



# Monitoring the Mental Health Act in 2011/12

## Summary



# CQC is focused firmly on dignity, recovery of people

Mental health is a major issue for this country. Nearly a quarter (23%) of the total burden of disease in the UK is attributable to mental disorder, compared to 16% for cancer and 16% for heart disease. Mental disorder has a broad range of impacts across health, education, work and criminal justice as well as links with health risk behaviour and associated premature mortality.

Mental health is high on the Government's agenda. In 2011, the Government stated its commitment to parity of esteem between mental and physical health services in its mental health strategy, No Health without Mental Health. This commitment has been reaffirmed recently in its mandate to the NHS Commissioning Board for the next two years, which legally requires the Board to pursue the objective of putting mental health on a par with physical health.

The Government's consultation on the NHS Constitution proposes amending the first guiding principle on the purpose of the NHS to explicitly include mental as well as physical health. The mid-term review, published in January 2013, includes improving the treatment and care of people with mental illness in its four key priorities for health and care.

This is the third annual report by the Care Quality Commission (CQC) on its monitoring of the use of the Mental Health Act 1983.

# 1,546

wards visited by CQC's  
MHA Commissioners

# 4,569

patients met in private

# 12,121

visits by CQC's Second  
Opinion Appointed Doctors

# involvement and the

## +5%

rise in number of detentions  
in 2011/12

## +10%

rise in number of community  
treatment orders

## 15%

of care plans not personalised  
or regularly reviewed

### What we found

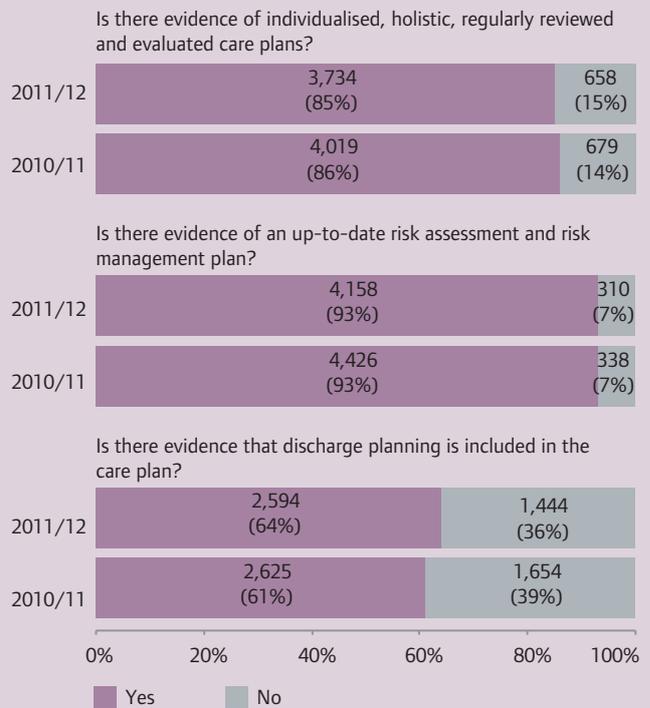
- **Some hospitals and wards are doing a very good job in treating patients with dignity and respect.** The report highlights good practice, for the first time naming the relevant providers in order that they may share good practice and learning.
- **CQC found some overall improvement but most of the concerns highlighted in previous reports remain,** particularly in respect of care planning, patient involvement and consent to treatment. For example, 37% of care plans checked by CQC showed no evidence of patients' views; there was no evidence that patients had been informed of their legal right to an Independent Mental Health Advocate (IMHA) in 21% of records reviewed; almost half (45%) of patient records reviewed still showed no evidence of consent to treatment discussions before the first administration of medication to a detained patient
- **There is a significant gap between the realities CQC is observing in practice and the ambitions of the national mental health policy – No Health without Mental Health.**
- **CQC is concerned that cultures may persist where control and containment are prioritised over the treatment and support of individuals.** In this kind of culture, 'blanket rules' can become institutionalised. On one in five visits, CQC expressed concern about the de facto detention of patients who were voluntary rather than compulsory patients.

# Participation and respect

## Key findings

- CQC’s MHA Commissioners visited many mental health wards where a great deal of respect was given to patients.
- Patients were able to influence the running of their ward in almost all cases – 94% of all wards in 2011/12, up from 90%.
- Patients were more involved in planning their own care: their views were recorded in 63% of care plans, a rise from 58%. But this means an unacceptably high proportion – more than a third – did not have their views written down.
- More than half of patients were still not given a copy of their care plan.
- Most patients (90%) were given general information about their rights when they were first detained.
- But one patient in five was not informed of their right to an Independent Mental Health Advocate (IMHA).
- This may reflect continuing difficulties that some services have in accessing IMHAs. There was no evidence of an IMHA service in one in seven of the wards CQC visited.

## Analysis of care plans, 2010/11 and 2011/12



Source: CQC

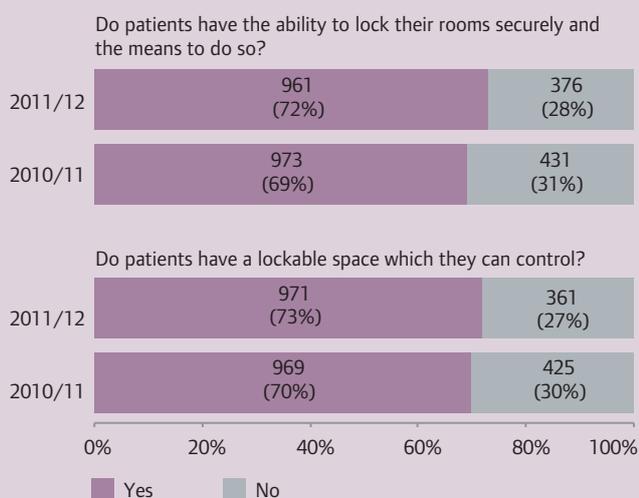
“ I don’t know much about care plans. I don’t have much experience of them ”

**Service user detained under section 3 (age 26, detained periodically from age 17)**

“Three patients were seen on the day, two whilst having lunch, and the third with her carers. They were all very confused. However, staff were observed to deal with patients’ confusion and agitation in a caring, calm and compassionate way, and the staff team are to be congratulated on their approach. The carers of patient 2 were also very positive about the care that their wife/mother was receiving and they were very pleased that she had settled well on the ward.”

February 2012

## Provision of lockable spaces for patients, 2010/11 and 2011/12



Source: CQC

BB During my section in 2011 my granddad was ill with cancer, we knew he didn’t have a lot of time left so I approached staff and asked if we could put a care plan in place for when he did pass away. I did this because I wanted to have my own views of how I wanted to be managed when the bad news came. My views and wishes were taken into account and together with my named nurse and social worker I made my own care plan of how I wanted to be managed and what support and care I thought would be necessary. A copy of the care plan was sent to all nurses on my ward so they could see it.

Unfortunately, the time did come and I was given the sad news that he had passed away but as my views and wishes had been taken into account I felt the whole situation was handled well and I was given the care and support I needed and had asked for.



**Service user detained under section 3**

# Coercion in practice

## Key findings

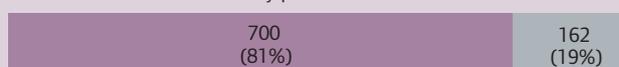
- The human rights of patients are often affected by controlling practices that only seem to serve the hospital's needs. Hospitals have a difficult task in balancing the realities of detention and compulsory treatment with the requirement that they provide services according to a principle of least restriction on patients. But it has proved all too easy for cultures to develop in which blanket rules deny people their basic rights – especially the right to dignity.
- In one in five visits – an unacceptably high number – MHA Commissioners thought that patients who were in hospital voluntarily might be detained in all but name. For example, in 88 out of 481 visits there were no signs on locked doors that explained to voluntary patients how they could leave the ward.
- On 24 occasions, patients had been secluded but the ward staff had not realised this was classed as seclusion and they had not applied the proper safeguards
- In many hospitals restraint practices are generally safe and appropriate. Almost all staff will now have some degree of training not only in physical methods of restraint, but in ways to prevent confrontational situations.
- However, CQC is still concerned at the lack of regulation of training programmes with regard to restraint. Safeguards could be improved.
- CQC is talking with the Department of Health about how to promote best practice around support for positive behaviour.

BB Now it's about more involvement – no decision about me without me – but when they make these blanket rules on the ward it undermines that. Like when you're not allowed to access your room during the day – some people like to relax and be in their own company and own space – they're grown men, they can't see why they can't go to their room whenever they want

### Service user detained under section 47/49

## Freedom of voluntary patients to leave the ward, 2011/12

Is there evidence that voluntary patients are free to leave the ward?



Are voluntary patients told of their right to leave the ward?



Yes No

Source: CQC

“All doors were operated by a swipe card held by staff. The main patient area has a quiet room; this was also controlled by swipe card and was locked on the morning of the visit. The patient toilet was also locked and the Commissioner observed a patient requesting to use the toilet and having to wait while the swipe card was activated.”

October 2011

# Care pathways

## Key findings

- CQC saw evidence that many Approved Mental Health Professionals are trying to find alternative care for people that avoids them having to be detained in hospital.
- Pressures on beds continued to put services and patients under stress, making it harder to provide appropriate care for people in times of crisis. In 2011/12, 93 wards (6% of all wards) visited had more patients than beds; a further 10% were at full capacity.
- Patients are being affected by reductions in staff numbers. For example, MHA Commissioners raised concerns in 77 visits that a lack of staff prevented patients taking escorted leave.
- In some services MHA Commissioners saw excellent examples of patients benefitting from psychological therapies. But in others, services were too ready to rely on psychiatric medication as their response to patients' distress.
- Patients are benefitting from good discharge planning in a number of units – with considerable investment in time and effort being spent in identifying step down accommodation and suitable support arrangements. But an unacceptably high proportion – more than a third of care plans – still showed no evidence of discharge planning.

 If you are going to restrict patients, care needs to be of a high quality and, to put it simply, the care component of detention leaves a lot to be desired. Everyone, not just in forensics, needs to have access to psychology – not simply added to a waiting list. Years ago I could have done with my emotional (not just medical) needs being met, but it was only when I entered the forensic unit that I had consistent psychological help. 

Service user on a forensic ward for women

**16%**  
of wards at or over  
full capacity

**77**  
ward visits where staffing  
availability affected patients'  
ability to take escorted leave

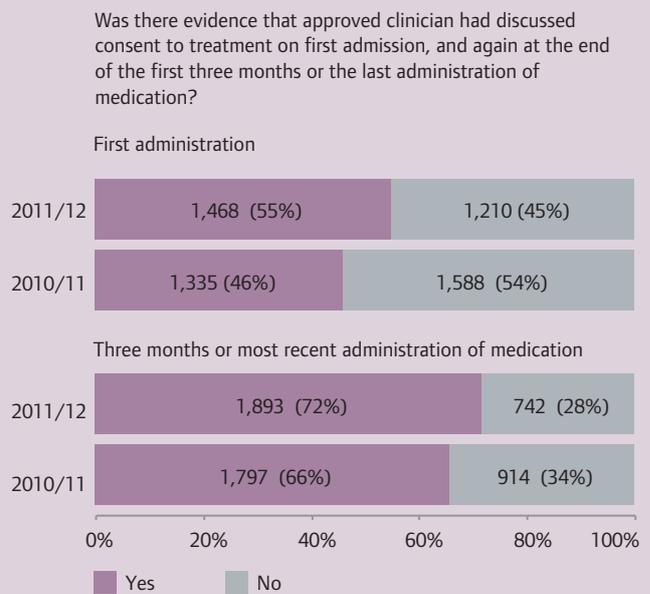
# Consent to treatment

## Key findings

- Consent to treatment discussions (before the first administration of medication) improved in 2011/12 – 55% of records showed these, up from 46% in 2010/11. But this means that in almost half of cases there was no evidence that doctors had talked to patients about whether they consented to proposed treatment.
- There was better evidence of consent discussions after the first use of medication (72% of records). But still this means consent was not discussed in more than a quarter of cases.
- One patient in 10 (receiving medication for three months or more) was prescribed medication above the legally authorised care plan.
- In CQC’s view, the assumption of a patient’s capacity to consent to or refuse treatment should be backed up by a written record. More than a third of records did not show any evidence of a capacity assessment (42% on admission; 36% at the end of three months or the last administration of medication).

- Patients may be reluctant to say what they think about their treatment in public, particularly in a traditional ward round. CQC saw some good services that have developed private arrangements instead of ward rounds.

## Consent to treatment, 2010/11 and 2011/12



Source: CQC

“ For every medication there is a side effect. I’d love to see side effects taken more seriously than they are at the moment. It’s like, as long as your mental state is good that’s all that matters. ”

Service user detained under section 47/49

# Community treatment orders

## Key findings

- CTOs are used widely by some providers, and used little by others. In an analysis of NHS organisations, the lowest reported 'discharge rate' onto a CTO was 4.0%; the highest was 45.5%.
- There were also a number of NHS organisations – with considerable rates of detention under the Act – that provided nil returns for the use of CTOs.
- A number of patients are worried that it isn't clear when a CTO will have served its purpose – and therefore they do not know what they have to do to come off a CTO.

"It was unclear how and when responsibility was transferred from the inpatient responsible clinician to the community responsible clinician. There seemed to be no clearly identified process for transferring responsible clinician duties from one doctor to another. Without a proper protocol in place for a handover to a community responsible clinician, delays can occur when an inpatient doctor disagrees with a community doctor about the CTO conditions or treatment regime."

 I just want to know how to get off a CTO – mine's just been renewed again – they say it's working. I made the biggest mistake of my life – I said to my doctor that the CTO saved my life. The worst thing I ever said, but I meant it at the time – for a period of time it actually did. But now I wish I could take that back, now how the hell do I get off it? 

**Service user subject to a CTO**

# 15%

of people on CTOs from the Black or Black British group, compared with 9.7% of inpatients

# Conclusions of the report

The priority given to mental health by the Government will be helpful in raising the profile of these issues and bringing a new impetus to the development of services in ways that reflect the vision of No Health without Mental Health.

The implementation framework for the national policy gives clear guidance to commissioners and providers of services on the actions that will support the expression of this vision in practice. NICE guidelines give further advice in relation to the treatment of specific conditions as well as the involvement of service users in their care and treatment.

The policy context, with supporting evidence base, expects that people will recover from mental ill health and that people will be involved in decisions about their treatment. This holds true for detained patients as much as it does for others. Where an individual's mental health problems persist, reasonable adjustments will be made in all relevant settings, under the requirements of equalities legislation, to ensure that people are supported to live as full and socially participative lives as possible.

Many of the findings and messages in this report are familiar from previous years. It is with great regret that CQC notes that there are themes that recur year on year and paint a picture of practice in some areas of mental health provision that is a far cry from the policy vision. Yet, it is clear from the excellent practice that CQC observes in some providers, that the policy vision is not an unrealistic one. These examples of excellent practice are important in highlighting what can be done and what organisations who fail to provide good care could do.

CQC therefore intends to strengthen the priority it gives to the regulation and monitoring of mental health services in the coming year. Mental health services must address the practice implications of parity and the recovery ethos enshrined in national policy. In particular CQC

expects to see change in the following areas of recurring concern in the care and treatment of people subject to the Act:

- 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 can not 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).

## Recommendations

- 1. Policy makers** must consider the reasons why there are rising numbers of people subject to the Act and develop an appropriate policy response.
- 2. The Boards of mental health trusts, independent providers of mental health care, and community trusts** are responsible and accountable for the quality of care people receive. They must drive the changes needed in their organisations. In particular they need to recognise and promote good practice and ensure that robust mechanisms are in place to understand individuals' experience of their services. CQC reminds providers of their own duties to monitor how they use powers derived from the Act (see the Code of Practice) and their duties under the Health and Social Care Act 2008 to demonstrate how they have learned lessons from practice and have made consequent improvements. This is an area that CQC will focus on in the next 12 months in its regulatory activity.
- 3. The NHS Commissioning Board, local authorities, clinical commissioning groups and specialist commissioners** must commission services that guarantee a person's dignity, recovery and participation. Clinical commissioning groups and local authorities must ensure that local needs assessments for community services and commissioned models of care are informed by an understanding of their statutory duties under the Act and by the experiences of people who use services.

## What CQC will do next

In line with its proposed strategic direction over the next three years, CQC's intention is to strengthen how it meets its responsibilities on mental health and mental capacity. Key to this will be making more use of CQC's unique sources of information, alongside better analysis of national data sets and strengthening how it works with its strategic partners. Consultation with the public and stakeholders has indicated strong support for this intention and for CQC establishing itself as an effective regulator of the care and treatment of people with mental health problems.

CQC will:

1. Increase the involvement of people who use services in Mental Health Act monitoring work, to inform CQC's understanding of service quality and of risks to the rights of vulnerable individuals.
2. Work with Healthwatch England to develop CQC's understanding of the experiences of people who use health services while subject to the powers of the Act.
3. Focus specifically on the areas of required improvement highlighted in this report. CQC will hold providers to account for positively improving in these areas through the different regulatory approaches at its disposal.
4. Continue to give a focus to good practice in order to promote improvement across the sector.

## How to contact us

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