November 2013 the Inquiry also released a UK-wide study of patient suicide: the impact of service changes. This study extended the findings of previous reports by being UK wide, examining a wider range of service changes and examining patient suicide rates over a longer period of time. The study offers five key messages for mental health services to improve patient safety:

- Provide specialist community services such as crisis resolution/home treatment, assertive outreach and services for patients with dual diagnosis.
- Implement NICE guidance on depression.
- Share information with criminal justice agencies.
- Ensure physical safety, and reduce absconding on inpatient wards.
- Create a learning culture based on multidisciplinary review.

In 2013/14 we will be working with the Inquiry to look at how we can strengthen information sharing and support the implementation of learning from the recommendations made in the report.

**Future work concerning deaths of patients subject to the Mental Health Act**

In 2013/14 we will continue to work with partner organisations to review how we can use our MHA and regulatory roles to ensure there is a comprehensive and consistent approach to reviewing and learning from individual deaths.

We will be looking at how we use our data to assess the safety of providers’ services. We will use our analysis of combined data sets on deaths to inform lines of enquiry in our plans for integrated inspections. To support this we have developed and implemented an outlier’s patient safety programme which includes the deaths of detained patients.

We will also be looking at how investigations are conducted locally. We will be seeking evidence that the views of families are being properly
sought and represented and that learning from investigations is being used in the design, delivery and planning of services. We will be using all the powers and knowledge available to us to ensure health and care services are doing all they can to improve their practice and share learning in this area.

We will report the data we hold on deaths of detained patients and those subject to CTOs in each annual report. We will agree with partners what information we will publish as a minimum and ways we may improve how we present our findings.
Conclusions and next steps

There are clear, recurring themes that come out of our findings. All parts of the health and care system need to work together to make the changes that are urgently needed and, in most cases, required as a minimum by the Mental Health Act and the accompanying Code of Practice.

We expect to see change in the following areas

1. Hospitals must ensure that their policies promote the principle of least restriction and that their staff are supported to promote the dignity and autonomy of people in their care.

2. Hospitals must promote cultures that support therapeutic practices and reduce to a minimum the use of restraint and seclusion. The principles of the Code of Practice and the emerging national evidence on restraint need to be considered by all services. We expect detaining authorities to audit and review their local practices to minimise the use of restraint and seclusion. We expect to see evidence of coordinated care planning that allows patients’ preferences to be taken into account. This is to promote individual choice and involvement in avoiding or managing episodes that may otherwise result in restraint or seclusion.

3. NHS and local authority service commissioners of mental health services must act on these findings and on guidance in the Implementation Framework to the national mental health outcomes strategy to improve access to services and outcomes for people with mental health problems. We expect Clinical Commissioning Groups to ensure that local special urgency arrangements (section 140) are clear and provided to local authorities.

4. Commissioners and providers of mental health services must be proactive in initiating and embedding learning from the deaths of people subject to the MHA. We expect to see alignment of local preventative and investigative work with the national findings on mental health related deaths. This includes emerging guidance from national bodies and the use of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness toolkit. We expect services to notify us of deaths of detained patients and patients who are on a community treatment order at the time of their death.
What CQC will do

We have identified five key areas of action for CQC. These are in line with and complement our strategic intentions.

- **Use of the Mental Health Act**
  It should be a source of considerable concern to the health and social care system in this country that use of the MHA continues to rise – despite the objectives of the national mental health policy and the investments in community services of recent years. We will be working across the system to consider possible changes to practice and policy that could result in a reduction or reverse to this trend. This will include working with our stakeholders to consider how increased use of the national data can inform our integrated regulatory model and how the findings and conclusions from current research in this area can be implemented.

- **Deaths of detained patients**
  People in the care of specialist mental health services are a high risk group for suicide and unidentified, poorly treated or preventable physical ill-health. We are concerned about how services respond to, review and report on deaths, so we are committing to include the information we hold on deaths in psychiatric detention in all future annual reports. We will work with partners, including NHS England and the National Confidential Inquiry into suicide and homicide by people with mental illness, to look at how we can do this in a way that offers better intelligence and opportunities for shared learning and preventative action.

- **Access to care during a mental health crisis**
  Our reports have consistently reported issues about the availability and responsiveness of services when people are in mental health crisis. This report has noted several significant pieces of national work that are aimed at improving this area and ensuring that parity of esteem becomes a reality.

  CQC will work with key partners in developing the Mental Health Crisis Care Concordat. This will focus attention on the issues that have been highlighted around emergency mental health care. CQC has committed to delivering a thematic programme around the experiences and outcomes of people experiencing a mental health crisis, and will take this forward over the course of 2014 with the intention of publishing a national report in the autumn.

- **Complaints about the Mental Health Act**
  We have a statutory duty to review and investigate complaints relating to the MHA. We will be looking at how we review the content and trends of these complaints. We will do this in line with our new regulatory approaches to complaints in our inspections and assessments of providers. We will be specifically looking at how local services respond to the MHA complaints from detained patients to the CQC and what mechanisms they have in place to make sure they are responded to and reported. Most importantly we will also check what system-wide learning takes place as a result of the themes that emerge from our MHA complaints data.

  In next year’s report, we will look at how the voices and experiences of detained patients are heard through the CQC MHA complaints system, and what we may do to improve the way we respond, collate and share that information with the wider system.

- **Involving people who use services**
  In our new integrated regulatory model, we will increase the voice of people who use services in our understanding of the operation of the MHA. We will spend more time talking to people who are affected by the MHA and working with local Healthwatch, and use this information more to inform our judgments of services. We will continue to ask people with experience of detention to be on our expert panels, and include MHA experts in our inspections and monitoring visits.

  Our new inspection reports in 2014 will combine our findings in a single report that covers both service inspection and MHA monitoring. Our aim is to increase public understanding and awareness of the experience of people who are detained.
Appendix: MHA report Advisory Group

An external Advisory Group provided experience and expertise on the approach and scope of this Mental Health Act annual report. The group met twice in 2013, offered comment and advice on the themes and issues covered by the report, and reviewed the detailed draft.

CQC is grateful for the time, support, advice and expertise given to the report by the group. The members were:

- Anthony Beschizza, Central and North West London NHS Foundation Trust
- Sara Cain, Healthwatch England
- Julie Chalmers, Royal College of Psychiatrists
- Steve Chamberlain, College of Social Work
- Alison Cobb, Mental Health Alliance
- Martin Coyle, Action for Advocacy
- Netta Hollings, Health and Social Care Information Centre
- Ian Hulatt, Royal College of Nursing
- Brenda Jones, Service User Reference Panel
- Matilda MacAttram, Black Mental Health UK
- Anne McDonald, Department of Health
- Claire Murdoch, Central and North West London NHS Foundation Trust
- Edwin Omorogije, Burke Niazi Solicitors
- Sarah Norman, ADASS
- Shaun Redwood, Service User Reference Panel
- Kathy Roberts, Mental Health Provider Forum
- Genevieve Smyth, British Association and College of Occupational Therapists
- Jo Webber, NHS Confederation
- Helen Wildbore, British Institute of Human Rights
- Sarah Yiannoullou, National Survivor User Network
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The Care Quality Commission is a member of the UK’s National Preventive Mechanism, a group of organisations that independently monitor all places of detention to meet the requirements of international human rights law.